Sex, Drugs, and Women's Desire

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ABSTRACT

Low desire is the most common sexual dysfunction in women. Pharmaceuticals are being developed to treat it, most notably Flibanserin, owned by Sprout Pharmaceuticals. Sometimes inaccurately referred to as "female Viagra," Flibanserin actually treats an entirely different problem. Viagra allows men to get an erection, meaning that it treats physical arousal problems. Flibanserin, and other drugs for low sexual desire in women, act on the brain. Women with low desire don't have a problem with physical arousal or with orgasm, but with desiring sex before it starts. Most women with low sexual desire disorder have partners with higher desire than they do. So is low desire a medical, physiological problem in the brain? Or is it a sociocultural, interpersonal issue? Some experts think that the majority of women with what has been called a "disorder" of low sexual desire have no abnormal physiological problem, but instead are living in a sociocultural and medical system that encourages them to think of themselves as broken, and may be best treated with non-pharmaceutical methods. Other experts think that low desire is a physiological problem and drugs are important to treat it. Cultural shame around communicating about sex, undervaluing of women's sexuality compared to men's, and unrealistic sexual expectations all feed into and complicate the issue.

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SEX, DRUGS, AND WOMEN'S DESIRE

Can drugs treat low sexual desire in women? And should they?

BY ANNA NOWOGRODZKI

Barbara Gattuso was talking about her sex life in front of a couple hundred strangers. The retired surgical nurse from San Diego wore a gray blazer and her blonde hair swept up. Her mouth drawn, she looked determined and controlled sitting at the front of the FDA conference room in White Oak, Maryland. She sat at a long rectangular table with three other women; three huge video cameras were placed in the middle aisle of the audience, with other patients and their representatives clustered at circular tables in front. They were all there for the FDA's patient-focused drug development public meeting on female sexual dysfunction.

It had happened gradually when Barbara was in her mid to late thirties, she later told me. She was married and had three kids, the youngest of whom was a toddler. Her husband Greg was wonderful, she says, and they had a great marriage (they are still married, more than twenty years later). But she slowly lost her desire to have sex with him.

It wasn't that she didn't enjoy sex once it was happening. "When you're in the act, you have desire. You like it when it's being done," she says. But beforehand, she felt no desire to have sex. This caused her "terrible stress." She'd get up earlier in the morning than her husband, go to bed later, or pretend to be asleep just to avoid the possibility. "It was awful," she says. "A horrible, horrible deception in a marriage."

She talked to gynecologists, and none of them knew what to do. "If you find something, please let us know," she says they told her. She called a "couple PhDs" who "claimed to be [in] sexual medicine." When she explained her problem, she says they hung up on her. So she didn't try sex therapy. She tried some over-the-counter remedies—nothing helped.

Barbara's situation lasted for over twenty years. She never told Greg about it. One day in 2011, she saw a notice somewhere—on TV or in something she read, she doesn't remember—of a clinical trial for a drug called Flibanserin. "I was really excited," she says.

Flibanserin was a drug in the development pipeline, not yet approved, that affected levels of the neurotransmitters dopamine, norepinephrine, and serotonin. It was originally proposed as an antidepressant, first described in a 1997 paper, but it wasn't found to be effective at treating depression in any of its nine Phase II trials. Many antidepressants carry a side effect of lower libido, and the later Phase II trials

for Flibanserin measured sexual dysfunction with an assessment that included the question, "How strong is your sex drive?" Women on Flibanserin had higher sex drives than women on a comparable antidepressant, and, to the researchers' surprise, higher sex drives than those on the placebo. So the Germany-based pharmaceutical company that owned Flibanserin, Boehringer Ingelheim (BI), began developing it as a drug to treat low desire.

Barbara hoped Flibanserin would work to increase her desire, or maybe as an antidepressant—either way, she could use it. "My dad was really ill at that time, and we lost our home in a fire. All this happened in six months." She thought, "I have nothing to lose."

Low desire has historically been considered a psychiatric condition, which means its diagnosis is defined in the bible of psychiatric disorders, the Diagnostic and Statistical Manual, or DSM. The definition has been updated over the years as different editions of the DSM have come out. When a group of experts met in 2000 to discuss updating the definition of female sexual dysfunction, "95 percent of them had financial relationships with the drug companies hoping to develop drugs for the very same condition," wrote Ray Moynihan in his book *Sex, Lies and Pharmaceuticals.*

In the current edition, DSM-V, what Barbara experienced is called Female Sexual Interest/Arousal Disorder (FSIAD). A woman has FSIAD when she has low or no desire for sex, and that distresses her. Plenty of people, including those who identify as asexual, experience low desire but are not upset by this. Many older women have low desire but "older women are less distressed" about it overall than younger women, says Dr. Cindy Meston, a sexual psychophysiologist at the University of Texas at Austin and a member of the advisory board of S1 Biopharma Inc. It's not a disorder unless it causes distress—this is true of most disorders in the DSM.

Why are some women bothered by low sexual desire? Lots of women probably have "desire discrepancy"—their desire level is different than their partner's, which causes personal and interpersonal distress. According to one 2008 study, having a partner who is more interested in sex than you are is a major predictor of low desire. Distress about sex is also linked with poor partner communication. In a 2001 study, women with low desire disorder reported the following causes: anticipatory anxiety about sex and their partner's negative reactions, fear of being abandoned, lack of emotional or sexual communication, lack of sexual pleasure, guilt, and shame about sex being inherently bad.

Drugs for low sexual desire in women are often described as "female Viagra," both because it's an easy way to place them in a category people are familiar with, and because it's an easy way for pharmaceutical marketing efforts to link desire drugs with something that's already approved as safe, implying that desire drugs deserve the same approval. But these drugs don't act like Viagra, they don't treat the same problem, and this positioning obscures the very real differences between the way

women's and men's sexuality are treated in American culture.

Women's bodies are a problem and a scapegoat in American culture. They are things to be controlled. Society views female sexuality as different from male sexuality, and often as less important, or primarily important for how it relates to men. It's a complex stew of real physiological differences (a clitoris and a penis are not the same thing) mixed with sociocultural repression and shame about sexuality, and women's sexuality in particular, that has held back research and held back society from disseminating the results of research for decades after it's well understood. Add to this the prevalence of rape in American society—sex is used as a weapon against women vastly more often than against men—which understandably can cause sex to carry more of a negative emotional valence for women than for men. And the fact that women are socialized to be people-pleasers who meet the expectations of those around them, and in heterosexual relationships they are often expected to shoulder the brunt of the relationship work—so that if anything isn't doing it for a woman sexually, she may in some cases be more comfortable conceptualizing it as her own low desire rather than talking to her partner about something he's doing that isn't working. Throw in an unhealthy dash of cultural expectations about how sex is "supposed" to happen, coupled with companies selling all kinds of products by keeping both women and men in a state of insecurity that everyone else is having more and better sex than they are.

Take these all into consideration and low sexual desire in women is clearly a thorny issue: is it a medical, physiological problem in the brain? Or is it a sociocultural, interpersonal issue? Almost all the experts I talked to, on both sides of the debate, think that in at least some small percentage of women with severe sexual dysfunction, a drug could someday help, if a safe and effective one was developed. But there is disagreement about how large this segment is—some experts without financial ties to pharmaceutical companies think that the majority of women with what has been called a disorder of low sexual desire actually have no abnormal physiological problem, but instead are living in a sociocultural and medical system that encourages them to think of themselves as broken, and would be best treated with non-pharmaceutical methods. And there's also disagreement about whether the current drugs in development are safe and effective. The research on non-pharmaceutical treatments shows that cognitive-behavioral therapy and mindfulness may be more effective than Flibanserin (with no side effects), but because they're not backed by pharmaceutical industry funding, the sample sizes are miniscule compared to drug clinical trials. This lopsidedness does nothing to help answer the real question: what's the best way to help women who are dealing with this problem?

Also at the FDA meeting was Barbara's daughter, Katherine. In a purple sleeveless dress, with long black hair, Katherine looked poised. "I feel like my body has let me down," she said, speaking of her own low sexual desire. "I feel like it's out of my control."

Katherine's libido disappeared after the birth of her first son, she said. At first, she thought it was because she had just had a baby. Women often experience lower sexual desire after giving birth, but by six months after childbirth, most women have started having sex again, according to a study from the Kinsey Institute for Research in Sex, Gender, and Reproduction. But Katherine's low desire persisted for a year and a half, until, as she said on Yahoo! News, "my husband was like, 'You need to go fix this.'"

"I told my doctor, 'I need something for low libido. What do you have for me?'" Katherine said at the FDA meeting. Her doctor replied, "There isn't anything for women with sexual dysfunction, but we can put you on an antidepressant." In other words, pharmaceutical treatment was the only thing Katherine or her doctor considered.

Katherine tried the antidepressant, but it didn't help. "My mood was happy, yes, but I was happily not wanting sex," she said to a smattering of laughter from the audience. At the time of the meeting, she was not on any treatment.

In her twenties, she "had an extremely healthy sexual appetite and a great relationship with my husband." She said she believed she was doing everything right: exercising four or five days a week, eating "organic fruits and vegetables," and maintaining a healthy BMI, or body mass index. "I live a low-stress lifestyle and I am not depressed," she said.

But she felt her sexual dysfunction was messing up her marriage. "I feel like I pulled a bait-and-switch with my poor husband." It was not a genital issue. "I have no trouble with orgasm," she said. It was a problem of desire.

"I want to think about sex, I want to initiate sex," Katherine said. "I want that part of my life back because just thinking about sex...makes me feel like a more sexual person. It makes me feel like a woman." Having drugs to treat her problem is so high a priority for her that "I highly doubt I would care about the side effect of the drug."

Right now, for Katherine, sex is "a success if he's having a good time, because it's out of obligation for me. ...I might not even want to have sex but if he wants sex then and I give it to him then, yes, I was a good wife today."

Katherine and Barbara, like everyone else who spoke at the FDA meeting, were required to disclose if they received compensation or if their travel expenses were paid for in order for them to come to the meeting. Both of their travel expenses were paid for by an event planning company called Veritas, which received funding from Sprout Pharmaceuticals, the company that bought the rights to Flibanserin from BI in 2011.

Katherine's approach—going to a doctor and asking for medical treatment—is common, and very well represented at the FDA meeting, but not ubiquitous. "Going to a doctor to treat sexual dysfunction is like going to a physical therapist to learn how to dance," says Emily Nagoski, sex educator and community wellness director at Smith College, who holds a PhD in health behavior and human sexuality from the Kinsey Institute at Indiana University and wrote the recent book *Come As You Are: The Surprising New Science That Will Transform Your Sex Life.* In other words, Nagoski argues that doctors are not the experts in sexuality. A physical therapist is trained in fixing problems, broken things. A doctor is trained in fixing problems, too. But not having enough dance in your life is not a problem to fix, the way a sprained ankle is. If you don't dance as well or as much as you want to, that doesn't mean you're broken. There's no normal level of dance that everyone should attain to be healthy. Some argue that a sex life is the same way.

I put the question to the author of the 2014 book *How Sexual Desire Works,* psychologist Frederick Toates: Is female sexual dysfunction a medical condition? "If you want to define medical as something that causes human suffering," he said, "then yes." But if the question is, is there some "measurable abnormality in the body that could be corrected by medicine...I'd probably have to say in most cases it isn't."

"It's so grey now and it seemed so simple once," he said.

But "drug development" is right there in the title of this FDA meeting, and the backdrop slide that we stare at all day shows a picture of unidentified pinkish lentil-shaped pills, so the discussion today focuses on drugs, as did Katherine when she went, at her husband's insistence, to her doctor's office.

FSIAD—the current official diagnosis for low desire disorder—is the most common sexual dysfunction in women, but it's hard to pin down an exact number for how prevalent it is. Different studies have found different percentages, because the studies vary in how they define low desire, how they asked women about it (via interviews or via self-reporting, for example), and what time periods they asked about. One of the largest studies in the US, of 31,000 women in 2008, found roughly 10% with distressing low sexual desire, which would translate to about 10 million American women in the full population. A frequently quoted study that found a much higher number—43%—simply measured the prevalence of any of seven different difficulties with sex, only one of which was low desire, and did not even ask respondents if their low desire was distressing or not.

In men, the most common sexual dysfunction is premature ejaculation, followed by erectile dysfunction. But men experience low desire too. Plenty of studies have asked men how often they experience low desire, but only very recently have any studies asked how often it's distressing to them. Two 2014 studies found that 14% of men experienced distressing low desire, although this often went along with other sexual problems as well. In a study of 570 Australian men ages 18–65 in heterosexual relationships, only 3% had distressing low desire on its own, and in a

study of over 5,000 men ages 18–75 from Portugal, Croatia, and Norway, only 7% had distressing low desire on its own.

There's a reason for the gender-binary language: there has been virtually no research on sexual dysfunction in people who identify as non-binary or trans. The research is also "overwhelmingly heterosexual," said Nagoski.

The most well-known drug for a sexual problem is of course Viagra (for men), approved by the FDA in 1998. It's not only a household name, but it has made billions of dollars for Pfizer, the company that owns it. Ever since Viagra's approval, pharmaceutical companies have been trying to develop a drug for sexual dysfunction in women. As Frederick Toates put in, there is "enormous commercial pressure to develop something treating it."

Many times, it's framed explicitly as a gender equality issue. Men can pop a pill that will help them get an erection. How unfair that women can't.

As a patient named Beverly said, "I think the thing that makes me most angry and most disappointed is that if I went to my doctor and I was a man and I said these things, they would be able to write me a prescription within a couple of minutes for a drug that is insurance-covered and FDA-approved."

But if she was a man with low desire, she couldn't really. Viagra treats an entirely different thing than Flibanserin: Viagra treats problems with physical arousal. Viagra treats erectile dysfunction in men by physically allowing the penis to fill with blood and become erect. In other words, it's not going to make you want sex more, it's just going to help you get an erection if you already want sex. There is no drug for men to increase their desire.

No one is actually trying to make a Viagra analog for women. For one thing, problems with physical arousal in women aren't as common as in men. If women do have problems with physical arousal, they are dryness and lack of lubrication—the sort of problems treated with lube, or with one of a couple of FDA-approved drugs for postmenopausal vaginal dryness.

But another reason no one is trying to make a Viagra for women has to do with the fact that in women, physical arousal doesn't often overlap with subjectively feeling aroused and interested in sex. (This is called arousal nonconcordance.)

Actually, this lack of overlap is common in men also, to a lesser extent. In men, physical genital arousal overlaps with feeling aroused about 50% of the time. In other words, in men there is a greater overlap between genital arousal and desire than there is in women.

In women, it's about 10% of the time. For whatever reason—no one knows for sure why—women's genitals become aroused when women watch a wide variety of

things, even when their subjective feeling about what they're seeing is blasé or even negative. As Frederick Toates writes in *How Sexual Desire Works*, women can become aroused when watching "film of pygmy chimpanzees copulating." Women's genitals can even become aroused during rape—this means nothing about how they felt about it and certainly doesn't imply that they liked it.

The gender difference in arousal overlap is not because of the strength of the signal from the genitals to the brain (i.e., "Hey, brain! There's physical arousal happening here!")—when researchers looked at the strength of activation in the area of the brain that receives this signal, it was just as strong in women as in men. No one knows exactly what neurological mechanism is responsible for the difference. Researchers have theorized about the reason, though: it may be evolutionarily adaptive for cis women's genitals to be prepared (that is, lubricated) for anything that might lead to sex or rape, because lubrication helps prevent injury (such as tearing).

When researchers tried showing women two erotic films, one shot from the traditional "male gaze," and one shot from a more "female gaze" point of view, the women had the same genital response for both. But that didn't mean anything about how they felt. In fact, they reported that they felt more aroused in response to the film from the female point of view.

So the drugs in development for low sexual desire in women are not like Viagra: none of them act on the genitals. These drugs act at the locus of desire. No, not the heart: the brain.

Sexual desire means wanting to engage in sexual behavior. Or as Nagoski says of the Smith College students she works with, "when my students say *desire,* what they're talking about, usually, is wanting more of whatever it is that's coming along."

But this doesn't explain where desire comes from, or how it emerges.

Sometimes sexual desire feels like it comes out of nowhere. This is spontaneous desire. If you're walking down the street and suddenly, for no immediate reason you're conscious of, you want sex, you're experiencing spontaneous desire.

Other times, or for other people, sexual desire feels like it happens in response to some external stimulus. This is responsive desire. If you're walking down the street with your partner, your partner kisses you or brushes a finger along your arm in that particular way that turns you on, and *then* you start to want sex, you're experiencing responsive desire. What Barbara experienced, when she didn't desire sex but once it was happening, she did feel desire? That's responsive desire too.

About three-quarters of men have primarily spontaneous desire and only 3% have responsive desire, according to a 2003 study of over 2,000 Norwegian and

Portuguese men. Roughly a third of women have primarily responsive desire, according to a 2007 study of 130 female nurses. Similarly, in a 2010 study of 1,800 Portuguese women without arousal difficulties, 30% said they often engaged in sexual activity first and then later felt arousal and desire, and 50% said they occasionally did. These types of desire are not necessarily either-or for men or women. A person can have spontaneous desire some of the time, and responsive desire some of the time—or spontaneous desire when they're younger, and responsive desire later in life.

Many sex researchers and sex educators take this research to suggest that someone who experiences exclusively responsive desire does not have a disorder. Based on the prevalence of responsive desire in women, they dispute to what extent most cases of "low sexual desire dysfunction" are dysfunctional at all, arguing that they are only dysfunctional if we assume that women are supposed to have spontaneous desire.

Nagoski says that the prevalence of responsive desire means it's fine to start having sex when you're theoretically interested but not actively desiring sex, which is not necessarily the way most of us are taught. "Which gets really complicated because I do...sexual consent work. When I talk about 'have sex before you actively want it,' people hear 'have sex when you *don't* want it' and there is this other space, of sort of neutrality, being like, OK, let's do some things that I like, let's see what happens. But...basically the way people are taught to think about desire is either you actively want it not to happen or else you actively want it to happen. And there's this really big space in the middle, I think, that we need to be more aware of."

Among sex researchers, there's a line of thinking that nothing truly comes out of nowhere, that there's no such thing as spontaneous desire. All desire happens in response to some stimulus—even if the stimulus is internal or unconscious.

In other words, spontaneous desire doesn't exist: it's all responsive. A number of influential sex researchers hold this view: the processing of sexual stimuli in the brain leads to *both* arousal and desire. There's some support and criticism of this; the definition is "based on expert opinion rather than on data," wrote Robert Segraves, a psychiatrist who studies female sexual dysfunction, in a 2006 study. It's never been directly empirically tested.

Even among validated empirical ways to measure sexual desire, it's conceptualized in many different ways: frequency and intensity of desire, frequency of sexual activity or fantasy or initiation or receptivity or of liking sexual activity, pleasure thinking of sex, pleasure in seeing erotic material, or desire when you see someone attractive.

Back in 2011, Barbara told me, she picked up the phone and enrolled in the clinical trial for Flibanserin that she'd seen advertised. It was a blind trial. She

felt anxious driving to her intake visit, where the doctors did a physical exam and EKG test, but she had no anxiety about the trial after that. "I really, really, really wanted this to work," she says. But she didn't feel any increase in desire.

Eventually, her husband Greg noticed that Barbara was keeping records every day—she had to keep track of her responses to the treatment, like how many "satisfying sexual encounters" she'd had. Halfway through the trial, he asked her what the records were about. That was the first time she talked to him about her low sexual desire.

A few weeks or months after Barbara told Greg about the Flibanserin trial and her low desire, BI decided they had enough information and stopped the trial. Barbara, it turned out, had been on the placebo. As is common in clinical trials once the company decides they have enough information to believe the drug is working, they offered everyone on the placebo a chance to go on the real thing.

She jumped at the chance to try Flibanserin—this time, not in a blind study, because she knew she was getting the drug. "My sexual desire came back in full swing," she says. "It changed everything about me." She started to initiate sex more often. "It made my husband very happy." She experienced no side effects. Her response was in fact unusual.

As the background report for the FDA advisory committee states: in Phase III clinical trials, Flibanserin did not show a statistically significant difference in sexual desire (self-reported) compared to the placebo. On top of that, 15% of patients on Flibanserin stopped treatment during the trial because of a side effect (compared to 7% of patients on the placebo), and patients tolerated Flibanserin less well if they were on common prescription drugs including SSRIs and hormonal contraception, or if they drank alcohol.

Barbara was only on Flibanserin for about two weeks. BI dropped the drug in 2010 because the FDA advisory committee had voted against approving it.

When Barbara heard she'd be taken off of Flibanserin, she was very upset. "Dr. Goldstein was there when I found out that they pulled it," she recalls. "He said, 'Can I interview you right now?'" He recorded her reaction to the news right there in his office. Barbara says, "he took that to Cindy Whitehead at Sprout. Sprout picked it up and bought the rights to Flibanserin [from BI] and kept clinical trials going."

Sprout Pharmaceuticals is a Raleigh, N.C.-based company started by husband-and-wife team Cindy and Bob Whitehead. "Cindy has more than 20 years of experience building brands and companies, managing high performing sales organizations and leading marketing and corporate communications functions" says Sprout's website. The Whiteheads bought the rights to Flibanserin for an undisclosed sum in 2011. A July 2012 article in *Triangle Business Journal* reported that Sprout had raised $25 million from April to July 2012 to invest in the drug.

Aphrodisiacs go back to ancient times. A list in PV Taberner's 1985 book *Aphrodisiacs* includes hundreds of them, from absinthe to yohimbine, and including brains, peacock and hyena bones, beets, goat's eyes, goat's testicles, mandrake, lard, lamprey, "lion fat," plover's eggs, snails' necks, nail clippings, rook heart, sperm, Spanish flies, swallows' nest soup, swans' genitals, "vulva of the sow," and "weasel ashes." But just as in modern times, ancient medicines to increase lust or facilitate arousal were mostly meant for men to take. Options for women were pretty much either infertility treatments or love potions.

The lineage of our current scientific understanding of treatments for low desire began with Masters & Johnson, who published the seminal work *Human Sexual Inadequacy* in 1970. They worked in a laboratory where women came and had orgasms for science. So they developed a model of sexual functioning that made no mention of desire. It just went from arousal (or excitement) to orgasm.

It wasn't until 1977 that Helen Singer Kaplan and Harold Lief independently introduced the idea of low sexual desire as a diagnosis. Both were psychiatrists with psychoanalytic training. Their model of sex was still linear: desire leads to arousal, which leads to orgasm. First you want sex, then your genitals become aroused, then you have an orgasm.

Kaplan believed that there was a balance between the sexual motor and the brakes. Her strategy for treating low desire was to use erotic materials, encourage fantasy, and give masturbation assignments. If that didn't work, she would use brief dynamic psychotherapy with her patients, both male and female, to analyze their resistance to sexual pleasure.

In 1980, the DSM-III included a diagnosis of inhibited sexual desire, which had to be persistent. In 1987, the next version, the DSM-III-R, was the first to use the term hypoactive sexual desire disorder (HSDD). This needed to cause significant personal or interpersonal distress.

But since then, researchers Ellen Laan and Stephanie Both in the Netherlands have amassed a large body of research, beginning in 1995, that goes against this linear model and suggests that both desire and arousal emerge simultaneously from the brain's processing of sexual stimuli. And on a practical level, a 2009 study did find that when women are asked about the difference between desire and arousal, many speak of them as conflated.

To reflect this research, in the most recent revision of the DSM, the disorder HSDD was combined with female sexual arousal disorder (FSAD) into the current diagnosis, FSIAD.

On the day after a February blizzard, I met Emily Nagoski in her office at Smith College in the small, extremely snow-covered town of Northampton, MA. She greeted me without shaking my hand, explaining this lapse by saying, "Hello, I have lube all over my hands." It was coconut oil; she had just discovered it could be used as lube. She had laid out three kinds of condoms on her desk—latex, nitrile, and a synthetic latex called polyisoprene—and she wanted to test them each by rubbing them with coconut oil to see if the oil could be used safely with different condom materials or if it would cause condom breakage.

Nagoski is short and energetic, with often-widened eyes and dark blue mad scientist hair. Her office contained a large desk and a couch for the students who drop in to see her, with some fidget toys on an end table next to it—a tiny sand garden, which was a gift from her intern last spring, and a pile of metal balls on top of a magnet. "I have a lot of fidgety students," she says. "There's one student who keeps track of the little balls, and every time, she organizes them in a way that she'll recognize when she comes back to see if anybody else has changed it." Pictures of Nagoski's twin sister and parents lined the shelves above the books. A plush, anatomically accurate vulva the size of a dinner plate sat across from her desk.

"Do you want to make a video?" she asked me. Of course I agreed. One after the other, she blew up each of the condoms like a balloon while I filmed. She held the condom closed with one hand and vigorously rubbed coconut oil on its surface with the other. "Ah, it smells really good. It smells like cookies," she said. We sang "Twinkle, Twinkle, Little Star" for timing (it's about twenty seconds long, which Nagoski had learned because it's good for making sure you wash your hands long enough). The latex and polyisoprene condoms broke after about a minute each. The nitrile didn't, but we only tested it for about three minutes. She pronounced the nitrile experiment inconclusive, but promising. "Thank you for the science!" she said when we had finished filming.

When I asked her about the development of drugs for women's sexual dysfunction, she replied, "I have all these feels!" The idea of helping women with low desire disorder is "ultimately nice and good. We have exactly the same goal in mind," she said. But "for fifteen years they've been looking for a drug. Research in pursuit of that drug has shown us why it will never work. I'm pretty sure they'll never find one."

Nagoski was invited to a webinar hosted by Sprout on October 15, 2014. "I talked to their publicist; he's really good." She also talked to a woman going by the name Cara (not her real name) who, like Barbara, suffered from low desire and participated in one of the Flibanserin trials. "She was so into the drug," said Nagoski.

"I asked Cara if she experienced pleasure," Nagoski said. "Her answer was, 'Yes, I have orgasm.' Not pleasure, but orgasm ...If she has pleasure, what that means is she has responsive desire intact."

In other words, she does have desire—responsive desire, which is normal for women. Nagoski thinks Cara does not have a dysfunction of desire, but is simply unaware that responsive desire is normal. "She's not broken is the thing," said Nagoski.

"She told me that she had experienced really severe fatigue" when she took Flibanserin in the morning. "She couldn't drive herself home. She had to take a sick day at work one day because it was so serious. As long as she took it at night it was pretty much OK... Which is why the next round, what the FDA has asked for is you need to test this and see if people are safe driving. Because that's not an OK risk, to increase your sexual desire or satisfaction by this little amount and risk people dying in traffic accidents. Not a good balance of risk and benefit."

Nagoski asked to speak privately on the phone with Cara, and they spoke for 45 minutes. Nagoski explained responsive desire to Cara and, at Cara's request, sent her a copy of her book.

Nagoski's book *Come As You Are* came out on March 3. She says she wrote it basically to tell women that there's nothing wrong with them—that the science of sex research says they're normal.

"When I see this covered in the mainstream media, the stories are always framed by the pharmaceutical industry," Nagoski says. Cognitive Behavioral Therapy and mindfulness work to treat low desire, she says. "But there's no profit motive in promoting those."

As Lori Brotto, a psychologist and women's sexual health researcher at University of British Columbia, says of women's sexual dysfunction, it's "a lot of science mixed with a lot of politics mixed with, some might even argue, hidden agendas, and it's hard to sift through it all."

Nagoski thinks drugs for FSIAD are a non-starter not just because of responsive desire and arousal nonconcordance in women, but also because of a third pillar of recent sexuality research: the gas and the brakes.

Both women and men can be thought of as having a gas pedal and a brake pedal in terms of sexual stimuli, according to the Dual Control Model developed at the Kinsey Institute. The gas—called the Sexual Excitation System or SES—turns on in response to sexually exciting stimuli. The brake—called the Sexual Inhibition System or SIS—turns on in response to threats and stress. In women's sexual dysfunction, it's not usually the gas pedal that's the problem. "Sexual desire difficulties are almost always about too much activation to the brake," says Nagoski.

"Women's brakes are more sensitive to a broader range of contextual factors than men's," such as trust, reputation, relationship issues, body image, and trauma

history, says Nagoski. So if a woman feels bad about how she looks, or feels stressed over all the work she has to do tomorrow, or is annoyed at her partner, or is worried she might get pregnant or someone will think she's slutty or she won't be able to orgasm fast enough, or at all–any and all of those can activate the brakes. In women both with and without desire problems, cognitive distraction leads to weaker sexual arousal.

Beverly, a patient with FSIAD, describes it this way. When she and her boyfriend have sex, she says, "What goes through my head is, 'Am I going to be able to orgasm during this, and is that going to impact how he feels about our relationship?'... it's a huge part of men's self-worth if they can get you there." Worrying that her lack of orgasm might weaken their relationship is stressful, and stress turns on the brakes.

In other words, Nagoski says sex happens in a context, and "How would you go about making a drug that creates a sex-positive context?"

Nagoski is careful to point out that just wanting to be sex-positive, or feeling she should be sex-positive, doesn't make the weight on the brakes go away for a woman. Wishful thinking won't do it. "We have to be explicit about reasons not to have sex and reasons to have sex—that there *are* good reasons not to have sex, and we can't dismiss those. Just because you don't want there to be reasons not to have sex, doesn't make those reasons go away, right? Especially when they're the cultural things around sexual shame and body image. Like, you believe those things should not hit your brake, and it would be great if they didn't. And the fact is they do, so we need to work with that reality instead."

Researchers don't know why women's brakes are more sensitive to contextual factors than men's, or how exactly the process works. But they do know that women's brakes are more sensitive, which means that they're activated by the mountains of crap women have to deal with about their sexuality: expectations that they should remain pure and not have sex, expectations that they owe men sex, the disproportionate amounts of blame women accrue for having children too young or out of wedlock or just generally not toeing the vanishingly thin line of what's expected of them. No one knows what the brakes are made of neurologically, which makes it hard to try to intervene with the brakes pharmaceutically, although the European pharmaceutical company Emotional Brain is trying to do with the development of their drug Lybrido. They are trying to develop a pair of drugs: Lybrido to turn off the brakes, and Lybridos to push down on the gas pedal.

But Nagoski says, "Women's sexual wellbeing can't be dis-integrated from overall wellbeing. Overall wellbeing is the single best predictor of a woman's sexual wellbeing."

The things that hit the brake, generally, "are not brain mechanisms, they're life," says Nagoski. "Hardware is not the issue. It's having learned that you are inadequate."

And the fact is that life is different depending on your gender presentation in our culture. Society and cultural conditioning sends very different messages to boys and girls. Girls "get taught all kinds of shame" about sex, says Nagoski.

"We teach girls that sex is dangerous. And we have a culture where very literally sex is used as a weapon against them, so that sex often is dangerous," says Nagoski. Sexual assault is a very real danger for women, and though sexual assault happens to men too, sex is used to threaten women far more often than men. According to the Rape, Abuse & Incest National Network (RAINN), one out of six American women has experienced sexual assault in her lifetime, and in the year 2003, 9 out of 10 rape victims were women. "And then when they get to 18 or whatever we expect them to be multiply orgasmic sexual dynamos," says Nagoski. "Really?"

American culture also teaches girls—if it teaches them about sex at all—a certain model of how sex is supposed to work. Sex is supposed to end in orgasm for both partners. If it doesn't, you're supposed to fake it so your partner doesn't feel bad. When you're in a sexual relationship, you're supposed to have sex with some frequency that's "normal," though no one knows what that is. There's no reason women—or men for that matter—need either of these things to find sex pleasurable, nor is there any indication that checking these boxes will guarantee pleasurable sex.

Also, many people, both women and men, learn about sex through the consumption of media—like porn—that portrays sex unrealistically across the board, but especially for women. "Porn represents women's sexual satisfaction as very fast and easy," says Thea Cacchioni. Porn of penetrative sex usually shows partners having simultaneous orgasms—not as easy in real life—and women having orgasms from vaginal penetration alone, when in reality a third of women rarely or never orgasm from vaginal penetration alone.

But this isn't just a *Cosmopolitan*-magazine-and-porn-movie-level communications failure. Even scientific sexology literature communicates that there's a standard, normative, healthy amount of female desire, according to Nicolson and Burr in a 2003 paper. The literature also focuses on "sexual fulfillment" (that is, orgasm), which makes it seem like anything that doesn't end in orgasm is a disorder.

Dr. David Goldmeier, a British clinician who's been working on sexual health since 1973, agrees. People are "very goal-oriented" about sex, he says, and they don't need to be. He says, "a sexual event is like a meal. You don't have a goal in a meal—you actually enjoy the food as you're going along." He advocates that people "stop thinking about goals."

Like most people in American culture when it comes to sex, women with low sexual desire disorder tend to be goal-oriented. They talk about wanting to have more sex,

and wanting to feel desire, but they don't talk about wanting to feel more pleasure. Like Cara, they often assume that pleasure and orgasm mean the same thing—that orgasm is the only relevant sexual pleasure, and in order to have pleasure you must have orgasm. And it's no surprise they are—the research does the same thing. In an analysis and comment paper, Marta Meana made this recommendation for future research: "Make sexual desire, not sexual activity, the dependent variable in experiments."

Or, as Nagoski said, "The other piece is that—they want to want sex, and to have sex—what I want to know is do they want to *like* sex."

Dr. Irwin Goldstein, the director of the Institute for Sexual Medicine in San Diego and the man who had presided over Barbara's Flibanserin clinical trial, was at the FDA meeting too, with his wife Sue Goldstein. Neatly dressed in a suit, he had white hair and glasses. During the panel, Dr. Goldstein argued over and over again that FSIAD is an "unmet need" for drug development. The FDA has a special fast-tracked development process for drugs that they deem treat an unmet need, meaning that existing treatment options are not adequate.

At lunch at the FDA meeting, Dr. Goldstein came over to a circular table of women eating outside. "When are we going to go on TV?" Beverly asked him. Dr. Goldstein kissed everyone on the cheek in greeting: Beverly, his patient Luann, and a young urologist at Georgetown who wanted to join his practice. He kissed me too, even though I shook my head no and said, "I'm good." He rubbed Luann's shoulders. When his wife Sue, sitting at a nearby table, looked over, Luann half-jokingly indicated that he might be in trouble with her, and he left to go talk to her.

One of Dr. Goldstein's points was that we need drugs to treat FSIAD because only then will the medical system take it seriously as a condition and begin educating medical students about it. "The way this works is it all comes from the top down," he said. "If a drug gets soon approved, there will be much more interest in everybody learning and understanding this drug. We will then have education in medical schools for women's sexual health. We'll have doctors being trained. We'll have research being generated."

Any additional education of doctors about sexual dysfunctions would be an improvement. As Nagoski said, "Doctors, on average in America, get 3–10 hours of sex education over...four years of medical education.

Flibanserin works on neurotrasmitters in the brain. As the Sprout website says, "It is thought that Flibanserin corrects an imbalance of...neurotransmitters by increasing dopamine and norepinephrine (both responsible for sexual excitement) and decreasing serotonin (responsible for sexual inhibition). ... This is likely accomplished by reduced glutamate transmission."

It's designed to be taken every day, not like Viagra, which is designed for men to take on an as-needed basis before they have sex.

Dr. Goldmeier, the British sexual health clinician, says Flibanserin "probably showed some efficacy. Probably it's actually safe." The problem, he says, was "the placebo response rate is so high...you have problems showing it was better than the placebo."

In total, Flibanserin has been studied in about 11,000 women in clinical trials. One of the results they measured was frequency of Sexually Satisfying Events, or SSEs. Women on Flibanserin had, on average, 0.8 more SSEs per month than women on the placebo: 4.5 satisfying events for Flibanserin versus 3.7 for the placebo. This difference was statistically significant, and patients, at least those who spoke at the FDA meeting, said they found it meaningful. But was it worth the associated risks? Was it better than any other available treatment for FSIAD?

Women in the clinical trials also kept a daily eDiary—the diary Greg saw Barbara recording—in which they recorded their most intense level of sexual desire that day, on a scale from 0-3. The eDiary sexual desire scores were not significantly different between women on Flibanserin and women on the placebo.

The most common adverse side effects of Flibanserin were dizziness, nausea, fatigue, and sleepiness. The fatigue and dizziness, in particular, were more common in women also taking a hormonal contraceptive, women taking an SSRI, or women who drank alcohol. Women taking a triptan, a drug used to treat migraines, showed greater sleepiness and depression.

"Quite honestly I think way too much is being made about this whole issue," says Dr. Meston, the University of Texas psychophysiologist. "Get real; the FDA approves so many drugs that are not all that safe."

Sprout and other advocates for Flibanserin are very savvy about their communications. They often frame the issue as being about choice. "All we're asking for is a choice," said Sue Goldstein at the FDA meeting.

"No medically approved option hurts women," echoed Dr. Michael Krychman, a sexual medicine gynecologist, sex therapist, and clinical researcher, when he got up to speak at the FDA meeting. He disclosed a bevy of pharmaceutical interests, including Sprout, Shionogi, Pfizer, Palatin, Noven. "I believe in women," he said. "Let us learn from history. We did not think women were smart enough to vote. We denied them this privilege. We have been taught wrong. We didn't think women were strong enough to defend our country and we again have been taught wrong. ...Women will not remain on treatment if it's not effective or they experience adverse events. Allow women their constitutional autonomy to be smart and

strong."

Ray Moynihan began writing about the marketing of medical conditions as a journalist around 1999. "As I drilled into this story I realized that the companies weren't just sponsoring the science, they were actively helping to construct it," he says. Pharmaceutical company employees and doctors with financial ties to the industry are directly involved in designing the questionnaires used to diagnose FSAID, the diagnostic criteria, and the outcome measures used to determine whether drugs are successful. "I was shocked to see how much the marketing and the science were merging," says Moynihan.

"On certain outcome measures they keep failing, and on other outcome measures, which they've helped design, they can win," says Moynihan. "That, I think, is one of the major pushes of Even the Score: to get the FDA to change the way it measures success in trials."

Even the Score is an informative-looking website partially supported by Sprout and by the pharmaceutical companies Trimel and Palatin. This is disclosed in a graphic at the very bottom of the About page: all of their nonprofit supporters are listed first and the pharmaceutical companies are under "other supporters." At the top of the About page and the homepage, logos of all their supporters are displayed: the pharmaceutical companies' logos are all partially obscured by a purple panel and lettering over the top of them. The Sprout logo in particular is almost impossible to read on the homepage, directly covered by block lettering urging readers to SHARE YOUR STORY and JOIN THE MOVEMENT.

Even the Score uses feminist language to frame the FDA's denial of approval for drugs for FSIAD as an issue of institutional sexism, and position approval as a move toward gender equality. "Will you join us in telling the FDA that it is time to even the score and give women the options they deserve for the treatment of sexual dysfunction?" the website asks. "Sign the petition today and become an advocate for women's sexual health equity." They claim that drugs for women's sexual dysfunction are being held to a higher standard than drugs for men, that the FDA just doesn't think women's sex lives are as important as men's.

"It's an amazing powerful reframing of the issue," says Nagoski. "That the pharmaceutical industry is feminist, whereas the FDA is misogynist." The reframing is "sort of brilliant, but it's wrong. It is, however, really persuasive. The pharmaceutical industry has been so effective at communicating this message."

Leonore Tiefer, a sex educator and psychologist at NYU, founded a group called the New View Campaign. She remembers "when Viagra was approved for men, and the press started saying, 'And where's the Viagra for women?' I thought it was really important that somebody create a space to challenge that question...and so I thought well, I guess I'm the person. So I started this New View Campaign to

challenge the medicalization of women's sexuality, because as a feminist, that's what I had thought was the most important focus for my work."

Medicalization is when non-harmful variation or difficulties are redefined or reframed as the symptoms of an illness or disorder. One way this often happens is by pushing the definitions of an existing disorder outwards to encompass more and more people who were not previously thought of as ill. Some argue that mental health has been medicalized in this way.

"People are anxious and ignorant and they look for experts," Tiefer says. "They're raised in a mystified way. When something goes wrong" with their sexuality, "of course they're not experts."

Tiefer attended the FDA meeting, along with other anti-medicalization advocates, including Adriane Fugh-Berman, director of a project to educate healthcare professionals about pharmaceutical marketing, and Thea Cacchioni. On the second day of the FDA meeting, Tiefer said, "The amount of misinformation that people have about sexuality is incalculable...We heard a lot of myths yesterday from patients, with all due respect."

Cacchioni said, "I'd like to personally thank the FDA. Thank you for not approving a drug that is not safe or effective." She also expressed her "disappointment that this is a patient-centered hearing but it has been mainly people who have been sponsored by industry."

Nagoski believes the anti-medicalization group has the science right, but "the rhetoric on the anti-medicalization side is really bad," she says. "They're failing to communicate effectively with the population of women who they need most effectively to communicate with: women who want a drug because they feel broken. The starting place has to be recognizing that these women feel not just broken but helpless and hopeless and lost, they genuinely believe that the only option available...is a medical treatment. That their bodies are busted. You have to start from that point and meet them where they are."

"I'm frustrated overall with the way the anti-medicalization folks talk, because they think that treating the pharmaceutical industry as the enemy is the way forward, and it's not, because the people they need to persuade do not give a shit about the profit motive of the pharmaceutical industry. What they care about is getting help and feeling better and having sex lives that they can feel good about. They need to offer solutions."

There is one type of women's sexual dysfunction that has a well-documented and agreed-upon non-drug treatment: anorgasmia, or inability to orgasm. For this, there are data supporting a very simple non-drug treatment: reading. Giving a woman a book on directed masturbation—basically, focusing on what feels good in

a non-judgmental way—is very effective. The classic text is Julia Heiman's *Becoming Orgasmic*, first published in 1976. "All a woman has to do is basically read the book," said Dr. Cindy Meston.

But for low desire, the waters are murkier. Experts disagree on whether non-pharmaceutical treatments are effective. Dr. Christina Chang of the FDA said at the FDA meeting, "We are not aware of any large-scale studies to support" non-drug treatment options. But Nagoski says, "There are non-pharmaceutical interventions that work."

Both of these statements are true, actually. Studies do exist showing that non-drug treatments are effective. But these studies have much smaller sample sizes than the average pharmaceutical study. Several factors contribute to the smaller sample sizes: the challenge of finding people willing and able to commit to a regular therapy session for the duration of the study, the need for trained sex educators or therapists to run each group, and just the lack of pharmaceutical industry funding. But there are some recent studies of treatments. These include sex therapy, cognitive-behavioral therapy (CBT), and mindfulness therapy.

One of the earliest controlled studies, in 2001, found cognitive-behavioral therapy to be effective at decreasing the symptoms of low desire disorder in women. Seventy-four cohabiting heterosexual couples participated in the study (38 got treatment, and 36 were put on a waiting list control). All the women had had low desire for at least six months, and the average was six years. Couples ranged in age from 20 to 55.

Before treatment, about 60% of the women in the study reported believing each of the following sexual myths: men are always ready to have sex, and sex shouldn't be planned. Roughly a third of the women believed each of these three sexual myths: sex should always end in orgasm, couples shouldn't have too much or too little sex, and you can't have sex if a man doesn't have an erection.

The treatment was three months long, and consisted of a weekly two-hour sex therapy group for couples, with homework assignments. The group sessions included the topics of sexual information, couple's sexual intimacy exercises, communication skills, sensate focus, cognitive restructuring, analysis of causal factors, and sexual fantasy training.

After treatment, the percentage of women in the treatment group with all six criteria for low desire disorder decreased from 100% to 26%. The percentage of women who said they had no symptoms increased from 0 to 28%. Participants, both men and women, judged all the techniques they were taught to be useful, especially the sensate focus and communication skills.

More recently, Lori Brotto and Rosemary Basson studied the effects of group therapy that blended mindfulness, cognitive therapy, and education. In their 2014 study, they treated 95 women: half received treatment consisting of a 90-minute

group session once every two weeks for a total of four sessions. The other half, the control group, had their treatment delayed. The gold standard for a study is random assignment to the treatment or control group: in this study, only half of the women were randomly assigned, and the other half had to be assigned to the treatment that fit in their schedule. The average age of both groups was about 41, and 8–10% of women in the study were single.

The four sessions included mindfulness meditation, the practice of nonjudgmentally paying attention to one's feelings and sensations. Drawing on Buddhist meditation traditions, mindfulness therapy has grown in popularity in recent years. It teaches that negative emotions (like fear and anger) and thoughts (like *I'm a terrible person*) aren't inherently bad and don't mean anything about a person. Mindfulness meditation trains people to ignore these thoughts—not to forcefully push them away, but to simply focus their attention on something else.

The treatment sessions also included education about responsive desire and how mindfulness affects brain function, a guided body scan in which participants noticed sensations from their bodies, a body scan of the genitals, looking at their own genitals with a mirror, and group discussions. Women were assigned homework of daily mindfulness practice, and noticing their sexual beliefs and body image.

When they followed up six months later, they found that desire increased more in the treatment group—by about 6 points on a 51-point scale, from 31% to 43%. Distress decreased in both groups about the same amount.

Hucker and McCabe found online mindfulness therapy to be effective in a 2014 study. Twenty-six women completed treatment, and compared to a waitlist control group they had more improvements in sexual intimacy, emotional intimacy, and communication.

One issue with therapy and mindfulness treatments is that going to treatment regularly—even online—is more of a time commitment than taking a pill. People drop out, to the point where McCabe and Jones published a study in 2013 on the attrition from an internet-based treatment for FSD, trying to figure out which factors contributed to people dropping out. Out of 40 people in the study, 23 dropped out. People who dropped out had significantly lower relationship satisfaction and intimacy than those who stayed, so they recommend the treatment for women with high relationship satisfaction and intimacy. But that doesn't help those not in that category.

Dr. Goldmeier says mindfulness and cognitive-behavioral therapy are "not the quick fix that most people want." Also, the studies present a problem. "There isn't an actual placebo that you can have for mindfulness. Most of the control groups are waiting lists."

Non-pharmaceutical treatments aren't just for women, either. Dr. Goldmeier treats men in his own practice with mindfulness, and, anecdotally, finds it effective. A combined analysis of many studies on men, published in 2014, found that Viagra and psychosocial therapy together were more effective on sexual satisfaction than either were alone. This was regardless of length of treatment in the study or, as the authors put it delicately, "researcher allegiance."

On February 17, 2015, Sprout put out a press release announcing that they had resubmitted Flibanserin to the FDA for approval, and Katie Couric interviewed Barbara, Greg, and Katherine on Yahoo! News.

The Katie Couric segment included interviews with Dr. Goldstein, Cindy Whitehead, and Dr. Leah Millheiser, a clinical professor of obstetrics and gynecology at Stanford Medical School. Dr. Millheiser explained, "We have evidence through functional MRI imaging that there is a difference in the brain activity of a woman with HSDD and a woman who doesn't have HSDD. We know that there is this area of the limbic system that is associated with the neurotransmitters dopamine and norepinephrine that is functioning differently in the women with HSDD."

The brain study she's referring to was published in 2011. Researchers studied the brains of 28 right-handed premenopausal women in heterosexual relationships: thirteen with HSDD and fifteen without. The women lay in an fMRI machine and looked at erotic stimuli—pictures of male underwear models—and non-erotic stimuli. When they saw the male models, the brains of the women with HSDD lit up differently: the regions of the brain responsible for processing erotic stimuli were less active, and the regions of inhibition—those associated with higher-order social and cognitive functions—were more active.

Proponents of pharmaceuticals take this to mean that women with HSDD have a physiological difference in their brains that causes their distressing low sexual desire. But just because this brain activity pattern is *correlated* with low desire doesn't mean it *caused* the low desire. It's possible that both the brain pattern and the low desire were caused by a third factor, or that the low desire caused the brain activity pattern.

Barbara, for her part, sees her low sexual desire as a dysfunction, and a terrible one. FSIAD is "a very bad thing for a relationship," she says. "You want to hug your partner, you want to be close to your partner, but you don't want sex. And that's screwed up; there's something wrong there...And how do you think the partner feels? Totally shut down, like there's something wrong with them."

What Barbara describes as "screwed up" sounds like normal responsive desire. Wanting to hug, snuggle, or kiss a partner without wanting to have sex at the moment is perfectly fine. What would it be like for Barbara if she knew that responsive desire is normal? It might not be a magic bullet, but it's hard to believe

it's not at least a starting place.

The partners of women with FSIAD also need to know that nothing is wrong with them, and that at the same time, low desire often correlates with relationship and communication issues.

"The scary thing for me," says Nagoski, "is that the pharmaceutical industry now has a vested interest in making sure women never learn about how sexual desire really works, because only if women believe they're broken is there a market for the pill." If women are not broken, then society is, but telling people that society is broken doesn't sell pharmaceuticals, and your health insurance won't reimburse you for it.

Everything happens in our brains. Our brains are the site of our experiences, our emotions. Almost any individual differences could be brain malfunctions if "brain malfunction" is defined as "something for which the fMRI image looks different from a so-called normal person." Interpersonal conflict activates a part of the brain called the anterior cingulate cortex: does that mean it's a brain malfunction that makes sense to treat with pharmaceuticals? What would be the implications of treating a conflict between two people by giving one of them drugs to change their brain function? Emotions give us valuable information about the world. How much of our psychological landscape can we control with drugs?

As Marta Meana recommended in her 2010 paper, it's "important that we not increase the ubiquitous sexual pressure on women through the therapeutic mandating of sexual desire." Most of the time, low desire is only a problem if it's low relative to your partner's. But that doesn't mean the solution is for the low-desire or responsive-desire partner to medicate themselves to match the high-desire or spontaneous-desire partner. The current default treatment of low desire in the American medical establishment probably at least partly reflects that fact that women, socialized to be people-pleasers and conciliators more than men, are typically expected to fix relationship problems anyway.

Perhaps it isn't so much a question of whether it's possible to develop drugs to affect low desire. Researchers have developed other drugs that affect the brain—Prozac, Zoloft, Ritalin—and it seems reasonably likely that they can develop a drug that will have some effect on low desire, given enough time and money. But the question remains of whether drugs are the best way—if they're reasonably effective, and if they offer a reasonable amount of benefit for a tolerable amount of risk.

The problem with medicalization isn't that people are lazy, numb pill-popping automatons. I'm on an SSRI myself; I am no anti-drug true believer. The problem is that every aspect of our medical system and economy and society is stacked in favor of pills, rather than stacked in favor of whatever is actually the most effective treatment. And one aspect of this is shame.

There's a lot of criticism of medicalization, but not much is said about its effect on shame. In American culture, people tend to blame themselves for psychological or mental health problems. *Why am I like this? Why can't I just get over it?* We feel broken, and that feels like our own fault. We feel this to the point where it often feels difficult—embarrassing, shameful—to seek help for things like depression, anxiety, and low desire for the partner we chose and committed to and are supposed to want to have sex with.

So one rhetorical maneuver used to get over the shame goes like this: Would you feel embarrassed or ashamed to go to the doctor to set a broken leg? Treat a heart problem? A mental health problem is no different than a broken leg. It's not your fault: your brain has a chemical imbalance. Or, as Dr. Goldstein said on the Katie Couric segment, women with low desire "have a brain malfunction in their hard wiring—the innate desire for sex is not there." There's a reason he crammed three different terms into the same sentence that are all neon blinking arrows pointing to *this is a problem based in the physical body and it's not your fault.*

And to be clear, this rhetorical maneuver is rock-solid: there really is no need to feel ashamed to get help treating a mental health problem, or a problem of low sexual desire, or a broken leg. It's just interesting that we need it. It's interesting that we need to feel like something is a physical problem in order for it to be valid. It's interesting that American culture thinks it's acceptable to treat a bodily problem but not a mental one. Perhaps this is partly due to what Ray Moynihan called the "deep love affair we have with medical science."

Perhaps medicalization is on the rise because it's such an effective end-run around shame. And we seem to badly need end-runs around shame. And in American society, women in particular are blamed and told to feel bad about themselves, especially for their sexuality and any aspect of it that does not conform to the absurd and contradictory expectations placed on it.

This explains why pointing out the shortcomings of pharmaceutical treatment is so often poorly received. When people question medicalization or question whether a particular drug is effective, the people who were helped by that drug, or by thinking that their condition is physical, hear the anti-medicalization message as: *now it's your fault again.*

Katherine described how she thinks of her condition during her Yahoo! News interview. "It's your body failing you; it has nothing to do with what you want in your heart," she said. But it doesn't need to be a physical problem to not be Katherine's fault. There's a whole sociocultural and medical system that has too well avoided its share of the blame.

People Interviewed

Lori Brotto
Thea Cacchioni
Barbara Gattuso
Dr. David Goldmeier
Dr. Cindy Meston
Ray Moynihan
Emily Nagoski
Leonore Tiefer
Frederick Toates

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