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Is High Sexual Desire a Risk for Women's Relationship and Sexual Well-Being?

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Historically, women's sexual desire has been deemed socially problematic. The growing popularity of the concept of hypersexuality—which lists high sexual desire among its core components—poses a risk of re-pathologizing female sexual desire. Data from a 2014 online survey of 2,599 Croatian women aged 18–60 years was used to examine whether high sexual desire is detrimental to women's relationship and sexual well-being. Based on the highest scores on an indicator of sexual desire, 178 women were classified in the high sexual desire (HSD) group; women who scored higher than one standard deviation above the Hypersexual Disorder Screening Inventory mean were categorized in the hypersexuality (HYP) group (n = 239). Fifty-seven women met the classification criteria for both groups (HYP&HSD). Compared to other groups, the HSD was the most sexually active group. Compared to controls, the HYP and HYP&HSD groups—but not the HSD group—reported significantly more negative consequences associated with their sexuality. Compared to the HYP group, women with HSD reported better sexual function, higher sexual satisfaction, and lower odds of negative behavioral consequences. The findings suggest that, at least among women, hypersexuality should not be conflated with high sexual desire and frequent sexual activity.

Keywords: high sexual desire, hypersexuality, problematic sexuality, relationship intimacy, sexual well-being, women

Sexual desire has been defined as “the sum of the forces that lean us toward and push us away from sexual behavior” (Levine, 2003, p. 280) and can be conceptualized as a continuum ranging from very low or absent to very high sexual desire. Although useful for heuristic purposes, Levine's definition has been criticized, in particular with regards to women's experiences, given that they can engage in sexual activity or not for reasons unrelated to desire (Cain et al., 2003) and may experience desire without necessarily engaging in sexual activity (Brotto, Heiman, & Tolman, 2009). From a historical perspective, women's sexual desire has been viewed as socially problematic, whether construed as lacking (e.g., ‘inhibited’ desire) or in excess (e.g., nymphomania), with little empirical research supporting prevailing stereotypes.

In reviews focusing on women's sexual desire disorders, high sexual desire is seldom discussed (cf. Both, Laan, & Schultz, 2010; Laan & Both, 2011). This is not surprising as high sexual desire among women has been particularly challenging to define. This is reflected in the absence of a standard definition of women's high sexual desire and in researchers' inclination toward operational definitions based on some statistical criterion (a cut-off indicating high levels of sexual desire), participants' self-description, or a combination of the two (see Blumberg, 2003). Although there are some data showing that women characterized by high desire are more open to engaging in a variety of sexual activities (Wentland, Herold, Desmarais, & Milhausen, 2009), little is known about their relationship and sexual well-being, as well as about whether negative consequences may be associated with their high desire. To further muddy the waters, the potential conceptual overlap between high sexual desire and hypersexuality—defined as “recurrent and intense sexual fantasies, urges and behaviors” (Kafka, 2010, p. 379),

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along with feelings of diminished (or lack of) control over one's sexuality and significant personal distress or impairment in important areas of functioning (Reid et al., 2012)—has led to studies characterized by heterogeneous samples, with few attempts to distinguish high sexual desire from hypersexuality.

As research on female high sexual desire and hypersexuality is scarce, little is known about whether purported negative outcomes, such as sexual risk taking (Klein, Rettenberger, & Briken, 2014) and lower psychological adjustment (Carvalho, Guerra, Neves, & Nobre, 2014) associated with hypersexuality, are merely the consequences of normative pressures and a societal stigma attached to women's high desire. In other words, what is at times termed hypersexuality could simply be the end of a continuum of female sexual desire ranging from absent to very high. Strikingly, in studies focusing on hypersexuality, little attention has been paid to women's desire and overall sexual function. In addition, there is a lack of research examining the quality of romantic relationships among women with high sexual desire.

Taking into account controversies surrounding hypersexuality, particularly the risk of pathologizing highly sexually active individuals, we initially distinguished hypersexuality from high sexual desire by its (potential) clinical relevance. The rationale behind this decision was based on the emerging literature on women's high sexual desire suggesting that high sexual desire is not necessarily problematic for women. For example, a few studies reported positive outcomes associated with high dyadic sexual desire among partnered and non-partnered women (Dosch, Rochat, Ghisletta, Favez, & Van der Linden, 2015; Wentland et al., 2009). Unlike hypersexuality, we did not expect high sexual desire to be problematic, that is, to interfere with everyday functioning and resulting in significant distress and other negative consequences. Consequently, we did not assume that hypersexuality is necessarily coupled with high sexual desire.

High Sexual Desire

The association that is assumed to exist between female high sexual desire and hypersexuality may overlook important distinctions between men's and women's sexual desire. First, women's desire is not always aimed at sexual activity (Meana, 2010; Regan & Berscheid, 1996). Women could potentially experience high levels of desire without engaging in a high frequency of sexual activity. A study on sexual fantasies showed that desire and sexual gratification were significantly and positively correlated for men, but not for women (Zurbriggen & Yost, 2004). Second, sexual desire is embedded in, and influenced by, romantic and sexual relationships (Dewitte, 2014), more so for women than for men (Baumeister, 2000). In particular, emotional intimacy with a partner is thought to facilitate the emergence of sexual desire (Diamond, 2004; Levine, 2002) and to reinforce it through sexual satisfaction (Basson, 2002).

Third, powerful sociocultural forces have shaped the experience and expression of women's sexual desire (Meana, 2010). Specifically, women's sexual desire has been historically viewed as socially problematic and disruptive, which extended into the twentieth century (McLaren, 1999; Moynihan, 2003; Tanenbaum, 1999). As demonstrated by the example of the continuing practice of female genital cutting, which is to a large extent based on a belief that women's sexual desire needs to be (surgically) moderated to ensure marital stability (El-Gibaly, Ibrahim, Mensch, & Clark, 2002; WHO, 2008), the pathologizing of female desire has not been limited to the Western world.

Several studies provide evidence that more contemporary normative pressures and societal expectations—primarily, the double standard and a stricter societal regulation of female sexuality—remain a source of distress for women with high sexual desire, affecting their self-evaluation and sexual well-being (Blumberg, 2003; Tolman & Diamond, 2001). Blumberg's qualitative study, including 44 highly sexual American women aged 20–82 years, showed that difficulties with the societal imperative of monogamous relationships and experiences of being labeled or negatively perceived by society were almost unanimously shared (Blumberg, 2003). Unsurprisingly, some of the highly sexual participants kept their sexual activity hidden.

Other studies have shown that women's high sexual desire may be associated with positive outcomes. In a North American study of 932 women self-identified as heterosexual, those classified as 'highly sexual' had more positive attitudes toward different aspects of sexuality, in addition to better sexual self-esteem, communication and body image (Wentland et al., 2009). A Swiss population-based study involving 300 men and 300 women who had been cohabiting with their partner for at least one year found that women with high dyadic sexual desire and activity were the most sexually satisfied and had better psychological adjustment than those with low dyadic sexual desire and activity (Dosch et al., 2015). Specifically, high desire women were characterized by higher approach motivation for sex, a more secure attachment style, higher self-control, and higher mindfulness.

Hypersexuality

High sexual desire has been also conceptualized as one of the constitutive elements of hypersexuality (Kafka, 2010; Reid et al., 2012). A contested and controversial concept, hypersexuality has been suggested to provide a systematic psychiatric rationale for helping individuals who appear unable to control or downregulate their sexuality. It is this compulsive quality of their sexual urges and activities that makes hypersexual men and women vulnerable to sexually transmitted infections, sexual offending or victimization, relationship conflict, and a range of problems in daily functioning (Kafka, 2010). As shown in a recent overview (Hook, Reid, Penberthy, Davis, & Jennings, 2014), different treatments have been suggested, developed, and used to

treat hypersexuality. This perspective has been criticized for a lack of sufficient empirical evidence (Winters, 2010), conceptual problems and a risk of false positive diagnoses (Wakefield, 2011), pathologizing high sexual interest and “immoral” behaviors (Giles, 2006; Moser, 2011), medicalization of aberrant sexuality (Halpern, 2011), and possible forensic abuse (Halpern, 2011; Wakefield, 2011). Although the proposal to include criteria for hypersexual disorder in the DSM-5 was ultimately rejected by the American Psychiatric Association, the controversy over hypersexuality has not waned (Kafka, 2014; Reid & Kafka, 2014).

Some authors have suggested that hypersexuality may be more about dysregulated sexuality, such as impulse control problems (Levine, 2010) or compulsive sexual behavior (Coleman, 1990), than about high sexual desire. It has been also argued that high or disinhibited sexual desire is not a sufficient criterion to determine the presence of hypersexuality and that, as for any other sexual difficulty deemed clinically significant, personal distress and problems in social functioning are relevant criteria that should be taken into account when attempting to characterize hypersexuality (Mick & Hollander, 2006; Reid et al., 2012a).

Research on women’s hypersexuality, sometimes also referred to as “sexual addiction,” has yielded heterogeneous findings. In a clinical sample of 99 female self-described sexual addicts, half of whom were receiving treatment—higher depression scores, lower family adaptability or flexibility, and drug abuse were the three unique contributors to sexual addiction (Opitz, Tsytarev, & Froh, 2009). A second uncontrolled clinical study compared facets of personality in treatment-seeking hypersexual men and women using validated measures (Reid, Dhuffar, Parhami, & Fong, 2012). The definition of hypersexuality included distress and problems in social functioning. Men and women exhibited similar levels of impulsivity, emotional dysregulation, and difficulties coping with stress.

With the valid aim of moving away from samples of self-identified hypersexual women, two studies focused on college students. In an online survey of 988 female students in Germany, Klein, Rettenberger, and Brikken found that higher current masturbation frequency, higher number of partners and more pornography use were associated with increased odds of reporting hypersexual behavior, suggesting that high sexual desire might be a facet of hypersexuality (Klein et al., 2014). Another study conducted among 235 Portuguese university students showed that social alienation and impulsiveness were the two significant predictors of hypersexuality in women (Carvalho et al., 2014). Unfortunately, the sexual compulsivity scale used in this study has been shown to contain items that do not sufficiently discriminate between sexually compulsive and highly sexually motivated individuals (Dodge, Reece, Cole, & Sandfort, 2004; Štulhofer, Jelovica, & Ružić, 2008).

Two studies assessed hypersexuality using large-scale community samples. At age 32, participants in the Dunedin Multidisciplinary Health and Development Study birth cohort were asked online about out of control sexual experiences. Among the 466 female participants,

7% reported such experiences in the past year. These women were more likely to have had a higher number of opposite sex partners, concurrent sexual relationships, sex with a partner met on the Internet, and higher likelihood of same sex attraction and behavior (Skegg, Nada-Raja, Dickson, & Paul, 2010). These experiences were associated with impulsivity and negative affectivity. However, fewer than two percent of the surveyed women reported that their sexual behaviors, fantasies, and urges interfered with their daily life, hence, that they were distressed. In another North American online survey involving over seven thousand women, the authors aimed to differentiate hypersexuality from high sexual desire (Winters, Christoff, & Gorzalka, 2010). The study found that less than one percent of female participants had ever sought treatment for sexual compulsivity, addiction, or impulsivity. Compared to non-treatment seeking women, those who had sought treatment had higher scores on dyadic sexual desire, solitary sexual desire, sexual compulsivity, and sexual excitation, and lower scores on sexual inhibition and sexual satisfaction. Nevertheless, there were no significant differences between the groups in average frequency of various sexual behaviors. Despite some measurement limitations, the study’s findings suggest that distress reported by individuals labeled as hypersexual could be a result of the difficulties involved in managing high sexual desire.

Research using more conceptually relevant and better validated measures of hypersexuality is needed to further clarify the distinction between hypersexuality and high sexual desire among women. In addition, examining women’s sexual desire and behavior in a psychosocial vacuum—i.e., without inquiring about their sexual and relationship well-being or interference with daily functioning—poses a risk of pathologizing women’s diverse modes of sexual expression and of using moral values to determine what constitutes problematic or dysregulated sexuality.

Study Aims

The present study aimed to compare relationship and sexual well-being among four groups of women in a community sample—those characterized by high sexual desire, hypersexuality, hypersexuality and high sexual desire, and controls—in order to provide clinically relevant insights about the correlates of women’s high sexual desire. Specifically, we examined relationship intimacy, sexual function, sexual satisfaction, and the negative consequences of sexual activity on daily functioning. Based on the literature demonstrating neutral or positive outcomes associated with high sexual desire, we hypothesized that women with high sexual desire would not be significantly different than controls on relationship and sexual well-being outcomes, and that both of these groups would fare significantly better than women classified in the hypersexuality and hypersexuality and high sexual desire groups.

Method

Participants

Recruited online in April 2014, 2,599 women aged 18–60 years ($M = 28.3$, $SD = 8.57$) participated in this study. Participants were recruited through *Facebook* and banners posted on Croatian news portals, an online dating website, and the local *Cosmopolitan* magazine edition website. To access the questionnaire, prospective participants had to confirm that they were of legal age and to provide informed consent by clicking the appropriate button. No other selection criteria were used.

A majority of participants had college education or higher (55.7%), which is over three times the prevalence in the national population. Less than a third of the sample was single (30.3%) at the time of the survey. Being married was reported by 17.3% of participants, while 13.8% were cohabiting. The rest of the sample reported being in a relationship but not living together with their partner. Two thirds of participants identified as exclusively heterosexual (66.9%) and a small minority (5.8%) as exclusively homosexual.

Procedure

The survey, hosted on a commercial site dedicated to online research, was advertised as focusing on Internet pornography use and sexual health (for more details about the study see Štulhofer, Jurin, & Briken, in press). Participants' IP addresses were not permanently recorded to ensure anonymity. A number of skip patterns served to minimize time required to complete the survey. Median time to complete the questionnaire was under 20 minutes.

All study procedures were approved by the Ethical Review Board of the Department of Sociology, Faculty of Humanities and Social Sciences, University of Zagreb.

Measures

The online questionnaire included 166 items indicating sociodemographic and sociosexual characteristics, relationship status and the quality of current relationship, sexual satisfaction, sexual function, sexual behavior, including the consequences of sexual activity on daily functioning, and hypersexuality.

Sexual orientation was assessed with a one-item indicator that focused on identity (“What is your sexual orientation?”). A five-point scale, ranging from 1 = exclusively homosexual to 5 = exclusively heterosexual, was used for responses. The measure was dichotomized into 0 = heterosexual (5) and 1 = non-heterosexual (1–4).

Sexual well-being was conceptualized as a combination of sexual function, sexual satisfaction, and the consequences of sexual activity on daily functioning. *Sexual function* was measured using a brief, 6-item version of the Female Sexual Function Index (FSFI-B6) (Isidori et al., 2010). The six

items cover sexual interest, arousal, lubrication, orgasm, pain at penetration, and overall sexual satisfaction domains. In this study, the FSFI-B6 had somewhat lower reliability than reported in the original Italian study (Cronbach's $\alpha = .70$ and $.79$, respectively). A short, 12-item version of the New Scale of Sexual Satisfaction (Mark, Herbenick, Fortenberry, Sanders, & Reece, 2014; Štulhofer, Buško, & Brouillard, 2010, 2011) was used to assess *sexual satisfaction* in the past six months. This composite measure had high internal consistency (Cronbach's $\alpha = .93$), with higher scores indicating higher sexual satisfaction. Finally, negative *behavioral consequences* associated with sexual activity were measured using the multi-faceted Hypersexual Behavioral Consequences Scale (HBCS) (Reid, Garos, & Fong, 2012). This 22-item measure, which taps into both the private and public negative consequences of hard-to-control sexuality (such as losing a job, having legal problems, experiencing a relationship breakup, losing self-respect, deteriorating mental health, feeling lonely, etc.), had satisfactory reliability in this study (Cronbach's $\alpha = .89$). Higher scale scores denote a higher frequency of negative consequences. Because the distribution of the composite indicators of behavioral consequences violated the assumption of normality, the measure was categorized into quartiles.

Relationship well-being was measured using the five-item Emotional Intimacy Scale (Sinclair & Dowdy, 2005). This scale was chosen to tap into the affective, subjective aspects of women's romantic relationships. Each of the included items assessed a different aspect of emotional intimacy shared with a current (or the most recent) partner/spouse: acceptance, self-disclosure, caring, support, and affirmation. The total score was calculated as a sum of scores across the items, with higher scale scores reflecting a higher level of emotional intimacy. In this study, Cronbach's α for the scale was .91.

To measure *sexual behaviors*, we assessed the frequency of masturbation (from 1 = never to 7 = several times a day) and sexual intercourse (from 1 = never to 6 = daily or almost daily) in the past six months, the frequency of pornography use (from 1 = never to 8 = daily or almost daily), and total sexual outlet (TSO), defined as the number of orgasms in a typical week over the past 12 months.

Sexual desire was measured with the following question: “Please think of a typical week in the last year and mark the degree of your desire for sexual activities?” A 10-point scale, ranging from 1 = nonexistent to 10 = extremely intense desire, was used to anchor answers.

Hypersexuality was assessed using the recently developed and validated Hypersexual Disorder Screening Inventory (HDSI) (Parsons et al., 2013; Scanavino et al., 2014). The studies found support for a unidimensional structure of the HDSI among men of different sexual orientations. Following Kafka's proposal for DSM-5 (Kafka, 2010), the HDSI items assess the frequency of sexual fantasies and urges, using sex to cope with negative mood, perceived inability to control one's sexuality, engaging in sex in spite of harmful consequences, and distress and

shame associated with one's sexual behaviors. The scale had satisfactory reliability in this sample (Cronbach's $\alpha = .82$).

Analytical Strategy

Using the indicators of sexual desire and hypersexuality, we divided participants into four groups: (1) the high sexual desire (HSD) group, (2) the hypersexuality (HYP) group, (3) the "overlap" (HYP&HSD) group, and (4) the rest of the sample, which served as controls. A participant was classified as a member of the HSD group if she reported the highest scores (9 or 10) on the indicator of sexual desire. Those who scored above one standard deviation (SD) from the HDSI mean were classified as members of the HYP group. The women who satisfied inclusion criteria for both groups were included in the HYP&HSD group. All other women were treated as controls.

The four groups were first compared on sexual behavior characteristics (TSO and the frequency of sex, masturbation, and pornography use) using one-way analysis of variance, with Bonferroni corrected p -values for multiple comparisons to provide a behavioral validation of the group distinctions. Next, controlling for age and (college) education, multinomial regression analysis with the controls as the reference group was used to examine the contribution of the indicators of relationship and sexual well-being to the prediction of membership in the HSD, HYP, and HYP&HSD groups. To further explore differences between the HYP, HYP&HSD, and HSD groups, another multinomial regression analysis was carried out with the HYP group (the largest of the three) as the reference category.

Results

Group Sociodemographic Characteristics

Based on the highest scores (9 and 10) on the indicator of sexual desire, 178 women (6.8% of the sample) were classified in the HSD group. A slightly larger proportion of women (9.2%, $n = 239$) scored higher than one SD above the HDSI mean and were categorized in the HYP group. Fifty seven women (2.2%) who qualified for membership in both groups (HYP&HSD) were included only in the second set of analyses. For comparative purposes, women who were not classified as HYP, HSD or HYP&HSD groups were treated as controls.

Regarding age, the HYP&HSD was the youngest ($M = 25.4$, $SD = 7.10$), and controls the oldest, group ($M = 28.6$, $SD = 8.71$). This was the only age difference that reached statistical significance ($F = 4.47$, $p < .01$). No significant differences in the frequency of churchgoing were found among the four groups of participants ($F = 1.23$, $p > .29$). Completed college education was most frequently reported among controls (57.3%) and least frequently reported in the HYP&HSD group (40.4%)—which is to be expected based on the observed age differences between the

two groups. The differences among groups were statistically significant ($\chi^2 = 15.35$, $p < .001$). In addition, the four groups differed significantly in reported sexual orientation ($\chi^2 = 35.42$, $p < .001$). Fifty-two percent of women in the HYP&HSD group self-identified as exclusively heterosexual, 52.5% in the HYP group, 62.7% in the HSD group, and 69.7% among controls.

Relationship status also differed among the groups ($\chi^2 = 21.55$, $p < .001$). The HYP group was characterized by the smallest proportion of women being in a relationship or married at the time of the survey (56.9%). In contrast, a steady relationship or marriage was reported by 64.9% of HYP&HSD women, 69.7% of HSD women, and 71.2% of controls. No significant inter-group differences in religiosity were observed.

Group Sexual Behavior Characteristics

To explore behavioral differences between the four groups, we first compared their mean HDSI scores. Recently, a clinically relevant HDSI cutoff score of 20 was reported to indicate hypersexuality among non-heterosexual men (Parsons et al., 2013). No similar cutoff has been reported for women. In this study, the mean HDSI score was 20.3 ($SD = 3.32$) in the HYP and 22.18 ($SD = 5.40$) in the HYP&HSD groups. The HSD participants and controls scored significantly lower ($M = 10.5$, $SD = 3.19$ and $M = 10.2$, $SD = 2.88$, respectively). The observed difference in mean HDSI scores between the HYP and HSD groups was large (Cohen's $d = 3.0$).

Table 1 shows differences in sexual behaviors among all four groups. As expected, statistically significant differences (all at $p < .001$ level; Bonferroni corrected p -value = .013) were observed among the groups on all four indicators. Compared to controls, the HSD group was consistently more sexually active. When compared to the HYP and HYP&HSD groups, women in the HSD group reported significantly more coupled and less solitary sex (women in the HYP&HSD group reported the highest levels of solitary sex). Interestingly, the HYP group was characterized by having significantly less frequent coupled and more frequent solitary sex than controls.

Group Differences in Relationship and Sexual Well-Being

Women in the HYP&HSD group differed significantly from controls in being characterized by somewhat lower odds of reporting exclusive heterosexuality. Compared to the referent group, better sexual functioning was associated with higher odds of belonging to any of the three specific groups (see Table 2). Even after the first FSFI-B6 item (indicating the level of sexual desire) was omitted from the composite scale, the difference remained significant for the HSD and the HYP&HSD groups. In the case of the HYP group, it bordered on significance ($AOR = 1.07$, 95% $CI = 1.00$ – 1.14 , $p < .06$). Compared to controls, both the

Table 1. *Patterns of Sexual Behavior Among the Hypersexuality Group (HYP), the High Sexual Desire Group (HSD), the Hypersexuality and High Sexual Desire Group (HYP&HSD), and Controls*

	HYP group (n = 214–239) (A)	HSD group (n = 140–165) (B)	HYP&HSD group (n = 56–57) (C)	Controls (n = 1,568–1,744) (D)	F (post hoc tests)
	M (SD)	M (SD)	M (SD)	M (SD)	
Frequency of masturbation in the past six months	4.01 (1.59)	4.18 (1.67)	4.89 (1.70)	3.32 (1.52)	42.94* (A ≠ C, D; B ≠ C, D; C ≠ A, B, D)
Frequency of sex in the past six months	3.64 (1.36)	4.58 (1.40)	3.88 (1.48)	3.91 (1.29)	17.22* (A ≠ B,D; B ≠ A, C, D)
Pornography use in the past 12 months	4.81 (1.97)	4.63 (1.95)	5.54 (1.92)	4.06 (1.91)	22.39* (A ≠ D; B ≠ C, D; C ≠ B, D)
Total sexual outlet in a typical week over the past 12 months	5.07 (5.17)	8.11 (6.91)	7.18 (7.10)	4.03 (4.26)	45.20* (A ≠ B, D; B ≠ A, C, D)

Note. * $p < .001$. Bonferroni corrected p for multiple comparisons = .013.

Table 2. *Differences in Relationship and Sexual Well-being Between Women in the High Sexual Desire Group (HSD), the Hypersexuality Group (HYP), the Hypersexuality and High Sexual Desire Group (HYP&HSD) and Controls (Reference Group; n = 1,197)*

	HSD group (n = 119) AOR (95% CI)	HYP group (n = 189) AOR (95% CI)	HYP&HSD group (n = 51) AOR (95% CI)
Not in a relationship	1.28 (.76–2.15)	1.38 (0.93–2.05)	1.47 (0.73–2.96)
Exclusively heterosexual	0.68 (0.45–1.04)	0.76 (0.54–1.08)	0.52 (0.29–0.95)*
Female Sexual Function Index	1.48 (1.33–1.64)***	1.10 (1.04–1.17)**	1.32 (1.16–1.49)***
Relationship intimacy	0.91 (0.86–0.97)**	0.91 (0.87–0.95)***	0.98 (0.90–1.07)
Sexual satisfaction	1.02 (0.98–1.06)	0.96 (0.94–0.98) **	0.94 (0.90–0.98)**
Negative behavioral consequences			
1 st quartile	0.85 (0.49–1.49)	0.13 (0.08–0.21)***	0.15 (0.06–0.35)***
2 nd quartile	0.54 (0.24–1.20)	0.23 (0.12–0.43)***	0.19 (0.06–0.65)**
3 rd quartile	0.95 (0.52–1.75)	0.41 (0.27–0.61)***	0.38 (0.18–0.78)**
4 th quartile (reference)	1	1	1

Note. AOR = odds ratios controlled for age and (college) education, and adjusted for the contribution of other independent variables; CI = confidence interval.

* $p < .05$. ** $p < .01$. *** $p < .001$.

HSD and HYP groups were characterized by significantly lower levels of relationship intimacy. However, lower sexual satisfaction and lower odds of reporting fewer negative behavioral consequences were predictive of membership in the HYP and the HYP&HSD groups, but not of membership in the HSD group.

Differences in Relationship and Sexual Well-Being Between Women in the HYP Group and Women in the HPY&HSP and HSD Groups

To explore differences between the HYP group and the HYP&HSD and HSD groups, another multinomial regression analysis was carried out (Table 3). Compared to the

referent group (HYP), women in the HSD group were characterized by significantly better sexual function, higher sexual satisfaction, and lower odds of negative behavioral consequences. The only significant difference between the HYP group and the HYP&HSD group was somewhat better sexual function among the latter.

Discussion

In a large-scale online sample, we aimed to explore differences in the relationship and sexual well-being among different groups of women. We focused on the differences between women characterized by high sexual desire and hypersexuality,

Table 3. Differences in Relationship and Sexual Well-being Between Women in the High Sexual Desire Group (HSD) and the High Sexual Desire and Hypersexuality Group (HSD&HYP), and Women in the Hypersexuality Group (HYP) as Reference Group ($n = 189$)

	HSD&HYP group ($n = 51$)	HSD group ($n = 119$)
	AOR (95% CI)	AOR (95% CI)
Not in a relationship	1.13 (0.52–2.45)	0.97 (0.48–1.95)
Exclusively heterosexual	0.68 (0.35–1.31)	0.79 (0.44–1.42)
Female Sexual Function Index	1.19 (1.05–1.35)**	1.31 (1.15–1.489)***
Relationship intimacy	1.08 (1.00–1.18)	0.98 (0.90–1.06)
Sexual satisfaction	0.99 (0.94–1.03)	1.07 (1.02–1.12)**
Negative behavioral consequences		
1 st quartile	0.97 (0.39–2.69)	6.69 (3.10–14.45)***
2 nd quartile	0.98 (0.24–3.96)	2.51 (0.84–7.52)
3 rd quartile	0.90 (0.42–2.13)	2.39 (1.14–5.02)*
4 th quartile (reference)	1	1

Note. AOR = odds ratios controlled for age and education, and adjusted for the contribution of other independent variables; CI = confidence interval
* $p < .05$. ** $p < .01$. *** $p < .001$.

as the two constructs have been repeatedly conflated. Compared to controls, the HSD, HYP, and HYP&HSD (the “overlap”) groups had slightly better sexual function, even when adjusted for different levels of sexual desire. However, women in the HYP and HYP&HSD groups—but not those in the HSD group—reported significantly lower sexual satisfaction and more negative behavioral consequences associated with their sexuality than controls.

Women in the HSD group systematically differed from those in the HYP and HYP&HSD groups. Consistent with our hypothesis, lower sexual satisfaction and more negative behavioral consequences were associated with increased odds of being in the HYP or HYP&HSD groups, but not in the HSD group—notwithstanding the fact that high sexual desire women reported substantially higher levels of dyadic sexual activity than all other participants in this study. Compared to controls, women in the HYP group reported lower sexual satisfaction and more interference of their sexuality with valued life goals, relationships, health, and daily functioning, despite better sexual functioning. Although sexual function and satisfaction are often correlated in clinical and general population samples (Rosen & Bachmann, 2008), the present findings further support the importance of measuring both constructs separately in studies of women’s sexuality. Whereas sexual function encompasses desire, arousal, lubrication, orgasm, and pain/discomfort during sex (Rosen et al., 2000), with a strong focus on the physiological aspects of the sexual response cycle, sexual satisfaction is conceptualized as “an affective response arising from one’s subjective evaluation of the positive and negative dimensions associated with one’s sexual relationship” (Lawrance & Byers, 1995). A combination of lower relationship intimacy, higher frequency of solitary

sexual activity and negative consequences associated with one’s sexual interest and activities, which distinguished women in the HYP group from controls, points toward possible difficulties with the relational and emotional aspects of sexuality. As romantic attachment and emotion regulation are thought to be closely related (Dewitte, 2014), it is possible that women in the HYP group experienced some challenges in both of these areas.

This study’s findings suggest that the construct of hypersexuality is more complex, more heterogeneous (Cantor et al., 2013; Levine, 2010; Sutton, Stratton, Pytyck, Kolla, & Cantor, 2014), and less about sex per se than is high sexual desire. Alternatively, the current conceptualization of hypersexuality may be overly inclusive or empirically elusive (Reid & Kafka, 2014). Not the least because of historical and cultural reasons, women with high sexual desire seem to be at risk of being labeled hypersexual and recommended a treatment for problematic sexuality. Apart from a small number of women in the “overlap” group, who reported distressful outcomes associated with their high sexual desire, most women characterized by high sexual desire differed systematically from those who reported a lack of control over their sexuality and associated behavioral problems. In contrast, a number of women with unremarkable levels of desire appear to have normative, moral or other (self-stigmatizing) issues with their sexuality. Our findings do not support the view that high sexual desire constitutes a problem, or the notion that hypersexuality is the end of a continuum ranging from low to high sexual desire. Clearly, it would be a mistake to conflate women’s high sexual desire and hypersexuality.

Although the HSD&HYP group was very similar in sexual and relationship well-being to the HYP group, its higher sexual desire and overall higher sexual activity suggest that this group would fit Kafka’s criteria for hypersexuality disorder (Kafka, 2010, 2013) much better than the HYP group. Apart from being more sexually active and reporting somewhat better sexual function, women in the HYP&HSD group were characterized by similar negative behavioral consequences as women in the HYP group. Both groups seem to be at odds with their sexuality, but the analyses did not suggest sexual identity issues as a possible source. Whether they have internalized restrictive, sex-negative societal norms and pressures to a greater extent than other participants remains to be tested in future research. Interestingly, this study did not find a significant association between religiosity and membership in the HYP and HYP&HSD groups. It may be, however, that faith or personal beliefs about divinity would be better predictors of the internalization of sex-negative norms than the institutionalized practice of attending religious rituals.

Assessing the need for clinical intervention among the HYP&HSD women, characterized by high sexual desire and seemingly insufficient control over their sexuality, is another task for future research. A potential obstacle to more systematic and detailed analyses may be the small size of this group. In this relatively large-scale online study, only about

two percent of participants were classified in the HSD&HYP group, which suggests a low base rate of this phenomenon—particularly if we take into account the way the study was advertised. Interestingly, a New Zealand cohort study found that less than one percent of women reported both a lack of control over their sexual fantasies/urges and actual sexual behavior that interfered with their daily life (Skegg et al., 2010).

Lower relationship intimacy, compared to controls, was also observed among women with high sexual desire. It is possible, as expressed by participants in a qualitative study focusing on highly sexual women (Blumberg, 2003), that a mismatch in sexual motivation between partners may make committed relationships more tenuous. High sexual desire may generate frictions in romantic relationships and impede intimacy, if there is a desire discrepancy between partners. Alternatively, sexual desire may provide a substitute for intimacy or be conceptualized as a shortcut to intimacy. As our measure of relationship closeness only tapped into emotional aspects of intimacy, it may be that higher sexual desire and more frequent sexual activity reflected the more physical aspects of intimacy, which was not captured by the measure used. From a different perspective, the finding that women in the HSD group reported lower levels of emotional intimacy than controls may indicate that, for some women, lower intimacy may facilitate the experience of sexual desire in a relationship (Perel, 2010). In any case, keeping in mind that a similar proportion of women in the HSD group and controls reported being in a relationship at the time of the survey—notwithstanding the fact that women characterized with high sexual desire were significantly younger—the observed differences in emotional intimacy should not be overemphasized.

Methodological strengths of the present study include a large, non-clinical sample of women of varying ages, the use of validated measures, and an online survey design that allowed full anonymity and confidentiality. The novel contribution of this study lies in its attempt to tease apart women's high sexual desire from hypersexuality, providing a less biased perspective of the still misunderstood phenomenon of female hypersexuality. Finally, the present study tackled this challenging conceptual and clinical issue by integrating relationship and sexual well-being dimensions.

Several study limitations need to be briefly discussed. The non-probabilistic sampling strategy used in this study, which resulted in oversampling of highly educated younger and non-exclusively heterosexual women (less likely to be living with a partner) precludes drawing any conclusions about the prevalence of the phenomena studied. Advertised as focusing on pornography use and sexual health, it is likely that our study also oversampled women concerned about their sexuality. Future studies to be carried out in different samples of women would be needed to replicate our findings. Taking the aforementioned biases into account, the likely hypersexual women (the HSD&HYP group) seem to be extremely rare cases (about two percent of participants in this sample). The small size of this group

of participants was responsible for low statistical power in comparative analyses, possibly obscuring some inter-group differences.

The identity-based measure of sexual orientation used in this study needed to be dichotomized for practical reasons. Given that self-identified bisexual women reported the most frequent sexual activity in this study (findings not presented here), grouping together all women who did not identify as exclusively heterosexual may have affected some analyses. Several indicators of potential interest for the comparative analysis undertaken in this study were not included in the questionnaire. This is primarily the case with measures of childhood trauma and emotion regulation, which have been associated with hypersexuality (Aaron, 2012; Kafka, 2010; Parsons et al., 2008; Reid, 2010; Reid, Carpenter, Spackman, & Willes, 2008; Riemersma & Sytsma, 2013; Skegg et al., 2010). Finally, in the absence of clinical assessment, our categorization of women in the HYP and HYP&HSD groups should be considered with caution.

In conclusion, the results of this study suggest that women's high sexual desire and/or frequent sexual activity are not associated with negative behavioral consequences. The construct of high sexual desire seems to represent a phenomenon distinct from hypersexuality, understood as denoting dysregulated sexuality. These distinctions seem also relevant, analytically and clinically, for men (Štulhofer et al., in press). According to the findings presented in another publication from this research project, systematic differences between high sexual desire and problematic sexuality are not gender-specific (Carvalho, Štulhofer, Vieira, & Jurin, 2015).

In most cases, high levels of female sexual desire and coupled sexual activity do not appear to have any particular clinical relevance and should not be considered as problematic. Women consulting for hypersexuality-related issues should not be assumed to have high sexual desire or a high frequency of (coupled) sexual activity. Apart from a small subgroup, they may be better helped by interventions aimed at reducing self-stigma and internalization of sex-negative norms, as well as by targeting negative consequences in social and occupational functioning, than by focusing on their level of sexual desire. Future research should aim to make clear conceptual and measurement distinctions between high sexual desire and hypersexuality in women.

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