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An Examination of the Relationship between Authenticity and Female Sexual Dysfunction

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Since the late 1990s, researchers have reported a high degree of sexual dysfunction among American women that is associated with significant negative consequences (e.g., reduced quality of life and sexual satisfaction). In addition, sexual satisfaction is a primary factor in marital stability. Because of the widespread impact on both individual well-being and marital relationships, female sexual dysfunction is a significant public health problem. Most research has supported the predominance of psychocultural factors in women's sexual issues. Authenticity, defined by Kernis and Goldman as acting in accord with one's natural inclinations, is associated with increased well-being, but researchers have often overlooked it in the literature on female sexual dysfunction. This study, guided by Kernis and Goldman's authenticity theory, argued that gender culture impairs the ability of women to be authentic in the sexual realm, and, thereby, increases the risk of sexual problems. The purpose of this research study was to examine the relationship between authenticity, as measured by The Authenticity Inventory, Version 3, and female sexual dysfunction, as measured by The Female Sexual Function Index and The Female Sexual Distress Scale, Revised, in a group of 55 women attending an online university. The hypothesis was that women with higher rates of dysfunction and/or distress would score lower on authenticity. The results from a regression analysis did not reach significance and failed to confirm the hypothesis; however, there was an association between distress and dysfunction. This study contributes to social change by examining an association between authenticity and female sexual dysfunction that is of help to researchers and therapists working with women in the area of sexual health.

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Dedication

This dissertation is dedicated to my beloved mother, Anne Royston Smith, without whose belief in me and unceasing love I would never have attempted something of this magnitude. Thank you Mama, rest in peace.

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Chapter 1: Introduction to the Study

Preface

In the late 1990s, the introduction of Viagra led to an increased interest in women's sexual problems, defined as female sexual dysfunction (FSD) (Tiefer, 2006a). This diagnosis has been the subject of intense controversy since its inclusion in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1998. Critics have charged that in the race to find the female equivalent of Viagra, sociocultural factors involved in women's sexual malaise are frequently ignored (Drew, 2003; Tiefer, 2001b). For instance, Drew (2003) argued that women's sexual problems were often the result of continuing gender inequities and a view of sexuality that was male centered. In the past, women who did not conform to androcentric sexual norms were pathologized and subjected to sexual medicine, including treatments as diverse as clitordectomies, physician-assisted vulvar massage, and opherectomes (Cacchioni & Tiefer, 2012; Maines, 1999). My dissertation examined whether sexual authenticity was more problematic for women because it implies a divergence from androcentric sexuality. Not only are the symptoms of FSD created, in part, by gendered culture, the concept of women's sexual pathology has its roots in the historical invalidation of women and female sexuality. This study used Kernis and Goldman's (2004) authenticity theory as a theoretical framework and applied it to FSD. Kernis and Goldman believed that authentic individuals live their lives according to what feels right to them—acting from their own inner desires—rather than from external demands. Correspondingly, these individuals have higher rates of psychological well-

being, self-esteem, and life functioning. It would stand to reason that authenticity would be associated with greater sexual well-being and a reduced risk of dysfunction. Therefore, this study examined how authenticity informs women's experiences of their sexuality. There had been little research in the area of authenticity and sexual functioning, and studying the connection between these variables has provided a fuller understanding of FSD, which is not only a very complex topic but one that is correlated with relationship and life satisfaction (Laumann, Paik, & Rosen, 1999). The remaining sections of this chapter will focus on defining the background, understanding the theoretical orientation, study purpose, definition of terms, research questions, and the study's limitations and significance.

Background

Tiefer (2001) argued that the current biomedical approach to sexuality research has ignored the sociopolitical context of FSD. Authenticity, as it relates to female sexuality, has received scant attention in the literature. One of the few researchers to look at this issue was Barbour (2008), who conducted a qualitative research project on young, Canadian women and sexual authenticity. She found that many of her participants defined their self-worth by their relationship status and used their sexuality as a commodity to trade for male investment, which the author loosely defined as anything from a relationship to mere attention. For these young women, sexuality was other-focused—a way of preserving and maintaining relationship ties, often at the expense of the self. Themes of commodification, leftover discourses of Victorian gender ideology, and sexual objectification shaped her participants' experiences and made authenticity

difficult to achieve (Barbour, 2008). Due to the importance ascribed to sexuality in modern life, the paucity of research in the area of sexual authenticity, and the significance of nonmedical factors in FSD, this study fills an important gap in determining the role that authenticity and self-expression play in women's sexual issues. It builds on the existing research regarding gender socialization and its impact on sexuality.

Problem Statement and Purpose of Study

According to Laumann et al. (1999), sexual dysfunction is pandemic in American society—particularly among women. Their study found that 43% of American women experienced some type of sexual problem. Critics have questioned this highly controversial, widely disseminated statistic and charged that pharmaceutical companies have used it as a linchpin for a possibly unwarranted, medicalized approach to FSD (Monihan, 2003; Tiefer, 2012). Sexual dysfunction in women usually takes the form of inhibited desire or orgasmic dysfunction; though the boundaries between the various clinical diagnoses associated with FSD usually overlap (Talakoub et al, 2002). Sexual dysfunction can have a negative impact on overall well-being and sexual satisfaction (Davison, Bell, LaChina, Holden, & Davis, 2009; Laumann et al., 1999; Warnock, 2002). This is true for both men and women, but the repercussions are especially pronounced for the latter (Laumann et al., 1999).

In undertaking this research, I was interested in understanding how the independent variable of authenticity, using Kernis and Goldman's (2004) theory as a theoretical lens, affects the dependent variables of female sexual functioning and distress.

Therefore, the purpose of this correlational, quantitative study was to examine the relationship between these two variables (authenticity and FSD).

Definitions and Theoretical Constructs

Kernis and Goldman's (2004) authenticity theory contains four components:

- Awareness: Authenticity is associated with greater self-awareness.
- Unbiased processing: Authentic individuals are less likely to make use of maladaptive defense mechanisms that distort reality, and therefore have greater access to their emotions.
- Behavior: Authentic people are more likely to behave in accordance with their own personal values and are less concerned with pleasing others.
- Relational orientation: Authentic people seek genuine intimacy and are willing to risk being seen by others. They are less likely to fabricate a false-self façade.

In Chapter 2, using this framework for my literature review, I identified how sexual culture impacts the four components of authenticity in a woman's life. For instance, historically, the female body was regarded as an inferior inverse of the male's, intercourse was the only socially acceptable sexual act, and knowledge about the clitoris was kept out of public discourse (Blackledge, 2004; Maines, 1999). According to research (Barbour, 2008), such social norms have had a negative effect on female self-awareness (the first component of authenticity), sexual self-knowledge, comfort with masturbation, and sexual agency. Fredrickson and Roberts (1997) argued that female self-objectification and body shame created barriers to the unfiltered accessing of bodily

sensations, which speaks to Kernis and Goldman's (2004) concept of unbiased processing (the second component of authenticity). An authentic individual, from Kernis and Goldman's point of view, is more aware of all of his or her feelings, both positive and negative. Gender socialization impedes women's bodily awareness—particularly as it pertains to sexuality. In research studies, women reported less awareness of physiological sexual arousal than men did and more anxiety and cognitive distraction during sexual activity (Meana & Nunnik, 2006; Meston, 2000; Sanchez & Keifer, 2007).

Gender norms also undermine behavioral authenticity; women are more likely to have unwanted sex, to fake orgasms, and to prioritize their partner's needs ahead of their own (Muehlenhard & Shippee, 2010; Regnerus & Uecker, 2011). Twentieth-century changes in gender demographics created a low male-to-female ratio that has profoundly affected women's dyadic power (Guttentag & Secord, 1983). This, coupled with continuing inequities in women's capacity to access structural power, potentially undermines relationship authenticity. Women are socialized to invest heavily in their romantic affiliations and are often confronted with double binds that pit their own needs against social norms that dictate self-sacrifice (Jack, 1991).

Definitions

Authenticity: Kernis and Goldman (2004) defined authenticity "as the unobstructed operation of one's true or core self in one's daily enterprise" (p. 32). They argued that the concept can be looked at from a multipoint conceptualization that consists of four components: awareness, unbiased processing, behavior, and relational orientation.

Female sexual dysfunction (FSD): According to the *DSM* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000), sexual dysfunction is defined as "a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse" (para. 5). The sexual response cycle consists of four phases: desire, excitement, orgasm, and resolution. Sexual dysfunction can occur at any one or more of these phases, but only if a particular individual is distressed about his or her sexual response.

FSD is further divided into five clinical categories: (a) hypoactive desire disorder, (b) sexual aversion disorder, (c) female sexual arousal disorder, (d) female orgasmic disorder, and (e) sexual pain disorder. The *DSM-IV-TR* (2000) also considered such factors as age, adequacy of stimulation, and whether or not the problem is ongoing in making an appropriate diagnosis. Dysfunctions were furthered codified by subtypes as follows: lifelong (has always been an issue in an individual's sex life), acquired (has only occurred after a period of normal sexual functioning), generalized (the problem is not limited to certain situations or partners), and situational (the problem only occurs under certain conditions or with certain partners; American Psychiatric Association, 2000).

Androcentricism: Hegarty and Buechel (2006) referred to androcentricism as the tendency of Western culture to view male behavior, inclinations, and experiences as the norm and to see gender differences as limited to women's deviation from masculine standards of normality. The term may have originated with Gilman (1911), who argued that human history and culture were usually interpreted from a masculine standpoint.

Nature of the Study

This was a correlational study that examined the relationship between authenticity and FSD/distress. It included women who were currently sexually active, and used data that was collected via the Internet. This design was chosen because my study examined the association between variables and did not involve any experimental manipulation. This study looked at the relationship of the independent variable authenticity to the two dependent variables of FSD and sexual distress. For a fuller description of the methodology, see Chapter 3.

Research Questions and Hypothesis

Research Question 1: What is the relationship between reported female sexual dysfunction and reported authenticity?

Research Question 2: What is the relationship between reported female sexual distress and reported authenticity?

Hypothesis 1: There is a negative relationship between sexual dysfunction (as measured by The Female Sexual Function Index) and authenticity (as measured by The Authenticity Inventory, Version 3).

Null Hypothesis 1: There is no relationship between sexual dysfunction (as measured by The Female Sexual Function Index) and authenticity (as measured by The Authenticity Inventory, Version 3).

Hypothesis 2: There is a negative relationship between sexual distress (as measured by The Female Sexual Distress Scale, Revised) and authenticity (as measured by The Authenticity Inventory, Version 3).

Null Hypothesis 2: There is no relationship between sexual distress (as measured by The Female Sexual Distress Scale, Revised) and authenticity (as measured by The Authenticity Inventory, Version 3).

Significance, Limitations, and Assumptions

Human sexuality is a complex topic, which is increasingly emphasized in the public sphere. Explicit sexual images, including pornography, are easily available to anyone with an Internet connection, and sexuality figures prominently in media discussions of sociopolitical topics such as reproductive rights. Sexual activity is increasingly accepted in nonmarital relationships, while sexual satisfaction is increasingly emphasized in marriage. Research (Whitehead & Popenoe, 2001) has found that most young people want to marry their soul mate, which usually means a relationship with a high degree of both intimacy and passion. In the soul mate marriage, sex is said to be the "glue" that binds a couple together in wedded bliss (Edwards & Booth, 1994; Regnerus & Uecker, 2011). Indeed, Edwards and Booth (1994) noted that sexual intimacy is often an obligatory barometer of marital adjustment in modern culture. According to Wilcox, Marquardt, Popenoe, and Whitehead (2011), satisfactory marital sex is associated with greater relationship stability, while dysfunction is correlated with increased marital disruption, and reduced life and sexual satisfaction (Kinsey, 1953; Laumann et al., 1999).

Coontz (2005) argued that one of the most profound changes over the course of the 20th century was the shift from a sentimental to a sexualized view of marriage. This shift was part of a larger cultural trend that viewed individual happiness (of which sex is believed to be a contributing factor) to be a matter of paramount importance (Coontz,

2005). Furthermore, the trend was exacerbated by the psychological and social revolutions of the 1960s and 1970s, which not only reduced the stigma of divorce but promoted a view of marriage where "one's primary obligation was not to one's family but to one's self; hence, marital success was defined not by successfully meeting obligations to one's spouse and children but by a strong sense of subjective happiness" (Wilcox, 2009, p. 83). In other words, from the standpoint of modern culture, it became acceptable to dispose of a spouse who was failing in any one of his or her socially appointed roles, be it friend, partner, or sexual playmate.

Given the huge importance of sexuality in modern culture, it is vital to understand what happens when sexual functioning goes awry. This issue transcends socioeconomic, racial, and ethnic divisions. Understanding (and possibly, through increased insight, alleviating) sexual dysfunction is one way to preserve martial ties, reduce divorce, and improve individual well-being. Reducing divorce would mitigate some of the well-documented social effects of marital dissolution. For instance, Amato (2000) found that divorce had long-term repercussions for both parents and children, including loss of social support, decline in economic stability, and a disruption in parental and other ties. This study provided some insight into a little examined area of FSD that could assist psychologists, sex educators/therapists, and couples themselves in dealing with sexual dissatisfaction in women. My dissertation aided social change by contributing to the literature on FSD, and increasing the knowledge base on this complex topic is one way to empower women and enhance marital stability.

However, there were limitations to my study. I confined my research to a select sample of participants—women who were willing to discuss a very private area of their lives. Furthermore, this dissertation's sample was drawn from an online audience through Walden's participant pool. Therefore, the study did not generalize to the American or global population as a whole. Another limitation was that this was a correlational study that did not provide information on causation or direction of effect (e.g., that X precedes Y, or vice versa). The sample was also limited to women who were currently sexually active.

There were certain assumptions that informed the design of this project: There was the assumption that participants would be truthful in their responses and that the virtual nature of the study would not deleteriously bias the results or affect veracity. In addition, I hoped that sexually active women would be willing to participate in a research project that dealt with a very sensitive topic. There was the assumption that the research measures used in this project were scientifically sound and that the lack of direct experimental control would still allow for a strong, scientific study.

Summary

To summarize, this research project examined how female sexual functioning relates to authenticity. Gendered culture shapes all elements of human experience, and female sexuality is constrained by gender norms that derive from the larger framework of sociopolitical androcentricism. These constraints limit women's capacity to be authentic in many areas of life—especially sexual activity. Chapter 2 contains a review of the literature in the field of female sexuality, FSD, and authenticity. Using Kernis and

Goldman's (2004) authenticity theory as a theoretical lens, I examined how the theory's four components (awareness, unbiased processing, behavioral, and relational experience) are negatively impacted by gender norms that shape female sexual expression. Chapter 3 looks at this research project's design, what measures were used, research questions that shaped the design, participant demographics, and the statistical software used.

Chapter 2: Literature Review

Preview of Literature Review and Research Strategies Used

My literature review is organized in several sections. It begins with a brief overview of FSD, the *DSM-IV-TR* (2000) definition of the diagnosis, and some of the controversies surrounding the topic. Next, I provide some background material on the androcentric sexual model, its influence on how heterosexual sex is defined, the historical view of female sexuality, and cultural impediments to female sexual expression. I include in this section a general discussion of previous sexual pathologies, such as hysteria and nymphomania, that have long been associated with female sexuality. I then move into the main body of the literature review with a discussion on authenticity as a theoretical tradition, the limited research on sexual authenticity, and, finally, the application of Kernis and Golman's (2004) authenticity theory as framework to understand women's sexual issues. Kernis and Goldman's theory consists of four components: (a) awareness, (b) unbiased processing, (c) behavior, and (c) relational orientation. Using this framework, I examined whether women's capacity to be authentic, via these four components, is undermined by sexual culture in various ways:

- Awareness: This section of Chapter 2 looks at how cultural norms shape women's sexual self-awareness. Variables examined were women's lack of awareness of their genitalia and tendency to self-objectify (Fredrickson and Roberts 1997; Meana & Nunnik, 2006; Meston, 2000; Sanchez & Keifer, 2007). The impact of body image on sexual dissatisfaction was also investigated.

- Unbiased Processing: Sexual culture reduces women's unfiltered processing of both sexual and body states. Women's capacity to access sexual feelings is diminished by gender norms that foster high levels of cognitive distraction, spectatoring, and self-objectification. In this section, research into the disconnect women report between objective physiological arousal and subjective arousal is examined, as was the literature on cognitive distraction (Meana & Nunnik, 2006; Meston, 2000; Sanchez & Keifer, 2007).
- Behavior: This section looked at such issues as sexual scripting and behavior, how sex is actually carried out in practice, and the behaviors expected of men and women. The orgasm gap, the mechanics of heterosexual sex, and communication barriers are examined in relation to women's authenticity.
- Relational orientation: The impact of power differentials on women's sexual authenticity was examined in this section. The principle area of concern was relationship power inequities brought about by the wage gap, the principle of least interest, the low male-to-female ratio, and the instability of modern relationships.

Research Strategies

My literature review has a strong historical component. In order to understand FSD, and the controversies surrounding it better, it is important to place the diagnosis in a sociohistorical context. Therefore, I looked at documents dating back to the 19th century. There has been little research on female sexual authenticity, and much of the current focus in professional sexuality literature has been on biological factors and medical

treatments for dysfunction. Due to this fact, my literature review included both historical and current sources and was not limited to research published within the last 5 years. I also looked beyond the field of psychology and examined studies in social history, evolutionary psychology, anthropology, and sociology. The primary databases I used were as follows: Academic Search Complete/Premier, PsycARTICLES, Psychology: A SAGE Full-Text Collection, PsycINFO, SocINDEX with Full Text, Dissertations & Theses, and eBrary e-book collections. The search terms used were *female sexual dysfunction, sexual dysfunction, women and sex, sexual dissatisfaction, gender and power, authenticity theory, sexual authenticity, women and orgasm, orgasm gap*.

Introduction

Viagra Nation

In October 1998, 7 months after the introduction of Viagra, the first ever International Consensus Development Conference convened in Boston and proposed a new categorical addition to the *DSM*: FSD (Basson et al., 2001; Moynihan, 2003). The unprecedented success of Viagra coupled with the possibility that sexual dysfunction was even more prevalent in women motivated the development of the new diagnosis (Moynihan, 2003). A high rate of FSD was later confirmed by research extrapolated from the National Health and Social Life Survey, which found a dysfunction rate of 43% in female participants (but only 31% in male participants; Laumann et al., 1999). Though the 43% dysfunction rate has been widely reported in the media, it has also been contested by feminists, sexologists, and others because of controversy over the study's

method of determining dysfunction (Drew, 2003; Moynihan, 2003; Tiefer, 2001b, 2006a).

Critics have argued that the concept of FSD merely repeats historical tendencies to pathologize female sexuality (Drew, 2003; Tolman, 2001). In that sense, it takes its place alongside hysteria, nymphomania, and frigidity as the dysfunction du jour. As in the case of past female sexual pathologies, various medical interventions have been proposed as treatment (Cacchioni, 2007; Tiefer, 2006a). However, John Bancroft, the former director of the Kinsey Institute, told journalist Roy Moynihan that portraying women's sexual issues as "dysfunctions" could encourage doctors to prescribe pills for problems that are not suitable for sexual medicine—and could lead women to believe that they need drugs when they do not (Moynihan, 2003).

FSD, by its very definition, implies a lack of sexual normalcy and, because normalcy is connected intricately with cultural expectations regarding appropriate sexual behavior, it also implies a failure to conform to current sexual norms regarding how a "normal" woman experiences her sexuality. Not only is sexual dysfunction socially constructed, but it is also a product of gender socialization. The concept brings to the fore issues of self-expression. In most societies, there is an antagonism between the individual's needs and what is defined as socially acceptable sexual expression. All societies seek to regulate sexual behavior (Baumeister, 2000; DeLamater, 1981), and female sexuality has been subjected to more censure and suppression than male sexuality has (Baumeister, 2000). It could be argued that this makes female sexual authenticity problematic—in the sense that self-expression would be associated with greater risk for

women than men. Not being able to express one's needs makes it unlikely that they will be met, negatively impacting a woman's ability to experience sexual satisfaction. This lack of satisfaction is then redefined by current sexology as dysfunction.

Conversely, being able to express oneself authentically has been linked with enhanced psychological well-being. According to Kernis and Goldman (2004), authentic individuals are less likely to conform to other-oriented social norms and behave according to their own inner dictates, which, they asserted, was associated with greater happiness and psychological health. In a qualitative study examining female sexual authenticity, Barbour (2008) argued that cultural injunctions favoring women's subordination limited their capacity to express their own genuine inclinations and reduced their sexual well-being. This was an idea echoed by Boyle (1993), who stated that, "For heterosexual women, the enactment of their assigned role in sex has been a replication of their social subordination" (p. 77). Furthermore, Drew (2003) proposed that sexual norms continue to privilege male sexuality and women who deviate from androcentric sex risk being seen as dysfunctional.

However, according to Tiefer (2001b), gender politics are largely ignored by profit-oriented FSD research. She argued that the impact of gender socialization and culture on female sexual functioning can easily be dispensed with in the quest to "pink" Viagra—a drug that has made over $1 billion in sales revenue for its parent company, Pfeizer. Market-driven corporate pharmacology has the money to promote a medicalized schema of FSD, while there is "limited to no availability of public funding to contribute [to] a diversified sexuality research agenda" (Barbour, 2008, p. 53). By shifting the

discourse to a dysfunction orientation, pharmaceutical companies and various other sexual experts pave the way for both greater profit and a "corporate medical model" of female sexual functioning (Allina, 2001, p. 211). One major underpinning of this approach is the idea that there is a normative range of sexual response based on an average level of desire and orgasmic ability (Tiefer, 2001a, 2005), but one could argue that sexual appetite, like musical or athletic ability, varies from individual to individual, and it is not valued the same by everyone.

Proponents of FSD, as a classification system, insist that there are genuine physiological factors that can interfere with sexual functioning in both men and women and that medical science should be used to develop a treatment rationale (Basson et al., 2001). Basson et al. (2001) argued that, unlike male sexual dysfunction, little is known about the biopsychological underpinnings of FSD and that "epidemiological research on the prevalence, predictors and outcomes of sexual dysfunction in women is urgently needed" (p. 89). The authors also called for more research on such anatomical correlates of sexual response as pelvic neurophysiology and the effects of steroid production on female sexuality. Indeed, one category of FSD, sexual pain disorder, appears to have a strong medical component. For example, vulvodynia and vestibulodynia (forms of dypareunia) are understood to be neurosensory disorders possibly triggered by vaginal infections and/or hormonal contraception (Baron, Florendo, Sandbo, Mihai, & Lindau, 2011). Sexual pain can be created by endometriosis, pelvic trauma, and medical conditions like lichen sclerosis and Crohn's disease (Baron et al., 2011). Furthermore, sexual desire can plummet due to a variety of causes, such as reduced androgen levels,

adrenal dysfunction, postpartum states, and hormonal contraception (Arlt et al., 1999; Warnock, 2002). As a result of warring factions within the scientific community, FSD has remained one of the most controversial areas in modern sex research (Cacchioni, 2007).

The Dysfunction Du Jour

FSD is composed of several categorically distinct dysfunctions including the following: hypoactive sexual desire disorder, sexual aversion disorder, sexual arousal disorder, orgasmic disorder, and sexual pain disorder (American Psychiatric Association, 2000). Sexual dysfunction is highly correlated with reduced quality of life, and both emotional and sexual dissatisfaction (Laumann et al., 1999; Warnock, 2002). Indeed, FSD has more negative repercussions for women than men (Laumann et al., 1999). According to the *DSM-IV-TR* (2000), FSD is composed of these clinical features:

Hypoactive Sexual Desire Disorder

> A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life. (para. 13)

Sexual Aversion Disorder

> A. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner. (para. 24)

Sexual Arousal Disorder

A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement. (para. 32)

Orgasmic Disorder

A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives. (para.55)

Dyspareunia

A. Recurrent or persistent genital pain associated with sexual intercourse in either a male or a female.(para. 87)

Vaginismus

A. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. (para. 98)

Furthermore, in order for a clinician to make a diagnosis of sexual dysfunction, all the categories of FSD must cause significant distress for the individual. In 2013, the revised *DSM-5* made some changes in the diagnosis of FSD, but continued to require that distress be present. Sexual aversion disorder was eliminated, and the diagnostic criteria for FSD was streamlined into three clinical categories. The changes were as follows:

Female Orgasmic Disorder

A. Presence of either of the following symptoms and experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
    1. Marked delay in, marked infrequency of, or absence of orgasm.
    2. Markedly reduced intensity of orgasmic sensations. (para.37).

Female Sexual Interest/Arousal Disorder

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, and typically unreceptive to a partner's attempts to initiate.
    4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
    5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
    6. Absent/reduced genital or nongenital sensations during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts). (para.58)

Genito-Pelvic Pain/Penetration Disorder

A. Persistent or recurrent difficulties with one (or more) of the following:

1. Vaginal penetration during intercourse.
2. Marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts.
3. Marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration.
4. Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration. (para.80)

Many women complain of an amalgamation of symptoms, including problems with reduced desire, arousal, and orgasmic ability (Talakoub et al., 2002). Very few women diagnosed with FSD fall into one clinical category. The boundaries between each discrete diagnosis blur and overlap (Talakoub et al., 2002). A problem with orgasm could interfere with desire, and issues with sexual arousal (e.g., lack of lubrication) could engender sexual pain.

According to Laumann et al. (1999), around 30% of women, from 18 to 59 reported a lack of sexual desire, while only 11 to 24 % of men reported this issue. Over 20% of women stated that sex was not pleasurable at all, which was only true for around 16% or fewer of men. Orgasmic disorder (also called anorgasmia or preorgasmia) was prevalent and was much higher in women without a high school education than in those with a 4-year degree (34% versus 18% respectively).

Orgasmic disorder can be differentiated into primary and secondary anorgasmia. Primary anorgasmia is a lifelong inability to experience orgasm under any circumstances. Secondary anorgasmia occurs when a woman is unable to climax in a certain situation or under a specific set of conditions. For example, a woman might be orgasmic during masturbation but not during sex with a partner (Carlson, 2003).

According to Laumann, et al. (2005), sexual dysfunction is common in many parts of the world. Cross-culturally, women's most common complaints are issues with desire and orgasm. Problems with desire afflict from 26 to 43% of women in global studies, while issues with orgasm are common for 18 to 41% of women. Southeast and East Asia report the greatest rate of sexual dysfunction in both men and women (Laumann et al., 2005).

An Androcentric Sexual Model

In every culture there are social norms that control how, when, with whom, and where sexual activity occurs. These norms form the basis of sexual scripts that govern gender and sexual expression (Wiederman, 2005). According to Maines (1999), western sexual scripts are androcentric and privilege male over female pleasure.

Maines (1999) argued that there are three essential features to androcentric sex 1. Sexual preparation—this refers to foreplay (e.g., oral or manual sex) that is conducted by a man to prepare a woman's vagina to receive his penis. 2. Intercourse—penetration of a vagina by a penis is integral to the very definition of sex for most people. 3. Ejaculation as the conclusion of sex. Sex generally ends with the male orgasm, which is also deemed intrinsic to its definition in many cases. Neither oral nor manual stimulation usually count

as “real” sex—in spite of the fact that these acts are more likely to lead to orgasm for the average female. For example, Sanders et al. (2010) conducted a study that looked at how sex was defined and found that coitus still remained the definitive sexual act, according to a sample of 486 men and women between the ages of 18 and 96. Three in 10 respondents did not consider oral sex to be “sex” and more than half did not regard manual stimulation as sex. Even anal intercourse was not deemed sex by 20% of the participants. While 90% of the respondents considered vaginal intercourse real sex—this number dropped to 89.1% when male ejaculation was not present. The researchers found that it was primarily males of the youngest and the oldest age cohorts who had the most limited definition of sex.

One startling example of this cultural proclivity was the infamous “Zippergate” scandal during which former president Bill Clinton insisted that he did not have a sex with Monica Lewinsky because he never had intercourse with her. Therefore, his activities did not count as “real sex”. In a move that bucked cultural tradition, neither Kenneth W. Starr nor Congress agreed with Clinton’s view and impeached him anyway (Baker & Harris, 1998).

The cultural fixation on penetration is a “coital imperative”, according to Gavey, McPhillips and Braun (1999, p. 36) that turns intercourse into an essential requirement for heterosexual sex. Not surprisingly, Michael, Gagnon, and Laumann (1994) found that 95% of heterosexuals had intercourse during their last sexual encounter, 80% always had intercourse during sexual activity, and an additional 15% had it most of the time. Among heterosexuals, oral/manual sex occurred less often than coitus—and only 20% of women

reported receiving cunnilingus during their last sexual encounter. Furthermore, the occurrence of oral sex among heterosexuals was highly influenced by race, age, class, and education levels. It is usually more common among white, educated, younger Americans (Michael et al., 1994). Though the National Health and Social Life Survey (NHSLS), (the first nationally representative study of American sexual behavior) found that most people have a very limited sexual menu, the National Survey of Sexual Health and Behavior (NSSHB) argued that Americans had expanded their erotic repertoire considerably since the NHSLS was conducted in the early 1990s (Reece et al., 2010). In the NSSHB study of 5,865 adults and adolescents from 14 to 94 years old, the researchers found that both oral and anal sex had become increasingly popular over the course of the last 18 years, possibly due to the rise of the Internet. Over 40 variations of sexual acts were reported by participants during their most recent sexual encounter. Nonetheless, the coital imperative remains intact. More women reported having vaginal intercourse, in all age cohorts, than any other sexual act in the preceding month. This was also true for men; males from 25 to 49 reported that vaginal intercourse was the most frequently reported sexual activity (Reece et al., 2010).

The coital imperative operates even in situations where its risks far outweigh whatever pleasures it provides—as in the case of Romania under the pronatalist Ceausescu government (Baban & David, as cited in Gavey et al., 1999). Under this repressive regime, which lasted from the mid-1960s to the late 1980s, abortion was forbidden for women under 40 years old, and contraception was illegal. Both were very difficult to attain. However, that did not stop women from having illegal abortions—

sometimes multiple abortions. Baban and David conducted interviews with women who had lived through this regime, and many women reported having as many as 16 abortions. One woman had 32. Some women opted for self-induced abortions. One mother of three described ingesting photochemical solution to eliminate an unwanted pregnancy. She also injected oxitocin for the same purpose. She had obtained the chemical from a veterinarian who used it to induce abortion in cattle. In regards to such horrific experiences, she stated that, "a couple of times I thought I'd die." (Baban & David, as cited in Gail & Kligman, 2000, p. 231). Over 10,000 women did die from illegal abortions during this 23 year time span. Nonetheless, intercourse continued to be the primary sexual act—whether the woman derived any pleasure from it or not (Baban & David, as cited in Gavy et al., 1999). According to Baban and David (as cited in Gavey et al., 1999), only one woman they interviewed stopped having intercourse—and only after a particularly horrible abortion.

From a legal standpoint, intercourse is also considered the preeminent sexual act. Omori (2008) pointed out that intercourse to male ejaculation has historically been required for a federal definition of rape and for the legal consummation of a marriage. Within the context of androcentric sexuality, the female orgasm has been accorded less social emphasis and rendered, in many cases, a disposable option (Maines, 1999; Omori, 2008).

Research (Armstrong, England, & Fogarty, 2009; Michael et al., 1994) has found that the there is a orgasm gap between men and women that is at least partially attributable to the popular equating of sex with vaginal intercourse and the corresponding

fact that coitus is an unreliable means to orgasm for most women (Fisher, 1973; Hite 1976; Lloyd, 2001; Maines, 1999). In a meta-analysis of research on the female orgasm, Lloyd (2001) found that only 15-35% of women reported climaxing during unassisted intercourse (coitus without concurrent clitoral stimulation), while 31-54% reported climaxing during both assisted (coitus with concurrent clitoral stimulation) and unassisted intercourse. The clitoris and the penis develop out of the same embryonic tissue and are analogous organs from a biological standpoint (Chalker, 2000). Unfortunately, the clitoris (unlike the penis) receives limited, indirect stimulation during intercourse that is not sufficient for most women to orgasm (Hite, 1976; Lloyd, 2005).

Limiting clitoral stimulation to foreplay makes the female orgasm less likely to occur (Hite, 1976). Hite found that women, unlike men, need continuous stimulation to orgasm. If stimulation is discontinued at any point, arousal stops, even if a woman is in the midst of an orgasm. Women often report that their level of arousal drops during intercourse (Hite, 1976; Masters & Johnson, 1979). The abandonment of clitoral stimulation could be one explanation for this problem.

In spite of this fact, sexual images, in both the mainstream media and porn, portray women as effortlessly orgasmic during vaginal intercourse—possibly, adding to women's sexual shame and frustration. According to Hite (1976), many of her participants reported feeling defective or abnormal if they were unable to climax vaginally. Furthermore, they also felt pressured by male partners to orgasm this way.

Consequently, many women resort to faking an orgasm if they are unable to climax during intercourse. Over 50% of women have reportedly faked an orgasm at some

point in time. (Muehlenhard, & Shippee, 2010; Wiederman, 1997). Ironically, sexually experienced women are more likely to fake than their less experienced counterparts (Weiderman, 1997). In Wiederman's study of 161 young, adult women, he found that having more and varied sexual experience, greater sexual self-esteem, and a higher rate of self-reported facial attractiveness was associated with pretended orgasm. Wiederman had hypothesized that pretenders would be higher on self-monitoring than non-pretenders, but this did not prove to be the case. However, pretenders did have a higher number of lifetime fellatio partners (after controlling for age), leading Wiederman to surmise that one factor for their propensity to pretend might be a greater regard for a partner's satisfaction. Muehlenhard and Shippee (2010) did find that more women than men reported faking an orgasm to please a partner. While men also faked orgasms at times, they were more likely to do so to end an encounter that was not going well because they were intoxicated or because they had already had an orgasm.

Women are more orgasmic when the sexual menu is varied. Because androcentric sexual scripting requires women to be sexually passive (Tolman, 2001) the female orgasm is highly dependent on a partner's willingness to provide "extra" (clitoral) stimulation during sex (Boyle, 1993; Hite, 1976), and whether men are willing to do this depends on cultural norms regarding female pleasure. According to Mead (1949), anthropological studies of diverse cultures have found that the occurrence of the female orgasm is contingent on its value within a given society:

> the capacity to learn a total orgasmic response is present differentially in all women, and that the differentials are perhaps very slight, depending on such

> details as the relative sensitivity of a variety of erogenous zones….Societies like Samoa that emphasise a highly varied and diffuse type of foreplay will include in the repertoire of the male acts that will effectively awaken almost all women. (p. 203)

In other words, given the variety in women's sexual response patterns, a larger repertoire of sexual activities would be advantageous for most women—a fact that has been borne out by research. While men are more likely to orgasm during a sexual encounter than includes vaginal intercourse, women are more orgasmic when a variety of sexual acts are included on the sexual menu, including coitus (Reece et al., 2010). Societies that value the female orgasm incorporate diverse activities that lead to its achievement as a matter of course (Mead, 1949).

In cultures where female orgasm is irrelevant, little effort is made to ensure its occurrence and sexual activities are often limited. Cross culturally, the female orgasm is often more of a possibility than an actuality, due to heterosexual gender norms (Mead, 1949). The orgasm gap is more pronounced during heterosexual sex than during masturbation (Hite, 1976; Laumann, Gagnon, Michael, & Michael, 1994). Hite reported that 96% of her participants, who were regular masturbators, climaxed reliability during self-stimulation, while only 30% did so consistently during intercourse. Laumann et al. (1994) found that 81% of women who masturbated, on a weekly basis, were orgasmic usually or always during their autoerotic experiences. In addition, better educated women (some graduate school) were more likely to masturbate and 87% of them reported always having an orgasm during self-stimulation. However, many women do not masturbate that

often, which can reduce their ability to orgasm during self-stimulation. According to Laumann et al. (1994), individuals who are members of social groups (e.g., women, African-Americans, older individuals etc.) where masturbation is not as commonly practiced masturbate less often and are less likely to orgasm from this activity.

Impediments to Female Sexual Expression

Kernis and Goldman (2004) defined authenticity as "the unobstructed operation of one's true or core self in one's daily enterprise." (p.32). Theorists such as Gilligan (1982), Jack (1991), and Neff and Harter (2002) have argued that cultural dynamics impede female self-expression in a variety of areas, including conflict resolution, psychological development, and depression. This concept has been operationalized in various ways, and the metaphor of "voice" frequently used. For example, Gilligan (1982) spoke of the use of gender biased theories to explain the social development of both men and women as derogating the female voice; while Jack (1991) used the metaphor to describe women's self-silencing tendencies in heterosexual relationships. Babour (2008) and Neff and Harter (2002) preferred the term authenticity, which they believed was suppressed in women by gendered culture.

Authentic female sexual expression is undermined by gender inequality that limits personal empowerment (Barbour, 2008; Few, 1997). Severe consequences (e.g., honor killings) are experienced by women who dare breach cultural norms (Ryan & Jetha, 2010). The cultural assault on women's authenticity impacts sexual satisfaction, agency, and self-acceptance. Research has found that women often have problems discussing their sexual needs with a partner—especially needs related to clitoral stimulation (Hite,

1976, Kelly, Strassberg, & Kircher, 1990; Kelly, Strassberg & Turner, 2004). Many women report body image concerns that impact sexual satisfaction (Koch, Mansfield, Thurau, & Carey, 2005) and having sex that is either unwanted or coerced (Impett and Peplau, 2002).

According to Gilligan (1982), western culture has traditionally considered men the default model, regarding women as "deviant" when they failed to conform to the "masculine cloth" (p. 6). Never has this been truer than in historical attitudes toward female sexuality. Throughout history, the female body itself has been conceptualized as problematic, inferior, and disease prone (Blackledge, 2004; Maines, 1999; Omori, 2008). Prior to the 18th century, women were considered to be inverted and inferior versions of men—the "one-sex theory" (Laqueur, 1990, p.vii)

Hippocrates believed that men and women were made of different humors. Women were made of cold, moist, earthy humors, while men were composed of fiery, airy humors. Women needed to be heated up for conception, and orgasm (in both men and women) was the kindling that lit the reproductive flame (Aroba, 2000; Blackledge, 2004). It was believed that ovulation occurred at the precise moment a woman climaxed; thus, the female orgasm was indispensible for conception (Aroba, 2000).

The vagina was regarded as an inverted penis. Because women lacked sufficient heat, they were unable to project the interior penis outward from the body (Blackledge, 2004)—a fact reiterated by Galen, "The woman is less perfect than the man in respect to the generative parts. For the parts were formed within her when she was still a foetus, but

could not because of the defect in heat emerge and project on the outside". (Blackledge, 2004, p.70).

With the advent of the Industrial Revolution, the female orgasm fell out of favor. During the late 18th century, scientists realized that ovulation was a spontaneous event that was independent of a woman's orgasmic satisfaction, and the female orgasm was quickly declared unnecessary (Aroba, 2000). There were corresponding changes in the way the human body was viewed as well. The new industrial age valued mechanical efficiency, and the female body with its complex reproductive function was seen as inefficient and wasteful compared to more the streamlined male anatomy. The "two sex theory" that men and women were diametrically opposed opposites destined for different spheres came into vogue and replaced the original "one sex theory" (Laqueur, 1990, p. vii).

Female subjugation has traditionally been based on women's deviation from the male model and from the view that men and women are destined for different roles with the female role being subordinate to the male, and sexual activity, like other forms of intimacy, occurs within this framework of inequality (Hite, 1976; Laumman et al., 2004). The traditional sexual model of foreplay, intercourse to male ejaculation, with the female orgasm an oft-neglected side item, is tolerated by many women and constitutes a form of "sexual slavery", according to Hite (1976, p. 333). However, it is a reflection of an overall pattern in gendered culture that encourages women to sacrifice their own feelings and needs in order to maintain relationships (Hite, 1976; Jack, 1991; Maines, 1999). For instance, Nicolson and Burr (2003) found that women often internalized cultural norms

and saw their own orgasms as insignificant. In their qualitative study of 33 women, it was common for the participants to regard their sexuality as a way of giving to men and to feel that they should not expect an orgasm as a matter of course because it would put too much pressure on their male lovers:

> in one example,[sic] a respondent demonstrated a fear of being perceived as sexually demanding. The respondent stated that to expect orgasms would amount to pressure and I wouldn't put that pressure on my partner… I wouldn't demand it every time. In other words women actively seek to not be perceived as sexually demanding in return for [the]idea that her male partner would be happy with me and fulfilled. (Nicolson & Burr, 2003, p. 1743)

Gender socialization creates different relationship expectations and emotional needs for men and women. According to Chodorow (1989), women have a gender identity that is formed within the context of relationships, while the male gender identity evolves in a context of autonomy and achieved status.

In the context of their personal relationships many women must deal with no-win double binds where authenticity is pitted against relationship stability (Gilligan, 1982; Jack, 1991). Jack (1991) believed that women often use self-silencing behaviors to placate a significant other, and postulated that female socialization creates a schism between the authentic inner voice and the Over-eye—the internalized collective voice of society. A woman, looking at herself from the perspective of the Over-eye, sees herself from a third person perspective. This idea harkens back to what Mead (1956) referred to as the "generalized other", which is the traditional way that "the community exercises

control over the conduct of its members" (p.219-220). Both the Over-eye and the generalized other involve absorbing and internalizing society's values and shaping one's own behavior and attitudes to conform to these norms. Jack (1991) pointed out that these norms frequently reflect patriarchal attitudes that look at women from the standpoint of the male gaze: "[This perspective] like a cataract over clear vision, occludes a woman's ability to see for herself and silences her willingness to speak from her own perspective." (p. 133). In her study on depressed women, there were several specific ways that these women silenced their own voices.

For one, looking at oneself from the perspective of the Over-eye encourages the dismissal of the authentic self's natural needs and inclinations. A woman who is self-silencing questions her own perspective and focuses her attention on pleasing others—especially men (Jack, 1991).

Two, a woman utilizing the Over-eye becomes detached from the self, which she comes to regard as an object (Jack, 1991). Frederickson and Roberts (1997) called a similar process objectification—which, unlike Jack's Over-eye, referred exclusively to the phenomenon whereby a woman views her body from the standpoint of the male gaze. They argued that body self-objectification reduced a woman's ability to be spontaneous, led to habitual self-consciousness, increased the risk for depression, and engendered sexual dysfunction (Frederickson & Roberts, 1997).

Three, an essential prerequisite for self-silencing involves the suppression of disruptive feelings such as anger that are defended against by the use of elaborate defense mechanisms, like rationalization, denial, and repression (Jack, 1991).

Authenticity as a Theoretical Tradition

According to Kernis and Goldman (2006), the idea of authenticity is nothing new. It has been a central concern of philosophical traditions for many years and discussion has typically revolved around two distinct areas: self-knowledge, including objective metacogniton of personal limitations, and how one behaves in one's relationships. Philosophers from Socrates to Sartre have pondered the notion of the self and its realization. In the field of psychology, it has also played a role in the concept of psychological health. For instance, Freud (1923) argued that neurosis was the result of maladaptive defense mechanisms. He believed that the human psyche consists of the id, the super ego, and the ego. The id contains unconscious and often forbidden impulses related to aggression and sexuality that threaten the moral restraints of the super ego (the internalized voice of society). This conflict creates anxiety for the individual. The ego is then called into play to moderate between the id and the super ego often making use of elaborate defense mechanisms such as denial, repression, reaction formation, and sublimation that distort and deny reality (Freud, 1923). This process limits self-awareness and unbiased processing—two prominent features of authenticity, according to Kernis and Goldman, (2004).

Horney (1950), one of Freud's followers, was also concerned with the connection between authenticity and emotional health. She believed that there were serious repercussions resulting from the loss of the authentic self, which she referred to "as the alive, unique, personal center of ourselves" (p. 155). She called the suppression of the real self a "devil's pact" that "corresponds to the selling of one's soul" (p. 155). Like

Freud, she too believed that losing the self was a prime factor in the development of neurosis.

Fromm (1947) looked at the connection between social theory, economic systems, and authenticity. He believed that modern capitalism spawned a kind of personality orientation that he referred to as the marketing character, best described by the tagline "I am what I do" (Fromm, 1947, p. 72). This type of individual sees the world as a marketplace, where he or she molds his or her behavior according to whatever trend predominates. People and relationships are regarded as commodities to be traded, and the new is valued above all else. Authenticity is less important that being a marketable individual.

Finally, Maslow's (1968) theory of self-actualization conjectured an association between optimal psychological health and authenticity. He asserted that self-realization required a lack of psychopathology and an "acceptance and expression of the inner core or self, i.e., actualization of these latent capacities, and potentialities, "full functioning," availability of the human and personal essence" (p. 218).

According to Kernis and Goldman (2006), self-determination theory (SDT) also played a critical role in the formation of their concept of authenticity (Deci, 1980). The central premise of SDT is that authenticity occurs when an individual's behavior reflects his/her own inner leanings and core values. SDT posits three core human needs: relatedness, autonomy, and competence that must be met for the individual to attain optimal psychological health (Deci & Ryan, 2000). Furthermore, they believed that only

when an individual's growth oriented impulses and needs were thwarted by external factors will he or she stop striving for psychosocial integration.

Sexual Authenticity

In general, authenticity as it relates to sexuality is an under-researched area. There have been a few studies focused around this area. Impett, Schooler, and Tolmen (2006) looked at how internalization of social norms regarding femininity in the areas of relationship inauthenticy and body objectification impacted sexual efficacy and health. This study of 116, teenage girls found that participants who had higher reports of body objectification and relationship inauthenticity had lower scores on the sexual self-efficacy measure, and, in turn, this was associated with less use of contraception and less sexual experience. In Kleinplatz's (2007) study of optimal sexuality, she found that the second characteristic participants listed for "great" sex was authenticity, which was defined as feeling free enough with one's partner to be oneself. Participants spoke of being "emotionally naked" with a partner and "to stop getting in your own way" as being imperative for enjoyable sex (p. 74).

Barbour (2008) conducted a qualitative study on the subject of female sexual authenticity in young Nova Scotian women. She found that objectification, commodifaction (the trading of sex for other rewards), and gender role ideology reduced women's capacity to express sexual authenticity. Women also reported confusion regarding how to navigate through the minefield of cultural mixed messages regarding sexual activity—particularly as it related to the Madonna/whore dichotomy. Though being "sexy" is culturally valued to a degree, deciphering what is "sexy" from what is

"slutty" can be an arduous task for young women. This was also an emerging theme in Phillips's (1999) qualitative study. Phillips noted that cultural trends toward more permissive sexual norms for women are frequently in conflict with traditional discourses that dictate sexual reticence—this is especially true for women from ethnic backgrounds that value modesty in females.

Kernis and Goldman's Authenticity Theory and Female Sexuality

Using Kernis and Goldman's (2004) authenticity theory, one can trace the mechanisms involved in women's sexual self-silencing and the cultural suppression of female sexuality. Kernis and Goldman believe that there are four components to authenticity. 1. Awareness: Authenticity requires a high degree of awareness regarding one's own feelings, inclinations, goals, and dispositional characteristics. People who have higher levels of self-awareness are also more cognizant of their polarities and are better able to integrate opposing dispositional propensities into a coherent whole. As Kernis and Goldman (2004) pointed out, dualities like extrovert and introvert, emotional or stoic are not as mutually exclusive as they appear. Polar personality traits usually assume a figure/ground relationship with predominating traits taking precedence at certain times (figure), while other traits are overshadowed (ground).

2. Unbiased Processing: This refers to the objective processing of self-relevant material. People who are high on authenticity do not use a lot of defense mechanisms to block painful emotions from self-awareness. Nor do they rely on "self-serving biases, and illusions" (Kernis & Goldman, 2004, p.33). Maladaptive defense mechanisms have the effect of distorting reality which makes the resolution of personal issues problematic.

Minimal use of defense mechanisms allows the individual better reality testing and access to relevant self-information (2004).

3. Behavior: People who are highly authentic in their personal behavior act in accordance with their own inner dictates. They are less concerned with pleasing others and are more inner directed. However, it is also true that in the real world, people are put in double binds. As a result authentic behavior may be harder to manifest in certain circumstances; though, the authentic individual may still be both self-aware and unbiased in their processing of relevant personal information (Kernis & Goldman, 2004).

4. Relational Orientation: People who are more authentic value relationships where they are known. They are less concerned with the presentation of a false self in order to get rewards and avoid consequences. They are also more likely to experience genuine intimacy in their relationships. Kernis and Goldman (2004) make the point that these four components while separate are still inter-related.

Historical View of Female Sexuality

In order to understand the relationship between authenticity and FSD, it is important to put the disorder in a sociohistorical context. Many common aspects of female sexuality have historically been viewed as pathological, socially destabilizing, and potentially destructive (Maines, 1999). Gendered culture renders any aspect of women's sexual response that deviates from the male model as either invisible or subversive. Indeed, women's primary sexual organ, the clitoris, has gone in and out of fashion—depending largely on whether or not the female orgasm was in vogue. Throughout

history, the female body was viewed as inferior to the male and prone to dysfunction—usually, requiring some type of medical treatment (Groneman, 1994; Maines, 1999).

The type of treatment has varied with the disorder and includes such measures as bloodletting and ovarectomies, (for nymphomania), physician and midwife assisted genital massage, vibrators, and mandatory sexual intercourse (for hysteria) and cornflakes, clitoraldectomies, and restraints for masturbation (D'Emilio & Freedman, 1988; Groneman,1994; Maines, 1999; Studd, 2007). Currently, some of the recommendations to treat FSD include clitoral pumps and androgen replacement (Moynihan, 2005; Munarriz, Maitland, Garcia, Talakoub, & Goldstein, 2003).

Hysteria

Hysteria was known to both the Ancient Greeks and the Egyptians and was only removed from the *DSM* in 1952 (Barbour, 2008; Maines, 1999). It was a common malady, said to afflict primarily women (Maines, 1999). The word hysteria comes from the Greek word hysterikos meaning "that which proceeds from the uterus" (Maines, 1999, p. 21). Over the centuries, hysteria was called by a variety of names, including praefocatio matricis (suffocation of the mother), suffocation ex semine retento (suffocation because of retained seed), womb-furie, and greensickness (Blackledge, 2004; Maines, 1999).

Sexual deprivation, according to the great thinkers of antiquity, creates a condition in which the uterus revolts against neglect (i.e., abstinence), and hysteria was considered a disease of the uterus. Plato argued that the condition occurred when the uterus left its appointed location and wandered around the body in an aimless fashion

creating both physical and psychological havoc—such as strangulation brought about by the organ crawling up the windpipe (Maines, 1999).

One popular theory held that hysteria involved the retention of female seed. The emission of body fluids (blood, semen, sweat) was believed to promote health, while retention led to disease "retained semen, according to 17th-century thinking degenerated into a poison of great strength—equivalent to the venom of a mad dog, serpent, and scorpion" (Blackledge, 2004, p. 204). Hysteria was believed to be rampant in widowed and virginal woman and reached epidemic proportions in the 17th century (Maines, 1999).

There were a plethora of symptoms associated with the disease, including yawning, itching, stomach upsets, insomnia, reading French novels while wearing tight corsets, marital disagreement, too much bicycling and/or imbibing, anxiety, feelings of abdominal heaviness, vaginal lubrication, and sexual fantasy. According to Maines (1999; Omori, 2008), hysteria was regarded as a normal aspect of female functioning.

The traditional cure for hysteria was vaginal intercourse (Maines, 1999). If this did not alleviate the symptoms, alternative treatments were available. Vulvar massage by a trained physician or midwife was one of the most recommended procedures, quite popular throughout the ages, and one that eventually led to the development of the vibrator "a capital-labor substitution innovation" in the late 19th century (Maines, 1999, p. xv).

Nymphomania

Nymphomania, a favorite aberration of Victorian physicians, also had an especially pernicious symptomology. According to Groneman (1994), by the 19th century, it was believed to be an organic disorder with a specific set of symptoms and a specific etiology. Concerns about nymphomania were a product of the Victorian view of women as not very much troubled with sexual feeling of any kind" in the words of British physician William Acton (as cited in D' Emilio & Freedman, 1988, p. 70). Since women were asexual creatures any evidence to the contrary must be a sign of degeneracy—possibly brought about by diseased genitalia or faulty menstruation. This was a new view of female sexuality that correlated with the rise of industrialization and the middle class (Groneman, 1994).

From the middle ages to the mid-18th century, women were considered as lusty as men. The change in social norms regarding female sexual expression paralleled the economic segregation of the sexes (Groneman, 1994). During the Colonial era, women played a vital role in the family economy. Women in the 18th century ran taverns and shops and occasionally were involved in professional careers like medicine and journalism. The Colonial wife contributed to the family economy by working alongside her husband to produce goods. The idea that the husband was the breadwinner because his wife was too delicate to withstand the harsh realities of the working world was both nonexistent and largely an invention of the 19th century. By the Victorian age, the Industrial Revolution, spurred on by capitalism, had moved the means of production from the family-run farm to the factory. This segregated the sexes, and the market place

became the domain of men, while the home became the providence of women (Bernard, 1981; Coontz, 1992).

According to Coontz (1992), in the free market economy reciprocal obligation and sentiment, formerly the social glue of precapitalist culture, were seen as unprofessional and inappropriate. In the market place, individualism and competition reigned supreme. Since the cut-throat world of the free market was no place for the Victorian Madonna, a woman's place was regulated to the home where the white, middle class woman enjoyed a protected and cherished status. But it was a status that "gave women indulgence as a substitute for justice" (Tannahill, 1980, p. 349). The 19th-century woman was denied access to economic independence, could not vote, or receive higher education (Coontz, 1992). That women could participate fully in the outer world was unthinkable and would destroy their delicate sensibilities unfit for such egregious tasks as education or commerce (Tannahill, 1980).

The Victorian gender norms infantilized women and promulgated asexual motherhood as their only natural role (Bean, 2002). In this context, women who did not conform to this image were considered degenerate; hence, the widespread worry about nymphomania and its ill reputed cousin masturbation (Groneman, 1994). It should be pointed out that moral restraint was deemed representative of the middle class, white woman only. Working class or black women were seen as sexual opportunists of easy virtue (D'Emilio & Freedman, 1988; Groneman, 1994).

A typical case of nymphomania was described by the 19th century physician Horatio R. Storer (1856): Mrs. B was a 24 year old, married woman who dreamed and

fantasized about men with whom she had a casual acquaintanceship. These thoughts were very sexual in nature and disturbed the patient a great deal. Storer (1856) reported that Mrs. B "Enjoys intercourse greatly; is conscious of excessive local excitement, so great that she not unfrequently faints during penetration" (p. 385). Mrs. B had intercourse every night of her married life, even during menstruation. Storer asserted that were she to continue with such behavior, she would likely end up in an asylum. The cure for her nymphomania was temporary sexual abstinence, the cessation of novel writing and brandy consumption, a bland, meatless diet, and the application of borax to the vagina. (Storer, 1856; Groneman, 1994).

According to Groneman (1994), the typical nymphomaniac was a woman like Mrs. B who desired (or had) frequent sex, engaged in masturbation, or who exhibited lesbian leanings. There were several varieties of nymphomania, including puerperal nymphomania (a disorder associated with childbirth), nymphomania induced by opium, homosexual nymphomania, and platonic nymphomania. Nymphomania had been noted prior to the 19th century but was generally believed to be connected with love sickness, or morbid erotic passion. Galen referred to nymphomania as furor uterinus, or uterine fury. Some of the treatments for this condition were bleeding to drain the humors and restore balance to the body, purges, emetics, and cold baths. Since enlargement of the clitoris was believed to be a major factor in nymphomania, its removal (via clitoraldectomy) along with the labia was also recommended—an early proponent of such procedures was Sir Isaac Baker Brown. Oophorectomies (removal of the ovaries) were also proposed to curb sexual insatiability (Groneman, 1994).

Masturbation was a huge concern of the 19th century moralists, and it was believed that nymphomaniacs were especially prone to the "solitary vice" to their inevitable detriment. According to Smith (1892), a masturbating woman might find herself adverse to conjugal relations because the "substitution of mechanical, and iniquitous excitations [vibrators and/or masturbation] affords more thorough satisfaction than the mutual, legitimate ones do" (p. 677). A plethora of scientific papers dealing with the dangers of masturbation proliferated in the late 19th and early 20th century (Blackledge, 2004). Such papers educated doctors on how to tell if their female patients were masturbating by looking for such tell tale signs as having one vaginal lip longer than the other and being inordinately sensitive to sexual stimulation. Treatments such as sending an electric shock through the urethra and applications of carbolic or sulphuric acid to the clitoris were common recommendations for female masturbation (Blackledge, 2004).

Frigidity

Sigmund Freud's theory of psychosexual development created a broader appreciation of sexuality and its impact on psychological development in the early 20th century. But his views of female sexuality have been criticized by feminists (Brownmiller, 1975; Gerhard, 2000; Hite, 1976; Koedt, 1970; & Maines, 1999) for their androcentric bias. Freud (1915) contended that clitoral orgasms in women were immature and masculine. A proper, mature woman was vaginally orgasmic through coitus. At puberty, psychologically and sexually healthy females transferred their erotic focus from the clitoris to the vagina when they began having sexual intercourse. He believed that this

process occurred as a form of repression in women. What was repressed was the clitoral (i.e., masculine) component of sexuality. The clitoris still had a role to play as a progenitor during foreplay. According to Freud (1915), its role was "the task, namely, of transmitting the excitation to the adjacent female sexual parts, just as—to use a simile—pine shavings can be kindled to set a log of harder wood on fire." (p. 87). Failure to make this transfer led to a anesthetizing of the vagina and a fixation on the clitoris. The process and, in particular, the failure of the erotogenic transfer from the clitoris to the vagina is one reason for women's greater propensity "to neurosis and especially hysteria" (Freud, 1915, p. 87). Clitorally orgasmic women were unable to achieve a well integrated feminine gender identity (1915).

Frigidity was a huge topic of psychoanalytic concern from the 1920s to the 1960s (Gerhard, 2000). Freud's views on the disorder were carried through much of the century by his colleagues and students. Sexuality was intricately associated with gender role requirements, and many Freudians believed that women were intrinsically passive, maternal, and vaginally orgasmic. Women who remained invested in their (masculine) clitorises were viewed as rebelling against the normal female gender role. For instance, Deutsch (1944) believed that the vagina, a nonfunctioning sexual organ in little girls, must be awakened by the male during intercourse because the natural nature of femininity is narcissistic, passive, and masochistic. She also concurred with her mentor, Freud, that frigidity was the result of clitoral fixation, "The competition of the clitoris, which intercepts the excitations unable to reach the vagina and the genital trauma then create the dispositional basis of a permanent sexual inhibition" (Deutsch, 1944, p. 233).

The idea of vaginal frigidity came under fire when Kinsey and Masters and Johnson published their research in the 1950s and 1960s. The new sexology brought with it actual scientific data, that in contrast to psychoanalytic suppositions, called into question the veracity of the vaginal orgasm (Gerhard, 2000). According to Gerhard (2000), Kinsey insisted that the female orgasm was predicated on the same physiological responses as the male's. The vagina, the epicenter of Freudian femininity, was for Kinsey and his associates inadequate at producing sexual pleasure. Kinsey completed a series of experiments with a Q tip that were engineered to show that the vagina was lacking in surface nerve receptor cells and therefore "of minimum importance in contributing to the erotic responses of the female" (Kinsey, 1953, p. 592). Later, Masters and Johnson (1966) questioned the validity of a distinct vaginal orgasm, claiming that all orgasms in women were clitoral in nature. Using such research, 1960s and 1970s feminists began to systematically dismantle traditional, androcentric views of female sexuality by dissociating it from reproductive and heterosexist social norms (Gerhard, 2000).

FSD

According to Tiefer (2006a), FSD is the latest dysfunction to be associated with female sexuality. Like hysteria and nymphomania in earlier times, much of the interest in the new diagnosis is permeated by a decidedly medical slant. In the 1970s, the two dominant approaches to sex research were social constructionism (looking at sexuality within a contextual setting) and biological reductionism (sexuality as a biological event). Tiefer (2006b) argued that by the 1980s the biomedical discourse began to dominate in academic circles, due partly to an increase in the number of urologists working in sexual

medicine. This influx occurred because of two happenstance changes to the field of urology; the introduction of lithotripsy therapy for kidney stones and the development of pharmaceutical treatments for male prostate enlargement. Both of these changes reduced the need for surgical interventions that had been mainstays of urology practice, which meant doctors needed to find alternate avenues for professional aggrandizement (Tiefer, 2006b). This coupled with researcher's hope that the blockbuster success of Viagra could be duplicated with a female elixir meant that the stage was set for FSD to be defined as a medical problem (Tiefer, 2006b). Furthermore, in order for a lifestyle drug (like Viagra) to be approved by the FDA, there must be evidence that it treats a "medical" condition. The FDA does not consider improved quality of life to be a valid reason for a drug to be prescribed in the United States (Fishman, 2004).

However, FSD has been mired in controversy and confusion since its inception. One of sexuopharmacology's primary building blocks has been the 43% dysfunction rate reported by the University of Chicago from research extrapolated from the (NHSLS) (Laumann et al., 1999). This statistic has been widely reported in the popular press and has come under attack for several reasons. For one, the designation of "dysfunction" was applied if a participant affirmed that she had experienced one of seven sexual symptoms for 2 months or longer over the past year. Whether the woman considered her symptom a problem was not taken into consideration (Laumann et al., 1999). Second, there are charges that the 43% statistic overmedicalizes female sexual problems. As clinical psychologist Sandra Leiblum pointed out, "I think that there is dissatisfaction and

perhaps disinterest among a lot of women, but that doesn't mean they have a disease."(as cited in Monyhan, 2003, p. 46).

Another point of contention has been the applicability of the *DSM-IV-TR* diagnostic system to female sexual problems. The classifications used in the *DSM-IV-TR* to make a diagnosis of dysfunction are based on Masters and Johnson's studies of the Human Sexual Response Model (HSRM) that were conducted on a highly select sample of easily orgasmic, largely Caucasian, and economically advantaged participants (Masters & Johnson, 1966). Furthermore, most of the female participants in Masters and Johnson's sample were orgasmic during intercourse (1966), which is not true for the majority of women (Fisher, 1973; Hite, 1976; Lloyd, 2005). The original model consisted of four phases: excitement, plateau, orgasm, and resolution. These stages were derived from physiological changes that occur during sexual excitement. Critics have charged that the HSRM does not represent female response very well (Basson, 2000; Tiefer, 2001a). For example, the model is often represented as a linear cycle with a smooth transition from desire to arousal, to orgasm, to resolution. But, Basson (2000) argued, female arousal does not always follow a linear pattern, and often desire is not the chief motivating factor in women's sexual involvement but rather takes a secondary position to nonsexual rewards, such as enhanced intimacy. The confusion among sex researchers as to what constitutes "normal" and "dysfunctional" sexual response patterns in women has also been considered a controversial and problematic issue in FSD classification (Kleinplatz, 2005; Moynihan, 2005).

Moreover, Laumann et al.'s (1999) research contradicted many of the tenets of the medical model. For example, they found far fewer age-related medical problems in women than in men. In contrast to cultural stereotypes associating marriage and menopausal status with less sexual enjoyment, Laumann et al. found that younger, single women exhibited more sexual problems than older, married women on every measure of dysfunction except trouble lubricating. Women aged 20 to 29 had higher rates of orgasmic dysfunction, sexual pain, performance anxiety, lack of pleasure, and hypoactive desire disorder. Single women were almost twice as likely to have problems with orgasm. Sexuality was found to be very influenced by race, educational attainment, and class. African American women experienced higher rates of inhibited desire and pleasureless sex, but less sexual pain than Caucasian women. Hispanics had the lowest rates of sexual dissatisfaction—though, this could be related to a greater reticence to discuss sexual issues. Lower educational attainment was associated with more sexual problems for both men and women (Laumann et al., 1999).

Unlike men, women's sexual issues were not associated with increasing age or poor health. Older men were found to have more problems with age-related erectile dysfunction and lower sexual desire than younger men, but in women, sexual problems decreased with age. Furthermore, while ill health was associated with a multitude of male sexual complaints, this also was not true for women. Stress, marital status, and economics were more important predictors of sexual issues for women (Laumann et al., 1999).

Prior to the advent of sexuopharmacology, sex therapy was the dominant treatment paradigm for most sexual issues. In the 1960s and 1970s, Masters and Johnson

developed a brief, couple-centered model that combined psychotherapy with behavioral exercises tailored to each couple's specific problem (Hicks, 2005). According to Tiefer (2001a), since the rise of sexual medicine in the 1990s there are fewer sex therapy clinics or training programs available. Furthermore, most of the new professional journals that deal with sexual issues focus on pharmacology or physiology. Advances in sexual medicine have been bolstered by improved technology that has made it possible to examine biological experiences in a way never before possible and to use that data to make a clinical diagnosis. For example, genital blood flow and nerve transmission can now be measured and incorporated into a *DSM-IV-TR* diagnosis like erectile disorder or sexual arousal disorder (Tiefer, 2006a).

Nonetheless, the hunt for a female Viagra has proved largely fruitless. Initially, Pfizer sought FDA approval to market Viagra itself to women but withdrew their submission when several controlled studies, including one involving 3,000 women with sexual arousal disorder, failed to demonstrate statistical significance. It is still being prescribed off-label by some doctors for sexual arousal disorder (Tiefer, 2006a). Currently, the only FDA approved treatment for FSD is the Eros CTD therapy device, a high priced clitoral pump/vibrator that is available by prescription only, and like Viagra, increases blood flow to the genitals (Tiefer, 2006a).

Tiefer (2006) charged that FSD is good example of "disease mongering" (para.1).The Boston conference was funded and attended by researchers with corporate ties to drug companies, and 18 out of 19 of the authors of the new designation (FSD) had alliances with 22 pharmaceutical companies. In addition, many of the subsequent

conferences and research into the area of FSD have been sponsored by Pfizer and other pharmaceutical companies. Moynihan argued that studies like Laumann et al. (1999) have been co-opted by drug companies as a way of marketing a female Viagra—the first step of which is to convince the public of the need for such pharmaceuticals by claiming a high degree of medicalized sexual dysfunction (2003).

When Proctor and Gamble were attempting to get their Intrinsa testosterone patch approved by the FDA, they launched a massive marketing campaign to create public awareness about the role of testosterone in sexual functioning including sponsoring scientific meetings on androgen insufficiency, creating a website, and hiring three public relations firms to publicize the condition hypoactive desire disorder. Proctor and Gamble developed an advertising budget in the range of 100 million to publicize their new product, which was not "an exceptional amount of fire power" (Moynihan, 2005, p. 192). According to Tiefer (as cited in Moynihan, 2005), "Proctor and Gamble has a marketing plan that worked for shampoo. Create a buzz, get the word out, heighten consciousness, [and] get people talking." (p.192). The FDA refused to approve Intrinsa due to the increased risks for breast cancer and cardiovascular disease (Moynihan, 2005).

Research into the use of androgens for hypoactive desire disorder has been mixed because of confusion regarding how these hormones affect female sexual functioning (Nyunt et al., 2005). Also, researchers have had problems identifying an average hormonal range for women, particularly as they age. Women have far lower levels of androgens than men, and blood tests are not sensitive to women's lower free testosterone ranges (Miller, Vigersky and Wierman, 2006). According to Guay and Jacobson (2002),

another reason for the confusion could lie in the fact that most laboratory estimates of normal female testosterone levels may have been, at least in part, solicited from women with FSD, since sexual difficulties are not taken into consideration during the screening process to establish these levels.

Nonetheless, clinical trials for Intrinsa did show an increase in monthly sexual activity, among participants, but only by one episode in comparison with placebo (though there was an increase of two episodes in comparison with baseline activity) (Moynihan, 2005). The product is available in Europe, as of 2007, but not in the United States (Martin, 2007).

Sexuophamacology's myopic thinking negates the impact of gender power inequities, body image concerns, and continued cultural invalidation of female sexuality in women's sexual satisfaction. According John Bancroft, former director of the Kinsey Institute; "The danger of portraying sexual difficulties as dysfunction is that it is likely to encourage doctors to prescribe drugs to change sexual function when the attention should be paid to other aspects of the woman's life." (Moynihan, 2003, p. 46).

Due to the numerous issues related to the *DSM*'s diagnostic classification for FSD, Tiefer and colleagues (New View Campaign, 2011) have developed "A New View of Women's Sexual Problems" to look at female sexual issues from a holistic perspective. It includes a classification system that incorporates cultural and relationship based causes. They define a sexual problem as "discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience, may arise in one or more of the following interrelated aspects of women's sexual lives." (2011, para. 1). There are four

components of their criteria: 1. Sexual problems due to sociocultural, political, or economic factors. 2. Sexual problems relating to partner and relationship. 3. Sexual problems due to psychological factors. 4. Sexual problems due to medical factors. The New View of Women's Sexual Problems takes into consideration the complexity of the issues involved and has spawned both a manual and a book (New View Campaign, 2011).

Component 1: Women and Sexual Awareness

The Closeted Clitoris

> As an object the clitoris is an anatomical organ—but as a subject it is contested social terrain: an epicenter of female sexuality in which pleasure and repression collide on an embodied fault line that is both private and public, political and existential, symbolic and corporeal." (Waskul, Vannini, & Wiesen, 2007, p. 152)

Early feminist argued that the "personal is the political" and nowhere is this more apparent than in issues concerning sexuality. Historical invalidation of female sexuality has shaped women's awareness and understanding of their own responses. Knowledge of the clitoris is still not made available to many women, though it is the analogous organ to the penis. It is seldom discussed in the common vernacular, or even in the scientific literature (Ogletree, & Ginsberg, 2000). Ogletree and Ginsberg (2000) looked at the terms used to describe genitalia in the PsychINFO database from 1887 to 2000 and found that penis was used in 1,482 sources, vagina in 409, while clitoris was only mentioned in 83. They also analyzed 57 books listed in a computer database for sex instruction. In the

majority of the books, penis was the most commonly discussed body part—mentioned more than clitoris, vagina, and uterus.

When Allegier and Allegier (2000) studied students in a human sexuality class, they found that only 14% of participants had heard their mothers use the word clitoris in reference to the female anatomy in 1994—unfortunately, by 1998, that figure had decreased to a mere 1% in a follow-up study. In both classes (1994 and 1998) the majority of the student's mothers had spoken of the female genitals as "vagina" (Allegier & Allegier, 2000).

Many women never hear the word clitoris used in their homes, among their friends, or on television. Even in an era of open public discourse about sexuality, the mass media still restricts information on some sensitive topics. According to sex educator Carlin Ross, when she and her associate Betty Dodson speak about women's sexuality on American TV, they are required to refer to the clitoris as the "c spot" (Dodson & Ross, 2011, para. 2). The absence of the clitoris from the public vernacular creates a "symbolic clitoridectomy" according to Ogletree and Ginsberg (2000, p. 925).

Waskul et al. (2007) argued that most women develop an acquaintance with the clitoris long before they understand how it functions as a part of the female genital anatomy. Prior to its full incorporation into a woman's linguistic and cognitive vocabulary, it exists in a nebulous way station that the authors refer to as "symbolic purgatory" (Waskul et al., 2007, p. 151).

The clitoris, like the female orgasm, has gone in and out of fashion for centuries. It was regarded as playing a major role in the female orgasm prior to the 18th century.

Unfortunately, once the female orgasm fell out of favor, so did the clitoris. The rise of industrialization and the realization that ovulation was a spontaneous event led to knowledge of the clitoris being effectively lost. In some anatomy books, the clitoris was reduced to that of a mere squiggle (Blackledge, 2004; Chalker, 2000). According to McClintock, (1992) the clitoris's linguistic castration reflects "the blank balance sheet of our society's concern for women's pleasure" (p.115).

Women's sexual awareness has often followed suit. Waskul et al. (2007 reported that most women in their study did not learn what the clitoris was until the late teens—even though they had an appreciation for its erotic possibilities much earlier. Sexual debut often precedes knowledge of the clitoris, leading Waskul et al. (2007) to opine that this was the equivalent of a "symbolic clitoridectomy: a form of putting the clitoris under erasure not by way of sheer silencing but by a restrictive economy of discourse—among other significant forces—that confines the clitoris in a symbolic purgatory." (p. 160).

McClintock (1992) believed that one reason for this symbolic purgatory is because the clitoris exists outside the parameters of the dominant reproductive model—in a shadow zone, much like homosexuality. Because clitoral eroticism is not dependent on an erect penis, the clitoris becomes an organ of transgression, whose presence threatens the status quo. Confusion as to the exact nature of "down there" is also created by calling the female genitalia by a misnomer, the vagina. According to Waskul et al., the majority of women in their study reported never being told about all of the parts of the vulva either in school or at home (2007). The entire genitals were simply called "vagina". Some feminists (Dodson, 2002) have objected to this common practice because it promotes a

view of sexuality that privileges male over female pleasure and reproduction over orgasmic satisfaction. The cultural invisibility of the clitoris marginalizes and mystifies the female anatomy and makes it more difficult for women to define sex on their own terms, given the fact that these terms are never included in the common vocabulary used to describe the female body. Women's sexual reality is, thereby, rendered inconsequential.

Women's lack of awareness and appreciation for their genitals has a profound impact on their sexuality. Studies (Kinsey, 1953; Michael et al., 1994) have shown that women begin masturbation at a later age than men and do so less often. Kinsey (1953) found that only 20% of women in a given year had masturbated, by 1992 that number had increased to 40% (Michael et al. (1994). Both males and females masturbate as small children but, after a certain age, masturbation is put away and later relearned (Francoeur, 1998). Interestingly, males are more likely to relearn the act from other males, while females learn alone, often after they have become sexually active with a partner (Francoeur, 1998; Kinsey, 1953). It is not unusual for a woman to lose her virginity without having any self-knowledge regarding her sexual responses (Kinsey, 1953; Michael et al., 1994).

This puts a young woman at a distinct disadvantage in regards to possible sexual satisfaction. Indeed, Hite (1976) found that the majority of anorgasmic women in her study had never masturbated. Because of the high correlation between a lack of masturbation history and orgasmic disorder, directed masturbation exercises are often used by sex therapists to help women learn how to orgasm (Meston, 2006).

Body Image and Diminished Self-Awareness

In Kernis and Goldman's (2004) theory of authenticity, awareness refers to cognizance of one's emotional state. Gendered culture creates barriers to effective awareness of sexual feeling states for many women. According to Fredrickson and Roberts (1997), attenuated self-awareness is accomplished through the mechanism of self-objectification. Objectification theory has much in common with Jack's (1991) concept of the Over-eye. In both theories, women look at themselves from a third person perspective based on gender scripting.

However, in objectification theory, the body becomes the primary object of inspection. Women are looked at more than men and are subject to appearance scrutiny more. Consequently, they learn to view themselves as sex objects. High rates of sexualization have been found in most media depictions of women where female sexuality is presented as a currency that young women trade to attain status and power (Fredrickson & Roberts, 1997). The APA (2010) argued that sexualization socializes women to think their primary role is to be sexually attractive for other people's benefit. Indeed, according to Fredrickson and Roberts (1997), a woman's success in life may hinge on physical attractiveness. Attractive women have more dating and marital opportunities, suffer less appearance based job discrimination, and are more likely to go to college. However, for a woman to attain the socioeconomic benefits of physical beauty, she must conform to the beauty ideal exemplified by mass advertising (Fredrickson & Roberts, 1997). Sexualization has become a popular marketing ploy to

sell everything from cars to toothpaste. Its major selling point is the semi-clad, female form (APA, 2010; Reichert & Carpenter, 2004).

The female body is ubiquitously displayed on billboard and magazine ads, in movies, music videos, and TV. Reichert and Carpenter (2004) looked at a sample of media ads from 2003 and found that women were scantily attired in about 49% of women's magazines and 78% of men's magazines. Women were also depicted in sexualized and/or violent positions that emphasized the body, while de-emphasizing the face. For example, it is common to photograph the female form in sections where one body part is the exclusive center of interest. Men are seldom portrayed this way. Most media depictions of men focus on the face, not the body (Fredrickson & Roberts, 1997). Plous and Neptune (1997) found that the rate of White female body exposure in magazine ads increased from 34% to 50% in the years 1985 to 1994. Breast exposure increased from 22.8 % to 42.8% among White women in those years, and for Black women, the rate increased from 30% in 1986-1988 to over 40% in 1993-1994. Furthermore, female celebrities are more likely to be semi-clothed or nude on magazine covers and in advertising (APA, 2010; Frederickson & Roberts, 1997; Plous & Neptune, 1997).

Body Image and Sexual Satisfaction

According to Buss (1994), beauty in both sexes has become an increasingly important ingredient for romantic relationships over the last few decades due to the influence of the mass media. On a scale of 0.00 to 3.00 the importance of beauty in a marital partner went from 1.50 in 1939 to 2.11 in 1989 for men and .94 in 1939 to 1.67 for women in 1989.

However, youth and beauty continue to be disproportionately emphasized in women, with dire repercussions. Women have much higher rates of both eating disorders and plastic surgery (Buss, 1994, Buss & Meston, 2009). Roughly, 45% of American women are on a diet at any given time compared to only 25% of men (Smolak, 1996). Americans spend astronomical sums of money on dieting and dieting related products and books—with $40 billion a year going to the goal of dropping those last 10 pounds (1996). Over 91% of all cosmetic surgery procedures are performed on women (American Society of Plastic Surgeons, 2010), and 8.6 million women in 2010 had some form of cosmetic enhancement (American Society for Aesthetic Plastic Surgery, 2010).

One of the most disturbing trends in plastic surgery (with potentially negative repercussions for female sexual response) is the cosmetic enhancement of the female genitalia—the designer vagina as it has been dubbed by media pundits. Several surgical procedures have been developed including labiaplasty (the removal or alteration of the labia minora) and hymenalplasty (the reconstruction of the hymen). The increasing availability of explicit porn that includes "beaver shots" (vulva close-ups) is one of the major instigators behind the recent interest in elective, gynecological surgery (Green, 2005). Liao and Creighton (2007) found that women seeking labiaplasty routinely showed up at doctor's offices with images of their ideal vulva, much as they do when getting a new hair style. These images were often altered by digital technology to look a certain way. Liao and Creighton (2007) blasted genitoplasty procedures as risky and pointed out that loss of genital sensation was a possible side effect. The American College of Obstetricians and Gynecologists (2007) also issued a warning that these

procedures could increase the risk of infection, scaring, altered sensation, and dyspareunia and that there was no, “documentation of their safety and effectiveness” (para. 1).

Dissatisfaction with one’s appearance can have profound sexual repercussions. Koch et al. (2005) found that poor body image had a far greater negative impact on female sexual response than the biological changes of menopause. In a study of 307 women, between the ages of 35 and 55, the researchers found that the majority of women believed that they were more attractive10 years earlier, regardless of menopausal status. The less attractive a woman perceived herself as being, the more her sexual desire dwindled. Conversely, feeling more attractive led to an increase in desire. Body dissatisfaction was common among the participants, and 21% of the women could not identify one single attractive feature on their bodies. Many reported a general feeling of body dissatisfaction. They were primarily dissatisfied with the parts of the body (stomach, hips, and legs) where weight tends to accumulate with age (Koch et al., 2005).

Other studies (Anderson & LeGrand, 1991) have supported body satisfaction as an important part of female sexual satisfaction. Sexual activity, orgasmic responsiveness, and sexual initiative are more common in women who feel attractive (Ackard, Kearney-Cooke, & Peterson, 2000). Furthermore, people who are more dissatisfied with their bodies are more sexually avoidant and have less sexual experience than individuals with healthier body images (Faith & Schare, 1993).

Beauty in women is often inversely correlated with age, with younger women perceived as more beautiful—primarily, because youth is associated with fertility in

women (Buss, 1994). According to Wolf (1991), male control of economic resources puts women in the position of having to compete with one another to achieve financial security. Correspondingly, many male dominated cultures emphasize youth and beauty in women. Women absorb these massages from the larger culture and internalize them, often seeing themselves as not measuring up to cultural norms of attractiveness as they age. Giesen (1989) found in a series of interviews with women between the ages of 28 and 63 that most of the married participants thought female beauty peaked between the early 20s and the mid-thirties, while they believed that male beauty peaked from early 40s to late 50s. It should be pointed out that the 20s and 30s are primetime ages for female fertility, while the 40s and 50s are primetime ages for male status, since men accumulate more economic resources with age (Buss, 1994). In contrast, single women were more likely to report that female beauty peaked from early thirties to early fifties, while agreeing with their married counterparts regarding the timeline for male attractiveness (Giesen, 1989).

Weight is a huge source of distress for many women. With age, the body's metabolism slows down and both weight and fat increase. Even if a woman remains the same size, her body tends to change shape as she ages, gaining weight around the middle of the body (Koch et al., 2005). According to Roberts and Gettman (2004), preoccupation with one's physical appearance has tangible emotional costs including shame, disgust, anxiety, and sexual dysfunction.

Component 2: Unbiased Processing

Objectification Theory

In Kernis and Goldman's (2002) theory, unbiased processing refers to experiencing one's emotions without distortion or denial. Self-objectification and an other-oriented focus often distract women from a full immersion in the bodily process of sexual arousal. According to Frederickson and Roberts (1997), the constant self-monitoring required by beauty maintenance behaviors, such as dieting, exercise, fashion, and cosmetics, shifts a woman's attention outward—to how she looks—and away from internal states. When a woman diets, she ignores hunger pains, and when she exercises excessively, she may ignore feelings of fatigue and discomfort. Over time, a woman may lose awareness of what her body is feeling because her attention is so riveted on how she looks. She becomes self-conscious, distracted, and disconnected from her authentic self.

In a study (Frederickson et al., 1998) that looked at self-objectification in college women, participants tried on either a bathing suit or a sweater while waiting in a dressing room for 15 minutes. While they were waiting, both groups took a math test. The young women assigned to the sweater group did substantially better on the math test than their counterparts in the bathing suit group. The researchers argued that the self-consciousness, engendered by focusing attention on the body, consumed attentional resources away from other pertinent tasks. Furthermore, cultural sexual objectification of women leads them to self-objectify. It is important to note that when men were used in the same experiment, there was no difference in academic performance between the bathing suit and the sweater groups (Fredrickson, Noll, Roberts, Quinn, & Twenge, 1998). Frederickson and

Harrison (2005) also found that teen girls who scored higher on a self-objectification measure performed worse on a test where they had to throw a ball against a wall. The physical movements of the appearance conscious girls were literally hampered by their attentional self-focus (Fredrickson & Harrison, 2005).

Taking the concept of self-objectification into the bedroom, Sanchez and Keifer (2007) found that both men and women with higher rates of body shame reported more sexual problems (operationalized as difficulties with arousal and orgasm) and reported less enjoyment overall. People who were more uncomfortable with their bodies displayed more self-consciousness during sexual activity as a result of self-objectification, and this significantly decreased their ability to enjoy physical intimacy. Though both sexes reported that body shame was detrimental to sexual functioning, women were more likely to report this issue than men. Steer and Tiggemann (2008) also found an indirect association between self-objectification and sexual dysfunction in 116 Australian, female undergraduates. Self-objectification increased scores on body shame and appearance anxiety, which were both correlated with sexual dysfunction.

Other research has also found negative self-focus and cognitive distraction to be primary causes of sexual dysfunction (Barlow, 1986; Dove & Wiederman, 2000; Masters & Johnson, 1970; Meana & Nunnink, 2006). Masters and Johnson (1970) coined the term "spectatoring" to refer to excessive self-valence during sexual activity, which they believed to be the most important deterrent to healthy sexual functioning (p.11). Spectatoring is marked by an extreme monitoring of one's sexual performance and an inability to lose oneself in the present moment. Rather, the individual is preoccupied with

performance fears regarding sexual adequacy. Spectatoring, like self-objectification, involves seeing oneself from a third person perspective. Usually, such self-preoccupation leads to an over-arousal of the autonomic nervous system, which interferes with sexual functioning (Barlow, 1986). It is clear in such cases that anxiety plays a central role in sexual inhibition, but, on the whole, the role of anxiety in sexual dysfunction is poorly understood. For certain men, anxiety may be arousing (Barlow, 1986). For instance, Sarrel and Masterson (as cited in Barlow, 1986) found that some men were able to perform sexually (i.e., get and keep an erection during intercourse) during the, little examined, phenomenon of female on male rape—possibly due to their anxiety.

Whether anxiety creates sexual problems seems to be connected with the level of distraction present. Barlow (1986) argued that sexually dysfunctional men processed anxiety differently than men without clinical problems, in that they were so distracted by performance anxiety that they were unable to process important arousal cues crucial for sexual response (Barlow, 1986).

Cognitive distraction is even more salient an issue in sexual dysfunction for women than it is for men (Meana & Nunnik, 2006). Furthermore, in keeping with Frederickson and Robert's (1997) objectification theory, female distraction is more intimately connected with body image concerns. In a study (Dove & Wiederman, 2000) that looked at the effect of cognitive distraction on the sexual functioning of college women, participants who had higher rates of distraction reported less satisfaction, lower sexual self-esteem, lower rates of orgasm, and higher rates of faked orgasm. In women, performance related distraction overlapped with appearance related concerns, leading the

researchers to opine that being physically desirable is how women perform sexually. Dove and Wiederman (2000) also called into question the long standing use of sensate focus (nongenital body touching) in treating performance anxiety by pointing out that this technique could exacerbate women's self-consciousness about their body.

Indeed, body image anxiety may be the female equivalent to male performance fears. According to Meana and Nunnink (2006), women have more problems with distraction during sex than men. In their study of 623 college students, females displayed higher levels of distraction overall than males, and in contrast to the researcher's hypothesis, had as much performance related anxiety as the male participants and more appearance related anxiety and distraction.

The Orgasmic Female Brain and Sexual Absorption

The repercussions of this tendency have been reiterated by recent research in brain imaging (Georgiadis et al., 2006). One prominent characteristic of the female orgasm is the deactivation of brain areas associated with anxiety, which means that the presence of this emotion could actively interfere with sexual arousal and the attainment of an orgasm. When scientists looked at the orgasmic female brain using positron-emission tomography (PET scans) there were some interesting findings. The most unusual of which is that at the moment of orgasm the female brain shuts down. While the orgasmic male brain lights up in areas associated with reward, the orgasmic female brain slows down to the point of deactivation (Georgiadis et al., 2006). This phenomenon is one of the hallmarks of a real orgasm as opposed to a faked one. One of the authors of the study, Dutch researcher Gert Holstege, told ABC news that, "When women faked

orgasm, the cortex, the part of the brain governing conscious action, lit up. It was not activated during genuine orgasm." (Ross, 2005, para.9).

Areas of the brain associated with self-control (the left lateral orbitofrontal cortex), moral reasoning/social judgment, (the dorsomedial prefrontal cortex), and fear/anxiety (the amygdala) showed decreased activity (Georgiadis et al., 2006). Indeed, Holstege reported that a woman in the throes of orgasm does not "have any emotional feelings" (Porner, 2009, para.21). According to Holstege, for most women this means that, "Fear and anxiety need to be avoided at all costs if a woman wishes to have an orgasm; we knew that but now we can see it happening in the depths of the brain" (Portner, 2009, para. 21).

Not surprisingly, the ability to let go of self-consciousness and become absorbed in the sensory experience has been identified as a very important component of women's sexual satisfaction (Scantling & Browder, 1993, Swartz; 1994). In Scantling and Browder's (1993) study of 86 women who were identified as supersexual (i.e., women who reported a high degree of sexual pleasure), a prime characteristic of such women was the ability to lose themselves in the erotic experience . These participants were found by Scantling and Browder to be high in absorption according to their Tellegen scores, a scale for measuring absorption. Swartz (1994) hypothesized that sexual absorption was "an obligatory pathway to high physiological sexual arousal and to orgasm in many, perhaps all, females."(p. 244). While for men, sexual absorption merely acted as an enhancer not a prerequisite for sexual arousal (Swartz, 1994).

Absorption should not be confused with striving, which is a purposeful, goal oriented state; rather, absorption is best understood as an altered state of consciousness, much like day dreaming or meditation. Like these aforementioned states, it is often accompanied by unusual psychophysiological experiences, such as the sensation of flying or floating, and the loss of personal boundaries (Swartz, 1994).

Absorption is a prime characteristic in what has been referred to as peak experiences, or flow. Csikszentmihalyi (1990) believed that such moments were intrinsically rewarding. Usually, they occurred when an individual was fully absorbed in a task and challenged to his/her maximum limits. Csikszentmihalyi believed that having more "flow" moments improved the quality of an individual's life. He also argued that flow was impossible when a person was highly self-conscious.

Sexual absorption is incongruent with the third person perspective typified by self-objectification. The inability of most women to conform to current beauty standards engenders shame and anxiety that is counterproductive to sexual arousal (Wolf, 1991; Fredrickson & Roberts, 1997). It is one possible explanation for the aforementioned high rates of distractibility that women report during sex. The current beauty ideal bears little resemblance to the reality of most women's bodies, and yet, through the medium of mass culture, these ideal images are increasingly the most commonly found representations of womanhood (Wolf, 1991).

The average American woman is 5'4 and weighs over 140 pounds; whereas, the average model is 5'11 and 117 pounds (Smolak, 1996). Furthermore, American women are getting heavier. The average American woman weighed over 20 pounds more in 2002

than she did in 1960 (Ogden, Fryar, Carroll, & Flegal , 2004). The mass media driven by consumerist motives has invalidated the body reality of most women and created a milieu of feminine body loathing and shame, according to Frederickson and Roberts (1997). Indeed, according to research, women (and girls) do report feeling shame more often than men (Silberstein, Striegel-Moore, & Rodin, 1987; Stapley & Haviland, 1989). Fallon and Rozen (1985) found that many women think of themselves as overweight because of their failure to conform to beauty norms, even if they are not by objective standards.

Beauty norms grow more unrealistic with each improvement in computer generated imagery. Media images of models and actresses are frequently retouched using digital imaging programs like Photoshop. Computer aided tools make it easy to alter a face or body in a variety of ways: eyes and lips can be enlarged, body parts can be replaced, and legs can be stretched to coltish proportions (Bennent, Childress, & Schrobsdorff, 2007). In a Newsweek article on the controversial issue of media photoshopping, a successful retoucher reported, “We're always stretching the models' legs and slimming their thighs…Sometimes I feel a little like Frankenstein.” (Bennett, Childress & Schrobsodorff, 2007, para. 4).

A Woman Divided: The Mind-Body Split

Self-objectification leads women to experience a disconnect from their bodily processes. Indeed, one consistent research finding on female sexuality is the desynchrony between physical and subjective states of sexual arousal (Meston, 2000). In laboratory tests that measure physiological arousal with a vaginal photoplethysmograph (a device that measures blood flow), it is not unusual for a woman to report that she is not sexually

excited, in spite of displaying signs of physical arousal (e.g., lubrication or genital engorgement). In women, subjective arousal is often disconnected from the physical, can occur later in the sexual cycle, or may not occur at all (Basson, 2000, 2002; Meston, 2000). Women also report less awareness of other physiological processes like heartbeat regulation, blood sugar levels, and stomach contractions than men (Fredrickson & Roberts, 1997; Meston, 2000).

This finding has important implications for FSD research. Women diagnosed with FSD display the same physiological reactions to erotic material as women in the nonclinical population—and with the same desynchrony between genital and subjective responses as the nonclinical population (Laan & Van Lunsen, 2009). Indeed, Laan and Van Lunsen (2009) stated emphatically, that was theirs was the "seventh study that failed to find differences in vaginal vasocongestion between women with and without FSAD [female sexual arousal disorder]" (p. 295). In their research (Laan, Van Driel, &Van Lunsen, 2008), the genital response rates of women with FSAD and a control group without were very similar when the two groups were shown erotic videos while hooked up to a vaginal photoplethysmograph. Both the clinical and the nonclinical groups were identical in terms of speed and intensity of genital response, operationalized as vaginal pulse amplitude (VPA). Consequently, Laan et al. (2008) questioned the pharmaceutical zeal for developing vasculogenic drugs for women with FSAD, as well as the appropriateness of a *DSM-IV-TR* criteria for arousal disorder, asserting that, "In medically healthy women, impaired genital responsiveness is not a valid diagnostic criterion." (Laan et al., 2008, p. 1424).

According to Laan and Both (2008), most healthy women are more physically aroused by visual erotica than from any other form of stimuli, including erotic literature, explicit audiotapes, and sexual fantasy. Oddly, sexual fantasy generated the lowest level of genital engorgement, while erotic movies elicited the most instantaneous and robust response. Most women displayed an increase in vaginal blood flow starting within seconds of viewing an erotic film. Furthermore, there was a positive correlation between film explicitness and intensity of genital response. Women displayed these genital reactions in the absence of subjective sexual excitement, when they did not like the movie, and even with deficient testosterone levels. It seems that healthy women are designed to arouse easily—at least, in terms of genital engorgement. This ease of female response has even been noted during nonconsensual encounters where rape victims have reported vaginal lubrication and orgasm and when pelvic magnetic resonance imaging (MRI) scans have been substituted for vaginal photoplethysmography. (Laan & Both, 2008).

Component 3: Authenticity and Behavior

Sexual Scripts

According to Weiderman (2005), sexual scripts are internalized rules of conduct that govern what a culture considers normative sexual behavior. These scripts provide direction in sexual situations, and, therefore, alleviate anxiety regarding correct behavior. Men and women follow complimentary sexual scripts that are highly gendered. These scripts make for romantic sex where explicit communication regarding behavior is not necessary. If each participant follows the script, he or she knows his or her role due to

prior socialization. People rely most heavily on culturally determined scripts during the early phase of relationship building. According to Weiderman (2005), as a relationship matures, most couples are able to build an individualized and expansive variation of the cultural template that suits their own respective needs.

While the male sexual script exalts exploration, the female script posits restraint and passivity as appropriate norms of behavior (Gavey, et al., 1999). Female sexuality has been severely circumscribed in many cultures in a variety of ways: social expectations of chastity, claustration, the focus on intercourse as the definitive heterosexual act, and the denial of and/or actual physical removal of the clitoris. Historically, virginity in women was not only expected but required by both religious and social doctrine, with severe punishment (sometimes by death) accorded to the nonchaste (Buss & Meston, 2009).

Though female virginity is less valuable than it once was (Baumeister & Vohs, 2004; Buss & Meston, 2009), women are still expected to be less sexually active than men. Sex is still scripted as a valuable resource that women possess and give to men in exchange for socioeconomic support (Baumeister & Vohs, 2004).

The Orgasm Gap

One area where the reality of female sexuality slams squarely into the androcentric ideal is in the orgasm gap between men and women. Though the female orgasm is increasingly emphasized in heterosexual sex, gender norms make its expression unlikely in many cases (Armstrong, England, & Fogerty, 2009; Hite, 1976). The types of activities most likely to lead to female orgasm are not regarded as “real sex” and,

therefore, may not be continued long enough for a woman to climax (Hite, 1976). The discrepancy between ideal and real female sexual response makes it harder for women to be honest about their needs and create challenges in getting those needs met—particularly, if one deviates far from the cultural norms of acceptable female behavior. The orgasm gap is very much a feature of partner sex for many women. While 75% of men claim to always orgasm during partner sex, this is true for only 29% of women (Michael, Gagnon, & Laumann, 1994). According to Hite (2003), many of her female participants reported losing interest in sexual activity because they were not orgasmic during sex. Other studies (Hulbert, 1993; Hulbert & Apt, 1995) have also asserted that increasing orgasmic consistency during heterosexual sex improves sexual interest and satisfaction in women.

This issue is most pronounced during casual hook-ups. According to Armstrong, England, and Fogarty (2012), college age women reported climaxing only 11% of the time in first time hook-ups, and less than half the time in repeat hook-ups (more than one sexual encounter with the same person). The researchers, studying over 13,484 students at 21 different universities, found a double-standard regarding women's right to sexual pleasure in a casual context was a large part of the problem. For instance, women were much more likely to give oral sex during a hookup than to receive it. While women were recipients of cunnilingus in only 26% of hook-up, men received fellatio during 41% of these encounters. Oral sex is considered to be a very effective form of clitoral stimulation, and its absence could be detrimental to a woman's satisfaction (Armstrong et al., 2009). In an interview, researcher Paula England asserted that, "The orgasm gap is an

inequity that's as serious as the pay gap, and it's producing a rampant culture of sexual asymmetry" (Seligson, 2009, p. 2). One of the primary reasons that relationship based sex is often more orgasmic for women is the fact that it may include more clitoral stimulation. Women in relationships received oral sex 56% of the time, while this occurred in only 23% of hook-ups (Armstrong et al., 2012). Furthermore, increased sexual contact with the same person is more likely to include more clitoral stimulation, leading to a higher rate of orgasm among for women. For example, if a woman had been with the same partner six or more times, she was 2 to 3 times more likely to climax (Armstrong et al., 2009). According to Armstrong et al., "Relationships certainly increase investment in the other's sexual pleasure, but there may be a gendered pattern such that women beginning to invest in the partner's pleasure from the first sexual event, and men invest only later in committed relationships." (p. 6).

Women and the Mechanics of Sex

Given the fact that masturbation does not depend on the presence of a partner and is not culturally scripted, how an individual chooses to self-stimulate provides a great deal of information on his or her true sexual preferences. Women demonstrate a huge variation in masturbation styles, while heterosexual sex is both limited in technique and socially scripted (Hite, 1976). In general, female sexual response patterns are similarly diverse (Hite, 1976; Laumman et al., 1994; Mead, 1949). Incorporating the types of activities that a woman uses for self-stimulation into sex with a partner is one good way to increase orgasmic consistency. In fact, directed masturbation is a common therapeutic intervention used by sex therapists to help anorgasmic women learn to experience orgasm

(Hulbert & Apt, 1995). How a particular woman masturbates can also influence how she experiences pleasure with a partner (de Bruijn, 1982; Hite, 1976). Sadly, this is another area where feminine response clashes with androcentric sexual scripting. For example, a woman who masturbates by actively moving her pelvis against an object may have problems being orgasmic in her culturally determined role as passive recipient of partner stimulation (de Bruijn, 1982).

In de Bruijn's (1982) study on secondary orgasmic dysfunction (the ability to orgasm in one situation, but not in another), she observed that some women are better able to translate their solo experiences into partner sex better than others and looked at some of the factors pivotal to a satisfactory translation. It should be pointed out that many women do not translate their solo experiences to partner sexual activity very well. Twice as many women are orgasmic during masturbation than with a partner (Laumann, et al., 1994). Though most women who suffer from primary orgasmic dysfunction (the inability to climax in any situation) are able to learn to orgasm, secondary orgasmic dysfunction is less amenable to treatment (de Bruijn, 1982).

As de Bruijn (1982) noted, male (but not female) masturbation is very similar to heterosexual sex:

> it can justifiably be stated that the self-stimulation of females (unlike the self-stimulation of males) is usually quite different from the type of stimulation received during coitus. This is especially true for the very common type of coitus where the male partner sets the rhythm and the type of movements. (1982, p. 152)

Men masturbate by rubbing their penis with their hands. During coitus, the penis receives direct stimulation, and men are usually the ones in control of how that stimulation occurs. Most women stimulate the clitoris more than the vagina during masturbation; however, during heterosexual sex, the inverse often occurs (Hite, 1976). Furthermore, when women engage in sexual activity with men, they are expected to be passive recipients of partner stimulation (de Bruijn, 1982)—a situation which removes the level of control present in masturbation.

According to de Bruijn (1982), some female masturbation styles transfer into traditional heterosexual sex better than others. In her study of 443 women, she placed participants into two masturbatory camps: one she dubbed pelvic active, the other pelvic passive. Women with pelvic active styles involve their entire bodies, particularly their pelvises, in self-stimulation. For instance, a woman may rub against some object, such as a door frame, a stuffed toy, or bed covers to generate orgasm. Pelvic active masturbators often rely on building muscular tension in the lower body through tensing and pressing the leg muscles together to facilitate orgasm. Pelvic passive masturbators (the predominate style) remain still and move some object (hand, vibrator, shower massager, etc.) against their genitals. de Brujin(1982), like Hite (1976), found that women who masturbate lying on their stomachs in pelvic active mode had a slighter higher rate of orgasm during intercourse. In general, pelvic passive masturbators are better able to climax from partner stimulation—especially oral sex.

For pelvic active masturbators, gender norms that dictate female passivity make attaining orgasm during partner sex more challenging. de Bruijin reported that it was

common for a participant not to engage in behavior that she regarded as exciting (e.g., female active behaviors, or oral sex) because of partner reticence, or her own discomfort with violating gender norms. For instance, a pelvic active woman has to:

> direct her own movements, possibly even interrupting his. And she is not making these movements to please her partner, but to please herself. It is the doing something which may be really threatening for women—more than requesting someone else to do it for her. (de Bruijin, 1982, pp. 161-162)

This is especially true of behaviors like pelvic rubbing motions (either during intercourse, or against a partner's leg or stomach) that require a woman to be active and her partner to be passive. Lesbian women, however, evidenced no such reticence against incorporating these actions into sex. While heterosexual women refrained from doing exciting activities that were not socially normative, they engaged in high levels of non-arousing but gendered behaviors, such as following a partner's movements during intercourse. This activity was not considered exciting for 32% of the participants but was always or sometimes engaged in by over 80% of them (de Brujin, 1982).

Overall, one out of two women in the study rarely or never climaxed from female active sexual behaviors during partnered sex. And though both pelvic active and pelvic passive women both experienced most of their orgasms from partner active stimulation, pelvic active masturbators climaxed less than pelvic passive masturbators during partner active sex (45% compared with 55% respectively). Furthermore, one woman in two was not consistently orgasmic during sex with a partner, regardless of masturbation style (de Bruijin, 1982).

Though women, as a group, are more varied in their masturbation techniques than men, on an individual basis, a woman may require certain established habits in order to orgasm—and sometimes may not be orgasmic without these long established routines (Hite, 1976). For instance, Hite (1976) found that women often preferred certain positions during masturbation (e.g., lying on the stomach, or on the back) and many women had a preference for a particular leg position (e.g., either spread apart or close together) in order to orgasm. Some women in Hite's study were unable to orgasm without a vibrator. Indeed, many women in Hite's study were unable to orgasm unless they masturbated in a certain way, in a certain position (1976).

Habits such as these can make orgasmic partner sex problematic for some women. A large part of the androcentric sexual script is that a woman must orgasm via partner stimulation, ideally from intercourse, but at least via partner active oral or manual sex. Unfortunately, even women who are pelvic passive masturbators are not always able to climax by partner stimulation—even if they are orgasmic during masturbation. Sometimes this occurs because such women require an unusually precise or idiosyncratic masturbation technique that is not congruent with traditional partner sex (e.g., they masturbate with their legs together, or by water), they are only orgasmic from female active behaviors, or they need the kind of intense stimulation that a vibrator provides (de Bruijn, 1982; Hite, 1976).

According to Braun, Gavey, and McPhillips (2003), within the last few decades, cultural discourses of heterosexuality have increasingly focused on the ideal of reciprocity. The idea being, that sex and orgasm are a mutual exchange of pleasure for

both men and women. Unfortunately, this reciprocity ideal exists within an unequal power structure where a man proves both sexual skills/competence and the modern values of sensitivity and enlightenment by giving his partner with an orgasm. If he fails at this task, he ameliorates both the reciprocity ideal and his competence in his socially appointed role as bedroom leader. Braun et al. (2003) asserted that the reciprocity ideal puts women under a lot of pressure to orgasm. Due to the difficulties inherent in the active male/ passive female sexual script, feminist sex educators like Betty Dodson (2002) have argued that women must be assertive and proactive during sex. Dodson recommends that women incorporate their favorite form of clitoral stimulation (often derived from masturbation) into partner sex and that they should provide this stimulation themselves rather than depending on a partner to do it for them. Though Dodson's recommendations have merit, they also violate gender norms. Heterosexual sex continues to be scripted as something that a man does to a woman rather than with her.

Communication Barriers During Heterosexual Sex

Because many women are not orgasmic from intercourse alone, a woman must be willing to ask for extra and prolonged clitoral stimulation (Hite, 1976). And a man must be willing to both provide this stimulation and be somewhat effective at its application. "Effective", in this sense, means eliciting an orgasmic response from a female partner. This may require a high level of equally effective communication—particularly on the part of the woman. MacNeil and Byers (1997) found that female sexual self-disclosure enhanced satisfaction for both men and women in their study of 87 participants involved in long-term, heterosexual relationships. And in a Canadian telephone study of 996

participants the most important quality associated with sexual satisfaction among married couples (excluding husbands over 60) was the ability to communicate effectively about sexual preferences (Trudel, 2002). Research (Kilmann et al., 1984; Masters & Johnson, 1970; Kelly et al., 1990; Kelly et al., 2004) has consistently shown that one characteristic of anorgasmic women is that their relationships are typically fraught with inadequate sexual communication.

Kelly et al. (2004) found that anorgasmic women had significantly more problems discussing clitoral stimulation than orgasmic women. In addition, both anorgasmic women and their partners expressed greater discomfort discussing clitoral stimulation than a control group without these concerns. In a similar study conducted earlier, Kelly et al., (1990) also found that anorgasmic women had issues with partner communication. This study consisted of an experimental group of 24 anorgasmic women and 10 controls. The researchers found that the anorgasmic group had more guilt about masturbation, were more likely to believe in untrue sexual myths, and were more uncomfortable discussing clitoral stimulation, but not intercourse. The study also required that the participants watch a series of erotic videotapes and document their arousal. No differences were found between the subjects and the controls groups in activities engaged in with a partner, or self-reported responses to erotic videos (Kelly et al., 1990).

The two aforementioned studies were very similar and contained two of the same authors. One weakness present in both was the researcher's unwillingness to look at androcentric sexual discourses. In the first study (Kelly et al., 1990), anorgasmia was defined in gendered terms as a woman's inability to climax from partner active

stimulation—the kind of female active techniques advocated by Dodson (2002) and other feminist sex educators (Hite, 1976) was not mentioned. Sex was defined as something that the male partner provided for the female, and her satisfaction hinged on her ability to communicate her needs effectively and his ability to follow directions.

In the second study, Kelly et al. (2004) found, but postulated no theory as to why, anorgasmic women had more problems discussing clitoral but not copulatory stimulation. Since authentic female sexuality typically deviates from the ideal supported by both social norms and media representations, it would seem probable that many women would be somewhat uncomfortable with sexual self-disclosure. Specifically, one could ask, how comfortably can a woman discuss her sexual preferences in a culture that consistently, ignores, marginalizes, and invalidates those preferences?

Western culture is inundated with media depictions of sex (Kim et al., 2007). Total porn revenue is reputed to be anywhere from$10 to $14 billion a year in the U.S alone (Rich, 2001). For most people watching pornography or an R rated film is the only time they see other people having sex, given its private nature in western society. Unfortunately, media depictions of sex are usually saturated with gendered sexual scripts making sexual authenticity a risky proposition (Kim et al., 2007).

For a woman to discuss the types of clitoral stimulation that she prefers with a partner often means the admission of coital anorgasmia and the need for what could be viewed as unacceptable stimulation i.e., oral sex, self-stimulation, or a vibrator. For some women, this may feel like an admission of a shameful personal defect that they are not comfortable sharing with a partner (Hite, 1976). Nor are all men accepting of

nonandrocentric sexuality in their female lovers. When Hite (1981) looked how men preferred their female partners to orgasm, only 3 to 9% chose clitoral stimulation. The vast majority preferred that a woman climax during intercourse alone. In addition, some men expressed resentment or confusion at women's need for clitoral stimulation. One man stated, "I was married for 15 years but we were never able to find her clitoris." (p. 638).

While effective communication is important for female gratification, it is equally, if not more, important for a couple to have a compatible view of sex. According to Purnine and Carey (1997), a woman's sexual satisfaction is highly dependent on her male partner's understanding of, and agreement with, her sexual needs and preferences. This was not found to be true for men, though male satisfaction was bolstered by a satisfied partner. Partner understanding is less significant for men given that the vast majority of males orgasm during heterosexual intercourse from their own agentic behavior, not from partner contingent stimulation (Braun et al., 2003; Hite, 1981). According to Purnine and Carey, it was more important for men that they see themselves as good lovers—a fact echoed in other studies (Braun, et al., 2003; Hite, 1981; Potts, 2000). There are limits to the benefits of communication though. Communication primarily enhanced understanding, it did not promote agreement, which was very important for both sexual and relationship satisfaction in men and women (Purnine & Carey).

Male partners of women with orgasmic disorder often have a poor understanding of their female partner's sexual preferences (Kelly et al., 1990; Kelly et al., 2004; Kilmann et al., 1986; Purnine & Carey, 1997). Purnine and Carey (1997) pointed out that

the real value of sexual communication was that it allows a couple to develop a compatible and mutual sexual script that satisfies both partners' respective needs.

Though honest communication can be advantageous to both men and women, there are many pitfalls to its application in an actual sexual encounter. Self-help culture assumes that most problems can be resolved by talking it out with one's partner and finding a good compromise. It also assumes a level playing field between men and women in regards to power. Both of these assumptions are wrong. Gottman (1999) asserted that in many healthy relationships some issues are never effectively resolved, and power differentials can make sexual negotiation difficult for women. For instance, many women have problems insisting on condom usage, even though unprotected sex can be very dangerous to their health (Elifson, Klein & Sterk, 2010; Higgins & Brown, 2008; Higgins & Hirsch, 2008; Roberts, Kippax, Waldby, & Crawford, 1995).

Stimulating a partner to an orgasm requires a feedback loop between the partner who is the giver and the partner who is the receiver. Not everyone is comfortable with this kind of sexual honesty, which can make open discussion about sex problematic (MacNeil & Byers, 1997). Plus, in order to communicate one's preferences, one must know what they are. Given the fact that women typically begin masturbation at a later age and do so less often than men, sexual communication may require a level of self-knowledge that some women do not possess. (Weiderman, 2005). For example, Michael et al. (1994) found that only 40% of women had masturbated in a single year. Furthermore, a woman's sexual partner must be open to receiving information about her

preferences, which may not be feasible if he is strongly invested in the male as sexual expert discourse (Masters and Johnson, 1979).

Sexual communication has the potential to open up a Pandora's Box of gender politics. According to Roberts et al., (1995), western culture thinks in terms of binaries, such as a good and bad, reason and emotion, and male and female. Within this system, women are aligned with the emotions and with the body, while men are aligned with the rational mind. Sex is conceptualized as a performance oriented endeavor in which the rational male proves his mastery over the irrational (defective) female body. For men, it is a triumph of mind over matter or technique over chaotic nature. Popular thinking holds that the female orgasm is less natural, harder to achieve, and more labor intensive than the relatively automatic male response.

In addition, direct sexual communication presupposes that a woman has sexual knowledge, which she is not supposed to possess, and implies possible experiences that she is not supposed to have had (Where did she learn about such things?). The importance placed on communication by most advice literature ignores the fact that talking about sex brings up the awkward issue of gender role expectations and restrictions. A woman may worry that if she brings up a certain topic that she may appear "slutty", or in some cases too ignorant and possibly prudish, while a man may worry that he looks ignorant and inept if he asks questions.

Not surprisingly, many people fall back on gendered sexual scripts and stereotypical assumptions regarding what an opposite sex partner enjoys (Miller & Byers, 2004). Miller and Byers (2004) looked at ideal versus actual length of foreplay and

intercourse in 152 heterosexual couples. The researchers examined what participants reported were their ideal preferences in terms of foreplay and intercourse duration, what participants thought their partners preferred, and what participants thought most people preferred. Both men and women did not differ in terms of desired length of foreplay, but women vastly underestimated how long their partners wanted foreplay and intercourse to last. Men wanted intercourse to last longer than their female partners. In general, both men and women reported a longer ideal duration for both foreplay and coitus than they were actually experiencing. Miller and Byers found that participants relied on stereotypical beliefs about what the other gender wanted sexually, instead of finding out what their real-life partners preferred. Women, in the study, assumed that men did not enjoy lengthy foreplay. Men were more likely to believe one of two stereotypical assumptions: all women want lengthy intercourse; or conversely, women do not particularly enjoy intercourse and would rather get that part of sex over with in hurry. Such stereotypical beliefs can negatively impact sexual satisfaction. If a couple is too incongruent in their perception of their partner's preferences, they may have problems having satisfying sexual relations (Miller & Byers, 2004).

Limitations Inherent in Androcentric Sexual Scripts

The limitations of the androcentric model of heterosexuality were most apparent in Masters and Johnson's (1979) comparison study of gays and heterosexuals. The study consisted of 176 gay men and women (94 males and 82 females) and 681 heterosexuals (567 culled from the original Human Sexual Response Study). The two groups were compared while engaging in sexual activity in a laboratory setting. Masters and Johnson

(1979) found that in comparison with the leisurely, pleasure centered approach of gay individuals most heterosexuals conducted sex with a "get the job done" (p.65) mentality that turned erotic encounters into a goal oriented exercise.

Unlike heterosexuals, most gay men and women viewed orgasm as another point in a continuum of pleasure (Masters & Johnson, 1979). A teasing approach to partner gratification was commonly used by both gays and lesbians. It was not unusual to stimulate a partner to a high state of arousal, back off, and then bring them back up again. This approach was rare among heterosexuals. The idea behind this kind of erotic teasing was for the active partner to provide the receptive partner the most gratification possible. "The exchange of pleasure at all levels of sexual excitement appeared to be of greatest importance, with the orgasmic experience merely one more step in the pleasure sequence." (Masters & Johnson, 1979, p. 65).

Heterosexual men were found to rush through non-erogenous zone touching to immediate breast and genital foreplay. Men began breast or genital stimulation within 30 seconds to one minute of sexual contact with a female partner. Among lesbians, overt breast or genital contact took place much later in a sexual encounter. Breast stimulation was commonly performed by lesbians, gay men and heterosexual men. Heterosexual women, unlike gay men, seldom stimulated a male partner's breasts or nipples, and, in contrast to gay women, only two thirds of them enjoyed having their own breasts touched. Perhaps, this was because men engaged in breast play more for their own arousal and were largely oblivious to the responses of their female partners, according to Masters and Johnson (1979).

Several times Masters and Johnson noted this pattern of male obliviousness to female response during heterosexual sex. Nor, were women much better at partner stimulation than men. Most women did not know how to touch a man's penis or read his body language. In general, heterosexuals displayed little understanding of their opposite sex partner and communicated poorly. Intercourse occurred when the male partner decided he was aroused enough for penetration and usually in the missionary position. According to Masters and Johnson (1979), inept foreplay prevented heterosexuals from attaining a high level of absorption in the experience. Consequently, intercourse was an exercise in distraction for both sexes—and especially for women.

Because men control the thrusting pattern during vaginal sex, women were put in the position of accommodating their male partners, often to their own sexual detriment "The continuing requirement for accommodation distracted many women from whatever levels of excitement they previously had attained during precoital stimulation." (Masters & Johnson, 1979, p. 80). A fact noticed by Hite (1976) who found that women's level of sexual arousal often went down during vaginal intercourse. Hite attributed this tendency to the common habit of terminating clitoral stimulation once intercourse had begun, while Masters and Johnson attributed it to men's control of the coital movement (i.e., men move in ways that feel good to them, not to their partners), which they regarded as the "greatest detriment to female response." (Masters & Johnson, 1979, p. 81).

The researchers attributed the relatively poor quality of heterosexual sex to lack of communication and the male as sexual expert discourse. In an interview with Time magazine, Masters asserted that, "What we have established in this book is that the male

will have to give up his position as sex expert and the one with the greater sexual facility - which he doesn't have." (Time, 1979, para.13).

Twenty years later, not much had changed. In the late 1990s, Phillip's (2000) found that sex was still defined in androcentric terms that disadvantaged women. In her qualitative study of young women and sexual mores, her participants spoke of having to maneuver around a minefield of competing and often conflicting gender messages that dictated female passivity, compliance, and a confusing amalgamation of sophistication and innocence.

These confusing messages regarding "right" behavior made it hard for many of her participants to remain psychologically present during sex. Similar to the Masters and Johnson's study, women still reported feeling under pressure to accommodate men. And consequently, problems with distraction were common. Many young women spoke of feeling disembodied during sexual encounters—and of observing themselves from a third party perspective. One woman described her behavior as follows:

> I always feel like I'm there but not there. Like I'm up on the ceiling looking down on the whole thing, making sure I'm acting the right way and trying to figure out what the right way even is. It gets so that I'm so busy observing myself that I don't even feel what I'm feeling. I'm always checking everything out, making sure I'm making the right noises and pretending I like everything because I don't want him to think I'm frigid or inhibited or I don't know what I'm doing. So when the guy is all hot, I pretend I am too, even if I don't like what he's doing, because I don't want to seem like a cold fish or a little child. It's important to me,

> I guess, to present myself like I know what I want, even though I really just go along with whatever the guy is doing. (Phillips, 2000, p.104)

Furthermore, unlike Masters and Johnson, some current genres of sexual advice literature view gender inequality as "normal" heterosexual behavior. John Gray has created an entire self-help franchise based on the assumption that men and women are from two different planets. Though Gray is poorly regarded by academics, due to the nonscientific nature of his assertions, his books are wildly successful with the general public (Crawford, 2004; Potts, 1997). His first book, Mars and Venus, sold over 40 million copies and has been translated into 45 different languages (Harper-Collins, 2012). It is also a good example of the heterosexual script in action. In Mars and Venus in the Bedroom (1995), John Gray portrayed androcentric sexuality as the result of gender essentialism. He advised his mostly female readership to accept gender differences that privileged male sexuality as biologically determined, rather than as the result of power differentials between the sexes (Potts, 1997).

Potts's (1997) feminist critique of Mars and Venus in the Bedroom found several elements of the adrocentric script in his postulations. She asserted that one essential premise of Gray's theory is that because men and women are from two different worlds; their interactions are a form of cross-culturalism. Gray portrayed himself as a translator explaining the two worlds to one another, though rarely were his assertions backed up with any scientific data. Consequently, Potts (1997) argued, his suppositions are more "science/fiction" than science" (p.153).

According to Gray (1995), men and women are poorly matched and continually at odds. Men are primarily interested in sex, while women are primarily interested in romance. In spite of men and women's obvious incompatibility, marital intercourse is both compulsory and essential for mental health—especially for men. One disturbing element in this book is the idea that it is the duty of a good wife to supply a steady diet of coitus, regardless of her own desires, as a way of taking care of her husband's well-being. Her own satisfaction, and even interest, is optional. Though Gray (1995) acknowledged the necessity of luxuriant, female-centered lovemaking on a regular basis, he nonetheless argued that "guilt-free quickies" (p.81) are essential for male happiness. One section of the book detailed Gray's experience counseling a couple on their differing sexual proclivities. During the session, the husband attempted to cajole his wife into having quickies by telling her that she didn't have to respond during these encounters, "or get anything out of it." She just had to, "lie there like a dead log." (Gray, 1995, p.79). Furthermore, Gray warned women of the dangers of rejecting their husband's advances by insisting that such behavior lessens a man's attraction to his wife and injures him psychologically. Gray's argument puts women in a classic double-bind situation and compromises their capacity to authentically engage in sexual interaction. As Potts pointed out:

> The man is clear of responsibility in this scenario. He has no choice; being a man, he must have sex whenever he needs to. The woman, therefore, must cooperate when confronted with a set of false choices: to participate enthusiastically, to

> 'participate' inertly, or to decline sex and be responsible for the eventual disintegration of the relationship (Potts, 1997, para.35).

From Gray's perspective, the male is the still the bedroom expert, and the female body the instrument through which he proves his expertise. Male sexuality is active, biologically driven, and overwhelming, while female sexuality is romantic, emotional, and relationship oriented. Most men do not really like foreplay, according to Gray; nonetheless, they value female satisfaction. This conundrum creates further conflict. Clitoral stimulation is necessary to get most women aroused, but it is also at odds with the masculine desire to move directly into intercourse and ejaculation (Gray, 1995). As Potts observed, "Whereas the man's natural sexuality functions as a 'race towards orgasm', satisfying the woman becomes a competition to 'beat the clock' by slowing down, a tedious chore to be endured for a given period of time." (Potts, 1997, para.55).

A woman's response to a man's sexual mastery is considered to be her performance and is often more important than any sexual expertise she might demonstrate. When a woman does not respond according to cultural norms, she runs the risk of being considered abnormal. This fear is often a factor in proscribing and limiting sexual behavior for women. Androcentric constructs regarding sexual normalcy strangle alternative forms of eroticism and effectively shut down sexual authenticity (Gavey et al., 1999; Phillips, 2000). And not just for women, Sanchez, Crocker and Boike (2005) argued that gender norms limit sexual expression for both sexes.

Component 4: Authenticity and Relationships

Gender and Power

Androcentric sexual scripts reflect cultural discrepancies in power between men and women (Sanchez et al., 2005). As Jack (1991) observed, in many heterosexual relationships "intimacy occurs within a context of inequality", (p.21). The Victorians created a forerunner of modern marriage where there were separate spheres for men and women and a distinction between public and private life. The Victorian wife lived only to serve others. And the female domain of home and hearth was a safe haven from the cut-throat masculine world of business and commerce. Jack asserted that most women are still socialized with these gender norms in mind—norms that dictate people pleasing, self-sacrifice, compliance, and self-silencing on the part of women (1991). Consequently, relationship dynamics are at the forefront of many female sexual problems (Kelly et al., 2004; Witting et al., 2008)

In most societies, men have greater access to institutional power than women. And these power asymmetries create gender differences in satisfaction and sexual well-being that vary from culture to culture, correlating with the degree of male domination (Laumann et al., 2006). Furthermore, in very male dominated cultures, both men and women report lower levels of sexual well-being. Laumann et al. (2006) looked at 27,500 men and women, between the ages of 40 and 80 in 29 countries, and examined such aspects of sexuality as emotional and physical satisfaction, the relative importance ascribed to sexuality in an individual's life, and contentment with sexual functioning and health. In the most patriarchal societies (East Asia and the Middle East) both sexes, but

especially women, had relatively low rates of sexual satisfaction. In the Middle East, only 38% of women reported being sexually satisfied compared with 50% of men, and in East Asia, only 12% of women said sex was important to them, while 28% of men regarded it as important. Austria, the United States, Spain, and Canada reported the highest rates of sexual wellbeing, while Japan and Taiwan reported the lowest. In general, men had higher rates of sexual satisfaction cross-culturally, leading the researchers to opine that "true parity remains an ideal even in countries where beliefs about gender equality are more widespread."(Laumann et al., 2006, p. 22).

In male defined cultures, women's sexual satisfaction is marginalized and the relational components of the experience are also similarly discredited. Egalitarian societies take a companionate view of romantic relationships and view sex within a relational framework; whereas, patriarchal cultures see sex as a reproductive duty for both men and women (Laumann et al., 2006).

According to Kernis and Goldman (2004), relational authenticity is associated with a deeper, richer experience of intimacy. Authentic individuals are both more securely attached in their relationships and happier, while less authenticity has dire repercussions for both self and relationship health. Some of these repercussions include defensiveness, lack of genuine intimacy, over-reactivity, relationship demise and/or dissatisfaction, "these costs contribute to shallow unsatisfying relationships that are prone to dissolve over time or be continually fraught with problems and challenges" (Kernis & Goldman, 2004, p. 46). Kernis and Goldman postulated that fear of rejection, low self-

esteem, poor interpersonal skills, and high public self-consciousness are all block to genuine self-expression. To this list, one could add the experience of gender.

Gender Power Inequities

Gender power imbalances undermine women's relational authenticity and self-expression in many areas of life, including sexuality (Katz & Tirone, 2008). Women are socialized to invest a lot of themselves in their relationships. A woman's self-esteem and emotional well-being is highly influenced by the state of her relationships, while men place a higher value on independence and personal goals (Ryff, Singer, Wing, & Love, 2001). The significance women ascribe to affiliative ties puts them in a vulnerable position—given that such investment can make authenticity especially risky. Following one's own inner dictates, means that significant others may not be happy with one's decisions, and women often engage in self-silencing behaviors as a way of resolving such conflicts (Jack, 1991, Impett et al., 2006; Katz & Tirone, 2008). Indeed, it is this difference in the importance ascribed to relationships that is a major kingpin in gender power differentials. According to social exchange theory, the member who is the least invested in a relationship paradoxically has the most dyadic power. This is referred to as the "principle of least interest". According Waller, "the person is able to dictate the conditions of the association whose interest in the continuance of the affair is the least." (Waller, 1938, p. 275).

Felmlee (1994) asserted that in many heterosexual relationships the partner with the most power, and the least interest was often the man. In her study of 101 heterosexual, dating couples, men had both a lower rate of investment and a greater

degree of relationship control. In over half of the couples (53.9%), perceived power inequities were reported, and the male partner was twice as likely to be regarded as having more power in these relationships. Felmlee (1994) also found that most of her study's participants believed that men were less emotionally invested, made more relationship decisions , and got a "better deal" (p. 275).

This was also replicated in Sprecher and Felmlee's 1997 study of power dynamics in heterosexual couples. Men had more relationship power and were also the least interested member of the couple. This was a longitudal study that examined dating couples over a 4-year period. Both members of a couple were assessed, which was one of the major strengths of this study. Sprecher and Felmlee pointed out that in spite of professed egalitarian ideals, gender imbalances in power persist both in actuality and in perception. Men, in particular, are prone to perceiving themselves as the dominant partner in their relationships. And, according to Sprecher and Felmlee (1997), power differentials among couples were remarkably stable over the course of a relationship.

Power imbalances are especially prevalent among married couple and are associated with less marital satisfaction (Felmlee, 1994). One way that men hoard power is by resisting influence from their wives, often with dire consequences for relationship longevity. According to Gottman (1999), men who do so are 81% more likely to divorce than men who share power with a spouse. Such relationships are also marked by higher rates of domestic abuse. (Coan, Gottman, Babcock, & Jacobson, 1997; Blanc, 2001). Other researchers (Felmlee, 1994) have contradicted these findings and have argued that male dominance is not associated with dyad instability, but that female dominance and

egalitarianism are associated with relationship dissolution. Possibly, because women who were more empowered are less likely to remain in unhappy relationships.

Women's greater investment in relationships has also been supported by various health studies (Ryff et al., 2001). In research on gender and well-being, women rank supportive relationships as the most satisfying aspects of their lives, while men rank independence and individual growth as the satisfying (Ryff et al., 2001). Men report less overall satisfaction with relationships than women, though there are some age-related incremental gains (Ryff et al., 2001). Furthermore, women's health is impacted by the quality of their interpersonal ties more so than men's (Coyne et al., 2001; Kiecolt-Glaser, Glaser, Cacioppo, & Malarkey, 1998). Conflict-ridden romantic relationships are especially hazardous for females. For instance, Kiecolt-Glaser et al., (1998) found that older women (but not men) displayed lower endocrine and immune system functioning during a laboratory study of marital discord. During a 30-minute videotaped argument, the female participants (mean age 67) experienced a 16% to 21% change in variance in the levels of cortisol, norepinephrine, and ACTH. Some studies (Coyne et al., 2001) have found a higher rate of morbidity among unhappy wives with congestive heart failure than among unhappy husbands with the illness. Furthermore, women are more likely to die from an emotional blow than men (Wittstein et al., 2005).

Factors in Investment Disparity

Money. There are many reasons for gender differences in relationship investment, including both social and economic factors. The latter variable is especially important. One reason women place so much emphasis on their romantic relationships maybe due to

economic realities that continue to privilege men. For instance, in a male dominated economy, a woman who has not been able to find an appropriate mate runs the risk of poverty (Shaffner-Goldberg, 2009; United States Government Accountability Office, 2011). This is also true if she loses that mate, according to Shaffner-Goldberg (2009). In the 1970s, due to increasing numbers of single, female-headed families, poverty became feminized—a trend that has continued over the last few decades. According to the 2009 Census, women make up the majority of impoverished Americans. Over 59% of the poor are single females, in spite of the fact that they make up less than half of the adult female population. About 20.8% of single women live in poverty in contrast to 6.2% of married women. Women of color are more likely to be poor than Caucasian women. And over 30% of single African-American women live in poverty in comparison to 18.5% of single Caucasian females. Around 29.5% of Hispanic women are also impoverished (United States Census Bureau, 2008)

Though more women than ever before are employed, they still make less money than men. And this continues to be true regardless of a woman's level of education, her occupation, or where she lives. White women earn 77 cents for every dollar a man makes, African-American women earn 61 cents, and Hispanic women make only 52 cents for every dollar a white man earns. Over the course of a lifetime, women lose over $400,000 to the gender pay gap. Ironically, women with the most education lose the most money. Women with bachelor's degrees and beyond lose over $700,000 a year, while female high school graduates lose only 300,000 (United States Census Bureau, 2009; Boushey, Arons, & Smith, 2010).

Even elite, female physician researchers are paid less than their male counterparts. According to Jagsi et al. (2012), female doctors employed at American academic institutions made over $12,000 less a year than male physicians in a study of recipients of the 2000-2003 National Institutes of Health (NIH) K08 and K23 awards. Since it has been argued that some of the pay gap owes its existence to the particular choices women make (i.e., the tendency of women to go into lower paying careers like education, rather than into STEM fields, or to work part-time due to caretaking responsibilities), Jagsi et al. made a concerted effort to compare physicians of comparable status (Kuehn, 2012). And after controlling for academic rank, hours worked, publication productivity, and job specialty, the pay gap still existed. Furthermore, the female doctors were less likely to be parents than their male counterparts. Over the course of their career, Jagsi et al. (2012) estimated that these topflight, female doctors would lose over $350,000 to the gender pay gap.

In general, women are over-represented in service sector, social work, and educational fields and they make up the majority of low-paid American workers (United States Government Accountability Office, 2011). The Great Recession has led to high rates of unemployment for both men and women, and though fewer women were unemployed than men, more women worked part-time due to inability to find full-time employment. By 2011, 1 in 5 women were employed part-time, a decline from 2000s rate of 1 in 10 (International Labor Association, 2011). Whether a woman is employed full or part-time, she often finds herself pulling a second shift when she gets home. Married women frequently perform the majority of household and child care tasks, and perceived

inequity regarding household chores is often associated with marital conflict and an increased risk of divorce (Frisco & Williams, 2003). Given that stress and relationship issues are associated with sexual problems (Laumann et al., 1999), the debilitating effects of this second shift could be a major factor in FSD.

In a qualitative study that looked at desire loss among women in long-term, happy relationships, many participants reported feeling both overwhelmed and desexualized by their "to-do" list (Sims & Meana, 2010).The constant demands of balancing motherhood and work responsibilities interfered with their capacity to feel sexual. Furthermore, some participants also felt that the roles of "lover" and "mother" were incongruent and depleted their desire for physical intimacy with their spouses. For some, the constant tactile demands of caring for a small child left them feeling on sensory overload, with little energy for more physical contact. Other women reported feeling that mothers weren't supposed to be sexual—that there was a profound difference between the roles of "vixen" and "mom"—and they couldn't switch from one role to the other quickly or seamlessly (Sims & Meana, 2010).

Social roles. Chodorow (1989) argued that one reason women are so focused on relationships stems from cross-cultural childrearing practices. In most societies, women are the primary care-givers of children, and she asserted that this practice has widespread consequences for human relationships. Women develop a self-in-relation. That is, women's self-concept is intimately connected with their relationships. As young infants, both sexes have their most intense bond with the mother, who is regarded as an extension of the self. At about 9 months old, a child begins to separate from the mother and develop

a sense of him or herself as an individual. For boys, the development of a masculine gender identity means that the mother must be replaced by the father as a suitable role model. This process disrupts the mother-son bond, with the young boy experiencing this shift as a rejection from the mother (Chodorow, 1989).

Chodorow believed that in the process of attaining manhood, a boy's own femininity was repressed. And in adult men intimacy ignites deep-seated fears of engulfment, loss of masculinity, and rejection by the mother, while women, who have a less problematic gender role development, experience no such conflicts. As a result of social conditioning, men are threatened by intimacy, while women are threatened by individuation (Chodorow, 1989).

However, in order to maintain valued relationships, women resort to self-silencing unacceptable feelings and needs (Impett et al., 2006; Jack, 1991; Neff & Harter, 2002).While Chodorow saw this kind of prioritizing on the part of women as indicative of an other oriented connectedness, Neff and Harter (2002) argued that women do this for pragmatic reasons that favor the creation of a false-self façade. It is, therefore, a reflection of gender politics and not an authentic expression of the self.

In their study of 251 heterosexual couples, women who subordinated their own needs were found to have partners who were self-prioritizers. While men who sacrificed their own needs were equally likely to regard their partners as self-sacrificers, self-prioritizers, or compromisers. A high proportion of self-sacrificing women did so to avoid negative consequences and many reported feeling that their actions were inauthentic to the self. According to Neff and Harter (2002), "women in relationships

where self-sacrificing behavior was reciprocal were able to be their true selves, but those in unequal relationship were not." (p. 413).

The sexual economy. According to Buss (1994), gender discrepancies in relationship investment are also rooted in evolutionary sexual strategies. For men short-term mating plans that entail immediate sexual activity with minimal investment of resources are a huge reproductive bonus. Women, on the other hand, saddled with 9 months of gestation and lengthy child rearing, typically regard indiscriminate sexual choices as foolhardy. Consequently, women have evolved a more sexually conservative mating strategy to avoid wasting their reproductive resources on unworthy candidates (Buss, 1994; Buss & Meston, 2009). Women typically prefer men who are healthier genetic material, industrious, intelligent, and better off financially (Buss, 1994; Buss & Meston 2009). Schmidt (2005) found in his study of 48 countries that even though women clearly have evolved a short-term mating strategy (in addition, to a long-term plan), they still prefer quality over quantity in both scenarios; whereas, men demonstrate the inverse. That is, they have a decided preference for indiscriminate, short-term mating—a triumph of quantity over quality.

This puts men and women in conflict over both sexual access and resource sharing. Buss (1994) asserted that the kinds of male behaviors that are most upsetting to women revolve around men's inability to disclose their feelings, general neglect of relationships, and tendency to express contempt. Emotional displays of affection betray one's level of involvement and signal investment, while minimizing such behaviors

allows space for other mating opportunities, which has definite evolutionary advantages (more offspring with minimal loss of resources) (Buss, 1994).

Baumeister and Voh's (2004) theory of sexual economy utilizes many principles of evolutionary psychology and comes up with the startling premise that if human mating habits are interpreted within an economic framework, women are the sellers and men are the buyers—and in the current sexual system, it is a buyer's market. In other words, contemporary sexual norms are more congenial to male sexual strategies than female, which has important ramifications for female sexual authenticity.

Baumester and Voh's (2004) argued that the mating game functions very much like the economic market place with buyers and sellers competing with one another to sell their wares. Sexual access is the primary resource being exchanged, and it is highly influenced by market based environmental pressures. Under this system, sex is a female resource only, while male sexuality is "relatively worthless" (Baumeister & Vohs, 2004, p. 340).

Therefore, in order for sex to be an equal exchange, a male must supply some kind of nonsexual resource. It is very common in many cultures for a man to woo a prospective mate with a gift as a part of courtship. Seldom in the inverse noted (Baumeister & Vohs, 2004; Buss & Meston, 2009). Women often use their sexuality as a bargaining tool to obtain needed resources. In Buss and Meston's (2009) study of the sexual motivations of 1,006 women, many of the participants admitted to trading sexual favors for goods and services. Indeed, Baumeister and Voh's (2004) argued that one of

the primary motivating factors for women to participate in the sexual economy is the widespread male monopolization of economic resources in many cultures.

The relative social value assigned to a woman's sexual worth determines how much a man can be expected to contribute in the way of resources. Usually, women who are younger, more attractive, and less sexually experienced are more valuable and subsequently command the most in return for their favors. Sex is also subject to local market fluctuations. How much of a price a woman can put on her sexuality depends on the going market rate in her particular culture and her sexual value within that culture.

This latter fact is of prime importance in understanding women's struggle with sexual authenticity. According to Barbour (2008), who used Baumeister and Voh's theory in her study of sexual authenticity, the sexual economy requires women (as suppliers) to market their product to meet men's (consumer) driven demands. The old business adage "the customer is always right" informs women's experiences of their sexuality and creates a focus on pleasing the partner that is often in direct opposition to the reality of the authentic self. She argued that because most heterosexual women are forced into the role of suppliers within this market driven system very few women are able to act as "entrepreneurs"—that is, independents who define their sexuality for themselves.

Baumeister and Voh's (2004) theory rests on the debatable assumption that sex is a female resource because men are inherently more interested in sexual activity than women; therefore, they are willing to pay a price for its occurrence. In the sexual marketplace both men and women try to get the best deal possible, and for men that

means easy sex at a low cost (limited investment of time, money, or commitment), while women, who incur significantly more risks from erotic congress, prefer to keep the price of sex high (Baumeister & Vohs, 2004).

The sexual economy, much like the monetary one, is dominated by supply and demand market pressures. Anything that affects the balance of either one of these variables in a given market place should also affect how sex is operationalized in that environment. Baumeister and Voh's (2004) asserted that one strong determinant of the sexual economy is the ratio of women to men in the population. In times of male scarcity, the price of sex goes down because of intensified mate competition among women. That is, women may have sex with less investment to under-price their competitors (i.e., other women) due to the fact that supply (women offering sex) now outstrips demand (men seeking sex).The inverse occurs when women are in short supply. Sexually permissive eras (low male resource investment) occur when men are the gender minority; whereas, when women are in the minority, sexual conservatism (high male resource investment) is the rule (Baumeister & Vohs, 2004; Buss, 1994; Buss & Meston, 2009).

Every now and then a culture will experience a shift in the male/female demographics, creating an oversupply of one sex and a dearth of the other. This is most often due to war, male emigration or imprisonment, famine, female infanticide, maternal death in childbirth, baby booms, and male on male violence (Buss, 1994; Guttentag & Secord, 1983).

Guttentag and Secord (1983) looked at the gender ratio in several different eras and cultures, including Medieval Europe, ancient Greece, and the civil war era south to

find out how demographics impacted sexual and marital norms. They found that the minority gender had greater dyadic power and were able to dictate the terms of the association because they had more romantic prospects than the gender majority. Societies in which females were scarce valued women more and treated them with greater respect but limited their political and economic power. Nonetheless, suicide rates among women decreased, rates of divorce and illegitimacy were low, while marriage rates were high. When men were the gender minority, divorce was common, sexual objectification of women replaced chivalry, illegitimacy rates rose, and men (but not women) enjoyed multiple partners. Because of male scarcity, women were forced to share lovers but were denied multiple liaisons themselves, due to lack of available prospects. However, women's economic and social power increased, as did the prevalence of lesbianism. The shortage of men means that not every woman will have a husband; therefore, women focus on developing economic independence and are more likely to protest institutionalized power inequities that interfere with that independence when they are the gender majority (Guttentag & Secord, 1983).

Gender demographics can profoundly reduce women's sexual agency, and in both high and low ratio eras, authentic female sexual expression is curtailed—though not for the same reasons. When women are a scarce commodity, men seek to control female sexuality by directly limiting women's behavior and jealously guarding their investment. More men means more potential rivals who could lure away a dissatisfied wife or lover; therefore, men use mate guarding behaviors under such circumstances—and this often takes the form of violence against women and increased male on male aggression. When

there are too many women, their individual capacity to be authentic is pitted squarely against a lopsided sexual market place that favors the male consumer. Consequently, women compete with one another for scarce male attention by focusing on their appearance, and offering sex to men at cut-rate prices (Buss, 1994).

In 20th century America, due to a number of changes in the social landscape, women began to outnumber men. Census data from 1900 to 2000 reveals a major shift in the male to female ratio. For over two centuries (the 18th and the 19th), American men were the gender majority. And in the first part of the 20th century, there were more men than women. For example, in 1900 there were 104.6 men per 100 women; by 1910 this number climbed to the century's all-time high of 106.2 men per 100 women. Starting from 1950 on, the numbers reversed their upward trend, and the male female ratio declined. In 1950 there were 98.7 men to 100 women. By 1980, the male female ratio hit an all-time low of 94.5 men to 100 women (United States Census Bureau, 2001). Female mortality declined in the United States during the 20th century partly due to a drop in maternal death rates. In 1915, there were 607.9 deaths per 100,000 live births, by 2003 that number had dropped to 12.1 deaths per 100,000 live births (Centers for Disease Control and Prevention, 2007). Since 1980, there has been a steady increase in the ratio of males to females engendered by a decline in mortality among men and an increase in male immigration (United States Census Bureau, 2001).

The sexual revolution of the mid 20th century occurred partly because of the shortage of men, according to Buss (1994). Women usually marry men older than themselves, but hard-hit, baby boomer women had fewer potential mates born in the

preceding birth cohort to marry. Birth rates declined steadily throughout the 20th century and reached their lowest point in 1945—the year before the start of the baby boom (Guttentag & Secord, 1983).

Though the gender ratio has risen, men still remain the minority gender, which means there are simply not enough males for every woman to have a mate. Simply put, more women spend much of their lives in an unattached state, which may not be self-chosen. African American women are especially hard hit by these issues. According to Banks (2011), African American women are the least likely to marry of any ethnic group. Seven out of 10 Black women are single—the result, in part, of a severe man shortage brought about by the high incarceration rates of African American men (1 in 10 of whom are in prison by their early thirties) (Banks, 2011; West, & Sabol, 2009).

Further complicating these issues is the fact that women continue to prefer males who are older with greater material resources. That is, women desire to "marry up" (Buss, 1994). Male "success objects" are increasingly in short supply, given the realities of low educational attainment among men (Mortensen, 2008). According to Mortensen, over the last few decades, there are both fewer high paying jobs that do not require a 4-year degree, and fewer men pursuing the academic credentials needed to succeed in competitive, white-collar service industries (the fastest growing employment sector). Male-dominated jobs in dangerous, but profitable, areas such as forestry and mining have diminished as have many farming and manufacturing positions, leading to a high rate of male unemployment (especially among blue collar men). Higher numbers of men are

unmarried, living with their parents, or incarnated than in preceding decades (Mortensen, 2008).

Furthermore, American women not only have to contend with fewer acceptable marital prospects, but their own surplus numbers in the dating pool. The current high divorce rate has engendered an abundance of available women—leading the New York Times to report in 2007 that, for the first time in United States history, more women were living alone than were living with a husband (Buss, 1994; Roberts, 2007).

After a divorce, men are more likely to remarry than women and often to younger spouses (Buss, 1994). Buss (1994) found that aging, high status males chose increasingly younger mates for romantic relationships. Men in their twenties preferred women slightly younger (2 to 3 years), while men in their thirties preferred their mates 5 to 10 years younger. By the time a man reached 40 or 50, his partner was often 10 to 20 years younger than himself.

Looking at census data of 5-year community samples from the 2006 through 2010, reveals that 66.5% of men in the age range of 45-54 are currently married, in comparison to only 63.9% of women. Furthermore, more women than men are listed as divorced, separated, or widowed—though a higher number of men, in all age ranges, have never married (United States Census, 2010).

It is not just older women who suffer from a scarcity of available mates. College campuses, traditionally meccas for young women seeking husbands, are currently inundated with females. Over the last few decades, the number of women pursuing 4-year degrees has risen exponentially, while the number of men seeking higher education has

fallen (Mortensen, 2008). According to Mortensen (2008), there were over 2.6 million more women than men enrolled in college in 2005. Given the lower proportions of men on America's college campuses, one would expect, according to sexual economy theory, that low investment, casual sex would be common, which is exactly what one finds. According to England and Thomas (2007), traditional dating has largely disappeared from the college milieu—replaced by a low investment model of sexuality termed "hooking up"—a subject of much media attention over the last few years.

Regnerus and Uecker (2011), analyzing data from the Add Health study, also found evidence of a male-defined, low investment model of sex among emerging adults. They asserted that one indicator of male investment is timing of sex. When sexual intimacy occurs early in a relationship, it is indicative of less "work" on the part of a man, while later sex indicates more effort expended. Looking at Add Health data, they found that early sex was the norm among emerging adults. Thirty-six percent of young men had sex within 2 weeks of beginning a relationship, and over 70% were sexually intimate with a lover by the end of 6 months. Another indicator of reduced masculine investment is the fact that men with the least resources often have the most sex. Among 22 year-old males in the Add Health study, the number of sexual partners was inversely correlated with the level of education (a traditional marker of earning potential). That is, high school dropouts reported higher numbers of life-time sex partners than college graduates. Traditionally, men have acquired material resources and/or status, declared commitment, and given the appearance of a promising career trajectory as a way to

obtain sex with a fertile female. Regnerus and Uecker (2011) argued that this was no longer necessary.

Gender Ratio, Female Sexuality, and Cultural Norms

According to Guttentag and Secord's (1983) theory, the gender that is in the minority has the most dyadic (relationship) power, but not necessarily the most social power. In many societies, men have more structural (i.e., institutional) power than women. And, when they are the gender majority, they typically use their greater socioeconomic clout to limit women's sexual, political, and economic choices. Cultural differences in gender ratios spawn very different interpretations of female sexuality. And what is considered a sexual pathology by a culture is often a reflection of the gender demographics of that society. For example, high gender ratios were common in the 19th century (Guttentag & Secord, 1983). Under conditions where there were frequently more men than women, it is not surprising that nymphomania was such a subject of social concern—the imbalanced demographics made women a scarce (hence, guarded) resource and female sexual permissiveness was a threat to male investment. Victorians feared the potentially transgressive nature of female desire. Since women were viewed as the backbone of Victorian morality, and inherently more refined and delicate than men, any deviation from that role was potentially disruptive to the patriarchal family and the moral order (Groneman, 1994).

In the 20th century with low gender ratios predominant, interest shifted to the damaging effects of FSD. Now, it was low, rather than high sex drive that was a social concern and a medical pathology. Within the context of a male centered sexual economy,

FSD has the potential to be a major liability for women in the romantic market place given the value ascribed to sexuality by men. Research (Baumeister, Catanese, & Vohs, 2001) has found that men report a greater emphasis on sexuality in their lives and their relationships than women in a number of ways, including a greater desire for sex, a greater preference for sexual variety, and a greater willingness to take risks to get sex. Given this social backdrop, there is the possibility that a woman with a sexual dysfunction may encounter significant problems acquiring and maintaining romantic relationships. The connection between sexual dysfunction and single status offer some support for this conjecture. Research from the NHSLS found that both single males and females experienced significantly more sexual problems than married individuals. For example, single women were anorgasmic 112 times more often than their married counterparts (Laumann et al., 1999). While it is possible that a stable marriage could reduce the incidence of sexual dysfunction, another explanation for the higher rate of sexual problems among singles is that the sexually dysfunctional may have a harder time maintaining stable relationships and are perceived as less desirable marital partners. It is also possible that a high level of sexual functioning and/or a happy sex life could promote relationship health and longevity. For example, Wilcox et al. (2011) did find that sexual satisfaction was one of the top five predictors of marital stability. But whether a healthy sex life creates a healthy relationship, or vice versa remains to be seen. Byers (2005) argued that while many research studies have found a positive correlation between sexual satisfaction and relationship quality, a directional and causal relationship between the two variables has never been established. In other words, researchers are not clear how much

sex contributes to relationship satisfaction. Nonetheless, in the popular mind, the idea that good sex is a "glue" that bonds a couple together continues to be a deeply entrenched notion—particularly among young adults (Regnerus & Uecker, 2011).

Liquid Love and the Rise of the Sexual Marriage

Certainly, one of the hallmarks of contemporary marriage is the high value placed on sexuality, romantic love, and personal happiness. The traditional reasons that people married for in the past (socioeconomic stability, cultural injunction, child rearing, religious faith, and shared spousal support) have been replaced by a "soul-mate" model of marriage that is based on the ideal of a deep emotional and sexual connection with a significant other (Coontz, 2005; Wilcox, 2009). Indeed, in one study of young, unmarried adults, over 94% agreed with the statement that your spouse "should be your soul-mate first and foremost" (Whitehead & Popenoe, 2001, p. 6). Americans have very high expectations of marital life and a correspondingly high divorce rate. Almost 50% of all first marriages fail, though this statistic tends to be mitigated by social class and education (i.e., wealthier, better educated individuals are less likely to divorce) (Regnerus & Uecker, 2011). The ease with which people enter and leave contemporary relationships has been noted by a number of theorists and referred to in a number of different ways. Bauman (2003) used the term "liquid love" to describe the amorphous, transitory nature of contemporary bonds, while Giddens (1992) spoke of "pure relationships" (p.50) that were defined by mutual self-interest and existed only as long as they benefited both parties. Jack (1991), harking back to Fromm (1956), asserted that modern ideas of intimacy are infused with capitalist ideology. Contemporary relationships, like

capitalism, are concerned with the "functional". Capitalism requires autonomous individuals to make rational choices based on economic self-interest. And a functionalistic view of relationships is quite similar. Relationships continue as long as they are profitable to both participants. But, like any other business venture, they are terminated whenever a better deal comes along, or when they are no longer mutually gratifying. Under this system, relationships are a means to an end, and one should not be overly dependent on one's romantic partner (Jack, 1991).

Wilcox (2009) pointed out that the psychological revolution of the 1960s created a climate in which one's own personal fulfillment was of utmost importance—and the concept of institutionalized marriage (marriage as a social obligation) was abandoned in the process, leading to an epidemic of divorce. While Coontz (2005), taking a broader, historic view, argued that the ideal of marrying for love and personal happiness was fairly entrenched by the 19th century. At which point, social pundits decried loveless marriage and asserted that matrimonial unions should be based on a sincere spiritual connection, what Coontz called sentimental marriage. Over the course of the twentieth century, this ideal was replaced by a sexualized notion of wedlock that both eroticized romantic love and emphasized sexual gratification as an important component of marital success (Coontz, 2005).

The new century introduced the writings of Sigmund Freud and Havelock Ellis, both of whom made sex a popular topic of conversation. Furthermore, the accessibility of birth control, the decline in gender segregation, the rise of the mass media (which quickly

discovered the monetary value of erotic innuendo and imagery) all promoted the demise of sexual repression (Coontz, 2005).

According to Coontz (2005), most of those pushing for sexual freedom sincerely believed that erotic love had the capacity to bolster marital ties—just as the traditional, socioeconomic bulwarks were fading out of existence. This did not prove to be the case. The first sexual revolution in the 1920s ushered in an increase in premarital sexual activity, and a simultaneous increase in both divorce and infidelity. In the 1920s, popular sex manuals like Marie Stope's Married Love, and Theodore Van de Velde's Ideal Marriage provided education on achieving erotic happiness in the modern marriage, as critics bewailed the new sexual freedom and predicted the end of the institution. While their worries may have been premature at the time, the second sexual revolution of the 1960s-1970s did see a massive increase in divorce (Coontz, 2005).

Sex His Way: Women and Unwanted Sex

Sexual permissiveness was originally intended to promote better marriages, but, over the course of the 20th century, an alternative discourse evolved that disassociated sex from stable social ties, viewing it instead as an instrumental, sensation driven, episodic, act devoid of larger emotional implications. (Attwood, 2006; Coontz, 2005; Giddens, 1992). Casual sex is popular among certain sectors of emerging adults and represents the intertwined ethos of porn culture and a male defined sexual economy (Baumesiter & Vohs, 2004; Regnerus & Uecker, 2011). According to Attwood (2006), in the last few decades, sex has also come to represent social identity, liberation, and consumerism. It has become both a badge of fashionable hipness and a polymorphous

emblem that stands for many things, while conversely remaining important in its own right. What women are offered in the current cultural context is the opportunity to be active sexual consumers—within a male defined system (Attwood, 2006). And that, one could argue, is the problem. Sexual authenticity is about the expression of the real self. And women's capacity to express their real selves continues to be undermined by androcentric sexual norms, the instability of modern love, the skewing of gender demographics, and the relentless pressure to "sex it up" demanded by porn culture and a lopsided sexual marketplace. While women continue to be socialized to invest much of themselves in their relationships, modern intimate ties grow increasingly fragile; authenticity is then pitted against the desire for relationship stability. For many women, this means sacrificing their own inclinations to meet partner expectations and social norms regarding sexual normalcy as a way of protecting their valuable (and scarce) investment (Barbour, 2008; Impett & Peplau, 2003; Regnerus & Uecker, 2011).

For example, Regnerus and Uecker (2011) found that women frequently consented to sexual acts that they did not enjoy. In their study, anal sex was disliked by all but a minority of women, and yet over 45% of females who reported disliking the act "somewhat" expected that they would do it again at some point in time. And 10% of those who really disliked it also reported that they would engage in the activity again as well. A gender discrepancy in consenting to disliked sexual acts was also observed by Kaestle (2009) in her examination of Wave 3 of the National Longitudinal Study of Adolescent Health. She found that while 12% of women engaged in disliked sexual acts, this was true for only 3% of men in the 4, 469 participant study. Married women were

even more likely than single women to engage in sexual activities they did not enjoy. Gender differences can make negotiating sex difficult for some couples. Men typically find a greater variety of sexual acts appealing than women, and they prefer to have sex earlier in the course of a relationship (Laumann et al., 1994; Morgan, Johnson & Sigler, 2006; Peterson, Geher & Kaufman, 2011). Some of the reasons that women continue to tolerate and comply with disliked sexual acts are rooted in gender power inequities and the skewed dynamics of the sexual marketplace. Men continue to have more social power than women, and fewer males mean more mate competition between women and more relationship instability (Baumester & Vohs, 2004; Buss, 1994; Guttentag & Secord, 1983). For instance, Regnerus and Uecker (2011) argued that the fear of partner loss and the desire to appear fashionably "cool" motivated acquiescence in many cases. Other reasons included:

> [1.] Direct pressure from a partner (which hinges on power dynamics and the ability to say no) [2.] Perceptions about the script of what a good or loving sexual partner ought to do [3.] Fear that the partner will pursue sex with someone else if rejected. [4.] Perceptions that it's useless to refuse repeated sexual requests for long [5.] The diminished price of sex, making saying no seem unreasonable and inexplicable. [6.] The accumulation of partner's credit within the relationship [7.] A genuine desire to satisfy a partner's wishes or to foster intimacy. [8.] Interest in avoiding the conflict or tension that saying no might generate [9.] The trading of a sexual favor in return for resources in other areas of the relationship… [10.]

> Inhibited expression of reluctance due to the nonverbal nature of sexual interaction. (Regnerus & Uecker, 2011, p.99)

According to Regnerus and Uecker (2011), pornography was one factor motivating some of men's less popular sexual requests. Anal sex is more common among heterosexuals now than in earlier decades, though it is not a typical part of the heterosexual script. It has, nonetheless, been experienced by 30% of Americans—a fact the researchers attribute to its prevalence in pornography. Pornography is especially popular among young adults and constitutes 25% of all Internet search requests (Carroll et al., 2008). According to Carroll et al. (2008), in their study of 813 college students, 67% of young men and 49% of young women approved of pornography usage. While emerging adult women were accepting of pornography use in theory, they reported using it far less than men. For instance, only 31% of young women ever looked at sexually explicit material, in comparison to 87% of emerging adult men.

Not only are women consenting to disliked sexual acts but often unwanted sex as well. Rarely is sexual desire identically matched in any relationship. In many situations, one partner is interested in pursuing sexual activity, while the other is not. This scenario can be resolved in different ways. A common resolution is for the non-interested party to consent to unwanted consensual sex (Impett & Peplau, 2003). According to a study on sexual compliance by Impett and Peplau (as cited in Impett & Peplau, 2003), 65% of women have consented to sex that they were not interested in having, in comparison to 40% of men. Impett and Peplau (2003) argued that if one looks at sexual behavior over a period of time, both men and women will report consenting to unwanted sex, but women

tend to do so with a greater frequency than men. Some women consent to unwanted sex because of love for their partner, while others wish to avoid conflict. Feminist scholars have long pointed out that gender differences in regards to money and power place many women in the position of having to comply with partner sexual requests (Impett & Peplau, 2003).

In another study on sexual compliance, Impett and Peplau (2002), using attachment theory, found that anxiously attached women were more willing to consent to unwanted, consensual sex than other attachment styles. They also reported having a greater degree of commitment in their relationships and said that they would acquiesce to unwanted sex to avoid losing a partner. Impett and Peplau acknowledged that while attachment styles do develop in infancy, anxiety could also originate from the experience of being in a relationship where one is more committed than one's partner, which some researchers have found to be a common occurrence among heterosexual women (Felmlee (1994). This is also predicted by Guttentag and Secord's (1983) theory that having too many women in a population decreases both female dyadic power and male commitment.

Katz and Tirone (2008) pointed out that consenting to unwanted sex has several negative repercussions for women. For one, if the sexual activity includes intercourse, a woman is at risk for an untended pregnancy and an increased risk of HIV or sexual transmitted diseases. According to Blackledge (2004), intercourse without adequate arousal (a possibility if one is not in the mood for sex) increases a woman's risk of urinary tract infections and vaginal tearing.

Katz and Tirone (2008) made a distinction between freely consenting to unwanted sex and consenting due to partner coercion (i.e., being begged or pressured to have sex). They focused their query on women's sexual consent to unwanted intercourse without partner duress. According to Katz and Tirone (2004), approach or avoidance incentives underlie most female sexual compliance. Approach motives are about promoting intimacy with a partner, showing affection, and taking care of a partner's needs, while avoidance motives are more concerned with reducing relationship tensions and the possibility of partner loss. If women consented to unwanted sex for approach reasons, they were less likely to have negative emotional consequences from the experience. Consent due to avoidance was associated with less overall relationship satisfaction (Katz & Tirone, 2008).

Katz and Tirone (2008) found that most of the compliant women in their study reported more gender role conformity, which emphasized the role of social norms in female acquiescence. Furthermore, sexually compliant women did not report greater relationship satisfaction (which did not support the hypothesis), and this was true even when they were motivated by approach tactics. In their statistical analysis, there was no significant association between relationship satisfaction and approach incentives. So, even though women comply with their partner's requests for sexual activity in order to promote intimacy (and approach motives were more common in the sample), they were not happier with their relationships in general. However, women who were more motivated by avoidance tactics were significantly unhappier with their relationships.

The central feature of Kernis and Goldman's (2004) theory of relational authenticity is behaving according to one's own inner dictates, not following along with someone else's wishes. The high prevalence of unwanted sex among women portends to problems with authenticity that may have serious repercussions for female sexual well-being. It is possible that the high rate of unwanted sex could be one factor behind loss of desire in women. For a woman to have sex when she is not interested and/or engage in sexual activities that she does not enjoy (and may even consider repulsive) could make it harder for her to get sexually excited during an encounter, thereby disrupting the conditional link between sexual activity and her own gratification. Sexual arousal occurs partly through the mechanism of classical conditioning and is therefore a learned reaction. (Both et al., 2007). According to Both et al.:

> Low sexual desire and arousal may be caused by a lack of association between sexually rewarding experiences and stimuli, resulting in a limited number of potential sexual incentives that can activate sexual responses… Increasing the association between sexually rewarding experiences and stimuli may result in a larger number of potential sexual incentives. (2007, p. 107)

Furthermore, given that sexual arousal is essential for intercourse to be comfortable, a negative conditional association between sexual activity and pain might further disrupt desire and possibly engender sexual pain disorder. For instance, a negative association between pain and intercourse is one factor behind vaginismus. If a woman has had a bad experience with penetration in the past, or has had any medical condition that created painful penetration, vaginismus could occur simply from the fear that intercourse will be

painful again—even if the condition or the circumstances that created the pain have changed. A woman who has learned to associate intercourse with pain may unconsciously contract her vaginal muscles in anticipation of further discomfort. (Baron et al., 2011).

Hormonal Birth Control, FSD, and Gender Norms

The use of hormonal contraception has also been implicated in FSD (Graham, Bancroft, Doll, Greco, & Tanner, 2007; Sanders, Graham, Bass, & Bancroft, 200l). And this is the primary form of birth control for most women in long-term relationships. One could argue that, in addition to ease of use and efficacy, women use the pill because they do not have to negotiate condom usage with a partner, which could bring up issues of power and self-assertion. Condom usage requires a woman to talk about sex and insist on protected coitus. Research in sexual health (Blanc, 2001; Impett et al., 2006) has repeatedly found that for many women this is extremely difficult to do given their particular life circumstances, in spite of the fact that 68% of individuals afflicted with HIV from heterosexual intercourse are female and condoms reduce HIV transmission (Centers for Disease Control and Prevention, 2011). The pill allows women to protect themselves against pregnancy without a partner's consent—but with a possible price. Hormonal contraception doesn't protect against HIV, and it suppresses free testosterone by elevating levels of sex hormone-binding globulin (SHBG). Androgens play a role in female desire and functioning, and SHBG binds free testosterone and puts it out of commission (Graham et al., 2007). In addition, the pill also reduces levels of dehydro-epiandrosterone-sulfate (DHEA) and DHEA-S.

Researchers have known for a while that the pill decreases androgen production. However, recent research has suggested that this effect may be long term, or possibly permanent. In a study that compared women who had never been on the pill, those who had been on the pill for at least 6 months, and former users who had discontinued the pill after 6 months, it was found that in discontinued users SHBG levels remained elevated months after the contraceptive had been discontinued (Panzer et al., 2006). The researcher's opined that "Long-term sexual, metabolic, and mental health consequences might result as a consequence of chronic SHBG elevation." (Panzer et al., 2006, p. 104). However, other studies have not supported this conclusion. Graham et al. (2007) found that the pill had limited effects on women's sexual interest—even when testosterone levels were substantially reduced. In spite of possible negative consequences, the pill remains the contraception of choice for most sexually active women (Panzer et al., 2006).

Chapter 2 Summary

FSD remains a very controversial and often dichotomized diagnosis. According to Tiefer (2001b), much of the research conducted over the last few years has favored a biodeterministic paradigm. It is true that there are huge gaps in the scientific understanding of female sexual biology (e.g., confusion over the impact of hormones on desire), but in the race to find a pharmaceutical treatment for this condition, sociocultural factors have been relegated to the sidelines (Tiefer, 2001b). Authenticity, inevitably calls into question issues surrounding self-expression, power, and gender and has been missing from the discourse on FSD. There have been few studies examining the impact of the authenticity on female sexuality and none on sexual dysfunction. At the same time,

researchers (Laumann et al, 1999) have acknowledged the significance of nonmedical factors on FSD. This study attempted to fill a gap in a, little examined, area that may play a major role in sexual dysfunction in women. Chapter 3 goes into more detail regarding the methodology of this study, which is correlational in nature. This is an appropriate design approach for this topic because correlation examines the relationship between variables, both independent and dependent, and does not involve variable manipulation. It would be impossible to manipulate sexual dysfunction as an experimental construct. So, my study relied on having participants report their experiences regarding sexual functioning and authenticity. Regression analysis was used to predict a relationship between the variables.

Chapter 3: Research Method

Introduction

In Chapter 2, using Kernis and Goldman's (2004) authenticity theory as a theoretical framework, I examined the impact of cultural constraints on female sexuality. Authenticity is associated with a greater degree of personal well-being and relationship satisfaction. However, there are negative consequences to being authentic—particularly for women and especially in regards to sexual expression. For example, women face social censure for not conforming to cultural injunctions regarding right sexual behavior, and authentic sexual expression may be dangerous, in some cases, to relationship stability (Barbour, 2008; Regnerus & Uecker, 2011). Not surprisingly, many women have reported a variety of sexual complaints including issues with desire, sexual pain, and difficulties with orgasm (Laumann et al. 1999). Women's continued social subordination, coupled with conflicting discourses regarding gender and sexuality, undermine female authenticity in a variety of ways, such as body awareness, comfort with self-assertion, and sexual communication—all of which play a role in the etiology of FSD.

Understanding the role authenticity plays in FSD aids social change by providing more insight into a little researched topic. The purpose of this correlational study was to examine the association between authenticity and FSD, specifically how authenticity influenced sexual functioning and satisfaction in women. This chapter's focus is on the procedures and methods used to gather and analyze the data, including a discussion of participant acquisition, sample size, and measures that were utilized in the study.

Research Methodology

This study used a correlational research design and incorporated a variety of self-report measures. This was an appropriate design for this type of research because I was comparing scores on authenticity and FSD self-report inventories and examining the association between these two variables. The study did not prove causation because there was no experimental manipulation of the variables. However, it did provide information as to whether there was a positive, negative, or no correlation between these variables. The independent variable was defined as authenticity and the two dependent variables were defined as sexual dysfunction and sexual distress.

Sampling Procedures and Participants

Using a G*Power analysis (Faul, Erdfelder, Lang, & Butcher, 2007) for a multiple regression with a medium effect size off $f^2 = .15$, two predictors, a power of .80, and an alpha of .05, I had estimated that I would need 55 participants, which I recruited from Walden's participant pool. I used a convenience sample based on the following criteria: (a) accessibility, (b) female gender, (c) currently sexually active, (d) over the age of 18.

Measures

Demographics

Standard demographics regarding age, education, income, marital status, and relationship length were gathered as part of the study in order to provide a fuller description of my subjects. Information regarding education, marital status, and income is especially important given their association with sexual dysfunction (Laumman et al., 1999; Sims & Meana, 2010). Therefore, these variables were entered into Model 1 of a

hierarchical regression and AI-3 was added into Model 2. See Appendix A for questionnaire. This research project was conducted online via a Survey Monkey link.

This study utilized The Female Sexual Function Index (FSFI), The Female Sexual Distress Scale, Revised (FSDS-R), and the Authenticity Inventory, Version 3 (AI-3) DeRogatis et al., 2008; Kernis & Goldman, 2004; Rosen et al., 2000).

FSFI

The FSFI (Rosen et al., 2000) is a short, multidimensional questionnaire that measures the various clinical categories of FSD, though it was normed primarily on participants with female sexual arousal disorder (FSAD); a clinical group of 128 women with this disorder and a control group of 131 women without FSAD (Rosen et al.,2000). The test was designed to measure six domains: (a) desire, (b) arousal, (c) lubrication, (d) orgasm, (e) satisfaction, and (f) pain. This measure was chosen because it examines the various dimensions of response used to make a *DSM* diagnosis of FSD. For example, the *DSM-IV-TR* (2000) regarded sexual dysfunction as "a disturbance in the processes that characterize the sexual response cycle [consisting of four phases: desire, excitement, orgasm, and resolution] or by pain associated with sexual intercourse" (para. 5). There has been a considerable amount of research on sexual satisfaction and various measures of the construct have been developed. However, as Lawrence and Byers (1992) have noted, many of these suffer from conceptual problems, and in many cases the psychometric properties of the measures have not been reported or are poor (Pinney et al, 1987).

I chose the FSFI for my study because this widely used measure was developed to specifically reflect the *DSM-IV-TR* diagnostic criteria for FSD. In addition, it has the advantage of being short, focused only on the woman's experiences and behaviors, and, in contrast to many other measures, it has very good psychometric properties (Rosen et al., 2000). Rosen et al. (2000) specifically developed the FSFI as a way of examining the dimensions used in the current *DSM* classification system for FSD. Earlier measures were created prior to the 2000 *DSM-IV-TR* revisions and were largely unidimensional examinations of behavior (Rosen et al, 2000). For example, the Golombok-Rust Inventory of Sexual Satisfaction (Rust & Golombok, 1983), which had high split-half reliability scores (.87 to .94) and was good at identifying individuals with sexual issues, was created in 1983—well before the 2000 *DSM-IV-TR* changes. Also, the test was not created to specifically address female sexual concerns. Instead, it examines dysfunction in both men and women. The Sexual Satisfaction Scale for Women (Meston & Trapnell, 2005) was specifically designed to measure satisfaction in women and was created after the *DSM* revisions. The Sexual Satisfaction Scale for Women looks primarily at relational sexual satisfaction and contentment. However, it has not been as extensively used as the FSFI and has lower reliability coefficients than the FSFI. The Sexual Satisfaction Scale for Women had test-retest reliability scores of $r = 0.62$ to 0.79 for women with FSD and $r = 0.58$ to 0.79)for a control group without FSD. The FSFI has been widely used in research on female sexuality and has been validated in populations as diverse as Malay (Sidi, Abdullah, Puteh, & Midin, 2007) and The Netherlands (Ter Kuile, Brauer, & Laan, 2006). The FSFI has high test-retest reliability ($r = 0.79$ to 0.86)

and internal consistency (Cronbach's alpha 0.82 and above). Construct validity was ascertained and determined to be very significant by comparing the domain means of the control group with the FSAD group. In addition, the FSFI also showed divergent validity when compared with a measure of marital satisfaction (Rosen et al., 2000).

The FSFI is self-administered and its six domains are assessed with a Likert scale ranging from 0 to 5. Four of the 19 questions allow only five response options. The other 14 questions provide six response options. The FSFI is scored by adding up the individual domain responses and multiplying by the domain factor (which ranges from 0.3 to 0.6). The individual domain scores are then added to form the total FSFI score. A score of 2.0 is considered to be in the minimal full score range, while 36.0 is considered to be in the maximum full score range (Rosen et al., 2000).

FSDS-R

The FSDS-R (DeRogatis et al.,2008) is a self-report inventory that examines sexual distress. This unidimensional measure was chosen because the concept of distress is integral to a *DSM-IV-TR* (2000) diagnosis for FSD. According to Derogatis et al., (2002), sexual distress has a profound impact on an individual's quality of life, and the FSDS was created due to the absence of any adequate measures of this concept. A sexual distress measure was included in this study because sexual distress is required for a *DSM* diagnosis and because it has a curious relationship with women's sexual issues. Many women reported physical problems, such as low desire or anorgasmia, with little distress about them (Whitting et al., 2008). For instance, Dennerstein, Koochaki, Barton, and Graziottin (2006) found that while 16% of women between the ages of 20 and 49 in a

Western European sample reported lack of sexual desire, this number dropped to 7% when distress was required for a clinical diagnosis. To ensure that all elements in the *DSM* criteria were represented in this study, a focused measure of sexual distress was added. The FSDS (DeRogatis et al., 2002) was specifically designed to measure sexual distress in women.

FSDS-R (DeRogatis et al., 2008) is identical to the original measure, but contains one question specifically targeted at women with low sex drive or hypoactive desire disorder. The original FSDS was validated using three groups of 500 women. Test-retest reliability was found to be high and ranged from .80 (pilot study) to .91 (over a 4-week period in the second study) to .92 (total sample, third study, over a 4-week period); internal consistency ranged from .86 (initial study) to lower .90s (later clinical trials). The test also had excellent discriminate validity; ROC analysis was able to identify, in 90% of female participants, whether sexual distress was present during the third trial using a cutoff score of < 15 (DeRogatis et al., 2002).

The FSDS-R was validated on 255 women and had good discriminate validity and in 92.7% of participants identified the presence of low sex drive or hypoactive desire disorder in women being screened for the disorder. The interclass correlation coefficient was used as a way of gauging test-retest reliability and was found to be most effective with a 7-day recall time frame (DeRogatis, Clayton, Lewis-D'Agostino, Wunderlich, & Fu, 2008).

The FSDS-R is a self-administered inventory on a 4-point Likert scale. On the test, a woman is asked a series of 13 questions regarding how often she has felt distressed

about some element of her sexual life/response in the past 30 days. Responses available are 0 = *never*, 1 = *rarely*, 2 = *occasionally*, to 3 = *frequently*, 4 = *always*. L. DeRogatis (personal communication, May 18, 2012) provided scoring information via e-mail (see Appendix B for record of correspondence). The FSDS-R is scored by adding up the individual items to get the composite score. Anything over 15 is considered to be in the clinical range of sexual distress.

AI-3

The AI-3 (Kernis & Goldman, 2004) was developed as a way of measuring authenticity. The test was chosen because Kernis and Goldman's (2004) theory of authenticity was my theoretical framework and their measure looked at authenticity as a global psychological construct. The subscales of the AI-3 have good internal consistency: Awareness scale = .79, Unbiased Processing scale = .64, Behavioral scale = .80, Relational Orientation scale = .78 with an alpha composite score of .90. Test-retest reliability was high over a 4-week time period (total composite $r = .87$, Awareness $r = .80$, Unbiased Processing $r = .69$, Behavioral $r = .73$, and Relational Orientation $r = .80$). Construct validity was determined by comparing the AI-3 with The Defensive Verbal Behavior Assessment; it was found the AI-3 was inversely correlated with the Defensive Verbal Behavior Assessment ($r = -.25$, $p < .02$), which supported the hypothesis that individuals high in authenticity would score lower on defensiveness (Kernis & Goldman, 2006). There are other measures of authenticity that were useful but were not specific to my theory. For instance, The Authenticity in Relationships Scale (Lopez & Rice, 2006) was a similar measure of authenticity that focused on understanding the relational

dimensions of the concept, which Lopez and Rice (2006) considered to be underdeveloped in the AI-3. The Authenticity in Relationships Scale did have good reliability according to factor analysis, and the authors had used a two-factor design and internal consistency scores on both factors had scored as high as .90 for Chronbach's coefficient alpas. However, the measure was specific to relational authenticity only and did not look at authenticity in a multidimensional framework. This was an issue in other measures that I examined such as Jack's (1991) Silencing the Self Scale, which looked only at self-silencing in relationships, not at other components of authenticity.

The AI-3 is scored on a 5-point Likert scale. The participant checks a list of available responses such as 1 = *strongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, and 5 = *strongly agree*. The test consists of 45 questions. Items 1, 14, 34, and 36 pertain to the Awareness scale, Items 7, 13, 16, 19, 30, 35, 37, 39, 41, and 42 pertain to the Unbiased Processing scale, Items 2, 8, 10, 11, and 33 pertain to the Behavior scale, and Items 17, 22, and 26 pertain to the Relational Orientation scale; these are all reverse scored. The AI-3 is scored on a continuum. In an e-mail correspondence with AI-3 author B. Goldman (personal communication, May 23, 2012), he stated that "it was sensible to consider that persons reporting subscale or composite scores that are less than the midpoint would reflect being 'at risk' for diminished levels of authenticity or would reflect being relatively inauthentic." The test is scored by summing the individual item scores (reverse scoring when appropriate). According to B. Goldman (personal communication, May 23, 2012), individual scores can be obtained on each of the four subscales as well as a total composite score on all of the 45 questions. See Appendix C

for correspondence. In general, the participants' presenting symptoms, and their relationship to authenticity, were examined using continuous measures, not distinct diagnostic classifications.

Research Questions and Hypothesis

Research Question 1: What is the relationship between reported female sexual dysfunction and reported authenticity?

Research Question 2: What is the relationship between reported female sexual distress and reported authenticity?

Hypothesis 1: There is a negative relationship between sexual dysfunction (as measured by The Female Sexual Function Index) and authenticity (as measured by The Authenticity Inventory, Version 3).

Null Hypothesis 1: There is no relationship between sexual dysfunction (as measured by The Female Sexual Function Index) and authenticity (as measured by The Authenticity Inventory, Version 3).

Hypothesis 2: There is a negative relationship between sexual distress (as measured by The Female Sexual Distress Scale, Revised) and authenticity (as measured by The Authenticity Inventory, Version 3).

Null Hypothesis 2: There is no relationship between sexual distress (as measured by The Female Sexual Distress Scale, Revised) and authenticity (as measured by The Authenticity Inventory, Version 3).

Data Analysis

The research data were gathered by having the participants fill out the three measures and the demographics questionnaire online through a Survey Monkey link. Statistical Package for the Social Sciences version 21.0.0 was used to analyze the data. A linear regression was run on the composite scores of the AI-3 and the FSFI, and on the composite scores of the AI-3 and the FSDS-R to see if sexual dysfunction and sexual distress predict authenticity scores. Separate linear regressions were run on each of the subscales of the FSFI and the FSDS-R. Descriptive statistics were used to report such aspects of the study as mean and frequency distribution. This information was displayed via a table.

Limitations and Delimitations

There were several limitations to my study. It was an Internet-based research project, which provides less control over veracity. Also, I used a select sample of women who were willing to disclose information regarding a very touchy and intimate subject—their sex lives. Furthermore, it was a correlational study that did not provide any information about causation. Therefore, I was not able to state whether authenticity creates better sexual functioning in women. My delimiters were related to gender and sexual activity. I was examining sexually active, female participants only. In addition, authenticity theory was also a delimiter in its role as theoretical framework.

Ethical Considerations

An informed consent form was provided for the participants prior to the acquisition of data gathering. In addition, Walden University's Institutional Review

Board (IRB) board approval was sought to conduct the study and use human participants. The participants were informed of their rights as research subjects, including the right to withdraw at any time during the study. The informed consent form addressed such issues as confidentially, risks and benefits of the study, and research procedures. The participants were assured that all research material would be kept confidential and that the study was completely voluntary. The first measure to be administered was the AI-3 followed by the FSFI, and finally the FSDS-R. Only women who consented to participate in the study (via checking the informed consent box) were included as participants. There was no need for any poststudy follow-up. Security measures were undertaken to protect the confidentially of my data, which are password protected on my computer and will be kept for a minimum of 5 years. My advisor, Dr. Gordon Forbes, and I are only people to have access to these data. This research study will be disseminated via publication in a professional journal.

Chapter 3 Summary

In this chapter, the methodology of this study was described. This was a quantitative, correlational research project that investigated how female sexual functioning was affected by the personal variable of authenticity. Authenticity was examined using the AI-3, while sexual functioning and sexual distress were measured with the FSFI and the FSDS-R, respectively. All measures used were self-report inventories; there was no manipulation of variables. Chapter 4 will provide the results of this study.

Chapter 4: Results

Introduction

The purpose of this research project was to examine the association between the variables authenticity as measured by the AI-3 (Kernis & Goldman, 2004), FSD as measured by the FSFI (Rosen et al., 2000) and the FSDS-R (DeRogatis et al., 2008). There were two research questions and two hypotheses:

Research Question 1: What is the relationship between reported female sexual dysfunction and reported authenticity?

Research Question 2: What is the relationship between reported female sexual distress and reported authenticity?

Hypothesis 1: There is a negative relationship between sexual dysfunction (as measured by The Female Sexual Function Index) and authenticity (as measured by The Authenticity Inventory, Version 3).

Hypothesis 2: There is a negative relationship between sexual distress (as measured by The Female Sexual Distress Scale, Revised) and authenticity (as measured by The Authenticity Inventory, Version 3).

The rest of this chapter presents the results of this study in detail, including a description of the participants and the design.

Data Collection

Sample

From October 2014 to June 2015, data were collected online using Walden University's participant pool. Walden is an international distance learning school with an

enrollment of approximately 47, 800 students in over 150 countries (Walden University, 2015). The participant pool is open to both undergraduate and graduate students of the university. Participation was voluntary and was not compensated in any manner. There were four selection criteria: the participants were Walden University students, self-identified as women, were at least 18 years of age, and self-identified as sexually active. The research was approved by the Walden University IRB. The IRB approval and authorization number was # 07-25-14-0112043 with an expiration date of July 25, 2015. The study was completed before the IRB approval expired.

Method

A link to the study was posted on the participant pool website. This link went directly to Survey Monkey where the study was hosted. On the Survey Monkey site, participants were presented with a consent form. After they had indicated their consent, they were automatically taken to the study. They first completed a brief demographic questionnaire. (Appendix A). This was followed, in order, by the three study measures: AI-3, FSFI, and FSDS-R.

Reliability

Using Cronbach's Alpha, the reliabilities on the AI-3, FSFI, and FSDS-R were computed and compared with the original studies. The AI-3 compared favorably to the original. This study found an $\alpha = .88$, while Kernis and Goldman (2004) reported an $\alpha = .87$. In regards to the FSFI, this study found the same reliability ($\alpha = .88$) as the original authors (Rosen et al., 2000). The reliability scores of the FSDS-R in this study ($\alpha = .92$) were similar to the original ($\alpha = .86$; DeRogatis et al., 2002).

Fifty-nine participants began the study, but two dropped out, reducing the total number of participants to 57. Two of the participants self-identified as men, and their data were discarded. This resulted in a final sample of 55, sexually active, adult women. This was the minimum number of participants specified by the a priori power analysis described in Chapter 3. Though there was a wide age range sampled among the participants, the study was not representative of the larger population of American women in regards to race, ethnicity, income, or education. The demographic characteristics of this sample are presented in Table 1.

Table 1

Demographic Characteristics of the Sample (N = 55)

Characteristic	N	%	Characteristic	N	%
Age Bracket			Education		
20-30	11	20.0	2-year degree	1	1.8
31-40	17	30.9	4-year degree	7	12.7
41-50	18	32.7	Some graduate work	13	23.6
51-60	9	16.4	Masters	32	58.2
Relationship			Doctoral degree	2	3.6
Married	26	47.3	Religious/Church Attendance		
Living with Partner	8	14.5	More than once a week	5	9.1
Dating	10	18.2	Once a week	11	20.0
Single	11	20.0	Once or twice a month	1	1.8
Widowed	0	0.0	A few times a year	18	32.7
Race/Ethnicity			Never	20	36.4
Hispanic/Latino or Latin	2	3.6	Yearly Income[1]		
Black	15	27.3	Under $25,000	6	10.9
White	34	61.8	$25,000-49,000	20	36.4
Other	4	7.3	$50,000-74,000	14	25.5
			$75,000-99,000	7	12.7
			100,000 and above	6	10.9

Note. [1]*N* = 53 because of missing data.

The sample consisted of women between the ages of 23 and 59. Most of the women (80 %) were in some form of romantic relationship (married, living with a partner, or dating). This was an extremely well-educated group with over 98.1% having a bachelor's degree or above. In regards to religious participation, roughly one third were regular church attendees, one third were irregular church attendees, and one third never attended at all. The vast majority of the sample (89.1%) was either White or Black. There were no Asians or Native Americans.

Results

The data were analyzed with the assistance of SPSS (IBM SPSS, Version 21.0) in a series of three steps. Step 1 consisted of addressing missing data. In Step 2, means and standard deviations for each of the measures and the intercorrelations were computed among all three measures. In Step 3, the hypotheses were tested using multiple regression analysis.

Step 1: Missing Data

There were relatively few missing data. On the 45-item AI-3 survey, 13 participants omitted one item, two participants omitted two items, and one participant omitted three items. On the 19-item FSFI, five participants omitted one item each. There were no missing data on the 13-item FSDS-R. The missing data for the AI-3 and the FSFI were replaced by substituting the participant's mean score on the completed items from that scale.

Step 2: Means, Standard Deviations, and Intercorrelations Among All Variables

In Step 2, means, standard deviations, and intercorrelations were computed for all variables. These results are shown in Table 2.

Table 2

Means, Standard Deviations, and Intercorrelations

Variable	ASI	FSFI	FSDR-R	Mean	SD
ASI	--	.096	.207	168.02	17.25
FSFI			-.309*	66.04	16.30
FSDR-R				16.69	11.67

Note. ASI-R = Authenticity Inventory, Version 3; FSFI = Female Sexual Function Index, FSDS-R = Female Sexual Distress Scale- Revised.
* equals .05. df = 53

No relationships were found between the AI-3 (a measure of authenticity) and either the FSFI (a measure of FSD) or the FSDR-R (a measure of sexual distress). However, a significant correlation of .309 was found between the FSFI and the FSDR-R.

Step 3: Regression Analysis

Hypothesis 1: There is a negative relationship between sexual dysfunction (as measured by The Female Sexual Function Index) and authenticity (as measured by The Authenticity Inventory, Version 3).

Null Hypothesis 1: There is no relationship between sexual dysfunction (as measured by The Female Sexual Function Index) and authenticity (as measured by The Authenticity Inventory, Version 3).

Hypothesis 2: There is a negative relationship between sexual distress (as measured by The Female Sexual Distress Scale, Revised) and authenticity (as measured by The Authenticity Inventory, Version 3).

Null Hypothesis 2: There is no relationship between sexual distress (as measured by The Female Sexual Distress Scale, Revised) and authenticity (as measured by The Authenticity Inventory, Version 3).

Hypotheses 1 and 2 were tested by regressing AI-3 on the FSFI and FSDS-R. Prior to computing the regression, VIFs were computed for each predictor. The VIFs for both the FSFI and the FSDR-R were 1.11. These values, like the relatively low first order correlation among the two predictors (r = .309) shown in Table 2, indicated that it is very unlikely multicollinearity was present (Statistical Solutions, 2015). The multiple regression was not significant $F(2,52) = 1.99$. p = .147. The unstandardized betas and their standard errors, standardized betas, ts, and semipartial correlations squared (r_{sp}^2) are shown in Table 3.

Table 3

Multiple Regression of AI-3 on FSFI and FSDS-R

	Unstandardized Coefficients		Standardized Coefficients				
	B	Standard Error	β	T	P	r_{sp}^2	VIF
(Constant)	162.15	9.63		16.85	<.001		
FSFI	.187	.149	.177	1.26	.215	.028	1.11
FSDS	-.387	.208	2.622	-1.86	.068	.062	1.11

Note. ASI-R = Authenticity Inventory, Version 3; FSFI = Female Sexual Function Index; FSDS-R = Female Sexual Distress Scale- Revised.
* equals .05. df = 53

Hypothesis 1 predicted that there would be a negative relationship between authenticity, as measured by the AI-3, and sexual dysfunction as measured by the FSFI.

However, inspection of Table 3 indicated that no relationship was found between the AI-3 and the FSFI. This indicated that the null hypotheses could not be rejected. Hypothesis 2 had predicted there would be a negative relationship between authenticity as measured by the AI-3 and sexual distress as measured by the FSDS-R. As was predicted, the standardized beta of -.262 was negative, indicating an inverse relationship between authenticity and sexual distress. However, this relationship also failed to reach significance (p = .068), and the null hypothesis could not be rejected. Consequently, the results failed to support either hypothesis.

Summary

The hypotheses predicted a negative relationship between the dependent variable authenticity and the predictor variables sexual satisfaction (FSFI), and sexual distress (FSDS-R). However, a study of 55 sexually active adult women between the ages of 23 and 59 found no support for these hypotheses. In Chapter 5, the results of the study will be discussed in further detail, including the study's strengths, weaknesses, and limitations. The possible impact of the results on social change will be discussed, and recommendations for further research in the area of FSD and authenticity will be made.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Scientific literature since the late 1990s has found a high rate of sexual dysfunction in the general population, much of which has not supported the medical model of FSD (Laumann et al., 1999). This study examined how one important psychosocial variable, authenticity as measured by the AI-3, affected women's sexual functioning as measured by the FSFI and the FSDS-R. It was hypothesized that as authenticity levels increased levels of sexual dysfunction and distress would decrease. In other words, there would be an inverse relationship between authenticity and levels dysfunction and distress. The results failed to support the hypothesis. That is, regression analysis failed to detect statistically significant relationships between authenticity and either measure of FSD. However, a statistically significant correlation was found between scores on the FSFI and the FSDS-R ($r = .309$, $p < .05$).

Interpretation of Findings

This study was carried out online at Walden University over a period of 8 months. A total of 55 women were the final participants. The sample consisted of a racially/ethnically limited (largely White and Black, but no Asians or Native Americans), highly educated group of adult females that were not representative of the larger population of American women.

It was theorized that because authentic self-expression is associated with greater emotional well-being (Kernis & Goldman, 2004), authenticity would be associated with less sexual dysfunction or distress. Authenticity has been largely ignored as a factor in

sexual dysfunction, though it has been examined in general studies on sexuality. Kleinplatz and Menard (2007) found that authenticity was one of the building blocks of what that they referred to as optimal sexuality. They associated authenticity with the ability to be open to one's desires and to express them freely with a partner. Babour (2008) looked at how authenticity was hindered by gender norms. In a series of qualitative interviews with young, Canadian women she found that modern culture's schism between Victorian prudery and sexual commodification reduced authenticity and turned sexuality into something her participants bartered in order to have and maintain relationships.

Using Kernis and Goldman's (2004) authenticity concept as a theoretical lens, I hypothesized that authenticity in women would be undermined by gendered culture. Kernis and Goldman's theory consists of four components:

- Awareness: Individuals who score higher on authenticity exhibit greater self-awareness.
- Unbiased processing: Authentic individuals make less use of denial and other maladaptive defense mechanisms and, consequently, have greater access to their emotions.
- Behavior: Individuals who are more authentic follow their own inclinations and are less concerned with people-pleasing.
- Relational orientation: Personal authenticity allows for the development of genuinely intimate relationships that are not based on a false-self facade.

The authentic person risks being seen by others for who he or she is. In Chapter 2, using this framework, it was shown how women's capacity to be authentic was undermined by gender culture in various ways:

- Awareness: This section of Chapter 2 examined how cultural norms shaped and limited women's sexual self-awareness. Variables examined were the lack of information most girls were given regarding their anatomy, cultural silence regarding the clitoris, and the tendency to refer to the female genitalia by a misnomer (i.e., as vagina; Blackledge, 2004; Maines, 1999).
- Unbiased processing: Sexual culture reduces women's ability to lose themselves in bodily sensations during the sexual act. Women tend to report higher levels of self-objectification and cognitive distraction, and a greater disconnect between objective physiological arousal and subjective arousal, during laboratory studies (Fredrickson & Roberts, 1997; Meana & Nunnik, 2006; Meston, 2000; Sanchez & Keifer, 2007).
- Behavior: Research has found that women exhibit more inauthentic sexual behaviors than men. For example, women are more likely to have unwanted sex, to consent to disliked sexual acts, and to fake orgasms than men (Muehlenhard & Shippee, 2010; Regnerus & Uecker, 2011).
- Relational orientation: Patriarchal culture negatively impacts women's relationships through continued gender inequities that reduce women's access to structural power and postulate female acquiescence (Jack, 1991).

This study filled a gap in the literature on FSD by examining an underresearched, theoretical association between authenticity and sexual dysfunction. However, due to the study's limitations, it did not confirm any of the findings in the previous literature (Babour, 2008; Kleinplatz & Menard, 2007) on female sexuality and authenticity. There was some confirmation for the previously found link (Laumann et al., 1999) between sexual dysfunction and decreased well-being and sexual dissatisfaction, given that this study also found a statistically significant negative correlation between scores on the sexual dysfunction index (FSFI) and scores on the sexual distress scale (FSDS-R).

Limitations of Study

The most obvious limitation of the present study is that, like all correlational designs, it did not allow for the determination of causality. Furthermore, this research project was conducted entirely online, and there are certain limitations inherent in this type of study. For instance, it is more difficult to verify participant responses in regards to certain crucial elements of the study (e.g., that the participant is female and of the age of consent) than in nonvirtual research. In addition to these obvious limitations, there are other factors that reduce confidence in the results. The most serious problem was the use of a small sample that was not representative of the general population.

The study's participants were highly educated with the majority (98.1%) having a bachelor’s degree or above. Over 58% had an advanced degree. This is important because it has been clearly established that sexual problems are related to education levels. For example, Laumann et al. (1999) found that sexual dysfunction was inversely related to education level. Women with less than a high school education were 16% more likely to

be anorgasmic than women with a college degree. In addition, women with less than a high school degree reported lower sexual desire, more sexual pain, and more sexual anxiety than better educated women. Similar relationships were found for the effect of income. Lauman et al. also reported that lower income was associated with an increase in every category of sexual dysfunction in women. Because of the negative relationship between income and/or education level and sexual dysfunction, the economic and educational bias in this sample may have artificially restricted the range of scores and thereby limited the size of the possible relationship between authenticity and the measures of FSD. According to Goodwin and Leech (2006), "It is well known among statisticians that, other things being equal, the value of r will be greater if there is more variability among the observations than if there is less variability" (p. 255).

Along similar lines, the relatively homogenous racial/ethnic makeup of the sample might also have impacted the ability to find significant results—especially due to the lack of Asian participants. In a study of over 13,000 people from 29 countries, Laumann et al., (2005) found the highest rates of sexual dissatisfaction in East and Southeast Asian countries. These findings suggested that the absence of Asian participants may also have served to restrict the range of scores on the measures of sexual dysfunction. Both sexual practices and sexual problems are highly influenced by racial and ethnic differences (Laumann et al., 1999; Michael et al., 1994, Regnerus & Uecker, 2011). For instance, African American women reported less sexual pleasure and desire but fewer problems with sexual pain than White women, while Hispanic women reported less sexual dysfunction in general (Laumann et al., 1999). It is possible with a more

educationally, ethnically/racially diverse population that different results might have been found regarding the association of authenticity and FSD. Also, a more heterogeneous sample would have allowed for greater generalizability of the study's findings to the larger population of American women.

Another problem (common in any self-report study of human sexuality) is the fact that the sample was limited to participants who were willing to disclose intimate information about their sexual lives. It seems very likely that there are both qualitative and quantitative differences between people who volunteer for such studies and those who do not. It seems likely that participants in this study had a greater comfort level and consequently greater satisfaction with their sexuality than individuals who chose not participate. To the extent that this happens, the range of scores on the predictor variables would be attenuated.

Another factor that may have contributed to a lack of significant findings was the relatively small sample size. A G*Power analysis (Faul et al., 2007) estimated that a minimum of 55 participants would be needed to detect medium effect ($f^2 = .15$) with two predictors, a power of .80, and an alpha of .05. Because of the difficulty in obtaining participants, data collection was terminated when the minimum sample size of 55 was reached. In retrospect, this was an unfortunate decision. It also seems likely that estimating the effect size as medium was overly optimistic. To the extent that the latter is true, the G*Power analysis would underestimate the necessary number of participants.

Chapter 2 reviewed the strong theoretical basis to hypothesize a relationship between authenticity and sexual dysfunction. Given the strong theoretical support for the

hypothesis, the failure to find significant results was unexpected. However, it is likely that multiple factors restricted the range of predictor scores and consequently attenuated the strength of the relationship between FSD and authenticity. The observation that the relationship between sexual distress as measured by the FSDS-R and authenticity approached significance ($p = .068$) and was in the predicted direction is consistent with this interpretation.

Recommendations for Future Research

This study has broadened the literature in the field of FSD research by analyzing a hypothesized association between authenticity and sexual dysfunction/distress. Although speculative, there are good reasons to expect that a study employing a larger and more representative sample may find a significant relationship between FSD and authenticity. Utilizing women from different socioeconomic groups, educational backgrounds, and ethnicities would provide more information on what role context plays in authenticity and FSD.

Given the strong influence of sexual scripting and heterosexual norms on sexuality, it might also be useful to do a comparison study on the differences between gay/lesbian and heterosexual women in regards to this topic. Gay and lesbian participants are often underrepresented in research studies on human sexuality and dysfunction, and the few studies that have been conducted have found higher rates of sexual and emotional satisfaction in lesbian women's romantic relationships (Bhugra & Wright, 2007; Hite, 1976; Masters & Johnson, 1979; Paduchowski-Butland, 2009). There is much to be

learned in exploring how authenticity operates in sexual relationships that are less constrained by the heteronormative script.

It is also important to examine what role authenticity plays in male sexual dysfunction. Male sexual behavior is just as scripted and circumscribed as female's (albeit in a different, often complimentary way). Gender culture assumes that male sexuality is demanding, active, and power oriented, while female sexuality is acquiescent, passive, emotional, and restrained. Men have historically been expected to carry the mantle of sexual expertise in the bedroom (Masters & Johnson, 1979; Potts, 1998). This is no doubt experienced as a heavy burden and possibly a false-self charade by some men. What role this might play in the etiology of erectile dysfunction or premature ejaculation has not been addressed.

One of the relative strengths of this study was its use of two measures of FSD: the FSFI and the FSDS-R. Sexual dysfunction is a very complex multifaceted issue, especially in women. This study examined both physiological and subjective correlates of sexual functioning. It could also be argued that authenticity is a similarly complex phenomenon. Future studies analyzing this issue would benefit from multiple measures of both authenticity and FSD as a way to examine the topic from the broadest perspective possible.

Social Change

In Chapter 2 of this dissertation, the literature available on FSD was extensively reviewed, and it was found to be a significant social and personal problem for a sizable

percentage of women. I had two research questions that I was investigating in this dissertation:

Research Question 1: What is the relationship between reported female sexual dysfunction and reported authenticity?

Research Question 2: What is the relationship between reported female sexual distress and reported authenticity?

Both corresponding hypotheses indicated that interpersonal variables would significantly influence female sexuality and it would be shaped by social conditions that reduced sexual satisfaction for women. Though my results were not significant, the volume of literature on FSD pointed to a possible association between the variables of authenticity and sexual dysfunction that deserves further exploration. Furthermore, in my research, the association between the FSDS-R and the AI-3 did approach significance. This implies that higher rates of authenticity might reduce sexual distress in women. This dissertation contributed to social change by highlighting one possibly crucial piece of the FSD puzzle—the relationship between personal authenticity and sexual well-being.

In Chapter 2, the effects of gender norms and social conditioning and their impact on female sexuality were explored in depth. Sexual dysfunction has a powerful impact on society—primarily in a circuitous way. Sexuality is highly valued by modern culture, and sexual satisfaction is an integral part of modern marriage ideology. Therefore, sexual problems take a toll on both relationships and individual well-being (Bancroft, Loftus, & Long, 2003; Laumann, et al., 1999). The potential disruption of marital ties is one especially pernicious consequence of FSD that has far-reaching social implications. The

much desired "soul mate" marital ideal designates a pleasing combination of emotional and sexual gratification as one of its core philosophies (Whitehead & Popenoe, 2001). It ups the ante in regards to what spouses expect from one another. For some individuals with a utilitarian view of love, disposing of a partner who is not fulfilling his or her role (either as a lover or a companion) is no worse than firing an inept employee. Not surprisingly, roughly 50% of all first-time marriages fail (Regnerus & Uecker, 2011).

Studies over the last few decades (Byers, 2005; Kinsey, 1953; Laumann, et al., 1999; Wilcox et al., 2011) have found an association between marital and sexual satisfaction. Happier couples report being happier with their sex lives, as well as their overall relationships, while unhappy couples report the inverse. According to Byers (2005), the direction of this association is not known. In other words, it is not understood whether happier couples are happier because of their better sex lives or if they have better sex lives because they are happier.

Furthermore, the issue of male scarcity coupled with a greater male focus on sexuality in relationships could mean that females with sexual dysfunction might be at a greater risk for relationship instability than their male counterparts. The possible association between relationship demise, gender, and sexual dysfunction is another important, underresearched area of FSD and a possible avenue for further study.

It would stand to reason that finding an effective way to deal with sexual problems might promote marital stability and prevent some of the deleterious social effects of divorce. In order to positively impact social change on this issue, FSD must be

understood in its entirety. It is imperative that all elements of FSD be addressed, including both medical, personal, and social.

Summary

In conclusion, this study has broken new ground in the area of FSD research. It has analyzed the role of authenticity on sexual dysfunction in women. In spite of the fact that the regression analysis failed to reach statistical significance, the bulk of data in the literature review has supported the idea that authenticity is a factor in FSD. The results of this study were hampered by the presence of a small sample that was not representative of the larger population of American women. Future research on this topic should examine FSD from a broad perspective that encompasses social, political, economic, gender-related components.

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Appendix A: Demographic Questionnaire

About Me

Age

- How old are you? _____

Gender

- Male
- Female

Relationships

What is your relationship status?

- Married
- Living with a partner
- Dating
- Single/not dating
- Widowed

Education

What is the highest level of education you have completed?

- Grammar school only
- Some high school, but did not finish
- Completed high school
- Some college, but did not finish
- Two-year college degree / A.A / A.S.
- Vocational/technical school (2 year)
- Four-year college degree / B.A. / B.S.
- Some graduate work
- Completed Masters
- Completed doctoral degree

Religiosity/ Religious Preference

How often do you attend religious services?

- More than once a week

- Once a week
- Once or twice a month
- A few times a year
- Never

Racial/Ethnic Identity

How would you describe your ethnicity?

- American Indian / Native American
- Asian
- Black / African American
- Hispanic / Latino
- White / Caucasian
- Pacific Islander
- Other

Income

What is your income level?

- Under $25,000
- $25,000 - $39,999
- $40,000 - $49,999
- $50,000 - $74,999
- $75,000 - $99,999
- $100,000 – and above

Appendix B: Correspondence Regarding FSDS-R

E-mail Correspondence between Dr. Leonard DeRogatis and Kaye Smith Regarding the use of the Female Sexual Distress Scale, Revised Edition

From: kayesmith_kaye_976@msn.com

Sent: Thu 5/17/12 3:14 PM

To: Derogatis; Female Sexual Distress Scale-R

Hi Dr. Derogatis,

Thank you for your speedy reply. I would like to acquire your FSDS-R for my doctoral dissertation on female sexual dysfunction.

Thanks,

Kaye Smith M.S

From: Derogatis, Leonard R. (LDerogatis@sheppardpratt.org)

Sent: Fri 5/18/12 8:27 AM

To: 'kaye smith' (kayesmith_kaye_976@msn.com)

Hotmail Active View

2 attachments (total 290.3 KB)

JSM-FSDS-...pdf

Download(263.6 KB)

FSDS-R.doc

View online

Download(26.7 KB)

Download all as zip

Dear Kaye:

Thank you for your interest in my work. Attached please find the materials you are interested in.

Best regards,

Leonard R. DeRogatis, Ph.D.

Director, Center For Sexual Medicine

at Sheppard Pratt, Associate Professor

of Psychiatry, Johns Hopkins Univ. School of Medicine

6501 N. Charles St.

Baltimore, MD 21285

Phone: (410) 938-4336

Fax; (410) 938-4340

email: Lderogatis@sheppardpratt.org

To lderogatis@sheppardpratt.org

From: kaye smith (kayesmith_kaye_976@msn.com)

Sent: Fri 5/18/12 1:55 PM

To: lderogatis@sheppardpratt.org

Hello Dr. Derogatis,

Thank you for sending me your measure. Do you have any scoring instructions available?

Sincerely,

Kaye Smith M.S

From: Derogatis, Leonard R. (LDerogatis@sheppardpratt.org)

Sent: Fri 5/18/12 1:57 PM

To: 'kaye smith' (kayesmith_kaye_976@msn.com)

Hi Kaye:

Simply sum the item scores to get the total score. Total scores greater than 15 have been treated as “in the clinical range” in all of our drug trials.

Best of luck,

Len DeRogatis

To lderogatis@sheppardpratt.org

From: kaye smith (kayesmith_kaye_976@msn.com)

Sent: Fri 5/18/12 2:12 PM

To: lderogatis@sheppardpratt.org

Hello Dr. Derogatis,

Thanks again for your swift reply and instructions.

Thanks,

Kaye Smith M.S

Appendix C: Correspondence Regarding AI-3

E-mail Correspondence between Dr. Brian Goldman and Kaye Smith

Regarding use of Authenticity Inventory, Version 3

To briangoldman@clayton.edu
From: kaye smith (kayesmith_kaye_976@msn.com)
Sent: Tue 5/22/12 1:51 PM
To: briangoldman@clayton.edu
Dear Dr. Goldman,

I am a doctoral student at Walden University, and I would like to use your Authenticity Inventory, version 3 for my dissertation on female sexual dysfunction. I was wondering if you could provide me any information on how to acquire and score the measure.

Thank you,

Kaye Smith M.S.

To kayesmith_kaye_976@msn.com
From: Brian Goldman (BrianGoldman@mail.clayton.edu)
Sent: Wed 5/23/12 8:25 AM
To: kaye smith (kayesmith_kaye_976@msn.com)
Hotmail Active View
1 attachment (43.1 KB)

AUT_BMV3_...doc
View online
Download(43.1 KB)
Download as zip

Hi Kaye,

Sounds like a fascinating dissertation and as far as I know it would pave new ground in examining if a link exists between authenticity and sexual dysfunction. I am sending an attachment of the AI-3 measure that includes the reference for the Advances in Experimental Social Psychology paper (Kernis & Goldman, 2006) in which the formal

measure is published. The attachment also provides the scoring and some of the psychometric properties of the measure (e.g., reliability) which you may find beneficial. The Advances chapter is pretty comprehensive and may be useful for you to read. I'd be happy to send an attachment of it if you like. Good luck with your research. Please keep me updated on what you find when you get a chance, and please do not hesitate if you have any questions.

Best Wishes,

-brian

Dr. Brian M. Goldman
Associate Professor of Psychology

Contact Information:
Phone: (678) 466-4845
Office: Behavior and Natural Sciences Building , Room 110

Mailing Address:
Dr. Brian M. Goldman
Clayton State University
Psychology Department, Behavior and Natural Sciences Building
2000 Clayton State Boulevard
Morrow, GA 30260-0285

To briangoldman@mail.clayton.edu

From: kaye smith (kayesmith_kaye_976@msn.com)

Sent: Wed 5/23/12 1:25 PM

To: briangoldman@mail.clayton.edu

Hi Brian,

Thank you for your speedy reply and for the information you sent. I just have a few more questions about scoring. From what I understand, I just add the item scores up for the total score? Is there a certain score range where the test-taker is clearly identified as being

more inauthentic? When is the test-taker considered to be in a good range regarding authenticity?

Kaye Smith M.S.

To kayesmith_kaye_976@msn.com

From: Brian Goldman (BrianGoldman@mail.clayton.edu)

Sent: Wed 5/23/12 3:11 PM

To: kayesmith_kaye_976@msn.com

Hi Kaye,

The scoring is based on simply summing the items up but be careful to reverse score the appropriate items (they are specified on the attachment I had sent). You can attain separate subscale scores for each respective component of authenticity and also calculate a composite score comprised of all 45-items. As is the case with many measures in social psychology we did not formally investigate a cutoff point for designating high or low, nor a "good range" for authenticity but rather have treated it as a continuum. I think its sensible to attempt to establish a cutoff and that doing so may be particularly useful for distinguishing various clinical outcomes as was the case in measures like Beck's Depression Inventory (BDI) but as far as I know this has not been done. If you would like additional information concerning various descriptive stats or sample frequency distribution results in which various ranges can be established based on percentiles of interest (e.g., quartiles, etc.) I can provide those for you. At a conceptual level I've always thought it was sensible to consider that persons reporting subscale or composite scores that are less than the midpoint would reflect being "at risk" for diminished levels of authenticity or would reflect being relatively inauthentic, but am unclear as to where the "starting point" may be in crossing the threshold for entering the "good range" of authenticity. I hope this reply has been helpful. Please feel free to let me know if you have any additional questions.

-Brian

Dr. Brian M. Goldman

Associate Professor of Psychology

Contact Information:

Phone: (678) 466-4845

Office: Behavior and Natural Sciences Building , Room 110

Mailing Address:

Dr. Brian M. Goldman

Clayton State University

Psychology Department, Behavior and Natural Sciences Building

2000 Clayton State Boulevard

Morrow, GA 30260-0285

To briangoldman@mail.clayton.edu

From: kaye smith (kayesmith_kaye_976@msn.com)

Sent: Thu 5/24/12 5:03 PM

To: briangoldman@mail.clayton.edu

Hi Brian,

Thank you for more information. I think I understand how to score the measure now. If I have any more questions, I will let you know. Have a great summer.

Thanks,

Kaye Smith M.S.