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THE EXPERIENCE AND MEANING OF POSTMENOPAUSAL WOMEN'S
SEXUAL DESIRE: A GROUNDED THEORY STUDY

A Thesis in

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by

Jill M. Wood

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The thesis of [Jill M. Wood](#) was reviewed and approved* by the following:

Patricia Barthalow Koch
Associate Professor of Biobehavioral Health and Women's Studies
Thesis Advisor
Co-chair of Committee

Phyllis Kernoff Mansfield
Professor of Women's Studies
Co-chair of Committee

Linda Wray
Assistant Professor of Biobehavioral Health

Collins O. Airhihenbuwa
Professor of Biobehavioral Health

Edgar Yoder
Professor of Agricultural and Extension Education

Lynn Kozlowski
Professor of Biobehavioral Health
Head of the Department of Biobehavioral Health

*Signatures are on file in the Graduate School

ABSTRACT

Much of the research on women's sexual desire adopts a biomedical approach to the study of women's sexuality. Feminist thought has been critical of this approach because it posits women's biology as the sole determinant of women's sexual experiences, such that sexual response is represented as universal, static, and unmalleable. This essentialist approach to women's sexuality is especially problematic for midlife and older women due to institutionalized ageist medical ideology, in which postmenopausal women are viewed as deficient and diseased. This research on women's sexual desire has been primarily quantitative, and therefore there is currently a dearth of information on women's experiences and meanings of sexual desire. Based on these perceived shortcomings of the research on women's sexual desire, especially among postmenopausal women, this research project was developed. A qualitative grounded theory research design, situated within a feminist paradigm, was used to fulfill the goals of this study. Twenty-two postmenopausal women participated in semi-structured telephone interviews, and the resulting data were analyzed in *Nvivo 2.0* using the constant comparison method (developed by Glaser & Strauss, 1967). The results of this study suggest that postmenopausal women's experience and meaning of sexual desire is intrinsically related to their negotiation of their sexual agency. Feminist scholars and theorists use the term sexual agency as a concept that describes the degree to which women are able to act on behalf of their own needs, desires, and wishes in terms of sexual behavior, sexual decision making, and even in terms of how women's sexuality is viewed within society (e.g. Brumberg, 1997; Fine, 1988; Vance, 1992; Wolf, 1998).

Similarly, feminists make a distinction between women as sexual subjects and as sexual objects. Theoretically, as sexual subjects (much like as sexual agents), women are in control not only of their own bodies, but also in charge of how sexual desire is constructed in terms of gender roles and who sexual behavior and activity benefits and disempowers. This research found that women negotiated their sexual agency within three sites: within themselves, within their relationships with partners, and within their interactions with the medical system. Women's negotiation of sexual agency was central to their experience of sexual desire, as well as the meanings that were attached to their experience. Findings are discussed with regard to how women's sexual desire is deeply embedded in the sociocultural and politically charged context of their lives. One significant result of this research was that women rarely discussed their sexual desire, even when they were repeatedly and directly asked about it. The "still missing discourse of desire" (a term borrowed from Fine, 1988) indicates that women's own sense of themselves as sexual agents is entrenched within sociocultural meanings about what it means to be a woman who embodies sexual desire. When women's sexual desire is appropriated by and for others (e.g. male partners, physicians) women's ability to negotiate sexual agency is curtailed. In other words, when women's sexual desire is stigmatized and associated with pejorative terms (e.g. "slut") the discourse of women's sexuality is constructed as negative and taboo, thereby making women's ability to negotiate sexual desire in light of such negative messages more difficult.

Implications of this study include the need to reconsider the current conceptualization and definition of sexual desire, as well as the need for researchers to acknowledge the effects of the political climate and sociocultural messages (often rooted

in institutional sexism) that shape women's experience of sexual desire and the various meanings associated with women who embody their sexual desire. Additionally, current models of sexual response may be limited, and the results of this research suggest that the treatment of women's low sexual desire as a sexual dysfunction or disorder may be inappropriate. Recommendations for future research are also discussed with regard to the need for more (feminist) research that acknowledges the politically charged nature of women's sexuality. Future work on women's sexual desire must address and critique the limitations and assumptions of much of the work on women's sexual response and sexual desire. Without critical scholarship, additional research may stray further and further from women's perceptions and lived experiences. Without understanding women's experiences of sexual desire (and other aspects of sexual response), realistic and applicable models of sexual response cannot be developed. Utilizing feminist scholarship, since it focuses on women's power and the politics of knowledge and sexuality, is likely the first necessary step in critically thinking about the "still missing discourse of desire" for women.

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DEDICATION

It is with the utmost joy and overwhelming sense of love that I unabashedly honor my paternal grandmother, Louise Davis Wood, by dedicating my dissertation and graduate work to her and to her memory. Thank you Grandma, for convincing me that I can do anything.

Chapter 1

Introduction

This chapter will introduce the purpose and significance of this study on menopausal women's sexual desire. First, an overview of menopausal women's sexuality changes will be discussed. Next, the various disciplinary perspectives used to study women's sexual desire will be reviewed. The last section of this chapter introduces the purpose of the study and the research questions. Finally, the researcher's motivation for the study and assumptions about the area of inquiry are addressed.

Women's Sexuality Changes During Menopause: An Overview

Research suggests that menopause has a significant effect on various aspects of women's sexuality and sexual response (e.g. Boston Women's Health Book Collective, 2000). In fact, menopause is the single most commonly researched influence on women's sexuality during middle and later life. Research on women's sexuality is typically approached from one of two perspectives: a biomedical perspective or a biopsychosocial paradigm. Most often, women's sexuality changes during menopause are studied from a biomedical perspective.

Traditionally, researchers and scholars concerned with sexuality have conceptualized sexuality as men's sexuality. Indeed, the field of sexuality was founded on studies primarily focused on men's sexual response (Ussher, 1993). Today, sexuality is still framed in terms of men's needs and desires, and sexual response continues to be predicated on male norms. For instance, the well-known pharmaceutical Viagra was

developed several years ago to treat aging men's erectile dysfunction. As a result, more attention is currently being devoted to women's changing sexual response in middle and later life. Kingsberg (2000) describes the "Viagrization" of America as partially responsible for renewed research and scholarship in the area of menopausal women's sexuality. However, this increased interest in women's sexuality is not necessarily synonymous with an increased understanding of women's sexuality (Koch & Mansfield, 2001, 2002).

Currently, both researchers and scholars in academia and the public sector are scrambling to understand women's sexuality and sexual response. Several pharmaceutical companies, including Pfizer, Natestch, and BioSante Phramaceuticals, are currently attempting to develop a "Viagra for women" (<http://www.womensenews.org/article.cfm/dyn/aid/620>). Similarly, physicians are prescribing Viagra to women despite the fact that it has not been approved by the Food and Drug Administration (FDA) for safe use in women, thus suggesting the incredible demand on the part of physicians to manage women's changing sexual response in middle and later life (Cohen, 1998). Thus, as more women are currently entering middle age, there is an increasing interest in women's sexuality and sexual response.

The study of women's sexuality is booming, literally. As the generation of Americans referred to as the "Baby Boomers" ages, an increasingly large segment of the population is currently middle-aged and older. It is estimated that approximately 40 million women will experience menopause in the next two decades, and that women now live one third of their lives postmenopausally (Kingsberg, 2000). The "Baby Boomers" aging suggests that more women than ever before will experience any of a number of

sexuality changes related to the menopausal transition. The lack of research, and subsequent information, on women's sexuality that considers women's sexual agency within the context of women's lives necessitates the study of women's sexuality from women's perspectives.

Women's Sexual Desire

Women's sexual desire is one component of women's sexuality and sexual response that has recently received a great deal of attention in the research literature. One reason may be that sexual desire is the component of the sexual response cycle that is believed to be most influenced by hormonal factors, and thus is seen as treatable with hormones, especially among menopausal women (e.g. Koster & Garde, 1993; Riley & Riley, 2000). In fact, it is believed that a great deal of women's sexual "dysfunction" could be treated via increasing women's sexual desire, perhaps hormonally (Galyer, Congaglen, Hare, & Conaglen, 1999; Basson, 2001).

Most research exploring women's sexual desire changes during the menopausal transition has been predominantly concerned with women's *negative* sexual desire changes. There is ample reason for this research attention. First, low sexual desire is estimated to affect anywhere from 23 percent (Mansfield, Koch, & Voda, 1998) to 33 percent (Laumann, Paik, & Rosen, 1999) to 67 percent (Nusbaum, Gamble, Skinner, & Heiman, 2000) of women, depending on the population and how low sexual desire is defined and reported. Also, women's self-reported low sexual desire is the most common reason that women seek sex therapy (Everaerd, Laan, Both, & van der Velde, 2000). In addition, most community and large-scale studies of American women demonstrate that

women, especially mid-life women, are concerned with their levels of sexual desire (Ellison, 2000).

Despite the fact that there is currently a research focus on women's sexual desire, the majority of this research, especially with regards to the menopausal transition, continues to be based on obsolete conceptualizations and definitions of sexual desire. There is a great deal of ambiguity regarding the definition, operationalization, and conceptualization of women's sexual desire (Levine, 1998). For instance, sexual desire has been variously defined as: specific sensations which move the individual to seek out or become receptive to sexual experiences (Kaplan, 1979), sexual excitement (Everitt & Bancroft, 1991), and the subjective experience of being attracted to or pushed towards objects or behaviors with potential rewarding effects (Everaerd, Laan, Both, & Spiering, 2001).

Paradigms of Women's Sexuality

Philosophers of science and epistemologists suggest that social science research is typically guided by three research paradigms: positivism, interpretive social science, and critical social science (e.g. Kuhn, 1970, Miller, 1987). Sexology is a multiparadigm science, meaning that all three paradigms are used to guide research on sexuality. Thus, these three paradigms will be used to organize the literature review in the next chapter, but will be introduced here to provide a framework for explaining the significance of the proposed study.

Positivism is the most commonly used paradigm in social science research and is variously referred to as logical empiricism, naturalism, and behaviorism. In essence, positivist research suggests that science is logical, that universally experienced phenomena are able to be “objectively” observed and that hypotheses tested using rigorous methods, including experimental methods and quantitative statistics, can demonstrate the Truth. Neuman (1997) describes positivism: “Positivism sees social science as an organized method for combining deductive logic with precise empirical observations of individual behavior in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity” (p.63). Biomedical research on women’s sexuality is guided by the positivist paradigm.

Interpretive social science is concerned with understanding the meaning of people’s behaviors, experiences, or actions. Instead of viewing phenomena as universal and science as objective, researchers guided by the interpretive paradigm focus on the context in which social action occurs and influences the phenomenon of inquiry. Similarly, the interpretive researcher does not assume that research findings are Truth since people’s realities are multiple and fluid. Various research methods are used in the interpretive social science paradigm. Biopsychosocial research and sociocultural research share many characteristics of the interpretive research paradigm.

The last research paradigm discussed by philosophers of science is referred to as critical social science, which includes feminist analysis, queer theory, critical theory, and poststructuralism. Critical social research is similar to interpretive research in that it focuses on the subjectivity of the researcher and the meaning of the phenomena of inquiry for the participants. However, critical research paradigms go beyond the

perspective of the interpretive paradigm; critical researchers are most interested in myths, stereotypes, and institutional forces that influence participants' experiences and meanings of the phenomenon of inquiry. Similarly, the ultimate goal of critical research is to empower, emancipate, and disrupt the injustice in society (Neuman, 1997).

Research guided by feminist theory is an example of critical social science research.

These three paradigms are useful in critically examining the assumptions and underpinnings of research in a specific area. Thus, these three paradigms will be used to guide the discussion of research on women's sexuality during the menopausal transition.

The Positivist Paradigm: Biomedical Research on Women's Sexuality During Menopause

There is a great deal of biomedical research on women's menopause-related sexuality changes. From this perspective, hormonal levels and physiological function are the key factors studied. Often, the goal of this research is to define and document women's varying degrees of sexual response in order to treat so-called sexuality-related deficiencies (Tiefer, 2001).

Similarly, it is not unusual for sexologists to adopt a biological framework in the study of women's sexuality. Often, sexologists opt for "objective" measures to assess women's sexual response, in an attempt to legitimize their work (e.g. Masters & Johnson, 1966). Typically, this biologically-oriented research attempts to explain women's changing sexuality and sexual response during middle age and older in terms of "deteriorating" function and "deficient" levels of reproductive hormones related to the menopausal transition. For instance, researchers who adopt a biomedical, disease-

oriented perspective of sexuality have described menopausal women's sexual desire as "deficient" (Bergman & Brenner, 1987) and their vaginas as "atrophied" (McCoy, 1992) or "stiff and unyielding" (Delaney et al., 1988). This disease-oriented perspective posits mid-life women as deficient, thus creating the need for medical and pharmacological intervention, typically via hormone (replacement) therapy (Boston Women's Health Book Collective, 2000; Greer, 1991; Tiefer, 2001). While it is clear that biological factors do influence women's sexuality changes during the menopausal transition, the degree to which such factors determine women's sexual expression is a topic of considerable debate.

Interpretive & Critical Social Science: Sociocultural Research & Feminist Scholarship on Women's Sexuality During Menopause

Researchers studying women's sexuality from a biopsychosocial perspective, as well as feminist scholars, repudiate the findings (and attached meanings) of researchers who employ a solely biomedical perspective (Tiefer, 1995; Choi, 1995; McCormick, 1994, 1996; Mansfield et al., 1995, 1998, 2000). Interdisciplinary scholars who study women's sexuality describe the "hormone hypothesis" as reductionistic and too narrowly focused (e.g. Mansfield, Koch & Voda, 1998, 2000). Similarly, feminist scholars and researchers suggest that it is implausible that biological phenomena, like menopause, affect women uniformly. Thus, to understand how women's sexuality is affected during mid-life and beyond, contextual and cultural factors must also be examined. More holistic research paradigms, such as the biopsychosocial model, account for contextual factors that may directly or indirectly affect a woman's sexuality during mid-life. In this

approach, women's sexuality is conceptualized as the interaction of several factors as opposed to being solely biologically determined (Davis, 1995; Koch, 1995; Tiefer, 1995; McCormick, 1996). Recently, researchers and scholars have focused on developing more holistic and interdisciplinary conceptualizations of women's sexuality, specifically sexual desire.

Research that is solely rooted in a biological or medical epistemology is not only incomplete, but is potentially harmful to women. While there is no doubt that physiological factors, such as hormones, do influence women's health and sexuality, contextual factors, such as women's relationships, self-esteem, and body-image, are also important factors in determining women's health and sexuality changes during the menopausal transition (Koch, Mansfield, Thureau, & Carey, In Review). Feminism, and more specifically, feminist epistemology, are necessary tools in deconstructing biomedically-oriented information on women's health and sexuality. Concepts such as power and privilege are critical in understanding how the control of health and sexuality information relates to the oppression of women. A more holistic view of women's health, one that includes contextual life factors in addition to biological influences, will lead to a more complete understanding of women's mid-life sexuality changes. Furthermore, the current interest in women's sexuality will contribute to the dissemination of these research findings so that women and their healthcare providers will be better informed and more equipped to make healthcare decisions. However, women's voices and own experiences have been absent from researchers' conceptualizations of women's sexual desire. It is this missing element, women's perceptions and women's lived experiences, that this research project will focus on.

Purpose of the Inquiry

The purpose of this study is to understand women's experiences of sexual desire during menopause. In addition, the meaning the women attach to their sexual desire will also be explored within the context of women's lived experience. Four over-arching research questions will guide the study: (1) How do menopausal women experience sexual desire?, (2) How do menopausal women perceive and make sense of their sexual desire?, (3) What influences women's experience of sexual desire during menopause?, (4) What differentiates women's experience of "high" sexual desire from their experience of "low" sexual desire during menopause?

The Researcher's Motivation for the Study and Assumptions

I believe that it is necessary and critical for us, as members of society, to question the source and intent of information we receive. Paulo Freire (1994) bell hooks (1994, 2003), and other scholars concerned with social freedoms refer to this method of critically analyzing the source of our education, whether formal or not, as liberatory or critical pedagogy. In other words, in order to universally extend social freedoms and rights, we must first deconstruct the ways in which privilege, power, and authority are used to withhold social freedoms from certain groups.

The women's health movement was primarily concerned with the ways in which the medical system has constructed information about women's bodies, sexuality, and health in a manner that served to disempower women. Feminists have repeatedly demonstrated how medicine has privileged men, assigned power to physicians, and appropriated decision-making about women's bodies and health to the medical establishment as a systematic method of control. Had second-wave feminists not been so

concerned with women's health, life threatening medical products such as The Dalkon Shield and diethylstilbestrol (DES) might very well be available to me and women of my generation. Thus, I am extremely grateful and indebted to women of previous generations for their devotion to feminism and the women's health movement so that my generation need not suffer the atrocities and health consequences of unsafe and unacceptable healthcare.

However, there is still much work to do. It is my belief that women are still not empowered, or even necessarily safe, in physicians' offices and the medical system in general. Recently, a study on women taking hormone therapy (HT) was prematurely stopped, based on serious health risks to women involved (Women's Health Initiative, 2002, <http://www.nhlbi.nih.gov/new/press/02-02-09.htm>). For years, physicians have prescribed hormones to women to treat menopausal symptoms, such as hot flashes, sleep disturbances, and negatively evaluated sexual changes. Furthermore, the medical establishment suggested that HT had protective health benefits for women in terms of decreasing their risk for cardiovascular disease and osteoporosis. However, feminist women's health researchers and scholars have long been skeptical of such claims. And, in fact, they were correct. Before the study was ended, results indicated that women using HT, even short-term, are at increased risk for breast cancer, cervical cancer, and heart disease (Writing Group for the Women's Health Initiative Investigators, 2002).

Thus, it is my belief that the women's health movement needs to be used as a guide in order to protect women, their bodies, and their health. I am grateful to be in a position to make some contribution. Through my study of women's health and women's sexuality, it is clear to me that women's sexuality is still highly stigmatized, especially

during middle and later life, as “old” women are not viewed as sexually desirable in this ageist culture. Thus, women’s sexuality is still viewed in terms of how it serves others, predominately men. Women’s lack of sexual agency only contributes to the appropriation of women’s sexuality changes during menopause by the medical system as a “disease” in need of treatment.

Through my work with other researchers on the Tremin Research Program on Women’s Health, a longitudinal women’s health study that includes sexuality measures, it is clear that not all women experience sexuality changes during menopause as negative. In fact, there is a percentage of women that actually report an increase in sexual responses, such as sexual desire (Mansfield, Koch & Voda, 1998, 2000). Research on menopausal lesbians has also indicated a similar pattern (Wood & Koch, 1999). Thus, I believe that research focused on women’s experiences of sexuality-related changes during menopause will enhance our understanding of the relationship between sexuality changes and the menopausal transition. Based on the women’s health movement’s example, I expect that the dissemination of research findings will empower women by giving them more information about their bodies and their sexuality so that they are better able to make informed decisions about their health.

Chapter 2

Review of the Literature

As discussed in chapter one, the purpose of this study is to explore the experiences and meanings that women associate with sexual desire during menopause. Four over-arching research questions will guide the study: (1) How do menopausal women experience sexual desire?, (2) How do menopausal women perceive and make sense of their sexual desire?, (3) What influences women's experience of sexual desire during menopause?, (4) What differentiates women's experience of "high" sexual desire from their experience of "low" sexual desire during menopause?

This chapter reviews the literature on various areas of study that relate to women's sexuality and sexual desire during midlife and the menopausal transition including: (a) the theoretical conceptualizations of women's sexuality, (b) research on sexual desire in women, and (c) research on women's sexual desire during menopause. This literature review spans several disciplines, including medical studies and biologically-oriented research, sociological and cultural studies, and feminist theories that are used to deconstruct assumptions in the aforementioned fields.

Because women's sexuality is studied in multidisciplinary fields, it is necessary to first understand the various perspectives from which women's sexuality is researched before reviewing work that is specifically pertinent to this study's research questions. Thus, this chapter will first discuss the conceptualization of women's sexuality as a topic of inquiry in a general sense. Next, the study of women's sexual desire, including

definitions and measurement, will be reviewed. It is believed that these two areas of scholarship are necessary components to any discussion of research related to the topic of this study: women's sexual desire changes during the menopausal transition.

Theoretical Conceptualizations of Women's Sexuality

Women's sexuality as a field of study is truly multidisciplinary. Researchers and scholars from a variety of fields, including medicine and biologically-oriented fields, psychology, sociology, cultural studies, women's studies, and even philosophy have all published work in the area of female sexology. Geer & O'Donohue (1987) identified fourteen different theoretical perspectives applied to the study of human sexuality. To study 'women's sexuality' is an ambiguous topic as the term 'sexuality' varies according to one's theoretical perspective (White, Bondurant, & Travis, 2000). Each discipline brings its own perspectives, biases, and assumptions to the study of women's sexuality. Thus, it is not surprising that there are disparate research findings and perspectives on this one topic. The conceptualization of women's sexuality differs dramatically according to which discipline is used to examine it. However, not all disciplines are equally represented in the field of sexology. The study of women's sexuality has been dominated by biological and medical perspectives that influence how sexuality as a concept is perceived, conceptualized, and researched (Tiefer, 1995).

Biomedical Conceptualizations of Women's Sexuality

Medical and biological perspectives were first applied to sexuality in the early twentieth century. In fact, the field of human sexuality developed in response to increased interest in biology and medicine. The developing profession of medicine in the twentieth century fueled the need for more information about human biology and reproduction, and thus the interconnectedness between biology, medicine, and sexuality was born (White, Bondurant, & Travis, 2000).

Between 1897 and 1928, Havelock Ellis, an English physician, wrote seven volumes on his theories of sexuality, including women's sexuality, which he described as characteristically more complex than men's (Kirkpatrick, 1980). Ellis' theories on women's sexuality and sexual response posited women as innately more sexual than men due to his belief that women's sexual response was more complex as compared to that of men. For instance, Ellis suggested that women's sexual response involved more anatomical parts (e.g. the clitoris, uterus, vagina, and breasts) while men's sexual response was located only in the penis. Thus, women were believed to be more sexually responsive based on increased surface area for physiological stimuli and response in their bodies. This reasoning is an excellent example to illustrate the ideology of the biomedical perspective of women's sexuality. That is, biological factors located within the individual are viewed as the causal agents for sexual response. Similarly, sexuality is seen as a phenomenon determined by an individual's physiology.

Since the time of Ellis' theorizing, biomedical research on women's sexuality has occurred, and more theories on the biological basis of women's sexuality have been

proposed. The Kinsey report on women's sexuality, Sexual Behavior of the Human Female (1953), is another example of biologically-oriented research that revolutionized the field of women's sexuality. Kinsey interviewed over six thousand women with an emphasis on sexual response as physiologically determined. Using interview data, Kinsey deduced that women reach their sexual peaks around age thirty, approximately fifteen years later than men. Women's delayed sexual peak was attributed to physiological differences between women and men (although these differences were never specified). Kinsey also believed that sexuality, specifically sexual responses such as arousal and orgasm, was physiologically identical in both women and men (Kirkpatrick, 1980). Later, Masters and Johnson were credited with developing the first model of human sexual response, based largely on Kinsey's preliminary work on sexual physiology.

Masters and Johnson revolutionized the field of human sexuality with the publication of their book Human Sexual Response (1966). In this book, Masters and Johnson detailed the physiological response to various sexual stimuli as evidenced through their laboratory observations of various biological indicators (e.g. heart rate, blood flow/vasocongestion, muscle tension/myotonia) as recorded in almost 700 individuals who volunteered to participate in the study (women: n=382). Essentially, Masters and Johnson observed women and men engaging in a variety of sexual behaviors to collect data on physiological responses to sexual stimuli. Their theory of human sexual response proposed that individuals, both women and men, experience various phases of sexual response (e.g. arousal, plateau, orgasm, and resolution) based on physical changes that occur in the body (e.g. vasocongestion and myotonia). Their work

demonstrated that sexual stimuli elicit physiological responses that constitute a sexual response, and that an individual's sexual response is based primarily on physiological changes in response to sexual stimuli. Masters and Johnson's work is another example that illustrates the biomedical perspective of women's sexuality.

Biological influences on human sexuality are not limited to sexual response, however. Recent work in the area of human sexuality uses biologically-based sex differences that are thought to result from hormonal differences, evolutionary differences, and even developmental brain differences, to account for differences in sexual identity and orientation, as well as behavior. Since the time of Masters & Johnson, biological influences on human sexuality have gained in popularity. White, Bondurant, & Travis (2000) elaborate on more recent work in the area of human sexuality from a biomedical perspective:

This approach views sex as a biological process, rooted in anatomical differences and in the reproductive cycle. Different proportions of male and female hormones entering the brain exert masculinizing and feminizing influences on the personality and behavior of the developing child. This developmental pattern is seen as part of the natural scheme of evolution. Sex differences present at birth are cited as supporting evidence. ... hormonal processes are set in motion by genetic determinations. These processes not only influence the development of internal sex organs and external genitalia, but also enter the brain and alter its anatomic structure and, eventually, cognitive function. Thus, certain masculine and feminine characteristics, as well as sexual orientation, are congruent with each other and natural in origin. From this perspective sexuality is assumed to be a biological given that shapes sexual desires, including choice of love objects (p. 19-20).

Thus, biological and medical perspectives on women's sexuality posit physiological factors as responsible for sexual response changes, sexual satisfaction, sexual identity and orientation, and sexuality in general. The biomedical perspective of sexuality has been so

pervasive in sexology that Tiefer (2000) describes the biomedical view of sexuality as synonymous with the “sexological model of sexuality”:

Although the study of sexuality is multidisciplinary, there are certain core ideas I will label the “sexological model of sexuality”. This sexological model of sexuality ... is a distinct perspective on sexual life that privileges biological ... factors while making universal claims about sexuality. These emphases come through in the discussion of purposes for sexuality (procreation, pleasure, intimacy, health, and tension release), causes of sexuality (evolution, physiological factors ...), types of sexuality (normal and abnormal forms of arousal and sexual activity), and experts on sexuality (medical and other professionals) (p.80).

In the review of the research on women’ sexuality changes (specifically sexual desire) to follow, it is clear that this perspective is frequently used to study women’s sexuality changes during the menopausal transition.

A Feminist Critique of Biomedical Conceptualizations of Women’s Sexuality

Feminist scholars and researchers have critiqued the dominant conceptualization of women’s sexuality as reductionistic and disease-centered (McCormick, 1994; Mansfield, Koch, & Voda, 1998, 2000; Tiefer, 1995). They also argue that it ignores the sociocultural, political, and relational factors that affect women’s sexual lives (Daniluk, 1999). The gendered nature of power, social control, and sexual agency are central to feminists’ critique of research and scholarship on human sexuality.

The biomedical view of sexuality ignores sociocultural factors, like the gendered division of social power, so that gender differences are either ignored, controlled for, or posited as natural (Tiefer, 2000). When gender differences are ignored because the social

construction of gender is disregarded, the dominant view of sexuality is constructed as male. Tiefer (2000) explains:

... too often in the sexological model of sexuality the normative standard has been man's sexual experience ... The idea that heterosexual impulses are the norm, that sexuality exists in individuals, that biological factors are the prime source of desire, that the best way to see sex is as a material series of physical changes in specific activities – assumptions in the sexological model – seem more in accordance with men's experience (or maybe we should say with the phallogocentric experience) (p. 102).

Thus, one of the most basic levels in which feminists reject the biomedical perspective of women's sexuality is based on its epistemological assumptions about science and its impact on women's lives.

Feminist philosophers and historians of science have described the specific ways in which the characteristic objectivity of scientific knowledge is a male way of relating to the world that specifically excludes women (Fee, 1981; Haraway, 1978; Hein, 1981; Keller, 1982). The manner in which men relate to the world, subsequently produce knowledge, and legitimate it using scientific discourse is the predominant epistemology in the biomedical paradigm (Harding, 1987). The notion that medicine and science are male ways of knowing and that biomedicine is the predominate perspective of sexology is no surprise considering that origins of the field of human sexuality stemmed from the burgeoning field of medicine (Ehrenreich & English, 1979). In fact, it is believed that sexologists, even as late as the 1950s and 1960s, used medicine and biology as a way to legitimate their "taboo" field of inquiry (Irvine, 1990; Tiefer, 1995).

Biomedical paradigms of thought are typically characterized by two underlying themes that legitimate their perspective. First, these epistemologies employ the notion of objectivity to differentiate scientific knowledge from other types of knowledge.

Objectivity describes a researcher's distance from the topic of inquiry (Tuana, 1989). A researcher's disinterested, value-free stance towards the research project is supposed to ensure objectivity, a claim that has been important in distinguishing scientific knowledge from other types of knowledge. However, feminists have demonstrated that science is no more objective than other types of knowledge: "The supposedly objective social sciences present a view of reality that offered dominant groups the picture it pleased them to see. Rather than being politically or morally neutral, mainstream methods and language were more likely to reproduce, or at least leave unchallenged, the ideological discourses that justify and recreate the social relations of gender" (Zalk & Gordon-Kelter, 1992, p.9). Thus, so-called objective ways of knowing and researchers' disinterested conceptualizations of their field of inquiry, both characteristic of the biomedical perspective of women's sexuality, are a fallacy to feminist thought.

Secondly, sexology researchers who use a biomedical perspective use "objective" biological measures as representative of women's sexuality. For instance, in their study of women's sexual response, Masters and Johnson used biology to legitimate their observation of human sexual behavior in their laboratories. A sexual stimulus (e.g. sexual behavior) was observed, then biological measures, like muscle tension (myotonia) and blood flow into genital tissues (vasocongestion), were used as indicators of women's sexual response. The researchers then used these measures to define women's sexual response and operationalize human sexual response into four neat categories that were assumed to be universal.

Tiefer (1995) and others have criticized Masters' and Johnson's development of *the* Human Sexual Response Cycle (HSRC) suggesting instead that it is only one of many

possible models of human sexual response (e.g. Irvine, 1990; Koch, 1995). In fact, the HSRC proposed by Masters and Johnson has been criticized for several reasons, although the most common criticism is that the model was posited as a universal model for everyone, without accounting for variability in sexual response for any reason. Three other criticisms of the HSRC include: concerns with the missing element of sexual desire or drive from the model, methodological criticisms, and issues regarding how gender was considered and constructed.

First, that Masters and Johnson failed to include a motivating factor, like sexual desire, appetite, or interest, to serve as an initiating factor in their HSRC has been criticized on several grounds. During the 1950s, when Masters and Johnson's work was most popular, the notion of sexual drive (which was ambiguously termed sexual drive, appetite, interest, energy, or passion) was reportedly troublesome for sex researchers (Tiefer, 1995). In order to avoid having to operationalize a term as seemingly subjective as sexual desire, Masters and Johnson simply excluded the concept from their model. Tiefer argues that sexual drive is one of the most variable aspects of sexual behavior among and between people, and that omitting a motivational factor from the model further serves to establish that the model is not universal.

Masters and Johnson's work on the HSRC has also been criticized for a lack of scientific rigor with regards to selection bias and experimenter bias. The researchers made it a criterion for inclusion in their study that participants must have previously experienced orgasm, either from coitus or masturbation. Thus, the sexual response modeled in the HSRC proposed by Masters and Johnson was based only on people who had a previous history of experiencing orgasm. Thus, an important limitation of this

work is that it completely excluded anyone who had never had an orgasm before. This restriction disproportionately affected women, as it is common for women to have difficulty achieving orgasm, especially through coitus. Moreover, the researchers purposely selected participants from certain socioeconomic classes and educational levels. While Masters and Johnson never explained their rationale, they did state that they purposely weighted the sample with people with higher intelligence levels and those in the middle and upper-middle classes. Based on the limitations from the selection criteria alone, it is clearly impossible to imply that the HSRC is a universal model of sexual response.

Another limitation of Masters and Johnson's research is that of experimenter bias. Participants in their research underwent a "period of training" in which Masters and Johnson provided feedback to participants on how well they were responding to sexual stimuli. For instance, when a participant achieved an orgasm, s/he was praised and the incident of sexual activity was referred to as a success. Alternatively, if a participant did not reach orgasm, the episode was termed a failure. The researchers acted as sex therapists by interrupting the sexual activity and giving the participant(s) suggestions about helpful hints on how to correct their sexual response. Thus, it is clear that the wishes and expectations of the researchers were not only communicated to the participants, but likely changed their behavior, either consciously or unconsciously.

A final set of criticisms of the HSRC relates to how gender was considered and constructed throughout the research process. Masters and Johnson suggested that the HSRC was gender-neutral and that women's and men's sexual response was identical. Yet, feminist researchers have argued that the HSRC privileges men in terms of what is

considered sexual response. The HSRC focuses primarily on physiological reactions to physical stimuli, yet gender role socialization teaches women that their sexual desire and arousal is secondary to men's sexual satisfaction. Similarly, the sexual double standard serves to stigmatize and attach pejorative terms to women who enjoy sex. Thus, women's sexual response is likely different than a man's based on sociocultural differences in what is considered appropriate for each gender. Moreover, non-physical sexual stimuli, such as emotional closeness or intimacy, were not even considered in the HSRC. In sum, feminist researchers argue that not only is the HSRC gender biased (and thus not universal), but it also reinforces gender inequity.

Locating sexuality within the individual serves to depoliticize the nature of sexuality. In other words, an essentially biological view of sexuality discounts the historical, cultural, and interpersonal dimensions of human sexuality, thus positing sexuality as a universal, inherent, natural truth (Tiefer, 1988). When human sexuality and sexual behavior are viewed as intrinsic and natural, the ramifications of the conceptualization of sexuality are viewed as immutable. Moore & Travis (2000) explain:

Distortions of sexuality couched in the language of neuroanatomy, hormones, and sociobiology seem to be numerous scholarly efforts to expose the conceptual basis, methodological limitations, and practical inadequacies of these models. From what should be thorough discrediting and debunking, they rise like a phoenix. ... Apparently these models persist in part because they offer a framework for understanding and managing sexuality that has the appearance of being especially scientific. Biological models are judged, by Western sensibilities, to be inherently more scientific (i.e. precise, objective, and factual) than models that deal with large-scale variables. Importantly, the science of biological models is perceived to be demonstrably accurate and in some fundamental sense true. Hence any science that relies on biological precepts is also apolitical (p. 35).

Based on such criticisms of the biomedical perspective of sexology, feminist scholars are fairly critical of the work of researchers like Masters and Johnson (e.g. Tiefer, 1995). For instance, Masters and Johnson described women's physiological response of vasocongestion as "an invitation to mount" (1966, p. 69) and described an erection as the physiological evidence of men's "demand" for intercourse (1970, p. 195). Furthermore, feminist sex researchers have refuted the notion that human sexuality is a natural, intrinsic, universal phenomenon based on differences among individuals with regards to gender, class and ethnicity, history, sexual identity and orientation, environmental factors, and even HIV status (e.g. White, Bondurant, & Travis, 2000). Similarly, cross-cultural research has documented various cultural patterns that influence individual's sexuality including patterns of erotic development, sexual identity and orientation, and sexual behaviors (e.g. Herdt, 1991).

Despite critiques of the biomedical model's conceptualization of sexuality by feminist scholars and others, women's sexuality continues to be studied predominately from a biomedical perspective. The dominant perspective of the biomedical model as it applies to female sexology is particularly clear with regards to women's sexuality changes, especially sexual desire, during the menopausal transition, a process most often characterized by various biological and physiological changes. Thus, the conceptualization of women's sexuality from a biomedical perspective will be revisited later in this chapter.

Sociocultural Conceptualizations of Women's Sexuality

The sociocultural study of women's sexuality is another perspective that is also pervasive in sexology. In contrast to the biomedical model that locates sexuality within the individual, sociocultural studies focus on larger societal variables as influences on an individual's sexuality. Sociologists and cultural theorists who study sexuality from a sociocultural perspective maintain that sexuality is dramatically shaped by one's environment and culture, and that institutional factors like religion, education, family, the law, and medicine determine how sexuality is learned and expressed (DeLamater, 1987). Similarly, socioeconomic and cultural factors, such as one's ethnicity or gender, also shape individuals' sense of what is appropriate sexually through interactions with peers, parents, and partners. Both micro (e.g. interpersonal relationships) and macro (e.g. institutional socialization) factors simultaneously shape sexual norms, which thereby shape an individual's sexuality.

An individual's personal sense of her/his own sexuality, as influenced by various sociocultural factors, is termed a sexual script (Gagnon, 1990). Through socialization, individuals learn how sexuality is appropriately expressed in their culture, and their individual sense of sexual norms result in personalized sexual scripts. Sexual scripts not only determine an individual's sexual behavior, but also establish the meanings associated with this behavior based on cultural norms. For instance, the "double standard" is a cultural norm in the United States that ascribes sexual agency to men and passivity and subservience to women (Lips, 1997). In other words, the sexual double standard dictates two different sexual norms for women and men.

The sociocultural perspective of sexuality explains that gender differences in sexuality are constructed through gender socialization beginning in early childhood (Hyde & Oliver, 2000). However, social constructionists often differ with regards to how gender socialization manifests as differences in sexuality. One theory is an adaptation of Bandura's Social Learning Theory (1977).

Social Learning Theory suggests that children's gender-specific behavior is reinforced while androgynous behavior is either ignored or punished (Francis & Skelton, 2001). Simultaneously, children model the behavior of same-gendered adults they interact with and see in their surroundings, such as in the media. In terms of gender differences in sexuality, social learning theory suggests that children learn gender differences in attitudes, beliefs, and norms that ultimately determine behavior. For example, social learning theory explains the sexual double standard in terms of how males are rewarded for their sexuality via praise from peers or improved social status. Conversely, females are punished for their sexuality through shame, embarrassment, or denigration by their peers. Thus, social learning theory predicts that men will have more sexual partners than women and that women will have more negative attitudes towards sexuality in general, a pattern that is generally supported in the research literature (Hyde & Oliver, 2000). Similarly, Social Learning Theory can be used to explain why midlife and older women feel especially negative about their sexuality. Ageist social scripts present older men as mature and sexually vibrant, while older women are viewed as asexual, dowdy, and matronly.

A Feminist Critique of Sociocultural Conceptualizations of Women's Sexuality

Snitow, Stansell, & Thompson (1983) were among the first feminist scholars to discuss the social construction of sexuality. Despite publicity about sex, they note that sexuality is oddly taboo, especially for women. They draw on the work of Foucault, who suggests that the mere existence of sexuality discourse serves to manipulate and construct our experiences of sexuality and the meanings attached to it. Foucault (1978) argues that the social construction of sexuality is the means through which sexuality is controlled and regulated. That is, through discussion and study of sexuality, professionals are in fact proscribing what is and is not sexually acceptable, desirable, and normative. Tolman & Diamond (2001) explain: "The very fact that some individuals' sexual experiences are deemed "normal", investigated, tabulated, and worried about, whereas other individuals' experiences are ignored or considered deviant lays bare the inherently political nature of questions about sexuality and sexual desire" (p. 33).

Like Foucault, Snitow and colleagues agree that sexuality is constructed. However, Snitow and colleagues take Foucault's analysis one-step further. Their criticism of Foucault is that he fails to examine the male perspective that has characterized sexuality discourse. Thus, Snitow et al. maintain that women's sexuality, much like femininity, is constructed from a male perspective, and thus women's relationship to sexuality discourse is a disempowering one.

Feminist scholars have long noted the constructivist nature of women's sexual realities. Similarly, social constructionists have discussed the role of societal expectations for women in shaping what is considered socially acceptable or

unacceptable, appropriate versus inappropriate, and healthy versus unhealthy sexuality. Despite the seemingly feminist nature of social constructionist perspectives of women's sexuality, Daniluk (1993) has noted that such an approach is characterized by dualisms that are antithetical to feminist scholarship. Daniluk explains: "To date, dichotomous sexual truths have characterized the social constructions of female sexuality and have provided the lenses through which women understand and experience our sexualities" (p.54). That is, Daniluk suggests that male-oriented paradigms of women's sexuality like Foucault's, despite their social constructionist nature, cannot provide women with a conceptualization of sexuality that is rooted in women's needs, urges, and realities. Thus, feminists note that the way in which the sociocultural perspective of sexuality explains gender differences in sexual socialization is not value-neutral. In fact, there are significant power differentials in the sexual roles ascribed to women and men. Lips (1997) explains:

The double standard has long dictated that women restrict and are restricted in their sexuality more than men are. This difference in what males and females are implicitly given permission to do may well influence the sexual expression and experiences of both. Women, more often watched and warned about sexuality than men are, and encouraged to play a "gatekeeper" role, may learn to inhibit their sexual responses. Once in a committed sexual relationship, when they have no reason for inhibition, they may find they have learned the lesson too well: They find it difficult to let go. Men, who are allowed more leeway in terms of masturbation, exposure to erotica, and heterosexual activity, and who may even learn to view sex as a way to "prove" their masculinity, may learn to treat sex as a goal-oriented activity - the goal being to produce an orgasm and/or to "score". This narrow focus may cause them to miss out on some of the pleasure of sexual experience. The "sexual scripts" that lead women to associated being "good" with avoiding sex and lead men to associate sex not with intimacy, but with achievement and conquest, tend to limit the sexuality of both women and men. (p.220).

After considering the two most common theoretical perspectives on women's sexuality, that of the biomedical model and the sociocultural perspective, as well as feminist critiques of each perspective, research on women's sexual desire will be reviewed. As discussed in chapter one, the purpose of this study is to understand women's experiences of sexual desire during menopause. As evidenced by the discussion of theoretical perspectives of the study of women's sexuality, it will become clear that it is also necessary to explore the conceptualization of the term "sexual desire" in order to better understand how this specific aspect of women's sexual response is defined, operationalized, and measured. Thus, the next section of the literature review will discuss women's sexual desire in terms of how it is conceptualized and defined from the two perspectives previously discussed, the biomedical and sociocultural views, including a feminist critique of these two perspectives. Next, determinants and influences of women's sexual desire will be discussed from both the biomedical and sociocultural perspectives. Again, a feminist perspective will illustrate limitations of each of these two perspectives. Lastly, research measures used to assess women's degree and amount of sexual desire will be reviewed from both the biomedical research literature and research employing a sociocultural perspective. Feminist scholarship on women's sexual desire will again be used to illustrate the shortcomings of such measures as well as to suggest challenges to both perspectives' use of such measures.

Conceptualizations of Sexual Desire in Women

Like the more general field of sexuality, the study of women's sexual desire is a multidisciplinary endeavor. However, sexual desire is viewed as a biological construct to such an extreme that even correlates of sexual desire are viewed as hormone-dependent: "Sexual thoughts, desires, and fantasies all are products of the brain and seem to be androgen dependent" (Aperloo, VanDerSteghe, Hoek, & Schultz, 2003, p. 93). Nevertheless, scholars from various disciplines, including biomedicine, sociology, psychology, psychiatry, endocrinology, health studies, cultural studies, and even pharmacology, have published research in this field. As discussed in chapter one, research on women's sexual desire is currently a popular research topic. A variety of factors, including economic incentives from pharmaceutical companies and the aging population, have contributed to the popularity and importance of understanding women's sexual desire. For instance, Bancroft and colleagues (2003) suggest that women's sexuality became a commercial issue with the introduction of Viagra to treat men's sexual dysfunction (Bancroft, Lotus, & Long, 2003). Thus, research on women's sexual desire has been "invisible" until fairly recently (Tiefer, 1995). That is, researchers who did study women's sexual desire were not necessarily published in top-tiered journals as research on women's sexual desire was viewed as a superfluous topic, at best (McCormick, 1994). However, recent interest in women's sexuality, specifically women's sexual desire, has revolutionized this field of study and publications on this topic have dramatically increased as of late. Similar to the study of women's sexuality, research on women's sexual desire is predominately studied from biomedical and

sociocultural perspectives. As discussed previously in this chapter, a researcher's perspective on a topic shapes what research questions are developed, how these questions are investigated, and the larger real world implications of findings (Harding, 1987). Thus, before reviewing the recent research on women's sexual desire, the conceptualization and definitions of the term "sexual desire" and how this term applies to women's sexual response will be discussed.

The Biomedical Conceptualization of Women's Sexual Desire

Despite the fact that sexual desire has been the topic of various recent research projects and scholarly work, there is a great deal of ambiguity regarding the definition, operationalization, and conceptualization of the term "sexual desire" as it relates to women (Basson, 2002; Levine, 1998, 2000). The largest degree of variation in how sexual desire is conceptualized, and therefore defined, relates to the particular discipline or approach used to study it. As discussed earlier in this chapter, biomedically-oriented fields of study tend to locate the cause or source of phenomena within the individual. Sexual desire as a phenomenon of study in women is no different; biomedical research on sexual desire focuses on biological factors, such as reproductive physiology, endocrinology, and chemical changes within the body that determine or predict sexual desire. Most often, biomedically-oriented research on women's sexual desire examines the association between sexual desire and hormones. For instance, Apperloo, VanDerstege, Hoek, & Schultz (2003) state: "Sexual thoughts, desires, and fantasies all are products of the brain and seem to be androgen dependent" (p.93).

Recently, there has been a great deal of research and scholarship from biomedically-oriented sexologists regarding how to categorize women's sexual desire. In a review of the research examining the association between hormones and sexual desire, Regan (1999) discusses the ambiguity in the definition and operationalization of sexual desire. For example, researchers interested in the hormonal correlates of sexual desire have defined the term sexual desire variously, including: sexual motivation, sexual drive, sexual interest, libido, sexual appetite, sexual wishes, thoughts, cravings, or feelings. Specifically, sexual desire has been defined in the biomedical research literature as: an innate force that is expressed in either sexual or nonsexual outlets, also referred to as libido (Kaplan, 1979); a biologically based behavior to seek sexual stimulation (Levine, 1992); the sum of the forces that incline us toward and away from sexual behavior (Levine, 2000); an interaction of external incentives (like sexual stimuli) and internal states (such as sexual deprivation) (Singer & Toates, 1987); and a setting event (e.g. a phenomenon that precedes sexual behavior) as well as a consequence of sexual activity (Leiblum & Rosen, 1988). In a discussion of challenges regarding the definition of sexual desire in the medical field, Heiman (2001) explains: "... [it] is a complex problem defining desire, whether it is a noun or a verb (i.e. something one has or something one is), and whether the object of desire is a person, an activity, a response, or an emotional state" (p. 118). Table **Error! Reference source not found.** demonstrates the large amount of variability between researchers' definitions of sexual desire.

Table 1: Various definitions of sexual desire

Citation	Definition
Kinsey et al. (1953)	Sexual capacity: the capacity to respond to stimulation with physical arousal
Kaplan (1979)	Specific sensations which move the individual to seek out or become receptive to sexual experiences; an innate force that is expressed in either sexual or nonsexual outlets, also referred to as libido
Singer & Toates (1987)	An interaction of external incentives (like sexual stimuli) and internal states (such as sexual deprivation)
Leiblum & Rosen (1988)	A setting event (e.g. a phenomenon that precedes sexual behavior) as well as a consequence of sexual activity
Everitt & Bancroft (1991)	Sexual excitement
Levine (1992)	A biologically based behavior to seek sexual stimulation
Spector et al. (1996)	An interest in sexual activity. It is primarily a cognitive variable, which can be measured through the amount and strength of thought directed toward approaching or being responsive to sexual stimuli. Sexual desire involves thoughts that may motivate an individual to seek out or be receptive to sexual opportunities
Leiblum & Rosen (1988)	A setting event (e.g. a phenomenon that precedes sexual behavior) as well as a consequence of sexual activity
Pariser & Nidermier (1998)	Libido
American Psychiatric Association (2000)	Sexual fantasies, sexual interest, motivation to seek sexual stimuli; desire for sexual activity may encompass all forms of sexual behavior or may be situational and specific to one partner or one activity
Levine (2000)	The sum of the forces that incline us toward and away from sexual behavior
Riley & Riley (2000)	Object-focused sexual drive, the focusing involves motivational and aspirational processes
Basson (2001)	The motivation to seek sexual stimuli as primarily a means to fulfill the desire for emotional intimacy
Dennerstein et al. (2001)	Libido
Avis et al. (2002)	Sexual thoughts and fantasy

Based on the ambiguity in defining sexual desire, it is unclear how distinct one phase of sexual response is from another. For instance, at what point does sexual desire become sexual arousal, and if sexual desire is not present can sexual arousal exist? Basson (2002) locates the root of such conceptualization problems with sexual desire in the linear model of sexual response. According to Basson (2001), the Human Sexual Response Cycle typically used to guide research on sexual response is limited in that it considers desire a precursor to arousal, which is a precursor to orgasm. However, various research has demonstrated that women often engage in sexual behaviors with partners without experiencing sexual desire (Tiefer, 2000). Clearly, there are reasons that women have sex that do not require sexual desire, including sex motivated by intimacy, security, money, coercion, or fear (Heiman, 2001). In other words, women often skip the desire phase of sexual response. Thus, the sexual response of women who engage in sexual behavior without sexual desire is not adequately conceptualized by this model. Basson (2001) critiques the traditional human sexual response models developed by Masters and Johnson and Kaplan based on the conceptualization of sexual desire in these frameworks. Traditional models of human sexual response consider sexual desire to be conscious sexual thoughts, fantasies, or urges to be sexual (either alone or with a partner).

In contrast, Basson acknowledges that women's sexual experiences are often initiated from a nonsexual state. That is, women often engage in sexual activity without desire. In light of this knowledge, Basson suggests that sexual desire is not for sexual activity per se, but instead for intimacy associated with sexual activity. As such, Basson developed a new human sexual response cycle that considers the motivation to seek

sexual stimuli as primarily a means to fulfill the desire for emotional intimacy. In other words, Basson's sexual response cycle considers the starting point of sexual response as sexual neutrality, and sexual stimuli which then produces sexual desire and arousal, is a mediating factor for the underlying goal, which is emotional intimacy. In this manner, emotional intimacy serves as the reinforcing factor for sexual activity, arousal, and desire.

Although Basson's model initially appears to consider emotional components of sexual desire, the model is inherently a biological one since it is based on physiological responses to sexual stimuli, even if the stimuli are emotional. Basson (2002) explains:

If the emotional response to any perceived physical arousal is negative (dysphoric arousal), the sexual centres may cease to transmit excitatory input to the lumbar sacral centres. For some women, it appears that excitatory neurotransmission does continue: the genitalia remain engorged but the woman does not feel sexually aroused. The response is typically shown by women diagnosed with arousal disorders, who in the laboratory setting, demonstrate a normal genital congestive response to erotic stimuli but feel no subjective arousal. The genital physiological response would appear to be an involuntary reflex mediated by the (unconscious) autonomic nervous system (pp. 359-60).

In other words, Basson's model, like the traditional models of human sexual response established by Masters & Johnson and Kaplan, emphasizes the physiological processes associated with sexual desire and sexual response. As Basson notes, the implications for a model of human sexual response that adequately conceptualizes sexual desire, as distinct from other stages of sexual response, has far reaching implications for how sexual response concerns are addressed (2001, 2002).

Typically, biomedical efforts to define and assess women's sexual desire are an attempt to understand how to improve not only sexual desire, but women's overall

sexuality response. Since the development of Viagra for men, medical professionals have been interested in developing a similar pharmaceutical in women to treat sexual response concerns, like low sexual desire (e.g. Basson, McInnes, Smith, Hodgson, Spain, & Knoppiker, 2002). However, based on difficulties defining sexual desire, the prevalence of sexual desire disorders in need of treatment is not clear. In other words, without an adequate definition of 'sexual desire' it is difficult to define what constitutes 'low sexual desire'.

Regardless, various estimates indicate that women's low sexual desire is a significant problem reported to physicians and sex therapists. Low sexual desire is estimated to affect anywhere from 23 percent (Mansfield, Koch, & Voda, 1998) to 33 percent (Laumann, Paik, & Rosen, 1999; Warnock, 2002) to 67 percent (Nusbaum, Amle, Skinner, & Heiman, 2000) of women, depending on the population and how low sexual desire is defined and reported. For instance, when self-reported, women's low sexual desire is the most common reason that women seek sex therapy (Everaerd, Laan, Both, & van der Velde, 2000). Similarly, a survey distributed to nearly 3,000 (white, college educated) American women born between 1905 and 1977 asked participants to describe their most pressing sexual concern (Ellison, 2000; www.womenssexualities.com). The most commonly indicated concern (34%, n=555) was low sexual desire. In fact, most community and large-scale studies of American women demonstrate that women are concerned with their levels of sexual desire (Ellison, 2000). Thus, efforts to define, assess, and manage women's low sexual desire disorders appear to have the ability to affect a large number of women. Based on the number of women estimated to be affected by desire disorders, and the discrepancy with which sexual desire is defined and

operationalized, a consensus conference on women's sexual dysfunction was recently organized to better define and classify women's sexual concerns.

Bancroft (2002) questioned the conceptualization of women's sexual dysfunction based solely on male-centered sexual response models, and suggests that women's lack of sexual response may in fact be an adaptive mechanism. Bancroft explains: "If we accept that central mechanisms of excitation and inhibition are involved in female sexual response, and for most of us are adaptive, then we should consider circumstances where the behavior of the male partner, or the context of sexual interaction is less than exciting, or may actually be invoking inhibition in the woman. This may be an understandable and adaptive inhibition of sexual responsiveness in the presence of stress, depression, or marked tiredness, or the continuing presence of negative or threatening patterns of behavior in the partner. The woman may not be responding sexually because it is adaptive for her not to do so. Such lack of response should not be regarded as a "dysfunction"(pp.454-5). However, diagnostic criteria for women's sexual dysfunction (e.g. *DSM-IV-TR*, *ICD-10*) fail to consider the context in which women are sexual, especially with regards to power discrepancies between partners such as non-consensual sexual activity.

In response to the controversy among sex researchers on how to best conceptualize women's sexual concerns, Bancroft and colleagues (2003) used results from a national survey of women to investigate how many women experience distress about their sex lives and what they consider as the determinants of their sexual distress. Women were recruited from a national sampling frame via telephone using random digit dialing. In order to participate in the study, women had to be heterosexual and in a

sexual relationship with a man for at least six months, ages 20-65, fluent in English, and either white or black/African-American. Participants (n=853) were monetarily compensated (\$25) in exchange for their participation in a two-part telephone survey. The first part of the survey was administered by a computer (*Computer Assisted Telephone Interview, CATI*) in order to collect demographic information and health-related information such as medication use, menopausal status, and indicators of health status (e.g. height, weight).

The second portion of the interview, also administered by computer, included questions about participants' quality of life, physical and mental health, and detailed questions about women's sexual experiences over the past month. Additionally, an instrument ("Interviewer's Ratings of Sexual Function", Cawood & Bancroft, 1996) was administered to collect information about the frequency of sexual activity with and without a partner, frequency of orgasm, arousal, vaginal lubrication, pleasure, sexual satisfaction, and unpleasantness or pain. However, the interviewers did not ask participants any questions about their sexual desire. The researchers' main interest, sexual distress, was assessed by two questions: "During the past 4 weeks, how much distress or worry has your sexual relationship caused you?", and "During the past 4 weeks, how much distress or worry has your own sexuality caused you?" (p. 196). Participants' answered using a Likert-type scale, with possible responses including: "no distress", "slight distress", "moderate distress", and "a great deal of distress".

Researchers analyzed data using survey weights and the multinomial logit model to model the effects of independent variables on indicators of sexual distress. The researchers found that menopausal status was not a predictor of sexual distress, nor was

socioeconomic status. Women's age did predict sexual concerns, but not necessarily sexual distress. Older women reported more sexual problems than younger women did ($P=0.08$), but when younger women reported sexual problems, they had more distress about their sexual concerns as compared to older women. The strongest predictor of sexual distress was women's mental health, suggesting an association between depression, general unhappiness, and sexual distress. However, the analyses demonstrated only an association between mental health and sexual distress. Thus, it remains to be determined whether poor mental health causes sexual distress or vice-versa.

Finally, the researchers examined women's subjective response during sexual activity with a partner, which included measures of women's self-reported pleasure, feeling emotionally close to their partner, and feelings of discomfort, unpleasantness, or pain. Women's subjective response was a predictor of women's distress about sex within the relationship. Researchers noted that diagnostic criteria for sexual dysfunction failed to include any indicator of women's subjective response within a sexual relationship with a partner, despite the fact that it predicted women's sexual response. Thus, Bancroft and colleagues suggest that women's lack of emotional well-being and mental health, combined with women's feelings towards her partner during sexual activity, are more important determinants of women's sexual distress than physiological aspects of sexual response. Similarly, the researchers suggested that older women's lack of distress about sexual concerns was an indication that women's sexual concerns are not necessarily "problems" for them. In other words, if women themselves do not identify lack of lubrication or difficulty with orgasm as a problem, then perhaps researchers should conceptualize women's sexual dysfunction and disorders differently.

The International Consensus Development Conference on Female Sexual Dysfunction, held in Boston, Massachusetts in October 1998, was primarily concerned with developing a concise definition and classification scheme for female sexual dysfunction (Basson et al., 2001). As conference participants have noted, a universal classification system for diagnosing female sexual dysfunction was necessary, as previous diagnostic systems were either ambiguous or inconsistent. For instance, the World Health Organization's International Classifications of Diseases-10 (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) each define female sexual desire disorders differently. Figure 1 shows these differing definitions. The classification of a sexual desire disorder has ramifications for clinical evaluation and outcome measures following treatment. To this end, the International Consensus Development Conference on Female Sexual Dysfunction was organized to address ambiguity in the definition and classification of female sexual disorders.

Figure 1: Diagnostic Criteria for Sexual Desire Disorders

	ICD-10 (1993)	DSM-IV-TR (2000)
Diagnostic Terminology & Code	Lack or loss of sexual desire; F52.0	Hypoactive sexual desire disorder; 302.71
Diagnostic Criteria	<ul style="list-style-type: none"> * The individual is unable to participate in a sexual relationship as desired * A lack or loss of sexual desire manifested by a lack of interest in: seeking sexual cues, thinking about sex with associated feelings of desire or appetite, or sexual fantasies * A lack of interest initiating sexual activity (either with a partner or masturbation) which results in less sexual activity than expected (taking age and context of previous levels of sexual activity into account) 	<ul style="list-style-type: none"> * A deficiency of absence of sexual fantasies and desire for sexual activity * The disturbance in sexual activity must cause marked distress or interpersonal difficulty * The dysfunction is not otherwise explained (except by another sexual dysfunction) and is not due to a medical condition or medication * Subtypes indicate onset (acquired vs. lifelong), context (generalized vs. situational), and etiological factors (psychological or various combined factors).

Based on traditional human sexual response cycles developed by Masters and Johnson, and later by Kaplan, Basson and colleagues established four major categories of female sexual dysfunction: desire, arousal, orgasmic, and sexual pain disorders. More specifically, desire disorders include two sub-categories including hypoactive sexual desire disorder and sexual aversion disorder. Hypoactive sexual desire disorder is defined as: “the persistent or recurrent deficiency (or absence) of sexual fantasies/thought, and/or desire for or receptivity to sexual activity, which causes personal distress” (p.87). Conversely, sexual aversion disorder is: “the persistent or

recurrent phobic aversion to and avoidance of sexual contact with a sexual partner, which causes personal distress” (p.87).

In addition to establishing more consistent classifications for female sexual dysfunctions, the consensus conference also established current research needs and priorities with regards to female sexuality. Specifically, the authors cite the need for more research on midlife women’s sexuality: “The effects of aging and menopause on female sexual functioning are important areas for further research” (p.89). Furthermore, Basson and colleagues note that despite decades of research on the topic of female sexual desire, the determinants of sexual desire have yet to be established and adequately evaluated. As a result of the conference, lengthy reports detailing the established classification of women’s sexual dysfunction, including sexual desire disorders, and definitions of such dysfunctions were released and widely disseminated to health and medical professionals (e.g. Basson et al., 2001).

In summary, research on women’s sexual desire from a biomedical perspective is characterized by several themes. First, the term “sexual desire” is ambiguous and researchers have not agreed upon what this aspect of sexual response entails. Secondly, the human sexual response cycles used to conceptualize sexual desire as it relates to other aspects of sexual response focus primarily on physiological mechanisms that either enable or disable one to experience sexual desire. Finally, efforts to develop a universal classification system for assessing and operationalizing women’s sexual desire disorders are intended to increase the medical profession’s ability to manage and treat such disorders in women.

A Feminist Critique of the Biomedical Conceptualization of Women's Sexual Desire

Feminist scholars are critical of the biomedical conceptualization of sexual desire for several reasons. First, there is concern that biomedical researchers focus primarily on sexual desire as a phenomenon located solely within the individual. By locating sexual desire within the woman, external factors and their influence on how sexual desire is conceptualized is ignored (McCormick, 1994; Tiefer, 1995, 2000, 2002). In addition to the reductionistic nature of biomedical conceptualizations of sexual desire, feminist scholars also suggest that biomedical disciplines construct sexual desire as disease-focused. That is, the biomedical view of sexual desire is predominately concerned with what constitutes “normal” and “abnormal”, “high” and “low” levels of sexual desire as if all women experience sexual desire similarly (The Working Group on a “New View of Women’s Sexual Problems”, 2002). Thus, by classifying and categorizing sexual desire, researchers are in essence labeling women who do not fit the norm as pathological and dysfunctional. In fact, some researchers and scholars note that “normal” sexual desire is an anathema and that sexual desire cannot be conceptualized, let alone defined, without noting one’s interpersonal and cultural context (Tolman & Diamond, 2001; Ussher & Baker, 1993). Ussher (1993) notes that the ramifications of disease-focused conceptualizations of sexual desire result in the medicalization of women’s sexuality.

Tiefer (2002) explains the medicalization of sexuality:

Sociologists construe medicalization as a process of social control whereby diverse areas of human behavior are brought within a medical frame of discourse both conceptually and institutionally. The medicalization of sexuality prescribes and demarcates sexual interests and activities defining normality and deviance in the language of sexual health and illness. The process of medicalization, promoted by industry, media,

health experts, and conservative political actors, produces sexual values, language, classification systems, and authorities, and profoundly shapes the popular view of sexuality, despite a culture full of diverse sexual voices (p. 64).

Moreover, Ussher (1993) explains that the process through which women's sexual desire is named, labeled, and professionally defined has real life implications for women: "Women clearly internalize these definitions of "normal" sexual functioning and as a result refer themselves for help, thus reinforcing the notion of pathology and of the need for expert intervention" (p. 19). Similarly, a study by Jones (1994) found that women internalized the ideology that menopause (and related sexuality issues) are diseases in need of treatment.

Since feminists are primarily concerned with issues of power, it is not considered trivial or coincidental that medical experts have defined normal sexual desire and classified desire disorders in order to treat a problem that they have in essence constructed (Tiefer, 1995, 2000, 2002). In other words, it is noteworthy that the medical profession reaps power from the biomedical conceptualization of women's sexual desire. As discussed earlier in this chapter, notions of objectivity and science are used to reify and legitimate this power by locating sexual desire within individual women's bodies.

The International Consensus Development Conference on Female Sexual Dysfunction (1998) and resulting conference report (Basson et al., 2001) is an excellent example of the reductionistic, disease-focused nature of the biomedical conceptualization of women's sexual desire. Various feminist researchers and scholars have criticized the limited view of women's sexuality used at this conference, including aspects of sexual response such as sexual desire (e.g. Tiefer, 2001). In fact, a group of feminist scholars

and researchers in the field of sexuality organized a working group to convene and respond to the flawed assumptions regarding women's sexuality at this conference. The Working Group for "A New View of Women's Sexual Problems" produced an entire volume (Kaschak & Tiefer, 2002) of commentary and research articles disputing the biomedical conceptualization of women's sexuality used to guide the conference and its end result, the "Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications" (Basson et al., 2001). The Working Group explains:

In recent years, publicity about new treatments for men's erection problems has focused attention on women's sexuality and provoked a competitive commercial hunt for "the female Viagra". But women's sexual problems differ from men's in basic ways that are not being examined or addressed. We believe that a fundamental barrier to understanding women's sexuality is the medical classification scheme in current use ... It divides women's sexual problems into four categories of sexual "dysfunction": sexual desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders. These "dysfunctions" are disturbances in an assumed universal physiological sexual response pattern ("normal function") originally described by Masters and Johnson in the 1960s. ... [There are] serious distortions produced by a framework that reduces sexual problems to disorders of physiological function, comparable to breathing or digestive disorders (p. 3).

The Working Group then details the three most serious flaws with the current biomedical conceptualization of women's sexuality concerns (including sexual desire disorders) as represented in the medical classification system proposed at the 1998 conference.

First, women's sexuality and sexuality concerns are not similar to men's, although an identical classification scheme is used. For instance, when women themselves are asked to describe their sexual desire concerns, the concepts of "desire" and "arousal" are

indistinguishable. Recently, the possibility that sexual arousal and desire may or may not be distinct concepts has been a matter of considerable debate.

For instance, some researchers and scholars who study women's sexuality maintain that desire and arousal are distinct phases of the sexual response cycle (Basson, 2001, 2002). At the 16th World Congress of Sexology conference in Havana, Cuba in March 2003, two esteemed sexologists discussed the notion that sexual desire and arousal are distinct, but overlapping concepts (Leiblum, 2003; Whipple, 2003). Leiblum (2003) suggested that because women are typically aware of arousal, but not desire, these two concepts must be distinct from one another. However, Leiblum also noted that sexual arousal and desire are difficult to distinguish from one another because women's lack of arousal often contributes to women's concerns with desire and even orgasm.

Leiblum also reported that many women experience a disconnect between their awareness of physical arousal and their subjective sense of awareness of arousal. In other words, physical indicators of arousal, such as vaginal lubrication and vasocongestion, may be present, yet women don't report feeling aroused. This phenomenon was recently termed "missed sexual arousal" and it is plausible that if sexual desire was better defined and understood that other sexual concerns, such as "missed sexual arousal", may need to be reconceptualized. In other words, women's concerns regarding their sexual desire relate to their subjective sense of desire, not to physiological correlates of sexual desire which are often actually indicators of sexual arousal. Similarly, in her discussion of women with Persistent Sexual Arousal Syndrome (PSAS), Whipple (2003) noted that women who experience weeks or months of clitoral engorgement or vaginal lubrication, both of which are indicators of arousal, rarely report any sexual desire during these times.

Thus, Whipple suggested that sexual desire and arousal are distinct, although related, concepts.

Unfortunately, research on women's sexuality, specifically sexual response, is flawed in that models of sexual response were developed before adequately defining and differentiating specific aspects of response from one another. As part of her discussion of women's sexual response, specifically orgasm, Whipple (2003) noted that the current definition of orgasm is so specific and limited that it excludes sensations in non-genital areas, despite the fact that women define such feelings as an orgasm. In order to enable all women, especially women with spinal injuries or other nerve damage, to be included in the conceptualization of what an orgasm entails, Whipple suggested that the term orgasm be redefined. Whipple suggested, "Orgasm is what a woman says is orgasm". Whipple's criticism of flawed definitions of orgasm suggests that research to date has ignored women's own experiences. Certainly the current conceptualization of sexual desire could benefit from understanding what women say sexual desire is like for them.

Basson (2002) noted that our definitions of women's sexual desire are too broad and our conceptualization of sexual desire is too narrow, yet she also fails to define or conceptualize sexual desire. While she notes that failing to define sexual desire creates a host of other problems in terms of diagnosing sexual concerns relating to a lack of desire, Basson discusses that the crux of the problem is the fact that desire and arousal have not been distinguished from one another. Basson suggests that sexual desire includes the appraisal of sexual arousal, and that the crucial component of women's sexual desire is a willingness and ability to find and respond to sexual stimuli. Moreover, Basson

suggests that traditional markers of sexual desire, such as fantasizing, masturbating, and sexual urges, may or may not be normative for women. Thus, Basson notes that sexual desire varies among and between women.

According to The Working Group, the second flaw in the current biomedical conceptualization of women's sexuality concerns, including sexual desire, is the erasure of the relational context of sexuality. In other words, when sexuality is considered an individual physiological phenomenon, interrelational partnership issues that interrupt women's sexual response, such as fear of violence or the need to please a partner, are ignored. For instance, research has demonstrated that there is a relationship between women's decreased sexual response and women's interest in changing qualities in her partner, such as attentiveness and sensitivity ((Koch & Mansfield, 2002; Mansfield, Koch, & Voda, 1998).

Finally, The Working Group is critical of the universality in the biomedical conceptualization of sexuality and women's sexual concerns. They explain: "All women are not the same, and their sexual needs, satisfactions, and problems do not fit neatly into categories of desire, arousal, orgasm, or pain. Women differ in their values, approaches to sexuality, social and cultural backgrounds, and current situations, and these differences cannot be smoothed over into an identical notion of "dysfunction" – or an identical, one-size-fits-all treatment" (p. 3).

Similarly, in an earlier article titled "The "Consensus" Conference on Female Sexual Dysfunction: Conflicts of interest and hidden agendas" that appeared in the Journal of Sex & Marital Therapy, Tiefer (2001) suggested that the recent Consensus Conference on Female Sexual Dysfunction has served to legitimize the medicalization of

women's sexuality as conference attendees failed to consider the larger sociocultural and political context in which women's sexuality exists:

The Basson et al. (2000) article on "female sexual dysfunction" exists in the larger context of ongoing social struggles over the meaning of gender and of changes in women's sexual experiences, expectations, and entitlements. ... overall, women's real-world sexual experiences and problems are not at the heart of this classification system, and therein lies its failure. Ultimately, this is not a document for women, but for the interests of pharmaceutical industry clinical trials (p.227).

Thus, Tiefer suggested that the resulting report of the conference is not so much a "consensus" report as a necessary first step to create a legitimate classification system for so-called female sexual dysfunction. Moreover, Tiefer suggested that interests of conference participants were more aligned with developing the need for a pharmaceutical market for women with "sexual dysfunction" than accurately reporting and summarizing scientific research on female sexuality.

For instance, Tiefer noted a significant area of multidisciplinary research on women's sexuality that conference attendees completely ignored, perhaps since such research warned against ignoring the historical and cultural contexts that influence women's sexuality in lieu of biological reductionism. For example, contextual factors that are known to influence women's overall sexual satisfaction and sexual desire, such as lack of romance and tenderness in sex play (Daniluk, 1993), inhibition related to cultural variables (Kiely, 1997) or body image issues (Koch et al., In Review), fear of domestic violence (Fine, 1988), genital shame (Jones, 1994), or resentment towards a partner based on unequal childcare or household responsibilities (Mansfield, Koch, & Voda, 1998), were utterly ignored by the conference participants. Instead, the report emphasized biological causes of women's sexuality, thereby emphasizing and

legitimizing the notion that women's sexual dissatisfaction is organically caused by disease despite the lack of factual evidence to support such claims. Similarly, Bancroft and colleagues (2003) note that the recommendations made to update the classification scheme only reinforce the male model of sexual response.

Tiefer suggested that the agenda of this conference, sponsored solely by pharmaceutical companies, was to create and define "female sexual dysfunction" ambiguously so that there was a need for drug treatment: "This consensus report ... will be used by commercial interests to justify drug trial research designs that will exclude most of women's sexual issues. ... Federally approved, expensive, prescription drugs will then be advertised directly to women who have no other sources of information or help" (p. 235). In fact, the Food and Drug Administration's Center for Drug Evaluation and Research released guidelines for drug trials on female sexual dysfunction shortly following the publication of the consensus report:

(www.fda.gov/cder/guidance/index/htm). Moreover, publications of initial studies that have tested the efficacy of Viagra in women have already started to appear in medical and health journals (e.g. Caruso, Insteliano, Lupo, Agnello, 2001; Basson, McInnes, Smith, Hodgson, Spain, & Koppiker, 2002).

The Sociocultural Conceptualization of Women's Sexual Desire

Compared to the biomedical perspective, there has not been as much research or scholarship regarding the conceptualization of women's sexual desire from a sociocultural perspective. As previously discussed in this chapter, a sociocultural

perspective of sexuality does not consider sexual response as a universal human phenomenon or even as a natural, intrinsic force. Instead, sociocultural perspectives of sexual response, including sexual desire, focus on how sexual experiences, both behaviors and motivations for behaviors, are shaped by social trends, meaning and values. That is, a sociocultural perspective of women's sexual desire moves beyond physiological mechanisms to view the importance of the cultural and social contexts in which desire occurs or doesn't occur (Gagnon & Parker, 1995). Similarly, this perspective considers that a behavior or identity isn't considered sexual until it is constructed that way. In other words, any aspect of behavior or social life can be sexualized or desexualized through definition and regulation (Weeks, 1990). Thus, the sociocultural perspective notes the manner in which health and medical professionals depict and construct sexual realities, including aspects of sexual response like sexual desire, as the sexual norm (Tiefer, 2000). Similarly, the regulation of how sexual response is defined is highly dependent on how sexuality is constructed, specifically with regard to expectations as to what will produce a sexual experience. For instance, Fisher (1999) suggests that women's sexual desire is more context-based than men's: "Female sexuality is nested in a broader lattice of emotions, a wider range of physical sensations and a more extensive social and environmental context – all reflections of feminine web thinking. Men's sex drive is far more focused on the act of copulation itself ..." (p. 203). Similarly, Kaplan (1979) notes that sexual desire in women includes an evaluation of the sexual scenario, including related feelings and cognitions, as opposed to a physical ability to respond sexually. More recently, Leiblum (2002) suggested that as women gain greater political, social, economic, and reproductive freedom, women's opportunities to express

sexual desire increase and expand: “ For instance, there are more women who are displaying an active interest in sexual erotica and explicit pornography as well as in erotic chat rooms. Many bisexual and lesbian women show a keen appreciation of sexual variety and more aggressive sexual expression, e.g. sadomasochistic sex. There are women who choose ‘sex work’ as an occupation, despite its dangers, because of the sexual freedom it permits” (p. 61).

Blumberg (2003) designed an exploratory study to better understand the experiences of highly sexual women. Well aware of the social stigma associated with being a highly sexual woman, Blumberg was interested in what it is like as a highly sexual woman in American culture, as well as to how women’s highly sexual nature influences women’s relationships. The operational definition of “highly sexual” was determined using the frequency of sexual activity as an indicator. (Blumberg established the statistical norm as two standard deviations above of the average number of times a woman in America has sex per week as a cutoff, 6 or 7 times per week). Alternatively, Blumberg also allowed women’s own conceptualizations of their sexual desire as a determinant of their highly sexual status. Thus, women who reported that sex strongly and frequently affected their behavior, life choices, and life satisfaction were also considered to be highly sexual. Women (n=44, age range: 20-82) were recruited using convenience sampling methods, and data collection involved a questionnaire (to assess demographic information) and semi-structured interviews that lasted between 2 and 3 hours. Interview questions were designed to enable participants to talk about their perceptions of what it means to be a highly sexual woman, how their desire for sex affected their significant relationships, and their ideal frequency of sexual behaviors (both

with and without a partner). Interviews were recorded, transcribed, and analyzed (although the methodology used was not specified). Analysis indicated that highly sexual women's lives were almost completely organized around their sexuality.

Two specific themes emerged from the analysis. First, women's demand for sexual satisfaction and excitement was so strong that they reported they were unable to ignore their desire. Often, women's need for sex organized their daily lives. Secondly, women experienced difficulty and challenges in their lives related to the derogatory ways in which highly sexual women are characterized in American culture. Women's self-esteem, feelings towards sexual partners, and relationships with friends suffered as a result of women's internalization of pejorative stereotypes. However, every woman in the study reported that sexuality was part of their core being, and most women perceived their highly sexual nature as a positive aspect of their personality. Thus, most women reported feeling a discrepancy between their own perceptions of their sexuality and larger societal messages about appropriate sexual scripts for women. Similarly, many women reported difficulty negotiating their sexuality and relationships, as most women mentioned the impossibility of sexual satisfaction from any singly relationship.

A Feminist Critique of the Sociocultural Conceptualization of Women's Sexual Desire

Feminists are typically more aligned with sociocultural perspectives of sexuality than with biomedical views since the former acknowledges the context in which women's sexuality exists. However, attention to how social and cultural norms are constructed with regards to women's sexuality does not constitute a feminist perspective. As discussed earlier in this chapter, on the most basic level, feminism is concerned with the

hierarchical power distribution in society according to gender. Thus, a feminist perspective on women's sexual desire concerns inherently focuses on power dynamics and how gendered constructions of what constitutes sexual desire serve to empower or disempower women.

Feminist scholars have long noted the constructivist nature of women's sexual realities. Similarly, social constructionists have discussed the role of societal expectations for women in shaping what is considered socially acceptable or unacceptable, appropriate versus inappropriate, and healthy versus unhealthy sexuality. For instance, Foucault (1978) discussed the regulation of sexuality as a mechanism for exerting power and maintaining social control based on what society defines as sexually acceptable or deviant. Feminist criticism of the sociocultural conceptualization of women's sexual desire suggests that social and cultural norms regarding sexuality often reproduce the sexual double standard and otherwise construct sexual desire as a male-identified phenomenon. Thus, despite the seemingly feminist nature of social constructionist perspectives of women's sexuality, Daniluk (1993) noted that such an approach is characterized by dualisms that are antithetical to feminist scholarship. Daniluk explained: "To date, dichotomous sexual truths have characterized the social constructions of female sexuality and have provided the lenses through which women understand and experience our sexualities" (p.54). That is, Daniluk suggests that male-oriented paradigms of women's sexuality, despite their social constructionist nature, cannot provide women with a conceptualization of our sexuality that is rooted in our needs, urges, and realities.

Based on the need to conceptualize women's sexuality in terms of women's own lived experience, Daniluk (1993) designed a study to understand women's own experiences of their sexuality and the meanings that women associated with such experiences. She interviewed ten women (ages 30-66, mean age=42.2) of varying classes, educational levels, relationship status, race/ethnicity and sexual orientation to better understand the meaning and experience of women's sexuality from an emic, or native, perspective. Women were interviewed in a focus group setting for approximately 3 hours once a week for eleven weeks. Interviews were tape recorded and immediately transcribed by the researcher. Data analysis was based on Colaizzi's (1978) phenomenological method. Two major themes emerged from the data: women's sexual development and their sense of sexuality is influenced by (1) structural and institutional sources and (2) life events.

Daniluk's analyses of the focus groups revealed four contextual sources of disempowerment for women's sexual development. Women reported that the institutions of medicine and religion communicated negative messages with regards to women's sexual self-esteem. Women's experience of living in a culture that has institutionalized sexual violence against women has also served to disable women's construction of themselves as sexual beings. Finally, the media's portrayal of women as sexual objects had a variety of negative implications for women's body image and related sexuality issues. Similarly, various events in women's lives, whether related to reproduction or relationships, that had shaped their own experience of sexuality were characterized either by shame for being a woman or self-blame for how women are treated in this culture. Daniluk observed that during data collection women often had trouble discussing their

lived experiences of their sexuality as a result of the lack of appropriate terminology, language, and a discourse that gives voice to women's conceptualization of their own sexuality. Daniluk suggests that the absence of such discourse eventually serves to further disempower women and to perpetuate women's silence, submission, and isolation.

Similarly, Kiely (1997) noted the androcentric bias in sexology's ideology of desire that has resulted in the conceptualization of women's sexual desire as pathologically disordered and deficient. In her review of socioculturally oriented research and theories on women's sexual desire, Kiely systematically demonstrated that this work is based on culturally constructed beliefs that posit male sexual behavior as the norm.

She explained:

... the field's quite culture-bound approach to treatment ... perpetuates and codifies cultural stereotypes rather than illuminating and breaking them. Problems are located individually most often in the woman; this continues a long history of pathologizing women. There is a strong unacknowledged bias ... that supports male dominance in heterosexual relationships. There is no acknowledgment of the ways gender inequality and the ideologies connected with it structure and influence treatment, or more importantly; how these forces may structure and influence the problems individuals bring (p. 26-7).

In addition to discussing the inherent problems of evaluating women's sexuality against a male-oriented standard, Kiely noted another problematic feature of sociocultural perspectives of female sexuality. Noting that more women than men are diagnosed with desire disorders, Kiely suggested that sexuality and desire are culturally constructed phenomena that stem from gender role expectations and exist in a larger cultural context of gender role socialization. That is, sexuality and desire are not solely biological or instinctual entities, but subjectivities that have different meanings depending on various

social contexts. For instance, girls and women experience desire within a cultural context that has socialized women to silence and ignore desire. Thus, the silence surrounding women's sexual desire disguises the meanings of desire because the very existence of such a term depends on culturally constructed beliefs. Further, the meaning that women attach to desire varies according to their experience of their sexual subjectivity. That is, Kiely suggests that social and cultural meanings associated with gender will influence the meaning of desire. In addition, Kiely suggests that desire develops and acquires meaning in relational contexts.

Using feminist theories to critique the socially constructed theoretical perspective that guides most research on women's sexuality, Kiely concludes her review by suggesting that what is missing in the discussion of women's sexual desire is understanding women's meanings of desire. Thus, Kiely sought to study women's sexual desire using a feminist, narrative methodology to explore the meaning of sexual desire for women.

Kiely (1997) designed a study to explore women's psychosexual development, specifically sexual desire from a woman-centered, culturally constructed perspective. The purpose of the study was to understand how women intersubjectively construct meanings about their sexuality and desire within a larger context of social attitudes that shape women's gender and sexuality. In addition, the study sought to understand how women make sense of life experiences and relationships throughout the life cycle with respect to gender and sexuality ideologies. Results suggest that the meaning of desire for women is constructed intersubjectively, that is, within relationships, and that women's conceptualization of desire is shaped by gender role socialization.

Tolman's work is a great example of a feminist interactionist approach to the study of women's sexual desire, as she acknowledges the necessity to examine both cultural and biological influences on sexual desire: "Sexual desires are always embedded in particular sociocultural contexts (i.e., relationships nested within societies nested within cultures and historical epochs) *and* always embedded in particular biological contexts (including not only chromosomal and hormonal status, but nutritional status, age, and general health)" (Tolman & Diamond, 2001, sic, p. 34). Tolman and Diamond's study of sexual desire extends beyond a study of the frequency or prevalence of sexual thoughts, behaviors, or fantasies in order to focus on the multiple meanings and the various qualities of sexual desire for women across various sociocultural and interpersonal contexts.

Tolman & Diamond describe an interactionist approach to the study of women's sexual desire:

Instead of simply assessing whether changes in specific hormone levels correlated with changes in sexual thoughts and behaviors, we might investigate how a girl's specific social and interpersonal context influences the nature and subjective quality of the changes at an experiential level. ... Such factors might help explain why some women come to experience their desires as powerful versus weak, uncontrollable versus manageable, loving versus lustful, exciting versus frightening. Understanding desire at these experiential levels enables an understanding of *how* biological underpinnings of sexuality are woven together with cognitively and emotionally mediated cultural discourses to produce specific embodied experiences (p. 59).

Like other feminist scholars and researchers (e.g. Fine, 1988), Tolman's approach to understanding women's experience of sexual desire notes the extent to which women's sexual desire has been appropriated by men and mainstream culture. Traditional notions of women's sexual desire are rooted in (and reproduce) systematic inequalities based on

gender such that men's position is privileged and serves to oppress women's ability to act on and express sexual desire. Tolman explains: "By sending powerful messages that women do not have the same types of desires as men, culture (translated through institutions, media, and everyday talk) creates a self-fulfilling prophecy. Women are, in effect, trained to discount their own bodily experiences of sexual desire because they lack the cultural basis to acknowledge and meaningfully interpret such feelings and experiences" (pp. 38-9).

It is important to note that women don't universally experience sexual desire as a positive phenomenon. In fact, some research has found that women who have internalized cultural messages about deficient older women's sexuality experience distress with sexual desire in midlife and later life (Banister, 2000). In other words, women have internalized the cultural belief that older women aren't sexual, and thus women may feel ashamed or embarrassed if they experience sexual desire during a time of their lives that they have been socialized to believe is supposed to be sexless (Jones, 1994).

In sum, feminists in the field of sexology suggest that women's sexual desire, and concerns with expressing sexual desire, is an expected response related to cultural norms and gender expectations. That is, sexual desire, as conceptualized in both the biomedical and sociocultural perspectives, is at odds with women's gender role socialization so that women's experience of sexual desire is made problematic by feminine gender expectations. Thus, both biomedical and sociocultural conceptualizations of women's sexual desire serve to disempower women, albeit in different ways. In the following section, it will

become apparent that the conceptualization of women's sexual desire is closely related to how researchers investigate both biological determinants of women's sexual desire as well as sociocultural influences on women's sexual desire.

Determinants of and Influences on Women's Sexual Desire

Biologically Oriented Factors

Biomedical research on women's sexual desire focuses primarily on the relationships between anatomical factors and hormones on sexual behavior. It is posited that women's hormones influence sexual desire both directly and indirectly via hormonal influences on women's anatomy. First, research on androgens and their direct effects on sexual desire will be discussed. Next, research on the indirect effects of estrogen on women's sexual desire will be examined.

Androgens

The majority of research supporting the relationship between hormones and sexual behavior is based on men (Andersen & Cyranowski, 1995), and thus the focus of this research is primarily on the role of androgens. Like in men, there is a relationship between androgens, primarily testosterone, and women's sexual desire (Bassoon, 2003). However, the nature of the relationship between hormones and sexual desire is a point of contention, even among biologically-oriented researchers. Women have three sources of androgen production, although the respective amounts from each location vary over a

woman's lifetime: the ovaries, adrenal glands, and the peripheral conversion of other steroids to androgens in adipose tissue, muscle, and skin (Levine, 1998). For instance, women's total amount of available testosterone decreases with age, beginning in a woman's mid-twenties (Davis, 2000). Testosterone, the most potent androgen and the one associated with sexual desire, is present in the body in two forms: bound and unbound. When bound, testosterone forms a bond to one of two proteins, sex hormone binding globulin (SHBG) and albumin. Both SHBG and albumin are non-specific proteins; that is, they can bind to other sex steroids, although they have the highest binding affinity for testosterone. Thus, when SHBG and/or albumin are present in the bloodstream, they will bind to all of the testosterone available. Thus, most testosterone in the body (96-98%) is present in bound form (Itoh et al., 1991; Rosenfield, 1990). When testosterone is bound to SHBG or albumin, it is not biologically active because it is unable to bind to other cellular receptors. In other words, bound testosterone is unable to exert biological effects in the body. The small amount of testosterone that is unbound in the bloodstream is referred to as active or free testosterone because it is able to bind to receptors elsewhere in the body and exert its effects (Regan, 1999). Free testosterone, which constitutes a very small percentage of overall testosterone levels, then is the hormone associated with exerting biological effects on target tissues related to sexual desire.

Riley & Riley (2000) studied the relationship between hormone levels and sexual desire among premenopausal women with a history of no sexual drive. The researchers conceptualized sexual desire as "object-focused sexual drive" and they considered no sexual drive to be the "absence of spontaneous sexual arousal, reduced or absent sexual

fantasies, sexual thoughts and sexual daydreams” (p. 271). The researchers hypothesized that absent sexual drive is caused by hormonal concentrations, specifically reduced androgen levels or elevated prolactin levels. To test their hypothesis, the researchers recruited women with absent sexual drive from a sex therapy clinic and matched volunteers (also recruited from the same sex therapy clinic) for the control group for demographic information (ages 18 to 45). Each group consisted of 15 women, all of whom were in a heterosexual relationship for at least six months.

The researchers collected basic demographic information and measures of sexual desire including the Hurlbert Index of Sexual Desire (HISD), and the Hurlbert Index of Sexual Excitability (HISE). In addition, the women completed a daily record of their sexual desire, including any sexual activity or sexual fantasy, in a diary for a minimum of one menstrual cycle. Women also completed a menstrual calendar card to record menses. Women’s hormone levels (including testosterone, prolactin, and estradiol) were assayed mid-cycle, as determined by women’s use of a home ovulation test. Hormone assays were performed once using a blood sample.

Analyses indicated only one difference between groups with regards to hormonal concentrations. Women without sexual drive had slightly lower mean concentrations of free testosterone ($p=0.023$). In addition, analyses also revealed a correlation between sexual behavior and hormone levels. In the control group, analyses revealed a positive correlation between sexual thoughts (reported through the daily sexual diary) and total testosterone levels ($r=0.540$, $p=0.003$) as well as with free testosterone ($r=0.671$, $p=0.003$). Similarly, self-reports of a need for sex among women in the control group positively correlated with free testosterone ($r=0.608$, $p=0.016$). Average coital frequency

among women in the control group also correlated with total testosterone ($r=0.527$, $p=0.044$). In the second group of women with absent sexual drive, coital frequency correlated with total testosterone ($r=0.527$, $p=0.044$).

The researchers concluded that women with a chronic absence of sexual drive had a significantly lower level of free testosterone than women in the control group. However, the researchers' analyses only included correlations, which cannot be used to infer causation, and the validity and reliability of the hormonal assays are not clear as only one hormonal sample was used.

There are two areas of the body that have been found to have the highest concentrations of testosterone receptors, the preoptic area and the hypothalamus, both located in the brain (Bixo, Backstrom, Winblad, & Andersson, 1995). Thus, it is believed that the relationship between testosterone and sexual desire is mediated in the brain (Davis, 1998; DeCherney, 2000). Bancroft (1988) explains the brain's role in determining sexual desire: "What we experience as appetite for sex is also a complex interaction between cognitive processes, neurophysiological and biochemical mechanisms and mood. Some state of central arousability is involved, determining the individual's capacity for reaction to sexual stimuli with a sexual response and representing the neurophysiological substrate of our sexuality" (p.11). Research has more recently demonstrated that what Bancroft refers to as "central arousability" is determined by neurotransmitters in the brain.

Tuiten, VanHonk, Koppeschaar, Bernaards, Thijssen, & Berbaten (2000) demonstrated that the administration of a single dose of testosterone affects physiological and subjective indices of sexual response in healthy, premenopausal women ($n=8$).

Although the study did not focus on sexual desire per se, subjective measures of sexual interest, lust, and arousal were included, although such measures were not specified. Using a double blind, placebo-controlled, crossover design, the researchers randomly administered either a placebo or testosterone to participants during six consecutive experimental trials. Following the administration of the placebo or testosterone, blood samples were taken to measure testosterone (in both bound and unbound forms) and the amount of SHBG. In addition, participants were asked to rate their interest in sex, lust, and arousal using a Likert-scale, although the specific scale used was not indicated.

Results indicated that there were no differences in subjective sexuality measures when participants received the placebo, but there were significant differences between placebo and testosterone. Analyses revealed significant Spearman correlation coefficients with sexual lust ($r=0.83$, $P=0.01$) and arousal ($r=0.80$, $P=0.02$) in the testosterone treatments. Moreover, the researchers noted that the effects of testosterone were time dependent. Women's subjective reports of increases in sexual arousal and lust occurred within four hours of testosterone administration. Tuiten et al. explain their results based on the involvement of sex hormone receptor-containing neurotransmitters in the brain.

Two types of neurotransmitters in the brain, serotonin and catecholamines (e.g. dopamine, noradrenaline, adrenaline), have been associated with sexual desire and sexual cognitions, including sexual fantasy and thoughts (Sherwin, 1991). To this end, it is believed that the relationship between testosterone, the brain, and sexual desire is mediated by neurotransmitters that enable or enhance sexual cognitions (Regan, 1999).

Thus, a minimum level of unbound testosterone in the brain is believed to be necessary, but not sufficient, for sexual desire.

Research on the effects of testosterone therapy suggests that testosterone has additional effects on sexual desire elsewhere in the body as well. For instance, Davis (1999) found that testosterone therapy results in increased vaginal vasocongestion and increased libido. However, testosterone administration, regardless of dose, does not increase women's subjective sense of sexual excitement or lust. In other words, testosterone therapy appears to affect only the biological aspects of sexual desire, which are more aptly referred to as libido or sexual drive. Davis (1999) concluded that testosterone is not responsible for the cognitive or affective processing that is necessary to feel a subjective sense of sexual desire: "Hence, testosterone substitution alone is not adequate to restore sexual desire when appropriate cognition and emotions are absent, and impulses are processed as unimportant or even undesirable" (p.35).

Problems with measures of sexual desire, the ambiguity in the definition and operationalization of sexual desire, and a lack of research in humans are all barriers to better understanding the exact role that testosterone plays in determining sexual desire, although some research has attempted to distinguish the interrelationship between hormones and other influences on sexual desire.

For instance, Galyer and colleagues (1999) compared sexual desire in women who had recently undergone a hysterectomy (n=30) to women who had recently undergone a non-gynecological surgery (n=7) to examine the hormonal and situational correlates of sexual desire. Women (ages 30-65) who had had surgery within the last 6 to 18 months were recruited by their surgeons for participation in the study. Testosterone

levels as well as overall androgen concentrations were measured via blood samples, although it is not clear how often or at what times such assays were performed. Sexual desire was measured using the Sexual Desire Questionnaire developed by Beck and colleagues (1991). The questionnaire assesses participants' frequency of sexual behavior, manifestations of desire, and life events that may influence sexual desire. The questionnaire also had some open-ended questions to collect information about life events that affected participants' sexual desire. In addition, the Hurlbert Index of Sexual Desire (HISD) was used to calculate an overall score for each participant that discriminates high sexual desire from low sexual desire (Apt & Hurlbert, 1992). Finally, the Sexual Desire Inventory (SDI2) was used to measure sexual desire through both autonomous and partner-related sexual activity (Spector, Carey, & Steinberg, 1996). The SDI2 asks participants to rate the importance and frequency of various sexual activities in relation to their sexual desire.

A one-way analysis of variance revealed no significant differences in any measures of sexual desire between the two groups. Similarly, there were no significant differences in hormone concentrations between the two groups, nor were there differences in hormone levels between women whose composite score on the HISD indicated a high level of sexual desire versus a low level of sexual desire. In conclusion, this study failed to support the notion that there is a causal relationship between testosterone and sexual desire. Similarly, this research suggests that there is no relationship between surgery, whether a hysterectomy or otherwise, and sexual desire.

Estrogen

In women, estrogen is produced primarily in the ovaries, with smaller amounts secreted in the adrenal cortex and peripheral tissues (e.g. fat, muscle, and the hypothalamus). The most potent form of estrogen, estradiol, is a by-product of the metabolism of testosterone, which occurs in various peripheral tissues in the body, while less potent forms of estrogen, such as estrone and estriol, are primarily secreted from the ovary and other endocrine glands. Like testosterone, estradiol is present in both bound and unbound forms. In fact, both testosterone and estrogen bind to the same proteins, SHBG and albumin. However, SHBG has a higher affinity for testosterone and other androgens (e.g. androsteridiol) than for estradiol and other estrogens (Davis, 1998). Thus, the relative amounts of bioavailable testosterone and estrogens in the bloodstream are somewhat regulated via SHBG. For instance, an increase in SHBG reduces the amount of bioavailable testosterone, which in turn increases the amount of bioavailable estradiol. Thus, the relationship between levels of bioavailable testosterone and estradiol is indirect. (The physiology of these sex hormones and their relationship to one another will be particularly important in discussing how menopause influences changes in hormone levels). Unfortunately, the relationship between estrogens and sexual desire is not as well understood as the relationships between estrogen and androgens.

Despite decades of research on the role of estrogen in sexual desire (e.g. Benedek & Rubenstein, 1939), the physiological effects of estrogen are not completely understood (Regan, 1999). Some research indicates that high levels of estrogen, especially estradiol, decrease sexual desire. However, this relationship has been demonstrated consistently

only in men, specifically through the administration of large doses of estradiol to male sex offenders (e.g. Bancroft, 1974).

In contrast, some research suggests that estrogens, especially estradiol, are necessary for sexual desire in women. However, this research suggests that the relationship between sexual desire and estradiol in women is not a direct one (e.g. Leiblum, Bachmann, Kemmann, Colburn, & Schwartzman, 1983; Kaplan, 1992). For instance, Schreiner-Engel and colleagues (1989) compared estradiol levels in two groups of women over the menstrual cycle: women who were clinically diagnosed with sexual drive disorders (n=17) and women without a history of sexual desire concerns and were otherwise healthy (n=13). The researchers found no differences in estradiol levels. Similarly, Dennerstein et al. (1994) found no correlation between sexual desire and levels of estrogens as assessed in women's daily urine samples over the course of one menstrual cycle. Studies of menopausal status, estrogen levels, and sexual desire will be reviewed later in the chapter, but the results are similar, suggesting that sexual desire is not estrogen dependent.

However, research has consistently demonstrated an indirect relationship between estrogens and sexual desire in two ways: through bodily changes and via brain chemistry. First, estrogens are responsible for various genital responses that are associated with (but not indicators of) sexual desire, including vaginal lubrication, constriction of blood vessels in the genitals that contribute to vasocongestion, and even the perception of touch (Hallstrom & Samelson, 1990; McCoy, 1992; Sherwin, 1991; Sarrel, 2000). A good example of the indirect relationship between estrogen-related physiology and women's sexual desire is vaginal lubrication. Women who consistently experience concerns with

vaginal lubrication may avoid sexual interactions for fear of experiencing pain during intercourse (dyspareunia) (Bachmann, 1990; McCoy, 1992). Thus, estrogen's effect on sexual desire in this example is indirect; estrogen's effects on vaginal lubrication (an indicator of arousal) may facilitate a woman's sexual desire, but certainly does not cause desire. Other researchers suggest that estrogen deficiency causes urogenital aging, with effects including vaginal dryness, incontinence, urethritis, and vaginal irritability. It is estimated that urogenital discomfort resulting from estrogen deficiency affects 50% of menopausal women (Pariser & Niedermier, 1998).

The second mechanism by which estrogens have indirect influences on women's sexual desire is via the brain. Like testosterone, there are specialized hormone receptors for estradiol in areas of the brain, specifically in the hypothalamus and the preoptic area. Interestingly, there are also large amounts of testosterone in these areas of the brain as well. In fact, research suggests that there is a fairly constant conversion of testosterone to estradiol in these regions of the brain, although the significance of this finding is not fully understood (Davis, 1998). It appears as though estradiol, like testosterone, binds to receptors that then elicit a change in neurotransmitters. Bancroft (1988) suggests that while testosterone is responsible for the cognitive aspects of sexual desire via increased neurotransmitter activity, estradiol operates similarly although it is responsible for affective components of sexual desire. That is, estrogens' relationship to sexual desire in women may be mediated by neurological components of mood.

In addition to hormones, there are several other biological factors that may affect a woman's sexual desire. Medical conditions and medication use are also known to influence women's sexual desire. For instance, diabetes, hypertension, irritable bowel

syndrome and chronic renal failure have been associated with decreased sexual desire in both women and men (e.g. Zemel, 1988). Similarly, some medications, such as Tamoxifen and anti-depressants, have also been associated with lower levels of sexual desire (e.g. Pariser & Niedermier, 1998).

A Feminist Critique of Biologically-Oriented Factors as Determinants of Women's Sexual Desire

Feminists suggest that the notion that hormones cause, or even determine, women's sexual desire is an excellent example of biological reductionism. Tiefer (1991) explains: "Another pillar of the medical model, biological reductionism, is the idea that medical phenomena can ultimately and with greatest precision and generalizability be understood via research on their constituent biological elements (e.g. biochemical or neuropsychological processes)" (p. 261). Biological measures of sexual desire are not only methodologically flawed, but they also assume that sexual desire is a phenomenon located within the individual, and that the individual is in essence solely her biology. As discussed earlier in this chapter, the epistemological assumption that women's sexuality is dependent on their biology has larger sociopolitical implications for women, including the medicalization of sexuality and unnecessary and often unsafe pharmacological interventions. Moreover, the focus on hormones as determinants of desire ignores the context of women's lives. Currently women in our society must confront the discrepancies in their power and control over their own bodies, concern about women's ability to make their own sexual choices (especially in abusive and violent relationships), the sexual double standard, and an ageist culture.

Sociocultural Factors as Influences on Women's Sexual Desire

Most research indicates that sociocultural factors have more influence on women's sexual desire than biological factors (e.g. Angier, 1999; Leiblum, 2002; Mansfield, Voda, & Koch, 1998). In contrast to biological influences on sexual desire, sociocultural factors that influence women's sexual desire consider the power of society and culture to shape women's sexual lives and influence their sexual desire. Leiblum explains the significant and complex effect of cultural factors on women's sexuality:

In most Western countries, a woman's comfort with her sexuality is eroded by narrow and unrealistic expectations of female beauty and desirability, a greater history of sexual coercion and physical abuse, concerns about getting pregnant or acquiring sexually transmitted diseases, resentment about power inequities in their relationships, childcare responsibilities, etc. There is no real way to assess the true and accumulated impact of socialization, convention and expectation on women's experience and enjoyment of their sexuality, generally and on their awareness of their sexual drive (p. 66).

Thus, factors such as relationship satisfaction and quality, gender identity, women's life circumstances, and women's self-perceptions about body image and age are all sociocultural influences on women's sexual desire. For instance, Kirchengast and colleagues (1996) found a positive correlation between women's body weight and fat indices and reduced interest in sex. (Kirchengast, Hartmann, Gruber, & Huber, 1996). Typically, sociocultural research on women's sexual desire (in this country) focuses on how interpersonal factors influence women's sexual desire, perhaps since sexual activity often occurs within the context of a relationship (e.g. Trudel, Marchand, Ravart, Aubin, Turgeon, & Fortier, 2001). Kingsberg (2000) explains: "Sexuality can be fully understood only by assessing the context in which it occurs. That is, one must

understand the context of the relationship in which it occurs and the significant issues affecting a person's life" (p. S-34). Research has demonstrated that a variety of relationship factors are directly related to women's sexual desire, including low sexual satisfaction, the frequency of sexual activity within the relationship, and unresolved relationship problems (e.g. extramarital affairs). In fact, many of these factors actually predict desire disorders in women (Trudel et al., 1993, 1995, 1997). Based on the impact of relationship factors on women's sexual desire, Trudel and colleagues (2001) designed a study to assess the effectiveness of a behavioral-cognitive couple's sex therapy intervention on women's sexual desire.

Trudel et al. (2001) recruited couples, in which the woman had a history (at least six months) of hypoactive sexual desire disorder (HSD), from a local newspaper for participation in a sex therapy research group. Couples were included in the study only after the researchers confirmed a clinical diagnosis of HSD. The final sample consisted of seventy-four couples (mean age of women=37.4 years) who had been together for an average of thirteen years with a women's mean length of HSD of six years. Couples were randomly assigned to either the control group (n=36) or the treatment group (n=38) and data were collected via various psychological assessments and interviews occurring at regular intervals: pre-test, three months and also one year post-test. Couples in the treatment group met in small groups with a team of female and male therapists once a week for two hours each for twelve consecutive weeks. The treatment program consisted of the following therapeutic techniques: analysis of causal factors related to HSD, sexual information, couples sexual intimacy exercises, communication skills, sensate focus techniques, and sexual fantasy training.

Comparison of the treatment and control groups indicated that the treatment was effective in decreasing women's HSD. All of the women in the treatment group reported an increase in sexual desire immediately following treatment and 38% of these women sustained this increase at the one-year follow-up. The researchers did not report whether this change was statistically significant as compared to the control group.

Perhaps more important than the fact that the treatment was effective, however, was the researchers' assessment of attributions for women's sexual desire disorder. The commonly reported attributions for women's (in both groups) HSD were: anxiety toward sexual activity and partner's negative reactions (67.6%), fear of sexual abandonment (67.6%), lack of emotional and sexual communication (62.2%), lack of sexual pleasure and satisfaction (60.8%), messages related to sexual guilt or shame (50%), and the absence of sexual fantasies (44.6%).

Similarly, the researchers identified three types of negative thoughts associated with women's HSD. First, women's negative thoughts about themselves were associated with low sexual desire including: physical appearance and body image (44.6%), performance anxiety (33.6%), self-esteem issues and devaluation (21.6%), and preoccupation with other life issues such as work, family, or finances (21.6%). Secondly, women's HSD was also associated with women's negative thoughts about their partners including: partner's obsession with sex (35.1%), absence of intimacy and empathy from partner (27%), partner's sexual inhibitions (17.6%), and feeling pressured and controlled by partner (13.5%). Finally, women's negative thoughts about the relationship were also associated with their HSD including: lack of communication and intimacy (20.3%), lack of commitment (17.6%), and a boring couple lifestyle (13.5%). In addition, women in the

treatment group divulged stories about personal traumas (e.g. sexual victimization) and marital conflicts (e.g. chronic feelings of anger and resentment regarding partner's extramarital affairs) during the therapy sessions that are believed to influence women's sexual desire, although the significance or mechanism was not quantified or specifically investigated. Thus, research by Trudel et al. (2001) suggests that relationship factors are a significant contributor to women's sexual desire concerns. Other researchers have also found a strong association between marital adjustment and frequency of coitus (e.g., Hawton, Gath, & Day, 1994).

Adherence to gender roles is another sociocultural factor that has been shown to influence women's sexual desire. Katz & Farrow (2000) examined the relationship between gender identity, specifically conformity to stereotypical gender role behavior, and sexual adjustment. The researchers used sexual script theory to guide the study. Thus researchers were interested in how women and men behaved in relation to socially proscribed sexual scripts: the notion that men are the initiators and aggressors of sexual activity whereas women are expected to be submissive and passive. The researchers' a priori hypothesis was based on self-verification theory, which says that people whose views, and therefore sexual scripts, differ from gender-based sexual scripts will experience some conflict between their socioculturally proscribed roles and their actual behavior. This conflict may manifest itself in terms of discomfort with sexual interactions, specifically with problems with sexual anxiety and sexual desire.

The researchers used several self-report measures to collect survey data among a group of heterosexual, mostly white (84%) undergraduate college students (n=313, 183 women), including a measure of gender-typed personality traits (the BEM sex role

inventory), a sexual anxiety inventory, and a sexual desire inventory (SDI). Based on their sex-role inventory, participants were classified into categories and a two-by-four analysis of variance (ANOVA) was used to analyze the relationship between sex-role categories and sexual desire and sexual anxiety.

Analyses indicated that women with male-identified personality characteristics, such as aggression and assertiveness, were significantly more likely than androgynous women and women with female-identified personality characteristics, such as passivity, to experience sexual anxiety. Similarly, women with male-identified personality characteristics reported significantly less sexual desire than androgynous women and women with female-identified personalities. Thus, the researchers concluded that women with masculine gender role identities reported significantly more sexual anxiety and less sexual desire than women who identified as either androgynous or with feminine gender role identities. In conclusion, the researchers suggested that women who identified as more feminine may have less anxiety and greater desire because of gender-based sexual scripts that suggest women should be sexually passive. It appears that women's gender identity does in fact influence women's sexual desire.

Research has also demonstrated that life circumstances, such as work and family, affect women's sexual desire. In their study to examine the hormonal and situational correlates of sexual desire (discussed earlier in this chapter), Galyer and colleagues (1999) compared self-reported levels of sexual desire in women (ages 30-65) who had recently undergone a hysterectomy (n=30) to women who had recently undergone a non-gynecological surgery (n=7). In addition to assessing hormone levels, data were collected using surveys with various self-report measures to assess sexual desire, as well

as open-ended questions to collect information about participants' major life events. The study failed to support any relationship between testosterone or other androgens and sexual desire. However a relationship was found between sexual desire and women's life circumstances. Through open-ended questions, participants reported several life events that negatively influenced their sexual desire, including work and family stress, fatigue, and concerns for their relationship. Similarly, quantitative analyses revealed that life circumstances, such as work or money worries and family arguments, were significant predictors of low sexual desire. In contrast, women reported that factors such as having leisure time to spend with their partner and reading or watching romantic entertainment increased their desire for sex. Nonetheless, a majority of the women reported engaging in sexual activity most of the time without sexual desire.

A Feminist Critique of Sociocultural Factors as Influences on Women's Sexual Desire

While most feminists would agree with the notion that women's sexuality, at least to some degree, is socially constructed, research based on social constructionism has still received some feminist criticism when it fails to acknowledge the power of gender to shape one's sexuality. Feminist scholars have noted the patriarchy's role in silencing women's sexual desire (e.g. Fine, 1988). Thus, the study of socially or culturally proscribed sexual roles or expectations that fails to include the power of gender to shape sexual desire receives a great deal of feminist criticism. For instance, girls are socialized during adolescence to experience their sexuality from a male's perspective so that sexual desire is relational for girls as opposed to embodied, for boys (Tolman, 1994). Despite

the fact that the power of gender socialization has been the topic of feminist research on women's sexuality for decades, socioculturally-oriented research often still fails to include gender as a powerful force that influences women's sexual desire.

Fine (1988) discusses girls' and women's sexual agency in her research on sexuality education curricula in New York city public schools. Through interviews with teachers and students, and observations of sexuality education in classrooms, Fine suggests that sexuality education systematically silences girls' discussions of sexual desire and teaches girls to associate their sexuality with danger and victimization. Fine terms this pattern of dismissing girls' agency of their own sexuality "the missing discourse of desire". Fine argues that when issues of desire or sexual interest are presented through sexuality education, the agent of desire is always male. That is, girls' and women's desire is completely absent from sexual activity, behaviors, or intercourse as discussed in sexuality education materials. Girls learn that they have sex done to them, while boys learn to desire and obtain sex. As such, girls learn to be passive in sex, often becoming victims to boys' advances. Fine explains: "...public schooling may actually disable young women in their negotiations as sexual subjects. Trained through and into positions of passivity and victimization, young women are currently educated away from positions of self-interest" (p. 90). Moreover, if girls' sexual desire is mentioned, it is associated with negative consequences, including pregnancy, disease, social stigma, and financial, emotional, and other physical problems.

Like Fine, various French feminists argue that patriarchal systems must silence girls and women, especially in terms of women's own subjective voices about their bodies and sexuality, in order to maintain social control and order (e.g. Cixous, 1981;

Irigaray, 1985). More than ten years after the publication of Fine's work that illustrates the real-world implications for women when their sexual desire is inadequately conceptualized, studied, and understood, Fine maintains that the "missing discourse of desire" is still alive and well (Personal Communication, April 2002).

Vance's work on women's sexual pleasure as related to sexual danger also examines the role of women's sexual agency as an influence on women's sexual desire. Like Fine, Vance (1992) argues that women's sexuality exists in a larger sociocultural context that influences their ability to fully realize that women can be agents of their own sexual desire and sexual pleasure. Vance explains that unlike male sexuality, women's sexuality is fraught with contradictions and dichotomies. For instance, Vance criticizes scholars who focus solely on women's sexual pleasure in discussing women's sexuality as this ignores the patriarchal context in which women live their lives and negotiate their sexual agency. Vance argues that restriction, repression, and danger are unfortunate characteristics of women's sexuality, but to ignore them is to negate the reality of the tension between sexual pleasure and danger in women's lives. Similarly, to focus solely on sexual danger is to ignore women's sexual agency and to reinforce the sexual danger that is a reality for some women. Yet, the tension between sexual pleasure and danger in women's lives is reified through the sociocultural script that women are the gatekeepers of sex with men. Vance explains:

Through a culturally dictated chain of reasoning, women become the moral custodians of male behavior, which they are perceived in instigating and eliciting. Women inherit a substantial task: the management of their own sexual desire and its public expression. Self-control and watchfulness become major and necessary female virtues. As a result, female desire is suspect from its first tingle, questionable until proven safe, and frequently too expensive when evaluated within the larger cultural framework which

poses the question: is it really worth it? When unwanted pregnancy, street harassment, stigma, unemployment, queer-bashing, rape, and arrest are arrayed on the side of caution and inaction, passion often doesn't have a chance (p. 4).

Similarly, Tolman (1994) interviewed thirty adolescent girls to examine the process through which girls learn to silence and stifle their sexual desire. Data were analyzed using a methodology referred to as The Listening Guide, which combines the principles of hermeneutics and feminist standpoint epistemology. Data analysis focuses on listening to the multiple voices and layers of meaning associated with a phenomena. All of the girls in Tolman's study reported feeling conflicted once they became aware of their own sexual desire. Girls described the conflict between their embodied sexual desire and their perceptions of societal expectations of them based on their gender. For instance, the girls perceived their sexual desire as something that could get them into trouble, and therefore separated their bodily experiences of sexual desire from their evaluation of their sexual desire. Tolman suggested that girls begin to feel the internalized oppression of women's bodies through societal forces of social control (such as social stigma or embarrassment associated with sexual activity) during adolescence. In other words, women learn, as girls, to control their sexual desire as part of their gender-role socialization.

Measures to Assess Women's Sexual Desire

Measures Used in Biologically-Oriented Research on Women's Sexual Desire

Biological and medical research on women's sexual desire typically measure women's sexual desire in one of two ways: through physiological response (e.g. vasocongestion, lubrication) or through the assessment of hormone levels believed to be an indicator of sexual desire. There are several standard physiological measures to assess sexual response through laboratory measures. Physiological genital changes, such as vaginal blood flow, in response to visual or auditory sexual stimuli are often used to indicate sexual arousability in terms of genital response. However, it has been noted that genital response is not necessarily a valid indicator of sexual arousal and/or desire since women with sexual desire disorders do not necessarily exhibit problems with physiological genital response in response to erotic stimuli (Bancroft, 1988). Similarly, other measures of arousability such as skin conductance or blood pressure are too non-specific to sexual arousal to be used to indicate sexual desire.

Researchers interested in the relationship between hormones and sexual desire typically focus on assessing testosterone levels, since it is the most potent androgen. Specifically, free testosterone is the hormonal component most often assessed in studies on sexual desire since unbound testosterone is the form of this hormone available to elicit biological changes elsewhere in the body (Regan, 1999). Numerous hormonal assays exist to measure free testosterone through various bodily fluids via various data collection methods. These methods are extensive and have been reviewed elsewhere (Davis, 1999, 2000).

A Feminist Critique of Biological Measures of Women's Sexual Desire

Researchers who use the biomedical model to study women's sexual desire often employ biological measures since these are often viewed as more "objective" and therefore more scientific (Tiefer, 1995). For instance, researchers who study the relationship between circulating hormone levels (estradiol and androgens) and sexual desire have assessed hormone levels via radioimmunoassay tests on women's blood samples (e.g. McCoy, 1992). In addition to assuming that women's endocrinology is causally related to their sexuality, the epistemological flaw in this approach is the notion that the hormonal measure employed is valid and accurate. In fact, researchers report a large degree of variation in circulating hormone levels among women over time and with regards to varying circumstances (Voda, 1997). As a result, a one-time measure of a woman's circulating estradiol levels is not necessarily indicative of her estrogen secretion. Similarly, it has been demonstrated that hormone levels change constantly over the course of a day as well as in response to external events (e.g. stress) that are not accounted for by hormonal assays (e.g. Voda, 1992). Moreover, there are measurement problems associated with specific types of hormones. For instance, testosterone that is bound to albumin is likely to dissociate into free testosterone, even temporarily, because the bond between testosterone and albumin is not as strong as the bond between testosterone and SHBG. Thus, measures of free testosterone have been characterized as unreliable by many researchers (Petak, Baskin, Bergman, Dickey, & Nankin, 1998; Winters, Kelley, Goodpaster, 1998). Biological measures of sexual desire are not only methodologically flawed, but they also assume that sexual desire is a phenomenon

located within the individual, and that the individual is in essence solely her biology. As discussed earlier in this chapter, the epistemological assumption that women's sexuality is dependent on their biology has larger sociopolitical implications for women, including the medicalization of sexuality and unnecessary and often unsafe pharmacological interventions.

Measures Used in Sociocultural Research on Women's Sexual Desire

Sociocultural research on sexual desire typically measures sexual desire via self-report, either through psychometric scales, interviews, or sexual diaries. Typically, these measures ask women to assess either their frequency or intensity of sexual desire (Galyer et al, 1999). Other researchers ask women about their sexual interest as a measure of sexual desire, with regards to frequency, level, degree, or amount of sexual interest. Still other researchers use motivationally-oriented terms such as sexual motivation, sexual drives, urges, cravings, or appetite to assess sexual desire (Regan, 1999). In addition, measures of sexual desire often include the assessment of sexual behavior or activity. Finally, some researchers focus more on cognitive aspects of sexual desire such as sexual wishes, thoughts, fantasies, or sexual imagery (e.g. Sherwin, 1985). However, there are several possible confounds for assessing sexual desire through these measures.

For instance, measures of sexual desire based on frequency or interest in sexual activity often do not account for issues of partner availability or for individuals who experience sexual desire but choose not to engage in sexual activity (King & Allgeier, 2000). Several researchers have demonstrated that it is fairly common for women to

engage in sexual activity without sexual desire, thus indicating that sexual activity is not a valid measure for sexual desire (e.g. Beck, Bozman, & Qualtrough, 1991; Galyer, 1999; Hurlbert, Apt, Hurlbert, Pierce, 2000). Measures that attempt to assess sexual desire as a cognitive phenomenon (e.g. “How often do you experience sexual desire”) using a single item Likert scale measurement over-simplify the complex nature of sexual desire. That is, sexual desire is not unidimensional and therefore cannot be measured by one item. Finally, researchers have demonstrated that sexual motivation is a discrete concept from sexual desire, thus motivational aspects of sexual desire, such as sexual interest, are likely confounded (King & Allgeier, 2000). In sum, ambiguity in the conceptualization of sexual desire, measures that attempt to assess sexual desire based on cognitive aspects of sexual desire (e.g. fantasy) or motivational aspects of sexual desire (e.g. interest), have received a great deal of methodological criticism. For instance, Davis et al. (1998) explain: “To date, sexologists have had difficulty measuring this [sexual desire] construct. Previous measurement of sexual desire involved either indirect measurement through examining frequency of sexual behavior or broad self-report cognitions such as “rate your sexual desire”. Both these methods are *less accurate* measures of sexual desire because first, sexual desire is theoretically a multidimensional construct, and second, no empirical data are perfectly correlated” (emphasis mine, p. 174). Unfortunately, Davis never provided recommendations for *more accurate* measures of sexual desire. However, other researchers have developed specific scales in an attempt to better measure sexual desire.

There are three scales designed specifically to measure sexual desire: The Sexual Desire Inventory (SDI), the Hurlbert Index of Sexual Desire (HISD), and the Sexual

Desire Questionnaire. The Sexual Desire Inventory (Spector, Carey, Steinberg, 1996) is the most often used scale to assess sexual desire. In fact, researchers have demonstrated the psychometric properties of this scale in a wide variety of populations including in general and clinical populations, as well as college students (e.g. King & Allgeier, 2000), residents of geriatric long-term care facilities (e.g. Spector & Fremeth, 1996), and individuals and couples of all ages (Spector & Davies, 1995). The researchers who developed the scale have described its development and psychometric properties extensively.

Based on ambiguity in the literature regarding the meaning of the term ‘sexual desire’ and associated problems with measurement of the concept, the researchers’ first step in developing a scale to assess sexual desire was to define the construct ‘sexual desire’. The researchers explain: “Sexual desire refers to interest in sexual activity. It is primarily a cognitive variable, which can be measured through the amount and strength of thought directed toward approaching or being responsive to sexual stimuli. Sexual desire is not a behavior ... Rather, desire involves thoughts that may motivate an individual to seek out or be receptive to sexual opportunities” (pp. 178-9).

Using this working definition of sexual desire, the researchers initially developed the eleven items of the SDI based on various theoretical models of sexual response as well as with the help of clinical sexologists who had experience treating sexual desire concerns. These eleven items were then pilot tested (n=20) and rated for clarity and content validity by professionals in the field. Each item asks participants to recall their interest in or wish for sexual activity within the last month and rate their response using an 8-point Likert scale. Questions elicit information about the following aspects of

sexual desire: interest in dyadic sexual behavior (e.g. desired frequency of intercourse), interest in individual sexual behavior (e.g. desired frequency of masturbation), cognitive processes (e.g. fantasies), and the importance of sexual needs. The items were pilot tested in a group of college students (n=300) in order to perform a factor analysis. Items loaded on two factors: dyadic (i.e. intercourse) sexual desire and solitary sexual desire. Each factor had an eigenvalue greater than one and internal consistency was established using Cronbach's alpha (Dyadic scale, $r=0.86$; Solitary scale, $r=0.96$). Test-retest reliability was established after one month ($r=0.76$). In addition, concurrent validity analyses revealed that solitary sexual desire is correlated with frequency of solitary sexual behavior ($r=0.80$, $p<0.0001$) and dyadic desire is correlated with the frequency of dyadic sexual behavior ($r=0.34$, $p<0.0001$). More recently, King & Allgeier (2000) confirmed the concurrent validity of the SDI among a study of 90 college students, many of who were sexually inexperienced. King & Allgeier found that the SDI is not confounded with consummatory behavior, indicating that the items accurately assess sexual desire without assuming previous sexual activity.

Spector, Carey, & Steinberg suggest that the two discrete factors, dyadic and solitary sexual desire, suggest that the nature of sexual desire may differ when expressed individually versus with a partner: "Perhaps interest in using erotic materials and masturbation represent one aspect of sexual desire: interest in behaving sexually by oneself (or solitary sexual desire). It is possible that expression of solitary sexual desire serves a different purpose (e.g. tension release) than expression of desire to behave sexually with another person (or dyadic sexual desire). Dyadic behaviors may allow one to feel emotional as well as physical intimacy. Solitary desire may be more physical in

nature and allow a person to focus on his or her own sexual needs and wishes without attending to those of a partner” (p.182).

The second scale developed to assess sexual desire, the Hurlbert Index of Sexual Desire (HSID), has not been tested as much as the SDI, and thus, the psychometric properties are not as well established. The HSID was initially developed in 1988 but was not used in any published research until 1992, when it was used to assess women’s sexual desire one year postpartum (Apt & Hurlbert, 1992). The HSID consists of 25 items that ask participants to rate how often they engage in a variety of indicators of sexual desire using a 5-point Likert scale (e.g. “all of the time” to “never”). Items include cognitive aspects of sexual desire (e.g. thinking about or daydreaming about sex), libido (e.g. appetite for sex), and frequency of sexual desire (e.g. “It is easy for me to go weeks without wanting to have sex with my partner”). However, with the exception of questions related to sexual fantasy, all of the items refer to sexual desire in terms of engaging in sexual behavior with a partner. The scale does not contain any references to solitary sexual behavior (e.g. masturbation) and several of the items require that the respondent have a partner to answer the question (e.g. “I desire sex more than my partner does”; “I feel that sex is not an important aspect of the relationship I share with my partner”). Thus, the HSID may not be useful in assessing the sexual desire of women without a partner.

Finally, the Sexual Desire Questionnaire, developed by Beck, Bozmn, & Qualtrough (1991) is another instrument developed specifically to measure sexual desire, although it has not been used extensively and thus the psychometric properties of the instrument are not known. The Sexual Desire Questionnaire (SDQ) was developed by

Beck and colleagues because of the ambiguity in definitions and lack of agreement as to how to assess sexual desire. The questionnaire is based on Leiblum & Rosen's (1988) definition of sexual desire: "a subjective feeling state that may be triggered by both internal and external cues, and that may or may not result in overt sexual behavior" (p.5). Thus, several aspects of sexual desire are included in the SDQ including: the frequency of desire, the frequency of sexual activity with high levels of sexual desire, the frequency with which sexual desire but not sexual activity are experienced, and ways that individuals gauge their own level of sexual desire. Items on the questionnaire are written in a forced-choice format with Likert-scale responses. Additionally, several open-ended questions were included in the questionnaire.

The instrument was tested in a group of college students (n=144, 60% women) of varying ages (mean=26.9, SD=7.5 years) and varying ethnicities (85% white, 7% black, 5% Mexican-American, 1% Asian-American). Results indicate that a majority of women (82%), regardless of age, reported engaging in sexual activity without experiencing sexual desire. In addition, women indicated that the best index of sexual desire for them was using indicators such as genital arousal, intercourse, and sexual daydreams. Additional information about the nature of sexual desire as measured through this instrument is not available. Statistical analyses, including psychometric properties of the instrument, were not performed, although it is not clear why. Thus, the SDQ does not appear to be especially helpful in assuaging ambiguity in the definition and measurement of sexual desire.

A Feminist Critique of Sociocultural Measures of Women's Sexual Desire

While feminist researchers and scholars are more accepting of sociocultural measures of women's sexual desire as compared to purely biological measures, issues of context and women's lived experience of sexual desire are often still absent when sexual desire is assessed via surveys, sexual diaries, and other self-report measures. Specifically, feminists note that scales, especially those without open-ended questions, fail to give women a voice and sexual agency. That is, such surveys force women's responses to be represented by a numerical value, which is stripped of its context and meaning (Bleier, 1984, 1986, Harding, 1987). For instance, development of the Sexual Desire Inventory (Spector, Carey, Steinberg, 1996) included feedback from professionals working in the field of sexology, but not from actual women. Thus, women's voices and experiences may not be reflected in the items used to assess women's sexual desire. Open-ended questions, especially questions that ask women to elaborate on the social and political realities that shape their lived experiences of sexual desire, not only represent women's sexual desire from a woman's perspective, but also serve to reinforce women's sexual agency (Fine, 1988).

Women's Sexual Desire During Midlife and Menopause

Menopause is characterized by a variety of changes that occur in a woman's body. Both biological factors, such as hormone levels, and sociocultural changes, such as the negative stereotypes associated with being an older woman in this culture, affect a woman's sexuality during midlife and menopause. Many women experience changes in their level of sexual desire during the menopausal transition, and most research indicates

that this change is that of decreased sexual desire (The Boston Women's Health Book Collective, 1998; Mansfield et. al, 1998; Mansfield et al, 1995; Leiblum, 1990). Most often, research on menopausal women's sexual desire changes has focused on fluctuations in hormone levels. However, since sexual desire is a multidimensional construct, other researchers have studied women's changes in sexual desire from a broader perspective, including the effects of aging as they relate to midlife women's sexuality changes. This section of this chapter will review the literature on menopausal women's sexual desire changes from a biomedical perspective, which typically focuses on hormones and other physiological changes, as well as from a sociocultural perspective, including sociopolitical meanings associated with aging for women in Western culture.

Biomedical Research on Women's Sexual Desire During Menopause

The dominant, biomedical paradigm for conceptualizing the study of women's sexuality views biological factors as solely responsible for determining sexual desire. Specifically, declines in sexual desire are perceived to be the direct or indirect result of deficient levels of estrogen (Bottiglioni & DeAloysio, 1982; Hallstrom, 1977; Hallstrom & Samelson, 1990; McCoy, 1992). As women approach menopause, the number of maturing follicles from the ovary decreases, and the ovaries are less sensitive to pituitary hormones (FSH & LH) that direct the production of estrogen (Hatcher et al., 1998). Although estrogen is produced elsewhere in the body (via the conversion of androgens in the limbic system) circulating levels of estrogen in a perimenopausal or postmenopausal

woman are significantly lower than in their younger counterparts (Sherwin, 1991; Voda, 1997).

Low levels of estrogen have been directly associated with several physiological processes that accompany sexual desire in women, including decreased vaginal lubrication, decreased vasoconstriction in the genitals, and decreased sensory perception (Bottiglioni & DeAloysio, 1982; Hallstrom, 1977; Hallstrom & Samelson, 1990; McCoy, 1992; Sarrel, 2000; Sherwin, 1991). For instance, because estrogen is responsible for maintaining elasticity in genitourinary tissues (Voda, 1997) as well as maintaining blood flow in vascular structures (Sherwin, 1991), decreased estrogen levels are thought to decrease the vagina's ability to produce lubrication and to maintain adequate levels of vasocongestion necessary for orgasm (Kinsey, Pomeroy, Martin, & Gebhard, 1953; McCoy, 1992; Sherwin, 1991). Similarly, research has demonstrated an association between decreased estrogen levels and decreased sense perception, specifically with regards to touch (Sarrel, 2000).

Other researchers speculate that there is an association between decreased estrogen levels and sexual desire, but that the relationship is indirect (Bachmann, 1990; Leiblum, 2002; McCoy, Cutler, Davidson, 1985; McCoy, 1992). Perhaps the best example of this point is the relationship between hot flashes and sexual desire. Hot flashes, the most commonly reported menopausal symptom, are thought to result from decreased estrogen levels. Voda (1992) explains: "as estrogen levels decrease, the fine tuning of the temperature-regulating mechanism in the brain and/or peripheral blood vessels is altered. Blood vessels that normally would open and close (dilate, constrict) when presented with an appropriate internal or external stimulus, ... no longer fine

tune”(p. 173). Women who experience hot flashes often report decreases in sexual responsivity and desire. This relationship may be due to secondary effects of hot flashes, such as tiredness as a result of hot flash related sleep disturbances (McCoy, Cutler, & Davidson, 1985).

Another example of the indirect effects of estrogen on women’s sexual desire is that of decreased vaginal lubrication. Women who experience decreased vaginal lubrication may avoid sexual interactions for fear of experiencing pain during intercourse (dyspareunia) (Bachman, 1990; McCoy, 1992). More recently, Dennerstein and colleagues (2003) studied women across the menopausal transition over an eight-year period to study the relationship between estrogen and decreased sexual desire. Dennerstein et al. found that the only hormone related to decreased sexual desire was estradiol (Dennerstein, Dudley, & Guthrie, 2003).

In addition to studying estrogen’s effects on women’s sexuality, researchers have also examined the relationship between androgen levels and women’s sexual desire. Some researchers have demonstrated a causal relationship between testosterone and sex drive in women (Dow, Hart, & Forrest, 1983; Leiblum, Bachmann, Kemmann, Colburn, & Swartzman, 1983; Sanders & Bancroft, 1982). There is some evidence that women in the menopausal transition secrete substantially less testosterone than in their premenopausal years. For instance, some research suggests that only about 50% of postmenopausal women continue to secrete testosterone from the ovary and that the concentrations produced are significantly lower than in pre-menopausal women (Longcope, Hunter, & Franz, 1980; Lucisano, Acampora, Russo, Maniccia, Montemurro, & Dell’Acquia, 1984).

However, more recent research suggests that menopause may not have such a significant effect on testosterone levels as was once believed. Levine (1998) explains that premenopausal women generate most (approximately fifty percent) of their total testosterone from the peripheral conversion of steroids into testosterone, while about twenty-five percent of testosterone is produced in the ovaries. Thus, while ovarian testosterone production does decrease during menopause, the overall effect is not drastic since the majority of testosterone is produced elsewhere in the body. Moreover, recent research has demonstrated that testosterone production begins to decline in women's mid-twenties and steadily decreases thereafter, thus repudiating the notion that the menopausal transition is characterized by dramatic changes in levels of androgens (Davis, 1999, 2000.).

Thus, contrary to some researchers claims that there is an association between decreased androgenic hormone levels during menopause and sexual desire, other researchers have found no association between changing levels of testosterone during the menopausal transition and women's decreased sexual desire (e.g. Leiblum, 1990). Moreover, Burger and colleagues have noted that the amount of bioavailable testosterone actually increases as women pass through the menopausal transition, thus suggesting that the hypothesis that testosterone is responsible for diminished sexual desire is unlikely (Burger, Dudley, Cui, Dennerstein, & Hooper, 2000).

Another area of research involving menopausal women that often relates to changing sexual response, including sexual desire, includes research on hormone replacement therapy (HRT). Ever since HRT became popular, an increasing number of researchers have focused on the relationship between HRT, in its various forms, and

women's sexuality changes. In a meta-analysis of sexuality and menopause research, Myers (1995) examined the relationship between hormones and sexuality among perimenopausal and postmenopausal women enrolled in thirty-three empirical studies from 1972 to 1995. Statistical relationships between hormones and various sexuality measures (e.g. frequency of masturbation/intercourse/orgasm, sexual satisfaction, levels of sexual desire/libido) were converted to effect size (i.e. assigned numerical weights) in order to compare differences in terms of standard deviation units. Myers found that hormones do appear to play a role in postmenopausal sexuality, although the amount of variance in sexuality changes that hormones account for is very small (e.g. 7%).

In addition to research that examines the hormonal influences on sexual desire changes during the menopausal transition, biomedical research also considers the effects of physiological aging on midlife women's sexual desire. Some research has attempted to disentangle the effects of aging and menopause on sexuality changes. For instance, Hallstrom (1977) used a cross-sectional study, with a sample stratified by age (as opposed to age groups) to control for age as a confounding factor of menopausal status to examine sexuality changes. At each age, participants were separated into groups based on their menopausal status (pre, peri, and postmenopausal) to compare changes in self-reported sexuality changes. When age was controlled for, the relationship between menopausal status and decreased sexual function was significant. However, when menopausal status was held constant, the relationship between age and sexual functioning was not significant, suggesting that menopause contributes to changes in sexual functioning independently of age. Similarly, other cross-sectional studies have also found that menopausal status independently affects sexuality measures (e.g. Pfeiffer,

Verwoerdt, & Davis, 1972; Hunter, Battersby, & Whitehead, 1986; Dennerstein, Smith, Morse, & Burger, 1994). However, other researchers have documented conflicting results, notably that independent of age, menopausal status has no effect on sexuality changes (e.g. Hawton, Gathy, & Day, 1994; Mansfield, Voda, & Koch, 1995).

More recently, Dennerstein and colleagues designed a methodologically savvy study to assuredly determine the possible confounding effects of menopause and aging on sexuality changes. A longitudinal Australian health project, The Melbourne Women's Midlife Health Project, by Dennerstein and colleagues (1994, 1997, 1999, 2000, 2001), has published a good deal of research on the topic of sexuality changes during the menopausal transition in an effort to disentangle confounding factors, like aging, from menopausally-related changes in sexual desire. This research project has also focused on modeling various contributions, such as hormones and psychosocial factors, on women's midlife and menopausal sexuality changes. Much of this work has included sexual desire, although Dennerstein and colleagues conceptualize this construct as libido.

The Melbourne Women's Midlife Health Project was initially started in 1991 by enrolling willing participants (women ages 45-55, mean age= 48.5, 86% married, n=438) who were currently menstruating and not using exogenous hormones, using random telephone digit dialing. Menopausal status was determined based on women's self-reported menstrual patterns during an annual interview. Women were considered premenopausal if they reported no change in menstrual frequency or pattern. Women who had reported a change in menstrual frequency, but who were still menstruating were said to be early perimenopausal. Women were considered to be late perimenopausal if they reported more than 3 but less than 12 months of amenorrhea. Finally, women who

had not menstruated for 12 or more months were considered to be postmenopausal (Dennerstein, Dudley, & Burger, 2001). At baseline, initial demographic, health, and sexuality information (including libido) was collected via questionnaire during an interview. At follow-up eight years later, the questionnaire was re-administered to women who had not experienced surgical menopause and had not used exogenous hormones since enrollment in the study (n=197). Two control groups, premenopausal and postmenopausal, were formed of women who did not experience a change in menopausal status between baseline and follow-up. These groups were designed to control for the effect of menopausal status on sexuality changes that may be age-related. Next, women who had experienced a change in their menopausal status over the duration of the study were assigned to one of three groups based on their current menopausal status: "Pre" (premenopausal and early perimenopausal combined), 'Lperi' (late perimenopausal), and 'Post' (postmenopausal). T-tests were used to compare mean scores on various sexuality measures for each of the groups, including the controls. Analyses indicated that various aspects of women's sexuality were affected differently depending on the stage of menopausal transition (Dennerstein, Dudley, & Burger, 2001). The only significant (negative) change in libido was found between late perimenopause and postmenopause ($P < 0.01$). There was no change in libido in the control groups. Based on other research findings by the same researchers (Dennerstein, Lehert, Burger, & Dudley, 1999) indicating the role of hormones in maintaining vaginal tissue integrity, the researchers suggest that significant changes in libido in solely postmenopausal women may be due to the significant increase in vaginal dyspareunia during this stage of menopause.

Other findings by this team of researchers (Dennerstein, Dudley, Hopper, & Burger, 1997) suggest that hormone levels may be indirectly responsible for changes in libido during the later stages of menopause. Using structural equation modeling to test the effects of hormones on sexuality measures such as libido, assessed through hormonal assays (tested after fasting via blood measures), the researchers found no direct effect of hormone levels on sexuality changes. However, the researchers did find a significant relationship between the number and frequency of menopausal symptoms and libido. Thus, the researchers suggest that the effect of hormones on libido is indirect; hormonal changes cause menopausal symptoms (e.g. hot flashes, vaginal dryness), which in turn affect libido (Dennerstein, Dudley, Hopper, Guthrie, Burger, 2000). Thus, research suggests that hormonal fluctuations, whether age-related or associated with the menopausal transition, influence changes in women's sexual desire.

A Feminist Critique of Biomedical Research on Women's Sexual Desire Associated with Menopause

Feminist scholars and researchers have critiqued the dominant conceptualization of midlife women's sexuality changes as reductionistic and disease-centered (McCormick, 1994; Mansfield, Koch, & Voda, 1998, 2000; Tiefer, 1995). In this view, sexuality changes that occur during the menopausal transition are attributed to women's decreasing hormone levels, specifically estrogen and progesterone (Voda & George, 1986). Researchers who adopt a biomedical, disease-oriented perspective of sexuality have described menopausal women's sexuality primarily in regards to negative changes, referring to their sexual desire as "deficient" and their vaginas as "atrophied" (McCoy,

1992) or “stiff and unyielding” (Delaney et al. 1988). Sherwin (1991) is a good example of this perspective:

Because the integrity of the tissues of the female reproductive tract is dependent on estrogen, degenerative changes in these structures ensue when levels of estrogen decrease after the menopause. The vaginal epithelium of postmenopausal women who do not receive estrogen therapy becomes attenuated and appears pale due to a decrease in vascularity. Marked atrophic changes may result in atrophic vaginitis. In this condition, the vaginal epithelium is very thin and may become inflamed or even ulcerated. These changes, in turn, may lead to severe diminution in vaginal lubrication and/or dyspareunia (p.184).

Previous research documenting menopausal women’s sexuality changes typically describes a wide variety of women’s sexuality changes as negative, focusing on declines in vaginal lubrication, the frequency of orgasm, intercourse, sexual fantasies, and lessened sexual desire and sexual satisfaction with a partner (Hallstrom, 1977; Bottiglioni & DeAloysio, 1982; McCoy & Davidson, 1985; Cole, 1988; Hallstrom & Samelsson, 1990). Feminist scholars, researchers, and practitioners have criticized this perspective because it ignores the larger sociocultural, political and relational factors that affect women’s lives (Daniluk, 1999; McCormick, 1994; Tiefer, 1995). In addition, this disease-oriented perspective posits a midlife woman as deficient, thus creating the need for medical and pharmacological intervention, typically via hormone replacement therapy (The Boston Women’s Health Book Collective, 1998, Rostosky & Travis, 2000).

As a result of the negative side effects associated with HRT, researchers are examining alternatives to HRT for menopausal women. Recently, Tibolone, a pharmaceutical that is prescribed to menopausal women in almost 100 countries abroad, has received a great deal of attention as a viable alternative to HRT (Speroff & Clarkson,

2003). Tibolone was developed in the 1960s to treat osteoporosis, although it has been used to treat menopausal symptoms such as hot flashes, decreased libido, vaginal dryness, and mood changes for decades in other countries. Approval by the Food and Drug Administration (FDA) in the United States is currently pending.

It is important to note that the exact mechanism of action of Tibolone is not fully understood. While there have been some studies on humans, a majority of the research on Tibolone and its effects is based on surgically postmenopausal cynomolgus monkeys. In fact, the most recent review of Tibolone's side effects, chemical properties, and mechanism of action in terms of an alternative to HRT was co-authored by a doctor of veterinary medicine (Speroff & Clarkson, 2003). Thus, it is notable that the safety of Tibolone has not yet been established in *women*. However, it is necessary to review what is known about Tibolone and what remains to be demonstrated about this drug's effects on women's health.

The exact mechanisms of Tibolone are not fully understood, especially since the drug exerts different actions at various sites in the body. It seems as if the drug has both estrogenic and androgenic effects on tissues (Speroff & Clarkson, 2003). For instance, Tibolone causes a decrease in the concentration of testosterone, but an increase in the amount of unbound (free) testosterone. Thus, the androgenic effects of Tibolone appear to include an increase in libido, arousal, and orgasm. However, Tibolone exerts estrogenic effects on the vagina, relieving vaginal dryness and dysparenia.

Researchers suggest that Tibolone's side effects are at worst benign, and in fact are often helpful. For instance, Tibolone has not been shown to cause endometrial proliferation or changes in the density of breast tissue. Similarly, it is believed that

Tibolone has a protective effect on bone mineral density, and in fact Tibolone was originally developed to prevent osteoporosis.

The effects on cardiovascular risk factors, such as cholesterol, are not yet well established. Some data suggest that Tibolone reduces HDL levels about 20% even two years after all treatment has ceased, which is problematic given the protective effects of HDL. Despite the potentially harmful effects of an extended decrease in “good” cholesterol, proponents of Tibolone suggest it is perfectly harmless: “Results in the monkey model are consistent with an overall neutral impact on the cardiovascular system. A long-term (average of 7.5 years) follow-up of women treated with Tibolone found no increase in carotid artery ... thickness and the number of atherosclerotic plaques, results that are consistent with the monkey data” (Speroff & Clarkson, 2003, p. 56). Speroff & Clarkson conclude their review of Tibolone by stating: “Tibolone is an appropriate choice for hormonal therapy, suitable for most postmenopausal women” (p.59). Clearly, there is still much to be learned about Tibolone, especially with regards to its long-term side effects on women. However, it is anticipated that the FDA will quickly approve the drug and it will likely be marketed to women as a safe, viable alternative to HRT, although research does not support its efficacy or safety.

Furthermore, the fact that women are distinct from one another based on race/ethnicity, sexual orientation, gender, geographical location, class, and/or educational status goes unnoticed by research findings that generalize study results to all women. Moreover, political implications of research that ignores dissimilarities between people of varying backgrounds legitimates power disparities. That is, researchers who fail to acknowledge the social and political implications of their research findings reinforce

classist, racist, sexist, ableist, and heterosexist assumptions (Zalk & Gordon-Kelter, 1992). Researchers who study women's midlife sexuality changes from a biomedical perspective are especially likely to over-generalize research findings and ignore the social/political implications of their findings because their assumption is that biological factors are objective and therefore neutral.

For example, researchers who collect biological data (e.g. hormone samples) among a select group of women and who fail to acknowledge variations in hormone levels, both between and within women, significantly limit the generalizability of their results. However, biomedical researchers often assume that hormonal changes are universal among women, and therefore, sexuality changes (that are assumed to be determined by women's endocrinology) are also universal. Typically, research findings are then communicated to women via their health care practitioners or media messages and women's decreasing sexual response during midlife becomes a self-fulfilling phenomenon (Daniluk, 1999; Tiefer, 2002). Some research suggests that women's main source of information about menopause is from their physicians, and women often report that they are not satisfied with the information they get from their doctors (Jones, 1994). In contrast, other research has demonstrated that physicians are not a source of menopausal information for women (Mansfield, & Voda, 1994). Feminists have suggested that researchers' failure to contextualize their findings with regards to the limitations of their guiding epistemology, research design and methodology contributes to women's dependency on external structures (i.e. the medical system) for information about their own bodily experiences (Schiebinger, 1999; The Boston Women's Health Book Collective, 1998). Said another way, when researchers establish biomedical ways

of knowing as objective, universal, and/or neutral, women's ways of knowing and interpreting their own experiences are devalued (Daniluk, 1999).

Sociocultural Research on Women's Sexual Desire During Menopause

In contrast to research that examines the direct and indirect physiological effects associated with decreased hormone levels, other researchers have focused on the influence of sociocultural factors and life circumstances on menopausal women's sexual desire (e.g. Bachmann et al., 1985; Conway-Turner, 1992; Mansfield, Voda, & Koch, 1995, 2000; Mansfield, Koch, & Voda, 1998). Researchers adopting a biopsychosocial perspective to study women's experience of sexuality changes during menopause have examined the context in which women experience menopause and behave sexually as sociocultural factors that either directly or indirectly influence women's sexual desire. For instance, some research suggests that the cultural context in which women age and the sociocultural perspective of menopause have ramifications for how women experience menopause.

The medicalization of menopause, the notion that menopause is a hormone-deficiency disease that requires hormonal treatment, has been shown to influence women's personal attitudes towards menopause such that women often have negative expectations even before entering the menopausal transition (Bell, 1990). Similarly, Gannon and Stevens (1998) found that women's beliefs about menopause influenced their menopausal experience. Women with negative attitudes towards menopause experienced more menopausal symptoms, primarily depression and fatigue. Furthermore,

Olofsson & Collins (2000) found that women's attitudes toward menopause and women's perceived attitudes of society towards aging women were significantly associated with increased physical and psychological menopausal symptoms. Interestingly, postmenopausal women often report that their experience of menopause and of aging in general is not as negative for them as they had expected based on sociocultural influences (Gannon & Ekstrom, 1993). Further evidence of the role of sociocultural factors on women's experience of the menopausal transition comes from cross-cultural studies. For instance, cross-cultural research comparing Japanese and American women shows significant differences in menopausal symptoms, with Japanese women reporting fewer symptoms. Researchers speculate that such differences may be due to cultural factors, such as lifestyle, that differ between the countries (Avis, Kaufert, Lock, McKinlay & Vass, 1993).

Recently, Olofsson & Collins (2000) studied the relationship between psychosocial factors, attitude towards menopause, and menopausal symptoms, including changes in sexual desire, in Swedish women in varying stages of the menopausal transition. The study, part of a population-based longitudinal study, used a cross-section of data of 53-year old women, all in varying stages of menopause (27% of the women were perimenopausal, 15% were postmenopausal, and 52% were taking HRT). Most (78%) women were married, most (94%) had children, and almost one-third (30%) of the women had a college education. In addition to health data that were collected annually as part of the larger longitudinal research project, women were also interviewed regarding a variety of psychosocial factors, including life stress, work roles, lifestyle characteristics. The interview was also designed to collect information about their experience of

menopause, including menopausal status, attitude towards menopause, and perceptions about menopause. They also completed several scales to rate menopausal symptoms and to record the possible use of HRT. The symptom scale, that included 67 items designed to measure both physical and psychological menopausal symptoms, used a Likert-scale response system with four possible options to indicate the degree of the symptom (“not at all” to “extremely”). Qualitative analysis of the interview data revealed three types of attitudes towards menopause: positive (51%), negative (24%), and neutral (25%). Next, quantitative analyses compared symptoms between women based on menopausal status (perimenopausal, postmenopausal, and HRT). ANOVA demonstrated only one significant difference in symptoms across groups: postmenopausal women had significantly more vasomotor symptoms ($p < 0.0001$). There were no other differences in physical or psychological correlates of sexual desire between menopausal groups.

Finally, the researchers performed a multiple stepwise regression of symptoms by various background factors including: education, occupation, relationship with partner, menopausal status, somatic health, perception of work role, smoking, use of HRT and other medications, physical exercise, life stress, stress at work, satisfaction with work, attitude towards menopause, and perceived attitude of others towards women and aging/menopause. The researchers found that increased sexual desire was significantly associated with physical activity (some form of physical exercise at least once a week). Interestingly, HRT was not found to have any significant effect on any symptoms other than vasomotor symptoms, suggesting that HRT had no relationship to sexual desire among women enrolled in this study.

In another recent study, also part of a larger, longitudinal research project, Avis and colleagues examined various contributions, including health, psychosocial characteristics, and partner attributes, and menopausal status, on women's sexuality changes (Avis, Stellato, Crawford, Johannes, & Longcope, 2000). The Massachusetts Women's Health Study, a random, population-based study begun in 1982, collects data on sexual functioning, various lifestyle and health factors, social and psychological adjustment data, as well as biomedical measures (e.g. levels of estradiol). This particular aspect of the study began in 1986, and subsequent data collection occurred for all aspects of health, psychological and social status with the exception of sexual functioning yearly until 1991. Women who used HRT, who had experienced surgical menopause, or who lacked a sexual partner were excluded from the study. These selection criteria resulted in a final sample of women (n=200), ages 51-61 (mean age=54), most (89.5%) of whom were married and were in various stages of the menopausal transition. A third of the sample was premenopausal, a quarter of the sample was perimenopausal, and the remainder of the sample was postmenopausal.

Unlike the health and psychosocial/lifestyle data, sexuality data were only collected once, during the second year of follow-up via questionnaire. The researchers developed the Sexual Activity Questionnaire (SAQ) based on questions used for the Massachusetts Male Aging Study, which included 23 ordinally scaled items about various aspects of sexual functioning. A factor analysis and Cronbach's alpha were used to distinguish seven discrete aspects of sexuality including: satisfaction with current sexual relationship, sexual desire (frequency of desire and frequency of psychological correlates of desire like fantasy and sexual thoughts), frequency of sexual activity, agreement with

the belief that interest in sex declines with age, current level of arousal, difficulty reaching orgasm, and pain in the pelvis. The researchers used a variety of regression models to assess the predictive value of various factors on these seven aspects of sexuality. The most consistent predictors of sexual activity were women's health and marital status. Specifically, women in better health (measured through self-report) reported greater sexual satisfaction and more frequent sexual activity. Married women had lower levels of sexual desire and reported more agreement with the belief that sexual interest declines with age than non-married women.

Other factors also were related to sexual desire. Women with symptoms that indicated depression had lower desire, as did women who smoked. Finally, menopausal status was related to sexual desire, although different regression models revealed contradictory results. In an unadjusted regression, sexual desire was lower in postmenopausal women ($p < 0.05$). However, in results of multiple regression models that included other covariates, such as health and marital status, sexual desire was lowest among perimenopausal women, although this result was not statistically significant. Thus, the researchers conclude that other factors, including lifestyle and health characteristics, have more of an effect on sexual desire than does menopausal status.

One sociocultural factor that has been well researched in relation to its effect on women's experience of menopause and sexuality changes is that of women's intimate relationships. Researchers have studied women's marital relationships and other life circumstances that affect women's lives, and thereby, their sexual experiences. Bachmann et al. (1985) found a positive correlation between desire and marital adjustment, suggesting that women's relationships with their husbands affect their sexual

desire. The researchers used a clinical sample of postmenopausal women (n=22, all white, mean age = 55.3 years) to collect survey data on women's medical history, nutritional status, exercise habits, and sexuality information, including scales on sexual desire and sexual activity. In addition, the researchers used blood samples from the participants to assess levels of estradiol, testosterone, FSH, and LH. Women enrolled in this study who reported decreases in sexual desire attributed their sexual changes to partner unavailability, lack of privacy or time, and/or marital conflict. Moreover, Bachmann and colleagues found no relationship between decreased sexual desire and hormone levels. Other researchers also have found an association between marital satisfaction and sexual desire, and that marital satisfaction is positively correlated with sexual desire (e.g. Brezsnjak, 2002; McCarthy, 1990).

Mansfield, Voda, & Koch (1995) found that being married was a predictor of decreased sexual desire, although they found no relationship between menopausal status and sexual desire. The researchers used participants from the Midlife Women's Health Survey (MWHS) to investigate predictors of women's sexual response. The researchers have described the demographics of their participants and sampling methods at length elsewhere (e.g. Mansfield, Voda, & Koch, 1995), although certain sample characteristics are worth noting here. Women were excluded from the analyses if they were using exogenous hormones, if they were postmenopausal, or if they were lesbian. Survey data was collected from participants (n=391) via annual health report forms, including extensive demographic and health information, as well as scales to measure menopausal attitudes and sexual functioning.

The researchers used logistic regression to predict changes in women's sexual response, including measures of sexual desire, enjoyment, and orgasm. Two factors, marital status and vaginal dryness, were statistically significant predictors of women's changes in sexual desire. Interestingly, married women reported less sexual desire than did non-married women. The researchers suggested several possible explanations for married women's decreased sexual desire as compared to their single peers. One possible explanation is that married women may become bored or dissatisfied with a long-term sexual partner. Conversely, women's husbands may have felt dissatisfied with their sexual relationships, thereby affecting women's sexual expectations. On the other hand, a new partner may provide a spark of excitement and freshness in a relationship. Finally, there may be differences between married and single women that were not accounted for, such as autonomy, assertiveness, and self-esteem issues, that may influence the level of sexual desire.

Another study by the same group of researchers, using the same sample of women, examined women's sexual response changes in relationship to the qualities they desired in their sexual relationships (Mansfield, Koch, & Voda, 1998). The researchers found a significant relationship between women's decreased sexual desire and wanting to change their own and/or their partner's sexual qualities. For example, participants who reported declines in sexual desire (and other aspects of sexual response, such as sexual arousal) were significantly more likely to want to develop the following qualities in themselves: assertiveness, trustworthiness, affectionate, and sensitivity. In addition, women who reported decreases in sexual desire were significantly more likely to want their partners to be more affectionate, loving, passionate, and egalitarian.

In yet another study by the same researchers using the same sample of women, women's attributions for their sexual response changes, including sexual desire, were examined (Mansfield, Koch, & Voda, 2000). The researchers found that women attributed decreases in their sexual responding to physiological events, while increases were attributed to life events. For instance, of all the women who reported a decrease in sexual desire, 32.3% attributed this change to physical changes related to menopause. Other physical attributes that women made for decreased desire include: hot flashes (41.6%), vaginal dryness (31.3%), and weight gain (57.9%). Women who reported an increase in sexual desire attributed this change to changing life circumstances (38.5%) such as a new job or moving into a new home. These results suggest that women's individual experiences and perceptions of life events, (a contextual factor), are significantly related to women's sexual desire.

In another study on sociocultural factors that affect women's sexual desire during midlife, Kingsberg (2000) examined the relationship between sociocultural aspects of aging and women's sexual desire. Kingsberg discusses women's body image and identity as specific factors that influence women's sexuality in midlife. Age-related physical changes, such as graying hair and changes in body shape, are likely to affect a woman's body image, sensuality, and sexual interest. Similarly, the meanings associated with women's loss of reproductive status may also result in negative changes in body image and sexual identity. Conversely, women might also experience a change in reproductive capacity as freeing them from the worry of unintended pregnancy.

TREMIN researchers recently investigated the relationship between body image and sexual response changes in midlife women who were enrolled in the TREMIN study

(Koch et al., under review). Participants (n=307, ages 35-55) indicated their perception of their attractiveness and self-reported various sexual response indicators (including sexual desire) on annual health report surveys. Results indicated that neither age nor menopausal status was a predictor of women's perceived attractiveness. However, women did consider themselves more attractive when they were ten years younger, suggesting the important role that ageism plays in women's body image. Additionally, the researchers also found a relationship between women's self-perceived attractiveness and level of sexual response. Specifically, a woman's perception of herself as less attractive compared to ten years earlier was related to lower levels of sexual desire. Conversely, if a woman currently perceived herself as more attractive than she was ten years ago, the greater the likelihood that her sexual response, including sexual desire, was higher. The researchers noted the sexist and ageist underpinnings of women's body image issues and concluded that the context of women's lives, including perceptions of attractiveness and body image, are key factors in understanding midlife women's sexual response.

Similarly, Dixon (2000) interviewed women (n=18) as part of a grounded theory study on the relationships between women's body image, sexuality, and self-concept. Results indicated a strong relationship between women's body image and sexual satisfaction. Additionally, women explained that they had received contradictory societal messages about their bodies and their sexuality. Women specifically discussed five such paradoxes, with regard to their bodies, their weight, their sexuality, interpersonal relationships, and their own voice and agency. Women's ability to negotiate the conflictual messages within these paradoxes determined women's body image and sexual

satisfaction. In other words, women who successfully negotiated these paradoxes reported a more positive body image and were more sexually satisfied. Conversely, women who were not able to negotiate these paradoxes had a more negative body image and were less sexually satisfied. Dixon concluded that women's body image influences women's experience of sexual desire.

Nappi and colleagues (2001) also examined psychosocial and cultural factors, such as gender identity, in married menopausal Italian women. Half (n=40) of the participants were recruited for participation in the study based on their attendance at a menopausal clinic for medical treatment of sexuality problems. In addition, forty more women were enrolled in the study who attended the clinic solely for treatment of menopausal symptoms. The women (total n=80) were matched for demographic characteristics such that there were no significant differences between the two groups based on education, age, menopausal status (determined using a hormonal test for level of follicle stimulating hormone, FSH), parity, physical stature, or length of their marriage. Participants completed three questionnaires as part of data collection. The first assessed menopausal symptoms (including vasomotor, psychosocial, and sexual domains). A second questionnaire determined possible desire, arousal, orgasmic, or sexual pain disorders based on the DSM-IV criteria. Finally, a self-report questionnaire on female identity was administered that assessed women's adherence to the traditional feminine gender role based on four components: beauty, motherhood, eroticism, and career.

Results indicated that the women who sought help for sexual problems had significantly more vasomotor symptoms, especially hot flashes ($p < 0.001$), than women who attended the clinic specifically for menopausal symptom relief. Similar differences

existed with regards to psychological symptoms. Menopausal women with sexual problems were significantly more likely to experience psychological symptoms, especially depression, as compared to women who initially attended the clinic to treat their menopausal symptoms ($p < 0.04$). There were also within-group differences among women who referred themselves to the clinic for sexual dysfunction treatment. Women with arousal problems were significantly more likely to also experience vasomotor symptoms ($p < 0.001$), while women with desire disorders were more likely to experience psychological symptoms ($p < 0.001$). Interestingly, there were no significant differences on any sexuality/genital symptom ratings between the two groups, despite the fact that half of the women were initially enrolled in the study based on their desire to seek treatment for sexual concerns. Finally, women identified as having a sexual dysfunction were more likely to have ascribed greater importance to the value of beauty and motherhood in their lives ($p < 0.05$, $p < 0.04$, respectively).

Based on the lack of differences between the two groups on any of the sexuality/genital measures, the researchers concluded that the differences between the women were based largely on psychosocial and cultural factors. The researchers specified the role that gender identity plays in women's experience of sexuality changes during the menopausal transition:

...climacteric symptoms vary greatly across cultures, not only because of lifestyle variables, but also depending on dissimilar ideals of femininity during the reproductive life cycle. ... the most important characteristics of female identity in Italian women are beauty and motherhood, and that the personal attitudes towards such feminine dimensions may play a role in the occurrence of sexual dysfunctions during menopause (p.574).

In another study on the psychosocial effects of menopause on women's sexuality changes, Borissova and colleagues (2001) recruited women to participate in this cross-sectional study as part of a campaign for free bone scans in three large cities in Bulgaria (Borissova, Kovatcheva, Shinkov, Vukov, 2001). Both menstruating (n=295, mean age=44.8) and postmenopausal women (n=332, mean age=51.2) were enrolled in the study, most of whom were married and all of whom were employed, many with a college degree (40.6%). Most (83.5%) of the women experienced menopause naturally and only 10.8% of the postmenopausal women used HRT. Data collection occurred via a questionnaire that included questions on psychosocial status and sexuality; however the specific content of these questions and measurement of these constructs is unclear. Women were divided into three groups: menstruating, postmenopausal, and postmenopausal using HRT.

Results indicated that the most frequent sexuality change after menopause was decreased sexual activity (41.6%, $P < 0.001$). Similarly, the researchers found a significant difference between pre and postmenopausal women's sexual desire, with an especially big difference between postmenopausal HRT users and non-users. Postmenopausal non-HRT users reported the lowest sexual desire of all three groups. The authors concluded that sexuality changes during menopause are determined by psychosocial factors (and influenced by hormones).

Finally, Walter (2000) recently examined women's experiences of menopause from a psychosocial perspective using a qualitative study design. Menopausal women of various backgrounds (n=21, mostly white, varying SES, varying sexual orientation and partner/marital status) were interviewed to understand women's experiences of the

menopausal transition. Interview data were transcribed and analyzed for content by two researchers to elicit specific themes and recurrent responses. In general, participants viewed menopause as a significant life transition. Most of the women discussed menopause as a positive change, one that conferred wisdom and new freedoms to them. More specifically, the content analysis of women's experiences of menopause revealed five themes. First, women felt that menopause was a "marker event" in their lives in that it forced them to acknowledge their aging due to physical changes in their bodies. Secondly, women discussed how menopause impacted their sense of self. Often, women felt out of control and vulnerable based on their uncertainty regarding physical changes in their body. Thirdly, women discussed the effect of menopause on their intimate relationships. Single women discussed feeling lonely and sad that they did not have a significant other with whom to share their experiences, while all of the (heterosexual) married women except two reported feeling unsupported and dismissed by their husbands. Another theme in women's responses was that of menopause's impact on women's sexuality. Most of the women who lived with their partners complained of negative sexual response changes, especially with regards to sexual desire.

Women discussed several reasons for their decreased sexual desire including hot flashes, which required them to physically distance themselves from their partners, vaginal dryness, and increased difficulty reaching orgasm. In addition to other menopausal symptoms that caused women to feel fatigued and less confident about their bodies, women suggested that addressing specific sexuality-related issues, like vaginal dryness or difficulty reaching orgasm, was just too overwhelming. Simply going without sex seemed easier and more desirable to them. Finally, women discussed feeling that

menopause was a taboo topic with their friends, doctors, and even their mothers. Despite the nature of the relationship, women reported wanting to discuss menopause more in order to share their experiences and learn of other women's menopausal experiences. In fact, many women reported switching physicians after their (male) gynecologists dismissed their questions or stories about their menopausal experience. Walter suggests that women's difficulty in sharing their menopausal experiences is a result of society's medical view of menopause as a deficiency disease, which in turn results in their lack of information about menopause.

In qualitative study on the psychosocial effects of menopause on women's sexuality, Winterich (2003) interviewed 30 postmenopausal women (varied ethnicity, ages= 46-71, 19 heterosexuals, 11 lesbians) to understand how important women's menopausal status and associated changes are with regard to their sexual experiences, including sexual desire. Results indicated that women's sexual agency was crucial in terms of their ability to recognize and act on their sexual desire. For example, heterosexual women were more constrained by sociocultural norms (e.g. heterosexism, ageism, adherence to gender roles) and thus they demonstrated less sexual agency as compared to lesbians. Very few women discussed their menopausal status or menopausal related symptoms, and those who did did not place much emphasis on these factors. An overwhelming majority of the participants emphasized the influence of social and cultural issues on their experiences of sexuality, including sexual desire and sexual agency. Thus, Winterich concludes that menopause per se is not as important as sociocultural influences on women's experiences of sexuality.

Perhaps the clearest way to identify the significance of contextual factors on women's sexual changes is to study a population of women who are characteristically distinct with regard to life circumstances and/or sociocultural backgrounds. For instance, lesbians, who are not able to legally marry (and therefore are often financially less stable), have significantly different life circumstances, and perhaps life events, as compared to their heterosexual counterparts. Researchers who have studied sexuality changes in midlife lesbians have found that compared to their heterosexual peers, lesbians have a more positive experience of the menopausal transition (Cole & Rothblum, 1991; Kehoe, 1989; Morgan, 1991, Sang, 1991; Sang, 1993).

Differences in how lesbians and heterosexual women experience changes in their sexual desire during midlife appear to stem from two factors. First, lesbians seem to stress different aspects of their sexual relationships than do heterosexual women. For instance, Kehoe (1989) recruited 100 older lesbian women from lesbian and gay organizations, feminist bookstores, and women's centers. Each woman completed an anonymous questionnaire that assessed eight areas of their lives including lifestyle identification, social life, relationships, sexuality, health, and life satisfaction. Women were asked to compare their (previous) sexual relationships with men to their sexual relationships with women. Women described woman-to-woman intimacy as more emotional, caring, sharing, spiritual, gentle, sensitive, understanding, and sympathetic. One participant said: "Women are less sexually demanding, less hurried, less mechanical and more affectionate, intimate, and natural" (p. 146). While Kehoe's research is certainly woman-centered, the lack of attention to issues of power within the context of women's sexual lives distinguishes this research as primarily sociocultural in nature.

A second difference in how lesbians and heterosexual women experience sexual desire changes during midlife seems to lie in how women perceive their sexual experiences as well as their experience of the menopausal transition. It appears that lesbians may experience the same physiological symptoms during menopausal transition as do heterosexual women, but these changes do not necessarily negatively affect their sexual behavior or sexual response. Morgan (1991) found that many lesbian women appreciate changes in their body as they age. As one woman explains: "We are all aware that some midlife women are lesbians and that lesbians grow older and still are sexual. It is certainly true that ... physical changes ... do not make lesbians sexless. 'Reduced sex drive' can facilitate long, relaxed lovemaking and many women are relieved not to have menstrual periods. Women may be able in the middle years to appreciate their accomplishments in work and life, and confidence certainly enhances a sexual relationship (p.179)".

Similarly, Sang (1991) found that for many lesbians, midlife was a time for a new sense of freedom. Lesbians at midlife frequently described themselves as more open, playful, and spontaneous. Another woman describes how her feeling of community has enhanced her sexuality: "To my old-time sense of sexual bravado have been added the woman-loving-woman insights of lesbian feminism that have helped me to value myself more as a woman, making aging an honorable process (Nestle, 1991, p.181)". Additionally, many lesbians feel comforted that they are able to experience the menopausal transition simultaneously with their partners.

In sum, research suggests that lesbians experience sexuality during the menopausal transition more positively than do heterosexual women. However, it remains

to be determined what efforts, if any, lesbians make to negotiate the physical and psychological factors associated with sexuality changes during the menopausal transition so that the role that sexuality plays in their lives is not diminished.

A Feminist Critique of Sociocultural Research on Women's Sexual Desire During Menopause

Social constructionists have noted the implications of understanding women's self-construction of their sexual meanings and women's larger self-schemas (Fausto-Sterling, 2002; Foucault, 1978; Parker & Gagnon, 1995; Ussher, 1989; Weeks, 1990). Thus, sexual meanings that are imposed on women or are otherwise disempowering are implicated in women's sexual "problems" and "disorders" (Tiefer, 1995). However, attention to contextual factors is a necessary but not sufficient condition for feminist research. Sociocultural factors lend themselves just as easily to the essentializing that ultimately posits women as a falsely homogenous group based on a socially construed characterizations, such as gender identity or femininity, as their biological counterparts (Fausto-Sterling, 2002) while concepts like power, privilege, and oppression, that characterize a feminist analysis, are ignored.

Research that considers women's sexual double standard, the dichotomy between power and pleasure, and the youth-obsessed culture that midlife women are immersed in more accurately portray the conflicting issues that shape women's sexuality (Fine, 1988; Vance, 1992). For instance, in an attempt to give voice to midlife women's sexual experiences, Meadows (1997) interviewed thirty women (ages 30 to 40) about their sexuality. This research sought to understand midlife women's heterosexual sexual

experiences in order to create a positive discourse on women's sexuality. The women, all of whom were recruited from public advertisements for volunteers, represented a variety of racial/ethnic and class backgrounds. Most women were in a relationship with a man (n=22) and had children (n=26). Data were collected via semi-structured interviews that lasted between one and two hours. Women were asked about their past and present sexual relationships.

Themes that emerged from data analyses focused on the power of heterosexuality in sexuality discourse. All of the women interviewed spoke of sexuality and relationships as a phenomenon that occurred solely with men. Clearly, women's expectations and assumptions about sexuality and sexual activity within relationships were defined according to heterosexuality. For instance, women discussed intercourse solely in terms of vaginal-penile intercourse.

Despite these limitations, women reported being able to negotiate positive sexual experiences for a variety of reasons. First, women considered their sexual relationships to be primarily social relationships. Women reported that their sexual relationships were important, but because they were only a part of a more intricate social network of relationships, they did not rely on their sexual relationship to fulfill all of their relationship needs. Secondly, women reported a healthy concept of themselves with clear concepts about their rights to sexual pleasure and their rights to make informed choices about their own bodies; they made sexual choices based on their own sense of confidence and control over the situation and partnership. For instance, one woman chose to stay celibate in order to regain control over her own sense of self. However, in order to reclaim her identity she also realized that she might need to sacrifice sexual

pleasure. Similarly, most of the women reported that their heterosexual relationships were sites of conflict for them. Women's sexual relationships with men often illuminated issues that were both contradictory and competing for women, such as power and pleasure.

A feminist approach to the study of menopausal women's sexuality changes must acknowledge the social construction of medical power and authority that has pathologized women's sexuality and aging. Moreover, feminist sex research must strive to return power and sexual agency to women through their own empowerment (Rostosky & Travis, 2000). Often, what defines a study as feminist is not necessarily its research design, but the implications and interpretations of findings within the context of issues of power and privilege in women's lives. In terms of power dynamics within women's sexual realities, Caplan & Caplan (1994) suggest that viewing women's sexuality as a process as opposed to a fixed entity is a more accurate conceptualization of sexuality from women's perspectives, and thus is empowering for women. Similarly, Daniluk (1998) suggests that women's own negotiation of their sexuality and sexual meanings is an essential component of women's sexual agency. In other words, because sexual meanings are shaped by both individual and social contexts, as well as the interactions between these two contexts, women's sexual meanings are constantly being created, negotiated, and re-created: "As women live out the changes in their bodies and relationships throughout life, they take in a host of messages from significant others and from their culture, about the meanings of these experiences relative to their sexuality. These messages both *form* and *inform* their understanding and self-conceptions. In this way, all of women's experiences are imbued with cultural and social meanings ..." (p.10).

An excellent example of a feminist approach to understanding women's sexuality is illustrated by a recent qualitative study designed to understand women's experience of sexual arousal and desire. Graham, Sanders, Milhausen, & McBride (in press) qualitatively studied women's experiences of sexual arousal, including facilitators and inhibitors of arousal. Women (n=80, mean age=34.3 years) discussed their conceptualization and experiences of sexual arousal in focus groups.

Participants defined sexual desire as sexual interest, and women conceptualized sexual arousal and sexual desire as distinct concepts. Women reported that they were often aware of their sexual desire through specific indicators of their desire. The indicators of women's sexual desire were often non-genital, such as feeling warm, sweaty or flushed, and having tingling sensations in their breasts. In contrast, women conceptualized sexual arousal as more physical and also as more detectable than sexual desire. Women defined sexual arousal as a physical state and as being ready for sex. The most common indicator of sexual arousal for women was vaginal lubrication.

Most of the women in Graham's study explained that they did not make a distinction between sexual arousal and sexual desire (defined by the researchers as "sexual interest"), thus the researchers concluded that arousal and desire are distinct concepts and different aspects of women's sexual response. Unfortunately, the researchers, not the women, defined sexual desire and it is not clear whether the researchers shared this information with participants so that the women's conceptualization and definition of this term was the same as that of the researchers.

Graham and colleagues did ask the participants to share their experiences, meanings, and conceptualization of sexual arousal, however. The participants

conceptualized sexual arousal as readiness for sex, both in terms of their emotional feelings and through indications from their bodies. Women discussed various cues for sexual arousal as well as factors that inhibit and facilitate their sexual arousal.

Participants described a variety of sexual arousal cues, including: physical cues (both genital and non-genital), emotional/cognitive cues (e.g. increased awareness, anticipation), and behavioral cues (e.g. moaning). Women also described genital changes associated with sexual arousal, such as tingling feelings, feeling warm and swollen in their genitals, and also vaginal lubrication. In addition, women also discussed non-genital physical changes that indicated their sexual arousal to them, including feeling “butterflies” in their stomach and feeling flushed.

Conclusion

Based on a review of the current literature on women’s sexual desire during midlife and menopause, several conclusions can be drawn about this research topic. First, the two main disciplinary paradigms that are used to study women’s sexuality, the biomedical and sociocultural perspectives, conceptualize women’s sexual desire quite differently. The biomedical perspective views women’s sexuality as rooted in physiological mechanisms and hormonal causes. Thus, research on women’s sexual desire from a biomedical perspective is characterized by the study of the determinants of sexual desire, including various hormonal correlates. In contrast, researchers who use a sociocultural perspective to study women’s sexuality focus on how social, cultural, and institutional factors influence women’s sexual desire. Thus, sociocultural studies on

women's sexual desire focus on women's sexual relationships, women's body image, and the impact of gender socialization as influences on women's sexual desire. A feminist critique of the research on women's sexual desire from both the biomedical and sociocultural paradigms demonstrates the need to understand women's sexual desire from a perspective that is rooted in the reality of women's lives. It is crucial for feminist sex researchers to acknowledge that women's lives are often characterized by sexual disempowerment and a lack of sexual agency.

Another conclusion that can be drawn from the review of the literature on women's sexuality is that there is a great deal of ambiguity in how sexual desire is defined, among both biomedical and sociocultural researchers. This lack of agreement among researchers as to what constitutes sexual desire, how it is measured, and its determinants is also evident in the research on midlife women's sexuality. Despite decades of research on women's sexual desire, the literature on menopausal women's sexual desire still does not include research on women's own experiences of sexual desire, what their sexual desire means to them, or what the significance of sexual desire is within the context of their lives at midlife.

Finally, the recent popularity in research on women's sexuality suggests that current research on midlife women's sexuality, specifically sexual desire, will have far-reaching implications for women, their healthcare practitioners, and the healthcare industry. The current interest in women's sexual desire on the part of pharmaceutical companies and researchers sponsored by such companies has the potential to further medicalize women's sexuality. In other words, the conceptualization and definition of sexual desire has ramifications for clinical populations and the evaluation of women's

sexuality as “healthy” or “disordered”. A majority of the most recent research on women’s sexual desire posits menopausal women as “deficient” and “diseased” and their sexuality as “dysfunctional”. Thus, research is needed to counteract the reductionistic themes that characterize such research and to accurately represent the variety of women’s experiences with regards to sexual desire in midlife.

Chapter 3

Methods

Purpose Statement & Research Questions

A review of the research literature on menopausal women's sexuality, as discussed in chapter two, demonstrates that there is still much to be learned about midlife women's sexual response, specifically sexual desire. Certainly, the roles that both sociocultural and biological factors play in shaping women's sexuality during menopause remain to be determined. Despite differences in the literature with regard to the specific research paradigm employed (e.g. biomedical or sociocultural perspectives), the literature predominately reflects the use of quantitative survey data as a means to study women's menopausal sexual desire. Thus, there is currently a lack of information regarding women's perspectives and experiences of their sexual desire during menopause.

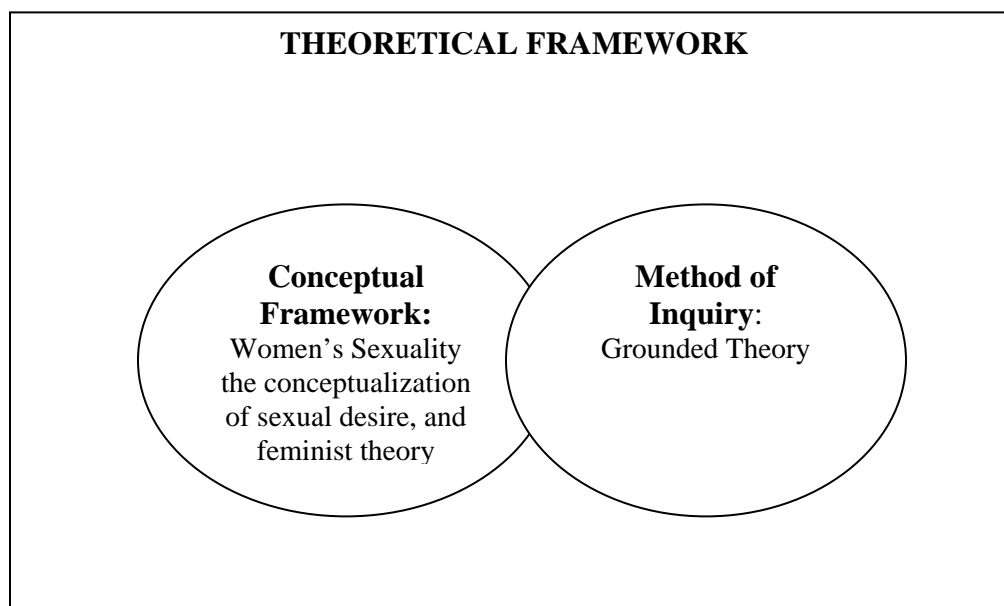
Thus, the purpose of this research project is to understand postmenopausal women's experiences of sexual desire. In addition, the meanings that women attach to their sexual desire must be explored within the context of women's lived experiences. Four over-arching research questions guided the study: (1) How do menopausal women experience sexual desire?, (2) How do menopausal women perceive and make sense of their sexual desire?, (3) What influences women's experience of sexual desire during menopause?, (4) What differentiates women's experience of "high" sexual desire from their experience of "low" sexual desire during menopause?

Based on trends and gaps in the literature, as well as the purpose of the inquiry, qualitative research methods were chosen to fulfill the purposes of this study. Similarly, since women's voices and sexual agency have been ignored in lieu of certain agendas (e.g. the development of pharmacological interventions to treat women's sexual dysfunctions), a feminist qualitative research methodology was chosen to investigate women's sexual desire during menopause from their own perspectives. This chapter discusses the underpinnings of qualitative research and outlines the specific research methodology used to fulfill the purposes of this study.

Theoretical Framework

The theoretical framework of a study refers to two components: the conceptual framework and the method of inquiry (Creswell, 1998). The conceptual framework, including women's sexuality, the conceptualization of sexual desire, and feminist theory, was discussed in chapter two, in the review of the literature. Figure 2 illustrates the theoretical framework of this study. However, it is important to note here that the various perspectives contained in these concepts were used to guide the development of research questions and subsequent methodology. Methodology and the tradition of inquiry, or the type of qualitative research used to address the purposes of the study, constitute the remainder of the theoretical framework. Methodological issues, including the overall concept of qualitative research, data collection techniques including sampling, data analysis, and issues of credibility and rigor will all be addressed in this chapter.

Figure 2: Visual Representation of the Theoretical Framework



The Tradition of Inquiry: Grounded Theory

Qualitative methods are becoming increasingly popular in health research in order to study topics about which little is understood, particularly when describing the phenomenon from the emic (or native) perspective (Grbich, 1999; Kuzel, 2000; Morse, Swanson, & Kuzel, 2001; Schreiber, 2001). Thus, qualitative research methodology was used to fulfill the purposes of this study in order to explore, understand, and examine women's experiences and associated meanings of sexual desire during the menopausal transition.

Grounded theory is the specific qualitative methodology that guided data collection and analysis. Grounded theory is the technique best used to understand participants' everyday life situations where the focus of the study is on understanding meanings, adaptations, processes, and relationships between phenomena (Grbich, 1999). The purpose of grounded theory is to inductively analyze data in order to understand participants' lived experiences of particular phenomena and then to generate a substantive theory to explain the phenomena that is grounded in the data. Merriam (2002) describes substantive theory that results from a grounded theory study as: "... localized, dealing with particular real-world situations" (p.8). In other words, grounded theory allows theoretical categories to emerge from the data to explain how individuals experience and process meaning associated with their experiences (Strauss & Corbin, 1990). Resulting theory reflects and explains participants' perceptions, experiences, and meanings of the phenomena of inquiry from a real-world perspective. Moreover, grounded theory lends itself to critical analyses, including such paradigms as post-modernism, critical theory, and feminist critique (Rothe, 2000).

Guiding Theory: Feminist Thought

Reinharz (1992) states that while there is no one particular feminist methodology that constitutes feminist research, the tenets of qualitative methodology are often similar to feminist principles. For instance, studying women's experiences within their sociocultural context and from women's own perspectives provides a new position among a sea of androcentric research (Reinharz, 1992).

Feminist qualitative research methodology, derived in part from critical theory research methods, begins with the assumption that knowledge is a commodity that is value-laden. In other words, knowledge is created for specific purposes, often to control others, since knowledge is inextricably linked to ideology. That is, critical theorists maintain that specific types of knowledge are reified, emphasized, and re-presented to the extent that such knowledge becomes ideology. Ideology is then linked to broader power relationships in society (Rothe, 2000). Thus, feminist qualitative research methods seek to understand the assumptions underlying knowledge that is legitimized and maintained by such ideologies. This understanding then illustrates the gendered nature of broader power structures and systems, and serves to emancipate women from such ideologies (Rothe, 2000).

A basic tenet of feminist qualitative research is that women experience the world differently than men do because of the sociocultural implications associated with what it means to be a woman in Western culture today. Grbich (1999) discusses several enduring principles of feminist research. First is the need to focus on the social constructedness of gender, thus acknowledging that women (as a group) are oppressed. To do this, a non-exploitative, egalitarian and emancipatory relationship between the researcher and participants should be employed. The researcher must acknowledge her own subjectivity, meaning that the researcher must reveal her position, emotions and values regarding the topic of inquiry. She should further explore how her assumptions and beliefs affect her view of reality, and how this reality is managed in terms of data analyses. In addition, Grbich suggests that feminist research must present results in a manner that addresses issues of power, honesty and ownership (p. 53).

A final principle of feminist research relates to ethical position. Grbich (1999) suggests that feminist ethics must include an element of reflective critique both during and after the study. Issues such as maintaining non-hierarchical relationships between the researcher and participants, the sharing of knowledge that emerged from the study, and attention to keeping language used within the study accessible and demystifying are all concerns that the feminist researcher must keep in mind. Therefore, based on the suggestions of experts in the field (e.g. Grbich, 1999; Merriam, 2002; Reinharz, 1992; Rothe, 2000) every effort was made in this current research to adhere to the principles and underlying assumptions of feminist research.

Research Design

Sample

Women enrolled in a longitudinal research project, the TREMIN Research Program on Women's Health, directed by Dr. Mansfield, were recruited for participation in this study. Women enrolled in TREMIN were recruited in three cohorts. The first cohort consisted of undergraduate women from the University of Minnesota, who were recruited in 1934 (n=2350). A second group of women students at the University of Minnesota (n=1600) was recruited in 1964. Finally, members of the class of 1963 at Douglass College were recruited in 1990 for a special midlife study (n=505). Demographically, TREMIN is an extremely homogenous sample; over 90% of the women are white, highly educated (with post-baccalaureate education) and are

heterosexual (Koch & Mansfield, 2002). However, TREMIN is unique in that the participants are willing to provide extensive information on various aspects of their health, including sexuality, on a regular basis over long periods of time.

TREMIN participants complete an annual report to assess health and menopausal status, hormone use, menopausal symptoms, and various sexuality measures, including sexual desire. Sexuality data have been collected from the participants from 1990 to 2000 on an annual basis, and then on a biennial basis ever since, using the Sexual Responding Survey (SRS). The SRS (see Appendix A) asks women to indicate their strength of feelings over the past year regarding desire, arousal, enjoyment, and orgasm for non-genital and genital sexual activities, including those with a partner, fantasies, and solitary masturbation. Participants indicate their strength of feelings using a Likert scale, with possible responses from 1 (nonexistent feelings) to 9 (very strong feelings). Women's responses to one question, strength of sexual desire for genital activity with a partner (item "e"), were used as a criterion for participation in this study.

Selection Criteria

In grounded theory research, participants are selected for inclusion in the study based on their knowledge of a particular phenomenon or their lived experience of a phenomenon (Patton, 1990). This sampling method, known as purposeful sampling or criterion-based sampling, is used to collect in-depth, detailed information about participants' lived experiences about a phenomenon and to understand how such experiences come to hold meaning or significance in people's lives (Morse et al., 2001).

Based on the purposes of this study, several eligibility criteria were used to select participants. First, data from the 2002 annual health report forms, including the Sexual Responding Survey, were used to determine women's strength of feelings regarding their own sexual desire. For the purposes of criterion sampling, women who responded at the more extreme ends of the scale (1,2,3 for "low" desire and 7,8,9 for "high" desire) were considered eligible for participation in the study, as it was believed that they would be more likely to contribute data that illustrate the nature of such experiences. This technique of purposeful sampling is referred to as maximum variation and is intended to ensure that as many different experiences as possible are included among the participants (Grbich, 1999; Strauss & Corbin, 1990). Thus, women who responded by indicating a 1, 2, or 3 were grouped together and considered to have "low" sexual desire while women with a 7,8, or 9 were grouped together and considered to have "high" sexual desire.

The second criterion for eligibility related to menopausal status. Only women who were postmenopausal, defined as women who have not menstruated for at least twelve months, were included in the study to minimize possibly confounding factors associated with perimenopause. Women's menopausal status was determined by their responses to a question on self-perceived menstrual status on the 2002 health report form. Finally, the last criteria for eligibility related to the use of exogenous hormones. Women who were currently using hormone therapy were excluded from participation, as it is believed that hormone therapy may be a confounding factor.

In summary, postmenopausal women who did not use hormones at the time of the study and reported "low" or "high" sexual desire were eligible for participation in the study. Previous research by the TREMIN research team indicates no differences with

regard to age and other demographic variables between women who have low and high sexual desire (Mansfield, Voda, & Koch, 1995).

The gold standard for how many participants to include in a grounded theory study is that data collection and sampling continue until a point at which saturation is reached. In other words, participants continue to be enrolled and interviewed until themes in the data overlap. Saturation was reached after 18 women were interviewed, although the final sample size for this study was 22 women. Additional women were interviewed after the point of saturation was reached for two reasons. First, the researcher had already made appointments to speak with the women. Secondly, the additional participants were useful in theory development, which will be discussed later in chapter five.

Sample size in grounded theory study tends to remain small and experts in the field suggest various optimal sample sizes: 10-30 participants (Creswell, 1998), 12-15 participants (Dana & Dana, personal communication, 1997), and 15-20 (Yoder, personal communication, 2003). Thus, the goal of sampling was to recruit between 20 and 30 women who fit the selection criteria and who were comfortable talking about their sexual desire. The final sample size (n=22) was consistent with suggestions by researchers in the field and with the aims and goals of this study.

Recruitment

IRB approval was received before the researcher had any verbal communication with the participants. Consent forms were distributed and collected from each participant

as required for human subjects protections. Women were recruited as part of the annual survey that all TREMIN participants receive. Women were first invited to consider participation in this study via a short explanation of the study at the end of the 2003 health report form, mailed to participants in January 2003. Those interested in participating indicated this at the bottom of the survey, which was returned to the TREMIN research office along with their TREMIN survey materials. Approximately 120 women indicated an interest in participating in this study, and approximately 60 women fit the eligibility criteria (i.e. no exogenous hormone use, postmenopausal status, and “low” or “high” levels of sexual desire). Women who indicated an interest in participating in the study and who fit the inclusion criteria were mailed a packet of research materials, including a letter describing the project, two consent forms (one for the women to keep), and a form with space for the participant to indicate convenient interview dates and times, as well as space for the woman’s first name and phone number. In addition, another copy of the SRS was distributed and collected from participants, in order to ensure the accuracy of their established level of sexual desire (e.g. “low” or “high”).

Two waves of recruitment occurred. The first wave of participants (n=24) was mailed packets of informational materials (i.e. letter of introduction, consent forms, form to return with convenient times to be contacted) on June 25, 2003. By October, only 6 women had responded, so reminder postcards were mailed out to encourage women to return their materials if they were interested in participating in the study. Thirteen of the 24 women responded (54% response rate), 11 of whom were interviewed. (Two women returned the materials and indicated that they were no longer able to participate because

of serious illnesses). A second wave of recruitment occurred in mid-October, and 26 women received research materials identical to those distributed in the first wave of recruitment. Eleven women responded and were interviewed; a response rate of 43% for the second wave of recruitment. In summary, 50 women received research materials to participate in the study, 24 of whom responded, and 22 of whom were interviewed.

Attempts were made to include approximately equal numbers of women who reported high and low sexual desire. To avoid bias, the primary researcher was blinded as to the level of sexual desire reported by each individual woman. Thus, Dr. Koch assisted with recruitment by assigning an ID number that only she was able to trace to the participants' original identity, and by reviewing the SRS scores of participants in order to include women with both low and high sexual desire scores. Dr. Koch also collected consent forms and other materials that contained identifying information about the participants. Thus, during the interviews the researcher focused on the nature and essence of women's experience of sexual desire instead of focusing on any preconceived ideas of their level or strength of sexual desire.

Data Collection

Data collection occurred via audiotaped, telephone, semi-structured interviews. In both qualitative and feminist research methods, the preferred method of data collection is interviews in order to best understand participants' lived experiences from the emic (native) perspective (Rothe, 2000). More specifically, semi-structured interviews are preferred from both feminist and grounded theory perspectives. In other words, the less

structured the interview, the more the conversation is guided by the participant. Such an approach incorporates participants' life stories, as well as empowering them to share their experiences in their own words and in their own way (Reinharz, 1992; Rothe, 2000).

Feminist methodologists suggest that as the researcher focuses less on answering specific interview questions, the data collection process can become more interviewee-guided, thus making room for subtleties, such as hesitancy or pauses in speech, that relate to the condition and realities of women's lives. Reinharz (1992) elaborates: "The use of semi-structured interviews has become the *principal means* by which feminists have sought to achieve the active involvement of their respondents in the construction of data about their lives" (p. 18). Finally, feminist scholars and researchers consider the very act of enabling women to discuss topics that are considered taboo as radical, subversive acts (Hyde, 2001; Tolman & Szalacha, 1999). In sum, an interview conversation that is guided by the participants is likely to reflect experiences that women deem important and influential in their sexual lives, as well as to enable them to claim part of themselves that is often silenced by mainstream culture.

If the interview is to be truly guided by the participant, there will likely be wide variations in the duration of the interview in order to understand women's lived experience of the phenomena in question (Reinharz, 1992). In grounded theory studies, data collection and analysis continues until a point at which saturation is reached. Meadows & Morse (2000) explain: "Data collection and analysis proceed until the researcher has collected adequate data - data from different participants, various contexts, and various circumstances and situations - that are similar and fit within the same category" (p. 192).

For this study, data collection occurred through audiotape-recorded, semi-structured telephone interviews that lasted approximately one hour in length. The first wave of data collection (which involved interviews with seven women) resulted in some contradictory responses from participants, so these particular women were contacted a second time for a short follow-up interview. The interview schedule (see Appendix B) was developed based on the purpose of the study and the research questions used to guide the study. The purpose of this research project was to understand postmenopausal women's experiences of sexual desire, as well as the meanings that women attached to their experiences of sexual desire. The four over-arching research questions that were used to guide the study included: (1) How do menopausal women perceive and make sense of their sexual desire?, (2) How do menopausal women experience sexual desire?, (3) What influences women's experience of sexual desire during menopause?, (4) What differentiates women's experience of increased sexual desire from their experience of decreased sexual desire during menopause?

Thus, interview questions such as "Tell me what the term sexual desire means to you" and "What do you think has shaped your ideas about sexual desire?" were used to understand how women conceptualize sexual desire. Additionally, probes were used to understand the various influences on and messages about sexual desire that women received throughout their lifetime. Questions such as "How would you describe your sexual desire?" and "How do you know when you experience sexual desire?" were used to understand women's experiences of sexual desire, and probes were used (when necessary) to understand where women located sexual desire in their body and what influenced women's experiences of their sexual desire. Next, questions including "Tell

me how you think menopause has affected your sexual desire” and “If you were talking to a woman who was approaching menopause, what would you tell her about menopause, sex, and sexual desire?” were used to understand what influences postmenopausal women’s sexual desire. Again, probes were used when necessary to understand women’s expectations of menopause and its relationship to sexual desire, as well as to hear women’s perceptions about bodily changes (e.g. fat distribution) and possible relationships to sexual desire.

Telephone interviews are often preferred methods of data collection when the topic of inquiry is an especially sensitive one, and researchers have found that participants actually reveal more information over the phone since they feel more comfortable not being face-to-face with the interviewer (e.g. Kvale, 1996). Given the nature of the topic, and the discomfort some women experience talking about their sexuality, it was considered beneficial not to be face-to-face with the participants.

Based on suggestions by experts in the field, several techniques were used to ensure the credibility and trustworthiness during the interview process. For example, immediate interpretation of the data occurred in order to be sure that the interviewer understood women’s intended meaning. Thus, the interviewer “sent back” the meaning of women’s responses to each question and probe in order to confirm the intended message. As described by Kvale (1996), this is one of the most significant measures to ensure the trustworthiness of the data during the interview process:

... the interviewer, during the interview, condenses and interprets the meaning of what the interviewee describes, and "sends" the meaning back. The interviewee then has the opportunity to reply. ... This dialogue ideally continues until there is only one possible interpretation left. ... this form of interviewing implies an ongoing “on-the-line” interpretation with

the possibility of “on-the-spot” confirmation or disconfirmation of the interviewer’s interpretations (p.189).

Another technique used to ensure the credibility of the data was a transcription technique. Audiotapes were immediately transcribed by the researcher following each interview, and every effort was made to preserve the auditory nature and context of the interview. For instance, the interviewer included notations of sighs, stammers, and pauses, as well as the inflection of participants’ responses into the interview transcript. Often, the notation of laughter, a pause, or a quizzical intonation was necessary in order to understand meanings that women attached to their experiences. Kelly (1988) describes such transcription techniques as necessary in order to “hear” the speech of the participants.

Data Analysis

Grounded theory studies use the constant comparative method of data analysis, originally developed by sociologists Glaser & Strauss (1967). The nature of open-ended or semi-structured interviews suggests that a variety of data will be elicited from the participants. The constant comparative method of data analysis uses an inductive approach to analyze data that takes advantage of nonstandardized information that results from these interview techniques. Thus, the constant comparative method of data analysis, used to examine differences between and among interviewees, maximized the full range of differences among participants and their experiences.

The constant comparison method of data analysis involves a continual comparison of themes, concepts, and experiences within or between data sets (Merriam, 1998). Several levels of data analysis exist, including data description, category construction, and making inferences to explain the data (Creswell, 1998). Three types of coding occur during analysis using the constant comparison method: open-coding, axial coding, and selective coding (Grbich, 1999). To describe how this method was used in the current study, the process of data analysis will be described first. Then the application of the computer program *Nvivo 2.0* (QSR International, 2002) will be described in terms of its use in each step of the coding process.

Open coding occurs first, immediately after transcription of the interview. Analysis occurs word-by-word and line-by-line in order to fracture the data into various conceptual parts. Often, in-vivo codes, or terms used by the participants themselves, emerge during this phase of analysis. Provisional names are assigned to each code and data are constantly compared to understand what the data indicate about the phenomena of inquiry. Grbich (1999) explains: “The idea is to allow categories to emerge from the data, rather than impose already constructed ones upon the data. . . . The focus should be on the constant comparison of incident to incident . . . When concepts do emerge, the focus should then be on the comparison of incidents to concepts” (p.176).

Axial coding is similar to open coding and often a researcher moves between open and axial coding during preliminary analysis of data. In axial coding, the researcher focuses on one category that has emerged from open coding. Axial coding is used to understand the connections between data fragments within one category and to develop subcategories when significant differences or variations in data fragments are found.

Finally, selective coding is used to verify the relationship between a core category, a category that is central to describing the phenomena, and other more superfluous categories. Core categories are what connects themes from the data and often core categories are indicated by the pure volume of data fragments that are inherently similar in their description of participants' lived experience or perspective of the phenomena of inquiry.

A non-numerical data analysis program, *Nvivo 2.0* (QSR International, 2002), was used to assist in data analysis. Qualitative research analysis programs like *Nvivo* assist the researcher in managing the plethora of data collected. *Nvivo* enables the researcher to import various documents, such as interview transcripts, into the program and sort the data into codes established by the researcher. Using *Nvivo*, the researcher stored each interview transcript as a separate text document. Next, each transcript was read and portions of the transcript were highlighted and color-coded. Thus, preliminary codes were established using the women's own words. Using the digital "notebook" feature in *Nvivo*, the researcher immediately documented her thoughts and rationale for establishing each preliminary code. In this manner, each interview transcript was read, re-read, and re-read again to pull meaning (as represented in the preliminary codes) from each transcript. The preliminary codes were established, justified, and often adjusted as women's experiences and associated meanings became apparent in the data. Data were constantly compared through the establishment, consideration, and adjustment of these preliminary codes. Open coding was achieved in this manner (Grbich, 1999; Yoder, personal communication, 2003).

Next, data were placed on nodes, which are codes established by the researcher to organize the preliminary codes (segments of highlighted and color-coded data) within each interview transcript. Again, as data are coded, *Nvivo* assisted the researcher in establishing an audit trail by keeping track of codes and relationships between codes using the digital notebook feature. At this point in the data analysis, the preliminary codes, which are highlighted portions of interview transcripts, are sorted into codes (nodes in *Nvivo*) based on shared meanings and themes. Thus, codes were established from the “ground up”, using women’s own voices and words to establish codes (a.k.a. nodes) that encompassed the experiences and meanings of all the highlighted text segments that were similar. This step is axial coding (Grbich, 1999; Yoder, personal communication, 2003). *Nvivo* provided the researcher with visual representations of each text segment (grouped together by color) in order to manage this portion of the data analysis. Thus, *Nvivo* did not analyze data for the researcher; it provided the researcher with a framework in which to manage data analyses instead.

Finally, the researcher focused on the relationships among the various axial codes (a.k.a. nodes in *Nvivo*). Using the report feature in *Nvivo*, the researcher grouped axial codes into themes based on shared meanings and their relationships to one another. During selective coding, the researcher was unblinded as to participants’ initial levels of sexual desire. Women’s “low” or “high” sexual desire, as determined via survey data, introduced additional opportunities to explore differences and similarities in women’s experiences of sexual desire during the menopausal transition. Using a pictorial diagram of the hierarchy of codes (nodes) in *Nvivo*, selective coding was used to establish the core variable, based on its interconnectedness to all levels of coding. Following the

development of core categories, an indicator that the end of data analysis was near, the core variable was established and theory development ensued.

Thus, through these three stages of data analysis - open-coding, axial coding, and selective coding - data were constantly compared to allow themes to emerge. The results of each stage of coding, as well as the overall results for this research project, are presented in chapter four.

Issues of Credibility & Accuracy

The qualitative research paradigm addresses issues of data accuracy and credibility differently than in the quantitative research paradigm. In qualitative research, “good research” correctly represents the lived experiences, perceptions, and associated meanings of phenomena of the participants (Merriam, 2002). For instance, in qualitative research, validity refers to collecting accurate and true impressions of the phenomena being studied. In a valid qualitative study, a researcher’s conclusions are the participants’ reasons, perceptions, and meanings for why they act, think, and behave in regard to the phenomenon in question. In other words, a valid qualitative study describes reality as it exists in the minds of the participants (Rothe, 2000).

In this sense, validity is of most concern during the data collection and analysis processes. Based on suggestions by experts in the field, several techniques were used to ensure the credibility of the data for this study. The first is an abbreviated form of member-checking. In member checking, the researcher provides participants with copies of the interview transcripts (specific to their discussions) along with the researcher’s

interpretation and preliminary analyses (Meadows & Morse, 2000). In this way, participants are able to reflect on their interview responses, compare them with the researcher's interpretation, and clarify, correct, or confirm the analyses. In the interest of keeping women's participation time at a minimum (to one hour, as promised), as well as a lack of monetary resources for additional mailing costs, an abbreviated version of member-checking was used. As previously discussed in this chapter, an "on-the-line" interpretation of the participants' responses occurred during the interview process so that the researcher "sent back" the interpretation of the participants' responses until only one possible interpretation was left.

In addition, the researcher kept an audit trail during all phases of data collection and analysis: "An audit trail is a documentation of the researcher's decisions, choices, and insights including subjective interpretations; it assists the researcher in demonstrating theoretical rigor. Basic types of documentation for the audit trail are contextual documentation, methodological documentation, analytic documentation, and personal response documentation (Meadows & Morse, 2000, p.196). *Nvivo* enables the researcher to build an audit trail, using the electronic notebook feature, describing coding decisions as data analysis occurs. At the conclusion of analysis a coding report can be generated, describing all codes, the dates codes were established, and tracing all coding decisions.

Another benefit of maintaining an audit trail relates to the credibility and trustworthiness of the research. The audit trail provides a great deal of information about how the study was carried out, especially with regard to decisions made during the interview and data analysis processes. Rothe (2000) suggests that a researcher interested in building credibility should include the following: "Open disclosure of preconceptions

and assumptions that may have influenced data collection and analysis, visible data or surrounding text such as transcripts or filed notes so that readers can judge the accuracy of claims, [and] the purpose of the study, and how that purpose was realized” (p. 134). Thus, the audit trail, including the electronic notebook and report features in *Nvivo*, provided the researcher with ample resources to ensure the validity and credibility at all stages during the research process.

The final aspect of credibility addressed in this study involves the researcher’s self-reflexivity. Self-reflexivity is a researcher’s ability to critically reflect on her/his work and acknowledge the values and assumptions in one’s work (Gribch, 1999). This researcher’s values and assumptions regarding women’s sexuality, the conceptualization of sexual desire, biomedical perspectives on women’s sexuality during menopause, and the importance of this study have been previously acknowledged in chapter one of this document and in the beginning of this chapter. Similarly, the researcher has discussed at length in chapter two the importance of a researcher’s epistemological stance in terms of how it shapes the purpose of the study, the development of research questions, and the establishment of methodological decisions. To this end, this researcher has made her values with regard to the field of medicine, its treatment of women’s bodies, and the implications for women’s health and sexual well-being clear. Similarly, this researcher has acknowledged her subjective bias and designated her perspective on this study as a feminist one. The researcher has divulged such information and shared her assumptions and values in an attempt to be forthcoming about epistemological “bias” associated with this study. Thorne & Hayes (1997) discuss the importance of a researcher’s approach to knowledge making throughout the research process:

Epistemological integrity: There is a defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained (p.120); representative credibility: The theoretical claims they purport to make are consistent with the manner in which the phenomenon under study was sampled (p.120); analytic logic: Makes explicit the reasoning of the researcher from the inevitable forestructure through to the interpretations and knowledge claims made on the basis of what was learned in the research; (p.121) and interpretative authority: Assurance that a researcher's interpretations are trustworthy, that they fairly illustrate or reveal some truth external to his or her own bias or experience (p.121)

Limitations

One disadvantage of qualitative methodology is that it reflects social and culturally shaped and shared experiences, not transcendent ones. Thus, themes elucidated from grounded theory analysis may provide insight into larger societal norms via the resulting substantive theory, but there is no ability to generalize to larger populations. Similarly, because qualitative methods focus on shared experiences and meanings, it is difficult to pinpoint individual versus sociocultural influences of the phenomenon in question (Rothe, 2000). Thus, the results of this study apply only to the participants and not to all women.

A second limitation of this study is the homogenous sample. Most women in TREMIN are white, educated, heterosexual, middle-class women. It is not the intention of the researcher to marginalize minority women by virtue of the sample characteristics and generalizability of these research findings. However, since feminist theory has influenced the development of this study, it must be noted that the lived experiences of minority women are often considerably different than women who are privileged by

virtue of their race/ethnicity, class, sexual orientation, and educational status. Thus, it is to be expected that the results of this research may have few implications for women without these privileges. Current research efforts by the TREMIN research team involve recruitment efforts to enroll a more diverse group of women.

Chapter 4

Results: Analysis and Presentation of the Data

The purpose of this study was to understand women's experiences of sexual desire during menopause. In addition, the meanings that women attach to their sexual desire were also explored within the context of women's lived experience. Four overarching research questions were used to guide the study: (1) How do menopausal women experience sexual desire?, (2) How do menopausal women perceive and make sense of their sexual desire?, (3) What influences women's experience of sexual desire during menopause?, and (4) What differentiates women's experience of "high" sexual desire from their experience of "low" sexual desire during menopause?

Before the themes that emerged from the data analysis are discussed, it is first necessary to note the history and context of the participants' lives. Specifically, the experiences and meanings that these women associate with sexual desire and sexuality in general are associated with a generational and cohort effect. Participants ranged in age from 58-65 (mean age: 62.4) and many of the women's experiences were shaped by the conservative era of the 1950s. Since most of these women were recruited from the University of Minnesota (into the "Tremin Trust"), many of these women also grew up in the Midwest of the United States (a sexually conservative and religious region). At the time data collection occurred, the participants lived all over the United States, including in Florida, California, Minnesota, Pennsylvania, Michigan, Virginia, Texas, New Jersey, Louisiana, Colorado, Maryland, and Wisconsin. Based on the participants' residences at

the time of data collection, no discernable geographical pattern in terms of regional effect was evident. Thus, before turning to the results of this study, it is noteworthy that the findings of this study may have been very altered with a different cohort or generation of women.

This chapter will first discuss the themes that emerged from each phase of the coding process. Next, themes that emerged from data analysis to address the research questions used to guide this study are presented. As discussed in chapter 3, data were collected via audiotape recorded semi-structured interviews with 22 participants. The interviews were immediately transcribed by the primary researcher following each interview. Next, each text document was loaded into *Nvivo*, in order to manage the enormous amount of data collected from participants. Using *Nvivo*, the primary researcher was able to code data, maintain an audit trail of coding decisions, and make notes in an electronic version of a researcher's notebook to document the development of codes and themes that emerged from data analysis. As discussed in chapter 3, the constant comparison method of data analysis was used to analyze the interview data. This method of data analysis involved a continual comparison of themes, concepts, and experiences within and between data. To this end, three waves of coding, including open-coding, axial coding, and selective coding, occurred in order to allow themes to emerge from the data. Data will be presented here in terms of how themes emerged from the codes at each level of analysis, or from "the ground up".

Presentation of Data: Coding

Open Coding

Open coding occurred immediately after the transcription of the interview. During open coding, data were examined word by word and line by line, a process that was facilitated by *Nvivo*. *Nvivo* allowed the researcher to select and highlight words, phrases, or entire paragraphs of text within an interview transcript. The researcher then assigned a preliminary code to the highlighted portion of text, and documented the rationale for developing the code. In this manner, codes were fluid so that preliminary codes assigned during open coding could be easily changed, and an audit trail existed to maintain the integrity of the coding process. After preliminary codes had been established based on selected text within each transcript, *Nvivo* color-coded each segment of highlighted text, thus allowing the researcher to compare codes both within and between participants. After each transcript was open coded, the researcher physically printed each interview transcript in order to visually appreciate the variety of codes (differentiated by color) among and between women. Open coding occurred immediately after transcription, so that often days or even weeks separated the coding of one woman's transcript from another. This time separation was helpful in allowing the researcher to ruminate about similarities and differences that slowly emerged from the data. At the completion of open coding, *Nvivo* enabled the researcher to generate a coding report, listing the codes developed as well as the frequency of text segments associated with each code. Times and dates documenting when each code was developed and altered were also noted. At the conclusion of the open coding process, 44 open codes had been established.

Axial Coding

Axial coding occurred somewhat simultaneously with open coding, although the purposes of each type of coding were distinct. In axial coding, the researcher focused on one specific code and followed it throughout the entire data set. It is common in qualitative research for codes to overlap and thus category construction may at times seem redundant (Yoder, personal communication, 2003). It is also important to note that the placement of codes as part of category construction was based on the context of the conversation in the interview. Data analysis occurred from the ground up so that coding decisions were made to reflect women's experiences and meanings. In other words, while the placement of a code within a larger category may seem perplexing to the reader, the researcher carefully constructed categories to reflect women's lived experiences and women's perceptions.

In sum, the purpose of axial coding was to examine the similarities and differences in the data through the conceptual lens of the code of interest. For example, in axial coding, the researcher followed the code "hormones" through each interview transcript to understand how the use of exogenous hormones related to women's experiences of sexual desire and the meanings attached to those experiences. *Nvivo* enabled the researcher to generate a coding report that selected and copied all the highlighted text for one code from each transcript. *Nvivo* labeled each text segment with the ID number, date, and time that the interview occurred as well as when the codes were developed for that particular data set. In other words, using a coding report, the

researcher was able to view all the coded text for each woman for a specific code (e.g. “hormones”) at one time in one place.

As a visual learner, this researcher chose to print out copies of each coding report and hang them on a large wall in order to be able to better move in and out of the data to understand the meanings that women attached to each code. Codes that were similar were collapsed into one broader code with subcategories, and codes that had different meanings to different women were clarified. For instance, with the code “hormones,” it became clear that a few women had internalized their physician’s explanation that their menopausal symptoms or sexuality concerns (e.g. decreased vaginal lubrication) were based on their “deficiency” of hormones. Thus, the meaning that women attached to hormones, whether exogenous or endogenous, was really the same: women viewed hormones as being able to treat some of the bothersome symptoms they experienced and associated with menopause. Thus, the code “hormones” was expanded to include both naturally occurring hormones and synthetic pharmaceuticals. Similarly, it became clear that women’s doctors were responsible for communicating a great deal of information about menopausal symptoms and associated physiological changes (e.g. decreased vaginal lubrication, discomfort during intercourse) that had implications for women’s experience of sex and sexual desire. Thus the code “doctor knows best” and the code “hormones” became subcategories under the code “the medical system”.

Axial coding continued until all 44 codes developed in open coding were either established as subcategories of larger, more pervasive codes, or were discarded based on a lack of frequency and continuity within the data set. At the conclusion of axial coding, three main themes were established, including: “the sexual self”, “partners”, and “the

medical system”. Each axial code had several subcategories that described and explained that code. These codes are discussed at length in the next section of this chapter.

Nvivo was especially helpful in generating an on-going audit trail to keep track of coding decisions and category construction. For instance, the code “partner availability” only occurred once and for only one woman, and it was mentioned in passing. As the code was discarded, the researcher was able to make a note describing that nearly all of the women who participated were married, a possible explanation for why “partner availability” or access to a partner was not a theme that emerged from these data. However, later in the analysis, it became clear that married women were also concerned with the availability of their partners/husbands, although from an emotional and intimate standpoint. Women’s description of their frustration with their husbands’ lack of emotional availability or interest in an intimate connection with them was therefore included in the code “partner availability”. The code was reinstated and the change in the code’s meaning was noted in the researcher’s electronic journal, and thus is part of the audit trail for the study.

Selective Coding: The Core Variable

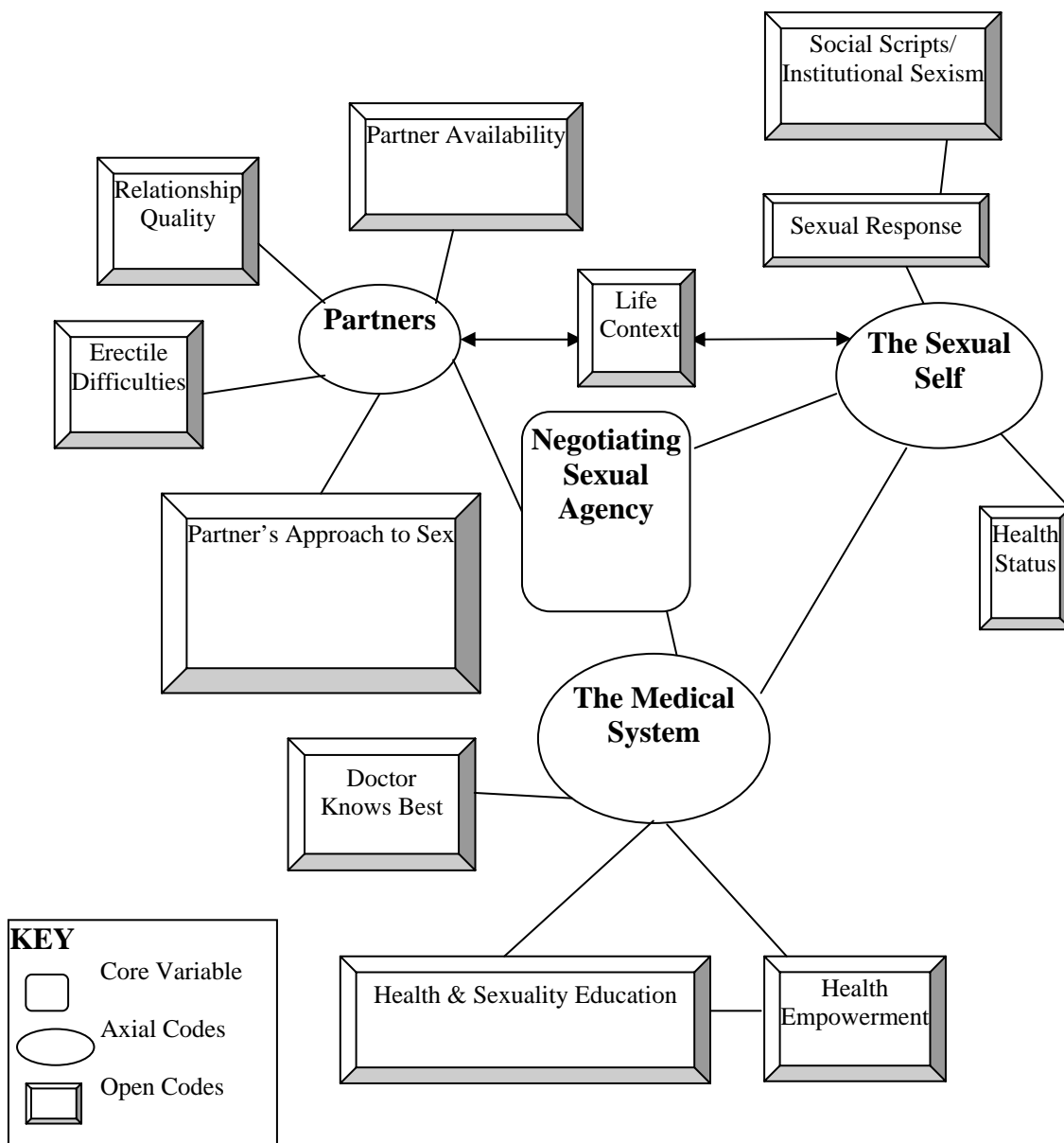
The last type of coding was selective coding, and the primary purpose of selective coding was to establish the core variable. Often, the core variable begins to emerge early in the coding process, as it did in this project. In the midst of axial coding, it became clear that a similar thread existed among all the codes, that of sexual agency. The core variable was clear for several reasons. First, the frequency of the code was overwhelming.

“Sexual agency” was established during open coding to refer to times when women discussed feeling like they had no control over their sexual satisfaction, or when they were unhappy with their husband’s approach to sex (that often assumed sex was necessarily penetrative and concluded when the male partner reached orgasm). On the other hand, some women discussed acting as sexual agents. For example, these women described feeling in charge and in control of their sexual satisfaction and overall sexuality. “Sexual agency” was a code that appeared in every transcript, and there were over 30 fragments of text (ranging from a few words to several paragraphs) coded as such during open coding. During axial coding, when text segments were compared and categories were constructed, it became clear that “sexual agency” was a thread that ran through every category. It was as if each code was a bead on a necklace, and “sexual agency” was the cord that connected each code.

In selective coding, each code and the associated subcategories were listed and the researcher systematically went through each code, in order to understand if and how each code related to the code “sexual agency”. It soon became clear that not only was “sexual agency” related to each code, but also that each code helped to explain how women negotiated their sexual agency since sexual agency was not an either/or dichotomy. In other words, women were sometimes (simultaneously) sexual agents and at other times, not at all in charge of their sexuality, depending on various circumstances. Thus it was clear to the researcher that the core variable was actually women’s ability to negotiate their sexual agency within the context of their lives. Specifically, there were three spheres or groups with whom women discussed having to negotiate their sexual agency and their experiences of sexual desire: the medical system, partners, and within

themselves. Thus, the core variable, “negotiating sexual agency”, explains women’s interactions with the three main axial codes, “partners”, “the medical system” and “the sexual self” in regard to women’s experiences of sexual desire. Figure 3 shows a visual representation of this relationship, as well as the associations between sub-codes (open codes) and axial codes.

Figure 3: Visual Representation of Codes & Relationships to the Core Variable



Feminist scholars and theorists use the term sexual agency as a concept that describes the degree to which women are able to act on behalf of their own needs, desires, and wishes in terms of sexual behavior, sexual decision making, and even in terms of how women's sexuality is viewed within society (e.g. Brumberg, 1997; Fine, 1988; Vance, 1992; Wolf, 1998). Similarly, feminists make a distinction between women as sexual subjects and as sexual objects. Theoretically, as sexual subjects (much like as sexual agents), women are in control not only of their own bodies, but also in charge of how sexual desire is constructed in terms of gender roles and who sexual behavior and activity benefits and disempowers. Women's sexual subjectivity means that women are agents of their own sexuality. In contrast, women as sexual objects are not actors at all. Instead women are *viewed* by others and used in terms of how their bodies and sexual activity privilege and serve others, primarily men.

In this sense, sexual agency (like sexual subjectivity) is a complex and abstract concept. It refers not only to women's ability to make their own choices about sex, but also to what degree women have internalized patriarchal constructions about women's roles as sexual beings, including how sexual desire is appropriated and conceptualized. Thus, sexual agency is not a dichotomous concept, although it is useful to understand the relationship between sexual subjectivity and objectivity in this manner. That is, women do not either have or not have sexual agency, especially given the extensive array of factors that influence women's sexual lives. Instead, women negotiate sexual agency on a continual basis, as will be discussed later in this chapter.

It is noteworthy that the focus of this study was on women's sexual desire, but that sexual desire was not a primary theme or code that emerged during data analysis. As

this chapter will explain, women talked very little about their sexual desire per se, even though they were directly asked about their sexual desire repeatedly. Thus, it is interesting that women were quite verbose about various aspects of their life (such as their gardens, children, work, and health issues), but were not specifically talkative about their sexual desire, sexual activity, or sexual response. This issue will be addressed in chapter five, as part of the discussion of the results, although it is mentioned briefly here for the benefit of the reader.

Similarly, it is important to understand how women conceptualize and perceive their sexual desire in order to fully understand the core variable and themes that explain this variable. This conceptualization emerged during women's discussion of their sexual response under the theme of "the sexual self", but will be discussed here (see Figure 4). Women conceptualized sexual desire as a whole body feeling, including both emotional and physical aspects, for an interest in sexual activity, either with a partner or alone. Women described their sexual desire as: a sexual energy that built within them, a willingness to participate in sex, a state of being, and an interest in sex. Some women explained that it takes them a long time to "warm up" and for them to feel sexual desire in their bodies. For these women, sexual desire was a willingness to participate in sex as opposed to feeling "turned on". One woman says,

I don't ever feel sexual desire before anything happens. He has to almost warm me up, and I have to be patient and go along with it for a while even though I don't feel anything pleasurable yet. ... I'm not really aware of feeling sexual desire until we're already having sex play, at least. It's more a willingness to participate (ID # 4, Lines 98-107).

When asked to *define* sexual desire, women responded variously and used different terms to describe their awareness of their sexual desire. One woman explained:

Sexual desire. Hmm, well, the idea that you desire to be with another person sexually, and um, to have intercourse (ID# 3, Line 9).

Another woman said:

Uh, I guess sexual desire is the desire for sex, for sexual closeness (ID #4, Line 9).

Finally, another woman defined sexual desire as:

.. finding my partner irresistible, attractive, and desirable. For me, it's a way that I feel (ID # 6, Lines 10-11).

Women most often described sexual desire in terms of desire for sexual activity, often intercourse, with a partner, but when prompted three women acknowledged that sexual desire might also be directed towards an interest in masturbation. When asked if sexual desire is specifically for intercourse, one woman said:

... it could be self-help (ID #12, Lines 7-8).

When another woman was asked to clarify if sexual desire was always directed towards her husband, said:

No, sexual desire could be for masturbation too (ID#10, Lines 22-3).

Women were asked to explain how they knew that they were experiencing sexual desire, and to give examples of indicators of their sexual desire. Women commonly associated sexual desire with emotional feelings, including feeling closeness to a partner or wanting to experience intimacy with a partner through sex.

Several women (who were interviewed early in the research process) gave either vague or contradictory answers when they were asked about their experience of sexual desire. For instance, many women were stumped and explained that they had never really thought about what indicated that they were experiencing sexual desire. Some women talked about feeling disconnected from their bodies and about sexual desire as

something they thought about or felt in a cognitive or affective sense, not necessarily something physical located within their bodies. However, later in the interview these same women referred to physical aspects of sexual desire, such as vaginal lubrication or increased breast tenderness.

Women who discussed contradictory meanings of sexual desire were contacted a second time for a short, follow-up interview to clarify their intended meanings and to better understand their conceptualization of sexual desire. Some women were unable to discuss how they were aware of their sexual desire, and these women could not think of any indicators of sexual desire. Other women described their awareness of sexual desire as “feeling warm or sweaty”, “a warm rising fluttering pressure in their core body and in their hearts”, and “tingling sensations in their breasts”. One woman said:

If you hadn't brought it to my attention, I probably wouldn't ever have thought about it. Sometimes, it's a swallow in my throat, sometimes it's a feeling in the very base part of my body. But it's definitely a feeling, uh, uh, and at the beginning, and then it just kind of increases and increases and increases (ID# 6, Lines 47-50).

Women who were aware of physical indicators of sexual desire usually discussed non-genital signs of their sexual desire.

Women's conceptualization of sexual desire was very complex, including their definitions of sexual desire as well as their descriptions of the experience of sexual desire. Women's experiences suggest that sexual desire for women is a whole body feeling that indicates an interest or a willingness to engage in sexual activity (primarily vaginal-penile intercourse, but also masturbation). Some women were acutely aware of physical indicators of their sexual desire, such as vaginal moistness, while other women had no awareness of their sexual desire in a bodily sense. When asked to clarify the

meaning and significance of physical indicators of sexual desire (e.g. vaginal lubrication), women unanimously made a distinction between sexual desire and sexual arousal. For instance, one woman initially described an association between sexual desire and sexual arousal in terms of indicators of desire:

I think that nothing beats feeling moist in your vaginal area, and when I start to feel *sexual desire* I very definitely feel moisture in that area. ... other things do happen. I sometimes, uh, I don't use deodorant, and when I feel *sexually aroused* the perspiration under my arms begins to have like a musky smell. It's really wonderful you know what your body does ... Maybe I blush a little or I get a little flushed, and my eyes get a little sparkly. I have a heightened sense of excitement, but it's not stressful excitement, it's a peaceful excitement (ID #5, Lines 29-40).

During a follow-up phone conversation, the interviewer asked this woman to clarify her distinction between sexual desire and arousal. When pressed, this woman did make a distinction between sexual desire and arousal:

Yes, I understand what you're asking now. Yes, I mean sure they're different, but how and why is what you're asking me. Sexual desire is wanting it, sex, feeling like you want to have sex, or even maybe the need to have sex. Arousal, well, that's later, usually. That's the, uh, sense that sex could happen and your body is getting ready for it. It's feeling turned on, sexy. ... Being moist in my vagina, feeling my breasts harden, all the things that accompany being turned on. I guess they're different for everybody. ... for me the most important is definitely being wet (ID #5, Follow-up Interview, Lines 11-24).

Thus, while some women initially distinguished between sexual arousal and sexual desire, other women needed to be asked a second time, more directly, to clarify the meanings associated with each of these terms. In the end, an overwhelming majority of the participants made a distinction between sexual desire (an interest or willingness to engage in sexual activity) and sexual arousal. It should be noted here that the researcher's interest in clarifying the meanings of women's use of the terms sexual desire

and sexual arousal may have forced the issue, so that women may have made distinctions between these terms solely because they were asked to do so.

Women described sexual arousal as being turned on and as being ready for sex. When asked how they were aware of their sexual arousal, women discussed physical indicators of their arousal, including vaginal moistness/lubrication, increased sensation in their breasts, and other non-genital changes. Women conceptualized sexual arousal as a physical state and remarked that arousal is more easily detectable than sexual desire based on noticeable physiological changes. One woman explained the difference between sexual desire and arousal:

I guess desire is “I want it” and arousal is physical, like physically ready. Where I guess desire is more mental (ID# 13, Lines 12-13).

Another woman said:

Sexual arousal is more a sign of sexual desire (ID# 2, Line 9).

Finally, one woman described sexual arousal in terms of how she is aware of it:

Oh yeah, arousal would be the real bodily sensations, the real, the antsiness and the heat, and the building intensity, really discomfort almost. Arousal is about the physical sensations (ID# 8, Lines 11-13).

Vaginal lubrication was an important indicator of women’s sexual arousal, and it was the only specific physiological aspect of sexual response that women discussed without being prompted. Women stated that vaginal lubrication was an important in terms of their awareness of their sexual arousal. One woman explained:

I think that for older women who are going through menopause, if they lose that moisture, that must be awful, they have to have other indications, and do other things to moisten themselves (ID #5, Lines 33-34).

Vaginal lubrication was important for other women in terms of preventing vaginal discomfort during intercourse. One woman said:

It's just, like, it's that frustration with lubrication, it's more difficult to feel turned on (ID #18, Line 47).

The women who discussed vaginal lubrication and dryness in terms of discomfort or pain during sex did so regardless of whether or not they had coping mechanisms in place to deal with possible discomfort (e.g. exogenous lubrication, cunnilingus). That is, women who mentioned that vaginal dryness was a problem for them in that it led to vaginal discomfort or pain, discussed strategies they used to try to avoid vaginal-penile intercourse, even if they had used a synthetic lubricant and were relatively satisfied with how it worked. One woman said:

Well, we've tried things to, you know, make it less uncomfortable for me. KY Jelly helps some and so does uh, oral sex, that's a bit better. But, it's just that, well, I mean, it's just not the same. It doesn't feel the same as it used to and so ..., I don't know, it's just not as comfortable, I'm just not as interested if this is how it's going to be. I'd rather just give it up (ID# 20, Lines 55-63).

Some women spoke of vaginal discomfort, and even pain, that they attributed to vaginal dryness, not necessarily solely during vaginal-penile intercourse, but also during sex play, including when their genitals were fondled (either by themselves or by partners). One woman said:

... the act is so much more difficult because I, I have no lubrication whatsoever so it's almost painful, no matter how much you want to do, and you know you can use products, but that part is frustrating to me ... I've been trying to work with it, it just is so much more difficult. It's just more painful without having, uh, the lubrication ... it's very frustrating. Even when I have the desire to have sex, even if it's solitary, it's just uncomfortable so I end up passing, avoiding it (ID# 8, Lines 54-68).

Thus, it is clear that vaginal lubrication is an important aspect of sexual response for women and that women attributed various meanings to the presence or absence of vaginal lubrication. Specifically, some women associated vaginal lubrication with sexual readiness and arousal, while other women perceived vaginal lubrication as an important aspect of penetrative sex with regards to preventing discomfort or pain. Now that the ways that women conceptualized sexual desire have been discussed, the ways that women negotiated their sexual agency with regard to sexual desire will be explored.

Data Analysis: The Emergence of Themes

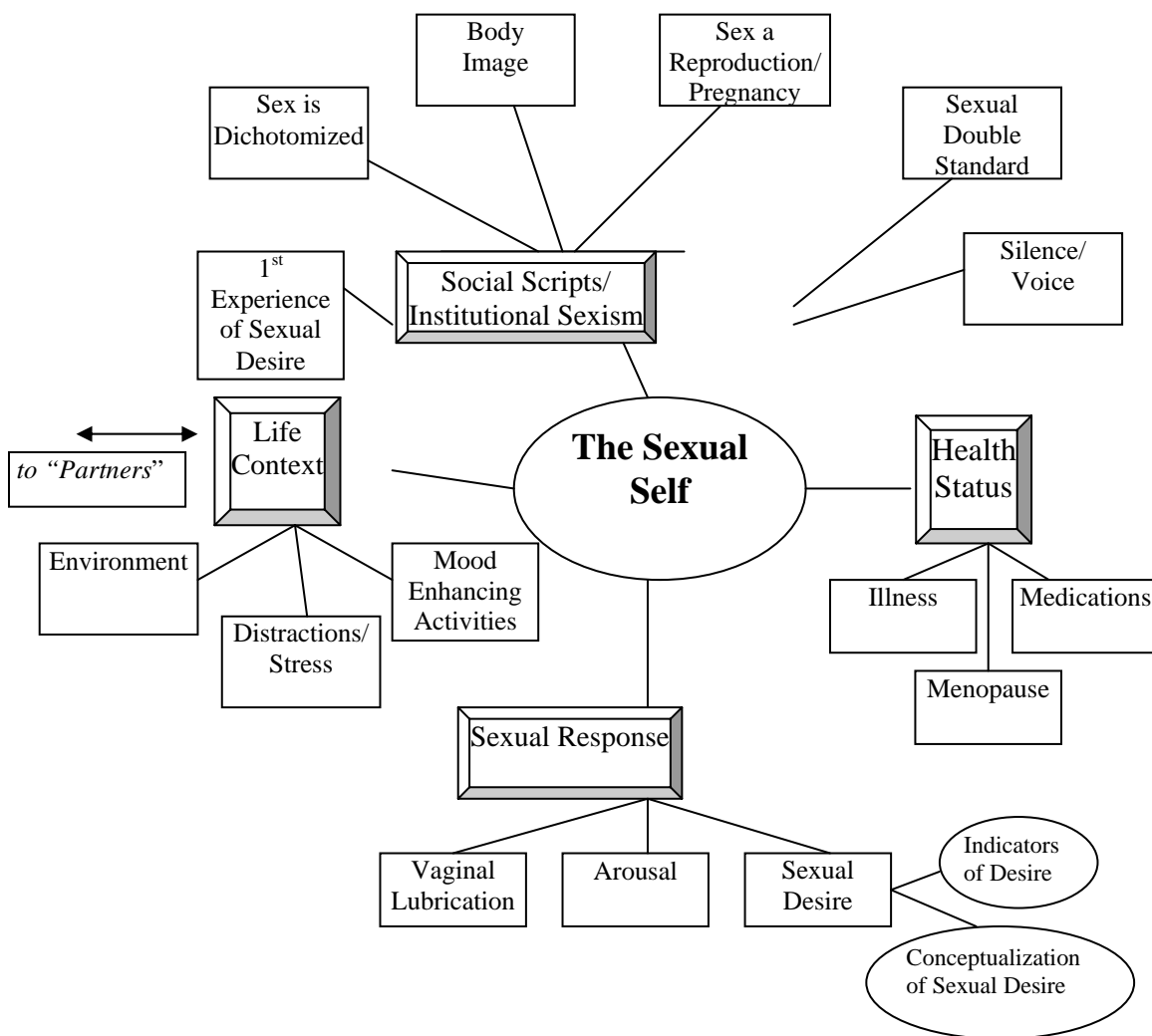
As discussed earlier in this chapter, several main codes emerged from the data during axial coding to explain how women negotiated their sexual agency in regard to their experience of sexual desire, including with “the sexual self,” “partners”, and the “medical system”. These themes will be presented in order to understand women’s negotiation of their sexual agency in regard to their experience of sexual desire. Next, the themes that emerged from data analysis will be used to answer the research questions for this study. In response to one of the research questions, the theory developed from these analyses will be presented.

The Sexual Self

Women negotiated sexual agency within themselves, and in regard to their own perspectives of themselves as sexual agents and sexual beings with sexual rights and

needs. The code “the sexual self” refers to women’s sexuality in a holistic sense, encompassing a variety of issues that influence women’s experiences of themselves as sexual beings. The “sexual self” consists of four categories, which were formed from 21 of the original codes developed during open coding. They are: “sexual response”, “social scripts/institutional sexism”, “health concerns”, and “life context”. The category of sexual response has already been presented. The other categories will be discussed further in order to illustrate the extensive explanatory power of the category “the sexual self” in understanding the meanings that women attach to their experiences of sexual desire. Taken together, these categories illustrate the complex, internal negotiation that women experience in acting on behalf of their own sexual rights, needs, and pleasure. Figure 4 presents a visual representation of these codes.

Figure 4: Visual Representation of Codes & Relationship of Codes and Sub-codes of



“The Sexual Self”

Sexual Self”Social Scripts/Institutional Sexism

The two codes “social scripts” and “institutional sexism” are intricately connected in how they explain women’s experience and meaning of sexual desire. While these two concepts are not completely disparate, they will be discussed separately here for the purposes of clarity.

Social Scripts

The code “social scripts” was developed during axial coding to explain the various messages that women received and internalized with regard to what they had learned about the appropriate place for sexuality in their lives. During the interview, women were asked to discuss influences on their conceptualization of sexual desire. Women discussed a plethora of factors that influenced their conceptualization of sexual desire including: parents, schooling, the conservative era of the 1950s in which they were raised, religion, partners, marriage and children, and the media. The messages that they received about women’s sexuality and sexual desire from these influences were overwhelmingly negative. One woman said:

Yeah, well initially, in the fifties there was the whole thing of the propriety of being very modest and virginal. You know I’ll tell you how far back this goes, a real seminal experience, uh, I was already something of a tomboy because I had three brothers and you know in a patriarchal society boys had more freedom and seemed to be more valued. In second grade, I remember thinking, that there was something going on about women that I was picking up from adults in the community. That there was something about women who moved their hips freely who were free and easy in their bodies that was very judged about. And I remember thinking, “I am never going to let them ...”, because there was that mocking and denigration, that you know, icky icky feelings. So I remember locking up my hips right then and there. And in third grade, where every year you have a program in the grade school for the community at the end of the year, every grade had a different country, and we had Cuba, which was interesting, so we were going to be doing the rumba and I was good at dancing, you know I had it down pat. But they tried to get me, they wanted me to be in the center, and I hated the costumes, they emphasized your hips and they wanted me to move my hips! And there was this silly headdress, it was just mortifying, and I wouldn’t move my hips. But they still wanted me because I really had it down, but that discomfort was the teachers and the school people who had really put out the message about how unacceptable it was, you know them telling me to do it, and especially it seemed so inappropriate for a girl. And I remember really being puzzled about that (ID# 9, Lines 26-43).

Another woman said:

Uh, well I suppose a lot has to do with how you are brought up and how sex was talked about when you were young. And uh, that, I think I came from a prime period when it wasn't talked about as much and women weren't supposed to have those needs as much. Now, it's kind of, now it seems different, like there are more people for who the sexual desire part has nothing to do with the emotional part (ID# 8, Lines 13-17).

Another woman explained:

Well, I grew up in a very repressive time, a generation, and also in a very repressive family. Sex was never talked about in my family, and when it was it was always in a negative way. Especially us girls, my brother was never really talked to in the same way about sex, as girls we were somehow more blamed about sex, that there were bad things that could happen and it was our job to stay away from it, sex (ID#4, Lines 11-15).

Interestingly, the few women who said that they had received messages about sex that were neutral or even somewhat positive discussed messages that were not really about sex itself as much as related to romance, intimacy, and closeness. In other words, women who said that they did not receive negative messages about sexuality actually discussed the emotional or interpersonal aspects of sex. For instance, one woman explained:

My Mom and Dad have been married for 62 years, and even though we're from Minnesota and not as probably demonstrative, or um, we don't talk, I mean, my Mom talked about nothing about our sexual education, I mean very, very little, but you could always tell that they loved each other, they hugged and sat together sometimes in the same chair, so I could see that there was a definite connection both physically and their love (ID #1, Lines 13-17).

Thus, it is noteworthy that women's conceptualization of sexual desire was influenced by messages they had received about the acceptability of women as sexual beings and sexual agents. These messages were rooted in institutional sexism.

Institutional Sexism

Another theme that emerged from data analysis regarding women's sexual selves that is also closely related to social scripts for women is that of institutional sexism. The code "institutional sexism" was difficult to establish, as it initially seemed that various social and cultural aspects of women's sexual lives, such as the sexual double standard and the notion that sex for women must be rooted in love or emotional necessity, were disparate. However, it became clear that the underpinnings of these social and cultural messages about women's sexual desire actually served to appropriate sexual desire (and sex in general) to men, in order to serve men's sexual needs to the exclusion of women's sexual agency. Thus, the interconnectedness between various sociocultural messages that women received that helped shape their social scripts was rooted in underlying institutional sexism. Women discussed five categories or examples of institutional sexism: the sexual double standard, the notion that the meaning of sex is dichotomized for women, sexual silence/voice, sex as reproduction, and body image issues.

The sexual double standard is the notion that the acceptability or appropriateness of certain aspects of sexuality (e.g. types of activity, frequency, number of partners) is different for women than for men, and more specifically, that men have more flexibility and permission to act as sexual agents. The code the "sexual double standard" was developed very early during the process of data analysis, as this was a very common part of women's discussions about their experience of sexual desire. Women discussed feeling that there was a social stigma toward women who embodied or who were in tune with their sexual needs and sexual desire. These women are viewed as "sluts" and

labeled with derogatory terms. However, women were aware that no such terms existed for men who acted on their sexual desires. In fact, women mentioned that men in our culture are often lauded for acting on their sexual urges. One woman said:

Yeah, I mean, men were always supposed to be sowing their wild oats while women had to save themselves, that idea. You were supposed to be a virgin in those days. You know, well, I mean people still sometimes think of that nowadays, and still men have that freedom where women are, well you wouldn't want to say the word slut, but that kind of thing, it's still a different standard (ID# 8, Lines 21-6).

And another woman explained that the sexual double standard also creates a catch-22 for women because they are expected to be attractive for men and to get attention from them, but also to make sure that men do not get the wrong impression from their efforts to be attractive. She explained:

Yeah, there's a tightrope for you [women] ... to not ask for it. Be attractive and like the attention you get from men [based on how you look], but not wanting to, you know, be interpreted as being one of THOSE {emphasis} women. I really made that clear, that I wasn't one of those women. I mean I never even wore make-up... (ID# 9, Lines 49, 52-56).

While not all women discussed the sexual double standard, it was a prevalent theme that emerged during data analysis. In their discussion of the sexual double standard, women stated that the seemingly contradictory messages that they received about when and how sexual desire is and is not appropriate actually served to distance them from their experience of sexual desire. One woman said:

The only way I can explain it, this feeling that my sexual desire is out there somewhere, away from myself, is that there are all of these other forces dictating when a woman, at least in my generation, should and could have sex. And the rules or standards about women feeling turned on or interested in sex were even more confusing. You know: "Have sex for your husband, get excited for him, but not too excited because you want him to feel like he can please you and satisfy you. Don't be turned on by

other men who aren't your husband, that's wrong". It's like, someone else has dictated with who, where, and when I should have sex and how excited I should be about it, I just {pause}, it's like I just stopped trying to have it be mine. I gave up trying to understand and sort out all of those rules and mixed messages. I rarely feel sexual desire anymore at all (ID# 18, Lines 80-97).

Many women learned, through social scripts that are rooted in patriarchal assumptions about the nature and purpose of sex, to separate their sexual desire from themselves and from their bodies. That is, they learned to place their sexual desire outside of their own experiences, thereby surrendering their sexual agency. In this sense, women's ability to negotiate of their sexual desire with regard to the sexual double standard was quite problematic for many women, and explains how the sexual double standard stifles women's ability to truly experience sexual desire as part of their sexual response and sexual agency.

Another aspect of institutional sexism that is related to the sexual double standard is the sexual dichotomy that exists in terms of the meanings attached to women's sexual desire. The code "sex is dichotomized" was also established very early in the data analyses process based on the frequency and explanatory power of this code. Women stated that there were two reasons to have sex, either for sexual pleasure (i.e. lust) or to fulfill the need for intimacy (e.g. love). Women explained that men have sex out of lust, to fulfill their sexual needs. On the other hand, women have sex in order to feel emotionally close to their partners, and only within a loving relationship. One woman explained:

I think so many times for guys, [it's] the physical thing, where they feel the pressure build up, they need release, whereas for me it's just an expression of love (ID# 1, Lines 35-6).

While women often recognized the absurdity of these scripts, they nevertheless had internalized the notion that their sexual desire was somehow problematic. For example, some women used terms like “risky” and “dangerous” in reference to their sexual desire. Women explained that they felt pressure from social scripts to regulate their sexual desire. Women most often discussed regulating their sexual desire in terms of expressing it only in very specific ways for very specific reasons. For instance, one woman said:

... I’m from a Christian background and knew that it [sex] was, you know, God’s expression between two people, well that’s what I believe, of love, and it wasn’t about the physical stuff for me, but it was, uh, more deeply felt and emotional than that (ID#2, Lines 27-9).

Another woman said:

... I think just the way I was brought up probably, it’s not as free, you were more suppressed ... You were, you know, you were supposed to hold all that stuff [sexual desire] in until the day that you got married, and I think in some ways that has made it more difficult for me through time (ID# 15, Lines 15-9).

Another woman was more aware of her internal negotiation of her sexual agency and her willingness and ability to act on her sexual desire, despite the limitations she felt as a result of this sexual dichotomy. She said:

Well, right now I’m grappling with do you need love with sex {sigh}? And, at this point in my life there aren’t many opportunities for sex. And I have to say, for a lot of women, past the age of, well, I don’t know, whatever, for women, I think they do grapple with this more, and I think a lot of women do not have the opportunity for sex and would like to have more sex, and they just, it just doesn’t really happen. So, you have to, I think decide I’m just not going to wait for Prince Charming, and to have love involved, if it seems like an opportunity and it’s safe, you know, go for it. But, it’s still hard. ... a man, who I’ve seen in the past, we are now friends again, and I’ve had a lot of orgasms with him I’ve had the best orgasms I’ve ever had in my life with him, so I’m trying to decide whether I can work something out. To get those orgasms again without having to form an emotional attachment (ID# 5, Lines 7-13; 25-30).

Thus, it is clear that despite women's experience of sexual pleasure and desire, the notion that sex is either an expression of love or lust curtails women's ability to fully act as sexual agents on their own behalf.

Another aspect of institutional sexism that women described as influential in their experience of sexual desire was the ability to discuss sex. The code "sexual voice" describes women's ability to discuss their sexuality with people in their lives (i.e. partners, friends, health professionals). Conversely, "sexual silence" refers to women's inability to discuss sexuality-related issues, as many women believed that such discussion is inappropriate for women. These two codes were collapsed into one code, "sexual voice/silence" because a woman might experience both voice and silence, depending on the other person with whom she is communicating.

Women's sexual voice or silence was inherently related to other messages that women received about sex and sexual desire, including social scripts influenced by the sexual double standard. Often women had learned that discussing sex was an indicator of promiscuity and that such talk was not appropriate for "ladies". One woman said:

... I mean my stepsister worked in a meat packing supermarket when she was about 18 or 19, and I think the women there tried to embarrass her by talking about having a good time [sex]. You know, they would try to make her blush. But I mean, no, otherwise I don't think we did ever talk about it [sex]. ... [At the same time] I was having sex with my boyfriend, in the bushes down the street, or in his house, blah blah blah. But did I talk about it? No. Why would I talk about it? I don't know that it would have added anything (ID # 10, Lines 42-50).

In this example, it is noteworthy that this woman was having sex, but still felt that discussing her sexual activity was inappropriate. As this example illustrates, women's

negotiation of their sexual agency was complex, so that women's sexual silence was not necessarily indicative of women's sexual behavior or level of sexual desire.

Women's sexual voice or silence was also apparent in women's discussions with the researcher during the interview. Before the interview began, the researcher thanked each participant for her time and explained that she could pass on any question that she was uncomfortable answering. She could also end the interview at any time (as also explained on the consent form). The participants were also given an opportunity to share comments or to ask questions of the researcher both before and after the interview occurred. Several women used this opportunity to remark about their discomfort discussing sexuality issues in general, but that they had agreed to participate because they believed this research was necessary and important. For example, one woman said:

I have to admit, I'm real hesitant. I do think that it's a really valid area of study, and if it can help somebody else then good, but I'm just not real comfortable talking about sex (ID# 13, Lines 4-6).

In contrast, some women said that they were finally glad to have someone to discuss their experiences of sexual desire (and other sexuality issues) with. Two separate women ended the interview by profusely thanking the researcher for listening to their experiences and for valuing their stories. Another woman cried at the end of the interview because she did not realize how silent she had been about her sexual desire, and her sexual fears and concerns. She vowed to find someone in her life that she could talk with about such issues. Another woman said:

And I really enjoyed talking with you too. Your call came at a very good time. . . . Just talking to you made me feel that I am very lucky, and so this was a well-timed call (ID#5, Lines 205-7).

Women also associated sex with reproductive capacity, and fear of pregnancy was a common inhibitor of sexual desire for women, even though they were postmenopausal! Several women explained that even though they were aware that pregnancy was no longer a viable outcome of sex for them, they had feared unintended pregnancy so much and for so long that they somewhat unconsciously associated sex with a fear of pregnancy. This relationship still inhibited their ability to experience sexual desire. One woman explains her experience of the fear of pregnancy:

You know, there's another factor too though. When I was young, I had an aunt that died in childbirth, and another aunt who had a very difficult childbirth. She had a child born dead and a second one that died very shortly after it was born. And I think somewhere along the line, I learned to be very fearful of childbirth, and I remember reading, uh, a romance magazine one time when I was a teenager, and then reading about childbirth, and it occurred to me that this could happen to me, that this was going to happen to me if I had children of my own, and I became very afraid. And I, and I, I kind of wonder. I mean I've never had any children of my own, ... and uh, I wonder if you know, before I got married, when I was going with guys I really enjoyed, in quotes *making out with*, as we called it then, um, if you know, I didn't have intercourse because the full intercourse was so fearful (ID# 19, Lines 57-65).

On the other hand, other women expressed that menopause was a freeing experience for them in terms of no longer experiencing menstruation and needing to worry about contraception. In this sense, women viewed menopause as a positive experience in that it relieved the stress associated with menstruation and pregnancy prevention. In fact, some women stated that they had positively anticipated menopause because they looked forward to the cessation of menstruation. One woman said:

I haven't felt that menopause has been a negative thing for my body, in fact I think, you know, I haven't minded it at all, and I thought that it was a good transition, {laughing}, mainly because I didn't have my period! Not that I had such a terrible period, but see, I went until 55, so I was ready. Yeah, I was part of the TREMIN study so I kept track of my period

ever since I was in college, and um, I know my Mom would keep asking me, “Are you still having your period?”, and I would say, “Uh-Huh”. {Laughing}. I thought, oh man, I am tired of this. So I was very pleased when finally at 55 I started going through my change of life. You know, it was kind of like, “Yes!” {Laughing} (ID# 1, Lines 104-112).

The final aspect of institutional sexism that women described as influential in their experience of sexual desire was that of body image. Women were not asked directly about body image per se, but they were asked about their relationship with their bodies. Many of the women discussed their bodies in terms of how attractive they were to their partners or the value of their bodies in terms of attracting a partner. In this sense, women had internalized the perspective that women’s bodies exist in terms of serving men’s sexual needs. About half of the women discussed making *alterations* to their bodies, in terms of making them more attractive, including: liposuction, plastic surgery (“tummy tucks” and face lifts), and severe instances of dieting and exercise programs. One woman said:

There were periods when I did not feel very desirable ... and one of the things that I did about that, I had um, I had extremely large hips, that I would have to wear a size 12 pants and I’d wear an 8 top. So I did something, I remember talking to Ron, my husband, telling him how much I hated how I looked in clothes. I could never go into a store and buy a suit, unless I bought separates. I could never buy a straight skirt. And I said I want to do something about it. He said, “what do you want to do?”. I said I think I need liposuction. He said, “well if you do, than that’s what we do”. And having had that done, and that was right around menopause when I had that done, made all the difference in the world for me because I can wear a size 10 slacks and a 10 top, I can wear a straight skirt, I can wear a suit, I can wear clothes! No amount of exercise or no amount of weight was ever going to change my body structure, I carried it all in my hips and in my legs. So, yes, image was important to me, my own, I mean some of us are our worst critics. And I was my worst critic. I knew that I could never wear plaids, I could never wear prints, I could never wear anything that brought attention to my hips, but how could you not?! But after that, um, I felt a lot better about myself and I still do (ID# 6, Lines 257-75).

Another woman said:

Um, yeah, I think, you know, if I feel attractive, it uh, my sexual desire is stronger (ID# 2, Line 72).

Women felt that the message that they should alter their appearance for men, in an effort to be more attractive and sexy, was everywhere, but extremely prominent in the media. Nearly all of the women referred to the unattainable skinny, young, gorgeous beauty standard presented by the mainstream media as an influence on how they feel about their own bodies. Women who had adopted a patriarchal perspective of their bodies, which viewed women's bodies in terms of being attractive for men and to men, also referred to their bodies as "sexual objects".

A majority of the women disliked their bodies, and these women discussed a relationship with their body that was based on their clothing size or their weight. In contrast, the few women who liked their bodies discussed feeling in tune and connected to their bodies, often in terms of how their bodies facilitated their enjoyment of life. In other words, women who had a good relationship with their bodies did not discuss their attractiveness to men, but rather the ability of their bodies to facilitate other life pleasures. Women with more positive body image had a more holistic view of their bodies and were not focused on their appearance or attractiveness to others. These women discussed how their bodies afforded them the opportunity to participate in leisure activities such as canoeing, hiking, gardening, and swimming. Notably, the few women who discussed their bodies in this holistic sense had also experienced health problems, ranging in severity from back problems to cancer. Perhaps these women's experiences with

debilitating illnesses gave them a more “whole body” appreciation and a different approach to body image.

Social scripts influenced by institutional sexism have an impact on women’s actual experience of sexual desire. For instance, some women explained that specific situations and circumstances in their lives affected the acceptability of their experience of sexual desire. For example, women explained feeling that sexual desire was permissible if (and only if) their desire was situated within the larger need for love and within an appropriate relationship (which for most women was marriage). In this way, women learned very early in their lives that sexual desire was something that they needed to control, to turn on and off as deemed appropriate by others. As a result of social and sexual scripts, women discussed how they had learned to stifle their desire, depending on the circumstances and the context of their sexual feelings. One woman said:

You know, it was just really confusing. As a girl and even in college, you know, I was really aware of how it was my responsibility to keep boys at bay, to be a proper young woman, and to not invite behavior that might get me into trouble, if you know what I mean. But then, you meet a nice boy and he courts you and you all of a sudden are supposed to be attractive and invite his interest. ... My mother called me after my wedding night to see if I made out ok. It was as if, well, suddenly I had to drop all the proper behavior and I was supposed to be passionate, excited, and interested in sex. I had learned all along to push those feelings way, way down inside of me. How was I going to get them back? It was frustrating and confusing, especially since I was so young (ID# 16, Lines 78-91).

Thus, it is also clear that the meanings women attach to their experience of sexual desire are embedded in the sociocultural context of women’s lives, such that sexual desire is a much more complex concept than researchers and scholars may have previously described.

In addition to negative messages that women received about their sexual desire, women's first experiences of sexual desire were also a good indicator of women's internal negotiation of sexual scripts in terms of their sexual agency. Women discussed first feeling sexual desire anywhere from five to eighteen years old, and some women seemed to enjoy reminiscing about their first experiences with sexual desire. These women had not learned to distance themselves from their sexual desire at this early age, and they stated that their first experiences of sexual desire were more genuine or somehow more real than were their experiences of sexual desire when they were older.

For example, one woman said:

I remember in 6th grade having a boy that I had some fantasies about, he was the best dancer and he was smart, and things like that. And one day he carried my books home from school, we walked home from school about a block. And that was about it, and just sort of that was more as I say there would be an attraction and an excitement about guys, and then the whole thing about the dancing, the close ballroom dancing that would be fairly arousing and you'd get really hot and feel kind of tickly and prickly and excited. I didn't have any desire to push it into sexual encounters, but in high school, by my senior year of high school I had a boyfriend where, where there was petting and um, some discomfort about whether that was Ok or not. ... By that time I had learned from cultural messages that, well, I just wasn't comfortable anymore. (ID# 9, Lines 109-117, 123-124).

Thus, before these women were inundated with messages that appropriated their sexual desire in specific ways, women discussed feeling free to explore their sexual desire and sexual feelings. However, as women internalized social scripts about the acceptability of women as sexual beings and when and how sex was permissible, women were less able to be sexual agents, even as young girls.

Alternatively, other women stated that their later sexual experiences were more satisfactory and that their sexual desire strengthened as they matured. For example, one woman said:

... I really think that physiologically, certain things happen, particularly with women, not until later in life. And, so, having this sexual feeling, desire, happens with women I think when they are more mature (ID# 5, Lines 30-33).

In sum, women negotiated their sexual agency in light of social scripts that they had internalized throughout their lives.

Health Status

Women were not asked directly about their health, and consequently very few women mentioned their health as an important influence on their sexual desire. However, for the few women who did discuss their health, significant health problems were important contributors to their experience of sexual desire. In other words, while health status was not frequently mentioned, it was an overwhelming influence on a few women's sexual desire.

A few women in the study had serious health problems, including polio, breast cancer, degenerative back problems, and severe clinical depression. These women said that their illness affected their sex life, especially in terms of decreasing their sexual desire. One woman explained:

... I have physical effects from when I had polio. I am dealing with fatigue and with pain A LOT {emphasis}. And it's really hard to get past those issues in order to be interested in sex (ID# 13, Lines 23-4).

And another woman said:

I have had some surgeries, so I'm not, I don't really know exactly, but I don't really have any feeling in some parts of my body, and I don't really have any response sexually. And then ... I had surgery for a cyst on my spine that was causing me a lot of pain, and I really think that probably after that I really, uh, I don't know, I mean, I can control my bladder and all of those sorts of things, but I don't have a lot of sensation down there (ID#7, Lines 31-3; 37-40).

Similarly, some women attributed their lack of sexual desire to medications, although to a lesser degree than illnesses. Although women were not specifically asked about their use of medications, some women did volunteer that they were currently using anti-depressants. Interestingly, some of the women said that their primary care physicians had prescribed anti-depressants to treat menopausal symptoms such as hot flashes, despite the fact that decreased sexual desire is reportedly a common side effect of such medications. This phenomenon will be discussed later in this chapter in terms of the medicalization of menopause and related sexuality issues.

Finally, women discussed menopause as part of their health status. Women were directly asked how they thought menopause had affected their sexual desire during the interview. Some women thought that aging was a bigger influence on their sexual desire, while other women discussed the impact that menopausal symptoms, such as hot flashes and vaginal dryness, had on their sexual desire. Women who discussed the effects of aging on their sexual desire had surprisingly little to say about the influence that their menopausal status had on their sexual desire. For instance, one woman said:

Menopause wasn't really that bad for me. ... Menopause was just something that happened to me and it didn't have an effect on too much of my life (ID# 4, Lines 72-5).

When asked by the interviewer to disentangle the differences between menopause and the overall aging process, women were often unable to do so, except for specific symptoms associated with menopause.

Women who discussed the effects of troublesome menopausal symptoms mentioned the indirect effects of hot flashes on their sexual desire. When asked to describe the effects of menopause on her sexual desire, one woman said:

{Laughing}. Well again, I thought that you got most of those symptoms after your period stopped, not before. I went through, well here's the thing, for a while they were called hot flashes, then power surges, and my favorite one is personal summer. It's wonderful, especially said with a southern accent and a fan in your hand. I told my friends, pretend you're looking for something in the freezer, stick your whole head in the freezer, or I used to go out back at work and come in the front, which cooled me down just enough. Uh, hot flashes were hell, for a while they were happening every two and a half hours, day and night. Night sweats. Um, it got to the point where at one point I decided that I'd write down when I had them, and it was like, "Oh there's one, oohp, there it is". And I wasn't waiting for it, but it was just amazing how regular they were. It happened for months. ... It's terrible to live with anyone when you're going through that, I was not a pleasant person, and I most certainly didn't want to have sex. I was too damn hot! (ID# 10, Lines 150-161).

As discussed previously in the section on sexual response, women were quite bothered by vaginal dryness.

Life Context

Life context is a fluid category that links women's life context to their relationships. The category "life context" was one of the last categories to be developed because there were not many codes associated with it, and the meaning of "life context"

is admittedly somewhat vague. However, this category encapsulates various contextual factors that influenced women's experience of sexual desire including: distractions and stress, mood enhancing activities, and the environment. For instance, women discussed various contextual factors that facilitated or stimulated their sexual desire, including recent activities and entertainment (e.g. a romantic movie or book), feeling especially connected to a partner, or the overall mood of the day or evening. One woman said:

Well, I have to tell you something. We went up to this lodge, up in Wisconsin; it was some friends' of ours. It was just a beautiful place, and our bedroom had a skylight, and {laughing}, I really got turned on then, you know. I really had a lot of desire then. It was a completely different setting and I loved it there. And I was excited, and we had this big bedroom by ourselves. I think the setting really has a lot to do with it, because years ago, we were in this motel and it wasn't very nice, and it smelled like smoke and all that, and I just couldn't get in the mood, it just didn't work, so I chalked it up to the place or a bad night, or whatever. You know, yeah, it just didn't matter what we did, nothing doing (ID# 17, Lines 37-43).

Another woman said:

Now sometimes, you know, if I'm reading a good book or if we go to a real romantic movie, that helps too. You've had a great date or times we've really communicated together, or a fight even (ID# 1, Lines 38-41).

Thus, it is noteworthy that women locate facilitators of sexual desire outside of themselves, such as within their relationship with their partner or in terms of a sexual or romantic stimulus from entertainment or the surrounding environment. That is, women did not discuss sexual desire as facilitated within their own bodies or by their own thoughts or affect, and as a result women discussed feeling that they had little control over facilitators of desire.

In addition to discussing relationship and partner-oriented inhibitors of sexual desire, women also discussed distractions in their lives and stress that inhibited their

sexual desire. Nearly all of the women mentioned feeling rushed and busy in their lives, and feeling that there just was not enough time in the day to accomplish what they needed to do. Women explained that feeling distracted by unfinished tasks, worries, and various stressful life events (e.g. family visits, holiday food preparation, grandchildren) made them feel tense and therefore less interested in sex. For instance, one woman said:

If I'm just very tense about something, who knows what, and that will, you know, then nothing's going to happen (ID# 14, Lines 59-61).

Another woman said:

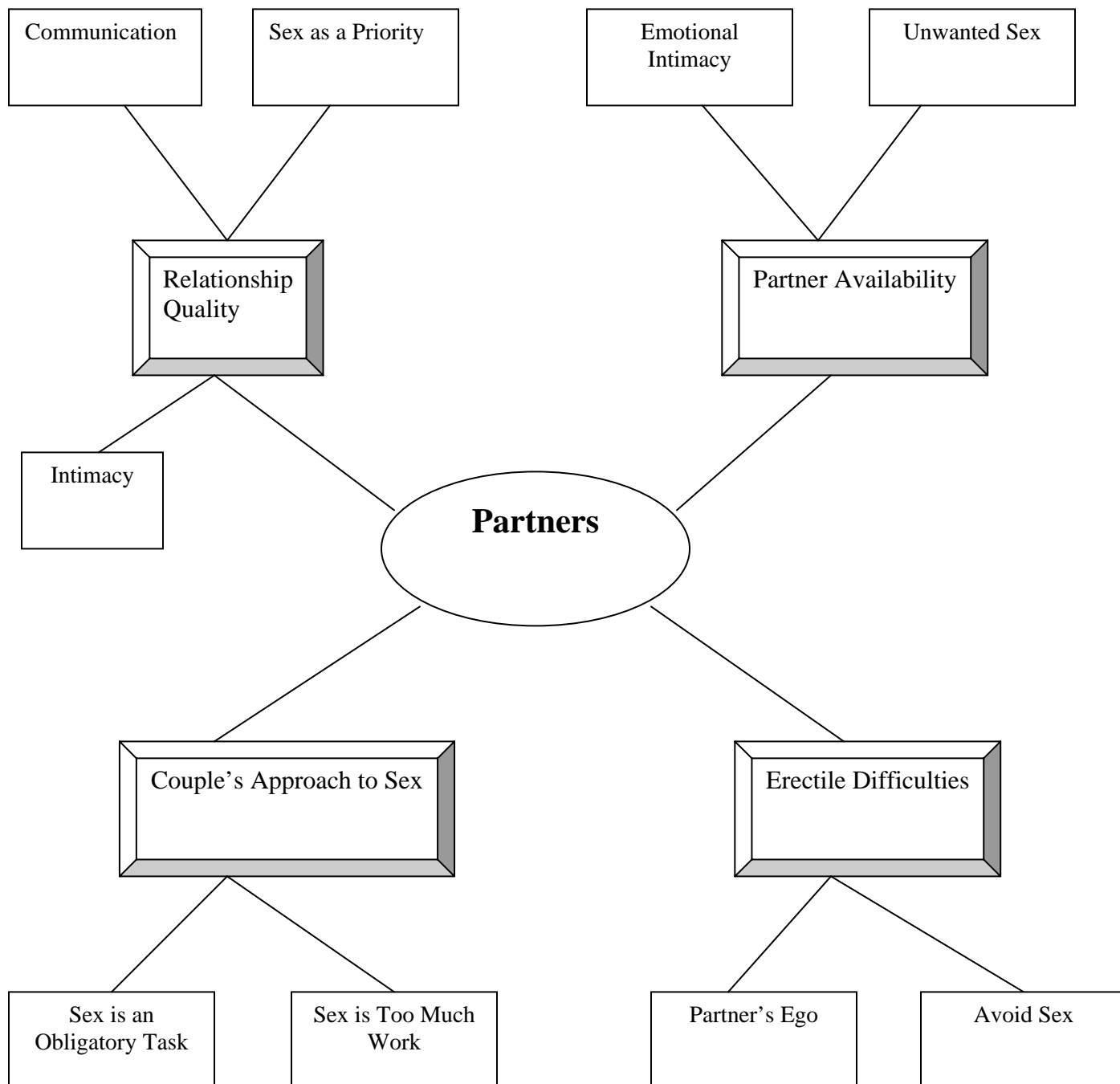
I mean you just have LOTS {emphasis} of things to think about, and that can be an inhibitor. I mean, your mind is just so packed of things (ID# 1, Lines 53-4).

Partners

Women negotiated sexual agency with their partners and in the context of their relationships with partners. Four main partner factors influenced women's ability to successfully negotiate their sexual agency: partner availability, the couple's approach to sex, partners' erectile difficulties, and the quality of the relationship with their partner.

Figure 5 shows the visual representation of these codes.

Figure 5: Visual Representation of the Relationship of Codes and Sub-codes of “Partner”



Partner Availability

As discussed earlier in this chapter, the code “partner availability” was developed during open coding, early in the process of data analysis. Initially, “partner availability” referred to a woman’s physical access to a partner, and seemed to apply only to the few women who were single. For instance, a few single women discussed feeling frustrated at the lack of available bachelors in their age range and in their area who were of any interest to them other than in terms of a friendship. One woman was so frustrated that she and her friends were having such a difficult time meeting men with whom they wanted to have sex that she joked:

I mean, I was joking around a few months ago thinking that I want to start some kind of service where women can go to get sex. I mean, like men go to prostitutes... (ID# 5, Lines 38-40).

Another woman used terms like “frustrating” and “trying” to describe her search for a sexual partner, and she noted how disappointed she was once after finding a suitable partner who then ended up having erectile difficulties. Thus, access to a sexual partner was an issue for only a few single women. However, as data analysis continued it became evident that women’s discussion of partner availability was not limited to the presence or absence of a suitable partner, but rather included wanting a partner who was emotionally available to them and attentive to their wants and needs, including sexual needs. To this end, access to a partner and the emotional availability of a partner were both represented by the category “partner availability”.

Women’s negotiation of their sexual agency with regard to partner availability was two-fold. First, women negotiated their sexual agency in terms of actually finding a suitable partner, as described above. Second, women referred to their negotiation of

wanting to feel emotionally connected to their partner, and to be intimate, but not necessarily through sex. In other words, women explained feeling disappointed and frustrated that they had sex with their partner in order to feel connected or emotionally close, whereas they would have preferred to establish intimacy in a non-sexual way, such as through hugging, holding hands, or talking. One woman says:

Sometimes I just feel like I want a hug or a kiss on the cheek. Or just for him to tell me how much he loves me. Having sex definitely gives me that feeling, that sense of being connected with him, but sometimes I want to get that in other ways, not through sex. He's, my husband, is just not good at being emotionally expressive though. Sometimes it ends up being easier for me to just have sex to get that feeling I need (ID# 20, Lines 80-87).

Thus, women's negotiation of their sexual agency was often in terms of having (unwanted) sex to fulfill their desire for connectedness or intimacy. Interestingly, only one woman discussed having sex for fun or for her own excitement, and notably this woman was single. She says:

I remember that I had one partner, we got together early in the mid70s, and then again later, and he commented that he saw, you know, the growth in my enjoyment of sex (ID #5, Lines 56-8).

Women's negotiation of intimacy and will also be discussed later in this chapter, as part of the category "relationship quality".

Couple's Approach to Sex

The second aspect of women's sexual agency that is negotiated with partners is with regard to the couple's approach to sex. Some women discussed feeling that their partners were not interested in taking the necessary time to ensure that sex was pleasurable and satisfying for them too. These women discussed often feeling like sex

was too much work, especially in terms of needing more foreplay to feel sexual desire or become aroused. Women also talked about needing to use an exogenous lubricant to avoid pain during intercourse, and these women often discussed feeling that all the preparation needed to have sex was just not worth it. For example, one woman said:

Well you know, it's really not that pleasant for me because you know I'm drier and it kind of hurts a little bit at first, even though I use estrogen cream and stuff. Um, I don't know how to say this, my husband, you know he has a hard time holding an erection, he's 72. And uh, he's diabetic, and so that makes it kind of unpleasant in a way because, you know, you're not sure if he's going to keep holding it together. I also, you know, have had a lot of bladder infections and vaginal infections which have resulted from sex. And uh, I mean, I think it's just the irritation or whatever, and then I had a kidney removed that was chronically infected when I was 26. And um, and so, I think that, you know, after a while you tend to be not wanting to have it because, oh {sigh}, I'll probably have to have another vaginal infection and go to the doctor. Now, finally the obstetrician did tell me, and talked to my husband too and told him to wear a condom or he could take Flagyl. And, he chose to wear a condom because he didn't like the idea of taking Flagyl because of his diabetes, and all with Cumadin because he has an artificial heart valve, so that, wearing the condom has helped a lot, in terms of I haven't had an infection since then, so that's been really helpful. But I guess still there's an attitude on my part, it's just, and then my desire isn't really, you know, up there like it used to be, and I don't know, I could get along fine without it. Even though I love my husband and I love being close to him and hugging and kissing, and anything else I love, but intercourse is just not that pleasant anymore. ... It's just too much to deal with, getting ready for sex and worrying if it will happen, you know. It's just not worth the hassle anymore (ID# 2, Lines 39-59).

However, these women also felt some obligation to attend to their partner's sexual needs, which often meant engaging in intercourse that was not necessarily wanted, satisfying, or pleasurable for them. To this end, women negotiated their sexual agency in terms of balancing their feelings of apathy or lack of interest in sex with their sense that sex was an obligatory task in their partnership or marriage. One woman said:

Oh boy! I can remember getting a message from an adult when I was first married, 'Never say no or he'll go somewhere else' (ID# 6, Lines 28-9).

Another woman said:

You know my husband says that his doctor, who is a woman, tells him that he needs to keep having regular sex for his prostate. I don't know how much I believe him (ID# 19, Lines 92-6).

In a sense, women's approach to sex was a result of her partner's approach to sex, often described by the women as "wham bam thank you maam". When women's sexual and intimacy needs were not being met through sex, they were often uninterested in sex.

While some women attempted to discuss their concerns with their partners, most women did not communicate with their partners about their approach to sex. Thus, women negotiated not only their right to pleasure during sex, but also their right to refuse sex that they were not interested in within larger sociocultural messages they had received that suggested women should serve men's sexual needs and privilege men's sexual needs over their own pleasure.

Partner's Erectile Difficulties

Another issue that influenced women's negotiation of their sexual agency in terms of their experience of sexual desire was related to women's concerns about their partners' ability to obtain and maintain an erection. An overwhelming majority of the women interviewed expressed concern about her partner's erectile difficulties as part of her *own* concerns about sexual satisfaction and sexual desire. Women negotiated how to handle instances in which their partners lost their erection during sex or were not able to obtain an erection during sex play. Interestingly, women were most concerned with their

partners' egos, as opposed to being frustrated or disappointed that the sexual encounter was not pleasurable or satisfying for them, although this was certainly a secondary concern for women. Women negotiated this awkward position, of wanting to protect their partner from experiencing an erectile difficulty while also avoiding a sexual experience that was unpleasant for them as well, by often avoiding sex altogether. One woman explained:

... as far as my husband is concerned, I mean, he's real sexual, and he probably wants to have sex more often than we have it, but I just back off because I'm just afraid when we get in that situation {pause}, and he doesn't enjoy that either, but {pause}. And it doesn't happen all the time, but it does happen. And when it happens I get tired and my vagina is sore too. So, I just {laughing}, you know, don't do it for awhile (ID# 3, Lines 43-8).

And another woman said:

Well, part of it is my husband. If he can't perform, then the situation ends up being uncomfortable and unsatisfying for both of us. So by spacing it out I'm almost preventing that from happening (ID# 4, Lines 29-31).

Similarly, another woman said:

I think he would like it [sex] more, but then, I don't encourage it too much because then he has a failure ... (ID# 12, Lines 58-9).

Many of the women stated that their partners had previously used Viagra in an attempt to address erectile difficulties. However, none of them said that Viagra had been helpful.

Relationship Quality

The quality of women's relationships with their partners was the most commonly discussed aspect of all partner-related influences on women's experience of sexual desire.

Women explained that sex was just one aspect of a good relationship. Women associated

qualities like “sensitivity”, “respectfulness”, “kindness”, “tenderness”, “light-heartedness”, “mutuality”, “feeling safe”, and “being connected” with healthy, positive relationships. In contrast, women used terms like “selfishness”, “clueless”, “sexist”, “removed”, and “distant” to describe relationships that they considered unhealthy and negative.

An overwhelming majority of the women explained that when they felt unconditionally loved and respected by their partner, they were also more interested in having sex. In general, women who characterized their relationship with their partner as healthy and positive also described having fairly high levels of sexual desire and being mostly satisfied with their sexual experiences. One woman said:

I think the secret is having satisfying, loving relationships. I think that’s the biggest key, if you really have, you know, someone who you’re in love with and they love you the way you are, they don’t care that you’re getting older or about the menopause part or anything like that, um, that when you feel loved and that they, you know, are respectful of your own responses, what they are, I think that makes all the difference in the world. ... I think for me, I love to be excited and as excited as my husband. I like that I feel like that’s really fun, but it doesn’t always happen. I don’t always have an orgasm. And, I think ... for me, it feels good, either way, but maybe not as exciting And I think it’s especially good when you feel like you’ve really connected (ID# 1, Lines 26-30, 69-72).

And another woman said:

I think in most cases [when I feel sexual desire] it’s what you’re doing with your partner at the time, and how satisfied you feel with that. And, that seems to trigger it more than other, I guess that’s probably the biggest stimulus, that relationship. ... And what you’re actually doing, like if you’re just having a good time doing, a hike or a bike ride, or just eating a meal and enjoying it together, it’s more those types of triggers, feeling close and loved (ID# 8, Lines 75-83).

Women who felt that they were in good relationships were better able to negotiate their sexual agency because women felt safe and respected *as people* by their partners, not just

as sexual objects. Similarly, women's ability to negotiate their sexual agency within their relationship was very much related to the amount of communication in the relationship, especially communication about sex.

The women who were able to talk to their partners about sex and about their sexual satisfaction also discussed being more interested in sex (i.e. sexual desire) and being more satisfied with their sexual experiences overall. Communication was a very important aspect of women's sexual agency. Women who talked to their partners about how to facilitate their sexual desire also discussed feeling more sexual desire. One woman said:

... my husband and I had a really good talk about how I don't have to have to go off or have an orgasm every time, and he's really good about that. He can tell when I've had one, but it's OK for him if I don't. He doesn't feel like he's failed as a lover or something. We just talked about this, I just am not as sexual or I think he felt like he wasn't doing his job, and I told him, I said "You know, for me it doesn't really happen all the time", but it's still really good and I love making love with him, but just not to expect that I'm always some way or the other way. And I think he understands ... and I feel like, that making love is really a learning process, you learn what and how your body responds and you know what you like and don't like. When you're able to say that and talk about it, you know that you can learn how to make your body respond, you know, kind of a learning process and he learns what I like and what I don't like (ID# 22, Lines 24-32, 77-80).

In contrast to facilitators of sexual desire, women also discussed factors that inhibited their experience of sexual desire. Most often, women discussed relationship or partner-related factors as inhibitors of desire, including being angry with their partner, their partner's phallogocentric approach to sex, or not feeling attracted to their partner for hygiene reasons (e.g. body odor, stubbly beard, sweat) or for fear of a partner's erectile difficulties. One woman explained:

Oh yeah, if I'm irritated at him for something, that will definitely affect it. I just won't even let him touch me {laughing}. You know, I don't even want to start. ... And, I'm just afraid that he won't be able to, you know, perform. And then I get some bad results, it takes him a long time, you know, and of he course he wants to keep trying until he reaches his high point, and I get the bad end of the stick (ID#16, Lines 39-44).

Another woman said:

Oh, and if you don't feel like you've been treated sensitively or that you're not, not valued, that you don't feel appreciated. Then I'm not interested. (ID# 8, Lines 40-43).

Finally, another woman said:

If he's not at his best. You know, for example, I don't like it when he hasn't shaved (ID# 6, Lines 58-9).

Women who characterized their relationship with their partners as positive, healthy, and fulfilling also stated that sex was an intricate part of their lives and their relationships. Women discussed establishing sex as a priority in their lives so that sex did not accidentally fall to the wayside. Moreover, women who discussed feeling higher sexual desire had prioritized sex in their life, not necessarily because they wanted to have a lot of sex or more sex, but because sex served an important function to them in their relationships. One woman said:

Sex is an important part of our relationship. We make time for it, just like we would for any other activity that we like, hiking or canoeing. In a good marriage, sex is the icing on the cake (ID# 15, Lines 44-47).

On the other hand, women who did not view sex as a priority in their lives discussed feeling that sex was relatively unimportant and unfulfilling to them. These women explained that there were other activities that they were more interested in than sex. Therefore, sex was not a priority in their lives or in their relationship. This emphasizes the contextual nature of women's sexual desire. One woman said:

... basically I think my own personal need for sex is not the most important thing in the world to me. Most of the time, there are so many other things that I really like {laughing} better than sex. So, it's not really something I'm really drawn to work towards or make happen ... (ID# 16, Lines 42-46).

Thus, whether or not women were concerned with their level of sexual desire was very much related to how much of a priority sex was to them and the function that sex served in their relationship. When women prioritized sex because it was important to them and because it served a valuable function in the relationship, women had a vested interest in making time for sex. Alternatively, if sex was unfulfilling and unsatisfying for women, sex was not a priority for them. The relationship between women's sexual satisfaction, the importance of sex for each woman, and her negotiation of sexual agency was complex and context dependent.

The final aspect of relationship quality that women discussed as related to their experience of sexual desire was intimacy. One woman describes the relationship between sexual desire and intimacy:

Even though it's been a rough time, he's been so ... I don't want to say sexual, but he's been very supportive and very touchy and very caring, so those are, you know, those are classified as sexual kind of things, that's certainly, I have to respond to that if with nothing more than a kiss of an "I love you". But it definitely creates something in me when he does that. Reaching for my hand, in the car, if we're driving, he'll reach over and take my hand. There's something that happens when he does that. ... And those are all, I don't want to say sexual, but they're really important for the, uh, the make up of the relationship. It's an intimacy beyond anything I can describe. And maybe that intimacy is what fosters that sexual desire (ID# 6, Lines 154-169).

Most women discussed really wanting intimacy and a sense of emotional closeness with their partner. Some women viewed sex as a means to fulfill their needs for intimacy even

if the sex per se was not fulfilling and even if they engaged in sex without really wanting it, without feeling sexual desire. In this sense, women discussed using sex as a means to feel connected to their partners. Interestingly, women who said they had sex *solely* to fulfill their intimacy needs used terms like “boring” to describe sex and phrases such as “take it or leave it” to describe their interest in sex. Women who had sex solely to feel emotionally close to their partner described their attitude toward sex as apathetic, and for this reason these women were not concerned with their level of sexual desire, even if it was low.

Most of the women were primarily interested in feeling and expressing a sense of connectedness to their partner, and women often described wanting to fulfill their needs for intimacy in non-sexual ways. One woman said,

... it's like emotionally I feel like I want the closeness, maybe that's it, the closeness, maybe not intercourse, but the closeness more ... (ID# 13, Lines 37-8).

Other women, however, had sex for reasons that were not necessarily related to women's need or desire for intimacy. These women viewed sex as a physical pleasure and engaged in sex for fun and for sexual satisfaction. Notably, all of the women who discussed engaging in sex for fun were single. Women who discussed seeking out sex for pleasure also had higher levels of sexual desire, and this was often frustrating for women.

One woman said:

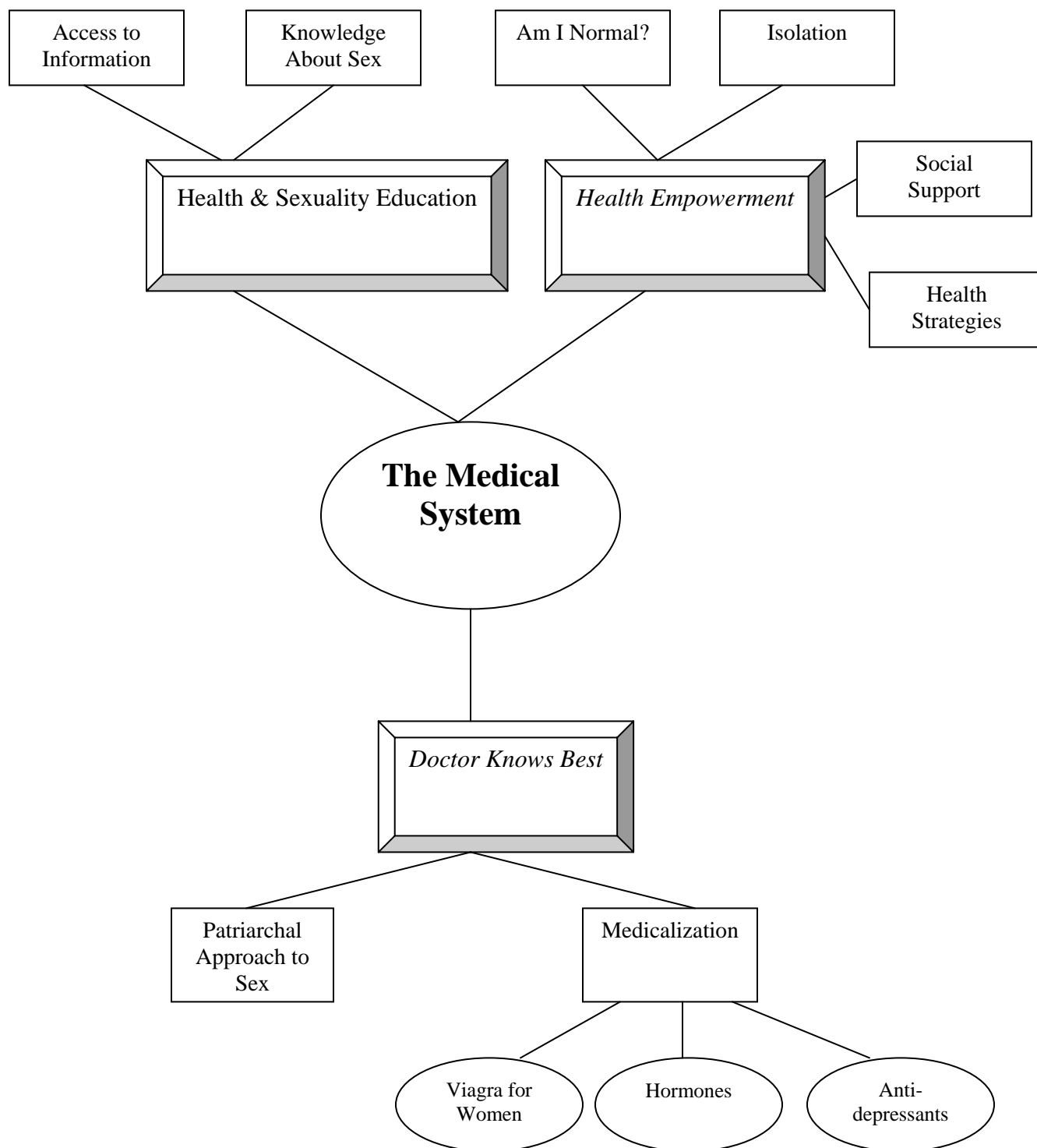
[My sexual desire is] High, it's very high. Sometimes it's very annoying, because I'm not getting enough. I want more and more sex. It's also the quality of sex. ... but I really think that even when I had a younger man, 14 years younger than me, I was having pretty frequent sex. The sex became routine, it wasn't as fabulous as it could have been, should have been... (ID# 5, Lines 91-98).

Thus, intimacy was a very important component of the sexual relationship for most women, as intimacy facilitated sexual desire and was also a motivating factor for women's sexual activity. Other (single) women, however, did not mention intimacy as an aspect of their sexual relationships or as a prerequisite for sex.

Medical System

Women also negotiated their sexual agency within the medical system. Three codes emerged from the data relating to women's ability to view themselves as sexual agents with their own sexual needs and rights, including "doctor knows best", "health and sexuality education", and "health empowerment". The relationship between these codes is illustrated in Figure 6.

Figure 6: Visual Representation of the Relationship of Codes and Sub-codes of “The Medical System”



Doctor Knows Best

Nearly all of the women interviewed said that their doctors (or other health practitioner) had talked to them about sexuality issues only as related to menopause, specifically, vaginal dryness and vaginal pain/discomfort. Women discussed receiving primarily negative messages from their physicians, especially in terms of negative changes that were associated with menopause, such as vaginal dryness. For instance, women described that their physicians presented these negative changes as unavoidable symptoms associated with menopause. Women used phrases such as “I thought I’d just have to accept it” or “I just have to deal with it” to describe their response to their physicians suggestion that menopause is a negative life event that can be treated but not *cured*. In other words, women’s descriptions of their interactions with their physicians regarding menopause sounded as if women had just been diagnosed with an illness.

Very few of the women said that their doctors had been helpful with their sexual concerns or questions. In fact, even women who liked their physicians and felt they had a good relationship with them discussed the overwhelmingly negative messages they received from their doctors about sexuality issues associated with menopause. Thus, while women valued the advice of their physicians, only one woman felt as though her physician had given her assistance in terms of addressing her sexual concerns.

Physicians were the one to initiate discussions about menopause and sexuality issues most of the time. Many women described feeling resigned to experiencing negative changes and symptoms of menopause, especially with regards to vaginal dryness and pain. That is, physicians had a great deal of power in terms of giving women

messages about sex and menopause, but the little *information* that doctors could offer women was of little help. Interestingly, most women did not question why their physicians had not provided them with better information on sexuality issues or invited questions about sexual desire and menopause. In fact, women did not question their physicians, even when their physician's perspective on postmenopausal women's sexual desire was overtly patriarchal. For instance, one woman explained that she was having problems becoming lubricated during foreplay, even though she felt sexual desire and was interested in having sex with her husband. Despite her nervousness about broaching the topic of sex with her (male) physician, the woman asked what she could do to become more lubricated in order to avoid vaginal pain during sex. The woman explained that her physician suggested KY Jelly, but in the interest of pleasing her husband. The woman said:

He [the doctor] was pretty understanding. He also saw sex from a male point of view though. You know, 'Gee, you can't deprive your husband of sex'. So, I think that was why he suggested it [the KY Jelly] (ID# 10, Lines 88-94).

Thus, the code "doctors know best" describes physicians' approach to women's experience of sexual desire. More specifically, physicians were not attentive to women's sexual desire at all. As a result, one of the underlying themes in women's relationship to their physicians is that women must negotiate their sexual agency with their physicians in terms of their ability to even feel legitimate in their experience of sexual desire.

Very few women broached the topic of sex with their physicians (although physicians may have initiated a discussion of menopausal-related sexuality issues such as

vaginal dryness), despite the fact that many of the women had questions and concerns about their sexual response. One woman explained:

I really like my doctor. And I think I can talk to him about anything but sex, I'm really uncomfortable talking to him about anything sexual. I don't know why (ID# 13, Lines 51-3).

Another woman explained that she believed that her physician would tell her anything that she needed to know, and therefore there was really no need to ask any questions (ID# 21, Lines 64-69). Thus, the code “doctor knows best” also refers to women’s beliefs that their physicians know what is best for them.

Medicalization

Another theme that emerged from the data in terms of women and their physicians was the process of medicalization (a term described at length in chapters one and two). “Medicalization” refers to an interest in treating women’s menopausal and sexuality-related issues with pharmaceutical interventions, as opposed to investigating underlying issues associated with the woman’s relationship or other pertinent influences. Many women and most women’s physicians adopted this approach, and the codes “hormones”, “anti-depressants”, and “Viagra for women” are included in this category.

The code “hormones” was first developed in the initial stages of data analysis, during open coding based on the sheer frequency with which women mentioned hormone therapy, and the use of other exogenous hormones. An overwhelming majority of the women mentioned that their doctors had previously prescribed hormones to *treat* menopausal symptoms such as hot flashes or to *prevent* conditions that they believed

were caused by or associated with menopause (e.g. osteoporosis, cardiovascular disease). Some of the women were not aware of why they had taken hormone therapy, aside from the fact that their doctors had recommended it.

At the time of the interviews, none of the women still used hormones (either HT or other exogenous hormones). Most of the women spoke with high regard about their physicians' timely recommendation that they stop hormone use immediately following the release of the Women's Health Initiative findings that hormone therapy was associated with an increased risk for several serious health conditions (Women's Health Initiative, 2002). One woman explained:

I can't pooh-pooh hormone replacement therapy. It seemed to work for me. My physician put me on hormones for a while, for hot flashes. But who was the first one who stopped when all of this information came out? My {emphasis} doctor. He {emphasis} suggested I stop. So I went right out there and stopped. I don't take them anymore (ID# 17, Lines 94-100).

In other words, women still did not question their physicians even after they knew that the exogenous hormones they had been prescribed were possibly harmful to them. Instead, women were interested in what other medications could *treat* their menopausal symptoms and *prevent* so-called menopausal-related *diseases*.

It is also of interest that women discussed hormone use only in terms of menopausal symptoms, not in relation to any sexuality concerns, even though most of the women discussed their concerns with vaginal lubrication and/or pain during intercourse throughout the interviews. When asked, women had to really think hard about whether or not hormone therapy affected their sexual desire, and it was as if women had not previously considered the effect that hormones might have had on their sexual desire. After much consideration, only two women could pinpoint a relationship between using

some type of exogenous hormones and their experience of sexual desire. One woman explained:

When I first started using it [testosterone cream], my fantasy life went berserk. And it was, it was rather amazing. I've never had sadistic tendencies that I know of, and I was having sadistic tendencies. And my interest in sex, my desire was out of control, it was like I just couldn't get enough sex! (ID# 10, Lines 55-61).

In contrast, most women said that they did not notice any difference in their level of sexual desire, or any other aspect of their sexual response, during the time that they were using hormones. One woman said:

No, I actually didn't notice any difference at all. The only thing that has ever made a difference in my sex life is from lubrication (ID# 4, Lines 39-41).

In addition to the use of hormones, several women mentioned that their physicians had prescribed various anti-depressants, (in lieu of HT), to treat hot flashes and other menopausal symptoms. One woman said:

The other thing I wanted to say is that my physician put me on hormones for a while, for hot flashes, but I'm not on them anymore, I didn't really like them. Now I take Paxil, which he put me on to kind of help with the hot flashes, but it's also an antidepressant ... (ID# 13, Lines 125-128).

None of the women questioned or seem concerned with this off-label use. In fact, many women seemed pleased that their doctors had suggested an easy strategy for them to combat troublesome menopausal symptoms.

Similarly, several women inquired about the status of a "Viagra for women" during the interview. For women who were concerned with their low levels of sexual desire, a "magic pill" seemed like the perfect solution for them, especially in light of the

messages (and prescriptions) women received from their physicians. One woman who wished that she could be more interested in having sex with her husband said:

I wish there were a Viagra for women, or at least for me (ID# 7, Lines 63).

Another woman said:

... you know men have their, uh, Viagra, but I wish there was something that would make it better for women. ...[if you] could come up with a really cool Viagra type thing for women {laughing}, I'd be thrilled! I know that's not part of your study, but I think we need something ... (ID#8, Lines 57-9; 169-171).

Regardless of women's reasons for wanting to use anti-depressants to manage menopausal symptoms or for a "Viagra for women" to increase their sexual desire, it is clear that some women have adopted the medical model's approach to women's sexuality and women's health. This approach assigns power to the physician, (or the pharmaceutical industry), so that women relinquish their power over their own bodies and sexuality.

Health & Sexuality Education

Another theme that emerged from data analysis in terms of how women negotiated sexual agency within the medical system related to education and information about health issues, including menopause and related sexuality issues. Women who had access to information on how menopause might affect their sexuality felt better able to negotiate their sexual agency with their physicians. For instance, one woman talked about how she had made up her mind not to take hormone therapy, and how her knowledge about its effects helped her refuse her physician's advice to use HT. She said:

Well, again, I think each person has to sort of decide for themselves, I think it was really good that I read so much about it, it really, uh, my sister did take hormone replacement, and I knew that I was going to be going through menopause, and so I really read A LOT {emphasis}. The stuff that was coming out from the TREMIN study was very helpful, and they recommended some books that I read, and I just decided that I really didn't want to take hormones, and I think for me, I really felt good about it. I knew what I was talking about when I had to talk with my doctor (ID# 22, Lines 56-65).

Another woman explained:

I think that the part that I felt like I wondered if I was making the right decisions in not taking hormone replacement. It felt like, you know, they said, "Oh it's good for your bones, it's good for your heart", all these things, and I thought, am I doing the right thing to not take them? And so I felt like, um, you really have to read a lot of different things, and I think that, it was because of one book, and I can't even remember who it was, which really made me think, it was some woman, I think she was probably WAY {emphasis} on the other side, of saying the only reason we're told to take hormones is for men's pleasure because it's supposed to make us feel sexually more or younger, and that um, just because we don't respond like we did when we were young doesn't mean ...{inaudible}. And she felt like it was more a money thing, selling the hormones, them saying that you need these, and when people didn't buy the "It helps you sexually", it was the other things it does for you, it can help your bones, it can help your skin. And I remember being scared that I was not doing the right thing for myself. Yeah, and reading other people's, not just a few things, but different points of view and making a decision yourself. I felt good about my decision, but just everybody my age was taking hormones! It was just like, it was the thing to do, people say, "Don't take my hormones and my contacts!". And that's where this TREMIN study was good for me, I did see the negative side of taking hormones, if you need it, it was normal it was Ok to go through some of these changes without it, so that's where I felt like I was ahead of the game, all of the information that had been funneled to me (ID# 1, Lines 70-90).

Women's knowledge about their sexuality, and sex in general, also influenced their negotiation of sexual agency, especially with regard to sexual desire. For instance, women who indicated they were knowledgeable about how their bodies responded sexually stated that it was important that any sexual experience be equally pleasurable or

satisfactory for both them and their partners. Similarly, women who read about sex, even pornography and erotica, seemed to be comfortable suggesting sexual techniques or activities to their partner that brought them pleasure. One woman said:

I learned about masturbation from that book by Shere Hite. And man, did I make up for lost time {laughing}. I mean, when I read about people doing it, masturbating on the edge of the sink, I thought, “You know, maybe I’m missing something here”. {laughing} ... So, that was it really. I decided that I wasn’t going to miss anything {emphasis} anymore (ID# 10, Lines 35-44).

Health Empowerment

The degree to which women felt empowered about their health was also an important factor in terms of how they negotiated their sexual agency within the medical system. The code “health empowerment” was developed during axial coding as themes from the data emerged indicating that women who made their own decisions and felt that they had control over their bodies and their health were better prepared to negotiate their sexual agency with their physicians and other health professionals. For example, women who said that they felt in control of their own health also discussed various strategies they used, such as exercise, eating habits, and vitamin supplements, in order to positively influence their health. One woman talked about her holistic approach to her health:

Um, it would be about healthy eating, about using some of the uh, organic methods of dealing with hot flashes, some of the other things that are out there now that are really well researched and prescribed, and I don’t mean prescriptions I mean natural products. Yeah, uh, I’m trying to think of one that, and I’m going blank, cohosh is it? Yes, black cohosh (ID # 6, Lines 289-93).

And another woman discussed her use of herbal remedies:

... magical herbs, I think red clover was the best thing, it made me survive it, but there was a study done at the University of Minnesota that said it had no bearing whatsoever. Well I took it and my secretary took it, we just, it really helped [relieve hot flashes] so I recommend it to friends and they say, “I don’t care what that study said, it worked! (ID# 8, Lines 181-6).

Thus, women used various health strategies to feel more in control and more in tune with their bodies, and subsequently their health.

Another health empowerment theme that emerged from the data related to social support. Women discussed various forms of social support, including informal groups of friends who would laugh about hot flashes over lunch, as well as a more formal group of women who met regularly to discuss what was going on in their lives. Regardless of the actual form that the social support took, women used phrases like “my friends understand”, “I’m not alone”, “it’s important to laugh about it” to describe the function of social support in their lives. When asked why friends or other forms of social support mattered to them, women explained that it was important for them to feel like someone cared about their experiences and that if need be, they would have someone to talk to about their health or sexuality concerns. Women also explained that it was helpful for them to know that their experiences, (with hot flashes, for instance), were normal, and that other women were experiencing the same things.

Social support seemed to be a very powerful factor in terms of whether or not women felt isolated and whether or not they felt that their experiences with menopause were normal or not. Women who had some type of social support discussed the importance of being able to share their experiences, and feel that their experiences were legitimated by other women’s stories.

Interestingly, most of the women, even those who met regularly with other women, did not discuss sexual desire, or other sexuality issues, per se. Instead, women tended to talk primarily with each other about their menopausal experience, either in terms of how they approached coping with symptoms or how they discussed their “treatment” options with physicians. Very rarely did women report talking about sexuality issues, such as sexual desire, even with their friends. When asked why they did not discuss sex, even sexual concerns, with their friends, women explained that sex was a taboo topic, and that it was not appropriate to discuss. When the researcher sent the meaning of their conversation back to one participant who had explained that sex was not an appropriate topic of discussion, she became defensive and sounded angry. She said:

Why would we talk about it [sexual desire]? What’s there to say? (ID# 19, Lines 54-6).

Although women did not talk about sexuality issues with their friends or within their social support networks, they explained that having social support was important in case they ever needed to or wanted to discuss such issues. In other words, while women did not use social support as a way to share their perceptions or concerns about sexuality, they felt comfort in the fact that the social support was available if need be.

The one exception to women’s silence about sexuality-related issues was that women did talk about vaginal lubrication and associated discomfort or pain during intercourse. When asked why vaginal lubrication was an acceptable topic to discuss while sexual desire was not, women explained that vaginal dryness was a medical problem and thus, was part of their medical discussions in terms of how to manage

menopausal symptoms. In other words, when women viewed sexuality-related issues as medical issues, the stigma associated with sex was no longer a deterrent.

Many of the women did not have some form of social support, and they discussed feeling isolated and wondered if their experiences with menopause and sexual desire were normal. Women who felt isolated explained that they knew that their friends were probably also going through menopause, but that they never talked about their experiences. One woman said:

My friends and I don't really talk about it, menopause and sex. Not for any particular reason I don't think. It just isn't something we sit around and talk about (ID# 4, Lines 23-4).

Another woman explained:

And that's something I haven't talked to my friends about, to see if they have the same frustrations or if that's just the way my body is reacting. I don't know why we haven't talked about it. Sex just doesn't seem like something you talk about in that way (ID# 8, Lines 31-5).

Women who felt isolated and wondered if their experiences with sexual desire and with menopause were normal were less able to negotiate their sexual agency within the medical system, especially with their doctors. Women who felt isolated and wondered if they were normal were also very interested in asking the interviewer what other women in the study said about their experience of sexual desire and menopause. One woman said:

I'd be interested in the results of your study, in how other women are feeling. I mean, what do other women say? Do they feel like menopause has affected their sexual desire? I mean, is it different for every woman? (ID# 2, Lines 85-7).

And another woman said:

... I assume that other women have the same difficulties [with sexual desire]. ... I have to assume that I'm not alone, but I just don't know. I mean, am I normal? (ID# 7, Lines 63, 67-8).

Thus, women who felt isolated from understanding other women's experiences with sexual desire and with menopausal issues were interested in comparing their experiences with other women in order to determine if they were normal or not. Women who did not have social support to validate their own experiences felt as though they had no one to turn to if they did need or want to discuss sexuality or health issues.

On the other hand, there were other women who did not discuss feeling isolated or concerned about the normality of their menopausal experience. Notably, women who described having social support in terms of being able to talk to their friends about their menopausal experience were not concerned with the results of this study or the experiences of other women who were interviewed.

In conclusion, there were three main spheres in which women negotiated their sexual agency: the sexual self, partners, and the medical system. Figure 3 illustrates the interconnectedness of these codes.

In the remaining part of this chapter, the themes and codes that were just discussed will be used to answer the research questions that guided this study. The explanatory theory generated through this research on postmenopausal women's experiences and meanings of sexual desire will be presented in response to the third research question.

Results: Returning to the Research Questions

The 22 postmenopausal women who participated in this research described their experiences of sexual desire and the meanings attached to these experiences through semi-structured telephone interviews with the researcher, as discussed in chapter three. As previously noted, the results of this study are not generalizable to the general population, or even to all postmenopausal women. Noting this limitation, the research questions will be addressed.

Research Question #1: How do menopausal women experience sexual desire?

Postmenopausal women's experiences of sexual desire were quite varied, and the results of this study suggest that sexual desire is an elusive concept that women uniquely experience. Women described sexual desire as a whole body feeling that they experienced affectively, cognitively, and physically. Women defined sexual desire as an interest in sexual activity, most often vaginal-penile intercourse (although when prompted, three women mentioned masturbation too). Participants stated that they associated their experience of sexual desire with feeling attracted to their partner and a desire for intimacy (i.e. emotional connection). Women stated that sexual desire was often associated with other changes in their body, such as feeling warm and flushed, but they did not conceptualize sexual desire as solely physiological or as genitally focused. When prompted, women also made a distinction between sexual arousal and desire, explaining that arousal is being physically ready for sex while desire is wanting to have sex. Notably, women indicated that sexual desire did not always precede sexual activity.

Some women mentioned that they did not feel sexual desire until after sexual activity had begun and until they got “warmed up”. Other women stated that they might have sex, but not experience sexual desire at all.

Another important aspect of women’s experience of sexual desire relates to women’s life context. Women’s sexual desire is so immersed in the context of their lives that it is difficult for women to tease out the distinctions between their sexuality, (and more specifically sexual desire), and the rest of their lives. Thus, the results of this study are extensive, emphasizing the incredibly broad array of factors that influence women’s experience of sexual desire, in the context of the sexual self, with partners, and the medical system. Finally, women’s ability to negotiate their sexual agency within these various contexts was a critical influence in how women experienced sexual desire, as discussed later as part of research question number three.

Research Question #2: How do menopausal women perceive and make sense of their sexual desire?

Women described sexual desire as a whole body feeling, interest in sexual activity (most often intercourse), and sexual attraction and intimacy with a partner. Notably, none of the women described sexual desire as an innate drive (libido). Women perceive that sexual desire is a feeling, (not a physical state), often initiated outside of themselves and often outside of their control (e.g. the environment). Women who were aware of their sexual desire realized it through bodily cues such as being flushed and feeling “tingly” in their breasts or stomachs.

Postmenopausal women make sense of their sexual desire through the lens of their own background, their upbringing, their current relationship, and societal views on women's sexual agency and sexual desire, including those of the medical system. That is, women make sense of their sexual desire within the context of their lives.

Women's perceptions of their sexual desire are filtered through their experiences of sexual desire and the overwhelming number of messages that women receive about sex. Women internalize these messages and negotiate (or attempt to negotiate) their sexual agency in light of these messages. Similarly, women's social scripts influence when and how it is permissible for women to embody and act on their sexual desire, which often serves to distance women from their experience of sexual desire. For instance, women discussed a variety of factors, both social and individual, that influenced their conceptualization of sexual desire including: parents, schooling, the conservative era of the 1950s in which they were raised, religion, partners, marriage and children, and the media. Similarly, social scripts rooted in institutional sexism send women various negative messages about the meaning of their sexual desire, including: sexual desire is for men, the sexual double standard, the notion that the meaning of sex is dichotomized for women, sexual silence/voice, sex as reproduction/pregnancy, and body image issues.

Women's interaction with the medical system, and specifically with their physicians, influences their perceptions of their own sexual desire. Many women had adopted the medical model's view of women's sexuality, one that privileges men's sexual needs at the expense of women's and posits quick fixes (i.e. pharmaceuticals) as viable solutions to women's concerns with sexual desire. Thus, it is noteworthy that women's conceptualization of sexual desire was influenced by messages they received growing up

about the acceptability of women as sexual beings and sexual agents. Moreover, it is also clear that the meanings women attach to their experience of sexual desire are rooted in the sociocultural context of women's lives, such that sexual desire is a much more complex concept than researchers and scholars may have previously described.

Research Question #3: What influences women's experience of sexual desire during menopause?

Women's negotiation of their sexual agency lies at the heart of women's experiences of sexual desire. Women defined sexual desire as an interest in sex, and an overwhelming majority of women conceptualized sex solely as penetrative vaginal-penile intercourse. Yet, many women engaged in sex without experiencing sexual desire (defined as an interest in sex). These women viewed sex as a means to an end, that is, as an avenue for fulfillment of their needs for emotional intimacy, closeness, and security with their partners. Similarly, women often surrendered their sexual agency in order to address other non-sexual needs in their life that took priority (e.g. health and relationship concerns).

The most important site for negotiating sexual agency was in a relationship with a partner. The degree to which women were able to act as sexual agents within their relationship influenced women's experience of sexual desire. Women who perceived that their relationship was positive or healthy also characterized their relationship as communicative, especially in terms of being able to discuss sexual issues with their partner.

It is noteworthy that women's interest in sex (i.e. sexual desire) did not necessarily constitute an interest in more frequent sex. In other words, women who had "high" sexual desire and women who experienced sexual desire often were not necessarily interested in having more sex. Instead, women with high sexual desire discussed being engrossed and engaged in the sex that they were already having. Thus, the relationship between a woman's sexual agency within her relationship, communication about sex, and her experience of sexual desire was important, although of course a qualitative study cannot infer what the direction of this relationship is or whether it is causal, especially given the complexity of these associations.

In contrast, women who were unable to negotiate their sexual agency within their relationship or women who tried to negotiate their sexual agency but did so unsuccessfully were often uninterested in sex (i.e. low sexual desire). Again, low sexual desire did not necessarily mean that women were not having sex or have very infrequent sex, but it was sex that they did not really want.

Another important site in which women negotiated their sexual agency was within themselves, and women's "sexual selves" were shaped by their sexual socialization, including social scripts rooted in institutional sexism that appropriated negative meaning to women's experience of sexual desire. It is clear from data analyses that women's experience and meaning of sexual desire are fully immersed within the context of their lives, so that it is often difficult to tease out women's experiences of sexual desire from the meanings attached to those experiences. Sexist social scripts (that women have often internalized) greatly influenced the degree to which women were able to even recognize their own sexual agency as a phenomenon to be negotiated. For instance, the

appropriation of sexual desire to men and the notion that sex has been assigned distinctive meanings for women (i.e. love) and for men (i.e. lust) is indicative of the power of gender roles in shaping one's experiences and the meanings associated with those experiences.

Moreover, such gender roles and sexist social scripts systematically serve to privilege men's sexual needs, thereby negating women's own sense of themselves as sexual agents. The stigma associated with women who exhibit sexual agency and who embody their sexual desire is so normative and so pervasive that women often do not even realize that their own actions and behaviors serve to reinforce their oppression (e.g. women's *alterations* of their bodies to be more attractive, women's silence about their own sexual dissatisfaction).

The last site in which women negotiated sexual agency in terms of influences on their experience of sexual desire (and the meaning associated with that experience) is the medical system. Women's experiences within the medical system, and the degree to which these experiences shaped women's sexual desire, depended on women's ability to negotiate sexual agency, often with their physicians. Negative messages about sexuality and sexual desire, communicated to women via physicians, conveyed the idea that sexual desire is a health/medical issue that can be treated via pharmaceutical intervention.

Women who were empowered in terms of taking control of their own bodies and health, as well as women who had access to good information about sexuality and menopause, were better able to resist such messages. However, many women concurred with the medicalization of sexual desire and were interested in "fixing" their low sexual desire in any manner possible (including asking the researcher about the development of "Viagra

for women”). Women who pleaded for the development of a “Viagra for women” had already relinquished control of their sexual desire to the medical and pharmaceutical establishments, thereby resigning their sexual agency.

Finally, women’s marital status also seemed to influence their experience of sexual desire. As discussed earlier in this chapter, there appeared to be a distinction between married and single women’s experiences of sexual desire. For instance, married women were much more likely to associate intimacy with sex. In contrast, single women described their motivations for sex as rooted more in their desire for sexual pleasure. Married women, on the other hand, often stated that they acquiesced to unwanted sex in exchange for the security and stability of the relationship, as well as for their partners’ pleasure and to feel connected or intimate with their partner.

Research Question #4: What differentiates women’s experience of “high” and “low” sexual desire during menopause?

Data analyses did not reveal any consistent distinctions between women with “high” and “low” sexual desire. Admittedly, this finding, (or lack thereof), surprised the researcher, so the advisors of the project were consulted and the data were reanalyzed. There are sporadic differences between some women who have high desire and some women who have low desire. For instance, some women with high desire were more likely to have social support than some women with low desire, but this trend was not discernable for even half of the participants. Despite the researcher’s expectation that there would be discrete characteristics associated with different women based on their level of sexual desire, there were no such clear-cut distinctions.

However, an underlying theme did emerge from the second wave of data analysis that explains women's level of sexual desire in terms of the quality of their sexual relationships, and this theme applies to most (i.e. more than three-quarters) of the participants. The data suggest that the quality of women's sexual relationships and sexual communication is associated with their level of sexual desire. In general, women with high sexual desire characterized their sexual relationships as positive, and these women attributed part of their relationship satisfaction to their ability to communicate about sexuality-related issues with their partner. In contrast, women with low sexual desire were generally less satisfied with the quality of their relationship with their partner, and these women generally did not sexually communicate with their partners.

As previously stated, the association between relationship quality, sexual communication, and level of sexual desire was not salient for all of the women in the study. For instance, this theme did not apply to any of the single women in the study, perhaps due to the absence of a long-term partner. Since the association between relationship quality and level of sexual desire did not apply to the single women, the researcher reanalyzed these data separately (a third time), to look for possible themes to explain what differentiates single women's levels of sexual desire. The researcher could not discern any patterns in the single women's experience of sexual desire to explain their levels of sexual desire. Perhaps women's experience of sexual desire is so immersed in the context of their lives that there is not a single, universal distinction between women with high and low sexual desire, or the distinction is more complex than previously assumed.

Now that the results of the study have been presented and the research questions have been answered, chapter five will discuss these findings and incorporate relevant research from the literature on women's sexual desire.

Chapter 5

Discussion of the Findings

The purpose of this study was to understand postmenopausal women's experiences of sexual desire. In addition, the meanings that women attached to their sexual desire were also explored within the context of women's lived experiences. Four over-arching research questions guided the study: (1) How do menopausal women experience sexual desire?, (2) How do menopausal women perceive and make sense of their sexual desire?, (3) What influences women's experience of sexual desire during menopause?, (4) What differentiates women's experience of "high" sexual desire from their experience of "low" sexual desire during menopause? A grounded theory study using semi-structured telephone interviews with 22 postmenopausal women was used to fulfill the aims of this study. Data were analyzed using the constant comparison method, and data management was facilitated using *Nvivo 2.0*. Chapter four presented the results of this analysis and the importance of women's negotiation of sexual agency in mediating women's experience of sexual desire as well as the meanings that women attach to their experiences.

This chapter will discuss the answers to the research questions for this study within the context of the three sites in which women negotiated their sexual agency. For example, discussion of the findings relevant to research question one can be found in the section on sexual response. The findings most relevant to research question two are primarily discussed in the sections on social scripts and institutional sexism. In addition,

women's perceptions of their sexual desire were influenced by the medical system and thus the discussion found in the section on the medical system is also applicable to research question two. Since postmenopausal women's sexual desire is fully immersed within the total context of their lives, the discussion of the findings for research question three include all the ways that women negotiate their sexual agency including within their sexual selves, in their relationships with partners, and in their interactions with the medical system. Since the results of this research did not directly answer research question four, this issue will be addressed separately in chapter six, as part of the researcher's reflections on the study.

The Core Variable: Negotiating Sexual Agency

As mentioned in chapter four, the focus of this study was on women's sexual desire, but sexual desire was not a primary theme or code that emerged during data analysis. Participants talked very little about their sexual desire, even though they were directly asked about it repeatedly. It is noteworthy that women were quite verbose about various other aspects of their life, but they were not specifically talkative about their sexual desire. Even the women who were comfortable discussing sex in general, such as sexual behaviors or activities, did not discuss sexual desire in any detailed way.

At first, this gap between the purpose of the study (and the interview questions) and the themes that emerged from the data was perplexing. The researcher was initially worried that the research questions seemed incongruent with the data collected through the interviews with the participants. However, after additional analysis, thought, and

consultation with the chairs of this project, it became clear that women's sexual desire is so immersed in the context of women's lives that it is difficult for women to tease out the distinctions between their sexuality (and more specifically sexual desire) and the rest of their lives. Fisher (1999) and Kaplan (1979) have also described women's sexual desire as intricately woven into the fabric of women's lives, and that the context of women's lives is an important influence on women's overall experience of sexuality (including sexual desire).

The gap between the research questions and women's experience of sexual desire has several possible explanations. Perhaps women do not make a distinction between sexual desire and other aspects of sexuality, or even between sexual desire and sexuality in general. Or perhaps, they use a different terminology, like "sexual interest" instead of sexual desire. In other words, the term sexual desire is one that is used by researchers and scholars, but perhaps not women themselves. Graham et al. (in press) have also suggested that terms such as sexual desire may have very little meaning for women.

Another explanation for the lack of focus on sexual desire in the data that emerged from the interviews relates to the methodology used in this study. As discussed in chapter three, grounded theory analysis begins with the participants' own voices and experiences, and the codes and themes of the data emerge from the ground up. Semi-structured interviews were purposely chosen as the method of data collection to enable the participants to have as much control as possible over the conversation and the emerging data. Thus, while the purpose of this research project was to understand postmenopausal women's experiences of sexual desire, women's conceptualization of sexual desire and their experiences with sexual desire were very complex and very broad.

In other words, women's experience of sexual desire and of sexuality in general was far more complex than the researcher had anticipated, such that sexual desire is not a discrete concept as the literature might suggest. As discussed in chapter four, sexual desire is an amorphous and elusive concept, especially when it is studied from women's own perspectives and with regard to the meanings that women make out of their experiences of sexual desire. To this end, the themes that emerged from these data are relevant to women's sexual desire, although they are not solely focused on sexual desire or on women's postmenopausal status. Instead, this research demonstrates the complex and holistic nature of women's sexuality and the importance of the context and realities of women's lived experience in explaining postmenopausal women's sexual desire.

Therefore, as discussed in chapter four, the core variable that emerged for this study was sexual agency. Women's negotiation of sexual agency occurred at three sites: within themselves ("the sexual self"), with partners and within the medical system. The process of women's negotiation of their sexual agency at these various sites influenced women's experiences and meanings of sexual desire. In this way, women's negotiation of their sexual agency illustrates how embedded women's experience and meaning of sexual desire are within the context of their lives. For instance, women's negotiation of sexual agency either detracted from or enhanced women's experience of sexual desire. When women acted as sexual agents, women were often more in tune with and more able to fully experience their sexual desire. In this way, women's sexual agency enabled women to act on their sexual desire based on women's *own* needs, wants, and choices. In contrast, women who had difficulty negotiating sexual agency often felt distanced and distracted from their sexual desire, if they were attuned to their sexual desire at all. For

instance, women who could not negotiate their sexual agency often engaged in sex (without sexual desire) for reasons that were not consistent with women's *own* needs, desires, and choices.

In this study, sexual agency was conceptualized as the degree to which women were able to act on behalf of their own needs, desires, and wishes in terms of sexual behavior, sexual decision-making, and the social scripts that influenced how women's sexuality is viewed and appropriated in society. Women negotiated sexual agency on a continual basis and within various contexts. The process of women's negotiation of their sexual agency at various sites and within various contexts influenced their experiences and meanings of sexual desire.

The term "sexual agency" has been used by other feminist researchers and scholars to describe women's ability to realize and to act on behalf of their own wishes, needs, and interests in terms of sexual decision making and sexual behavior (e.g. Fine, 1988; Vance 1992; Winterich, 2003). As previously discussed, sexual agency is not a dichotomous concept; instead, sexual agency is fluid and context dependent. This fluidity was found in this current study, such that women may have exhibited sexual agency in some contexts while relinquishing it in others. Other feminist scholars and theorists have similarly noted the relationship between women's ability to exhibit sexual agency and societal and cultural views of women's sexuality. For instance, Brumberg (1997) and Wolf (1998) have suggested that when women internalize a male (read: phallogentric) view of sexuality, they are less able to negotiate their sexual agency. Similarly, women in this current study had difficulty negotiating their sexual agency when they perceived that their partner's sexual needs were more important or more

pressing than their own needs, interests, and choices. In this manner, women in this current study who felt disconnected from their sexual desire also had difficulty negotiating their sexual desire within the context of their relationship.

Women's internalization of sociocultural assumptions (that privilege men's sexual needs) is often unconscious because such beliefs are viewed as normative. Thus, women often unconsciously contribute to their sexual objectivity through adherence to gender roles that encourage women to be attractive for men and to seek out attention from men through sexual coyness. For instance, in this current study some women altered their appearance (e.g. cosmetic surgery, extreme dieting) in order to feel more attractive. This illustrates the relationship between women's body image, sociocultural expectations for women, and the difficult negotiation of sexual agency (versus sexual objectivity). In other words, women who were focused on being attractive *for their partners* often had difficulty negotiating sexual agency in light of their internalized social scripts which suggested that men's sexual pleasure is more important than their own sexual desire. In this way, women often learned to dissociate themselves from their own experience of sexual desire and pleasure in order to serve their partner's sexual needs.

The relationship between sexual agency (or sexual subjectivity) and sexual desire has most often been studied among adolescent girls, as it is believed that the negotiation of sexual agency is a critical aspect of young women's development, especially in terms of their sense of empowerment and personal entitlement (see Lees, 1993; Thompson 1995; Tolman, 1994). For instance, Hollway (1989) found that young women systematically suppress their sexual agency as they become more interested in being attractive to men (e.g. the object of men's sexual desire). As a feminist, Hollway

characterized this process as disempowering for young women as they relinquished control over their bodies and sense of selves to others (i.e. men, the patriarchal culture). In this current study, some women's tendency to privilege their partners' sexual needs over their own detracted from women's ability to negotiate their sexual agency.

This current study is the first research to report on the influence of postmenopausal women's negotiation of sexual agency on their experience and meaning of sexual desire in women, although previous research and scholarship supports this finding in other populations (e.g. Fine, 1988; Hollway, 1989; Tolman, 1994; Ussher & Mooney-Somers, 2000). Women's negotiation of sexual agency at each of the three sites ("the sexual self", "partners", and "the medical system") will now be discussed in terms of their experience and meaning of sexual desire.

The Sexual Self

As discussed in chapter four, women's internal negotiation of their sexual agency was an important influence on their experience and meanings of sexual desire. Four themes (main codes) emerged from data analysis as important contributors to women's own sense of themselves as sexual beings and sexual agents - sexual response, social scripts/institutional sexism, health status, and life context. Each of these factors will be reviewed here, with a discussion of relevant scholarship and research.

Sexual Response

As discussed in chapter four, many women did not specifically discuss their sexual desire, even when they were repeatedly asked about it. Many women were completely unaware of their sexual desire because they were not attuned to their own sexual needs. In this way, women's negotiation of sexual agency was intricately connected to women's experience of sexual desire. Women's ability to negotiate their sexual agency (in light of social scripts and/or within their relationships) facilitated women's experience of sexual desire. In other words, women's sexual subjectivity enhanced women's experience of sexual desire in various ways. First, these women were more attuned to their sexual desire and were more aware of their own interest in sexual activity (whether it was for intimacy or sexual enjoyment). Secondly, women who acted as sexual agents were less focused on their partner's sexual needs, and were more likely to believe that sexual activity should be pleasurable for both partners. Finally, women's position as a sexual subject often enhanced their ability to influence their experience of their own sexual desire through environments and situations that women recognized as facilitators of their sexual desire.

Women discussed three aspects of sexual response that were important influences on their experience of sexual desire, including the conceptualization of sexual desire, sexual arousal, and vaginal lubrication. An important finding of this present research is that women defined sexual desire as an interest in sex, and an overwhelming majority of the women conceptualized sex as vaginal-penile intercourse. Another researcher has also found that women define sex as vaginal-penile intercourse (e.g. Meadows, 1997).

This research project was one of the first efforts to understand older women's *own* conceptualization of sexual desire. As discussed in chapter four, those women who discussed sexual desire described it as a feeling, including both emotional and physical aspects, for an interest in sexual activity (primarily vaginal-penile intercourse). Women also described sexual desire as sexual energy with both cognitive and affective aspects. Notably, women often described sexual desire and arousal as overlapping concepts unless they were specifically asked to make a distinction. For instance, women often described sexual arousal as a sign of sexual desire, such that sexual arousal referred to the physical signs (e.g. vaginal lubrication, breast sensitivity) of sexual desire. Of all the various physical indicators of sexual desire, women most often referred to vaginal lubrication. Notably, women's descriptions of their experience of sexual desire demonstrated that sexual desire did not always precede sexual activity. In fact, some women discussed that they did not feel sexual desire until sexual activity had already ensued, and other women explained that they might never experience sexual desire during sexual activity.

In comparison to participants' conceptualization of sexual desire, the literature on sexual desire (as discussed in chapter two) defines sexual desire in various and ambiguous ways. Sexual desire has been variously defined and is conceptualized differently, based on the epistemological assumptions of the researcher as well as the goals of the study (Regan, 1999). Such ambiguity has made it more difficult to understand women's sexual responding; for example, it is unclear whether sexual desire and arousal are distinct or overlapping concepts.

In the studies reviewed for this project, sexual desire was often defined as libido, an innate force, similar to sex drive (see Table I in chapter 2). Libido has a very different

meaning than the definition for sexual desire provided by women in this study, who discussed sexual desire as an interest in sexual activity. Spector et al. (1996) also defined sexual desire as an interest in sexual activity, and conceptualized sexual desire primarily as a cognitive phenomenon. Spector's definition of sexual desire fits most closely with how participants in this current study conceptualized sexual desire, although women in this study described their awareness of sexual desire as within their bodies (as opposed to solely a cognitive phenomenon as discussed by Spector). Similarly, Graham et al. (in press) defined sexual desire as sexual interest, which is very similar to how women in this study defined desire.

It is important to understand what women mean by the term "sexual desire", especially since sexual desire is most often measured quantitatively, and thus the validity (the degree to which a measure accurately reflects the concept's true meaning) of such measures are questionable. That is, if participants' conceptualization of sexual desire differs from that of a researcher's, and the researcher did not clarify the meaning of this term, then the results may be misinterpreted. For example, sexual desire is often measured by frequency of intercourse (e.g. Apt & Hurlbert, 1992). However, the results of this current research project suggest that the frequency of sex and the desire for sex are distinct from one another for two reasons. First, many women reported engaging in sex (read: vaginal-penile intercourse) without desire and women have sex for reasons other than in response to their sexual desire (e.g. Basson, 2002; Heiman, 2001). Sexual desire is not necessarily a motivating factor for sex, and it cannot be assumed that sexual activity is an indicator of sexual desire. Secondly, women in this study with self-reported "high" sexual desire did not necessarily want more sex than they were already having.

Thus, the distinction between “high” and “low” sexual desire does not appear to be the frequency of sex, but rather the degree of interest attached to engaging in vaginal-penile sex with their partners.

As discussed in chapter two, the conceptualization and definition of women’s sexual desire and arousal are currently contentious issues among sexuality researchers. There is a great deal of controversy over whether sexual arousal and desire are distinct concepts or not, and the issue is not merely one of semantics. The ramifications of these definitions are significant in terms of understanding women’s sexual response and in defining and treating women’s sexual dysfunction. For instance, research suggests that anywhere from 33 percent (Laumann et al., 1999; Warnock, 2002) to 67 percent (Nusbaum, et al., 2000) of women have low sexual desire. However, if “sexual desire” is not clearly conceptualized and defined, then estimates of low and high sexual desire are less meaningful.

Thus, an important finding of this research is how women conceptualized sexual arousal and sexual desire. As previously stated, it was common for women to define sexual desire as an interest in sex (vaginal-penile intercourse). But other women reported that they were often aware of their sexual desire through specific physical indicators of their desire. These women regarded sexual arousal as an indicator of sexual desire. Even when women made a distinction between sexual desire and arousal when prompted by the researcher, they seemed to think of sexual desire and sexual arousal as overlapping concepts rather than the linear, distinct stages of sexual response that many theorists and researchers have purported them to be. That is, the results of this study contradict one of the key tenets of biomedical research on women’s sexual desire – that sexual response is

a universal, linear phenomenon and that sexual arousal and desire are distinct concepts. Feminist scholars and researchers also argue against the notion that sexual desire and arousal are distinct concepts (e.g. Graham, in press; Tiefer, 1995).

As illustrated by research question number four (“What differentiates women’s experience of “high” sexual desire from their experience of “low” sexual desire during menopause?”), it was expected that there would be a clear distinction between women with low and high sexual desire. However, as discussed in chapter four, there was not one single factor that distinguished women with low sexual desire from high sexual desire. In other words, there was not a clear distinction between women with low or high sexual desire. This finding was surprising in light of the distinction usually made between abnormally low (hyposexual) and high (hypersexual) desire disorders in the literature (e.g. Laumann et al., 1999; Nusbaum, et al., 2000).

Although hyposexual desire disorder is considered in the literature as a dysfunction in need of treatment, it is noteworthy that the women in the present study with low sexual desire were not necessarily concerned with their current level of sexual desire, nor were women with high sexual desire necessarily pleased with their current level of sexual desire. While some women with low sexual desire did inquire about the development of a “Viagra for women”, other women never expressed any concern over their low interest in sex. In fact, many of these women discussed that they would much rather spend their time gardening, canoeing, or hiking than having sex.

It is important to understand the meanings that women attach to their experience of low sexual desire, especially given the medicalization of women’s low sexual desire as a disorder in need of pharmaceutical treatment. The perspective posited in the

biomedical literature on women's sexual desire, that women are distressed by their low levels of sexual desire, was not salient for the women in this study. Other researcher has also found that women's low levels of sexual desire are not necessarily disconcerting for them (Bancroft et al., 2003). Given the fact that women may not be distressed about their level of sexual desire, the current emphasis on pharmaceuticals to artificially increase women's sexual desire seems inappropriate. Furthermore, it is unlikely that there is a "quick fix" for women who are concerned about their level of sexual desire as there was not a clear distinction between women with low and high level of sexual desire despite the large amount of data collected that spanned aspects of women's lives.

The final aspect of sexual response that women in this study discussed was vaginal lubrication. Participants discussed the importance of vaginal lubrication for them in terms of its role in preventing discomfort or pain during intercourse, and also as an indicator of sexual arousal. The association between sexual arousal and vaginal lubrication is well established in the literature on women's sexual response (e.g. Basson, 2002; Everaerd et al., 2000). Similarly, the research by Graham and colleagues (in press) also found that vaginal lubrication was an important arousal cue for women.

Social Scripts/Institutional Sexism

As discussed in chapter four, two intricately related social phenomena that influenced women's experiences and meaning of sexual desire were those of social scripts and institutional sexism. Gagnon (1990) defines a social script as an individual's personal sense of her/his own sexuality, as influenced by various sociocultural factors.

DeLamater (1987) has also discussed the impact of environmental and cultural factors in shaping how individuals learn about and express sexuality. Similarly, script theory explains an individual's personal sense of her/his own sexuality, as shaped by various sociocultural factors, including gender role expectations, religion, the media, and generational factors.

In this current study, women's social scripts with regards to their sexual desire were interconnected in that they all privileged men's sexual needs and sexual desire. As illustrated in chapter four, institutional sexism was an important underpinning of the women's social scripts, especially in light of the overwhelmingly negative messages that they received about their sexuality and sexual desire. These messages indicated how sexist social beliefs influenced women's negotiation of sexual agency as well as their experience and meaning of sexual desire. For instance, women who had internalized social scripts that privileged men's sexual needs over their own were less able to negotiate sexual agency and this detracted from women's experience of sexual desire. Other researchers have also noted how negative sexual messages have served to interfere with women's sexual expression and sexual desire, as well (e.g. Katz & Farrow, 2000, Trudel, 2001).

Participants in this present study discussed various social scripts that influenced their experience and meaning of sexual desire, and they also described the various sources of these messages, such as parents, schooling, the conservative era of the 1950s in which they were raised, religion, the media, and their relationships with their partners. The social scripts women described tended to dichotomize the meaning of their sexual desire depending on their life context and specific circumstances. Women perceived that

social scripts appropriated their sexual desire, and that sex was either motivated by lust or by love. Women explained that the messages they received about the appropriateness of their sexual desire were often contradictory and confusing. For instance, some women explained that they were simultaneously expected to be attractive for boys and men, but they were also expected to serve as the gatekeeper for sexual activity, especially in terms of moral character. In this manner, women discussed that they had learned to turn on and turn off their sexual desire as dictated by others (e.g. partners, religion) and according to various circumstances (e.g. marital status). For instance, women described the importance of intimacy and emotional closeness as a socially acceptable motivation for their sexual desire, while sexual interest for the sake of pleasure or fun was considered inappropriate for them.

The notion that sex for women must be rooted in love, while men are permitted to have sex to fulfill their sexual wants and needs, is a derivative of the sexual double standard (Hollway, 1989; Muehlenhard & McCoy, 1991). Women's sexual desire is controlled in this manner through their relationship to men. As women in this study discussed, women's sexual desire is often viewed as a requisite aspect of the marital relationship, while conversely sex is viewed as immoral or inappropriate for unmarried women (Gilfoyle et al., 1992). Similarly, Graham and colleagues research (in press) also found that women's concern about their reputations (e.g. being labeled a "slut") inhibited women's sexual response.

Participants' accounts of their first experience of sexual desire were revealing of the way that women's social scripts influenced their sexual desire. During recollections of their first experiences of sexual desire, women often described themselves as sexual

agents of their desire. For instance, some women described feeling connected and in tune with their bodies and in control of their sexual choices during their first experiences with sexual desire. In contrast, some women's descriptions of their experience of sexual desire at their current (postmenopausal) stage of life sounded more distant, almost as if they were giving a third-person account. During their first experiences of sexual desire, the women were relatively young (ages 5-18) and they generally had not yet distanced themselves from their experience of desire. Fine (1988) & Tolman (2002) have discussed at length how girls learn in adolescence to surrender their sexual agency in order to become sexual objects to seek boys' and men's attention. As part of this process, girls also learn to manage their sexual desire and arousal, and to stifle these feelings when the "costs" are too high (e.g. feeling unsafe, fear of pregnancy, fear of negative reputation). Similarly, in this current study some women surrendered their sexual agency by stifling their sexual desire when others perceived it as inappropriate or taboo.

By contrast, some women in this study described how their sexual desire grew stronger as they aged. As these women aged, they became more mature and more comfortable with their sexual desire, and these women experienced their postmenopausal years as freeing and as more conducive to experiencing sexual desire. Other women in the study described how they were currently less focused on sex than they had been in their younger years. These women described being more interested in attending to other needs and wants in their life, such as gardening and enjoying their grandchildren. Research on midlife women's sexual response suggests that middle and later life is a freeing time for women, and that factors that constrain women's sexual desire (e.g. children, adherence to impossible beauty standards) may be somewhat alleviated (e.g.

Koch & Mansfield, 2001/2002; Mansfield et al., 1995). Notably, women in this study who had low sexual desire were not necessarily disappointed or bothered by their lack of interest in sex. In fact, these women seemed grateful to have more time and energy to devote to activities that they were interested in.

Another aspect of social scripts and institutional sexism that women in this study discussed was body image. As presented in chapter four, women discussed body image in terms of how and why they valued their bodies. For instance, some women (often those who had experienced health problems) valued their bodies in terms of how it facilitated their daily activities or enriched their lives (e.g. hiking, canoeing, other leisure activities). Women who appreciated their bodies in a holistic way did not discuss the value of their bodies in terms of their attractiveness to others, the crux of body image issues and body loathing. Other researchers and scholars have termed this holistic perspective, one in which women appreciate their bodies for the functions they perform, “physicality” (e.g. Bartky, 1998; McDermott, 2000). For instance, McDermott (2000) discussed physicality as a complex phenomenon that involves agency, self-perception, and body awareness, and found that women’s physicality was an important influence on their meaning and experience of body image. While McDermott’s research is not directly relevant to this study (her research examined differences in women’s physicality based on their participation in two gendered physical activities: aerobics and wilderness canoeing), her findings on the relationship between agency and body image do help to illustrate how interconnected women’s sexual selves are with their ability to negotiate sexual agency. Specifically, women in this current study had difficulty negotiating their sexual agency if

they had internalized social scripts that posit women's bodies as objects to entice men and serve men's sexual needs and interests.

In addition to McDermott's work on the association between agency and body image, other scholars also have discussed the importance of understanding women's perceptions of their bodies in the social, cultural, and political climate in which women live. For instance, Bordo (e.g. 1993) has written extensively about the damage done to women's sense of themselves as individuals in a culture that values women's physical attractiveness (to men) over other attributes. Similarly, Daniluk (1993) found that the sexual objectification of women has negative implications for women's body image and sexuality. Finally, Bordo and others (e.g. Herzig, 2001) have argued that women cannot have agency or subjectivity in a culture that objectifies them.

TREMIN researchers also found a relationship between midlife women's self-perceived attractiveness and level of sexual response (Koch et al., under review). The more a woman perceived herself as less attractive than before, the more likely she was to experience a decline in sexual desire or frequency of sexual activity over the past ten years. On the other hand, the more she perceived herself as attractive, the more likely she was to experience an increase in sexual desire, orgasm, enjoyment, or frequency of sexual activity. Similarly, Dixon (2000) found a strong positive correlation between women's body image and sexual satisfaction. Other research also supports the results of this current study, suggesting that women's body image influences their negotiation of sexual agency, which is an important influence on women's experience of sexual desire (Kingsberg, 2000; Trudel, 2001).

Another finding in this current study related to women's negotiation of sexual agency in light of social scripts related to women's association of sex with reproductive capacity. Some women explained that their fear of pregnancy inhibited their sexual desire, despite the fact that they were postmenopausal. Several women explained that even though they were aware that pregnancy was no longer a viable outcome of sex for them, they had feared unintended pregnancy so much and for so long that they unconsciously associated sex with a fear of pregnancy. Thus, it seems that women's perceived responsibility for preventing pregnancy is a burden that has implications for women's experience of sexual desire well beyond women's childbearing years.

Other research supports the finding that women's sexual response is inhibited by fear of pregnancy. For instance, women in Graham's study (in press) discussed how they had learned how to "put on the brakes" or stop themselves from feeling sexual arousal for fear of negative repercussions, such as pregnancy.

The sexual double standard was another social script rooted in institutional sexism that influenced women's experience and meaning of sexual desire. Participants in this present study discussed the sexual double standard as an example of the interconnectedness of social scripts and institutional sexism. Women discussed feeling that there was a social stigma toward women who embodied their sexual desire (e.g. "sluts"). The sexual double standard was a pervasive and common theme among women's discussions of the experience and meaning of sexual desire for them. The sexual double standard influences women's ability to negotiate sexual agency and also influences women's experience and meaning of sexual desire.

Feminist scholars and researchers have written a great deal on the sexual double standard and how it systematically negates women's sexual agency and women's right to experience sexual desire (Gentry, 1998; Gilfoyle, Wilson, & Brown, 1992; Lips, 1997; McCormick, 1994; Milhausen & Herold, 2001; O'Sullivan, 1995). The sexual double standard is quite complex and its effects on sexual expression are significant. Essentially, the sexual double standard ascribes one set of expectations regarding sexual behavior to women, and another set of expectations to men. Specifically, the sexual double standard affords more sexual freedom to men (Milhausen & Herold, 2001). Muehlenhard & McCoy (1991) distinguish between "the old sexual double standard", which refused women the privilege of having sex outside of marriage, and the new version that tolerates premarital and extramarital sex for women, but with more restrictive circumstances for women than for men (e.g. for love). In this current study, both versions of the sexual double standard were described by the participants, perhaps due in part to the generation in which these women were raised. Other researchers have also found that the sexual double standard exists on two dimensions, societally (i.e. social scripts) and individually (i.e. women and men who adhere to socially defined gender-specific roles) (Gilfoyle et al., 1992; Muehlenhard, 1988; Milhausen & Herold, 2001). For instance, Muehlenhard & McCoy (1991) found a relationship between women's acceptance of the sexual double standard and their refusal of sexual advances despite their interest in sex (i.e. sexual desire). The researchers termed this manifestation of the sexual double standard "scripted refusal", to describe women's refusal of sex to avoid appearing "easy" or a "slut" despite her willingness and interest in sex. Moreover, the researchers found that women who had internalized the sexual double standard were reluctant to even

acknowledge their sexual desire for fear of negative implications. Other research has also found that the sexual double standard censures women's sexual agency, sexual desire, and sexual activity (e.g. Gentry, 1998; Muehlenhard, 1988; O'Sullivan, 1995).

Finally, sexual silence/voice was the last aspect of social scripts as related to institutional sexism that women in this study discussed. Sexual silence/voice describes the degree to which women were able to discuss their sexual desire, both with others in their life and with the researcher during the interview. Women in this current study experienced both voice and silence, depending on the other person with whom they were communicating. Women's sexual voice or silence was inherently related to other messages that women received about sex and sexual desire, including social scripts and the sexual double standard. For instance, some women stated that they felt uncomfortable discussing sex with others in their life. In this way, a woman's sexual silence had important implications for her expression of sexual desire, particularly if she had difficulty communicating about sex with her partner. To this end, a woman's sexual voice or sexual silence was often an indicator of her negotiation of sexual agency. Similarly, some women had learned to separate their sexual desire from themselves and from their bodies through social scripts that were rooted in patriarchal assumptions about the nature and purpose of sex. These women had learned to place their sexual desire outside of their own experiences, thereby surrendering their sexual agency. In this sense, the sexual double standard (and other sexist social scripts) stifled women's ability to fully experience sexual desire as part of sexual response and sexual agency by socializing women to be sexual objects.

Other research and scholarship supports the results of this study, that women's ability to communicate about sex is an influence on their sexual desire and is an indicator of sexual agency. For instance, Allen (2003) found that dominant heterosexuality discourse influenced an individual's sexual subjectivity and that an individual's voice reflects her perception of herself as a sexual being. Specifically, Allen found that participants' ability to talk about themselves as sexual beings was a gendered phenomenon, and that voice was associated with sexual subjectivity (i.e. agency), while silence was often an indication of sexual objectivity.

Similarly, Gilfoyle and colleagues (1992) also found a relationship between heterosexuality discourse, voice, and sexual agency. Specifically, the researchers found that gender-specific roles conveyed to women through heterosexuality discourse were a powerful influence on their position as a sexual subject or object. More importantly, the positions of sexual subjectivity and objectivity are not equally available to women and men. Instead, sexual objectivity is appropriated to women and sexual subjectivity to men through heterosexuality discourse.

It is noteworthy that women's experiences and meanings of sexual desire in this study tended to be devoid of any mention of sex for fun, pleasure, stress relief, or relaxation. In fact, women's descriptions of their sexual activity often focused on how sexual activity was something they could do for their partners, to quell their partners' sexual desire. Fine (1988) terms the systematic dismissal of girls' sexual agency "the missing discourse of desire". Fine argues that when issues of desire or sexual interest are presented through popular discourses, the agent of desire is always male, and girls' and women's desire is completely absent from discussions of sexual activity, behaviors,

or intercourse. Fine's work demonstrated that girls learn that they have sex done to them, while boys learn to desire and obtain sex. As such, girls learn to be passive in sex, and learn that one function of sex is to serve boys' needs and interests.

The results of this current research project, nearly two decades after Fine coined the phrase "the missing discourse of desire", suggest that older women's sexuality discourse is still missing any mention of women's entitlement to sexual equality, including the right to make sexual choices and the right to experience sexual desire and pleasure without guilt. The current state of women's sexuality can be characterized as "still missing the discourse of desire". Daniluk (1993) suggests that the absence of such a discourse further disempowers women and perpetuates women's sexual silence, submission, and isolation.

Health Status

Women's health status was another aspect of women's sexual selves that influenced women's experience of sexual desire. As discussed in chapter four, both illness and the regular use of medications affected women's negotiation of sexual agency (e.g. to feel in control of their bodies) and women's experience of sexual desire. Women's use of medications (such as anti-depressants) and illnesses (such as breast cancer, back pain) either distracted women from their sexual desire or decreased women's level of sexual desire. As discussed in chapter two, the literature on women's sexual desire has recognized that women's health status is an important influence on women's sexual desire, sexual satisfaction, and other sexual response measures (e.g. Avis

et al., 2000; Koester & Garde 1993). For instance, diabetes, hypertension, irritable bowel syndrome and chronic renal failure have been associated with decreased sexual desire in both women and men (e.g. Zemel, 1988). Similarly, research has found a correlation between women's sexual concerns and depression (Nappi et al., 2000). Medications, such as anti-depressants, have also been associated with lower levels of sexual desire (e.g. Nappi et al., 2001; Pariser & Niedermier, 1998).

It is interesting that most women in this study did not discuss their partner's health status as influential in their experience of sexual desire and other sexuality issues. By contrast, other researchers have found that a partner's poor health (either emotional or physical) is often a detriment to the sexual relationship (e.g. Laumann & Rosen, 1999; Mansfield et al., 1995). There are two possible reasons to explain the omission of partner-related health issues from women's discussion. First, since the participants were volunteers it is possible that women with ill partners did not volunteer to be interviewed. Secondly, because the nature of the interview focused on *women's sexual desire* (as opposed to sexual satisfaction, for instance) perhaps women did not think that their partner's health issues affected their own interest in sexual activity (especially since a few of the women made it clear that sexual desire could be directed towards an interest in masturbation too).

Finally, it is also interesting that women did not focus on menopausal symptoms (or their postmenopausal status) as an important contributor to their experience of sexual agency or as an influence on their sexual desire. The exceptions, however, were women's discussion of vaginal dryness and hot flashes. Many of the women mentioned

vaginal lubrication as an important indicator of their sexual arousal, and other women mentioned vaginal dryness as a barrier to their enjoyment of vaginal-penile intercourse.

One possible explanation for the omission of menopause in the women's discussions is, perhaps because the participants were *postmenopausal* and menopausal symptoms are typically characteristic of the menopausal transition. If the participants had been perimenopausal it is likely that their experience of menopausal symptoms would have been different.

Postmenopausal women were chosen for this study based on biomedical research and theory that posits postmenopausal women's sexuality as deficient based on decreased levels of reproductive hormones. Specifically, researchers have suggested that women's decreased testosterone and estrogen levels as a result of menopause are responsible for women's decreased sexual desire (e.g. Davis, 1999; Hallstrom & Samelson, 1990; McCoy, 1992; Regan, 1999; Sherwin, 1991; Tuiten et al., 2000). Other research has suggested that women's hormone levels (and menopausal status) have an indirect effect on women's sexual desire. For instance, researchers point to hot flashes and vaginal lubrication as examples of the indirect effects of decreased estrogen levels on women's sexual desire (Bachman, 1990; Leiblum, 2002; McCoy et al., 1985; McCoy, 1992). Perhaps women in this study did not perceive menopause as an influence on their experience of sexual desire due to the indirect nature of the effects. In fact, Mansfield and colleagues (2000) found that women's attributions for their sexual response changes were often different from their actual experiences. Specifically, older women were most likely to attribute lessening sexual desire to physical changes associated with menopause

even though the actual symptoms that they reported were not significantly related to decreasing sexual desire as measured in a self-report survey.

Other research suggests that cultural and social issues, not menopausal status and related health issues, are the most important determinants of women's sexual response. For instance in Winterich's study (2003), very few women discussed their menopausal status or menopausal related symptoms, and those who did, not much emphasis was placed on these factors. Instead, an overwhelming majority of the participants emphasized the influence of social and cultural issues on their experiences of sexuality, including sexual desire and sexual agency. Winterich concluded that menopause per se is not as important as sociocultural influences on women's experiences of sexuality. Avis et al. (2000) also suggested that lifestyle and health factors have a greater impact on women's sexual desire than menopause.

Life Context

As discussed in chapter four, "life context" described contextual factors in a woman's life that often facilitated or inhibited her sexual desire, including environmental factors and the overall mood of a situation. Participants in this study discussed various inhibitors and facilitators of their sexual desire, including the environment, the mood, and stress or distractions. These factors were all context-dependent. In other words, women located these influences and determinants of their sexual desire outside of themselves.

Women's relationships and their sexual partners were often facilitators or inhibitors of women's sexual desire, and thus "life context" mediated the relationship

between “the sexual self” and partner-related factors. One of the life context issues women discussed as an inhibitor of their sexual desire was distractions, as well as being preoccupied with other thoughts during sex. Women explained that tasks, including errands, getting ready for houseguests, and spending time with their grandchildren, diverted their attention away from their experience of sexual desire.

This is an interesting finding since many women look forward to middle and later life as a time to focus on their own wants and needs, as opposed to focusing on the needs of others in their lives, especially children. In this sense, many women look forward to menopause as a more freeing and less demanding time in their life (e.g. Mansfield et al., 1995; Sang, 1993). The results of this study suggest that women remain preoccupied with other life issues well into menopause and beyond. However, it cannot be assumed that other issues in women’s lives detract from women’s experience of sexual desire as they may prefer other activities to engaging in sex. In other words, it cannot be assumed that women’s lives *distract* them from their sexual desire, as women may legitimately be more interested in their grandchildren or their gardens, for instance, than in sex.

Women in this current study also described how environmental factors and the overall mood of a situation influences their experience of sexual desire. For instance, women said that feeling connected to their partners, through hiking or canoeing for example, enhanced their sexual desire. Similarly, environments, such as a mountain lodge or a special occasion, which set a romantic mood, also increased women’s sexual desire.

Other researchers have also demonstrated the importance of contextual variables in influencing women’s sexual response. For instance, the Graham et al. (in press)

findings emphasized the importance of context in women's experience of sexual arousal, especially in terms of facilitators and inhibitors of arousal. More specifically, inhibition of arousal often stemmed from relational factors (e.g. partner's hygiene) as well as sociocultural factors (e.g. the sexual double standard). Other research has also demonstrated how contextual factors influence women's overall sexual satisfaction and sexual desire, including romance and tenderness in sex play (Daniluk, 1993), sexual inhibition related to cultural beliefs (Kiely, 1997), body image issues (Koch et al., under review), fear of domestic violence (Fine, 1988), genital shame (Jones, 1994), or resentment towards a partner based on unequal childcare or household responsibilities (Mansfield, Koch, & Voda, 1998).

Other researchers have also found a relationship between stress/distractions and women's sexual desire. For instance, Galyer et al. (1999) found that contextual issues in women's lives, including work and family stress, fatigue, and concerns for their relationship, negatively influenced their sexual desire. Analyses revealed that life circumstances, such as work or money worries and family arguments, were significant predictors of low sexual desire. In contrast, women reported that factors such as having leisure time to spend with their partner and reading or watching romantic entertainment increased their desire for sex. Similarly, Trudel et al. (2001) studied couples in which the woman was diagnosed with hypoactive sexual desire disorder (HSD). The researchers found that more than 20% of women diagnosed with HSD reported being preoccupied with aspects of their life (e.g. work, finances, family) to the extent that they could not concentrate during sex. Similarly, Dove & Wiederman (2000) examined the relationship between cognitive distraction and sexual dysfunction (including low sexual desire) in

young women (ages 18-21). The researchers found a correlation between women who reported cognitive distraction during sex and their level of self-reported sexual desire. The researchers concluded that cognitive distraction inhibits women's sexual desire. These results support the findings of this current study.

The importance of life context in terms of its influence on women's sexual desire also has implications for understanding women's sexual response. As discussed in chapter two, traditional human sexual response cycles tend to stringently define and conceptualize the stages of sexual response in order to represent sexual response as universal. Thus, models of sexual response tend to locate determinants of sexual response within individuals, often in terms of physiological mechanisms, and thus contextual issues are often ignored or discounted. Zilbergeld & Ellison's model of sexual response (1980), is the exception to this trend. While the model they proposed is still linear, it does emphasize the power of contextual factors to shape a person's sexual response. More specifically, Zilbergeld & Ellison stress the notion that each individual has a unique set of situations and contextual factors that will facilitate their sexual desire and arousal, which they termed "conditions for good sex". Similarly, the women in this study discussed conditions in their lives and relationships that facilitated their experience of sexual desire, as discussed in chapter four.

Partners

As discussed in chapter four, four partner factors emerged as influencing women's ability to negotiate their sexual agency: partner availability, the couple's

approach to sex, partner's erectile difficulties, and the quality of the partner relationship. These results will be briefly reviewed here and relevant findings from other research will be incorporated into this discussion.

Partner Availability

As discussed in chapter four, partner availability referred to both physical access to a partner as well as partners' emotional availability. Important differences between the single and married women emerged in terms of partner availability. For instance, single women discussed a lack of suitable partners, an issue that affected their access to a partner in terms of the physical availability of a partner. Thus, single women discussed partner availability in terms of their difficulty in finding a suitable sexual partner. In contrast the married women discussed partner availability in terms of their partner's emotional availability. Married women explained that they wanted their partners to be emotionally available to them and attentive to their wants and needs, including their sexual needs. Other research has also found differences between married and single women's experience of sexual desire. For instance, Avis et al. (2000) and Mansfield et al. (1995) found that married women had lower levels of sexual desire than their single counterparts.

There is a good amount of literature that has examined how the lack of a (suitable) partner inhibits women's sexual response (e.g. Bachmann et al., 1985; King & Allgeier, 2000; Koch & Mansfield, 2001/2002; Trudel, 1991, 2002). Typically this research has focused on midlife and older couples, and often has examined the effects of

a sick, disabled, or recently deceased partner on women's sexual response (e.g. Laumann & Rosen, 1999). For instance, in a study that focused on women's sexual desire, Koester & Garde (1993) found that women's frequency of sexual desire was highly correlated to their partner's health status and partner availability. Thus, the results of this study, that women's experience of sexual desire is affected by the physical availability of a partner, are supported by other research.

While the emotional availability of their partners was an important issue for women in this current study, to date there has been no published research that focused on the emotional availability of women's partners as an influence on their sexual desire. One reason for this limitation may be that research on women's sexual desire has only recently begun to focus on partner-related factors (Trudel, 2002). Or, it is possible that researchers have considered emotional availability as part of a larger construct, such as relationship quality or relationship satisfaction, which will be discussed later in this chapter. Alternatively, perhaps emotional availability is a less obvious construct than other relationship issues that may influence women's sexual desire and research has simply not yet focused on emotional availability.

Couple's Approach to Sex

As presented in chapter four, a couple's approach to sex was an important influence on women's negotiation of sexual agency and her experience and meaning of sexual desire. Several specific findings are noteworthy with regard to the influence of a couple's approach to sex on women's sexual desire. First, women expressed feeling

disappointed and frustrated about their own use of sex as a means to feel emotionally close and connected to their partners. Additionally, some women perceived that their partners were not interested in taking the necessary time (i.e. foreplay) to ensure that sex was pleasurable and satisfying for them. These women explained that sex felt too overwhelming for them at times, especially if lack of foreplay and vaginal dryness were issues they grappled with. To this end, these women felt as though sex was too much work. Finally, many of the women felt an obligation to attend to their partner's sexual needs, even if they contradicted her own wishes. Similarly, because some women viewed sex as an obligatory marital task, many women discussed how they had engaged in sex that they were not necessarily interested in. Thus, many women had sex without experiencing sexual desire. These findings illustrate how women negotiated their sexual agency within the context of the couple's approach to sex. Specifically, if women perceived their partner's sexual needs as more important than their own, women often surrendered their sexual agency in order to meet their partner's sexual needs. In contrast, women's sexual agency often facilitated women's experience of sexual desire and sexual pleasure when women perceived that their sexual needs and desires were equally as important as their partner's.

Other researchers have also found a relationship between sexual agency and a partner's approach to sex, although not with regard to sexual desire and not in midlife or menopausal women. For instance, as discussed in chapter two, Tolman (2002) used longitudinal survey data to study eighth-grade girls (ages 13-14) in a northeast urban area. She found that girls who felt less sexual agency were more likely to censor and compromise themselves in a relationship, especially in terms of wanting to sexually

please their partners. Similarly, Fine's noted study (1988) on adolescent girls in New York City found a similar relationship between a girl's lack of agency and her boyfriend's patriarchal approach to sex (e.g. objectification). However, there is currently no previous research that specifically examines the relationship between midlife or menopausal women's sexual desire, sexual agency, and their partners' approach to sex.

An important result from this current study is that married women's approach to sex was often one in which women engaged in sex without sexual desire. As discussed earlier in this chapter, women defined sexual desire as an interest in sex, and so the fact that women engaged in sex without desire amounts to women having unwanted (but consensual) sex. Some women said that they eventually felt desire after the sexual activity began; however other women discussed having sex but never feeling sexual desire.

Women had various explanations for why they consented to sex that they were not interested in. Some women believed that sex was an obligatory task in marriage. Some women perceived that men's sexual desire was more important than their own sexual wishes. This was especially true among women who viewed men's sexual needs as primal and uncontrollable. Yet, some women did not perceive their involvement in unwanted sex as problematic or as disconcerting. Perhaps patriarchal messages that privilege men's sexuality at the expense of women's sexual choices are so pervasive and normative that women are not even conscious of their sexual oppression. Alternatively, perhaps women believe that obligatory sex is the price they pay for the security and stability of marriage.

There are several researchers who have studied the phenomenon of young women who consent to unwanted sex, and this practice has been termed “consensual unwanted sex” and “compliant sexual behavior” (Impett & Peplau, 2002; O’Sullivan & Allgeier, 1998; Walker, 1997). Research on women’s compliant sexual behavior is often conducted among heterosexual college students, and researchers have found that between 50% (Impett & Peplau, 2002; O’Sullivan & Allgeier, 1998) and 63% of college women have consented to unwanted sex (Sprecher, Hatfield, Cortese, Potapova, & Levitskaya, 1994). Researchers have found that women consent to unwanted sex for various reasons, most of which relate to their partner’s perceived need or desire for sex. Women have unwanted sex because they believe that sex is an obligatory relationship task (O’Sullivan & Allgeier, 1998), because they believe that sex is how to communicate love and experience intimacy with their male partner (Impett & Peplau, 2002, Regan & Berscheid, 1999), and because women believe that men’s sex drive is uncontrollable and that men simply require more sex (Moore & Rosenthal, 1993; Walker, 1997). In other words, many young women have sex that they do not want because men’s sexual needs are privileged over their own sexual agency, to the extent that women do not even recognize that it is legitimate to refuse sex that they are not interested in. Thus, the literature on young women’s compliant sexual behavior supports the findings of this research project with older women. Women in this study had internalized society’s (patriarchal) approach to sex and discussed having unwanted sex to fulfill their marital scripts and as a way to seek out intimacy with their partners.

Partner's Erectile Difficulties

Participants in this study also described how their partner's erectile difficulties inhibited their sexual desire. Most women expressed concerns about their partners' erectile problems as part of their own concerns about sexual desire and sexual satisfaction. For instance, some women would purposely ignore their sexual desire in order to prevent their partner from experiencing erectile difficulties. Women were more concerned with their partners' egos as a result of their inability to obtain or maintain an erection than they were for their own enjoyment of sex and their experience of sexual desire. Thus, women negotiated wanting to protect their partners from experiencing erectile difficulties and avoiding a sexual experience that would be unpleasant for them by often avoiding sex altogether. Many of the women explained that their partners had tried Viagra in an attempt to address these erectile concerns; however none of the women mentioned that Viagra had been helpful.

The literature on sexual dysfunction, marital satisfaction, and sexual therapy all discuss men's erectile issues as important influences on a couple's overall sexual satisfaction, relationship quality, and women's sexual response. For instance, Deeks & McCabe (2001) found that the sexual functioning of women's male partners was an important influence on women's overall sexual satisfaction. Rosen (2003) provided a review of male erectile dysfunction, including its negative effects on men's relationships and their female partners. Interestingly, such research focused on ways to remedy (read: treat) men's erectile dysfunction as a way to enhance the sexual satisfaction of both

members in the relationship. However, participants in this current study discussed how their partner's ego, not the state of their penis, was the reason for the avoidance of sex.

Other research has also found that women's avoidance of sex is one way that women can exercise their sexual agency. For instance, participants in Walter's (2000) study said that simply going without sex was easier and more desirable for them than having unsatisfactory or even unpleasant sex. Many midlife women in Koch and Mansfield's sample (2001/2002) stated that having sexual relations was not worth the price if the overall relationship was not fulfilling. Similarly, Meadows (1997) found that women's choice to stay celibate was often in order to regain their own sense of self and sexual agency. Unfortunately, heretofore, the research on men's erectile difficulties is too focused on the efficacy of Viagra to examine the importance of men's egos as an influence on their female partners' willingness and interest in sex.

Finally, it is noteworthy that a woman's conceptualization of sex as vaginal-penile intercourse is an important contributor to women's avoidance of sex based on her partner's erectile issues. In other words, if women had conceptualized sex more broadly, to include non-penetrative or non-genital behaviors, then perhaps a partner's erectile difficulty would not be such a concern. Of course, women's conceptualization of sex as intercourse is deeply rooted in sociocultural beliefs and norms, and is reinforced through heterosexual discourse. Thus, in order for women to reconceptualize the meaning of sex, women need to be able to exercise sexual agency, and act as sexual subjects, both within their relationships and in the larger culture.

Relationship Quality

As presented in chapter four, women's self-reported quality of their relationships with their partners was the greatest influence on their negotiation of sexual agency and subsequent experience of sexual desire. There were various findings that explained how relationship quality influenced women's sexual desire. First, women explained that sex was just one aspect of a good relationship. Women associated a good relationship with qualities in their partner such as "sensitivity", "respectfulness", "kindness", "tenderness", and "light-heartedness". Women described that "mutuality", "feeling safe", and "feeling connected" were important aspects of healthy, positive relationships. When women's overall relationships were positive, they described feeling more sexual desire, as well as being more satisfied with their sexual experiences in general.

Communication was a very important influence on women's experience of sexual desire. Generally, women who were able to communicate with their partners about sex and their sexual satisfaction also reported having more sexual desire. For this reason, many women thought that communication, especially about sex, was an important aspect of a good relationship. Additionally, many partner-related factors and relationship factors inhibited women's sexual desire, including when women felt that their partner was being insensitive, when a woman felt that her partner was being insensitive, when a woman was angry with her partner, and if a woman was not attracted to her partner for hygiene reasons. Finally, women who described feeling a lot of sexual desire had also prioritized sex in their lives because they believed that sex served an important function for them and in their relationships. In contrast, women who had not established sex as a

priority in their lives often discussed feeling that sex was relatively unimportant and unfulfilling for them.

There is a huge amount of literature on the association between relationship quality and women's sexual satisfaction, including measures of sexual response. Generally, research has shown a positive correlation between relationship satisfaction and women's sexual satisfaction (see Christopher & Sprecher, 2000; Sprecher & Regan, 2000 for a review). There is less research that has focused specifically on women's sexual desire as related to overall relationship quality. In a study of midlife women, those who reported decreasing sexual desire also reported that they wanted their partner to be more passionate and assertive and to treat them more equally (Mansfield et al., 1998). In addition, research by clinicians has found that women diagnosed with hypoactive sexual desire are more likely to be dissatisfied with the quality of their marital relationship (e.g. Atwood & Dershowitz, 1992; Trudel, 1991) and that the quality of a relationship improves after successful treatment of a sexual desire disorder (Trudel, Marchand, Ravart, Aubin, Turgeon, & Fortier, 2001).

Similarly, Trudel (2002) established that good sexual communication was a significant predictor of women's marital satisfaction. Thus, as found in this current study, communication about sexuality-related issues influenced women's perception of the overall quality of their relationship. Similarly, women's ability to effectively communicate with their partners about sexuality-related issues was an important factor in women's negotiation of sexual agency. Finally, women's negotiation of sexual agency within their relationships influenced women's overall perception of the quality of that relationship, and subsequently affected women's experience of sexual desire.

In this study, women's desire for intimacy with their partners was also an important factor in their experience and meaning of sexual desire. Intimacy was an important aspect of women's sexual relationships, so much so that women discussed having sex solely to fulfill their needs for intimacy. Most women discussed wanting intimacy and a sense of emotional closeness with their partners. Women often viewed sex as a means to fulfill their needs for intimacy even if the sex, per se, was not fulfilling and even if they engaged in sex without really wanting it (read: without feeling sexual desire). However, women clearly made a distinction between sexual desire (defined as an interest in sex) and intimacy, which they associated with emotional connection to their partner.

Recently, research on women's sexual response has focused on the role of intimacy in women's sexual expression and sexual behavior. For instance, Basson (2001) has incorporated intimacy into her sexual response model. As discussed in chapter two, Basson posits intimacy as women's primary motivation to engage in sex with a partner, and in this sense Basson views intimacy as a prerequisite for sexual desire. The relationship between sexual desire and intimacy in this study was not as clear-cut as Basson suggests (especially since there were women in this study who had sex without sexual desire). However, the results from this current study that indicate intimacy is a motivating factor for engaging in sex are certainly supported by Basson's work.

The work of other researchers also supports the findings of this current research. For instance, Kiely (1997) concludes that sexual desire develops and acquires meaning only within a relational context. In their sample of married, midlife women, most of the women described that what they liked most about their sexuality was some aspect of

intimacy shared with their partners (Koch & Mansfield, 2001/2002). Women in this sample also wanted more physical closeness and intimacy with their partners (Mansfield et al., 1998). Similarly, Trudel et al. (2001) found that women diagnosed with hyposexual desire disorder were more likely to have negative feelings about the quality of their relationship, especially in terms of communication and a lack of intimacy. Kingsberg (2000) concludes: "Sexuality can be fully understood only by assessing the context in which it occurs. That is, one must understand the context of the relationship in which it occurs and the significant issues affecting a person's life" (p. S-34).

The Medical System

As discussed in chapter four, women's negotiation of their sexual agency within the medical system also influenced their experiences and meanings of their sexual desire. Specifically, three themes (codes) described women's negotiation of their sexual agency as related to their experience of sexual desire, including the notion that doctors know what is best for women and their bodies ("doctor knows best"), women's health and sexuality education, and women's health empowerment. These factors will be discussed here with regard to the findings from this study and relevant research from the literature on these topics.

Doctor Knows Best

As discussed in chapter four, participants received negative *messages* from their physicians about their sexual desire, but very little *information* about their sexual desire or other sexuality issues related to menopause. Very few of the women said that their doctors had been helpful with their sexual concerns or questions. In fact, most women did not question their physicians nor did they broach the topic of sex or sexual desire with their doctors. For instance, all of the women in this study had at one time taken exogenous hormones at the suggestion of their physicians. Yet none of the women questioned their use, illustrating the power that physicians have over women's health and sexuality. From women's perspectives, their physicians were not attentive to their sexual desire at all. In another study involving TREMIN participants, Kittel & Mansfield (2000) found various factors that influenced women's decision-making on whether or not to take HT, included women's health knowledge and information and interactions with their physicians. The researchers found that women assumed one of three roles with physicians in deciding whether or not to use hormones, including taking a physician's advice, making the decision mutually, or taking control over the decision making process. In this sense, women's sense of agency influenced their interactions with their physicians and their decision-making process about healthcare. Women in this current study who simply accepted their physician's advice (and consequently took HT) explained that they trusted that their doctors knew what was in their best interest in terms of their health.

Medicalization

As presented in chapter four, an overwhelming majority of the women mentioned that their doctors had previously prescribed hormones to treat their menopausal symptoms, such as hot flashes, or to prevent conditions that they associated with menopause (e.g. osteoporosis). Notably, most of the women did not perceive that their hormone use had affected their sexual desire. Mansfield & Koch's (1998) research on married midlife TREMIN participants also found no significant differences in sexual response (including sexual desire) between hormone users and nonhormone users. Thus, the finding of this current research – that women do not perceive hormones as an influence on their sexual desire - is supported by other research. These results suggest that the relationship between hormone levels and women's sexual desire is not directly a causal one (e.g. Dennerstein et al., 1994; Voda, 1993).

Another example of the medicalization of women's sexuality and health by physicians is the off-label prescription of anti-depressants to *treat* hot flashes, which may indirectly affect women's sexuality. Several of the women in this study casually mentioned that their physician had prescribed Paxil or Effexor as a replacement for hormone therapy, and none of the women questioned this. Evidently the practice of prescribing anti-depressants has become commonplace and there are several studies (funded by the pharmaceutical companies that manufacture these drugs) to test the efficacy of anti-depressant drug therapy in preventing hot flashes (e.g. Stearns, Beebe, Iyengar, & Dube, 2003; Tarim, Bagis, Kiliedag, Erkanli, Aslan, & Kuscu, 2002). While these studies have demonstrated that anti-depressants are effective in ignificantly

decreasing the frequency and severity of hot flashes, there is considerable risk associated with off-label prescription practices. Given the history of the over-marketing of prescription drugs to women, especially menopausal women, it seems questionable that the off-label use of antidepressant drugs should be considered a viable alternative to HT without adequate research on the safety and side effects of such drugs.

Another instance in which women's negotiation of sexual agency is influenced by the medicalization of their sexuality and health in this study was participants' interest in and demand for a "Viagra for women". As discussed in chapter four, several women asked the researcher during the interview when a "quick fix" in pill form would be available for women who wanted to increase their sexual desire. Tiefer (2003) termed the medicalization of women's sexuality through pharmaceutical interventions "biopropaganda", and she is especially critical of the practice of off-label prescriptions of Viagra and other "sexual enhancers" (e.g. Avlimil, an over-the-counter sexual enhancer) for women. Part of the genius of biopropaganda, according to Tiefer, is that there is now a demand on the part of women for these drugs. Tiefer explained that women's demand for such drugs is an indication that they have relinquished any hope that their partners will change their approach to sex. Moreover, Tiefer believes that women's participation in biopropaganda is evidence of women's complete exhaustion from the gender wars. In other words, women have resigned themselves to the fact that household responsibilities, childcare, and other types of "women's work" are not shared equally, and this utter exhaustion has sapped away women's interest in demanding an egalitarian relationship, even in bed and in terms of women's sexual pleasure. Tiefer explained that it is much easier for women to simply take a pill than it is for women to address the variety of

contextual and partner issues that influence her experience of sexual desire. Thus, the results of this study, especially that some women perceive that sex is too much work and that women avoid sex for various reasons, are supported by Tiefer's scholarship.

Tiefer's analysis suggests that women's demand for a women's version of Viagra is a coping mechanism of sorts to avoid addressing underlying issues that contribute to their (low) sexual desire. Certainly some of the participants in this study were more interested in a "quick fix" than addressing their partner's approach to sex, their partner's erectile difficulties, or their own contradictory meanings about their own sexual desire. Similarly, it is interesting to explore women's motivation for a pharmaceutical sexual enhancer to increase their sexual desire. Perhaps women's desire for a "Viagra for women" is rooted in women's interest in making sex (that may be unwanted) as pleasant as possible.

Health & Sexuality Education

As presented in chapter four, women who had access to information on how menopause might affect their sexual desire and educational materials on general sexuality issues were better able to negotiate their sexual agency. Similarly, women who knew how their bodies responded sexually said that it was important that any sexual experience be equally pleasurable or satisfactory for both them and their partners.

The notion that women's education about their bodies and their health affects women's overall health, and women's ability to control their own health, is an important tenet of the women's health movement. For instance, *The Boston Women's Health Book*

Collective (e.g. 1998) began publishing educational books, such as Our Bodies, Our Selves, for exactly this reason. Similarly, other researchers have noted the power of education (or lack thereof) to shape girls' and women's experiences and to prepare them to take control of their own bodies (e.g. Fine, 1988). While there is not previous research available that specifically examines the relationship between health and sexuality education on postmenopausal women's sexual agency and subsequent experiences with sexual desire, it is clear that education and information are vital tools for a woman to make sexuality-related and health care decisions for herself.

It is noteworthy that the participants in this study were a unique group of women. TREMIN participants are especially attuned to their bodies and health issues for several reasons. First, the participants have recorded health information and have kept menstrual calendar cards for years, suggesting that these women are especially attuned to what is going on in their bodies. Secondly, the participants are educated about sexuality, health, and menopause. TREMIN researchers have supplied the participants of the research project with good health information, including a TREMIN newsletter and suggested women's health books. Many of the women in this current study mentioned reading books suggested by TREMIN, as well as their appreciation for receiving health information from the newsletter. The fact that the participants were informed about their health and sexuality made the women especially good candidates for this research as the women were considered to be key informants and experts on their own bodies, health, and sexuality.

Health Empowerment

As presented in chapter four, the degree to which women felt empowered about their health was an important factor in terms of how women negotiated their sexual agency within the medical system. Women who said that they felt in control of their own health also discussed various strategies in order to positively influence their health. Similarly, women's social support was an important determinant in whether or not women felt that their experiences with sexual desire and menopause were "normal" and legitimate. Notably, even women who expressed that they had discussed their menopausal experiences with people in their social support network did not discuss sexual desire because this was viewed as a taboo subject. Although women did not use social support as a way to share their concerns about their sexual desire, they felt comfort in the fact that the social support network was available if needed. In sum, both women's health and sexuality education and women's social support helped women negotiate their sexual agency.

The health promotion literature has long recognized the power of social support in determining one's health outcomes (Koch & Mansfield, in press). However, there is not much research on how social support influences women's sexual agency or women's experience of sexual desire. For instance, Langhammer (1998) demonstrated a relationship between women's health empowerment (via social support), agency, and sexual desire. The study was very exploratory in nature and the results are not generalizable based on the methodology. However, Langhammer found that single women struggled to negotiate their sexual desire needs with their sense of self and other

life priorities (e.g. work). Women with social support systems were less likely to compromise themselves in their search to fulfill their sexual desire needs because they felt more empowered to act on their own (i.e. agency). In other words, women with social support were more empowered to act in accordance with their own values, beliefs, and priorities in terms of acting on their sexual desire. These results are similar to the findings of this study, although in this current study women's social support systems were helpful in mediating their interactions with the medical system, not with potential sexual partners.

Summary of the Grounded Theory that Emerged in this Research

The grounded theory that emerged from this research is one of the most important aspects of this study. Although the grounded theory is discussed at length in chapter four, it will be briefly summarized again here for the benefit of the reader. The grounded theory in this research describes how women's negotiation of sexual agency lies at the heart of women's experiences of sexual desire. Thus, women's negotiation of sexual agency within various sites in their lives (e.g. "sexual selves", "partner", and "the medical system") had important implications for how women experienced and made sense of their sexual desire.

Some women surrendered their sexual agency in order to address other non-sexual needs in their life that took priority. For instance, many women viewed sex as a means to an end; that is, as an avenue for fulfillment of their needs for emotional intimacy and closeness with their partners. Thus, many women engaged in sex without

experiencing sexual desire, defined as an interest in sex. Furthermore, women had sex despite the fact that sex was not necessarily wanted, as women had sex for reasons other than due to sexual desire.

The most important site of negotiating sexual agency for women in terms of their level of sexual desire (i.e. high or low) was regards to their relationship with a partner. The degree to which women were able to act as sexual agents within their relationship determined women's (self-reported level) of sexual desire. Women who perceived that their relationship was positive or healthy also characterized their relationship as communicative, especially in terms of being able to discuss sexual issues with their partner. In contrast, women who were unable to negotiate their sexual agency within their relationship or women who tried to negotiate their sexual agency but did so unsuccessfully were often uninterested in sex (i.e. low sexual desire). Again, low sexual desire did not necessarily mean that women were not having sex, because some women were having sex, but it was sex that they did not really want.

Another important site in which women negotiate their sexual agency was within themselves and in light of sociocultural messages about women's sexuality in general and more specifically, about women's sexual desire. Women's experience of sexual desire is fully immersed within the context of their lives, so that it was often difficult to tease out women's experiences of sexual desire from the meanings attached to those experiences. Social scripts (that women have often internalized) greatly influence the degree to which women are able to even recognize their own sexual agency as a phenomenon to be negotiated. For instance, the appropriation of sexual desire to men and the notion that sex has been assigned distinctive meanings for women (i.e. love) than for men (i.e. lust)

is indicative of the power of gender roles to shape one's experiences and the meanings associated with those experiences. Moreover, such gender roles and sexist social scripts systematically serve to privilege men's sexual needs; thereby negating women's own sense of themselves as sexual agents. The stigma associated with women who exhibit sexual agency and who embody their sexual desire is so normative and so pervasive that women often do not even realize that their own actions and behaviors serve to reinforce their oppression (e.g. women's *alterations* of their bodies to be more attractive, women's silence about their own sexual dissatisfaction).

The last site in which women negotiate sexual agency in terms of influences on their experience of sexual desire (and the meaning associated with that experience) was the medical system. Women's experiences within the medical system, and the degree to which these experiences had shaped women's sexual desire, depended on women's ability to negotiate sexual agency, often with their physicians. Negative messages about sexuality and sexual desire, communicated to women via physicians, conveyed the idea that sexual desire is a health/medical issue that can be treated via pharmaceutical intervention. Women who were empowered in terms of taking control of their own bodies and health, as well as women who had access to good information about sexuality and menopause were better able to resist such messages.

Now that the numerous results of this study have been discussed, chapter six will summarize this research project and review the limitations of this study. The important implications of the finding will also be explored. Finally, the researcher's reflections on this research and recommendations for future research will be discussed.

Chapter 6

Summary, Recommendations, & Implications of the Study

The purpose of this study was to understand postmenopausal women's experiences of sexual desire and the meanings that they attached to their sexual desire within the context of their lives. Four over-arching research questions guided the study: (1) How do menopausal women experience sexual desire?, (2) How do menopausal women perceive and make sense of their sexual desire?, (3) What influences women's experience of sexual desire during menopause?, and (4) What differentiates women's experience of "high" sexual desire from their experience of "low" sexual desire during menopause? As discussed in chapter three, a grounded theory study using semi-structured telephone interviews with 22 postmenopausal women was used to fulfill the aims of this study. Chapter four presented the results of the data analysis, and chapter five discussed these results in terms of other relevant research. Finally, this chapter will include a summary of the study, a discussion of the limitations of this research, and implications of the findings, and recommendations for future research.

Summary & Limitations of the Study

This research project was developed based on the current state of information and research on women's sexual desire. As discussed in chapters one and two, an overwhelming majority of the research on women's sexual desire adopts a biomedical

approach. Feminist thought, as presented in chapter two, has been critical of this approach because it posits women's biology as the sole determinant of women's sexual experiences, such that sexual response is represented as universal, static, and unmalleable. This essentialist approach to women's sexuality is especially problematic for midlife and older women due to institutionalized ageist medical ideology, in which postmenopausal women are viewed as deficient and diseased. Finally, the research on women's sexual desire has been primarily quantitative, leaving a dearth of information on women's experiences and meanings of sexual desire. Based on these perceived shortcomings of the research on women's sexual desire, especially among postmenopausal women, this research project was developed.

As discussed in chapter three, a qualitative research design, situated within a feminist paradigm, was used to fulfill the goals of this study. Twenty-two postmenopausal women participated in semi-structured telephone interviews. The resulting data were analyzed in *Nvivo 2.0* using the constant comparison method (developed by Glaser & Strauss, 1967). As discussed in chapter three, numerous strategies (as suggested by Lincoln & Guba, 1985 and Creswell, 1998) were used in this study to ensure the reliability and trustworthiness of this research. These quality assurance strategies are illustrated in Figure 7.

Figure 7: Quality Indicators for Qualitative Research

Quality Indicator	Conceptualization of the Term	How the issue was addressed in this study
Trustworthiness	Credibility, transferability, dependability, & confirmability	Thick description of data, extended engagement with participants, and audit trail,
Reliability	Repeatability	Audit trail, interview techniques (abridged form of member checks)
Validity	To capture the essence of what is being studied	Semi-structured interviews, Clarifying researcher's bias,

Chapter three discussed the benefits and limitations of qualitative research at length, but it is important to review two key methodological limitations here for emphasis. First, the results of this study are not generalizable, neither to all women nor all postmenopausal women. Epistemologically speaking, the results of this research are merely one researcher's findings and the researcher makes no claim to represent these findings as applicable to all women. Secondly, the participants in this study were an extremely homogenous and privileged group of women. As discussed in chapter three, the participants were all white, middle class, highly educated women. The privilege afforded to these women by virtue of their race/ethnicity, class, and educational status is noteworthy and the researcher is aware of the implications of this limitation, both epistemologically and in terms of (the lack of) generalizability of the sample. Moreover, by virtue of the fact that TREMIN participants have completed annual health report forms and kept menstrual calendar cards it is likely that these women were more attuned to changes in their bodies. Similarly, these women may have been more aware of influences on their health or sexuality, especially since specific health and sexuality

information has been funneled to the participants from the TREMIN researchers. While these participants were considered to be key informants (and excellent candidates for this research project), the homogenous sample severely limits the generalizability of this research.

Another limitation of this study relates to how participants were selected for inclusion in this project. As discussed in chapter three, TREMIN participants (who indicated interest in the study) were chosen based on their self-reported level of sexual desire on the previous year's health survey. This survey asked women to rate their desire for sex using a Likert-type scale. Women's level of sexual desire was determined based on their self-reported level of "desire for sex" and women with extremely "high" or "low" sexual desire were purposely chosen in order to ensure maximum variation in sampling. However, there was not necessarily congruence between these scale points and women's descriptions of their sexual desire in the interview. It is possible that the scale used to assess women's sexual desire did not accurately or comprehensively capture women's conceptualization of sexual desire. Since women conceptualized sexual desire as sexual interest, perhaps asking women to rate their sexual interest would have been more helpful. Alternatively, since women's sexual desire was found to be influenced by so many factors within their lives, their experiences may have changed from the time they completed the self-report scale and the time they were interviewed.

Another limitation of this study relates to the possibility that the researcher inadvertently steered participants to a particular topic of conversation during the interviews. As explained in chapters four and five, women did not initially distinguish between sexual arousal and sexual desire. Most women described sexual arousal and

sexual desire as overlapping concepts. However, when prompted by the researcher, women did make a distinction between these two concepts. Women's ambiguous distinction between sexual arousal and desire may be due, in part, to the researcher's coaxing. In other words, the researcher may have prompted the participants to make a distinction that they would not have otherwise made. In retrospect, the interview questions that were designed to understand women's experiences of sexual desire and arousal could have been leading questions, such that women may have discussed aspects of sexual desire solely because the researcher asked about them.

Despite these limitations, the results of this study, as discussed in chapters four and five, were fascinating, extensive and complex. The results of this study suggest that postmenopausal women's experience and meaning of sexual desire is intrinsically related to their negotiation of their sexual agency. Specifically, this research found that women negotiated their sexual agency within three sites: women's sexual selves, their relationships with partners, and their interactions with the medical system. As discussed in chapter five, women's sexual agency enhanced or detracted from women's experience of sexual desire. For example, women who acted as sexual agents were more likely to be attuned to their experience of sexual desire, and these women were more likely to describe their sexual desire as embodied and subsequently these women described experiencing more sexual satisfaction and pleasure. Alternatively, women who surrendered their sexual agency (to attend to their partners' sexual needs, for example) were less likely to be aware of their sexual desire and had more difficulty describing their experience of sexual desire. These women stated that they engaged in sex without sexual

desire and these women often avoided sex because they found it unsatisfactory and sometimes even unpleasant.

Women's internal negotiation of their sexual agency (the category "women's sexual selves") influenced women's experience of sexual desire through five factors, including: sexual response, social scripts/institutional sexism, health status, and life context. Because these findings have already been extensively discussed (in chapters four and five), they will simply be outlined below. The findings related to women's sexual response included the following:

- Women conceptualized sexual desire as a feeling, with cognitive, affective, and physical aspects, for an interest in sexual activity (primarily vaginal-penile intercourse, but sometimes masturbation too).
- Women described sexual desire as sexual energy that builds within them, and also as something they felt in both an affective and cognitive sense.
- Women often described sexual desire and sexual arousal as overlapping concepts. When prompted, women made a distinction between sexual desire and arousal such that sexual arousal was often considered a sign of sexual desire. Women associated sexual arousal with physical signs, especially vaginal lubrication.
- Women said that sexual desire did not always precede sexual activity. Some women said that they usually felt sexual desire after sexual activity had already begun. Other women explained that they rarely felt sexual desire in association with sexual activity. These women discussed having sex when they were not actually interested in having sex (that is, without feeling sexual desire).
- Some women had difficulty conceptualizing or describing sexual desire as distinct from their overall experience of sexuality.
- Vaginal lubrication was the most commonly described physical indicator of women's sexual desire, and vaginal lubrication was also important for women in terms of preventing discomfort or pain during sex

The results of this research illustrate how women's experience of sexual desire is deeply embedded in the context of women's lives. Results specific to women's negotiation of sexual agency with regard to social scripts and institutional sexism included the following:

- A variety of factors influenced women's conceptualization of sexual desire, such as their parents, the media, the generation in which they were raised, religion, their partner, and even their marriage and children.
- Women said that an overwhelming majority of the messages they had received about their sexuality and sexual desire were negative. These messages were rooted in patriarchal assumptions about sex that privilege men's sexual needs over women's (institutional sexism).
- Examples of the negative messages (social scripts) that women received included: the sexual double standard, the notion that sex is dichotomized for women as either lust (physical pleasure) or love (intimacy), women's sexual silence/voice (women's (in) ability to discuss sexuality-related issues), the notion that sex is primarily about reproductive capacity for women so that the fear of unintended pregnancy is salient even for postmenopausal women, and body image issues relating to women's perceived attractiveness.
- Some women explained how they had learned to distance themselves from their sexual desire and to control their sexual desire based on its perceived appropriateness to others. Other women explained that menopause and aging had given them permission to feel freer with their sexuality and sexual desire.

Women's health status was another aspect of their "sexual selves" that influenced their negotiation of sexual agency. Results specific to women's negotiation of sexual agency with regard to their health status included the following:

- Women who suffered from health problems, including depression, back problems, and various types of cancer, said that their illnesses decreased their sexual desire. Similarly, some women attributed their lack of sexual desire to medications, specifically anti-depressants.
- Overall, women did not perceive that their menopausal status had affected their sexual desire. However, many of the women did

complain that vaginal dryness decreased their interest in sex, and the literature has established that estrogen is the hormone responsible for maintaining vaginal lubrication. Thus, menopause did have an indirect effect on women's sexual desire, although women did not perceive this effect.

Factors related to women's life context either inhibited or facilitated their sexual desire. Results specific to women's negotiation of sexual agency with regard to life context included the following:

- Women's sexual desire was enhanced when they engaged in non-sexual activities with their partners, such as hiking or canoeing, that helped women to feel more connected to their partners. Similarly, romantic environments and intimate moods enhanced women's sexual desire.
- Stress and distractions in women's lives inhibited their sexual desire.

The results of this research also illustrate how women's experience of sexual desire is intricately connected with women's relationships. As discussed in chapters four and five, women's negotiation of sexual desire with their partners and was an important influence on women's experience of sexual desire. Four themes emerged from the data regarding the category "partner", including partner availability, the couple's approach to sex, partner's erectile difficulties, and the overall quality of the relationship. Results specific to women's negotiation of sexual agency with regard to partner availability included the following:

- Women's physical access to a suitable sexual partner (especially for single women) as well as their partners' emotional availability (especially for married women) affected women's sexual desire. While single women struggled with finding suitable partners, married women discussed feeling frustrated that they often used sex as a means to establish intimacy with their husbands.

Results specific to women's negotiation of sexual agency with regard to the couple's approach to sex included the following:

- Some women discussed feeling that their partners were not interested in taking the time to ensure that sex (vaginal-penile intercourse) was comfortable, pleasurable, and satisfying for them. Women who grappled with issues like lack of foreplay and vaginal dryness often felt like sex was too much work (even if they felt sexual desire), and these women tended to avoid sex.
- Some women felt that they had an obligation to attend to their partner's sexual needs and to satisfy their partner's sexual desire. These women explained that they viewed sex as an obligatory marital task. These women often had sex (consensually) to please their partner even though they did not necessarily want to have sex.

Results specific to women's negotiation of sexual agency with regard to their partner's erectile difficulties included the following:

- Most women expressed concern about their partner's erectile difficulties as part of their own concerns about sexual satisfaction and sexual desire. These women were more concerned about their partner's egos as a result of erectile difficulties than they were concerned about their own experience of sexual desire or pleasure. Some women avoided sex (even when they felt sexual desire) to avoid erectile difficulties.
- Many of the women discussed how their partners had used Viagra to address their erectile concerns, however none of them said that Viagra had been helpful.

Results specific to women's negotiation of sexual agency with regard to relationship quality included the following:

- Women's perceptions of the overall quality of their relationship with their partner was the greatest influence on their negotiation of sexual desire and their subsequent experience of sexual desire.
- Women discussed qualities of a good relationship, including mutuality, communication, and egalitarianism. Women also described sex as one aspect of a good relationship.

- Women who perceived their relationship to be positive also described having more sexual desire and being more satisfied with their sexual experiences.
- Sexual communication was an important factor that facilitated women's sexual desire. In contrast, women said that there were relationship factors and partner-related factors that inhibited their sexual desire, such as their partner's insensitive approach to sex, concern over erectile difficulties, and not being attracted to their partners for hygiene reasons.
- Women who described having high sexual desire also said that they had prioritized sex in their lives because they believed that sex served an important function to them in their relationships. In contrast, women who did not view sex as a priority discussed having low sexual desire and that sex was not very fulfilling.
- Most women craved intimacy and a sense of emotional connection or closeness with their partners. Many women used sex as a means to fulfill these needs, even if they were not necessarily interested in having sex and even if sex was not fulfilling for them.

The results of this research also illustrate how women negotiate their experience of sexual desire as well as their sexual agency with regards to the medical system. Four themes emerged from the data regarding the medical system, including: the notion that physicians know what is best for women (“doctor knows best”), the medicalization of women's sexuality and sexual desire, women's health and sexuality education, and women's health empowerment. Results specific to women's negotiation of sexual agency with regard to the notion that physicians know what is best for women included the following:

- Women discussed that they had received primarily negative messages from their physicians, especially in terms of menopausal symptoms. Very few women said that their physicians had been at all helpful in addressing women's questions about their sexual concerns. Yet, most women did not question the care they received from their physicians, and they typically did not initiate conversations about sex with their doctors. In sum, women's physicians were not attentive to women's experience of sexual desire.

Results specific to women's negotiation of sexual agency with regard to the medicalization of women's sexuality and sexual desire included the following:

- An overwhelming majority of the women reported that their physicians had previously prescribed hormones for their menopausal symptoms or conditions commonly associated with menopause. Women described that they felt as though they were being diagnosed with an illness. Women never questioned their physicians, despite the fact that many women knew that the hormone therapy (HT) they had taken was possibly harmful to them.
- Most women said that they did not notice any difference in their sexual desire when using the HT.
- Many women said that their physicians had also prescribed antidepressants to "treat" hot flashes and other menopausal symptoms, and none of the women questioned this, even if the antidepressants decreased their sexual desire.
- Several women inquired about the status of a "Viagra for women" during the interview. Women who were concerned with their low sexual desire were especially interested in this seemingly "magic pill" to "fix" their sexual desire.

Results specific to women's negotiation of sexual agency with regard to their health and sexuality education included the following:

- Women who had access to information on how menopause might affect their sexual desire and their sexuality in general felt better able to negotiate their sexual agency with their physicians.
- Similarly, women who knew how their bodies responded sexually discussed that it was important to them that their sexual experiences be pleasurable and equally satisfactory for both them and their partners.

Results specific to women's negotiation of sexual agency with regard to women's health empowerment included the following:

- Women who said that they felt in control of their own health also discussed various strategies they used to improve or maintain their health.

- Women's perceived degree of social support was a powerful factor in terms of whether or not women felt isolated and whether or not they felt that their menopausal experiences were normal or not. Women generally did not discuss sex as part of their menopausal experiences, even with their social support network. Thus, women did not use social support as a way to share their concerns or questions about sexuality, but rather women felt comforted knowing that they had social support if needed.

Now that the findings of this research have been outlined, the implications of the findings will be addressed.

Implications

Given the numerous and complex findings of this research, the implications of this study are endless. Some of the wide-ranging implications of this research include: social policy issues, women's healthcare practitioners, marriage and family therapy, and health educators and researchers. Additionally, this research demonstrates the need for additional research and scholarship on various aspects of women's sexuality: women's sexual response, motivations for sex that are conflated with sexual desire (e.g. intimacy needs), and the language used to describe women's sexual desire (e.g. "interest", "libido").

Two major implications of this research deserve special mention. First, it is believed that the introduction of women's lived experiences of their sexual desire into the literature on women's sexuality will demonstrate to researchers that the current understanding of women's sexual response and sexual desire is very limited as it has excluded women's perspectives and narratives heretofore. This research project is very

timely in that feminist and qualitative research on women's sexual response has been called for in the literature (e.g. Graham et al., in press, "A New View of Women's Sexuality"). Women's experiences and meanings of sexual desire are of the utmost importance in developing new and refuting old sexual responding models, especially when such models are the basis for defining sexual disorders and dysfunctions.

Secondly, this research demonstrates that the context of women's lives (not just women's sexual lives) is a critical and crucial influence on women's experience of sexual desire as well as the meaning that women attach to their sexual desire. Since the negotiation of women's sexual agency in various contexts was central to women's experience and meaning of sexual desire, perhaps women can feel empowered to examine other aspects of their lives in search of explanations for their sexuality-related concerns. In other words, because factors outside of women's selves are often responsible for women's degree of sexual interest, it is hoped that women will feel less shame and blame for having "low" sexual desire, vaginal dryness, etc. To facilitate women's education about the importance of considering their sexuality within their life context, the researcher will disseminate the findings of this current research project (in lay terminology) to the women who participated in this project. The researcher is currently considering how to disseminate these research findings to more women as well.

Moreover, the implications of this study for women suggest that the diagnosis and treatment of "sexual desire disorders" is inappropriate when *women* do not consider their level of desire to be problematic. Currently, the conceptualization of women's "low" and "high" sexual desire is based on epistemologically and methodologically flawed research that has resulted in the establishment of unsound definitions as to what constitutes

“normal” and “abnormal” levels of sexual desire. Notably, diagnostic standards (e.g. DSM-IV-R) are rooted in biomedical research that locates the source of women’s sexual desire within the physical body, including factors such as hormones and tissue elasticity. However, these diagnostic factors completely exclude the context of women’s lives, such as women’s partners, other life priorities, and the politically charged nature of women’s sexuality. As demonstrated by this current research project, women may choose to avoid sex for various legitimate reasons, including dissatisfaction with the nature of the relationship, pain or discomfort during intercourse, or simply a lack of interest in sex. Women’s choice to not engage in sex when it is not pleasurable or satisfactory for them needs to be recognized as a legitimate option for women. Furthermore, the diagnosis and treatment of women’s “low” sexual desire is completely inappropriate when *women* are not concerned with their level of sexual interest. Thus, it is believed that this research has implications for relieving the undue burden and stress placed on women who are viewed as “diseased” and “disordered” for being true to their own sexual needs and interest (or lack thereof).

Recommendations for Future Research

The researcher has three recommendations for future research on women’s sexual response and sexual desire specifically. First, because the term “sexual desire” is ambiguous, elusive, and may have little meaning for women, it is suggested that future research be wary of this term. The term “sexual interest” may refer conceptually to what researcher’s mean by “sexual desire”, but women do not speak in terms of their sexual

desire. In other words, the term “sexual interest” has more meaning for women. It is in researchers’ best interests to conceptualize sexual response as women do, as threats to reliability and validity are introduced when terms are unclear and have little real-world meaning to women.

Secondly, while there has been a great deal of research recently on women’s sexual desire and sexual response, there has not been very much scholarship on the significance or implications of this research. As a result, research that is not even epistemologically or methodologically sound is disseminated and used (against women) by establishing various dysfunctions and disorders. Future work on women’s sexual desire must address and critique the limitations and assumptions of much of the work on women’s sexual response and sexual desire. Without critical scholarship, additional research may stray further and further from women’s perceptions and lived experiences. Without understanding women’s experiences of sexual response, realistic and applicable models of sexual response realistically cannot be developed. Utilizing feminist scholarship, since it focuses on women’s power and the politics of knowledge and sexuality, is likely the first necessary step in critically thinking about the “still missing discourse of desire” for women.

Finally, it is recommended that future research focus on women’s participation in consensual, but unwanted sex. The notion that women engage in sex for reasons other than sexual interest (i.e. money, fear, coercion, or security) has been studied by other (feminist) researchers, although never in a midlife or postmenopausal sample. Research on compliant sex typically focuses on younger women, as it is believed that mature women are more in control of their lives and their sexuality. The findings of this

research, however suggest that older women participate in compliant sex for a number of reasons: for intimacy with their partner, because they believe that sex is an obligatory marital task, and because they believe that men's sexual needs are more important than women's own needs or choices. Given the overwhelming number of participants who discussed engaging in unwanted sex, future research on this phenomenon in this population is warranted.

Reflections on the Methodology

The use of *Nvivo 2.0* greatly aided the researcher in this project in several ways. First, the program was invaluable in managing the enormous amount of data collected in this study. For instance, as interviews were transcribed, the researcher was able to enter preliminary thoughts and observations into Nvivo, thereby documenting initial issues that arose in the early stages of data analysis. Secondly, the coding function of Nvivo was the most helpful aspect of the program. Notably, the "coder" in Nvivo is much more user-friendly than coding procedures in NUDIST. Specifically, Nvivo's "coder" is in its own computer "window" so that the researcher can move it around the screen and view the codes while simultaneously viewing the hierarchy of nodes or the actual interview transcript. Moreover, the color-coded "highlighting" function of the coder was helpful for this researcher, especially as a visual learner. Additionally, the built-in documentation process associated with adding, developing, or changing a code was extremely helpful in maintaining an in-depth audit trail.

Finally, the modeling function of Nvivo was helpful in establishing the relationships between the various levels of codes. Especially during the final stages of data analysis, the “modeler” enabled the researcher to move in and out of the hierarchy of codes effortlessly. Nvivo is very user-friendly and well worth the initial investment in learning the program as a tool in analyzing large, complex qualitative data.

Finally, it is important to note the researcher’s perspective and the associated epistemological limitations. As discussed in chapter three in regards to the theoretical framework of this study, the researcher’s own perspectives, views, and experiences served to filter information and meaning from the interviews with the participants. This researcher’s perspective includes a feminist, holistic perspective on women’s health and sexuality, while another’s researcher with a different background may have interpreted women’s experiences, meanings, and realities differently.

Reflections of the Investigator

It is useful for a researcher to reflect on what aspects of the study could have been improved or done differently. In retrospect, the researcher would have eliminated research question number four (“What differentiates women’s experience of “high” sexual desire from their experience of “low” sexual desire during menopause?”) from the study. As discussed in chapters four and five, there was no clear-cut distinction between women with low and high sexual desire, which is an important finding that has not been discussed in any of the literature on women’s sexual desire. Additionally, the researcher

would have limited the sample to either married or single women, but not both as there were considerable differences in women's experiences based on their marital status and in the end, marital status proved to be a confounding factor in the study. This difference was not anticipated at the start of the project.

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Appendix A

Sexual Responding Scale (SRS)

Directions: Here is a list of different ways people express themselves sexually. Some involve a partner, others do not. How would you rate your level of response to each? Imagine a continuum with one being nonexistent feelings, 5 being moderate feelings, and 9 being very strong feelings. Circle the number that best describes the *strength of your feelings* for each form of sexual expression.

TYPE OF ACTIVITY

STRENGTH OF FEELINGS

Non-genital sexual activity with partner **(Hugging, kissing, fondling, etc.)**

- | | |
|--------------------------------|-------------------|
| a. Desire it | 1 2 3 4 5 6 7 8 9 |
| b. Aroused (turned on by it) | 1 2 3 4 5 6 7 8 9 |
| c. Enjoy it | 1 2 3 4 5 6 7 8 9 |
| d. Intensity of orgasm from it | 1 2 3 4 5 6 7 8 9 |

Genital sexual activity with partner

- | | |
|--------------------------------|-------------------|
| e. Desire it | 1 2 3 4 5 6 7 8 9 |
| f. Aroused (turned on by it) | 1 2 3 4 5 6 7 8 9 |
| g. Enjoy it | 1 2 3 4 5 6 7 8 9 |
| h. Intensity of orgasm from it | 1 2 3 4 5 6 7 8 9 |

Appendix B

Interview Schedule

Research Question #1: How do menopausal women conceptualize sexual desire?

- * *Tell me what the term “sex” means to you. [Note: Probe to see if “sex” means genital and non-genital activities other than vaginal-penile intercourse.]*
- Tell me what the term ‘sexual desire’ means to you.
- Tell me what the term ‘sexual arousal’ means to you.
- What do you think has *shaped* your *ideas about* sexual desire?
- Probes:
- *What messages have you received about sexual desire throughout your life? [NOTE: Probe for WHO these messages came from, WHEN (e.g. what stages of life), and HOW they were perceived (e.g. as positive, negative, or neutral)].*
- Do you think that others’ ideas about menopausal women’s sexual desire affect your own beliefs about your body and your sexuality? [NOTE: Include probes about “others” including healthcare practitioners, partner, friends, and media sources].

Research Question #2: How do menopausal women experience sexual desire?

- Tell me what sex is like for you. [PROBES: *When sex is good, what do you think makes it good? When sex is bad, what do you think makes it bad? How much control do you feel you have over your sexual satisfaction?*]
- How would you describe your sexual desire?

- How do you know when you feel sexual desire? [*PROBE: Are there changes in your body? Do you feel specific emotions? What are the circumstances in which you experience sexual desire?*]
- When are you MOST aware of your sexual desire [*PROBE: In sexual situations? Before sexual activity? During sexual activity?*]
- Tell me what stimulates or facilitates your sexual desire?
- Tell me what inhibits your sexual desire?
- How important is sexual desire to you? [*PROBE: If you are currently in a relationship, how important is sexual desire in your relationship? How does your relationship influence your experience of sexual desire?*]

Research Question #3: What do women think influences their sexual desire during menopause?

- * *What do you remember as your first feelings of sexual desire? How has your sexual desire changed, if at all, throughout your life? [Note: Probe for reasons why she thinks it has changed.]*
- Before you became menopausal, what expectations did you have about sex during menopause? *Where did these expectations come from?*
- Before you became menopausal, what did you expect about your sexual desire during menopause? *Where did these expectations come from?*
- Did your previous expectations about sex and sexual desire change as you became menopausal [*If so, how?*]

- Do you think that menopause *or aging* has affected your sexual desire? If so, how?
[*PROBE: Tell me about your relationship with your body.*]
- *How do you think your relationship with your sexual partner affects your sexual desire?*
- If you were talking to a woman who was approaching menopause, what would you tell her about menopause, *sex*, and sexual desire?
- Do you have any questions that you'd like to ask me?
- Is there anything else you'd like to share with me?

Research Question #4: What differentiates women's experience of *high and low* sexual desire during menopause?

Note: Interview questions were not asked in regard to this research question. Instead, the researcher used this research question to guide the analysis of themes that emerged from the data.

VITA

Jill M. Wood

Work Address:

117 Willard Building, University Park PA 16802

Email: jmw193@psu.edu

Education

The Pennsylvania State University, B.S., Biobehavioral Health. May 1997.
Emphasis: Biological mechanisms of health

The Pennsylvania State University, M.S., Biobehavioral Health. May 1999.
Emphasis: Menstruation & Menopause
Thesis: "College Students' Conceptualization of 'Normal' and 'Abnormal' Menstruation".

The Pennsylvania State University, Ph.D., Biobehavioral Health. May 2004.
Minor: Women's Studies. Emphasis: Women's Health & Sexuality
Comprehensive Exams passed May 2001.
Dissertation: "The Meaning and Experience of Menopausal Women's Sexual Desire: A Grounded Theory Study". Dissertation Defense: February 2004.

Teaching Experience

Visiting Assistant Professor
Bucknell University
Women's and Gender Studies Program

Instructor, Penn State University
Penn State University, Women's Studies Program and Department of Biobehavioral Health

Research Experience

Research Assistantship:
Senior Research Assistant, Tremin Trust/BIMORA (Biodemographic Models of Reproduction & Aging) Project. Fall 1997-Fall 1999.

Publications, Book Chapter, and Conference Presentations

List available upon request.