A STUDY OF THE CONNECTION BETWEEN INSECURE ATTACHMENT AND LOW SEXUAL DESIRE IN FEMALES

A Doctoral Project

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By

Dianna Troutt

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APPROVAL

We, the undersigned, certify we have read this Doctoral Project and approve it as adequate in scope and quality for the degree of Doctor of Psychology.

Learner: Dianna Troutt

Title of Doctoral Project: A study of the connection between insecure attachment and low sexual desire in females

Doctoral Project Committee:

Project Chair: Patrick McKiernan, Ph.D.	Date
Committee Member: Kathleen Andrews, Ph.D.	Date
Committee Member: Linda Salvucci, Ph.D.	Date
Dean, School Behavioral Sciences: Barbara Grimes, Ph.D.	Date

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DOCTORAL PROJECT ABSTRACT

Title: A study of the connection between insecure attachment and low sexual desire in females

Author: Dianna Troutt

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Scope of Study: The present study is an investigation of the connection between insecure attachment and female low sexual desire. Because low sexual desire is prevalent in over 50 percent of couples who enter relationship therapy, more targeted interventions need to be identified to effectively treat this common distressing dysfunction. Previously, low sexual has been more associated with emotional insecurity than organic causes. However, clinicians need a more thorough understanding of the specific impact of attachment distress on the etiology and maintenance of inadequate desire. An extensive literature review examined the individual and relational factors that contribute to female hypoactive sexual desire from a non-attachment and an attachment perspective. The behavioral patterns associated with secure, anxious, and avoidant attachment styles were examined to find associations with female low sexual desire.

Findings and Conclusions: Findings indicate that attachment insecurity triggers problematic behaviors that significantly reduce female responsive desire, the primary desire activated in long-term romantic relationships. Securely attached women were found to have sufficient emotional reciprocity needed for responsive desire. However, when distressed, the insecurely attached use behaviors that significantly interfere with

the female sexual response system. Anxiously attached females use angry demands for reassurance, and avoidant females deactivate feelings of closeness to preserve psychological independence. By aiming interventions to increase attachment security, clinicians can use superior approaches so that desire levels improve. Emotionally Focused Therapy is one such attachment-focused treatment. Additional research is needed to substantiate the finding that increasing attachment security is necessary to treat relationally-based low sexual desire.

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Chapter One: Introduction

Introduction to the Problem

Sexual urges can be felt for a non-emotionally significant person, as in a one-night stand (Birnbaum, 2015). However, when a woman is in a relationship, female sexual desire is not just an individual physiological response that occurs separate from the interpersonal interactions with a partner (Birnbaum, 2015; McCabe & Goldhammer, 2012). Consequently, desire levels cannot be appropriately understood without also taking into account the contextual, relational factors involved in a woman's response (Birnbaum, 2015). Because romantic partners are usually attracted to and emotionally attached to one another, those who predominantly consider low sexual desire an individually-based problem omit a critical antecedent for the sexual dysfunction (Johnson & Zuccarini, 2010, 2011). When prevalent, emotional safety and security can be crucial elements in the relationship that enhance sexual desire, or these elements can impede desire when they are less frequent (Johnson & Zuccarini, 2010, 2011).

The presence or lack of relational safety and security often are rooted in each partner's attachment style, according to attachment theory (Bowlby, 1969, 1988). Attachment styles include secure and insecure, such as anxious and avoidant (Bowlby, 1969, 1988). In this study, each attachment style was explored concerning its relationship to sexual desire. In particular, both insecure attachment styles were examined extensively to understand their roles in etiology and maintenance of low sexual desire in females. Significant individual and relational antecedents for low sexual desire that are non-attachment-based and their correlations with attachment-related

factors, when pertinent, will also be reported in this study to discuss the topic comprehensively.

Low sexual desire in women is an important area of study because of the amount of emotional pain that this sexual problem causes when partners feel undesirable (Crooks & Baur, 2011). Low sexual desire also has a significant impact on relationship dissatisfaction (Péloquin, Brassard, Lafontaine, & Shaver, 2014). Insufficient desire is a prevalent complaint brought to sex and marriage therapists, and 60% of couples coming to therapy report significant relational and sexual distress (Crooks & Baur, 2011; Péloquin, Brassard, et al., 2014). Sexual distress may compound problems in relationships because couples who have frequent sex can overcome relational problems more effectively than those who do not (Little, McNulty, & Russell, 2010). Additionally, couples that have greater relationship satisfaction have more frequent sex than couples who feel dissatisfied in their relationship (Little et al., 2010; Mark, 2012).

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It is essential for mental health professionals to understand the etiology and factors involved in low sexual desire in females in order to treat desire problems effectively. However, effective treatments have eluded therapists, as low desire is surprisingly complex and resistant to improvement (Brotto & Luria, 2014). Low sexual desire has previously been thought of as primarily a problem of hormonal imbalance, fatigue, over-familiarity, or a lack of novelty in the sexual encounters rather than being related to a person's difficulties with emotional intimacy rooted in his or her attachment style (Brotto & Luria, 2014; Kaplan, 1995; Perel, 2007).

Much has been written about the role of individual factors that contribute to low sexual desire. Rather than relational factors, it is often easier to identify individual

factors contributing to low sexual desire such as hormonal imbalance, medication side-effects, fatigue, low self-esteem, anxiety, depression, prior child abuse, and cultural beliefs (Brotto & Luria, 2014). For example, depressed women between the ages of 40 and 80 are twice as likely to have a loss of sexual desire (Brotto & Luria, 2014). Prior sexual abuse can result in associating guilt or shame with sexual situations (Brotto & Luria, 2014). Sociocultural factors that contribute to a lack of desire can include religious teachings that are antithetical to sexual pleasure, being raised with a belief of unattractiveness, or being taught that one is undeserving of sexual attention (Brotto & Luria, 2014).

Both relational and sexual functioning are dynamic processes and create their own feedback loops (Dewitte, 2014; Little et al., 2010). These feedback loops may either enhance or weaken couples' attachment and/or sexual bonds, depending on strategies and signals that partners send to one another. Included in these feedback loops are the couples' habitual styles of relating to one another both in and out of the sexual arena (Dewitte, 2014; Little et al., 2010).

Couples who primarily use negative feedback strategies may do so because of their insecure attachment styles. Couples may use avoidance or hypervigilance to control communication, emotional level, or proximity, thereby possibly weakening the bond of trust and emotional safety (Dewitte, 2014). Sexually and non-sexually, these couples tend to be less happy than couples who use more positive strategies such as connection and reassurance (Dewitte, 2014; Little et al., 2010). As a result, overall dissatisfaction in the relationship appears to correlate with lower sexual functioning (Dewitte, 2014; Little et al., 2010).

Statement of the Problem

Hypoactive sexual desire disorder (HSDD) is one of the most prevalent problems that couples present within both sex therapy and couples therapy. In non-clinical populations, 33% of females are affected by low or absent sexual desire (Weeks, Hertlein, & Gambescia, 2009). Significantly more clinically distressed couples seeking treatment report the presence of inadequate sexual desire. Weeks, Hertlein, and Gambescia (2009) stated that over 50% of couples complain about low sexual desire, and more than 60% of clinical couples report both significant relational and sexual distress (Péloquin, Brassard et al., 2014). Importantly, these authors indicated that clinicians have an obligation to realize the impact of relationship distress on sexual distress as well as the impact of sexual distress on relationship distress. Although couples may come to therapy for other reasons, treating therapists need to inquire about the impact of those problems on their sexual functioning, as they are likely intertwined (Johnson & Zuccarini, 2010, 2011).

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Few empirical studies were found that distinguish the individual versus relational factors that impact sexual desire (Brassard, Péloquin, Dupuy, Wright, & Shaver, 2012). Some researchers have reported that relational aspects such as safety and security are critical when addressing sexual problems and that those can outweigh individual contributions, but the scant number of studies on this matter is problematic (Brassard et al., 2012; Johnson & Zuccarini, 2010). Therefore, this significant gap in the literature needs to be addressed. Couples come into treatment because they expect that the therapist will have an empirical understanding of how to address their presenting problem. By examining the role of insecure attachment in low sexual desire, it is hoped

that a better understanding will be achieved regarding the important factors that are necessary to treat in order to improve sexual desire. By bridging this gap in the psychological literature, treatment plans designed for such individuals or couples facing the problem of low sexual desire can be more successful than current approaches (Brassard et al., 2012).

Background of the Problem

Grant (1951) presented his view of the importance of attachment style during the sexual act. He noted that much had been written about the physical process and practices involved in sex, including a variety of sexual behaviors and deviations. However, this author stated that, strangely, little had been written about emotional experiences during sex. He wondered if sentiment was purposefully excluded in the literature in order to appear scientific. Sex had also previously been characterized as a more fundamental animalistic desire to relieve erotic tension of the sex organs rather than as an attempt to create an emotional connection.

He further stated that the above explanations fail to capture experiences such as "romantic love" or the "genuine emotional state" of erotic affection toward a preferred partner over time (Grant, 1951, p. 188). Grant (1951) recognized that when couples are in a relationship, one partner is selected among many for the expression of amorous affection and sex is typically solely with that person, and other researchers have noted that premise as well (Dewitte, 2012). Consequently, those couples may form a strong romantic attachment that links attachment and sex (Dewitte, 2012; Grant, 1951). Dewitte (2012) added to Grant's work by noting that couples that are exclusive romantic partners then expect more from sex partners without that level of commitment, so

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attachment needs get activated to a greater degree in committed relationships. However, Grant (1951) did not address attachment problems or non-committed sexual relationships except to say that weak amorous feelings lead to unstable attachments and subsequent fickle behaviors.

Attachment theory originated as a branch of object relations theory (Bowlby, 1988; Mikulincer & Shaver, 2007). Attachment theory recognizes the importance of a child having a dependable, emotionally responsive caregiver in order to develop confidence that his needs will be met. This ongoing sense of confidence is called a secure attachment (Bowlby, 1988; Mikulincer & Shaver, 2007). A secure attachment is important because attachment security is a predictor of healthy emotional functioning later in life while an insecure attachment can predispose individuals to relational struggles later in life (Bowlby, 1988; Mikulincer & Shaver, 2007).

The originators of attachment theory are John Bowlby and Mary Ainsworth. After World War II, Bowlby developed a great interest in the effects of maternal deprivation on children (Goldman & Greenberg, 2013). He later noticed that the same emotional needs of children were present in adults (Goldman & Greenberg, 2013). In the 1950s, Ainsworth started to confirm the universality of attachment behaviors with mothers and children in both Africa and the United States (Bowlby, 1988; Brassard, Lussier, & Shaver, 2009). Attachment theory has been studied extensively and is regarded as one of the most researched socioemotional theories available (Johnson & Zuccarini, 2010; Mikulincer & Shaver, 2007).

Bowlby (1969) stated that attachment is a universal need, and that significant attachment figures are special persons that the individual can turn to in times of distress

when protection and support are needed. He also indicated that attachments form and strengthen when the child becomes confident that the attachment figure (usually the mother) will be available when needed (Bowlby, 1969, 1988). Conversely, the real or emotional separation from a significant attachment figure causes distress and results in attachment behaviors designed to regulate the separation anxiety (Bowlby, 1969, 1988; Goldman & Greenberg, 2013).

Emotionally available attachment figures serve as a secure base (Bowlby, 1969, 1988; Goldman & Greenberg, 2013). A secure base then provides emotional regulation and recovery for the person feeling threatened and seeking support. Positive experiences with attachment figures over infancy, childhood, and adolescence consequently reduce fears and create confidence that significant needs will be met (Bowlby, 1988; Goldman & Greenberg, 2013). Bowlby noted that either positive or negative experiences with attachment figures form expectations about future interactions with other significant persons, including romantic partners (Bowlby, 1988; Goldman & Greenberg, 2013). Consequently, he formulated that attachment needs are a lifelong process that does not end with childhood (Bowlby, 1969, 1988).

According to attachment theory, attachment needs regularly affect intimate relational interactions, and those relational interactions include sexual encounters with a romantic partner (Dewitte, 2012; Péloquin, Brassard, et al., 2014). Additionally, any relational distress will heighten those attachment needs and, therefore, relational factors should be considered when treating sexual dysfunction (Péloquin, Brassard, et al., 2014). For example, Masters and Johnson's (1970) work on sexual inadequacy emphasized the importance of treating sexual dysfunction in the context of the

relationship. The authors stated that the idea of an uninvolved partner is a myth when any sexual dysfunction is present. They indicated that successful resolution of sexual problems requires the participation of a supportive, cooperative partner, as low sexual desire is not something solved by behavioral or medical interventions alone (Masters & Johnson, 1970; McCarthy & Wald, 2012).

Masters and Johnson's belief that sexual dysfunction could not be treated effectively outside the context of the relationship countered the prevailing treatment strategies of sex therapists (Masters & Johnson, 1970). In the years to follow Masters and Johnson's work, the sex therapy clinicians have typically used an atheoretical diagnosis-focused methodology and have ignored Masters and Johnson's recommendations to consider relationship factors as crucial (Johnson & Zuccarini, 2010). Instead, most sex and couples therapists have been taught that sexual problems are best thought of as individual problems (Johnson & Zuccarini, 2010). Consequently, sexual problems have been treated with mechanistic, behaviorally-focused interventions or by medical treatments (Johnson & Zuccarini, 2010).

Relational factors were first studied as an important component of low sexual desire by Talmadge and Talmadge (1986). They wrote primarily about how to understand and treat low sexual desire in married couples that were not physiological in origin. In their article, these authors stated that too little attention had been paid to the marital system, particularly the nature of the emotional relatedness of the couple experiencing such sexual difficulties. They referred to the nature of the couple's emotional connection during sexual intimacy as relational sexuality (Talmadge & Talmadge, 1986).

The authors stated that any treatments for low sexual desire that are designed without taking into account the role of conflict or other relational factors are incomplete and shortsighted (Talmadge & Talmadge, 1986). They also stated that low success rates of sex therapy techniques exist because they do not address the emotional aspects of the relationship or the persons involved. They asserted that sexual functioning was greatly affected by fears, vulnerability, and intimacy problems (Talmadge & Talmadge, 1986). Consequently, these intrapsychic problems interact with and further create interpersonal problems and resulting mistrust in the relationship (Talmadge & Talmadge, 1986). Instead, couples need to better manage power, affection, intimacy, and communication in a way that nurtures each partner and the relationship. They recommended treating low sexual desire using a combination of systems and gestalt approaches, as marriages that are more emotionally intense, connected, and nurturing result in a more passionate sexual relationship (Talmadge & Talmadge, 1986).

Romantic love was first addressed specifically as an attachment process by Hazan and Shaver (1987). These authors explored romantic love as an extension of Bowlby's work on attachment, separation, and loss. They studied how different attachment styles perceive romantic love differently. Secure lovers tended to believe that romantic feelings wax and wane over time, but their love often remained strong and reliable (Hazan & Shaver, 1987). Avoidant lovers are fearful of intimacy, and anxious lovers tend to be obsessive and desire their love to be returned to a greater degree than they receive. However, this study focused more on participants' ideas of love than measuring their sexual desire level (Hazan & Shaver, 1987).

In the 1980s, some researchers began to realize the complex biological, psychological, and interpersonal aspects of low sexual desire. Intrapsychic conflict was seen as a barrier to desire (Rosen & Leiblum, 1987). Additionally, low sexual desire was being put into a relational context, so others postulated that lack of desire existed due to a lack of environmental stimuli for arousal (Rosen & Leiblum, 1987). Researchers realized that external factors, including partner stimulus, contributed a greater role than simply libido (Rosen & Leiblum, 1987). Interpersonal issues were also beginning to be recognized as contributors to low sexual desire. Power/control struggles, hostility, mistrust, and rejection contributed a large role in sexual apathy, and researchers advised clinicians to use a systemic approach to assessment and treatment of desire problems (Brotto & Luria, 2014; Rosen & Leiblum, 1987; Weeks et al., 2009).

Some researchers considered the reaction of the spouse to low sexual desire and how partner responses may have maintained desire problems (MacPhee, Johnson, & Van der Veer, 1995). Often, the reaction of the asymptomatic spouse is to feel rejected and threatened by his or her partner's lack of sexual pursuit (MacPhee et al., 1995). Consequently, the rejected partner may seek sexual reassurance by pressuring the other partner to participate in unwanted sexual encounters (MacPhee et al., 1995). However, this pressure only creates a greater reluctance in the low desire spouse, setting up a demand-withdrawal cycle characteristic of insecurely attached partners (MacPhee et al., 1995).

Frühauf, Gerger, Schmidt, Munder, and Barth (2013) wrote that MacPhee et al. (1995) conducted the first controlled study on the effect of marital therapy on what was then called inhibited sexual desire (ISD). In that study, couples received 10 sessions of

emotionally focused therapy (EFT) that concentrated on enhancing the expression of emotion in more constructive ways to increase attachment. While the treatment group did experience an increase in desire, these couples did not significantly improve in sexual functioning (Frühauf et al., 2013). Frühauf et al. (2013) posited that, while 10 sessions may have been enough to reduce conflict in non-sexually distressed couples, 10 sessions may not have been enough to reduce or resolve the complex conflict dynamics when sexual distress is involved.

Some studies have looked at the connection between insecure attachment and sexual distress or lower sexual motivation (Birnbaum, Mikulincer, & Austerlitz, 2013), but few have been found that actually pinpoint the connection between the lower quality of attachment and the degree of low sexual desire. Johnson and Zuccarini (2010) reported that the success of commonly prescribed techniques such as sensate focuses or other sexual stimulation techniques greatly depend on a couple's communication ratings prior to participation. The same authors reported that confusion exists over which relationship factors actually make a difference in treating sexual dysfunction (Johnson & Zuccarini, 2010). This confusion causes the treatment of sexual problems to still be more behaviorally- or diagnosis-focused (Johnson & Zuccarini, 2010).

Gentzler and Kerns (2004) and Johnson and Zuccarini (2010) stated that extant research indicates there may be a stronger relationship between secure attachment and more satisfying sexual experiences than previously thought. Other authors have found that romantic attachment insecurity predicts sexual dissatisfaction in couples seeking marital therapy (Brassard et al., 2012). Their findings support the need to include further

attachment dimensions when treating sexual problems in couples counseling (Brassard et al., 2012).

Purpose of the Study

The purpose of this study was to examine the possible role of insecure attachment in the creation and maintenance of low sexual desire in women. The individual antecedents for low sexual desire in females are reported first. Non-attachment individual factors were first examined and then the attachment-related individual factors related to inadequate desire were explored. Next, relational antecedents for female low sexual desire were then explored by examining the non-attachment relational factors and then the attachment-related relational factors. If insecure attachment does play a role in the etiology and sustenance of low sexual desire, an additional purpose of this study was to determine the treatment implications of that association.

Significance of the Study

This study is significant as the project bridges a gap in the psychological literature and helps to further understand the role of insecure attachment in the etiology and/or maintenance of low sexual desire. Although emotionally focused therapy, a treatment modality based on attachment theory, has been empirically validated as an effective treatment for distressed couples (Johnson & Zuccarini, 2010), little investigation has been found that focused on the treatment of sexual dysfunction or, more specifically, low sexual desire. Consequently, this study benefits future researchers who want to understand the relational attachment aspects involved in the psychology of low sexual desire.

This study is also significant to clinicians who are treating couples with both relational and sexual difficulties. This study focuses on identifying relevant or superior treatment strategies so that these problematic factors can be improved or resolved in shorter treatment timeframes.

Theoretical Framework

This paper explores the connection between insecure attachment and low sexual desire within the theoretical framework of attachment theory. Attachment theory explores the theoretical underpinnings of the significant ongoing interactions between significant attachment figures (Mikulincer & Shaver, 2007). This theory gives a comprehensive understanding of how those interactions co-create and regulate subsequent feelings, thoughts, and behaviors that become triggers for future interactions. According to Johnson and Zuccarini (2010), attachment theory also offers the most coherent and empirically validated theory of adult love relationships. Consequently, attachment theory offers guidance to couples therapists, who often also need to address sexual issues with couples in a clinical setting (Brassard et al., 2012).

Research Questions

Primary research questions are centered on the connection between insecure attachment and low sexual desire:

- What are general, non-attachment-based individual antecedents of female low sexual desire?
- What are attachment-based individual antecedents of female low sexual desire?
- What are general, non-attachment-based relationship factors that are antecedents of female low sexual desire?

- What are attachment-based relationship factors that are antecedents of female low sexual desire?

Based on the premise that a relationship between insecure attachment and low sexual desire in females is present, what treatment implications exist for couples?

Importance of the Study

This study can help clinicians understand the essential roots of low sexual desire so that therapeutic benefits are more attainable. If low sexual desire is more related to female insecure attachment than a separate sexual behavioral problem, interventions to address the underlying relational issues and attachment distress become more necessary to increase sexual desire successfully. As researchers recognize and determine the roots of low sexual desire, more effective treatment methods can be designed so that couples can create healthier interaction patterns both in and out of the bedroom. Because a person's level of sexual desire is predictive of overall life happiness, couples experiencing sexual distress may be the beneficiaries of the therapists' increasing competence (Johnson & Zuccarini, 2010; Péloquin et al., 2014).

Scope of the Study

The scope of this study included a comprehensive literature review of scholarly peer-reviewed articles, as well as a few scholarly books on sexuality and/or attachment theory. The global literature search did not include popular magazines written on the subject. The majority of the articles reviewed in this study were published in the last seven years. However, this study also includes significant resources that are older than that. Articles that answer the research questions more directly are included in this paper as well as those that do not. In addition, the history and evolution of understanding of this

topic will be included. The scope of this study is to understand the phenomenon of low sexual desire within the context of primarily opposite sex couples in long-term relationships where medical or hormonal problems are not the primary etiology.

Definition of Terms

- *Anxious avoidant attachment*—Having little confidence that an attachment figure will respond when needed and instead expecting to be rejected, people with this style use deactivating strategies by denying proximity or attachment needs, including avoiding closeness or vulnerability. Anxious avoidant people often attempt to live life being self-sufficient; this is often referred to as avoidant attachment (Mikulincer & Shaver, 2012).
- *Anxious resistant attachment*—Worries that attachment figures will not be available or responsive in times of need, people with this style tend to use hyperactivating strategies to get proximity and support, feel mistrusting, and get angry when those needs are not met (Mikulincer & Shaver, 2012).
- *Attachment behavior*—Actions aroused by the security level of the attachment to gain proximity to an attachment figure for purposes of easing emotional dysregulation (Mikulincer & Shaver, 2012).
- *Attachment Bond*—A strong emotional tie that bonds one person intimately with a preferred person (Stefanou & McCabe, 2012).
- *Attachment needs*—Needs for the attachment figure that are activated by threats or distress include bids for proximity and support (Mikulincer & Shaver, 2012).
- *Attachment theory*—An attempt to explain attachment behavior, including how early interactions with significant others form expectations and beliefs that shape feelings,

thoughts, and behaviors that shape interactions with others, including romantic partners in adulthood (Stefanou & McCabe, 2012).

- *Insecure attachment*—The unresponsiveness and inaccessibility of the attachment figures fail to ease distress, so a felt sense of security is undermined. Negative representations of self and others are formed, increasing the chances of later emotional problems because of the inability to accurately interpret relational cues (Mikulincer & Shaver, 2012; Pietromonaco & Beck, 2015).
- *Insecure attachment styles*—Two styles (i.e., anxious resistant attachment and anxious avoidant attachment) develop from chronic parental inattentiveness and failures, and these styles become reflexive ways of dealing with threats and distress as life-long predispositions (Mikulincer & Shaver, 2012).
- *Low sexual desire*—A lack of interest in sexual activity that creates personal or relational distress (Brotto & Luria, 2014).
- *Secure attachment*—Pervasive feelings of safety produced by the availability and responsiveness of the attachment figure(s). Security that the attachment figure will return and respond leads to the formation of positive mental representations of self and others (Mikulincer & Shaver, 2012).
- *Secure base*—An attachment figure that will respond when called during times of need in order to comfort distress (Mikulincer & Shaver, 2012).*Sexual desire*—A combination of biological drive, psychological motivation, and erotic thoughts resulting in urges to behave sexually (Brotto & Luria, 2014).

Summary and Organization of Remaining Chapters

Chapter Two covers a comprehensive review of the related literature on reasons for low sexual desire, attachment theory in the context of adult relationships, and their possible connection and integration. Chapter Three covers the research design and methodology. This will include meta-analysis of the findings, assumptions, and limitations of the study. Chapter Four focuses on the results. These results are subdivided into an introduction, results, analysis of the findings, and a summary. Finally, Chapter Five focuses on the summary, conclusions, and recommendations. The conclusion in this chapter focuses on what can be inferred from the study's current findings in response to the research questions, the problem statement, and the impact on the field as defined in Chapter One. Directions for further research are included in this discussion.

Chapter Two: Literature Review

Introduction

The purpose of this study is to examine the relationship between insecure attachment and low sexual desire in females. This is an important area of study because of the reciprocal relationship between sexual distress and relational distress. Low sexual desire is present in 50-60% of couples seeking treatment and is highly correlated with overall perceptions of relational unhappiness (Brassard, Dupuy, Bergeron, & Shaver, 2015). Couples who have relational distress also have been found to experience significant sexual distress (Johnson & Zuccarini, 2010). Research also shows that 50-60% of unhappy mates attribute their distress to sexual difficulties (Johnson & Zuccarini, 2010), while happier couples can experience periodic drops in sexual desire without experiencing the same level of distress (Stephenson & Meston, 2015). Sexual distress leads to serious tension and relational conflict that widens the emotional distance between the couple, causing more emotional pain (Honarparvaran, Tabrizy, Navabinejad, & Shafiabady, 2010).

It is necessary for clinicians to help sexually distressed couples because sexual satisfaction predicts relationship satisfaction and perceptions of well-being (Stephenson & Meston, 2015; Yoo, Bartle-Haring, Day, & Gangamma, 2014). For example, sexual well-being outweighed other factors as a contributor to happiness more than socializing, eating, and praying (Stephenson & Meston, 2015).

Although sexual desire is an important area of study, McCabe and Goldhammer (2013) maintained that confusion still exists among practitioners about its definition, its origin, and how lack of desire is best treated. Low sexual desire is a difficult problem to

treat given its complex biopsychosocial nature, as low sexual desire is resistant to improvement (Brotto & Luria, 2014). Consequently, the improvement of sexual desire remains one of the most vexing problems confronting therapists (Dürr, 2009). This project intends to fill that gap by examining and reporting results from the current literature through the lens of attachment theory.

Individually based, non-attachment antecedents to low sexual desire were initially explored. Then, the effects of insecure attachment on individual antecedents to low sexual desire among women were reported. Non-attachment relational factors' antecedents for inadequate desire were examined next, and then the role of attachment on relational factors that lead to low sexual desire among women was considered, as reported in the current literature. Additionally, this study examined treatment implications for couples in sexual distress due to low sexual desire. As a result, therapists may implement more relevant and effective interventions. Last, this study makes recommendations for further research regarding the association between insecure attachment and low sexual desire in females.

The beneficiaries of this study are the large number of couples seeking relationship counseling as well as the professional therapists they are seeing. These professionals will be able to better assess relevant factors and target treatment methods to existing presenting sexual problems unrelated to organic causes (Hertlein & Weeks, 2009; Johnson & Zuccarini, 2010).

Individual Non-attachment Antecedents of Female Low Sexual Desire

Individual factors affecting low sexual desire can include hormonal imbalance, menopause, stress, fatigue, or illness (Dürr, 2009; McCarthy & McCarthy, 2014; Weeks

et al., 2009). Other individual factors that affect sexual desire include values, attitudes about sex, self-esteem, anxiety, depression, anger, and psychological resilience (Dürr, 2009; Weeks et al., 2009). Weeks et al. (2009) found that low self-esteem, apprehension, and worry interfere with sexual pleasure, and anxiety inhibits sexual excitation in women (Dèttore, Pucciarelli, & Santarnecchi, 2013). Brotto and Luria (2014) stated that depressed women between the ages of 40 and 80 are twice as likely to have a loss of sexual desire. In addition, childhood physical or sexual traumas can replace pleasurable sensations with shame, fear, and anxiety (Brotto & Luria, 2014; Weeks et al., 2009). Women with a history of childhood sexual abuse showed higher levels of sexual distress, including low sexual desire, especially when abused by a family member (Stephenson, Hughan, & Meston, 2013).

Intergenerational factors such as religious beliefs, values, family, and cultural expectations around sexual experiences also affect an individual's sexual desire levels (Brotto & Luria, 2014; Weeks et al., 2009; Woo, Brotto, & Gorzalka, 2011) For example, a repressive family environment or some forms of religiosity can restrict the development of healthy sexuality, introducing guilt and shame instead of acceptance and enjoyment (Brotto & Luria, 2014; Weeks et al., 2009). Woo et al. (2011) found that Caucasian women reported significantly higher sexual desire and reported significantly less sex-guilt than did East Asian female university students.

According to Brotto and Luria (2014), low sexual desire is the most common reason why women seek sex therapy. Therefore, it is imperative that practitioners have an understanding of its etiology and maintenance. Affected women also have a reduced capacity for sexual arousal, which can lead to relational difficulties and feelings of

rejection by a partner (Brotto & Luria, 2014). Conversely, couples who have frequent day-to-day desire experience higher self-perceptions of their sexual encounters (Brotto & Luria, 2014). While occasional drops in desire levels are normal and do not have such a large impact on feelings of sexual fulfillment, couples who consistently experience a lack of desire notice a more drastic negative impact on the future quality of sexual motivation and overall sexual satisfaction (Herbenick, Mullinax, & Mark, 2014; Mark, 2014). The antecedents for low sexual desire need to be better understood, including how individual versus relational factors play a role in its etiology and maintenance (McCarthy & Wald, 2012).

According to Nobre (2009), low sexual desire is the most common sexual difficulty for women. Findings show that even in satisfying, loving, long-term relationships, spontaneous sexual desire diminishes over time. Therefore, the problem is not always originally rooted in relationship difficulties but instead can become a source of rejection and emotional pain if partners do not maintain positive cues for physical intimacy (Dürr, 2009).

Sexual desire previously was considered an instinctual, spontaneous, and adamant drive that seeks periodic relief. However, female sexuality is now regarded as a dynamic process that is activated by individual, environmental, or relational stimuli (Dewitte, 2014). Sexual desire arises from interactions between the sexual response system and stimuli that begin to activate that system, producing sexual interest and arousal. The stimuli can be real or imagined, which then triggers sexual motivation (used synonymously for desire in the literature; Dewitte, 2014). However, the stimulus only becomes effective in the context of a system that allows for sexual responsiveness.

These complex processes then cause emotions, motivations, and behaviors that lead to sexual experiences (Dewitte, 2014; Toates, 2009).

As sexual stimuli evoke positive affect and expectations, the experience is appraised as rewarding by the individual (Dewitte, 2014; Pfaus, 2009). These favorable perceptions cause motivation to continue in the interaction (Dewitte, 2014; Pfaus, 2009). Such positive experiences then cause a subjective sense of sexual arousal, which then reciprocally creates expectancy that is more positive and greater feelings of desire. Ongoing pleasurable sexual responses and sensations then activate the motivation to enter into sexual activity (Dewitte, 2014; Pfaus, 2009).

However, negative appraisals or emotions can also decrease feelings of desire or arousal, shutting down the individual's sexual response system (Dewitte, 2014; Pfaus, 2009). If too many of these negative experiences occur, ongoing sexual dysfunction can emerge. When individuals ignore or pay little attention to sexual stimulation or if they experience sexual interactions as being undesirable due to physical (pain), relational, or psychological reasons, sexual arousal will be inhibited (Dewitte, 2014; Pfaus, 2009). Therefore, desire and arousal problems can begin.

Dürr (2009) confirmed this problematic cycle by stating that the desire/arousal phase of the female sexual response cycle is fragile, and any perception of threat can impair desire for future sexual encounters (Dürr, 2009). Pain or negative emotional experiences during sexual interactions can have a cascading effect, causing anxiety and difficulty in experiencing pleasure (Dürr, 2009). The resulting low arousal and a reduction in emotional intimacy lead to no motivation for future sexual encounters (Dürr, 2009). Hypervigilance then develops to avoid the perceived feeling of threat, which only

then causes a rigid entrenchment that becomes more difficult to address therapeutically (Dewitte, 2014). Therefore, it is important to understand the complex reasons underlying low sexual desire, as sexual desire grows or is inhibited in response to a myriad of factors (Brotto & Luria, 2014; Brotto & Smith, 2014).

Individual Attachment-based Antecedents of Female Low Sexual Desire

Theory and research show that the sexual behavior system is influenced by an individual's attachment style, which is an individually based quality (Mikulincer & Shaver, 2007). As a consequence, attachment style affects an individual's sexual attitudes (Birnbaum, 2010; Mikulincer & Shaver, 2007). Attachment theory states that the patterns that a child learns with significant caregivers when young becomes a blueprint for the future (Burri, Schweitzer, & O'Brien, 2014).

Individuals who have a secure attachment style have positive mental representations of both self and others, which create a felt sense of security (Mikulincer & Shaver, 2012). This inner feeling of security allows for effective emotional self-regulation, including comfort with closeness. Reduced anxiety also allows for an accurate interpretation of the inner sexual signals of arousal and attraction (Mikulincer & Shaver, 2007). This secure attachment bond is also facilitated within the individual by the release of oxytocin during foreplay (kissing, caressing, breast play, and nipple stimulation), during intercourse, and just preceding orgasm (Birnbaum, 2014).

Securely attached individuals have had positive role models while growing up (Birnbaum, 2010; Mikulincer & Shaver, 2007). Consequently, they have learned to value themselves and have confidence in their own desirability. These qualities create a foundation for positive sexual attitudes and experiences and allow the securely attached

to be relaxed during sex (Dewitte, 2012). Therefore, maximal sexual pleasure is possible because the person feels less afraid and can focus on connection instead of self-protection (Birnbaum, 2010; Dewitte, 2012; Mikulincer & Shaver, 2007).

Insecure individuals include those with an anxious (sometimes called anxious-ambivalent) attachment style as well as an avoidant attachment style. These styles develop because the person received inconsistent or inadequate caregiving by a parent figure while growing up. Insecurely attached persons are preoccupied with protection or needs for ego-replenishment that interfere with the sexual response system (Birnbaum, 2010; Mikulincer & Shaver, 2007).

Anxiously attached individuals typically wish for more love than they receive because of insufficient caregiving experiences when young (Bennett, Beal, & Beal, 2012). They are highly sensitive to cues and have more intense emotional reactivity in response to distress. Their unmet earlier needs leave anxiously attached persons in a hypervigilant state, predicting negativity (Dewitte, 2014). This preoccupation with worry and fear leads to difficulty with relaxation (Dewitte, 2014). The subsequent lack of confidence can create a compulsive need for ego replenishment through hyperactivating strategies. These strategies can include angry demands or clingy, intrusive behaviors to assuage inner fears of rejection or abandonment (Dewitte, 2014). These inner fears cause an interference between the attachment and the sexual systems, as insecurity interrupts the safety needed for the anxious partner to notice and respond to sexual cues. As a result, responsive desire does not develop (Dewitte, 2014; Mikulincer & Shaver, 2007; Pietromonaco & Beck, 2015).

Conversely, avoidantly attached individuals have negative models of self and others because of overwhelming childhood experiences (Mikulincer & Shaver, 2007). Avoidantly attached persons have an inadequate view of self, which causes fear (Birnbaum, Hirschberger, & Goldenberg, 2011). As a result of feeling chronically overwhelmed, avoidant persons rely on inner deactivating strategies for emotional regulation (Birnbaum et al., 2011; Birnbaum, 2014; Mikulincer & Shaver, 2007). For example, they shut down or give muted responses to prevent further attachment distress, and they have a greater need to distance or avoid when stress occurs than those with a secure attachment. This inner pessimistic filter causes greater emotional dysregulation, which contributes to the person's own anxiety both in and out of the bedroom (Birnbaum, Mikulincer, Szepsenwol, Shaver, & Mizrahi, 2014). Consequently, by deactivating the attachment system, avoidant persons are less aware of their own or their partner's sexual cues and responses. This lack of awareness can lead to low sexual desire (Birnbaum et al., 2011; Birnbaum, Mikulincer, & Austerlitz, 2013; Mikulincer & Shaver, 2007).

Avoidant persons have difficulty with flexibility (Mikulincer & Shaver, 2007). This lack of openness in avoidant persons is associated with an overreliance on independence and control, or a narcissistic preoccupation with self (Mikulincer & Shaver, 2007). As a result, an avoidant attachment style can cause a dismissal of inner sexual needs and difficulty being sexually expressive (Birnbaum et al., 2011). Additionally, avoidant persons favor a separate view of sex and love, believing that the Hollywood portrayal of romantic sex does not exist. Therefore, they tend to experience sexuality as a self-focused pursuit (Birnbaum et al., 2013). These individually-based

attachment factors can lead to low sexual desire (Birnbaum et al., 2013; Mikulincer & Shaver, 2007).

Relational Non-attachment Antecedents of Female Low Sexual Desire

Dewitte (2014) stated that sexuality and desire do not take place in a relational vacuum, and both are strongly influenced by contextual and relational factors, including current and past experiences. Therefore, sexual difficulties both mirror the relationship problems as well as exacerbate the conflict, becoming another source of angst and reason for emotional distance for the couple (Johnson & Zuccarini, 2010). Therefore, a growing number of authors recognize that a systemic view of sexual desire is needed to understand this prevalent problem (Brotto & Luria, 2014; Brotto & Smith, 2014).

The need for a systemic approach to sexual desire was also recognized by the DSM-V committee as they revised the relevant diagnostic category (American Psychiatric Association, 2013). The DSM-V committee on sexual desire merged the previously separate DSM-IV diagnoses of hypoactive sexual desire disorder (HSDD) and female sexual arousal disorder (FSAD) into sexual interest arousal disorder (SIAD) (American Psychiatric Association, 2000, 2013). Various researchers recommended this merging to better reflect women's experiences that desire and arousal were not two distinct experiences and instead have considerable overlap (Brotto, 2010; Brotto, Graham, Binik, Segraves, & Zucker, 2010).

This new systemic understanding of female sexual desire is based on the empirically based incentive sexual motivation model. This model is different for females than for males and includes biological, psychological, and contextual/relational factors (Brotto & Luria, 2014; Brotto & Smith, 2014). Similarly, other authors have also called

for a systemic understanding of low sexual desire that includes a greater emphasis on relational factors, rather than only focusing on individual factors (e.g., current biological factors, boredom, or pathology) or prior historical factors (Weeks et al., 2009).

Relationship factors have a significant role in low sexual desire difficulties (Weeks et al., 2009). Differences in sexual desire levels, high conflict levels, power and control dynamics, and lack of communication have a detrimental effect on sexual appetites (Weeks et al., 2009). Pascoal, Narciso, and Pereira (2012) found that low emotional intimacy in a relationship was the best predictor of sexual arousal problems. Additionally, some partners have low sexual desire due to anger or resentment toward a partner that is expressed through disinterest in sex or avoidance of intimacy. Some partners that are dissatisfied relationally enjoyed solo sexual activity, indicating partner-specific sexual avoidance is occurring rather than a global disinterest in sex (Weeks et al., 2009).

Other authors concur that relational insecurity plays a large role in low sexual desire. Brotto and Luria (2014) stated that women lack motivation for sex due to lack of trust or respect for the partner as well as low relational, emotional intimacy. Feelings toward the partner, particularly a lack of relational security, have an even greater role than individual hormonal factors in the presence of low sexual desire (Brotto & Luria, 2014).

Using a population of 244 monozygotic twins scoring discordantly among each pair, relationship factors were found to be the strongest independent predictor of female sexual dysfunction (Burri, Spector, & Rahman, 2013). Female sexual dysfunction was defined as low desire, low arousal, lubrication, and orgasm problems. In each set of

identical twins, one twin had either no sexual problems or recent sexual dysfunction, and the other twin had lifelong sexual problems. Once genetic factors were controlled for, self-reported relationship dissatisfaction was significantly associated with desire, orgasm, and other sexual problems. The authors concluded that their study is strong evidence that communication problems and unresolved conflict significantly contribute to sexual desire and overall sexual dissatisfaction (Burri et al., 2013). A study limitation is recall bias, as subjects may not report their symptoms accurately. Another limitation is that subjects came from a pool of twins that participated in a prior sexual study. Therefore, results may reflect liberal attitudes not representative of the general population. Also, twin subject results may not generalize to singletons in the general population (Burri et al., 2013).

Another study found similar results that relationship factors were more strongly associated with low sexual desire than was age or menopause (Burri & Spector, 2011). This study attempted to identify the risk factors associated with female sexual dysfunction (FSD) by administering empirically validated questionnaires such as the Female Sexual Function Index (FSFI) and the Female Sexual Distress Scale (FSDS) to a sample of 1,489 adult female twins from the United Kingdom. Relationship dissatisfaction with a romantic partner played the greatest role in predicting recent or lifelong female sexual dysfunction. Low sexual desire was the most prevalent sexual complaint reported, with 21.4% reporting recent FSD and 17.3% reporting lifelong FSD. Findings showed that factors such a childhood abuse (sexual, physical or emotional), low emotional intelligence, or high anxiety significantly contributed to lifelong but not to recent FSD, indicating the importance of relational issues for non-organic or abuse-

driven sexual dysfunction (Burri & Spector, 2011). Various limitations of this study exist. This study relied on self-report measures, and subjects may underreport sexual distress. Also, twin subject results may not generalize to singletons in the general population, and 70% of subjects also were mostly perimenopausal or postmenopausal, so results may not apply to a younger population (Burri & Spector, 2011).

Another study determined that relational cues are needed for desire (Brotto, Heiman, & Tolman, 2009). The authors explored sexual desire by listening to narrative descriptions of desire in middle-aged women. Twelve women with a mean age of 45 without female sexual arousal disorder (FSAD) were compared with 10 women with a mean age of 55 who did have FSAD. Both groups described desire as elements of genital and non-genital physical reactions as well as thoughts and emotional responses. Triggers for desire included touch, memories, fantasies, and partner's responses, the latter of which could either enhance or reduce desire. Touch was an important kinesthetic trigger for sexual desire, as a partner's touch evoked a transition from neutrality to an actual willingness to be sexual. However, both groups reported that touch was not a sufficient condition unless partners also felt comfortable, safe, and protected in the relationship (Brotto et al., 2009).

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Findings showed that the most important relational factor for sexual desire was the partner expressing desire in return, which then produced sexual responsiveness based on those cues (Brotto et al., 2009). Both groups could recall similar experiences that produced desire; although the FSAD group had greater difficulty explaining the difference between desire and arousal (Brotto et al., 2009). Both groups also agreed that desire required a stimulus, and emotional connection was the most important goal

of desire for nearly all of the women studied. The authors concluded that female desire is both highly relational and responsive to the contextual cues of sexual interactions (Brotto et al., 2009).

Brotto and Luria (2014) also explained a phenomenon commonly experienced by females called responsive sexual desire (RSD), as opposed to spontaneous desire (described by the colloquial expression “feeling horny”). Spontaneous desire is more typical of male sexuality, young women, or those in new relationships (Brotto & Luria, 2014; Dürr, 2009). Dürr (2009) concurred that a review of the research shows women rarely feel spontaneous desire in long-term relationships.

Other authors have stated that low sexual desire for women can be caused by overfamiliarity or a lack of novel interactions when couples do not take the time to maintain positive relational or sexual cues (Perel, 2007; Sims & Meana, 2010). Sims and Meana (2010) conducted open-ended interviews with 19 married women reporting low sexual desire. The purpose of the study was to ask these women their personal theory surrounding the loss of sexual interest. The authors found that when couples are married sex can be overly available removing the planning and anticipation that is so exciting for newer couples (Sims & Meana, 2010). Routines can set in with longstanding couples, so pre-sex and sexual encounters become habitual and lose their thrill. Additionally, some women reported their low desire to a desexualization of self, stating that fatigue and competing priorities of children, aging parents, and work obligations can all take away from the time and relaxation needed to enjoy sexual pleasure (Sims & Meana, 2010). Therefore, these factors set up the distressing scenario for the emergence of low sexual desire in otherwise content couples (Sims & Meana, 2010).

Participants often suggested their low sexual desire could be remedied by lifestyle changes such as interactions with the partner that are more positive, greater sexual variety, or time to enjoy more erotic sexual encounters (Sims & Meana, 2010). Results need to be replicated with a much larger sample size (including possibly a comparison to a similar group that had maintained sexual desire) to draw conclusions for clinical couples. Also, the study was performed on highly educated, mostly Caucasian married females, so it is difficult to know if the results will generalize to other cultures or populations (Sims & Meana, 2010).

Other authors supported the finding that relationship duration had a detrimental effect on sexual desire. One study showed that, for females, relationship duration had a significantly negative effect on desire for those in a relationship for over one year. Therefore, a reduction in spontaneous sexual desire over time is expected in women (Murray & Milhausen, 2012). Participants were heterosexual couples attending a university. Findings showed lower sexual desire each month over eight months on the FSFI for female participants. Conversely, the men studied did not have a similar drop in desire (Murray & Milhausen, 2012). These findings are consistent with the literature indicating that men have a more consistent level of spontaneous sexual desire than females do (Mark & Murray, 2012). The authors concluded that a desire discrepancy can form due to innate gender differences. That discrepancy then contributes to ongoing sexual problems, and a higher desire discrepancy predicated greater relationship dissatisfaction for male subjects (Mark & Murray, 2012). Sexual satisfaction and relationship satisfaction were positively correlated for both genders, and higher levels of sexual desire correlated with higher levels of sexual satisfaction (Murray &

Milhausen, 2012). A limitation is that the couples were Caucasian college students in a relationship, so results may not generalize to a more heterogeneous sample including clinical, married, older couples, or those from a different culture (Murray & Milhausen, 2012).

In addition to relationship duration effects, desire for women is elusive or fragile due to the variability of sexual psychological or contextual cues necessary for its sustenance (Brotto & Luria, 2014; Brotto & Smith, 2014; Dürr, 2009). Research shows that women initiate or are receptive to sexual encounters for a variety of reasons, both sexual and nonsexual in nature (Brotto & Luria, 2014). Nonsexual reasons for engaging in sex can include positive reasons such as emotional closeness or partner expectations, or they can include an attempt to remove a negative such as not wanting to upset a partner or to avoid a fight (Brotto & Luria, 2014; Dürr, 2009; Muise, Impett, & Desmarais, 2013). Therefore, women may enter sexual encounters feeling sexually neutral (Brotto & Luria, 2014; Dürr, 2009).

Responsive desire will be triggered if, during the sexual encounter, a woman experiences enjoyment, arousal/excitement, and sexual pleasure (Brotto & Luria, 2014; Dürr, 2009). A wish for the sexual activity to continue grows due to the now emerging positive sexual feelings. This positive, rewarding experience can have a lasting effect on future feelings of sexual desire. RSD can increase motivation to initiate sexual activity or respond to sexual cues in the future, as there will now be greater anticipation of positive sexual feelings and pleasure later in the interaction even when they are not initially present (Brotto & Luria, 2014; Mehta, Walls, Blood, & Shrier, 2014). Conversely, couples who have negative emotional or physical experiences when being sexual will

have aversive reactions that can reduce future feelings of sexual desire (Both, Laan, & Schultz, 2010; Dürr, 2009; McCarthy & McCarthy, 2014; McCarthy & McDonald, 2009).

Sexual arousal problems were best predicted by relational difficulties in emotional intimacy for 96 women (Pascoal, Narciso, & Pereira, 2012). Emotional intimacy was defined as communication, conflict management, and expression of feelings. Researchers found that emotional intimacy has the greatest impact on sexual satisfaction as measured by the Global Measure of Sexual Satisfaction (Pascoal et al., 2012). Body-related variables such as cognitive distortion effects disappeared when considered along with relationship variable effects. Only the emotional intimacy variable remained significant (Pascoal et al., 2012). Authors concluded that actor-partner effects need to be studied to understand better which partner variables create higher sexual satisfaction for females with sexual arousal problems (Pascoal et al., 2012).

Brotto and Smith (2014) wrote an extensive literature review about sexual desire that reported both theoretical and empirical studies have shown significant associations between sexual desire and relationship factors. These authors reported findings from a prior study asking 49 women to describe their sexual difficulties in their own words. In this study, Nicholls' research (as cited in Brotto & Smith, 2014) found that of the 31 subjects whose sexual problems could be subcategorized, 65% were classified as relationship- or partner-related while only 7% were due to medical problems. The remaining problems were attributed to psychological factors such as prior sexual abuse, depression/anxiety, or sociocultural/political/ economic factors (Brotto & Smith, 2014).

A recent study found that relational reasons such as the need for closeness, love, and intimacy, were the largest factors contributing to female sexual desire followed

closely by a need to feel sexually desirable (Mark, Herbenick, Fortenberry, Sanders, & Reece, 2014). These results differed from those found in men, who reported sexual desire for greater reasons of sexual release, orgasm, and the desire to please their partner (Mark et al., 2014). Authors also reported that the sexual fantasies of women had more romantic-emotional content than did men's fantasies (Mark et al., 2014). Findings indicated that male desire is more driven by intra-individual physical or erotic external factors, while female desire is driven by the interpersonal and romantic factors (Mark et al., 2014). These findings are consistent with the extant literature (Mark et al., 2014).

Relational Attachment-based Antecedents of Female Low Sexual Desire

Johnson and Zuccarini (2010) advised therapists to see healthy sexual functioning as more than a physical act but instead to see desire through the lens of an attachment bond. Sexual acts typically take place in a relational context; therefore, romantic partners often activate the attachment system as well as the sexual system. Although they can function independently of one another (strong affectional bonds can be formed devoid of sexuality, and sexual acts can happen without emotional attachments), adult romantic relationships typically involve both types of interactions. Therefore, romantic partners serve as both sexual partners and primary attachment figures (Birnbaum, 2010; Fagundes & Schindler, 2012).

Researchers of sexuality are beginning to examine the effects of attachment style on the sexual interactions of the couple, including sexual motivation and desire levels (Dewitte, 2012). Some adages are emerging in current research. Emotional

safety and feelings of security appear to play a critical, but less understood, role in low sexual desire (Birnbaum, 2010; Birnbaum et al., 2014).

McCarthy and Farr (2012) cited the importance of being a securely attached couple to create the conditions for sexual desire. Other authors stated that sexual desire remains more vital for long-term couples who demonstrate openness, accessibility, and trust, all relational features of a secure attachment (McCarthy & Farr, 2012). Conversely, sex reduces insecurity in couples and fosters the consolidation of the relational attachment bond in romantic couples (Birnbaum, 2014).

Attachment style is important in the study of sexuality because attachment explains many of the relational factors leading to constructive versus difficult sexual encounters (Birnbaum, 2010). Attachment differences also influence interpersonal goals and explain the variations regarding how partners experience the relational intimacy required in sexual interactions (Birnbaum, 2010).

Securely attached individuals enjoy sexual encounters due to greater trust, comfort, and closeness as they evoke more positive representations of self and others (Birnbaum, 2010). These more positive views of self and other allow for greater intimacy and more gratifying sexual experiences (Birnbaum, 2010). For example, greater comfort with closeness allows greater enjoyment of sexual experiences that increase the bond and love for their partner. Secure attachment also allows flexible shifting between roles of giver and receiver during sexual encounters, thus, enhancing the experience (Brassard et al., 2012).

This inner sense of security allows for greater trust, emotional flexibility, and responsiveness with a partner (Brassard et al., 2009; Mikulincer & Shaver, 2007).

Those with a secure attachment style experience greater relational satisfaction, both non-sexually and sexually, as they can retain their emotional regulation instead of being flooded with anxiety or anger. Securely attached persons are more consistently responsive to the partner's bids for support, love, and comfort (Brassard et al., 2009). They also receive comfort when care is offered instead of being skeptical or mistrusting, which facilitates the repair of emotional injuries (Johnson & Zuccarini, 2011). This greater ability to offer or receive repair allows couples to return more quickly to a positive homeostasis, as they act as co-regulators of one another's emotions. This diffusing of emotional anxiety maintains more satisfying interactions (Johnson & Zuccarini, 2011). Those with more secure attachment can better negotiate closeness (Bennett et al., 2012), and their interactions contribute to greater relationship quality and stability as well as more satisfying friendships (Birnbaum, 2010; Impett, Muise, & Peragine, 2014).

Insecure attachment reflects an individual's discomfort with closeness and dependency (Stefanou & McCabe, 2012). Adult insecure attachment affects interactions with significant others both in and out of the bedroom, and insecure attachment is associated with greater relationship dissatisfaction (Brassard et al., 2009). Therefore, attachment style predicts how the partner approaches the other for sex, including the underlying attachment motivations for closeness or distance (Johnson & Zuccarini, 2010). Additionally, Johnson and Zuccarini (2010) stated that attachment security greatly affects sexual expectations, desire levels, and subsequent actions. Both insecure attachment styles are more prone to interpreting ambiguous cues from a romantic partner in a more negative light. This distress can then lead partners to

become fearful, withdraw, or become hostile with one another (Pietromonaco & Beck, 2015).

According to Brassard et al. (2012), anxiously attached individuals use sexual activity to meet attachment needs for closeness; therefore, the sexual encounters take on an exaggerated level of importance in the relationship. Birnbaum, Mikulincer, Szepsenwol, Shaver, and Mizrahi (2014) noted that anxiously attached persons tend to overemphasize the role of sex in the relationship; yet, they are also preoccupied with fears about their sexual undesirability and possible lack of performance. Undue need to feel acceptance by the partner has been associated with poor sexual assertiveness. Those with an anxious attachment style are less likely to communicate and act on their own sexual wishes for fear that they may risk criticism or rejection from the partner (Péloquin, Bigras, et al., 2014).

Attachment anxiety can also lead to a sense of urgency around sexual gratification that can lead to impulsive sexual behaviors without concern for the emotional needs of the partner (Birnbaum et al., 2014). However, because the sexual experiences are given such importance, the encounters become more emotionally fragile, creating a vicious cycle of sex-related anxiety (Birnbaum et al., 2014).

For the anxiously attached person, the sexual experiences are fraught with meaning and the need for perfect mirroring from the partners increases. Anxiously attached individuals worry about rejection and can be preoccupied with their own possibly inadequate sexual performance, which places undue pressure on each sexual encounter (Birnbaum et al., 2014). Each sexual experience becomes an overall barometer of the relationship that does not allow for the occasional disappointment or

“failure” that is normal in physical encounters, even in the happiest of couples. Therefore, these attachment insecurities limit their ability to attend to their partner’s needs, reducing their own experience of arousal and pleasure (Brassard et al., 2012; Stephenson & Meston, 2015). As a greater number of frustrating sexual encounters occur, the fear of rejection intensifies and the couple experiences greater sexual and relational difficulties (Birnbaum et al., 2014). Similarly, another study showed that the use of self-esteem motives was negatively related to sexual satisfaction. Therefore, it appears to be an unsuccessful strategy to feel better about oneself through sexual activity (Stephenson, Ahrold, & Meston, 2011).

Avoidant individuals suppress emotional and relational reasons for sex as a way to avoid the risk associated with intimacy (Brassard et al., 2012). Therefore, they place a greater priority on satisfying their own erotic needs while having a lower emphasis on their partner’s sexual and emotional needs. Avoidant persons are more likely to engage in casual sex with less sexual interest or pleasure and have fewer long-term, stable relationships as they value autonomy and independence (Brassard et al., 2012). When in a committed relationship, avoidant individuals may avoid sexual encounters or prefer solitary sexuality (Brassard et al., 2012).

Attachment researchers also recognize that sexuality is a fundamental part of marital functioning and adult love relationships. Therefore, sexual dysfunction is an important area of study (Péloquin, Brassard, et al., 2014). This area of study takes on greater magnitude when findings show that over 50% of adults experience some kind of sexual difficulty, and over 60% of couples presenting in marital therapy are experiencing significant sexual distress (Péloquin, Brassard, et al., 2014). Attachment researchers

believe that sexuality and caregiving are part of the attachment-related behaviors exhibited in adult romantic relationships. These authors stated the relationship between insecure attachment (anxious or avoidant), relationship factors, and low sexual functioning is important to understand (Péloquin, Brassard, et al., 2014).

Much has been written on the subject, but a scarcity of studies exists on the connection between attachment and sexuality (Burri et al., 2014). In a review of past research, Stefanou and McCabe (2012) indicated that an individual's attachment style affects the quality of sexual interactions with a partner. Pietromonaco and Beck (2015) and others have reviewed how attachment styles affect interactions in romantic relationships, both sexually and non-sexually. McCarthy and Farr (2012) indicated that secure attachment facilitates sexual desire, as safety, comfort, and emotional connectedness is necessary for sexual initiation.

Romantic attachment insecurity predicted sexual dissatisfaction in couples who are seeking therapy (Brassard et al., 2012). Both insecure attachment styles are correlated with discomfort with physical touch, excessive worry, and intrusive or interfering thoughts during sexual experiences that disrupt the natural flow that allows pleasure and sexual fulfillment (Péloquin, et al., 2014).

Little, McNulty, and Russell (2010) studied two groups of newlyweds to see if sexual frequency or sexual satisfaction moderated the negative effects of the insecure attachment system. The first group of 72 couples took measures of their attachment style, frequency of sexual intercourse over the last 30 days, and marital satisfaction. A second group of 135 newlyweds used a seven-day diary to report their sexual satisfaction and relationship satisfaction as well as partner expectancy for partner

availability. Findings showed that attachment style is not a fixed characteristic but can vary according to circumstances in the relationship (Little et al., 2010). Also, anxious and avoidant attachment was negatively associated with sexual satisfaction in both studies. However, anxiously attached partners who reported more satisfying sex had higher marital satisfaction than those who did not (Little et al., 2010). In addition, avoidantly attached partners who had more frequent sex felt greater marital satisfaction. Authors concluded sexual encounters help buffer the effects of insecure attachment on the relationship and, thus, may serve as a protective factor (Little et al., 2010). However, limitations of these studies included subjects that were newlyweds; therefore, results may not extend to couples who are not married (who may be more or less satisfied overall) or who have been together much longer (Little et al., 2010).

Brassard et al. (2012) studied sexual satisfaction and attachment style in 242 heterosexual Canadian couples receiving couples therapy in a private practice setting. One-half of these couples were married (51.5%) and half were cohabiting (48.5%). Participants' mean age was 40 years for women and 43 years for men. Partners had been in their current relationship for an average of 13 years with an average of 1.76 children. In this sample, 60% of the couples reported sexual dissatisfaction. Authors found that anxiously attached women predicted a significant degree of sexual dissatisfaction, similar to what other studies have shown (Brassard et al., 2012). Greater sexual anxiety and doubt of a partner's availability are possible reasons for sexual dissatisfaction, as well as poor sexual communication and assertiveness. Avoidant women showed greater withdrawal from affection or physical intimacy, but the withdrawal did not cause them as much distress as their male partners (Brassard et al.,

2012). Authors concluded that conflicts reduced females' desire to engage in sexual activity more than they did for men, as women may not want to behave sexually in a troubled relationship (Brassard et al., 2012).

Stefanou and McCabe (2012) completed a comprehensive review concerning the strengths and weaknesses of the literature on the relationship between adult attachment and sexual functioning. Fifteen articles published from 2002 to 2011 met the inclusion criteria. Sexual functioning was measured in terms of sexual frequency, sexual problems, sexual satisfaction, sexual motives, and sexual goals. Reviewed findings showed that both anxious and avoidant styles were consistently found to be associated with less satisfying sexual encounters (Stefanou & McCabe, 2012). However, one study showed that only anxious attachment negatively affected sexual satisfaction with no similar findings for avoidantly attached persons (Stefanou & McCabe, 2012). This negative finding may have been due to the older participants (mean age of 44.95 years), as they were in more committed relationships. These females reported more relational and sexual satisfaction than other avoidantly attached females in other studies who are younger and in typically less committed relationships (Stefanou & McCabe, 2012). Other findings showed that insecure attachment was associated with less arousal, problems with lubrication, lack of orgasm, and sexual pain (Stefanou & McCabe, 2012). In particular, two studies found that avoidant attachment was found to be related to lower intercourse frequency, although one study showed that anxiously attached individuals had higher rates of intercourse, possibly due to an intense need for closeness to reduce relational insecurity (Stefanou & McCabe, 2012).

Stefanou and McCabe (2012) also found five studies the results of which were consistent with other literature. Anxiously attached partners thought of sex as romantic love and wanted to have sex to reduce relational insecurity. Conversely, avoidantly attached partners viewed sex and romantic love as two separate components (Stefanou & McCabe, 2012). These individuals had discomfort with closeness and intimacy. Avoidantly attached individuals did not use sex to assess relationship quality, but anxiously attached individuals did because they experienced disappointing experiences as partner disapproval (Stefanou & McCabe, 2012).

Birnbaum, Mikulincer, and Austerlitz (2013) presented the effects of a conflictual discussion on various couples' sexual motivation as a function of gender and attachment. Sixty-one couples ages 19-38 were recruited in Israel. Criteria included being in a steady monogamous relationship for over three months and being sexually active (vaginal sex at least once weekly for the two months prior to the study). The couples were divided into two groups who were demographically similar regarding age, education, and relationship length. The experimental group (n = 31) was videotaped while having a conflictual discussion of a major relationship problem or about their daily routine while the control group (n = 30) was videotaped having a non-conflictual discussion about their relationship. No statistical differences were found in the demographics between the experimental and control groups, and all discussions lasted five to eight minutes. Couples were then asked to complete self-report questionnaires on attachment, current sexual attractiveness felt toward the partner, and relational distress-reduction reasons for having sex after the conflict (if desired). The authors then compared the results of the two groups (Birnbaum et al., 2013).

The authors concluded both gender and attachment effects exist after a conflict, but gender effects were greater than only the attachment effects (Birnbaum et al., 2013). Conflict had a greater negative effect on women's sexual motivation than their male partners did. Women who had fewer relationship-based motives to have sex to nurture one's partner experienced their partner as less attractive after conflict compared to the non-conflict group (Birnbaum et al., 2013). Conversely, conflict increased men's sexual motivation. Partners of both genders expressed a desire to have sex to experience relief from stress except when the partner's attachment anxiety was high, and partners did not seek sex to feel close to a partner after conflict when the partner's attachment avoidance was high (Birnbaum et al., 2013). In conclusion, those who expected distress reduction experienced greater sexual motivation than those who did not (Birnbaum et al., 2013).

Péloquin, Brassard, et al. (2014) determined that attachment, caregiving, and sexual satisfaction are interrelated in adult romantic relationships. Anxious attachments reflect a negative model of self (unworthiness), and avoidant attachments reflect a negative model of others (discomfort with closeness). Secure individuals have internalized a more positive image of self and others rooted in early experiences and current social interactions (Péloquin, Brassard, et al., 2014). The caregiving system in adults is activated by a threat to perceived safety and security and is managed by offering proximity and emotional sensitivity to the partner. Healthy caregiving is only possible when a person's own sense of security is adequate while unhealthy caregiving is characterized by the tendency to take on too much responsibility for the partner through control or by intrusive compulsive caregiving (Péloquin, Brassard, et al., 2014).

Both anxiously-attached and avoidantly-attached individuals reported lower sexual satisfaction than those with secure attachment (Péloquin, Brassard, et al., 2014).

Péloquin, Brassard, et al. (2014) examined the link between attachment style and the sexual aspects of a couple's relationship. This study specifically looked at the roles of caregiving (proximity, sensitivity, control, and compulsive caregiving) as mediators between attachment insecurities and sexual satisfaction in two groups: 126 Canadian couples from the general community and 55 clinically distressed couples. Participants were administered the Experiences in Close Relationships measure to assess attachment, the Caregiving Questionnaire, and the Global Measure of Sexual Satisfaction. Results indicated that proximity seeking mediated attachment avoidance and indicated greater sexual satisfaction in distressed and non-distressed couples (Péloquin, Brassard, et al., 2014). Sensitivity (i.e., the ability to sense and respond to distress) only mediated the same association in the non-distressed group. Male attachment insecurity led to controlling caregiving, which led to lower sexual satisfaction (Péloquin, Brassard, et al., 2014). Compulsive caretaking from attachment anxiety did not show up as a factor in either partner's sexual satisfaction. Both controlling caretaking as a result of insecure attachment style and compulsive caretaking indicated a lower ability to feel synchronicity with a partner's sexual needs (Péloquin, Brassard, et al., 2014).

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Comment: This is correct, as it has a citation "twin" from the same year. See above explanation.

The same authors concluded that caregiving proximity leads to greater emotional closeness and higher sexual interest in both clinical and non-clinical couples (Péloquin, Brassard, et al., 2014). Only those low in attachment insecurity were able to provide caregiving proximity. Authors reasoned that caregiving sensitivity or control related to

higher sexual satisfaction in nonclinical couples because distressed couples are less likely to be able to be empathetic or meet their partner's emotional needs (Péloquin, Brassard, et al., 2014). Instead, distressed couples with insecure attachment styles have greater negative affect or communication conflict that may interfere with effective caregiving behaviors. The bi-directional nature of the correlation found may also indicate that higher sexual satisfaction may also create greater comfort with proximity and other caregiving behaviors, which then leads to greater attachment security and relationship satisfaction (Péloquin, Brassard, et al., 2014). Therefore, the caregiving system works in conjunction with the attachment system and the sexual system. The authors concluded that each of the three systems alternates with and activates the others (Péloquin, Brassard, et al., 2014).

Ciocca et al. (2014) found that insecure attachment style plays a significant role in sexual dysfunction. Researchers investigated attachment styles in both men and women with sexual dysfunction. The study was done with 44 subjects (21 women and 23 men) in the experimental group with 41 subjects (21 women and 20 men) having healthy sexual function in the control group. Female subjects were of childbearing age. Subjects were excluded if they had organic conditions such as diabetes or cardiovascular disease or if they had severe mental illness such as psychosis, depression, or post-traumatic stress disorder. The experimental and control groups were also matched on sociodemographic parameters, such as education and relationship stability. Each was given instruments evaluating his or her sexual function as well as attachment style. Results showed significant attachment style differences between those with FSD and those with healthy sexual function (Ciocca et al., 2014).

Women with sexual problems tested high in three measures of correlating with insecure attachment. For females, the “discomfort with closeness” score and the “relationship as secondary” score significantly correlated with the insecure avoidant attachment style, while the high “need for approval” score significantly correlated with subjects with the insecure anxious attachment style (Ciocca et al., 2014). The authors strongly concluded that their research confirmed the presence of an insecure attachment styles in those with non-organic sexual dysfunction. A fearful anxious style particularly predicted the presence of sexual problems and the need for security for healthy sexual functioning (Ciocca et al., 2014). A limitation of this study was the small sample size; the authors encouraged the replication of this study with a larger number of subjects to confirm the results.

Burri et al. (2014) found that there was a strong correlation between higher levels of attachment anxiety or avoidance and sexual problems in 230 female subjects who were sexually active adults. The same researchers also considered the effects of differentiation of self (i.e., how a person manages individuality vs. togetherness, a key component of emotional regulation) on female sexual dysfunction. Each participant completed online assessments for attachment style, sexual functioning, differentiation of self, and the covariates studied (i.e., history of abuse and personal distress). Although both insecure attachment styles showed a positive correlation with sexual problems, avoidant attachment was a stronger predictor of sexual difficulties (Burri et al., 2014). Individuals reporting a lower level of differentiation also were more likely to report sexual difficulties. The findings support a relational and psychological focus to understand female sexuality (Burri et al., 2014). One limitation of this study is that the initial email

recruitment was done solely with Caucasian university students. Therefore, results may not generalize to the overall population. Also, other limitations are that self-report measures can be distorted due to social desirability factors, and those participating in a sex-related study may be more extroverted and less conservative than those in the general population (Burri et al., 2014).

However, another study showed conflicting results with the prior study (Timm & Keiley, 2011). Differentiation of self and attachment style were independent variables compared to the self-report measures of sexual communication, sexual satisfaction, and marital satisfaction. In a sample of 205 nonclinical, married adults were studied, including 105 women and 100 men. Attachment style did predict a positive relationship with both sexual satisfaction and marital satisfaction, but a much higher correlation existed with marital satisfaction (Timm & Keiley, 2011). However, satisfying sexual communication was significantly related to sexual satisfaction. No significant gender differences were noted in this study (Timm & Keiley, 2011).

Through an attachment lens, Stephenson and Meston (2015) studied the link between sexual well-being and life satisfaction in females. This study was the first to include women with a variety of sexual problems, and this research showed how attachment security plays an important role in both sexual and life satisfaction (Stephenson & Meston, 2015). By using interviews, self-report measures, and daily online assessments over a period of 4 weeks, 87 adult women who were in an exclusive heterosexual relationship were studied. To be included in the study, some sexual difficulty needed to be present in the last month. Sexual difficulties included low sexual desire or arousal, difficulty reaching orgasm, or pain or discomfort during or following

sexual activity. Participants had to want to be willing to engage in sexual activity and not have a physical illness that would preclude sexual activity. Participants were administered measures of relationship satisfaction, attachment orientation, and life satisfaction (Stephenson & Meston, 2015).

Results of this study showed that attachment style and the quality of the participants' sex lives correlated with, and thus predicted, life satisfaction (Stephenson & Meston, 2015). Higher sexual satisfaction also predicted life satisfaction, along with high relational satisfaction and low attachment anxiety (Stephenson & Meston, 2015). Low attachment anxiety and relationship satisfaction also served as protective factors that also suppressed the effects of sexual dissatisfaction, but dissatisfying sexual experiences have a greater effect on those with attachment fears of abandonment or who are in unsatisfying relationships (Stephenson & Meston, 2015).

Results also showed that greater sexual distress also predicted greater life dissatisfaction over wider interpersonal factors (Stephenson & Meston, 2015). These results are consistent with prior results that sexual activity is one of the strongest predictors of self-report experiences of happiness (Stephenson & Meston, 2015). Also, a secure attachment plays an equally important role in regulating emotions in relationships (Dewitte, 2012) and is strongly associated with a satisfying sex life (Stephenson & Meston, 2015). Limitations of this study are that investigation was only four weeks long and larger sample sizes would be needed to confirm results. The authors also cautioned against drawing causation conclusions without further double-blind controlled studies (Stephenson & Meston, 2015).

Impett, Gordon, and Strachman (2008) conducted an empirical investigation of the effects of attachment styles on daily sexual goals for both the person's own attachment style (i.e., actor effects) and that of the partner attachment orientation (i.e., partner effects). Female attachment anxiety was associated with higher desire, having sex to reduce relational insecurity and get reassurance, to please one's partner, and as an expression or a sign of love (Impett et al., 2008). Anxiously attached individuals tended to defer to the partner's needs and saw the partner's desire as an indicator of love. Conversely, female attachment avoidance was associated with engaging in sex as a way to avoid disappointing or upsetting a partner, to avoid conflict, or to experience their own physical pleasure instead of having sex to seek emotional closeness or approval (Impett et al., 2008). Avoidantly attached individuals tend to down-regulate their attachment systems and reduce their need for emotional and sexual intimacy (Impett et al., 2008). Therefore, those with negative models of self and others are more likely to experience lower relaxation in relationships and, thus, experience a disruption in sexual desire and sexual satisfaction (Impett et al., 2008). Although findings were consistent with prior studies on sexual functioning and attachment, limitations include that this study was done on college students over 14 days. More research needs to be completed to determine if the results generalize to married couples or clinical couples over a longer period (Impett et al., 2008).

In a literature review, Toates (2009) described findings showing the overlap between sexual motivation and attachment motivation. Although romantic attachment and the sexual motivation systems are thought to be separate, they interact with one another in a potent way. For anxiously or securely attached persons, intimacy amplifies

sexual attraction and desire. However, “dismissing” individuals tend to avoid kissing and mutual gaze, even when engaging in sexual activity (Toates, 2009). Possibly due to higher oxytocin levels, women also show a greater link between emotional affiliation and sexual arousal than men do (Toates, 2009). For example, lack of affection in marriage was a strong contributor to a loss of sexual desire in females. Spontaneous desire was more present in men, while women tended to experience greater desire as a result of external relational events such as a lack of fear or a positive perception of the overall quality of the relationship (Toates, 2009). The author reported that desire levels tended to fluctuate depending on contextual, relational cues (Toates, 2009).

Ambivalent motivation, often present in insecurely attached persons, is an important factor in low desire (McCarthy & McDonald, 2009). If a partner is angry or feels alienated, has inner shame, or has prior sexual injury such as sexual abuse, there can be low motivation to enter a sexual encounter (McCarthy & McDonald, 2009). Another reason that low sexual desire exists is the difficulty tolerating a dissatisfying sexual experience. When couples demand that the sexual experience be near perfect each time, they are only one failure away from feeling helpless or hopeless. This helplessness or hopelessness then causes avoidance and, thus, reduces sexual desire (McCarthy & McDonald, 2009). Individuals with insecure attachment are more likely to rely on the need for perfection and are consequently more vulnerable to using rigid sexual strategies that reduce a feeling of security and acceptance during sexual encounters (Johnson & Zuccarini, 2011).

Birnbaum et al. (2014) developed a Sexual System Functioning Scale and administered the measure to 18 groups of individuals ranging in size. Groups ranged

from 17 to 278 persons under a variety of situations. Differing situations were designed to assess hyperactivating and deactivating sexual motivations based on attachment style. Sexual hyperactivation existed in anxiously attached individuals who expressed an intense need for sexual encounters and anxious expressions of desire (Birnbaum et al., 2014). Sexual deactivation strategies used by avoidantly attached individuals involved inhibition of sexual inclinations (Birnbaum et al., 2014).

Results indicated findings that are consistent with prior literature concerning the role of anxious or avoidant attachment behaviors on participants' sexual attitudes, feelings, and behaviors (Birnbaum et al., 2014). Authors attributed these differences in attachment styles to both heritable factors and familial experiences that then shape variability in sexual approach strategies (Birnbaum et al., 2014). They also posited that the sexual system can operate in the reverse to strengthen or weaken attachment bonds, which will then have an ongoing reciprocal effect on further sexual behaviors (Birnbaum et al., 2014). Limitations of this study include that the results were taken from one point in time rather than studying how the sexual system's functioning scale may reflect dissimilar results over different stages of the relationship (Birnbaum et al., 2014).

Treatments for Female Low Sexual Desire

Individual treatments. The etiology of desire difficulties for females can be difficult to discern because sexual desire has a complex biopsychosocial nature. Therefore, clinicians need to do a complete assessment before implementing any treatment strategy (Brotto, Bitzer, Laan, Leiblum, & Luria, 2010; Brotto & Luria, 2014). During the comprehensive assessment, clinicians need to ask open-ended questions about relationship issues, current life circumstances, cultural issues, past abuse,

negative sexual experiences, and the extent to which sexual cues for desire are present or absent (Timm, 2009). Kleinplatz (2011) suggested that researchers ask women when they were most sexually excited and what factors led to those experiences. These answers may help women rediscover their sexual cues that are so important in the female sexual response. As part of the initial assessment, individuals experiencing desire difficulty should be referred for a complete gynecological and physical examination to assess for and rule out any medical factors that may contribute to the dysfunction (Brotto, Bitzer, et al., 2010).

Only a small percentage of sexual desire problems are solely biologically based (Brotto & Smith, 2014). The remaining majority of low sexual desire problems need to be treated through other approaches. Although Masters and Johnson noted in the early 1970s that a supportive, cooperative partner was needed to resolve sexual issues, the sex therapy field stepped away from relational approaches to genital-focused behavioral or medical treatments for many years (Johnson & Zuccarini, 2010). For non-organically-based dysfunction, sex therapy has typically consisted of psychoeducation in conjunction with procedural steps to follow based on the type of sexual dysfunction present (e.g., masturbation and self-exploration for female orgasmic disorder, dilators to treat vaginismus, and the start-stop and squeeze techniques to treat premature ejaculation; Binik & Hall, 2014; Binik & Meana, 2009). However, there have been a sparse number of randomized controlled experiments testing the efficacy of those treatments (Binik & Meana, 2009).

Dewitte (2014) reported that prior research showed patients did benefit from some individually based treatments for low sexual desire, including behavioral methods,

hormonal methods, or psychoeducational approaches. However, a strictly pharmacological approach has not addressed the intricate components of desire (Brotto & Smith, 2014). Some researchers sought use of Sildenafil (Viagra) with women to solve desire problems by assuming that male and female sexual feelings develop similarly. However, the resulting increased clitoral blood flow in women did not translate into a feeling of desire or arousal but instead was likened to feeling "a head cold in one's crotch" (Kleinplatz, 2011, p. #). After eight years of research, Pfizer withdrew Viagra from further clinical trials with women in 2004, claiming that female sexuality had a much greater psychological complexity that overrode biomedical intervention (Kleinplatz, 2011).

Evidence for the efficacy of testosterone treatment for female desire problems has been conflictual. Testosterone was linked to solitary desire and masturbation frequency in healthy, young females (Van Anders, 2012). However, there were no similar effects on dyadic desire for the same sample, so authors concluded dyadic desire may be more complex and dependent on other factors (Van Anders, 2012). Other researchers also found that "feelings for partner" was a stronger predictor for libido than any hormones such as estrogen or testosterone (Brotto & Smith, 2014). Although testosterone supplementation was thought to be a way to improve low sexual desire, the methodology of prior studies showing improvements have been questioned (Brotto & Smith, 2014). Recent studies on testosterone as a treatment for sexual desire have, therefore, proven inconclusive (Brotto & Smith, 2014).

One psychoeducation study on sexual dysfunction found that bibliotherapy significantly improved sexual desire, sexual arousal, and satisfaction over the course of

six weeks compared to controls when participants read a self-help book. Gains were also maintained in a 7-week follow-up (Mintz, Balzer, Zhao, & Bush, 2012). Van Lankveld (2009) did a comprehensive literature review on self-help strategies that supported the efficacy of bibliotherapy to no treatment with four older studies reporting an average effect size (ES) of 1.28. No follow-up data were reported. This author also reported another meta-analysis of 12 controlled bibliotherapy studies in 1998 showed a smaller mean ES of 0.68 at post-treatment, but gains had substantially eroded at follow-up (van Lankveld, 2009). In a more robust study, 199 couples received cognitive-behavioral bibliotherapy for sexual dysfunction using sensate focus and rational-emotive therapy with limited therapeutic assistance. Again, while sexual frequency and sexual distress improved when measured after a 10-week treatment period, these gains had mostly eroded at follow-up (van Lankveld, 2009). Treatment compliance was the largest factor for outcome post-treatment and at follow-up. Val Lankveld concluded that bibliotherapy was a cost-effective treatment for sexual desire, but the treatment effects may not be longstanding (van Lankveld, 2009). He suggested that other self-help methods such as video- or computer-based treatments may also be effective for sexual distress, but the outcome studies to date have been insufficient to make clinical recommendations (van Lankveld, 2009).

Cognitive-behavior therapy (CBT) has been used extensively to treat the anxiety around sexual performance that can interfere with desire (Brotto & Luria, 2014). Spectating causes the person to evaluate one's own performance in a critical manner during sexual encounters. Preoccupation with adverse self-appraisals triggers negative affect that hinders sexual response. CBT treats low sexual desire by replacing negative,

automatic responses with more adaptive, positive responses. There is evidence that eight weeks of individual CBT including sensate focus and directed masturbation resulted in significantly greater sexual desire and lasting improvements at a six-month follow-up (Brotto & Luria, 2014). Group CBT over twelve weeks showed significantly reduced HSDD with gains maintained at a one-year follow-up. However, CBT for low desire administered through a self-help manual with minimal clinician involvement did not lead to improvements (Brotto & Luria, 2014). The authors concluded that a self-help approach may be inadequate to treat the complexity of low sexual desire in a relationship (Brotto & Luria, 2014).

Mindfulness is now enhancing CBT by teaching women to use a non-judgmental stance along with attentional focus on body sensations to increase feelings of sexual pleasure (Brotto & Basson, 2014). One study was performed on 117 women. A 4-session 90-minute group mindfulness therapy significantly improved sexual desire, arousal, lubrication, satisfaction, and overall sexual functioning for 68 women compared to a delayed treatment control group consisting of 49 women (Brotto & Basson, 2014). These findings have been confirmed by other studies as well (Brotto, 2013).

Even though researchers have found that CBT and mindfulness-based approaches to individual treatment have been effective, patients may need a combination of approaches, especially when interpersonal issues are present (Brotto & Luria, 2014). Consequently, a more integrated approach to low sexual desire treatments is important, as some individual approaches or diagnosis-driven treatment strategies have often proven inconsistent or ineffective (Brotto & Smith, 2014).

Non-attachment relational treatments for low sexual desire. Mechanistic methods, hormonal treatments, and psychoeducation have not proven to be the antidote to sexual dysfunction that practitioners were hoping for because there appears to be a myriad of factors contributing to sexual difficulties for many couples (Brotto & Smith, 2014). Therefore, treatment strategies need to be multidimensional to be effective (Brotto & Smith, 2014). While certain persons found individual modalities clearly helpful, some individuals suffering from low sexual desire needed an expanded model that also includes relational factors, especially for women (Dewitte, 2014; McCabe & Goldhammer, 2013).

Other researchers concur that women particularly need this broader model for the treatment of sexual issues, as they tend to emphasize relationship and commitment as the context for sexuality to a greater degree than do men (Impett et al., 2014). In addition, female sexual response greatly depends on the relational communication patterns and the present situational dynamics. Because the main predictor of sexual satisfaction is emotional intimacy, clinicians should include treatment strategies that promote communication, security, and relational closeness when addressing sexual arousal problems (Pascoal et al., 2012)**.** These important factors appear to be needed for couples to experience more positive sexual encounters (Pascoal et al., 2012). The inclusion of relational strategies can significantly increase intervention success when treating sexual dysfunction (Impett et al., 2014; Pascoal et al., 2012).

As such, researchers have called for a more integrated approach to sex therapy that would better treat the complex factors underlying sexual problems rather than an individualistic approach, which has been previously emphasized in the field (Brotto &

Luria, 2014; Johnson & Zuccarini, 2011). By defining low sexual desire in a systemic, relational way, more effective treatment strategies can be developed (Johnson & Zuccarini, 2010; McCarthy & McCarthy, 2014; McCarthy & Wald, 2012). Similarly, McCarthy and McCarthy (2014) advise couples to work as a team to improve their sexual relationship and emphasized relational factors over individual ones. This helps couples get out of a blaming stance that interferes with sexual responsiveness (McCarthy & McCarthy, 2014).

Recently, sex therapy treatment strategies are starting to have a greater systems focus according to Brotto and Luria (2014). These authors noted that sexual problems can both create and result in poor relationship satisfaction. Partner-related attributes such as attractiveness, too high or low sexual demand, or mistreatment by a partner can also affect sexual desire (Brotto & Luria, 2014). From an emotional-motivation view, partners will seek sexual experiences they expect will be positive and avoid or reduce sexual contact in situations they anticipate will be unpleasant (Brotto & Luria, 2014).

Relational treatments for sexual desire are not a recent phenomenon. Sensate focus exercises were first developed by Masters and Johnson (1970). These exercises have been a long-standing technique that uses a relational approach to the treatment of low sexual desire in women (Brotto & Smith, 2014). Sensate focus employs touch exercises done over a period of weeks where couples gradually move from enjoying non-genital massage to progressively more intimate genital touch. Sensate focus techniques are intended to reduce anxiety around the sexual response cycle and to help restore a couple's ability to re-experience sexual pleasure as they focus on positive physical sensations (Brotto & Smith, 2014). Couples can then experience enjoyment in

a non-demand atmosphere, as intercourse is prohibited so performance anxiety is reduced (Brotto & Smith, 2014; Frühauf et al., 2013).

One study of 60 heterosexual couples showed that sensate focus exercises resolved or largely resolved the desire problems with 47% retaining those improvements at 3-month follow-up (Brotto & Smith, 2014). In 1997, a seven-week treatment program for couples using sensate focus showed that 65% of women with HSDD and 63% of men had a successful treatment outcome, defined as resolution of the original sexual problem with no new problems and the couple having weekly intercourse for the last three weeks of the program (Brotto & Smith, 2014).

While effective treatments for low sexual desire exist, many couples do not have the skills to address these often complex and emotionally painful issues without the help of a professional (Johnson & Zuccarini, 2010). Therefore**,** Johnson and Zuccarini (2010) concluded that, in theory, couples therapy is an optimal place for couples to talk about their sexual difficulties so that couples can receive the psychoeducation and support needed to change longstanding patterns. Johnson and Zuccarini's recommendation is supported by research stating that couples therapy has been shown to positively impact over 70% of clinically distressed couples (Lebow, Chambers, Christensen, & Johnson, 2012). Couples reported greater relationship satisfaction after receiving marital therapy over controls who did not receive treatment. Couples in less distress have more successful communication strategies, and couples with less conflict have higher sexual satisfaction (Péloquin, Bigras, et al., 2014).

There is also a greater call for the integration of marital and sex therapy to achieve greater levels of success in treatment rather than viewing sex therapy as its

own specialty (Binik & Meana, 2009). Consequently, the previously rigid barrier between couples therapy and sex therapy needs to become more permeable (Binik & Meana, 2009; McCarthy & Wald, 2012). Researchers recommended that couples therapists need to integrate sexuality, and sex therapists need to integrate treatment of relational factors to address sexual desire difficulties (Brotto & Luria, 2014; McCarthy & Wald, 2012; Sims & Meana, 2010).

McCarthy and Wald (2013) recommended that therapists and couples use a good enough sex (GES) modality to increase desire in couples. GES attempts to increase a couple's feeling of security and enjoyment of erotic interactions. This modality encourages the couple to work as an intimate team to improve their sexual desire and emphasizes relational communication factors using mindfulness techniques, including non-judgement. Therapists using the GES approach teach couples to have a positive, realistic approach to sexual encounters instead of expecting amazing, passionate sex each time, which then leads to disappointment (McCarthy & Wald, 2012). Couples are taught to expect and accept variations in sexual desire and experiences, especially with the challenges of children, job stress, and aging (McCarthy & Wald, 2012).

McCarthy and McCarthy (2014) reported that many couples experience sexual desire issues because they only function at two levels: nonsexual affection and intercourse. These two levels can feel mundane and unsatisfying for women. GES teaches couples to have a greater sexual range including playfulness, passionate massage, and eroticism that may not lead to intercourse (McCarthy & McCarthy, 2014). Couples are taught to find their erotic voice with one another to talk about sexual

desires and needs in an emotionally safe way. Desire can increase as couples can accept gender differences in the sexual response cycle. GES helps couples recognize that the female partner may enjoy multiple types of stimulation that may lead to orgasm (manual, oral, rubbing, or vibrator) and that not climaxing during intercourse is normal (McCarthy & McCarthy, 2014; McCarthy & Wald, 2013). Clinical studies on the GES model are needed to demonstrate its effectiveness, although McCarthy and Wald (2013) stated that GES's effectiveness is comparable to other mindfulness treatment strategies for low sexual desire (McCarthy & Wald, 2013).

Attachment-based relational treatments for low sexual desire. Stephenson and Meston (2010) concluded that the negative effects of distressing sexual problems on quality of life can be reduced by increasing the attachment security and, thus, the relational framework within which they are occurring. Lebow et al. (2012) reported that emotionally focused therapy (EFT) is a successful couple modality that attempts to change the partners' attachment bonds from insecure to secure. According to Lebow et al. (2012), a meta-analysis done in 1999 showed that over 70% of couples receiving EFT moved from distressed to non-distressed, and 86% reported significant improvement in their relationship. Results remained stable at follow-up, even for high-risk couples or those with significant emotional injuries (Lebow et al., 2012).

In another study, 15 of 24 mild to moderately distressed clinical couples resolved a significant attachment injury after receiving 13 sessions of EFT (Makinen & Johnson, 2006). Examples of attachment injuries included 10 instances of infidelity and actual or perceived abandonment. After treatment, resolved couples reported feeling greater feelings of forgiveness and significantly less relational distress than did non-resolved

couples (Makinen & Johnson, 2006). These couples were observed to have fewer hostile responses (e.g., belittling, blaming, defending, or withdrawing) at treatment end versus non-resolved couples (Makinen & Johnson, 2006). Twelve of these couples participated in a follow-up study. These couples maintained these gains at a three-year follow-up using the Dyadic Adjustment Scales on trust and forgiveness (Halchuk, Makinen, & Johnson, 2010).

Johnson and Zuccarini (2010, 2011) proposed that emotionally focused couple therapy is a modality that is particularly well matched to address the potentially negative effects of insecure attachment on sexual issues, including low desire problems. Attachment-based treatment strategies offer a comprehensive treatment approach that takes into account couples' emotional, physical, and sexual response patterns that affect sexual desire and subsequent sexual behaviors (Johnson & Zuccarini, 2011). Attachment styles explain the existence of many negative couple interactions, both sexual and nonsexual, as insecure persons rely on secondary attachment strategies such as hyperactivation (e.g., verbal attacks or angry demands) and deactivation (i.e., withdrawal) that create serious problems in relationships (Mikulincer & Shaver, 2012).

These secondary attachment strategies are ineffective coping mechanisms that need to be understood as ways to satisfy unmet attachment needs that negatively trigger the partner both in and out of the bedroom (Johnson & Zuccarini, 2011). Before treatment, anxiously attached partners overwhelmed their avoidant partners, and their avoidant partners shut down (Johnson & Zuccarini, 2011). These strategies only increased the fears of abandonment already present in their anxiously attached lover. This negative cycle produces a mutually created demand-withdraw pattern that both find

dissatisfying, but the pattern becomes reciprocally reinforcing (Johnson & Zuccarini, 2011). EFT focuses on breaking this cycle so that couples can enjoy one another instead of inducing fear in each other (Lebow et al., 2012).

In EFT, as couples learn to answer calls for connection and emotional safety, they soothe one another and, thus, relate more effectively (Johnson & Zuccarini, 2011). Couples who receive EFT are better able to control negative emotional reactivity and express greater positive emotion such as vulnerable primary emotions and underlying attachment needs (Johnson & Zuccarini, 2011; Lebow et al., 2012). Enhancement of attachment security can also facilitate the reduction of individual psychopathology that has a negative effect on the couple's relationship (Mikulincer & Shaver, 2012).

EFT has been shown to be a modestly effective treatment for couples in sexual distress in two studies (Honarparvaran et al., 2010; MacPhee et al., 1995). One controlled experiment studied 49 couples experiencing low sexual desire (MacPhee et al., 1995). Couples were randomly assigned to a treatment group that received 10 sessions of EFT or to a wait-list control group. No significant differences between groups were initially found on demographic and desire measures pretreatment. After treatment, females reported significantly more desire on one measure than did control group females, but results did not translate to a higher frequency of sex or desire toward a partner (MacPhee et al., 1995). Also, couples reporting low marital distress after treatment experienced better overall sexual adjustment compared to those with high marital distress, but later analysis showed that couples who were in less distress pre-treatment showed the highest gains (MacPhee et al., 1995). The authors attributed the lack of

more robust findings to the possibly more entrenched nature of the sexual problems that required a greater number of sessions (MacPhee et al., 1995).

More recently, another study done on the treatment of sexual problems using EFT found that EFT reduced sexual dissatisfaction among couples (Honarparvaran et al., 2010). Sixteen couples of 100 couples reporting sexual dissatisfaction on the Index of Sexual Satisfaction were randomly selected and then distributed into experimental and control groups. Measures of sexual satisfaction were taken at pre- and post-study. The group that received EFT training showed significantly higher sexual satisfaction than controls, especially among female participants who reported a significantly higher level of sexual satisfaction than men (Honarparvaran et al., 2010). No significant differences were reported among genders in the control group, and the control group did not show improvement (Honarparvaran et al., 2010). Limitations of this research are that the authors do not specify what type of training the experimental group received, nor to they specify the treatment received by the control group (no treatment or an alternative treatment). The value of this research is questionable, as their methodology is not specific and, therefore, difficult to replicate. Another limitation is the small sample size. Therefore, a larger study would need to be performed to extend the results to the general population (Honarparvaran et al., 2010).

Some authors have recommended a combination of attachment and traditional sex therapy approaches (Bennett et al., 2012; Johnson & Zuccarini, 2011). Notably, Bennett et al. (2012) indicated that attachment style is not fixed and can change. As attachment style becomes increasingly secure, couples can better address existing sexual dysfunction, including low sexual desire (Bennett et al., 2012). An effective

treatment approach would assess each partner's attachment style and his or her ability to provide a secure base for the other. Theoretically, treatment interventions teaching co-regulation when couples are in attachment distress would then create more satisfying relational interactions (Bennett et al., 2012; Johnson & Zuccarini, 2011).

Bennett et al. (2012) recommended an eight-step treatment model built on sensate focus to create or enhance feelings of attachment security between the partners. To increase attachment security, the therapist needs to facilitate emotionally safe sessions in which the couple can learn to interact in a vulnerable way where seeking and providing caregiving leads to emotionally significant experiences (Bennett et al., 2012). After ruling out medical explanations for the sexual dysfunction, the clinician would take a sexual history of each partner and encourage discussions about each partner's thoughts, feelings, worries, and desires. Any past sexual traumas also need to be addressed, as that can clearly block desire (Bennett et al., 2012). The therapist would then normalize sexuality, explain the sexual response cycle, and then review the importance of safety, caregiving, listening, and intimacy in building attachment. The counselor would then lead various enactments in the session promoting trust and vulnerability (Bennett et al., 2012).

As emotional trust and connection grow in the sessions, couples can move to non-sexual interactions promoting closeness at home such as date nights or daily sharing times (Bennett et al., 2012). Next, non-sexual touch exercises (intercourse is prohibited) are added to build physical trust and safety such as hugs or massage. Then, as the couple feels safe enough to enjoy sexual touching without intercourse, desire can be reignited (Bennett et al., 2012). They can then feel secure enough to be givers and

receivers of sexual pleasure and can enjoy intercourse (Bennett et al., 2012). Couples that are more secure are no longer preoccupied with anxiety around sexual communication and are better able to communicate sexual feelings, needs, and wishes (Bennett et al., 2012).

Treatment implications were discussed after Timm and Keiley (2011) noted the effects of attachment style on relationship satisfaction, sexual communication, and sexual satisfaction. Because satisfaction around communicating with sexual matters allows partners to talk openly to one another about sexual needs and preferences, the authors conclude that addressing any underlying insecure attachment style would be necessary before that didactic communication skills training or sex therapy would be successful (Timm & Keiley, 2011). By helping couples increase the level of security in their attachment, couples can have better affect regulation (Timm & Keiley, 2011). As couples can better tolerate the anxiety around discussing sexual issues in the relationship, they can communicate more effectively (Timm & Keiley, 2011). These treatment goals will then have a positive effect on both marital and sexual satisfaction (Timm & Keiley, 2011).

Timm and Keiley (2011) recommended emotionally focused therapy (EFT) because EFT is an empirically validated approach to treating distraught couples. Also, EFT is currently the only couples modality that specifically seeks to improve the attachment style of clinical patients (Timm & Keiley, 2011). Areas of distress in the relationship are seen as insecure bonds that cause rigid interaction patterns. Rigidity then blocks flexible emotional engagement patterns that could help the couples resolve problematic issues (Timm & Keiley, 2011). If clinicians do not use EFT, they are

encouraged to incorporate attachment theory and attempts to build relational security into whatever model of relational therapy they are using. Limitations of this study are that the participants were from a nonclinical married population, so results may not be generalizable to clinical, nonmarried, or same-sex populations (Timm & Keiley, 2011).

Péloquin, Bigras, et al. (2014) recommended including interventions for sexually distressed partners that increase demonstrations of support to increase attachment security. Findings showed that partner support moderated the negative effects of insecure attachment on sexual anxiety and sexual assertiveness (Péloquin, Bigras, et al., 2014). These authors maintained that support and demonstrations of caregiving become especially important if one partner has attachment insecurity. These authors specifically recommended an approach such as EFT to address sexual difficulties (Péloquin, Bigras, et al., 2014). The EFT therapist attempts to restructure the couple's relational interactions so that distressing exchanges are understood through the attachment framework. Couples are encouraged to see problematic communication or cues surrounding their sexual dysfunction as part of their overall communication patterns (Péloquin, Bigras, et al., 2014). These communication patterns are referred to as a dance where they each impact the other in a reciprocal fashion, but no one person is to blame (Péloquin, Bigras, et al., 2014).

By promoting more expression of vulnerable emotions such as hurt or fear (i.e., primary emotions) instead of anger or blame (i.e., secondary emotions), the therapist can create a safe haven for the couple (Péloquin, Bigras, et al., 2014). In this atmosphere of safety, positive caregiving can replace accusations, stress, and uncertainty, increasing the security of the couple's attachment (Péloquin, Bigras, et al.,

2014; Péloquin, Brassard, Delisle, & Bédard, 2013). The sexual problems can then be addressed successfully. Thoughtful offers of support decrease the negative effects of insecurity, allowing more enjoyable sexual experiences (Péloquin et al., 2013; Péloquin, Bigras, et al., 2014).

Once couples begin to enjoy their sexual experiences and feel more secure, research shows that sex pillow talk (sharing about what each partner enjoyed) significantly increases feelings of sexual fulfillment (McCarthy & McCarthy, 2014). Feelings of sexual fulfillment are important so that desire for future sexual experiences will grow. When couples can replace mundane sexual routines with anticipation for playful, erotic experiences, then excitement can return (Kleinplatz, 2011; Kleinplatz et al., 2009)

Chapter Three: Research Methods and Procedures

Introduction

The purpose of this study was to analyze the data on the antecedents of low sexual desire in females from a non-attachment and then an attachment-based focus. The emphasis of this study was to examine the relationship between attachment style, especially insecure attachment, and low sexual desire among females. Once such a relationship was found, treatment implications for couples were also examined. These topics were considered through the perspective of attachment theory, which was discussed in the literature review. The specific research questions addressed in this dissertation were as follows:

- What are general, non-attachment-based individual antecedents of low sexual desire among women?
- What are attachment-based individual antecedents of low sexual desire among women?
- What are general, non-attachment-based relationship factors that are antecedents of low sexual desire among women?
- What are attachment-based relationship factors that are antecedents of low sexual desire among women?
- Based on the premise that a relationship between insecure attachment and low sexual desire in females is present, what treatment implications exist for couples?

Methodology

This project is a theoretical study that conducted an extensive literature review to

answer the above research questions. Theoretical studies are a scientific method that broadens understanding and offers new interpretations to scholarly research (Creswell, 2013). The interpretive/theoretical literature review is an approach that traces the progression of the field including comparisons and contrasts (Creswell, 2013). In this study, the information from the research was analyzed to determine the significance of evidence or deficiencies of findings to answer the research questions (Creswell, 2013).

The extensive literature review performed in this paper consisted of 72 peer-reviewed journal articles and 8 chapters in scholarly books. The majority of the literature reviewed was obtained through the California Southern University library database of scholarly journal articles from EBSCOhost, Psychology and Behavioral Sciences Collection, and the ProQuest search engine. The remaining articles were obtained through the Google Scholar search engine or from interlibrary loan. The keywords searched for were: attachment, insecure attachment, female low sexual desire, relationship, female sexual dysfunction, hypoactive sexual desire disorder, emotionally focused therapy, and low sexual desire treatments for women. Certain prominent researchers in the field were also searched for by name in the above search engines to find additional pertinent articles or book chapters. Relevant books were purchased.

The articles and chapters were then systematically analyzed and organized according to relevance to the research questions. Comprehensive and thorough readings were initiated to synthesize, interpret, and summarize the current scholarly literature. After reading the material, the research questions were answered based on the analysis of the literature data.

Because of the broad range of articles available on general sexuality, this study limited the articles and chapters reviewed to those pertaining to female low sexual desire. Factors required for female sexual satisfaction does not agree with the purpose section. The literature of greatest focus pertained to relationship or attachment style, and female low sexual desire. Articles or chapters exclusively about male subjects or only male sexuality were excluded.

This study then examined the non-attachment individual antecedents of female low sexual desire in greater depth. These include hormonal dysfunction, child abuse, and familial or cultural factors (Brotto & Luria, 2014; Brotto & Smith, 2014). Attachment-based individual reasons for low sexual desire were examined. The three main attachment styles were each defined and explained (i.e., secure, anxious, and avoidant). Then their respective impact on individual sexual desire was explored. Supporting literature was examined in great depth.

Then, the core of the study began by exploring the literature regarding the impact of relational factors as antecedents of low sexual desire among women. Initially, non-attachment relational reasons for low sexual desire in females were analyzed after an extensive literature review. The non-attachment based relational factors associated with low sexual desire in the current literature were explored, such as relationship duration, conflict, relational insecurity, relationship dissatisfaction, and lack of responsive desire.

Attachment-based relational reasons for low sexual desire among females were then explored. After reporting the effects of secure attachment on the sexual response cycle, the study comprehensively reviewed the effects of the two insecure attachment

styles (i.e., anxious and avoidant) on sexual satisfaction and desire, noting both positive and negative findings where applicable.

Last, treatment implications for couples were explored in situations where the female was experiencing low sexual desire, and sexual desire was noted as a complex biopsychosocial process that was resistant to improvement. An analysis of individual approaches was performed to compare and contrast those methods with a comprehensive analysis of relational and attachment-based treatment strategies. Individual treatment methods reviewed included biomedical/hormonal treatments, cognitive-behavioral therapy, and psychoeducational approaches. Relational treatment strategies analyzed included non-attachment methods (i.e., sensate-focus or the good enough sex model), and attachment-focused methods (i.e., emotionally-focused therapy or attachment-based traditional couple therapy).

Data Analysis

Articles and chapters included in this literature review were chosen based on their quality factors, including credibility, objectivity (consideration of contrary findings), sound methodology, persuasiveness, and level of contribution to the field. Any exceptions to these elements were noted. In addition, for inclusion purposes, research that is more recent was considered more valuable than older research. The articles and chapters used in this project were less than seven years old, except for a few older references that were noteworthy enough for inclusion. These older references were included because they were considered so important or pertinent that the project would be lacking without them.

Articles and chapters were then evaluated by research question. The data were analyzed by examining the frequency of common themes and study results of each article.

These results were then obtained for each relevant article and then coded on an Excel spreadsheet looking for common themes to answer each research question from the evidence gathered (See Appendix: Relevant Key Words Used to Obtain Results for Research Questions).

Assumptions and Limitations

This study operates under the assumption that secure attachment, anxious attachment, and avoidant attachment are terms uniformly understood in the research community, as they are based on Bowlby's attachment theory (Bowlby, 1969, 1988). This doctoral project also assumes that the various researchers in the field have a common understanding of low sexual desire and sexual dysfunction based on the DSM-IV and DSM-V definitions (American Psychiatric Association, 2000, 2013).

Limitations of this study arose because female sexual desire takes different forms. This study was primarily focused on how insecure attachment affects low sexual desire in heterosexual females of childbearing age because that was the age range studied or written about in the majority of the articles or chapters. Consequently, the results of this study may not generalize to female same-sex couples. In addition, sexuality in post-menopausal or older heterosexual couples was not a focus of this study. Therefore, the results may not generalize to this segment of the female population.

Another consideration that may be a limitation of this project is that it is unknown if those who participate in sexual studies are representative of the general population. Because discussing sexuality with researchers or reporting sexual symptoms can be embarrassing or off-limits for some conservative persons, it is difficult to know if the

results of sexual research are applicable to conservative or more religious females due to self-selection bias (Burri et al., 2013). Therefore, this study has some limitations when applying the results to the general population.

Chapter Four: Findings

Introduction

This chapter provides a summary of the findings, data gathered from the global literature review, and conclusions addressing each of the research questions. The purpose of this study was to determine the individual and relational antecedents of low sexual desire for females, each from a non-attachment-based focus and then from an attachment-based focus. If a connection between insecure attachment and low sexual desire in this study is found, treatment implications for both therapists are discussed. A comprehensive literature review was conducted to obtain the data necessary to perform this study. Information was gathered to determine relevant treatment strategies so that clinicians can improve treatment outcomes for low sexual desire, which remains a difficult to treat biopsychosocial phenomenon (Brotto & Luria, 2014). The factors required for sexual satisfaction are an important area of study because sexual satisfaction highly correlates with both relationship satisfaction and life satisfaction (Stephenson & Meston, 2015).

Research Findings

Low sexual desire is an extremely important topic to study, as inadequate desire is relevant in 50-60% of cases when clinical couples present in therapy (Brassard et al., 2015). Unresolved desire problems have a tremendously negative effect on a couples' feeling of overall relationship satisfaction more so than other factors such as praying, eating, and socializing (Stephenson & Meston, 2015). Researchers have also found that poor sexual intimacy is experienced in a more detrimental way for women who have

high attachment anxiety/fears of abandonment or who are in more unsatisfying relationships (Stephenson & Meston, 2015).

Bennett et al. (2012) stated that a person's attachment style significantly affects both adult romantic relationships and sexual functioning. Consequently, it is important to understand the effects of attachment style on sexual dysfunction, as the attachment system is activated during sexual intimacy with an adult romantic partner (Bennett et al., 2012; Birnbaum, 2015).

The caregiving, attachment, and sexual systems all interact with one another and have a reciprocal effect in adult romantic relationships, especially for females (Brassard et al., 2015; Péloquin et al., 2013; Péloquin, Brassard, et al., 2014). In addition, it is important to understand the effects of the attachment model on the sexual system to add to the body of literature germane to this study's topic. This study extends the results of prior studies on the relationship between attachment insecurities and sexual motivation, as motivation is a fundamental concept in attachment theory (Mikulincer & Shaver, 2007).

Results

The global literature review for this study was performed through an extensive literary search for scholarly journals through the California Southern University Library Sources EBSCOhost database entitled Psychology and Behavioral Sciences Collection. This search delivered 884 journal articles. After review and data analysis, a further reduction was made to 145 relevant journal articles. In addition, the ProQuest search engine for the terms attachment and sexual dysfunction yielded 1,857 articles. This search was then narrowed to 29 articles related to female low sexual desire that were

published since 2009. Additional resources were obtained through the Google Scholar search engine or through interlibrary loan by searching for articles authored by prominent researchers. The keywords utilized were attachment, insecure attachment, female low sexual desire, relationship, female sexual dysfunction, hypoactive sexual desire disorder, emotionally focused therapy, and low sexual desire treatments for women. Relevant books were purchased. Ultimately, 92 resources were used to obtain the results of this study.

An analysis was conducted on research data in order to draw significant conclusions as well as identify areas for future inquiry. Within this chapter are the results of this data analysis as they relate to each of the five research questions contained in this study (See Appendix: Relevant Key Words Used to Obtain Results for Research Questions).

Research Question One

What are general, non-attachment-based individual antecedents of low sexual desire among women?

Certain common themes have emerged after examining non-attachment-based individual factors that contribute to low sexual desire in females. Dürr (2009) highlighted the most important psychological themes that contribute to low sexual desire. These include anger, depression, anxiety, child sexual abuse, religious teachings, and cultural values. Individually-based physical factors such as hormonal imbalance, health problems, and pain can also interfere with adequate desire (Brotto & Luria, 2014; Dürr, 2009). All of the 11 articles used to determine the important antecedents of low sexual

desire among women mention each of these psychologically-based and physically-based factors.

Research Question Two

What are attachment-based individual antecedents of low sexual desire among women?

Securely attached persons had backgrounds with caregivers that were more available and responsive to their childhood emotional needs (Dewitte, 2012). This comfort helped them develop a trusting view of self and others (Mikulincer & Shaver, 2012). As a result, persons with a secure attachment perceive themselves as more lovable and sexually desirable as an adult, and they also perceive their partners as available and responsive (Dewitte, 2012).

During sexual intimacy, this inner representation of a secure base frees up emotional resources within securely attached individuals that allow them to be emotionally present instead of anxious and self-protected (Birnbaum, 2010; Dewitte, 2012). As a result, securely attached persons are more comfortable with giving and receiving than the insecurely attached (Dewitte, 2012). This resulting emotional availability allows attunement and responsiveness to their own erotic cues as well the sexual cues of a partner (Birnbaum, 2010). This responsiveness has a beneficial effect on the couple's sexual intimacy, as it facilitates mutual feelings of desire and sexual gratification (Birnbaum, 2010; Dewitte, 2012, 2014).

This inner-felt sense of security helps those with a secure attachment withstand disappointments and times of disharmony and conflict, both sexually and non-sexually (Dewitte, 2012). The trusting inner representation of self and others provides a

foundation of positive expectations during upsetting interactions when the attachment system is activated as a result of distress (Dewitte, 2012, 2014). Consequently, greater frustration tolerance exists in those with a secure attachment, and recovery can be more easily achieved during the emotionally vulnerable moments of sexual intimacy when relational problems occur (Birnbaum, 2010).

Anxiously attached individuals are commonly described in the literature as having unmet childhood security needs, leaving them with doubts about their self-worth and sexual desirability (Birnbaum et al., 2014). This insecure attachment leaves them with fears and the subsequent overactive drive to feel important (Birnbaum et al., 2014). The subsequent hypervigilant emotional state causes anxiously attached persons to be highly sensitive to cues of abandonment, where any sign of rejection causes significant attachment distress (Birnbaum et al., 2014; Dewitte, 2014). As a result, anxiously attached individuals attempt to soothe their sense of loss and ensuing attachment panic through angry demand strategies (Dewitte, 2014; Mikulincer & Shaver, 2007; Pietromonaco & Beck, 2015).

Even in the presence of sexual cues, results show that persistent cycles of worry and anger can shut down the sexual response system for those that are anxiously attached (Pietromonaco & Beck, 2015). Therefore, desire and subsequent arousal do not emerge (Pietromonaco & Beck, 2015). In the presence of persistent fear, the attachment system overrides the sexual response system, and low sexual desire can become a chronic problem for the individual (Birnbaum et al., 2011). Consequently, individually based antecedents of worry and fears of abandonment cause anxiously attached individuals to have low sexual desire (Birnbaum, 2015; Birnbaum et al., 2014;

Pietromonaco & Beck, 2015). These common themes were written about in 23 articles explored in the literature review for this study.

Results also show that avoidant persons have various individually-based antecedents of low sexual desire. Avoidant individuals are typically fearful of potential loss due to child experiences of inadequate emotional comfort (Mikulincer & Shaver, 2007). Consequently, self-reliance becomes a primary coping strategy for the avoidantly attached, as no expectations formed that feelings serve a productive purpose. As a result, avoidantly attached persons use deactivating strategies such as avoidance or muted responses to numb feelings (Birnbaum, 2014). These constricted, inflexible responses exist in order to reduce potential attachment distress. Consequently, avoidant persons are less aware of sexual cues for themselves and their partners, and they have more problems with being sexually expressive (Birnbaum et al., 2013).

Avoidantly attached persons resist the vulnerability associated with sexual intimacy, as their insecure attachment causes them to remain in an emotionally guarded position (Birnbaum et al., 2013). Consequently, their sexual encounters can be brief, self-focused events rather than opportunities for extended emotional and physical connection, as they are for the securely attached (Birnbaum et al., 2013). These individually-bases attachment factors are antecedents to low sexual desire for the avoidantly attached, and these results are confirmed by 22 sources that were reviewed in the literature analysis performed for this study.

Research Question Three

What are general, non-attachment-based relationship factors that are antecedents of low sexual desire among women?

Non-attachment-based relationship factors have a fundamental effect as determinants of low sexual desire among females (Dürr, 2009). Females specifically are sensitive to a multiplicity of relational elements that have a detrimental effect on the emergence of desire (Dürr, 2009). This study found that the motivational factors required for desire are both complex and fragile (Dürr, 2009). Couples who present in therapy often have both inadequate erotic stimulation and negative expectations around the relational dynamics during sex (such as arguing or anxiety) based on past experiences (Both et al., 2010). Both of these deficiencies will be relational antecedents for low sexual desire (Both et al., 2010).

For females, desire typically emerges in the context of the relational interactions that precede the possible sexual experience (Both et al., 2010; Brotto & Luria, 2014). The cues that have sexual meaning that are positively appraised then activate the sexual response system, and then the person experiences signs of physiological arousal such as vaginal lubrication, emotional excitement, and anticipation (Brotto & Luria, 2014). Brotto called this type of desire *responsive desire*. Responsive desire emerges and becomes stronger depending on the level of relational closeness and emotional intimacy present in the relationship as the couple considers initiating a sexual experience (Both et al., 2010). Conversely, if any of these necessary conditions is not met, the sexual response system will break down, and responsive desire will not emerge (Both et al., 2010).

If the sexual response cycle is repeatedly interrupted, low sexual desire may emerge as a chronic problem (Both et al., 2010). Most of the low desire couples that are seen in clinical settings do not have health or hormonal causes for their decreased

sexual desire (Both et al., 2010). Instead, these low sexual desire couples no longer appraise the sexual interactions as pleasant or rewarding (Both et al., 2010). Consequently, this study finds that negative relational factors such as a lack of emotional intimacy are more important for females in the emergence of low sexual desire than are individually-based factors such as age, hormonal factors, and depression (Both et al., 2010).

Thirty-nine of the 92 articles that discussed relational sexuality mentioned the importance of relationship satisfaction on responsive desire and how relational dynamics have a pivotal impact on sexual motivation. Relationship satisfaction is highly correlated with sexual desire (Both et al., 2010). Although causation cannot be determined, this study concludes that female partners are particularly sensitive to the interpersonal characteristics of the sexual dynamics. Therefore, low sexual desire is present in women to a greater degree when fear and insecurity are chronically present, as fear and insecurity impede feelings of desire (Both et al., 2010). The findings of this study show that the psychosocial aspects of care, concern, safety, and emotional security are more important cues for sexual desire for females than are physiological cues (Both et al., 2010).

Research Question Four

What are attachment-based relationship factors that are antecedents of low sexual desire among women?

Attachment style developed in childhood impacts adult romantic relationships and sexual functioning (Bennett et al., 2012; Impett et al., 2008). Securely attached individuals have a greater capacity to negotiate closeness and, therefore, are able to

make a considerable investment in a romantic partner (Bennett et al., 2012). Their relationships are associated with higher levels of trust, emotional closeness, and satisfaction (Bennett et al., 2012). Stephenson and Meston (2010) found securely attached persons are not as distressed when desire problems emerge and can better tolerate those problems without experiencing residual relationship distress while insecurely attached persons tend to have negative assumptions regarding the quality of the relationship. As a result, this study finds that a secure attachment orientation and relational intimacy moderate low sexual desire and sexual distress in women (Stephenson & Meston, 2010).

Results indicate common themes that show that women who experience attachment anxiety have greater desire dysfunction than those without attachment anxiety (Stephenson & Meston, 2010). Consequently, factors that contribute to low sexual desire include the attributes of anxious attachment (Birnbaum, Weisberg, & Simpson, 2010). Doubts about being loved during sexual intimacy significantly interfere with sexual desire for anxiously attached persons (Birnbaum et al., 2010; Stephenson & Meston, 2010). For example, they use hyperactivating strategies such as neediness, clingy behaviors, and vigilance in order to demand reassurance from their partners in an angry way. These methods lead to a non-relaxed state for those who are anxiously attached, which negatively impacts levels of desire (Bennett et al., 2012).

Chronic fear of loss causes attachment distress for anxiously attached persons (Bennett et al., 2012). The resulting threat produces distracting biopsychosocial effects that reduce feelings of desire (Birnbaum et al., 2010). Rather than feeling psychobiological arousal, results show that anxiously attached persons instead tend to

have sex to please one's partner and express/receive love (Birnbaum et al., 2010). A focus on relational insecurity can interfere with the emergence of the responsive desire that women need to enjoy sexual experiences (Birnbaum et al., 2010). This result was commonly found among 14 studies. Therefore, this project finds that anxious attachment is positively associated with low sexual desire among females (Birnbaum, 2014).

Although sexual intimacy can be pursued by the anxiously attached to assuage fears of abandonment, those feelings should not be confused with satisfying levels of desire that arise from a partner's responsiveness (Birnbaum et al., 2011; Stefanou & McCabe, 2012). As a result, when an anxiously attached female seeks sex for self-focused reasons, her advances are often rejected by a partner and are not experienced positively (Stefanou & McCabe, 2012). Therefore, this study concludes that seeking sex simply to feel secure does not promote the emotional closeness or safety required for responsive desire.

Avoidantly attached individuals instead use deactivating strategies (Impett et al., 2014). They prefer independence and avoid emotional intimacy with a partner in an effort to protect themselves from emotional injury (Impett et al., 2014). Common relational patterns affecting sexual desire have emerged regarding avoidant persons in the comprehensive literature search performed as part of this study.

Studies show that avoidant persons are emotionally detached and unresponsive to their partner's needs during conflict resolution as well as sexual interactions (Birnbaum et al., 2013). Consequently, this study finds that the fear of emotional intimacy and resulting deactivating attachment strategies are antecedents of low sexual

desire among females who have an avoidant attachment style (Birnbaum et al., 2013). Additionally, partners of avoidant persons are less likely to pursue sexual intimacy to compensate for relational distress because those persons are less confident their avoidant partners will be responsive to their emotional needs (Birnbaum et al., 2013). This cycle creates a reduction of erotic cues that diminish the overall feelings of desire within the relational system (Dewitte, 2014). These findings are confirmed by 19 journal articles reviewed for this study.

Research Question Five

Based on the premise of a relationship between insecure attachment and low sexual desire in females, what treatment implications exist for couples?

Findings show that any treatment plan should start with a thorough assessment to understand any factors contributing to low sexual desire because of its complex biopsychosocial nature (Brotto, Bitzer, et al., 2010; Brotto & Luria, 2014). Women should be referred to a gynecologist to rule out any organicity that could be contributing to any sexual dysfunction (Brotto, Bitzer, et al., 2010). Psychosocial factors should be explored by understanding past sexual attitudes and experiences, including a lack of erotic cues, that may be associated with a lack of desire (Timm, 2009).

Results show that individually-based treatments such as cognitive-behavioral methods, medical treatments, or psychoeducational approaches can work for certain clients. However, cognitive approaches, psychoeducation through bibliotherapy, hormonal treatments, and pharmacological treatments are inadequate when positive relational cues are missing. For example, mindfulness advocates such as Brotto and Luria (2014) indicate that, while CBT and mindfulness have shown positive results in

increasing desire, these treatments do not adequately address relationally-based desire problems. Therefore, a more integrated couples approach is needed to address low sexual desire when relational dissatisfaction exists, especially for women (Dewitte, 2014; McCabe & Goldhammer, 2013).

Women tend to prioritize emotional connection to a greater degree than do men as a preferred context for sexuality (Impett et al., 2014). Therefore, the emergence of sexual desire is often dependent on the present dynamics when interacting with a partner. Any threat to relational closeness can cause insecurity, which then has a detrimental effect on emotional intimacy as well as sexual intimacy (Impett et al., 2014). Because the main predictor of sexual satisfaction is emotional intimacy, clinicians should include treatment strategies that promote communication, security, and relational closeness when addressing sexual arousal problems (Pascoal et al., 2012).

Because of the above positive findings that an insecure attachment style has an association with low sexual desire for females (as found in questions two and four), the implication for couples is that sexual distress can be diminished and sexual desire can increase by improving the level of attachment security within the relationship (Stephenson & Meston, 2015). As a result, relationship satisfaction is expected to improve, which then has a reciprocally positive effect on sexual functioning (Birnbaum, 2015).

This present finding is supported by Bennett et al. (2012) who stated that, to improve sexual dysfunction, it is crucial to address the attachment styles of each individual. Increasing attachment security can be accomplished by using approaches to specifically address relational security, or by using a modality such as EFT that focuses

on increasing attachment security. As individuals begin to build a more secure attachment, this study finds that the couple can experience greater feelings of emotional security that will increase responsive desire (Bennett et al., 2012; Johnson & Zuccarini, 2011).

Females specifically benefit from this focus on the attachment system. Therefore, couples can be the beneficiary of more effective treatment strategies for low sexual desire (Bennett et al., 2012). Other researchers concur that relational security is rooted in attachment security (Brassard et al., 2015). Without a secure attachment, couples will use negative strategies in times of distress and then activate one another's deepest fears (Dewitte, 2012).

Analysis and Evaluation of Findings

The premise that insecure attachment and female low sexual desire are related was explored. Research concerning both attachment theory and female low sexual desire were reviewed and studied to obtain this study's findings. Results indicate that antecedents of low sexual desire in females can include both individual and relational components. Each of those components can have non-attachment and attachment-based factors that form a complex constellation of negative symptoms. These symptoms can result in a diminished sexual desire that causes both psychological distress and interference with sexual functioning.

While the development of a secure attachment style is associated with healthy sexual functioning, both anxious and avoidant insecure attachment styles are associated with behavioral patterns that interfere with adequate sexual desire. Prior attachment injuries create an inadequate self-concept and a mistrusting view of others

that impedes open communication and sexual initiation. Insecure attachment styles also can cause a misreading of sexual cues by a partner, causing a more negative interpretation of unclear sexual signals. When signals are interpreted more negatively, attachment distress with the romantic partner is activated. As a result, insecurely attached partners have more difficulty recovering from such moments and often will respond to the perceived threat with anger or detachment to a greater degree than those with a secure attachment style. Repetitive negative patterns can result in future avoidance of sexual encounters and an overall reduction in adequate desire, especially the responsive desire that females need to function sexually in long-term relationships.

While some women struggle with low sexual desire because of organically based issues such as hormones or other medical problems, the vast majority of low sexual desire problems for women are associated with a lack of security/emotional intimacy in the relationship (Impett et al., 2014). To sufficiently change the relational patterns that are associated with low sexual desire, clinicians need to incorporate modalities that increase security and relational closeness when addressing sexual arousal problems (Pascoal et al., 2012).

Summary

Chapter Four provides a summary of the analyses performed in an attempt to answer the five research questions posed within this project. The literature used in this project suggests that when females have an insecure attachment, pessimistic views of self and others chronically cause attachment distress (Pietromonaco & Beck, 2015). The resulting anxiety fuels a need for self-protection that outweighs the caregiving and the sexual response systems (Birnbaum, 2015). Insecure attachment causes safety

needs in these women to become chronically preeminent, as there are not enough emotional resources left over to remain in a flexible, responsive stance (Birnbaum et al., 2014). Apprehensiveness will cause a lack of receptiveness that interferes with the emergence of sexual desire (Birnbaum et al., 2014). If this cycle happens repeatedly, low sexual desire can become a chronic issue for a couple (Birnbaum et al., 2014).

This study's findings are crucially important because negative sexual patterns are present for many couples, and low sexual desire causes tremendous relational distress. In a clinical setting, over 50-60% of couples having relationship problems are also suffering from some type of low sexual desire (Brassard et al., 2015). Therefore, it is essential that clinicians have effective treatments to address this prevalent problem.

Because an insecure attachment style is associated with low sexual desire in females, sexual distress can be lessened as the couple learns to relate to one another in a way to increases attachment security (Stephenson & Meston, 2015). By using modalities that focus on emotional safety for both partners such as sensate focus or EFT, new patterns of positive caregiving and comfort can emerge, which creates greater attachment security (Péloquin et al., 2013; Péloquin, Bigras, et al., 2014). The sexual desire problems can then be resolved successfully because relational satisfaction and increased emotional bonding have reciprocally positive effects on sexual satisfaction and responsive desire (Birnbaum, 2015).

Chapter Five: Summary, Conclusions, and Recommendations

This chapter provides a summary of findings and conclusions drawn from the literature review. Conclusions incorporated from the empirical data found themes that supported the research questions. This study was grounded in attachment theory and covered the topic of the connection between insecure attachment and low sexual desire in females.

This study was primarily focused on how insecure attachment affects low sexual desire in heterosexual females of childbearing age. The data and results are limited by the articles and chapters that were reviewed. The literature reviewed referred particularly to female subjects of childbearing age who were in heterosexual relationships. Therefore, the results of this study are limited to that population. Consequently, it is not possible to generalize the results to other populations, as they were not included in the sampling of articles used in the literature search for this study. Consistent findings were noted from the literature with few exceptions; therefore, resulting themes emerged and were reported. Any negative findings were reported, and explanations for those findings were proposed.

Significant results were found for each of the five research questions posed in this study. These results are important because they add to the body of literature seeking to explain the antecedents of, and treatment implications for, the complex biopsychosocial phenomenon of low sexual desire in females.

Summary

Research question one. What are general, non-attachment-based individual antecedents of low sexual desire among women?

Certain common themes have emerged after examining non-attachment-based individual factors that contribute to low sexual desire in females. Dürr (2009) highlighted the most important psychological themes that contribute to low sexual desire. These include anger, depression, anxiety, child sexual abuse, religious teachings, and cultural values. Individually-based physical factors such as hormonal imbalance, health problems, and pain can also interfere with adequate desire (Brotto & Luria, 2014; Dürr, 2009). All of the 11 articles used to determine the important antecedents of low sexual desire among women mention these psychologically-based and physically-based factors.

Research question two. What are attachment-based individual antecedents of low sexual desire among women?

Persons with a secure attachment perceive themselves as more lovable and sexually desirable as adults, and they perceive their partners as available and responsive. During sexual intimacy, this inner representation of a secure base frees up emotional resources within the individual that allow them to be emotionally present instead of anxious and self-protected (Birnbaum, 2010; Dewitte, 2012). As a result, securely attached persons are more comfortable with giving and receiving than the insecurely attached (Dewitte, 2012). This resulting emotional availability allows attunement and responsiveness to their own erotic cues as well the sexual cues of a partner, facilitating mutual feelings of desire (Birnbaum, 2010).

Anxiously attached individuals are plagued by doubts and fears about their self-worth and sexual desirability (Birnbaum et al., 2014). Even in the presence of inviting sexual cues, results show that persistent cycles of worry and anger can shut down the

sexual response system for those who are anxiously attached (Birnbaum et al., 2014). Consequently, individually-based antecedents of worry and fears of abandonment cause anxiously attached individuals to have low sexual desire (Birnbaum et al., 2014). These common themes were written about in 22 articles explored in the literature review for this study.

Avoidant individuals are typically fearful of emotional intimacy and remain emotionally guarded. As a result, avoidantly attached individuals use deactivating strategies such as avoidance or muted responses to numb feelings. Consequently, avoidant persons are less aware of sexual cues for themselves and their partners, and they have more problems with being sexually expressive. Consequently, their sexual encounters can be brief, self-focused events of physical release rather opportunities for closeness (Birnbaum et al., 2013). These individually-based attachment factors are antecedents to low sexual desire for the avoidantly attached.

Research question three. What are general, non-attachment-based relationship factors that are antecedents of low sexual desire among women?

For females, desire is not simply spontaneous but instead emerges in the context of the relational interactions that precede the possible sexual experience. This responsive desire emerges and becomes stronger depending on the level of relational closeness and emotional intimacy that is present in the relationship (Both et al., 2010; Brotto & Luria, 2014). Conversely, if any of these necessary conditions are not met, the sexual response system will break down, and responsive desire will not emerge, as the factors required for desire are both complex and fragile (Both et al., 2010).

Low sexual desire may emerge as a chronic problem when couples no longer appraise the sexual interactions as pleasant or rewarding (Both et al., 2010). Consequently, this study finds that negative relational factors such as a lack of emotional intimacy are more important for females in the emergence of low sexual desire than are individually-based factors such as age, hormonal factors, and depression (Both et al., 2010).

Although causation cannot be determined, this study concludes that female partners are particularly sensitive to the interpersonal characteristics of the sexual dynamics (Both et al., 2010; Mark et al., 2014). Therefore, low sexual desire is present in women to a greater degree when fear and insecurity are chronically present, as fear and insecurity impede feelings of desire (Both et al., 2010). Emotional security is a crucial cue for sexual desire (Both et al., 2010; Mark et al., 2014).

Research question four. What are attachment-based relationship factors that are antecedents of low sexual desire among women?

Attachment style developed in childhood significantly impacts adult romantic relationships and sexual functioning (Bennett et al., 2012; Impett et al., 2008). Securely attached individuals have a greater capacity to negotiate closeness, can more accurately interpret relational cues, and are, therefore, able to make considerable investment in a romantic partner (Bennett et al., 2012; Birnbaum, 2015; Pietromonaco & Beck, 2015). Their relationships are associated with higher levels of trust, emotional closeness, and satisfaction (Bennett et al., 2012). As a result, this study finds that a secure attachment orientation and relational intimacy moderate low sexual desire and sexual distress in women (Péloquin, Bigras, et al., 2014; Stephenson & Meston, 2010).

Conversely, doubts about being loved during sexual intimacy significantly interfere with sexual desire for anxiously attached persons (Birnbaum et al., 2010; Stephenson & Meston, 2010). The chronic feelings of impending threat and insecurity interfere with the emergence of the responsive desire that women need to enjoy sexual experiences (Birnbaum et al., 2010). A sexual partner then does not feel positive relational cues (Birnbaum et al., 2014). This project finds that an insecure style of anxious attachment is an antecedent of low sexual desire among females and also creates a systemic feedback loop that sustains a lack of desire (Birnbaum, 2014).

Although sexual intimacy can be pursued by the anxiously attached to assuage fears of abandonment, those feelings should not be confused with satisfying levels of desire that arise from a partner's responsiveness (Stefanou & McCabe, 2012). As a result, when an anxiously attached female seeks sex for self-focused reasons, her advances are often rejected by a partner and are not experienced positively (Stefanou & McCabe, 2012). Therefore, this study concludes that seeking sex predominantly for security reasons does not promote the emotional closeness or safety required for responsive desire.

Avoidantly attached individuals instead use deactivating strategies, as they prefer independence and an avoidance of emotional intimacy with a partner in an effort to reduce potential psychological injury (Impett et al., 2014). Studies show that emotional detachment and unresponsiveness are antecedents of low sexual desire among females who have an avoidant attachment style (Birnbaum et al., 2013). Additionally, partners of avoidant persons are less confident that their avoidant partners will be

responsive (Birnbaum et al., 2013). This cycle creates a reduction of erotic cues that diminish the overall feelings of desire within the relational system (Dewitte, 2014).

Research question five. Based on the premise that there is a relationship between insecure attachment and low sexual desire in females, what treatment implications exist for couples?

Results shows that cognitive approaches, psychoeducation through bibliotherapy, hormonal treatments, and pharmacology are inadequate treatments for low sexual desire when positive relational cues are missing (Brotto & Smith, 2014). Because the main predictor of sexual satisfaction is emotional intimacy, a strong implication of this study is that clinicians should include treatment strategies that promote communication, emotional security, and relational closeness when addressing sexual arousal problems (Pascoal et al., 2012).

Because of the positive findings that an insecure attachment style has an association with low sexual desire for females (as found in questions two and four), this study finds that sexual distress can be diminished and sexual desire can increased by improving the level of attachment security within the relationship (Stephenson & Meston, 2015). This present finding is supported by Bennett et al. (2012), who stated that to improve sexual dysfunction, it is crucial to address the attachment styles of each individual because attachment insecurity substantially interferes with desire.

Increasing attachment security can be accomplished by using approaches to specifically address relational security, or by using a modality such as EFT that focuses on increasing attachment security (Johnson & Zuccarini, 2010, 2011). According to attachment theory, the sexual and attachment systems are inextricably intertwined for

females that are sexually intimate with an emotionally significant romantic partner (Bennett et al., 2012). Therefore, one system cannot be improved without improving the other. As individuals begin to change to a more secure attachment, this study finds that the couple can experience greater feelings of emotional security that will increase responsive desire, a necessary factor for satisfying sexual functioning (Bennett et al., 2012).

Conclusions

According to the data analysis of the articles and chapters sampled, the findings supported the main objectives of this study. The research confirmed the need to examine the connection between insecure attachment and low sexual desire in females. Treatment implications of the association between attachment insecurity and low sexual desire among female patients were addressed.

The more emotionally vested that a woman is in her partner; the more she needs to believe that she matters to that person (Mikulincer & Shaver, 2007). Often for women, emotional connection leads to a longing for physical and/or sexual connection (Birnbaum, 2015). If the relationship is going well, adult romantic attachment typically leads to sexual attachment (Birnbaum, 2015). Therefore, a secure relational system creates and sustains desire as long as the couple provides adequate erotic cues (Birnbaum, 2015; Pietromonaco & Beck, 2015).

However, desire does not thrive in some relationships due to the interrelated factors of relational/attachment insecurity (Birnbaum et al., 2014). One area that may particularly elevate any attachment fears is the vulnerable act of sexual intimacy (Birnbaum et al., 2014). If the relationship has experienced conflict or emotional

distance prior to or during sexual intimacy, attachment distress can become a dominant response (Birnbaum et al., 2013). Those with an insecure attachment are particularly susceptible to reacting in ways that inhibit the sexual response system, as previously discussed (Birnbaum et al., 2014).

Although attachment theory acknowledges that many factors can affect the functioning of the sexual response system, attachment theory serves as a solid foundation for this study. The strength of attachment theory is that it is a well-researched, grounded approach, and hundreds of studies have shown its relevance to adult functioning, including functioning in romantic relationships (Birnbaum, 2015; Mikulincer & Shaver, 2007). However, some limitations of attachment theory should be noted. Some researchers suggest that attachment theory exaggerates the importance of childhood experiences on adult functioning and that the theory neglects the importance of adulthood as a developmental phase (Mikulincer & Shaver, 2007). Other researchers criticize attachment theory in that it does not adequately explain aggression or the need for dominance and instead blames all relational problems on attachment insecurity (Mikulincer & Shaver, 2007).

Implications

Training in sex therapy should be just as important as training for depression and anxiety for the new therapist so that he or she is equipped to help couples with these critical psychosocial factors that produce sexual distress (Binik & Meana, 2009). Additionally, psychologists need to have at least a basic understanding of the psychology and physiology of sexuality so that effective treatment strategies can be designed (Binik & Meana, 2009). Binik and Meana (2009) and McCarthy and Wald

(2012) strongly recommended a more modern integration of the treatment of sexual dysfunction into the couples therapy milieu instead of viewing sex therapy as a separate specialty.

Other researchers concur with this study that relational security is rooted in attachment security (Brassard et al., 2015). Without a secure attachment, couples use negative strategies in times of distress, which will only make their problems worse (Dewitte, 2012). This study is an instruction to therapists that building relational security is crucial for the treatment of all forms of sexual dysfunction, including low sexual desire.

Although couples may come to therapy for other reasons, treating therapists need to inquire about the impact of relational insecurities on their sexual functioning, as they are likely entangled (Johnson & Zuccarini, 2010, 2011). Additionally, clinicians have an obligation to realize the impact of relationship distress on sexual distress as well as the impact of sexual distress on relationship distress (Johnson & Zuccarini, 2010). Research also shows that 50-60% of unhappy mates attribute their relationship distress to sexual difficulties, so successfully addressing sexual dysfunction is fundamental to positive outcomes for clinicians (Johnson & Zuccarini, 2010). Because of this study, clinicians can better focus relevant treatment strategies on attachment when low sexual desire is resistant to improvement in order to gain results that are more satisfying for their couples.

Although examined in this study as discrete areas, psychological, relational, and attachment-related antecedents of low sexual desire are interrelated to a greater degree that has been previously considered. Therefore, it is an artificial distinction to view

psychological or relationship factors as separate from attachment-based factors (Birnbaum, 2015). As stated in attachment theory, these factors are strongly interconnected because the attachment system becomes activated along with the sexual system in any important romantic relationship (Mikulincer & Shaver, 2012). The attachment system and the sexual system cannot be thought of as separate components.

Therefore, it is another implication of this study that relationally-based sexual desire difficulties are unlikely to improve without adequately addressing the underlying attachment distress of hurt and fear that will result from such difficulties. Attempts to treat low desire issues behaviorally or through superficial psychoeducation/coaching will ultimately be unsuccessful because such methods fail to address the emotional insecurity that is fueling the dysfunctional responses of each partner. It is only when these attachment insecurities are addressed successfully that the sexual system will operate smoothly. Clinicians need to ensure that each partner's connection and emotional safety with one another is of preeminent concern to adequately improve any low sexual desire problems. Emotional attunement and responsiveness are essential to creating such emotional safety, and couples would benefit from working with an attachment theory therapist to overcome such difficulties (Johnson & Zuccarini, 2011).

Recommendations for Future Research

Researchers have often backed away from researching the psychosocial aspects of sexuality because of their complexity, but doing more research in this area is critical for practitioners who are treating low sexual desire (Binik & Meana, 2009). As the various psychosocial antecedents contributing to low sexual desire are better

understood, more targeted interventions can be implemented so that low sexual desire symptoms can be improved (Binik & Meana, 2009).

A relatively sparse number of studies exist regarding the effects of insecure attachment on low sexual desire in females (Brassard et al., 2012); therefore, more high-quality studies need to be performed in this area to confirm or disconfirm this study's findings. It is important that controlled double-blind studies with large sample sizes be conducted to demonstrate further evidence for this study's assertion that it is necessary to increase attachment security to improve low sexual desire (Birnbaum, 2015).

Another area of possible study would be to determine how desire levels are affected by attachment over different stages of the relationship. For example, are couples in shorter-duration relationships as dependent on attachment style affecting desire as those in longer-term relationships? Still another area of possible research would be to extend the topic of attachment and sexual desire to minority populations such as same-sex couples or post-menopausal couples. In addition, more controlled studies are necessary to understand the gender differences between males and females regarding sex and attachment style.

This study was comprehensive and summarized a substantial amount of the recent research done on attachment theory and sexual desire. However, more research is needed to extend the topic of sex and attachment. Despite the need for such research, Binik and Meana (2009) pointed out that too few high-quality randomized sexual dysfunction treatment studies exist outside of the biological realm. Many of the studies that have been conducted about sex and attachment have small sample sizes,

which limit their usefulness. These authors stated that it is time for social scientists and psychologists to research the importance of psychosocial aspects of sexuality and how they impact the biological functioning of sexual desire (Binik & Meana, 2009).

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Appendix

Relevant Keywords Used to Obtain Results for Research Questions

Research Question One—What are general, non-attachment-based individual antecedents of female low sexual desire?

- Keywords used for results include individual, child abuse, sexual abuse, PTSD, cultural factors, hormonal factors, testosterone, estrogen, medication, biological, organic, medical diagnoses, menopause, cognitions, sexual beliefs, religious beliefs, religiosity, conservative beliefs, shame, guilt, depression, anxiety, mental illness, worry, asexuality, negative sexual schemas, low self-esteem, sexual pain, HSDD.

Research Question Two—What are attachment-based individual antecedents of female low sexual desire?

- Keywords used for results include attachment, attachment style, secure attachment, security, positive sexual attitudes, pleasure, insecurity, anxiety, anxious attachment, worry, fear, hypervigilance, hyperactivation, clingy, demanding, angry, criticism, avoidance, withdrawal, distance, detachment, deactivating strategies.

Research Question Three—What are general, non-attachment-based relationship factors that are antecedents of female low sexual desire?

- Keywords used for results include sexual relationship, interpersonal factors, sexual motivation, satisfaction, communication problems, trust, commitment, anger, distress, conflict, resentment, fight, duration, overfamiliarity, boredom,

routine, power, responsive desire, desexualization, arousal, lubrication, emotional intimacy, erotic cues, sexual excitement.

Research Question Four—What are attachment-based relationship factors that are antecedents of female low sexual desire?

- Keywords used for results include attachment, attachment style, secure attachment, security, positive sexual attitudes, pleasure, insecurity, anxiety, anxious attachment, attachment injuries, worry, fear, hypervigilance, hyperactivation, clingy, demanding, angry, criticism, avoidance, withdrawal, distance, detachment, deactivating strategies, trust, commitment, emotional safety, emotional bonding, relational intimacy, closeness, connected, comfort, support, satisfaction, dependence.

Research Question Five—Based on the premise that a relationship between insecure attachment and low sexual desire in females is present, what treatment implications exist for couples?

- Keywords used for results include assessment, organicity, history, sex therapy, couples therapy, behavioral methods, cognitive-behavioral methods, mindfulness, hormonal treatments, psychoeducational treatments, pharmacological treatments, bibliotherapy for sexual problems, sensate-focus, Sildenafil (Viagra) for women, attachment therapy, good enough sex model, emotionally focused therapy (EFT).