ORIGINAL RESEARCH—EPIDEMIOLOGY & RISK FACTORS

Why Is Impaired Sexual Function Distressing to Women? The Primacy of Pleasure in Female Sexual Dysfunction

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DOI: 10.1111/jsm.12804

ABSTRACT

Introduction. Recent research has highlighted a complex association between female sexual function and subjective distress regarding sexual activity. These findings are difficult to explain given limited knowledge as to the mechanisms through which impaired sexual function causes distress.

Aim. The current study assessed whether a number of specific consequences of impaired sexual function, including decreased physical pleasure, disruption of sexual activity, and negative partner responses, mediated the association between sexual function and distress.

Methods. Eighty-seven women in sexually active relationships reporting impairments in sexual function completed validated self-report measures and daily online assessments of sexual experiences.

Main Outcome Measures. Participants completed the Sexual Satisfaction Scale for Women, the Female Sexual Function Index, and the Measure of Sexual Consequences.

Results. Results suggested that decreased physical pleasure and disruption of sexual activity, but not partner responses, statistically mediated the association between sexual function and distress.

Conclusion. Sexual consequences represent potential maintaining factors of sexual dysfunction that are highly distressing to women. Results are discussed in the context of theoretical models of sexual dysfunction and related treatments. **Stephenson KR and Meston CM. Why is impaired sexual function distressing to women? The primacy of pleasure in female sexual dysfunction. J Sex Med 2015;12:728–737.**

Key Words. Sexual Distress; Sexual Function; Female Sexual Dysfunction

Introduction

Impaired sexual function, including low sexual desire/arousal, difficulty reaching orgasm, and the presence of sexual pain, has been reported by approximately 58% of women in the United States in the past year [1]. This prevalence is higher than that of depression [2], social anxiety [3], and other common forms of psychopathology. Given that sexuality is an important component of overall quality of life [4], it is important to develop a comprehensive understanding of sexual dysfunction, along with effective treatments for sexual problems.

However, these goals are difficult to achieve given limited knowledge regarding basic processes underlying sexual dysfunction. One of these processes is how and why impairments in sexual function give rise to subjective distress regarding one's sex life. A number of studies have suggested the existence of a complex relationship between women's sexual function and their subsequent affective responses. In many cases, women report significantly impaired sexual function without notable levels of subjective distress [5]. For example, Rosen and colleagues [6] found that, although rates of low sexual desire rise with age, rates of *distress* regarding low desire decrease in

older age. In other cases, women report high levels of distress regarding sexual function in the asbsence of severe impairments in sexual function. For example, Stephenson and colleagues [7] found that women with a history of childhood sexual abuse reported high levels of distress regarding their sexual function, even in the context of high levels of desire and arousal. This variation in the association between sexual function and subjective distress is difficult to fully explain because it is unclear *why* impaired sexual function gives rise to distress in some cases and not in others. In other words, what are the mechanisms through which sexual function affects distress levels?

Barlow's model of sexual dysfunction [8] outlines various relationships among sexual function, attention, and affect. The model posits that individuals with sexual dysfunction enter into sexual situations with negative affect and expectancies, and their attentional focus is subsequently drawn to nonerotic stimuli including external stressors, body image concerns, and the consequences of perceived poor sexual performance. This focus on nonerotic stimuli during sexual activity is thought to increase anxiety and maintain low levels of arousal through distraction, resulting in continued poor performance and later avoidance of erotic cues and sexual situations. Barlow's model has strongly influenced research on sexual dysfunction; in particular, its focus on anxiety and attentional focus has guided the creation of effective treatments utilizing systematic desensitization [9] and mindfulness meditation [10].

Barlow's model describes the link between sexual function and subjective distress in particular using one primary mechanism: avoidance. Essentially, impaired sexual function gives rise to later behavioral and/or experiential avoidance, and this avoidance maintains the negative affect and expectancies that initiate the dysfunctional sexual cycle during subsequent sexual experiences. The role of avoidance is thought to be essential in maintaining the circular and self-reinforcing nature of the model. Avoidance following a negative experience has been identified as a key maintaining factor of negative affect in a wide range of disorders by preventing new learning that would correct the overestimation of likelihood and/or severity of feared outcomes [11]. Similarly, after an initial negative sexual experience, avoidance can prevent new learning regarding the benign nature of impaired sexual function, thus maintaining distress and anxiety regarding sexual activity. However, a number of common clinical presentations are difficult to reconcile with this model. First, many women who experience impaired sexual function continue to engage in high levels of sexual activity and attend to erotic cues, meaning that avoidance may not be the only mechanism through which sexual distress is maintained. Second, many instances of nondistressing impaired sexual function are maintained for long periods of time, which runs counter to the theoretical model in which negative affect entering sexual activity initiates the sexually dysfunctional cycle. Lastly, although the model specifies that consequences of impaired sexual function draw attention away from helpful erotic cues (e.g., pleasure), we are aware of little research that specifies what these consequences are or which are most distressing to the individual.

Expansions of Barlow's model have been suggested a number of times [12], especially to take into account interpersonal contextual factors of sexual activity [13]. We propose that the aspects of this model that outline the link between impaired sexual function and subsequent negative affect may benefit from similar expansion. In particular, an alternative or additional mechanism that maintains distress regarding sexual activity may be the repeated experience of legitimate negative consequences of impaired sexual function. In other words, impaired sexual function may *not* be benign in many cases but rather may result in distressing consequences such as disruption of sexual activity and/or conflict with the sexual partner. In these cases, sexual distress may be maintained through repeatedly learning that sexual activity is, in fact, an emotionally threatening environment, rather than failing to learn that it is not.

This potential maintaining factor of sexual distress is important in that it may suggest a distinct locus of "pathology" and, as such, may lend itself to different treatment aims. For example, if a woman's low arousal during sex prevents the couple from engaging in sexual activity and causes her partner to express anger toward her, a clinician may be best served by addressing the couple's sexual script [14,15] and general patterns of conflict, rather than attempting to decrease the woman's level of anxiety and avoidance of sexual activity. In other words, the woman's impaired sexual function may be *accurately* viewed as threatening, and it would be the context of the dysfunction in need of alteration, rather than the cognitions (thoughts) within the individual. Indeed, Bancroft and colleagues [16] have proposed a similar distinction, suggesting that many