

Let's talk about sex —

A Critical Narrative Analysis of

Heterosexual Couples' Accounts of Low

Sexual Desire

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A thesis submitted to London Metropolitan University

in partial fulfilment of the requirements for the

Professional Doctorate in Counselling

Psychology

September 2013

Acknowledgements

To the eight people who generously shared their stories for this research study, thank you.

I would also like to thank most sincerely my supervisor, Dr. Elaine Kasket, whose insightful skill has significantly improved the thesis and whose infectious enthusiasm and energy have kept me motivated.

A special note of thanks goes to Kevin Hobbs whose wisdom in the field of psychosexual therapy has been invaluable. Thank you, Kevin, for helping me out of the generosity of your heart. This thesis has been much enriched by your input. Thanks also to Dr. Kathryn May who has reviewed the work and added knowledge (and commas) in good measure.

I am grateful to Dr. Elena Gil-Rodriguez, my initial supervisor, whose guidance was inspirational. Also to Dr. Mark Donati, my Director of Studies, whose support and erudition kept my work on track.

Thanks are due to the people in external organisations who went 'above and beyond'. I appreciate the fact that you have busy work schedules and yet you all took the time to help me in my work, from purely altruistic motives. So thank you, Chrissie Roach, Sexual Health Service Manager, Dr. Jane Ashby, Consultant HIV/GU medicine, Ann Commins, Psychosexual Therapist and Joanne Pike, Research Support Officer.

I would also like to express my appreciation to my family and friends for their continuous and patient support: to Kerri, who supplied me with priceless practical input and many hours of listening and reviews; to Deirdre who supplied unstinting friendship and proofreading; to Sue who devoted much skill and time (including precious holiday-time) to proofreading; to John, who took the children out when I was struggling to work in the holidays and put up with my workload, and finally to my children, Robbie and Jenny, who now need convincing that I am not umbilically attached to a computer.

Table of Contents

	Page
Abstract	6
Introduction	8
Broad topical overview	8
Key definitions and aetiology	9
Female Sexual Interest/Arousal Disorder, HSDD and DSM 5	9
Aetiology	10
Diagnosis and counselling psychology	10
Terminology	11
Counselling psychology (CP) research and relevance of this study to CP	12
Personal reflexivity	13
Literature review	15
Literature review method	15
Low desire for sex - historical background	16
Contemporary context	18
Contribution from feminist thinkers	19
Critique of feminist stance	20
Epidemiology, diagnosis and treatment	21
Epidemiology	21
Diagnosis	22
Treatment	23
Pharmacological treatments	23
Hormonal treatments	24
Psychological treatments	24
Low sexual desire and counselling psychology	25
Rationale for the study	27
Contribution from research to our understanding of what it is like to have low sex drive	27
Research on partners' views of low desire for sex	28
Rationale, research question and aim	29
Methodology and Procedures	30
Choice of a qualitative approach	30
Choice of Narrative approach	30
Choice of Narrative Analysis over Interpretative Phenomenological Analysis and Discourse Analysis	31

	Page
Type of Narrative Analysis	33
Method	34
Recruitment	34
Interviews	34
Analysis	35
Results/Critical Narrative Analysis	40
Overview	40
Critique of the illusions of subjectivity	41
Introduction to couples, their narratives, attendant tone and rhetorical function	41
Lauren and David	42
Jane and Johnny	45
Sue and Steve	46
Mandy and Nick	48
Identity work	49
Men's role of victim	50
Women's role of self-sacrificing heroine	51
Main themes	52
Blame - As a defence against vulnerability	52
Communication - Different song sheets and destructive styles	54
Importance of sex - Entitlement and Conflation (men)	56
Doubt - Eroding self-confidence and corroding the relationship foundation (men)	57
Causes - Reasons to be sexless (women)	59
Abnormality - There is something wrong with me (women)	60
Destabilising the narrative	61
Pathologisation of normal variation	62
Man-centred views about sexuality	62
Discussion	64
Overview	64
Synthesis or summary	64
Participant summary	64
Themes, identity work and feminist critique summary	64
Review with regard to literature and suggestions for therapeutic application	65
Blame - As a defence against vulnerability	65
Communication - Different song sheets and destructive styles	66

	Page
Importance of sex - Entitlement and Conflation (men)	68
Doubt - Eroding self-confidence and corroding the relationship foundation (men)	71
Causes - Reasons to be sexless (women)	72
Abnormality - There is something wrong with me (women)	74
Identity work	75
Critique from feminist perspective	76
Summary of themes connected to therapeutic techniques	78
Relevance of findings to general clinical practice and counselling psychology	79
Methodological considerations and limitations of the current study	80
Epistemological reflexivity	80
Methodological reflexivity	82
Limitations	82
Suggested directions for future research	83
Final reflexivity	84
Conclusions	86
References	88
Appendices	111
Appendix 1 – Recruitment Poster	112
Appendix 2 – Participant Information Sheet	113
Appendix 3 – Participant Consent Form	116
Appendix 4 – Interview Schedule – for women and partners	117
Appendix 5 – Distress Protocol	119
Appendix 6 – Demographic questionnaire	121
Appendix 7 – Debriefing sheet	123
Appendix 8 – List of support services	124
Appendix 9 – Letter of ethical approval from Research Ethics Committee	126
Appendix 10 – Summary of demographic information	127
Appendix 11 – Sample of annotated participant transcript - David	128
 List of tables and figures:	
Table 1: Prevalence of Sexual desire or interest problems in the U.K.	21
Figure 1: Schematic of results layout	40
Table 2: Summary of main findings	64
Table 3: Summary of connection of themes with therapeutic techniques	78
Table 4: Summary of demographic information on couples	127

Abstract

Background: Low desire for sex is a common problem in the lives of women. It features in *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) as Female Sexual Interest/Arousal Disorder (FSI/AD) and often causes distress where there is a desire discrepancy in a relationship. A literature search revealed that very little research has been undertaken on couple aspects of the problem. This is a qualitative study of heterosexual couples where the woman experiences low desire and incorporates a feminist critique, a counselling psychology perspective and an emphasis on tying the findings to therapeutic techniques. Due to paucity of research this study provides original insight and contributes to practical work with couples.

Aim: The research aims were to explore couples' narratives of low sexual desire and to connect these findings to potential application in the practice of counselling psychology or allied professions.

Method: The study employed a qualitative design using semi-structured interviews from four participant couples, which were analysed using Langdridge's 2007 Critical Narrative Analysis.

Results: Six main themes were uncovered including couple's experiences of blame and problematic communication patterns. Men's themes included entitlement, doubt and conflation of love and sex. Prevalent women's themes were anxiety over abnormality and seeking causes of low desire. The concept of identity was explored with men adopting a role of victim while the women occupied a role of self-sacrifice. Use of a feminist critique found evidence of pathologisation of normal sexual variation and man-centred views about sexuality.

Ways of addressing these findings in a therapeutic arena were explored. For example, the benefits of a systemic approach, normalisation of experience and the importance of arriving at a shared narrative of problems and potential

solutions in therapy were underlined. Counselling psychology's emphasis on reflexive practice and a pluralistic approach were proposed as being advantageous for couples presenting with this problem.

Introduction

Broad topical overview

Women's libido is the subject of varying opinion, representing different perspectives. This can be seen in changing attitudes towards women's low interest in sex across the progression of time. For example, a century ago women who were overly interested in sex were reviled as nymphomaniacs (a condition now re-named as hyper-sexuality) and were subjected to medical scrutiny. A notion prevalent at the end of the 19th century was that women were asexual (Robinson, 1989a). Asexuality (also known as non-sexuality), describes lack of sexual attraction, or interest in, or desire for sex. So, lack of sexual interest in women was once considered normal. Nowadays, lack of libido is considered dysfunctional and is recognised as a disorder named Female Sexual Interest/Arousal Disorder (FSI/AD) in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders, DSM-5* (American Psychiatric Association, 2013).

Contemporary differences in popular opinion abound as to what accurately describes women's appetite for sex. For example U.K. actor and comedian, Stephen Fry who is attributed to have over 6 million followers on Twitter ("Stephen Fry Twitter Statistics", 2013), instigated much controversy with his stated view in *Attitude* magazine that "The only reason women will have sex with them [men] is that sex is the price they are willing to pay for a relationship with a man, which is what they want." (Fry, as cited in Flynn, 2010, p. 56). On the other hand, women's magazines such as *Cosmopolitan* seem to take the stance that women have an unquenchable sexual appetite.

Issues of sexuality and sexual practices are often the subject of much personal angst. As such, they feature in the clinical world of the many professionals who deal with human distress: psychosexual counsellors, clinical and counselling psychologists, counsellors and psychotherapists. This study has been carried out by a trainee counselling psychologist with the intent of using the research outcome to enlighten work with heterosexual couples where the woman has a low desire for sex.

The rationale for looking at heterosexual couples, and excluding same-sex couples and men with low desire for sex, was to maintain homogeneity in the participant group. A woman with low desire in a heterosexual couple is the most common presentation of this problem (Segraves & Segraves, 1991), and this arrangement was chosen as a matter of pragmatism.

Key definitions and aetiology.

This section begins by describing how low sexual desire can be portrayed by some professions and is followed by a section on how diagnosis is often viewed in a less categorical manner by counselling psychology.

When considering modern disorders, one of the most widely established Western systems for classification is the *DSM-5* produced by the American Psychiatric Association (American Psychiatric Association, 2013). This fifth edition was published in May 2013 (close to the submission date of this paper), and was preceded by a fourth text revision *DSM-IV-TR* (American Psychiatric Association, 2000).

Female Sexual Interest/Arousal Disorder, HSDD and DSM-5.

The revised definition of low sexual desire in *DSM-5* is incorporated under the umbrella term of FSI/AD (American Psychiatric Association, 2013). The stipulated criteria for a diagnosis are: Criterion (A) Lack of sexual interest/arousal as manifested by at least three of six symptoms such as (1) absent/reduced interest in sexual activity or (2) absent/reduced sexual/erotic thoughts or fantasies. Criterion (B) states the latter symptoms must be of at least 6 months duration. Criterion (C) says the dysfunction must cause clinically significant distress in the individual. Criterion (D) stipulates the problem must not be better accounted for by a nonsexual mental disorder, or be attributable to other significant stressors such as partner violence, substance mis-use or other medical conditions. It is worthy of note that there are no published normative data within any of the *DSM* manuals. Hence, there are no measures distinguishing normal from abnormal levels of desire (Segraves & Woodard, 2006) and, therefore, whether or not a disorder exists is based on the clinical

judgement of the consulted professional. Prior to the publication of *DSM-5*, low sexual desire in women was referred to as hypoactive sexual desire disorder (HSDD) within the *DSM-IV-TR* and *DSM-IV* (American Psychiatric Association, 2000 and American Psychiatric Association, 1994).

Aetiology.

Diagnosis of FSI/AD specifies subtypes of lifelong/acquired, generalised/situational and mild to severe. In essence these classify the person according to whether they have had a lifelong lack of desire, or if it is associated only with one partner, timespan or situation. Causes of FSI/AD can be associated with a myriad of factors such as medical or health problems, mental health difficulties of individual and partner, intimacy difficulty, hormone levels, relationship issues, addiction, illness and family-of-origin legacies. These difficulties may operate singly, or in combination.

Diagnosis and counselling psychology.

There are wider prevailing debates on diagnosis of mental disorders that are pertinent to a discussion of low sexual desire. As touched upon in the Introduction, and exemplified by the declassifying of homosexuality as a disorder by membership vote of the American Psychiatric Association in 1974 (Sadler, 2004), views on what is normal with regard to sexual habits change with the vagaries of public opinion. As with many disorders in the *DSM* canon (American Psychiatric Association, 2013), diagnosis is dependent on a clinician's view of what is normal. If no normative data is used, a diagnostic criterion becomes a construct of the opinion of the diagnosing physician. Writers such as Caplan (1995) question the wisdom of placing such an important decision in the (possibly) arbitrary judgement of one individual.

Debates over the value and validity of psychiatric diagnoses have led to clashes between the professions of psychology and psychiatry. As this paper goes forward for submission in September 2013, the recent publication of *DSM-5* (American Psychiatric Association, 2013) has sparked a flurry of critical press articles questioning the biomedical model of mental illness reified in the *DSM*

series (“Media debate over psychiatric diagnosis”, 2013; Sample, 2013; Satel, 2013). Dr Pam James, the chair of the Division of Counselling Psychology (DCoP), stated that new additions to the *DSM* “conceptualise human response to life events as a ‘disorder’ rather than natural human reactions in certain circumstances.” (DCoP, personal communication, May 13, 2013). These debates can be seen to have great relevance in the case of low desire for sex. The psychiatric HSDD and FSI/AD labels seem to locate the difficulty within an individual, without much acknowledgement of their relational and societal context. For example, low desire is often a problem which happens within a relationship, over time. Usually it does not cause much distress if the person is on their own, not seeking a sexual partner. It can be a problem with roots in childhood relationships, culture and attitudes. Hence it is often inextricably social in nature. As this paper is written by a counselling psychologist, whose professional identity privileges engaging “with subjectivity and intersubjectivity” (Division of Counselling Psychology, 2006), the emphasis will be on looking at the phenomenon with a wide-angle lens in an attempt to encompass the embedded nature of a low desire sufferer.

A question that might be asked of this study is why diagnoses and *DSM* terminology have been used in a counselling psychology study if they are unclear and might pathologise normal variation. In answer to this, the use of *DSM* terminology has been driven by a need to communicate with the wider research and clinical community who do use *DSM* diagnoses. In addition much of the research devoted to low sexual desire has used psychiatric nomenclature, and to ignore such research would impoverish the breadth of this thesis.

Terminology.

The word ‘sex’, which has multiple meanings, is taken to mean sexual intercourse in this study. Also the term HSDD is sometimes used as a term for low sexual desire, where papers that use this nomenclature are discussed. The term ‘person with low sexual desire’ is the preferred term used in this thesis to describe someone who has a self-reported low, problematic desire for sex.

Counselling psychology (CP) research and relevance of this study to counselling psychology

Before commenting on the relevance of this research to the field of counselling psychology, a brief background will be given here as to what makes counselling psychology research distinct from research in other closely-aligned professions such as clinical psychology or psychotherapy.

Values which mark out the counselling psychology profession include an acknowledgement of inherent subjectivity, intersubjectivity and a humanistic focus on facilitating growth (Division of Counselling Psychology, 2006; Kasket, 2012). Taking the first of these values - subjectivity - and relating it to research, a counselling psychology view is that a researcher has the potential to “contaminate” their research with their own subjective views (Etherington, 2004). In order to address this subjectivity, and to increase the rigour of the research, a number of reflexive sections will be incorporated (Willig, 2008a). These include a section on personal reflexivity, where I make explicit my background and personal beliefs with regard to the research topic and the means by which I have attempted to hold in mind an awareness of these personal views. The Discussion section contains an epistemological reflexivity which seeks to explore what can be uncovered by my chosen research methodology. In a similar vein the limitations of the methodology will be discussed, and a methodological reflexivity passage addresses the challenges which arose during design, data collection and analysis.

The third value given above as pertaining to counselling psychology is a focus on facilitating growth. In applying this value to research, the research should make a positive contribution to the lives of those who access it for knowledge. Counselling psychology research should ideally have a potential for direct application to the work of counselling psychologists. This research seeks to fulfil this aim by investigating a topic which is often poorly managed within couples. Due perhaps to the societally embedded nature of the topic, there are many unspoken rules: for example, a proper wife/partner is available for sex with her partner: other people are “doing it” frequently: it’s not normal to not want sex. Perhaps there are unspoken rules within the therapy industry where these

societal values get played out, for example, an appropriate goal of psychosexual therapy for low desire can be for the low-sex-drive partner to increase their sexual willingness to become more in line with the higher-drive partner, or to “restore desire” (Weeks, Hertlein & Gambescia, 2009, p.94). In order to initiate a good therapeutic alliance with a couple it may be important for the therapist to understand some of the anxiety and feelings clients might bring to the first session. By investigating couples’ stories it is hoped some of these underlying attitudes will surface and can be analysed.

Personal reflexivity

A reflexive statement has been included for the reason outlined in the previous section that, as a trainee counselling psychologist, it is consistent with this professional perspective to “engage with subjectivity and intersubjectivity, values and beliefs” (British Psychological Society, 2005). The reflexive statement seeks to highlight how my own experiences and social identities have fashioned this research. The Discussion section also considers how doing this review has changed me – both as an individual and as a practitioner. A reflexive statement also helps increase the validity of this study, by making me as the researcher more visible to the reader and illuminating how I have had an effect on the way this thesis has been produced. This aligns with Yardley’s (2000) call for transparency in her guidelines for validity in qualitative research.

Many writers, including Glassner and Hertz (2003), point out that a researcher’s life experiences push or pull them into particular areas of study. My own experiences have, indeed, opened my eyes to this topic area, and so I include here some of my personal history leading to my interest in low sexual desire. I am a white, female, researcher of Catholic parents in my late forties, who grew up in a medium sized town in central Ireland. It is part of the stereotype of Ireland that the Catholic Church’s influence causes repression and guilt around the topic of sex. As someone growing up there, I can say sex was never spoken of, in school, or at home. This left me to struggle with aspects of low sexual desire at some points in my life. I attempted to get treatment from various sources (the U.K. National Health Service, private clinics) at different

times, and found a profound lack of knowledge even in a basic understanding of the problem. I self-disclose this because I know that experience of low sexual desire, combined with my background, leads me potentially to privilege certain parts of this topic above others. In order to counteract this potential bias I have kept a reflexive journal throughout the research process, to promote increased self-awareness of where my personal agenda may be driving the research agenda. In order to maintain rigour (Kasket, 2012), I have employed a number of supplementary techniques: vigilance about bracketing (holding back one's own beliefs); drawing on my counselling psychology experience in interviewing; and taking extra care with interview questions and mid-interview prompting in order not to lead or encourage participants towards areas that chime with my experience. In analysis, I have used other researchers to add a verification step where they have reviewed my data to help assess if the themes chosen match with participants' views. Lastly, I have consulted an external advisor (additional to my academic supervisor) who works as a psychosexual counsellor and who was asked to validate my findings.

Literature review

Low desire for sex has been dogged by debate and controversy. This literature review first reviews the emergence of low desire for sex as an object of study through the decades. It should be noted at the outset that women's sexual desire has been the subject of extensive recent research activity. However, while it is not within the scope of this paper to carry out reviews of all this research, some of the current research picture of diagnosis, epidemiology and treatment is considered. Finally, literature is reviewed on how individuals (women, their partners and couples) experience life with the disorder, leading to the rationale for this research.

Literature review method

A conventional literature search was undertaken using the terms 'female sexual desire', 'female hypo-active sexual desire', 'female and HSDD' and 'low sexual desire and female'. Further searches were undertaken looking for the above terms ('low sexual desire and female') with the terms 'treatment', 'diagnosis', 'epidemiology', 'prevalence' and 'counselling psychology'.

In the early stages of research (2009-10) the databases searched were PsycEXTRA, International Bibliography of the Social Sciences, MEDLINE, PsycINFO, PsycARTICLES and Academic Search Complete. In a later phase from 2011, these databases were refined to PsycINFO, PsycARTICLES and Academic Search Complete with Full Text as a restraint. No date range exclusions were made for papers, although as separate classification of HSDD is a relatively recent phenomenon, pertinent papers were usually contemporary.

Other relevant literature such as books and book chapters were identified through the iterative approach of berry-picking (Bates, 1989) or snowballing (Ridley, 2008) based on journal papers. Some papers not available online were sourced from the journal section of Senate House Library, London and from the British Library.

An historical background will follow to give context to the current situation.

Low desire for sex – historical background

As sexual behaviour and practices have been taboo topics in the past, there are few sources of reliable data as to the historical prevalence of low sexual desire. Evidence on sexual practices from the 19th century is sparse and largely anecdotal and, as such, has been used to tell two different stories around Victorian sexuality. On the one side is Steven Marcus' *The Other Victorians* (2009) which paints the more generally accepted stereotype of repressed Victorians. Ranged on the other side are writers such as Peter Gay (1984, 1986) and Michel Foucault (1998), who assert that Victorians were libidinous and sex had become part of the general discourse. While it is difficult for us to know with any certainty what was the true state at that time, we do know (as mentioned in the Introduction) there was widespread belief at the end of the 19th century that women were asexual (Robinson, 1989a), that is, had no interest in sex.

With the dawn of the 20th century, the study of sex became much more systematic and empirical. Freud, the most famous of the modern sexual theorists, had much to say about sexuality. In his 1905 book *Three Essays on the Theory of Sexuality* (Freud, 1977, original work published in 1905), he links aberrations in sexual drives to psycho neurotics (i.e. sufferers from hysteria, obsessional neurosis, neurasthenia, dementia praecox and paranoia). He explains that, in his experience, all these psychoneuroses are founded on sexual instinctual forces and claims all the symptoms of neurotics are, at source, caused by resistance against the sexual instinct. Many of these theories were derived from his own clinical work and Freud recommended psychoanalysis as a way to rechannel the sexual forces. While current research (Phillips & Slaughter, 2000) shows loss of libido is frequently related to major depression, Freud's concepts were so much a part of his larger philosophies they do not offer a consistent theory on sexual practices.

Other names with great standing in the 20th century field of sexually-related research are those of Havelock Ellis (1951), Alfred Kinsey (1953) and William Masters and Virginia Johnson (1966a). These can be thought of as modernists in

that they had moved from 19th century ideas to views which held sex as “neither a threat to moral character nor a drain on vital resources” (Robinson, 1989b, p.2). They rejected the Victorian denial of women having a sexual existence and argued their sexual equivalence with men. Havelock Ellis (a British physician, psychologist and social reformer who studied human sexuality) was the first to express this equivalency, which became a prevailing part of the contemporary sexual attitude. Alfred Kinsey is a more household name than Ellis, and is famed for taking a taxonomic approach to American sexual practices. *Sexual Behaviour in the Human Female* was published in 1953, five years after its famous predecessor *Sexual Behaviour in the Human Male*. In this, Kinsey averred while women enjoyed orgasm as much as men, the wish to seek it came upon them substantially less often than for men. Kinsey used statistics on masturbation and nocturnal sex dreams as evidence of women’s lack of desire for sex, as he felt that these impulses were generated by women alone and not influenced by male initiation. However, Kinsey can be criticized for the non-random nature of his sample of women. Contemporary critics of Kinsey, such as Landis (1954), claim Kinsey’s sample was weighted with a select group of sexually promiscuous women.

While Alfred Kinsey’s work was largely based on personal interviews, the next major sex researchers - William Masters and Virginia Johnson - used laboratory observation to pioneer research into sexual responses and dysfunctions. Masters and Johnson (1966b) acknowledged Kinsey’s work as a “monumental compilation of statistics reflecting patterns of sexual behaviour from 1938-1952” (p.3). However, they aimed to fill the gap left by Kinsey’s sociological investigation by their own research into physiological and psychological sexual responses. Their two seminal texts were *Human Sexual Response* (1966a) and *Human Sexual Inadequacy* (1970). In compiling data for these books they observed and recorded approximately 14,000 sexual acts. In the first chapter of *Human Sexual Response*, they classify the four phases of the sexual response cycle into their classic four-stage model of excitement, plateau, orgasm and resolution. With the publication of *Human Sexual Inadequacy*, sexual dysfunctions started to be classified according to Masters and Johnson’s phases. However, there is very little or no consideration of a pre-sexual

stimulation desire phase. Masters and Johnson's phases were open to criticism as they were based on a male response cycle.

It took a further decade before conceptualisation and definition of sexual desire problems happened. This was instigated by the work of Harold Lief and Helen Singer Kaplan (1979). Lief (1977) pioneered the need to include a desire (or libido) phase in the model of sexual response. He also advocated a greater focus on problems in desire and advised a clinical approach to evaluating and treating such disorders. These changes were driven by his noting a large number of patients at sex therapy clinics could not have their problems classified according to the Masters and Johnson model. He logged the numbers of referrals due to loss of sexual interest at nearly 50% in one early study. His proposal that a new diagnostic term of 'inhibited sexual desire' be added to the classification of sexual dysfunction had an immediate effect on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, as it was included in the third edition of 1980 (American Psychiatric Association, 1980).

A more contemporary survey of British opinion was undertaken in the 1990s with the National Survey of Sexual Attitudes and Lifestyles (funded by the Wellcome Trust). Two books were produced from this research: Johnson, Wadsworth, Wellings and Field's 1994 *Sexual Attitudes and Lifestyles* and Wellings, Field, Johnson and Wadsworth's 1994 *Sexual Behaviour in Britain*. However, prevailing social concerns dictated the survey's interests, which were the epidemiological details of HIV and AIDS and hence the primary focus of these books was on whether behaviour was high risk, not on the levels of desire or pleasure involved.

Contemporary context

As the previous section on historical background has related, the last century largely proceeded with the view that women's sexual responses would mimic men's sexual response cycle. The *DSM* reflected the sexual response phases from Masters and Johnson's work until Lief (1977) pushed for a desire phase. In the 21st century Rosemary Basson and colleagues (2000) reconceptualised women's sexual responses, recommending an expansion and revision of current

definitions of female sexual dysfunction. Basson broadened the linear models of Kaplan and Masters and Johnson, where sexual response was conceptualized as a progression of phases, rather than a subjective experience. She highlighted the fact that women have sex for many reasons – not just due to innate feelings of sexual desire. Reasons include a desire for emotional intimacy (Hill & Preston, 1996; Regan & Berscheid, 1996), to please a partner and because a partner wants to (Leigh, 1989). Basson proposed a revised sex response cycle, which included an element of spontaneous desire that could be triggered at later points in the sexual event – not just at initiation as was implicit in *DSM* definitions of HSDD.

In a paper from 2004 an International Definitions Committee of 13 experts from seven countries, led by Basson, proposed new definitions of women's sexual dysfunction and presented this at the 2nd International Consultation on Sexual Medicine (ICSM) in Paris, July 2003 (Basson et al., 2004). Table 1 in this 2004 paper lists 41 papers in support of the view that facets of women's sexual function differ from the traditional view. With regard to HSDD, it proposed a new definition as 'Women's Sexual Interest/Desire Disorder' (Basson et al., 2003). There has been a further update on these recommendations, published in January 2010 (Basson, Wierman, van Lankveld & Brotto, 2010) involving a much-expanded group of experts from 33 countries formed 25 committees. The resultant recommendations on sexual dysfunctions in women gave a number of proposals designed to improve diagnosis and management of female sexual dysfunctions. Some of these proposals have been listened to and were incorporated into *DSM-5*. For example, female lack of interest (FSI/AD) has been separated from male low interest which has retained the former nomenclature of HSDD – now classified as Male HSDD.

Contribution from feminist thinkers

Feminists have had much to say about women's sexuality with some espousing a social constructionist view asserting that definitions of sexuality are the result of social and historical environment. Dr. Leonore Tiefer (an author, educator, researcher, therapist and activist specialising in sexuality) is one influential representative of the social constructionist view. She criticises Masters and Johnson for choosing a non-representative sample, as they only

chose women who could be sexually responsive in a laboratory setting (Tiefer, 1991a), a sample which would possibly exclude women with a low sex-drive. She further claims the Masters and Johnson model of sexual response was already devised before they collected research data, leaving them open to accusations of circularity. Tiefer also argues against a Masters and Johnson model which obscures the differences between men and women and reduces sexual response to a series of physiological changes. She notes this ignores the different values and expectations women attach to sex, which have an impact on sexual functioning.

More recently Tiefer, Hall and Travis (2002) argued against the *DSM-IV* (2000) definition of women's sexual problems. They claim it is biased towards a medical and genital focus and ignores the relational context of sexuality that is often a pivotal factor in women's sexual lives. Tiefer has also written that a medical and genital focus feeds into the pharmaceutical industry's agenda of developing drugs to treat women's sexual dysfunction.

Critique of current feminist approach.

As described in the historical background section, there is a lobby of voices which have been raised against the American Psychiatric Association's nomenclature for women's sexual problems. In October 2000 a new theoretical framework and classification was proposed by Tiefer and like-minded feminist clinicians and social scientists in a document titled *A New View on Women's Sexual Problems* (Kaschak & Tiefer, 2001). Part 3 of this document proposes a woman-centric definition of sexual problems as follows: "... discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience" (p.229). It provides four categories of causes for sexual problems (i) sociocultural, political or economic factors (e.g. inadequate sex education) (ii) partnership and relationship factors (e.g. dislike of, or abuse by, a partner) (iii) psychological factors (e.g. attachment problems) and (iv) medical factors (e.g. pain). The *New View* is designed for educators, researchers, medical and non-medical clinicians planning to help women with their sexual lives. The document certainly enforces a broader view than the current *DSM* category, allowing discussion of relationship factors, and broader contextual issues.

However, it is hard to see how such a broad definition can be useful in clinical work as it makes the spectrum of women falling within sexual problem categories even wider. The question could be asked: Is there any woman (or man) who does not experience some aspect of “discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience” (Tiefer et al., 2002, p.229)? The *New View* criticises the current establishment for over-medicalising women, but such a broad definition gives scope for this problem to worsen.

Epidemiology, diagnosis and treatment

Epidemiology.

Epidemiologic studies have reported prevalence estimates for women’s sexual problems in the U.K. Prevalence is defined as “the proportion of a population exhibiting a health condition during a specified time interval” (Paik & Laumann, 2006, p.23).

Study Name	Age Range	Prevalence
<u>Prevalence – last 12 months</u> Osborn, Hawton & Gath., 1988	35 - 59	17%
<u>Prevalence – last 1-6 months</u> Johnson et al., 2001a	16-44	10%
Mercer et al., 2003	16-44	41%

Table 1: Prevalence of sexual desire or interest problems in the U.K.

Osborn et al. (1988) present a community survey which polled a random sample of 600 women from an Oxford-based General Practitioner’s practice. As such, it claims a dependable sample, as only a small proportion (13%) refused interview. However, the use of a face-to-face, semi-structured, interview may have caused an under-reporting bias due to personal concerns about social stigmatisation.

This problem was partly circumvented by the next study quoted above of Johnson et al. (2001a) as it used computer-assisted self-interview (CASI),

Johnson et al. (2001b) for the more sensitive questions. Their paper reported the results of a British National Survey of Sexual Attitudes and Lifestyles in the U.K. between 1999-2001 which polled 6,399 women. The study is not truly representative, however, because it had an interest in high-risk behaviour and, therefore, over-sampled in Greater London where prevalence of risk behaviours was expected to be higher.

The Mercer et al. (2003) study comes from the same survey data as used in the Johnson et al. (2001a) study quoted in the previous paragraph. Mercer and her colleagues found, for at least one month in the previous year, approximately 41% of women had a lack of interest in sex. The 2001a Johnson et al. study found this figure reduced to 10% if the period investigated was at least six months in the past year.

Thus, it can be seen prevalence data varies widely. However, a common theme when looking at data across the U.K. is that, even at its lowest estimate (10% in studies listed here), low sexual desire is a relatively common problem in the lives of women.

Diagnosis.

Diagnosis of low sexual desire can be a problematic area. In England, free health care is provided by a publicly funded body known as the National Health Service (NHS). A common pathway for people concerned about a sexual problem is to consult with their local doctor (general practitioner [G.P.]), who will then – if appropriate - refer them on to more specialist provision such as a sexual health or genitourinary medicine (GUM) clinic. A questionnaire survey of 133 G.P.s by Humphrey and Nazareth (2001) found the majority of G.P.s cited barriers to managing sexual dysfunction, the most common of which were personal embarrassment, anxiety about their own knowledge and expertise in this area and fears of “opening a floodgate” (p.517). A more qualitative investigation by Gott, Galena, Hinchliffe and Elford (2004) also found the term “opening a can of worms” (p.528) summarised G.P.s’ beliefs that sexually-related issues are highly problematic because of their sensitivity, complexity and the constraints of G.P.’s time and expertise.

What of the specialist services beyond a G.P. referral? Green and Goldmeier (2008) conducted a postal survey into the level and type of sexual dysfunction (SD) provision within the U.K. GUM services in 2007. They found only 25% of GUM clinics provide a designated SD service and a marked regional variation in the level of service provision was highlighted. Research from the U.S .by Maserejian et al. (2010) found even when women already have a clinical diagnosis of HSDD, less than half of these seek formal health care for their decreased desire problem.

In summary, it can be seen from this section that it is not an easy path for low desire sufferers to get diagnosed. Further, even when they are diagnosed they do not always seek treatment and NHS treatment is not universally available.

Treatment.

General prevalence in the UK population was presented in a previous section, with a postscript that only a fraction of women who report sexual dysfunction in research situations then go on to seek help and achieve a clinical diagnosis (Dunn, Croft & Hackett, 1999). In order to provide a rounded and complete picture, some of the treatments available will be briefly presented here. Treatments for low sexual desire have been developed from three different approaches; pharmacological, hormonal and psychological.

Pharmacological treatments.

Drug companies hoping to find a women's equivalent of Sildenafil (also known under one trade name as Viagra) have long been searching for a drug to treat low women's sexual desire. However, it is questionable whether low sexual desire, which can have a myriad of causes, is treatable by drugs alone. There has been some evidence that bupropion hydrochloride has had some mild to moderate benefit over placebo (Segraves et al., 2001). This single-blind study found 29% responded to the drug with a self-reported increase in libido, while none responded to the placebo.

Hormonal treatments.

Hormones known to have an influence on women's sexuality include oestrogens, androgens (for example testosterone) and progesterone. Complex interactions occur between these hormones and several neurotransmitters in the body's nervous system. It should be noted there is currently a lack of conclusive research to support usage of hormone therapy in otherwise healthy pre-menopausal women.

Testosterone therapy has been found to increase libido in post-menopausal women (Sarrel, Dobay & Witta, 1998). However, there is a lack of long-term data for the safety and benefit of testosterone therapy. Contraindications to testosterone therapy include androgenic alopecia (hair loss), seborrhoea (inflammatory skin disorder), and hirsutism (excessive hairiness).

The U.S. Food and Drug Administration currently do not recommend androgens for female sexual dysfunction (Hobbs & Handler, 2013). There have been mixed results in studies looking at the effect of a synthetic steroid called Tibolone. One double-blind controlled study found Tibolone increased both desire and arousal in post-menopausal women (Laan, Van Lunsen & Everaerd, 2001). Comparatively few hormonal studies have been done on pre-menopausal women.

Psychological treatments.

Psychological approaches are the most common treatment approach taken for low sexual desire, and these include the methods highlighted here. Cognitive Behaviour Therapy (CBT) is used to look at distorted thinking about sex, or to re-structure myths (Ford, 2010). Sensate focus techniques are used to re-introduce sexual behaviour on a graduated scale (Litvinoff, 2001). Couple therapy or relationship counselling might be used where relationship issues are a problem (Bobes & Rothman, 2002). Sex therapy can address the problem by looking at changing attitudes, thoughts and behaviour (Boul & Kerr, 2012).

Psychodynamic therapy can be used where the problem may have originated in the family of origin (Daines & Perrett, 2000).

What of the efficacy of these psychological treatments? Seagraves and Woodard (2006) note there are no well-controlled studies indicating the efficacy of any of these approaches. They also report, that although clinicians claim some clinical success, the disorder is often refractory to treatment. A study undertaken in 2001 by Trudel, Marchand, Ravart, Aubin, Turgeon and Fortier looked at the effect of a CBT group treatment programme, compared to an untreated control group. At the end of 12 weeks of treatment, 26% of the HSDD sufferers still had HSDD, with this percentage rising to 36% one year later.

Three studies that evaluated treating low sexual desire in a group setting were Brotto, Basson and Luria (2008), Hurlbert (1993) and, more recently, Mintz, Balzer, Zhao and Bush (2012) on the effectiveness of bibliotherapy on women suffering from low sexual desire. It is of interest to note that no studies were found which assessed the effectiveness of couple therapy on the difficulty, despite couple or relationship therapy being a possible avenue of treatment.

Low sexual desire and counselling psychology.

Two areas were considered in this section, the first of which is whether there is an existing body of research pertaining to low sexual desire written from a counselling psychology perspective (as recommended by Kasket & Gil-Rodriguez, 2011). The second of these is how a counselling psychologist may approach or deal with a presentation of low sexual desire in their clinical practice.

A literature search was carried out to investigate whether low sexual desire has been looked at from a counselling psychology standpoint. Examining mainstream electronic database sources such as PsycINFO, PsycARTICLES and Academic Search Complete with Full Text for research literature on the two topics of low sexual desire and counselling psychology, revealed only two papers that have tangential relevance. The first is a 1995 paper from Post and Avery that looked at therapeutic approaches to inhibited sexual desire in lesbians.

However while aiming general criticism at mainstream therapies for being male-defined and based on heterosexist theories, the paper's interest is relatively narrow as it only reviews a single therapeutic approach of Kohut's self-psychology (1971, 1977, 1984). The second paper is the aforementioned study on the effectiveness of bibliotherapy on women suffering from low sexual desire by Mintz, Balzer, Zhao and Bush (2012). This paper's main interest was in assessing the effectiveness of a self-help book authored by Mintz – one of the researchers (*A Tired Woman's Guide to Passionate Sex* (Mintz, 2009)). Although the study demonstrates statistically significant gains over time for the intervention group, a limitation lies in the purposive sampling of participants to encompass heterosexual women who have satisfying marriages and believe their low sex drive is due to stress and exhaustion. Hence the study lacks generalisability.

A search through the *Counselling Psychology Review*, as showcased on the BPS website, revealed no relevant articles (*Counselling Psychology Review* is the Division of Counselling Psychology's quarterly peer reviewed research publication). In 2009, the U.K. threshold for registration of counselling psychologists was changed to a requirement for doctoral-level research from trainees on the course route to qualification. As research produced by trainee counselling psychologists may not have been disseminated to published journals, a search was also undertaken on EThOS, the electronic service of the British Library giving access to online electronic theses. However, again, no relevant papers were found. A conjectured reason for this lack of research carried out by counselling psychologists could be that no counselling psychology course running in the United Kingdom at the time of writing has psychosexual counselling as one of its core modules for trainees. As a result, there are very few trainees who work in psychosexual clinic placements. These placements are often the source of research ideas and interests.

Counselling psychologists not only produce research, but also often work in clinics or applied settings where they relate their theoretical knowledge to the world of psychological therapy. Therefore, a second area of consideration when thinking of low sexual desire is how a counselling psychologist might approach a

low sexual desire client different from other fields of therapy. The types of therapeutic approaches espoused by counselling psychology in the U.K. are diverse in nature. Most training courses offer training in one or two major schools such as CBT and psychodynamic methods. Some courses have at their core existential or person-centred philosophies. Therefore, counselling psychologists adopt a broad range of approaches to therapeutic work and often adopt integrationist or eclectic methods. A current Zeitgeist which seems to fit counselling psychology's spirit of engaging with diversity is the epistemological position of pluralism. Pluralism expresses the idea that "any substantial question admits of a variety of plausible but mutually conflicting responses" (Rescher, 1993, p.79). In Cooper and McLeod's 2011 publication on pluralistic counselling and psychotherapy a systematic way of working pluralistically is measured out. Here a key essence is that different clients may want different things from a practitioner at different times and, in order to progress, we should ask the client on what - and how - they wish to work.

Rationale for the study

From the preceding epidemiology, it has been shown there is a high prevalence of low sexual desire in women (41% [Mercer et al., 2003]) and difficulties in diagnosis (Gott, Galena, Hinchliffe & Elford, 2004). Only two-thirds of those diagnosed are offered treatment (Maserejian et al, 2010) and treatments are not always effective (Segraves et al., 2001, Trudel et al., 2001). Thus, there appears to be a rather bleak outlook for sufferers of low sexual desire. Given these difficulties, there follow further sections on studies which have been conducted on what it is like to have low desire for sex, which leads into the rationale for this study.

Contribution from research to our understanding of what it is like to have low desire for sex.

A recent qualitative study which has looked at heterosexual women with sexual desire loss is Hinchliff, Gott and Wylie, 2009. The paper acknowledges the debates about lack of consensus on how female sexual dysfunction (FSD) should be defined. It turns away from the traditional positivist framework normally used to look at sexual problems, and concentrates on how women

might subjectively experience FSD. The researchers carried out in-depth, semi-structured, interviews on seventeen women aged 31 to 58, who were attendees at a psychosexual clinic in England. Their interviews were then analysed using a material-discursive approach (Ussher, 1997). The paper describes the way loss of sexual desire can affect the participants' sense of themselves as women: they suffer from isolation and 'otherness', and in marital life have a feeling of not being a "proper wife" (Hinchliff et al., p. 457). Here is evidence that there is a feeling of abnormality (otherness) which has an associated distress. With regard to Yardley's criteria for judging the validity of qualitative research (2000), the use of a material-discursive method shows good sensitivity to the context of the study. Hinchliff et al. wished to study a subject (sexual disorder) with implications both in the material – or physiological body – and in socio-cultural constructions or discourses. However, the study lacks full coherence as it mentions 32 women were interviewed but does not explain how the 17 chosen for this study were distinguished from the full sample.

Research on partners' views of low desire for sex.

Low desire for sex is an interesting disorder because it can be deemed not to be a disorder when it does not cause distress. For example, to a single person who is not seeking a romantic relationship, having a low desire for sex often is non-problematic. It is a problem only if the context of the person is such that it causes problems: for example, where there is a desire discrepancy in a relationship. In these cases low sexual desire is a problem with a direct impact on intimate sexual relationships. As one of the main treatments is couple therapy, a literature search was conducted for research looking at the couple element of low sexual desire and exploring the view of the other person in the couple dyad. What was immediately striking about the search outcomes was how little is written about this aspect of the problem. There are studies which apply differing solutions to the problem, such as a sexual health model (Robinson, Munns, Weber-Main, Lowe & Raymond, 2011), emotionally focused therapy (MacPhee, Johnson & van der Veer, 1995), experimental psychotherapy (Kleinplatz, 2007) and the Basson Sexual Response Cycle (Gehring, 2003). There are books incorporating chapters that describe treatment approaches to low sexual desire such as Schnarch (2000) and Weeks, Hertlein & Gambescia (2009).

In the latter publication, Hertlein and Weeks (2009) bemoan the disconnection between theory and practice, saying “Standard treatment is typically ...not research informed” (p. 45).

In contrast to the lack of research found on the viewpoint of the partner in a couple experiencing women’s low sexual desire, many studies have been conducted on the impact of the male sexual problem erectile dysfunction (ED) on female partners (Conaglen & Conaglen, 2008; Fisher, Eardley, McCabe & Sand, 2009; McCabe & Matic, 2008). The first two of these studies both investigated ED with fixed aims in mind, such as whether some women’s attitudes had an effect on using specific treatments (Fisher et al., 2009) and compared male/female quality of life (McCabe & Matic, 2008). The Conaglen study was a more open qualitative study which used thematic analysis to gain a sense of the issues women experience as a result of their partner’s ED. The paper outlined feelings experienced by the women such as self-blame, or worry that their partner now viewed them as less attractive than before. The conclusions highlighted a need for educational resources on sexual difficulties for the general public and their physicians. In addition, the study illustrated the value of involving the female partner during treatment.

Rationale, research question and aim.

As the previous section has shown, there is little research exploring the views of both people in the couple. However, in the area of ED, research has contributed significantly to expertise on the disorder as sexual disorders do not usually happen in a contextual vacuum and investigating the partner aspect adds to our general body of knowledge. Consequently, the following research question is proposed as the central point of investigation by this paper:

How do men and women living with women’s low sexual desire construct narratives of their experience?

In addition, the study aims to contribute to knowledge by considering how themes uncovered from this enquiry inform counselling psychology or other clinical practice.

Methodology and Procedures

The method chosen to investigate these research questions is Critical Narrative Analysis (CNA). This section will explore why this method was chosen, and why others were discarded. In so doing, the philosophy and basic assumptions behind the method will be discussed as these inevitably have an impact on the type of knowledge produced. Finally, a précis of how the analysis was carried out will be given.

Choice of a qualitative approach

“The pond you fish in determines the fish you can catch” (Suzuki, Ahluwalia, Arora, & Mattis, 2007, p. 295). This statement is certainly true of research methodologies as different types of research methodologies shape different types of knowledge. Psychologist Jerome Bruner (1986) believed there are two disparate ways of looking at or construing reality. The first of which is the paradigmatic way, which seeks to establish ‘cause-effect’ and ‘if-then’ statements about a positivist world. This type of knowledge is most easily investigated using quantitative research methods. Bruner postulated that the second way of knowing the world is through narrative-knowing. This type of knowledge involves how we as human beings make sense of the events in our world by telling stories to ourselves and others. As one of the primary aims of this research is to uncover subjective experience of couples living through low sexual desire, it follows that the most suitable research methods are those which look at individual narratives. Such narratives are usually accessed using qualitative methods of enquiry.

Choice of a narrative approach.

The many different types of qualitative methodologies each seek to investigate different facets of how we construct our worlds. They derive their means of investigation from their theoretical and philosophical underpinnings. Lyons (2007) discusses how Madill, Jordan & Shirley (2000) theorise epistemological differences as they place qualitative research approaches along a

spectrum, which has one pole of naïve realism and an opposing pole of radical constructionism. Naïve realism makes the assumption that reality is accessible and can be uncovered. Quantitative methods traditionally have an implicit, tacit basis in naïve realism. Radical constructionism denies that data can reflect reality and avers that reality is constructed through language. In between these two extreme poles lies a contextual constructionist position, which assumes a real world exists independent of our experience of it. This belief has echoes of naïve realism with its acceptance of a consistent, fixed world. However, it also reflects the constructionist ideas by acknowledging that all knowledge is influenced by the listener or receiver and knowledge is context specific i.e. knowledge is situated in a certain time and place. Narrative analysis is based on a contextual constructionist epistemology and, therefore, rests on assumptions that peoples' language reflects in a relatively straight-forward way their experiences and the meanings they attach to them. It is also based on a phenomenological approach, which asserts that, by focusing on detailed description of people's experiences, it is possible to extract an essence or specific truths about the experience. However, there is also an acknowledgement that opening up people's meanings and experiences requires interpretation from a researcher. Narrative analysis pays particular attention to the role of the researcher. It assumes that the researcher can access the cultural meanings surrounding participants' narratives and use those to analyse the data, while also providing an account of the researcher's own background and context.

Choice of Narrative Analysis over Interpretative Phenomenological Analysis and Discourse Analysis.

Narrative is defined by Murray (2003) as “an organized interpretation of a sequence of events [which] involves attributing agency to the characters in the narrative and inferring causal links between the events” (p.113). As a method narrative research can involve asking different questions of the account given by a participant. These questions can concern story structure, content, themes and social and psychological functions of the narrative. Here narrative parts company from other qualitative methods such as Discourse Analysis (DA) and Interpretative Phenomenological Analysis (IPA). IPA research usually involves

mining for overarching themes between participant accounts, whereas Narrative analysis (NA) aims not only to look at themes (as in IPA), but to examine narrative structure and connection to societal context. A difference between NA and DA lies in the way DA would dispute attributing personhood and inner experience to the participants. NA has a humanistic image of the person as self-aware and agentic, and involved in striving for fulfilment and control. This NA view is in closer alignment with counselling psychology's humanistic values (Strawbridge & Woolfe, 2010).

Narrative Analysis is an appropriate method where there is little extant research on an area. It was felt this method would not impose assumptions onto the participants' data, but would allow a concentrated focus on their experiences and feelings and would facilitate an emphasis on individual 'meaning-making'. This dovetails neatly with the aim of the study to uncover individual's views as well as fitting with a counselling psychology philosophy of investigating a problem in context and unpacking individual layers of meaning by "engaging with subjectivity" (Division of Counselling Psychology, 2006).

Thematic narrative analysis, rather than pure thematic analysis is favoured in order to privilege keeping narratives intact rather than fragmenting them into thematic units. This allows theorising from a single narrative case rather than from component themes (categories) across cases (Riessman, 2008). It is hypothesised this will give a clearer link between individual cases and any clinical application. Further, keeping narratives intact also aligns closely with the ethos of counselling psychology, which seeks to "respect first person accounts as valid in their own right" (Division of Counselling Psychology, 2006). It is envisaged such a method would provide information applicable to the practice of counselling psychologists. It allows investigation into whether couples' narratives match with one another and how much of a narrative is shared. This can have a clear link to types of treatment and possible difficulties in treatment.

Type of Narrative Analysis.

There are a wide variety of approaches to narrative analysis with each having different strengths and weaknesses. Following wide reading and exploration of different narrative approaches (Gee, 1991; Hiles & Čermák, 2008; Labov, 1997; Riessman, 2008) I chose critical narrative analysis as developed by Langdrige (2007) building on the work of Ricoeur. This decision was predicated on selecting the best method to cast light on the research question and aim, which are based on understanding subjective experiences and then extending this understanding onto application in therapeutic work. As was made clear in the Introduction, sexual practices are very much a product of culture, time and place. It was felt that a method which could illuminate both the embedded nature of the researcher, and the participants in current social ideas, would be most useful to the topic. Hence, a method was required which would allow this comparison as part of the analysis. One of the distinguishing features of Langdrige's method is the attempt "made to interrogate the text using aspects of social theory as a hermeneutic of suspicion" (2007a, p.130). Hermeneutics is defined as the theory or practice of interpretation, whilst a hermeneutic (singular) refers to a particular strand or method of interpretation. Hence Langdrige's method interrogates material using a social theory which relates to the subject matter as a tool for critically examining or understanding the material. Due to the socially-constructed nature of what is deemed 'normal' in the sexual arena, it seemed of interest to interrogate the narratives with Tiefer's feminist, social constructionist theory from her 2004a writings.

The six stages of Langdrige's methods are listed below; a fuller account is given in the ensuing Method section with a description of how I applied them within this study. For a complete breakdown please refer to Langdrige (2007).

Stage 1: A critique of the illusions of the subject

Stage 2: Identifying narratives, narrative tone and rhetorical function

Stage 3: Identities and identity work

Stage 4: Thematic priorities and relationships

Stage 5: Destabilising the narrative

Stage 6: A critical synthesis.

Method

This section covers a description of the method used and how events proceeded with the study.

Recruitment.

Participants were sought from a local NHS psychosexual clinic, once NHS ethical approval had been gained. Psychosexual practitioners at the clinic were asked to refer women patients to me who had presented to them reporting low interest in sex. However, no couples were forthcoming from the local clinic, due to a combination of few presentations with low sexual desire and women saying that, while they were happy to participate, their partners were unwilling. Participants were then sought from a more distant clinic where the clinician was an external advisor for the research: one couple was referred from this clinic. Participants were also recruited from a network of colleagues and three couples came forward from this network.

Interviews.

Separate semi-structured interviews were held with the couples. The interview schedule took the form of an open invitation: “To begin with, could you tell me about your history of low sexual desire from when it started to now?” Participants were asked to think about and structure their answer as a story, with a beginning, middle and end. If common topics were not covered by the participant this was then followed by more topic-oriented open questions “Tell me about any treatment you may have sought or had....”. It was made clear before the interview participants would not be asked directing or leading questions. A pilot interview was held and it was found the interview style

needed to be warm, open and conversational, as a more traditional formal style tended to elicit less expansive answers from the participants.

Each woman and man in the heterosexual couple had a separate private interview lasting from 35 minutes to 1 hour in length. In all, eight audio-recorded interviews were used for this main study (four couples): demographic details were also taken (see Appendix 6).

As the subject area was one which might provoke distressing feelings (for example, low sexual desire may occur when the participant has been the victim of sexual abuse), ethically a distress protocol was required to handle mild, medium or severe distress during interview. This was prepared but was not used. It was of further ethical benefit that two of the participants were in the process of receiving help from a referring clinic. Post-interview, participants were debriefed and given time to ask questions and discuss emotions which the interview may have aroused before being given a hand-out detailing sources of further support.

Following each interview notes were made of my own personal reactions in a reflexive diary. As a general comment I felt that interviewing the women was easier: drawing out the men's views seemed much more difficult, as I had to work harder to gain a sense of their experience of living with low sexual desire in a partner.

Analysis.

There follows a description of how I applied Langdridge's six stages of analysis.

Stage 1: A critique of the illusions of the subject. The audio recordings gathered from the interviews were transcribed and personal identifiers deleted to maintain confidentiality. These raw transcripts were read through several times in order to facilitate immersion in the participants' context and story.

Following Langdrige's stages, reflexive work was then carried out. He recommends the researcher critiquing themselves with a hermeneutic that best fits the topic under investigation. Langdrige lists some possible critical hermeneutics of suspicion such as: gender, class, race or sexual analysis. The function of this step is to illuminate researcher assumptions. I wrote some paragraphs about myself and how my situation might affect my understanding of the interviews (see Critique of the illusions of subjectivity in Results chapter). Such a reflexive stage also fits with a counselling psychology perspective, as consideration of subjectivity and inter-subjectivity are one hallmark of a counselling psychology approach (DCoP, 2006). As Bold (2012) has written in contemplation of writing by Finlay and Gough (2003): "Reflexivity brings into the process a more personal dimension, a thoughtful self-awareness of the dynamics between you and the people you are researching" (p. 3).

Stage 2: Identifying narratives, narrative tone and rhetorical function. Each interview can be viewed as one narrative, but can also have other narratives intertwined with it: for example, narratives of being a good wife or traditional husband. This stage involved a search for distinct stories in the text. New beginnings were noted in each account, for example, where new places or people were introduced. Usually, a person's narrative will reveal how they relate their story to canonical narrative (Bruner, 1990). Canonical narratives are "narratives that can be found in individual personal stories but represent broader societal stories of how lives should be lived" (Langdrige, 2007a, p.147).

For each interview a narrative tone was identified, along with its shifts throughout the transcript. For example, tone can be optimistic or pessimistic, tragic or comic.

Identifying the rhetorical function of the text was the next stage of analysis. What function did the story seem to serve? For example, was it justifying a stance or criticising a situation? The reason for looking at this is to position the speaker with regard to the wider pool of stories society allows. As a method, CNA is very interested in the rhetorical work being done by the narrative and how this changes throughout. Rhetorical discourse is combative talk, the

purpose of which is to justify, explain or criticise (Bakhtin, 1986). Bakhtin claims people are always positioning themselves versus other counter-positions.

Stage 3: Identities and identity work. This stage led naturally from the prior stage, examining the rhetorical work done by the individual in their narratives to position themselves in the world. As we each construct our identities in the stories we tell the world, I investigated what self was being described in each narrative: was the person a hero, a victim, replete with power or adrift without a compass?

Stage 4: Thematic priorities and relationships. This stage involved identifying the main themes in the text without losing sight of the coherent narratives being presented. The aim was to determine key themes from a direct reading of the text, rather than breaking it down to disparate phrases and coding separate units of meaning. I read (and re-read several times) the text, noting emerging ideas and key sentences. It was important to keep in mind my own views from Stage 1 and ensure the ideas emerging from the text were the participants' distinct views. The emerging ideas were listed separately with line numbers, to explore whether they could be grouped into clusters of meaning. The themes were then examined to see whether they could be further distilled into one category or if they were, indeed, stand alone. This was an iterative process, requiring many re-visits to the original transcripts, refining categories, core themes and relationships between categories.

Stage 5: Destabilising the narrative. This penultimate stage marks a difference between CNA and other forms of narrative analysis. Langdrige recommends critiquing the narrative of each participant from an appropriate hermeneutic (interpretative lens). He describes this stage as political, as it requires the researcher to engage with critical social theories, listing six possible hermeneutics of suspicion which include gender analysis/feminism. CNA prescribes the use of a hermeneutic to cast "imaginative suspicion" on the interviews should teleological rather than archaeological. That is, it should open up "future possibilities for the narrative rather than digging down to uncover hidden meaning" (Langdrige, 2007a, p. 150).

The hermeneutic I have chosen is from a feminist, social constructionist stance advocated by Tiefer (2004a). Her work has been selected as it is more up-to-date than other well-known theorists in this area such as Paula Nicolson (1993) and Jane Ussher (1997). A brief summary of the feminist tenets used to critique the narratives are given in the following paragraph.

Two aspects of Tiefer's essays seem particularly apt when brought to bear on the subject area of this study: medicalisation (or pathologisation) of normal variation and man-centred sexology.

Medicalisation (or pathologisation) of normal variation: Tiefer (2004b) describes how the current use of a biomedical health model for sexual desire introduces assumptions of normal versus abnormal levels of drive. In her opinion, as a clinical psychologist, sexologist and sex therapist, "there are no valid clinical norms for sexuality" (Tiefer, 2004c, p. 190). This is because she believes there is too much "lifestyle, historical and cultural variability in sexual behavior standards for us to be able to establish clinical norms of sexual activity performance, choices, frequencies, partners and subjectivities" (p.190). Reinforcement and endorsement for Tiefer's views can be found in the prevalence section of this report. If what is "normal" is taken to mean what is common, it was seen from prevalence studies that with prevalence rates of 41 to 10%, low desire for sex is a very common experience for women. Tiefer argues that it is not right to pathologise what might be a normal variation in women's lives.

Man-centred sexology: A second area which Tiefer denounces is that sexology (the inter-disciplinary scientific study of human sexuality) is, and has been, man-centred (Tiefer 1988; 1991b). As was noted in the Historical background section of this report, there has been an adoption in medicine, psychiatry and research of sexuality as men's sexuality (Irvine, 1990). Tiefer, 2004c, bemoans this saying: "Women's official dysfunctions are directly related to performing coitus – proper vaginal lubrication, orgasm, absence of vaginal constriction, desire and absence of genital aversions" (p.194). Factors such as "love, gentleness, passion, body freedom, freedom from fear, lack of coercion, communication, emotional involvement..." (p.194) are absent from a medical

view of women's sexual problems. A male-centred view has been characterised in research by Baumeister (2000) as being “relatively constant and unchanging, which suggests a powerful role for relatively rigid innate determinants” (p. 347).

Stage 6: A critical synthesis. Langdrige makes this an explicit stage in order to describe how the findings are presented, recommending the presentation of key narratives with themes privileging the voices of participants. This is followed by a description of identity work and a presentation of the findings from the hermeneutic of suspicion: these findings are presented in full in the Results section, while the synthesis, or summary, of findings is given at the start of the Discussion section.

Results/Critical Narrative Analysis

Overview

As described in the preceding sections, analysis proceeded through six distinct stages which are reflected in this Results section. Beginning with a self reflexive piece, critiquing the concept of my subjectivity in this research, it moves on to focus on the participants, giving brief biographical introductions to each of the four couples. An overview of their narratives is then given alongside analysis work on the narrative tone and rhetorical functions noted in the text, following which the themes and identity work that seemed predominant in the interviews are described. In the final part of this section, the narratives are viewed using Tiefer's social constructionist viewpoint. The function this serves is to allow the presenting narratives to be viewed from a standpoint other than the researcher's and to evaluate whether that standpoint gives more flexibility to a therapist or counselling psychologist who may be presented with the couples' situation.

As this is a complex method, which has an added layer of complexity due to multiple participants with interaction between couple narratives, the diagram below gives a schematic representation of how the results are laid out.

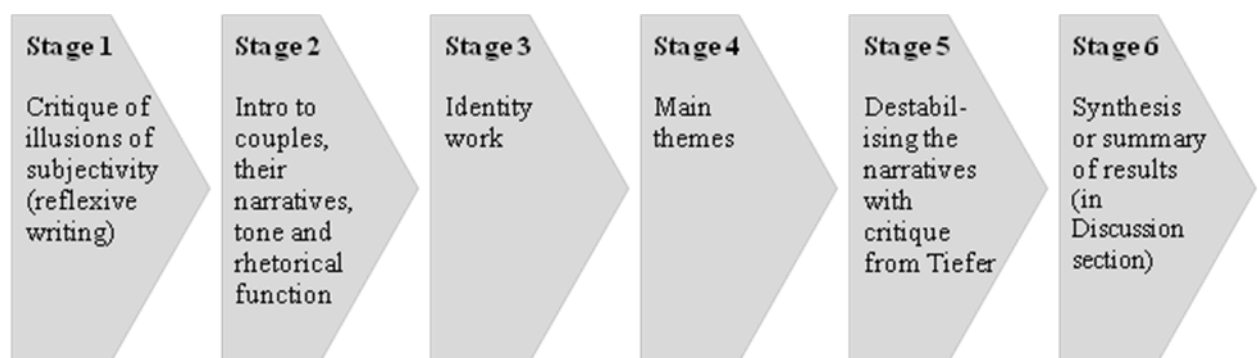


Figure 1: Schematic of results layout

Critique of the illusions of subjectivity

The function of this analytical stage is to illuminate better the assumptions that underpin my analytic position. Having initially read through the transcripts, I paused to think through how my subject position might influence the analysis as it has at least two facets with a direct bearing on what I might 'see' in the analyses. The first, of my own experience of having suffered from low sexual desire, meant I had to be careful not to impose my experience or feelings on the transcripts from participants. I recognised the need to stay as balanced as possible and to concentrate purely on what the participants were saying.

The second potentially influential facet of my subject position is that of my gender. I addressed this by allowing each couple to choose in what order they spoke to me - men or women first; in all four couples the women chose to be interviewed first, followed by the men. A possible consequence of this is the man may have felt he was countering any views given by the woman where their views were oppositional (as they turned out to be on topics such as the importance of sex). Consideration of the possible effects of gender bias continued beyond the interview process when I analysed the interviews in a different order: analysing the men's interviews first in two cases. I will discuss this gender issue further in the Discussion section in Final reflexivity.

Introduction to couples, their narratives, attendant tone and rhetorical function.

Before laying out the study's findings, this section gives a brief introduction to the eight people who participated in the interviews. The purpose of this section is to give some basic background, relational and cultural context to the stories upon which this research is based. A broader cultural picture is considered important because - as illustrated in the Introduction section - sexual practices are often a product of the time and place in which we live. The couples are introduced in the order in which the interviews took place; all names have been replaced by pseudonyms. A table giving a summary of the broad

demographic details of the four participant couples has been included in Appendix 10.

These introductions are followed by an outline of the stories each participant told in their interviews. The narratives are included to provide a context to the further findings related later in this section. Each participant narrative is followed by the results of the part of analysis which looked at tone and rhetorical function.

Lauren and David.

Lauren was a 34-year-old, white, heterosexual woman born in the U.K. Her education extended to undertaking, but not completing, a degree, and she was in full-time employment. Lauren had been married to David for six years, and they had been a couple for two years prior to marriage. They had one child of two years and Lauren was pregnant with their second child.

David was a 32-year-old, white, bisexual British man. He was educated to college-level and was self-employed.

The couple lived in a semi-rural location in the south of England.

Lauren's narratives: Lauren's personal narrative of low sexual desire covered an initial "active" sex life. There then followed accounts of increasing cross-dressing by her husband, child-bearing and an account of how her bisexual husband had an escalating liking for anal sex – all of which Lauren felt had contributed to her lower libido. Canonical narratives included that of a honeymoon period (where sex is frequent in the first flush of a new relationship) and a lapse in women's sexual desire after childbirth. Lauren described how she was considering separation from David before falling pregnant with their first child. At the time of the interview Lauren was nearly eight months pregnant with their second child and was having sex instigated by David at a frequency of once a fortnight. There was an unspoken expectation that this was not enough sex. Lauren stated that she could go without sex permanently.

The general tone of the narratives of Lauren's narrative was tragic, sad and despondent.

With regard to rhetorical function, Lauren gave much justification of her current position. Reflecting on where blame resided for the issues under discussion Lauren cited her husband's habits, which were a "turnoff", as underlying reasons for her low libido. Lauren was able to hold this narrative of blame towards David while suspending an explanation for the same lowering of appetite with a former boyfriend.

In analysing the function of Lauren's rhetoric, it positioned her as someone who was just like everyone else. However, she had become a victim of circumstance in that her husband had behaviours which caused her to lose interest ("turnoff") and her children got in the way of a marital relationship. Lauren positioned herself as blameless - the lack of sexual interest was not her fault. The function this diversion of blame onto the children or David played, was that Lauren felt she was now stuck "...and I suppose in some ways we were making the decision whether to separate or not and then I became pregnant. So that went out the window." Later she said in a tone of resignation: "...but hey, I married him, didn't I?" In this way, Lauren seemed to feel that her agency and power to change her situation have been removed. Marriage and children were nails in the coffin of her freedom. Psychologically, it is possible that blaming others removed the pressure from Lauren having to change her situation. This is further illustrated in the Main Themes section.

David's narratives: David was less talkative than Lauren, so different narratives in his interview were initially generated by my questions. Also the narratives were less defined (without a beginning, middle and end) and tended to be a sequence of criticisms of Lauren.

David's narrative of his marital sex life was one of thinking his wife had a really high sex drive when they were first together. However, he now questioned whether she was "more accommodating than she wanted to be". There followed a description of what he no longer got from Lauren: he had to instigate sex, he then felt guilty for doing so, there was a lack of intimacy and no holding

or touching. This led him to question the basis of their relationship. There was a narrative about him being bisexual and a defiance that he had always been open about this “I don’t care....that’s who I am”. The canonical narrative of children being a sex-dampener was invoked. There was a fleeting reference to an ex-partner who had David’s first child, following which her sexual appetite was less than Lauren’s, which led to that relationship breaking down.

The general tone of David’s narratives was sad and disappointed, while interspersed with humour. The tone of David’s narrative changed at points from being strong in tone in places where he discussed his bisexuality or criticised Lauren’s marriage counselling and Lauren. In other sections the tone was withdrawn and non-forthcoming, for example when discussing his ex-partner’s lack of sexual desire and in saying that Lauren had to “accept it and get on with it”. Perhaps this suggests that he is confident and sure-footed when criticising others and his views on what is right sexually i.e. he has a right to assert his sexuality, whereas Lauren has no right to show a lack of interest in sex.

In reviewing David’s interview for rhetorical function, David did less justification work for his sexual appetites than Lauren who, in comparison, did more footwork to justify her situation. He criticised Lauren extensively, making clear what her low drive for sex does to him. This extended into where I asked him to describe Lauren in general, as a person, and the terms he used were mostly derogatory and pejorative.

The overall function of the rhetorical work was to emphasise that David is the victim. Lauren was to blame for making him feel guilty, insecure over his attractiveness, making him instigate sex, which caused him frustration and upset, as he wanted Lauren to be the instigator. She made him doubt the basis of the relationship. David invoked grand, canonical narratives of what sex meant, such as it being a large part of a relationship, the underpinnings of a relationship and the “window to someone’s soul” in order to persuade that Lauren was in the wrong and occupied an unnatural position.

Jane and Johnny.

Jane was a 34-year-old, white, heterosexual, British-born woman. She was educated to college level and had a part-time job. Jane had been married to Johnny for 11 years and they had a child together who is now seven years old. Jane had been married previously to an abusive partner with whom she had a child. This child was now 15 years old and lived with Jane and Johnny.

Johnny was a 45-year-old white, heterosexual British man. He was educated to secondary school standard and was self-employed.

The couple lived in a suburban location in the south-east of England.

Jane's narratives: Jane's narratives were short, factual and unembellished, without extraneous description or emotion. Her story was one of living through a number of difficulties so that her low sexual desire seemed self-evident to her given her prior life circumstances. Firstly Jane cited the birth of her second child (Sam) as the cause of her low desire for sex as Sam was "difficult" and sickly. This led to a lack of time and work overload, resulting in tiredness and irritation with her husband. Jane said she also had a lack of interest in sex with her first husband who was physically abusive towards her. Jane told the story of giving birth to her first son and having to have three different surgeries to repair the birth damage. This was followed by pre-cancer of the cervix and operations to prevent haemorrhaging during periods: in all Jane has had seven gynaecological operations. Jane cited these medical difficulties in addition to a lack of confidence, a moody husband and constant tiredness for her low desire for sex.

The general tone of the narratives ranged from matter-of-fact to thoughtful.

With regard to rhetorical function, when Jane talked about priorities in relation to sex, she placed it behind healthy children and parents who were alive, and placed herself on the moral high ground with regard to what was important in life. Jane trivialised men's needs ("we [men] get moody and we this and we that"), placing women as more emotionally consistent. Further, her need for

sleep was more important than Johnny's need for sex: her priorities were on a higher plane as she was busy and tired.

Johnny's narratives: Johnny's narrative was also short and it felt difficult to draw him out as he seemed a man of few words. He related a story of Jane's sexual desire waning over their 11 year relationship from a honeymoon period "being at it like rabbits" to a current rate of "once a month, if I'm lucky". He related how frustrating this was for him as it raised self-doubt as well as doubts about the relationship. Johnny referred to sex as "getting it" adding how there was conflict in their relationship over other issues. He seemed resigned to accept his wife as she was, while placing all blame for her low sex drive with her.

The tone of Johnny's narrative was resigned and withdrawn.

The rhetorical work being done in this narrative was largely around themes of blame. In Johnny's story, Jane was patently to blame as the fault lay within her. There were accompanying themes of Johnny being a powerless victim, subject to the whim of Jane's low sexual appetite. Sometimes he was "luckier" than others with regard to the amount of times that he "gets it" but the reasons for these shifts in luck remained obscure to Johnny. There were occasional flashes of self-doubt, where he doubted her feelings and the level of affection he showed. However, throughout a comparatively short interview he laid the blame on Jane five times. Johnny, therefore, positioned himself as a luckless victim of Jane's low sexual appetite.

Sue and Steve.

Sue was a 41-year-old, white, heterosexual Irish-born woman. She was educated to secondary school level and her occupation was that of full-time mother and carer to her older son. Sue was divorced and had two children from a previous marriage. The older of Sue's children was a profoundly disabled 13-year old and the younger 10-year old had a diagnosis of autism. Sue had been with Steve for eight years in a committed relationship. They lived apart during the week due to diverse work locations, but spent weekends living together.

Steve was a 39-year-old, white, heterosexual Irish man. Steve did not complete secondary school and was now self-employed.

Steve and Sue spent weekends together in Sue's house, which was in a rural location in the west of Ireland.

Sue's narratives: Sue's narratives included tales of difficulty and damage. The birth of her first son 13 years ago led to physical damage that took two years to repair surgically. In her "unhappy" marriage sex was always difficult after that and had to be alcohol fuelled. In her current relationship with Steve, Sue has been convinced by Steve of the importance of sex for the relationship. However, she admitted to not caring less about sex and sometimes forcing herself to do it. Sue recalled a history of having sex to keep men happy. She recounted her mother telling her that sex was "horrible, it was roll-on and roll-off." There is a canonical narrative about sex in Sue's account with her avowal that "you should be enjoying it, like, you should be enjoying, you should want it really."

The main tones in Sue's interview were contemplative and humorous.

With regard to rhetorical function, Sue did not seek to persuade much in the text. She spent time explaining how her sex drive has been impacted by various life-situations. Steve's interview was imbued with arguments about the importance of sex and Sue's interview revealed that she has discussed not having sex with Steve and had come around to his way of thinking (his "theory") that sex is important to a strong relationship.

Steve's narratives: Steve told me before we began that he did not believe his partner, Sue, had a low interest in sex. In the first part of the interview he seemed to be arguing against an imagined opponent who said that sex is not that important. His view, stated at the end of the interview, was that sex was "mighty" and was very important. Steve positioned himself as an evolved, rational man – not like other young men who were "Neanderthals" and looked for mindless sex with "anything that moves."

Steve's tone was light, contemplative and amusing in most places, interspersed with emphatic tones when seeking to persuade.

In considering the rhetorical function of Steve's statements, there were many arguments made in the script such as an emphasis on the centrality of sex in a relationship. Steve positioned himself a number of times as a mature, clever, adult man. One anecdote related to his out-smarting village gossip. He also described his male peers as "giggling children" and "like talking to a lamp-post." In this way Steve positioned himself as smarter than others.

Mandy and Nick.

Mandy was a 37-year-old, white, heterosexual, British woman. She was educated to college level and held a part-time job. Mandy had been with Nick for eight years and married for seven, with an eight-month separation in the middle of the marriage. They had a six year old child who had a diagnosis of autism.

Nick was a 33-year-old, white, heterosexual, British man. He was educated to college level and was in full-time employment.

The couple lived in a suburban location in south-east England.

Mandy's narratives: Mandy pinpointed her low interest in sex from early in her pregnancy. After giving birth, Mandy described the next three years as "sexless" and the couple decided to separate. However, following eight months of separation Mandy said she realised how much she loved Nick and they reunited. Sexual relations were good when they first got back together but once more things deteriorated in the bedroom and the couple sought help. At the time of the interview they were coming to the end of approximately six sessions of psychosexual therapy, which was going well.

The tone of Mandy's interview was mostly light and optimistic, interposed with a thoughtful tone when reviewing the past.

Mandy used the interview to explain how her sex drive had fluctuated throughout her relationship with Nick. From a rhetorical function perspective, Mandy appeared to seek less to persuade than to explain. Her interview talked about how six months previously (pre-therapy) she would not have been able to talk to me, whereas now she felt comfortable to do so. Before it was “all a mess in my head, I didn’t know what was causing it.” Therapy had given her a plausible story or cause for low sexual desire that she believed.

Nick’s narratives: Nick’s narrative covered his feelings of doubt of Mandy’s love for him when her desire for sex was low. He described how they went for therapy before their mid-marriage separation. Therapy, at that time, concentrated on Nick’s issues and so Nick felt it was “off subject.” He described how his therapy now had a clearer agenda and was, therefore, much more successful. Therapy was concentrating on communication and Mandy’s habit of taking on too much work.

The tone was predominantly thoughtful and slow in delivery, with flashes of a more definite tone when talking about himself.

In thinking of rhetorical function, Nick gave fairly simple, minimal answers to the questions I asked him. He did not seek to persuade or justify anything. He just explained how it has been for him.

This tied in with a seeming lack of agency in Nick’s description of his behaviour. Things happened to him without much input from him. For example, in describing how their therapist had asked them to set aside time for communication, he said “we now find time, how I don’t know it’s just happened.”

Identity work

This phase of the analysis refers to the sense of identity projected by the participant. Throughout each interview there was a great deal of identity work being done by each interviewee (see Methodology section on analysis for an

explanation of identity work). The position in which each person seemed to place themselves was analysed and the most common and predominant roles are discussed here.

Men's role of victim.

The role of victim came across very strongly in three of the four men's interviews. In the first interview with David, his narrative constructed a person who felt aggrieved about being denied something that was there at the beginning of the relationship. Furthermore, in his opinion, a partner's interest in sex should be there in every relationship as it is a "subconscious expectation" or "underpinning". The self being brought into being by the narratives was a victim of emotional neglect. In describing Lauren, David uses descriptors that would fit a parent as described by a child. The role he seemed to play is that of a child who wanted to keep playing and getting good things back from his former playmate (intimacy, cuddles, re-assurance), but he was always left alone to instigate the play.

In Johnny's interview, the self being described in the narratives was someone who seemed to accept submissively the way Jane was about sex. He talked about being lucky if sex was more plentiful than normal and did not seem to be aware of any effect he might have on that lottery. He was non-agentic, accepting and passive. In a similar way, the self being brought into being in Nick's narrative seemed a non-agentic person who found it difficult to communicate with the world. He described being given material on low sex drive from the Internet by Mandy, but there was too much information and he wanted set guidelines. With regard to communication Nick described how, when Mandy's low desire for sex happened before, he would "sit there and just keep it to myself and end up stressed." He described difficulties with communication several times and with his tendency not to communicate or take control, positioned himself as a hapless victim of circumstance.

Women's role of self-sacrificing heroine.

The identity work done by the women had strong themes of self-sacrifice across three of the interviews. In Lauren's interview the person described was a martyr figure: she had sex driven by David's needs, without enjoyment, putting her own satisfaction as the last thing on her mind. There were echoes of a trapped heroine. She was a heroine because she put her children, marriage and husband's needs before her own enjoyment. Once Lauren became pregnant she stopped considering separation from her husband, accepting a joyless martyr role in subjugating her own needs. Perhaps this self-sacrificing helped Lauren to occupy the moral high ground as a good mother and wife and allows her to live without the anxiety of making a decision to leave.

Sue painted a picture of someone who did things for other people, for example, when she had sex just because her boyfriends wanted her to. There was a self-sacrificing individual in these narratives: someone who was seduced by the fantasy of love and who was told by her mother that sex was something you had to do and was "horrible, it was roll-on and roll off." Eventually Sue was able to trace the blame back to her mother. The self in these stories was a disillusioned, self-sacrificing heroine, who says she had failed to achieve the fairy-tale loving relationship.

There was a tendency in Mandy's interview for her to infantilise her husband Nick and, therefore, the self projected in the interview was that of an adult who protecting a husband who "finds it difficult to communicate and express how he feels." With her self-described propensity to take on everyone's problems and not accept help, Mandy positioned herself as a selfless beast of burden. There were numerous places in her interview where a theme of self-sacrifice was evident. The role Mandy assumed was that of an altruistic and unselfish heroine, while her husband was an infantilised man.

Main themes

The main themes that emerged from the thematic analysis stage are described in this section. Interviews were conducted separately with men and women so that themes arising were not influenced by the presence of their partner. Firstly, the most predominant themes arising in both women's and men's interviews are given, followed by the most common themes that came up in only the men's or women's interviews.

Included in the following descriptions of themes are quotes from individual participants that illustrate the ubiquity and power of each theme. The quotes contain all the participants' expressions, with any utterances of mine indicated by the word 'researcher', in parentheses and italicised. I have excluded my words where they were minimal encouragers such as a murmured 'mmm' or 'yeah'.

Blame - As a defence against vulnerability.

The topic of blame permeated the majority of the interviews. Taking a step back before looking at how blame presented itself, it is helpful to consider where each partner sits with regard to knowledge of the women's low sexual desire. The woman may (or may not) understand why her desire has waned and may struggle with why she cannot switch desire on and off at will. Hence she may suffer from the terror of not-knowing or not being in control. Her partner is often much more in the dark with regard to causes and what it means. He may feel out of control, powerless, isolated and helpless. Blame can be used to relieve psychological problems such as fear, uncertainty, lack of power and helplessness. For example, Yalom (1998) notes that people use blame to avoid personal responsibility, because responsibility can be frightening as it carries implications of an unpredictable and uncontrollable world.

In the women's interviews, blame was allocated to all perceived causes of what started the low desire for sex. It can be seen in extracts from Lauren's interview below that she was pointing the finger at her children, work and David. The implicit message was that if they were to blame, then there was nothing wrong with Lauren and she did not have to change.

Lauren: having children is a big, you're so tired a lot of the time, you're working, erm, I was studying up until recently as well, which I've deferred for a year until I've had my baby so, yeah, too much, too much. And then sex is just the last thing that I, I just want to go to sleep in the evening, you know. Erm, yeah and we have a toddler which, erm, wakes up in the middle of the night and wants to come into our bed so.
Erm, and they get regular colds as well, they, they're always poorly, coughing and yeah, it's a real killer for the old, er, bedroom antics. (Lines 122-35)

Lauren: Erm, yeah, obviously low, my low sexual desire is definitely linked in with, with that (David's cross-dressing) in our relationship. (Lines 434-35)

In the men's interviews, blame was squarely placed on the woman's shoulders.

Johnny: Jane, to me, Jane has just gotta low sex drive anyway.

Researcher: *Yeah and it's not got..., nothing to do with what, what else is happening?*

Johnny: No. (Lines 157-61)

However, in David's interviews blame seemed to be used as a psychological defence against vulnerability. Often when the tone of his narrative was sad and he was discussing his sexual losses, guilt or self-doubt, David would switch to blaming or criticising Lauren:

David: Yeah, I think so. Yeah, there are so many, sort of levels that I feel that, that maybe this is what makes me feel guilty. Maybe she doesn't want to have sex at all.

Researcher: *Yeah, so you think...?*

David: Sometimes yeah. Maybe she doesn't enjoy it. Don't know. I mean I don't nec-. Yeah She's not particularly dominant either. She's not that way so she has to accept it and get on with it, you know, on whole level of ways. (Lines 209-18)

Similarly in the following excerpt David moved from feeling self-blame to defiance:

David: ... I'm bisexual, I'm not straight, um, I'm not a sort of, you know, the manliest man or, you know, maybe I'm not Lauren's ideal you know. Maybe I don't give her the right signals that, you know, make her feel attracted, or I dunno ...

Researcher: *It makes you feel perhaps there's something in you?*

David: Maybe, um, yeah, on that level I don't care because that's not who I am, that's who I am. Probably if I changed. We are what we are and you're either attracted or you're not, that's, at the end of the day. (Lines 138-47)

It is speculated that feelings aroused by Lauren's low desire for sex, such as rejection or low self-esteem, were too painful to bear and so David switched to an anger mode, blaming his partner for making him feel vulnerable.

The use of blame to switch narratives will be discussed further in the Discussion section.

Communication - Different song sheets and destructive styles.

The theme of communication came up strongly across three of the four couple interviews (Lauren and David, Sue and Steve, Mandy and Nick). Research has found that one of the most common presenting problems of couples in relationship distress is communication difficulties (Geiss and O'Leary, 1981). In analysing the interviews some quite striking characteristics of communication emerged within couples where there is low sexual desire.

The first question addressed to both women and men asked for the story of the low sex drive, with a beginning, middle and end. In analysis a remarkable variation in responses was found between the men and women. All the women answered this question with much contextual detail around the reasons behind their sexual difficulties: for example, tiredness, illness and overwork featured in practically all their stories. This is unsurprising as the women have the most knowledge of their story within the dyad. The men's responses generally reflected little recognition of the impact ongoing pressures of life may have had on their partners - with the exception of the immediate consequences of childbirth. This lack of acknowledgement of their partner's situation is exemplified in the following quotes.

David answered the invitation to recount the history by diverting quickly onto the effects Lauren's low sex drive had on him:

David: It's erm, it never used to be that low, but it's never been high, the thing about she never erm, it's nearly always me that's been the instigator and that was very, that's really frustrating, it was quite, it's quite, emotionally it's quite upsetting. (Lines 38-41)

Johnny's answer was to give a frequency count of how often he gets sexual intercourse:

Johnny: Erm, day after day...as time's gone on, erm, less interested on her behalf not on my behalf, on Jane's behalf. And, erm, I would say the last three, four years once a month if I'm lucky sometimes. (Lines 16-9)

Steve's story reflected a similar lack of shared narrative of Sue's struggles with life and sex. Nick gave a factual account that matched Mandy's timeline of how her sex drive had changed. However, while it was factual with regard to

dates, it reflected no appreciation of the stress and emotional journey Mandy had been on. This disparity of narratives evidences a lack of shared narrative between the couple as to the provenance of the low sexual desire.

Evidence of lack of communication emerged from three of the women who spoke of not verbally communicating their lack of interest or enjoyment. Lauren and Sue did not give reasons for their lack of openness, while Mandy explained not talking to Nick was because she did not understand why she was feeling low sexual desire:

Mandy: I suppose I kept a lot hidden but not deliberately because I kind of didn't know, I was a bit confused I didn't really see things so clear, (Lines 287-9)

This comment from Mandy aligned with her comment to me that she could not have spoken to me six months ago due to confusion about her situation.

In addition to the lack of a shared narrative and lack of communication, another noticeable characteristic of communication in the interviews is that of less-than-ideal communication styles and behaviours (Christensen & Shenk, 1991). There were signs of a passive communication style or behaviour in most of the participants (Lauren, Johnny, Sue, Mandy and Nick) while David and Steve showed more aggressive qualities.

Nick and Johnny displayed passive conversational styles as they both talked little. When they did talk, they used vague, non-committal communication and required much drawing out to elicit responses:

Nick: ... but I'm not a very good talk... I keep things to myself generally. (Lines 194-5)

Lauren, Sue and Mandy spoke of passive-style behaviours such as self-sacrifice and having sex for others:

Lauren: I don't, I don't particularly enjoy having sex. [*Slow, hesitant tone*]

Researcher: Yeah. So it's not what you want to be doing?

Lauren: Not, not particularly. I'm, I'm ok once I get going, but I, I'd go without it permanently probably, although I do it for my husband... ..to keep our relationship going. (Lines 56-63)

Lauren: Erm (pause) and I know some women would say, oh you should just stand up and tell him to, you know, if you don't wanna do it, you don't, don't do it, but I, I'm in a relationship with my husband. My husband has sexual needs and I feel that I should please him (Lines 583-7)

Sue: Yeah, I'm there physically but I'm not there in my mind, erm, like I still sometimes feel scarred and, you know, as a woman physically, erm, and sometimes, you know, I only make love with Steve because I know it's something he needs. (Lines 113-6)

Sue: I mean those earlier relationships that I was in, erm, I only had sex because they wanted to have sex [*low voice*]. I didn't particularly enjoy it. (Lines 152-5)

Mandy: because I suppose in a way I thought that I was... because I wanted to do the absolute best I could for everybody and I just, I suppose I was just being selfless (Lines 113-5)

Mandy: I've got quite a lot of empathy, um, and I do tend to put others first a lot of the time before me. Um, yeah so I'm not... I'm quite selfless. (Lines 172-4)

David, Jane and Steve displayed aggressive styles, such as constant criticism and disrespect of others, in their interviews. David was very critical of his wife throughout his interview: in response to a question about finding three words that described his wife, he took a pause of nearly 40 seconds before giving mostly derogatory descriptors. Communication styles that are passive or aggressive are generally agreed not to be very effective in relationships (Christensen & Shenk, 1991). This is covered further in the Discussion section.

Men-only themes ♂ :

Importance of sex - Entitlement and conflation. ♂

The centrality of sex was a major theme in three out of four men's interviews. David and Steve, in particular, spent a large portion of their interviews recounting what sex gave to them and, therefore, what they lost when sex was not part of the relationship. Behind the messages of the importance of sex were some strong themes of entitlement to sex in a relationship.

David described sex as giving him intimacy and connectivity. He also cited how the loss of his wife instigating sex and his always having to start the ball rolling made him feel insecure:

David: sex is still quite a large part of it. It's just part of any relationship. (Lines 50-1)

David: Yeah, because however much we like to think that we're above and beyond, you know, so ...it's...we just like that intimacy thing, touch and feel and some sort of connectivity. (Lines 86-8)

David: And it does upset me quite deeply that I have to instigate sex and I do like, I like someone that makes love to me as well as someone I'm making love to. And even I have to instigate to try and get her to make love to me. (Lines 353-7)

The use of 'even' in the last sentence in the excerpt above demonstrates how David feels aggrieved that his wife does not seduce him and suggested an undercurrent of entitlement. Next David described sex as the underpinnings of a relationship:

David: Um, but even you know, if you have a relationship very much based on, you know, personality and your interests, and your aims and objectives and goals and what you want in life, it's still, you know, part of your sub conscious expectations for a relationship. Sex is its underpinnings. (Lines 389-94).

This centrality of sex to the relationship was the main theme in Steve's interview:

Steve: Oh it is yeah coz you can get to the point of no return, and then what, like? Then either one or the other is going to think, I miss this, I need this and you're not supplying it and...If it's not happening here, it can happen over there somewhere and that's the ruination of half, of most relationships I think. Like I said it's not the key element in any relationship, but it is a key part. So ...I do believe that. (Lines 220-6)

In the same vein, Nick had left his relationship when Mandy had no interest in sex, as he felt it was no longer a loving relationship:

Nick: Because of having... not having a sex life then affected the way you know how much affection we were showing to each other and then it was basically nothing so we did literally er, well we lived in the same house but didn't touch or talk much or anything so yeah it did feel like housemates. (Lines 167-71)

It can be seen in the quotes above that the men were equating sex with love, a conflation which will be addressed in the Discussion.

Doubt - Eroding self-confidence and corroding the relationship foundation. ♂

Themes of doubt covering self-doubt, doubting the relationship and doubts about their partner, percolated through all the men's interviews. Nick was the participant who suffered most from doubt and his interview illustrated the many elements of doubt that low desire for sex can evoke:

Nick: ...it did make me question whether she loved me at one point (Line 44)

Nick: I wasn't showing her much affection and because I was doubting myself I was doubting the way she felt for me...(Lines 95-6)

Nick: ... it's a whole range of things that... it does to you, it makes you doubt your trust in that person, you doubt their trust in you, um so it makes you question whether they love you... er... and it causes problems the other way as well because I mean... you know Mandy accused me of having affairs because she said you know I don't do anything for you... (Lines 398-403)

Nick: ...when we'd split, not that I was looking for anybody but I was always, I was thinking myself I'm never going to find anyone now because if my wife didn't want me who's going to ever want me now...(Lines 464-7)

In Nick's accounts, doubt arising from a low-sex relationship ate away at male self-confidence. Nick's final line above echoed feelings of profound rejection. The losses for men seemed to those of a deep level of affirmation and a seal of certainty of their partner's love. Once the seeds of doubt were sown there was evidence of the men conflating sex with love i.e. where there is no sex there can be no love. Hence sexual doubt led to insecurity about the whole relationship:

David: Yeah that sometimes it's hard. Sometimes I wonder what the basis, what the real relationship is about [Pause] or you know if I'd done something wrong maybe, you expect it. (Lines 127-31)

The presence of both doubt and blame in the men's narratives may appear conflicting: even though the man can blame the women for lack of interest, her behaviour begs the question whether the man might, himself, have done something wrong. Doubt can also be followed by blame as a defence, as was shown in a previous theme, and is further illustrated a few lines on from the above excerpt, where David blamed his wife for not telling him if this is so:

David: I don't know. I, yeah, don't know if there is a breakdown in our relationship in that way. There could be. But then I expect Lauren to say something. (Lines 132-4)

The presence of doubt in the men's interviews can be viewed as a consequence of the conflation the men made between sex and love in the previous theme. If there is no sex, there can be no love, and if there is no love, then self-doubt and loss of self-confidence can occur. The first half of the adage: "Men need to have sex in order to feel loved and women need to feel loved in order to have sex" (unattributed), was demonstrated in these interviews.

Women-only themes ♀:

Causes - Reasons to be sex-less. ♀

As a direct counterpoint to the men-only theme of the central importance of sex, all four women made clear that sex was of little importance or enjoyment to them. All talked of being stressed, over-burdened and tired, and these being prime causes for their low desire. Lauren spoke below about how sex was another item on her list of things to do for others:

Lauren: I don't, I don't particularly enjoy having sex.

Researcher: Yeah. So it's not what you want to be doing?

Lauren: Not, not particularly. I'm, I'm ok once I get going, but I, I'd go without it permanently probably, although I do it for my husband...(Lines 56-61)

The concurrence of over-responsibility and lack of sexual desire was evident in Mandy's narrative:

Mandy: No the only thing I can put it down to is the fact that I've now got a child and it was that factor that, because I'm like I am worrying about everybody, um, then having a child then having so many more responsibilities to juggle and feel responsible for solely responsible for, that that's what really affected me (Lines 449-53)

Sue also recounted how her resentment for Steve occurred simultaneously with the onset of fear and depression when she "got into a complete panic" about her imagined future caring for her profoundly disabled son:

Sue: Two months ago I went to talk to my GP and said 'I can't stop thinking', everything was getting like I hated Steve, you know, I was going into a complete panic about my son [son's name] who's almost 14, he's starting to develop now and I got into a complete panic...I thought I don't want to be looking after an adult...you know and I got into a complete fit about that. (Lines 385-91)

Sue spoke here of resentment with Steve when he visited at weekends at the time of her anxiety about her son:

Sue: ...so the first thing that kind of started for me, happening for me was I became resentful of him coming up at the weekends and in my mind like landing for the ride and heading off again, and I started to resent him. And I felt kind of a bit like a piece of meat I suppose, that was one of the things that was going on in my head and so I kind of [unclear] my lack of interest and so some weekends he'd come over and we wouldn't have any, er, sexual relations (Lines 77-84)

It would seem from both Mandy and Sue's narratives that sexual desire waned when anxiety, fear and excessive ♀ responsibility overwhelmed them. In

these cases the flagging of sexual desire could be read as a signal of distress. However, if the man greeted the lack of sexual desire with a lack of loving understanding or empathy, the woman may feel anger at this lack of support.

One school of thought asserts that a low interest in sex can be a form of non-verbal communication of passive anger (Giurguis, 1991; Meyer, 2013). An instance of this can be found in Jane's interview when she suggests in the following excerpt that a "moany" husband leads to her withholding sex:

Jane: So I [sigh] I do think, aah, poor Johnny, but he shouldn't be moany and miserable should he? He should be nice. [*Laughing*] And then he might get it offered a bit more. (Lines 275-8)

The narrative method gives added information by looking at *how* the women argue their position. All the women placed children and work as first in the hierarchy of where their energy and effort was currently focussed. By positioning sex as a demand made of them when they were already tired in the service of "higher" values such as children, the women were placing themselves on the moral high ground. This is illustrated by Jane as she explains how other things in her life, such as sleep, were more important:

Jane: ... I think it's important to have sex with your partner, erm, I do think it helps, erm, your relationship but [sigh] I kind of do think that, but then I think well, erm, my parents being alive, and my kids being healthy are more important than that. I know it is a big thing and it is important and it's important in his life more than it is in mine so I should really ...so I should really try more, but I kind of sometimes think I'm too tired, other things matter more than that. (Lines 190-98)

Abnormality - There is something wrong with me. ♀

Different themes of abnormality ran through the women's interviews. The women used various sources for social comparison – their mothers, friends and the media. Their worries about being abnormal when comparing themselves to media messages about sex in relationships are exemplified in the following passages:

Lauren: [*long pause*] I suppose I, I do wonder whether there's something wrong with me, whether there's something wrong with the chemicals in my brain or my body, erm, that's not functioning how it should. (Lines 182-5)

Sue: Yes, yeah, because sometimes I do wonder like, you know, is there something wrong with me.. Really let's face it. As I said I've discovered as I've got older that it is a very important part of a relationship and it should be good for both people, (Lines 454-7)

In order to check this supposed abnormality, both Lauren and Sue reported talking to their friends. Sue had spoken to five friends and of these only one enjoyed sex. However, Sue did not believe the evidence of her own circle above messages from the media and advertising:

Sue: It has a detrimental effect on a relationship. But I have to say it has a bad effect on oneself like, you don't feel good when ...coz the world is full of advertising 'n stuff about these great relationships and couples and sex and mighty stuff. If you don't have that, then you do feel different like, you're not the same as everyone else. (Line 481-5)

Mandy spoke of how she wished she could be "normal" and get on with it like everyone else. Hence there is a canonical assumption around normality that everyone is having regular, uncomplicated sex:

Mandy: Yeah and a bit boring and I suppose jealous of other women as well, it made me feel a little bit that way. I'd look and think 'Oh I wish I could just get on with it like everybody else' I suppose but I mean obviously I don't know what their home life or what goes on in their house but I'd look and think I just wish I could be normal I suppose. (Lines 242-7)

In addition to feeling abnormal, there were other negative effects on the women's self-concept arising from a low sex drive. Mandy described how it made her feel prudish, old before her time and boring; she reiterated she could not have talked to me before therapy because the topic made her too uncomfortable. Such discomfort is suggestive of shame, which was also noted in Sue's interview when she conveyed to me in whispers the fact that she did not, and had never had, a sexual appetite. Her whispered tone was suggestive of a shameful secret and a silenced sexuality.

Destabilising the narrative

The final stage of the analysis is where the narratives are subjected to critique from the hermeneutic of Tiefer's (2004a) feminist, social constructionist

perspective. The interviews were reviewed for evidence of pathologisation of normal variation and a man-centred view about sexuality.

Pathologisation of normal variation.

Tiefer (2004a) argues that the biomedical health model for sexual desire introduces assumptions of normal versus abnormal levels of drive, and that it is incorrect to pathologise what might be a normal variation in women's lives. As can be seen from the women's theme of 'Abnormality - There is something wrong with me', described previously, there is an underlying fear that low libido indicates abnormality. All the women described having a satisfactory level of desire before the occurrence of major changes to their lives, such as the arrival of children. Two women had children who imposed high demands on them due to their special needs. All women interviewees described having a heavy workload. It is an accepted stereotype for a highly-stressed, hard-working male executive to say that he does not have the energy for sex (Aschka, Himmel, Ittner & Kochen, 2001). Yet, none of the women - apart from Jane - chose narratives that asserted a right to be where they were in their sexual lives. Mandy had only realised the impact of workload and over-responsibility on her libido following therapy. Tiefer's point of not separating sex-drive from the context of women's lives is shown to full effect in these interviews. Each woman had apparently valid reasons for suffering from low libido, yet the majority spent time wondering why they were different. These findings, combined with Tiefer's views on asserting the normality of women's experiences, suggest that re-assuring women of normalcy would have stand-alone therapeutic benefit. A possible reason for the women's self-pathologisation emerges when considering gendered power relations; this is examined in the Discussion.

Man-centred views about sexuality.

As described earlier in the Literature review section, there has been a tendency to regard a male model of sexuality as standard. The men's theme of 'Importance of sex - Entitlement and conflation' certainly displayed this tendency with the men's interviews subscribing to this notion of entitlement.

The excerpt below from Steve showed he feels that men will be bad-tempered if they are “not getting any”:

Steve: Yeah and it also it takes away any tension that you have. I mean let’s face it, after sex, if it’s decent sex, well me anyway and most men...are going to say, and then they’re far more relaxed, and they’re far more into their partner than they were. I mean if you’re not getting any, as they say, I mean you’re not going to be the happy camper. You’re going to be sulking in the corner or something, like, and the slightest little thing, it’s like ‘what?’ (*In louder, irritable voice*)

When the men described what lack of sex did to them, a pervading view was that man’s need for sex trumped women’s lack of desire.

Further, there was an underlying tendency for the men to feel aggrieved that the women’s sex drives had changed, when their expectation was female libido should remain constant. Male sex drives are more fixed (Baumeister, 2000) and any female variation was viewed with suspicion. Both David and Steve appeared unhappy when my interview questions asked about their partner’s low desire for sex. This was despite their partners having self-reported low libido. The following quote was from David when I asked him to tell me the story of Lauren’s low sex drive:

David: Yeah, this is the thing, I never realised that she had a low sex drive, we used to have, she used to have a really high sex drive, or maybe she didn’t, and when we were first together she was more, you know, more accommodating than maybe she wanted to be, I don’t know, if you see what I mean, erm (Lines 25-30)

The above quote showed some confusion as David seemed to struggle with the concept that Lauren’s libido was once high. If it was low now, he suggested that she was pretending before (being ‘more accommodating’). There seemed to be an underlying assumption that her drive should be constant – either low or high – which is a more male model (Baumeister, 2000).

Discussion

Overview of section

In this section, the findings of the study will be summarised, reviewed and explored in the light of existing literature. The relevance of the findings will be considered in the context of clinical practice in general and counselling psychology in particular. The study will be critically evaluated, looking at its limitations with suggestions for possible improvements and for future research directions. The section will end with reflections and conclusions.

Summary or synthesis of results

Participant summary.

The four couples interviewed in this study are all white, from the British Isles and relatively young (the oldest is 45). They have been together for at least eight years. All of the couples live with children.

Themes, identity work and feminist critique summary.

The findings of this paper are summarised in the box below. Each of these findings will next be discussed separately with regard to existing literature.

Source	Themes
Common across couples	Blame - As a defence against vulnerability Communication - Different song sheets and destructive styles
Men only	Importance of Sex - Entitlement and conflation Doubt - Eroding self-confidence and corroding the relationship foundation
Women only	Causes - Reasons to be sex-less Abnormality - There is something wrong with me
	Identity Work
Men	Victim
Women	Self-sacrificing heroine
	Critique with Tiefer
	Pathologisation with regard to normal variation
	Male-centred views about sexuality

Table 2: Summary of main findings

Review with regard to literature and suggestions for therapeutic application

In this section, the findings will be reviewed in the light of the existing body of relevant literature. As the focus of this paper (please see research question and aim in the Literature review section) is both on findings and the application of these findings to therapy, each sub-section includes a consideration of how the findings may influence a therapeutic endeavour.

Blame - As a defence against vulnerability.

A study by Kelly, Strassberg and Turner (2006), which carried out behavioural assessments of couples' communication where female orgasmic disorder was present, found similar findings to this study on the prevalence of blame within couples. It found that women with orgasmic disorder and their partners demonstrated more blame and less receptivity than their counterparts in a problem-free or chronic illness control group. In the study, blame was defined as the assignment of responsibility. Receptivity was coded as listening behaviours such as attentiveness and acknowledgement of their partner's view point.

In the current research a noteworthy aspect is the difference in blame between the men's and women's interviews. Women chiefly blamed external, situational factors such as workload, children or their partner, with some speculation about "internal" blame (for example, am I normal?). Men largely blamed the women, without much consideration of their situation (apart from presence of children). This male pattern of blaming shows evidence of the fundamental attribution error (FAE), which is a tendency to underestimate the influence of situational factors and overestimate the impact of dispositional factors (Heider, 1958). It also reflects Jones and Nisbett's (1971) actor/observer bias, wherein the actors (women) attribute their behaviour to situational forces and constraints. Meanwhile the observers (men in this case) attribute the same behaviour to the women actors' personalities (for example, Mandy's over-responsibility).

These theories of the FAE and the actor/observer effect have their epistemological bases in cognitive social psychology. Readers may question their place in a study that favours a phenomenological approach. Langdrige and Butt (2004) have written about the FAE from a phenomenological perspective. In simple terms they suggest it does not matter whether a person is right or wrong, biased or not, in their perception of the world. What matters is that our focus should be on the world as it appears to that person. When applying this phenomenological filter to the participants in this study, it is important to understand the men's and women's worlds. Pointing the finger of blame at other people or factors in their lives, can signify that neither party is taking responsibility for change in order to improve the situation.

It was further noted in the results section that one interviewee (David) showed a marked tendency to switch to blame whenever he expressed vulnerability. This feature of behaviour could be interpreted expressing a fight-or-flight reaction in response to the threat of vulnerability involved in perceived rejection by a close partner.

Application to therapy: Couples arriving in the therapy room with a conviction that someone else is to blame and that the solution is for that person to change their ways, can cause problems. It was seen in this study that Nick was unhappy and disengaged from therapy when he felt he was unfairly blamed for difficulties in his relationship. To reduce these blaming tendencies in a therapeutic context, Weeks and Treat (2001) recommend using reframing, a technique helping couples move from linear, blaming statements to more circular ones where the interaction of both parties is acknowledged.

Communication - Different song sheets and destructive styles.

As described in the Results section, interesting characteristics of communication were discernible in the interviews. First, the lack of acknowledgement of the women's story in the men's responses was noted and linked to women not communicating verbally to the men the extent of their disinterest or enjoyment. This finding is supported by research conducted by

Træen and Sogerbø in 2009. Using questionnaires in a study of 398 heterosexual couples, they found that, amongst women with mildly reduced sexual desire, there was a lack of communication with their partners about their own sexual needs. An alternative explanation for lack of appreciation of the woman's narrative is that communication between partners has occurred and there is a lack of acceptance of the others' point of view.

Application to therapy: The significant disparity of narratives between couple members, can be an indication of difficulty (White & Epston, 1990a). According to these family therapists and proponents of Narrative Therapy, couple therapy is likely to have a better outcome if the couple has a good shared understanding of, and agreement with, the problems to be tackled. Hence this indicates a need to work at the start of therapy towards achieving a shared narrative of the problem. Narrative Therapy encourages people to extend their initial "problem-saturated account" (White & Epston, 1990b, p.39) in order to incorporate "a wider perspective on the problem and on the person's self-view" (Payne, 2010, p. 19). A common technique used in Narrative Therapy is that of externalising the problem, which involves implicitly separating it from the self-identities of the couple (Freedman & Combs, 2008; Payne, 2010). This has the advantage of distancing the problem and establishing that "rather than *being* the problem, the ... couple has a *relationship* with the problem" (Freedman & Combs, 2008, p. 238). This can facilitate tackling blame and set the stage for a more holistic approach to the problem.

A second main finding under the theme of communication was that of unhelpful communication styles and behaviours. A passive communication style or behaviour was noted in five of the participants (three women, two men), while two men displayed aggressive qualities. In the field of couple and relationship studies, research has shown that a difference between partners in desired levels of intimacy can be a factor in development of problematic demand-withdraw communication (Christensen & Heavey, 1990). This pattern is one where one partner blames or pressures while the other withdraws into passive inaction (Christensen 1987, 1988). A consistent finding is that of gender differentiation with women in the demanding role and men in the withdrawing position

(Eldridge, Sevier, Jones, Atkins & Christensen, 2007). There was no opportunity in this study to observe couple communication as interviews were conducted separately. However, as the majority of women reflected passive behaviour in their accounts, it could be conjectured that a male demand-female withdraw dynamic may operate within these relationships. In addition, the act of withholding sex by the women can be seen as a meta-communication of female avoidance. As there was no opportunity to assess couple demand-withdraw patterns in-situ, this is outside the scope of this study and could be the subject of further research.

Application to therapy: Previous studies have demonstrated that unhelpful communication patterns in a marriage are associated with lower marital quality and divorce (Christensen & Shenk, 1991; Gottman, Murray, Swanson, Tyson, & Swanson, 2002). The current study indicates that communication difficulties are a likely feature of couples presenting with low women's desire. Therefore, the therapist needs to have strategies with which to address these difficulties.

Importance of sex - Entitlement and conflation.

The criticality of sex was a major theme in the men's interviews. It was of interest that the men did not talk about any physical effects of a lack of sex. Instead they dwelled on other, more psychological, losses such as effects on mood, unhappiness, doubt and lacking the feeling of being seduced. These psychological losses have been discussed in Wexler's *Men in Therapy* (2009). Dr. David Wexler has written many books on men's mental health and has received the Practitioner of the Year award from the Society for the Psychological Study of Men and Masculinity, a division of the American Psychological Association. Wexler writes of the importance of sex to men on levels apart from the physical, and says that sex "is for so many men, the profoundly deep, rich, and affirming experience of being desired" (p. 37).

Often going hand-in-hand with the message of the importance of sex for men, was a message of entitlement to sex. This was strongly verbally communicated by two participants (David and Steve), and was physically played out by Nick, who left his relationship for some months when sexual relations had ceased. If

ferent entitlement feelings are met with resistance from the women, it can precipitate feelings of distress in the men. This is an area where the *DSM-5* (American Psychiatric Association, 2013) diagnosis for FSI/AD does not capture the full extent of the distress in the relationship because the diagnosis concentrates mainly on the individual presenting patient's distress (Criterion C). For example, in this study Lauren reported feeling little or no distress about her low desire for sex, whereas David felt her loss of interest keenly. From the viewpoint of an FSI/AD diagnosis, Lauren's stating that she suffered no distress, would result in a non-diagnosis of low sexual desire. However, this ignores the distress present in David's account.

A further interesting facet of this theme is that in those couples where men's entitlement was a significant feature, their partners worried most about abnormality. This finding underscores the importance of looking at a problem in the relational context in which it has arisen.

Application to therapy: There is a disconnect between a medical, *DSM*-driven, focus on an individual and a therapeutic focus on the couple. The findings above, which show David's distress and the juxtaposition of men's entitlement with women's anxiety about normality, highlight the value of looking at the system, not just an individual, when examining this sexual problem. This is where approaches, such as the *DSM* or the pharmaceutical industry (Nappi et al., 2010), which view human difficulty as located within an individual, can be seen to be merely scratching the surface of that difficulty. The question could be asked whether there is much relevance in discussing low sexual desire without taking into account the context of the individual and the presence of the other partner (where one exists). By largely ignoring a person's relational context, the *DSM* can drive individuals to look within themselves for solutions. A *DSM* approach can promote an implicit expectation that the individual should be able to work out their problem with a hidden assumption of a backdrop of a neutral, benign relationship. While it might be the case for some individuals, this study has found that the relationship itself can be an environment of blame, difficult communication and doubt, and might not be robust enough to support an individual through potentially difficult change. As a profession, counselling

psychology has driven to include context in therapeutic practice (Orlans & van Scoyoc, 2009). Such a systemic approach is vindicated by these findings, which indicate that both the partner and the relationship can be the source of some distress, and must also be considered if they are to be the crucible of change.

The presence of strong entitlement feelings in both David and Steve's interviews was especially interesting when set beside the fact that both their partners said they continued to have sex purely for their partner's sake. This suggests that both women were complying with their partners' entitlement demands, and responding to a sexual script or discourse that implies that women are obliged to have sex once in a committed relationship. This finding aligns those from Træen and Sogerbø (2009) who found that two out of three women with general and distressing reduced sexual desire reported having had obligatory sex (i.e., sex which the woman feels obliged to provide, without internal motivation). The entitlement may ensure that the men have sex, but if this is 'obligatory' sex the long-term effects of this on the relationship are uncertain.

Application to therapy: The findings of entitlement and obligatory sex bring to the forefront issues of gendered power. The men felt entitled to assert their right to sex, and the women (apart from Jane) complied. This is discussed later in the section Critique from a feminist perspective, with reference to addressing power differentials in the therapeutic arena.

A second finding was the conflation of sex with love in the men's accounts. The general tenor of most of the men's interviews was that if the woman did not wish to have sex, the relationship was no longer a loving one. Lack of sexual interest on the part of the woman indicated a movement from loved one to mere housemate for Steve and Nick. This love/sex conflation contrasts with research carried out by Weis and Slosnerick (1981) who found that undergraduate men dissociated sex and love. Beck, Bozman and Qualtrough (1991) found a similar lack of correlation between sexual desire and love in both men and women college students. However, both these studies used samples of college students with an average age of 22.7 and 26.8 years respectively, who may have exhibited more promiscuous behaviour than the more established couples studied in this research. Further, both the above studies asked

participants about their own behaviour, whereas in my research, the men were commenting on how the behaviour of their spouse or long-term partner made them feel. Once again, as noted in the earlier citing of the actor/observer effect, understanding one's own motivation and underlying feelings and speculating on those of another appear to show marked dissimilarities.

Application to therapy: The presence of conflation of love and sex in the minds of the men suggests this is an area which therapy should consider broaching if it seems an issue. Asking men, and women, to talk about the meaning that withholding of sex has for them may open a useful discussion between the couple. And thus, counselling psychology, with its focus on subjectivity, presents a helpful approach: the profession emphasises the importance of asking questions such as “what does lack of sex mean to you?” As this research illustrates, sex means different things to different people (Paul, 2012), and therefore, practitioners should beware of relying on their own assumptions.

Doubt - Eroding self-confidence and corroding the relationship foundation.

Loss of confidence in oneself, the relationship and partner was the final major theme noted in the men's interviews. This was especially evident with Nick, who suffered from depression before his mid-marriage separation from Mandy. The lack of sex or female desire meant that the men doubted their partner's love, undermined trust and engendered self-doubt. These feelings of insecurity are consistent with writing by Tiefer which says: “Far more than is popularly realized, sexual activity is the means to gain or maintain important psychological feelings, and a challenge to one's sexuality is often a personal threat. Self-esteem, closeness, feelings of competence and well-being – these are the feelings sought from sex during modern times” (p.7, 2004b).

A search for other literature into male doubt and female sexual dysfunction produced little of relevance. Some parallels can be drawn between the situation of men living with women's low sexual desire, and women who live with men's erectile dysfunction in that they both live with a lack of sexual fulfilment. Research on women living with partner's erectile dysfunction talks about self-

doubt and some reduction in self-esteem experienced by the women partners (Conaglen & Conaglen, 2008; McCabe, Conaglen, Conaglen & O'Connor, 2010).

Application to therapy: Doubt can erode the very foundation of a relationship as it may lead to mistrust of a partner. Therapy can provide a safe and relatively neutral arena for doubts to be aired and discussed. The therapist needs to be aware that sexual dysfunction has the potential to sow seeds of doubt which threaten the very fabric and foundation of the relationship. It has been argued that the treatment of low sexual desire has been adversely affected by the fragmentation of therapy into different factions dealing with sexual, family or marital issues separately (Weeks, 2004). The presence of doubt in low sexual desire relationships underlines the need for a systemic approach to dealing with the many-headed hydra this difficulty can represent. A fragile relationship may need addressing before any work on sexual intimacy can begin.

Causes - Reasons to be sex-less.

All of the women in this study reported having satisfactory levels of sex at the beginning of their current relationships. They tried to pinpoint when desire declined which, for all of them, appeared to happen at times when they were over-burdened or anxious. Just as one would not expect a tired or stressed animal to perform sexually, it is reasonable that desire flags in these conditions (Aschka, Himmel, Ittner & Kochen, 2001). However, other factors that have a known effect on sexual desire were described in their accounts, including previous abusive partners, negative messages about sex from family of origin, gynaecological problems and conflict in their current relationships. These findings of multiple possible causes of low desire can be a typical feature of this problem (Sims & Meana, 2010). Numerous clinical practitioners such as Weeks, Hertlein and Gambescia (2009) write that HSDD can be caused by any number of bio-psycho-social factors. They say, for example, that sources of low desire for sex can often be a combination of elements such as relationship issues and an individual's beliefs about sexual intimacy.

Application to therapy: The presence of possible multiple sources of low desire points to the need for a therapist to be multi-skilled in a number of different

areas. For example, the therapist should have knowledge of possible organic or physical causes, and have the professional awareness to refer onwards where appropriate. The ideal therapist should also be able to assess and address individual family of origin issues, couple and sexual issues. The area is further complicated by the fact that low desire for sex can co-occur with problems such as anxiety, abuse or depression (Weeks, Hertlein & Gambescia, 2009). The current study has highlighted the impact of the couple aspect of the problem – for example it has illuminated blame, communication difficulties, and men’s entitlement and women’s uncertainty. With such prevalent inter-relational dynamics, systemic approaches provide techniques to conceptualise and address unhelpful interactional patterns.

The narrative method facilitated an examination of the way in which the women argued their case for not having sex. It was noted that they tended to place their reasons for not having sex, such as fatigue from children or paid work, as more important than their partner’s need for sex. There was a tendency to suggest that their tiredness trumped male need. This contrasts with the aforementioned men’s view that the men’s need for sex trumped women’s lack of desire.

Application to therapy: This type of impasse can be presented to a therapist by a couple with an expectation that the therapist will operate as a referee and declare a winner. A helpful technique in couples’ therapy (Guirguis, 1991) is for the therapist to set forth at the start of therapy the concept that the patient is the relationship, not the individual. This helps move the focus from two individuals entrenched in opposing conflicting positions, to a couple looking at a shared project. A discussion on treatment goals is imperative in this situation of conflict where the woman may be seen as the symptomatic partner and, therefore, the one who has to make changes, while the man can perceive himself as a mere bystander in therapy - a viewpoint which was put forward by Steve in his interview. Also in their book on *Systemic Sex Therapy*, Weeks, Hertlein and Gambescia state that “the fundamental goal of treatment is to restore sexual desire” (p.94, 2009). However, in this research, sex was no longer of primary importance to the women participants. It is, therefore, critical the woman feels

that the treatment goals represent a win-win situation, with advantages for her beyond possible increased sex. Increased sex can feel to the woman as if her needs are being subjugated in order to privilege her partner's needs. A counselling psychology framework which does not adopt a 'cookie-cutter' approach to individuals or impose a prescriptive view as to what should be the universal aim of therapy, is of benefit here, where it seems that an open discussion as to treatment goals is crucial.

Abnormality - There is something wrong with me.

The results showed that while the women participants wondered about possible causes of their low sex drive, they also engaged in thinking about how the condition made them feel. One recurring theme was whether they were normal. Despite evidence from their peers and close relatives that low libido is very common, they tended to take cues from the media and their men partners and judged themselves to be abnormal. In this way, the actual problem of low sexual desire is compounded by discursive and relational influences. The finding of a self-concept of abnormality is consistent with those of Hinchliff, Gott and Wylie (2009) who found that women's sexual desire loss led to feelings of abnormality. In their qualitative, thematically-analysed paper (previously covered in the Literature review) there was a discussion of the women's sense of isolation. Not wishing to disclose their situation to friends, family or work colleagues, due to their sense of feeling different, suggests a sense of shame in being different. Traces of shame were also found in the women's interviews in this current study. For example, Sue's tone dropped to a whisper when she disclosed her complete lack of sexual appetite. This finding of shame can be compared with findings from Katz (1996) who conducted a qualitative study investigating women's subjective experience of vulvar pain. Vulvar pain is experienced by some women during penetrative sex and can lead to avoidance of intercourse. Katz found that her participants spoke of isolation, feelings of inadequacy and shame.

Application to therapy: As was proposed earlier in the Results section on destabilising the narrative, normalisation of the woman's experience can have stand-alone therapeutic benefit. Use can be made of the prevalence studies given

in the epidemiology section to point out how common the experience of female low sexual desire can be.

Identity work.

The most common and predominant roles were found to be the men's role of victim and the women's role of self-sacrificing heroine. It is worth considering how these subject positions may have an impact on a therapy situation. If the man feels like a victim of women's low sexual desire with most blame attached to his partner, this can lead to his feeling that the problem and solution is completely in his partner's court. This is not a helpful position from which to start couple therapy. Similarly, if the woman already feels over-burdened and self-sacrificing, there may be little motivation to give more sex to the man. These positions can result in a situation where the man bringing a reluctant-to-change woman to therapy, with an implicit demand to the therapist to 'sort out the woman's problem'.

Application to therapy: At the outset of therapy, the therapist would do well to consider and have strategies ready if the potentially thorny issues of disengagement or lack of motivation are noted. A previously noted strategy is to make the relationship the patient in couple therapy: this can defuse the feeling that the higher-desire partner is in the right and that all change will have to be carried out by the woman. With the relationship as the patient, the therapist can ask each partner how the relationship would have to be different in order to bring sexual activity to a satisfactory level for both. Therapy aims need to be carefully negotiated with no assumptions made about what constitutes a satisfactory level or with regard to whether coitus is the primary route to sexual satisfaction. Women also need to feel that the sole focus of therapy is not just about meeting the sexual requirements of the man. The needs of the woman should be equally centre stage. For example, in this study, the woman's needs may be non-sexual such as re-distributing the domestic work schedule, child-care or wage-earning load, so she does not feel overburdened.

Critique from a feminist perspective.

The final stage of the analysis was a critique of the narratives from Tiefer's (2004) feminist, social constructionist perspective. The interviews were reviewed for evidence of pathologisation of normal variation and man-centred views about sexuality.

Pathologisation of normal variation: Evidence of this was found in the women's narratives where they wondered if they were abnormal.

Application to therapy: Again, normalisation of women's experiences could be of therapeutic benefit. Another area where there is value in normalising the reduction in women's libido is that of men's doubt. As the men's theme on doubt showed, women's low libido precipitates a flood of men's doubt in the relationship, the partner and himself. If the man had knowledge that lowered female libido is not simply a rejection of himself, this may allow the couple more cognitive space in which analyse the real issues. However, as an addendum to this point, it is acknowledged that there are times when there *is* a rejection of the man involved in women's low libido. For example, Lauren's accounts that David's increasing cross-dressing and sexual proclivities had become turn-offs for her.

Man-centred views about sexuality: This was discussed in the light of findings of men's entitlement for sex and an expectation of consistency/constancy in the women's sex drive.

Application to therapy: It is suggested that exploration of beliefs men and women may have with regard to women's sex-drives could be of benefit. This could be followed by psycho-education concerning possible differences between male and female libido.

In this section, the themes of women's self-pathologisation and men's entitlement come together in stark contrast. The women's narratives reflected accommodating behaviour and silenced sexuality such as Lauren's continuation with obligatory sex and Sue's whispered disclosure of no sexual appetite. Why were the women's narratives suppressed? Why were the men, such as David,

able to state: “I don’t care....that’s who I am” or, in Steve’s case, to convince the women of their theory that sex is extremely important? In contrast, the women (apart from Jane) adopted a position of self-castigation. Looking at these findings from the viewpoint of gendered power relations gives a fresh perspective. A 2013 paper by Dickerson (a U.S.-based nationally acclaimed, widely published clinician who specialises in narrative work with couples), describes the influence of patriarchy as follows. “Men have ‘access’ to ways of being and performing that are closed to women. Likewise, this same patriarchy influences women to respond in defined ways, often accommodating and deferring to male interests (Hare-Mustin & Maracek, 1988) ...” (p.103). These hidden under-currents of “an unacknowledged pre-eminence of men’s priorities, needs and desires in ways that seem unquestionable or ordinary” (Knudson-Martin, 2013, p. 6) are visible beneath the surface of the interviews. The therapeutic practitioner needs to be mindful of such a power differential as research shows that power imbalances are damaging to intimate relationships (Beavers, 1985; Steil, 1997). Researchers such as Knudson-Martin (2013) have written on ways to address power disparities with couples.

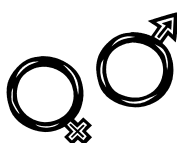
Summary of themes connected to therapeutic techniques.

To sum up, the discussion has connected findings from this research to therapeutic techniques that could help address their potential presence in a therapy scenario. The following table gives a précis of these connections.

Themes	Therapeutic Techniques
Blame Communication	Reframing Externalising the problem Communication training
Doubt Importance of sex: Entitlement and conflation	Systemic approach Systemic approach Discuss meaning of lack of sex to each individual
Causes Abnormality	Systemic approach View relationship as patient or client Normalisation; use of prevalence studies
Identity Work	
Victim	Lack of motivation to engage in therapy – relationship as patient or client.
Self-sacrificing heroine	Negotiation of mutually-satisfying goals
Critique with Tiefer	
Pathologisation with regard to normal variation	Normalisation
Male-centred views about sexuality	Discussion of differences between men and women's libido Awareness of possible gendered power differentials

Table 3: Summary of connection of themes with therapeutic techniques

The relevance of the findings will next be considered in the context of clinical practice in general and particularly in counselling psychology. The study will then be critically evaluated, looking at limitations of the research with suggestions for possible improvement and for future research directions. The section will end with reflections and conclusions.



Relevance of findings to general clinical practice and counselling psychology

This study has highlighted important considerations for clinical practice. As delineated throughout the previous section, each individual thematic and identity finding has potential implications within the therapy room. For example, the benefits of using a systemic approach and techniques such as normalisation of experience have been underscored a number of times. The final critique from a feminist perspective was used to bring to light pervading cultural and social notions that may lie hidden, but which could drive men and women's assumptions about therapeutic progress.

It is of interest to consider whether this study has particular applications to counselling psychology practice, as it has been carried out by a counselling psychology trainee. Values espoused by a counselling psychology approach were previously outlined in the Introduction: consideration of the impact of one's self in research and clinical practice, and adoption of practice to fit client needs through pluralistic practice. Taking the first of these values, self-reflection, this paper has fore-grounded and acknowledged where my background has driven the research. It has attempted to use this awareness to bracket my interests by seeking input and review from other professionals. There is a question whether counselling psychologists who traditionally adopt a practice of being reflective practitioners (Woolfe, 2012), can apply my research in their own practice. I found, in carrying out this research, that I was compelled to examine my own embedded cultural assumptions. For example, the topic of men's entitlement to sex within a committed relationship is a thorny one for me. My initial instincts were that this entitlement is a fact of life. The feminist position that men's sexual needs are not automatically given precedence is, in my eyes, challenging. Additionally, I have found when discussing my research with others, the notion that women without a sex drive are strange and need to be cured, appears widespread. My research suggests that assumptions about normal sex drives and positions about the primacy of men's sexual need are beliefs we all have a position on. These beliefs may have a direct effect on aims adopted in therapy. For example, Weeks, Hertlein and Gambescia (2009, p.94) state that in treatment of HSDD, a fundamental goal is to restore sexual desire. This position seems

prescriptive to me, as it makes global assumptions about people returning to some implicit, unarticulated, normative level of desire. My research points to the need for a reflective practitioner to examine these positions in order to engage more ethically with clients.

The second area where it could be argued that counselling psychological practice fits with this research, is in its adoption of a pluralistic approach. It can be seen throughout this paper that low sexual desire is a complex problem with many potential sources. The use of a one-size-fits-all approach such as sensate focus techniques is contra-indicated when factors such as family-of-origin attitudes, relationship conflict, issues with intimacy, unresolved anger, underlying mental health issues and so forth, may contribute to sexual difficulty. Training in counselling psychology, with its underlying humanistic, client-led core and non-alliance with one specific approach, seems a helpful tradition where client difficulty can lie in so many different areas. However, it is acknowledged that counselling psychology is not unique in respect of its broad church training and other disciplines share rigorous, multi-theoretical and varied training paths.

Methodological considerations and limitations of the current study

This section addresses epistemological and methodological reflexivity and leads on to observations on limitations of the study.

Epistemological reflexivity.

This section considers the assumptions that are implicitly built in to the research methodology chosen for this study. Willig (2008a) recommends questioning how the research question could have been investigated differently and to what extent this would have given rise to alternative understandings. CNA seeks to include an analysis grounded in phenomenology, while also attending to narrative aspects and, lastly, introducing a hermeneutic of suspicion. Alternate findings may have been arrived at if the study had used discourse analysis. A discursive approach would view the interview transcripts as a place for identifying the actions performed by the interviewee's words through analysing the language used. It would have looked at the interaction between the

interviews and analysed what subject positions the interviewees were adopting in order to construct identities within the interview. This would have led to speculation on the ways these identities are constructed in Western society. If the research had undertaken an IPA approach, the findings would have concentrated on a more nuanced explication of themes, with further penetration into the participants' experience.

The final step in CNA of introducing a critical phase is the one that makes it stand apart from most other phenomenological methods. The choice of critical social theory caused me most anxiety as a novice user of this method. Langdrige's recommendation that the chosen hermeneutic be teleological led me to the choice of Tiefer, whose theories opened up possibilities from a woman's point of view as she advocates a de-pathologising stance. However, it could be argued that this direction is a pro-female stance. As a reflexive researcher I acknowledge such a choice of social theory aligns with my feelings on the topic and suggests that further research could be undertaken using a different critical social theory. As a point of critique of other work that has used CNA (for example Langdrige, 2009; Mair, 2010), there is insufficient self-reflexivity on behalf of these researchers with regard to their chosen critical social theory.

The question can now be asked as to whether this method was suitable for the research aims of this study. The topic area of sexuality was shown in the Introduction to be especially sensitive to pervading social and cultural beliefs. This means that both the researcher and the participants are implanted in current social beliefs. The way CNA has allowed illumination of participants, researcher and social theory has acknowledged and allowed for this complexity. The method led to a rich understanding of couple's views about their situation. Use of feminist theory facilitated scrutiny of both the researcher's and participants' implicit assumptions. Such double scrutiny can be conceptualised as a mode of triangulation on the research data. The focus of the method on both personal reflexivity and critique from another perspective enabled the researcher to hold both an inward and an external viewpoint, which added rigour to the findings and a fresh perspective.

Methodological reflexivity.

This section will consider two aspects of methodological reflexivity, the first of which is a consideration of how the design of the study and the analysis method have ‘constructed’ the data and findings (Willig 2008b, pg 10). The second aspect will consider how the method was implemented in this study.

Use of a qualitative methodology, while ideal for exploratory questions such as posed in this study, has inherent limitations. The use of a small sample size means that the study does not make claims to generalisations about all couples’ experiences. Similarly, the recommendations made in the Discussion on therapeutic applications are not applicable in an unthinking, prescriptive manner, but should be subject to full consideration of each unique couple’s experiences and background. They are suggestions, rather than directives.

Implementation of the method in this particular study will now be considered. The use of a pilot study was a constructive learning experience as it highlighted the need for more preparation of the interviewees to answer the questions in a story-form (for example, not with ‘yes’ and ‘no’ answers). An additional question was added at the end, as a result of feedback from a pilot participant: “Do you feel like you have told me what it is like to live with someone who has low sexual desire?” This was because the pilot interviewee felt he had not fully imparted his experience in answering the interview questions. This turned out to be a useful additional closing question as it sometimes tapped into feelings the participants had not previously expressed.

Use of CNA as a method of analysis was predominantly a positive experience. However, there were times when it felt as if the method was too long, complex and protracted to enable a succinct distillation of useful findings. This is elaborated upon in the next section.

Limitations.

In carrying out the analysis there was a conflict felt between looking across a group to find common themes and yet privileging the subtleties of each couple.

There is a case to be made for doing a single-case study, as some individual complexities may have been overlooked while seeking larger group-wide commonalities. Langdridge's worked example, from his 2007 book outlining the method, is a single case study, and the chapter ends with recognition that CNA is a particularly demanding method. The combination in my study of a multi-faceted topic and the complexity of dyadic participants, might have benefited from a simpler analytical approach. However, I feel that the method, while ambitious, has offered illumination that would be difficult to replicate using other methods.

Suggested directions for future research

In view of the limited amount of research on couples who experience low sex drives, combined with the high prevalence rates outlined in the epidemiology section, this area provides rich possibilities for research to broaden our knowledge base and enhance treatment approaches. Previously in this discussion, the position of the *DSM*, with its focus on the individual has been juxtaposed with the findings of this paper, which have described the powerful inter-relational dynamics seen in the participating couples. Time and again findings have indicated that a systemic approach is of importance when seeking to alleviate this problem. This research also lends support to the benefits of including partners in treatment for low sexual desire.

My study has been helpful in highlighting attitudinal differences between men and women partners towards women's low sexual desire: for example, men's entitlement to sex and lack of feelings of male responsibility or female motivation to address the problem. Attitudes such as these are important for a therapist to be aware of at the outset of therapy. It would be useful to replicate this study to investigate the area further and strengthen the findings. The scope of this study was restricted due to difficulty in finding couples willing to participate. Three of the four couples were drawn from a network of peer contacts, while the remaining couple was referred from an NHS clinic. Only the

latter couple had been referred for couple therapy related to their sexual difficulties. The research could be replicated with couples who are due to start therapy for low sexual desire in order to increase participant homogeneity.

Previous sections in this Discussion have suggested areas where further research would be helpful, including suggestions for research on demand-withdraw patterns in couples who experience low sexual desire and the use of a different social theory to critique the results.

Final reflexivity

Personal reflexivity has been an important touchstone in this research. This section will discuss how reflexivity has added a further dimension to this study and how the research has affected both my research and clinical practice as a counselling psychologist, as recommended by Willig (2008a).

The personal resonance contained in my research has been outlined previously and I have used this awareness of personal investment to extend the rigour of my approach – for example, through the use of reviews by a peer and an independent specialist practitioner. The method of CNA has an inbuilt stage which encourages critiquing researcher subjectivity. One outcome of completing this stage was to compel me to consider the impact of my female gender on this study. As mentioned in the Results section, men were interviewed second as a matter of choice by each couple and this may have had an effect on me as I heard the woman's story first. Further, the men may have felt that, as a woman, I was biased towards the women's side. I attempted to counterbalance these potential gender effects by mixing the order in which I undertook analyses (two were analysed men first, women second). It is possible that replicating this research with a male interviewer or a gender mix of interviewers and analysers may extend the findings.

In my role as researcher I have found aspects of this research illuminating in unforeseen ways. In a former career I worked as an engineer, entailing a way of viewing the world as reducible to logic, mathematics and general laws of physics. This background lends itself more readily to a quantitative approach. In

conducting the study I have noticed features that may indicate an internal struggle with aspects of qualitative research: for example, a reviewer noted my use of the terms “males” and “females” rather than “men” and “women”. I believe this tendency towards use of the terms male/female may be an attempt to distance myself from the messiness of human difficulties, which do not easily rest alongside a clinical approach to research. In carrying out future research, I will retain my awareness of possible detachment, in the hope of guarding against such a tendency. This is because I believe qualitative research gives us access to humanity and the human condition, and this insight can be the lifeblood of therapeutic endeavour.

On a final note of reflexivity, I have considered how this research has changed my clinical practice as a counselling psychologist. There were times during the analysis stage when I felt I was pathologising or demonising one person over another. This led to me reflecting on how this is a parallel process to what may happen in the therapy room. Couple therapy can be prone to one party feeling the therapist is on the other person’s side. In the case of low sexual desire, where the findings have shown that strong feelings of blame may be present in the relationship, it is speculated that sensitivity to the issue of inclusion and validation of both parties is paramount. Relating this to practice as a counselling psychologist means keeping a constant weather eye on the therapeutic relationship. An example of putting this into practice is Yalom’s (2009) advice where he starts every session by asking each client: “How are *we* doing today?”, thereby taking the temperature of each client’s relationship with him, before proceeding to the main content of the session.

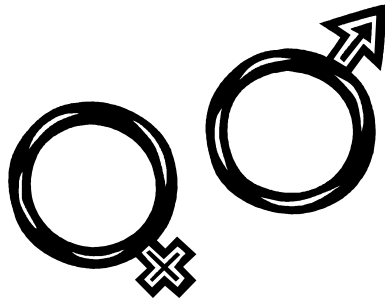
Conclusions

Low desire for sex is a problem that touches the lives of many. This research not only found themes, identities and prevailing social attitudes within participant interviews, it was also drawn into some wider debates – such as whether low desire in couples can be tackled on an individual basis.

It has been seen from Table 3 (in the Summary of themes connected to therapeutic techniques section) that most themes have a relational basis, for example, blame and doubt are usually directed at someone. It was also found that neither men or women participants described physical losses, but all expressed psychological losses such as confidence and security in the relationship. A further observation made in the Discussion is that the themes showed indications of gendered power relations, with the juxtaposition of entitlement-to-sex in the men coexisting with feelings of abnormality in the women. This is an example of how a feeling in one partner might engender a particular response in the other. It can also be seen in Table 3 that, time and again, a systemic approach was proposed as something that could address relational tension. This research, therefore, points towards the importance of treatment involving the other partner which flies in the face of the more individual focus that is implicitly enshrined in *DSM*-type classification. Furthermore it suggests that a purely pharmaceutical solution is unlikely to be a magic potion for an existing relationship.

Consideration was also given in the discussion as to how a counselling psychology approach can be of benefit. It was proposed that counselling psychology, with its emphasis on reflective practice to examine personal assumptions, its high level of training and pluralistic approach to tackle many possible complications seen in the interviews combined with focus on the therapeutic relationship to manage potential non-engagement of clients, is ideally placed to face the challenge of work in this area.

Given the lack of research in this area, it is hoped that this study presents a positive contribution from a counselling psychology perspective, to both research and to the practical application of this research, towards couples struggling with low desire for sex.



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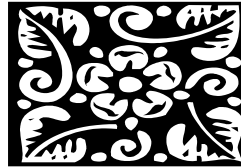
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Appendices:

Appendix 1 – Recruitment Poster	117
Appendix 2 – Participant Information Sheet	118
Appendix 3 – Participant Consent Form	121
Appendix 4 – Interview Schedule – for women and partners	122
Appendix 5 – Distress Protocol	124
Appendix 6 – Demographic questionnaire	126
Appendix 7 – Debriefing sheet	128
Appendix 8 – List of support services	129
Appendix 9 – Letter of ethical approval from Research Ethics Committee	131
Appendix 10 – Summary of demographic information	132
Appendix 11 – Sample of annotated participant transcript - David	133

Appendix 1 – Recruitment Poster

Recruitment Poster. Version 2.1 Date: 28th November 2011. REC ref:11/SC/0501



**ARE YOU A COUPLE WHERE THE
WOMAN HAS LOW SEXUAL DESIRE?**

Are you in a stable relationship?

ARE YOU AGED OVER 18 ?

**IF YOU MEET THE ABOVE CRITERIA, THEN PLEASE
READ ON....**

**My name is Jeanne Ling and I am currently studying towards a
Professional Doctorate in Counselling Psychology at London
Metropolitan University.**

**My research looks at the experience of low sexual desire for women
and their partners. Your participation in the study would mean
having a conversation with me lasting approximately an hour where
each of you would be asked to share your experiences in separate
interviews. Shopping vouchers to the value of £15 will be offered to
each of you as a token of appreciation for your time.**

University Ethical Approval has been gained for this study.

Please note that although this research has gained NHS ethical approval to proceed the research is independently-
managed of the NHS.

**If you are interested in participating or would like to know more
about the study please contact me at [email address] or on XXXX-
XXXXXXXX (work contact number).**

THANK YOU FOR TAKING TIME TO READ THIS POSTER

NHS poster Version 2.1 28th November 2011

Participant Info. Sheet. Version 2. Date: 28th Nov. 2011.REC

ref:11/SC/0501

PARTICIPANT INFORMATION SHEET

Study Title: Low sexual desire – Couples' individual perspectives on HSDD: a qualitative study

You are being invited to participate in a research study. However, before you decide whether you would like to take part or not, it is important that you understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and if you require, you may want to discuss this with other people. If you are unclear about any information or require more details, you are welcome to contact either me or my Research Supervisor (contact details are provided below). Please take your time in deciding whether you would like to take part or not.

Purpose of the study:

This research is being carried out as part of a Professional Doctorate Course in Counselling Psychology. The intention of the study is to explore the experience of women with low sexual desire and their partners. I am interested in understanding participants' experiences and seeing whether there are any common themes or issues that come up. The results of the study will help in developing a better understanding of the ways in which UK health services may benefit women with low sexual desire and take into account their partner's views.

Please note that although this research has gained NHS ethical approval to proceed the research is independently-managed of the NHS. As the research will take place on an NHS site it has been reviewed by an independent group of people called a Research Ethics Committee to protect your interests. This study has been reviewed and given permission to proceed by the Chair of the Research Ethics Committee as reviewed on 16th December 2012.

What happens after I decide to take part in the study?

You will be requested to complete the (attached) consent form. I will contact you to arrange a time that is convenient for you to talk about your experiences. The study will involve having a conversation with me for approximately 45-60 minutes. This means that I will ask you a series of general questions in relation to how you view, experience and deal with the topic area of low sexual desire in your life. If you decide to withdraw from the study following the interview, you are free to do so at any time without any adverse implications for you. This means that what you say during our conversation will not be used in the study. It also means that there will be no effect on your NHS treatment whether you proceed with the study or decide to withdraw.

What about confidentiality?

With your permission, the conversation will be audio-recorded, transcribed and segments of this may be incorporated into a report that will be accessible to other individuals such as the Research Supervisor and other tutors who will be formally assessing the report. However, you will remain completely anonymous i.e. your name and identity will not at any point be made available and will be kept separate from the findings of the interview. No one will have access to this information except for myself. After interview no information will be directly shared with your partner on opinions disclosed in the interview.

Data will be anonymised as described above. However the method of data analysis allows for use of direct quotes from interviews. Although many interviews will be carried out and themes may be similar across interviews, it may be possible for your partner to recognise your input in a published account. Hence I will ask you at the end of our conversation if there are any incidents described in your interview where you would not like direct quotes to be used.

Excerpts from interviews (omitting any identifying information) may be used in the writing up or publication of the study. Your name would not be used in connection with the results in any way and all information that may otherwise identify you (e.g. names of family members or friends) will be changed with a pseudonym prior to transcription.

Confidentiality will be broken if information is disclosed to the effect that you are putting yourself or others at risk. In this case, appropriate services or the authorities will need to be informed. Similarly confidentiality will be broken if you mention taking part in illegal activity in which case I would refer this information to the health professionals at the Garden Clinic.

All information that you provide will be secured in a safe place by the researcher. All audio-recordings and paper records will be kept in locked storage. Data stored on a computer will be password protected and encrypted so that it is only available to the researcher. The main researcher will have sole access to this data (there are no co-researchers). The recordings used during the conversation will be erased following transcription and once the study has been assessed and marked. Transcripts of the conversation will be kept for a maximum period of 5 years in case the study is published and will then be erased.

If you have any further questions on this, please ask the researcher.

Costs

The study will take place at an agreed location that is convenient and safe for both you and the researcher. At the end of the interview vouchers to the value of £15 will be given in order to offset any costs you may have incurred and as a token of appreciation for your time.

Risks

Given the personal nature of the issues you will be discussing in the interview, it is possible that this may evoke difficult thoughts and feelings. If you wish, you may also take small breaks during this period to help you feel more relaxed about discussing your experiences. Both you and I, the researcher, will have the right to put an end to the interview if at any point during the interview you become unduly distressed whilst talking about your experiences. This is to ensure that your well-being is safeguarded at all times.

It is possible that taking part in this study may bring about some upsetting feelings in you as you are requested to share your experiences of dealing with your personal difficulties. In this case, information will be provided to you regarding appropriate forms of help that you can access. These will include local counselling/therapeutic and general support services.

Making a complaint

If you wish to make a complaint about any aspect of the study, please contact my Research Supervisor, [Name] at London Metropolitan University: [email address, tel number].

What about the findings of the study?

If you wish to obtain a copy of a summary of the findings, please provide your contact details. These details will be kept separate from the material that you provide me during

our conversation. The results of the study may be published in a journal. However, no information identifying you as a participant will be included.

Your contribution to the study

Your input and contribution will offer helpful information to those professionals trying to make UK health services more useful and relevant to women with low sexual desire. I am happy to respond to any further questions or queries that you may have.

Thank you.

Jeanne Ling
3rd Year Professional Doctorate in Counselling Psychology Trainee,
Email address
Work mobile no

**LOW SEXUAL DESIRE – COUPLES' INDIVIDUAL
PERSPECTIVES ON HSDD: A QUALITATIVE STUDY**

Researcher: Jeanne Ling

CONSENT FORM

This consent form is to ensure that you are happy with the information you have received about the study. It is also important to check that you are aware of your rights as a participant and to confirm that you wish to take part in the study.

Description of procedure: In this research you will be asked a number of questions regarding your experience of women's low sexual desire within a voice recorded interview. Please initial the boxes to indicate agreement to each statement.

- I have read and understand the information sheet dated 28th November 2011, Version 2.1, on the above study. I have had the opportunity to ask questions and have had these answered satisfactorily.
- I understand the procedures to be used and agree to take part in the study.
- I understand I am free to withdraw at any time with no adverse effect on my NHS treatment.
- I understand that participation in this study is anonymous. My name will not be used in connection with the results in any way, a pseudonym will be used on the digital voice recording and all information that may otherwise identify me (e.g. family members, friend's names) will be changed prior to transcription. There are limits to confidentiality however; confidentiality will be breached if I am believed to be putting myself or others at immediate risk, or if I admit to taking part in illegal activity.
- I understand that the results of the study will be accessible to others when completed and that excerpts from my interview (minus identifying information) may be used in the writing up or publication of the study.
- I understand that I may find this interview upsetting and that it may evoke difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings at length post interview with the researcher. The researcher will also give information on further support available if required.
- I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given in the debriefing form.
- I understand that the data will be kept for five years and then erased.

Signature of participant:..... Signature of researcher:.....
Print name:..... Print name:.....
Date: Date:

Appendix 4 – Interview Schedule – for women and partners

Interview Schedule.Version 1.Date: 18th August 2011. REC ref:11/SC/0501

Interview Schedule –for women

Low sexual desire

1. To begin with, could you tell me about your history of low sexual desire from when it started to now?

Prompt: Can you say when you noticed you experienced low desire?

Identity/sense of self with regard to low sexual desire

2. How would you describe yourself as a person in general?

3. Has having low sexual desire made any difference to how you see yourself? Can you tell me more about that?

4. Can you tell me your thoughts or feelings you have about having low sexual desire?

Prompt: What does the condition mean to you?

5. Can you tell me about attitudes others may have towards the condition?

Prompt: Your partner, family, friends

Prompt: How many people have you told about the condition?

Help-seeking

6. Could you describe any times when you have sought help for low desire?

Prompt: What were your feelings about this/these episodes?

Prompt: Did you seek help any other time, from anywhere else?

Treatment

7. Can you tell me about treatment you may have had (for low sexual desire)?

Prompt: What were your thoughts or feelings about this approach?

Final questions

8. Is there anything I have failed to ask in this interview that you feel is important and would like to share?

9. Do you feel like you have told me what it is like to live with low sexual desire?

10. What has the experience of doing this interview been like for you?

11. Is there any incident described in your interview where you would like direct quotes not to be used?

Interview Schedule –for partners

Low sexual desire

1. To begin with, could you tell me about your experience of your partner's (insert partner's name -Xxxx) low sexual desire from when you first knew about it to now?

Prompt: Can you say when you noticed Xxxx's low desire?

Identity/sense of partner's self with regard to low sexual desire

2. How would you describe Xxxx as a person in general?
3. Has having low sexual desire made any difference to how you see Xxxx? Can you tell me more about that?
4. Can you tell me your thoughts or feelings you have about Xxxx having low sexual desire?

Prompt: What does the condition mean to you?

5. Can you tell me about attitudes others may have towards the condition?

Prompt: Xxxx, family, friends

Prompt: How many people have you told about the condition?

Help-seeking

6. Could you describe any times when Xxxx, or you, have sought help for low desire?

Prompt: What were your feelings about this/these episodes?

Prompt: Did you seek help any other time, from anywhere else?

Treatment

7. Can you tell me about treatment Xxxx may have had (for low sexual desire)?

Prompt: What were your thoughts or feelings about this approach?

Final questions

8. Is there anything I have failed to ask in this interview that you feel is important and would like to share?
9. Do you feel like you have told me what it is like to live with someone who has low sexual desire?
10. What has the experience of doing this interview been like for you?
11. Is there any incident described in your interview where you would like direct quotes not to be used?

Appendix 5 – Distress Protocol

Distress Protocol. Version 1. Date: 18th August 2011, REC ref:11/SC/0501

DISTRESS PROTOCOL

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the research whilst discussing their everyday life problems and difficulties.

The researcher is currently undergoing professional training in Counselling Psychology, and therefore has experience in managing situations where distress occurs. It is not expected that extreme distress will occur, or that the relevant action will become necessary. This will be verified in the form of an introductory telephone conversation with potential participants so as to minimise any risks. In the scenario where participants become unduly distressed, below is a three step protocol detailing signs of distress that the researcher will look out for, as well as action to take at each stage.

Mild distress:

Signs to look out for:

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking
- 3) Participant becomes distracted/ restless

Action to take:

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

- 1) Uncontrolled crying/ wailing, inability to talk coherently
- 2) Panic/anxiety attack- e.g. hyperventilation, shaking, fear of impending heart attack
- 3) Participant demonstrating extreme difficulties with concentration/attention owing to above

Action to take:

- 1) The researcher will intervene to terminate the interview
- 2) The debrief will begin immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation

4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to their everyday life difficulties/problems and that most people recover from such psychological distress.

5) Ask the participant if they would like to speak to a friend or a member of family (e.g. over the phone) to help reassure them

6) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss this further with mental health professionals and remind participants that this is not designed as a therapeutic interaction

7) Details of counselling/therapeutic services available will be offered to participants (Appendix 7)

Extreme distress:

Signs to look out for:

- 1) Severe emotional distress such as uncontrolled crying/wailing
- 2) Severe agitation and possible verbal or physical aggression
- 3) In very extreme cases- suicidal ideation and plans expressed/possible psychotic breakdown

Action to take:

- 1) Maintain safety of participant and researcher
- 2) If the researcher has concerns for the participant's or others' safety, she will inform them that she has a duty to inform the appropriate mental health services any such as their GP.
- 3) If the researcher believes that either the participant or someone else is in immediate danger, then she will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
- 4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain them and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

© Adapted from the Distress Protocol written by Chris Cocking, London Metropolitan University Nov 2008

Appendix 6 – Demographic questionnaire

Name _____ (Your name will not be used in any public files. All public research reports will use pseudonyms. I only ask your name in case you have any follow up questions)

1. In what year were you born? _____

2. What is your race/ethnicity? (Select all that apply)
 - a. White, British
 - b. White, Irish
 - c. Any other White background (please specify) _____
 - d. Mixed, White and Black Caribbean
 - e. Mixed, White and Black African
 - f. Asian
 - g. Mixed, White and Asian American Indian or Alaska Native
 - h. Native Hawaiian or Other Pacific Islander
 - i. Other (please specify) _____

3. What is your partnership status?
 - a. Married
 - b. Divorced
 - c. Widowed
 - d. Separated
 - e. Never married

4. If divorced, widowed, separated, or never married, what is your relationship status?
 - a. In a committed relationship, not living together
 - b. In a committed relationship, living together
 - c. Not in a relationship but dating
 - d. Other (please specify) _____

5. What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received.
 - a. Less than secondary school
 - b. Finished secondary school
 - c. College
 - d. 4-year college degree (BA, BS)
 - e. Master's degree (MA, MS, MBA)
 - g. Doctoral degree (PhD)
 - h. Other (please specify) _____

6. Employment status: Are you currently...?
 - a. Employed for wages/salary full-time
 - b. Employed for wages/salary part-time
 - c. Self-employed
 - d. Out of work and looking for work
 - e. Out of work but not currently looking for work
 - f. A homemaker
 - g. A student
 - h. Retired
 - i. Unable to work/disabled

7. What is your occupation?

8. What is your town/city and county of residence?

9. How would you characterize your place of residence?
 - a. urban
 - b. rural
 - c. suburban

WRITTEN DEBRIEFING SHEET

Title: LOW SEXUAL DESIRE – COUPLES' INDIVIDUAL PERSPECTIVES ON HSDD: A QUALITATIVE STUDY

Thank you for taking part in this research. This is part of a doctoral project that the researcher is conducting.

This debriefing is given as an opportunity for you to learn more about this research study, how your participation plays a part in this research and why this research may be important.

The purpose of this study is to understand how women suffering from low sexual desire and their partners experience the problem. The results of the study will help in developing a better understanding of the ways in which UK health services may benefit women with low sexual desire, and their partners.

Your generosity and willingness to participate in this study are greatly appreciated. I do however request that you do not discuss the nature of the study with others who may later participate in it, as this could affect the validity of the research conclusions.

Sometimes people find the subject matter of these interviews difficult. If answering any of these questions has resulted in any distress, anxiety or concern and you would like to speak to someone about your thoughts or concerns, I am enclosing a list of useful counselling/therapeutic and support services which you may find useful.

If you wish to withdraw please contact me as soon as possible.

Equally, if you have any questions or concerns you are more than welcome to address them now.

As stated before, the information that you provide will be kept anonymous except for myself, my supervisor and those formally assessing the report. Thus there will be no information that will identify you i.e. pseudonyms will be used. It may be possible that the results of this study are presented at academic conferences or published as an article in a journal. If you would like to receive a summary of the findings of this study or have any additional questions, you may contact either myself or my supervisor. Contact details are:

Student name and contact details: Jeanne Ling (email address)

Research Supervisor: Dr. (Name & email address supplied).

Appendix 8 – List of support services

Useful Services. Version 1. Date: 18th August 2011. REC ref:11/SC/0501

LIST OF USEFUL SERVICES

**IF YOU REQUIRE COUNSELLING OR SUPPORT FOR ANY ISSUE
YOU MAY CONTACT ANY OF THE FOLLOWING ORGANISATIONS:**

COUNSELLING/PSYCHOTHERAPY

British Psychological Society

St Andrews House
48 Princess Road East
Leicester LE1 7DR

Tel: +44 (0)116 254 9568

Fax: +44 (0)116 227 1314

Website: <http://www.bps.org.uk>

Provides details regarding qualified psychologists trained in a variety of methods/approaches in UK.

The British Association of Behavioural And Cognitive Psychotherapies (BABCP)

Cognitive Behavioural Therapy (CBT)
Globe Centre, PO Box 9
Accrington, BB5 2GD

Tel: 01254875277

Website: www.babcp.co.uk

Provides details regarding qualified Cognitive Behavioural Therapists in UK.

British Association for Counselling And Psychotherapy (BACP)

BACP House,
35 – 37 Albert St,
Rugby, Warwickshire
CV21 2SG.

Tel: 0870 443 5252

Website: www.bacp.co.uk

Offers CBT, counselling, group therapy and psychotherapy

Relate – the relationship people

Relate,
Premier House,
Carolina Court,
Lakeside, Doncaster, DN4 5RA

Tel: 0300 100 1234

Website: www.relate.org.uk

Offers relationship counselling, children and young people's counselling, family counselling and sex therapy

UK Council for Psychotherapy (UKCP)

167 – 169 Great Portland Street
London W1W 5PF

Tel: 0207 326 3002

Website: www.psychotherapy.org.uk

Offers CBT, couples, family, group therapy and psychotherapy

YOU MAY ALSO CONTACT YOUR GP IN ORDER TO ACCESS FREE
COUNSELLING AND PSYCHOLOGICAL SUPPORT.

<p>This list has been compiled by referring to a variety of sources taken from the internet.</p>
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Appendix 9 – Letter of ethical approval from Research Ethics Committee



Health Research Authority

NRES Committee South Central - Portsmouth

Bristol Research Ethics Centre
Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1382
Facsimile: 0117 342 0445

16 December, 2011

Mrs. Jeanne M. Ling
Trainee Counselling Psychologist
London Metropolitan University
Calcutta House
Old Castle Street, London
E1 7NT

Dear Mrs. Ling,

Study title: Low sexual desire - Couples' individual perspectives on
Hypoactive sexual desire disorder: a qualitative study
REC reference: 11/SC/0501

Thank you for your letter of 28 November 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

A Research Ethics Committee established by the Health Research Authority

Appendix 10 – Summary of demographic information

Gender	Age Range (years)	Ethnicity	Residence	Sexuality	Immediate Family	Level of education	Length of relationship
Women	34-41	3 white British 1 white Irish (Sue)	All British Isles	All heterosexual	All live with children. Sue has 1 child with profound disabilities, and another with a diagnosis of autism. Mandy and Nick's child has a diagnosis of autism	3 to college level 1 to secondary school (Sue)	11 - 8 years (approx)
Men	32-45	3 white British 1 white Irish (Steve)	All British Isles	3 heterosexual 1 bisexual (David)		2 to college level 1 to secondary school (Johnny) 1 left secondary school (Steve)	

Table 4 – Summary of basic demographic information

Appendix 11 – Sample of annotated participant transcript - David

Time/Line number	Stage2- (a)Narratives (b)Tone	Stage2- (b)Rhetorical Function	Stage 4 - Themes
B106			Theme of sex bringing intimacy, closeness (not just sex) (B104-6) Rhetorical work – describing the missing sex as not just physical (stereotypical male-type-need) but also missing 'being close and cuddling' (stereotypical-female type-needs) positions David as a modern man in touch with his female side(B104-6)
B121			Rhetorical work – positions Lauren as to blame for his feeling guilty (B121-2) and questioning basis of relationship, or if done something wrong (position of 'baddy')(B125-6)
B124	Despondent		Theme of love/sex conflation (B125)
B131	Ward off criticism		Theme of doubt (B127-9) Theme of blame-She causes me to doubt & should say why (B131)
B136	Narrative 4 Self focus	More definite tone	Switch of self -doubt to defiance

[name] and our relationship. [8:47 mins], I do miss that. Int 9: Yeah, it was important to you? Ppt B 9: Yeah, I do really value intimacy [9:00 mins] [laughs] and in lovemaking that, that level of intimacy [9:05 mins], not just the act, but it's that intimacy of it, just being close and cuddling [9:14 mins]. So I don't know if that's involved, has got anything to do with low sex drive, or not. Int 10: Yeah so that's not there just even in ...like walking down the high street or round the house, no touching [9:29 mins]. Ppt B 10: No, not generally [9:32 mins]. Int 10: Yeah. Yeah Ppt B: I do instigate it [9:35 mins] Int: Everything. Ppt B: I've always, Not always, as I say, not always, I might get a kiss [9:42 mins]. Int: Yeah. Ppt B: But yeah [9:50 mins]. Int 11: And, but that may make you a, a bit guilty sometimes. Ppt B 11: Yeah, if I have to instigate intimacy I do f- ,and then I get made to feel guilty. Int: Yeah [10:10 mins]. Ppt B: Yeah that sometimes it's hard. Sometimes I wonder what the basis, what the real relationship is about [10:16 mins][Pause] or you know if I'd done something wrong maybe, you expect it[10:22 mins]. You expect your partner to not want to be attracted (inaudible). Int 12: Yeah, or do you think that it's something you would have done [10:49 mins] ? Ppt B 12: I don't know. I, yeah, don't know if there is a breakdown in our relationship in that way. There could be. But then I expect [wife's name] to say something. [11:08 mins]. Int 13: [11.11 mins] and that conversation. That hasn't been there, you know. Or do you, do you talk about it? Ppt B 13: Yeah, she just says that 'don't want to have sex' (?? soft voice.) [11:21 mins]

Time/Line number	Stage2- (a) Narratives	Stage2- (b) Tone	Stage2- (b) Rhetorical Function
B140			
		Stronger tone	
B146			
B150			
B153			
B158			
B165			
14.30	Narrative 5		Critical
	Description of wife		

Int: Yeah, yeah. It sounds like she is [11:27 mins].	
Ppt B: But, yeah, maybe. I mean [I'm not, I'm, I'd say I'm probably, I'm bisexual, I'm not straight, um, I'm not a sort of, you know, the [11:41 mins] manliest man or, you know, maybe I'm not [wife's name]'s ideal you know. Maybe I don't give her the right signals that, you know, make her feel attracted, or I dunno ...	
Int 14: It makes you feel perhaps there's something in you? [12:00 mins]	
Ppt B 14: Maybe [12:04 mins], um, yeah, on that level I don't care because that's not who I am [12.14 mins], that's who I am. Probably if I changed [12:21 mins]. We are what we are and you're either attracted or you're not , that's, at the end of the day we were attracted maybe more at the beginning of the relationship. Maybe things have changed, don't know, but there's nothing really that I haven't told her, that I haven't been open [12:44 mins], [laughs], or that I haven't been open from the start, so...	
Int. 15: She wasn't [12:55 mins] open about at the start?	
Ppt B 15: No, there's no reason to doubt ...every other level in the relationship really, yeah, and I don't have a better relationship with anyone except on other levels, it's not everything is it [laughs].	
Int: No, no.	
Ppt B: But it is part of it.	
Int 16: Yeah, yeah. So just I guess the questions here about identity and ... [wife's name]'s self in regard to the sexual desire, erm, and these questions are the same, or virtually the same, I asked [wife's name] as well, so, but there are questions here about how would describe her as a person in general, so if you had to think of three words to describe her?	
Ppt B 16: Trying to think? Three words? [Pause-8 seconds] It is terrible, isn't it? [13:56 mins] [laughs], Erm [Pause 18 seconds]	
[14:30 mins] She's always inquisitive, she always wants to	

Stage 4 - Themes
Rhetorical work – I'm not Alpha Male (B136-141)
Theme of self-doubt B138-141
Theme of defiant 'Take me or Leave me' B144-9
'I am who I am' whether it's attractive or not (B144-49)
Rhetorical work – positions David as honest, unchanging (echoes of Gloria Gaynor's anthem (Double standard as both Lauren AND David have changed-from Lauren's interview) I've been open (B149-150)
Suggestion that wife has not been open (B150- Best relationship is with wife (B154-5)
Sex is not everything – but is part of it (B155-8)
Descriptors of wife are critical (B165-74)

