

Women's Sexual Desire: A Feminist Critique

Jill M. Wood

Pennsylvania State University

Patricia Barthalow Koch

Pennsylvania State University and Widener University

Phyllis Kernoff Mansfield

Pennsylvania State University

This article offers a critical feminist analysis of the biomedical conceptualization of women's sexual desire. The five major features of the biomedical model of female sexual desire examined and critiqued are (a) use of the male model as the standard, (b) use of a linear model of sexual response, (c) biological reductionism, (d) depoliticalization, and (e) medicalization of variation. A "New View," an alternative to the biomedical model, is offered for reconceptualizing women's sexual problems. This analysis concludes with recommendations for feminist-based biopsychosocial research.

Sexual desire is a key component of the current popular conceptualizations of sexual identity, sexual orientation, and sexual functioning and dysfunctioning. Some sexologists contend that no scholarly or scientific discussion of sexuality can occur without reference to it (Leiblum & Rosen, 2000; Levine, 2002). Even though sexual desire has been the topic of much recent research, there is a great deal of ambiguity and variation regarding the conceptualization, definition, operationalization, and application (in research and practice) of the term "sexual desire" as it relates to women (e.g. Basson, 2002b; Kaschak & Tiefer, 2002; Tiefer, 1995). This variation is profoundly related to the theoretical framework from which sexual desire is viewed. Most often sexual desire has been studied from a biomedical paradigm, as noted by Basson (2002a; 2002b), Rosen and Lieblum (1995), and Winton (2001). This paradigm posits sexuality as intrinsic, natural, and universal (Tiefer, 1988).

In contrast, feminist scholars and researchers have called for a critical analysis of the biomedical paradigm in favor of more woman-centered models of sexuality (e.g., Daniluk, 1998; McCormick, 1994; Tiefer, 1991, 1995, 2000). Feminism is not a monolithic ideology, but instead is defined and practiced in various ways by different people and groups (e.g., radical and liberal; McCormick). In its broadest interpretation, feminism represents advocacy for women's interests. In a stricter definition, it is the "theory of the political, social, and economic equality of the sexes" (LeGates, 1995, p. 494). Feminist sexology is the scholarly study of sexuality that is of, by, and for women's interests (Koch, 2004). Using diverse epistemologies, methods, and sources of data, feminist scholars examine women's sexual experiences and the cultural frame that constructs sexuality (Vance & Pollis, 1990). To this end,

Pollis (1988) has proposed the following principles to overcome the deficits in understanding women's experiences, gender and gender asymmetry, and sexuality:

1. acknowledgement of the pervasive influence of gender in all aspects of social life, including the practice of science;
2. conceptualization of gender as a social category, constructed and maintained through the gender-attribution process;
3. emphasis on the heterogeneity of experience and the central importance of language, community, culture, and historical context in creating the individual; and
4. commitment to engage in research that is based on women's experience and is likely to empower them to eliminate sexism and contribute to societal change.

This article offers a critical feminist analysis of the biomedical conceptualization of women's sexual desire. We examine and critique five major features of the biomedical model of female sexual desire: (a) use of the male model as the standard, (b) use of a linear model of sexual response, (c) biological reductionism, (d) depoliticalization, and (e) medicalization of variation. We offer a "New View," an alternative to the biomedical model, for reconceptualizing women's sexual problems, and conclude with recommendations for feminist-based biopsychosocial research.

USE OF THE MALE MODEL AS THE STANDARD FOR SEXUAL DESIRE

Traditionally, researchers and scholars have conceptualized sexuality as men's sexuality (Irvine, 1990). The field of sexuality has long focused on studies of men's sexual response and behavior that have established men's sexuality as the norm. This practice continues more than 100 years after the initial pioneering research in the field (Ussher, 1993). Tiefer (2000, p. 102) explained,

... too often in the sexological model of sexuality the normative standard has been man's sexual experience ... The idea that heterosexual impulses are the norm, that sexuality exists in individuals, that biological factors are the prime source of desire, that the

Address correspondence to Jill M. Wood, Ph.D., Women's Studies Department, 133 Willard Building, University Park, PA, 16802; email: jmw193@psu.edu.

best way to see sex is as a material series of physical changes in specific activities—assumptions in the sexological model—seem more in accordance with men's experience (or maybe we should say with the phallogocentric experience).

This same pattern is found in the study of sexual desire. Sexual desire has traditionally been viewed, and mostly measured, as spontaneous sexual thoughts and fantasies and biological urges creating a need to self-stimulate or initiate sexual activities with a partner (Basson, 2002b; Leiblum, 2002). Throughout the history of sexology, this conceptualization of sexual desire became embodied in various terms, including sexual drive, appetite, interest, cravings, motivation, and libido. This type of spontaneous, active, and physically-driven sexual response is the one depicted in the traditional human sexual response model developed by Masters and Johnson (1966), although no specific desire phase was included in this four-stage model of excitement, plateau, orgasm, and resolution. Kaplan (1979) specifically identified sexual desire as the first stage in her triphasic model of sexual response, the other stages being excitement and orgasm. She stated (p. 10),

Sexual desire or libido is experienced as specific sensations which move the individual to seek out, or become receptive to, sexual experience. These sensations are produced by the physical activation of a specific neural system in the brain. When this system is active, a person is 'horny,' he may feel genital sensations, or he may feel vaguely sexy, interested in sex, open to sex, or even just restless. These sensations cease after sexual gratification, i.e., orgasm. When this system is inactive or under the influence of inhibitory forces, a person has no interest in erotic matters; he 'loses his appetite' for sex and becomes 'asexual.'

In fact, the *Diagnostic and Statistical Manual of Mental Disorders*, considered the "bible" of sexual classification of disorders and dysfunctions, continues to be based on Kaplan's model (Leiblum, 2001).

Irvine (1990) observed that many sex therapists have adopted these traditional views of sexual desire and view it as "a surging energy that can be switched on or off" (p. 213). In summarizing the ambiguity in defining sexual desire, Tolman and Diamond (2001) opined that "according to the default view, sexual desires are discrete, easily identifiable experiences of lust (i.e., you know them when you feel them)" (p. 35).

The behaviors motivated by this type of spontaneous, active, and physically-driven response (e.g., sexual thoughts, fantasies, masturbation, initiation of partnered sex) are more common, on average, in men than women (Baumeister, Catanese, & Vohs, 2001; Beck, Bozman, & Qualtrough, 1991; Byers & Heinlien, 1989; Laumann, Gagnon, Michael, & Michaels, 1994; Leitenberg & Henning, 1995; O'Sullivan & Byers, 1992; Wallen, 2000). Many professionals and even the lay public have taken this as proof that men have more sexual desire than women, which appears true when using male standards. Yet such standards ignore the gendered division of social power so that gender differences are controlled for, posited as natural, or appear to be non-existent (Tiefer, 2000). As Tiefer

(2000) argued, we should not assume that "women's sexual experience would be better, more normal, or more fulfilling, if it more closely paralleled men's" (pp. 84-85). Further, Leiblum (2002) conjectured, "If sexual drive [desire] was defined less in terms of amount of genital contact and more in terms of sexuality, women would be perceived as being more sensual than men" (p. 61).

To understand women's sexual desire from a perspective free of such male-centered bias, we must root its conceptualization in women's lived experience. For example, a grounded theory study of the experience and meaning of postmenopausal women's sexual desire illustrated differences in women's experiences as compared to the male standard of sexual desire (Wood, Mansfield, & Koch, under review). Through semi-structured telephone interviews, women ($n = 22$, ages 58-65, mean age = 62.4) conceptualized sexual desire as a whole-body feeling, including both emotional and physical aspects, for an interest in sexual activity, either with a partner or alone. They described their sexual desire in various ways, including willingness to participate in sex, energy that built within them, state of being, and interest in sex. Some women explained that it takes them a long time to "warm up" and feel sexual desire in their bodies. For these women, sexual desire was a willingness to participate in sex as opposed to a feeling of being "turned on." They commonly associated sexual desire with emotional feelings, including feeling closeness to a partner or wanting to experience intimacy with a partner through sex. Some of the women discussed physical indicators of sexual desire, most of which were non-genital, such as an increased heartbeat, feeling "butterflies," perspiring, or tingling sensations in their breasts. Other women had no awareness of their sexual desire in a bodily sense. When specifically asked, these participants distinguished between sexual desire and arousal, explaining that desire was an interest in sexual activity and arousal was being physically ready for sexual activity.

USE OF A LINEAR MODEL OF SEXUAL DESIRE

Besides their use of male sexuality as the standard, another feature of the traditional human sexual response models (e.g., Masters & Johnson, 1966, and Kaplan, 1979) is their linearity (Sugrue & Whipple, 2001). Each phase acts as a distinct precursor to the next phase (e.g., desire preceding arousal). This creates the assumption that there is only one "correct" way to move throughout the model to experience sexual response. However, Basson (2001b; 2002b) questioned the validity of these traditional linear sexual response models for women. Based on her clinical experience, she found that sexual desire is not always a precursor to sexual arousal (excitement) in women (Basson, 2001a, 2001b). In addition, sexual desire is often motivated more by a desire for emotional intimacy than by a spontaneous urge. In Basson's circular model, sexual desire often does not occur until after the woman is involved in the sexual activity or may not occur at all. As Basson

(2001b) described sexual desire in this model,

When a woman senses a potential opportunity to be sexual with her partner, although she may not 'need' to experience arousal and resolution for her own sexual well-being, she is nevertheless motivated to deliberately do whatever is necessary to facilitate a sexual interaction as she expects potential benefits that, though not strictly sexual, are very important. The increased emotional closeness, bonding, commitment, tolerance of each other's imperfections, and expectation of increased well-being of the partner all serve as highly valid motivational factors that activate the cycle (pp. 396-397).

To validate this circular model of sexual response, Basson interviewed 47 women who had been referred to a clinic with a diagnosis of "low sexual desire" (Basson, 2001b). About half of these women considered insufficient emotional intimacy an important factor contributing to their lack of sexual desire. They saw sexual desire as a continuation of nonsexual intimacy:

...the most common needs expressed were those outside of the bedroom—an appropriate atmosphere, partner's consideration, respect, and warmth, and physical affection...In the area of sexual activity itself, leisurely, nongenital pleasuring was a common need as was genital but nonintercourse pleasuring (p. 400).

Other women reported a lack of desire due to remembered dyspareunia and the experience of pain, mental discomfort with sexual arousal (usually due to a history of childhood sexual abuse or current undesirable, even abusive, relationships), or striving for perfection, resulting in a tendency to self-monitor their sexual experiences and their ability to please their partners sexually. Other researchers have also found that there are many reasons that women have sex that do not require sexual desire, including sex motivated by security, money, coercion, or fear (Heiman, 2001).

A nonlinear interaction between sexual desire and arousal was also described in focus group research exploring 80 women's (mean age = 34.3 years, range 18-84) experiences (Graham, Sanders, Milhausen, & McBride, 2004). During the discussions, the researchers found that women defined sexual desire as "sexual interest." They tended to consider sexual interest "more thoughtful" and sexual arousal "more physical," yet many women said that they did not clearly differentiate them. These women sometimes perceived sexual interest as preceding arousal and sometimes following it.

BIOLOGICAL REDUCTIONISM OF SEXUAL DESIRE

Most sexologists and laypeople have historically viewed sexual desire as an innate, fixed, biologically-determined drive (Tolman & Diamond, 2001). Although research indicates that biological factors do influence women's sexual desire (Alexander & Sherwin, 1993; Sarrel, Dobay, & Witta, 1998; Wallen, 1995), the degree to which such factors determine women's sexual expression is a topic of considerable debate (for a review, see Sherwin, 1991). Researchers disagree as to the precise role that hormones play in determining or influencing women's sexual desire.

The majority of the research focuses on androgens, primarily testosterone (Basson, 2003). Some research indicates that there is a relationship between women's amount of free testosterone, sexual desire, and sexual behavior (e.g., Riley & Riley, 2000). This research is typically based on correlations between measured testosterone and self-reported sexual desire. These studies often conclude that some women have an absence of sexual desire due to low levels of free testosterone. However, since most studies use correlations as statistical tests, a causative link between testosterone and sexual desire can not be inferred. Moreover, some researchers question the validity and reliability of hormonal assays used to determine women's free testosterone levels, since typically only one hormonal sample is used and the concentrations of hormones vary at different times across the day and from one day to the next (e.g., Voda, 1997).

Despite decades of research on the role of estrogen (e.g., Benedek & Rubenstein, 1939), the physiological effects of estrogen on sexual desire are not completely understood (Regan, 1999). In general, the estrogen research suggests that the relationship between sexual desire and estradiol in women is not a direct one (e.g., Kaplan, 1992; Leiblum, Bachmann, Kemmann, Colburn, & Schwartzman, 1983). A good example of the indirect relationship between estrogen-related physiology and women's sexual desire is vaginal lubrication. Women who consistently experience concerns with lack of vaginal lubrication may avoid sexual interactions for fear of experiencing pain during intercourse (dyspareunia; Bachmann, 1990; McCoy, 1992). Thus, estrogen's effect on vaginal lubrication may facilitate a woman's sexual desire but does not cause it. Another way that estradiol may operate to influence sexual desire is through binding to neurotransmitters in the brain that affect the neurological components of mood (Bancroft, 1988).

Understanding the biological influences on sexual desire is important, and such study does not necessarily constitute a biomedical paradigm. However, when the biological determinants of desire are given undue influence and psychosocial factors are ignored or minimized, a biomedical paradigm emerges. Feminist sex researchers note that the assertion that hormones are the "cause" or even the primary determinants of women's sexual desire is an example of biological reductionism (e.g., Daniluk, 1998; McCormick, 1994; Tiefer, 1991, 1995, 2000). As Leiblum (2002) described, "While [hormones] fuel the flames of desire, psychological factors determine the intensity and direction of the flame. Inferring that hormones, in general, are the primary motivators of sexual activity in humans is a gross oversimplification" (p. 65).

In opposition to biological reductionism, research findings point to interpersonal and sociocultural contributors to the experience of sexual desire. As Basson (2001a) emphasized, sexual intimacy is the primary contributor to sexual desire for women, and this can be diminished through the lack of tenderness, mutuality, respect, commu-

nication, or pleasure from sexual touching; undue focus on the performance of vaginal-penile intercourse; or physical or emotional discomfort from any cause. Among the reasons that women give for being sexual, issues of enhanced emotional closeness and commitment, heightened sense of attraction and attractiveness, and physical pleasure that promotes sharing between the couple are very important (Basson, 2002b). Leiblum also emphasized the importance of relationship factors in determining sexual desire. Women lose sexual desire when they feel disrespected, devalued, or degraded and when their partners use poor sexual techniques or have sexual problems of their own (Leiblum, 2002; Leiblum & Rosen, 1988). In surveys of midlife women, poor body image, wanting more equality in one's sexual relationship, and wanting more passion from one's partner were significantly related to a decrease in a woman's sexual desire as they aged (Koch & Mansfield, 2001/2002; Koch, Mansfield, Thureau, & Carey, 2005; Mansfield, Koch, & Voda, 1998).

Feminist scholarship has produced an entire literature refuting the notion that human sexuality is a natural, intrinsic, and universal phenomenon by documenting sexual differences among individuals based on gender, class, race and ethnicity, history, culture, sexual identity and orientation, environmental factors, and even HIV status (e.g., Gagnon & Simon, 1973; McCormick, 1994; White, Bondurant, & Travis, 2000). Plummer (1995) asserted that each person's sexuality is a context- and culture-specific story that she or he lives while assuming that it is totally "natural" (biologically determined).

DEPOLITICIZING SEXUAL DESIRE

Feminists emphasize that locating sexuality solely within the individual (e.g., biological reductionism described above) serves to depoliticize the nature of sexuality by ignoring the sociocultural, political, and relational factors that affect women's lives (Daniluk, 1998). Foucault (1980) argued that histo-socio-cultural factors work at a very basic level to construct sexual experiences, not simply by enhancing or restricting biology. As interpreted by Tolman and Diamond (2001),

Foucault argued that conceptualizations of sexual desire as repressed 'essences' are *themselves* strategic social discourses that are crafted and deployed by those with social authority and power in the service of particular political and ideological ends. Importantly, such discourses are usually not visible as such; rather, they reflect what *appears* to be natural, factual, or objectively real (p. 38).

Subsequent feminist scholarship has uncovered numerous ways that majority men have been privileged in experiencing and acting on sexual desire, whereas women are restricted from such sexual agency (Duggan, 1990; Ramazanoglu & Holland, 1993). Fine (1988) provided an analysis of how the politicalization of sexuality education, as it was taught in New York City classrooms, resulted in a missing discourse of desire for adolescent females. She described the sexuality curriculum as focusing on young

women saying "no" to a question that they had no power in framing. The adolescent's sexuality was negotiated by, for, and despite the young woman herself. For her, desire became entwined with danger, buttressing the concept of woman-as-victim. Rather than protecting young women from victimization, teenage pregnancy, and sexually transmitted diseases, as professed in the curriculum, the denial of their sexual desire and agency left them disempowered, conflicted, and confused about their sexuality.

This initial silencing of their sexual desire is difficult for women to overcome as they age. Institutional sexism again surfaced as a theme in the grounded theory study of postmenopausal women's experience of sexual desire (Wood, 2004). In reflecting back over their lives, these older women identified numerous negative messages that they had received regarding sexual desire from their families, schools, communities, religion, partners, and the media. The sexist messages they received included the sexual double standard (e.g., it was fine for men to be sexual actors but not for women), sex as dichotomized (e.g., women should only have sex for love), sexual silence (e.g., women should not express interest in sex), sex as reproduction (e.g., pleasure was not expected), and women's bodies as objects of desire (e.g. high expectations of attractiveness leading to body image concerns). One woman described how this institutional sexism affected her sexual desire in this way:

The only way I can explain it, this feeling that my sexual desire is out there somewhere away from myself, is that there are all of these other forces dictating when a woman, at least in my generation, should and could have sex. And the rules or standards about women feeling turned on or interested in sex were even more confusing. You know: 'Have sex for your husband, get excited for him, but not too excited because you want him to feel like he can please you and satisfy you. Don't be turned on by other men who aren't your husband, that's wrong.' It's like someone else has dictated with who, where, and when I should have sex and how excited I should be about it. I just {pause}, it's like I just stopped trying to have it be mine. I gave up trying to understand and sort out all of those rules and mixed messages. . . . I rarely feel sexual desire anymore at all (p. 169).

MEDICALIZATION OF FEMALE SEXUAL DESIRE

Medicalization is a social process in which behaviors, conditions, or habits are considered matters of health and disease using the biomedical model (Tiefer, 2005). As Tiefer (2001b, p. 65) observed, "The medicalization of sexuality prescribes and demarcates sexual interests and activities, defining normality and deviance in the language of sexual health and illness" (Giami, 2000; Rubin, 1984; Tiefer, 1996). The biomedical view of sexual desire promotes concern over what constitutes "normal" versus "abnormal" and "high" versus "low" levels of desire. Such labeling presupposes that all women experience sexual desire similarly throughout differing times in their lives and in different relationships in a one-size-fits-all model. For example, Sugrue and Whipple (2001) argued that using the *DSM*, based on the triphasic model of sexual functioning,

to classify women's sexual experiences "inaccurately pathologizes what seems normal and natural for many women" (p. 222).

Ussher (1993) emphasized that the process through which women's sexual desire is labeled and professionally defined has real-life implications: "Women clearly internalize these definitions of 'normal' sexual functioning and as a result refer themselves for help, thus reinforcing the notion of pathology and of the need for expert intervention" (p. 19). This is evidenced by the fact that lack of sexual interest is currently the most common reason given by women for seeking sex therapy (Everaerd, Laan, Both, & van der Velde, 2000). Further, many community studies demonstrate that American women, especially during midlife, are concerned with their levels of sexual desire (Ellison, 2000).

Feminists emphasize that such biological reductionism spawns a disease-oriented approach to variation in desire (Leiblum, 2001). This disease-oriented approach posits women's bodies as "deficient," thus creating the need for medical and pharmacological intervention, typically via hormone (replacement) therapy (Boston Women's Health Book Collective, 2005; Shaw, 2001; Tiefer, 2001a). For example, research grounded in the biomedical paradigm tends to explain aging women's sexual desire in terms of "deteriorating" function and "deficient" levels of reproductive hormones related to the menopausal transition, as illustrated in this description of sexual functioning of postmenopausal women:

Changes in sexual function occur in the majority of women during the premenopausal and immediate postmenopausal years. These changes include modification of the physiology of sex response, the development of sexual dysfunctions, and change in levels of sexual desire. Because these changes occur coincident with decreases in ovarian hormone production and with biological evidence of the effects of hormone *deficiency* (e.g., pelvic *atrophy*), there is reason to believe that altered sexual function is at least in part due to hormone *deficiency*. To this end, hormone replacement therapy (HRT) has the potential for restoring previous levels of sexual function and desire (Sarrel, 2000, p. 25, italics added).

Since sexual desire is an aspect of sexual response thought to be highly influenced by hormonal factors, it is seen as "treatable" with hormones, especially among menopausal women (e.g., Koster & Garde, 1993; Riley & Riley, 2000). Specifically, increasing women's level of sexual desire is often considered as the way to treat "female sexual dysfunction" (FSD; Galyer, Congaglen, Hare, & Conaglen, 1999; Basson, 2001b). This has resulted in an emphasis by the pharmaceutical industry to develop "Viagra-type" drugs to enhance women's sexual responding in hopes that they would be a financial boon, as Viagra has been (Moynihan, 2003). Since sildenafil (Viagra) "sprang" onto the market in 1998, more than 17 million men have gotten prescriptions to treat their erectile dysfunction, resulting in sales of \$1.5 billion for Pfizer in 2001 (Moynihan). The new competitors (Lilly-ICOS's

tadalafil and Bayer's vardenafil) are expected to have yearly sales of \$1 billion each.

Thus, it is no coincidence that in October of 1998, an international consensus development conference, sponsored by educational grants by nine pharmaceutical companies, was convened by the Sexual Function Health Council of the American Foundation for Urologic Disease. Nineteen specialists in particular aspects of female sexuality (e.g., sex researchers, therapists, gynecologists, and urologists), most of whom had a professional relationship with the pharmaceutical companies, were invited to participate. The stated purpose was to address the shortcomings and problems associated with the previous classifications of "female sexual dysfunction" (Basson et al., 2000). The panel identified their primary goal as developing a consensus-based definition and classification scheme for FSD that would include psychogenic and organically-based disorders. They noted that previous diagnostic systems were ambiguous, inconsistent, or too limited based on the state of current knowledge. They agreed that "it may be useful to develop a classification system for female dysfunction that would parallel the clinical and basic science developments for men" (Basson et al., 2000, p. 889). Their other stated objectives included the development of guidelines for clinical evaluation, including identification of endpoints for treatment of FSD and the setting of priorities for future research.

As a result of this conference, participants recommended continuing the overall classification system used in the *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders 4th Edition* (American Psychiatric Association, 2000). Although many disorders were redefined, the system endorsed by the participants included sexual desire disorders, sexual arousal disorder, orgasmic disorder, and sexual pain disorders. Although a debate ensued over a new classification for sexual satisfaction disorder, it was not adopted. Specifically, hypoactive sexual desire disorder was defined as "the persistent or recurrent deficiency (or absence) of sexual fantasies/thoughts, and/or desire for or receptivity to sexual activity, which causes personal distress" (Basson et al., 2000, p. 890). Many panelists lauded this definition as superior to the previous one since it added receptivity to the repertoire of initiation of sexual activity, yet receptivity went undefined. In addition, participants explained that adding the criterion of personal distress eliminated the discrepancy of classifying someone as "dysfunctional" when she did not feel concerned with her level of sexual desire.

The report and new classification system for FSD that resulted from the consensus conference was criticized on numerous fronts (see the *Journal of Sex & Marital Therapy*, 2001, vol. 27). For example, Everaerd and Both (2001) criticized the panel's devotion to empiricism through the emphasis of quantifiable measures and endpoints without showing "much awareness of their roles of social constructionists" (p. 137). Some sexologists called into question the proprietary nature of the conference

(Fagan & Strand, 2001; Shaw, 2001). Some argued that the agenda of the consensus conference, sponsored primarily by pharmaceutical companies, was in actuality to define “female sexual dysfunction” in order to create a need and demand for drug treatment (Bancroft, Graham, & McCord, 2001; Hall, 2001; Tiefer, 2001a). As Tiefer (2002) conjectured:

This consensus report ... will be used by commercial interests to justify drug trial research designs that will exclude most of women's sexual issues... Federally approved, expensive, prescription drugs will then be advertised directly to women who have no other sources of information or help (p. 135).

Concerned with issues of power, feminists noted that the medical profession reaps power from the biomedical conceptualization of women's sexual desire (Shaw, 2001). Further, they observed that experts had defined normal sexual desire and classified desire disorders to facilitate treatment of a problem that they had, in essence, constructed (Moynihan, 2003; Tiefer, 1995, 2000, 2001a).

The Food and Drug Administration's Center for Drug Evaluation and Research released guidelines for drug trials on female sexual dysfunction shortly following the publication of the consensus report (FDA, 2002). The first drug trials tested the effects of sildenafil on women who were diagnosed with “female sexual arousal disorder” (Berman et al., 2001; Caruso, Intelesiano, Lupo, & Agnello, 2001). The results indicated that facilitating sexual arousal in women was not as simple as prescribing a pill. As Berman explained, “There is clearly a role for medical therapies, but not in isolation from emotional and relationship issues, which are equally if not more important with women” (Moynihan, 2003, p. 47). In February 2004, Pfizer announced that it was ending its research into the use of sildenafil with women due to poor results in the clinical trials.

The search for a drug to improve women's sexuality has shifted to increasing sexual desire through testosterone therapy. Proctor and Gamble was the first company to seek FDA approval for a testosterone patch, called “Intrinsa,” to treat “hypoactive sexual desire disorder.” The clinical trials for this drug were conducted with surgically menopausal women who were also using estrogen therapy. However, it was touted in the media that, if approved, this patch would probably be prescribed off-label for any woman, especially if she was reaching menopause. The results of the clinical trials showed that the placebo treatment (couples' counseling and support) increased the “endpoints” from women reporting two “satisfactory sexual episodes” to three a month (Tiefer, 2004). In comparison, the use of the testosterone patch added another sexual episode per month above that of the placebo group. However, at its December 2004 meeting, the FDA advisory committee did not find enough evidence of the effectiveness and (long-term) safety of Intrinsa to recommend approval of the drug to the FDA. Further, it recommended that more studies be conducted with naturally menopausal women, peri- and premenopausal women, and women

with real-life stresses and health issues. Thus, Proctor and Gamble withdrew its application for approval of Intrinsa from the FDA.

A “NEW VIEW” OF WOMEN'S SEXUAL PROBLEMS

To contest the biomedical model that was beginning to dominate research on women's sexuality and treatment of women's sexual concerns, a group of twelve feminist scholars, therapists, and researchers organized their own Working Group in 2000 (Tiefer, 2001a). This Working Group produced a volume of commentary and research articles disputing the biomedical conceptualization of women's sexuality used to construct the *DSM* classification scheme for female sexual dysfunction (Kaschak & Tiefer, 2002). They identified what they considered the three most serious distortions of women's sexuality produced by the biomedical model, which “reduces sexual problems to disorders of physiological function, comparable to breathing or digestive disorders” (Kaschak & Tiefer, p. 3).

First was the false notion of sexual equivalency between women and men endorsed by traditional models of sexual response and an identical classification system of sexual disorders and dysfunctions, even though women's responses and concerns are not always similar to those of men. (Refer to the previous section, Use of the Male Model as the Standard). Second was the erasure of the relational context of sexuality from the classification of sexual problems by assuming “that one can measure and treat genital and physical difficulties without regard to the relationship in which the sex occurs” (Ibid., p. 3). (Refer to the previous section, Biological Reductionism). The final distortion was the leveling of differences among women (a combination of biological reductionism and depoliticalization—see previous sections). This leveling was explained in this way:

All women are not the same, and their sexual needs, satisfactions, and problems do not fit neatly into categories of desire, arousal, orgasm, or pain. Women differ in their values, approaches to sexuality, social and cultural backgrounds, and current situations, and these differences cannot be smoothed over into an identical notion of ‘dysfunction’—or an identical, one-size-fits-all treatment (Ibid., p. 3).

The Working Group of “The New View of Women's Sexual Problems” recommended a different classification system for sexual concerns based on women's real-life experiences (Kaschak & Tiefer, 2002). To avoid the total medicalization of women's sexuality, they preferred the term “sexual problems” to “sexual dysfunction.” Sexual problems were defined as “discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience” (Ibid., p. 5). Women's sexual problems are “notoriously multifactorial in etiology” (Davis, 2001, p. 131). Thus, four comprehensive and interrelated areas were identified as the major contributors to women's sexual problems (Working Group, 2002, pp. 5-7). The first major contributor was sociocultural, political, or economic factors, including ignorance and anxiety due to inadequate sex education, lack of access to health services, or

other social constraints. Clashes between cultural norms were also acknowledged as inhibiting sexual expression. Another feature of most women's lives—lack of interest, fatigue, or lack of time due to family and work obligations—was also targeted in this category.

Partner and relationship issues were identified as the second major contributor to women's sexual problems, including discrepancies or conflicts over specific sexual issues (e.g., preferences for sexual activity) or more generalized relationship or life issues, like financial or health problems. Negative partner characteristics (e.g., domineering) or behavior (e.g., abuse) were also emphasized in this category. The third category highlighted psychological factors contributing to sexual problems, including general personality problems, depression, or anxiety. The role of past or current negative experiences and their consequences in creating sexual aversion and inhibition was also emphasized. Finally, medical factors were also recognized as important, including numerous local or systemic medical conditions; pregnancy, sexually transmitted diseases, or other sex-related conditions; side effects of drugs, medications, or medical treatments; and iatrogenic conditions.

Although there is always more to learn, much multidisciplinary research and scholarship has been conducted on women's sexuality, including their sexual desire. Bancroft and colleagues (2001) have emphasized that sexual desire problems present clinicians with a vast, heterogeneous group of etiologies, but that it seems that the approach has become, "If we concentrate hard enough on the women's pelvis, these other issues will disappear" (p. 102). It should be noted that each of the factors described by the "New View" has been identified through clinical practice and/or research as specifically impacting women's sexual desire (e.g., Bancroft et al., 2001; Basson, 2001a, 2001b, 2002b; Duggan, 1990; Fine, 1988; Gabbard, 2001; Heiman, 2001; Kameya, 2001; Koch & Mansfield, 2001/2002; Koch et al., 2005; Leiblum, 2001, 2002; Leiblum & Rosen, 1988; Mansfield et al., 1998; Ramazanoglu & Holland, 1993; Surgue & Whipple, 2001; Wood, 2004; Wood et al., in press).

Through numerous publications, presentations, and advocacy activities, the "New View" of women's sexual problems has gained recognition and made some inroads on sexual education, therapy, and public policy (see Kaschak & Tiefer, 2002; FSD Alert Campaign, 2006).

RECOMMENDATIONS FOR FUTURE RESEARCH

It is clear that conceptualizations and experiences of sexual desire are complex and holistic for women. We make the following recommendations for exploring, in more valid and beneficial ways, the answers to the following questions (Levine, 2002; Tolman & Diamond, 2001):

1. What is sexual desire for women?
2. How does it operate in women's lives?
3. How might the range of differing sociocultural, political, economic, relational, psychological, and biological processes interact to shape different forms of sexual desire in different contexts over the lifespan?

First, researchers need to be more mindful of the limitations and biases inherent in the paradigms they are using. Terms like "deficient," "disorder," and "dysfunction" have epistemological implications which both illustrate and influence notions about the nature of women's sexual desire. Failing to address bias inherent in a research paradigm not only affects the validity of a study, but also limits the explanatory power of the researchers' conclusions.

Second, the real-world implications of research findings on the general population need to be considered. To date, a majority of the research on women's sexual desire has encouraged (if not created) a culture in which women's sexual lives are labeled as "normal" or "dysfunctional." Increasing numbers of women are finding their level of sexual desire categorized as "disordered" or "deficient," yet women have had little power in defining their experiences for themselves (or to researchers). To this end, women are, in essence, socialized to seek out the advice of "experts" for "treatment" (e.g., a drug) to remedy a "disorder" that may or may not be problematic for them (Bancroft, Loftus, & Long, 2003). Women's own conceptualizations of sexual desire and sexual problems should supplant those purported by the strictly biomedical model.

Finally, future research needs to employ paradigms that acknowledge multiple influences on women's sexual desire. More qualitative research designed to increase the understanding of women's sexual desire (and sexuality) is sorely needed. In addition, biopsychosocial models should be utilized to account for contextual factors that may directly or indirectly affect a woman's sexuality, in addition to the biological factors. In this approach, women's sexuality is conceptualized as the interaction of several factors, as opposed to being solely biologically or socioculturally determined (e.g., Tiefer, 1995; McCormick, 1994). As Tolman & Diamond (2001) have observed, "sexual desire represents, in many ways, an ideal 'laboratory' for interactions between biological and sociocultural aspects of sexuality" (p. 36). In women's lives, this "laboratory" is constantly processing the myriad of sociocultural, political, economic, relational, psychological, and biological factors, from the mundane to the traumatic, that holistically result in the (lack of) experience of sexual desire.

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