Archives of Sexual Behavior (2019) 48:1659–1681
https://doi.org/10.1007/s10508-018-1212-9

TARGET ARTICLE

# The Relational and Bodily Experiences Theory of Sexual Desire in Women

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Received: 26 February 2017 / Revised: 22 March 2018 / Accepted: 3 April 2018 / Published online: 20 June 2018


## Abstract

We review the theory and research on women's sexual desire and present a theory that incorporates internalized representations of relational and bodily experiences into our understanding of the full range of desire in women. To this end, we move away from the current tendency to focus on low sexual desire in women and instead consider desire on a spectrum or continuum from absent or diminished to high desire across multiple sexual orientations, including heterosexual, bisexual, and lesbian. We review definitions of sexual desire, as well as the epidemiology and etiology of hypoactive sexual desire, the most prevalent sexual complaint in women, including the biological, psychological, and relationship correlates of inhibited sexual desire. Subsequently, we examine the research on highly sexual women, who tend to experience high levels of sexual desire, sexual agency, and sexual esteem, and distinguish between high sexual desire and hypersexuality. We introduce two important constructs that are integrated into the Relational and Bodily Experiences Theory (RBET) of sexual desire in women: attachment and sexual body self-representations, suggesting that women's internalized representations of self and other that stem from childhood and their capacity to embody their sexual bodies are integral to our understanding of the phenomenology of sexual desire in women. RBET calls for further research into the links between attachment, sexual body self-representations, and desire, and suggests that clinical interventions for sexual desire difficulties in women should emphasize internalized working models of relationships (i.e., attachment) and integrate bodily based approaches.

**Keywords** Women's sexual desire · Attachment · Sexual subjectivity · Self-objectification · Genital self-image

## Introduction

"What does a woman want?" (Freud, 1925) is the question that weaves through the history of the study of female sexuality, remaining impervious to the inquiries of some of the most prominent figures in the field. While Freud attempted to unravel the dynamics of female sexual desire by contrasting femininity with masculinity in psychosexual development, empirical research in the field of sexuality did not focus specifically on the topic of desire until Kaplan (1977, 1979) and Lief (1977) expanded the sexual response cycle developed by Masters and Johnson (1966) to include the phase of desire. The resultant triphasic sexual response cycle of desire, excitement, and orgasm has served as the model for the categories of sexual disorders since the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980).

Over the past decade, female sexual dysfunction, especially low sexual desire, has been a topic of debate and investigation, which intensified in the context of the preparation of the DSM-5 (Brotto, 2010). The current DSM-5 (American Psychiatric Association, 2013) combined the previous disorders of arousal and hypoactive sexual desire in women into a single diagnosis of female sexual interest/arousal disorder (FSIAD). In contrast, hypersexuality, typically referring to the pathology of heightened and dysregulated sexuality, did not make it into the current edition of the DSM, continuing to be the focus of much controversy concerning its designation as a sexual disorder. Further, hypersexuality has been conflated with high sexual desire (Carvalho, Stulhofer, Vieira, & Jurin, 2015; Stulhofer, Bergeron, & Jurin, 2016), thereby pathologizing the latter. Importantly, multiple models have been proposed

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and investigated to explain low sexual desire in women (e.g., Brotto, Petkau, Labrie, & Basson, 2011b; Carvalho & Nobre, 2010; Tiefer, Hall, & Tavris, 2002), while high sexual desire in women remains relatively unexamined (e.g., Wentland, Herold, Desmarais, & Milhausen, 2009).

The purpose of this article is twofold—to review what is known about women's sexual desire and to theoretically explain the processes that are implicated in inhibiting and heightening desire in women. In their review of research on gender and sexuality, Tolman and Diamond (2001) criticized the segregation of biological and sociocultural research on sexual desire and called for an integration of both perspectives into a comprehensive account of the forces that generate and inform women's experience of sexual desire. In this article, we aim to respond to their call for integration, incorporating the interpersonal and intrapsychic underpinnings of female sexual desire with the sociocultural and biological factors. The current review of female sexuality synthesizes empirical investigations of inhibited and high sexual desire with theoretical formulations pertaining to attachment and feminist sociocultural theories of female sexuality. Thus, we will elucidate the psychological and biological factors that contribute to inhibiting or heightening sexual desire in women, while being sensitive to the sociocultural forces affecting women's desire. In reframing Freud's question, "What does a woman want?", we propose addressing *how women come to want or desire* and overcome or perhaps circumvent the forces that inhibit their sexual desire.

To accomplish our tasks, we culled from the theoretical formulations of sexual desire of the past 15 years while incorporating the work of earlier sexologists such as Masters and Johnson (1966, 1970), and Kaplan (1977, 1979). We also reviewed the research and clinical literature on female sexual dysfunction, specifically in the domain of desire. Subsequently, we examined the investigations on highly sexual women and how hypersexuality intersects with high sexual desire as it pertains to women. In developing our theory of sexual desire in women, we targeted the research concerning the role of (1) attachment, (2) self-objectification, (3) sexual subjectivity, and (4) genital self-image in female sexuality. Because the sexual desire literature predominantly addresses heterosexual women, we conducted a separate search on sexual desire in sexual-minority women (e.g., lesbian, bisexual, queer, questioning).

In this article, we will first address the definition of sexual desire in the context of female sexuality. Subsequently, we will consider both inhibited and high sexual desire in women. The final sections of the review will examine two meta-constructs that we believe to be important in understanding sexual desire in women that incorporate the relational and bodily aspects of sexuality. Specifically, we will address how women's internalized working models of self and other (i.e., attachment styles) as well as their sexual body self-representations may be implicated in women's sexual desire. For sexual body self-representations, we will consider the literature on sexual subjectivity, self-objectification, sexual body esteem, and genital self-image to explore how women's sense of agency, competence, and ownership of their sexuality and bodies contribute to their sexual desire. The proposed theory is not meant to replace the current understanding of the factors affecting sexual desire, such as mood and relationship factors. Rather, we aim to augment the current conceptualization of women's sexual desire by addressing the more stable psychological processes that affect it, specifically women's internalized working models of relationships (i.e., attachment) and sexual body self-representations. Figure 1 depicts the Relational and Bodily Experiences Theory (RBET) of sexual desire in women.

## Sexual Desire

In addressing the definitional challenges of sexual desire in women, Meana (2010) highlights the importance of understanding what is being desired, and posits that while "pure" desire cannot be distilled from its sociocultural context, we must be attuned to the complexities of multiple contexts and the diversities of individuals' sexual experiences in operationalizing and clarifying the construct of desire. Indeed, sexual desire is a multi-dimensional rather than a single construct (van Anders, 2012).

In the empirical literature on human sexuality, sexual desire refers to the presence of sexual thoughts, fantasies, urges, and motivations to engage in sexual behavior in response to relevant internal and external cues (American Psychiatric Association, 2000; Bancroft, 2009; Kafka, 2010; Kaplan, 1995; Levin, 1994; Levine, 2002; Singer & Toates, 1987). Such conceptualization focuses on conscious affects and cognitions, which are assessed by observable behaviors. Feminist scholars, emphasizing the sociocultural context, suggest that young women's negotiation of sexual desire is essential to their development of a sense of personal empowerment and entitlement (Fine, 1988; Tolman, 2002). Psychoanalytic theory proposes the conscious and unconscious intrapsychic and interpersonal facets of sexual desire—as the wish to merge with a real or fantasied object, obliterating the boundary between self and other while retaining the autonomy of self (Braunschweig & Fain, 1971, 1975; Chodorow, 1978; Elise, 2000, 2008; Kernberg, 1995; Stein, 2008). We propose that all of these perspectives are relevant to the phenomenology of women's sexual desire.

Aiming to capture the multiple facets of sexual desire, including its affective, cognitive, bodily, and relational components, we propose women's sexual desire as the wish to engage in sexual activity in either a solitary or partnered context; the wanting to experience sexual arousal (subjective or physiological) and pleasure (which may or may not involve orgasm); the longing to connect with a fantasied or real other or to achieve a (temporary) merger with another; the yearning to express one's agency and ownership over one's body and sexuality; and/or the

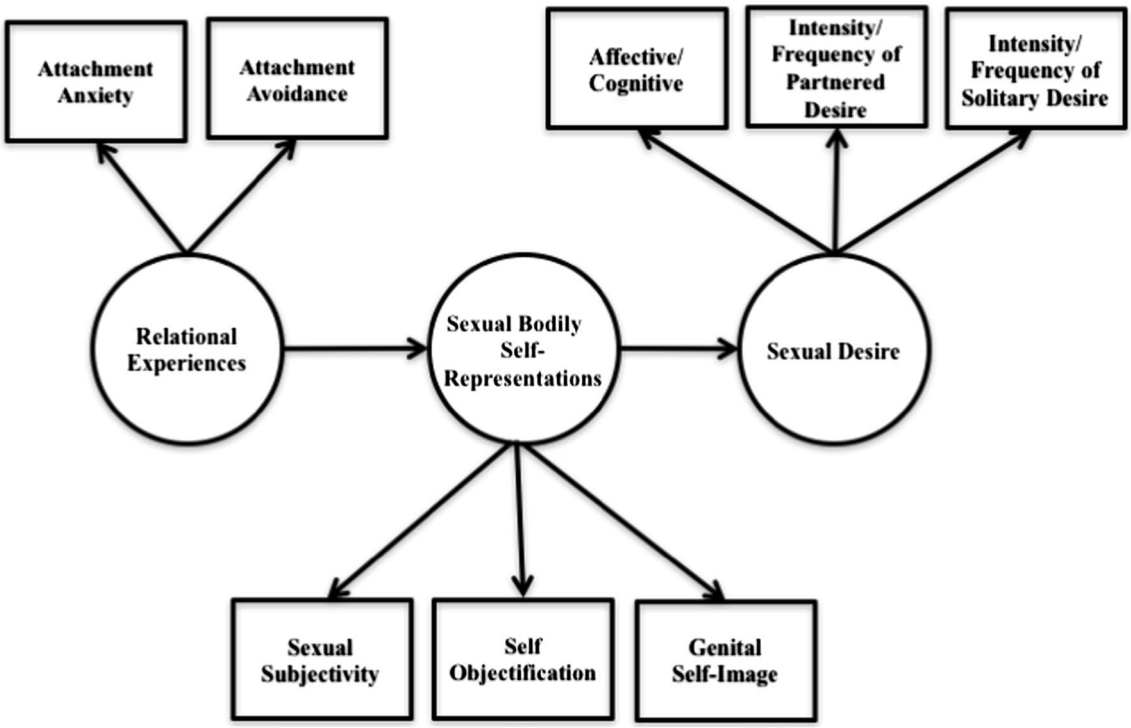


**Fig. 1** The Relational and Bodily Experiences Theory (RBET) of women's sexual desire

want to be the object of and to submit to another's desire. These may be experienced in the form of sexual affects, thoughts, fantasies, acts, or bodily sensations. We propose that a woman may experience all or some of these aspects of sexual desire, simultaneously or sequentially. Importantly, this definition does not solely consider the frequency of sexual activity but rather aims to capture the intrapsychic and interpersonal aspects of the subjective experience of sexual desire. While this definition may appear to be over-inclusive, it is indicative of the complex nature of women's experiences of sexual desire as will become apparent in our literature review of female sexuality.

Research suggests that women who identify as heterosexual, lesbian, bisexual, queer, or questioning tend to experience comparable levels of sexual desire and identify similar motivating factors (e.g., physical pleasure, emotional connection) regardless of the sex of the partner (Holmberg & Blair, 2009; Sanchez, Moss-Racusin, Phelan, & Crocker, 2011; Wood, Milhausen, & Jeffrey, 2014). Studies indicate that women's sexual desire may have multiple meanings: her wish to increase the emotional intimacy with her partner; to feel attractive, loved, and desired; to experience bodily arousal and pleasure (Basson, 2001b; Brotto, Heiman, & Tolman, 2009; Cain et al., 2003). Meana (2010) suggests that "desire for desire" also must be considered, arguing that the relational facet of women's sexual desire is often privileged, while other factors, such as women's feelings about themselves, are insufficiently examined. Further, Meana distinguishes between liking sex and wanting it, suggesting that a woman's enjoyment of a sexual encounter does not necessarily translate into desire for subsequent sexual encounters. Integrating the relational and socio-cultural contexts along with the intrapsychic and the bodily domains into the assessment of women's sexual desire enhances our understanding of their experience of desire.

## Sexual Desire and the Sexual Response Cycle

Masters and Johnson (1966) advanced the study of female sexuality in their four-phased sexual response cycle, a linear sequence of arousal, a plateau of excitement, followed by orgasm, and resolution. Although the subjective and the physiological components of arousal were included in the original sequence, the arousal phase in women became synonymous with genital arousal (vaginal lubrication and swelling), while the desire phase was excluded. Subsequently, Kaplan (1977) added desire as the first phase of the human sexual response cycle. Initially, intrinsic/spontaneous desire, which emerged from within the individual, was differentiated from extrinsic/responsive desire, which was triggered by external stimuli (Kaplan, 1979); however, only the former was integrated as the first stage in the sexual response cycle of the triphasic model, which served as the model for the DSM classification of sexual dysfunctions from DSM-III through DSM-IV-TR (American Psychiatric Association, 1980, 2000).

Subsequent models challenged the linear sexual response cycle developed by Masters and Johnson and later expanded by Kaplan. The incentive motivation model suggests that sexual desire does not precede arousal, but rather that sexual desire and sexual arousal are activated when certain conditions are met, including an intact sexual response system, the presence of sexual stimuli (internal and/or external), and circumstances that allow for sexual activity to occur (e.g., availability of sexual partner[s]) (Laan & Both, 2008; Toates, 2009). In this model, sexual motivation is not intrinsic but rather emerges and becomes stronger as these conditions are met (Both, Laan, & Schultz, 2010; Everaerd & Laan, 1995). In line with the ideas of the incentive motivation model, Basson (2001a, 2010) proposed that women's sexual response cycle is circular with overlapping phases that follow a variable order. In Basson's model, desire does not necessarily precede arousal but may be triggered during sexual activity once the woman has become aroused. The woman then begins to desire sexual satisfaction, which may or may not involve orgasm. An emotionally and physically positive outcome augments subsequent sexual motivation. The experience of subjective arousal thus overlaps with desire, while the physiological arousal, exhibited by vasocongestion and lubrication, appears to contribute relatively little to the level of desire (Basson, 2010). Basson concluded that for women, the genital response is an unconscious, involuntary reflex rather than a reflection of subjective arousal or desire. Indeed, studies have found a low correlation between women's subjective arousal and an objective assessment of vasocongestion, indicating that the latter is not the primary marker of women's arousal and desire (Chivers & Bailey, 2005; Chivers, Seto, Lalumiere, Laan, & Grimbos, 2010). Furthermore, women with sexual dysfunction often do not lack physiological arousal but report an absence of subjective arousal accompanied by negative cognitions when presented with erotic stimuli (Everaerd, Laan, Both, & van der Velde, 2000; Laan, van Driel, & van Lunsen, 2008).

While Basson (2010) does not eliminate the potential for initial spontaneous sexual desire (i.e., Kaplan's 1979, intrinsic desire), she argues that such desire is not as common in women as it is in men and, more importantly, is not necessary for a healthy and satisfying sexual experience. Contrary to the traditional sexual scripts that "boys want sex, girls want relationships" (Tolman, 2002), a qualitative study on sexual desire in lesbians found that the physical "urge" to have sex was one of the most frequently reported reasons for having sex (Ronson, Milhausen, & Wood, 2012), while another recent study found that sexual-minority women tend to engage in sex to experience bodily pleasure (Wood et al., 2014). These findings were interpreted as evidence that these women primarily experience autonomous or spontaneous sexual desire.

Multiple studies have examined women's endorsement of the linear and circular sexual response cycles. Sand and Fisher (2007) conducted a study to assess the extent to which women in a community sample supported the models of the sexual response cycle (sexual orientation was not indicated but over 80% of respondents reported having a male partner). They found that approximately equal numbers of women endorsed each of the three different models by Masters and Johnson, Kaplan, and Basson as reflecting their own sexual experience. Further, women who endorsed Basson's model had lower sexual desire, suggesting that women who do not experience spontaneous desire may report more sexual inhibition. A more recent study of a larger national sample of sexually active partnered women yielded similar findings but showed that slightly more women endorsed the Kaplan model (Giraldi, Kristensen, & Sand, 2015). This study further established that no single model describes women's sexual response. Importantly, both studies used Basson's partial model, which omitted the possibility of spontaneous desire.

Nowosielski, Wróbel, and Kowalczyk (2016) extended the investigation of women's endorsements of different sexual response cycles by including the composite Basson model, which incorporates spontaneous desire. This study examined the sexual response cycles of heterosexual women with and without DSM-5-based female sexual dysfunction (FSD). Women were asked to choose between the linear model, the partial Basson model (omitting spontaneous desire), the composite Basson model (including spontaneous desire), and a different model (individual or unknown). Wróbel and Kowalczyk found that the composite model was the most prevalent among women. Further, they demonstrated that women with FSD endorsed the partial model and a different model with more frequency than healthy controls who chose the linear and the composite models in similar proportions. When women with FSD were examined separately, the partial model was more characteristic of women with sexual interest/arousal disorders, while a different model or the composite model was associated with orgasmic and genitopelvic pain/penetration disorders. Wróbel and Kowalczyk further indicate that it may be relationship difficulties rather than FSD that determines women's endorsement of a particular model. Finally, they suggest that women's lacking sexual satisfaction with a partner may result in women's engagement in different, individual models of sexual response. Wróbel and Kowalczyk recommend that partner-related factors should be examined when treating women with sexual difficulties and incorporated into future diagnostic frameworks for sexual dysfunctions.

Based on clinical observations, Iasenza (2010) argues that while some couples tend to follow a particular sexual response model, others shift between different models as they negotiate their sexual lives. She suggests that the pressure to rigidly subscribe to a linear model, in which desire is the first stage, may result in feelings of sexual inadequacy in individuals who do not always experience spontaneous sexual desire, which is often the case in long-term relationships. Meana (2010), on the other hand, challenges the distinction between spontaneous

and responsive desire. Meana suggests that all desire occurs in response to some stimulus or stimuli, which may be outside one's conscious awareness thereby resulting in the experience of desire as spontaneous. These findings and observations indicate that a definition that solely focuses on sexual behaviors or the conscious motivation for sexual activity would not adequately capture the phenomenon of sexual desire in women (Giraldi et al., 2015; Nowosielski et al., 2016; Sand & Fisher, 2007), which is in line with our multifaceted conceptualization of desire. Further research is needed to elucidate the role of spontaneous versus responsive desire (if there is such a distinction) in the sexual experiences of sexual-minority and heterosexual women with and without sexual complaints.

## Inhibited Sexual Desire in Women

Sociocultural theories suggest that low desire in women is adaptive. Multiple theories and studies on female sexuality indicate that women are less interested in pursuing sexual pleasure and place less value on sex than do men (Baumeister & Tice, 2000; Baumeister & Twenge, 2002; McCormick, 1994). Evolutionary psychologists suggest that women are more interested in long-term commitment because they seek male partners who can provide for them and their offspring (Baumeister & Tice, 2000). Baumeister and Twenge (2002) proposed the female control theory, which argues that women inhibit one another's sexuality in an attempt to compensate for the relative scarcity of available male partners. Social learning theorists posit that sexually interested women are stigmatized for being sexually permissive and that women are reinforced for seeking long-term committed relationships, while men are rewarded for desiring multiple sex partners (Milhausen & Herold, 1999; Oliver & Hyde, 1993). Generally speaking, in Western society, men's sexual pursuits are more readily accepted and approved, whereas women repeatedly receive social messages that their sexuality is risky and transgressive. In the literature on lesbian sexuality, the phenomenon of "lesbian bed death"—a controversial term that was coined to designate a rapid and sharp drop in sexual desire and sexual activity in lesbian couples (Blumstein & Schwartz, 1983; Nichols, 1982, 1988, 1995; van Rosmalen-Nooijens, Vergeer, & Lagro-Janssen, 2008)—abounds and lesbians have been considered as "prototypes of sensual-rather-than sexual women" (Nichols, 2004, p. 363). In this way, inhibited sexual desire appears to be inevitable and perhaps even normative for women—an assumption that we will challenge across multiple sexual orientations in the subsequent section of this article based on theory and empirical data.

Diminished or absent sexual desire, the most common sexual complaint among women, has garnered much theoretical, empirical, and clinical attention. In the DSM-5, the previous diagnoses of hypoactive sexual desire (which applied to both women and men) and female sexual arousal disorder have been merged, while sexual aversion disorder was removed. The diagnostic merger is based on multiple studies that have demonstrated a high level of comorbidity between arousal and desire disorders (Brotto, 2010; Brotto, Bitzer, Laan, Leiblum, & Luria, 2010; Brotto, Graham, Binik, Segraves, & Zucker, 2011a; Carvalheira, Brotto, & Leal, 2010). The current criteria for the newly introduced diagnosis of female sexual interest/arousal disorder (FSIAD) in the DSM-5 include absent or decreased (1) sexual interest, (2) erotic thoughts or fantasies, (3) initiation of sexual activity or responsiveness to a partner's attempts to initiate it, (4) excitement and pleasure during sexual activity, (5) response to any internal or external sexual or erotic cues (e.g., verbal, visual, written), and (6) genital and/or nongenital sensations during sexual activity. The diagnosis requires endorsement of at least three criteria. The problem(s) must generate significant distress or impairment and not be attributable to another explanatory factor (e.g., illness, medication, partner violence) (American Psychiatric Association, 2013). Importantly, a woman may experience low or absent desire, but if she does not perceive it as a problem that interferes with her wellbeing, she would not meet criteria for the diagnosis.

Epidemiological studies on sexual dysfunctions indicate that desire complaints are the most frequent sexual difficulties reported by women. In a representative sample of U.S. women between the ages of 18 and 59 years, Laumann, Paik, and Rosen (1999) found that 43% experienced some form of sexual problem, with decreased sexual desire being the most prevalent difficulty, affecting 32% of women. In a review of prevalence rates of sexual disorders in women, Hayes, Bennett, Fairley, and Dennerstein (2006) found that among women with any sexual difficulty, 64% (range 16–75%) experienced desire difficulty compared to 35% for orgasm and 31% for arousal. In a comprehensive review of epidemiological findings published between 2002 and 2009, Lewis et al. (2010) reported that the prevalence of low sexual desire in women varied as a function of age, ranging from 17 to 55%, with an increase in prevalence as women aged: 10% of women up to the age of 49 years having low desire, 22% of women between 50 and 65 years, and 47% of women between 66 and 74 years of age. These findings suggest that sexual inhibition may not be as common in adult, premenopausal women as suggested by the studies by Laumann et al. (1999) and Hayes et al. (2006). Importantly, recent studies indicate that sexually related distress is much less common in women as compared to the prevalence of sexual problems (Mitchell et al., 2013; Shifren, Monz, Russo, Segreti, & Johannes, 2008). Shifren et al. found that while age-adjusted point prevalence for any sexual problem (including desire) and for sexually related distress was 43 and 22%, respectively, any distressing sexual problem occurred in 12% of women and peaked in midlife (45–64 years).

Research and clinical reports are inconsistent in terms of the prevalence of low sexual desire in sexual-minority women. Certain studies indicated that the level of sexual desire is

comparable in women who experience mixed-sex versus same-sex sexual desire (Armstrong & Reissing, 2013; Holmberg & Blair, 2009; Matthews, Hughes, & Tartaro, 2006), while other and older studies emphasize the phenomenon of "lesbian bed death," suggesting that lesbians frequently experience little or no desire in the context of long-term relationships (Blumstein & Schwartz, 1983; Nichols, 1982, 1988, 1995; van Rosmalen-Nooijens et al., 2008). Further, some studies suggest that women with high sex drive tend to have higher sexual desire for both men and women (Lippa, 2006) and that bisexual women show higher levels of sexual desire than lesbian and heterosexual women (Lippa, 2007). Importantly, epidemiological research on the prevalence of low sexual desire has not specifically addressed sexual-minority women as most of the studies focus on heterosexual women and traditional definitions of sexual practices (i.e., penile-vaginal sex), as far as we know.

## Etiology of Disorders of Desire

Consistent with the theories of multiple sexologists, ranging from the earlier work of Kaplan (1995) to the current antimedicalization model of Tiefer et al. (2002), research investigations over the past 10–15 years have demonstrated that women's sexual inhibition is multi-determined, implicating biological, psychological, and sociocultural factors. Kaplan (1995) proposed that sexual desire is governed by neurobiological mechanisms of the central nervous system and that malfunctions of these mechanisms lead to disorders of sexual desire. Further, she argued that on an unconscious level, individuals with low sexual desire suppress their sexual feelings by engaging negative cognitive and perceptual processes, accentuating their partners' negative qualities while ignoring their positive attributes. She argued that at the root of desire disorders lie one's intrapsychic sexual conflicts, or the incompatible wishes and urges within one's mind, and relational difficulties that are more severe than those observed with other sexual dysfunctions, such as anorgasmia. The Working Group for a New View of Women's Sexual Problems offers a feminist, antimedicalization critique of the classification system for and a redefinition of female sexual dysfunction, as "discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience," emphasizing the contribution of sociocultural and relational forces to women's sexual difficulties (Tiefer et al., 2002, p. 229). In line with Basson's circular sexual response cycle, Tiefer (2003) argues that there is no "normal" sexual response or experience, and thus no "normal" level of desire. She proposes four major aspects of women's sexual lives that potentially contribute to sexual difficulties (including lacking desire): relational, psychological, medical, and sociocultural/political/economic. Assessing this model of the New View, Nicholls (2008) found that women were more likely to attribute sexual difficulties to relational and contextual/external factors than to psychological or medical factors. Below we review the current findings of investigations into the etiology of low or absent desire, including biological, psychological, and relationships factors.

## Biological Factors

Researchers have not reached a consensus on the role of biology in sexual dysfunction, specifically in inhibiting or heightening women's sexual desire. The studies that have considered the role of biological factors in hypoactive desire in women addressed reduced sex hormone activity (e.g., estrogen, progestin, testosterone), sexually negative effects of medications (e.g., antidepressants), and, less frequently, hyperprolactinemia (elevated serum prolactin hormone) and hypothyroidism (reduced thyroid hormone) (Guay & Spark, 2006).

Findings with respect to the role of hormones in women's sexual desire are inconsistent. In a comprehensive review on the link between sex hormones and sexual desire, Giles (2008) suggested that sex hormones have a "nonessential relation" with sexual desire for both men and women, such that sex hormones are one of the multiple sources for sexual excitation from the interior of the body (others being vasocongestion, muscle tension) that may or may not result in sexual desire. In a review of the literature on female sexual function in the reproductive age range, Stuckey (2008) found that lacking sexual desire was prevalent in women despite being "hormone replete" (p. 2282). A recent review of the applicability of animal models for female sexual dysfunction indicated that changes in endocrine levels and neurotransmitter activity are unlikely causes of sexual dysfunctions, including hypoactive sexual desire (Agmo, 2014).

Many studies have focused on the influence of testosterone on sexual desire in women. While some studies found no association between androgen levels and sexual desire in women (Davis, Davison, Donath, & Bell, 2005; Nyunt et al., 2005), others demonstrated that women with low libido and sexual dysfunction were more likely to have low testosterone compared to healthy controls (Guay et al., 2004; Turna et al., 2005). A recent study on the role of hormones in the patterns of women's sexual activity indicated that sexual activity did not vary as a function of ovarian hormones, including estrogen, progesterone, and androgen (Caruso et al., 2014); however, Caruso et al. found that these hormones could increase the likelihood that sexual activity would occur more often when women were ovulating than during other stages of the menstrual cycle. Of note, this study focused on sexual behavior rather than sexual desire. Importantly, one of the major problems in studying the role of endogenous androgens in female sexual functioning is the lack of reliable testosterone assays within the female range (Taieb et al., 2003), potentially resulting in invalid null findings.

Studies examining psychobiological models have yielded interesting findings. One study (Brotto et al., 2011b) compared women with hypoactive sexual desire disorder (HSDD) with women with more symptomatic sexual interest/desire disorder

(SDID)[1] on hormonal (including testosterone) and nonhormonal (clinician-rated developmental history, psychiatric history, and psychosexual history) variables. The study found that the nine hormones were not significant predictors of group membership, while the addition of the six nonhormonal factors significantly increased the model's ability to predict group status. Specifically, compared to the HSDD group, women with SDID showed a greater contribution of psychosexual history, psychiatric history, and developmental history in accounting for their current symptoms of sexual dysfunction. The findings indicated that more negative early childhood factors, current or previous psychiatric symptoms, and negative sexual history were associated with less sexual desire. These findings suggest that early parent–child relations and trauma history as well as psychopathology may strongly influence women's sexual desire, while the influence of testosterone is less significant. In a study on the associations of testosterone and psychological factors (sexual–relational, stress–mood, body–embodiment) with sexual desire, van Anders (2012) found that solitary and dyadic sexual desire were differentially and oppositionally associated with testosterone: (1) testosterone was positively associated with women's solitary desire, with masturbation frequency influencing the link, and (2) negatively associated with dyadic desire when perceived social stress and cortisol were controlled. Importantly, the directionality of the association could not be established, given that all three (sexual activity, sexual thoughts, and testosterone) increased in women, suggesting that sexual desire may influence testosterone levels rather than the reverse. These studies emphasize the importance of considering psychological history and current mental status when examining associations of testosterone and other biological mechanisms with sexual desire.

Neuropeptide oxytocin, typically associated with childbirth, infant care, affectionate bonding, and sexuality also may play a role in sexual desire. Studies of animals (e.g., rats and prairie voles) have found that an exogenous administration of oxytocin stimulates females to seek out sexual activity (Floody, Cooper, & Albers, 1998) and to exhibit sexual receptivity to sexual requests (Arletti & Bertolini, 1985; Caldwell, Prange, & Pedersen, 1986; Gorzalka & Lester, 1987). In humans, oxytocin is at its highest levels during sexual activity and has been implicated in the subjective experience of orgasm intensity and sexual satiety (Carmichael, Warburton, Dixen, & Davidson, 1994; Carter, 1992, 1998; Riley, 1988). Notably, studies detected higher levels of oxytocin in women than in men and found oxytocin to be positively related to the subjective reports of orgasmic intensity in women who were multiorgasmic (Carmichael et al., 1994). Unfortunately, the role of oxytocin in women's sexual desire has been scarcely examined in favor of the traditional focus on testosterone (Tolman & Diamond, 2001).

A study on sexual-minority women indicated that during their peak estrogen levels, typically around ovulation, women who consistently identified as lesbian over a 10-year period showed a greater increase in their motivation to act on their same-sex sexual desires than women who were consistently bisexual and women who gave up their lesbian identities in favor of unlabeled or heterosexuals identities (Diamond & Wallen, 2011). Diamond and Wallen suggest that women with consistent versus variable same-sex sexual orientations over the life course may constitute a subset of sexual-minority women whose sexual desires are influenced by distinct forces (e.g., biological vs. relational and sociocultural). Further research in this area is warranted.

A recent review of women's sexual function and dysfunction at midlife indicated that most but not all longitudinal studies do show that advancing menopause has a negative effect on sexual functioning in women, including in the domain of desire (Thomas & Thurston, 2016). Thomas and Thurston indicate that previous studies found that while biological variables such as hormones (e.g., decrease in estrogen), medical problems, and anatomical changes (e.g., vaginal dryness) appear to play a role in the drop in desire during and after menopause, psychological (e.g., stress and mood symptoms), interpersonal (e.g., partner availability, relationship problems), and social (e.g., women's attitudes toward aging) factors also significantly contribute to the decline of sexual desire at midlife. Importantly, studies suggest that while naturally menopausal women do experience decreasing sexual desire, they do not necessarily experience the associated distress and therefore do not show a higher prevalence of HSDD as compared to younger women (West et al., 2008). While some of the studies included in the review (Thomas & Thurston, 2016) did find that lower estrogen (but not testosterone) contributed to sexual dysfunction, including low desire, the findings consistently indicated that psychosocial variables such as partner availability, depression, anxiety, and previous sexual functioning appeared to be the most important predictors of sexual problems in women who are peri- and postmenopausal (Dennerstein, Dudley, & Burger, 2001; Dennerstein & Lehert, 2004; Dennerstein, Lehert, & Burger, 2005; Dennerstein, Lehert, Burger, & Dudley, 1999; Guthrie, Dennerstein, Taffe, Lehert, & Burger, 2004).

Neuroimaging studies utilizing the functional magnetic resonance imagining (fMRI) have yielded significant findings that distinguish neural activation patterns in women with HSDD from health controls when exposed to highly erotic movies or images or neutral movies or images. In a recent review and meta-analysis of neuroimaging literature, Cacioppo (2017) found that women with HSDD compared to healthy controls showed hypoactivation in the sexual desire brain network

[1] The SDID, defined as low sexual desire, absent sexual fantasies, and a lack of "responsive desire," was proposed by the international multidisciplinary group of sexual researchers and clinicians to more accurately reflect sexual desire concerns in women (Basson et al., 2003).

(SDBN) and hyperactivation in the self-referential brain network (SRBN). For example, compared with healthy controls, women with HSDD showed lower levels of activity in brain areas that are involved in body image, self-other closeness, and self-representation, and in the mentalizing network, which are part of the cognitive system of SDBN. In the SRBN, women with HSDD showed more activity in brain areas that are involved in self-focus, egocentrism, and spectatoring (focusing on oneself from a third person perspective) (Masters & Johnson, 1970), in moral judgment and shyness, and in visual analyses and face processes. Based on these neuroimaging findings, Cacioppo (2017) indicates that HSDD results from women's conflictual or negative responses to sexual stimuli and/or dissociation when considering or encountering sexual stimuli. These findings highlight the importance of considering women's relational and bodily experiences in understanding sexual desire.

In summary, the role of biology in inhibiting sexual desire in women requires further investigation with more reliable testosterone assays that are sensitive to the subtle differences in women's hormonal profiles. Furthermore, examining hormonal levels as well as other biological factors (e.g., oxytocin) in women with high sexual desire (rather than just low or absent desire) might shed light on the role of biology in women's desire (high sexual desire will be discussed below). While biological factors may play a role in women's sexual desire, research has not conclusively demonstrated that biology is among the primary mechanisms involved in inhibiting sexual desire in women. Nonetheless, incorporating biological methods, such as fMRI, in the study of female sexual desire further elucidates the interplay of multiple forces in women's sexual functioning.

## Psychological Factors

Researchers have investigated the role of cognitive and emotional factors in diminished desire in women. Nobre and Pinto-Gouveia (2003, 2006a, b, 2008a, b, c) examined the role of erroneous sexual beliefs, maladaptive cognitive schemas, negative automatic thoughts, as well as negative affective states in women's sexual functioning. Diminished sexual desire in women was predicted by conservative sexual beliefs, failure/disengagement sexual thoughts (e.g., "I'm not getting turned on," "when will this be over?"), lack of erotic thoughts during a sexual encounter, sexual incompetence schemas (e.g., "I'm a failure," "I'm incompetent"), and the belief that sexual desire and pleasure are sinful, as well as feelings of sadness, disillusion, guilt, and lack of pleasure and satisfaction (Nobre, 2009; Nobre & Pinto-Gouveia, 2008a). More liberal sexual attitudes and the proclivity to experience romantic/passionate emotions were associated with higher levels of desire (Andersen & Cyranowski, 1994).

Further, studies demonstrated that psychiatric conditions such as anxiety and depression are associated with sexual dysfunction, including low desire (Bossini, Fagiolini, Valdagno, Polizzotto, & Castrogiovanni, 2007; Clayton et al., 2012; Kennedy, Dickens, Eisfeld, & Bagby, 1999). In addition to finding a significant link between HSDD and a current diagnosis of or symptoms of depression in a large sample of premenopausal women, Clayton et al. showed that the use of antidepressant medication is associated with HSDD only when depressive symptoms remain unresolved. Further, Clayton et al. suggested a bidirectional association between depression and HSDD. Not surprisingly, trauma, especially sexual trauma, was related to low or absent desire (Clayton, 2003; Kinzl, Traweger, & Biebl, 1995). Other correlates of diminished desire included sexual difficulties, such as an incapacity to experience physiological arousal, orgasmic difficulties, and sexual pain (Cherner & Reissing, 2013; Maserejian et al., 2010; Segraves & Segraves, 1991; ter Kuile, Both, & van Lankveld, 2012).

## Relationship Factors

Diamond (2003, 2004, 2013) delineates the links and distinctions between romantic love and sexual desire, which she considers to be functionally independent systems that are powerfully interconnected. Diamond posits that women's sexual desire may be particularly sensitive to interpersonal factors, such that romantic love can trigger sexual desire, which, in turn, can deviate from women's general sexual orientation. Sexual desire, on the other hand, by physically bringing individuals together, provides the prolonged contact and proximity that may kindle romantic love. In an exploration of the incentive value of sex for women, Meana (2010) suggests that women tend to make sexual choices that are not necessarily based on their sexual desires but on other relational qualities that are more highly valued but potentially less sexually desirable or arousing. Further, Meana suggests that the relational facet of sexual desire in women has been privileged over other important forces that may fuel or dampen desire. While research and clinical reports indicate a strong association between sexual and relationship factors that is bidirectional (Bancroft, Loftus, & Long, 2003; Hayes et al., 2008; King, Holt, & Nazareth, 2007; Mark & Murray, 2012; Oberg & Fugl-Meyer, 2005), the relative strength of each causal direction remains unclear.

Research and clinical data demonstrate that desire dwindles in long-term relationships (Basson, 2001b; Blumstein & Schwartz, 1983; Hatfield & Sprecher, 1986; Nichols, 1988; Perel, 2006). In a qualitative study, married women in long-term relationships ($M = 6.52$ years, $SD = 3.85$) attributed their diminishing sexual desire to the drawbacks of intimacy, closeness, and comfort rather than relationship problems and dissatisfaction (Sims & Meana, 2010). Specifically, women attributed their declines in desire to the institutionalization of the relationship through marriage (e.g., de-eroticized conceptualization of marriage, dampening effect of responsibility, lack

of transgression in married sex), over-familiarity (e.g., dissipation of romance, lack of individuality, overly familiar sexual advances), and de-sexualized roles (e.g., multiple role incompatibilities, lack of desirability). Further, these women believed that a novel relationship would reignite their sexual desire. This finding is consistent with an earlier study, which indicated that married women are less likely to rate feelings of love, security, partner support, commitment, and emotional closeness as triggers for sexual desire as compared to single women (McCall & Meston, 2006). A more recent qualitative study on young (between 18 and 29 years of age) heterosexual women's sexual desire in long-term relationships (defined as at least 2.5 years) found that compared to women who self-identified as having experienced a decrease in their sexual desire, women who self-identified as having maintained high sexual desire were sexually flexible (i.e., being generally open to changes in one's sexual life) (Murray, Milhausen, & Sutherland, 2014). This more desirous group of women had the ability to stay mentally present (i.e., tuned into the moment) and experienced better sexual communication. These women valued sex as an important component of the relationship and felt desired by their partner. They found their partner's sexual initiation effective, experienced relational intimacy, and positively interpreted monotony and routine. Murray et al. pointed out that women's acceptance of certain inevitabilities about sexual desire in the context of long-term relationships and their awareness that sex life required effort, attention, and maintenance distinguished the more desirous women from the low desire group.

In line with these findings, Perel (2006), a couples and sex therapist, suggests that the familiarity, safety, and closeness of long-term relationships deplete desire, which is fueled by novelty, distance, danger, the unknown, and uncertainty. Perel offers couples hope of retaining sexual desire in their relationships, recommending that couples who value and attend to the sexual domain in their lives, who are open to changes and fluctuations in their sexual activity, and who are able to offer one another privacy and distance, are able to preserve sexual desire in their long-term relationships. Iasenza (2010), also a couples and sex therapist, argues that helping couples to expand their sexual frameworks to include multiple sexual response cycles that do not necessarily begin with the phase of desire but allow desire to emerge in the course of a sexual experience (e.g., Basson, 2001b) can be helpful in enhancing desire and alleviating sexual dysfunction.

## Sexual Desire in Same-Sex Relationships

As already suggested, the literature on lesbian sexuality has been dominated by the phenomenon of "lesbian bed death" (Nichols, 1982, 1988, 1995; van Rosmalen-Nooijens et al., 2008). Sexual inhibition appears to be the most common and often the only sexual complaint in lesbians (Nichols, 2004). Most lesbian couples report very strong sexual desire in the beginning of their relationship followed by a rapid and intense decline within 1–2 years of the relationship (Nichols, 1995). Importantly, "lesbian bed death" seems to conflate the absence of sexual desire and that of sexual activity (Iasenza, 2008).

While empirical investigations have not adequately addressed the etiology of the dwindling desire in lesbian relationships, multiple theories have been described in the literature (Iasenza, 2008; Nichols, 1982, 1988, 1995; van Rosmalen-Nooijens et al., 2008). One prevalent theory suggests that lesbian couples tend to become overly fused or merged in the course of their relationship, thereby extinguishing sexual desire that requires a sense of separateness, difference, and autonomy (Nichols, 1982, 1988, 1995; van Rosmalen-Nooijens et al., 2008). The wish to merge with another—one facet of our conceptualization of sexual desire—ceases to be relevant if the couple already experiences a symbiotic connection. Further, Nichols (1995) suggests that women are culturally socialized to be sexually repressed and therefore experience guilt and conflict about their sexual urges and activities. Since the lesbian couple consists of two women, they are twice as likely to both be conflicted about sex and to harbor prohibitions against certain sexual desires, especially sexual desires that seem to resemble male sexual preferences. As a result, each member of the couple is less prone to initiate sex (Iasenza, 2008; Nichols, 1982, 1988, 1995; van Rosmalen-Nooijens et al., 2008) and to acknowledge, express, and act on sexual desire that she perceives as transgressive and ego-dystonic (e.g., submissive–dominant role play) (Nichols, 1995). Trauma is another important inhibiting force in lesbian sexuality, as women are sexually abused and assaulted more frequently than are men and, thus, lesbian relationships double the possibility that at least one of the partners will have a history of sexual trauma (Nichols, 1995). Experiences of sexual discrimination and internalized homophobia exacerbate the already extant injunctions against female sexuality (Nichols, 1982). In summary, the literature suggests that lesbians, not wanting to simulate male dominance in the bedroom and to re-traumatize their partners, and propelled by their own prohibitions against female and same-sex sexuality, tend to be more accepting of lacking sex in their relationships and to deny their conflict-laden, forbidden, and dangerous desires (Nichols, 1995).

Despite ample accounts of "lesbian bed death" in the literature, recent empirical, theoretical, and clinical work disputes such death as either a myth propagated by the patriarchal male-centered norms for sexuality or a dated cohort effect that is not relevant in the current sociocultural climate for younger generations of lesbians (Cohen & Byers, 2014; Engein-Maddox, Miller, & Doyle, 2011; Iasenza, 2008; Nichols, 2004). A recent study examined sexual-minority women in long-term same-sex relationships (1–36 years in duration) across the behavioral, motivational, and cognitive-affective domains of their sexuality (Cohen & Byers, 2014). The findings indicated that sexual-minority women experienced strong sexual desire, derived

pleasure and sexual satisfaction, and expressed positive sexual esteem, minimal anxiety, and infrequent negative automatic thoughts during sexual encounters. Cohen and Byers conclude that contrary to the assumptions of "lesbian bed death," sexual-minority women can continue to experience high levels of sexual desire and to have regular and satisfying sexual relations with their long-term female partners involving both genital and non-genital acts. Another study examined not only the differences in the frequency but also the duration of sexual encounters in same-sex and mixed-sex relationships (Blair & Pukall, 2014). Blair and Pukall found that while women in same-sex relationships tend to have sex with slightly less frequency as compared to men in same- and mixed-sex relationships and to women in mixed-sex relationships, female same-sex couples report significantly longer durations of each individual sexual encounter. This finding is consistent with previous suggestion that women in same-sex relationships may have more diverse sexual repertoires than those typically captured by assessments of sexual frequency (Nichols, 2004).

### Conclusion to the Etiology of Disorders of Desire

While the role of biology in women's capacity to experience desire remains unclear, studies indicate that relational and cognitive-emotional factors are significant contributors to female sexual inhibition. Nonetheless, the present account of women's sexual desire and factors that may inhibit (or heighten) sexual desire remains incomplete. Challenging the traditional patriarchal emphasis on genital penetration for the sole purpose of orgasm, sexologists such as Iasenza (2008), Nichols (2004), and Tiefer (2003, 2006) call for a re-conceptualization of the female sexual response to be tailored to women's sexual needs. To this end, we seek to consider the full spectrum of sexual desire and to further explore potential relational and bodily factors involved in inhibiting and/or heightening sexual desire in women.

As evident in our discussions thus far, inhibited desire in women tends to be the focus of the female sexuality literature, while normal or average levels of sexual desire (primarily based on women's self-report) tend to serve as a comparison group in investigations of low desire. High sexual desire as a healthy phenomenon in female sexuality remains scarcely investigated. Virtually no studies consider women's sexual desire on a spectrum from absent/low to average to high. And while up to 40% of women complain of low desire (Hayes et al., 2006; Laumann et al., 1999; Lewis et al., 2010), the remaining 60% do not experience this problem, indicating that women do, in fact, possess varying levels of sexual desire. Including high sexual desire in the spectrum of women's desires may highlight some differences that would aid in characterizing and understanding the various precipitating factors that may enhance or diminish sexual desire in women.

## High Sexual Desire, Hypersexuality, and Highly Sexual Women

Before we delve into the relatively limited literature on high sexual desire of women, it is important to clarify several terms and delineate how they overlap and diverge. "Hypersexuality" is an ambiguous term that has been conflated with high sexual desire and tends to connote the pathology of dysregulated sexuality. Hypersexuality generally refers to high levels of sexual urges, fantasies, and activities that may entail high risk behaviors and result in adverse outcomes (e.g., sexually transmitted infections [STIs], sexual coercion, pedophilia) (Bancroft & Vukadinovic, 2004; Dodge, Reece, Cole, & Sandfort 2004; Kafka, 2000; Kafka & Hennen, 2003). Importantly, most of the empirical evidence on hypersexuality is based on men, and while the speculated male/female prevalence ratio of hypersexuality is estimated at 5:1 (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Carnes & Delmonico, 1996; Schneider & Schneider, 1996), it is considered to be a male disorder. "Highly sexual" is a term that characterizes women who experience high and frequent sexual desire and who consider themselves to be highly sexual and who value sex as an important aspect of their lives (Blumberg, 2003). We will use highly sexual as a foil to hypersexuality to designate individuals who experience high levels of sexual desire as an expression of normative or non-pathological sexual functioning.

While some researchers point to an overlap between hypersexuality and high sexual desire (Winters, Christoff, & Gorzalka, 2010), others dispute the assumption that high sexual desire always accompanies problematic and dysregulated sexual behavior (Cantor et al., 2013). A recent study examined the overlap between hypersexuality and high sexual desire in a large sample of men and women between the ages of 18 and 60 years (Carvalho et al., 2015). Carvalho et al. identified two distinct clusters of individuals, distinguishing between those who lack control over their sexuality (i.e., self-perceived inability to control one's sexual fantasies, urges, and behavior) and, in turn, suffer negative sequelae (e.g., STIs, legal problems), and those who experience high levels of sexual desire and engage in frequent sexual activity (masturbation, partnered sex, pornography use). Compared with the high desire/sexual activity group, the lacking-control/negative-sequelae group reported more symptoms of psychopathology, including depression, substance abuse, and neuroticism, and subscribed to more traditional attitudes, such as negative attitudes toward pornography and higher levels of religiosity. Carvalho et al. point out that these findings challenge the concept of hypersexuality as involving excessive sexual activity, urges, and fantasies, accompanied by distressing lack of control over one's sexuality, and resulting in adverse behavioral consequences. In contrast, the highest levels of sexual desire and activity in this study were not associated with either the perceived inability to control one's sexuality or

with the negative behavioral sequelae. These findings indicated that the perceived sense of control over sexual affects, cognitions, and activity is more central to hypersexuality as a pathological condition than the level of sexual desire (Carvalho et al., 2015). Consistent with these findings, Stulhofer et al. (2016) found that compared to the hypersexual group, women between the ages of 18 and 60 years with high sexual desire reported better sexual function, higher levels of sexual satisfaction, and lower probability of negative behavioral consequences. Taken together, current research indicates that hypersexuality should not be conflated with high sexual desire, which does not necessarily constitute a disturbance or a clinical problem. Importantly, sexual behavior is not necessarily indicative of the level of sexual desire as one may engage in frequent sexual activity in the absence of high sexual desire and vice versa.

Diverging from the pathologizing stance of hypersexuality, studies have attempted to identify and examine the characteristics of highly sexual women (e.g., Blumberg, 2003; Wentland et al., 2009). These investigations have found that highly sexual women experience higher levels of subjective desire, arousal and sexual fantasy; express more sexual agency; engage in more frequent and diverse sexual activities in both solitary and partnered contexts; have higher levels of confidence about their sexuality and more positive sexual esteem; and are not dependent on their partner for sexual arousal (Blumberg, 2003; Wentland et al., 2009). These findings suggest that spontaneous sexual desire may be a defining characteristic of highly sexual women. Researchers postulate that highly sexual women reap the benefits of pleasure-focused sex, which outweigh the rewards provided by more traditional sexual practices, in which women are sexually passive and less interested in sex than men (Wentland et al., 2009). In addition, Blumberg (2003) argues that women with high sexual desire are less concerned with the negative impact of their sexuality on their reputation because of their self-acceptance and the importance of sex in their lives.

The literature on lesbian sexuality similarly offers evidence of high sexual desire in lesbians that undermines the assumption of the "lesbian bed death" described previously. In her critique of "lesbian bed death," Iasenza (2008) cites studies demonstrating that lesbians are more sexually arousable (capacity to become aroused and sexually motivated) (Coleman, Hoon, & Hoon, 1983; Iasenza, 1991), more sexually assertive (Iasenza, 1991, 2010; Masters & Johnson, 1979), and more comfortable using erotic language with their partners (Wells, 1990) than are heterosexual women. She presents excerpts from lesbians' narratives of sexual passion and play that reflect entitlement to sexual pleasure and agency, and that deconstruct traditional sexual scripts that are largely dichotomous (passive/active, masculine/feminine, penetrated/penetrating). Similarly, Nichols (1988, 2004) describes a transformation of sexual attitudes and practices within the lesbian community over the past 30 years with the emergence of the lesbian "sex radical" movement, which is diametrically opposed to the problem of low sexual desire. Lesbian radicals produce various forms of lesbian erotica, establish and participate in sex clubs, and engage in and are more accepting of a range of sex practices and sexual relationships, such as gender bending, kink, BDSM (bondage–discipline, dominance–submission, sadism–masochism), exhibitionism, polyamory, and other sexual play. We will return to potential disinhibiting forces in lesbian sexuality in our discussion of sexual subjectivity and self-objectification below.

While the studies on women with high sexual desire offer a valuable contribution to the field of female sexuality, the discrete or categorical distinction between the different levels of sexual desire is arbitrary, at times pathologizing, and likely counterproductive to the examination of women's sexual desire. Importantly, research has not sufficiently examined the factors that potentially explain the observed differences in sexual desire in women as it ranges on the continuum from highly sexual to less sexual to inhibited. Understanding the underlying mechanisms that render women more or less sexually desirous may allow researchers and clinicians to understand the forces that inhibit and/or enhance female sexuality.

## Other Mechanisms Explaining Women's Sexual Desire

As reviewed above, we have ample theories and research findings to explain how women's desires come to be doused or inhibited. However, certain gaps remain including a conceptualization of the psychological processes underlying not just inhibited sexual desire (see earlier discussion), but the full spectrum of sexual desire. While there may be various psychological processes that may be implicated in inhibiting or heightening sexual desire in women, there are two that stand out for us. In the RBET (Fig. 1), we proposed that women's internalized working models of self and other, reflected in their attachment styles, and sexual body self-representations, incorporating the constructs of self-objectification, sexual subjectivity, and genital self-image, also are implicated in the mechanisms that may inhibit or heighten women's sexual desire. While the construct of attachment weaves in women's early relational history with their parents, sexual body self-representations emphasizes the sociocultural framework within which women internalize their sense of their bodies and sexuality. In this way, these two meta-constructs encompass developmental experience from infancy through adulthood and a range of influences from intrapsychic to interpersonal to cultural in scope. We will return to the mediating role of bodily representations between attachment and desire later in the article, but we will first review the literature pertinent to each component of our model.

## Relational Experiences and Desire: Attachment and Sexuality

Attachment theory, developed by Bowlby (1969, 1973), conceptualizes the biological tendency of infants to establish an affectional bond with their primary caretakers within the first year of life. The resultant attachment system forms the basis of people's internal working models of close relationships that persist from early childhood throughout adulthood, with some degree of malleability. Bowlby indicated that when the person perceives the attachment figure as available and responsive to proximity-seeking behavior, she experiences a sense of *attachment security*, perceiving the attachment figure as trustworthy and reliable. These nurturing and attuned relational experiences foster positive internal representations of self and others that enhance self-confidence and trust in the attachment figures' readiness to offer support. Bowlby (1988) believed that attachment security (i.e., secure attachment) not only engenders a positive self-image and facilitates the development of mutually satisfying relationships but also allows the individual to explore and pursue non-attachment activities, such as sex.

Bowlby (1969, 1973) posited that due to biological pressures, children form attachments to their caregivers even if the caregiver is inconsistent, unresponsive, rejecting, neglectful, or abusive. Individuals who experience such disruptions in their attachment system tend to develop negative internal working models of self or others and adopt one of two defensive strategies of insecure attachment: *hyperactivation* or *deactivation* of the attachment system. Preoccupied with threats of abandonment, separation and betrayal, and apprehension that the attachment figure will be unavailable to meet their needs, anxiously attached individuals tend to engage in hyperactivating attachment behaviors, which Bowlby called "protest"—frenzied, unrelenting attempts to elicit caretaking behaviors in the attachment figure, including clinging, controlling, and forceful behaviors. A hyperactivated individual remains hypervigilant to any threats of abandonment, separation, and betrayal, which inadvertently and inevitably generates relational conflict thereby reinforcing feelings of insecurity. In a stance that Bowlby termed "compulsive self-reliance" (Bowlby, 1969), avoidantly attached individuals engage in deactivating behaviors characterized by the inhibition of proximity-seeking behaviors and maintenance of physical and emotional distance. Avoidantly attached individuals disregard threats to the relationship and avoid intimacy and interdependence when coping with attachment needs.

Mikulincer and Shaver (2007) argue that, although sexual and attachment systems are functionally independent, they nonetheless influence one another and contribute to relationship quality and stability. Securely attached individuals with positive internal representations of self and other are more likely to lower their defenses and experience positive feelings toward sex. Insecurely attached individuals, who harbor negative representations of self or other, are more likely to experience conflictual feelings with respect to sex (Shaver & Hazan, 1993) and engage in hyperactivating or deactivating strategies. Hyperactivating strategies in a sexual context constitute a compulsive, intrusive, and, at times, coercive effort to engage the partner in sexual activity, accompanied by exaggerated concerns over one's sexual attractiveness and sexual esteem (Mikulincer & Shaver, 2007; Shaver & Mikulincer, 2006). Deactivating sexual strategies entail inhibition of sexual desire and an erotophobic or avoidant attitude toward sex or an emotionless and cold approach to sex that decouples sex from intimacy, warmth, or kindness.

Studies have scarcely addressed the link between sexual desire and attachment style but have focused on sexual cognitions, affects, and behaviors, demonstrating that insecurely attached individuals reported experiencing negative feelings during sex (Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2006; Gentzler & Kerns, 2004; Tracy, Shaver, Albino, & Cooper, 2003), less enjoyment of sex (Hazan, Zeifman, & Middleton, 1994), and less positive appraisals of their sexual self-schemas, or cognitive views about the sexual aspects of the self (Cyranowski & Andersen, 1998). Anxious individuals reported a strong wish for their partner's emotional involvement during sex (Birnbaum et al., 2006) and endorsed an erotophilic attitude toward sex (i.e., tending to approach/respond to sexual cues) (Bogaert & Sadava, 2002), relying on sexual activity to quell their fears of abandonment and rejection. Furthermore, studies indicated that anxiously attached adolescents (Tracy et al., 2003) and adults (Davis, Shaver, & Vernon, 2004; Schachner & Shaver, 2004) pursued sexual relations in order to minimize their fears of rejection and abandonment while enhancing their feelings of reassurance, closeness, and love from a partner.

Research demonstrated that avoidant young adults engaged in sex less often but masturbated more frequently (Bogaert & Sadava, 2002; Gentzler & Kerns, 2004; Hazan et al., 1994), which likely diminished worries about intimacy, reflecting Bowlby's idea of "compulsive self-reliance." Further, studies show that when avoidantly attached adolescents (Tracy et al., 2003) and adults (Cooper et al., 2006; Davis et al., 2004; Schachner & Shaver, 2004) do engage in sex, they do so in order to obtain social prestige and power over their partner without any desire for intimacy or expression of love. Notably, Schachner and Shaver (2002) found that differences in sexual activity in avoidant individuals were not explained by variation in libido or sex drive.

A recent study found that both anxiously and avoidantly attached women, ages 18–30 years, were more likely to experience poor sexual esteem (or lacking confidence in their sexual prowess) and higher levels of sexual anxiety (or tension/discomfort about their sexual life), which in turn interfered with their sexual functioning, including desire and arousal (Brassard, Dupuy, Bergeron, & Shaver, 2015). The link between attachment and poor sexual functioning was fully explained by the

sexual esteem and anxiety in the anxious group and only partially explained in the avoidant group, suggesting that other mediators need to be considered. Brassard et al. indicated that anxiously attached women's preoccupation with negative feelings and self-perceptions and difficulty modulating such distress likely undermined their sexual desire and arousal. Further, they posited that avoidantly attached women's compromised abilities to tolerate and regulate the distress elicited by the intimacy and closeness of a sexual encounter may have interfered with sexual desire and arousal.

### Summary of Research on Attachment and Sexuality

Taken together, these findings indicate that individuals with attachment anxiety and avoidance tend to employ sexual strategies to fulfill their attachment related needs. Anxiously attached individuals sexualize their want or need for love and intimacy and exhibit ambivalence about sex, such that they simultaneously experience aversive feelings as well as the desire for intimacy and closeness. Avoidant individuals, harboring negative representations of others and seeking to escape closeness, abstain from partnered sexual activity, engage in masturbation, or pursue casual sex for prestige and power over others without actually experiencing sexual desire. While sexual desire appears to be relatively inhibited for the avoidantly attached individuals, it is steeped in conflict, ambivalence, and distressing emotions for those with anxious attachment styles.

As mentioned above, attachment research does not specifically focus on sexual desire. Nonetheless, these findings indicate that early relationships with caregivers not only establish the internalized working models for relationships but also organize individuals' sexual templates, including the experience of sexual desire. The link between attachment and sexuality is consistent with one of the facets of our conceptualization of sexual desire—the wish to connect and merge with a real or fantasied other. Such merger requires a capacity to simultaneously tolerate connectedness and distance between self and other, which is difficult to maintain for insecurely attached individuals who are either clinging (anxious) or distancing (avoidant).

## Sexual Body Self-Representations: The Hypothesized Mediator in RBET

Given the centrality of the physical body to the experience of sexual desire, it is important to integrate women's feelings about their bodies and their sense of embodiment into our understanding of female sexuality. In RBET (Fig. 1), we propose that women's sexual body self-representations explain (i.e., mediate) the link between internalized working models of parent–child relationships (i.e., attachment) and sexual desire. Internalized sexual body self-representations consists of sexual subjectivity, self-objectification, and genital self-image, which have been associated with women's sexual functioning, including desire (e.g., Berman, Berman, Miles, Pollets, & Powell, 2003; Buzwell & Rosenthal, 1996; Fredrickson & Roberts, 1997; Herbenick & Reece, 2010; Herbenick et al., 2011; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). The literature on sexual subjectivity and self-objectification addresses women's sense of ownership and agency with respect to their bodies and their sexuality, as well as their capacity to "embody their bodies." The latter is the sense of "living in and through" the body, staying connected to and tuned into the body, and experiencing sexual and pleasurable sensations in the body (Tolman, 2002). Research on sexual body esteem and genital self-image investigates women's feelings and thoughts about their bodies in a sexual context. Both these lines of investigation place female sexuality in a sociocultural context and consider how women's bodily experiences are implicated in their sexual functioning, including sexual desire.

### Sexual Subjectivity

Martin (1996) indicated that the capacity to embody one's body is essential to sexual subjectivity, defined as "the pleasure we get from our bodies and the experiences of living in a body" (p. 10). Sexual subjectivity, in turn, is crucial to sexual desire because the woman needs to be able to both feel herself to be the object of another's desire and to be the subject of her own desire (e.g., Benjamin, 1988; Tolman, 2002). Without sexual subjectivity and, thus, stripped of agency and power, the woman finds herself wedged in the position of object, monitoring the desire of the other rather than embodying her own.

Much of the theoretical and empirical literature on sexual subjectivity addresses adolescent female sexuality, citing the social forces that interfere with girls achieving sexual subjectivity and that result in adverse outcomes, including absent or unacknowledged sexual desire (Tolman, 2002). Given the high prevalence of sexual inhibition in adult women, one must consider the role of sexual subjectivity in understanding sexual desire in adult women.

In operationalizing female sexual subjectivity, Horne and Zimmer-Gembeck (2006) conceptualize sexual subjectivity as a multifaceted phenomenon that consists of sexual body esteem, entitlement to sexual desire and pleasure from self and other, as well as sexual self-reflection. Horne and Zimmer-Gembeck found that adolescent girls with higher levels of sexual subjectivity were more attuned to the internal aspects of their sexuality, including sexual feelings, motivations, desires, tendencies, and preferences. They were more likely to engage in safe-sex practices. They were less likely to engage in self-silencing in intimate and sexual relationships and less likely to embrace double standards. Components of sexual subjectivity were negatively correlated with sexual anxiety, and assuming that sexual anxiety has an inverse relationship with sexual functioning,

higher levels of sexual subjectivity likely indicate more positive sexual wellbeing.

While the research on sexual subjectivity in sexual-minority women is scarce, current literature suggests that these women may have unique access to sexual subjectivity that is less available to heterosexual women (Fine, 1988; Ussher, 2005; Ussher & Mooney-Somers, 2000). Feminist scholars posit that young women's negotiation of their sexual desire is central to the development of personal empowerment and entitlement (e.g., Fine, 1988; Tolman, 2002). Feminist scholars (Diamond, 2005; Fine, 1988) suggest that young sexual-minority women's engagement in the questioning process regarding their sexual orientation may foster greater ownership and agency with respect to their desires. They suggest that the process of grappling with the subjective experiences of same-sex sexual arousal, pleasure, affection, and attraction, and the social ramifications of these experiences may allow these young women to become aware of, deconstruct, and resist the explicit and implicit cultural scripts that tend to undermine and inhibit women's sexual desire. Ussher (2005) and Ussher and Mooney-Somers (2000) conducted qualitative interviews with a group of young lesbians called the Lesbian Avengers whose mission involved high profile, media-friendly, "sexy" actions to raise public awareness of lesbians. The obtained narratives indicated that lesbians' experience of being an object of another woman's desire and the resultant recognition of their own desirability and lesbianism were an empowering experience. In other words, being the object of another's desire did not strip these women of their agency. Rather, they were able to shift fluidly between the positions of active and passive, desiring and desired, sexual subject and object. Boislard-Pepin and Zimmer-Gembeck (2011) found that same-sex sexual experience in young women was associated with greater entitlement to self-pleasure, more sexual self-efficacy, and more sexual self-reflection. Boislard-Pepin and Zimmer-Gembeck suggest that possibly, a history of same-sex sexual experiences results in greater personal awareness of sexual entitlements and efficacy, and enhanced self-reflection about one's sexual desire. On the other hand, greater sexual subjectivity may render young women more open to sexual experimentation, and thus, sexual subjectivity may be the antecedent rather than the result of same-sex sexual experience. These findings are consistent with earlier mentioned evidence that lesbians tend to experience autonomous or spontaneous sexual desire. Thus, further research is necessary to consider the relations between same-sex desire, sexual subjectivity, and autonomous versus responsive desire.

## Self-Objectification

While sexual subjectivity reflects women's sense of sexual ownership and bodily competence, self-objectification represents women's submission to societal pressures, such that women relinquish their agency and embodiment of their sexuality and become the object of the patriarchal gaze and desire. The self-objectification theory of Fredrickson and Roberts (1997) posits that women's repeated subjection to sexual objectification—to physical scrutiny and examination—in Western culture has resulted in women internalizing an objectifying gaze, in which they take on the observer's perspective of their bodies. As a result, women come to regard themselves as objects to be looked at, inspected, and desired—as a collection of parts meant to be consumed by others. The resultant self-monitoring of the body's outward appearance, or self-surveillance (McKinley & Hyde, 1996), fosters increased body shame and appearance anxiety, which trigger negative feelings about the sexual aspects of the self and contribute to sexual dissatisfaction or sexual dysfunction (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998).

Studies have demonstrated the link between higher levels of self-objectification in women and less positive sexual esteem (Calogero & Thompson, 2009b; Fredrickson & Roberts, 1997; Wiederman, 2000) and less sexual pleasure (Calogero & Thompson, 2009a). These studies indicate that women, who generally engaged in self-surveillance, a marker for self-objectification, also did so in sexual situations. Women's propensity for self-surveillance or self-objectification resulted in higher levels of body-image self-consciousness during sexual activity, which is defined as a heightened sense of awareness of how one's body looks to a sexual partner during sexual activity (Wiederman, 2000). Such cognitive preoccupation with one's appearance, termed "spectatoring," results in dissociation from the immediate moment and detracts from the sexual experience in all ways, including the capacity to tune into, acknowledge and connect to one's desire (Masters & Johnson, 1970). Cash et al. (2004) found that women who experienced less self-consciousness and body-exposure avoidance (i.e., anxiety about exposing one's body) during sexual activity were more likely to derive pleasure from sexual experiences and to self-identify as a sexual person. These findings suggest that women who exhibit less self-objectification are more likely to experience higher levels of sexual desire.

Importantly, the self-objectification construct in our proposed theory differs from a related phenomenon proposed by Bogaert and Brotto (2014) in their theory of object of desire self-consciousness (ODSC), which refers to an individual's self-perception that one is romantically and sexually desirable in the eyes of the other. Unlike self-objectification theory, ODSC concerns the body and other factors, such as internal attributes and behavior. Furthermore, ODSC restricts its focus to the perception that one is desirable. Consistent with ODSC theory, studies find that women are sexually aroused by their self-perception as attractive and by their partner's apparent desire for them (e.g., Graham, Sanders, Milhausen, & McBride, 2004). ODSC theory also may have implications for sexual dysfunctions, including low desire, considering that women's belief that they are physically unattractive may attenuate their

sexual desire (Basson, 2002). In a study on gender differences in the content of sexual fantasies, women endorsed more object-of-desire themes than did men independent of self- and observer-rated attractiveness measures (Bogaert, Visser, & Pozzebon, 2015). While our proposed theory focuses on body-image self-consciousness as a marker for self-objectification, the ODSC theory and related findings highlight the importance of women perceiving themselves to be physically desirable to others as critical for their sexual desire, which is consistent with one of the facets of our definition of sexual desire—the wish to be the object of and to submit to another's desire.

Research findings on the application of the self-objectification theory for sexual-minority women are scarce and inconclusive. Studies consistently find that lesbian and heterosexual women experience similar levels of sexual objectification (Engein-Maddox et al., 2011; Hill & Fischer, 2008; Kozee & Tylka, 2006); however, the link between sexual objectification and self-objectification is less clear for lesbians. While some studies find evidence for self-objectification in lesbians (Hill & Fischer, 2008; Kozee & Tylka, 2006), others suggest that certain factors associated with the lesbian identity may attenuate the harmful impact of the objectifying gaze, thereby lessening the tendency for self-objectification in this population (Engein-Maddox et al., 2011). Kozee and Tylka found higher levels of body surveillance (i.e., a measure of self-objectification) in lesbians (18–26 years old) compared to heterosexual women (18–22 years old) and demonstrated direct pathways between sexual objectification and (1) body surveillance and (2) body shame in a college sample of lesbians. Kozee and Tylka suggest that lesbians may be more prone to self-surveillance because their sexual identity is inconsistent with the dominant culture's heterosexual orientation such that they monitor their appearance to avoid being dismissed or derided. Comparing lesbian and heterosexual women (18–61 years old), Hill and Fischer (2008) found that the association between women's experiences of sexual objectification and self-objectification did not differ as a function of sexual orientation. However, contrary to the findings of Kozee and Tylka (2006), Hill and Fischer found that lesbians reported significantly less body surveillance than heterosexual participants, suggesting that identifying with the lesbian community may protect women from some of the negative psychological corollaries associated with self-objectification. A recent study of a community sample of lesbians also found lower levels of body surveillance in lesbian (17–74 years old) compared to heterosexual women (16–58 years old) (Engein-Maddox et al., 2011). Engein-Maddox et al. suggest that the women in their sample were diverse in terms of age and recruited from a community setting, whereas the study by Kozee and Tylka investigated a college student population, suggesting that younger college women may be more vulnerable to self-objectification. Further, given the lower levels of self-objectification in lesbians compared to heterosexual women, Engein-Maddox et al. posit that the gaze of a woman may be both more relevant and less problematic for lesbians' body esteem. Given the handful of studies and inconclusive findings, the phenomenon of self-objectification in sexual-minority women requires further investigation. Importantly, the current literature on self-objectification focuses solely on lesbians, excluding other sexual-minority women such as bisexual, which constitutes another gap in the research.

Despite certain inconsistencies in findings, some of the above reviewed studies suggest that while all women irrespective of their sexual orientation experience sexual objectification, lesbians may be less likely to self-objectify in a sexual context, although this certainly requires further investigation. In light of the extant studies, we posit that women's propensity for self-objectification occurs on a continuum as a function of their vulnerability to patriarchal sexual scripts in which women are objects, not subjects. One possible explanation that we propose is that women in a same-sex relationship, aware of the realities of their upbringing and existence in patriarchy, face each other knowing they are objects. Awareness of this reality allows them to begin a process of examination and questioning, which grants them a certain level of freedom to vacillate between the positions of object and subject as argued in the previous section on sexual subjectivity. Women involved with men face the representative of patriarchy, which evokes the traditional male dominated sexual scripts in which the woman is an object of male desire. Thus, women in mixed-sex relationships may automatically find themselves in the position of object, irrespective of their particular male partners' tendency to objectify them. We offer these speculations as potential hypotheses that require further research to elucidate the role of self-objectification in the sexual functioning of sexual-minority women.

The literature on sexual subjectivity and self-objectification and female sexuality also reflects facets of our definition of sexual desire—the yearning to experience one's agency and ownership over one's body and sexuality as well as the want to be the object and to submit to another's desire. The capacity to experience sexual desire necessitates one's ability to occupy not only the position of object of another's desire but also the position of subject of one's own desire. Women's tendency to self-objectify in a sexual context which results in poor sexual body esteem and increased body-image self-consciousness lessens women's sexual subjectivity thereby deflating their sexual desires. On the other hand, agentic women who are able to circumvent the societal pressures to self-objectify, who have avoided internalizing the objectifying gaze, and who are able to shift between the positions of object and subject, are likely to experience and take ownership of higher levels of sexual desire.

### Genital Self-Image

Female genital self-image, which addresses women's perceptions of and feelings about their genitals in terms of appearance, smell, function, embarrassment, and comfort with allowing a partner or a healthcare provider to see or examine them, also has been implicated in women's sexual functioning (Berman et al., 2003; Herbenick & Reece, 2010; Herbenick et al., 2011). The studies found that women with more positive feelings about their genitals experienced higher levels of arousal, desire, orgasm, and satisfaction. In another study, Schick et al. (2010) found that women's dissatisfaction with their genital appearance was significantly linked to higher genital image self-consciousness during physical intimacy, which, in turn, predicted lower sexual self-esteem and lower sexual satisfaction. These findings suggest that women's feelings and beliefs about their genitals may be associated with their affective-evaluative orientation toward sexuality and with their comfort or willingness to engage in behaviors that involve close contact with their genitals (e.g., partnered sexual activity and masturbation). In this way, women's appraisal of their genitals is an important determinant of women's sexual esteem and sexual function. While studies have not specifically examined genital self-image in sexual-minority women, Jay and Young (1979) found that lesbians typically expressed positive feelings about their genitals, which is in line with Cohen and Byers' (2014) recent finding that sexual-minority women experience high levels of sexual desire and express positive sexual esteem and few negative automatic thoughts in the sexual context.

### Summary of Research on Sexual Body Self-Representations

Empirical research on sexual subjectivity, self-objectification, sexual body esteem, and genital self-image suggests that negative self-appraisal and monitoring of one's body may undermine women's sexual desire (Calogero & Thompson, 2009b; Fredrickson & Roberts, 1997; Wiederman, 2000). The sexual subjectivity literature suggests that women's capacity to experience sexual desire is contingent on their sense of agency and ownership with respect to their bodies and sexuality and their ability to embody their bodies (Horne & Zimmer-Gembeck, 2005; Martin, 1996; Tolman, 2002), while self-objectification theory indicates that patriarchal culture dominated by the objectifying gaze disconnects women from their bodies, leaving them feeling sexually incompetent and lacking access to their desires (Dove & Wiederman, 2000; Fredrickson & Roberts, 1997; McKinley & Hyde, 1996; Wiederman, 2000; Wiederman & Allgeier, 1993; Wiederman & Hurst, 1998). Finally, poor sexual body esteem and poor genital self-image intensify a propensity for self-surveillance and body-image self-consciousness, further detracting from the experience of sexual desire and pleasure. Distressing feelings about one's sexual body, as well as the tendency to observe rather than embody one's body, are likely to result in fragmentation of one's experience of desire. In contrast, positive sexual body self-representations play a prominent, powerful, and palpable role in enhancing women's sexual desires.

### Relations Between Attachment and Sexual Body Self-Representations

In bridging the roles of attachment and sexual body self-representations in enhancing or inhibiting sexual desire in women, the RBET of sexual desire in women proposes that the body serves as the conduit between early relational experiences and adult sexual desire. Attachment theory and research suggest that people's templates for relationships and internalized representations of self and other stem from their early experiences with their parental figures. Importantly, an infant's and young child's relationship with primary caretakers is largely physical, with the mother breastfeeding the baby and the parents bathing, dressing, caressing, kissing, rocking, and cradling the child to nourish, soothe, protect, and respond to the child's needs, as well as to bond and to express affection toward the child. Parental love, care, responsiveness, and attunement as well as intrusiveness, rejection, maltreatment, and abandonment are largely communicated through the body during the child's early years. The physicality of the parent–child relationship begins to recede as the child grows and becomes more verbal, but physical contact remains an important mode of connecting until adolescence when the developing child requires more privacy, firmer boundaries, and ownership over their maturing bodies. The physical body, therefore, serves as the earliest register for relational experiences. It follows that disturbances in the parent–child relationship such as intrusive, mis-attuned, unresponsive, or neglectful parenting, abandonment, and prolonged separations, would not only result in insecure attachment, but also interfere with the development of the capacity to embody one's body and achieve a sense of bodily competence and integrity. Incorporating internalized representations of relationships and sexual body self-representations into our understanding of the phenomenology of women's sexual desire resonates with our proposed definition of sexual desire, which similarly integrates the bodily and the relational components of sexual desire.

In our proposed RBET for the full spectrum (from low to high) of sexual desire, women's attachment styles are related to their experiences of sexual desire via their sexual body self-representations composed of sexual subjectivity, self-objectification, and genital self-image. In other words, we propose that women's sexual body self-representations constitute one of the underlying mechanisms that explain the link between women's attachment styles and their sexual desires (Fig. 1). Specifically, compared to insecurely attached (anxious and avoidant) individuals, women with a more secure attachment style are less

likely to be self-conscious about their bodies in a sexual context, are more likely to embody, feel ownership of, and have positive feelings toward their bodies, and therefore experience greater sexual subjectivity and less self-objectification. In turn, these women are more likely to have higher levels of sexual desire than anxiously and avoidantly attached women who are more likely to self-objectify, lack sexual subjectivity, and feel disconnected from and self-conscious about their bodies, especially in a sexual context. A recent empirical investigation of sexual desire in approximately 600 heterosexual women between the ages of 18 and 40 years of age supported RBET (Cherkasskaya & Rosario, 2017). The findings demonstrated that women's sexual body self-representations (comprised of sexual body esteem, self-objectification, and genital self-image) mediated the relations between their internalized working models of parent–child relationships (comprised of attachment and separation–individuation) and sexual desire (comprised of dyadic and solitary desire, cognitive and affective components of desire, entitlement to desire and pleasure, and sexual self-reflection) in adulthood.

## Conclusion

Women's sexual desire is a multifaceted phenomenon that consists of affective, cognitive, relational, and bodily components, spans a wide range from absent or diminished desire to high desire, and is shaped by an interplay of multiple forces and contexts, including the early relational, sociocultural, and biological. The literature currently focuses on low or absent desire, largely omitting the remaining spectrum and scarcely addressing high sexual desire in women. We thus have less insight into how women develop high sexual desire. By failing to appreciate the continuum of sexual desire in women from low to high, we run the risk of perpetuating a double standard, in which female sexuality is considered somewhat compromised—inhibited, absent, diminished, disempowered, and silenced.

While Kaplan's (1995) sexual response cycle continues to be applied widely in the study of sexuality and sexual dysfunctions, her ideas about the contribution of early childhood relationships with one's parents to "his or her lifetime erotic program or "love-map" and to sexual dysregulation are insufficiently addressed in the empirical literature. We argue for the importance of integrating internalized representations of self, other, and relationships (i.e., attachment) into the theory on sexual desire. Importantly, early relational experiences and the cultural attitudes toward the female body may serve to enhance female sexuality by engendering a sense of agency, bodily integrity, and ownership over her sexuality. On the other hand, early parent-child relationships may inhibit female sexuality by deflating her sense of sexual competence, sexual body esteem, and sexual agency, as well as by fostering self-consciousness about her appearance, thereby, impairing her sexual subjectivity and promoting self-objectification. In other words, positive attachment experiences in childhood may protect women from certain sociocultural forces that inhibit female sexuality, whereas negative attachment experiences may leave women more vulnerable to sexual objectification and oppression. Further investigation is necessary to elucidate these postulations.

While studies have investigated the links between attachment and sexuality, research has not sufficiently considered sexual desire and attachment orientation. Further, previous research has scarcely integrated sexual subjectivity, self-objectification, and genital self-image into the construct of sexual body self-representations that would account for women's sense of agency and embodiment, their tendency to self-objectify, and their perception of their bodies, particularly in a sexual context. A recent study evaluating RBET demonstrated that sexual body self-representations mediated the relations between women's internalized representations of relationships and sexual desire (Cherkasskaya & Rosario, 2017) in adult premenopausal heterosexual women. Further research is necessary to continue to evaluate RBET in women with varying levels of sexual desire, including its application to sexual-minority women across the lifespan and to men.

RBET has two important clinical implications for the treatment of desire difficulties in women. The inclusion of the attachment construct suggests that women's internalized working models of early parent–child relationships, specifically their attachment styles, are fundamental to understanding problems with sexual desire, and thus, attachment-based psychotherapy would benefit women struggling with sexual desire difficulties. Further, the integration of the sexual body self-representations construct highlights the importance of considering women's experiences of their bodies—their capacity to embody their bodies, their sexual body esteem, and their tendency to monitor their bodies during sexual activity—in the treatment of sexual desire concerns. The proposed theory is in line with existing sex therapy approaches (e.g., sensate focus) as well as other sexology literature recommending body-based approaches, including mindfulness, acupuncture, and yoga, for addressing women's sexual complaints (Brotto, Krychman, & Jacobson, 2008).

In summary, current theoretical formulations and research findings on women's sexual desire appear somewhat fragmented in terms of the definition of sexual desire, the emphasis on low desire and the omission of the remaining spectrum, and the etiology of desire difficulties. In addition, current conceptions do not sufficiently integrate the developmental perspective of attachment theory. As conceptualized by our multi-dimensional definition of sexual desire presented earlier in this article, women are diverse in their sexual wants, needs, and longings—some women want to feel connected and attuned to their partner, others want to experience bodily pleasure and satisfaction, still others want to feel empowered and recognized or to submit to another's desire, and some may want it

all! Importantly, for women to have access to and embody their desires, they require the capacity to be agents of their sexuality and their sexual bodies, which is contingent on their sense of autonomy and integrity of self and positive representations of self and other. If we are mindful of and aim to understand the full spectrum of sexual desire in women rather than focus on one facet (e.g., inhibited sexual desire), we may finally be able to appreciate this critical aspect of women's lives.

**Funding** This article was supported by the Far Fund, a private foundation in New York, NY. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Far Fund.

## Compliance with Ethical Standards

**Conflict of interest** The authors declare that they have no conflict of interest.

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