THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS

AT MAIMONIDES UNIVERSITY

SEXUAL-CONTEXTUAL THERAPY:

AN INTEGRATIVE APPROACH FOR THE TREATMENT OF HYPOACTIVE SEXUAL DESIRE IN WOMEN.

A DISSERTATION SUBMITTED TO THE FACULTY OF THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS AT MAIMONIDES UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

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MAY 2003

DISSERTATION APPROVAL

This dissertation submitted by Camila Salgado has been read and approved by three faculty members of the American Academy of Clinical Sexologists at Maimonides University.

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The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ACKNOWLEDGEMENTS

Working in this dissertation project, has been an incredibly rewarding and creative experience for me. I would like to express my heart felt thanks to the wonderful network of people that gave me their support, even if they live miles away from each other. I would like to express my gratitude to Doctor William Granzig whose knowledge, passion and compromise with his students, made possible for me and many others to develop an integrative and holistic concept of sexuality, a central issue in human life and mental health. His openness and respect of preferences is a lesson in the art of human coexistence and an attitude required for the ethical and efficient practice of sex therapy. I will always be grateful to my methodological research adviser, Doctor Maria Cristina Villegas, director of the master's program in research in the department of psychology, of Andes University, in Bogotá Colombia. Her expertise helped me to define, clarify and implement the complex project of a research intervention in psychotherapy, from a systemic epistemology, combined with cognitive behavioral instruments.

I wish to extend my gratitude to the women and their partners, who trusted me as a psychotherapist and gave me the opportunity to work with them on the subject of sexual desire. It was a wonderful experience to share with them the goal of self and couple growth that was the intervention's ultimate goal. Their expression of satisfaction with their achievements, was the best reward to the many hours of dedication and work it required.

Last but not least, I would like to thank my husband Pablo, my son Juan Pablo and my daughter Maria Camila, who always have believed in my potential and have offered me unconditional support in my endeavors.

ABSTRACT

Some of the factors that influence hypoactive sexual desired were examined in nine Colombian women. The effect of the proposed psychotherapeutic approach was evaluated. Instruments were designed to have a pre and post intervention comparison and also standardized measures were used. The results indicate that low assertiveness, anxiety, anger and resentment, and a negative nature of the sexual motive were present in the sample in the pretest evaluation. Psychotherapy was effective in increasing the subjective experience of the quality of desire. The findings suggest the importance of a differential evaluation and of a systemic multielement integrative approach. It also suggest that the nature of the sexual motive is a determinant factor in the outcome of the psychotherapeutic intervention.

CONTENTS

Chapter

PART II. RESULTS

Appendix

TABLES

Table

CHAPTER 1
INTRODUCTION

In the history of humanity, many have sought to teach lovers how to have a more satisfactory sex life. They have drawn their lessons from different perspectives such as medicine, popular healers, literature, philosophy and poetry. Ancient texts like the Kama Sutra, the Taoist art of the Bedchamber which dates from the Han Dynasty in China (206 BC to AD 24) and Ovid's Ars Amatoria, are examples of this concern.

All these first writings on sexuality consider that the art of seduction has to do with the quality of love making. In Vatsayana's "Kama Sutra," it is assumed that sexual behavior could be fragmented into precopulatory and copulatory components, interrelated in a lineal manner. For instance, the "Kama Sutra" recommends the use of erotic visual stimulation, scents, taste, etc, to awaken the force of desire. In Ovid's "Ars Amatoria," written two thousand yeas ago, the poet suggests specific methods such as teasing and ingesting certain aphrodisiacs to increase sexual flow to the genitalia and enhance sensual experience. Also, Ovid offers an ageless and detailed account of the things women could do to be more attractive objects of desire and thus become the recipients of masculine passion.

In these ancient texts, not only the biological and physiological dimensions of sex appear, but also the idea of the importance of the cognitive and symbolic elements in sexual desire that are taken into account by contemporary theorists and researchers. These works also offer suggestions about diet and substances that would treat disorders of desire, arousal, and orgasm (Pfaus 1999). The everlasting importance of seeking sexual pleasure as a way to improve one's

life and affective relationships is expressed in a myriad of manuals found in the self help section of postmodern bookstores, which intend to teach how to improve or discover better ways to achieve sexual satisfaction, considering the later achievement not only as a human right, but as a requisite to be a successful person.

The myriad of information about sex seems to be ineffective in the face of the fact that desire disorders have been, the most significant complaint and reason for seeking sexual therapy or consulting internet web pages in modern and post modern times (Owens and Annette 2002). However, it is possible that sexual discourse as expressed in the current self-help literature and in the media, could produce a paradoxical effect in the sense that sometimes it creates unrealistic expectations and frustration for some of those who cannot achieve the promised results.

My interest and fascination with the function of desire in relationships in and in sexual encounters stems from my experience as a person, psychotherapist, and teacher. These roles have motivated me to study theoretical works that describe the many psychosociocultural variables and historical developments that shape sexual behavior. Research findings of several authors (Lieblum and Rosen 2000) emphasize the importance of individual and systemic variables in the affective relationship context as a facilitator or inhibiting factor of sexual desire. Similarly, clinical case studies suggest that a loss or absence of desire is interpreted with alarm by relational partners (Kaplan 1977; Lieblum and Rosen 1989; Lieblum and Rosen 2000).

I have come to consider that the nature of the affective context of the sexual relationship is one of the most important factors, among the many variables that intervene in the experience of sexual desire. My reflections about importance of the experience of being in love as an element that shapes sexual expectations in the couple's sexual life, or in the individual's experience of desire, are the result of various years of practice as a psychotherapist. My practice has been

mainly from a systemic perspective and as a psychology instructor teaching couple's therapy and self development courses in the love process. While essentially working with the diverse problems and challenges of emotional relationships, I have come to understand that multiple factors affect our relational experience. Relationships are necessarily imbedded in the socio-cultural context and can be strongly influenced by myths and dominant beliefs in the collective imaginary, which sets expectations and roles that are reinforced by the mass media. By the same token, early experiences, family models, prior emotional, and sexual relationships, as well as the religious context associated with our development, give shape to our love map and influence our beliefs, attitudes, and expectations regarding sexuality and our love life in general.

Explanations such as "I can't have sexual relations with him ... I don't feel anything anymore with him … I feel as if I don't love him anymore … etc." And "I can't continue with her, the chemistry is over and there is no longer any magic between us," that I have heard from several women and some men during psychotherapeutic conversations, in regard to low sexual desire in their couple relationship, increased my interest to study and research problems on feminine sexual desire in Bogotá, Colombia, location in which I practice.

Through these conversations I found that some of these women, when they no longer experienced the intense emotions and physical reactions associated with being in love during the first stage of the relationship, came to the conclusion that they had stopped loving their partner. The women conceived sexuality within a romantic context and in the daily couple life it had lost its meaning. It was very difficult for them to imagine that without feeling all the emotional and physical reactions that come with infatuation they could experience, in the context of companionate love, sexual pleasure without so many romantic pre-requisites which considerably limit sexual life (Paternostro 2001).

These observations led me to focus my interest on love processes and falling in love to understand the context of the sexual functioning of a couple. As I made advances in my sexual and couple therapy practice, I started to understand that the essence of a good sexual relationship, especially for women, was that sexual relations would take place within a context that would favor the love encounter and that the effect of patriarchal culture on women generated a situation too complex to manage. In the patriarchal culture, women at the same time were prohibited the appropriation of their own bodies and the experience sexual pleasure, and simultaneously, were criticized for their lack of sexual desire and inability to enjoy sex with their partners; deficiency which could be conceived also as a natural result of socialization.

In contrast to the widespread interest in research and treatment of male sexual dysfunction, less attention has been paid in the past to the sexual problems of women and research on the causes and treatment of female sexual dysfunction has lagged far behind, even though there are some significant recent research papers on the subject (Basson et al. 2000; Lieblum and Rosen 2000).

There is no question that women and men in western culture are socialized differently about sex, and the scarcity of research on women in the past is a reflection of the male privilege regarding sex (Gagnon and Simon 1973, quoted by Bozon 2001) which explains partially why, women are much more susceptible to experience dysfunctions. Women with hypoactive sexual desire refer to their inhibited desire as a major stressor in their lives and relationships (Donahey and Carroll 1993; Hurlbert 1993). Sexual desire in women has been tied to their emotional well-being, psychological distress (Apt et al. 1996) and marital adjustment (Trudel et al. 1993).

With this study, I intend to go in depth in the area of the so called desire disorders, specifically female hypoactive sexual desire, from a systemic and an integrative perspective that

takes into account the participation of the self and the couple system dynamics in the functioning of desire.

I agree with the majority of therapists who have worked with desire disorders in regard to the complexity of these cases and the unclear positive psychotherapy outcome, if it is compared with the treatment of other sexual dysfunctions (Heidman, Hill, and Ellis 1995; Leitenberg, Henning, and Kris 1995; Beck 1995). Paradoxically, the low success rate reported by many authors and what I have experienced in my practice with this dysfunction, is one of the basic reasons that motivate me to embark on this kind of research.

Therefore, based on my clinical experience and the positions of some theorists (Butcher 1999) and researchers, I consider that there might be some psychological conditions as well as some contextual relationship factors, that can be related to the outcome of the intervention directed to improve the desire phase of the sexual response, specifically in women in long term committed relationships.

To summarize, this research aims to contribute to the comprehension of the inner and systemic workings of sexual desire in women in Colombia, who experience a sexual desire dysfunction. Also, I would like to be able to detect if there could be some specific conditions that would facilitate a positive psychotherapeutic outcome. I intend to research hypotheses related to the possible influence of some psychological factors such as assertiveness, tendency to hold resentment, the inconsistency between the intellectual assigned priority to sex as important in life but limited investment in sex as an integral part of a life style, anxiety related to the experience of sexual pleasure, absence of sexual fantasies and lack of connection with the body.

Clarity about the relative importance of these factors would allow to focus the psychotherapeutic intervention in a more knowledgeable and systematic way, which would facilitate the process of achieving the purpose of "re-establishing the order of desire."

The philosophy behind the intervention proposed is based on the social constructionist premise that "words create worlds." It is relational, appreciative and generative in nature. An emphasis on narratives was made because it was through narratives that I heard the participants' voices about their experiences of sexual desire. Conversations about these narratives, within a psychotherapeutic context, contributed to a better understanding of my participants' thoughts, feelings, motives and actions which in turn helped to use more appropriate psychotherapeutic interventions.

CHAPTER 2

In this chapter, the literature regarding contemporary conceptualizations about sexual desire and its clinical assessment is reviewed. This review elaborates on some of the most relevant biological, psychological and cultural factors associated with low sexual desire. Finally, an integrative sexual-contextual psychotherapeutic intervention for treating low sexual desire in women is proposed.

Sexual Desire

Most conceptualizations of sexual desire focus on the definition of sexual desire as a subjective, psychological experience or state, that can be understood broadly as an interest in sexual objects or activities, or as a wish, need, or drive to seek out sexual objects or to engage in sexual activities (e.g., Regan 2000) Sexual desire, arousal, and activity may co-occur (for discussion, see Regan and Berscheid 1999, quoted by Regan 2000).

The occurrence of sexual activity does not necessarily imply a desire for such activity, nor does the absence of sexual activity necessarily reflect a lack of desire. According to the DSM-IV-TR, desire must relate to sexual activity. Nevertheless, it has been observed that in desire disorders, some women have sex without desire to have sex or without desire for their specific partner, with aversive consequences. Others refrain from seeking sex actively or from accepting their partner's proposal to have sex, even when they experience desire and the partner is available simply do not have desire for their partner, but can not acknowledge this distressful fact.

Levine's conceptualization of sexual desire (quoted by Lieblum and Rosen 1989) incorporates at least three critical dimensions that include: (1) a biological drive component based on neuroendocrine mechanisms and evidenced by "endogenous or spontaneous manifestations of genital excitement," (2) a cognitive or attitudinal component refereed by the author as a "sexual wish" that typically reflects the mores and expectation of the peer group and society and (3) the "sexual motive" which implies the willingness to engage in sex.

In agreement with Lieblum and Rosen (1989), even if Levine's approach is more centered on the individual than in the workings of the couples' dynamic, he makes an important contribution to the complex understanding of the sexual desire disorders by placing an emphasis on the sexual motives and their relationship to the willingness to engage in sex.

Along this line of reasoning, the sexual desire phase implies the presence of the three components mentioned before, even though they do not necessarily appear together. For the "sexual motive" to result into sexual behavior, the complex action of diverse motivational mechanisms would be needed, and these mechanisms in turn are influenced by individual and systemic factors related to the relational context of the couple at a given moment.

If we assume that these three elements are present in sexual desire, it is possible to talk about a disorder of desire if one of these elements is missing or if there is lack of accord among them, as it would be the case between the cognitive dimension and the motivational dimension of sexual desire. The persistence or recurrence of the low desire symptom, could be explained as a lack of connection of one of the three components with the other, specially if the cognitive and actitudinal dimension are not joined and supported by the will to act sexually -the sexual motive- which as it was mentioned before, is the most important element.

Everaerd and Both (2000) define sexual desire as “a subjective experience that resides in the domain of motivation” (2) and use also the construct of motivation to explain the generation of action. They include the idea of the constraint on the subjective emotions and desires caused by the very object of desire, and the social rules, going one step further from the definition criteria given by the DSM-IV-TR.

I find this conceptualization more inclusive because without identifying sexual desire and motivation it takes into account many of the variables that take part in the sexual desire process and at the same time, allows for the fact of the separate functioning of sexual desire, motivation and sexual behavior. In this project, sexual desire more than a “subjective experience,” is considered an “intersubjective experience,” that takes into account that the low desire or the intense desire takes place in relation to another distinct form myself.

One of the important elements considered in this research project are the cognitive and motivational components of desire, which Levine (quoted by Lieblum and Rosen 1989) denominates “the sexual wish” and “the sexual motive.” The later is characterized by the willingness to engage in sex, and is considered by author and by Lieblum and Rosen (1989) the most important clinical factor to assess.

I am inclined to adhere to their evaluation of Levine’s proposal, due to the fact that some of my observations in cases with low therapeutic success, could be related to the discrepancy between the “willingness” to resolve the hypo sexual desire condition expressed in the fact of requesting psychotherapy, and the failure to act towards the accomplishment of therapeutic goals; as if it were difficult to recognize and acknowledge at the beginning of therapy, the underlying motivations to want to experience desire and the fact that this motivations might lack emotional acceptance at a deeper level. This has been considered in depth by Hulbert et al.

(2000) whose findings justify the inclusion of sexual motivation in the human response cycle as a distinct phase.

The cognitive and attitudinal component proposed by Levine has been present in the attempts of other researcher's measures of sexual desire, who have operationalzed the concept of sexual desire in terms of cognitive events (e.g., sexual wishes, sexual thoughts, sexual fantasies, sexual imagery) that are not associated with any overt sexual activity (Regan 1999). The assumption is that these phenomena represent motivational aspects of sexual experience and therefore may serve as indirect measures of sexual desire (e.g., Sherwin 1985, quoted by Regan 1999) even if in some there is no congruence among the subjective experience of desire and overt sexual response. This could be one of the relationship variables that requires more study.

The notions of sexual desire as a distinguishing feature of passionate love, and of the relative dependency of sexual activity and the passionate love experience, was mentioned before in this project, due to the fact that the presence of sexual desire in love relationships has been a common theme at many levels of the love discourse that range from ancient myths, great literary works, philosophy, religion, clinical and social psychology and the work of many authors and students of human relational behavior (Ellis 1933, 1963; Freud 1912, 1963; From 1956; Lepp 1954). Contemporary sociopsychological discourse on love suggests that the experience of passionate love is strongly linked with sexual desire (Cajiao 1995; Paz 1994).

These observations have been validated recently by Regan's work (2000). Her research explores the role of sexual desire and sexual activity in affective relationships and whether desire is more strongly associated than sexual activity with passionate love, as well as the different implications of desire and sexual activity in relationship maintenance. The author found that sexual desire was more strongly associated to passionate love than sexual activity, that "sexual

activity does not appear to be as integral a component of the passionate love experience as does sexual desire" (Regan 2000, 51). The greater the desire for the partner, less often participants thought about ending their current relationship. When they had low or non existent desire for their partners, they thought more about beginning a new relationship or reported about the possibility of being unfaithful to their partner. In conclusion, the higher the desire experienced, the greater probability of relationship maintenance.

Regan (2000) states that sexual desire can be understood broadly as an interest in sexual objects or activities, or as a wish, longing or craving to engage in sexual activities with another person. This author found in her study with dating couples, strong support for her hypotheses that sexual desire is the aspect of human sexuality most closely associated with passionate love:

> Specifically, sexual desire was significantly positively correlated with the amount of passionate love - but not with the amount of companionate love - that participants felt for their partners. In addition, sexual activity was unrelated to both types of love assessed in the present study. (55)

Regan's findings are very interesting considering that long term relationships are usually characterized by companionate love. The sexual desire disorder most often become clear after the infatuation phase is over. Some couples maintained relatively frequent sexual activity, before the desire discrepancy became significant and conflictive for the partners, fact that has been present in some of the cases I have worked with.

Levine's "sexual motive" and the "willingness to engage in sex" could be conceptualized from the systemic perspective, making emphasis on the co-creation of the difficulty and the role of language in the development of relationships and desire among partners. Sexual desire and sexual behavior that arise within the relational context, are systemic processes that to be fully understood, require also the consideration of the individual workings of the participants in their motivation process. Snarch (2000) considers the level of self differentiation (Bowen 1978) to be

the central personality factor that allows an individual to experience desire in a committed relationship. Kemberg (1995) is another author who has made important contributions on the importance of the individual factor in sexual desire in the couple's sexual desire process.

When Levine (1988, quoted by Lieblum and Rosen 1989) refers to the cognitive or actitudinal components of sexual desire -the sexual wish-, he mentions the mores and expectations of the peer group and society. These components are not necessarily the true reflection of the inner wishes that the person has constructed regarding sexual activity. They correspond to what motivation theorists refer as "extrinsic motivation." The concept of intrinsic motivation would encompass Levine's sexual motive or the willingness to engage in sex. From the systemic perspective, sexual desire would be conceptualized as a complex social construction shaped in the interactive relational context, along with the significance attributed to intimate and sexual experiences.

In my approach, one of the main psychotherapeutic goals would be the discovery and transformation of the meanings pertaining the "sexual motive," which could lead to the resignification of sexual desire as something one owns ethically to oneself and the other; not as a behavior dependent on extrinsic or circumstantial factors. If the intrinsic sexual motive increases in a positive direction, this would have a positive incidence in sexual desire.

Assessment of Hypoactive Sexual Desire

There are several theoretical conceptualizations regarding hypoactive sexual desire which generate different interpretations regarding the nature of sexual desire. LoPiccolo and Pridal (2000) point out the complexity of defining the meaning of the term and the need of a very careful assessment in order to make a valid formulation and treatment plan.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R) the diagnostic criteria for hypoactive sexual desire are:

1. Persistently of recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.
2. The disturbance causes marked distress or interpersonal difficulty.
3. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

The clinician must specify the type of the disorder, that is if it is lifelong type, acquired type, generalized type, situational type, due to psychological factors or due to combined factors. It must be differentiated from Sexual Aversion Disorder, which is defined as the persistent or recurrent phobic aversion to and avoidance of sexual contact with a sexual partner, which causes personal distress (Beck 1995).

Basson et al. (2000) reviewed and evaluated scientific information as well as current research and clinical practice in the field. They analyzed the consensus developed at the conference, which had as an objective to develop a consensus based definition and a classification system for female sexual dysfunctions, that would include psychogenic and organically based disorders and to develop guidelines for clinical evaluation and end points, identify critical knowledge gaps and priorities for future research. They recommended a "new female sexual dysfunction diagnostic and classification system based on physiological as well as psychological and a personal distress criteria for most diagnostic categories" (Basson et al. 2000, 888) which is a more realist and

holistic conception of the subject. Basson et al. (2000) offer a very pertinent model of female sexual dysfunction that privileges factors like perceived commitment and good affective communication in the psychophysiology of sexual desire in women.

According to LoPiccolo and Pridal (2000) sexual desire disorders require a "multielement" treatment approach that takes into consideration that:

> Low drive does not exist as a separate entity; it is inextricably intertwined with family-of – origin issues, thoughts and feelings about sex and sexuality, personal motivations and self image and the actual behaviors involved in being a sexual, sensual person… further research to develop an assessment protocol to identify the elements most critical to each client, would be beneficial.(80)

One of the objectives of this research intervention project is to contribute to the systemic compression of the problem, making emphasis in relational interpretations and the function of the particular narratives or stories the client has regarding their sexual experience, specially the narratives around resentment, anxiety, sexual assertiveness and attitudes towards the body as an instrument of pleasure, etc, in order to plan personalized interventions to facilitate the co-creation of more functional stories that to guide their sexual practice.

Causes of Hypoactive Sexual Desire in Women

Female sexual dysfunction is a multi-dimensional problem combining biological, psychosocial and interpersonal or systemic determinants. I will make emphasis on the numerous psychosocial and systemic relational variables that have been linked to hypoactive sexual desire in women. I will deal mainly with personality factors- sexual knowledge, body acceptance, self-esteem-, systemic relationship issues- life style and priorities, life changes, sexual history, and degree of attraction and compatibility to the partner, as part of the many variables related to sexual desire.

Biological Factors

Although I will emphasize the relational and psychosocial aspects of the dysfunction, it is important to take into consideration the "chemistry of love" and the influence of hormones and neurotransmitters with its differential effect on desire, which in most instances increase the willingness to have sex. When the new couple is in love, elevated levels of fenylethylamine, a naturally occurring amphetamine like neurotransmitter, dopamine or norepinephrine, influence behavior. Love (1999) refers to this process: "that both stimulates libido and mobilizes people to actively pursue the pleasure of love making" (38) modify temporarily sexual behavior; raising sexual drive and fantasies in lovers (Crenshaw 1997).

In order to understand the biological foundations of female sexual response and the physiology of desire, several aspects have to be taken into account (Lieblum et al. 1995; Kaplan 1995; Butcher 1999). The functional integrity of the structures involved in the sexual response, the possible effects of several illness and medications on sexual desire, life and relationship, stressors, as well as the influence of sex hormones in sexual desire and activity, has to be considered. Even women with low sexual desire have an increased desire to have sex when they are in love, because of the action of the amphetamines like substances that generate initially a feeling of euphoria. Since this condition can not be permanent, its disappearance generates uneasiness and emptiness. Due to the impossibility of the brain to tolerate this condition beyond a certain period of time, substances like endorphins and encephalines, similar to morphine are liberated and – attachment phase might take over– with the help of this substances, which provide the committed couple with a feeling of peace, tranquility and security.

The artificial elevation of desire, that takes place in the attraction and falling in love stage of the couple's bonding, erases constitutional sexual desire discrepancies (Love 1999). Although

research is in progress searching for a drug to improve sexual desire in women, so far what is clear is that there are other complex and symbolic factors that nurture female sexual desire and that they are connected with attachment, commitment and validation needs. Often, when women speak of sexual compatibility, they imply also that they have a relationship characterized by a positive affective context and that they are compatible with their partners in other issues (Hulbert 2000).

Psychological Factors

Some very important researchers like Kaplan (1987-1995) and Granero (1979-2002) in Latin America make emphasis on factors such as anger and lack of assertiveness in women with hypoactive sexual desire. In my practice as a psychotherapist I have also and often observed that resentment, lack of assertiveness, lack of connection with the body and bodily sensations, and fidelity to traditional family norms and cultural myths, are almost always present and this follows the trend of the observations made by practitioners in countries like the United States.

For the purpose of this research these factors will be conceptualized as experiences that are organized in narratives. The psychological factors related to hypoactive sexual desire will not be considered as fixed elements but as agreements constructed from conversational processes or narratives. Narratives according to Gergen (1994) are:

> Ways of accounting for reality; they are expositions that are imbedded in social action, they make social events visible and they characteristically establish expectancies for these events. (232)

I will make emphasis on the concept that narratives that women have regarding sexual desire induce certain actions and inhibit others. This is based on the assumption that personality factors are constituted as phenomena that may be investigated not because they are inserted within the

human psique, but because they are expressed in the emotional discourse that appears in patterns of cultural relationships.

The language weaved around assertiveness, resentment, anxiety, negative relations, treatment rejection, that the woman with hypoactive sexual desire might be using to conceptualize herself, her partner and their sexual life, is considered from this integrative systemic framework, as a factor that could contribute to the way she is generating her actions, without her conscious knowledge.

Many women present as their main complaint, the fact that they hardly ever experience sexual desire and/or a discrepancy in the level and/or frequency of sexual desire in their relationship. Some of these women, once they allow themselves to respond or initiate the encounter, have an adequate sexual functioning. Others are pre-orgasmic or have had experiences that prevent them from anticipating the sexual encounter as something "good" or pleasurable. As Young-Eisendrath (1993) states:

> Until the woman has some regular, direct sexual pleasure in her own experience, she cannot be expected to have desire and neither can her partner be expected to take responsibility for her lack of desire.(180)

If some women do not achieve pleasure from their sexual relations or if their sexual desire is low, this fact could be related to the social conditions. Only recently it is taken into account that there is a vast amount of medications, even those taken for common cold, and antidepressive medications, that lower libido in women, altering the delicate hormonal balance which is the biological foundation of feminine sexual desire.

Assertiveness

Salmurri (1991) defines assertiveness as a personal ability that facilitates the expression of emotions, feelings, thoughts and opinions at the right moment, in the appropriate context and in a proper way without denial or neglect of the rights of other's. Assertiveness implies good communication skills, empathy and the ability to discriminate among assertion, aggression and passivity. Morokoff and Harlow (Quoted by Morokoff et al. 1997), proposed a construct of sexual assertiveness based on their general conceptualization of assertiveness centered on human rights and autonomy, in order to organize and further the understanding of strategies used by women in the context of their sexual relationships.

In the field of sexual behavior, assertiveness has had great importance because for instance, the difficulty to communicate feelings of anger or to specify desired behavior from the partner, is a factor that is connected to being unable to refuse sex, even if the experience has been aversive to the woman and this submission to involve in sex without emotional acceptance, results in greater tendency to avoid sexual situations and may increase existing resentments. Research conducted in United States, (Perper and Weis 1987; Blumstein and Schwartz 1983, quoted by Morokoff, Quina, et al. 1997) suggests that a very low percentage of women initiate sexual activity and that women are more likely to have unwanted sex. This facts are congruent with one of my hypotheses about how this submissive behavior increases low sexual desire and resentment in women. Such nonviolent sexual coercion is more common than violent sexual coercion and Paternostro (2001) makes reference to the great extension of this phenomena in Latin America, among women from different socioeconomic strata, even if their external motivations seem different.

Research on the effect of infantile sexual abuse and later sexual attitudes and behavior suggests that women who have experienced abuse, tend to be more accepting of sexual activity, even when they do not want to. In this project, sexual abuse is one of the exclusion criteria because it would require specific psychotherapeutic interventions beyond the scope of this project.

Some women experience hypoactive sexual desire associated to a pre-orgasmic condition. In relation to this experience, Granero (1987-2002) found the pre-orgasmic condition associated to low assertiveness and a higher level of anxiety in her research subjects. Likewise, she shows how orgasmic women have more sexual fantasies than the pre-orgasmic ones. These authors findings are congruent with other clinical findings (Muehlenhard and Cook 1988, quoted by Morokoff, Quina, et al. 1997), which report that rates of unwanted intercourse are alarmingly high and that it is required for women to learn how to negotiate sexual behavior with a partner.

These authors also hypothesized that anticipation of a negative partner response to assertive sexual behaviors would be inversely related to sexual assertiveness. This involves playing a sexually active role that conflicts with traditional gender expectations but which is imperative now, not only to improve women's quality of life and sexual autonomy, but to preserve their life. Over the past several years, women have become the fastest growing group of people with acquired immunodeficiency syndrome (Centers for Disease Control and Prevention 1995; quoted by Morokoff, Quina, et al. 1997; Paternostro 2001).

In order to make a rupture with the negative effect of acculturation in some women regarding their right to act and enjoy sexuality, they require to develop autonomy over their body and sexual feelings, to change their traditional submissive role in the relationship with men partners. This change in the cognitive and affective domain will be connected to the co-creation in the

psychotherapeutic system of new, more adaptative stories about their role as women and their relationship with their sexual selves, which will facilitate for them the experience desire and enjoyment of sexual life.

Sexual self- acceptance and sexual autonomy are closely related, as differentiation and the capacity to experience love and desire are connected. One main question would be how to integrate sexual desire in the experience of self identity- the story we have constructed about our selves that makes us different from others. Also, is the experience of sexual desire something that fits in the story or narrative the couple has about their life? This is important because some people are not aware of the existence and effect of the stories and narrative in their experience of love or sex. It is as if in one level they may want to change, but this goal is negatively affected by their not conscious expectations associated to their stories.

Anxiety

Anxiety has been defined by Reber (1995) as a vague, displeasing emotional condition, with apprehension, ill feelings, dread and uneasiness. For the purpose of this research, I will use the definition of Tobal (1990) as:

> An emotional response, or a pattern of responses that encompasses displeasing cognitive aspects of tension and apprehension, physiological aspects, characterized by a high degree of activation of the autonomous nervous system and motor aspects that usually implicate behavior not well adjusted and scarcely adaptative. The anxiety response can be elicited as well by external stimuli or internal such as thoughts, ideas, images, etc, that are perceived by the individual as dangerous or threatening. The kind of stimuli that will evoke anxiety will be largely determined by the individual differences and there are significant differences regarding the tendency to suffer anxiety in different situations. (310)

Fear is more connected to a particular object or situation than anxiety. Anxiety is much more vague and pervasive. In this project, I will use the term anxiety when referring to the emotions of uneasiness or and negative anticipations associated to sexual activity. The interference of anxiety

in female sexual desire can affects sexual responsiveness due to the action of negative cognitions and mental images like the anticipation of performance failure, of being criticized because lack of desire and the fear of being abandoned.

Barlow (1986) suggests a work model for sexual disorders based on anxiety and the effects of the same over excitement and the perception of control over excitement, the distraction during sexual stimulation and how the response varies when anxiety is active.

In hypoactive sexual desire cases, not being able to perform the expected role and not being at the level of expectations of the partner, as well as the pressure to have sex and the fear of abandonment or infidelity –due to not being able to give the other what they ask for–, are causes of anxiety for the majority of people, specially to the women interviewed.

The relationship between anxiety and sexual behavior has been extensively studied in the field of sexual therapy. After the classic findings of Master and Johnson, and Helen Kaplan, several researchers have tried to establish the relationship between anxiety and sexual dysfunctions. Recent findings (Van Minen and Kampman 2000) suggest different effects of anxiety in masculine and feminine sexual behavior and imply that specifically in women, low sexual desire is correlated positively to anxiety disorders as well as to obsessive compulsive disorders. The study suggests that sexual dysfunction is related to avoidance, and it is clear that in desire disorders, avoidance of the sexual situation is a primary factor. The dysfunctional women showed relatively lower sexual arousal as a result of their negative cognitions and expectations of sexuality as it was found by Van Minen and Kampman (2000) in desire disorders. These authors concluded that the sexual problems of female anxiety patients are most likely to involve sexual desire, the first phase of the sexual response cycle.

Elliot and O'Donohue (1997, quoted by Van Minen and Kampman 2000) showed also that the demand for sexual performance was a source of anxiety, because it gave rise to negative cognitions like anticipated failure in sexual performance, which in turn can lead to distraction and lowers arousal. Also research data evidence that anxiety lowers arousal and can lead to avoidance of sexual activity, because of anticipated fear of not been able to respond to the partner's expectations.

Kaplan's (1979- 1984) model postulates that sexual desire can be interrupted or "shut off" by emotional conflicts, particularly feelings of anxiety and anger which can be derived from unresolved relationship issues or from individual history past events, which interfere with actual relationships.

Beck and Bozman's research (1991-1995) supports Kaplan's model assumption of the suppression of sexual drive, via shutting off emotional responding, due to the action of anxiety and anger. The results indicate that for women, both anger and anxiety significantly reduced desire, whit anger showing a more marked effect. Beck and Bozman (1995) state:

> Women's average time to termination of the sexual encounter, was significantly faster than men's in the anger condition … As the level of sexual intimacy increased, the observed effects of anxiety and anger diminished for males … In contrast, the effect of anxiety and anger of female subjects, specifically, significantly reduced desire throughout the duration of the sexual encounter. (608-609)

It was clear that more women than men expressed an intent to terminate the sexual encounter in the anger condition. This implies that anger has a greater negative impact on the desire of women to continue sexually involved under this emotional experience. Also, this same study suggests that they tolerate anxiety better, all of which suggest gender difference in the experience of anxiety and anger in a sexual encounter and also, a possible gender difference in the interrelationships between sexual desire and sexual behavior. This later evidence of the

importance of differences in sexual behavior, could be used to develop systemic strategies to generate growth process in the couple.

I find very interesting the conceptualization of Snarch (2000) regarding anxiety as something the person has to develop tolerance to, not to reduce or avoid in order to improve sexual functioning, as the classical paradigm states. He thinks that tolerance to anxiety promotes growth and facilitates facing the interpersonal situations of intimacy that provoke it. Tolerance to anxiety and discomfort is essential to self development and it is something that we will have to face for the rest of our life if we dare to look within ourselves, face our deep fears of rejection and be able to express then in the context of an intimate relation. If we can not do that, we might develop a "pseudo relationship" (Masterson 1997) and our connection with our partner will be damaged by the unexpressed feelings. Personal growth is essential to solve desire problems in the couple. This author centers his efforts on emotional resilience in his model of sexual marital therapy, based in Bowen's theory of differentiation of the self, as necessary condition for mature and satisfactory affective relationships.

Anger and Resentment

In this project anger will be considered as an emotional state that arises from instigating stimuli that can be internal like thoughts or images or external events. As such it has physiological correlates, cognitive appraisal and motivational properties. It is generally associated to feelings of keen displeasure, usually with a desire to punish for what we regard as wrong towards ourselves or others. As with many emotions, anger is very difficult to define objectively and overlaps with the definition of other emotional reactions such as rage, indignation, hostility or hatred, and some use it as a synonymous of resentment (Reber 1995).

Here, I will consider resentment as an emotional state but as a much more long lasting mood condition, that some times arises and intensifies spontaneously by memory associations or related cues. Its intensity can be related to the inability to express anger at a given moment to the partner and the failure to forgive.

The emotion of anger as well as resentment, arise within the context of relationships and they come with cognitive elements, contained in narratives the person has developed and reinforced in the context of the relationship.

According to Messina and Messina (2002) resentment is:

> Unresolved anger over a negative event that occurred in past life …. lack of forgiving, the inability to let go and forget, … long term suffering in silence when an open expression of hurt is unwanted and uninvited. It can be the outcome of accepting negative treatment form others passively, never expressions negative feelings about it … agreeing to do something for others yet feeling taken for granted or taken advantage of never getting the chance to seek reparation for having been victimized. (1-2)

Resentment is expressed itself in intrusive thoughts about real or imagined injustices making them seem worse and making the resentful person more emotional, due to the action of the histories related to the experience. Due to cultural factors and lack of assertiveness, women are more prone to experience resentment. Low sexual desire can be self inflicted and intimately related to non-resolved resentment. For the therapist to facilitate the client's transformation of the narrative or the history she has about the origin of the desire dysfunction, to help her to achieve forgiveness, is basic in order to abandon resentment towards her partner. Once resentment is solved, it could be easier to develop the right emotional attitude to experience desire and act sexually.

Kaplan (1979 -1995) refers to negative emotions and anger in women with hypoactive sexual desire. Case studies I have realized with some women show the failure to achieve personal and couple ideals, as an important source of resentment towards their partner and as a deterrent of

sexual desire. This fact leads to the importance of dealing psychotherapeutically with grief due to the loss of ideals in the relationship context, to remove the emotional “shut off” of sexual desire, in words of Helen Kaplan.

Some people engage in passive aggressive revenge tactics, such as sexual sarcasm, being overweight and not doing anything effective about it, being careless about physical appearance or personal hygiene. According to Messina and Messina (2002) these behaviors are not recognized easily and involve stated willingness and desire to have an active sex life and yet, the behaviors say the opposite. Sometimes the person is not aware of the passive aggressive behaviors or the fact that in one hand, the person loves to be loved and wanted and another part of the person, hates and dislikes sexual activity because the pain and hurt it once brought to her life, as for instance, when you were abused in the sense that you felt disqualified or taken for granted.

Women tend to make more emphasis in the general affective qualities of the relationship and to identify good sexual life with a positive affective relationship. One of my basic hypotheses is that the tendency to accumulate resentment and to have some times sexual relations for reasons different from sexual desire, have a negative effect on the perceived quality of the relationship and lower sexual desire for the partner.

Fantasy

Fantasies can be used to stimulate sexual arousal and arousal can stimulate fantasies (Leitenberg et al. 1995). According to my practice, the reversal is also possible in the sense that women, who do not engage normally in sexual fantasies, when they experience arousal, suppress it because of anger or resentment towards their partner. Many times resentful women engage in

negative anticipatory fantasies regarding the sexual encounter and their partner, inhibiting themselves from participating and/or enjoying sexual activity. I call this process "self induced desire disorder."

I agree with Singer (1966 quoted by Leitenberg et al. 1995) that sexual fantasies reflect a healthy sexuality and that the ability to use fantasies is essential in the context of sex therapy. In general, a fantasy or daydream is considered an act of the imagination. This study works mainly with externally triggered sex fantasies and aims to transform internally triggered sexual fantasies through the construction of new narratives that will facilitate positive anticipation of sexual encounters.

The differences in the frequency of fantasies can be culturally explained (Paternostro 2001). Several studies (Leitenberg et al. 1995) have consistently reported that men estimate having more sexual fantasies per day than women. Men seem to be more likely to have more sexual fantasies during masturbation and during the day than women. Men masturbate more frequently than women and tend to start at an earlier age. Their sex fantasies have had a greater opportunity to be paired with orgasms and therefore the possibility to be positively reinforced.

In spite of the fact that fantasies are crucial, to go in depth on this topic is beyond the purpose of the present study. The interested reader is referred to Leitenberg et al. (1995).

Sexual Life and Psychological Maturity

There are many conceptualizations from different theoretical approaches, regarding the nature and meaning of psychosexual development. Regardless the theoretical bias of the authors, many agree that it is an evolutive process that has stages that every human being has to undergo. This

stages require the fulfillment of specific developmental tasks, which in turn facilitate or block the path of subsequent development.

I find that Erikson's (1964) work referring to the "Eight ages of man" is relevant to this research project, specially what concerns to the last four stages of development- identity vs. role confusion, intimacy vs. isolation, generativity vs. stagnation and ego integrity vs despair, which imply that the adult person requires a clear identity, a "solid sense of self," in order to move and manage within the continuum of intimacy and isolation, that close relationships require. Couple relationships require a balance between autonomy and differentiation needs as Bowen (1975-1978) states. Snarch (2000) takes differentiation as a foundation for his systemic conceptualizacion of sexual desire and expresses:

> The crucible approach is the first application of differentiation theory (originally proposed by Murray Bowen, 1975,1978) to integrated sexual-marital therapy. (26)

I think that to be able to give sex life the importance it has, one has to be willing to confront and work towards the solution of the problems that naturally will arise in the context of long time couple relations, such as hypoactive sexual desire. It is part of the ethical adult position that Erikson (1964) refers to when he speaks about ego integrity, quality he defines as "the ego's accrued assurance for its proclivity for order and meaning. It is a post narcissistic love of the human ego -not of the self- as an experience which conveys some world order and spiritual sense; no matter how dearly paid for." (268)

To be able to give importance to sexual life in the couple's relationship, is a part of the commitment required in long term couple life. When there is a discrepancy of desire among the partners, after some time of living together, this discrepancy could be felt as lack of equity. Freud (quoted by Erikson 1964, 265) stated that what a normal person would be able to do well, was "Love and work." From his theoretical position, love meant genital love. He refererred to a

general work-productiveness, which would not preoccupy the individual to the extent he would lose his capacity to a genital and loving being.

For Erikson (1964): “The competitive encounter and the sexual embrace are different …. they eventually become subject to that *ethical sense* which is the mark of adulthood.” (264) Genitality can not become a kind of genital combat, as it does when resentment and passive aggressive behaviors dominate. On the other hand, genitality is also described as a “permanent state of reciprocal bliss,” which would lead from my point of view to the narrative of romantic context as a condition sine qua non of sex. Sexual desire and mature love (Kemberg 1992) require the capacity to experience of love and hate in the same “love object.” It implies transcending idealization characteristic of the stage of falling in love. When Erikson proposes the “genital utopia,” he also talks about the need to have a tolerance to frustration, as it arises in everyday life and in all relationships, even in the best ones. The sense of commitment and the ethical notions, are very useful to keep on in the relationship, despite its vicissitudes, and seek a conjoint solution. This concepts I find quite useful, because of the action of myths and unrealistic expectations regarding sexual satisfactions and the conditions to experience sexual desire, some women and some men still have.

Beyond that, the mature human being according to Erickson, has developed generativity, in such a way as to contribute to others and the next generation. The final stage of ego development is beautifully described and summarized by this author, when he states paraphrasing the relation of adult integrity and infantile trust, “that healthy children will not fear life if their elders have integrity enough not to fear death” (Erikson 1964, 269). This means to me, that a well differentiated adult, is capable of mature love, because he has developed enough trust and discrimination not to be afraid of the other’s judgment as a treat to abandonment or rejection. He

is capable of committing and abandoning himself to the full experience of sexual desire in the couple's domain, that kind of experience as suggested by Paz (1994) that transcends the physical level.

Social Historical Discourses

As a builder of social realities and by its being determinant of attitudes and behaviors, the discourse about sex and specifically about female sexuality is important to understand women's sexual role, her relationship with her body and her perspective as the subject and object of desire. Sexual desire occurs within a systemic language mediated relationship context as many have observed. It is possible that certain feelings and stories generated systemically in the relationship context give rise and maintain the desire disorder (Davies, Katz, and Jackson 1999).

Throughout history, women have been deprived of their sexuality and of the knowledge of the pleasure and freedom that their body can give them. Andahazi (1997) in his novel the Anatomist, describes the odyssey of the Italian Anatomist, Mateo Colon, who in fact discovered the function of the clitoris and escaped being burnt alive by a miracle. His findings were published after his death, in 1559.

Before Shirley Hite, the anatomist Mateo Colon discovered :

> That which at some time every man dreamed of: The magic key that opens women's hearts, the secret that rules the mysterious will of female love ..... or what could be even worse, what would happen if Eve's daughters discover that they carry between their legs the keys to heaven and hell? (Andahazi 1997, 12-13)

The repression of feminine sexuality registered in the writings of the fathers of the Catholic Church has been described by Pagels (1990). Paternostro (2001) who makes a revision about how women in Latin America live and how the learning of their role prevents them from being assertive in face of the masculine dominance in every domain, especially in the sexual one. This

authors, from different perspectives indicate the negative influence of religion and socialization on women's sexuality associated to the idea that sexual pleasure is not their domain and that to foster the experience of sexual desire, would even endanger their position in society. When women comply to gender-based norms for sexual behavior in patriarchal societies and at the same time they become recipients of the modern and postmodern discourse on sexuality and its implications on the behavior expected from women in our times, a new source of tension arises for women, due to the lack of synchronicity among external social discourse and internal experience. In spite of the sexually aggressive women displayed sometimes in the mass media, many women in Latin America tend in general to adopt a passive role and lose the opportunity to initiate sexual activity directly. Some women blame themselves for their passive attitude, others become too active, and many are plagued by ambivalence. This gender perspective regarding role and the experience of sexuality, has been maintained by a complex network of myths and belief systems and influences the experience of sexual desire.

Since the belief system affects sexual performance, I considered important the revision of the most frequent myths in the general population and specifically in the Colombian female population, which is the subject of this study. The belief system is determined as much by the person's own experiences as well as by the historical moment in which they are living, prevailing myths in culture and the rules and attitudes derived from the family of origin.

One of the myths that most affects the treatment of sexual dysfunctions is that "sex should be natural and spontaneous," "a man is always ready for sex, not so women." Romantic myths and conceptualization histories about sex within the context of an ideal romantic encounter and sometimes the lack of self-sexual knowledge, prevent women from recognizing what turns them

on an off sexually. Also, as Granero (1987-2002) mentions, lack of assertiveness prevents women from communicating with their partners about her feelings and preferences.

The “Beauty Myth” (Wolf 1999) has turn the woman into an esthetic slave, dictated by interests other than her own, in which in order to be an object of desire, has to achieve an ideal, which in our country, does not fit with many of the prevailing stereotypes on the mass media. Some women reject the possibility of having sexual relations and progressively inhibit their potential for excitement and desire and sexual experience, by not being comfortable with their bodies, which could be beautiful, if only they could release themselves from the imposed model and appreciate their peculiar beauty.

In Colombia, Betancourth, Garcia, and Mejia (1997) state that issues regarding acceptance of the body and physical appearance, were found both in women that managed the traditional and modern discourse in sexuality. Women were very concerned with the body image and a body ideal that all would like to attain. This ideal was related to the social prevailing image of the feminine body. Not to have this “ideal body” was found to be a source of frustration in some vital moments of the women’s lives interviewed in their study. According to the same authors, it has had a negative effect on the sexual life of the women studied and a has deprived some of them of sexual enjoyment, out of shame of their own bodies.

Gender Related Factors, Sexual Roles and the Experience of Sexual Desire

The ideals of masculinity and femininity that could be denominated traditional, have changed and are being transformed by the action of reflexive discourse in society. In postmodern times or in late modern times, in which women and men seem to be something different from what they

were, there is a co-existence of the traditional and the innovative so much in between the actors of the relationship as inside the person's subjectivity (Carril 2000).

Dio Bleichmar (quoted by Carril 2000) states:

> That feminity/masculinity is not only a role or a prescribed behavior, but an organizing principle of the entire subjectivity, the source of desire is not an anatomical body but a body constructed in the whole of the discourses and their intersubjective practices. (2)

This coexistence is conflictive, because the subjective times are not the same as the historical times and not always the innovative practices are joined by the subjective appropriation of this changes.

According to Betacourth, Garcia, and Mejia (1997) each woman creates her own discourse from that coexistence of discourses. Their study found that women have two types of discourse to explain feminine sexuality: The modern type which implies the idea that adult life cycle is the proper time to have sex, that a woman should be a virgin until she marries and that sex and love have to come together in order to have an ideal relation. The second type of discourse is characterized by the belief that to seek pleasure is possible for a woman as well as to get pleasure out of her body. This idea is connected to the economic autonomy women have due to their work.

Betancourth, Garcia, and Mejia's findings reveal that the modern discourse is expressed more as an ideology and the tradition tends to direct sexual behavior much more:

> Sexual pleasure is subject to constructed norms that dictate how bodies should be, specially women's and how to behave …. because of these structural limitations, many times the essential fact- the construction of a personal satisfactory sexual experience- is forgotten …. women who achieved joy and pleasure from their sexual encounters had to depart from traditional ideas and make a personal transition into a new sexual behavior, that sometimes implied a rupture for instance with family of origin legacies regarding sexual roles and behavior. (7)

Each culture in each historical moment privileges certain generic ideals, that women and men appropriate through process of identification which constitute part of their subjectivity. According to Thomas (1999) sexuality is a particular symbolic inscription, which can not ignore that anatomy, the way we relate and psychosexual development, are not the same for both sexes. In our Latin American society, relationships among the sexes are polarized and depend on ownership of the woman, not in recognition of her personal identity as a sexual free being. In Cali, Colombia, Londoño (1982) ran a study with 264 women in reproductive age, to explore their conceptualizations about sex, how do they experience their sexual relationships and some women's attitudes regarding sexual exchanges. The author concludes that there is a passive and dependent sexual attitude in women, the adoption of traditional patriarchal roles and the acceptance of masculine wishes over their own. Fear and obligation are characteristics of the sexual life of these women. Paternostro (2001) has made an excellent survey on the subject of women and their sexual roles in Brazil and Colombia, exploring thoroughly the socio-cultural perspective and pointing out the actual and potential dangers of these attitudes in women who live in a land dominated by men and the traditional Catholic Church, that jeopardizes not only their sexual rights and happiness, but even their life in this age of human immunodeficiency virus (HIV). This when it becomes a speech, guides the experience and practice of the female sexuality and has a lot to do with the experience and dysfunctions of desire. Still, women see themselves restricted by these models that lead her to conceive herself as a "saint," whore or victim.

According to Thomas (1993) women in the mass media are presented in Colombia in three constructions: An abnegate femininity, imbued with the Holy Virgin's model, a femininity that

duplicates the masculine model and a transgressor-construction that only gives the option of being a man or of not being at all.

Another important factor is the life and professional cycle the woman and the couple are undergoing (Bozon 2000). As the professional role increases, the lover role diminishes. One difficulty is how to distribute time in order to have time for sex. I have found that some times, the low desire is the unavoidable result of a hectic life style that does not allow time for a relationship and pleasure oriented activities. I have observed that this is also related to the incongruence among the priorities expressed in discourse and actual behavior. Sometimes when they realize that this kind of practice is in conflict with their values, they are surprised or shocked.

Messages received when learning about one's sexuality, like: mothers are not sexual beings, men only want sex, women's genitals are dirty, parent's values, religion, patriarchal society norms, etc, make it difficult to have a positive attitude about sex. How can a woman desire to have sex when she is ignorant of its pleasurable aspect or when she is overwhelmed by her role in the relationship?

The subject of desire dysfunctions deals also with questions about the nature of traditional sexual monogamous marriages. Barash and Lipton (2001) conclude that we do indeed have a mildly polygamous nature. However, they successfully avoid the naturalistic fallacy explaining that just because we may have a "natural" predisposition for non monogamy, does not necessarily mean it would be a good thing to jump at the opportunity to have them. The last meeting of the American Academy of Family Therapy also questions the usefulness of the contemporary models of marriage for the younger generation and suggest the need for further

research in this topic. This is important in the context of desire disorders, since in many instances, the desire disorder is only related to the partner and not to a new object of desire.

Romantic Attraction and Female Sexual Desire

When checking the women's narratives and their experiences in regards to the optimal conditions to have a sexual encounter, many times, the effect that the myth about romantic love has, and which has prevailed in the west for several generations, comes up.

This cultural histories tend to construct unreal expectations in regards to their behavior, their partner's behavior, what will be sexually stimulating for them, the context of the sexual relation, etc. Also, the fact that women are sometimes unable to separate the romantic expectations from sexual pleasure in itself, makes this more complex. Since the love bonding process is anything but static, it is fundamental to distinguish between the initial attraction phase –falling in love–, falling out of love or disenchantment-and companionate love, in order to understand that sexual desire requires the co-creation of particular affective relational context to develop and lead to satisfactory sexual interactions as the couple progresses through their life cycle.

Falling in love is accompanied by the experience of sexual desire. Mature companionate love among two differentiated persons allows for the experience of desire, out of fullness, not of need to be completed by the other, as Snarch (2000) states. In this context I focus on the difference experience of sexual desire that take place in the phase of being in love and in long term relations, because the participants in this research intervention project are in the stage of developing companionate love process, that ideally would take place after the inevitable experience of disenchantment, when the initial idealization of the other and the relationship begins to fade.

Love as an affective experience, take place in the domain of language where words are a bridge that connect people. The verbal exchanges may be kind and loving, indifferent or violent. Thus will be the circular interaction. When the couple change the language used, when they go from tenderness and care to disqualification and selective perception of what is negative in the other, more and more aggressive forms of behavior may appear and this will certainly affect negatively their sexual interactions.

When we are overtaken by routine, these acts lose their connection with the love experience and they become meaningless. Lang (2001) suggests that if we look at our loved one each morning in a fresh unprejudiced way, we might discover in him a new meaning and thus, we will awake with a new person every morning. Gonzales (1993) states that in order to experience desire for the other, which is essential to love, one must experience curiosity for that person and that is given by the constant self actualization of both members of the couple. Love requires self knowledge and respect towards oneself and towards the other in the context of a shared life project in which the participants have a very clear notion of circular causality.

Marriage, Daily Life, Love and Sexual Desire

One of the main variables to consider in this conceptualization of sexual desire disorder is the effect of every day life, competing roles and its vicissitudes in the sexual life of the couple and specially in their experience of desire. Sexual desire problems in the relationship context are developed and maintained systemically. It is easy to understand how the symptom decreases when the member of the couple with the high level of desire, stops pressuring for sex. His new behavior allows the low level person to change roles. Also, the voices of women in my practice indicate that sometimes when they experience more desire, their partners lowers theirs.

Bozon (2001) tackles the major issues concerning the relation between sexuality and conjugality in a socio-historical and cross-cultural perspective. I make emphasis also in the need of being object of desire, versus the woman as an object of possession, and the importance of knowing how to be the object of desire.

In the context of a love relationship, the “other one” has to be the “object of desire” to keep interest and desire alive and it is precisely that sometimes this is lost when people live together, when the couple plunges themselves into the essential trivialities of daily living.

There appears to be a link between sexual desire and relationship functioning. For men having sex solves relationship problems, no so for women. It seems that for women is the affective quality of the relationship which defines sexual satisfaction. The focus on sexual disorders and problems in clinical samples of couples has not allowed researchers to understand fully the ways in which sexual desire discrepancies may influence non distressed couples and also the fact that sex even if it is quite important in couple relationships, is only one part of marriage, not its totality (Apt et al. 1996; Morokoff and Gilleland 1993, quoted by Morokoff et al. 1997.)

Looking back to Gagnon and Simon's (1973 quoted by Bozon 2001) description of marital sex, one is struck by one difference. The authors pictured partners who were doing their best to enrich the scenarios for intercourse, despite restrictive internalized scripts eliciting feelings of guilt or inconvenience. For instance, everything that might signify a certain amount of female initiative was still felt to be a source of embarrassment and often brought about resistance among men and women. New behaviors and attitudes have become common. From the very start of their conjugal life, male and female partners have a rather diversified sexual repertoire, which has developed from their juvenile sex experiences. Female and shared initiative of intercourse are common, expected by men, and provide more satisfaction than does male initiative only. But,

ironically, this variety in the behavior of the couple early in the relationship gradually decreases over the course of conjugal life, as does the personal involvement of women. Marital sex evolves over time, less out of routine and habituation than out of gradual female disinvestments. This gender specific disinvestments cannot be considered a "relatively unimportant" phenomenon, as Gagnon and Simon felt about the decline in sexual interest in the couple in general. It is one of the factors and contemporary expressions of the disillusionment of partners, particularly women, with marriage in general and requires specific investigation.

In research on sex in couple relationships, the links between the nonsexual and the sexual remain an under explored area, all the more so as the relations between the emotional and the sexual, which are a very limited aspect of these links, are overemphasized in the literature (e.g., Aron and Aron 1991; Frey and Hojjat 1998; Marston et al. 1998, quotes by Bozon 2001). More than a rational exchange between partners -sex against sex, or sex against nonsexual rewards- conjugal sex ought to be analyzed as an organized social activity. In most cases, it is a conjugal habit, inscribed in a daily routine; it may be, on the other hand, an expected element in an out-of-home leisure practice. Short-term, rather than long-term trends in sexual activity need to be better understood. It would be useful to know more about sex in the context of the social organization of the week, to understand the differences between holiday sex, sex after an argument, and sexual routine-breaking practices. The significance of sexual activity in the relationship is better understood when the links of sexual events to other individual and conjugal practices, to individual life stories, and to the general functioning of the couple are taken into account (Bozon 2001).

The facts described by the general couples literature, which suggest that there is a strong relationship between sexual and marital satisfaction in couples (Morokoff and Gilleland 1993,

quoted by Morokoff et al. 1997), and the interpretation of this research findings by the popular media, contribute to the surge of the need to experience higher levels of sexual desire and activity, even though the couple or the individual were originally satisfied with their low level of desire and sexual activity.

One of my questions in this research is concerning the discrepancy among the verbalized recognition of the importance of sexual life and the actual actions that confirm the opposite. The incongruence between expressed belief and action, as it is present some times in desire disorders, could be better understood if we consider the effect cultural discourse evolution regarding sexuality expressed previously.

In China, a national report in sexual behavior (1992, quoted by Liu et al. 1997), found in many married couples a confusion regarding what is and what is not love, and that the marriages have high stability and low quality. The authors of the research concluded that to improve sex among married couples, maybe it would be necessary to emphasize the function of love and affection in marriage. They state that there is a need for adult sex education and that it should emphasize the importance and difference among affection and moral duties, rights and responsibilities. To maintain a happy and lasting marital relationship, it is not good to depend only in the strength of morality and law, because these can maintain, in the best of circumstances, only a superficial stability. The teachings about mutual respect and love on the other hand, would strengthen the foundations of a stable and happy marriage.

An integrative treatment for hypoactive sexual desire in women: Sexual-Contextual Therapy

The appearance of sexual therapy, in the context of history of psychotherapy, is a response to the need and the right of the human being to find a more satisfactory sex life. Recent findings

indicate that one of the most frequent disorders in the sexual field are the desire dysfunctions; specific psychotherapeutic approaches seek to facilitate the patient's recovery or development of sexual desire, excitement, and a more satisfactory sexual response.

Departing from Masters and Johnson (1970) conceptualization of the human sexual response cycle, Kaplan (1977) focused on desire and recommended the adoption of a three-phase model of sexual response, with desire as the first and most fundamental component of sexual arousal. She suggested that desire disorders were symptomatic of long standing intra-psychic conflicts, particularly in the area of intimacy and emotional control.

In recent years, some authors (LoPiccolo and Prior 2000; Heidman and Ellis 1995; Lieblum and Rosen 2000; Hulbert et al. 2000; Snarch 2000) have made significant contributions to the field and to the comprehension of desire disorders; integrating cognitive-behavioral, object-relations and systemic frameworks within the actual practice of sex therapy. Since the work and the contributions of these authors is so well known, I will not give a detailed description of their psychotherapeutic models.

In this study, I conceive my psychotherapeutic proposal as a systemic-contextual integrative approach, which takes into account previous contributions and makes special emphasis in the differential assessment of the factors that could have a greater incidence in the affective, relational and motivational context in which desire emerges.

The psychotherapeutic intervention offered here is conceptually derived from the systemic epistemology, which allows judicious eclecticism (Cecchin 2001). It also integrates cognitive-behavioral and gestalt techniques when appropriate. In agreement Heidman' statements (1995) the most conscientious position is:

> One that accommodates multiple theoretical frameworks and permits the therapist flexibility of interpretation and action. (476)

As a researcher, I seek to contribute to the integral and holistic comprehension of female hypoactive sexual desire disorder within a specific culture. According to this objective I developed an assessment protocol, starting with the clinical sexual history which specifically seeks to understand the nature of the desire disorder in each client, in order to orient the psychotherapeutic intervention.

Through the observations I have developed in psychotherapeutic encounters, I realized the importance of co-creating a psychotherapeutic context which would allow the client to experience that her particular needs are taken into account. One of the central ideas is that this intention could be achieved through the deliberate use of an appreciative language and inquiry which creates a context for change. A special emphasis is made on encouraging women to discover which is their sexual motive in order to be able to assume responsibility for their personal lives, and to feel entitled to the full experience of sexual desire.

Language as a psychotherapeutic tool

The language used to relate to sexual experience is developed within the context of the prevailing social discourse. Many of the difficulties a person experiences regarding sexual behavior have been developed within a linguistic context of prohibition, guilt, shame or negative attitudes towards lust, sensuality and sexual pleasure. It is the context of psychotherapy that alternative conversations can generate new understandings, affective reactions, and attitudes regarding sexual desire.

In the process of co-creating a psychotherapeutical system, I have chosen to use an appreciative language, first described by Lang (2000), which makes an emphasis on a positive connotation of the potential resources of clients; it opens hope in future possibilities used by

therapist and consultant within a context of respect for their distinctive view of reality. Heidman et al. (1995) values the integration of different psychotherapeutic models with language oriented approaches towards change without patologizing clients. As they say:

> There is not specific set of interventions or techniques, but rather process of examining the problem and coming up with possible solutions. (Heidman et al. 1995, 493)

Solutions are generated within the psychotherapeutic system via circular reflexive and generative questions and other systemic strategies. I use many elements of solution-focused therapy (Berg and De Jones 1996) because part of systemic epistemology is reflected in the emphasis on working with the systems' resources (Salgado de Bernal 1991). In this kind of therapy, interventions are characterized by reflexive questions generated from the narratives the clients bring, with emphasis in the exceptions to the problem behavior as exceptional situations in which the person has been able to cope successfully. The questions are predominantly oriented toward the future, opening new options and hope for the solution achievement. The therapist is encouraged to be creative and always alert to solutions embedded in clients' narratives.

When therapists stand from a position of respect for their clients' versions of reality, the co-construction of new metaphors become articulated as coherent aspects of the clients' new narratives. Furthermore, this attitude can facilitate clients' commitment to action. According to systemic theory, it is in the domain of aesthetics where we really create meanings about ourselves and our commitments (Kaj 2002).

My commitment with a congruent and systematic practice of appreciative language in this research intervention project, is based on the idea that it facilitates the interweaving of new expectations and experiences around sexual desire for the re-establishment of the order of desire.

Assuming Responsibility for one's Personal and Sexual Functioning

Johnson (1983) states that mature human love and satisfactory sex life are impossible without self-knowledge and self acceptance. These elements facilitate the return and integration of the rejected and projected material from the partner into the self. Contemporary Jungian authors (Johnson 1983; Woodman 1985) propose the capacity to retake the projected material and to develop individuation as a condition for mature love relations. Catheral (1993) for instance states that:

> The ultimate issue of therapeutic concern is not the mechanism of the projective identification itself, it is the couple's failure – as a system- to manage the disturbing thoughts and feelings that are the substance of projective identification. (355)

I also consider that the inclusion of the workings of the individual's self concept and self esteem is useful within this context of understanding the dynamics of the couple's system. These concepts are used to promote autonomy and differentiation, specially in those relationships characterized for blaming the other for the negative events or failures to archive sexual desire or other pleasures in couples' interactions.

Guided imagery

This technique is used to promote change. It has been found that there is a positive correlation between positive imagery and the development of positive action (Cooperrider 1999), even when the pathways that link mind and practice are unclear and require more research. According to Cooperrider (1999), human beings create their our own realities through symbolic and mental processes and because of this creative capacity, people can take the option of conscious evolution to a more promising future option. The author mentions:

> The intriguing suggestion that human systems are largely heliotropic in character, meaning that they exhibit an observable and largely automatic tendency to evolve in the direction of positive anticipatory images of the future… that just as plants of many varieties exhibit a tendency to grow in the direction of sunlight (symbolized by the Greek god Helios), there is an analogous process going on in all human systems. (30)

With these ideas in mind, it is possible to generate narratives and future images via the exploration of language. New stories and images that will generate a sense of possibility to make the experience of sexual desire, within the couple context easier to integrate. Images of trust, faith, playfulness and humor have a therapeutic value which I consider should characterize the context of therapy.

The possibility of positive images and words acting as a placebo is illustrated by Jaffe and Bresler (1980 quoted by Cooperrider 1999):

> Another important therapeutic use of imagery, namely, the use of positive future images to activate positive physical changes. Imagining a positive future outcome is an important technique for countering initial negative images, beliefs, and expectations a patient may have. In essence it transforms a negative placebo effect into a positive one . . . . The power of positive suggestion plants a seed which redirects the mind—and through the mind, the body—toward a positive goal. (135)

The technique of imaginery is used according to the narratives the client brings and her desired outcome. According to these authors, the force that drives the image is only part cognitive or intellectual, a much greater part is emotional, aesthetic, and spiritual. The image of the future not only acts as a barometer but actively promotes cognition and choice and in effect becomes self-fulfilling because it is self-propelling. Positive future images facilitate to seek transformations in conventional practice by replacing conventional images with images of a new and better future. When women engage in imaginery with positive sexual images, they build a bridge to unknown sexual possibilities.

Since imaginery is an inner symbolic language which constructs realities, one can speculate that language can function either as a cohesive element or as a source of conflict and separation

in human relations. Lakoff (2000 quoted by Zandee 2001) suggests that the use of appreciative epistemology and language contributes to the construction of better social realities.

The person of the therapist

In the intervention researched, the person of the therapist becomes a vehicle for clients' change. Therefore, the use of verbal and non-verbal language is a main intervention tool; it is through language that one can gain access to the meaning of the histories that people bring to therapy and it is in this context that new practices are built.

In the sexual-contextual therapy for low sexual desired proposed, openness, sense of humor and respect for diverse sexual dilemmas allows women clients to share their intimate experiences as well as unfulfilled sexual desires and expectations. It is fundamental for an ethical and aesthetical exercise of sex therapy that the therapist's personality has experienced the integration of the feminine in its diversity. Also, the practitioner of sex therapy must be aware of biases and prejudices, including the influence of sociocultural values and practices on the self and on the perception of the presenting problems.

The researcher's basic assumptions

In my practice of psychotherapy with women who present hypoactive sexual desire, I have observed that women present sexual desire complaints organized around some predominant themes or narratives, that deal with their particular comprehension of their sexual and other relational difficulties. Some of these are:

1. Love is equated to emotions and feelings of falling in love constraining possibilities to experience and respond to the sexual requests from male partners.

2. Anger and resentment tend to be associated with poor communication skills and lack of assertiveness.
3. Personal stories regarding the importance of sexual desire seem obscured by cultural and family of origin sexual narratives, minimizing the motivational power of sexuality.
4. Being a passive agent in sex leads to have intercourse without desire.
5. Personal beliefs that blame the partner for the sexual dissatisfaction .
6. Anticipated fear of rejection or other negative reactions from their partner
7. The use of sex as a reward or punishment for male partners' behavior.
8. Experiencing sexual desire threatens the stability of a chosen life style.

The presence of these elements along with the sexual difficulties and the literature review about treatment approaches for hypoactive female sexual desire disorder, foster the hypotheses which give direction to this exploratory research:

1. Women with hypoactive sexual desire have low assertiveness, resentment, anxiety, poor connection with their sexual self and difficulties in managing anger and aggression.
2. The sexual motive improves, if negative beliefs and myths received from the family of origin change.
3. If a change takes place in the nature of the sexual motive, the women will increase their level of sexual desire.
4. The proposed psychotherapy approach will have a positive impact on the subjective experience of sexual desire.

CHAPTER 3
METHOD

The purpose of this research was to contribute to the comprehension of the personal and systemic workings of sexual desire of women who experience hypoactive sexual desire in Colombia. The intervention was planned with a pre-test and a post-test design, to make an initial assessment of the factors associated with hypoactive sexual desire, and to observe if sexual desire increased after the proposed psychotherapeutic intervention was completed. A systemic epistemology contributed to enrich the theoretical and practical aspects taken into account in the proposed intervention. This framework was also complemented with cognitive-behavioral understandings and techniques, which have been proven to be very efficient in the field of sexual therapy (LoPiccolo 2000; Lieblum and Rosen 1989; Heidman, Hill, and Ellis 1995).

Participants

Nine Colombian heterosexual women ranging from 32 to 47 years of age volunteered to participate in this study. They all were college graduates and self- supporting. All but two of these women hold stable jobs. Several criteria were used to select participants for this study: 1. Absence of a Diagnosis of severe mental disorder or personality disorder according to DMS-IV-R criteria. 2. Presence of hypoactive sexual desire according to DMS-IV-R criteria. 3. Cohabitating in a committed heterosexual relationship for at least two years.

Table 1.Qualitative summary of the conditions and psychological characteristics of the sample.

Subjects	Demographic data	Presenting Problem	Main areas of conflict	Focus of the psychotherapeutic intervention
Vesta	32 year old professional. Has been married for seven years, with a son.	Acquired hypoactive sexual desire. Sexual desire has been almost absent for three years.	Resentment against her partner. Low assertiveness. Low sexual motive associated to family of origin issues regarding sexuality. Low contact with bodily sensations. Lack of permission to be sexual.	Work on resentment and forgiveness. Training on basic communicational skills. Family of origin differentiation. Permission to be sexual and to engage in autoerotic activities. Work on connection with corporal and sexual sensations. Sensate focus practice with partner.
Demeter	41 year old professional. Married for 15 years, with two daughters.	Life long hypoactive sexual desire. Never initiates sexual relation. Occasionally she has enjoyed sex.	Low sexual motive associated to family of origin issues regarding sexuality. Lack of body contact and self eroticism. Difficulty in the transition from discourse to action in the erotic and sexual area.	Family of origin differentiation. Permission to be sexual and to engage in autoerotic activities. Work on connection with corporal and sexual sensations. Work on the transition from speech to action in the erotic and sexual area.
Ninfa	34 year old professional. Married for 4 years, with two sons.	Acquired hypoactive sexual desire. Sexual desire as well as sexual fantasies have absent for the last couple of years.	Marital conflicts associated to partner's unjustified jealousy. Tendency to keep resentment. Low assertiveness Low body contact and disconnection from sexual feelings.	Training in communication and anger control. Work on resentment and forgiveness. Intervention with the partner to work his jealousy Increase connection with corporal and sexual sensations. Work on connection with corporal and sexual sensations.
Proserpina	36 years old technician. Married for 4 years.	Acquired hypoactive sexual desire. Low sexual desire for the last two years. Perceives as main problem her difficulty to respond and start the sexual encounter.	Marital conflicts and lack of satisfaction associated to routine and perceived inequity in roles. Poor anger control and tendency to hold resentment. Sexual performance anxiety Poor body contact and disconnection from sexual feelings.	Training in communication and anger control Work on self responsibility for life style. Cognitive restructuring over the roles of both of them. Work on autoeroticism and sexual fantasies. Work on sexual communication with her partner.

Table 1- *Continued.* Qualitative summary of the conditions and characteristics of the sample.

Subjects	Demographic data	Presenting Problem	Main areas of conflict	Focus of intervention
Diana	30 years old professional. Married for 8 years, with one daughter.	Life long hypoactive sexual desire. Significant discrepancy in the level of desire with her partner.	Poor anger control and tendency to hold resentment. Anxiety associated to fear of losing control. Low sexual motive associated to family of origin issues regarding sexuality. Poor body contact and disconnection from sexual feelings.	Training in communication and anger control. Family of origin differentiation. Permission to be sexual and to engage in autoerotic activities. Cognitive restructuring on the role of sexuality in her individual and couple life. Work on self responsibility for sexual experience and life style.
Minerva	38 years old professional. Married for 13 years with two daughters.	Life long hypoactive sexual desire. Requires specific environments to respond sexually to her partner.	Anxiety associated to fear of losing control. Low sexual motive associated to family of origin issues regarding sexuality. Difficulty in the transition from discourse into action in the erotic and sexual domain. Disconnection with the sexual self. Pre-orgasmic.	Cognitive restructuring on the role of sexuality in her individual and couple life. Redefinition of the meaning of loosing control sexually. Work on the connection with corporal and sexual sensations. Orgasmic training. Work on self responsibility for sexual experience and life style.
Mito	42 years old professional. Married for 18 years with two adoptive daughters.	Life long hypoactive sexual desire. States that she never feels sexual desire; that she could live very well without having sex.	Low sexual motive associated to family of origin issues regarding sexuality. Resentment associated to lack of sensitivity of her partner to her lack of desire for sexual relations. Lack of sexual assertiveness. Anxiety associated to fear of losing control. Disconnection with the sexual self. Pre-orgasmic.	Work on resentment and forgiveness. Family of origin differentiation. Rupture of the connection between sexuality and maternity. Work on the connection with corporal and sexual sensations. Orgasmic training. Redefinition of the meaning of loosing control sexually.
Psique	47 years old business woman. Married for a third time, for 2 years.	Life long hypoactive sexual desire. She has never enjoyed sexual relations. She feels empty and frustrated with sex.	Low sexual motive associated to family of origin issues regarding sexuality. Traumatic first sexual relation. Dispareunia. Resentment toward previous partners because of being insensitive to her affective and sexual experiences. Disconnection with the sexual self. Pre-orgasmic.	Work on resentment and forgiveness. Assertiveness training to prevent passive aggressive behavior and depression. Interventions focus in the post traumatic stress. Changing of narratives regarding herself and her sexual y potential. Emotional acceptance of her sexual herself. Orgasmic training.
Juno	48 year old professional. Married for the second time, for 20 years.	Life long hypoactive sexual desire. Stopped having sex with her partner two years ago.	Resentment towards her partner due to failure to meet her expectations. Low sexual motive associated to family of origin issues regarding sexuality. Disconnection with the sexual self.	Work on resentment and forgiveness. Family of origin differentiation. Work on the connection with corporal and sexual sensations. Cognitive restructuring on the role of sexuality and romantic expectations in her individual and couple life.

The participants in this study agreed to complete a pre and post battery of psychological assessment measures and to attend the eleven scheduled intervention sessions. Table 1 presents a summary of the demographic and psychological characteristics of the sample.

Instruments

For the purpose of this research nine assessment instruments were used, six of those were specifically designed for the present research and judged by four experienced couple therapists. Other assessment and intervention instruments already available were used: the Rathus assertiveness scale (Rathus 1973), the personality assessment inventory (Morey 1991), Kegel's exercises (Kegel 1956) and LoPiccolo's Becoming Orgasmic's video (1980). The following is a more detailed description of these instruments:

1. The "sex history questionnaire" consisted of 41questions to gather demographic information, significant medical background, relationship patterns, family of origin issues, values and moral issues, previous sexual experiences, degree of attraction to the partner, and expectations about sex and its affective context (see appendix A).
2. A "revised sex history questionnaire" consisted of 16 questions. This questionnaire provides information on the change indicators. It was designed with pertinent items of the first questionnaire, relative to the thoughts and behaviors, which would indicate the results of the intervention (see appendix B).
3. The "expectations and attitudes towards sexual desire questionnaire" consisted of 18 multiple choice item that evaluate the women's attitudes and expectations toward sexual desire (see appendix C).

4. Scale of sexual motive: This is a 12 item Likert scale designed to explore the participants' beliefs and feelings that conform the sexual motive (see appendix D). It was developed on the base of spontaneous answers of 70 women between 25 and 60 years old, and in different contexts randomly selected such as the work place or a health club. The basic question was: "What do you think about sex?" Six items of the scale reflect the positive attitudes and the other six, the negative ones. These items were scored in a range of 1-4 points. The positive items were scored by assigning 1 if the answer was absolutely false, 4 if the answer was absolutely true. The negative items were scored in the opposite direction. The totally false answer scored 4 and the absolutely true answer scored 1. The scale has a maximum score of 48 and a minimum score of 12. A score close to 12 indicates a more negative attitude towards sex, while a score near 48 indicates a more positive attitude towards sex.
5. Semi-structured interview with the participants' partners: This is a seven question interview designed to explore the participants' male partner understanding of the presented problem (see appendix E).
6. Change indicator questionnaire: This questionnaire was designed with the purpose of checking indicators of progress in the participants from their partner's perception (see appendix F).
7. Personality Assessment Inventory (PAI): This is a self administered objective inventory of adult personality designed to provide information on critical clinical variables. The PAI contains 344 items, which comprise 22 non-overlapping full scales: 4 validity scales, 11 clinical scales, 5 treatment scales, and 2 interpersonal scales. For the evaluation of the factors associated to low sexual desire, the aggression scale was selected because of the relationship between low sexual desire and the management of anger and aggression. The item content

includes indicators of verbal assertiveness and poor anger control. Since anxiety has been associated with low sexual desire in women, the anxiety scale was selected. The treatment rejection scale which gives a measure of attributes and attitudes associated with an interest in personal changes of a psychological or emotional nature, was selected to explore commitment to the treatment.

8. The Rathus assertiveness scale was used with the purpose of having an indicator of assertiveness which is related to feminine low desire disorders. The Rathus scale measures assertive behaviors across a variety of business and social contexts (Rathus 1973). The instrument includes 30 items, 16 reversed to avoid response bias, and employs a six-point Likert-type response format. In the Rathus scale both high reliability and concurrent and predictive validity have been reported.
9. Kegel's exercises: These are the most common method to strengthen the pubococcigeal muscle and have the effect of incrementing the awareness of sensation in the pelvis and an increased arousal. This is a set of exercises designed to strengthen and give voluntary control over the muscles surrounding the genitals (known as the pubococcygeus muscles) and thereby increase sexual pleasure and awareness.
10. LoPiccolo's Becoming Orgasmic video: Teaching audiovisual film that presents a woman who discovers her body and learns to masturbate and the process of becoming orgasmic.

Procedure

This study was conducted in Bogotá, Colombia. The intervention and application of all assessment instruments are in Spanish, since it is the native language for both therapist and participants.

Given that this research touched on very sensitive issues regarding sex, three ways of recruiting participants were tried. Initially, two Catholic marriage counseling services were contacted. However, it was not easy to engage participants through this method. In addition, letters were mailed to experienced clinicians hoping that through a professional network of colleagues, participants would be referred. Unfortunately, this was also unsuccessful. Finally, the department of psychology at Universidad de los Andes was contacted in order to access the population of female employees.

With prior consent from the Psychology Department at the Universidad de los Andes, participants were reached using the internal computerized data base that circulated information about the proposed study to university employees. The message included a small questionnaire of four questions about sexual feelings; it also included a brief summary of the researcher's clinical experience and a way to contact the researcher if in interested in getting involved in the study (see appendix G).

Nineteen women called me expressing their interest in the research. In this first telephone contact, they received initial information about the purpose of the study, the criteria for participation, and the responsibilities acquired if the decision to participate was made.

Ten women were excluded at that point for various reasons: three women were not involved in a cohabitating relationship at the moment; two had medical complaints; two had less than two years of cohabitating relationships with their partners; two were not college graduates; the last one said that it was impossible for her partner to collaborate in the study.

Nine women who seemed to be potential participants were given a first interview appointment to check if they met criteria for participation; they answered my questions to rule out a diagnosis of hypoactive sexual desire, according to the Diagnostic and Statistical Manual of

Mental Disorders (DSM-IV-TR).They also completed the Personality Assessment Inventory to exclude significant psychological pathology. Since all the respondents met the criteria for participation and agreed to participate voluntarily, they were further informed about their responsibilities in the research and gave me their verbal consent. They accepted my request of contacting by telephone their male partners to make sure that they would also consent to participate in the study.

Unintendedly, this first personal contact allowed me to establish rapport with the participants; I formed an initial idea about what desire difficulty meant for each of them. At the end of this meeting, we scheduled the following appointments, including frequency, time, and length of the intervention sessions. The interviews were conducted in my private practice office and most of the meetings were scheduled once a week, unless there was a holiday or an exceptional event.

Before the initiation of this research intervention project explained to the prospective participants that the collaboration of their partner was required. Fifty percent of them manifested their certainty that their partner would refuse to take part in the process. The use of appreciative language and the formulation of their help as a necessary condition to improve the possibility of success of the intervention was expressed in the following terms: “Your partner has chosen to participate in this study because she wants to overcome her difficulty with sexual desire. Since you are the person who is closest to her, you are the one who is able to give me the necessary information to effectively design her treatment plan.” None of them declined to participate in the individual interview and it was easier to introduce the notion of circularity in the co-creation of the presenting problem. Also, this approach increased the possibility of reaching agreements in the conjoint interview in a later session.

The psychotherapeutic process consisted of eleven intervention sessions, according to the brief therapy model. The following is a description of this process:

1st Session: I interviewed the participant using the sex history questionnaire and recorded her answers in writing. After that, she completed independently both the scale of beliefs about the meaning of sex and the expectations and attitudes towards sexual desire questionnaire.

2nd Session: The session began with an interview to explore further the presented problem; later, instructions regarding the practice of Kegel's exercises and gestaltic practices were given in order for the participant to get in touch with her body and sensuality.

3rd Session: The participant's male partner was interviewed using a semi-structured interview protocol to explore his thoughts, feelings, and reactions about his partner's low sexual desire.

4th Session: The participant began stating her basic goals for treatment and chose specific target behaviors to work on. She accepted to practice in between sessions the activities prescribed in order to facilitate to recover her sexual desire.

5th Session: Conjoint interview (participant and her partner): I interviewed the couple regarding experienced progress on the issues stated in the previous session, including the assigned homework; the session focused on the relational context of the couples' difficulties. The main goal of the session was to construct a circular conceptualization of the problem; from this understanding, new goals and additional tasks related with the erotic discovery were set.

6th Session: The woman participated in a process of finding ways to get in touch with her body, mainly through the use of cognitive-restructuring within the therapeutic context. According to the woman' specific needs, techniques that facilitate contact with the body and appropriation of the sexual being were offered. In some cases, the sensate focus tapes were used.

7th Session: Conversation about the accomplishment of the intervention goals, including the usefulness of the homework assigned. The session allowed for the participant to reflect on her views regarding the best ways in which she could achieve her goals we also dealt with her questions and the usefulness of homework and the sexual exercises.

8th Session: Conjoint session (participant and her male partner). This session sought to evaluate the progress and/or conflict relationship factors that could be interfering with the re-establishment of the order of desire. Homework was followed up.

9th Session: The participant attended the session individually. The psychotherapeutic intervention focused on specific issues brought up by the woman. The homework from the last session was followed up.

10th Session: Individual session. The session centered around exploring questions from the revised sex history questionnaire which was used to evaluate progress and achievements. This process provided feedback to the therapist regarding the changes generated via the psychotherapeutic intervention. The improvement in the items related to degree of interest in sexual life, behaviors related to the inhibition or avoidance of desire, and arousal and negative anticipation of sexual encounters were used as indicators of therapeutic changes.

11th Session: Individual session. Final evaluation of goals and achievements according to the individual intervention' goals. The woman completed again the scale of beliefs about the meaning of sex and the Rathus assertiveness scale.

Once the intervention was completed the participants' partners were interviewed by telephone. This interview included the questions of the change indicator questionnaire. The men received acknowledgment for their collaboration in their partner's process. Vesta's was not interviewed because Vesta decided to divorce after the seventh intervention session. Psique's

partner was not interview because after the holidays and before the date scheduled for this interview, (although in a conjoint session before the end of the process) he expressed that Psique had improved a lot in her capacity to enjoy and initiate sex. For the analysis of the findings, sessions 1, 2, 6, 10 and 11 were recorded (see appendix H). In order to preserve confidentiality, the participants were renamed using ancient mythological figures. Those sessions were chosen to record first impressions, the intervention progress in the middle of the process, and final impressions.

Non-parametrical tests were used to compare any significant changes that might have taken place in:

1. The level of sexual desire after the intervention process.
2. The level of assertiveness evaluated with the Rathus Scale.
3. The sex motive.
4. The participant's orgasmic capacity.
5. The participant's self- esteem level.

CHAPTER 4
RESULTS

Results from this exploratory study made use of non-parametric statistics and was enriched by the qualitative findings derived from psychotherapeutic intervention. The voices of the participants were integrated through quotations in order to record their experiences, attitudes, and beliefs regarding their low sexual desire. The results obtained prior to and following the psychotherapeutic intervention are described in Table 2.

This study found that low assertiveness, resentment, anxiety, and negative attitudes towards sexual and autoerotic practices were factors that had incidence in low sexual desire, as has been found in the studies of researchers in other countries. In addition, psychotherapy intervention proved to be helpful in improving the experienced level of sexual desire. It seemed that the systemic-contextual approach to the intervention facilitated the emergence of new narratives and possibilities for these women, as most of them began to show some ownership of their sexual self.

Concerning to treatment rejection, as results in Table 2 show, five out of nine participants obtained a T score between 32-40, indicating a high need for change and personal commitment. Three of them had scores ranging from 47-52 which reflect the need to change something in their lives and a sense of personal responsibility. The participant that changed least, Mito, had a T score of 54 which in the test reflects low commitment to psychotherapy. This is in agreement with the fact that what motivated her to participate, more than internal conviction was that she felt she did not fit well with contemporary expectations regarding sexual behavior.

This experienced need for change and treatment is partially responsible for the obtained success in the therapy, as it may be seen in table w, concerning changes in sexual desire. Those changes will be discussed later, following the order of results in Table 2.

Assertiveness

As it can be seen in Table 2, the phase prior to the intervention, the greatest percentage of women (six) had a low level of assertiveness according to the Rathus scale. After the intervention, all of them (nine) were in a level ranging from medium to high. The change was significant according to the sign test with a probability $p<0,05$.

Regarding sexual assertiveness, it appeared that none of the participants initiated sexual activity, a fact that was corroborated by their partners in the context of the semi structured interview. They all expressed that a good indicator of positive change in the sexual desire of their female partners would be that women initiated the sexual encounter. All but one of the women reported that they sometimes had sexual relations without desire, out of fear of their partners' anger, emotional pain, or potential infidelity. For instance these comments and similar verbalizations from other women, reflect that they became assertive enough to stop unwanted sexual relations. The fallowing are the answers of some of the participants regarding the fact of having sexual relations without desire and how they changed their position during the psychotherapeutic intervention process:

Psique (1st session): "Yes, I have had sex without wanting it, and I felt dreadful and angry because of my submission."

Diana (1st session): " Yes, sometimes out of fear of hurting him."

Table 2. Pre and post test conditions in the level of desire, frequency of sexual relations and psychological factors associated with sexual desire

Subjects	Assertiveness		Level of self esteem		Indicators of PAI				Resentment		Sex Motive		Orgasmic Dysfunction		Desire Level		Frec.Rel. Sex	
	Pre	Post	Pre	Post	Affective Anxiety	Cognitive Anxiety	Aggression	Treatment Rejection	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pret	Post
Vesta	Low	High	Low	High	57	61*	43**	33	Yes	No	35	45	Second	None	Low	High	Low	N.A.
Demeter	High	High	High	High	60*	57	44**	51	No	No	33	36	Second	None	Low	Med	Low	Low
Ninfa	Low	Med	Low	High	57	60*	43**	51	Yes	No	35	39	Second	None	Low	Med	Low	Med
Proser	Low	High	Low	High	69*	62*	60*	40	Yes	No	37	43	Second	None	Low	Med	Low	Med
Diana	Low	Med	Normal	High	68*	72*	72*	34	Yes	No	36	38	Second	None	Low	Med	Low	Med
Minerva	High	High	High	High	52	55	66*	40	No	No	33	33	Primary	None	Low	Med	Low	Low
Mito	Med	High	Low	Normal	68*	59	64*	54	Yes	Yes	28	32	primary	None	Low	Low	Low	Low
Psique	Low	Med	Low	High	62*	55	59	32	Yes	No	31	39	Primary	None	Low	Med	Low	Med
Juno	Low	Med	Low	Normal	62*	52	43**	47	Yes	No	24	32	Second	None	Low	Med	Low	N.A.
											32.4	37.4						

N.A: They separated during the intervention process.

* Moderate score increase compared to the standardization sample.

** Moderate score decrease compared to the standardization sample.

Vesta (1st session): "Yes. To avoid conflict and to preserve my marriage."

Diana (10th session): "I feel much better. He has understood that sometimes I do not want to have sex."

Vesta (6th session): That she refused to participate in the sensate focus exercises because she did not want to have sex anymore with her partner.

Self esteem

The "sign test" showed a significant change with a probability of $p<0,05$ in the reported self-esteem level of the participants. The change was evidenced by comparing the self-reported clinical history' before and after the intervention (see Table 2). Initially, six out of nine women reported that they experienced low self esteem associated with the low sexual desire complaint, where as in the post- test all of them had normal or high self-esteem. The fallowing answers of two of them to question three of the sexual history questionnaire: "Do you consider that this difficulty has affected your self esteem? If your answer is positive, express how?" reflect the effect of the sexual difficulty on their self esteem:

Ninfa: "Yes. He criticizes me for my lack of sexual interest and he also criticizes my body, even if I am not fat and exercise a lot."

Demeter: "Yes, a little. I ask myself sometimes if my husband finds me ugly or not desirable or if I am not so good in bed."

After the intervention, the self report on self esteem increased for most of the participants. The two women I refer to previously gave this answers to question eight of the revised sex history: "Do you consider that overcoming the difficulty with sexual desire influenced your self esteem? If your answer is positive, please explain how":

Ninfa: "Yes, because I was afraid of his reactions and unmotivated for sex. Now I know that what I do is right".

Demeter: "Yes, I feel better with myself because I know now that it is not only my problem."

Anxiety

The hypotheses regarding the presence of anxiety in women who evidence low sexual desire was confirmed. The Personality Assessment Inventory showed that six (6)out of nine of the participants showed significant affective anxiety while four showed cognitive anxiety. Two women showed significant levels of affective and cognitive anxiety (see Table 2). Women's narratives in this study manifest that the anticipation of the sexual encounter is a source of anxiety. One of the most significant voices regarding this experience was:

Diana (1st session): "I am shamed to tell you that I count the days between one relation and the other. I begin to prepare myself to feel desire and I do not always succeed."

Anger and Resentment

The results of the Personality Assessment Inventory in the column labeled aggression in Table 2, showed that three out of the nine participants had a moderately elevated score (60 T through 69 T) in the aggression scale, which suggests impatience and quick- temper. One out of the nine scored above 70 T, suggesting a tendency to be chronically angry and to freely express her anger and hostility. Four of them had a tendency to be passive regarding aggression.

Table 3. Extract from the interviews records.

Name	First Session	Sixth session	Tenth session
Vesta	"I am dying of anger and resentment because of the financial problems I face because of him."	"It is only now that I can protest. I do not keep things to myself anymore."	"Now I resent him for his financial lack of responsibility, not because of sex issues."
Demeter	She did not express resentment towards her partner.	"I am beginning to enjoy my role as a seductress, even if he does not react as I am expecting."	"He is very good at giving sensual massages, even if the genital relation is not perfect"
Diana	"I hate his direct approach, he ignores that I need caressing and other things before having sex."	" I am understanding how by being resentful like my mother, I have difficulty in expressing my needs and controlling anger. I have to let go of that."	"He has given me a lot of support for my difficulty to expose my body.. he is very tender and tells me that I am very beautiful and lovable.
Juno	"He has not given me the kind of support I need … how on earth does he expect me to respond sexually!"	"I have changed my attitude. Before I thought that a long face would do for him to react the way I wanted, but I know that I have to do something else."	"I understood that in my anger, because he did not accept my new way of relating , I could not appreciate the many positive qualities he had."
Minerva	She did not express resentment towards her partner.		
Mito	" I resent how he ignored me when I had sex with him without desire...He was extremely insensitive to my needs. I hated the smoothness of my father, the way he embraced me. He reminds me of his intrusive attitude. I hate that kind of touch.."	" I cannot let go of the resentment I felt when I had sex so many times to get pregnant and I had to fake pleasure not to hurt his virility".	"The problem is something very difficult to define and verbalize. He treats me too much as his equal, as if I were a male friend of his.. that hurts a lot."
Ninfa	"He does not believe in my lack of sexual desire. He is jealous and watching me all the time I feel a lot of resentment."	"Now that I do not lie to justify innocent things like going shopping after work, and I know how to communicate with him better, his questioning affects me less and I feel a lot less resentment."	"the relationship has improved. He takes care of the children. He controls himself better. We have much better communication...There are moments in which we are very close."
Proserpina	"I think that having sex so frequently takes the magic out of it ... I like him a lot, but absence of foreplay and routine makes me very angry."	"I poison myself keeping things inside , not expressing them. If I talk to him nicely, he stops being defensive. He is not as vindictive as I am."	"I think about what we got in therapy. If I speak nicely get what I want and I do not feel resentment."
Psique	"It pisses me off that he ignores that if I do not want sex it is because it hurts and that I am not making up an excuse."	" He has been very patient and considerate with me	"I worked on my sexuality for 18 months with him. I will always be grateful to him for that experience".

This finding was also confirmed by the self report obtained from the sexual history questionnaire, which reflected that seven (7) of the participants experimented anger and resentment towards their partners. Table 3 presents some of the causes of resentment. The effect of resentment and the decrease of marital satisfaction was observed in the present study from data derived from the self report instruments. Accordingly, 6 of them expressed a medium level of marital satisfaction and 3 women a low level.

A significant difference was found between the pre and post intervention reported answers concerning resentment. The sign test evidenced significant reduction in the level of resentment towards the partner ($p<0,05$). Once the psychotherapeutic intervention was completed, eight participants reported feeling no resentment toward their male partners.

Sexual Motive

In relation to the attitudes and beliefs respect to sexuality which are a part of the sexual motive and distinct from motivation, it was found that for a maximum score of 48, the greatest part of the subjects were in a rank among 31 and 37, except one of them whose score was in the average range. Interestingly, in the post test, eight participants increased their scores in this scale, showing a more positive attitude about sex as seen in Table 2. When the Wilcoxon test was applied the results reflected a significant change in sexual motives with a probability $W < 0,005$.

The findings with the sex motive scale could be associated to the answers the participants gave in the sexual history, regarding the traditional beliefs received from their family of origin about sexuality. Among the beliefs learned in the context of the family of origin, one theme was the conception of sex for procreation and not exclusively for pleasure. Another constant theme

was the notion that sex was so bad, that can not speak about it. Finally they expressed the notion of the prohibition of autoerotic practices and the high value of virginity.

Some of the answers to question number 8 of the sexual history questionnaire are an example of the prevailing beliefs and attitudes transgenerationally transmitted: "All families have beliefs regarding sexuality. Which do you believe were the most important you received?"

Vesta: "Sex equals something bad. Sex is more for procreation than for pleasure."

Myth: "We should never speak about sex. In a way, I inherited my mom's sexual feelings. Her disgust for it."

Minerva: "Masturbation is a sin. Fatness is bad and ugly. Men are philanderers."

Some of these family legacies regarding sex were modified during the intervention process. The self reports of the participants in the revised sex history questionnaire, indicate that most of the participants developed new meanings regarding sex. Some answers to question 9, "Which of the beliefs received from your family of origin did you revaluate?" were:

Vesta: "I demythologized sex. It is not only for reproduction but a legitimate way to generate one's own pleasure. I now know that it is something right."

Minerva: "To have autoerotic activity, to masturbate is not a sin."

Demeter: "Sex became a licit activity for me, something I could speak of. It was okay and important to develop appropriate sexual techniques."

The participants evidenced different attitudes regarding sex which ranged between acceptance, rejection or minimization of its significance their lives. The answers to question number twenty four of the sexual history reflect this diversity: "Which is your attitude towards sex in general?"

Minerva: "Sex is something right. I would like to enjoy it more."

Diana: "It is not the ultimate experience. One has to do it and sometimes it is pleasant."

Juno: "What a bore. It has been so in the past years. Not before because I was very much in love."

Myth: Sex is "A disqualifying experience."

Demeter: "Something I deeply connect with affection. No fucking for the sake of it."

It was interesting to note that none of the participants at the beginning of the study engaged in autoerotic behavior. It was necessary to use cognitive behavioral and systemic strategies to facilitate the behavior. It was interesting to observe that all of the participants blamed their mother's for instilling the idea that autoeroticism was morbid, bad, and something not approved. For example, the question number twenty seven of the sexual history: "If you decided to self explore your body to get in touch with it, know its functions and give yourself pleasure, would there be a disapproving internal voice? What would it tell you?"

Mito: "Yes. My mother's voice would disapprove saying that it is something immoral."

Diana: "Yes. The voice would say that it is not right."

Minerva: "Yes. I do not know whose voice. It would say that to masturbate is ugly, to make oneself experience sexual desire touching the body, would be bad."

All of the participants expressed the need for some romance before sex and felt frustrated by the absence of a romantic context for the sexual relationship. Two of them had desire and satisfactory sexual experiences only when the sexual encounters took place in special context like a couple trip or vacation. All the women associated the affective quality of the relational context with their availability for sex and sexual pleasure. Some comments from the participants when answering the sexual history, reflect this need:

Diana: "I never liked going to a motel. It seems to me that it implies that one proceeds immediately to sex … A care a lot for the previous affective context."

Ninfa: "There is no foreplay. He touches my breasts as if he was turning on the TV set."

Minerva: "Sometimes I think he is going to come too quickly and that I will serve him as a release."

Proserpina: "That both of us experience love in the encounter in a way that it can be felt and heard."

Within the conversations in the psychotherapeutic context, the participants constructed new narratives about sex and couple's relations. For instance:

Juno (6th session): "I am aware now that the idea I had of love maybe is not accurate ... The idea I had before was more romantic and now I do not have the same idea."

Psique (6th session): "Now I have started to see myself and situations in a different way. I did not know that I had so many limitations and that I had neglected myself."

Intervention outcome

To evaluate the efficacy of the psychotherapeutic approach proposed in the study, the sign test was used in order to compare the level of sexual desire of the participants pre and post intervention (see Table 2). Results indicate that the psychotherapeutic intervention was effective to improve the subjective perception of the women of their sexual desire level, with a probability $p< 0,05$, which supports the hypotheses associated with the notion which assumes that if the intervention is personalized and directed to the factors that inhibit sexual desire, such as nature of the sexual motive, low assertiveness, anxiety, resentment and anger, the women will increase their desire level.

Regarding the frequency of the genital sexual encounters reported by the participants pre and post intervention, no significant difference was found; this supports the conclusion that the proposed psychotherapeutic approach was effective to increase the subjective experience of the level of quality of sexual desire but not the frequency of desire and sexual activity (see Table 2). In the question 1 of the revised sex history questionnaire: "Have you experienced any change in your level of sexual desire after this psychotherapeutic intervention?" the answers reflect that a change has taken place:

Ninfa: "Yes, my sexual desire has improved, more in quality and in intensity than in frequency on relationships have been better, closer, more intense"

Proserpina: "Yes, I experienced improvement. I am closer to my partner and also I spend more time with him"

Diana: "Yes. A definite yes. My desire has improved because of the suggestions you gave me in the course of therapy. They have helped me very much."

In the post-test interview with the male partner of the couple, all men agreed that the participants frequency of desire to have sexual relations remained the same, even if the attitude towards sex and the quality of sexual relations improved in most of them.

The effectiveness of the intervention was also reflected in the fact that the participants overcame their difficulty with orgasm. The change was significant according to the sign test with a probability $p<0,01$. Three of the participants reported that they experienced orgasm through masturbation for the first time in their lives and after that they transferred it to the sexual relation with the partner. Psyche's beautiful words reflect this achievement:

Psique (5th session): "For the first time in my life at 47 years of age I felt the energy of desire running through my body. I felt in touch with my whole self. I felt integrated…."

Discussion

The results indicated that the nine Colombian participants in this study showed similar psychological factors as those described by other researchers in different samples with hypoactive sexual desire.

The lack of assertiveness was a common factor for the participants of the study. Even those two that in the Rathus scored high, lacked assertiveness in the sexual domain. This deficit was evident in the fact that all of them have had sexual relations on certain occasions, without desire. Also, most of them could not bring themselves to express their sexual needs to their partners This feature was in agreement with the findings of Perper and Weis (1987), Paternostro (2001) Blumstein and Schwartz (1983) (quoted by Morokoff, Quina, et al. 1997).

This low assertiveness in the women as a group seemed to reflect socialization influences on the women's perception of their feminine role in the couple relation. This in turn appears to have been influenced by maternal modeling which according to the participants narratives, reflected a lack of assertive expression of needs and feelings, of ability to set limits and to express emotions appropriately. For most women, to express whatever they felt was a way to be honest with their partners, without empathic discrimination of the effect of their words. Such a reaction could be explained as poor anger control as it was seen in the results of the personality assessment scales and subscales that reflected impulsivity in some and passivity which led to resentment. This indiscriminate expression of feeling and emotion could be conceptualized as a product of socialization associated with the idea of being honest in the couple relationship. These findings concurs with Salmurri (1991) who found that assertiveness was associated with good

communication skills, empathy and ability to discriminate among assertion, aggression and passivity.

It was also found that the anxiety related to the necessity of having unwanted sexual relations, reinforced the avoidance mechanisms of sexual situations; which agrees with the findings of Van minen and Kampman (2000) which suggest that for women sexual dysfunction is related to anticipatory anxiety of sexual situations which leads in turn to avoidance, primary characteristic of sexual desire disorders. The fact that 6 of the 9 women of the sample showed a tendency towards affective anxiety, corroborates Kaplan's (1979-1995) postulate that sexual desire could be interrupted or "shut off" by emotional factors such as anger and anxiety. In this particular study, anger, and resentment were related also to unresolved conflicts in other areas of the relationship such as financial issues, lack of equity in distribution of roles and domestic work, lack of balance between the needs for closeness and distance, or the incapacity of the partner to verbalize affection and imagine his partner's emotional and sexual needs. These unfinished issues which were transferred to the relationship acted for women as a restraint of sexual desire.

It was observed that when relationship problems were negotiated openly and satisfactorily, the attitude and disposition of the participant to engage in sexual relations improved. This in turn increased their motivation to compromise with the psychotherapeutic homework designed to increase sexual desire, such as the practice of erotic fantasies or exercises to increase sexual sensations.

All participants showed performance anxiety, in the form of negative anticipatory cognitions. Mental images of failure and displeasure appeared when they sensed that their partners wanted to engage in sex. They experienced incapacity to feel pleasure, to measure up to the expectations of

their partners, or were afraid of the negative consequences for their lack of responsiveness. These findings are in agreement with the ones of other researchers in North America (Barlow 1986; Van Minen and Kampman 2000; Master and Johnson 1970; Kaplan 1995).

There seems to be a circular relationship among lack of sexual assertiveness, anxiety regarding sexual performance and fear of the consequences of refusing to have sex. The inability to refuse unwanted sexed increased anxiety and resentment, which in most of the women appeared to play a role both on diminished sexual desire and on the negative perception of the partner and / or the relationship. The women's self report measures indicated that the women who had sexual relations against their will, even when angered, reinforced their resentment, a fact that coincides with Regan's (2000) formulations.

The majority of the participants required a romantic context to experience a desire to have sex and as a group they presented difficulty in assuming that relationships change over time and that it is unlikely to experience on a daily level the emotions and feelings of being in love at the beginning of a relationship.

The tension connected with carrying out the multiple roles their lifestyle demanded was reported as affecting negatively their sexual interest because they felt it was difficult to find time to develop sensuality and give priority to the couple's sexual life. These answers are related to Regan's (2000) work which establishes the relationship between passionate love and sexual desire, experience connected much more to the condition of being in love, than to companionate love. Regan's findings support my observation about women losing desire because they have ceased to experience the emotions and feelings of the infatuation phase of their initial bonding.

In the sexual history and the scale of the sexual motive, the participants reported some negative sexual attitudes related to their family of origin such as sex is for procreation and not

for pleasure, or notion that masturbation is something dirty, sex is something you do not talk about, men unlike women, are always ready to have sex and be unfaithful. The evaluation and intervention on the area of family of origin legacies regarding sexuality, adds to the importance of considering their influence on the nature of the sexual motive. In order to change the nature of the sexual motive, it is necessary to restructure these beliefs into more functional narratives which in turn implies differentiation from some values of the family of origin.

In relation to the body as source of pleasure all of them reflected guilt, and two of them, shame at their naked body, which I associated with the influence of the beauty myth and the conceptualization of the body as an aesthetic object not as a pleasure source, which concurs with the findings of Paternostro (2001), Londoño (1982), Thomas (1994) and Betancourt, García and Mejía (1997).

The remaining women overcame their secondary orgasmic dysfunction. The practice of Kegel's exercises was a first step in the process of connecting with their genitals and erotic sensations and also a first step in the systematic desensitization of their inhibition towards auto erotic stimulation. After the participants became familiar with Kegel's exercises, they started exploring their bodies and initiated masturbation, which facilitated orgasm. Also, there was a simultaneous change in the domain of sexual fantasies expressed in the fact that most of them acknowledged that they were beginning to fantasize about sex, even if only one of them shared her fantasy post intervention with her partner.

The participant who reported less progress in her subjective experience of desire, paradoxically, abandoned the practice of Kegel's exercises, because as she expressed "the exercises excited me and I fear that if my sexual desire increases, my partner will not be able to respond in the terms I need."

One of the intervening factors on the sexual difficulty and the outcome of the intervention, was that the motivation of the participants to overcome sexual difficulty when motivated by extrinsic factors such as social pressure, the fear of been judged inadequate, or of losing their partner, shifted to the domain of intrinsic motivation, there by generating the willingness and satisfaction considered by Lieblum and Rosen (2000) to be a necessary element for the comprehension of female sexual satisfaction disorders.

Change in a positive direction of the beliefs and attitudes implied a change in the nature of sexual motives. As the value given to sex was transformed and it became a stronger internal motive, the majority of the participants started to consider that part of the own ethics towards themselves and towards their partner was to enjoy sexuality. This new narrative can transform extrinsic motivation into a moral motive. The moral motive is according to Villegas de Posada (2002) the necessary condition to bridge the gap between information, discourse, and coherent behavior.

The later appreciations are congruent with the proposal of Hurlbert et al. (2000), about the importance of including the phase of motivation as a first phase, prior to desire, in the human sexual response. However, I consider that it would be important to take also into account the nature of the sexual motive that triggers motivation and leads to action. The difference between the influence of an extrinsic motive and an internal motive on sexual motivation was a significant element in the experience of sexual desire for the participants. When the internal sexual motive is congruent with the external motive or motives, the acceptance of the experience of desire and of sexual activity, is increased or could be more strongly rejected, as was with one of the participants, who found that to experience desire would threaten her basic internal motive

of being married and keeping her family, which suggest the action of higher order motives or moral motives that influence the meaning and experience of sexual desire.

It is interesting to take into account the fact that the increase on the women's subjective perception of the quality of desire and the sexual relation, does not imply a significant effect in the frequency of sexual desire, as it was subjectively evaluated by all of them and their male partners. The male partner's focused their evaluation of progress on the fact that the discrepancy of desire continued, in spite of the post intervention improvement of the quality of the sexual relations they had, and in spite of the women's perception of the increased pleasure in their sexual encounters.

The subjective increase in the experience of desire in the participants did not correspond to the expectancy of their partners of increase in overt sexual activity, which does not rule out their change in the level and quality of desire, because the experience of sexual desire as Regan (1999) and Sherwin (1985, quoted by Regan 1999) state, is not necessarily associated with any overt sexual activity.

Through the intervention, participants gained assertiveness which made it possible for them to interrupt the pattern of anxiety and avoidance of sexual situations and prevented the accumulation of resentment that inhibited sexual desire. The cultural and family legacies regarding sexuality and the feminine role in couple life, had a significant effect in the distress they experienced, partly because of their notion that their partner's were in a large degree responsible for their sexual disinterest.

The inclusion of a systemic conceptualizacion of sexual desire for the participants and their male partners was not only useful to interrupt the symptom's maintenance, but also to facilitate the women's appropriation of their power and responsibility in the sexual domain. Through

modified narratives, women were not seen as the problems or men as the demanding or insensitive ones; stories in which both members could co-create meaning was elaborated. The reformulation seemed to relieve participants from significant anxiety. They expressed it was all right for them to decline sex if they did not want to engage in it.

Participants' male partners apparently got a new understanding of the negative function that their pressure to have sex more frequently had on their partners, which could have been a factor that inhibited their possibility to take a more active role initiating the sexual encounter.

As the women became more differentiated from their cultural legacies and family of origin loyalties, they advanced towards the level of personal maturity and differentiation described by Bowen (1978) and considered by Snarch (2000) a central element in his systemic sexual perspective of desire. When intimacy increased together with assertiveness in communication, anger control improved and resentment decreased and became manageable in all cases. The relationship between personal responsibility and the possibility of enjoying sex within the context of couple life, was assumed by the participants as well as the circular nature of the sexual interaction.

The latter is a finding that supports the systemic principle of the role of language expressed in narratives as something that influences significantly the actions. In the particular case of this study, the stories the women had about the meaning of sexuality and what to expect from it, what was the adequate context for the sexual relation, and the expectations of their partner's sexual behavior, were factors that maintained systematically their low sexual desire, in agreement with the assumptions of Davies, Katz, and Jackson (1999.)

In the light of the global findings of the present research intervention, the conceptualization of sexual desire as a systemic process that should be approached from a contextual, multi-element

and integrative perspective, was reinforced and concurs with recent findings on its nature and psychotherapeutical approach (Snarch 2000; LoPiccolo and Pridal 2000). Lieblum and Rosen (1989) refer to Levine's three critical dimensions in his conceptualizacion of sexual desire: A biological drive component and a cognitive of attitudinal component referred as the sexual wish and the sexual motive. The findings in this study suggest that if the sexual motive is absent, the willingness to engage in sex is likely to remain at the level of discourse. This gives relevance to the sexual motive as a basic element in the sexual motivation process, which gives support to Everaerd and Both's (2000) conceptualization of sexual desire as a subjective experience that resides in the domain of motivation. In this sense it is possible to adhere to Hulbert et al., (2002) who affirm the need to include motivation as a first phase in the sexual response cycle that precedes sexual desire.

In women sexual desire and sexual experience, in general, has to do with their qualitative perception of the context in which the sexual relationship takes place. In this research sexual desire was conceptualized as an intersubjective experience, more than only a subjective experience, taking into account that low or intense desire takes place within a systemic affective relationship context. For some of the participants in the study, the factors that influenced the development of low sexual desire and resulted in the discrepancy of frequency of desire with their partner's, were related to circumstantial factors such as routine, absence of foreplay, inequity in the distribution of tasks and tension arising from double roles. These circumstantial factors for two of the participants, the lack of motivation to experience desire and engage in sexual relations, resided in the object of desire. They had no intrinsic motive to commit to the re-establishment of desire. Their symptom had to do with their incapacity to accept that they did not

want to continue with their partners because what had joined them at the beginning, was no longer present.

One of the contributions of this study is to reinforce the importance of the methodological integration of systemic epistemology with the cognitive behavioral model which favors adequate evaluation and treatment formulation. Appreciative language and systemic generative questioning together with the research evaluation methodology facilitated to the design of treatment plan focused on the particular needs of each subject, which was conceived as a starting point that was transforming itself as the psychotherapeutic process was advancing.

Another factor that I consider related to the positive outcome of the intervention, was my ethical and aesthetical posture during the whole process. I agree with the appreciation of Jacobson y Gurman (1995) regarding the importance of the person of the therapist in the process of psychotherapy. The fact that I am a woman, the participant's perceived reflection of my appreciation of my sexual self, to have been the subject of psychotherapy in several occasions, and to have the capacity to acknowledge and respect other's positions respect sexuality, were factors in agreement with the idea of the therapist's personality as a facilitator of change.

One of the basic factors to consider in the treatment of desire problems in agreement with the later assumptions regarding the profile of the sex therapist, is that an accurate approach to the treatment of desire disorders requires good training as a couples' therapist that combines evaluation procedures, multiple cognitive behavioral strategies and gestaltic techniques as required, within a systemic conceptualization of sexual human behavior. In the course of sexual treatment issues beyond the desire problem arise. Crisis develop, personal or circumstantial factors sometimes interfere, and all of these elements require capable, creative, and relevant

psychotherapeutic interventions, which demand a solid training as a couple's therapist and a handbag full of diverse psychotherapeutic skills.

The transformation of the cultural discourse that restricts the women participants in this study from appropriating their own bodies as a source of sexual pleasure as well as their development of a more positive attitude towards the experience of sexual desire, was an achievement that depended on cognitive restructuring, systemic language strategies, and psychotherapeutic modeling, which resulted in new conceptions and narratives regarding the sexual self and the endorsement of sexual desire and sexual activity as something they owed to themselves and their partners.

Although this was a study with a small sample, the results suggest that in a Colombian context, hypoactive sexual desire in women could be conceived as the result of mythical and restraining narratives about the function of sexuality, desire, and pleasure in women's lives associated to the influence the nature of their sexual motive. This vision concurs with the possibility of directing research efforts towards the development of more psycho-prophylactic strategies in the field of sexual education. It would be an interesting goal of future research interventions to work with larger populations in our context with the proposed psychotherapeutic approach, in order to contribute to further experimental support that would contribute to the efficacy of the psychosexual interventions and to the sexual well being of women in Latin America.

APPENDIX A
FEMALE SEXUAL DESIRE HISTORY

Name _____ Age:_____
Marital status:_____ Years of education:_____
Ocupation:_____
Address: _____
Phone: _____
Source of referral:
_____

I will pose you a series of questions that are related to the development and functioning of your sexuality. Your answers will be of great help for my understanding of the sexual difficulty you are experiencing now. Thank you for answering in the most spontaneous way you can.

1. How and under which circumstances did your actual difficulty with sexual desire start?
2. What have you tried to solve this problem?
3. Do you consider that this difficulty has affected your self esteem? If your answer is positive, please, express how.
4. Do you have sexual relations with your partner? Which is the frequency of these relations? Low___ Medium____ High _____
5. How would you describe the quality of these sexual relations? Good___ Regular_____ Bad_____

6. Are you under medical treatment now? If you are, what kind of treatment are you receiving now?
7. Do you think that there is compatibility between you and your partner? Please, explain .
8. All families have beliefs about sexuality. Which do you think were the most important ones you received?
9. How did your parents express affection between them?
10. Do you remember when was the first time that you felt sexually desired?
11. At what age did you have your first genital sexual experience?
12. How did you feel after your first sexual experience?
13. Have you had sexual relations with your partner without desire to do so?. If your answer is positive, explain why
14. Have you had a bewildering , disconcerting experience related to sex?
15. Have you felt sexual attraction for a person of your sex?
16. Have you had a pleasant sexual experience that generated moral conflict?
17. Have you experienced with masturbation or any other form of self stimulation that excited you sexually?
18. Do you think that you have had orgasms in your sexual relations?
19. Do you practice any contraception method?
20. Are you afraid of contracting sexually transmitted diseases?
21. Do you considerer yourself a sexually desirable woman?
22. Do you allow yourself to have sexual fantasies? If your answer is positive, explain what are they about?

23. If you engage in sexual fantasies, are they more frequent when your are alone or with your partner?
24. What type of attitude do you consider you have towards sex in general?
25. What kind of sexual activities are pleasant for you?
26. Have you experienced those pleasant activities with your partner?
27. If you decided to explore your body with the purpose of knowing it and experimenting sexual pleasure, would there be an internal disapproving voice? If your answer is yes, what would it say?
28. What do you expect to feel in a sexual relation?
29. What do you think your partner would have to change for you to increase your sexual willingness?
30. What sexual behaviors does he have now that you find disturbing and that you considerer that he cannot change?
31. What were your expectations regarding your partner's sexual behavior when you started the relationship?
32. Have you modified these expectancies in the course of time? If your answer is positive, explain how they have changed.
33. In your opinions, which are the reasons for your low sexual desire and availability for sexual activity?
34. Have you considered that your partner might have been unfaithful? If the answer is yes, how has this idea affected your sexual desire for him?
35. Have you experienced any change in your level of sexual desire after becoming a mother?
36. Are you acquainted with the areas of your body or erogenous zones that give you more pleasure when stimulated?
37. Have you shared with your partner which are those preferred erogenous zones?
38. Have you acted out with your partner some of your sexual fantasies?
39. Are there any sexual behaviors you are not willing to engage in?
40. Which is your attitude with respect of using sexual literature, movies or sex education videos ?
41. What would have to happen for you to experience sexual desire for your partner?

APPENDIX B
A REVISED SEX HISTORY QUESTIONNAIRE

Name _____ Age:_____
Marital status:_____ Years of education:_____
Ocupation:_____
Address: _____
Phone: _____

The fallowing questions deal with different issues related to the psychotherapeutic intervention that you had. Your answers will be of great help for a deeper understanding of feminine sexual desire. Please answer each one of them in the most spontaneous way you can. Thank you very much for participating in this study.

1. Have you experienced any change in your level of sexual desire after this psychotherapeutic intervention?
2. In relation to the beginning of this process, has the frequency of sexual relations with your partner increased?
3. How would you describe these sexual relations ?
    a. Good____
    b. Regular____
    c. Bad_____
4. From your experience, which were the most important factors that facilitated your change towards sexual desire?
5. How was it that the change you describe came about?
6. The changes you refer to, took place in any specific circumstance?
7. What did your partner do to increase your sexual willingness?
8. Do you consider that overcoming the difficulty with sexual desire influenced your self esteem? If your answer is positive, please explain how.
9. Which belief of beliefs did your revaluate in the intervention process?
10. How would you rate your degree of marital satisfaction?
    a. Good____
    b. Regular____
    c. Bad_____
11. Has any change taken place in the acceptance of your body?
12. Has your capacity to connect with bodily and erotic sensations increased?
13. If your connection with your bodily and erotic sensations has increased, to which kind of change in behavior or attitude is it connected?
14. How do you consider that your partner has reacted to your change in sexual desire?
15. What kind of new behaviors do you think you have to persist on if you wish to maintain your achievements?
16. What kind of behaviors you consider that your partner would keep on acting to facilitate the maintenance of the changes you have achieved in your sexual relationship?

APPENDIX C
EXPECTANCIES AND ATTITUDES REGARDING SEXUAL DESIRE

Several situations are described regarding the experience of sexual desire. They may apply or not to your particular situation. There are not right or wrong answers. Your answers will express a particular way of experimenting situations related to sexual activity. Your honest answer will facilitate the achievement of the objectives you are seeking with your participation in this project.

Read carefully each question and chose the sentence that you considerer reflects better your actual experience. If more than one sentence applies, assign number one to the first one and two to the second.

1. When I have sexual relations with my partner, normally I think:
   a. Why is it not possible for me to enjoy sex as much as I did before?
   b. It would be nice if my partner where somebody else.
   c. Why is it that I have never been able to enjoy sexual relations?
   d. It would be good to be able to enjoy this moment.
   e. None of the items apply
2. When facing the perspective of having sexual relations:
   a. I feel that I am not compatible with my partner in this domain.
   b. I feel uncomfortable with my body
   c. It is something that I do not enjoy when I do it.
   d. I fear becoming pregnant again.
   e. None of the items apply
3. My expectative regarding sexual relations are positive when:
   a. My partner stimulates me the way I like it
   b. I am not worried by financial issues, work or the children, etc.
   c. My partner has demonstrated that he still loves me.
   d. I can forget all the bad things he has done.
   e. None of the items apply
4. I think that investing time in sexual fantasies:
   a. It is a waste of time
   b. It something against my principles.
   c. It is something that can excite me and facilitate a good sexual encounter with my partner
   d. It is something I do not enjoy. I remember unpleasant experiences I had with my partner and I change the subject immediately
   e. None of the items apply
5. When I sense that my partner wants me to have sex with him, I:
   a. I become tense and we start to fight over anything.
   b. I start something to show that I am very busy.
   c. I tell myself, what a bore, but I have to do it.
   d. I smile internally and I am willing to approach him.
   e. None of the items apply

6. When I consider the possibility of having sexual relations, the first idea that comes to my mind is:
   a. I am going to be frustrated again.
   b. I do not understand why other women like this so much.
   c. I wish I could desire this and enjoy it.
   d. How nice!. We will be together sexually again.
   e. None of the items apply
7. When I have unwanted sexual relations, to avoid conflict or to gain something, my feeling is:
   a. Resentment for having to submit.
   b. Sadness not to feel the pleasure other's say they feel.
   c. Anger because I feel that he does not stimulate me well.
   d. I feel uncomfortable with myself for not refusing and not being able to enjoy it.
   e. None of the items apply
8. My lack of motivation to feel desire to have sexual relations could be due to:
   a. My difficulty for sexual excitement.
   b. Sometimes, sexual relations are physically painful for me.
   c. When I finish, I feel frustrated and empty
   d. Really, I never had an orgasm
   e. None of the items apply
9. I have lost the motivation to have sexual relations with my partner because:
   a. He does not make me feel the emotions that I experienced with him at the beginning of our relationship.
   b. I do not feel in love with him any more.
   c. I think he is being unfaithful and has stopped loving me.
   d. I feel attraction for other man.
   e. None of the items apply
10. The most difficult part of a sexual relation is:
   a. To decide to initiate it.
   b. To engage in them after having stopped to have sex for some time.
   c. To avoid thinking in other things that come to my mind at the moment.
   d. To have sex when I am angry with my partner
   e. None of the items apply
11. What attracted me more about my partner's personality was:
   a. His personal security.
   b. His tenderness towards me.
   c. His physical attractiveness
   d. His financial stability.
   e. None of the items apply
12. Our compatibility was expressed in:
   a. The same passion for some activities.
   b. The likeness of our respective families.
   c. Our affective and sexual communication.
   d. The similarity of our life projects.
   e. None of the items apply

13. I expect that my partner in the sexual relation:
    a. Creates a romantic context.
    b. Uses new and exciting stimuli
    c. Make me feel taking into account.
    d. Verbalize his affection and interest for me.
    e. None of the items apply
14. My partner has told me that:
    a. I almost never perceive his sexual intentions.
    b. He has difficulty reading or interpreting my sexual cues.
    c. I respond less than others to people or situations that are erotic or sexually provocative.
    d. I am very closed to new sexual experiences.
    e. None of the items apply
15. I am afraid that if my sexual desire increases:
    a. My partner will not be able to live up to my expectative.
    b. I will love and need him more and he will abandon me.
    c. The increase of sexual desire would be uncontrollable for me.
    d. My partner could think that I need too much sex and that I could be unfaithful.
    e. None of the items apply
16. Few times I have desire to have sex but I agree because of :
    a. Fear that my partner would feel hurt and rejected by my attitude.
    b. Fear that he finds other partner due to my coldness
    c. Fear to his violent reaction if I reject him.
    d. Fear that my marriage ends because of my refusal to have sex
    e. None of the items apply
17. One of the reasons why I am not so interested in involving myself sexually with my partner is;
    a. He does not kiss or caress me any more.
    b. We no longer flirt.
    c. He is not attractive for me anymore.
    d. I cannot bring my self to letting him know that I dislike the way he touches me sometimes.
    e. None of the items apply
18. What I expect from a sexual relation and I do not find with my partner is:

_____

APPENDIX D
SCALE OF SEXUAL MOTIVE

You will find some sentences with four answering possibilities. The sentences refer to the function and meaning of sex in life in general. According to your opinion, cross with an X the letter you choose.

A: Absolutely false.
B: False
C: True
D: Very true.

1. Sex is a way to show the person you love how he or she means for you. A B C D
2. Sex unites very much the couple and makes it more stable. A B C D
3. Not to want to have sex should not affect negatively the couple relationship. A B C D
4. Sex is good if it is not a duty. A B C D
5. Sex in inherent to the person as a way of physical and emotional expression. A B C D
6. I would be sad if for being old I could not have sexual relations. A B C D
7. Sex is for men. A B C D
8. Sex if life, health and happiness. A B C D
9. The quality of sexual life is not a priority for my couple relationship. A B C D
10. I am irritated by the importance sex is given in couple life. A B C D
11. I am bored with the sexual aspect of couple life. A B C D
12. I feel that sexuality is a burden. A B C D

APPENDIX E
SEMI-STRUCTURE INTERVIEW WITH THE PARTNER

Name _____ Age:_____
Marital status:_____ Years of education:_____
Ocupation:_____
Address: _____
Phone: _____

1. What is your theory or explanation about your partner's low sexual desire?
2. What are you doing to help her maintain her low sexual desire?
3. What do you consider that you can do to facilitate her change?
4. How would you feel if her sexual desire improves?
5. What kind of challenge will that change present to you?
6. What is in your opinion the fact that inhibits her more sexually?
7. If during the night a miracle would take place, when you open your eyes, what behavior from your partner would indicate that the difficulty with sexual desired was solved?

APPENDIX F
CHANGE INDICATOR QUESTIONNAIRE

Name _____ Age:_____
Marital status:_____ Years of education:_____
Ocupation:_____
Address: _____
Phone: _____

1. Do you think that your partner's sexual desire has increased?
2. If your answer is yes, in which behaviors show that she has changed positively?
3. Which is your theory about the reason or reasons for her achievement?
4. Has she initiated the sexual encounter during this treatment process?

APPENDIX G
INVITATION

If you answered yes to two or more of these questions, you might benefit from participating in a research I am developing.

1. Have you noticed that lately you have less desire to have sexual relations with your partner?
2. Have you stopped having fantasies or being curious about sex?
3. When you have the intuition of your partner's desire of having sex, do you try to avoid it engaging yourself in any other activity?
4. Have you questioned yourself why some people give so much importance to sex, when you hear people's enthusiasm regarding sex?

CAMILA SALGADO

Clinical psychologist. Sex therapist certified by the American Academy of sexology. Seminaries on couple therapy, love and falling in love and introduction to family therapy at Andes University.

Professional activity: Psychotherapy within a systemic orientation. Couple, individual and family therapy.

How to get in touch:

Phone: 2575968 (if the machine answers, please leave your name, phone number and state that you are willing to participate in this research.)

E-mail: camsal_2002@yahoo.com

APPENDIX H
SYNTHESIS OF THE THERAPY'S DEVELOPMENT

Vesta

She is a 32 year old professional manager. Her husband is a business administrator. They have been married for seven years, and have a son. She is well dressed and uses very appropriate language. She decided to participate in the study, in common agreement with her husband, because a discrepancy that had with the level and frequency of the sexual desire was affecting the relationship. She has had only had three failed sexual encounters during the past three years. Previously she was orgasmic and enjoyed sex with her partner. She is ashamed to recognize that she lost respect and sexual desire for her husband because of a bankruptcy they had.

Clinical impression:

My first clinical impression is that Vesta's problem is of a secondary and reactive type, which appears to be connected to extrinsic agents, such as the bankruptcy they experienced and the inequity perceived in the sharing of obligations. This touches family of origin issues and the male stereotype which emphasizes economical productivity. Vesta is thin, self confident at work, and has been able to answer to the challenge of economically supporting her family. When she got married she was overweigh and her self esteem was low, because she considered that she was not very efficient. Probably, the needs she had on the beginning and which helped her maintain the relationship have changed with time and a deeper difficulty exists in her relationship with her husband.

Intervention Focus:

1. Resolution of family of origin issues regarding sexuality. Permission to be sexual and to give pleasure to herself. Additional to the cognitive restructuring, gestalt exercises for this purpose were made.
2. Redefinition of her overprotective role in the couple relationship. The training on basic communicative skills and development of assertiveness.
3. Work on the resentment against her partner because of the frustration of her life expectations, through developing of self responsibility.
4. Sensate focus with the partner in order to desensitize her of the fear she has to return to a sexual genital relation. This didn't take place, because on the sixth session she decided she would divorce.

The lack of assertiveness in Vesta, was expressed on her overprotective behavior with her husband, which had negative consequences that she could not handle with assertiveness. Also, it had to do with her lack of capacity to talk to him and tell him that her sexual desire problem was a selective problem, caused by her disappointments due to his failures and lack of economical success, as well as by the overweight he had which disgusted her. In this case the low sexual desire was a reactive symptom to her frustration of no having of achieved the things she considered important in the relationship. In the firs session she said "I am dying of anger and resentment because of the financial problems I face because of him." Over three years she could not express to her husband or recognize to herself, that her sexual desire problem was only with him. She was not conscious that it was the result of all the resentment she had accumulated. She

was afraid of hurting him, and she did not know how to express it. One of the intervening variables in her case was the relationship she had in her childhood with a mother described as intrusive and dominant, who always wanted to control her life. The acquisition of communicative skills facilitated her to become assertive and establish limits, which allowed her throughout the process to ask for what she needed in a direct and clear way.

In the sixth session, Vesta has practiced Kegel's exercises and the masturbation. She recovered her orgasmic capacity and became painfully aware that her problem was not a sexual desire problem, but that she had been denying sexual feelings and avoiding sexual relations because she did not want to have them with him. "My mother put up with hell with dad because of us children and I am not going to do the same to end up divorcing later as she did" and she states: "I see him fat, ugly, he disgusts me and besides, he is not paying the bills on time ... he is too disorganized for me.. I accepted him when I was in the middle of a self esteem crisis, I was fat, feeling inferior and for my family, only my brother was important." Vesta expresses that she resents her mother very much: "I am very angry with my mother, she does not allow me to think about my wants or express what I feel ... she never expresses her feelings. As I told you, much of my sexual inhibition has to do directly with her." She affirms that she is tired of her mother's impositions and that now she has realized that she can be different form her and set limits to her intrusions: "My mother is so demanding in the area of not expressing feelings that she does not tolerate for me to tell her that I am tired."

The psychotherapeutic conversation theme is her lack of attraction for her partner and also her relationship with her mother and how the maternal model has been for her a source of conflict on the sexual domain as well as on her personal identity and assertiveness. We did a gestalt exercise with her mother in order to transform her mandates on sexuality, emotional expression and overprotective behavior on her part. The procedure was very intense and therapeutical for the achievement of her goals.

After this session, Vesta decided to divorce and by the eight session she had made the necessary arrangements. She expressed later that "even if it was hard to divorce from him, it was harder to set limits to my mother who wanted to take over my life when I started living alone with my son. She tried to manipulate me with guilt regarding my divorce and did not want me to go out , not even with girlfriends. She was afraid of what people would say and of my getting sexually involved with someone else. I had to be very firm with her." Vesta says that she feels quite well because of having been able to be assertive with her mother and with her husband and for being now assertive in her personal life and not only on her professional activity. After divorce, she has had a couple of dates, which she says she has enjoyed but recognizes that she is not ready yet for a new relationship. Finally, she summarizes her experience expression that to set limits to the economical failure of her husband and to successfully stop her mother on her efforts to control her decisions and way of life was not easy. When through self eroticism she was able to recognize she did have sexual desire and that the problem was with her husband, she was able to express it and go against her mother's will of not getting a divorce. At the end of the treatment she had recovered her sexual desire, and was hopeful to find a new future partner which "I only have to like and feel sexually attracted to."

Diana

She is a 30 year old professional manager. Her husband is a business administrator and they have a 5 year old daughter. She is well dressed and uses very appropriate language. She decided to participate in the study, in common agreement with her husband, because a discrepancy that

had with the level and frequency of the sexual desire was affecting the relationship. Diana said that although she had been able to have orgasms and enjoy sex, she did not think of it, sometimes it bored her and it was very difficult for her to start a sexual relation. She recognizes that her main problem is "starting the sexual relation ... I confess that I count the days between one relation and the other, and start preparing myself mentally so that I can have desire." One of her motives to want to improve this situation is that "he would not feel the need to look somewhere else ... he says that our sexual life is like of an old couple because it is not so scarce." She appreciates that her partner is verbally expressive, praises her physical appearance, that he supports her in her professional development, and that he is very committed with her in spite of their sexual difficulty, which motivates her more to change. Diana describes her mother as "cold with an impulsive character, who does not believe in men's fidelity and likely to express immediately what she thinks and feels." And recognizes that she also has difficulty in controlling anger.

Clinical Impression:

Diana is very committed with her partner and has his support. She is aware of her need to change, as well as of what she can get if she changes her attitude towards sexuality. She has a loving partner, sexually skillful, collaborating, who does not criticize too much and who loves her very much. Her high degree of "willingness" to commit and change, is a good prediction of psychotherapeutic success.

Intervention Focus.

1. Cognitive restructuring to foster -new narratives- concerning the role of sexuality in her life and the relationship with her partner.
2. Emotional acceptance of her sexual herself. Development of eroticism in relation to herself and her partner.
3. Redefinition of her romantic expectations concerning the context in which the sexual relation is to take place.
4. Departure from the l mother's model, to facilitate contact with her feelings and sexuality. Learning to manage anger and expression of tender emotions and how to benefit from her partner's tenderness.
5. Development of empathy in her emotional expression.

Her lack of assertiveness was reflected in the fact of having sexual relations with her husband although they did not take place in the context she wanted, because she did not want to offend him and because she was afraid of loosing him.

Diana from the beginning of the relationship had less sexual desire than her husband. This difference increased, because of her incapacity of communicating and talking with him about the mutual satisfaction of their sexual needs. Diana found herself in a transition stage between speech and action. Although she knew that her mother's way of thinking which was to use sex as a means to keep a husband was irrational, she continued to fulfill her marital obligation afraid that he would find someone else. She knew that she was beautiful but she was very shy about her body and her self esteem suffered because of her perceived incapacity to experience desire as other women. Being assertive through the development of autonomy over her body as a means towards pleasure was a process during psychotherapy that allowed her to validate her sexual self.

The intervention focus was centered on the cognitive restructuring of the role of sexuality in her life and in breaking with the maternal pattern which prohibited physical expression of affection and the pleasure of feeling the partner's tenderness. She practices in a conscious and disciplined way the sexual exercises along with others which were prescribed to help her overcome her fear of exposing her body to her partner. She made progress in communication skills and she managed to talk with her husband about the type of conditions they both needed to enjoy sex. Diana committed herself to the sexual tasks and to taking care of her body. The assertiveness that Diana already had in her working life began to move into her relationship and into her sexual intimacy. During the sixth session, Diana began telling that by her initiative they spent the weekend at a hotel in the city "we had a great time, we broke with the routine. I wanted to surprise him." When I asked her how she was doing with the exercises of Kegel , she answered: "Very good, I already identify that part of my body… I do not think that it is something physical what does not allow me to have sexual de sire. It is more the effect of work and stress over me." The session turned over on how she was doing things to reduce stress and says: "I try to break with the patterns of the daily routine … I think in myself without feeling I am being careless with my daughter, before this I never left her alone although she was in good hands even when I had to go to the beauty parlor … since February I began to have facial treatments which relax me a lot and I am thinking to go now every two weeks." This allows to deduce that the work made in a session before was effective, since it led her to redefine her loyalty to her mother, which before prevented her from taking herself into account or taking care of her body. This change was positive as well as the new actions that favored her sensuality. Also, she expressed how the resentment that characterized her mother was something se was getting rid of. She understood the relation between accumulating resentment due to her fear of expressing herself clearly and her difficulty in controlling anger. Finally, she connected the guilt feelings related to the sexual activity and pre marital sex, as something that was encouraged by her first boyfriend and not accepted by whom is her husband who convinced her that there was nothing wrong in problem having sexual relations before marriage. The intersession task was centered in continuing pleasing herself and the practice of the sexual exercises.

In the tenth session, Diana states that she is feeling well, more in touch with her body and that she has continued taking care of herself, with the facial treatment that relaxes her so much and she is thinking in going to a gym. She says that she still has some shyness, but he she practiced looking at herself naked in the mirror and validated her good figure. She has also been working with mental self instructions, to allow herself show more to her husband and be more sexy and less shy. She says that she is now abandoning the attitude of not appreciating her looks and assets she had when she was telling herself: " How on earth did he fall in love with me? What did he find?". Diana decided to continue with exercises of visualization, in which she imagines herself showing her body in a very confident way in front of her husband, who she recognizes always looks at her with desire and admiration. She adds that "It is true what he said here. My family did not recognize beauty. They never gave me an appraisal for the physical part, only for the academic results."

Juno

She is a 48 years old professional, with an administrative position. Juno is thin, her expression is tense and she dresses according to her position. Her second husband is a Biologist with whom she has had a 20 year relationship. They have a daughter who studies in the university. She decided to participate in this project apparently in common agreement with her husband,

because she considers that "lately I am worried about my position regarding sexual relations…since for four years ago we are living in separate houses, although he goes everyday to my house and we spend weekends and vacation together…we have not had sexual relations in almost two years, since I have not wanted. She adds that initially they shared many things, specially revolutionary ideas: "I was a rebel and a libertarian. Then, we married, I got pregnant and he did not support me which was very hard for me. I got resentful and at the same time he started drinking and was less supportive". My mother came to live with me. We were very close and she did not like my partner because of his drinking. He had depressions and a suicide attempt which finished with my patience. Now I am very distant with him. From her description, he was still the same one "I was the one who changed, who decided to be conventional to take better care of my family. She says that living in separate houses goes with his way of thinking, which she shared at the beginning, but not any more: "He continues looking for me sexually, but I feel very resentful." Also, she says that she has strict hygienic habits taught by her mother, who hated the smell of male genitals. She says she likes him well bathed and since he lives alone, sometimes he does not change his shirt daily or does not iron it very well. She says that her mother insisted on her need to avoid sexually transmuted diseases and of being aware of knowing who she was dealing with.

Clinical Impression:

Juno has had life long difficulties with sexual desire since her first marriage which according to her, ended for this reason. She states that she had a much better sexual desire and sexual activity period during courtship with her second partner which deteriorated because of the lack of support she felt during her pregnancy and because he did not make the same change to the traditional way of life she chose to raise her family Juno's mother was characterized for keeping all kinds of resentments and also had a negative attitude towards men. She has disconnected herself from sexuality and has taken good care of her body more in an aesthetic, than in a sexual way, being loyal to her mother's will, with whom she was very close until her death last year. She feels that taking into account her age, she could improve and take advantage of her sexuality and who despite her resentment, loves her partner. Juno seems committed with change, disciplined, conscious that psychotherapy requires work on her part and appears willing to improve her relationship with her partner.

Intervention Focus

1. Work on her resentment and on how to stop being "so loyal" to her mother in her experience of sexuality, of men in general and in the relationship with her partner.
2. Increase of contact with sexual sensations. Prescription of with Kegel´s exercises and self-eroticism according to LoPicolo´s model.
3. Positive connotation of the alternative life style she had initially with her partner and of the kind of arrangement he offers her now.
4. Cognitive restructuring of her romantic conceptions of sexuality and relationships. Construction of a new couple narrative which would start with being friends again.
5. Permission to enjoy sexuality and to take advantage of the resource she has in him, even though this is not the type of traditional union she dreamt of once.

Juno has a story of low sexual assertiveness since her first marriage "I already had difficulty with sexual desire…that was the main reason why my marriage ended since I had to have sexual

relations with him without wanting and I ended hating him." With her second partner she had sexual relations many times just to satisfy him until one day she decided not to do it any more, expressing through her denial to have sex her unhappiness with issues of the relationship that she did not get to communicate in a clear and explicit way. One of the intervening variables is the model of her mother, which was: "If you love, me you accept everything I say or think, if you are different you are against me." When she differed from her partner's ideas about their life style, she did not talk with him about the terms of the relationship because now, since he was not one hundred percent with her, he was against her. When Juno become aware of the influence that her mother's model had in her relationships, she decided to depart from it, which in turn changed her perception of her partner and her way of communicating.

Her decision to masturbate helped her to differentiate from her maternal model and facilitated her will to stop being loyal to her mother's mandates. She became aware of how she was automatically she was copying her mother's model, with whom she had a close relationship. Also, she recognized that as her mother, she expected the other to beg for her forgiveness, which prevented her from solving problems and also that conflicts happened because she did not accept different ways of thinking. She recognized that her partner had not changed his basic attitudes since they met and they both got together because of their rebelliousness towards an unfair social regime. She understood how the resentment she felt because he did not accept her new way style of life, prevented her from appreciating a number of positive things he had. In the tenth session, when I asked : what would happen if instead of being a couple in the traditional way you would became friends? She answered that she had not thought of that option, because she considered him as the cause of all of her misfortunes which now she knows is a fiction In the last session, she ends expressing that she feels much better now, that from one to ten, she feels she has lowered seven points her resentment level and that the change is so meaningful that now she has a better relation with her daughter, who tells that what happened was that she blamed her for all the conflicts her father had with her. Also, she mentions that she went to a party, danced and for the first time in several years, experienced herself as a content and sensual woman.

Ninfa

She is a 34 year old professional with an administrative position. Her expression is happy and confident. Her husband is a non professional business man. They have been married for five years and have two sons of 4 and 2 ½ years. She expresses that her marital relation has become conflictive, because her husband, whom according to her is more introverted that she is, has become very jealous from an incident which took place at an office party, where according to him, "she was extremely affectionate with a colleague." As the jealousy in him has increased in the last two years, the sexual desire in her has disappeared. She affirms that her lack of sexual desire is not a selective problem, that simply she does not feel sexual desire and has stopped to make sexual fantasies. She decided to participate in the project, in common agreement with her husband, because she thinks that she loves him and knows that her attitude toward sex is not normal: "I have had no problem with orgasm. Maybe, the fights we have, his jealous scenes and the stress at work, are what most affects me." She recognizes that she has a tendency to keep resentment, and associates it with a very hard period during her last pregnancy and post pregnancy, when he rejected her sexually all the time and did not show affection: "Little by little his attitude has made my affective expressions change and that has also happened in bed. As I feel more sexual pressure, I feel more anger and my desire for hi vanishes." She adds that she

contributes with the fights, since she has difficulty in controlling anger, and she expresses everything that goes through her mind in that moment. After the fights she feels released because she gets to express her feelings and that he becomes resentful, silent, more into himself, which has created an interaction pattern.

About the relationship she says: "There are not many affective expressions, communication has decreased, and weeks go through without talking too much to each other. It is very difficult to talk to him when he is mad because he isolates himself. He criticizes my physical appearance and compares me with fashion models." She concludes that although they have problems, she loves her husband and wants to make everything that is possible to make the relationship better.

Clinical Impression:

The absence of sexual desire seems to be reactive to the conflicts and the jealousy which prevail in the context of the marital relationship. Her working schedule is very intensive and there is no equal distribution of the domestic obligations and the caring of the children. Sexuality seems "well seen" in her family and there are no traumatic sexual experiences before her marriage. She is very committed to her husband although actually he does not tolerate her need for a personal space because of his jealousy, condition which might have been aggravated by economic difficulties he is experiencing now, due to a business failure. For all this reasons, they have stopped sharing recreational activities even though both desire to enjoy them again. Both are committed to the marriage and willing to work towards the solution of the desire difficulty.

Intervention focus:

1. Increase of contact with sexual sensations. Prescription of with Kegel´s exercises and self-eroticism according to LoPicolo´s model. Work to facilitate sexual fantasies
2. Gestalt exercises to externalize and solve her resentment problem.
3. Training in communication and anger control to improve her relationship with her husband.
4. Intervention with her husband to work on his jealous feelings and with his understanding of the effects that his behavior has on his wife's sexual desire.

In Ninfa, the low assertiveness is reflected on her lack of power to negotiate an equitable distribution of the domestic activities and caring of the children. Also, as she could not set limits to the restrictions her husband imposed over her free time, she had to tell him lies if she wanted to go the mall after work. She was not able to tell him that he could not pretend her to have sexual desire for him, after he was so rude with her and offended her so much with his distrust. The training in communication and assertiveness was effective and was supported by an intervention towards the change on her partner's jealousy. In regard to this, she mentioned in a session: "I have changed because his daily attitude has changed. Since I no longer tell him lies to justify innocent things such as going shopping after work, and I know how to talk to him better, I get less affected by his questions and I also feel less resentful. I also understand that the difference between our professional and labor development, gives him insecurity." Se adds that the fact that now he is now more kind, has permitted them to have a better sexual relationship: "I cannot disconnect the things of my life…if during the whole day he ignores me, criticizes me, how does he pretend that during the night I am going to open my legs for him?" The fact that he has stopped harassing her to have sexual relations, is something she considers has helped her a lot, as well as the fact that he has followed the guidelines to improve communication that were

given to him in his individual psychotherapeutic interview. Her purpose is to continue with the sexual exercises and the assertive and communication techniques, because on her own words: "to force sexual relations without desire is a time bomb, which does not favor my anger control." In the tenth session, Ninfa says she is very happy with the improvement in her relationship with her partner, which she attributes mainly to the fact that she has learned to communicate and control anger, which in turn has permitted her to change her attitude towards sexual relations, and has made easier the mutual support: "in very difficult economical situations which have depressed him a lot, and even so, he has helped with the children and for example, today he changed an appointment he had so that I could come here. He is dealing with his jealousy and it is going well and he shows he trusts me more. I think that now we have not had sexual relations because the economical problem is so big that it requires all of our energy. I think that when we get over it, everything is going to be better even in the sexual part. We have had close moments and our communication has begun to be more intimate and I am optimistic regarding the future of my relationship in the sexual and affective part." The interview was centered in detecting the necessary behavior on her side to keep alive the sexual desire, the erotic tone of her relationship and to continue improving their relationship in general.

Demeter

She is a 42 year old professional, with an important job position. Her demeanor and appearance correspond to her executive level. She has been married for 15 years to a successful professional and they have two daughters, 2 ½ and 7 ½ years old. She is thin and wears very classical clothing. She decided to participate in the project in common agreement with her husband, because she considered that she needed to grow sexually, She described her marital relationship as "a very good relationship, we have great intellectual affinity and tastes, we are good friends and have a very tender way of treating each other." She adds that the only problem her marriage has is they have not been able to totally develop their sexual relation, reason why she sometimes feels as if they were brothers. She said: "my sexual desire is fluctuating, most of the times I almost never feel like doing something sexual. I never take the initiative in the sexual encounter." Demeter's upbringing was very traditional and restrictive regarding sexuality. Her mother made so much emphasis that she had to get virgin to marriage that her partner had to convince her in a for more than a year for them to have pre-marital relations which were satisfactory. Now she considers that her sexual inhibition were present when they were dating, since her desire and sexual relations even then were very scarce.

Clinical Impression:

She is very committed with her relationship and loves her husband very much. She has a liberal discourse regarding sex but is very inhibited in the domain of sexual actions. She appears well adapted in her roles as a mother and as a professional and is she is well aware that it is time to grow sexually, increasing her sexual desire. She recognizes that they have good resources in the sense that they communicate about sex and that they can share sometimes pleasant sensual activities, such as massage. She thinks and states that her husband agrees with her, that the inhibition is in the level of seduction and passionate genital sex.

Intervention focus:

1. Cognitive restructuring and new narratives to facilitate the transition from speech to action in the erotic and sexual area
2. Work on how to stop being "so loyal" to her family tradition regarding the experience of sexuality, of men in general and in the relationship with her partner
3. Increase of contact with sexual sensations. Prescription of with Kegel´s exercises and self-eroticism according to LoPicolo´s model .
4. Sensate focus exercises with her partner.

During the fourth session, she reported that she was doing very good in the practice of Kegel´s exercises and that this had helped her increase her corporal consciousness and sexual desire. She was beginning to depart from the "good girl" image she had of herself: "a woman who wears only childish white cotton panties," and now she could imagine herself with bold clothes and sexy attitudes towards her husband. The interview was centered on her new sexual acquisition and how much fun the seductive role could be. Also, the new narrative included the possibility of her husband not responding so well at the beginning, which was a possibility because he had the same very traditional family and religious background. In the tenth session Demeter says that she has made all the exercises of sensorial focusing and that her husband is very good at giving massages which she enjoys. She says that before she was too prudish and now she was less ashamed of showing her body and that she does not feel a sinner as she would have experienced in her school years. She says that her husband recognizes that se has advanced a lot and that he is staying behind. Even he has had some problem in getting an erection which has frustrated him: "I got feed up and angry … I make all the effort and now, he is not reacting … rationally I understand his difficulty to get an erection, buy emotionally I do not accept it …" We worked with the concept of systemic imbalance in the couple and the fact that this could happen. Also, with the possibility she expressed that now, it was more his problem than hers. I validated her on her achievements and is clear that now, he also has a personal problem with sexuality, that is not only her problem. She acknowledges her love for him and wants to keep the relationship, even though she knows she still has to work on the sexual relation and on the development of her sexual self. On the last session she expressed that maybe he was going to have personal therapy and that she was happy because even if they still had difficulties, she was open to new possibilities in her sexual life with her partner, seeing herself in the future now not only as a mother and wife, but also as a desired lover.

Because of his actual problem with erection, he was given an additional session, were the need for individual treatment to overcome his inhibition was brought up and he accepted the possibility of having psychotherapy after finishing the project, with a therapist I would refer him to. Demeter, has continued reaffirming her personal accomplishments regarding body contact, allowing herself to have fantasies and self eroticism. Even though she knows that the sexual problem of her husband is a problem of both of them she feels now "normal," on what has to do with desire capacity and sexual pleasure. At the end of the session she expresses gratitude for the intervention and her desire that this type of project reaches more women.

Minerva

She is a 38 year old professional. Her husband is the director of a corporation. They have been married for 13 years and have two daughters of 10 and 6 years. Her attitude and attire correspond to a well educated middle high class woman. She decided to participate in the study

with mutual agreement with her husband. Her only concern now, is that her sexual desire is very low and that she needs specific situations such as a vacation with her partner, to get sexually attracted to him. Her difficulty with desire has been life long and she is much more liberal in her words than in her sexual behavior. She says that she is motivated to participate in the study, because she knows that improving her sexual desire is going to get her closer to her partner and because that will help her grow as a person. As a girl she had to take care of her younger brothers, while her mother played cards with her friends. The appraisal she received from her mother was according to the help she gave her. She describes the relationship among her parents as tense. His father was unfaithful and her mother was very jealous and became a fat woman, who did not take care of herself and who was not sexually attractive.

Clinical Impression.

Minerva was conscious that she had not devoted enough energy on her sexual life and she was afraid that her husband would get tired requesting her sexual attention. Se affirms that she knows that he disliked very much the fact that she only accepts to have sexual relations occasionally and that she never tokes the initiative. She is aware that she is wasting the option she has with her husband to have a plentiful sexual life and states, as if it was a joke, that she is still very dependent on being in a "special context," like a trip, to open herself sexually. She adds that her husband tells her that it is ridiculous that for her to have sexual desire they have to go out on a trip. Also, she recognizes that she has not made any effort to create a better context for her needs during her daily life, such as, sending her daughters to spend a weekend over her mother's or mother-in-law's house, which would probably help her, since she does not feel comfortable having sex when the girls they are near by. She describes herself as a disciplined person, who achieves goals, once she is convinced of their importance. Now, she is moving to another country with her husband and daughters, because of a new job offer here husband received. She thinks it is the right moment to work to improve her sexual couple relationship in order to fortify their commitment and her husband agrees with her and is willing to collaborate in the intervention process.

Intervention Focus

1. Redefinition of her sexual difficulty as contextual and as something that has taken too much control over her life.
2. Increase of contact with sexual sensations. Prescription of with Kegel´s exercises and self-eroticism according to LoPicolo´s model.
3. Facilitation of the fantasy function through imagenery techniques.
4. Development of a new narrative regarding the function of sexuality in her personal and couple life.
5. Search for alternative new meanings to the fear of loosing control if sexual desire increases.

During the fourth session, she recognizes that due to stress and to the additional work that moving to a new home requires, she has not been able to make the exercises, which are Kegel´s exercises and a slow self body massage with cream over all of her body. The session was centered on what I called "her imperial habits," her demand to be treated by her husband as the queen of Sheba. I used circular questions to explore the possible future ending if she continued with that attitude with him. I suggested that he also deserved to be an object of desire, which fits

very well with one of the dominant values of Minerva's speech, which is justice. Also, we went deeper on his sexual behavior, physical aspects that were not attractive for her. "I do not like him physically (although she recognizes he is very handsome), he does not fit with the physical type of my ideal man. He has no hair and is excessively white and refuses to get tanned." I explained my different point of view and how I did consider him very attractive, and maybe, she did not see that because she was always comparing him to an ideal man who was out of her reach. Minerva recognizes her capacity of feeling desire and behaving sexually during vacations and how she disconnects from her sexual self in daily routine. To my question about what would have to happen for her to feel sexual desire on her daily life, she answers: "Get disconnected from the problems of the day and try to separate the problems from sex." According to her definition of the problems, disconnection from them was agreed as the next homework between sessions.

During the tenth session, Minerva is about to travel with her family to another country and is very involved with this process, and experiencing her grief involved in leaving her country. She has permitted herself for the first time to express emotions such as fear and sadness, to her beloved ones and tells me how sorry she is to finish the therapeutic process. She says she is happy because the new house where she is going to live has more space and the main room has a small living room, a magnificent view and it is distant from the girl's bedroom. She has permitted herself to fantasize on the type of sexual encounter she can have in this new context with her partner. She is sure that her sexual desire will come back when she finds herself in a more calm situation and she has all the intention to dedicate and make the sexual exercises and make all the "homework" according to the goals in order to improve her relationship and create an erotic context inside the house, out of routine. She hopes that this change of country, although the adaptation difficulties, will lower the stress caused by her big family and by our country's insecurity. She expresses her gratitude and says she will communicate by e-mail. Minerva writes an e-mail from her new country. The challenges that this situation has, such as fixing the new house, her daughters´ schools, making new friends, have been a source of great stress and conflict with her husband. An intervention by e-mail was very useful, in the one I encouraged her to use her wisdom, which was inside her and that was characterized to defend until death her country and her people, and not make war nor in her home nor with her body. Finally I invited her to abandon the weapons towards the revival of Aphrodite, and the eroticism in her couple kingdom. Her answer reflected that the intervention had been useful, since she asked her husband to forgive her for being so aggressive with him and her empathy with all the economical and professional challenges he had to deal with and in her last mail, in the one she attaches the post test formats, she says that she is much better in her relationship, that she began walking one hour every day, to meditate and make fantasies that take her into the mood for sexual activity.

Mito

She is a 42 year old professional who runs her own business. Her husband is a business administrator. They have been married for 18 years and they have two adoptive daughters, 6 and 11 year old. She decided to participate in the study with mutual agreement with her husband. Her attitude and attire correspond to a well educated middle class woman old woman, with a modern classical style. Mito describes her marital relationship as excellent in every aspect, except in bed. "I feel no sexual desire at all. I could live very well without sex. I do not know why people talk so much about sex as if it was a plus." She has not experienced orgasm yet and recognizes that she is afraid to let go. Her role models are poor. Her father is described as

asexual, strict and psychologically violent, in the sense that he always disqualified her needs or preferences, but he did not do that with her sister, "the sexy one," or brother. She had an infertility problem, which was treated until she gave up. She hated to have sexual relations then, but "I did it because it is the way children are conceived … I resent that so much and my husband's insensitivity with my lack of pleasure in sex … he was putting so much pressure and many times I had sex, without desire, just to avoid a conflict with him." She is overprotective with the girls and is not comfortable having sex if they are in the apartment with them, but does nothing special to give herself and her partner the space she feels she needs. Also, she has high romantic expectations about her husband's sexual attitude and the physical context for sex to be pleasant to her. She accepts to participate in the study, although she has an ideological resistance towards sexuality, because she understands it is important for her partner and because although she insists that he is not so sexual, he has told her that he not happy with their sexual life.

Clinical Impression:

Her willingness for therapy is questionable, because she is filled with arguments against the cultural glorification of sex. Her attitude is ambivalent. She has the idea that sexual pleasure is a female privilege from which men deprive many women but the idea to make take part in activities to stimulate sexuality, does not convince her. She argues that it should be more spontaneous. One important aspect is the work on resentment and the rupture of the connection she established between maternity and sexuality; hating it because it did not serve her purpose of being a biological mother. A very sensitive area is her resistance to homework or to suggestions she could perceive as orders, sensitivity which probably is related to the psychological abuse she describes from both parents, who did not respect her opinion or desires, which suggest the convenience of strategic interventions

Intervention Focus:

1. Cognitive restructuring: A change in the narrative regarding the function that sexuality has in her relationship and how it could be an important part of the life project they share.
2. Increase of contact with sexual sensations. Prescription of with Kegel´s exercises and self-eroticism according to LoPicolo´s model.
3. Work on the resentment problems associated to the psychological violence she recalls regarding the lack of respect her parents had for her as an individual and differentiate the past from her partner's past and actual behavior.
4. Transform the connection she establishes between sexuality and maternity because of the negative effect of her anger for not being able to procreate in everything related to sexuality.
5. Facilitate empathy with the sexual needs of her partner and the emotional acceptance to the fact that he does not have towards her the same attitude a romantic her has.

During the fourth session, Mito says that her marital relationship has not changed because: "It is hard for me all this sexuality thing … to connect, to desire, is the hardest part for me." She adds: " I do not find an argument to justify what happens to me, nor how to change, maybe what happens is that I do not find, that I do not have in my vocabulary the word pleasure, My parents never taught me that." When she is asked if she is practicing Kegel´s exercises, she says she stopped doing them because "they excited me and I did not like that…" When we went deeper in the session about her problem in giving herself some space for sensations and sexual feelings,

although she had all the instruments to do it, she expressed that she can enjoy things such as food and be sensual with that, but that somehow, she resists having to work to release her sexual feelings. At this point, I tried to redefine her resistance with a paradoxical induction, and what came out later was that "when I was 17 years old without wanting it I had sex with the most inappropriate boy and he did not care about it," which caused her a lot of unexpressed anger. This memory was repressed because in the initial sexual history questionnaire, story she gave a different and subsequent age for her sexual initiation. I associated this memory to the fact that with her husband she had many unwanted sexual relations just because she wanted to procreate and faked she had pleasure sometimes just not to castrate his virility. A gestalt exercise was made to get her into the process of releasing her resentment. No other homework or sexual exercises were prescribed.

During the tenth session, Mito says that she has not achieved enough progress in the sexuality area, even after becoming orgasmic. She affirms that the most important issue is that they do not get sexuality to flow in the context of daily life. My answer is that now I am convinced that she does not have a sexual problem, since she could get an orgasm and have genital relation with pleasure with her husband under the appropriate context. This made her happy, since the emphasis was moved on to her dissatisfaction with certain aspects of the relationship where she said: "The problem is something very difficult to describe or talk about. He gives me a very normal treatment, as if I was a friend of his. We do not have a sexual language appropriate for lovers. He talks as if he was a teenager and makes comments like the one he made this week, when I had a very attractive bra and a dental thread panty. He looked at me once and instead of touching me with lust, he approached me , touched thee panty and asked if it was uncomfortable: "can you understand Camila what I mean with my example regarding his attitude?" I validated her feelings and she proceeded to compare her partner's attitude with the way a man who only is a social acquaintance looked at her in a way she could understand how attractive she was. Finally we got to the theme of her husband as object of her sexual desire and she said very strongly: " I have to devalue sex, there is no other choice in order to keep the marital relationship, which I do not want to end by any means. It has been very difficult for me to arrive to this conclusion and to share it with you." We concluded with the expression of her being worried by the way he treated the girls when they played in front of her, which made her remember the psychological abuse of her father. We both agreed that the final interview would be together with him. The final session was a conjoint interview. Its purpose was to discover a new meaning in her presenting problem, which would be useful to the two of them. The psychotherapeutic intervention continued on how the daily context of the relationship inhibited sexual desire and how to change that. She communicated him in a very appropriate way, how she felt because he did not treat her in a way that made her feel as a "woman". He recognized that because of his childhood experience, an absent mother and a cold father, he did not learn to express affection with caress or words: "what I see now is that I need a psychotherapist for me, focused on me getting those skills." This was welcomed by her, who said: "Dear, I understand that what happens is that you do not know how to be loving with me or look for me in a sexual way, so that I can respond. As brothers and friends we collaborate very well but in the erotic and sexual part, we both need to change." Also, we talked about how his way of playing with the girls could be inappropriate for their age and how this affected Mito who identified this behavior with the abusive behavior her father had with her. The type of communication they had during the session was affective, clear and collaborative. He recognized that she has changed a great deal sexually and that when he give her his full attention, she responds sexually and that

if they are alone, the sexual relation is good for both of them. He considers that although she has lived good sexual experiences with him, she disqualifies them. The session ends with the statement from both of them that their affective and sexual life would improve if he develops a new sexual approach.

Proserpina

She is a 36 year old college educated working woman. She has been married for 4 years to an industrial designer. They have no children because it would damage her health. Her clothing is informal and modern and appropriate for her type of work She is very active and her language is precise and clear. She arrives on time and says that she decided to participate in the study, in agreement with her partner, since the invitation that was made throughout the web of the university convinced her that she could find a solution to the sexual difficulty she has been experienced for the last couple of years. She states that her sexual desire is low. “He says that I am like an old car, which takes a long time to get initiated…” She says that both of them have a renal transplant and they met in the hospital where they were treated. They had a four year courtship and they have the same time living together. She says that what mostly affects her sexual desire is routine, and that her partner is too home-loving, too close to his family, and that they don't do anything fun or new. She adds they have problems in their relationship, because he gets on her nerves easily "because he tends to be very critical and to give me solutions instead of support when I need it." She says that he went as far as to give her instructions on her behavior on bed at the beginning of their relationship. She describes herself as always in a hurry, while he is very calm and tends to let go opportunities to get better work projects. She says that they have conflicts over silly things, such as tidiness or the distribution of domestic duties. Regarding her past sexual life, she had a boyfriend with whom she had sexual relations that were very good. He liked parties and was very creative. However, but she affirms that she loves her husband and that what she wants, is to find the way to feel more sexual desire for him, so that they can both be sexually good.

Clinical Impression:

Proserpina is very committed with her relationship and seems that what bores and puts her down is routine and the way he criticizes her, as well as the fact that he has not many affectionate details with her anymore. The conflicts in her relationship and her low sexual desire seemed to be linked to her being always in a hurry, to her need to control and her difficulty in controlling anger, which she recognizes as a problem. She says she is afraid that her partner may not collaborate, since he doesn't like psychologists. She accepts that I call him to invite him to participate and when we talk on the phone, he agrees easily and concurs with her on his perception of the need to solve the desire problem and other relational difficulties.

Intervention Focus:

1. Increase of contact with sexual sensations. Prescription of with Kegel´s exercises and self-eroticism according to LoPicolo´s model.
2. Training in communication and anger control, to improve the context of the relationship.
3. Motivation on her part to assume responsibility for making it easier for them to get out of the routine.

4. Cognitive restructuring over the roles of both of them. New narrative about the post modern way of life, which justifies the fact that she is the one who earns more money and works outside, while he stays home and helps with the domestic work.
5. Sensate focus exercises with her partner. Communication on sexual preferences and fantasies they can put into action.

In the fourth session, Proserpina reports that she is very happy, since things have changed in the context of the relationship. She tells that she is communicating better with him, being more tolerant and that he has also changed his language. She is happy because they bought a pair of bicycles, a sport they both like and can go out on Sundays, something that takes them out of the routine. She recognizes he is creative and makes beautiful things, like sending her cards he makes. The intervention was centered on the resources they both have, how fast they are getting out of the routine and we talked about communication techniques and anger control, since she recognizes that "when I fight, I am very tough with words and actions. I poison myself and know it is wrong." Also we worked on how to continue being loyal to the mother, but not copying her resentment and a bad anger control, but adopting other positive qualities she has. Proserpina is very committed in changing resentments and her way of expressing anger, since she recognizes that he is more noble, that even when she offends him, with a kind word she says is enough. She says that she has continued with the sexual exercises, which help her to recover her sexual desire, with her gym and that she doesn't feel uncomfortable any more with her vaginal discharge (associated with the medicine she's taking), since: "if it doesn't bother him, it is silly that I reject myself...we had a very pleasant relation..."

During the tenth session, she says that things are improving and that the individual interview with him had positive results as well as the conjoint session. She says that now he is more thoughtful with her and they communicate more; that she is no longer focusing on the negative perceptions and sees the things he does for her, which before she did not perceive, as well as his attempts to please her. She says that he has been "tender" and that she will take the initiative to invite him out for dinner, to a bar or to dance. She says that she doesn't care so much on taking the initiative to make different activities, because she has thought about "that of being a post modern couple," of having a different life style, according to her desires and accept the roles that are better for them. The interview was centered on accomplishment's validation, on making a new emphasis on the resources they have and in how they were using them and in finding new ways to get connected. The homework that was agreed on was to continue with the sexual exercises, to work on communication and tolerance of the differences, giving themselves the chance to create an erotic and satisfactory context. In the closing session, Proserpina expresses her gratitude for the opportunity of participating in the study, which in her opinion took place in a good moment to improve her relationship and her sexual life. Se adds that she learned how the resentments that she had for having sexual relations without wanting, her difficulty in accepting emotionally that they were compatible even if each had different ways of being were source of conflict. She reported that her partner had diminished his criticism and had agreed to share some domestic chores after negotiation, because he understood that if he accepted something and then he didn't do it, his failure had to do with her imposing it and his lack of assertiveness to refuse her demand. She says that now she knows they have to continue working on the relationship, that getting out of the routine depends on her, because if she asks him for it, he'll do it. That before, she got very frustrated waiting for him to suggest something, and that now she knows, there is no reason for not being her the one who takes the initiative. Regarding her sexual desire, she says

that it has improved and that she is happy, since she loves him very much and knows that he does too.

Psique

She is a 47 year old business woman. Her partner is also a business man. They have no children and this is her third permanent couple relationship. This is his second marriage. She decided to participate in the study with mutual agreement with her partner. Psique is well dressed and her language is fluent, even if she states that she is anxious s because she knows she will have to talk about things that shock her. She says that she has always had difficulty with sexuality:" It's like if my body didn't feel well with that." Answering to my questions she tells that she was 17 years when she got married against her family's will with a north American man. She had high expectation about sex: "at home the rule was to have sexual relationships once married...I was in Notre Dame College for ladies were I was a boarding student, my father and brothers were very demanding, tough and very patriarchal ... it's the same for me to have or not to have a partner in the sexual sense and I relate sex with procreation." She says that she assumed that her family's traditional behavior prescriptions as something that helped her to stay away from marihuana and premarital sex. She classifies her family like a family of the XVIII century. Her mother, she was told, was alcoholic who abandoned her when she was seven years old: "mother left or was forced to leave the house." She says that she met her again twenty years late, when she was a normal woman, and with a very organized life. She says that since she was the oldest daughter, she assumed very young the role of a surrogate mother and a housewife. Her first marriage was very short, she was so sexually shy at that time , that her wedding night she took off her clothes in the bathroom. The second marriage was with a very traditional man with whom she had her first son, who had the Potter's syndrome, and died almost immediately after birth. Her second child died in uterus and her gynecologist, according to her words, decided to leave him inside of her for three months, until one day she could not take it any longer and labor was induced. With her second husband she never had communication on her sexual needs and she never enjoyed sex with him. Now she lives has lived with her partner for two years. She feels that he has a very good attitude towards her and considers that the sexual desire problem is something that has to be solved as a couple. Psique recognizes he is a good man and thinks that this is the opportunity to get over this sexual problem. She also thinks that being called to participate in the project is an act of the providence. This is related to the fact that she has developed her spiritual side "also like a way to solve and compensate my sexual problem" and says she has studied a great deal on this topic and that she is trained in different ways of meditation and self help techniques.

Clinical Impression:

Psique has been influence by cultural and family myths regarding sexuality. Her family experience tell a story of sexuality as something sinful, good for procreation and a man's privilege. Her sexual Initiation was traumatic, she could not enjoy sex with her first husband and less with the second. The experience with the death of the first child and the second pregnancy, were source of grief and she did not have support in such difficult times. Her experience with her two husbands reinforced her fear and belief about the damage men could do. Actually, she expresses ambivalence towards sex: "it is as if I had two bodies in me.. one wants sex and the other, refuses to allow feelings." Psique has important resources like the resilience she has demonstrated through her life crisis. She has had psychotherapy and her answer to question nine

of the sexual story questionnaire reflects that she has managed blocking her feelings. She is so efficient at suppressing what she does not want to experience, that some years ago she smoked and the day she decided to quit, her desire for smoking totally disappeared. This ability was positively connoted as an extraordinary heeling power she could use in the direction she wanted.

Intervention focus:

1. Because of her initial traumatic experiences with sexuality, gestalt interventions were practiced and the Shapiro technique was used for the post traumatic stress, regarding her first and second pregnancies .
2. Increase of contact with sexual sensations. Prescription of with Kegel´s exercises and self-eroticism according to LoPicolo´s model to become orgasmic.
3. Development of new narratives regarding herself and her sexual potential.
4. Constant emphasis on her capacity of making things better, her wisdom using resources and also the "not feeling" as a way to survive.
5. Assertiveness training to prevent passive aggressive behavior and depression.

During the fourth session, Psique reports "Now, I am beginning to see myself and situations in a different way. I did not know I had so many limitations and that I had stopped caring for myself. Since I began the treatment I feel more peaceful because I know that what happened to me was not purely psychological, but that it also had an organic background." Regarding her husband she says "I am very happy because I feel the great commitment he has and the good quality of the relationship. I think that the sexual exercises have had a good effect on me because after we moved, one morning I went out for a walk before my husband woke up and suddenly I felt a flow of energy on my body and experienced sexual desire. I went home and took the initiative for the first time in my life and we had a very pleasant sexual relation. I feel that now, that I'm close to being fifty that I have started to live. Now I am enjoying for the first time things like being a housewife." I suggested that she continues with Kegel's exercises and that she allows herself to use the visualization techniques with fantasies of positive sexual anticipation.

Session number ten took place one month after due to Christmas holidays. Her relationship because of problems with her husband's son, came to a crisis, but she affirms that thanks to the clearness achieved in the previous therapy session, she managed well and that in spite of the change on the relationship, she will not stop appreciating that what she shared with him allowed to her to recover her sexual self and to learn and practice assertiveness. She says "I worked 18 months on my sexuality and on myself through him, that is why I will always be grateful to him." When she was asked if there were other factors that facilitated her achievement, she answered that experience of my assertive attitude, the way I talked about sex and the congruence she perceived in my actions and discourse, made it easier for her to assume that she could behave in a similar way, and leave aside her old models. She adds that she feels that in general, her attitude towards men has changed , that she is more open, and even more charming and that she hopes she can have a new partner if the conditions are given in the future. She concludes saying that the therapy and the help that the gynecologist I referred her to gave her, arrived in the exact moment of her life; that she feels that her sufferings were so many that although se has to work with herself, what she reached was something she deserved. In the closing session, it was evidenced that through the psychotherapy process Psique had achieved a second order change which has to do with her self concept, her recognition of sexuality and her

self perception as an individual capable of setting her own limits and differentiating form her family of origin. The two gestalt type interventions on family of origin issues matters were very useful, as well as cognitive restructuring referred to sexuality, which, created a different narrative.

Verifying that the dispareunia was linked to a normal medical condition for her age was of great help. She became orgasmic at the age of 47 years when the problems associated to acculturation and her the family of origin were solved. She released resentments and improved her self esteem when she could accept her sexual self.

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