Qualitative Examination of Sex Therapists' Perspectives Regarding Women with Low Sexual Desire

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Qualitative Examination of Sex Therapists' Perspectives Regarding Women with Low Sexual Desire

by

Tatiana C. Bryan

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Rehabilitation and Mental Health Counseling Department of Child and Family Studies College of Behavioral and Community Sciences University of South Florida

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Keywords: sexual health, grounded theory, sex counseling, pleasure

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Female sexual desire disorder is often discussed in the literature, but there is a paucity of data on how sex therapists conceptualize and treat this disorder. To address a gap in the current literature, this study collected the perspectives and attitudes of clinicians working with patients presenting with low sexual desire. This qualitative study aimed to understand how sex therapists’ conceptualization of female sexual desire disorder is used to make decisions about diagnosis, treatment and assessing patient progress. Grounded theory methodology was used to examine the attitudes and beliefs held by sex therapists. Results were used to generate a framework of conceptualization relevant to the symptom of low sexual desire and to explore whether clinicians have pre-existing belief systems that inform their perception of a desire problem and treatment plan. Results indicate that belief systems and cultural context are bidirectionally related, and this interaction informs how sex therapists perceive low desire issues and their patients’ perspectives about sexuality. The conceptual framework developed may help clinicians consider all factors pertinent to the symptom of low sexual desire in the conceptualization of assessment and treatment interventions with clients in clinical practice. This study may benefit researchers and practitioners alike by highlighting perspectives from sexuality experts that help to better understand and address sexual desire moving forward. Because results were symptomology focused rather than diagnostic, future research should explore diagnostic education in sex therapy training.

Keywords: desire, sex therapy, subjectivity, cultural context
Introduction

Female sexual desire disorder is often discussed in the literature, but there is a paucity of data on how sex therapists conceptualize and treat this disorder and research in the general field has not clearly identified this disorder. As a result, female sexual desire disorder has sparked controversy over definitional agreements within the literature (Clayton & Kim, 2016). This lack of consensus as well as the biopsychosocial complexities of female sexual desire disorder has made research in this field challenging. Moreover, perspectives from sex therapists and other health care professionals are lacking in the current available literature.

To address a gap in the current literature, this study examined the symptoms of low sexual desire and female sexual desire disorder in cisgender, heterosexual women from the perspectives of sex therapists. Given the existing literature focuses on heteronormative populations this research uses female sexual desire disorder to focus on biological sex, not gender. Specifically, this study aimed to elicit sex therapists’ conceptualization of female sexual desire disorder and understand how they make decisions about diagnosis, treatment and measuring progress with patients to generate a theory or framework of clinical practice. Through an inductive process, the researcher gathered data and built concepts from information collected, rather than deductively test a predetermined hypothesis. Theory-building emerged through simultaneous data collection and analysis to generate a framework relevant to sex therapists’ perspectives of low sexual desire in women seeking therapy for sexual complaints. This study may benefit researchers and practitioners alike by obtaining sex therapists perspectives on female sexual desire disorder that could help better understand the beliefs underlying treatment for low sexual desire, and possibly help create
a consensus on how to frame this disorder moving forward. This research was guided by the following questions:

1. What are sex therapists’ attitudes and perspectives regarding female sexual desire disorder?
   a. In what ways have sex therapists perceived the evolution of female sexual desire disorder?

2. How do sex therapists’ attitudes and perspectives shape their conceptualization of female sexual desire disorder?
   a. In what ways do clinicians detect and diagnose sexual desire disorder with their female patients?
      i. How do their perspectives shape this process?
   b. In what ways do clinicians treat and measure progress in treatment of female sexual desire disorder?
      i. How do their perspectives shape this process?

**Literature Review**

**Glossary of Terms**

To provide a uniform set of definitions from which to evaluate the literature, key terms and concepts are defined. The following terms help to better explicate the context in which female sexual desire disorder is conceptualized. Because female sexual desire disorder involves topics of sexual difficulty and resolution, defining sexual health is an important consideration as the end goal. Likewise, female sexual desire disorder falls under an umbrella of concepts including sexual health and dysfunction, desire and arousal, and low sexual desire.
**Sexual Health.** “Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled” (World Health Organization, 2012). Note the focus of this definition is not just on physical sexual functioning, but whether the individual can be fulfilled and satisfied in their physical, emotional, and social experiences with sex.

**Sexual Dysfunction.** Sexual dysfunctions are a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person’s ability to respond sexually or to experience sexual pleasure (American Psychiatric Association, 2015, p. 423).

**Desire & Arousal.** Oftentimes desire and arousal tend to be interrelated and it can be difficult to distinguish between the two. Sexual desire is typically defined as an interest in engaging in sexual activity and the presence of sexual thoughts/fantasies, whereas arousal has been defined as a genital arousal response to a sexual stimulus (Brotto, 2010).

**Low Sexual Desire.** Low sexual desire is considered both a symptom and a condition, as it remains a symptom until there is clinically significant distress that persists for at least six months, at which point it would move onto a chronic or ‘disease’ category that marks it as being qualitatively different. Low sexual desire is the most common form of female sexual dysfunction (Lehmiller, 2018). Symptoms encompassing low sex drive may include having no interest in any type of sexual activity, including masturbation, and a lack of sexual fantasies or thoughts. Symptoms of low sexual desire are not to be confused with asexuality. Given asexuality is a sexual orientation, it differs from low sexual desire disorder in that distress is not experienced from the
lack of desire. Thus, caution should be taken when labeling sexual attitudes and behaviors as “dysfunctional” as subjective perceptions are significant in preventing the creation of problems where none exist (Lehmiller, 2018).

**Sexual Response Cycle.** To fully grasp female sexual desire disorder, it is important to understand how sexual response functions in bodies with female anatomy, as low sexual desire is essentially an interruption in the sexual response cycle. The currently accepted three-phase linear model of the sexual response cycle is defined as desire, arousal, and orgasm (Kingsberg & Janata, 2007). The female sexual response cycle has been reconsidered as more frequently responsive, in other words consisting less of a start and end point structure and more so structured as a circular pattern with desire appearing at various points and overlapping with arousal (Basson 2007; Laan & Both, 2008; Diamond, 2006). Furthermore, it has also been found to be more relationally focused (Diamond, 2004), and is now understood as a reinforcer in the form of satisfaction (Basson, 2007; Working Group, 2000).

**Detection**

The first step in the treatment process is the recognition of lack of desire. The following outlines what clinicians look for in detecting female sexual desire disorder as represented within the literature.

Low sexual desire can be the product of many factors and its exploration should begin with a thorough collection of history using a biopsychosocial approach. If a diagnosis is relevant the *Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5)* is a common reference that is used help to conceptualize and diagnose the disorder (American Psychiatric Association, 2015). Low desire would fall under ‘female sexual interest and arousal disorder’ (FSIAD) using the DSM-5. Female sexual desire disorder can also be diagnosed as ‘hypoactive sexual desire

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disorder’ (HSDD) utilizing the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)*. For the purposes of conceptualizing this study, ‘female sexual desire disorder’ will be used to refer to FSIAD/HSDD collectively.

According to the DSM-5, to be diagnosed with a sexual dysfunction problem one must rule out nonsexual alternative explanations and the following factors must be considered when debating a diagnosis: 1) partner factors; 2) relationship factors; 3) individual vulnerability factors, psychiatric comorbidity, stressors; 4) cultural or religious factors; and 5) medical factors relevant to prognosis, course or treatment (American Psychiatric Association, 2015). Female sexual desire disorder would likely fall under the diagnostic criteria for female sexual interest/arousal disorder (FSIAD). Diagnostic criteria for female sexual interest and arousal disorder states an individual must experience a lack of, or significantly reduced, sexual interest/arousal, as manifested by at least three of the following: 1) absent/reduced interest in sexual activity; 2) absent/reduced sexual/erotic thoughts or fantasies; 3) no/reduced initiation of sexual activity; 4) absent/reduced sexual excitement/pleasure during sexual activity in almost all (approximately 75-100%) sexual encounters; 5) absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues; 6) absent/reduced genital or non-genital sensations during sexual activity in almost all sexual encounters (American Psychiatric Association, 2015). These symptoms must persist for at least six months and cause clinically significant distress. A polythetic approach (i.e. having many but not all properties in common) is used because women do not experience and express desire and arousal problems in a uniform manner.

One goal in developing the most updated DSM-5 diagnosis was to raise the standards needed to qualify for a diagnosis, as previously high rates of ‘dysfunction’ were reported in the literature. According to Graham (2016) several factors were considered in outlining diagnostic
criteria including: 1) it is difficult to clearly define desire; 2) women often have sexual activity in the absence of desire; 3) there is a reported low frequency of fantasy in women; 4) the complexity of understanding spontaneous vs responsive desire; and 5) the common co-occurrence of decreased arousal and desire (Brotto, 2010). Advocates of the DSM-5 FSIAD diagnosis assert that a circular model in which arousal may precede desire, rather than a linear model in which desire precedes arousal better describes the female sexual response cycle (Parish & Hahn, 2020). The diagnostic label has received negative feedback focusing on three primary concerns (Graham, 2016): 1) withdrawal from the long-standing linear concept of the sexual response cycle; 2) more stringent severity and duration criteria that may exclude women from receiving treatment; 3) the new DSM-5 criteria may ‘create havoc in the entire area of sexual dysfunction’ because DSM-IV diagnostic categories should be preserved to maintain continuity in research and clinical practice (Balon & Clayton, 2014). This appeal for continuity with the traditional categories of discrete desire, arousal and orgasm disorders has resulted in a reluctance to ‘return to the drawing board’ (Mitchell & Graham, 2008) even though research has consistently demonstrated that these traditional categories of sexual response do not fit the experiences of many women (Graham, 2016). The International Society for the Study of Women’s Sexual Health, a non-profit multidisciplinary organization dedicated to women’s sexual health, recently developed revised definitions for desire, arousal and orgasm dysfunctions and recommendations include a broadening and simplification of criteria (Parish & Hahn, 2020).

**Consequences of Low Sexual Desire.** Data suggests that the most common presenting sexual complaint in women attending clinics is low sexual desire (Bancroft, 2009). Bachman (2006) surveyed 1,946 health professionals attending four major specialty conferences (the American College of Obstetricians and Gynecologists, the Endocrine Society, the North American
Menopause Society, and the American Society for Reproductive Medicine) and found that 67% of respondents reported that low sexual desire was the most common type of sexual dysfunction among their female patients. According to the first systematic assessment of the prevalence of sexual problems in the United States, known as the National Health and Social Life Survey, low sexual desire for a period of at least 1 month in the previous 12 months was the most common sexual problem reported that affected 31.6% of women (Laumann, 1999).

The key component of the diagnostic definition for FSIAD is that the lack of desire experienced causes clinically significant distress. This distress may manifest itself as impaired body image, lack of connection to partner(s), frustration, grief, incompetence, worry or confusion (Goldstein et al., 2017). Other negative impacts of decreased sexual interest and desire in women may include feeling less feminine, feeling like a sexual failure, low self-esteem, and feeling insecure (Leiblum et al., 2006; Dennerstein et al., 2006). Moreover, a study looking at the impact of sexual dysfunction on quality of life found that a higher percentage of women with low sexual desire felt frustrated, concerned, unhappy, disappointed, hopeless, troubled, ashamed, and bitter compared to women with normal desire (Leiblum et al., 2006; Dennerstein et al., 2006). These effects of low sexual desire may lead to a domino effect that can further worsen an individual’s well-being and quality of life. Given these consequences, it is important to continue learning about female sexual desire to support these individuals.

**Predictors of Low Sexual Desire.** Loss of sexual desire can be the consequence of many psychological and physiological processes. Sexual dysfunctions, like female sexual desire disorder, can be attributed to various psychological causes. For example, relationship factors can contribute to sexual difficulties, including ineffective communication about sex, relationship problems, and how partners in a relationship view how sex can affect their performance and
satisfaction (Lehmiller, 2018). Women commonly report that relationship factors can affect arousal, such as feeling desired and accepted (Brotto et al., 2009; Graham et al., 2004), open communication (Byers, 2001), and intimacy (Regan & Berscheid, 1996). In one recent study of 356 Australian women (ages 20–70), relationship factors were found to be more important in predicting low sexual desire than age or menopause (Hayes et al., 2008). Internal attitudes towards sexual desire might also predict outcomes or one’s ability to cope. A study by Sutherland and Rehman (2018) sought to explore the impact of implicit theories on women’s coping. Results indicated that the belief system that sexual desire challenges are a chronic state (i.e., an entity theory of sexual desire) negatively influenced women’s coping with desire problems (Sutherland & Rehman, 2018). Conversely, the belief system that women’s desire fluctuates regularly (i.e., an incremental theory of sexual desire) was found to be a protective factor by acting as a buffer against helpless responses and helping women engage in problem-solving skills when faced with sexual desire challenges. This helps to illustrate the importance of clinician communication with patients and how it may impact the way a patient views their presenting problem and solutions.

We also know that biological factors such as natural aging, chronic illness, physical disabilities, sexually transmitted infections (STIs), and drugs may impact desire. Although the prevalence of low sexual desire increases with age, distress about low sexual desire decreases with age; thus, the prevalence of distressing low sexual desire stays relatively constant with increasing age (Parish & Hahn, 2020). Furthermore, normative fluctuations in sexual interest and arousal exist across the lifespan. Clinical judgment should be used to determine if sexual difficulties result from inadequate sexual stimulation, therefore nullifying the diagnosis of a sexual dysfunction (American Psychiatric Association, 2015).
The International Society for the Study of Women’s Sexual Health formulated an expert panel review to develop a concise resource to help clinicians screen for and treat women with female sexual desire disorder (Goldstein et al., 2017). This review supports using a biopsychosocial model for diagnoses and Annon’s (1976) stepwise model to patient care: Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT). This model provides a stepwise approach to women's sexual health care by guiding treatment from least to most intensive, as most people experiencing sexual dysfunction do not need substantial therapy. Using this model, clinicians might consider sex education and self-help books as a first-step approach in treating sexual dysfunction. If psychotherapy is needed, Goldstein et al. (2017) recommends referral to a certified sex therapist for management and treatment that focuses on the most distressing factors to the individual. Despite this, sex therapists’ perspectives are lacking in the current literature, including how and what psychotherapeutic approaches they utilize when treating female sexual desire disorder.

**Treatment Options**

Desire dysfunctions tend to be the most difficult to treat and typically have the lowest success rates of all sexual disorders (Lehmiller, 2018). Currently, there is no existing qualitative literature on how sex therapists treat female sexual desire disorder. At the cognitive level, patients consulting a physician for female sexual desire disorder often have false beliefs (Trudel & Ravart, 2001). Psychotherapy is a common treatment strategy that focuses on modifying the thoughts, beliefs, behaviors, emotions, and relationship behaviors that interfere with desire (Goldstein et al., 2017). In addition to psychological treatment options, there are also several emerging pharmaceutical interventions, both US Food and Drug Administration (FDA) approved and off-label, which are based on the physiologic mechanisms that modulate sexual desire.
Cognitive Behavioral Therapy. Cognitive behavior therapy (CBT) concentrates on altering the thoughts and behaviors that distract or inhibit sexual thoughts in sexual situations, especially automatic thoughts and cognitions (Meston, 2007). CBT builds on behavioral approaches that emphasize pleasure and self-exploration by combining them with theories of cognition that concentrate on reshaping thoughts and behaviors to focus on pleasure. Interventions may include psychoeducation to enhance one’s understanding about sex, cognitive approaches to restructure negative attitudes/beliefs, mindfulness to facilitate a physical-emotional connection with one’s sexual feelings and detachment from distractions, and emotional regulation techniques to improve on the management of conflicting negative emotions involving sexual relationships. Efforts to decrease inhibitory processes focus on negative beliefs and feelings about sex, body image concerns, and problems with relationships (Parish & Hahn, 2020). In contrast, efforts to increase excitatory processes may include education about sexual techniques and planning sexual activity (Parish & Hahn, 2020).

Sensate focus is a common behavioral sex therapy technique used in CBT to decrease the inhibitory effects of performance anxiety. Sensate focus therapy uses a graded series of non-sexual touch exercises to promote relaxation, communication, and intimacy (Lehmiller, 2018). For example, practices may begin with non-genital touching and lead to genital sexual activity by achieving antecedent progressive exercises. Cognitions addressed in CBT typically include negative thoughts, beliefs, expectations, cultural and religious standards, and attributions about sex and sexual activity that inhibit sexual desire (Goldstein et al., 2017). Desire inducing behaviors are thought as more likely to be repeated and continued by modifying these thoughts and behaviors to elicit more positive reinforcement.
**Mindfulness-based Cognitive Therapy.** A newer component to CBT is the infusion of mindfulness. This approach is based on the evidence that women with sexual desire/arousal difficulties are often distracted and judgmental (of themselves and/or their partners) during sexual activity (Brotto, 2016). Mindfulness-based cognitive therapy aims to connect with and engage one’s sexuality through practicing a variety of mindfulness techniques that prompt improvements in present awareness, acceptance, and self-compassion (Brotto & Basson, 2014). The mechanisms by which mindfulness improves symptoms in women with sexual dysfunction may relate to a decrease in spectating, defined by Masters and Johnson (1966) as the process of watching oneself during sexual activity from a third-person perspective. Mindfulness-based cognitive therapy helps to bring individuals back to the present moment and decrease anxiety, encourage an attitude of acceptance and non-judgment, and increase the perception of physical sexual response. This therapy also incorporates education by discovering and explaining how sexual interest and motivation can be influenced by thoughts, feelings, behaviors, and relationships (Goldstein et al., 2017).

One study compared female students without sexual difficulties who were randomized to either an 8-week mindfulness meditation group or an active control group and investigated how both groups rated the intensity of their physiological responses after viewing emotional photos (Silverstein, Brown, Roth & Britton, 2011). Results showed that women in the meditation group had significantly faster reaction times than women in the control group. The quicker reaction time significantly correlated with increases in mindfulness, attention, non-judgment, self-acceptance, and well-being, and decreased self-judgment and anxiety. This study raises the possibility that mindfulness may work with treating female sexual desire disorder, as it can potentially train the individual to better identify and respond to erotic cues, thus improving sexual functioning and
awareness of bodily sensations. Brotto (2016) examined the effects of a group mindfulness-based sex therapy on concordance between genital and subjective sexual arousal in women seeking treatment for sexual desire and/or arousal concerns. Findings suggest that skills enhancing a woman’s concentration and compassionate self-acceptance may be associated with greater integration of physical and mental sexual responses to erotic stimuli (Brotto, 2016). Because Brotto’s study (2016) used a combination of interventions, it is unknown whether benefits could be attributed to one specific component of treatment or their synergistic effects.

Trudel et al. (2001) compared the effects of CBT to a wait-list control in 74 couples in which women met the criteria for HSDD. Results showed that after 12-weeks, 74% of women no longer met diagnostic criteria for HSDD, which stabilized to 64% after a 1-year follow-up (Trudel et al., 2001). McCabe (2001) also evaluated the effectiveness of a CBT program to treat sexual dysfunction. Of the entire sample (N = 200), there were 105 females, 19.4% had a sexual arousal disorder, and 42.2% had a lack of sexual interest (McCabe, 2001). Results found the CBT program to be effective in 44.4% of women with sexual health concerns. While it was most likely effective in women with sexual arousal disorders, findings showed it to be least effective in women who experienced a lack of sexual interest, and a total of 54% of women who underwent CBT still reported a lack of sexual interest after CBT (McCabe, 2001).

Palaniappan et al. (2017) compared the effectiveness of a skill-based bibliotherapy intervention versus a placebo pill intervention purported to be efficacious in increasing women’s sexual desire based on the finding that most women struggling with low sexual desire will seek either pharmacological or self-help rather than in-person psychological treatment (Rosen et al., 2009; Basson, 2007). The book used—A Tired Woman’s Guide to Passionate Sex: Reclaim Your Desire and Reignite Your Relationship, by Laurie B. Mintz (2009)— is considered a research-
based cognitive behavioral self-help program to help women revive their interest, shown to be effective in increasing sexual desire and functioning in three prior clinical trials (Balzer & Mintz, 2015; and Mintz et al., 2012). Results demonstrated that the bibliotherapy group made more significant gains from pretest to follow-up in sexual desire and satisfaction compared to the placebo pill group. Nevertheless, the placebo pill group evidenced short-term improvements in sexual desire over time. Similarly, Jones and McCabe (2011) tested the effectiveness of a three-component internet-based CBT informed treatment program called “Revive” for female sexual dysfunction, requiring the presence of HSDD, sexual arousal disorder, anorgasmia, or genital pain for participation. The three components of Revive were communication skills training, sensate focus exercises, and regular contact with a therapist (Jones & McCabe, 2011). In total, 39 women (17 in the treatment group and 22 in the control group) completed the program, and results showed that sexual desire was significantly superior with treatment than with control (Jones & McCabe, 2011). These studies suggest that CBT can be effective for a proportion of women with low sexual desire but may also have limitations.

There is a lack of clinical trials with adequate controls to evaluate the efficacy of this treatment approach, thus making it difficult to draw definitive conclusions about any given treatment approach. Understanding perspectives from sex therapists, the clinicians typically administering these types of therapy, may contribute to better understanding what is efficacious in the treatment of low sexual desire by demonstrating the interventions therapists use within their treatment process and the overarching factors that impact how they arrive at those clinical decisions.

**Biological Treatment Options.** In addition to psychotherapeutic treatment options, several emerging pharmaceutical interventions are based on physiologic mechanisms that
modulate sexual desire. Both drugs that activate stimulatory pathways and reduce inhibitory pathways are being researched to treat female desire disorder. Currently, flibanserin or Addyi® (approved in 2015), and bremelanotide or Vyleesi® (approved in 2019), are the only FDA-approved pharmaceuticals for the treatment of female sexual desire disorder in pre-menopausal women. In addition to FDA-approved agents, other evidence-based off-label therapies for female sexual desire disorder exist, however, lack evidence for long-term safety. These agents may be used in conjunction with psychotherapy, and sex therapists’ experiences concerning this were investigated in the current research.

**Progress Metrics**

There is debate over detecting and measuring progress with female sexual desire disorder. Progress measurement can be conceptualized by considering the objective for treatment: to restore sexual desire and eliminate distress related to the loss of desire. Due to the complexity of clinical symptoms encompassing female sexual desire disorder, it is hard to narrow down what exactly is being cured when treating sexual desire disorder. Historically, sexually satisfying events (SSEs) have been the primary endpoint for treatment progress because it reflects a non-specific impairment as recommended by the FDA (Pyke & Clayton, 2017). However, the validity of this endpoint is criticized as it overlooks the subjective component of desire (FDA, 2014; 2015). Although many instruments are available for assessing changes in sexual desire and sexual dysfunction, there is a lack of consensus over which instruments are superior and what endpoints to prioritize.

As articulated by the dual control model of sexual excitation, the strategic objective of therapy is to decrease inhibitory and enhance sexual excitatory processes (Parish & Hahn, 2020). Evaluation of female sexual desire disorder treatment should assess a change in the quality and
quantity of the sexual behavior impacted by the loss of desire (Pyke & Clayton, 2017). Pyke and Clayton (2017) conducted a literature review to determine the most significant sexual behavioral correlates of female sexual desire disorder. Results report that desire for sexual activity was the only item on all sets explored, and sexual thoughts or fantasies, frequency of sexual activity, receptivity, and initiations were found in about half the sets analyzed (Pyke & Clayton, 2017). Furthermore, the idea that physiological arousal (as indicated by erections in men and by vasocongestion/lubrication in women) is inherently connected to the subjective experience of sexual feelings has been discredited in the research. Evidence shows a much lower concordance rate between physiological arousal and feeling “turned on” in women than men (Meana, 2010). For example, there is anecdotal evidence of women reporting vasocongestion, lubrication, and orgasm without any sexual desire and subjective arousal during unwanted sex (Levin & van Berlo, 2004). Because of the well-established low concordance rate between subjective arousal and genital response among women, the focus on behavioral measurements is curious (Chivers et al., 2010).

These findings highlight the importance of perception in diagnosing and treating sexual problems, as patterns of behavior can be considered arbitrary when what represents a sexual problem for one may be the desired outcome for another. For example, a study of patient-clinician communication about desire problems found that the most important goal of treatment was an improvement in levels of desire, rather than an increase in the frequency of sex or pleasure (Goldstein, Lines, Pyke & Scheld, 2009). This distinction between the level of desire and frequency of sex/pleasure should be considered when conceptualizing what constitutes progress in female sexual desire disorder treatment. Meana (2010) attests that sex is not always the goal of women's sexual desire and the experience of sexual desire may be its own reward. By looking at
sexual activity as the ultimate confirmation of desire, we may be entirely missing or failing to account for a great deal of women's desire (Meana, 2010). It has been suggested that sexual desire, rather than sexual activity, should be considered the primary endpoint. The incentive value of sex likely overlaps with desire and research should investigate factors that predict action tendencies toward the fulfillment of sexual desire (Meana, 2010).

**Key Trends in the Literature**

Lehmiller (2018, p. 350) states that “more and more people are receiving medication instead of working with therapies to deal with their sexual difficulties.” Limited effectiveness of current pharmacotherapies suggests that desire issues are likely attributed to relationship and environmental factors more so than biology (Lehmiller, 2018). This increase in pharmacotherapy has sparked controversy as it raises whether the biopsychosocial nature of sexual dysfunction is being ignored and poses the potential of medicalization as an example marketing technique where companies develop conditions concurrently with pharmaceutical interventions (Meixel, Yanchar & Fugh-Berman, 2015). A primary concern is that this value discrepancy results from quick, profitable, and convenient drug treatments rather than being empirically proven superior. A study done by Meixel, Yanchar and Fugh-Berman (2015) sought to explore the popular narrative that female sexual desire disorder is common but is a frequently under-diagnosed condition due to a lack of pharmacological interventions needed for clinicians to feel comfortable approaching the issue. This was investigated by identifying and theming continuing medical education courses for female sexual desire disorder. Continuing medical education courses are a vital marketing tool that has been used previously to increase clinician receptivity to new drug approvals. Of the 14 continuing medical education modules on female sexual desire disorder found, all were funded through educational grants by Boehringer Ingelheim pharmaceutical company. Common themes
found in these modules include female sexual desire disorder is common and underdiagnosed, women may be unaware they are distressed, simple questionnaires can assist in diagnosis, and it is problematic pharmaceuticals exist for men but not women yet (Meixel, Yanchar & Fugh-Berman, 2015). The current study was conducted to understand sex therapists’ attitudes toward female sexual desire disorder, including how they perceive the evolution of female sexual desire disorder and the impact these perceptions have on the ways they address desire disorder.

**Philosophical Assumptions**

**Ontological Position.** The current study used grounded theory methodology, including the constant comparative approach to analysis to develop a framework reflecting sex therapists’ perspectives about what causes female sexual desire disorder and how this shapes their treatment response. This research reflects an interpretivist position recognizing the subjectivity in sexuality and the variability in perspectives among sex therapists. This interpretivist framework is exemplified in the systematic procedures of grounded theory found in Strauss and Corbin (1990, 1998) and Corbin and Strauss (2007, 2015). Interpretivism compliments this study’s guiding research questions aimed at understanding sex therapists’ perspectives about female sexual desire disorder. Female sexual desire disorder is recognized; however, definitions have changed over time, allowing for interpretations based on other factors. This evolving conceptualization is partly due to a shift in attitudes and perspectives over time. Sexuality is an example of a concept that reflects multiple realities of how individuals experience desire, pleasure, and lack thereof, and is entirely dependent on the person. This helps to explain why there is a lack of consensus in sexual desire literature, as desire is a difficult concept to standardize. Furthermore, the understanding of gender and sexual identities have evolved but are not reflected in sexual desire literature. The scientific study of sex began around the mid-nineteenth century when several physicians started
publishing books about sexual behavior (Lehmiller, 2018). These books marked a significant shift from seeing sexual dysfunctions as moral failings to being reconceptualized as medical and mental issues (Lehmiller, 2018). Since then, research has increased, and conceptualization has continued to shift as we gain more knowledge. For this reason, it is important that the literature includes representation of sex therapists’ attitudes and perspectives, including how they have responded to such shifts in conceptualization over time, to understand the field of human sexuality better.

**Grounded Theory**

Grounded theory focuses on understanding a phenomenon of interest to produce a conceptual framework, model, or theory to explain its underlying processes (Creswell & Poth, 2016). Grounded theory is the primary research strategy considered in the development and execution of this study as it aims to understand an underlying process, in this case the conceptualization of female sexual desire disorder, to generate a framework to better understand the ways sex therapists frame detection, treatment, and assessment of progress with female sexual desire disorder. Interpretations are grounded in the data collected from participants who have clinical experience in responding to female sexual desire disorder in cisgender heteronormative women. This study focused on identifying patterns, categories, and themes from the bottom up by organizing data inductively into increasingly more abstract units of information (Creswell & Poth, 2016).

Past studies on the conceptualization of sexual desire have used a grounded theory informed methodology. For example, Wood et al. (2007) used grounded theory methodology to understand women’s lived experience of sexual desire and the meanings they attached to their desire. The analysis developed themes from the “ground up” using women’s own words to establish three broad contexts (“the self,” “partners,” and “the medical system”) in which women
considered their sexuality and sexual desire issues (Wood et al., 2007). The consistency in women’s discussions of their ability to act on behalf of their needs and desires led to the identification of the core category, negotiating sexual agency, that was used by the authors for explaining interrelationships, suggesting that this methodological approach helped identify important underlying factors in women’s lived experiences (Wood et al., 2007). The current study followed the same methodological approach used by Wood et al. to investigate therapists’ perspectives of desire rather than the lived experience of desire. Both interpretivism and grounded theory recognize the variability of the human experience and compliment the purpose of the current study to understand perspectives of sex therapists as informed by several factors, including their professional knowledge and beliefs shaped by a broader context.
Methods

This study utilized semi-structured interviews with American Association of Sexuality Educators Counselors and Therapists (AASECT) professionals to examine their perspectives on female sexual desire disorder. Participants were recruited using a criterion snowball sampling technique via email for participation in the study, and interviews took place over Microsoft Teams. Interview questions were developed to respond to gaps in the literature and covered key domains related to female sexual desire disorder. Analyses progressed through grounded theory informed procedures, including open, selective, and axial coding. Using the constant comparison method, the primary investigator looked for recurring regularities in the data to identify emergent themes to saturation and develop a framework highlighting the process of how the conceptualization of female sexual desire impacts decision-making regarding the treatment of low sexual desire.

Sample

Inclusion Criteria

Using participants who are familiar with the treatment of female sexual desire disorder contributes to collecting relevant data. Grounded theory calls for a purposeful sample to allow for an intentional selection of people that can best inform the researcher about the topic of investigation and contribute to the developing theory (Creswell & Poth, 2016). Initially, inclusion criteria for this study included being listed on The American Association of Sexuality Educators Counselors and Therapists (AASECT) public referral directory as a sex therapist located in the United States (American Association of Sexuality Educators Counselors and Therapists [AASECT], n.d.). The rationale for selecting AASECT certified clinicians as the primary inclusion
criteria for this study is based on the suggestion that affiliation with AASECT indicates participants are well-informed in human sexuality and likely familiar with female sexual desire disorder. Sex therapy is a highly specialized field; thus, there are only a small number of AASECT registered clinicians per state. For example, there are a total of 34 AASECT certified professionals registered in Florida. For this reason, geographic region was not a consideration in the recruitment process, and participants were recruited from around the United States. Although the primary investigator had to remove AASECT distinction from inclusion criteria to ensure that enough participants were recruited due to a lack of response from recruitment emails most of the sample was AASECT certified (77%).

**Recruitment Strategies**

A criterion snowball sampling strategy was used to recruit participants representing people who have experienced the phenomenon of interest. This sampling method was used to accrue an adequate sample of clinicians with expertise as there are a limited number of registered sex therapists. Participants were asked to share the principal investigator’s contact and study information with other potential participants to assist with the recruitment of subjects.

Participants were recruited for this study through a combination of emailing potential participants included in AASECT’s public directory and asking study participants to share the study information in their professional circles with other potential participants. For example, a few participants published study information on several listservs, including AASECT and the Society for Sex Therapy and Research (SSTAR).

. Participants were contacted via email (see Appendix A) for participation by the primary investigator once identified from AASECT’s public referral directory or by a colleague who considered them relevant for participation through snowball sampling procedures. The primary
investigator began by emailing AASECT certified professionals and initial emails included: 1) notification of the purpose, procedures and implications of the study; 2) statement of Institutional Board Review (IRB) approval; 3) access to a preliminary survey (see Appendix B); 4) a flyer which encapsulates the study for them to share. This research underwent IRB approval to ensure ethical practices. The preliminary survey, a short closed-ended online questionnaire, covered brief yes/no questions to reserve interview time for items that require further explanation. Domains covered within the preliminary survey included: 1) the interviewee’s professional background (theoretical orientation, clientele load, years in practice); 2) the interviewee’s experience of exposure to clients with desire complaints (frequency, percent of patients screened and treated); 3) their preferred criteria used for diagnosis (DSM, ICD, etc.). The primary investigator sent a follow-up email if no response was received within seven days of the initial email.

The preliminary survey included a space to input contact information. Once the survey was complete and notification was received, participants were contacted via email by the primary investigator to coordinate interview times. At the beginning of interviews, the interviewer followed the interview protocol (see Appendix C) and verbally reviewed informed consent, including the purposes and procedures of the study, the relevant risks and benefits, protection of confidentiality, the right for participants to withdraw from the study at any time, and the approximate amount of time needed to complete the interview. The interview protocol was used to guide the conversation with respondents, allowing for open sharing of their expertise and using prompts for more detail when needed.
Sample Size & Demographics

Table 1
Results from Preliminary Questionnaire

<table>
<thead>
<tr>
<th>Preliminary questionnaire &amp; demographic data</th>
<th></th>
</tr>
</thead>
</table>
| How long have you been practicing sex therapy? | 43.75% over 10 years  
25% 5-10 years  
31.25% 1-5 years  
0% less than a year |
| What are your credentials? | 31% LMHC  
25% LCSW  
25% Other  
12.5% LMFT  
6.25% Ph.D./Psy.D. |
| How many patients do you usually see in your practice? | 81.25% 10-30 patients/week  
18.75% 30-50 patients/week |
| What percentage of your caseload involves desire complaints? | 68.75% said 25-50% of patients  
25% said over half their patients  
6.25% said 10-25% of patients |
| What percentage receive a formal diagnosis? | 37.5% said less than 10%  
31.25% said between 10-25%  
25% said between 25-50%  
6.25% said over half |
| How long have you been treating female sexual desire disorder? | 43.75% for over 10 years  
37.5% for 1-5 years  
18.75% 5-10 years |
| What criteria do you reference for female sexual desire disorder? | 50% use the DSM-5  
43/75% use other  
6.25% use the ICD-10 |
| Geographic location: | 6 clinicians from Pennsylvania  
5 clinicians from Florida  
1 clinician from Massachusetts  
1 clinician from Georgia |
| Clinician gender identity: | 12 female clinicians  
1 male clinician |
| AA征服 certified: | 10 (77%) AA征服 certified clinicians  
3 non-AA征服 clinicians |

Note. A table organizing information obtained from the preliminary questionnaire

A table was used to organize information about the sample’s expertise, experience and profile of their clientele based on results from the preliminary questionnaire (see Table 1). This study obtained a sample size of N = 13 composed of 12 female therapists and one male therapist.
from around the United States. Two participants were AASECT certified sexuality counselors that had a non-therapy background, one was a certified nurse-midwife, and the other was a medical doctor. The rest of the sample came from counseling backgrounds, most notably licensure in mental health counseling (LMHC). Of the sample, 10 participants (77%) were AASECT certified, and the remaining three participants were certified sexuality counselors through other accreditation processes. The sample consisted of five clinicians from Florida, six clinicians from Pennsylvania, one clinician from Massachusetts, and one clinician from Georgia. 43.7% of the sample has been in sex therapy practice for over ten years, and 25% has been in practice for 5-10 years. 68.75% of participants indicated that 25-50% of their clientele involve desire complaints, indicating low desire may be a prevalent issue in sex therapy practices. Overall, the sample included a wide array of practitioners from various geographic regions who have a breadth of experience in general sex counseling and with desire-specific complaints.

A sample size of 13 is considered sufficient based on grounded theory research standards and similar studies using interviews with clinicians (Ulman, 2014; Wood, Mansfield & Koch, 2007; Berry & Lezos, 2017). For example, Ulman (2014) utilized semi-structured interviews with therapists and had a sample size of 12. Wood, Mansfield and Koch (2007) studied women’s meaning and experience of sexual desire using semi-structured interviews and included 22 participants, and Berry and Lezos (2017) facilitated a semi-structured interview-based study with a sample size of 34. Given that Ulman (2014) interviewed clinicians, whereas the other studies conducted interviews with the women experiencing desire disorders, a sample size of 13 is a reasonable size. Ulman’s (2014) study, which used grounded theory methodology, included a highly specialized group of experts, as does this study.
Data Collection

Interviews

Utilizing semi-structured interviews allowed for the delicate balance between using a reliable instrument that can be replicated while also maintaining an explorative approach that elicits detailed and potentially rich information. The interviewer encouraged participants to “be the expert” on the subject matter by using broad questions to allow participants to describe the phenomenon from their perspective, rather than have a predetermined hypothesis guide questioning. This aligns with the purpose and aims to explore sex therapists’ experiences of treating female sexual desire disorder, including how their understanding of various factors relevant to desire has shaped their understanding of the symptomatology associated with female sexual desire disorder and treatment recommendations.

Interview Questions. Interview questions intended to collect data responding to the proposed study’s guiding research questions regarding participants’ attitudes and beliefs relevant to female sexual desire disorder and how they shape their treatment recommendations. Questions were formulated to explore clinicians’ beliefs and experiences addressing female sexual desire disorder to understand how their perspectives as a highly trained specialist in this area affects their conceptualization and treatment of low sexual desire. Interview questions were piloted with a sex therapist uninvolved with the proposed study for feedback before use with study participants.

Open-ended questions and probing were used to yield detailed data. Probing occurred through asking for more details, clarification, or examples (Merriam & Tisdell, 2015). The semi-structured interview guide included the following key domains: 1) the interviewee’s conceptualization of female sexual desire disorder over time; 2) the interviewee’s treatment process for female sexual desire disorder; 3) the interviewee’s perspective of existing diagnostic
criteria for female sexual desire disorder. The final interview guide is based on questions from similar studies exploring physicians’ perspectives of HSDD (Harsh et al., 2008; Berry & Lezos, 2016). These earlier studies sought to explore physicians’ perspectives, not sex therapists’; thus, interviews in this study were tailored to their clinical perspectives. The interview protocol for the current study can be found in Appendix C.

**Interview Logistics.** Interviews were conducted over video call via Microsoft Teams to allow for participation to be socially distanced and accessible despite geographic location. Microsoft Teams is a HIPAA compliant server that guarantees participant confidentiality. Interviews ranged from 24 minutes to 52 minutes, with a mean of 35 minutes from beginning to end. This depended on how much clinicians shared and varied on a participant-by-participant basis.

The record meeting function on Microsoft Teams was used to store interview data for later transcription and analysis. Interviews took place in a designated lab space where no other people would be around to ensure confidentiality. Qualitative data collection via web-based platforms can be advantageous regarding cost, time efficiency and space flexibility, which allowed participants more time to consider and respond to questions, thus encouraging deeper reflections (Nicholas et al., 2010). Before the start of interviews, participants were given reassurances of confidentiality and anonymity, an opportunity to ask questions, and were informed of their right to withdraw at any point, as in line with USF IRB regulations.

**Transcription**

The primary investigator transcribed recorded video-call interviews from Microsoft Teams verbatim to prepare data for coding and analysis. Microsoft’s voice typing tool was used to get an initial rough draft of transcribed interviews. The primary investigator then carefully compared this rough draft to the original recording to identify any mistakes and made relevant adjustments before
producing the final draft of the transcript. Transcriptions focused on verbal content, despite data being in the form of a recorded video, as body language and other visual cues are more difficult to interpret accurately via video chat. Because transcription involves the close observation of data through repeated careful listening, this familiarity with the data helped facilitate realizations that emerged during analysis (Bailey, 2008). These realizations were recorded in notes and memos by the primary investigator.

**Data Management**

Data management methods used include: 1) creating a backup copy of computer files; 2) using the record meeting function on Microsoft Teams; 3) developing a master list of the information gathered; 4) maintaining an audit trail; 5) masking participant names in the data to protect anonymity. Pseudonyms of participant names were created and all identifying information was deleted; original names were kept on a separate master file. A searchable spreadsheet in a standard word processing format was used to organize and efficiently retrieve voluminous data. Information was organized by data form, participant ID, and collection date. Human subjects research records, including the original transcriptions, will be kept for at least five years after completion of the research as in accordance with IRB regulations, and identifiable data will remain at the University of South Florida for the duration of the applicable record retention period. Data will be destroyed after five years in line with USF and the American Psychological Association for record retention. No software was used in the process of coding or theming data.

The primary investigator used an audit trail to help explain how they came up with their findings. While it is unreasonable to expect others to replicate results within a qualitative study, it is prudent to explain how the researcher arrived at their results. An audit trail is a running record of the researcher’s interactions with their data, describing how data were collected, how categories
were derived, and how decisions were made throughout the analysis process to illustrate how small analytic leaps contribute to analysis as a whole. At the beginning of this study, a tracking document was created to document critical researcher decisions.

Data Analysis

As aforementioned, information learned about sex therapists’ interpretations of female desire disorder was used to build categories and themes to guide the formation of a framework that responds to this study’s research questions. In summary, the primary investigator led all facets of the study, including conducting and transcribing all interviews, establishing the codebook, coding, and theme building. A second coder assisted the primary investigator with inter-rater reliability. The constant comparative method for analysis is an inductive and comparative method that utilizes a systemic strategy for data analysis that involves comparing one segment of data, or interview, with another to determine similarities and differences (Merriam & Tisdell, 2015). Through constant comparison, the primary investigator looked for recurring regularities in the data and categories inductively emerged. These categories were used to interpret the meaning of the data collected and develop themes. The flowchart included in Figure 1 illustrates the analytical process used to create themes and establish the conceptual framework that outlines how low sexual desire is conceptualized and treated. Results were validated through an abbreviated member checking process, discussed further below.

After each interview, the primary researcher used notetaking and memoing to contribute to this refinement process. Notetaking refers to any field notes taken after interviews that detail any immediate impressions that may be compelling during later analysis. These notes may include observations of participant body language, thoughts related to any interactions that might lead to changes in data collection procedures, and any information that may be useful for analysis.
Likewise, the process of memoing plays a role in developing a theory. Memoing involves the primary researcher writing down ideas as data are collected and analyzed, thus contributing to data collection and analysis. In grounded theory research, memos include statements about the evolving theory. These notes could form preliminary propositions (hypotheses), ideas about emerging categories, or some aspects of connecting categories as in axial coding (Creswell & Poth, 2016). The primary investigator referenced these notes during analysis to help arrive at themes by using notes and memos to identify their ideas about the disorder and predilection for holistic health due to the primary investigator’s professional background. Notes and memos were reviewed during open, axial, and selective coding to reflect on the coded segments and later themes.

Figure 1
Analytical Procedures
Codebook

Finalizing a list of codes and creating definitions for each provides the foundation for a codebook (see Table 2), by articulating the distinct boundaries for each code and playing a critical role in assessing inter-rater reliability (Creswell & Poth, 2016). The codebook included a name for each code, a shortened label, a description of the code that defines inclusion/exclusion criteria, and any illustrative examples of the code using study data (Creswell & Poth, 2016). The codebook was developed to have codes representing both clinician’s conceptualization of the disorder itself and their conceptualization of the treatment process. The final codebook (see Table 2) that was used for open coding included the following codes: belief systems, meaning making, mind-body, relational, self-efficacy, normalize, trauma-informed, perception of patient perspectives, subjectivity, countenance, prioritization, cultural context, gender politics, treatment motivations, pathologizing, sexual morality, Ockham’s razor, public awareness, narrative shift, and referral network.

Initially, the primary investigator read through the data, including any transcripts, notes, and other documents to look for significant categories of information supported by the data, get a general sense of the material, and assign the initial set of codes. The primary investigator created a document including preliminary impressions and notable direct quotes to help facilitate the codebook creation. The primary investigator then went through this document to identify possible codes and key phrases and condensed this list of potential codes by looking for redundancy. This narrower list of potential codes was brainstormed with an uninvolved assistant who had no prior knowledge of the content of results to prioritize which words and phrases were the widest in breadth. The primary investigator then created the first iteration of the codebook. Following, the
primary investigator then coded the data entirely after establishing inter-rater reliability with a secondary coder who is distinct from the uninvolved assistant.

**Inter-rater Reliability.** Inter-rater reliability is based on using multiple coders to analyze transcribed data (Creswell & Poth, 2016). A second coder was utilized to cross-check the initial coding done by the primary investigator and support inter-rater reliability. In this process the secondary coder served to minimize bias and support reliable analysis. In summary, the secondary coder coded using the established codebook to code three transcripts independently, compared their results with the primary investigators’ initial codes, and both negotiated discrepancies accordingly. To simplify the comparison process, both coders used a table formatted by code, the relevant data segment, and the transcription number (see Appendix D). After the first round of comparing coding, the primary investigator updated the codebook accordingly by combining, amending, or removing select codes and their definitions. Both coders discussed coding to determine segments of coding agreement/disagreement, and this proportion produced an inter-rater reliability statistic of 97%, which is well above the ideal range of above 80% (McAlister et al., 2017). After comparing the second round of coding the primary investigator finalized the codebook (see Table 2).

**Table 2**

*Final Codebook*

<table>
<thead>
<tr>
<th>Code</th>
<th>Shortened Label</th>
<th>Description</th>
<th>Illustrative Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belief Systems</td>
<td>Beliefs</td>
<td>How sex therapists address client ideas and beliefs related to sex.</td>
<td>This may include obtaining an origin story, any narrative therapy, and addressing faulty logic.</td>
</tr>
<tr>
<td>Code</td>
<td>Shortened Label</td>
<td>Description</td>
<td>Illustrative Examples</td>
</tr>
<tr>
<td>-------------------</td>
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<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Treatment Motivations</td>
<td>Motivations</td>
<td>How sex therapists describe why people come to them for treatment and how they find their practice.</td>
<td>This may include client motivation due to partner pressure, self-diagnosis, a referral from another provider, or clinically significant distress.</td>
</tr>
<tr>
<td>Trauma-Informed</td>
<td>Trauma</td>
<td>How sex therapists are mindful of how trauma intersects with the presenting problem and treatment process.</td>
<td>This may include an assessment of trauma, obtaining consent/permission throughout the counseling process, and specific interventions. Trauma-informed practices emphasize safety, collaboration, empowerment, and transparency.</td>
</tr>
<tr>
<td>Normalize</td>
<td>Normalize</td>
<td>Sex therapists’ efforts at normalizing sexual experiences held by clients.</td>
<td>This may include psychoeducation and reality testing.</td>
</tr>
<tr>
<td>Prioritization</td>
<td>Prioritization</td>
<td>Sex therapists’ perception of how clients prioritize sex/sexual identity is in their lives.</td>
<td>This may include assessing a clients’ values, priorities, and the fraction of pleasurable activities in their daily lives.</td>
</tr>
<tr>
<td>Relational</td>
<td>Relational</td>
<td>Relating to relationships and communication.</td>
<td>This may include reference to a client’s relationship with self, partner and/or their higher power. Assertiveness and sexual communication training.</td>
</tr>
<tr>
<td>Code</td>
<td>Shortened Label</td>
<td>Description</td>
<td>Illustrative Examples</td>
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<td>-------------------------</td>
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</tr>
<tr>
<td>Self-Efficacy</td>
<td>Efficacy</td>
<td>Sex therapists’ efforts at encouraging clients to have an internal locus of control.</td>
<td>This may include treatment interventions directed at having clients explore their bodies, erotic language, and pleasure. Intentionality behind their sexuality by manufacturing desire, expanding on pleasure, and exploring kinks and different context settings.</td>
</tr>
<tr>
<td>Mind-Body</td>
<td>Mind-Body</td>
<td>Assessment and treatment interventions related to the mind-body connection.</td>
<td>This may include a biopsychosocial assessment process, sensory or body-centered work, mindfulness-based stress reduction, and behavioral conditioning.</td>
</tr>
<tr>
<td>Meaning Making</td>
<td>Meaning</td>
<td>Identifying meaning and intention behind sexual activity.</td>
<td>This may include emotional intimacy and connection, and pleasure.</td>
</tr>
<tr>
<td>Perception of</td>
<td>PRO</td>
<td>Clinicians’ perception of their client’s perspective of goals and assessment of progress.</td>
<td>This may include the perception that clients dictate clinically significant distress and treatment outcomes/goals.</td>
</tr>
<tr>
<td>Patient Perspectives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Countenance</td>
<td>Countenance</td>
<td>Therapist’s use of intuition and using body language as an indication of progress.</td>
<td>This may include therapists relying on their intuition and perspective of client interactions to assess progress more than formal assessments/data.</td>
</tr>
<tr>
<td>Code</td>
<td>Shortened Label</td>
<td>Description</td>
<td>Illustrative Examples</td>
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<tr>
<td>---------------------</td>
<td>-----------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sexual Morality</td>
<td>Morality</td>
<td>Any reference to sex is difficult to discuss due to its taboo nature or shame.</td>
<td>This may include the perspective it is hard to come to a sex therapist for help, sex viewed as deviant, and any perception of shame about sex.</td>
</tr>
<tr>
<td>Gender Politics</td>
<td>Gender</td>
<td>Reference to gender dynamics at play within the conceptualization of desire.</td>
<td>This may include the opinion that the disorder is genderless or that gender is becoming less relevant. Includes reference to the masculine/feminine dynamic or how gender intersects with sexual desire.</td>
</tr>
<tr>
<td>Pathologizing</td>
<td>Pathologizing</td>
<td>Reference to how the disorder is stigmatizing, non-inclusive and views people as abnormal.</td>
<td>This may include the opinion that female sexual desire disorder is oversimplified and doesn’t account for gender/sexual spectrums such as asexuality. References to client-held beliefs that something is wrong with them; or a sense of permanence associated with the disorder.</td>
</tr>
<tr>
<td>Narrative Shift</td>
<td>Narrative</td>
<td>Reference to the existence of a narrative shift within society of how sex is conceptualized.</td>
<td>This may include references to a sexual liberation, women feeling more empowered about being both ‘sexual and good,’ and generational differences.</td>
</tr>
</tbody>
</table>
Table 2. (Continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Shortened Label</th>
<th>Description</th>
<th>Illustrative Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cultural Context</strong></td>
<td>Culture</td>
<td>How culture interacts with the conceptualization of desire.</td>
<td>This may include societal expectations, shame-based messaging in media and porn consumption, purity culture, hypersexual culture, desire rooted in lifestyle factors, and desire disorder as a societal reaction to a cultural problem.</td>
</tr>
<tr>
<td><strong>Ockham’s Razor</strong></td>
<td>Ockham’s</td>
<td>The simplest explanation is usually correct. Lack of desire viewed as a symptom of a less specific disorder.</td>
<td>This may include references to HSDD/FSIAD being redundant, too broad, or too specific; lack of desire as a symptom vs. a disorder and loss of desire as more appropriately fitting a different diagnosis or attributed to an underlying issue.</td>
</tr>
<tr>
<td><strong>Public Awareness</strong></td>
<td>Awareness</td>
<td>Reference to the public awareness of sexual desire disorder and sex therapy.</td>
<td>This may include awareness, or lack thereof, of desire disorder, available treatments, recognition of the sex therapy field, reference to a societal shift towards more open dialogue/openness to discuss sex, and increased access to information.</td>
</tr>
</tbody>
</table>
Table 2. (Continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Shortened Label</th>
<th>Description</th>
<th>Illustrative Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subjectivity</strong></td>
<td>Subjectivity</td>
<td>Therapist perspectives of sexual desire as a highly subjective topic.</td>
<td>This may include discussion of sexual desire as highly subjective in both perception and treatment.</td>
</tr>
<tr>
<td><strong>Referral Network</strong></td>
<td>Referral</td>
<td>Reference to receiving or sending referrals.</td>
<td>This may include sex therapists building referral networks by spreading awareness of their practice or increasing their own awareness of appropriate referrals they can send - a holistic approach to maximizing impact.</td>
</tr>
</tbody>
</table>

**Coding**

Coding focused on identifying patterns relevant to the study’s purpose, and categories were organized to be mutually exclusive and encompass all relevant data to saturation. Grounded theory outlines a coordinated process to approach coding using open, axial, and selective coding. Open codes emerge from the text to break data into discrete components of data and each discrete piece is coded with a descriptive label based on the properties of the data. Axial codes involve finding the connections and relationships between codes to aggregate and condense codes into broader categories. The third phase, selective coding, refers to how the researcher may write a “storyline” that connects identified categories into themes (Creswell & Poth, 2016). Overall, the primary investigator identified themes that captured a recurring trend in the data, detected the connections between the overarching theme and the rest of the codes, removed codes or categories that did not have enough supporting data, and read over the transcripts once more with the overarching theme.
in mind. The end goal was to use the intersection of categories and themes to develop a theory or conceptual framework (Creswell & Poth, 2016). The process of analyzing codes to develop themes was executed through the following procedures: 1) created and organized data files; 2) read through and made memo notes including any ideas about the evolving framework; 3) described and applied open/axial/selective codes in a three-phase coding process to saturation; 4) developed a discursive set of theoretical propositions and a conceptual framework.

**Development of Themes**

Distinct from coding, classifying involves taking qualitative information apart and identifying broader categories. A comprehensive set of themes were established that focused on the perspectives participants hold about female desire disorder, recognizing that themes may not necessarily be in line with what is found in the current literature. A theme is defined as a pattern found in a segment of information that describes and organizes possible observations and interprets aspects of the phenomenon under study (Boyatzis, 1998). Reduction and combination of codes leading to themes was done by grouping similar codes together under categories. Separate files, distinguished by the code name, were used to sort all data segments corresponding to each respective category and facilitate the conceptualization of results to begin linking codes to themes.

At this point, the primary investigator read through the list of coded data and considered the emerging broader themes, recording any insights in memos. Codes were organized into categories, which were used to yield relationships between future axial codes. The primary investigator manually sorted and linked themes, developing the framework of a flow chart by writing out each code onto a flashcard and identifying relationships by stacking cards that could be condensed into one category. This flow chart was then transferred into a diagram within Word (see Appendix E) to help the primary investigator conceptualize how the themes or categories
identified related to the research questions. Narrative segments coded with the final code list of twenty categories of information were used to finalize a list of nine themes that correspond with this study’s guiding research questions investigating sex therapists’ conceptualization of low desire and how this conceptualization impacts their treatment processes and recommendations. At the broadest level of analysis, a conditional matrix/diagram was developed to illustrate the wide range of conditions and consequences related to the central phenomenon (Corbin & Strauss, 2015). The primary researcher used categories and identified themes to develop a conceptual framework that outlines the relationships between framework elements. These themes are expanded upon to extend understanding of the data the primary investigator interacted with to draw conclusions about the framework at play.

**Member Checking**

Member checking was used to ensure the accuracy of the primary researchers’ interpretations of interviewees’ perspectives based on raw data. Member checking, or participant validation, is a technique for exploring the credibility of results and involves taking data, interpretations, and conclusions back to participants so they can judge the accuracy of the account (Creswell & Poth, 2016). Member checking is vital for this study because the goal is to use therapists’ perspectives to develop a framework relevant to diagnosis and treatment decisions; thus, if perspectives are not accurately interpreted, then the overall credibility of the research is diminished. This process helps bridge the gap between participant perspectives and researcher interpretations. Member checking is considered an essential validation step to foster collaboration in how the data is interpreted and ultimately represented (Creswell & Poth, 2016).

Member checking was facilitated by returning results containing a description of themes, not raw data, to a non-participant who met inclusion criteria (see Appendix F). This was done near
the end of the study requesting that the individual check if results accurately represent their perspectives and experiences related to female sexual desire disorder. Specifically, the primary investigator returned three of the main themes identified (cultural context, belief systems, and perception of patient perspectives) to a non-participant clinician based in Florida who was a Licensed Mental Health Counselor, a Board Certified Sex Therapist, and a Nationally Certified Counselor in private practice since 2015. The primary investigator found this individual because they had indicated a previous interest in study participation after being referred to the current study through snowball sampling. However, they did not respond to the primary investigator’s emails requesting an interview appointment after completing the preliminary questionnaire; thus, they never completed an interview for the study. Fortunately, they did respond to the primary investigator’s request for member checking and confirmed that 100% of the themes returned coincided with their perspective. This confirmation of results by an objective clinician in the same field as study participants adds validity to the interpretation of study results.

**Role of Researcher**

The primary researcher undertook the bulk of this project with some support from a second coder. As an aspiring qualitative researcher and sex therapist, the primary researcher is generally aware of the roles and responsibilities associated with sex therapy but lacks an understanding of what it is like to be a practicing sex therapist. This study was used to fulfill the primary investigator’s requirements for the research track in their master’s program. Before conducting this study, the primary researcher worked as a practicum student under supervision at a holistic private counseling practice with plans to specialize in sex therapy, and taught trauma-informed yoga with a local non-profit. They hold a bachelor’s degree in Family Youth Community Sciences (B.S.), a certificate in Family Life Education, and a minor in International Studies. The primary
researcher’s positionality as a graduate student pursuing a career in sex therapy was considered and interviews adhered to grounded theory methodology, including efforts to reduce interviewer bias. In addition to being a counseling student, the primary investigator is a white, cisgender woman. This positionality may have allowed the primary researcher to develop a better understanding of the study participants’ world and how it is experienced from their perspective. This can be a challenge as all researchers must maintain marginality or the process by which the researcher maintains “one foot in the world of the participants and one foot in the outside world” (Bowers, 1990, p. 34). Marginality allows the researcher to experience the participants’ world while maintaining the distance necessary to guide interviews and data analysis (Bowers, 1990). As a result, reflexive notes about potential biases were documented throughout the progression of this research. Biases may relate to the primary investigator’s position within the counseling and holistic wellness community as a yoga teacher, and how these roles may inform their opinions on the medicalization of sexuality. The secondary coder used for inter-rater reliability is a post-bachelor’s student with a background in research methods, a bachelor’s degree in both Psychology (B.A.) and Behavioral Healthcare (B.S.), with a concentration in children, and a minor in Education. The secondary coder is also a woman of minority status.

Rigor

The trustworthiness of results is the foundation of high-quality qualitative research which seeks to mitigate the interpretive bias of a single researcher (McAlister et al., 2017). For this reason, inter-rater reliability was used to minimize interpretive bias. Methodological rigor is dependent on how clearly procedures are outlined to allow for possible replication of the steps for future reproduction, keeping in mind potential differences. Grounded theory methods contribute to rigor because they inherently involve systematic procedures (Strauss and Corbin, 1990, 1998).
Internal validity was based on the credibility of the findings. To support the assessment of internal validity, the primary researcher clarified their biases and assumptions through reflexivity. Reflexivity aims to attain objectivity by considering possible effects from biases and how they may impact interactions with participants and the data. Reflexive notes reflect on one’s knowledge of a topic, one’s expectations, and any preconceived notions one may have to clarify any assumptions. Reflexive notes helped encourage the primary researcher to describe their own experiences with the phenomenon and “bracket” out their views before proceeding to understand the experiences of others with fresh eyes (Creswell & Poth, 2016). These notes were stored as an additional type of data. Other strategies used for validation include member checking, maintaining an audit trail, eliciting detailed descriptions during interviews, and undergoing a peer review of the data and research process.
Results

Themes

Themes derived from axial and selective coding are first described as separate units, including what each denotes and encompasses using illustrative quotes. Themes include belief systems, cultural context, mind-body, relational, normalize, treatment motivations, pathologizing, public awareness, and perception of patient perspectives. Following, themes are related to one another to lead the reader towards the conceptual framework created that represents the interactions underlying how clinicians use what they know to conceptualize sexual desire disorder and treatment (see Figure 2). Related concepts are discussed to understand how themes function together. All themes and interactions can be illustrated by the conceptual framework as each theme represents a separate element of the conceptual framework. Together these elements interact to inform linking themes that relate to sex therapists’ conceptualization of sexual desire disorder. This order of presentation is done to guide the reader towards the interrelationships between themes represented in the conceptual framework.

Belief Systems

Belief systems was an overarching theme that included anything identified as having to do with meaning-making, or how clinicians perceive and encourage clients to identify the meaning and intention behind sexual activity, particularly as it relates to how therapists’ perceived belief systems belonging to both clients and society and how they address client ideas related to sex. For example, this included efforts by clinicians to obtain an origin story, address faulty logic, elicit
ideas about emotional intimacy, connection and pleasure, or provide narrative therapy. The intention behind this combination was to bridge the gap between theory and practice and examine how these concepts shape clinical practices with sex therapists.

Clinicians’ perception of beliefs belonging to both clients and society impacts the perception of low sexual desire, ultimately dictating their treatment approach. A Pennsylvania-based therapist who infuses spirituality into their interventions sums up this idea of belief systems from their perspective grounded in client interaction: “What's the mental story - what do they tell themselves, what are the beliefs, what are the judgments, what's the mental commentary about their experience that they're currently in, you know what's the inner story?” In addition, a Florida based therapist with over ten years of experience in private practice who is currently researching desire through their Ph.D. explained:

“A big part of being a sex therapist is from an educator’s angle because basically people have all kinds of belief systems about sex that can be traced back to the family of origin, spirituality, what they learned from their friends, any trauma, [and] relationship experiences. So, they have a belief system about how things should be. And typically, women can be very hard on themselves.”

Another therapist expressed a similar perspective using a metaphor to illustrate “The fact of sex is it is about pleasure. It needs to be about pleasure and changing that mentality. The same as like food, food should be about enjoying good food not just shoving it in your face.” These quotes relate to the ways clinicians perceive how their clients think about themselves, sex and desire, and how those beliefs interact with their client’s experience of low desire. Clinician’s perception of client-held beliefs indicated that from their clinical experience faulty beliefs are often the reason for low desire as the presenting problem. Clinicians perceive their clients as having beliefs which
can contribute to their low sexual desire. As a result, clinicians obtain origin stories from clients’
and use their interpretations of these beliefs to guide narrative therapy interventions.

**Cultural Context**

Cultural context comprised any clinician ideas related to how culture interacts with the
conceptualization of desire, including gender politics and any mention of gender dynamics within
the understanding of desire. Illustrative responses included clinicians’ opinions that desire disorder
is genderless, perspectives of societal expectations and shame-based messaging in media, and
perceptions of the impact purity culture and hypersexual media have on the conceptualization of
desire. Like belief systems, cultural context was conceptualized as an overarching influence
connected to belief systems. For example, one clinician elaborated:

“So, at some point, in some level, certainly it's distressing to somebody if they live within
a culture where they are told in one way or another that it [sex] is important, or normal, or
necessary in order to feel sexy or ‘good enough’ so to speak. To want it, let alone to want
in a certain way.”

This speaks to the interaction between beliefs and culture. In addition, a feminist therapist spoke
about their perception of desire disorder as a societal reaction to a cultural problem and elaborated
with:

“We have to just change the narrative. And I think like the culture is moving in some ways,
like ethical porn and having different representations of sexuality. But, if most people are
getting their scripts about sex and sexuality through mainstream culture, there’s just like a
lot of work to do on that.”

From participants’ perspectives, the consequence of sexuality is largely informed by the
overarching culture and can be demonstrated by the distress their clients experience in response to
feeling abnormal. This is often considered within sex therapists’ conceptualization of low desire by recognizing that the loss of desire may not be a disorder and is likely attributed to impact of shame-based messaging that is embedded in media and mainstream culture.

**Perception of Patient Perspectives**

Perception of the patient perspective included clinicians’ observation of sexual desire as highly subjective in both perception and treatment, use of intuition and body language as an indication of progress in the treatment of low desire, and discernment of how clients decide to prioritize their sexual identity. Perception of patient perspective reflected how the patient’s perspective determines the treatment progression for low sexual desire from the clinician’s point of view. For example, this theme highlighted clinicians use of their subjective perception of client interactions to assess progress more so than formal instruments or hard data, and clinicians’ evaluation of their clients’ fraction of pleasurable activities in their life, both sexual and nonsexual.

Clinicians’ perception of their clients’ perspectives was particularly relevant in assessing treatment progress with low desire and was perceived as the primary determinant of treatment plan direction. For example, one therapist explained their perception of progress “So, you know the enjoyment. How are they feeling about it? Has anything changed in the way they think about it? What experiences are they having with their partner? Their attitudes about it? If it’s shifting from where we started.” Another participant noted “It’s all subjective, right? I mean, someone could be having sex every day, and then think they should want it more. And some people could have it once a month and think they want it more.” Both segments highlight how clinicians’ let clients take the lead on what constitutes success concerning their treatment goals associated with low sexual desire. Another clinician and MD reiterated the importance of communication with their
patients in order to understand their perspectives, “I truly believe in talking to your patients. Whether I use a formal scale or not, just a matter of talking to your patients.”

Participants also spoke about the role their clients’ perspectives play in their initial assessment of the reason for low sexual desire. A nurse midwife and sexuality counselor used the phrasing “pleasure quotient” to explain their perspective:

“No I have these young women who are coming in and who are sobbing because they feel like something's wrong with them and I'm like “What are you talking about? You have a two-year-old at home, you're working full time, you work opposite shifts with your husband, he has a chronic pain syndrome. There's nothing wrong with you other than the fact that your life is too busy, and your pleasure quotient is in the gutter.”

This quote demonstrates how clinicians assess their clients’ perspectives and their efforts to reinterpret what their clients perceive regarding their low sexual desire. Furthermore:

“Desire, women’s desire, is a very complex multilayer multifactorial issue in women's lives. And it starts up there [your mind] and it also is rooted in lifestyle. It's rooted in having a disciplined practice around intimacy. Which sounds incredibly unromantic, but the fact of the matter is that there is an element of that. People have to consider it valuable enough to make time for it.”

This quote references how this therapist understands “desire” and in what way it works, which relates to how clinicians interpret their patients’ perspectives. While clinicians do let their patients take the lead on formulating treatment goals, they still challenge their patients’ perspectives to expand on and consider other factors that may affect low desire. This all helps to demonstrate how the client’s perspective is incorporated within sex therapists’ conceptualization of treatment goals
for low desire by considering what the client hopes to achieve from treatment and how much of a priority their sexuality is to them.

**Mind-Body**

Mind-body consisted of clinician’s consideration of the mind-body connection to understand and assess the presenting problem and recommend treatment interventions related to low desire. For example, any reference to the biopsychosocial assessment process, sensory work, CBT strategies, anxiety, stress reduction techniques, and behavioral conditioning may fall under this category. Every transcript included acknowledgement of the relationship between mind and body within the conceptualization of sexual desire. For example, a participant informed by feminist theory explained:

“What is the purpose of sex, right? If we’re not trying for babies, then, even if we are trying for babies, it's pleasure. Pleasure looks like a million different things and it's not one thing. It doesn't have to end in orgasm, like you know just kind of re-teaching some of those things.”

This speaks to how therapists educate their clients about the mind-body interaction to address low sexual desire. This idea was reiterated from another point of view that incorporated psychoeducation as means to normalization:

“So, just kind of educating on different reasons that low desire can be there. The hormones, the medications, the trauma. You know, not feeling comfortable with our partner, not feeling comfortable around being a sexual being at all. Maybe we're not even into the gender that our partner is, maybe that's not who we're really sexually attracted to.”

Desire was also repeatedly framed as a conditioned response by several respondents. A sex therapist and academic professor shared their view of the assessment process in this way:
“So, when I begin to listen to faulty thinking or irrational thinking or a belief system that tells me that there is something in there saying that ‘Sex is bad.’ Shame, right? Pain. The brain, you know, we are hardwired to move towards pleasure and avoid pain.”

This quote suggests that faulty thinking is framed as emotional pain, which illuminates the idea cognitions affect the behaviors being expressed, a guiding principle in CBT, and how belief systems are associated with the mind-body relationship. Therapists use this information to help clients redefine their experience through their overarching belief systems and acknowledge low desire as something they can have acceptance and control over. Additionally, several clinicians discussed their use of interventions informed by narrative therapy and CBT techniques to shift client perspectives during the treatment process. For example, one participant mentioned:

“Right, so sometimes it’s idea based. But really, we’re working a lot of like reprogramming that this is like a positive experience in a trauma informed lens. You are in control and consent is number one and consent has to be enthusiastic. Negotiating consent and teaching people how to like - I think it's really important that I try to work with my clients early on like how to say ‘No.’ Or how to pause or stop a sexual encounter once it's started if they don't want to continue. Because often their bodies will just kind of freeze and try to get through it because they're worried about the consequences. So, practicing ahead of time scripts.”

This speaks to clinicians’ practice of empowering their clients in the present and helping them to prepare for empowerment in future encounters. Clinicians also spoke about the role of anxiety in the perception of a desire problem. One interviewee, a Florida based sex therapist and academic professor, said:
“They have great anxiety. You know, when somebody comes up and starts rubbing their shoulders, and they’re like ‘Oh no you want to have sex,’ there’s not that ease of being in their own space. And so, there are a lot of anxiety reduction strategies which are very CBT and psychotherapeutic…. Like, you’re coming to me as a sex therapist, and I am going to tell you to stop having sex immediately. Because whatever you are doing is contributing to increased anxiety, increased performance issues, increased stress, increased feelings of hopelessness or worthlessness. And so, let’s stop what we are doing and figure out what each party can do to release the pressure valve and release the anxiety that’s associated with not feeling good about [sex].”

These transcript segments illustrate how therapists perceive the ways belief systems are embodied by individuals and speaks to clinicians’ efforts to address the mind through body-based techniques, and the body through mindfulness techniques. Clinicians indicated consideration for physical components of desire, including interactions from medications, fatigue, stress, endocrine and hormonal complexities, and pelvic floor trauma. One clinician, a sex counselor and educator, nurse-midwife, and a medical provider with experience working at Planned Parenthood shared their perspective:

“And then I can say this to you as a medical provider, then what we do is we put women on hormonal methods of birth control. Which then override ovarian function, interrupt any mammalian biological sex drive they may have mid cycle, and then say, “Oh you have hypoactive sexual desire disorder.”

Another therapist, a cancer survivor and diabetic, explained from their point of view:

“So, if it’s caused by hormonal issues, if it’s caused by medical menopause, or perimenopause, or any kind of other gynecological disorder - that is medical - versus post-
Sex therapists indicated that considering physical factors helps guide their treatment plans related to low sexual desire as the presenting problem. The ways clinicians help their clients is reflected by the perspective of one feminist-oriented therapist who described how they are “helping people to create new environments so they can experience themselves in a different way where those previous unhelpful mental scripts are interrupted.” This demonstrates the influence of belief systems on mind-body interactions and relates to self-efficacy by encouraging clients to build upon their pleasure individually. Therapists explained this could be achieved through interventions involving sensory work and exploring different context settings such as specific lighting, music, smells, etc. Mindfulness-based stress reduction was frequently recommended in conjunction with any treatment intervention. As one sex therapist shared their opinion:

“Mindfulness-based stress reduction is an absolute must, in my opinion, for all clients. Because if we're talking about habit change, be it neurological or behavioral - which what's the difference - but if we're asking someone to have the habit change then we've got to have the brain in optimal condition to be able to create new habits.”

The inability to be in the present moment is correlated with one’s inability to experience pleasure and desire, from sex therapists’ perspectives. Clinicians highlighted their use of mindfulness-based interventions to help counteract this. One feminist therapist explained their perspective on the conditioning of mind and body:
“I use a lot of mindfulness-based interventions. So, helping people get out of their head and into their body. I talk a lot about the nervous system, the parasympathetic nervous system and helping people just come back home.”

Clinicians represented in this study use mindfulness-based interventions to rewire their client’s faulty belief systems related to sex.

**Relational**

Relational comprised interpersonal factors such as relationships, communication, and self-efficacy demonstrated by how clinicians speak to or encourage an internal locus of control among their clientele. Relationships and communication were combined as they are inherently connected from the perspectives of clinicians who understand one’s relationship with themselves and others as interrelated. For example, this included clinicians’ references to a client’s relationship with themselves, their partner and/or their higher power; any mention of treatment interventions directed at having clients explore their own bodies and erotic language; and clinicians’ perceptions of their client’s sexual intentionality, including ideas related to manufacturing desire, expanding on pleasure, and exploring kinks and different context settings. Relational factors also related to an individual’s relationship with themselves, including their self-talk, which clinicians frequently emphasized as part of their treatment process for low sexual desire.

How a client communicates with others and the dynamics of their relationships are used in consideration to determine appropriate treatment interventions. For instance, one clinician spoke about teaching client’s assertiveness training not just in the context of their personal relationships, but also with in communication with their healthcare providers where openness to discuss sex was not present in the past. Building a client’s ability to address physically based influences of sexual desire with their healthcare providers is a treatment intervention used by sex therapists to address
low desire. A male therapist shared his perception of guiding clients to have these types of conversations and explained, “A lot of clients I’ve had have not talked to their OBG. So, then I have to kind of be the one to say, “OK well this is something we need to bring up and how do we do that?”

Another recurring concept was the need to address the dynamics between individuals in their romantic relationships. For example, one clinician explained their perspective of sexual communication training and interventions as “Really getting their sexual language beyond ‘Do you want to have sex?’ Like the playfulness, the exploration, the ‘What is the purpose of sex,’ right?” Partner dynamics were frequently reported to revolve around the concepts of imbalance and communication. Imbalance relates to desire discrepancies when one partner has a higher sexual drive than the other; thus, there is a discrepancy within the relationship of how much sex is preferred. Every interviewee acknowledged the need to determine if a client’s reported low sexual desire is specific to the client’s relationship or generalized. As one sex therapist from Florida explained:

“First, we're going to assess is it situational or generalized. So, is it situational meaning the person that they happen to be partnered with married to or whatever, if they're in a monogamist relationship. They may not have interest in that person for a whole myriad of reasons. OK? If it's generalized, they will report that they don't have any interest or sort of any kind of response point to anybody.”

When an imbalance is present in a coupled relationship, clinician perspectives indicated that communication training is the primary treatment intervention used. A doctoral candidate with over ten years in sex therapy practice explained, “If your partner wants one thing and you want something else, how do you compensate/negotiate on that? Because there’s always somebody with
a different level of desire.” Another interviewee involved in academia noted, “We're normalizing some of that and talking about negotiating on something that they can both feel good about. Finding a way to make them an intimate team, versus his way versus her way.” Additionally, a feminist-oriented therapist explained their perspective of their client’s reactions to a desire discrepancy:

“It's a couple level issue where there's a desire discrepancy and one partner is kind of like ‘I’m dissatisfied’ and the other partner recognizes that. And sometimes they come in out of pressure from the partner, and sometimes they come in out of their own perception of what the partner is experiencing.”

Similarly, other clinicians mentioned:

“Many, many times their partner is making them feel like there is something very wrong and they need to go and get it fixed. So, they come to my office talking about that.”

Another respondent concurred, saying:

“Often its interesting because a woman who doesn’t want isn’t generally in touch with her desire for any number of reasons and may not be able to say its distressing in general. Like she might be if it wasn’t a problem for her husband, she might be perfectly fine with that fact that she doesn’t have desire, so the distress is often coming in the relational aspect.”

The segments above all speak to how clinicians consider different relational dynamics when conceptualizing assessment and treatment for low sexual desire. Therapists’ perspectives also indicated that self-efficacy is understood as one’s relationship with themselves and rooted in the idea that the foundation of desire is based on an intentional practice around intimacy. For instance, one lesbian-identifying clinician spoke about what they called “sensual atrophy” and explained, “I do a life assessment and what I'm looking for is there anything in this description of this life that
sexy. Is there any room for sensuality and how sensually atrophic is this individual?” This points to a relationship between how much general pleasure exists in an individual’s daily lifestyle and their disinterest in being sexually intimate. Simultaneously, clinicians reflected interventions to intentionally encourage clients to explore themselves to expand on their pleasure. One feminist participant mentioned what they referenced as “the universal turn on theory” and explained it is “where people can be turned on to all kinds of things and places and people. And so, incorporating the idea of there's a whole universe of erotic turn-ons.” Another interviewee with more of a medical focus in their practice shared a similar perception:

“I talk about pleasure everywhere so having them do the things to work on what they do find pleasurable. For individuals, working on what makes you happy every day and then how to expand that because again I think a lot of people aren’t working with their pleasure.”

In addition, other clinicians expressed the intention to encourage client self-exploration to guide the individual to learn what is pleasurable to them, and this connects with a point highlighted here: “If there is not full pleasure experienced in the sexual activity that’s shared, perhaps there’s less drive for that behavior. So, the more pleasure that can be had in the experience, the more drive to have that experience again.” Universal turn-ons and similar terms were used by respondents to work with their patients on broadening what is considered pleasurable and experiencing more pleasure through an internal locus of control. This demonstrates how clinicians target clients’ relationships with themselves through interventions.

Sexual desire, arousal and response were inextricably linked to connections with others and with self by the clinicians in this study, and sexual activity was frequently referenced as something more than just a physical act. For example, one participant shared “If it’s a partnership, we work on emotional intimacy before even getting to the physical intimacy, making sure
everybody is feeling safe, and that obviously that there is good consent involved.” Additionally, sensate focus, a common sex therapy technique used to establish emotional safety before physical intimacy, was outlined as “a mindfulness-based technique but also a communication activity.” One participant explained their perspective that “Once the desire is back, treatment transitions away from the disorder piece and more into communication,” reinforcing the relationship between communication, emotional connection, and sexual intimacy.

**Normalize**

Normalize represented anything clinicians do to normalize and validate client experiences including trauma-informed practices that emphasize safety, collaboration, empowerment, and transparency. This included any assessment of trauma, obtaining consent and permission throughout the counseling process, and specific interventions such as psychoeducation and reality testing. For example, one clinician explained the importance of “permission-giving” and “normalizing that this [sex] is something we're talking about, and you know kind of thanking them for sharing it.” Clinicians spoke about their efforts to normalize client experiences during the treatment process for low sexual desire. For instance, one therapist and professor shared their perspective of their treatment process:

“Basically, people have all kinds of belief systems about sex that can be traced back to family of origin, spirituality, what they learned from their friends, trauma, and relationship experiences. And what I like to do as a sex therapist is to normalize things. First of all, that there is no normal. There is this natural thing, you know it is different for everybody and there is not one blueprint for every single person. And so, the resources that I give them might be things that help them explore topics at their own pace. It’s challenging to come in and talk about … By providing literature, it’s another opportunity for them to get to
know what other women are experiencing and pick up the appropriate language. Because you’ve got 60 minutes with someone, so in between sessions it’s nice if they have the chance to do some research. And I find that … when women learn about how many other women are experiencing this and why, it normalizes it. They don’t feel broken. They know that there are opportunities to make some changes.”

This helps to describe how therapists’ intentions to normalize client experiences are demonstrated in the form of treatment interventions and illustrates the influence of overarching belief systems. Clinicians encourage client beliefs to reflect an internal locus of control and use psychoeducation to reframe beliefs. A clinician in a unique position as a medical doctor (MD) and AASECT sexuality counselor, demonstrated normalization through their decision to sell vibrators in their office and wear a portable one around their stethoscope while doing patient rounds.

“I have some vibrators in the office and like there's just an age of women who have never in their lives realized that [they could use vibrators], like they would never think about it. And you know I introduce them ‘You know have you ever thought of a vibrator or introducing a vibrator into the relationship?’ and they look at me and I’m like ‘Let me go get one – let me show you.’ And it's because I’m their age and I introduced them to it, it becomes OK. Because they go like ‘I would never go and buy one online I don’t know looking at.’ But I introduce them to a few when they go ‘OK I'll try that one.’ And you know just because of the fact that I've given them permission, is all they need. You know to basically kind of spark things a little bit. And you know you give them permission it’s like, “You're allowed to be sexual.”

Another therapist and professor shared their perspective of their treatment process that reflects trauma informed methodology:
“And the relationship is always going to be my primary. You can’t do any work in any sort of therapy in any modality if you don’t have that unconditional positive regard, that amazing rapport where they feel safe, they feel cared for, understood, valued, affirmed.”

This highlights the need to establish safety in the therapeutic relationship before using any other treatment intervention.

**Treatment Motivation**

Treatment motivation represented how clinicians perceive and describe why or how people have come to them for help related to low sexual desire. This included clinicians’ perception of their client’s motivation due to partner pressure or self-diagnosis, how they receive referrals from other providers, and how they assess clinically significant distress. Often treatment motivations play a role in the clinician’s assessment of the presenting problem. A segment expressed by a MD and sexuality counselor exemplified this idea:

“I think more and more people come in to talk… with the thought that I am going to diagnose it or just give them the medication. Because of the fact of being a physician I have the ability to treat and give medication.”

Several participants alluded to clients desiring a diagnosis and quick fix as a primary motivator in seeking treatment. For example, one participant, a nurse-midwife and counselor explained:

“Well in same cases it [a diagnosis] gives me something to fall back on with certain patients who speak that language. I mean there some people that want a diagnosis, they want medication, they want something to attach their problem to. And so, if you classify it as an ICD-10 diagnostic category its somehow an anti-inflammatory for some patients.”

Another therapist explained, “People want change, but that doesn’t mean they are ready for change, or they are ready to do the work that it takes to create a change in what is happening.” This can
help explain any resistance towards building an internal locus of control on the part of patients. For instance, there were several mentions of clinicians’ perceptions of client resistance to the intervention of scheduling sex. One therapist shared their experience “I promote scheduling sex or making it a priority, and they’ll fight with me.” All of this demonstrates the ways that clinicians perceive a client’s motivation for seeking treatment and how that influences their treatment recommendations.

**Pathologizing**

Pathologizing comprised how clinicians perceive the disorder as stigmatizing and non-inclusive, sexual morality, any reference to sex being a difficult topic to discuss due to its taboo nature, and the principle of parsimony. Pathologizing represents the misunderstanding desire due to stigma and taboo and included clinicians’ perception that it may be challenging to come to a sex therapist for help because of shame, description of the ways clients and overarching belief systems allude sex is deviant, criticism of the diagnostic criteria female sexual desire disorder, or feedback that low desire may fit more appropriately under a different diagnosis or an underlying issue. This frequently came up in the context of the difficulty associated with coming to see a sex therapist. For instance, one therapist in academia mentioned:

“It’s challenging to come in and talk about. By the time someone’s in my office they’ve gone through really challenging times because now they are going to come to talk to a stranger about one of the most intimate and private things they’ve ever experienced possibly.”

And another therapist based in Georgia explained their perspective about help-seeking in this way:
“Just the fact that you got on the Internet and look for somebody to talk to your sex life out loud to and you just didn’t talk to your girlfriend, or read a book or a blog, or watch a YouTube video on it. Like people don’t get to me because they’re not in distress.”

Both respondents spoke to the impression that clinicians recognize stigma related to sex is embedded within our culture and how that places a lot of pressure on the individual experiencing low sexual desire to feel as though what they are experiencing is abnormal.

**Public Awareness**

Public awareness comprised clinicians’ references to their perception of public awareness/lack thereof as related to desire disorder and sexual health, any noticed or perceived changes in how sex is conceptualized within society, and any mention of receiving/sending referrals and building referral networks. Public awareness included reference to fluctuations in awareness regarding sexual health and sex therapy and clinicians’ perception of a sexual liberation happening within society, indicated by female empowerment and generational differences. These concepts were grouped to reflect how they all speak to a similar idea of increasing public knowledge about sex therapy and sexual health.

Public awareness highlights clinicians’ perception of public knowledge related to sexual health and how that has changed over time. For example, one therapist pursuing their Ph.D. shared their perspective on the future direction of sexual health “You know my hope is, part of why I am a sex therapist, is I want to create a much more sexually positive world. You know, where we can have conversations about this, that it’s not taboo.” This reflects therapists’ beliefs that sex should be something that can be talked about, yet frequently is not, as indicated by the experiences reflected by their clientele. One therapist with a particular focus on linkage to care explained, “I try to do like a social work approach to it. Because I feel like when people come to us especially,
they're so vulnerable and we have them possibly [for] very short periods of time.” This demonstrates how therapists try to increase awareness of sexual health and take a preventative approach to female sexual desire disorder. Another therapist in academia mentioned their perspective, which illustrates shifts in public awareness:

“You know as things shift in our world [there are] more opportunities to choose things other than maybe vanilla sex and monogamy sex. There's a lot more choices. So, it seems realistic that …. the attitudes and values that many younger people will carry about sexuality allows them a little bit more choice perhaps.”

This shift in public awareness is represented in sex therapists’ willingness to consider a broader spectrum of sexual choices available today and how those choices might relate to an individual’s desire, specifically those with low sexual desire. Additionally, a therapist with an ethnic minority background emphasized their perception of this shift:

“So, the wonderful thing about our culture today is mental health is popular again. And so, younger generations are more apt to say you need to talk to somebody about that, this is a problem, you should be talking to somebody about that, you need to get professional help.

And so, my younger clients will actually make sex therapy their first stop.”

These reflections from the clinicians’ interviewed in this study reiterate that the public awareness of sexual health has been insufficient in the past and continues to change with generational shifts. This shift plays a role in how sex therapists address low sexual desire, including advocation for wider options in sexuality and for sex therapy.

**Conceptual Framework for Linking Themes**

The conceptual framework presented in Figure 2 corresponds with the guiding research questions investigating sex therapists’ attitudes and perspectives regarding female sexual desire
disorder and how those attitudes and perspectives shape their conceptualization of low desire in women seeking care for a perceived or possible desire disorder. This framework focuses on symptoms of low desire rather than female sexual desire disorder, given the discussion on the part of study participants regarding their conceptualization of and treatment recommendations for low sexual desire. Through all phases of the treatment process, clinicians continually referenced their attention to client’s belief systems and how these are positioned within the overarching cultural context. Therapists’ conceptualization of low sexual desire was informed by their perception of a bidirectional relationship between their client’s belief systems and how those beliefs are informed by their cultural context and vice versa. Clinicians’ perspectives indicate they understand belief systems and cultural context as working together to influence a clients’ mind-body interaction, personal relations, experience of normalization and pathologizing attitudes, treatment motivations, and awareness of sexual health. This illustrates the observed influence that belief systems and cultural context have on the factors pertinent to a clinician’s perception of their patient’s perspective of low sexual desire. The following discussion aims to interrelate elements of the conceptual framework to demonstrate how they function together from sex therapists’ perspectives regarding low sexual desire in women. This is done by using sub-themes to illustrate some of the issues that inform the dynamics between the elements in the conceptual model.
Belief Systems & Cultural Context

Belief systems and cultural context influenced therapists’ perception of their clients’ interpersonal dynamics, mind-body relationship, and the level of normalization and awareness provided by their education and experiences. All these factors interact with one another to inform
clinicians’ perception of a client’s experience with detecting a desire concern, seeking treatment, and the process of providing professional support as a sex therapist. As one therapist and professor explained:

“I think there are a myriad of issues that are psychological, behavioral, and emotional. You know there are people dealing with all sorts of issues. In terms of the pandemic there are sociological issues, there are relational issues. And I think it is so multi layered and multifaceted. There is not one way to treat nor is there ever one issue that contributes to it, ever. That I have ever seen.”

As illustrated in Figure 2, clinicians consider how belief systems and cultural context influence one’s perception of their mind-body connection, relational factors, and normalization of sexual experiences. One participant exemplified this bidirectional relationship between belief systems and cultural context: “People have all kinds of belief systems about sex that can be traced back to the family of origin, spirituality, what they learned from their friends, any trauma, and relationship experiences.” This helps to inform the following discussion which details some of the issues that were found to inform the dynamics between belief systems and cultural context within the conceptual model.

**Cultural Pressure & Power Dynamics.** Pressure was a concept that was reiterated by clinicians’ perspectives of their client’s experiences as informed by the overarching cultural context. Pressure was alluded to within the data in several ways. As aforementioned, there was a recurring theme of partner pressure influencing the client’s decision to seek help. This links back to the cultural dynamics at play. A feminist-oriented interviewee spoke extensively about this and explained, “My role is to help clients address oppressive patriarchal ideas about sex and sex roles and understand what female pleasure really looks like.” This illustrates clinicians’ perception that
a client’s experienced pressure associated with sexual desire stems from the cultural context with which they interact with. This same participant continued to explain “In the past we were more likely to see the problem resided in the individual, and now we're starting to see that the problem is more of a reactive response to a cultural problem.” This speaks to the pressure to have sexual desire and perform “normally” as informed by cultural context and the importance of sex and sex appeal. Another participant explained their perspective relating to gender dynamics within a cultural context and how both impact client’s belief systems:

“We as women, we are, we have been conditioned generationally to be taking care of other people. And so, it can be counter to many women for them to turn their eyes on themselves and say I am going to take care of myself.”

The pressure underlying sex can also be connected to culture via the concept of obligation. To explain, one male participant highlighted their perception of the vague distinction regarding feeling obligated to have sex:

“And I like to try to instill that like there's a difference between being obligated to having sex with your partner, and not really being in the mood but willing to get in the mood. Trying to differentiate those and get away from the obligation piece. Because, that's just so prevalent but also so unhealthy. Because then your sexuality is not your own it's your partners.”

Obligation returns to the idea of heterosexual dynamics and how women feel the pressure to perform. Clinicians reverberated this underneath their perception of the client assumption “his pleasure comes first, and it is their job” and:
“Sometimes they get these messages that well sex isn’t for them anyway, it's there for their male partner. You know, their job. And I'm like, no, that's not the case. So, there's a lot of education around that, almost unlearning the things they have learned in the past.”

These masculine/feminine dynamics exist in any type of relationship, not exclusively heterosexual ones, as explained by one clinician:

“So, there's a sense that women need to feel connected in order to want sex, and men need to have sex in order to feel connected. And so, then we're always missing each other. So, if we can help couples, obviously that's stereotypical heterosexual, but we also see the masculine feminine dynamic in any type of partnership.”

In relationships where one partner is made to feel obligated to have sex, or a desire discrepancy is present, this can cause a power imbalance within the relationship. For instance, one therapist in academia explained their perception of this:

“The low desire partner carries quite a bit the power in the decision making over if/when, you know at least for partnered sex and intimacy if/when. And well we have to explore all kinds of relational dynamics if they're partnered.”

These quotes demonstrate the ways power dynamics can shift and are perceived differently by clinicians with different orientations (e.g., training, biases, experiences, etc.) and while power dynamics and conflict were identified, this is a process that requires an individualized approach for each case. Frequently, clinicians explained their use of treatment interventions directed at assertiveness training and teaching women how to ask for what they want. These interventions help to neutralize any power dynamics through clear communication. As aforementioned, some participants connected this with the generational conditioning of women that encourages them to
take care of other people and in what way that influences their hesitation to speak up. One clinician who was newer to the sex therapy field expressed their perspective:

“And a lot of women, at least here in Pittsburgh PA, are so afraid to express what they want and what they need. Or tell their partner, if this is a heterosexual partnership, that they don't like something that they're doing.”

**Extreme Culture Informing Belief Systems.** Culture was described by participants as falling within the context of two extremes, purity culture and hypersexual culture. As one therapist shared:

“In the grand scheme of things, you can't live in this society where sex is so sexualized and honored and worshiped in the way that it is, without some type of feeling outed or ostracized if you're not part of this image.”

This relates to the interaction of hypersexual media and culture with one’s belief systems. On the flip side, purity culture can play an equally significant role regarding shame-based belief systems as another feminist therapist explained, “A lot of those folks have like Christian background and that purity culture. And what's interesting is like now we're starting to see the consequences of like 20 years of funded purity culture sex education.” This can be framed as a response to learning a religious or social dogma taught to the individual and helps demonstrate the relationship between beliefs and cultural context. Cultural context often informs the education one receives, whether it is sex education or religious education, and this can impact the clients’ perception of low sexual desire. Clinicians disclosed the importance of addressing and repairing some of this previous learning that includes shame-based messaging, as illustrated by the interaction between cultural context, belief systems, and patient perspectives in the conceptual framework. To exemplify this, one interviewee shared:
“What's their relationship with a higher power if they still believe in one. Do they still fear judgment, or fear the wrath of God so to speak? And what is with pleasure outside of procreation particularly? So, what's that dynamic, what's the dogma, what's the paradigm? And a little bit of that goes into the mind as far as the beliefs and the judgments.”

**Relational & Mind-Body**

Clinicians frequently considered one’s mind-body relationship as indication of a client’s level of self-care and attitude towards themselves, which often influences recommended treatment interventions. One participant explained how they frequently ask, “Is there any room for sensuality and how sensually atrophic is this individual?” when assessing clients to develop a treatment plan. One way to assess attachment to pleasure, and ultimately attachment to life, is to look at a person’s relationship with themselves. Several participants connected the idea that this can often be indicated by physical exercise. For example, a nurse-midwife and counselor explained:

“It’s not just how you feel about your body/body image, but it’s do you move in it? I believe that being physically involved with yourself is the cornerstone of self-care. And I feel as though it gives me an indicator as to people’s attachment to life and to pleasure.”

Another interviewee reflected this concept from their perspective:

“I think the desire it’s non congruent a lot. Like women want to have desire, but they’re too, and I’m saying this in general, but they’re too anxious to be self-centered enough to have desire in the moments they need it. They’ll have desire for things like fudge brownies or something, right? But not allow that space to have desire for sex. And then if we have been taught it [sex education], we shouldn’t do it.”

This speaks to the underlying belief that clinicians perceive a woman’s relationship with themselves, or their body, as informed by the education they received, and how this steers their
treatment approach with clients. For example, through the use of psychoeducation and promotion of self-efficacy. Self-efficacy was often perceived to be related to sexual desire through clinicians’ emphasis on encouraging their clients to take control of their sexuality through intentional efforts to explore their body through movement and pleasure. Additionally, another participant referenced movement therapy as another helpful mind-body intervention that helps “them get off of the chair or off of the couch, which can keep people in their heads and keep their people in their minds.”

Pathologizing & Public Awareness

Therapists made a notable link between pathologizing beliefs and public awareness, and participants frequently mentioned the consequences of this interaction as observed in their patients. One therapist responded to a question on the preliminary questionnaire that investigated how they decided to pursue sex therapy as a profession:

“I noticed more and more people coming in with shame and guilt about desires and gender questions. I realized that I didn’t even feel comfortable talking about sexual intimacy with my best friends. I felt this was because we were taught to feel like it is “too private” or never even taught to have open dialogue about it.”

In this case, a lack of awareness regarding sex therapy was identified not only within the general public, but within the healthcare community as well. This expressed itself in several ways. First, participants commented on their perspectives regarding physicians’ knowledge base of sexually related issues. One interviewee explained, “Low desire is often based in the history of a physiological issue which physicians are not aware of and not trained in. Therefore, they diagnose it as a mental health disorder.” Second, interviewees drew attention to their perception that many providers avoid mentioning sex as reported to them by their clientele. This indicates a perceived lack of openness or comfort regarding discussing sex-related topics given it is seldom mentioned.
by healthcare providers as reported to therapists by their clients. For example, one therapist explained their experience with clients:

“I find out that you know nobody's asking them about their sex, like their sexual relationship with their partner, in any other setting. Even gynecologically speaking, other than ‘Do you worry that you have an STD?’ Like that's the extent that some of my clients are getting elsewhere. So, I think once they see sex therapist that they're like ‘OK, well maybe I can talk to this person?’ You know, so then advocating for them to be able to go to their medical doctors sometimes takes a while because they've not received that openness prior.”

Third, participants drew a connection between the lack of training for sexual-related issues among couples and individual therapists, which leads to sex therapy referrals that further perpetuate a sexual stigma. For instance, a male clinician explained, “I’ve had some come to me from other therapists, and basically it gets to a point where the therapist is like ‘OK, you need to talk to a sex therapist because I can't go any further with this’ you know.” Additionally, another younger therapist shared this perspective:

“I tend to be not their first stop with therapy, but their first stop addressing this. So, what happens is they will be in couples counseling or even individual counseling, and this will come up and their therapist would be like ‘I don't do that.’ Which is like further reinforcing this stigma that this is something separate.”

Many respondents also indicated putting forth intentional effort towards counteracting the lack of awareness associated with the sex therapy field. For example, several clinicians’ spoke about collaborating with providers of varied specialties within their geographic area. They advocated for a two-fold approach which included 1) educating providers about their sex therapy practice and
how to make appropriate referrals and 2) learning about other specialties, including how they can assist with addressing sexual concerns for referrals. A frequently mentioned provider was pelvic floor specialists. For example, a medically and spiritually focused clinician explained:

“I think what happens though, unfortunately, is sex therapist and pelvic floor physical therapist's they're just not widely known. … So, I take a ton of time [to spread the word about sex therapy]. I trained the psychiatrist locally, I trained other docs locally, just to put sex therapy constantly in their ear about it being an option. Because I think that's more of the issue, we should be the first stop or one of the first stops, but we're not because they don't even know we exist.”

This was reiterated by another therapist who shared:

“My supervision group met with the group of pelvic floor therapists in the area. So, we met them talk to them about what they do and how to refer. So, I can talk to my client about what that process is going to look like.”

This all helps demonstrate clinicians’ efforts to counteract the gaps in public awareness about the value of sex therapy and education as identified through their clinical experiences with clients or within their local provider community, and how these efforts are relevant to their conceptualization of low desire.

This extended discussion of the important relationships between framework elements further illuminates the ways that sex therapists perceive the symptoms of low desire and attribute their clients experienced low desire to factors outside of female sexual desire disorder. This may include their beliefs, culture, relationships, and education. Results indicate that sex therapists rely on their perception of patient perspectives to frame the presenting problem, treatment plan, and goals related to their clients’ experience of low sexual desire. Their conceptualization is heavily
influenced by a bidirectional relationship between an individual’s cultural context and belief systems, and how the impact of this relationship on their client is perceived informs clinicians recommended treatment process. This bidirectional relationship is demonstrated by how belief systems may be influenced by cultural context, and how cultural context may be informed by predominant belief systems. Moreover, the interaction of framework elements illuminates low sexual desire as a complex multifactorial concept that requires an individualized approach to conceptualization and treatment.

The presented framework can be used by clinicians to ensure all considerations have been made before providing treatment recommendations and help guide their conceptualization of the presenting desire-related problem. There are differences in treatment approaches for low sexual desire based on the perceived underlying cause; thus, this framework developed from results is significant and may be useful in guiding clinicians to consider what treatment approaches are appropriate for the symptom of low desire. For example, a clinician treating someone experiencing low sexual desire caused by relational issues may recommend couples counseling, whereas someone experiencing low desire due to anxiety, a conditioned mind-body response, may be recommended mindfulness-based stress reduction techniques and CBT.
Discussion

This research study addresses a gap in the literature by presenting sex therapists’ perspectives regarding female sexual desire disorder and the symptomology of low sexual desire. Overall, the findings suggest that clinicians recognize cultural context and belief systems as working together to shape their understanding of patient perspectives relevant to low sexual desire, and clinicians use this conceptualization to shape their treatment decisions. The views highlighted in this research belong to a select group of therapists that have been trained in a particular way. Although this research intended to focus on sex therapists’ conceptualization of the diagnostic classification of female sexual desire disorder, results relate more to the presentation of symptoms rather than diagnostic elements of low sexual desire. Clinicians shared their perspectives on the issues they understood as shaping their patients’ identification of a possible desire disorder or related concern. Sex therapists’ use the various elements represented within the conceptual framework to comprehend low sexual desire issues and how to treat them.

Results support and expand upon concepts that have been highlighted in the extant literature and can be used to guide future research. The meaning, importance, and relevance of results are discussed below as they relate to the guiding research questions and literature review exploring attitudes and perspectives regarding female sexual desire and how these shape the conceptualization of low desire. Findings that echo preexisting literature include the need for inclusive and comprehensive sex-positive education to provide accurate information about sex and respect for diverse populations. Implications for future practices and research include investigating what evidence-based criteria sex therapists use to help frame a presenting problem and if
conceptualization varies by a function of the training received. Furthermore, key areas of focus were found linking shame and emotional connection to sexual intimacy, which may have implications for future research and practice. Key areas discussing implications of study results are discussed below.

**Key Areas of Focus**

**Diagnostics vs. Symptomatology**

Although the primary investigator aimed to collect data about sex therapists’ conceptualization of female sexual desire disorder, the responses obtained during interviewing reflected their conceptualization of low sexual desire as a symptom. In the glossary at the start of this paper it was stated that “low sexual desire is the most common form of female sexual desire disorder” (Lehmiller, 2018). Although low sexual desire is not just a symptom, the clinicians represented in this study did not indicate using diagnostic criteria – which is established – to discuss how they approach female sexual desire disorder and low sexual desire in practice. Instead, these clinicians discussed how they used a “more holistic” approach that considers not just the symptoms, but any underlying issues that are socially constructed and may contribute to a woman’s experience of female sexual desire disorder/low sexual desire. From the perspectives collected in this research, clinicians spoke of their conceptualization of low sexual desire being based primarily on the presentation of symptoms and perceived distress. The clinicians’ represented in this study may be guided more by definitions of sexual health than they are by pathology of diagnostic criteria, which from their perspectives pathologize conditions that could be socially constructed. This is noteworthy and may be due in part to their specific training and evolving societal mores about sex including a wider spectrum of gender and sexual identities. Reflecting on the existing literature, a study exploring sexual health attitudes considered seven dimensions of sexual health
(emotional fulfillment, social connectedness, spirituality, overall pleasure, physical intimacy, mental fulfillment, reciprocal benefits) abstracted from existing global definitions of sexual health from The World Health Organization, The Centers for Disease Control and Prevention/Health Services Research Administration and the U.S. Surgeon-General (Hogben et al., 2019). These dimensions of sexual health closely correlate with the considerations made by sex therapists addressing low sexual desire. Questions remain as to how sex therapists use evidence-based diagnostic criteria to help frame the presenting problem regardless of if they assign a diagnosis.

Specific Training Informing Conceptualization. There are two lines of thought regarding the view of sex therapists’: 1) The field of sex therapy is inconsistent in the training and approaches to treatment by providers; 2) Sex therapists are one of the few healthcare professionals who are willing to address sex in a clinical setting. These opposing views are discussed below.

Given the consistency among participants in their resistance to diagnostic categories due to the opinion that diagnoses pathologize patients, one must question if this commonality among perspectives is a result of the clinicians represented receiving similar training. As aforementioned, most participants included in the sample received training through AASECT as either a therapist or counselor. The three participants who did not go through AASECT received accreditation through a different oversight process, however, they shared similar perspectives to the rest of the sample. AASECT requirements for training in sex therapy typically includes a minimum requirement of 90 hours of academic coursework in sexuality education from an accredited university and a minimum of 60 hours of training in how to effectively do sex therapy with patients whose diagnoses include the ‘Psychosexual Disorders’ described in the DSM-5. This training may be achieved through attending specific sex therapy training programs, AASECT workshops, or taking graduate-level academic courses that are specific to sex therapy techniques; thus, variability
exists in the types of training clinicians acquire to work towards certification (American Association of Sexuality Educators Counselors and Therapists [AASECT], n.d.). However, the perspectives represented in this study were relatively consistent in their understanding of low sexual desire, so it is plausible that training is consistent despite the perceived potential for variability. Zeglin et al. (2021) did a descriptive analysis of the training of clinicians who do sex therapy and found that 25% of sex therapists across the country are certified and 32% have zero graduate training in sex therapy. This has potential implications for the quality of care received by sex therapy clients (Zeglin et al., 2021) and may influence how clinicians’ approach low sexual desire in patients.

The studies above speak to the implications little awareness and regulation have on the field of sex therapy, making it unclear to what extent clinicians who advertise as providing “sex therapy” have the training to provide that service competently and ethically. Clinicians shared their beliefs relating to a lack of general awareness regarding sexual health and sex therapy and the consequences that has on their clients and society. For example, one participant mentioned the problem with falsely advertised faith-based therapists and the potential to harm misled clients in a vulnerable state. Binik & Meana (2009) wrote an article critiquing the sex therapy field for similar reasons. One apprehension they expressed was that specialization without standardization raises ethical concerns and explained that AASECT and SSTAR were created to regulate and increase professional standards of sex therapy (Binik & Meana, 2009). They argue that on one end specialization can breed expertise; however, on the other end it can breed a relinquishing of responsibility from non-specialists and tunnel vision for specialists (Binik & Meana, 2009). As a participant in the present study mentioned, receiving referrals from individual therapists can be stigmatizing for clients because it communicates to them that it’s not something their therapist is
comfortable discussing. This was echoed in Binik and Meana’s (2009) article, which explained that many health professionals immediately refer to a sex therapist when issues of sexuality are raised, communicating the notion that sexual dysfunction is different from every other kind of mental health problem and a specialist is required.

Research has shown many healthcare professionals are not comfortable addressing sex-related concerns, whereas sex therapists are willing and trained to do so. Although it is recommended that health care providers address sexual health with aging women at clinical visits (Woloski-Wruble et al., 2010), research highlights that some providers struggle with communication about sexual health, especially across gender, age, and cultural differences (Burd, Nevadunsky & Bachmann, 2005; Gott et al., 2004; and Gott & Hinchliff, 2003). Additionally, there is no universal standard for how sexuality should be taught in medical school or any requirements that it be taught at all and about half of U.S. medical schools mandate formal instruction in the area of sexuality (Warner et al., 2018). As evidence of this, one study involving over 2,000 U.S. medical students revealed that only 41% felt that they received comprehensive training in discussing safe-sex matters with patients (Frank, Coughlin & Elon, 2008). These findings coincide with the perspectives shared by sex therapists in the current study regarding the need for awareness of sex therapy and sexual health.

**Accounting for Asexuality**

Several statements found in the data support sex therapists’ perspectives that female sexual desire disorder is non-inclusive and stigmatizing. As one participant put it, “I feel like this may be one of those things that actually causes more harm than good to the sexual community because it may marginalize people in the future.” This is reiterated in the literature by Gupta (2017), who sought to analyze how some asexually identified individuals have negative experiences concerning
their sexual identity. Gupta (2017) explains that lack of interest in sex has historically been pathologized by Western medical and mental health professionals (Cryle & Moore, 2012; Gupta, 2015), and “pro-sex” aspects of contemporary Western society negatively affect asexually identified individuals. According to their review of the literature, asexually identified individuals can face being pathologized by others (Foster & Scherrer, 2014; Robbins, Low, & Query, 2015), difficulties in relationships and social situations (Carrigan, 2011), and disbelief or denial of their asexual self-identification (MacNeela & Murphy, 2014). This relates to sex therapists’ conceptualization of low or no desire as inherently pathologizing, given the potential it could be explained by one’s sexual orientation.

Part of clinicians’ conceptualization of low sexual desire is guided by their beliefs regarding asexuality and in practice with clients this is informed by the perception of where their client’s distress originates from. For example, by assessing how much of a priority a client’s sexual identity is to them the clinician can determine if low desire is better explained by an asexual orientation. Several participants mentioned how female sexual desire disorder clashes with gender and sexuality spectrums. Coincidentally, during the time this study was conducted, AASECT released an updated position statement on the Dignity and Rights of Asexual Individuals affirming that asexuality and ace-spectrum identities are not mental, developmental, or sexual disorders (AASECT, 2022). This statement coincides with sex therapists’ perspectives and acknowledges:

“They are not responses to trauma or inexperience. They are valid and fulfilling identities and orientations. We oppose any and all reparative or conversion therapies that seek to change, fix, or pathologize a person’s sexual orientation. We define reparative or conversion therapy as any service or intervention purporting to ‘cure’ any sexual orientation that is non-allosexual, or services that seek to change non-allosexual orientation
because of the assumption that asexuality or ace-spectrum identities are mental disorders” (AASECT, 2022).

**Desire Framed as Non-Gender Specific.** Several participants attested that the issue of low desire should be framed as genderless and expressed support for normalizing sexual desire for everyone, regardless of gender, to be more inclusive of gender and sexuality spectrums. Referencing the literature, Thomas and Gurevich (2021) employed a critical feminist lens to explore how female sexual desire is constructed in gendered terms in mainstream sexuality research and clinical work such as the DSM. This study highlighted the fact that female sexual desire disorder is the only disorder in the DSM with differential diagnostic criteria for the same construct based on gender and took the opinion that the entire enterprise of treating low sexual desire as a disorder is flawed, for any gender (Thomas & Gurevich, 2021). This helps explain the consequences of having a gendered diagnosis that the participants included in the current study reflected. While distress may be experienced related to low sexual desire, labeling that distress as “dysfunction” does not address the interpersonal and sociopolitical factors that contribute. As echoed by participants in this study, diagnosing desire differences as dysfunction, and variations in desire (influenced by a complex array of social and relational experiences and expectations), are mislabeled as a problem of individual functioning, failing to acknowledge unequal gendered power relations that are supported by social structures (Gill, 2008, 2009). Research is available that examines gender differences within the experience of low desire; however, no literature was available that focused on gender differences, or lack thereof, within the context of the psychotherapeutic treatment for low sexual desire.

At the same time, gender is relevant to sexuality as a large body of evidence suggests that men experience sexual desire more strongly and more frequently than do women (Dawson &
However, it is not clear whether sexual desire is truly gendered or if gender differences are influenced by how sexual desire is operationalized and assessed. A study that examined the evidence for gender differences and similarities in sexual desire found that sexual desire emerges similarly in women and men, and that other factors (e.g., measurement, gender norms, report biases) may explain observed gender differences in sexual desire (Dawson & Chivers, 2014). Clinicians in the current study reflected the idea that women are often held to strict and yet, contradictory standards regarding sex and sexual desire, echoing preexisting research in the literature presented above.

**Media Informs Public Awareness.** Clinicians shared their perception of how media and advertising interact to inform public awareness of sexual health, sex therapy, and available treatments. Media and advertising often reinforce faulty sexual and relational education by encouraging unrealistic romantic delusions, as discussed within the preexisting literature (Fine & McClelland, 2006). While female sexual desire may no longer be “missing” from conversations about sex, women’s sexual desire is tethered to the societal norms and expectations surrounding sex (Fine & McClelland, 2006). Women learn from a young age what it means to be sexually desirable and the consequences of having too much or too little desire (viewed as dysfunction), all of which are imbricated with social positioning (e.g., race, class, sexual orientation; Collins, 2004; Rubin, 1984; Tolman, 2002). This social positioning is viewed as reinforced by the cultural context surrounding an individual and the media they are exposed to. Participants drew attention to the influence of these things on a mind-body basis. There were also repeated references to the role advertisements and marketing play in the public awareness of female sexual desire disorder and available treatments. For example, several clinicians shared their experiences with clients tending to come in with a self-diagnosis in response to seeing advertisements for Addyi® on social media.
Sara McClelland’s (2010) framework highlights that embodied desire is inextricably linked to social and political conditions found in media and advertisements, such as gender, racialization, class, (dis)ability, etc., that enable or constrain what women feel entitled to explore and experience.

**Comprehensive & Inclusive Sex Positive Education**

Results reflect an approach of reducing stigma through increasing awareness and education shared by the beliefs of clinicians interviewed for this study. Perspectives from sex therapists suggest that patient awareness is needed to help understand that fluctuations in sexual drive is normal, and there are things that affect sex drive that do not fully constitute a disorder. Interviewees framed inclusive and comprehensive sex education as the key to public awareness in the future. Sex education in the past has been criticized for several reasons. In reviewing the literature, it was noted that between 1981 and 2010, United States federal funding for sex education went exclusively for abstinence-only education (McCarty-Caplan, 2013). This demonstrates the extremes seen by the sex therapists represented in the current study who spoke of their client’s shame-based logic as a potential consequence of 20 years of purity funded education in recent history.

Lamb, Lustig, and Graling (2013) analyzed sex-education curricula used in the U.S. in the past decade using qualitative thematic analysis and results revealed that the discourse around pleasurable sex was often linked to a range of dangerous or adverse outcomes, including not using condoms, rushing into sex without thinking, regretting sex, and pregnancy or STDs (Lamb, Lustig & Graling, 2013). Since Fine (1988) published an article pointing to the missing discourse of desire in sex education, the call for the inclusion of pleasure into sex education has gained popularity (Allen, 2004; APA, 2007; Bay-Cheng, 2003; Fine & McClelland, 2006; Thompson, 1990; and Tolman, 2002). This coincides with sex therapists’ perception of how their clients end up with
faulty shame-based belief systems and how they address such beliefs in their treatment process by emphasizing pleasure. Since its inception, sex education has been characterized as heteronormative and this reflects the larger cultural context. McCarty-Caplan (2013) suggests sex education developed from emerging fear of the effects of adolescent sexuality on social hygiene and has long reflected institutional marginalization. This supports the current study’s findings that cultural context and belief systems are the primary influencers of sexual experiences as perceived by sex therapists. Teaching individuals to explore their bodies, something frequently mentioned by participants, reflects sex-positive education. Comprehensive sex education is sex-positive by normalizing the idea of giving and receiving pleasure and stresses consent, healthy communication, and protection, rather than emphasizing shame. Ashcraft (2008) suggests the potential value of sex education to serve as a vehicle for creating learning environments that facilitate students’ critical thinking, civic and scholastic engagement, academic achievement, and social/emotional learning. This all coincides with points raised in every interview, and as one interview participant phased it:

“With greater access to information about the female body, and with reduction of stigma, taboo, and shame about sexual issues and sexual matters, many women will find that there are reasons [for their low desire]… If we put more into allowing women to explore their sexuality in healthy ways, and sexual health, and stop conflating sex with sexually transmitted diseases, sexual trauma, and unintended pregnancy, I think we would have a much better chance at helping women recognize “Oh this is how my body works, this is what I might need, this is what might be going on with me right now and my genitals.”
Emotional Connection

Clinicians frequently reflected the underlying meaning of sexual activity as emotional intimacy, pleasure, and connection. This is reiterated in the literature by Mark & Lasslo (2018), who described sexual self-disclosure, the quality, and the frequency of sexual communication as important interpersonal factors in sexual desire. Sexual self-disclosure leads to better sexual function and satisfaction (Mallory, Stanton, & Handy, 2019) by facilitating women’s sexual desire through strengthening and promoting sexual communication (Cupach & Metts, 1991). Thus, sexual self-disclosure may prevent the loss of desire in long-term relationships.

Shame was a commonly referenced with clinicians’ perception of their client’s belief systems. Sharing beliefs through vulnerability and feeling included within one’s culture may be framed as the antidote to shame. For example, social researcher Brene Brown (2006) conducted a grounded theory study to explain why and how women experience shame, how shame impacts women, and the various processes and strategies women use to resolve the feelings and consequences associated with shame. Shame was defined as “an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (Brown, 2006). This relates to codes such as pathologizing, sexual morality, and belief systems during the current study’s data analysis. Brown (2006) created a ‘shame resilience theory’ and like the framework produced in the current study, shame resilience theory reflects a psycho-social-cultural construct. In the context of the current study, psychological components may relate to a clinicians’ perspective of how clients emphasize their emotions, thoughts, and behaviors of self; social components may relate to clinicians’ perceptions of the way women experience shame in an interpersonal context that is inextricably tied to relationships and emotional connection; and cultural components may highlight clinicians’ perception of the prevalent role of cultural
expectations within the presenting problem. Shame resilience theory may apply to conceptualizing desire and developing relevant psychoeducational tools to help clients build resilience. Power, a concept incorporated with shame resilience, is seen as having three properties: awareness, access to choose, and the ability to affect change (Brown, 2006). This closely mimics the emphasis placed on self-efficacy by sex therapists in addressing low desire, including their assessment of a client’s priorities and treatment goals, their use of interventions that promote an internal locus of control, and use of psychoeducation on sexual health.

**Implications & Recommendations**

Findings indicate that the clinicians in this study consider several elements when assessing their patients who report low sexual desire or female sexual desire disorder. Providers take several social factors into account that they perceive as influencing low sexual desire. This is significant considering sex therapists’ distinction from other providers, as informed by their unique training and specialization. This distinctive training may explain therapists’ avoidance towards pathologizing their patients. More research is needed to explore if sex therapists’ attitudes regarding pathology vary by a function of the training received. The subjectivity of low sexual desire as a symptom versus a disorder influences the difficulty in standardizing pathology and developing clear definitional agreements. In the findings, there was a recurring theme of clinicians critiquing an over-reliance on diagnosis and how this may pathologize conditions that are not just individually based. This is an important implication of this study derived from the perspectives of the sex therapists included in the sample.

The findings and implications of this study can serve to inform future research and policies. Future research may expand on the proposed framework to explore the conceptualization of low sexual desire within marginalized populations less represented within the literature, including
exploring the perception of desire as non-gendered. This research also highlighted therapists’ perspectives, including their perception that there is a lack of available comprehensive sex education and more that regulation is needed within the sex therapy field. This is to ensure sex therapists are represented as a healthcare option and are marketed accurately based on their training and competencies. Future policies should support the normalization of sexual health through comprehensive and inclusive discussions about sexuality in education and more clearly defined regulation for the field of sex therapy. For example, 22 of 50 states require sex education be medically, factually, or technically accurate if provided (National Conference of State Legislatures, 2020). State definitions of “medically accurate” vary and policy reform should target state requirements that advocate for evidence-based practices.

**Limitations**

This research focused on understanding the perspectives of sex therapists working with low female sexual desire in cisgender, heterosexual women due to the content of data collected from the clinicians interviewed for this study. There is an evident bias regarding heteronormative populations within the existing literature and more research is needed to represent diverse populations. Overall, findings contrasted with what was initially expected as the primary investigator anticipated greater emphases around diagnosis for female sexual desire disorder, a recognized DSM-5 disorder. However, the content of interviews reflected a different way of clinicians understanding this problem more holistically by understanding the underlying issues they see as contributing to symptoms. This was unexpected given 50% of the sample indicated they reference the DSM-5 and literature indicates diagnostics as a part of sex therapy training. However, including the question ‘What criteria do you reference for female sexual desire
disorder?’ on the preliminary questionnaire involves the assumption that therapists use criteria at all, and this may reflect bias as most stated in interviews that they did not use formal diagnosis.

This discrepancy between what was expected and what was obtained in results may be attributed to the sample consisting of a group of specialized practitioners with specific training that emphasizes concepts such as the importance of recognizing a broader gender spectrum. Bias is inherent in this project based on a function of the sample included. Although this study recruited a highly specialized group of clinicians with variation in the sample as a function of geographic location (Florida, Georgia, Massachusetts, and Pennsylvania), gender (male and female), specialty (licensed therapists, medical doctor, nurse-midwife, nurse practitioner, doctorates) and theoretical orientation, the sample was relatively consistent in the type of training received which may contribute to the level of bias suggested. This study used a smaller sample and found that clinicians from diverse backgrounds (to some extent) were consistent in how they approach the identification of issues contributing to low sexual desire and their recommendations. Although a sample size of 13 participants was enough for saturation of the theory (Ulman, 2014; Wood, Mansfield & Koch, 2007; Berry & Lezos, 2017), this study may have been strengthened by having a larger sample including clinicians’ from more diverse backgrounds who may approach this issue from varied perspectives.

Results point to a standard of care lacking in the field of sex therapy, whether this can be attributed to the biopsychosocial complexities of sexual desire or the bias inherent to the sample included in this project is unclear. More research is needed to explore this, including if there are any differences as a function of the type of sex therapy training. Additionally, findings from both the literature review and the data collected for this study indicate a lack of official and consistent diagnostic criteria. Not a single clinician interviewed for this study indicated they used a formal
diagnosis when working with patients who report low sexual desire. For this reason, the conceptual framework that emerged provides an illustration of the various elements that these clinicians use to interpret their patients’ symptoms and experiences of low sexual desire and avoid pathologizing their patients. This is a significant finding that offers new information to the existing body of literature on female sexual desire.
Conclusion

This study sought to understand sex therapists’ attitudes and perspectives regarding female sexual desire disorder and how these perspectives shape the interventions they recommend for women. Thirteen practicing sex therapists and counselors were interviewed, and qualitative analysis rooted in grounded theory was used to make meaning of the data. Analysis produced a framework illustrating the sequence of influence in conceptualizing sexual desire. Although the study queried respondents on the broader topic of female sexual desire disorder, discussion related more to the underlying issues corresponding to a presentation of symptoms, rather than using diagnostic criteria like the DSM-5.

This conceptual framework demonstrates how sex therapists’ attitudes and perspectives indicate their perception of female sexual desire disorder as influenced by the overarching culture and belief systems they recognize, and this interaction affects a variety of factors that clinicians believe shape their perception of their patients’ perspectives which determine the conceptualization of treatment interventions. Clinicians can use the presented framework to ensure all considerations have been made before providing treatment recommendations and guide their conceptualization of desire-related issues with their clientele. Ultimately, disinformation and stigma are perceived to be the primary factors influencing a negative perception of low sexual desire, and public awareness achieved through comprehensive, inclusive, and sex-positive education is framed as part of the solution for faulty belief systems that impact sexual desire. This research collected perspectives from a unique and highly specialized group of clinicians to help to
bring a more inclusive understanding to the concept of sexual desire. Ultimately, more research is needed to disentangle perceived distress about desire from the political and interpersonal pressures to encourage empowerment in sexual identity.
References


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Appendices
Appendix A: Email Recruitment Script

Hello, my name is Tatiana Bryan and I am a Master’s student at the University of South Florida in their Rehabilitation and Mental Health Counseling program. You are being asked to take part in a research study. This study is being conducted at the University of South Florida via online based interviews. The purpose of the study is to assess sex therapists’ conceptualization of female sexual desire disorder and gain insight into their perspectives regarding the way they make decisions about diagnosis, treatment, and progress with patients.

Participation will involve a 30-minute interview on Microsoft Teams. You are being asked to take part because you have been identified, from a publicly available referral directory, as an AASECT distinguished sex therapist who may be knowledgeable in the area of interest. Interview questions are aimed at understanding how participants conceptualize female sexual desire disorder and their treatment process including what female sexual desire disorder means to them. Understanding sex therapists’ perspectives will illuminate the processes used in clinical decision making regarding female sexual desire disorder. An informational flyer encapsulating the purpose and procedures of this study is attached to this email.

If you are interested in participation, please click the following link https://www.surveymonkey.com/r/TQCRY9Y to fill out the preliminary survey. Once complete the Principal Investigator will reach out to schedule the interview. All potential participants are asked to share study information and the Principal Investigator’s contact to individuals who meet eligibility criteria (AASECT certified).

This study is being led by myself, Tatiana Bryan, the Principal Investigator. I am being guided in this research by Dr. Marilyn Stern in addition to Dr. Linda Callejas. This research has been approved by the University of South Florida Institutional Review Board. If you have any questions, concerns, or complaints about this study, call Principal Investigator Tatiana Bryan at (813) 421-0612. If you have questions about your rights, complaints, or issues as a person taking part in this study, call the USF IRB at (813) 974-5638 or contact by email at RSCH-IRB@usf.edu.

Privileged and Confidential: Unless otherwise indicated, the information contained in this message is privileged and/or confidential information intended solely for the use of the addressee.
Appendix B: Preliminary Survey

1. How long have you been practicing sex therapy?
   a. Less than a year
   b. 1 to 5 years
   c. 5 to 10 years
   d. Over 10 years

2. What are your credentials?
   a. LMHC
   b. LCSW
   c. LMFT
   d. Ph.D or Psy.D
   e. Other

3. How did you decide on pursuing this specialty? [OPEN RESPONSE]

4. How many patients do you usually see in your practice?
   i. Less than 10 clients per week
   ii. 10-30 clients per week
   iii. 30-50 clients per week
   iv. Over 50 clients per week
   a. What percentage do you estimate involve desire complaints?
      i. Less than 10%
      ii. 10 - 25%
      iii. 25 - 50%
      iv. Over 50%
   b. What percentage do you estimate receive a formal diagnosis?
      i. Less than 10%
      ii. 10 - 25%
      iii. 25 - 50%
      iv. Over 50%
   c. How long have you been treating female sexual desire disorder?
      i. Less than a year
      ii. 1 to 5 years
      iii. 5 to 10 years
      iv. Over 10 years

5. What criteria do you reference for female sexual desire disorder?
   a. DSM-5
   b. DSM-IV
   c. ICD-10
   d. Other
Appendix C: Interview Protocol

Interview Protocol

Hello and thank you for agreeing to participate in this study. My name is Tatiana Bryan and I am a Rehabilitation and Mental Health Counseling graduate student at the University of South Florida. The purpose of this research is to understand how clinicians make decisions about diagnosis, treatment and assessing progress with patients experiencing female sexual desire disorder which may be diagnosed as HSDD, hypoactive sexual desire disorder, or FSIAD, female sexual interest and arousal disorder. This research was approved by the Institutional Review Board (IRB#). Interview questions are aimed at understanding your conceptualization of female sexual desire disorder, and how you approach the treatment of low sexual desire. This interview will take approximately 30 to 60 minutes and you have the right to withdraw at any point. I ask that you try to filter out any content that could reveal the identity of any client, and any such content will be carefully screened and removed from interview transcriptions if this does occur.

KEY: questions numbered; probes lettered

INTERVIEW QUESTIONS

1. Have you read about or noticed a change in the conceptualization of female sexual desire disorder over time?
   a. How has this impacted your perspective of the treatment process with your patients who are diagnosed with female sexual desire disorder?
   b. What is your opinion on this disorder?
   c. Where do you see the future of female sexual desire disorder? Do you envision this changing as we learn more about female sexuality?

2. Take me through your treatment process for female sexual desire disorder from beginning to end.
   a. How do you diagnose female sexual desire disorder?
      i. How do you define clinically significant distress when evaluating for female sexual desire disorder?
   b. What treatment modalities do you use with female sexual desire disorder?
      i. How many of your patients are using medication to treat female sexual desire disorder?
   c. How do you measure patient progress when treating for female sexual desire disorder? *Provide assessment examples*
      i. Why do you pay attention to those progress measurements in particular?
      ii. What endpoints do you prioritize the most? (frequency of sex, frequency of orgasm, subjective level of desire and arousal, etc.)

General areas to explore:
- Diagnostic and treatment process regarding female sexual desire disorder
- Perspectives on the evolution of female sexual desire disorder
- How perspectives of female sexual desire disorder have shaped conceptualization of the treatment process

Thank you again for participating in this interview. I would like to reiterate that your participation is completely confidential. If you are willing, I will be reaching out near the end of this study to have participants confirm the interpretation of results coincides with their perspective.
Appendix D: Sample of Coding Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Data Segment</th>
<th>Transcription #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ockham’s Razor</strong></td>
<td>“So I think that's a big part, is I do look at it as not a differential diagnosis I look at it as like kind of a catchall which sends them to people like me as a sex therapist and then it's my job to kind of weed out what's really going on.”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Pathologizing</strong></td>
<td>“I guess it seems a little bit of pathologizing asexuality. Because the ace community would say that that maybe something as being ace which is not diagnostic.”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Ockham’s Razor</strong></td>
<td>“Because I do see a lot of people that they mistake desire as like that when there is any kind of like underlying anxiety, depression, you know the pandemic, like you know who's gonna have desire if you don't have the pleasure”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Relational</strong></td>
<td>“I do what I call like a 20,000 foot view is. Like if I take them out of this situation and they're you know maybe there with someone else they're not with them, would this still exist? And if the answer is yes and it's more of an actual disorder, compared to we have a lot of people where they'll talk about desire and it turns out that they just don't they love their partner but they don't sexually desire them.”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Self-Efficacy</strong></td>
<td>“The other thing that you know I talked about pleasure everywhere so you know having them do the things to</td>
<td>7</td>
</tr>
<tr>
<td><strong>Perception of Patient Perspectives</strong></td>
<td>“And then you know figuring out what their real goal is and then doing some interventions for the goal”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Referral Network</strong></td>
<td>“So I try to do like a social work approach to it 'cause I feel like when people come to us especially they're so vulnerable and we have them possibly very short periods of time”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Self Efficacy</strong></td>
<td>“You kinda have to manufacture that and they won't do it and then they then they keep repeat…….. Did you set the timer, did you work did you fantasize about your your favorite moments, did you create that”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Belief Systems</strong></td>
<td>“That they just again it's like the movie ends when people end up living together and people just think that it's whatever it happens. It’s like every whatever the other person desires at any given time, and nothing hurts, and you always find a hole, and you know it's like very delusional”</td>
<td>7</td>
</tr>
<tr>
<td><strong>Gender Politics</strong></td>
<td>“We need to see just more normalization again of desire both you know female male and all genders of it just being talked about as like a desire issue.”</td>
<td>7</td>
</tr>
</tbody>
</table>
Appendix E: Selective Coding

Figure 1A
Conceptual Flow Chart
Appendix F: Themes Returned for Member Checking

Overall, the findings suggests that cultural context and belief systems play a large role in how clinicians conceptualize low sexual desire and their perception of their clients who have experienced low sexual desire. Results indicate that sex therapists rely on their perspective of patient reported outcomes or perspectives, to frame the presenting problem, treatment plan and goals as related to their clients experience of low sexual desire. This thought process is heavily influenced by a bidirectional relationship between one’s cultural context and belief systems and how clinicians perceive the impact of this relationship. The bidirectional relationship is demonstrated by how belief systems may be influenced by cultural context and how cultural context may be informed by predominant belief systems.

Relational factors was a larger theme relating to an individual’s relationship with themselves, and this was something clinicians also frequently emphasized as part of their treatment process for low sexual desire from their perspective. One of the recurring themes throughout the data set relates to clinicians speaking to or encouraging an internal locus of control among their clientele. Self-efficacy was illustrated by any mention of treatment interventions directed at having clients explore their own bodies and erotic language and may include clinicians’ perception of their client’s sexual intentionality, such as beliefs related to manufacturing desire, expanding on pleasure, and exploring kinks and different context settings. Self-efficacy is rooted in the idea that the foundation of desire is based in a disciplined practice around intimacy.

Cultural context was another larger theme derived during axial coding. Originally, cultural context was expected to be used to notate any clinician ideas related to how culture interacts with the conceptualization of desire such as societal expectations, shame-based messaging in media, porn consumption, purity culture, hypersexual media, and reference to desire being rooted in lifestyle factors. Any mention to gender dynamics at play within the understanding of desire, was conceptualized as underneath the theme of cultural context. This included clinician opinions that desire disorder is genderless, perceptions that gender is becoming less relevant and of the masculine/feminine dynamic.

Do you have any feedback regarding these results? Do these themes coincide with your experiences as a sex therapist?
About the Author

Tatiana Bryan is pursuing a master’s degree in Rehabilitation and Mental Health Counseling at the University of South Florida. She received a Bachelor of Science with a major in Family Youth and Community Sciences, a certificate in Family Life Education, and a minor in International Studies from the University of Florida. While at the University of Florida she conducted an independent research project ‘The Mediterranean Diet and its Influence on Mental Well-Being’ (IRB#201802343) investigating the relationship between the Mediterranean diet and depressive symptomology. Tatiana has an interest in holistic wellness and is also a Registered Yoga (RYT ID: 338205). She teaches purpose-driven trauma informed yoga through a non-profit 501©(3) to individuals who are experiencing incarceration, vulnerable youth, veterans, and people living with mental health conditions. These classes are researched and evaluated by Boston University to show statistical significance in stress reduction and emotional regulation.