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Review

Sexual Shame and Women's Sexual Functioning

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Abstract: Sexual shame negatively affects women's sexual functioning, impacting arousal, desire, orgasm, and pain. This review summarizes the existing literature, highlighting the multiple, interacting factors contributing to sexual shame including sociocultural messages, body and genital self-image, sexual self-schemas, sexual pain, comorbid chronic disease, illness, medical disorders, and sexual trauma. The relationship between sexual shame and sexual functioning is often reciprocal, demonstrating sexual shame as a potential causal and maintaining mechanism underlying women's sexual difficulties. We present a model proposing the mechanisms by which sexual shame affects sexual functioning, underscoring the need for comprehensive approaches to mitigate the impact of sexual shame and foster sexual well-being for women. Growing research emphasizes emotional processes in models of sexual function, and emotional pathways underlying sexual difficulties and dysfunction. Given the impact of sexual shame on women's sexual functioning, therapeutic approaches that target sexual shame are recommended to help alleviate difficulties with sexual arousal, desire, orgasm, and sexual pain.

Keywords: sexual shame; women's sexual functioning; sexual arousal; desire; orgasm; sexual pain; emotion model; sociocultural messages; body image concerns; genital self-image; sexual self-schemas; sexual trauma; PTSD

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1. Introduction

Sexual difficulties affect a significant number of women across the globe, with between 30% and 50% of women reporting problems in one or more domains of sexual functioning including desire, arousal, orgasm, and pain [1–5]. It is likely that these statistics underestimate sexual problems experienced by women, given the stigma associated with acknowledging and reporting sexual difficulties. Women's sexual functioning and potential sexual difficulties are complex and multifactorial, with biological, psychological, interpersonal, and sociocultural contributors impacting the domains of desire, arousal, orgasm, and pain [6–8]. Sexual difficulties negatively impact one's quality of life and are associated with increased negative emotions, depression, and lower sexual and relationship satisfaction [7,9–11]. There are numerous psychological factors that accompany difficulties with sexual arousal and desire, orgasm, and sexual pain. These include anxiety associated with negative and adverse experiences in present or past sexual contexts, fear of negative response from partners, increased self-control and a propensity to hide one's emotions, impulsivity, low self-esteem, low energy, stress, attentional focus on performance versus emotional connection, and feelings of guilt or shame related to sexual activity [12,13]. This review summarizes relevant literature regarding shame and women's sexual functioning, highlighting the areas where shame plays a significant role in impacting sexual arousal, desire, orgasm, and pain. We then present a model proposing the role of sexual shame in women's sexual difficulties and discuss sexual shame as a target for clinical interventions to support women's sexual functioning.

In this review, we examined and synthesized reviews, empirical studies, discussion and theoretical papers, and dissertations obtained through keyword searches using Google Scholar. The keywords included women, shame, sexual shame, sexual functioning, sexual dysfunction, arousal, desire, orgasm, and pain. Additional relevant papers cited in the identified literature or related literature were also explored. A limitation of the literature reviewed is that it focuses primarily on cisgender women; therefore, unless otherwise stated, "women" refers to cisgender women. This limitation is further discussed in the future directions section of our review.

Shame is a negative emotion often connected to sex and sexuality [14–19]. From a social perspective, women may experience sexual shame as inherent to sexual experiences, demonstrated by the cultural tendency toward a sexual and gendered double standard—where women's sexual experience is viewed as a source of shame versus a source of pride, i.e., pleasure, satisfaction, and self-affirmation [20,21]. One expression of this is "slut shaming", a practice of vilifying women for presumed sexual activity and violating sexual standards, that stigmatizes and limits women's sexual expression [17,22]. Similarly, anatomical nomenclature has been argued as a societal contributor to shame related to sexuality, with the outer genitals being termed "pudendum" originating from the Latin root *pudēre* meaning "to be ashamed" [18,23]. Despite growing exploration of the role of shame associated with a range of mental health issues including depression, anxiety, addiction, eating disorders, self-inflicted injury, and traumatic stress reactions [24–29], discourse on sexual shame is primarily limited to clinical practice-based writing [18,30,31]. As a result, sexual shame has been identified as an important area of study with nascent research contributing an empirically defined, domain-specific construct of sexual shame [14,16,17,32]. This increase in scholarly work invites a more fulsome exploration of sexual shame and its possible role in shaping women's sexual difficulties.

There is growing research that emphasizes emotional processes in models of sexual function, and emotional pathways underlying sexual difficulties and dysfunction. Dewitte [33] conceptualizes sexual functioning as an emotion regulation mechanism involving complex interactions between cognitive, affective, and motivational responses, that are influenced by relational variables, processes, and social contexts. The Emotion–Motivation model of sexual response [34] offers potential causal and maintaining mechanisms of sexual difficulties for women that incorporates impacts of negative emotions on sexual functioning. The model informs this review, providing a theoretical understanding of sexual shame as a potential causal and maintaining mechanism underlying women's sexual difficulties and concerns. In this model, sexual response begins pre-attentively when a stimulus is appraised as sexually meaningful and potentially rewarding. This increases attention to the stimulus and activates cognitive, physiological, and emotional aspects of sexual response which, in turn, promote deliberate attention to and appraisal of a sexual stimulus. If the appraisal is positive, then a sexual response will continue to unfold, increasing physical and subjective sexual arousal and responsive desire [34]. If the appraisal is negative, e.g., the stimulus is not perceived as rewarding, pleasurable, safe, or is associated with shame, or cognitive distractions arise, i.e., negative beliefs or thoughts about sex, sexual responses are diminished [35–37].

According to the Emotion–Motivation model of sexual response, affective processes emerge alongside these cognitive processes, with emotional responses to sexual cues strengthening or diminishing sexual arousal and desire, depending on emotional valence. For example, high satisfaction, affection, and positive emotional responses are associated with greater sexual desire, whereas negative emotional responses, such as shame, fear, and disgust are linked to reduced arousal and desire [6,38]. Emotions, specifically low mood, are associated with sexual functioning and sexual response for women, with significantly more negative emotions, i.e., fear and sadness, being experienced by women with sexual dysfunction [7]. A recent scoping review [38] reported that emotion regulation difficulties were associated with poorer sexual functioning and satisfaction [38]. Emotion regulation may also be linked to additional variables underlying sexual difficulties, i.e., interpersonal

connection and relationship processes [38]. This increasing interest in how affective processes more specifically impact sexual response and the development and maintenance of sexual difficulties for women underscores the need for more targeted inquiry into specific emotions and affective states in relation to sexual functioning.

Given recent theorizing regarding sexual response as an emotion/motivational system, this review investigates the relationship between sexual shame and women's sexual functioning. First, we define sexual shame, then present the factors associated with sexual shame impacting sexual functioning for women, including sociocultural messaging, body image, genital self-image, sexual self-schemas, sexual pain, comorbid medical disorders and illness, and sexual trauma. We then discuss the impacts of sexual shame on women's sexual response, proposing a model with sexual shame potentially at the core of negative affective responses associated with sexual cues and sexual functioning. We conclude with recommendations for clinical interventions that target sexual shame to support sexual functioning for women and suggestions for future research.

2. Defining Sexual Shame

Shame is a self-conscious emotion involving global devaluation of the self [14,19,39,40]. Shame has been described as an attack on the self and at its core, holds the desire to be loved, valued, and seen as deserving and desirable [41,42]. Shame comprises both interpersonal and self-evaluative aspects [43]. For example, shame is a social emotion stemming from the real or perceived negative judgements of others, which can be further internalized with an individual shaming themselves in isolation [18]. In addition, shame can be conceptualized as a critical self-evaluation unrelated to a relational experience, arising from an internal experience of not meeting values that are deeply linked to identity [43].

Tomkins' affect theory [44] proposed that shame is automatically activated when positive affect is impeded and is experienced as an all-encompassing body experience that disconnects people from their joyful experience and connection with others [18,44]. Shame is rooted in our universal desire to be loved and need for safety and belonging, and manifests in response to experiencing ourselves as unlovable, and being inferior, inadequate, incompetent, defective, flawed, or broken [41,43,45]. Often, it is helpful to differentiate shame from guilt, with shame being an attack on the entire sense of self and guilt being associated with a specific behaviour [19,46]. A further discernment is the behaviour that each motivates; while guilt prompts taking action, i.e., apologizing or repairing, shame can manifest as the wish to hide and avoid any context or interpersonal experience that might reveal the flawed sense of self [47–49]. Shame has been associated with mental health difficulties including anxiety, depression, post-traumatic stress disorder (PTSD), engagement in suicidal and non-suicidal self-injury, substance abuse, eating disorders, fear of intimacy in relationships, and distress in couple relationships [19,45,50–53].

Sexual shame has been more recently defined in the literature as a domain-specific construct and as overlapping with the general construct of shame. Clark [14] provides an empirically derived definition and model of sexual shame being a visceral feeling of disgust and self-abasement directed toward one's physical body, sexual being, and identity, and includes beliefs and feelings of inferiority, inadequacy, and helplessness, resulting in perceiving the self as flawed and defective. As a domain-specific construct, sexual shame seems to elicit more disgust toward the self versus the intense embarrassment that characterizes more global descriptions of shame [14]. Sexual shame arises both internally and in the context of interpersonal relationships by undermining trust, communication, and negatively impacting physical and emotional intimacy [14]. Often, sexual shame persists beyond an interpersonal context, showing up as internalized messages of disgust and self-attack, which is similar to experiences of more generalized shame.

Using a grounded theory approach, Clark [14] explored the etiology and experience of sexual shame, which generated four subconstructs of sexual shame: internalized sexual shame, partnered relational shame, bodily/biological shame, and vulnerability shame. In this model, circular relationships exist between interpersonal and intrapersonal experiences

of sexual shame in relationship to sexual encounters. In an experience where sexual arousal is met with some interpersonal message that elicits shame, an internal cue of shame may become paired with arousal and, in an effort to avoid re-experiencing shame, an individual may inhibit sexual arousal responses in the future in a self-defeating cycle [14]. Sexual shame develops across complex, reciprocal, and interconnected levels of influence including individual, cultural, and societal experiences [14].

3. Factors Contributing to the Experience of Sexual Shame and Sexual Functioning Outcomes for Women

The existing literature identifies sociocultural messages, body image, genital self-image, sexual self-schemas, sexual pain, comorbid medical disorders and illness, and sexual trauma including childhood sexual abuse (CSA), adult sexual violence, and PTSD symptoms as predominant agents contributing to the development and maintenance of sexual shame and negatively affect sexual functioning for women.

3.1. Sociocultural Messages About Women's Sexuality

Sociocultural messages include moral and religious beliefs, socially constructed concepts of gender, sexuality, and sexual activity, and societal messages related to values, beliefs, and behaviours received through family, school, media, and social groups that often comprise a person's primary sexual education [54]. Sociocultural messages impact expectations and norms related to sex and sexuality, and further the sexual scripts and ideals that women internalize [18,32,54]. Shame about sex and sexuality is exemplified in the taboo nature that surrounds discussion of sex and sexuality in Western homes and is communicated through the embarrassment that often accompanies parents' discussions (or lack thereof) about genitals or sexuality in Western society [16,32]. Further, natural sexual curiosity and exploration, particularly for young women, is often criticized, pathologized, and stigmatized [16]. Cultural messages often communicate a gendered sexual double standard where sexual activity is seen as a source of pride for men and for women as something shameful [20]. These messages are often translated into feelings of anxiety, guilt, and shame affecting sexual functioning [54,55]. For example, women receive messages related to how much desire is acceptable to experience from numerous sociocultural influences, i.e., in interpersonal relationships, from family, media, and larger cultural and societal levels, that contribute to the experience of sexual shame [14]. Women may feel sexual shame from having too little desire or from expressing, seeking out, or fulfilling desire and pleasure [32]. In this way, the regulation and restriction of desire is learned by women. Recent research highlights the nuanced and locally constructed nature of gendered sexual double standards, suggesting these may be more transient and changing [56]. In addition, recent research also highlights the importance of further study related to the cultural construction of gendered sexual double standards and how these are expressed and reinforced in diverse communities [56].

Cognitive conceptualizations of sexual functioning highlight the influence of sociocultural factors in the development of cognitive schemas—for example, conservativism, and religious or age-related beliefs—and how these may be causal factors in the development of female sexual dysfunction [57]. For example, women endorsing age-related beliefs, i.e., "After menopause, women lose their sexual desire" or "As women age, the pleasure they get from sex decreases", are associated with sexual desire and pain disorders, conservative beliefs, and beliefs about sex as a sin [58].

Tiefer [59] noted that sexual problems, including sexual avoidance and inhibition, arise due to feeling unable to meet cultural and societal norms related to 'correct' sexuality, i.e., anxiety or shame about one's body, sexual responses, sexual orientation, identity, sexual fantasies, and desires. Similarly, Heiman and Meston [60] identified family messages communicating sex as "shameful" as a psychological and interpersonal factor contributing to women's sexual functioning, specifically orgasmic problems and *dyspareunia*, pain during vaginal penetration. Further, women experiencing sexual pain or dyspareunia have

reported more problematic penetration-related beliefs and pressure motives for having intercourse than women without sexual pain [54].

3.2. Body Image

A strong correlation has been reported between negative body image or body shame and sexual functioning, satisfaction, and experiencing pleasure [61–63]. Body image is conceptualized as multidimensional, comprising cognitive (i.e., dissatisfaction, want for change), affective (i.e., shame or dysphoria), and behavioural (i.e., avoidance and concealment) body-related evaluations and the meanings ascribed to these assessments [63–65]. Body shame refers to heightened feelings of worthlessness or inadequacy in response to perceived inadequacy to meet societal ideals of and expectations for physical appearance [39,62]. Regarding sexual difficulties, body shame in the context of sexual experiences has been suggested to undermine sexual pleasure by increasing cognitive preoccupation with the body and sexual self-consciousness [62]. For both women and men, body shame has been related to increased sexual self-consciousness during physical intimacy, is predictive of lower arousability, and is indirectly related to orgasm difficulty via reduced arousal [62]. For women specifically, higher levels of body shame have been reported and were a stronger predictor of sexual-self-consciousness, compared to men [62].

It has also been hypothesized that a reciprocal relationship may exist between body concerns and sexual outcomes and that sexual difficulties may bring about increased body shame. This relationship highlights the deleterious cycle between sexual shame, body concerns, and sexual functioning. In a 2012 review, body image issues were reported to impact all areas of sexual functioning, notably sexual desire, subjective arousal, lubrication, orgasm, and pain [63]. More recently, the degree to which differentiated cognitive, affective, and behavioural dimensions of body image impact sexual desire, arousal, and orgasm for women has been explored with the affective components of body image, i.e., body shame and negative feelings about one's body, particularly in the context of sexual activity, and its impact on arousal and orgasm [66]. In addition, women's negative feelings about their own appearance, as well as the internalized negative evaluations of others, have been found to impact sexual functioning and were predictive of decreased arousal and desire [66]. Affective components of body image, including shame and dysphoria, can be seen to disrupt sexual response and functioning for women.

3.3. Genital Self-Image

Genital self-image is a more specific aspect of body image with impacts on women's sexual functioning. It is noted that body image perception and dissatisfaction for women may not be equal across the body and that certain areas, such as the genitals, may be more vulnerable to negative evaluation, specifically in sexual contexts [67]. *Genital image self-consciousness* is the heightened awareness or preoccupation with the physical appearance of women's external genitalia, i.e., the vulva, including the labia minor, labia majora, clitoris, vulval vestibule, and mons pubis [67]. In general, research suggests genital self-image demonstrates a significant relationship with female sexual functioning, although there are some conflicting results as to the domains of women's sexual functioning that are impacted [68]. Berman and colleagues [69], have suggested genital self-image is related only to desire, whereas Komarnicky and colleagues [70] have reported genital self-image being significantly associated with women's experiences of sexual desire, sexual arousal, vaginal lubrication, orgasm, and sexual pain. It has been suggested that the lack of consensus is methodological, with different psychological constructs related to genital image being measured, including shame, embarrassment, and satisfaction [67].

Scant research on body image and genital self-image has extended to the area of pain in relation to women's sexual functioning and reporting dyspareunia or painful intercourse. Pazmany and colleagues [71] found that women with dyspareunia reported significantly more distress about their body image and genital image than pain-free women. Further, increased negative genital self-image was strongly associated with a higher like-

lihood of reporting dyspareunia. Notably, the authors suggest that this finding may be explained by qualitative research on women's affective experience of dyspareunia, highlighting the powerful negative feelings associated with dyspareunia, vulvodynia, and vulvar pain including guilt, shame, failure, inadequacy, isolation, and feeling damaged or abnormal [72,73]. Additionally, these negative feelings are often directed to their genitals, with women describing them as "dead" and "useless", and contributing to feeling like not a "real woman" [73,74]. Genital shame with respect to both appearance and functioning, can be seen as a contributing factor effecting desire, arousal, lubrication, and experiences of pain for women.

3.4. Sexual Self-Schemas

Shame has been related to sexual self-schemas, with women internalizing feelings of shame in response to sexual self-views with negative impacts on sexual functioning, increased psychological distress, and lower sexual satisfaction [32,75,76]. Sexual self-schemas, conceptualized by Anderson and Cyranowski [77] are: "cognitive generalizations about sexual aspects of oneself that are derived from past experience, manifest in current experience, influential in the processing of sexually relevant social information, and guide sexual behavior" [77] (p. 1079).

Women's sexual self-schemas or sexual self-views predict relevant emotions and behaviours in sexual contexts [77]. Women with more negative self-views described themselves as more self-conscious, embarrassed, insecure, and having more conservative values in sexual contexts [77]. Sexual self-schemas are predictive of sexual functioning [75]. Women with negative sexual self-schemas report lower levels of sexual desire, less frequent sexual activities, higher sexual anxiety, and avoidance of sexual situations [75].

Growing evidence suggests that sexual self-views are activated in the context of sexual stimuli and influence how sexual information is attended to and processed, with impacts on sexual response [34,78]. Negative and self-critical beliefs about one's sexual self, particularly those related to incompetence, can directly decrease attention to stimuli, impairing sexual desire [36,79]. Further study exploring the organization of women's sexual self-schemas reported that denser, or more closely interrelated, embarrassed–conservative self-views are related to lower sexual excitation and may be more relevant to difficulties with sexual arousal versus inhibition of sexual responses [78].

Del Rey and colleagues [76] discuss the relationship between sexual shame and sexual self-schemas in college-aged women, utilizing Kyle's [16] definition of sexual shame as a pervasive negative emotion elicited by critically viewing one's sexual thoughts and experiences. The authors reported that sexual self-schemas and sexual shame were significantly correlated in the negative direction, with sexual shame predicting the valence of women's sexual self-schemas. Further, this sexual shame was a better predictor of sexual self-schemas than sexual functioning [76]. Women experiencing higher levels of sexual shame report more negatively valenced sexual self-schemas, which, in turn, impacts sexual desire, arousal, sexual satisfaction, and romantic attachment [75,76].

3.5. Sexual Pain

Sexual shame is a significant factor contributing to sexual pain experienced by women, including genito-pelvic pain disorder (GPPD), previously termed dyspareunia (pain during vaginal penetration), *vaginismus* (involuntary contraction of vaginal muscles leading to painful or impossible vaginal penetration), and vulvar pain disorders, i.e., *vulvodynia*—chronic idiopathic vulvar pain and/or *provoked vestibulodynia*—and contact-induced *vulvodynia*, located at the vulvar vestibule [80].

Within the literature, vulvodynia has been acknowledged as a significant health problem, with a sizable proportion of women experiencing psychological distress and interference with sexual functioning for a significant period [71,72,81]. Qualitative research exploring the subjective experience of women experiencing vulvodynia and vulvar pain has highlighted shame as a psychological difficulty and dominant theme [72,81]. Many women

describe feelings of shame, guilt, inadequacy, failure, isolation, loss of self, and being broken or incomplete, and report interference with sexual aspects of relationships including arousal, prevention of pleasurable genital touch, including masturbation, and painful vaginal penetration [72,81]. Further, experiences of being 'silenced by shame' contributed to fear of physical pain, decreased sexual desire, avoidance of sexual contact, and barriers to experimenting with other forms of intimacy [72]. Quantitative research suggests that reporting a negative genital self-image is associated with increased likelihood of reporting dyspareunia, and sexual distress is strongly correlated with body image, genital self-image, and sexual functioning [71]. Similarly, negative body image during sexual activities is associated with worse sexual functioning for women with provoked vestibulodynia (PVD) [82]. Shallcross and colleagues [83], in a more recent systematic review and meta-ethnography, identified shame and guilt as key contributors to psychological distress, low mood, anxiety, and the relational impacts of vulvodynia. Additionally, the authors highlight women's experiences of socially constructed shame and what is deemed to be 'normal' with regard to gender and sexuality, i.e., the prioritization of penetrative, penile–vaginal sex and emphasis on male orgasm. In addition, problematic and shaming interactions with healthcare professionals likely play a significant role in the psychological difficulties and distress associated with vulvodynia [83].

A novel model outlined by Rosen and Bergeron [84] proposes interpersonal emotion regulation as a key mechanism in women's sexual dysfunctions, applying the example of GPPD. This conceptual framework highlights the complex interpersonal factors and high levels of negative affect, i.e., shame, guilt, anxiety, and threat associated with experiencing GPPD [83,84]. Rosen and Bergeron [84] describe emotion regulation via emotional awareness, emotional expression, and active accessing and reflecting on one's emotions as key interpersonal factors that impact women's sexual pain, sexual functioning, and psychological distress along with relationship satisfaction.

3.6. Comorbid Chronic Disease, Medical Disorders and Illness

Sexual shame has been identified as a psychological response to chronic disease, medical disorders, and illness including multiple sclerosis, spinal cord injury, pelvic floor dysfunction, endometriosis, diabetes, urinary tract conditions, urinary incontinence, cancer, vulvodynia, and Crohn's disease, each significantly impacting women's sexual functioning [85]. Shame and feelings of failure in response to experiencing chronic disease, medical disorders, and illness can disrupt sexual motivation, response, arousal, and functioning [85]. Additionally, sexual shame related to experiencing sexual difficulties as a result of chronic disease, medical disorders, and illness may further impact sexual functioning.

Caruso and colleagues [86] explored sexual functioning and quality of life for women diagnosed with different subtypes of urinary incontinence (UI) and reported significant negative impacts on sexual functioning, regardless of the subtype, in the areas of desire and orgasm. Findings suggest that embarrassment, guilt, and inadequacy, as underlying qualities of psychological distress assessed by the Female Sexual Distress Scale [87], may potentially be causal factors for sexual difficulties for women in addition to fear of urinary leakage during sexual activity [86]. In this way, chronic disease, illness, and medical disorders may predispose and precipitate difficulties with sexual functioning, and the sexual shame surrounding these difficulties further compounds sexual dysfunctions for women, extending to experiencing sexual difficulties. It has been proposed that medicalizing and categorizing sexual dysfunctions evokes shame for those experiencing sexual concerns, leading to the conclusion that one is dysfunctional rather than one is experiencing a dysfunction [32].

3.7. Sexual Trauma

Research on sexual trauma has described profound links between shame and women's sexual functioning [88–96]. Below, we discuss the impacts of different forms of sexual trauma on sexual functioning, including childhood sexual abuse (CSA), adult sexual

violence, and PTSD, highlighting the negative impact of sexual shame on women's arousal, desire, orgasm, and pain.

3.7.1. Childhood Sexual Abuse

Childhood sexual abuse (CSA) is defined by Kilimnik, Pulverman, and Meston [97] as unwanted sexual contact before the age of sixteen. It has been identified as one of the most potent risk factors associated with sexual problems in adulthood [88–91,96]. Women with histories of CSA have almost twice the rate of sexual dysfunction than the general population [95] and increased rates of sexual desire and arousal difficulties [93,95]. Although not all women experiencing CSA experience sexual problems in adulthood, low sexual desire, problems with arousal and orgasm, dyspareunia, vaginismus, and low sexual satisfaction have been identified as problems experienced by women reporting CSA [93,95].

Leonard and Follette [93] point to affective components related to CSA that may underpin the relationship between CSA and adult sexual problems. They discuss experiential avoidance as a coping strategy used during sexual activity to minimize, alter, or eliminate painful internal events, including thoughts, emotions, and memories associated with sexual trauma [98,99]. These strategies include alcohol and substance use, dissociation, and self-harming behaviours. Similarly, Greenberg and Paivio's emotion theory [92] conceptualizes how experiences of CSA may result in intimacy being associated with fear, shame, and expectations of harm from others, which has a significant impact on sexual functioning [92–94].

Mechanisms proposed to explain higher rates of sexual dysfunction among women with abuse histories include experiencing shame and guilt associated with CSA, along with body image, cognitive associations with sexuality, sexual self-schemas, and sympathetic nervous system activation [95]. Studies suggest that, for women with a history of abuse, negative affect, including shame, fear, anger, and disgust, before and during sexual stimuli, may contribute to the development and maintenance of sexual concerns, particularly sexual arousal [100–102].

Feiring and colleagues [15] found that reporting more abuse-specific *stigmatization*, defined as shame and self-blame, one year after CSA was expressed to authorities, predicted greater sexual difficulties six years later. In addition, shame and self-blame as emotional reactions to CSA may be more predictive of sexual difficulties than the characteristics and severity of abuse, i.e., the use of force, the presence of penetration, the duration of abuse, a familial or non-familial perpetrator, the number of events, and the duration. Stigmatization experienced during and following CSA can persist into non-abusive relationships, with shame disrupting intimacy through isolation, fear of self disclosure, anxiety related to one's worth as a partner, and expectations of censure from others [15,94].

Further research into the potential links between shame, guilt, and low body image for women with CSA histories has been recommended [95]. Pulverman and Meston [103] reported that *sexual shame*—shame related to one's past sexual experiences and behaviours—best explained the relationship between CSA and women's sexual function over previously associated candidate mechanisms, including dissociation during an erotic stimulus or sexual activity, disruption in attachment security, and body or genital self image. The authors posited that dissociation may be more significant for women with CSA histories, with regard to mental health versus sexual function, or that dissociation may be more relevant to sexual function for some but not all women with CSA histories. These findings have powerful implications for theory, research, and clinical practice. Pulverman and Meston [103] used Barlow's [104] cognitive-affective model of sexual function to explain the relationship between sexual shame and sexual function for women with CSA histories. This model postulates that distraction, resulting from negative affect and maladaptive causal attributions, impairs sexual functioning, with empirical evidence supporting this model for women's sexual functioning [105,106]. Distraction in the form of body image concerns, concerns about sexual abilities, and fear of sexually transmitted infections or unwanted pregnancy are present for women in general; however, for women with CSA

histories, distraction may also include more sexual shame-related cognitions, for example, related to feeling defective or not good enough, as highlighted in the Kyle Inventory of Sexual Shame (KISS) [16] measure: "When I think of my sexual past, I feel defective as a person", and "I feel like I am never quite good enough when it comes to sexuality" [16]. The results suggest that sexual shame is a differential factor for the sexual functioning of women with and without histories of CSA; however, the authors note that it is unclear from their correlational study whether sexual shame contributes to sexual problems or if sexual problems lead to sexual shame [103].

Gerwirtz-Meydan [107] addresses the relationship between CSA and sexual dysfunction by exploring the potential functional aspects of sexual dysfunction for survivors of CSA. Although healthy sexual functioning can be seen as desirable for individuals with CSA histories, in the context of trauma, four primary protective purposes are proposed for sexual dysfunction, including the avoidance of re-traumatization, the regulation of relational closeness, the avoidance of vulnerability through accessing power and control, and the restoration of a positive sense of self. This perspective has important clinical and research implications in viewing sexual dysfunction as a temporary protective coping strategy versus as an entirely negative outcome [107]. Shame and self-blame are highlighted as aspects of stigmatization and anticipatory stigma that may be internalized by CSA survivors, negatively impacting sexual self-schemas and giving rise to negative feelings during sexual arousal [15,100,107]. Sexual trauma also impacts the perception, interpretation, and experience of body signals, with the potential for perceiving the body as frightening or dangerous though a process termed *personification*, where bodily symptoms are seen as separate or more removed from the self [108]. Personification has been suggested as a potentially protective mechanism, where sexual dysfunction can be more attributed to the body 'failing' or being 'damaged', rather than the self [107]. This is relevant for consideration from a clinical perspective, specifically the potential protective aspects that sexual dysfunction following sexual trauma may serve.

Childhood sexual abuse (CSA) is established as a dominant risk factor for later sexual problems for women, including low sexual desire, problems with arousal and orgasm, sexual pain, and low sexual satisfaction. Sexual shame has been highlighted as a primary affective mechanism explaining the relationship between CSA and sexual functioning difficulties [15,93,95,100–103].

3.7.2. Adult Sexual Violence

Van Berlo and Ensink [109] reviewed several studies investigating sexual functioning after sexual assault and noted a decreased frequency of sexual contact, as well as diminished sexual satisfaction and pleasure for at least one year post-assault. Further, the inhibited sexual responses, i.e., fear or difficulty with arousal and desire, can persist for years after experiencing sexual trauma. Emotions experienced during and immediately after an assault were investigated and anger towards the self, shame, and guilt predicted a fear of sex, low levels of desire, and sexual aversion. The authors emphasize shame as a significant and underexplored contributor to sexual problems related to experiencing sexual assault [109].

A recent study by Nolin and colleagues [49] exploring the role of shame resulting from sexual violence in adulthood (SVA) found that stigmatization was associated with more shame about sexual violence and linked to higher sexual distress, avoidance, and lower sexual satisfaction and sexual functioning. Social reactions following women's disclosure of sexual violence also impacts sexual outcomes. Stigmatization from others may be internalized as shame and self-blame, characterized by feeling unworthy of love, loving others, or sexual pleasure [49,110]. Similarly to CSA, internalizing shame and self-blame may lead to coping strategies in the form of inhibition of sexual pleasure or avoidance of sexual behaviours [49]. Adult sexual violence is associated with experiencing sexual shame, which has a significant impact on women's sexual arousal, desire, and pleasure, often leading to sexual avoidance and further consequences for sexual outcomes.

3.7.3. Post-Traumatic Stress Disorder (PTSD)

Sexual shame is also suggested to play a role in how PTSD impacts sexual functioning for women, including low levels of desire, arousal, activity, and satisfaction [111]. Although sexual difficulties are not identified in the symptomatic criteria for PTSD, sexual problems are a significant concern for trauma survivors, regardless of whether the nature of the trauma is sexual or not [111,112].

PTSD is characterized by symptoms spanning four clusters related to reexperiencing the traumatic event(s). These include intrusion symptoms, i.e., recurrent, unwanted, and intensely distressing memories and flashbacks, avoidance symptoms reflecting efforts to avoid external and internal reminders that arouse distressing memories, thoughts, or feelings, negative alterations in cognition and mood, and marked alterations in arousal and reactivity [113].

Experiencing symptoms of PTSD has been suggested as a more primary driver of sexual problems, compared to the trauma event itself [111,112]. At the same time, shame has been identified as a significant mediator for developing PTSD symptoms following trauma [114,115]. Yehuda and colleagues [111] argue that PTSD-related changes to physiological, cognitive, and affective processes underlie the comorbidity between sexual dysfunction and PTSD. More specifically, PTSD disrupts neuroanatomical, neurochemical, and endocrinological processes that are essential to sexual desire, arousal, and orgasm [111]. Both PTSD and sexual functioning involve physiological arousal; however, healthy sexual functioning depends on the inhibition of fear and threat networks. PTSD is characterized by increased and sustained arousal and hypervigilance, as a result of impairments to networks that regulate arousal responses. Thus, sexual functioning can be impacted, as physiological arousal may become associated with fear, threat, and shame, while heightened arousal during sexual experiences may elicit panic, flashbacks, or increased shame. In addition, feelings of self-blame, shame, and self-schemas reflecting beliefs of being undeserving of love or pleasure further impact sexual functioning and active avoidance of sexual intimacy [111]. Shame has been identified as an independent predictor of developing PTSD symptoms following trauma, contributing to PTSD-related disruptions to sexual arousal responses, fueling further sexual difficulties via increased sexual shame, self-blame, and avoidance [111,114,115].

4. Discussion

There are many factors that contribute to women's experience of sexual shame, including sociocultural messages, body and genital image, sexual self-schemas, sexual pain, comorbid medical disorders and illness, and sexual trauma including childhood sexual abuse, adult sexual violence and PTSD, with deleterious impacts on sexual functioning.

Sexual shame has a complex etiological course and is maintained through interconnected and reciprocal biopsychosocial factors (See Figure 1). Societal and cultural messages may contribute to the development of sexual shame and, as a result, impact women's sexual functioning [54,55]. In a negative reciprocal cycle, feeling unable to meet societal standards and 'norms', i.e., experiencing sexual shame related to body concerns and sexual responses, including desire, arousal, and orgasm, contributes to and maintains sexual problems for women [59]. Body shame and genital shame, particularly related to sexual activity, is associated with increased sexual self-consciousness and is predictive of reduced sexual arousal, impacting sexual desire, subjective arousal, vaginal lubrication, orgasm, and experiencing sexual pain [62,63,67–70]. Current research is expanding the connection between sexual self-schemas, sexual functioning, and sexual shame [76]. Sexual shame is more predictive of sexual self-schemas than sexual functioning, and sexual shame is associated with more negative sexual self-schemas for women [76]. Qualitative research has highlighted the emotional experiences of women with dyspareunia, vulvodynia, and vulvar pain, including guilt, shame, failure, inadequacy, isolation, and feeling damaged or abnormal [72,73]. In addition, experiences of shame and being "silenced by shame" contribute to psychological distress and a fear of physical pain, and impact relational and

sexual functioning though decreased arousal, decreased desire, the prevention of pleasurable genital touch including masturbation, and painful vaginal penetration [72,81,83]. Shame as a psychological response to chronic disease, medical disorders, and illness has been identified as a factor that can impair sexual motivation, response, arousal, and functioning [85]. As a result, shame and feelings of failure related to both a medical condition and the associated sexual dysfunction impact sexual self-image, which further maintains difficulties with sexual functioning. Sexual shame is a contributing factor in the impacts on women's sexual functioning as a result of experiencing childhood sexual abuse (CSA), adult sexual violence, and PTSD in the areas of arousal, desire, orgasm, and pain [49,103,109,111]. It is important to note that the role of sexual shame in women's sexual functioning in terms of correlation, causality, and reciprocity must be further explored and that this review provides preliminary understanding using a synthesis of relevant literature.

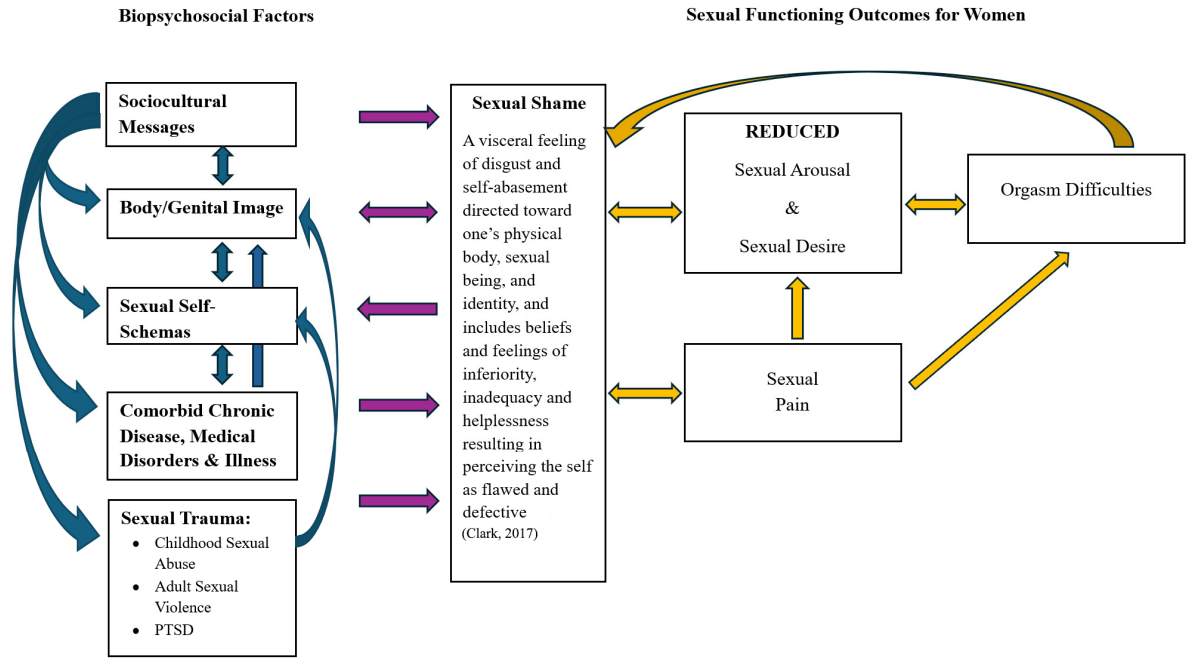

Figure 1. Sexual Shame and Women's Sexual Functioning [14].

Given the multifaceted connections between sexual shame and women's sexual functioning, we propose that shame and, more specifically, sexual shame, is a key component of the affective feedback influencing limbic processing, impacting the cognitive and attentional processes that regulate all stages of sexual response, including the pre-attentive processing of sexual cues, physiological and subjective sexual arousal, sexual desire, and future sexual motivation.

We pose a theoretical model proposing the role of sexual shame in women's sexual difficulties (see Figure 2). Our model is grounded in theoretically driven empirical work in the field of women's sexual responses, specifically the affective processes that underlie sexual response and influence cognitive processes impacting sexual arousal and desire [6,33–35,37,58,116–122]. The experience of sexual shame is not limited to cisgender women and, in theory, our model of the impact of sexual shame on processing pathways for sexual stimuli and sexual functioning may be similar across genders. For example, among men, sexual shame predicts inhibitory domains of men's sexual response [123] (See Figure 2). Although all people have the capacity to experience sexual shame, the sources of that shame will likely be different by an individual's experiences of their social locations, and gender is one axis along which experiences and sources of sexual shame likely vary. Further exploration of the experience and impact of sexual shame on sexual functioning

for transgender and gender-diverse folx is needed to support our model across diverse experiences of sexual shame.

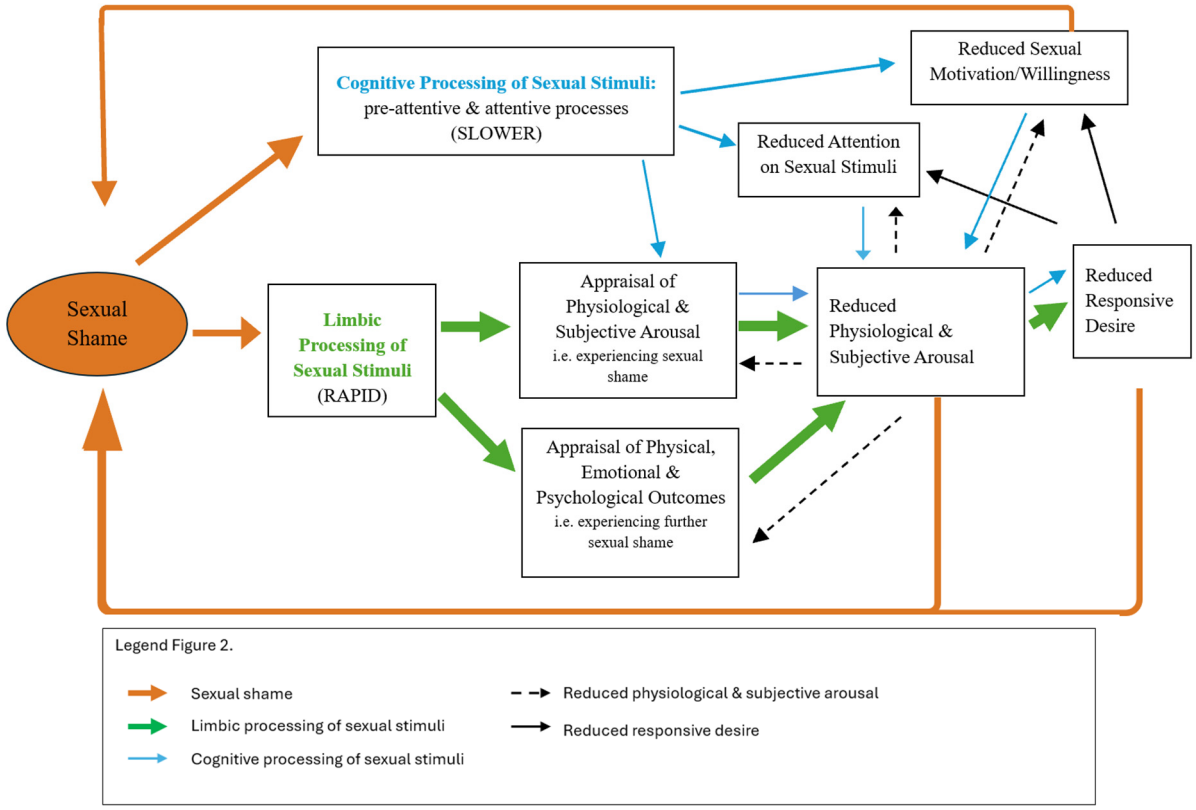

Figure 2. A Model of Sexual Shame and Women's Sexual Functioning.

We have developed our model to reflect Basson's [35,116] circular model of sexual response, wherein emergent sexual desire is a result of sustained physiological and subjective arousal, requiring a continued focus on sexual stimuli, the enjoyment of sexual arousal sensations, and an experience free of negative physical, emotional, or psychological outcomes. Similarly, we incorporate Emotion Theory and the Incentive Motivation Model (IMM) [122], which propose that desire emerges from emotional responses to effective sexual stimuli [117,121]. In addition, the model reflects aspects of the Information Processing Model, related to appraisal and attentional processes in sexual arousal [119,124]. Finally, this model integrates Dewitte's Emotion–Motivation model of sexual response [33], which conceptualizes sexual functioning as an emotion regulation process involving complex interactions between cognitive, affective, and motivational responses, further influenced by relational and social variables and contexts [33,34].

To begin, we utilized Clark's [14] empirically derived definition of sexual shame being a visceral feeling of disgust and self-abasement directed toward one's physical body, sexual being, and identity that includes beliefs and feelings of inferiority, inadequacy, and helplessness, resulting in perceiving the self as flawed and defective. In our model, sexual shame reflects the complex and interconnected biopsychosocial factors impacting women's sexual functioning that this review has highlighted.

In the conceptualization of sexual arousal as an emotional state, emotions strengthen or diminish sexual arousal and desire, with shame, fear, and disgust being associated with reduced arousal and desire [6,38]. We propose that sexual shame impacts the extremely rapid, pre-attentive processing of sexual stimuli by the limbic system. If the limbic appraisal of both physiological and subjective arousal elicits or includes sexual shame, this results in reduced physiological and subjective arousal and reduced responsive desire [37,58,119,125]. Concurrent cognitive pre-attentive and conscious attentional processes are similarly im-

pacted by sexual shame via bottom-up processing [118–120]. If attention to sexual stimuli is distracted by self-attacking or internalized beliefs arising from sexual shame, or if thoughts about sex involve sexual shame, physiological arousal, emerging subjective arousal, and responsive desire will be diminished [34–37,58].

This continuous integration of affective and cognitive feedback as a result of sexual shame impacts further limbic processing, creates interruptions to continued attention on sexual stimuli, impacts a woman's experience of sexual arousal and desire, and maintains increased sexual shame [125].

4.1. Clinical Implications

Given the impact of sexual shame on women's sexual functioning, therapeutic approaches that target sexual shame are recommended to help alleviate difficulties with sexual arousal, desire, orgasm, and pain. Research supports treatment interventions that focus on emotional factors, especially shame and anger, particularly for sexual dysfunction related to childhood sexual abuse (CSA) and sexual trauma [102]. Pulverman and Meston [103] propose that treatments directed toward reducing sexual shame may improve sexual functioning for women with CSA histories. Specifically, psychoeducation, cognitive restructuring, group therapy, and mindfulness-based approaches to reduce isolation and shame-related negative beliefs that support present-moment awareness and the acceptance of thoughts may be beneficial. Shallcross and colleagues [83] propose understanding the experiences of women with vulvodynia using Gilbert's [42] framework of shame and using compassion-based interventions to alleviate shame as a foundational and helpful approach. Further research, focused on mindfulness-based approaches for sexual concerns, has explored the possible mechanisms that support beneficial outcomes in women's sexual functioning, with self-compassion being identified as an important mediating factor.

Self-compassion is compassion directed inward, turning toward ourselves with kindness, understanding, and warmth when we suffer, fail, or feel inadequate [41]. Self-compassion, operationalized by Neff [126], is the integration of three elements—kindness, a sense of common humanity, and mindfulness—and can be understood as a psychological construct, process, practice, state, and trait [127]. Self-compassion has been proposed as a transdiagnostic and transtheoretical mechanism of change in psychotherapy and an empirically validated approach for alleviating distressing thoughts and emotions, generating physical and mental well-being [127,128]. Self-compassion has been conceptualized as the opposite or 'antidote' to shame [127]. Self-criticism, isolation, and overidentification or rumination—essential qualities of shame—are identified as opposing and having an inverse relationship with self-compassion [126–128]. Shame and self-criticism are often experienced in tandem, particularly in psychopathology [129].

In research related to women's sexual functioning, self-compassion—modelled by facilitators of mindfulness-based cognitive therapy (MBCT)—was a factor mediating improvements to overall sexual functioning for women with sexual interest/arousal disorder (SIAD) [130]. Similarly, self-compassion embodied by facilitators guiding mindfulness-training has been suggested as a factor mediating improvements in sexual distress for women with genital pain and mediating improvements to sexual desire and arousal for women with sexual interest/arousal disorder (SIAD) [36,131]. Interventions that target increasing self-compassion have been suggested to reduce psychological distress for women experiencing vulvodynia and their partners [132].

There is good preliminary evidence to suggest that self-compassion may act as a key mediating factor underlying the improvements seen in sexual functioning for women as a result of mindfulness-based approaches. As an outcome of this review, we recommend the development of interventions that directly build practices in and resources for self-compassion to target sexual shame, as this may be of great benefit to women experiencing sexual concerns and difficulties with sexual arousal, desire, orgasm, and pain.

4.2. Future Research

In exploring research related to women's sexual functioning it is important to acknowledge the limitations and exclusion of many women's experiences in the literature. Specifically, the literature on women's sexuality principally reports the experiences of white, cisgender women [14,32], while the experience of sexual shame and its impacts on sexual functioning is not exclusive to cisgender women. Future research exploring the experience and impacts of sexual shame on sexual functioning for transgender women, cisgender and transgender men, and gender-diverse individuals is greatly needed. Further, studies exploring how sexual shame is experienced cross-culturally and those exploring more specific cultural factors that impact sexual shame and sexual functioning are necessary to represent diverse experiences with sexual shame.

Experiencing clinically significant distress related to sexual difficulties is essential to a diagnosis of sexual dysfunction, according to the DSM5-TR, and contributes to the maintenance of symptoms [81]. As a future direction, we are curious as to how the more recently empirically derived construct of sexual shame relates to the construct of sexually related personal distress as measured by the widely utilized Female Sexual Distress Scale (FSDS) and the Female Sexual Distress Scale-Revised (FSDS-R) [87,133]. Research to better understand how sexual shame contributes to distress associated with sexual functioning for women is absent in the literature. We propose future research to investigate the association between levels of distress and sexual shame.

As previously recommended, the development of self-compassion-based approaches targeting sexual shame to support sexual functioning for women, men, and gender-diverse folx, as well as pilot studies to test efficacy could be a clinically relevant and beneficial avenue of future research.

5. Conclusions

This review brings attention to the powerful and negative impacts of sexual shame on women's sexual functioning in the areas of arousal, desire, orgasm, and pain. Additionally, we present a model theorizing how sexual shame impacts affective and attentional processes in sexual functioning for women. Our synthesis of research to date identifies the complex and multifactorial biopsychosocial and interpersonal factors that contribute to sexual shame and the association between sexual shame and negative sexual functioning outcomes for women. In presenting a model proposing the mechanisms by which sexual shame negatively impacts women's sexual functioning, we aim to support and expand on theoretical models highlighting the affective processes underlying sexual functioning and difficulties with sexual arousal, desire, orgasm, and sexual pain. Specifically, we aim to assert sexual shame as a potential primary causal and maintaining factor underlying sexual difficulties for women, via affective feedback impacting the rapid limbic processing of sexual stimuli, and cognitive and attentional processes regulating all stages of sexual response, including the pre-attentive processing of sexual cues, physiological and subjective sexual arousal, sexual desire, and future sexual motivation. Ultimately, we aim to inform clinical practice by recommending further research to develop and assess clinical interventions specifically targeting sexual shame, in order to support sexual functioning and well-being for women, men, and gender-diverse folx.

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