The Medicalization of Female Sexual Desire Disorder: Restricting Sexual Normalcy Under the Guise of Equality and Empowerment

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INTRODUCTION

The Food and Drug Administration's 2015 approval of Flibanserin, a drug intended to treat female sexual desire disorder, solidifies the classification of low female libido as a medical dysfunction. Initially hailed as innovative by the medical community for its attention to an alleged women's[1] health issue, Flibanserin has now come to represent the medical community's commodification and objectification of female sexualities—exemplifying the way in which female bodies are disproportionately subjected to the medical gaze and public scrutiny. Although a drug now exists to treat the alleged disorder, the medical and scientific communities lack consensus on what constitutes low libido and how this disorder should be quantified (Wood, Koch, & Mansfield, 2006). This disorder's prevailing diagnostic criteria lie within a woman's own sexual discontentment, highlighting the ambiguity of low female libido (American Psychiatric Association, 2013). While providing women with the power to recognize this disorder in themselves appears beneficial, this makes it difficult to ascertain whether women seek medical intervention for low libido because they want to want more sex or because they have been prompted by external sociocultural factors that cast their libidos as dysfunctional—such as unsatisfied romantic partners desiring additional sexual interactions. If this disorder is primarily diagnosed by assessing women's own frustrations with their lack of desire, but their lack of desire only frustrates them because it upsets their partners, can these women really be said to have a medical dysfunction? This seems to force women to shoulder the blame for their partners' sexual dissatisfaction. Answers to this question and the associated problems it raises have been rendered invisible within the medical arena, as such answers have the power to

[1] I do recognize that not all women have vulvas and vaginas and not all people with vulvas and vaginas identify as women. However, I have chosen to utilize the term "women" here and throughout the rest of this thesis to refer to cis-gender women in order to mirror the language utilized within the medical discourse on female sexual desire disorder.

destabilize the very foundation upon which this alleged dysfunction has been built. Utilizing social constructionist theory of sexual normalcy, this thesis will problematize biomedical conceptualizations of female sexual desire and will underscore the ways in which medicalization of low female libido lends authority to and is legitimized by predominant heteronormative, patriarchal sexual norms. The medicalization of this phenomenon lends credence to the problematic notion that frequent sex is the bedrock of a healthy relationship and that women must prioritize their male partners' sexual needs—transforming such questionable beliefs into seemingly unquestionable truths. Rather than addressing sociocultural influences that impact women's experiences of desire or deconstructing the problematic understanding of sex's role in romantic partnerships, medicalization solely legitimizes the idea that women's sexualities—and not the narrow constructions of normalcy with which they must attempt to align themselves—exist as the primary issue necessitating alteration.

SIGNIFICANCE

The authoritative role accorded to doctors and scientists in Western society arms the medical and scientific communities with the power to shape general understandings of sex, sexuality, and sexual dysfunction. As feminist scholar Leonore Tiefer notes, "[t]he process of medicalization, promoted by industry, media, health experts, and conservative political actors, produces sexual values, language, classification systems, and authorities, and profoundly shapes the popular view of sexuality, despite a culture full of diverse sexual voices" (Tiefer, 2002). Medicalization, therefore, absolutely demands critique. The process of medicalization often employs a myopic focus to depict health problems, portraying dysfunctions as byproducts of failed physiological processes (Conrad, 2007). While ensuring that women receive the health care that they seek is important, it is also important to recognize that medicalization is not a process inherently free from bias. One must not forget that the process of medicalization occurs

in an arena that has historically addressed women's health in a manner that not only fails to empower women, but also works to serve men and exert increasing social control over women's bodies and actions.

Rather than analyzing the sociocultural, political, or economic factors that may influence and construct notions of female sexual desire, the medical community has largely situated desire, and problems with desire, exclusively within the body, transforming women's bodies into sites of medical scrutiny. The way that low libido in women has been medicalized reflects and reinforces patriarchal notions of sexual normalcy, raising questions as to whether its medicalization advances women's health. It is crucial to challenge the existing misinformation about female sexual desire to avoid normalizing the consumption of drugs that attempt to treat what might simply be normal variations in human functioning and to avoid pathologizing women's refusal to engage in sexual intercourse.

BACKGROUND: HISTORICAL RELEVANCE, DIAGNOSTIC CRITERIA, AND CONVENTIONAL APPROACHES TO CONCEPTUALIZING DESIRE

This section will provide a brief overview of medicalized female sexuality's historical roots, low female libido's prevalence and diagnostic criteria, and conventional understandings of female sexual desire. Although brief, this historical relevance proves necessary as it demonstrates the ways in which women's bodies have long been objects of medical scrutiny. Additionally, understanding low female libido's prevalence and diagnostic criteria reveals the number of women that could potentially be diagnosed as sexually dysfunctional. This paves the way for questions as to how a phenomenon afflicting the majority of a population comes to be considered abnormal and dysfunctional. Furthermore, the conventional conceptualizations of female sexual desire that I outline are those that the medical and scientific community has relied

upon to designate low libido as a threat to health. Thus, understanding these conceptualizations allows for a more comprehensive approach to examining medicalized female sexualities.

Historical Relevance

The medicalization of an alleged female sexual dysfunction is not a novel phenomenon unique to low female libido. In fact, framing perceived female sexual problems as medical dysfunctions possesses deeply historical roots. In the early 20th century, Sigmund Freud began to diagnose women incapable of achieving orgasm via vaginal penetration alone with a disorder he referred to as "frigidity," suggesting that their failure to reach climax in this way existed as a medical problem (Koedt, 1973). According to Freud's portrayal of female sexual pleasure, sexual pleasure is initially associated with the clitoris, but as girls mature and begin having penile-vaginal sex with men, this association should shift to the vagina. This is because the vagina was said to be capable of producing orgasms that are more mature compared to those that the clitoris produced (Koedt, 1973). However, very few women are able to reach orgasm from penile-vaginal penetration alone; only about 7% of women are able to climax in this way (Wallen & Lloyd, 2011). Furthermore, sex researchers believe that what has been dubbed the "vaginal orgasm" is actually a mere variation of the clitoral orgasm (Wallen & Lloyd, 2011). The vagina and the clitoris are not entirely separate entities and beliefs that they are typically stem from misunderstandings regarding the clitoris's actual size. Despite the fact that only part of it is externally visible, the clitoral organ actually surrounds the vagina, urethra, and anus. In fact, Yale Urologist Amichai Kilchevsky argues that the "G-Spot" is just an extension of the clitoris inside the vagina (Kilchevsky et al., 2012). For some women, vaginal penetration is able to stimulate the clitoris and provide the friction necessary for orgasm. For most women, however, this is not possible and direct stimulation of the clitoris is typically necessary.

In response to the rigid restraints imposed upon women's sexualities in the early 1900s and the centuries prior, myriad second wave feminists in the late 1960s began to espouse the idea that women's freedom and liberation could not be achieved without sexual freedom and liberation, launching what is now referred to as the Sexual Revolution. This movement challenged Freud's misconceptions regarding the female orgasm and encouraged women to engage in sexual activities that were most pleasurable to them—regardless of whether or not they aligned with certain sociocultural expectations of sexual normalcy. During this time, sexual liberationists urged women to enjoy sex, have multiple sexual partners, engage in sexual experimentation, and initiate sexual advances (Greer, 1971). Additionally, this movement's efforts allowed for the development of the birth control pill, the legalization of abortion, normalization of premarital sex and pornography, and encouraged the acceptance of non-heterosexual sexualities. This movement encouraged women to shed the shame they harbored about their bodies and sexualities and suggested that it was not only possible, but also necessary for women to have sexual encounters that satisfied them just as much as it satisfied their male partners. Although women continue to face shame for expressing their sexuality in contemporary America, the Sexual Revolution did work to challenge the restrictive notion that women could not be active sexual subjects in their own lives in the same ways that men were.

The Prevalence of Female Sexual Desire Disorder

Despite the sexual liberation movement's apparent claims that all women exist as fundamentally sexual people, recent research reveals that low libido or lack of sexual interest exists as the most common sexual problem that Western women face (Kingsberg & Woodard, 2015). Juliet Richters and colleagues' large-scale Australian national survey discovered that 54.8 percent of women reported low sexual desire and lacked interest in having sex (Richters et al.,

2003). A singular cause for this lowered female libido remains elusive and impossible to pinpoint, as sexual desire exists as a vastly complex phenomenon. As Jennifer Drew notes in her article "The Myth of Female Sexual Dysfunction and its Medicalization," sexual desire remains confounded by various complexities. She writes, "[l]ack of sexual desire in women can be caused by complex inter-linked factors such as socio-cultural, economic, psychological, narrow gender roles and beliefs which influence women's and men's sexual expectations (Drew, 2003).

DSM-5 Conceptualization of Female Sexual Desire Disorder

Despite its complexities, myriad attempts have been made to examine and understand this apparent disorder, first garnering low female libido its own section in *The Diagnostic and Statistical Manual of Mental Disorders* in 1980 (American Psychological Association, 2009). The criteria used to diagnose and characterize this disorder have undergone several alterations since its inception in the 80s, both reflecting and influencing cultural beliefs regarding the female body. According to the *DSM-5* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), Sexual Interest/Arousal Disorder—the umbrella term under which female sexual desire disorder is categorized—exists as a disorder characterized by a "lack of, or significantly reduced, sexual interest/ arousal" (American Psychiatric Association, 2013). Despite its title, low female libido exists as the most common name for this disorder. Additionally, the DSM-5's definition of this dysfunction explicitly excludes low female libido that exists as a result of physical trauma or medication induced causes, casting sexual desire disorder as a dysfunction in its own right, rather than a side effect (American Psychiatric Association, 2013). Although the *DSM-5* contains a rather concise set of symptoms that seem to lend to an ease in diagnosis, research reveals that the medical and scientific community not only lack a consensus regarding the best ways in which to

understand and quantify this disorder, but also exhibit problematic understandings of "normal" female sexual desire and functioning (Segal, 2015).

Although the DSM-5 officially refers to what I call female sexual desire disorder as "female sexual interest/ arousal disorder," it goes by various different names in scholarly literature. These names include female sexual desire disorder, female hypoactive sexual desire disorder and low female libido. The multiple terms utilized to discuss female sexual interest/ arousal disorder seem to be reflective of the medical and scientific communities' failure to agree on its specifications. Furthermore, the official name "female sexual interest/ arousal disorder" is both misleading and confusing, as it actually refers to two distinct disorders. The DSM-5's female sexual interest/arousal disorder represents a merging of two formerly separate sexual dysfunctions: female hypoactive sexual desire disorder and female arousal disorder. The former is related to low female libido, while the latter refers to a physical inability to become aroused. For purposes of clarity and consistency, and because I find the DSM's label vague and deceptive, I will primarily refer to this disorder as female sexual desire disorder (FSDD), low libido, or low sex drive. Female sexual desire disorder is the term most often used in both relevant medical literature and feminist critiques of such literature. I decided to utilize the term female sexual desire disorder when referencing the medicalized conceptualizations of this phenomenon due to its prevalence in scholarly discourse. I also decided to utilize the terms low libido and low sex drive because they are widely used by both laypeople and scholars alike.

Conventional Understandings of Female Sexual Desire

A single, quantifiable definition of low female libido does not exist. It is instead left up to the individual woman to determine if her libido is low. Thus, low libido is cast as a "you know it when you have it" type of problem. This, however, has not prevented physicians from treating

these highly individualized experiences as medical problems. In order to define a disorder whose symptoms are predicated upon a lack of desire, the meaning of desire must first be established. However, the DSM-5—and other clinicians and researchers who aim to understand and address this disorder—have yet to definitively do so. Female sexual desire's definition—or lack thereof—is the first obstruction that those aiming to understand this phenomenon face. One might assume that a quantifiable definition exists due to Flibanserin's creation; however, this is not the case. Sexual desire remains a highly subjective experience that lacks consistent cognitive, physiological, or behavioral referents for all women (Meana, 2010; McCabe and Goldhammer, 2013). The research regarding desire that currently exists aims to classify and understand female desire using a biological conceptualization, an approach that medicalized constructions of female sexual desire disorder rely upon to cast low libido as a threat to health.

The most common model utilized to formulate understandings of female sexual desire is the Human Sexual Response Cycle—also known as the Linearity Model. This model refers to the theoretical model regarding sexual response first described by Masters and Johnson in 1966 (Masters & Johnson, 1966). This model understands female desire as a physically driven characteristic with easily distinguishable phases that proceed in a direct linear fashion. The phases it delineates are synonymous with those outlined in the male model of sexual response: excitement—which refers to physical arousal resulting from erotic stimuli, plateau, orgasm, and resolution (Hayes, 2011). This model suggests that sexual desire is a physical longing for or motivation to engage in sexual activity. It conflates physical arousal with sexual desire and fails to explicitly elucidate how desire comes into being in the first place. Because it situates desire as a physiological process that occurs within the body as the result of direct erotic stimulation and because this model continues to dominate the medical and scientific discourse on female sexual

desire, physicians and scientists are able to situate problems with desire as bodily malfunctions. (Wood, Koch, & Mansfield, 2006).

Despite the fact that an adequate definition of desire remains elusive, pharmaceutical intervention aiming to combat this alleged disorder has recently been introduced into the public arena (FDA News Release, 2015). This new drug is often incorrectly referred to as the "Pink Viagra" despite having no relationship to the erectile dysfunction drug. Viagra works by acting on the erectile tissue within the penis to increase blood flow in men with circulatory problems. The men utilizing Viagra do not have a problem in terms of sexual desire; the problem instead lies within their bodies' responses to that desire (Clayton et al., 2010). The available research regarding low female libido reveals that the problem lies within the existence—or lack thereof—of desire itself, not within their bodies' responses to desire. Flibanserin aims to correct neurochemical imbalances by providing the brain with a mix of alleged desire-inducing chemicals (Segal, 2015). According to information provided by the drug's producer, Sprout Pharmaceuticals, "Flibanserin increases dopamine and norepinephrine (both responsible for sexual excitement) while transiently decreasing serotonin (responsible for sexual satiety/inhibition) in the brain's prefrontal cortex" (Sprout Pharmaceuticals, 2015).

Additionally, research reveals that Flibanserin fails to work as the desire-inducing, magic pill that the pharmaceutical industry has portrayed it to be, as it possesses a minimal impact on female desire (Jasper et al., 2016). According to FDA analysis of Flibanserin, only eight to thirteen percent of women who take the drug will see improvement over the placebo. This improvement is defined as having .5 more sexually satisfying encounters per month (Gellad, Flynn, and Alexander, 2015). While having more sex might be the ultimate goal of those who take this drug, engaging in sexual intercourse does not necessarily mean that desire for the

encounter actually exists, as I will demonstrate in following sections. Furthermore, the FDA had rejected the drug twice prior to its approval in 2015 and its approval was the result of powerful marketing, rather than any actual improvement to the drug's efficacy or safety. (Belluz, 2015). In 2013, the drug's maker, Sprout Pharmaceuticals, launched the "Even the Score" campaign. "Even the Score" advocates for the creation of sexual pharmaceuticals for women because, according to the campaign, such drugs are available to men. The campaign's website states, "[w]ith 26 FDA-approved treatment options for men's sexual dysfunction and only 1 for women, we have a long way to go in recognizing the important role sexual desire plays in a woman's overall health." (Even the Score, 2015). By casting a lack of sexual pharmaceuticals for women as a matter of inequality, as this campaign does, it presumes that sexual pharmaceuticals are a necessarily positive entity without considering medicalization's negative ramifications. Providing both men and women with equal access to deleterious drugs is equality in name alone; it does nothing to truly advance the feminist movement or women's rights. Additionally, the information on the campaign's website is misleading. Flibanserin is the only drug of its kind on the market. The sexual dysfunction drugs available to men exist to treat physical inability to become aroused, whereas Flibanserin, as previously explained, is not intended to supplement physical arousal in women.

As demonstrated in this section, medicalized conceptualizations of female sexuality are not new or unique to female libido. Women's sexualities have been the subject of medical scrutiny for decades and understanding this history demonstrates the ways in which medicine exists as a double-edged sword that has the power to both benefit and disadvantage women. The biomedical approach to understanding sexual desire has dominated the field of low libido research, firmly situating this problem under the rubric of health. Despite the plethora of existing

biomedical research on female sexual desire, a single definition of low libido does not yet exist. So while low libido is reported to be a common problem for women, the medical and scientific communities still lack consensus on what low libido actually is. Although low libido remains difficult to define, pharmaceutical intervention has already been introduced aiming to combat this alleged problem. The pharmaceutical industry has created Flibanserin in an attempt to answer questions concerning how to change low libido in women, but the question of what low libido actually is and whether it truly needs to be changed remains unanswered. As evidenced Flibanserin's reported inefficacy, we cannot respond to a perceived problem until we fully understand what the problem actually is. Prior to creating additional pharmaceuticals to combat this alleged problem, an assessment as to whether or not low female libido should even be classified as a medical dysfunction proves necessary. Continuing to create drugs to treat a non-existent sexual dysfunction will not only do little to alter the perceived problem, but will also continue to reinforce the idea that women must engage in sex in a certain way in order to align with societal expectations of sexual normalcy.

METHODS

This thesis utilizes feminist theory to critique the predominant biomedical and pharmaceutical research on female sexual desire disorder and utilizes feminist ethnomethodology to draw upon women's personal narratives to examine low female libido as lived experience. This approach, as utilized by Brianne Fahs in her text *Performing Sex: The Making and Unmaking of Women's Erotic Lives*, involves speaking directly to women about their own sexual experiences to better understand how they conceptualize and internalize sociocultural meanings of sexual normalcy (Fahs, 2011). Focusing on women with low libidos' personal narratives demonstrates that a woman's sexual desire cannot be examined separately or disentangled from

the restrictive sociocultural forces that dictate norms regarding sexuality, intimacy, gender differences, romance, and even happiness—among myriad other things.

Additionally, my thesis relies upon social constructionist approaches to conceptualize sexuality and sexual desire. While myriad scholars continue to debate the specifications and mechanisms of social constructionism as it relates to sex, these theorists tend to agree that social institutions—such as mass media, religious organizations, political parties—and social interaction enact norms that signal and shape sexuality and sexual behavior (Schwartz and Rutter, 1998; Foucault, 1978; Lorber, 1994). In regards to social constructionist theories of sexuality, feminist scholars Pepper Schwartz and Virginia Rutter state, "[t]he sexual customs, values, and expectations of a culture, passed on to the young through teaching and by example, exert a powerful influence over individuals…Even with the nearly infinite variety of sexuality that individual experience produces, social circumstances shape sexual patterns" (Schwartz and Rutter, 1998). This quote succinctly highlights my theory of sexuality; social context exists as a powerful force that shapes our own understandings of the world and our position within it.

While I do critique biologically essentialist approaches to understanding how sexual desire comes into being and argue that sexual normalcy is largely a social construction in this thesis, I do not outright reject all claims that biology may have some influence in the experience of sexual desire. I would be welcome to an approach that understands sexuality as a byproduct of both social and biological circumstances. The reason I choose to focus my efforts on illuminating the complex social forces that influence desire—rather than an integration of biology and social context—is because the social as been rendered entirely invisible in the medicalization of sexual desire. Furthermore, framing sexuality as biological and natural tends to rigidly categorize certain sexualities as either normal or abnormal (Foucault, 1978). Biological explanations have

been exclusively privileged and it is time we recognize that what goes on outside of our bodies matters just as much and certainly influences what happens within them. I want to be clear: in asserting that sex is a byproduct of complex social forces I do not mean to say that sexuality is a choice and I am in no way suggesting that social constructs are not "real". To quote Schwartz and Rutter, "[t]he social world is as much a fact as in people's lives as the biological world" (Schwartz and Rutter, 1998).

The primary research method for this thesis is qualitative data garnered from ten semi-structured interviews with women who self identify as having low libido. Semi-structured interviews are commonly used by feminist ethnographic researchers and are often considered the best way to collect data that "captures the multitude of subjects' views of a theme so that the researcher comes to see the respondents' complex social world" (Wambui, 2013; Denzin & Lincoln, 2000). I chose to utilize this approach so as to analyze women's experiences from their own perspectives—research that would challenge the ways that the predominant biomedical research conceals women's subjectivity and silences their voices. I did not specify what low libido meant exactly when soliciting participants and in conversation with my interviewees, as it is subjective and differs for each individual. That is, the "lowness" of low libido is a thing that has been constructed and lacks definitive referents for all women. There is no single clear-cut definition of low libido and hearing about how these women conceptualize the meaning of this term is part of what my research aimed to discover.

I utilized the popular, well-trafficked Reddit discussion board titled "Sex" to recruit subjects. This message board—or subreddit according to the website's parlance—is the only website whose moderators approved my request to conduct research. "Sex" provides a platform for civil discussions and questions about sex and bans all pornographic material and erotic text.

This specific forum has 669,526 subscribers and has about 1,500 active readers at any given time, ensuring that my request for research participants reached a significant number of individuals. To garner participants, I posted two threads one month apart from each other signifying the characteristics I was looking for in subjects. The characteristics I signified required that women be older than 18 and identify as having low libido. Although I did not exclude non-heterosexual women from participating in my research, all but two of my ten participants identified as heterosexual. The ten women I spoke with ranged in age from 18 to 34-years-old. They each differed in the number of sexual partners that they had had and their current relationship status. I did not ask about race and class in the interview or solicitation process.

I utilized several questions to guide my interviews and while direction of the conversation often differed as a result of an individual respondent's answers, I made sure to incorporate key areas for discussion in each interview. The questions I included in each interview included asking these women what sexual desire means to them, how they came to understand their libido as low, and if their low libido bothers and if so, what bothers them most about it. I avoided asking questions that would elicit one word, yes or no answers in order to keep conversation flowing.

I conducted ten interviews total. Three interviews occurred via phone, five occurred via email, one took place via Skype Instant Message, and one took place via text message. The seven women who chose not to speak on the phone indicated fear that their partners or roommates might hear our conversation, highlighting the fact that low libido is considered embarrassing and taboo.

In addition to conducting interviews that prioritized women's lived experiences, I also conducted a review of the current literature on female sexual desire disorder. This consisted of an

interdisciplinary examination of peer-reviewed literature from various fields. These fields include—but are not limited to—biomedicine, feminist theory, sociology, and sexual anthropology. Utilizing various disciplines allowed for a more comprehensive understanding of female sexual desire disorder and the ways in which this illness has been constructed medically, socially, and culturally. Databases such as JStor, GenderWatch, Gender Studies, PubMed, Sociological Abstracts, and PsychINFO were utilized in order to conduct research. Vanderbilt's Discover Library database was utilized in addition to these databases, as it provided less specified results and articles from various disciplines. Because this alleged disorder exists as a recently medicalized illness, searches were not limited to specified time periods. I began my research with an examination of the *DSM-5*'s depiction of sexual dysfunctions to better understand current conceptualizations of this disorder. I then began researching female sexual desire disorder on the aforementioned databases. Upon collecting this data, I examined these articles for common themes, recognizing the problematic definitions utilized in medical literature and this literature's lack of discussion of external stressors and gender role assumptions. I then began research on feminist critiques of both the medicalization of female sexual desire and of medicalization more generally. I ultimately drew upon common themes to underscore the ways in which the medical community's framing of female sexual desire disorder relies upon patriarchal notions of women's bodies and sexualities.

In addition to a review of the current literature on female sexual desire disorder, I aimed to craft research that analyzed women's experiences from their own perspectives—research that would challenge the ways that the predominant biomedical research conceals women's subjectivity and silences their voices. In order to collect data that prioritizes women's lived experiences, I conducted semi-structured interviews with women who self identify as having low

libido. I did not specify what low libido meant exactly, as it is subjective and differs for each individual. What might be considered low for one woman could be high for another.

I utilized the popular, well-trafficked Reddit discussion board titled “Sex” to recruit subjects. This message board—or subreddit according to the website’s parlance—is the only website whose moderators approved my request to conduct research. “Sex” provides a platform for civil discussions and questions about sex and sexual relationships more generally and bans all pornographic material and erotic text. This specific forum has 669,526 subscribers and has about 1,500 active readers at any given time, ensuring that my request for research participants reached a significant number of individuals. To garner participants, posted two threads one month apart from each other signifying the characteristics I was looking for in subjects. The characteristics I signified required that women be older than 18 and identify as having low libido. Although I did not exclude non-heterosexual women from participating in my research, all but two of my ten participants identified as heterosexual. The two non-heterosexual participants identified as bisexual. The high number of heterosexual participants reinforces the notion that male sexual values continue to shape understandings of sexual normalcy. Straight women and women who sleep with men seem to be more concerned with having low libido because a lowered sex drive fails to align with what has been deemed normal in the context of heterosexual relationships.

I conducted ten interviews total. Three interviews occurred via phone, five occurred via email, one took place via Skype Instant Message, and one took place via text message. The seven women who chose not to speak on the phone indicated fear that their partners or roommates might hear our conversation, highlighting the fact that low libido is considered embarrassing and taboo.

This thesis also includes pilot research conducted in my graduate-level research methods course. This pilot research is comprised of both participant observation and two semi-structured interviews. This initial pilot research possesses significance as it facilitated my decision to interview women who actually live with low libido. I crafted this research in two seemingly contrasting arenas: a women's sexual health clinic and an adult entertainment store. At the women's sexual health clinic, I interviewed one of their nurse practitioners. At the adult entertainment store, I spoke with the store's manager, observed the environment, and noted the products they offered. While I initially worried about the stark differences I expected to find, the distinctions between these two locations presented a crucial source of additional analysis to accompany and further inform my thesis research.

CRITIQUES OF MEDICALIZED SEXUALITIES, RIGID DEFINITIONS OF SEXUAL NORMALCY, AND THE PROBLEMATIC IMPLICATIONS OF BIOMEDICAL CONCEPTUALIZATIONS OF DESIRE: A REVIEW OF CURRENT FEMINIST LITERATURE

In this section, I will underscore the relevant feminist critiques directed at the information contained within my background section. This will work to underscore the ways in which female sexual desire disorder merely represents an additional attempt to exert social control over women's bodies and define sexual normalcy according to men's pleasure. Additionally, this section will reveal the problematic implications associated with the predominant biomedical conceptualizations of female sexual desire. This will highlight the myriad faults within the very foundation upon which this medical disorder has been built.

Significance of Medicalized Low Female Libido's Historical Roots and the Issues They Raise

Freud's medicalization of Frigidity is not merely problematic due to its scientific inaccuracies regarding the vaginal orgasm. It proves problematic due to the fact that it exists as a

rather transparent attempt to define standard heterosexual sexual practices according to what is most pleasurable for men. This demonstrates that, historically, medicalization has been a tool utilized to serve male interests, rather than a tool intended to advance women's wellbeing. As Feminist scholar Anne Koedt notes in her essay "The Myth of the Vaginal Orgasm," medicalizing frigidity was merely an attempt to pathologize sexual acts that failed to prioritize male pleasure (Koedt, 1973). Penile-vaginal penetration allowed men to experience the friction necessary to reach climax; sex acts prioritizing the clitoris, however, need not even involve the penis. Because orgasms achieved via clitoral stimulation had the power to render the penis unnecessary, deeming this method of orgasm immature and representative of dysfunction ensured that women would conform to the sexual acts that benefited men. Essentially, acts that prioritize men's pleasure became the norm under the guise that vaginal penetration could produce a similar, more mature level of pleasure in women. Despite the fact that the vaginal orgasm is no longer considered a more mature form of climax, myriad men continue to operate under the belief that all women are capable of reaching orgasm via penetrative penile-vaginal sex. Analogous to the medicalization of frigidity, the medicalization of female sexual desire disorder works to police women's sexuality in a way that prioritizes male pleasure and restricts the definition of sexual normalcy. And since the myth of frigidity has persisted for almost 100 years, this does not bode well for the potential persistence of medicalized low libido.

Although the rise of sexual liberation in the 1970s has challenged the aforementioned problematic conceptions of sexual pleasure set forth by Freud and has provided women with an increased ability to express their sexualities, the rhetoric characterizing such liberation—both during the 1970s and in the decades since—has crafted rather narrow definitions of what sexual freedom ought to look like. Encouraging women to explore their sexuality certainly represented a

social volte-face from the existing narrow gender roles available to women at the time; however, it failed to dismantle the power imbalances between men and women in the sexual sphere and reinforced patriarchal assumptions regarding female sexuality (hooks, 1984). Sexual liberation's increased emphasis on engaging in more sexual intercourse rendered those who lacked a desire for such encounters invisible. Feminist theorist bell hooks highlights the limitations of sexual liberation in her 1983 text *Feminist Theory: From Margin to Center*. Hooks writes, " [t]o act sexually is deemed natural, normal; to not act, unnatural, abnormal…Women's liberationists' insistence that women should be sexually active as a gesture of liberation helped free female sexuality from the restraints imposed upon it by repressive double standards, but it did not remove the stigma attached to sexual inactivity. Until that stigma is removed, women and men will not feel free to participate in sexual activity when they desire" (hooks, 1984). The medicalization of female sexual desire disorder and the associated rhetoric of gender equality often utilized in discussions regarding the creation of a pill to treat such a disorder demonstrate that—like characterizations of sexual liberation in the 1970s—not having sex is still considered abnormal; women can be sexually liberated as long as sexual liberation means that they want to have often, initiate sexual encounters, and continue to engage in heterosexual sex whenever their partners want.

Critiques of Biomedical Conceptualizations of Female Sexual Desire

As previously discussed, the Human Sexual Response Cycle—or the Linearity Model—continues to dominate medical and scientific research on female sexual desire. While this model for understanding sexuality appears straightforward and might seem to lend to an ease in identifying sexual problems, feminist theorists have critiqued this model and deemed it an inadequate explanation for female sexuality. The Human Sexual Response Cycle has faced

immense criticism for three of its key issues. These issues are its reliance upon a male model standard to determine female sexual normalcy, its assumption that sexual desire is a fundamental, inherent component of all sexual activity, and its reduction of female sexual desire to a strictly biological process unaffected by external sociocultural factors.

The Human Sexual Response Cycle fails to differentiate between men and women's sexual responses and instead suggests that they are one in the same. However, the Human Sexual Response Cycle was initially created to conceptualize the male sexual response (Wood, Koch, & Mansfield, 2006). Despite this, it has been utilized to exemplify healthy, normal sexual response for both men and women. Feminist literature has strongly critiqued this model for its male-centered bias, which seems to suggest that women's sexual experiences are normal only if they closely align with that of their male counterparts (Wood, Koch, & Mansfield, 2006). Despite the problematic notions apparent in this model, and despite the fact that cis gender women do not necessarily follow this model in the ways that cis gender men do, this model has become dominant in discourse surrounding female sexual desire. (Wood, Koch, & Mansfield, 2006). By emphasizing the male-model standard of desire as the norm for both men and women, the medical community seems to suggest that failure to conform to male standards situates one beyond the realm of normalcy. If a man wants to have sex and his female partner does not, framing female desire in this way seems to suggest her lack of sex drive is abnormal; because men's and women's sexual responses are supposedly identical, any deviance from the prescribed norm exists as a dysfunction.

Additionally, the Human Sexual Response Cycle situates desire as a precursor to sex, but as research reveals, women engage in sexual intercourse for myriad reasons that do not necessarily include sexual desire (O'Sullivan & Allgeier, 1998). The women who do so state that

they engage in sexual activity to satisfy a partner's needs, to avoid rejecting a partner, to avoid a conflict, or to promote intimacy in the relationship (Impett & Peplau, 2002). While such reasons for pursuing sexual intercourse might be problematic due to the sense of obligation that these women feel, their reasons demonstrate that having sex and experiencing sexual desire are not necessarily concurrent. The Linearity model omits women's feelings, portraying actions as the only important factor in determining desire.

In addition to its focus on a male model standard and its failure to address the myriad reasons why women engage in sexual activity, feminist scholars have critiqued the biological conceptualization of desire for its reductionist focus on sexual desire as a phenomenon located within the body and for its focus on difference as disease (Tiefer, 1995; McCormick, 1994; Ussher, 1993). Scientific literature on female sexual desire renders women's subjectivity invisible and casts them as the mere sites of quantitative processes. By framing desire as an entirely internal response, biological conceptualizations discount external contextual factors that might affect women's urges to engage in sexual contact. As feminist scholar Leonore Tiefer notes, "[w]hen sexuality is seen primarily as a matter of health, research on biology predominates and is considered more central and definitive than research on sociocultural influences" (Tiefer, 1995). Framing desire itself as an entirely biological, internally driven response suggests that problems with desire also exist as biologically determined. Perhaps a woman with low libido has an exhausting, stressful job that entirely diminishes her sex drive. Perhaps she is simply no longer sexually attracted to her partner. Perhaps she just started watching a great new television show and would rather find out what happens in the next episode than have sex with her husband. The physiology and hormones of a woman with low libido might be perfectly fine; she could simply have other things going on in her life that render sex

unimportant or unappealing. This does not have to mean that she has a sexual dysfunction. As John Gagnon states, "[p]eople are not necessarily unhealthy or in need of medical treatment if they do not feel like having sex all the time" (Gagnon qtd in Fahs, 2011). All of this is not to suggest that biology plays no part in the creation of sexual desire, but rather to demonstrate how biological reductionism fails to address contextual or sociocultural factors that influence desire.

Feminists have also critiqued biological conceptualizations of female sexual desire because they inherently situate sexuality under the rubric of health (Tiefer, 1995). The medical/health model for understanding desire relies upon the assumption that there exists a clear demarcation between healthy and unhealthy sexuality, but this is not the case; sexual normalcy varies depending on lifestyle, historical, and cultural variability (Fausto-Sterling, 2000). Despite the myriad problems associated with biological and medical conceptualizations of female sexual desire, this approach continues to dominate the field of sexual research and rhetoric regarding sexuality. The biomedical conceptualization of sexuality is often privileged over sociocultural conceptualizations because it seems to impart legitimacy and neutrality to claims that sex exists as a natural act and a healthy behavior, rather than a display of deviance or lack of self-control. Leonore Tiefer underscores this in her text *Sex Is Not a Natural Act and Other Essays*. Tiefer writes:

> The contemporary reason [why biological reductionism has retained a grip on sexology], the political one, has to do with legitimacy for sex research. Sex is dirty, or at least risqué, but emphasizing the biological basis makes it a more reputable subject of study…Biology's privileged position within the contemporary sexuality discourse thus descended from early researchers' hope that 'objective science' would replace oppressive orthodoxies of the past (Tiefer, 1995).

While biology's alleged ability to provide objective proof as to why sex remains an important area of research appears beneficial, it ignores how physicians and scientists often construct sexual health norms based on cultural values rather than purely scientific sources (Tiefer, 1995). While some might argue that a biomedical lens for examining sexuality remains preferable to—for example—religious doctrines that cast all sex outside of marriage as sinful, biomedicine similarly rigidly defines and attempts to constrict meanings of sexual normalcy—except seemingly unbiased, objective scientific evidence supports the latter. This biomedical gaze, according to Foucault, exerts social control over sexuality through both public health institutions and self regulation (Foucault, 1978). By pretending that sexuality is natural and biologically fixed, deviations from sexual norms are framed as threats to wellbeing and livelihood that require medical intervention.

The Pharmaceutical Industry and Commodification of Feminism

Pharmaceutical intervention is a key facet of biomedicine. Thus, casting perceived sexual problems as biological ailments suggests a need for a drug to treat them. As Leonore Tiefer states in her article "Female Sexual Dysfunction: A Case Study of Disease Mongering and Activist Resistance," "[t]he public finds medicalization attractive because the notion of simple but scientific solutions fits in with a general cultural overinvestment in biological explanations and interventions, and promises to bypass sexual embarrassment, ignorance, and anxiety" (Tiefer, 2006). Tiefer's statement demonstrates that pharmaceutical intervention seems to provide a seemingly simple way to meet sociocultural expectations of normalcy. However, pharmaceuticals do not actually address the root of the problem: the predominant belief that sexual normalcy exists and everybody is born understanding how to practice and achieve such normalcy. While some might argue that pharmaceutical intervention remains a positive force as

it addresses a sexual problem about which many women feel distressed, pharmaceutical intervention is hardly reflective of feminist ideals. Breanne Fahs notes this in her text *Performing Sex.* She writes, " [w]hile feminism exists as a progressive force that tries to counter, circumvent, or smash the sexist practices that damage women in numerous ways, the pharmaceutical industry pushes a for-profit agenda that follows traditional ideas about gender norms by medicating women into compliance with appropriate femininity" (Fahs, 2011). Although the pharmaceutical industry often employs feminist rhetoric, such rhetoric is often a guise under which they produce and market their drugs. Ultimately, employing feminism to market a product that legitimizes patriarchal conceptualizations of sexual normalcy is antithetical to the feminist movement's goals. The pharmaceutical industry's portrayal of Flibanserin as fundamentally necessary for sexual equality exemplifies the insidious way that this industry employs feminist rhetoric to achieve some not-so-feminist ends. As previously discussed, Flibanserin ultimately achieved FDA approval as a result of its creators marketing it as a means to achieving sexual equality. This drug was said to be able to "level the playing field" and "even the score" between men and women, as though equality were a game that could be won with something as simple as a pill. Suggesting that sexual inequality can be cured with Flibanserin renders the deconstruction of social structures that contribute to discrimination unnecessary. While a quick fix for inequality is certainly attractive, Flibanserin merely reinforces and legitimizes the inequalities that already exist between men and women.

While Flibanserin might be a proverbial beacon of hope for the women seeking to change their sex drive, this drug's creators did not solely create this drug; they also helped to create and raise awareness about the disorder it intended to treat. In their article "Hypoactive sexual desire disorder: Inventing a Disease to Sell Low Libido," Antoine Meixel, Elena Yanchar, and Adriane

Fugh-Berman assert that female sexual desire disorder exists as a fabricated illness constructed by pharmaceutical industries in order to make a profit. They discuss the ways in which the pharmaceutical industry offers continuing medical education (CME) courses to clinicians in order to establish a disease and increase clinician receptivity to new products. Their article identifies fourteen pharmaceutical industry–funded CME modules on hypoactive sexual desire disorder in women that predated the production of Flibanserin. These themes included the idea that "women may not be aware that they are sick or distressed" and the idea that "it is problematic that there are medicines available to treat sexual problems for men but not women" (Meixel, Yanchar, and Fugh-Berman, 2015). The former theme seems to suggest that women are not capable of identifying sexual dysfunction in themselves, stripping them of expertise over their own body and contrasting with the very definition of female sexual desire disorder outlined in the DSM-5. It also seems to suggest that anyone could possess this dysfunction, whether they recognize it or not. Flibanserin's manufacturers suggesting that a woman might have a sexual disorder even without realizing it exemplifies a phenomenon outlined in Joseph Dumit's text *Drug's for Life*. He underscores the ways in which the pharmaceutical industry has redefined the meaning of health. He writes, "health is no longer the silence of the organs; it is the illness that is silent, often with no symptoms" (Dumit, 2012). Because the body is always at risk for infirmity, consuming an ever-increasing number of drugs becomes an imperative. Suggesting to women's doctors that their female patients are constantly at risk of sexual dysfunction has the potential to increase the number of women diagnosed with female sexual desire disorder and thus increase the number of people who will purchase Flibanserin. Redefining health and illness in this way simply allows for the pharmaceutical industry to make a profit.

As demonstrated in this section, the medicalization of women's sexuality has historically worked to serve male interests. Even attempts to promote women's sexual liberation often imposed standards that cast sexual inactivity as an inherent negativity and aligned—whether advertently or not—with male-centered beliefs about what normal sex should look like. The process of medicalization reaffirms this deeply embedded sociocultural belief that lack of sexual desire situates one beyond the realm of normalcy and legitimizes the taboos associated with sexual inactivity. Medicalization not only lends legitimacy to problematic conceptualizations of sexual normalcy, but also creates a myopic focus that renders sociocultural forces inconsequential to the formulation of sexual desire and encourages pharmaceutical intervention. This oversimplified portrayal of sexual desire suggests that not wanting to have sex is a health issue that can and should be changed through the consumption of drugs.

PILOT RESEARCH

This section thematically details how low female libido is conceptualized in medical and non-medical settings. I begin by analyzing the physical environments of the sexual health clinic and the adult entertainment store, demonstrating how these spaces act as a reflection of the approaches those who work within them use to understand sexual desire. I then examine the contrasting ways that the nurse practitioner and store manager respond to women's anxieties about their low libido's impact on their romantic relationships. This not only illuminates the ways that medical and non-medical settings differ in how they account for sociocultural influences, but also reveals the degree to which perceived relationship problems act as a catalyst for women to seek treatment for low libido. Finally, I explore the complex role that sexual pharmaceuticals play in these two settings. Inclusion of this material proves necessary as it paved the way for the guiding questions I decided to focus on in my interviews with women who have low libido.

The Physical Environments of the Clinic and Adult Entertainment Store

The physical environment of the sexual health clinic and the adult entertainment store represented the most salient difference that set them apart. The clinic's physical space was what one might expect from a doctor's office; it had white, clean looking walls adorned with bland artwork and bright fluorescent lights lining the ceiling. Like most doctors' offices, it was a rather cold, sterile environment. While such an environment is the standard for a clinical setting, it did not seem like a space that would make women feel comfortable enough to divulge information about their sex lives—information that Western society tends to characterize as taboo. Discussing sex in an environment typically associated with treating other physical ailments such as a sore throat or a bad back makes the act of sex appear incredibly clinical and detached from sociocultural influence. This highly sterile setting is seen as context free and suggests that sex is a physiological process uninfluenced by the sociocultural setting in which it is practiced. As feminist author Angela Carter notes, the notion that sex is an act uninfluenced by social context is gross, albeit common mischaracterization:

> Our flesh arrives to us out of history, like everything else does. We may believe we [have sex] stripped of social artifice; in bed, we even feel we touch the bedrock of human nature itself. But we are deceived. Flesh is not an irreducible human universal. Although the erotic relationship may seem to exist freely, on its own terms, among the distorted social relationships of a bourgeois society, it is, in fact, the most self-conscious of all human relationship, a direct confrontation of two beings whose actions in the bed are wholly determined by their acts when they are out of it (Carter, 1979).

This is not to say that all sexual problems necessarily stem from social problems, but rather to demonstrate how medicalizing sex and discussing sex in the context of medicalized

environments seems to transform the act into a biological process that either works well or remains broken. Ignoring the sociocultural influences that shape sexual interactions does a major disservice to common understandings of sexualities. The physical setting of the adult entertainment store contrasted starkly with the physical space of the women's health clinic. The store had colorful painted walls, warm lighting, upbeat music playing softly in the background, and adult products lining the walls and display tables. Overall, this space felt much more warm and inviting in comparison to that of the health clinic. While some might find this environment intimidating and the amount of products offered overwhelming, this setting appeared much more relaxed in comparison to the clinician's office.

Low Libido in the Context of Relationships

The relationship between women seeking treatment for low libido and problems in their romantic partnerships is one of the primary themes I explored in this pilot work. When asked if women are ever prompted by boyfriends or husbands to seek medical intervention or if women ever complain about relationship problems that their low libido causes, the nurse practitioner stated that she "will not diagnose them [women with low libido] if they report it as a result of a problem in their relationship." She went on to explain that women often express anxiety regarding the ways that low libido negatively impacts their romantic relationships. She asserted that as long as these relationship problems are not the reason these women seek treatment and they truly want to want more sex for themselves, then they can potentially receive medical intervention for their libido. At first, this answer appeared straightforward, but as I transcribed the recording later that evening, I recognized how confusing it truly was. A woman cannot be diagnosed with FSDD if her low libido stems from an existing problem in her romantic relationship, but if low libido is causing a problem in her relationship, she could potentially

receive treatment for it. A woman can claim that she is not seeking treatment as a result of fear that her libido might damage her relationship, but if she reports that such a problem exists how can it be entirely overlooked within the diagnostic process? The nurse practitioner must trust what her patients say as she is unable to read her patients' minds, but this still seems to underscore the existence of a metaphorical gray area within the medical arena. This not only demonstrates that women might pursue medical treatment for low libido because they fear its impacts on their relationship, but also reveals that such fear could play a role in the production of a medical problem.

The relationship between low libido and relationship problems in the context of the adult entertainment store contrasted starkly with its existence in the women's sexual health clinic. After informing the manager of my project, I began to peruse the shelves to see how the products were advertised and displayed. While the store featured myriad products that were advertised as tools to enhance one's sex life, those on display did not specifically mention women's libido in relation to their romantic relationship. I then asked the manager if women are ever prompted by boyfriends or husbands to seek a "fix" for low libido. The manager responded by asserting that women approached her regarding libido enhancing products to help manage and prevent relationship issues "all the time." She continued on to assert that she tells these women they should never have sex simply to appease a partner. Instead, she claimed that she asks these women about their levels of sexual satisfaction and offers advice and product recommendations with the potential to make sex an overall more enjoyable experience. She asserted that, "a lot of the time the sex these women do have isn't really satisfying and you know, if these women have sex that they actually like, who knows- they might even start to want more of it." The store manager's response to these women demonstrates that she aims to help them by addressing what

she sees as a potential source of low libido, rather than suggesting that they have a medical problem. In contrast, the concept of sexual pleasure remained entirely absent from my conversation with the nurse practitioner; she made sex seem like a process unconcerned with physical enjoyment. In the medical arena, sex was just something that was supposed to happen without any acknowledgment for the context in which it occurs. The adult store's manager saw pleasure as integral to any sexual encounter. According to her, finding ways to increase sexual desire proves useless until it is first established that these women are enjoying the sex they do have; the question should not be "how can I increase my sex drive?," but rather "do I even enjoy the sex I do have?" Nobody wants to do things that causes themselves pain or discomfort and trying to increase libido without confronting the existence—or lack thereof—of pleasure is merely trying to convince women to conform to what is expected without accounting for their feelings. This suggests that sex is not about pleasure and mutual enjoyment for both parties as popular culture and media might lead one to believe, but is rather about getting something done and ticking a chore of a list.

Low Libido and Sexual Pharmaceuticals

My interview with the nurse practitioner yielded significant information regarding her opinions on Flibanserin and treating low libido with a pill more generally. The literature I reviewed prior to conducting this interview suggested that Flibanserin is a perilous drug that not only endangers women's lives, but also fails to produce its intended results. In my conversation with the nurse practitioner, she asserted that she did prescribe the drug and that the women to whom she prescribes it typically report positive results. At one point, she even asserted that she has had women come in for follow-up appointments during which they cried tears of happiness over how much their libido had improved. It is, however, important to note that she testified to

the FDA on behalf of Sprout Pharmaceuticals, the pharmaceutical company that created Flibanserin, in order to demonstrate her support for the approval of the drug—suggesting that she might harbor biases that make her more inclined to prescribe it and speak highly of it.

The information the nurse practitioner revealed regarding the supposed dangers of the drug revealed the sexist practices utilized to produce Flibanserin. Flibanserin's warning label asserts that its interactions with alcohol can produce potentially life-threatening consequences. For that reason, women who take the drug—which is supposed to be taken every single day to prove effective—cannot consume any alcohol, acting as a deterrent that scares away potential consumers. When asked about these dangers, the nurse practitioner informed me that over 50% of the 11,000 women participating in Flibanserin's clinical trial drank alcohol socially during its duration and that only six of the women reported episodes of hypotension and fainting as a result of alcohol use. Only one of these women required a hospital visit as a result of these side effects and this woman had a prior history of low blood pressure and fainting. Furthermore, the placebo group had 3 women who reported episodes of fainting and hypotension, making it difficult to discern whether or not the alcohol and drug combination existed as the source of such health issues. The nurse practitioner continued on to tell me that the FDA still thought that this was enough to place a ban on any alcohol consumption whilst taking Flibanserin. In order to ensure that women do not consume alcohol on the drug, they must sign a form stating such—a form that is then placed in their medical records.

To ensure the accuracy of the nurse practitioners' statements, I decided to look into the available alcohol-interaction research further. I discovered that the information the nurse practitioner had provided was somewhat misleading; this study is not the basis for the drug's black box warning against alcohol. A black box warning refers to a warning that "appears on a

prescription drug's label and is designed to call attention to serious or life-threatening risks" associated with the drug (A Guide to Drug Safety Terms at FDA, 2012). The aforementioned data was deemed inconclusive, so Sprout Pharmaceuticals—the company manufacturing Flibanserin's brand name counterpart Addyi—decided to conduct an alcohol safety study (Dahl, 2015) This alcohol safety study was designed with FDA guidance and required that participants drink two to four shots of grain alcohol on an empty stomach within a timespan of ten minutes prior to taking the drug (Dahl, 2015). Not only does this study fail to reflect the actual circumstances in which a woman might consume alcohol and take this drug, the majority of the study's participants were men. The study was comprised of 23 men and only two women (Risk Evaluation and Mitigation Strategy, 2015) Studying alcohol's interaction with Flibanserin in men who take this drug proves useless, as this drug is not intended for and cannot be prescribed to men. Furthermore, using men as participants to study the interaction between this drug and alcohol potentially understates the complications that women could experience if they drink and take Flibanserin. It is commonly understood in the medical and scientific communities that women and men absorb and metabolize alcohol differently (Thomasson, 1995). Essentially, it is thought that women are more susceptible to alcohol's effects than men. Because this study was done on men and found to have effects serious enough to warrant a complete ban on alcohol while taking the drug and because men are understood to have a higher tolerance for alcohol, the effects that drinking alcohol and taking this drug could have on women are potentially devastating. So not only is testing the alcohol interaction utilizing men entirely irrelevant, it also potentially endangers for women. Ultimately, it is unknown how women who take Flibanserin will react if they choose to drink alcohol, because no study has been conducted aiming to elucidate this interaction. This is an example of the way that women are continuously

underrepresented in biomedical research and the way that men remain the benchmark for sexual normalcy; this drug is not even intended for male consumption, yet more men than women were still selected to participate in trials testing the drug's safety. Sprout's CEO, Cindy Whitehead claimed that the reason this study used men was because they failed find female participants willing to take the drug and drink that much alcohol that quickly (Dahl, 2015). If that truly was the case, Sprout should have put the study on hold until female participants could be found. However, the pharmaceutical company clearly prioritized introducing the drug to market over the need to ensure accuracy regarding the drug's safety and its affects on women.

In order to approach the theme of medicalization in the adult entertainment store, I asked the manager if she knew of any drugs available to treat low libido in women. She claimed that she was unaware of prescription drugs to treat this problem, but informed me that her store has herbal remedies for low female libido in stock. However, she did not speak highly of such remedies. She claimed that she deters customers from purchasing them and does not advertise their availability. Instead, she keeps them tucked away in a drawer behind the counter. She explained that she thinks the pills are merely caffeine pills that do nothing more than increase heart rate and induce a placebo effect. She asserted that she did not trust these pills—or any other pill—claiming to enhance libido. I then informed her about the creation of Flibanserin—a drug of which she had not previously heard. She conveyed anger and disappointment upon learning that a prescription drug to treat low female libido had been created. She stated that, "women should never have to take a pill to make them feel sexually normal. There's no such thing as 'normal' when it comes to sex". The manager then gave me three of the low libido herbal supplements that her store carries.

The supplements' packaging and names conjure imagery that reflects and reinforces sociocultural sexual expectations. These supplements are titled "JO FOR HER: LMAX NOW FEMALE PERFORMANCE," "Kangaroo: Easy to Be A Woman Maximum Strength Sexual Enhancement," and "Pandora: Unleash Her Inner Passion Sexual Enhancer for Women". Two of the three supplements utilize depictions of animals in their packaging. The Jo For Her: Lmax Now Female Performance supplement is emblazoned with a panther splayed across a bright pink background. The Kangaroo: Easy to Be a Woman supplement contains a reference to Kangaroos in both its name and packaging. The allusion to animals suggests that sex is a basic, animalistic instinct. During sex, one apparently transforms from a human being into an instinct-driven, un-restrained animal. Aside from the glaring problematic implications that this portrayal produces—such as contributing to rape culture when specifically attributed to male sexuality by suggesting that men are powerless against sexual urges—portraying sex as an instinct based act in this context makes little sense. It suggests that sex is one of the most natural of all human urges, despite the fact that this supplement exists in order to induce this urge for those who lack it. This would then make the resulting sexual desire an unnatural byproduct by definition. It is difficult to relate this directly to Flibanserin, as there have not been any television or print advertisement campaigns for this drug since its approval by the FDA. The mere existence of Flibanserin, however, speaks to the fact that the medical community has framed low libido as an abnormality.

Additionally, listed directly under the Kangaroo supplement's claim that this product makes it "easy to be a woman," is a list of this product's benefits. It states that this supplement creates better vaginal lubrication, lasts 72 hours, and creates intense orgasms. This suggests that being a woman necessitates intense orgasms, constant vaginal lubrication, and a constant willingness and need for sex. Women who fail to meet these qualifications are then not

considered actually “real” women. Furthermore, it also suggests that women alone are responsible for reaching orgasm in sexual encounters and that their sexual partners—who are assumed to be male due to the products use of a heterosexual couple on its packaging—play no part in women’s ability to climax. If a woman fails to have intense orgasms during sex, this product suggests that the best solution is consuming a pill, rather than communicating with her sexual partner about what might give her a higher degree of pleasure. And while advocating for women to experience more orgasms appears beneficial, the increased cultural emphasis on the necessity of the female orgasm has merely created an additional requirement that women must meet to achieve sexual normalcy. As Breanne Fahs notes, “[o]rgasms represent a synthesis of cultural performances women are expected to enact, for even those women who do not fake orgasms often claim that a great deal of performative effort goes into the production of them “ (Fahs, 2011). The female orgasm has become less about ensuring that heterosexual women are enjoying their sexual experiences and more about placating the male ego and assuring men that they have performed well. This forces women who are unable to reach climax in heterosexual sexual encounters to feel guilty as they feel as though their partner lacks visible proof of their sexual skill. Thus, a pill suggesting that “being a woman” necessitates that one have intense orgasms simultaneously reinforces and legitimizes yet another damaging, unrealistic demand for women’s sexuality as it pertains to men.

The Pandora Sexual Enhancer for Women also relies on beliefs regarding what constitutes womanhood in its packaging, albeit in a slightly different manner. Written on the packaging in gold lettering is “Unleash Her Inner Passion,” suggesting that women’s sexual desires are like caged animals waiting to be set free from captivity. It is as if to say that, although women are stereotypically seen as reserved and restrained, immeasurable pent up sexual energy

bubbles just beneath their surfaces. This suggestion proves problematic, as it seems to convey that although a woman might claim not to want sex, such a desire exists deep down and simply requires coaxing. Additionally, the name Pandora seems to be a reference to Pandora's box, an artifact in Greek mythology that was said to have contained all the world's evil. Pandora opened the box, thereby releasing evil into the world. Utilizing Pandora's box as a metaphor to represent the release of a woman's sexual desire equates that desire to the release of evil. Irrespective of the manufacturer's intent, this metaphor demonstrates that women's sexuality is simultaneously sought after and seen as a threatening force.

Although this pilot research revealed stark differences between the ways in which low libido is treated and responded to within medical and non-medical contexts, it also revealed the insidious ways that socially constructed ideas of sexual normalcy propel women to seek potential cures for perceived sexual abnormalities. Regardless of the context, not wanting to have sex was still confronted as a problem. However, the problematic portrayal of sexual inactivity and low libido did not begin in these two environments; these two environments are merely settings where this portrayal manifests. Because the problem did not start in the sexual health clinic or the adult entertainment store, they cannot be entirely dismantled there either. If a woman were to walk in to one of these two places asking for help to increase her sex drive and the nurse practitioner or the manager responded by telling her not to let socially constructed ideas of normalcy dictate how she feels about herself, I doubt that would do much to alter the anxiety she feels. While these two arenas certainly legitimize sexual norms—perhaps to different degrees—and can potentially work to challenge them, this still does not reveal how women come to understand these norms in the first place. Thus, this research prompted me to seek out women

with low libido in an attempt to understand how and why they came to see their sex drives as problems.

SOCIOCULTURAL CONCEPTUALIZATIONS OF FEMALE AND MALE SEXUALITY: WHAT THE BIOMEDICAL APPROACH IGNORES

As previously outlined, biomedical research regarding female sexual desire renders sociocultural influences invisible. The biomedical approach frames female sexuality utilizing an essentialist lens that conceals the patriarchal constructs in which women engage in heterosexual relationships. The interviews that I have conducted reflect the themes present within the sociocultural and feminist literature on female sexual desire and female sexuality more broadly. The women I interviewed share similar conceptualizations regarding the importance of romantic relationships, sex's importance within the context of those romantic relationships, the male sex drive, and feelings about their own low libidos. These themes work to challenge current biomedical research and demonstrate that women's low libidos are not the problem that requires change; it is the cultural expectations that women must meet that necessitate alteration.

The Importance of Romantic Relationships

Growing up, women are socialized to believe that romantic relationships are the pinnacle of interpersonal connection and that an absence of true love renders life incomplete. Beginning with fairytales in early childhood, women's lives are inculcated with a restrictive notion of what it means to be a successful woman (Dworkin, 1974). In fairytales, a happily-ever-after requires finding true love. While most women do not see Cinderella or Sleeping Beauty as particularly powerful role models and generally relegate these stories to categories of childish fantasy, they are not the sole source of such notions. The idea of finding love in order to positively transform one's life runs rampant in myriad media outlets. From magazines, to movies, to novels, the importance of romantic relationships is seemingly everywhere. While it appears simple to

dismiss the insidious messages that media perpetuate, as feminist scholar Jane M. Ussher notes, remaining completely immune to such messages proves difficult. She writes, "[m]ost women [claim to be immune to the media's messages]: 'I don't believe what I read in women's magazines,' or 'I take no notice of what I see on television,' is perhaps the most common retort when questioned on the subject. It is often mine, too. But few of us *are* immune" (Ussher, 1997 emphasis in original). Despite the fact that many recognize media portrayals of love as fabricated, these fabrications hold the power to affect one's interpretation of the world.

The women that I interviewed demonstrated the ways that the emphasis on finding romantic love permeates their lives and informs their understandings of what happiness requires. These women underscored a fear of being alone and a fear of remaining incapable of finding a romantic partner. One woman articulated fear about being unable to find "the one". She stated, "I felt really terrible about my libido for a long time because I thought it, you know, might prevent me from, I guess, finding 'the one' or Mr. Right as silly as it sounds…I really do consider myself to be this independent feminist woman or whatever, but I still get worried" (Participant A). This participant's comments reveal that although she recognizes how problematic and dubious the concept of one true love is, she remains incapable of denying the pressure she feels from these internalized patriarchal beliefs. Her quote reinforces Ussher's assertion that it is immensely difficult to remain immune to the normative expectation and the perceived importance of finding love. Another participant similarly expressed her fear of being alone. This participant stated that she feels incredibly insecure that her partner may break up with her because of her low libido and that if he did, she could end up being alone forever since her libido keeps "ruining relationships" (Participant B). Her claims were reminiscent of feminist scholar Laura Kipnis' discussions of marriage and love's portrayal as the pinnacle of human achievement in American

culture and the most important thing to which one can aspire. Kipnis asserts that the modern self is "defined by love, an empty vessel without it" (Kipnis, 2003). This participant's statements reflect Kipnis' assertions; she defines herself and her happiness in relation to the presence of romantic love. It is crucial to recognize that it is romantic love, rather than friendship or familial love that retains such high levels of importance. Although her low libido is inconsequential in her non-romantic relationships, these forms of interpersonal connection pale in comparison to the supposed significance of romantic love.

Furthermore, one participant explained the lengths she had gone to in order to avoid facing a break up. She explained how she had always felt that her low libido might be caused by the medication she takes. Her previous relationship began to have problems due to a lack of sex. She explained that she could sense that her partner was becoming increasingly unhappy and she wanted to try to boost her sex drive to appease him. However, she also asserted that she "did not even like this man very much," but she wanted to be with him rather than be alone. Despite not even deeply caring for this man, she decided to switch medications to see if a change would benefit her sex drive—even though her previous medication had been working well to reduce the severity of her illness's symptoms. This is not to say that deeply caring for her partner would be a suitable reason to change her medication and risk her health, but rather to highlight the fact that, for her, being in a relationship with someone she disliked was preferable to being single. Changing her medication sent her into an intense depression accompanied by suicidal ideation. She recognized that this was a result of the medication and after three weeks switched back to the drug she had formerly taken (Participant C). Her story reflects the concepts that both Ussher and Kipnis discuss; many women see singledom as an inherent negativity for which they will go to great lengths to avoid; being with any partner is far preferable to the alleged negativities

associated with singledom. Although she fortunately switched back to her former medication, the fact that she was even willing to risk her health in an attempt to ensure relationship stability underscores the level of importance she attributes to coupledom.

Frequent Sex as the Foundation of a Healthy Relationship

Sexual frequency is considered a foundational component of romantic partnerships, forcing those with low libido to view their sex drives as fundamentally inimical to a relationship's success. In their text, *The Gender of Sexuality* feminist sociologists Pepper Schwartz and Virginia Rutter highlight sex's increased importance. They assert, "[f]or both sexes, particularly in younger couples, the expectation of an extremely good, if not spectacular, sex life has become a common part of committed relationships…Sex is seen as the validation of the relationship, proof of the couple's compatibility" (Rutter and Schwartz, 1998). Sex is not simply one facet of a relationship; it is understood to be a reflection of the relationship in its entirety. If a couple's sex life is lackluster, it is said that that so too is the rest of their relationship. Despite overwhelming evidence suggesting that sexual frequency and sexual desire—particularly for women—tend to fade over the duration of couplehood, the portrayal of sex as a barometer for a relationship's health persists (Rutter and Schwartz, 1998; Klusmann, 2002; Ellwood-Clayton, 2012; Murray and Milhausen, 2012). Each couple wants to believe they are different and tends to operate under the belief that they will not be like those couples that stop having sex, despite the fact that the overwhelming majority of couples will experience decreased sexual frequency. The persistence of this idea seems to suggest that people are unaware that sexual frequency tends to diminish over time. However, this is not the case. One need only think of the popular joke about sexual frequency in marriage to recognize public understanding of sex as something that diminishes the longer a couple is together. Sexual

anthropologist Bella Ellwood-Clayton highlights this joke in *Sex Drive: In Pursuit of Female Desire*. She writes, "[I]f you were to put a marble in a jar every time you made love your first year of marriage, and then in your second year began to take a marble out every time, you'd never remove all the marbles from the jar" (Ellwood-Clayton, 2012). This demonstrates that cultural awareness of diminishing sexual frequency certainly exists, but because we are living in a time in which anything from television shows to physicians suggest that frequent sex is the key to happiness, the overemphasis on sex's importance remains. This cultural preoccupation with sex as an exceedingly important component of romantic relationships seems to be attributed to the fact that men are said to be obsessed with sex and that making a relationship work requires their happiness to be prioritized above all else (Farvid and Braun, 2006; Ussher, 1997). Men are typically portrayed as afraid of commitment and uninterested in coupledom, so in order to entice them into settling down, women must consistently provide them with the thing they are said to care about above all else: sex. In theory, one might be able to recognize that this is little more than a ridiculous stereotype, but because these stereotypes have been hailed as truth for so long, it remains difficult to completely dismiss them. Furthermore, men and women continue to be rewarded—or punished—for behavior that either deviates from or conforms to these stereotypes. Men are praised for sleeping with lots of women, while women are praised for finding a new boyfriend or convincing her partner to "put a ring on it".

Each of the women I interviewed considered frequent sex to be an essential element of romantic partnerships. These women claimed that frequent sex has the ability to increase the overall intimacy between romantic partners and make other relationship issues less problematic. These women also underscored the anxiety they felt when they had not had sex with their partners for an extended period of time. For example, one participant stated, "I think sex is

important in a relationship and I feel anxious without having sex for too long because I feel we are neglecting our bonding experience and feel pressured to have sex because when you're in a relationship there is a social stigma that you 'have to'. However, if I were single, I would be very content without any sex at all" (Participant F). This participant's comments highlight the way that the perceived importance given to sex in relationships frames sex as a job that needs to get done at all costs. She feels anxious not because she has a desire for sex that is not being met, but because she feels that bonding is hindered, if not entirely impossible, without sexual contact. For this woman, sex is not something done for the pleasure or mutual enjoyment of the parties involved, but is rather done in order to meet a quota. Failure to meet this arbitrary standard challenges the deeply ingrained notion that emotional intimacy necessitates sexual intimacy. By stating that she would be happy without ever having sex if she were single, she reveals that her low libido bothers her solely because it is said to threaten the bond she and her partner share and goes against sociocultural expectations for sex within a relationship.

Another participant claimed that frequent sex improves a relationship's chances at success because it renders other problems insignificant; relationship issues not related to sex can be overlooked in the presence of an active sex life. However, lack of sex merely amplifies other existing issues. This participant claimed that a couple can fight almost nonstop every single day, but as long as they have good sex—which she defined as frequent and satisfying—the other problems do not matter; being wildly sexually attracted to each other has the potential to sustain a relationship and make it successful (Participant C). Her comments seem to convey that sex is a panacea capable of remedying all relationship problems. This has deleterious implications: a good sex life does not necessarily indicate compatibility in other aspects of the relationship. Overlooking other relationship problems simply because the sex is great reinforces the notion

that sex is the absolute most important aspect of any romantic relationship. Furthermore, this demonstrates that it is impossible to disentangle concerns about low libido from concerns about one's romantic relationship; because sex has been framed as a reflection of a relationship in its entirety, sexual problems fundamentally are relationship problems. The nurse practitioner from the women's sexual health clinic had claimed that she will not prescribe Flibanserin if a woman reports that the distress about her low libido is because she feels it is a problem for her relationship, but her claim entirely disregards the fact that culturally, sex and relationships are portrayed as inherently intertwined.

Perhaps the most salient example of the participants' understanding of sex as fundamental to a relationship's success and overall health came from Participant G. She stated that, "you know you have to do it [have sex] because it's a huge part of a healthy relationship, but its just something you don't want to do at all and it becomes more and more of a terrible thing for you" (Participant G). If being in a "healthy" relationship requires that a woman—or a partner of any gender—prioritize something that she does not want to do, perhaps that isn't very healthy at all. Isn't a relationship in which one partner must compromise their feelings just to meet some arbitrary sexual expectation unhealthier than one in which sex is happening less frequently if at all? While some degree of compromise is necessary in any type of relationship, romantic or otherwise, engaging in an act that one sees as "terrible" in order to stave off guilt and be able to meet societal expectations certainly does not seem beneficial. This relates to the aforementioned idea that romantic partnerships possess immeasurable importance and one should be willing to sacrifice anything in order to ensure their success. Each of these women reinforced the fact that sex is considered a benchmark for measuring relationship health. By not having frequent sex with their partners, these women harbored immense feelings of guilt and felt

that without frequent sexual contact their relationships were threatened. Despite the fact that they loved their partners very much and continued to engage in other forms of intimacy with them—such as cuddling and handholding—lack of sex was consistently identified as a flaw that could engender a relationship's demise if not addressed and fixed.

Low Libido as a Problem Because it Negatively Affects Male Partners

Current feminist literature reveals that many heterosexual women with low libido are not concerned with their lack of desire, but are rather concerned with the implications that their lack of desire poses for their relationships (Farvid & Braun, 2006; Hayfield & Clarke, 2012; Taylor, 2015). In their 2012 study on sexual desire in heterosexual relationships, feminist scholars Nikki Hayfield and Victoria Clarke analyze data from their interviews with 10 British women. In these interviews, the women discussed sex and affection in their relationships (Hayfield & Clarke, 2012). They discovered that all participants experienced a decrease in their desire over the course their monogamous relationships. Their research also revealed that these women were bothered by their decreased desire primarily because it bothered their male partners (Hayfield & Clarke, 2012). This seems to challenge the very foundation upon which medicalized low libido has been built. The official disorder as described in the DSM-5 is characterized by low libido-induced distress. If a woman's low libido is causing her distress, she can be said to have female sexual desire disorder and can potentially be prescribed Flibanserin. However, if these women are unconcerned with the symptoms of low libido and are instead concerned with its consequences for their relationship, providing Flibanserin in such instances seems to be an attempt to medicate women into conforming to their partners' sexual desires.

The women I interviewed reinforced the findings in Hayfield and Clarke's study; they all suggested that they were bothered by their low libidos solely because they felt their low libidos

negatively affected their male partners. When asked if their low libido caused distress and if so, what distressed them most about it, each participant framed her answer in terms of her libido's effect on her partner. For example, one woman stated, "it does bother me. Recently my boyfriend said he wants to break up with me and I feel it's because I rarely initiate sex" (Participant B). She also claimed that declining sex caused her to experience immense guilt. Following the conclusion of our interview, this woman sent me an email asking if I knew of any products available that could help to increase her sexual desire. This underscores her desperation to increase her libido; despite knowing that I am not a trained medical professional and am examining this alleged disorder from a sociocultural perspective, this participant still hoped I might be able to help alter her sex drive. Another participant stated that her low libido rarely crosses her mind while single; the only time it ever proves problematic or causes her distress is in a romantic partnership (Participant C). This is reminiscent of Participant F's comments—both women explicitly stated that their libidos only bother them because they create relationship problems. These women are not bothered by low libido in and of itself, but are bothered by the fact that it makes it difficult to meet the alleged requirements necessary to be a good romantic partner. Each of the examples reinforces the findings outlined in Hayfield and Clarke's study; women with low libidos see their sex drive as problematic because it contributes to relationship strain. In the absence of a relationship, low libido goes unnoticed. This entirely contradicts the DSM diagnostic criteria for female sexual desire disorder. The DSM criteria assert that women cannot be said to have this disorder if their distress about their libido stems from the fact that it causes relationship strain. However, as these women demonstrate, low libido is constituted as a problem solely in the context of relationships.

Furthermore, my research suggests that it is not just romantic relationships in general that cause women with low libido to feel distress, but romantic relationships specifically with men. Only two non-heterosexual women approached me to participate in my research. This initially indicated that low female libido is framed primarily as a heterosexual problem. The interview I conducted with one of my bisexual participants confirmed this. As previously explained, two of my participants identified as bisexual, however, only one of these women had actually had any sexual experiences with women. This woman explained that although her sex drive was just as low in her relationships with other women, she felt guilt and pressure about her low libido only in heterosexual relationships (Participant G). She claimed that her male partner never pressured her or made her feel bad about her low libido, yet her guilt persisted. When asked why this might be, she could not definitively pinpoint why she felt this way, but thought that it might have to do with the fact that men are said to have higher sex drives than women and that women are expected to do everything in their power to please their partners. She stated, "I guess it's a mixture of the cultural messages that guys need more sex and that meeting their needs is the number one key to a successful relationship" (Participant G). Her response succinctly summarized why Flibanserin is not the feminist harbinger of equality that the pharmaceutical industry has dubbed it. Despite having low libido in both same sex and opposite sex relationships and despite the fact that her male partners never explicitly attempted to make her feel guilty about her libido, her guilt persisted solely in heterosexual relationships. If relationships between two women lack the tension that low libido contributes to in heterosexual relationships, then perhaps it is not low libido that exists as the source of the problem, but rather patriarchal heteronormativity's rigid standards.

The aforementioned idea that men consistently desire more sex than women arose in several different interviews and seemed to be the source of the guilt that even women with understanding romantic partners felt about their low libidos. One woman explained that her partner was supportive and never pressured her to have sex, yet she still harbored guilt knowing he longed for an increased number of sexual encounters. She asserted that her inability to satiate his needs bothers her most about her libido (Participant D). Both Participants A and E expressed similar sentiments; despite having understanding partners, they continued to consider their low libidos a problem because they believed that their partners—and men in general—are always interested in having sex. The idea that men supposedly have higher sex drives by nature exists as the source of the persistent guilt that these women feel; they explained that men are simply more sexual than women (Participant A and Participant E). In Hayfield and Clarke's study, the women commented on the role of media in suggesting that men require certain amounts of sex in order to be happy. Substantial research reinforces the idea that media portrays the male libido in a particular fashion; men are often depicted as being sex-obsessed and willing to do anything to "get it" (Ussher, 1997; Farvid and Braun, 2006).

The idea that men naturally have higher libidos than women was also apparent in my interview with Participant H. This woman claimed that despite the fact that her partner did not pressure her or attempt to make her feel bad about not wanting to have sex, her overwhelming guilt persisted. The guilt would be so overwhelming that, at times, she would "give in" and have sex despite not actually wanting to. When asked why she felt guilty about not wanting to have sex despite lack of pressure from her partner, she explained that she felt that men always want sex so even if her partner did not explicitly state it, that desire was still there. She stated, "I think men tend to be a bit more sex crazed than women...Like if the woman wants sex, the man will

always say yes. If a man wants sex the woman may say yes, but may say no" (Participant H). Her statements not only reflect sentiments similar to that expressed by the other participants regarding the male sex drive, they also point to a prominent, problematic sociocultural understanding of women as sexual gatekeepers. Men are understood to be in constant need of sex and simply waiting to hear yes from a woman. As Brianne Fahs notes, this notion "recklessly construct[s] women as merely the gatekeepers to men's pleasure rather than sexual agents in their own lives" (Fahs, 2011). The woman-as-gatekeeper narrative is especially dangerous and suggests that women stand in the way of men's ability to achieve sexual pleasure. Creating a pill intended to increase the female sex drive is simply an attempt to medicate women into aligning with patriarchal gender norms and an attempt to deconstruct some of the "obstacles" standing in the way of male pleasure. This drug's introduction in the medical arena reaffirms women's fears that low libido is abnormal and needs to be "fixed". Participant H, along with the other women I interviewed, reinforced the notion that men are seen as more sexual; although they thought of their partners as understanding, these women still felt that their boyfriends or husbands always desired additional sexual encounters and would never forego the opportunity to increase sexual frequency should such an opportunity present itself.

CONCLUSION

The biomedical approach for understanding female sexual desire strips women of their subjectivity and disregards the external contextual factors that influence sexual desire and women's attitudes toward sex. This inadequate approach is the framework upon which the medicalization of female sexual desire disorder is predicated—demonstrating that the construction of low libido as a medical illness remains inherently problematic. While it is important to ensure that women receive the health care and the medical research that they desire, this does not mean that all health research is inherently positive. It is imperative to recognize the

patriarchal framework of the society in which medicalization occurs. Additionally, since portrayals of male sexuality suggest that men desire sex far more than their female counterparts and because women are socialized to believe that a successful relationship necessitates a confirmation to male sexual standards, women are often made to feel that it is their responsibility to have more sex than they desire to satiate a male partner's needs. While feeling obligated to have sex to ensure a male partner's happiness and to ensure a relationship's success is problematic in and of itself, it is especially problematic considering that the drug to treat low libido is prescribed based almost entirely on the existence of distress; this seems to be an attempt to drug women so that they align with the standards of appropriate femininity. Physicians and nurse practitioners may claim that they will not prescribe Flibanserin if a woman's distress about her libido is solely because she feels it threatens her relationship, but the ten women I interviewed demonstrate that the "problem" of low libido is constructed exclusively within romantic partnerships. Non-relationship related low libido distress does not even seem to exist.

Furthermore, women are inundated with the message that being single renders happiness impossible and the idea that infrequent sex engenders a relationship's demise—of course women with low libido are going to recognize their sex drive as a source of distress. Portraying Flibanserin as a tool for achieving sexual equality—as the pharmaceutical industry and prescribing physicians often do—is disingenuous at best and dangerous at worst, especially when myriad women want to induce desire to please their partners. That is not equality; it is merely a repackaging of oppressive ideals utilizing feminist rhetoric. While some might argue that it is paternalistic to suggest that all women are only seeking pharmaceutical intervention for low libido due to internalized misogyny, it is vital to recognize that women's sexual development is always subject to sociocultural influence. Some women certainly do feel deeply distressed as a

result of their lowered sex drive, but perhaps the cure to such distress is not a pill, but rather a reconsideration of how we frame sex in our society.

In summation, my research reveals that not only is Flibanserin ineffective when it comes to supplementing sexual desire, but its existence is predicated on highly questionable assumptions regarding sexual normalcy and sexual expectations for women. The women I interviewed revealed that combating these expectations requires more than just recognition of their existence. Many of them explicitly asserted that they considered women's sexual pharmaceuticals to be detrimental to women's liberation and felt that the sexual expectations imposed upon women were unfair, yet could not deny their desire to increase their libidos in an attempt to remedy relationship problems. This demonstrates that simply being aware of sexual inequality does little to change the reality of the expectations for interpersonal, romantic relationships between men and women. A woman can be a self-proclaimed feminist, but subverting the sociocultural demands expected of her within opposite-sex relationships becomes increasingly complex behind closed doors and in between the sheets. The medical and scientific communities' failure to confront assumptions regarding sexual normalcy has resulted in the creation of a drug that legitimizes low libido as a medical disorder and sociocultural sexual expectations, yet does little to fix the perceived problem. However, this is not to say that creating an improved version of Flibanserin that actually augments female libido would engender positive, transformative change. Focusing research efforts on creating new drugs to increase women's sexual desire is a misplacement of energy and resources and attempts to provide an answer to what I argue is the wrong question. The question should not be "how can we make women want more sex," but should instead be "how can we dismantle the unrealistic expectations women feel they must meet in order to be considered normal?" I do not claim to

know the answer to this question—and perhaps a definitive answer does not exist—but actually listening to women's narratives about their own low libidos seems like a positive starting point.

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