

# Women's Sexual Desire: A Feminist Critique

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*This article offers a critical feminist analysis of the biomedical conceptualization of women's sexual desire. The five major features of the biomedical model of female sexual desire examined and critiqued are (a) use of the male model as the standard, (b) use of a linear model of sexual response, (c) biological reductionism, (d) depoliticalization, and (e) medicalization of variation. A "New View," an alternative to the biomedical model, is offered for reconceptualizing women's sexual problems. This analysis concludes with recommendations for feminist-based biopsychosocial research.*

Sexual desire is a key component of the current popular conceptualizations of sexual identity, sexual orientation, and sexual functioning and dysfunctioning. Some sexologists contend that no scholarly or scientific discussion of sexuality can occur without reference to it (Leiblum & Rosen, 2000; Levine, 2002). Even though sexual desire has been the topic of much recent research, there is a great deal of ambiguity and variation regarding the conceptualization, definition, operationalization, and application (in research and practice) of the term "sexual desire" as it relates to women (e.g. Basson, 2002b; Kaschak & Tiefer, 2002; Tiefer, 1995). This variation is profoundly related to the theoretical framework from which sexual desire is viewed. Most often sexual desire has been studied from a biomedical paradigm, as noted by Basson (2002a; 2002b), Rosen and Lieblum (1995), and Winton (2001). This paradigm posits sexuality as intrinsic, natural, and universal (Tiefer, 1988).

In contrast, feminist scholars and researchers have called for a critical analysis of the biomedical paradigm in favor of more woman-centered models of sexuality (e.g., Daniluk, 1998; McCormick, 1994; Tiefer, 1991, 1995, 2000). Feminism is not a monolithic ideology, but instead is defined and practiced in various ways by different people and groups (e.g., radical and liberal; McCormick). In its broadest interpretation, feminism represents advocacy for women's interests. In a stricter definition, it is the "theory of the political, social, and economic equality of the sexes" (LeGates, 1995, p. 494). Feminist sexology is the scholarly study of sexuality that is of, by, and for women's interests (Koch, 2004). Using diverse epistemologies, methods, and sources of data, feminist scholars examine women's sexual experiences and the cultural frame that constructs sexuality (Vance & Pollis, 1990). To this end,

Pollis (1988) has proposed the following principles to overcome the deficits in understanding women's experiences, gender and gender asymmetry, and sexuality:

1. acknowledgement of the pervasive influence of gender in all aspects of social life, including the practice of science;
2. conceptualization of gender as a social category, constructed and maintained through the gender-attribution process;
3. emphasis on the heterogeneity of experience and the central importance of language, community, culture, and historical context in creating the individual; and
4. commitment to engage in research that is based on women's experience and is likely to empower them to eliminate sexism and contribute to societal change.

This article offers a critical feminist analysis of the biomedical conceptualization of women's sexual desire. We examine and critique five major features of the biomedical model of female sexual desire: (a) use of the male model as the standard, (b) use of a linear model of sexual response, (c) biological reductionism, (d) depoliticalization, and (e) medicalization of variation. We offer a "New View," an alternative to the biomedical model, for reconceptualizing women's sexual problems, and conclude with recommendations for feminist-based biopsychosocial research.

## USE OF THE MALE MODEL AS THE STANDARD FOR SEXUAL DESIRE

Traditionally, researchers and scholars have conceptualized sexuality as men's sexuality (Irvine, 1990). The field of sexuality has long focused on studies of men's sexual response and behavior that have established men's sexuality as the norm. This practice continues more than 100 years after the initial pioneering research in the field (Ussher, 1993). Tiefer (2000, p. 102) explained,

... 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

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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).

This same pattern is found in the study of sexual desire. Sexual desire has traditionally been viewed, and mostly measured, as spontaneous sexual thoughts and fantasies and biological urges creating a need to self-stimulate or initiate sexual activities with a partner (Basson, 2002b; Leiblum, 2002). Throughout the history of sexology, this conceptualization of sexual desire became embodied in various terms, including sexual drive, appetite, interest, cravings, motivation, and libido. This type of spontaneous, active, and physically-driven sexual response is the one depicted in the traditional human sexual response model developed by Masters and Johnson (1966), although no specific desire phase was included in this four-stage model of excitement, plateau, orgasm, and resolution. Kaplan (1979) specifically identified sexual desire as the first stage in her triphasic model of sexual response, the other stages being excitement and orgasm. She stated (p. 10),

Sexual desire or libido is experienced as specific sensations which move the individual to seek out, or become receptive to, sexual experience. These sensations are produced by the physical activation of a specific neural system in the brain. When this system is active, a person is 'horny,' he may feel genital sensations, or he may feel vaguely sexy, interested in sex, open to sex, or even just restless. These sensations cease after sexual gratification, i.e., orgasm. When this system is inactive or under the influence of inhibitory forces, a person has no interest in erotic matters; he 'loses his appetite' for sex and becomes 'asexual.'

In fact, the *Diagnostic and Statistical Manual of Mental Disorders*, considered the "bible" of sexual classification of disorders and dysfunctions, continues to be based on Kaplan's model (Leiblum, 2001).

Irvine (1990) observed that many sex therapists have adopted these traditional views of sexual desire and view it as "a surging energy that can be switched on or off" (p. 213). In summarizing the ambiguity in defining sexual desire, Tolman and Diamond (2001) opined that "according to the default view, sexual desires are discrete, easily identifiable experiences of lust (i.e., you know them when you feel them)" (p. 35).

The behaviors motivated by this type of spontaneous, active, and physically-driven response (e.g., sexual thoughts, fantasies, masturbation, initiation of partnered sex) are more common, on average, in men than women (Baumeister, Catanese, & Vohs, 2001; Beck, Bozman, & Qualtrough, 1991; Byers & Heinlien, 1989; Laumann, Gagnon, Michael, & Michaels, 1994; Leitenberg & Henning, 1995; O'Sullivan & Byers, 1992; Wallen, 2000). Many professionals and even the lay public have taken this as proof that men have more sexual desire than women, which appears true when using male standards. Yet such standards ignore the gendered division of social power so that gender differences are controlled for, posited as natural, or appear to be non-existent (Tiefer, 2000). As Tiefer

(2000) argued, we should not assume that "women's sexual experience would be better, more normal, or more fulfilling, if it more closely paralleled men's" (pp. 84-85). Further, Leiblum (2002) conjectured, "If sexual drive [desire] was defined less in terms of amount of genital contact and more in terms of sexuality, women would be perceived as being more sensual than men" (p. 61).

To understand women's sexual desire from a perspective free of such male-centered bias, we must root its conceptualization in women's lived experience. For example, a grounded theory study of the experience and meaning of postmenopausal women's sexual desire illustrated differences in women's experiences as compared to the male standard of sexual desire (Wood, Mansfield, & Koch, under review). Through semi-structured telephone interviews, women ( $n = 22$ , ages 58-65, mean age = 62.4) 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. They described their sexual desire in various ways, including willingness to participate in sex, energy that built within them, state of being, and interest in sex. Some women explained that it takes them a long time to "warm up" and feel sexual desire in their bodies. For these women, sexual desire was a willingness to participate in sex as opposed to a feeling of being "turned on." They commonly associated sexual desire with emotional feelings, including feeling closeness to a partner or wanting to experience intimacy with a partner through sex. Some of the women discussed physical indicators of sexual desire, most of which were non-genital, such as an increased heartbeat, feeling "butterflies," perspiring, or tingling sensations in their breasts. Other women had no awareness of their sexual desire in a bodily sense. When specifically asked, these participants distinguished between sexual desire and arousal, explaining that desire was an interest in sexual activity and arousal was being physically ready for sexual activity.

#### USE OF A LINEAR MODEL OF SEXUAL DESIRE

Besides their use of male sexuality as the standard, another feature of the traditional human sexual response models (e.g., Masters & Johnson, 1966, and Kaplan, 1979) is their linearity (Sugrue & Whipple, 2001). Each phase acts as a distinct precursor to the next phase (e.g., desire preceding arousal). This creates the assumption that there is only one "correct" way to move throughout the model to experience sexual response. However, Basson (2001b; 2002b) questioned the validity of these traditional linear sexual response models for women. Based on her clinical experience, she found that sexual desire is not always a precursor to sexual arousal (excitement) in women (Basson, 2001a, 2001b). In addition, sexual desire is often motivated more by a desire for emotional intimacy than by a spontaneous urge. In Basson's circular model, sexual desire often does not occur until after the woman is involved in the sexual activity or may not occur at all. As Basson

(2001b) described sexual desire in this model,

When a woman senses a potential opportunity to be sexual with her partner, although she may not 'need' to experience arousal and resolution for her own sexual well-being, she is nevertheless motivated to deliberately do whatever is necessary to facilitate a sexual interaction as she expects potential benefits that, though not strictly sexual, are very important. The increased emotional closeness, bonding, commitment, tolerance of each other's imperfections, and expectation of increased well-being of the partner all serve as highly valid motivational factors that activate the cycle (pp. 396-397).

To validate this circular model of sexual response, Basson interviewed 47 women who had been referred to a clinic with a diagnosis of "low sexual desire" (Basson, 2001b). About half of these women considered insufficient emotional intimacy an important factor contributing to their lack of sexual desire. They saw sexual desire as a continuation of nonsexual intimacy:

...the most common needs expressed were those outside of the bedroom—an appropriate atmosphere, partner's consideration, respect, and warmth, and physical affection...In the area of sexual activity itself, leisurely, nongenital pleasuring was a common need as was genital but nonintercourse pleasuring (p. 400).

Other women reported a lack of desire due to remembered dyspareunia and the experience of pain, mental discomfort with sexual arousal (usually due to a history of childhood sexual abuse or current undesirable, even abusive, relationships), or striving for perfection, resulting in a tendency to self-monitor their sexual experiences and their ability to please their partners sexually. Other researchers have also found that there are many reasons that women have sex that do not require sexual desire, including sex motivated by security, money, coercion, or fear (Heiman, 2001).

A nonlinear interaction between sexual desire and arousal was also described in focus group research exploring 80 women's (mean age = 34.3 years, range 18-84) experiences (Graham, Sanders, Milhausen, & McBride, 2004). During the discussions, the researchers found that women defined sexual desire as "sexual interest." They tended to consider sexual interest "more thoughtful" and sexual arousal "more physical," yet many women said that they did not clearly differentiate them. These women sometimes perceived sexual interest as preceding arousal and sometimes following it.

### BIOLOGICAL REDUCTIONISM OF SEXUAL DESIRE

Most sexologists and laypeople have historically viewed sexual desire as an innate, fixed, biologically-determined drive (Tolman & Diamond, 2001). Although research indicates that biological factors do influence women's sexual desire (Alexander & Sherwin, 1993; Sarrel, Dobay, & Witta, 1998; Wallen, 1995), the degree to which such factors determine women's sexual expression is a topic of considerable debate (for a review, see Sherwin, 1991). Researchers disagree as to the precise role that hormones play in determining or influencing women's sexual desire.

The majority of the research focuses on androgens, primarily testosterone (Basson, 2003). Some research indicates that there is a relationship between women's amount of free testosterone, sexual desire, and sexual behavior (e.g., Riley & Riley, 2000). This research is typically based on correlations between measured testosterone and self-reported sexual desire. These studies often conclude that some women have an absence of sexual desire due to low levels of free testosterone. However, since most studies use correlations as statistical tests, a causative link between testosterone and sexual desire can not be inferred. Moreover, some researchers question the validity and reliability of hormonal assays used to determine women's free testosterone levels, since typically only one hormonal sample is used and the concentrations of hormones vary at different times across the day and from one day to the next (e.g., Voda, 1997).

Despite decades of research on the role of estrogen (e.g., Benedek & Rubenstein, 1939), the physiological effects of estrogen on sexual desire are not completely understood (Regan, 1999). In general, the estrogen research suggests that the relationship between sexual desire and estradiol in women is not a direct one (e.g., Kaplan, 1992; Leiblum, Bachmann, Kemmann, Colburn, & Schwartzman, 1983). 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 lack of vaginal lubrication may avoid sexual interactions for fear of experiencing pain during intercourse (dyspareunia; Bachmann, 1990; McCoy, 1992). Thus, estrogen's effect on vaginal lubrication may facilitate a woman's sexual desire but does not cause it. Another way that estradiol may operate to influence sexual desire is through binding to neurotransmitters in the brain that affect the neurological components of mood (Bancroft, 1988).

Understanding the biological influences on sexual desire is important, and such study does not necessarily constitute a biomedical paradigm. However, when the biological determinants of desire are given undue influence and psychosocial factors are ignored or minimized, a biomedical paradigm emerges. Feminist sex researchers note that the assertion that hormones are the "cause" or even the primary determinants of women's sexual desire is an example of biological reductionism (e.g., Daniluk, 1998; McCormick, 1994; Tiefer, 1991, 1995, 2000). As Leiblum (2002) described, "While [hormones] fuel the flames of desire, psychological factors determine the intensity and direction of the flame. Inferring that hormones, in general, are the primary motivators of sexual activity in humans is a gross oversimplification" (p. 65).

In opposition to biological reductionism, research findings point to interpersonal and sociocultural contributors to the experience of sexual desire. As Basson (2001a) emphasized, sexual intimacy is the primary contributor to sexual desire for women, and this can be diminished through the lack of tenderness, mutuality, respect, commu-

nication, or pleasure from sexual touching; undue focus on the performance of vaginal-penile intercourse; or physical or emotional discomfort from any cause. Among the reasons that women give for being sexual, issues of enhanced emotional closeness and commitment, heightened sense of attraction and attractiveness, and physical pleasure that promotes sharing between the couple are very important (Basson, 2002b). Leiblum also emphasized the importance of relationship factors in determining sexual desire. Women lose sexual desire when they feel disrespected, devalued, or degraded and when their partners use poor sexual techniques or have sexual problems of their own (Leiblum, 2002; Leiblum & Rosen, 1988). In surveys of midlife women, poor body image, wanting more equality in one's sexual relationship, and wanting more passion from one's partner were significantly related to a decrease in a woman's sexual desire as they aged (Koch & Mansfield, 2001/2002; Koch, Mansfield, Thureau, & Carey, 2005; Mansfield, Koch, & Voda, 1998).

Feminist scholarship has produced an entire literature refuting the notion that human sexuality is a natural, intrinsic, and universal phenomenon by documenting sexual differences among individuals based on gender, class, race and ethnicity, history, culture, sexual identity and orientation, environmental factors, and even HIV status (e.g., Gagnon & Simon, 1973; McCormick, 1994; White, Bondurant, & Travis, 2000). Plummer (1995) asserted that each person's sexuality is a context- and culture-specific story that she or he lives while assuming that it is totally "natural" (biologically determined).

#### DEPOLITICIZING SEXUAL DESIRE

Feminists emphasize that locating sexuality solely within the individual (e.g., biological reductionism described above) serves to depoliticize the nature of sexuality by ignoring the sociocultural, political, and relational factors that affect women's lives (Daniluk, 1998). Foucault (1980) argued that histo-socio-cultural factors work at a very basic level to construct sexual experiences, not simply by enhancing or restricting biology. As interpreted by Tolman and Diamond (2001),

Foucault argued that conceptualizations of sexual desire as repressed "essences" are themselves strategic social discourses that are crafted and deployed by those with social authority and power in the service of particular political and ideological ends. Importantly, such discourses are usually not visible as such; rather, they reflect what appears to be natural, factual, or objectively real (p. 38).

**Subsequent feminist scholarship has uncovered numerous ways that majority men have been privileged in expe-**

**rather, they reflect what appears to be natural, factual, or objectively real (p. 38).**









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