

# Women, Sex, and Society

PEUL CHOI



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*WRITER'S COMMENT: I recall watching a documentary around the spring of 2015 that discussed the emergence of the Female Sexual Dysfunction in recent years. Without a doubt, I was shocked – I wasn't aware that women encountered issues of such an extent regarding their sexual experience to the point where the issue was given an official identification as a "dysfunction" in the DSM-V. My sociology assignment to conceptualize a problem as a social issue was the perfect opportunity to conduct an in-depth analysis of FSD. I've constructed this paper with the hopes that readers will experience my bafflement at the fact that this "dysfunction" exists in general with no official solutions, when it could otherwise be prevented by removing the social stigma against female sexuality.*

*INSTRUCTOR'S COMMENT: Peul Choi wrote her paper for my introductory-level sociology class on social problems. The objective of the course's final essay is to analyze a social problem of the student's choosing, and evaluate an organized response to that problem. Particularly for an introductory course, the essay's goals are ambitious. It asks students to step back from their personal opinions about an issue, and assess it based on social science research. In the process, students often must factually support, or overturn, "common sense" understandings of the issue at hand. Peul's essay on "female sexual dysfunction" is an exemplar of these goals. Peul insightfully critiques "female sexual dysfunction" as the result of what sociologists call medicalization. This classification is the product of social, cultural, and economic forces, but also frequently taken for granted as a purely biological phenom-*

*enon. Moreover, Peul examines the potential for pharmaceutical firms to contribute to and capitalize on the medicalization of “female sexual dysfunction.” Ultimately, Peul develops a nuanced understanding of “female sexual dysfunction,” and demonstrates the research skills that I hope all students develop in my course.*

*– Ryan Finnigan, Sociology*

In 2013, the American Psychological Association added a “newly discovered,” now diagnoseable, disorder to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*. “Female Sexual Dysfunction,” otherwise referred to as “FSD,” is described as persistent and recurrent disruptions in any of the components of the sexual response cycle (excitement, plateau, orgasm, and resolution). FSD leads to low desire for sexual intercourse, lack of lubrication, pain during sex, inability to achieve orgasm, etc., distressing the individual and negatively impacting her relationship with her partner (Mayo Clinic 2015). Like male impotence, FSD is commonly understood to be age and health-related; less known is the fact that many women affected by FSD are between the ages of 18 and 40 with no major health issues (Song *et al.* 2008). The medicalization of FSD with regards to age and health is certainly appropriate. The percentage of FSD reports in young and otherwise healthy women, however, is alarming.

The Florida Hospital contends that 40% of women in America suffer from Female Sexual Dysfunction (Florida Hospital 2016). A 2008 study conducted in Korea found that out of 504 women, 43.1% of women under the age of 40 suffered from FSD - arousal problems in 49%, lubrication problems in 37%, orgasm problems in 32%, and pain problems in 34.6% (Song *et al.* 2008). These two reports, consistent with other findings worldwide, suggest that roughly one in three women suffer from FSD; the number may be larger as many women are hesitant to admit or lack knowledge of FSD (Laumann *et al.* 1999). If FSD affects these women’s sexual partners as well, it impacts an even larger portion of society (Basson *et al.* 2000).

Medical causes (such as diabetes, various cancers, surgeries, and menopause) are not the only factors contributing to Female Sexual Dysfunction. Socio-cultural influences, such as family and religious values, societal norms, and the lack of female sexual education, influence

and may further increase the 40% statistic (Florida Hospital 2016). Some male-centric societies, for instance, teach young women that “sex is only for procreation, that sex is not to be enjoyed” (Ohl 2007). Societal norms placing higher relative importance on men achieving orgasm may lead women to focus entirely on their partner’s pleasure, choosing to “quietly wait for the partner to reach orgasm and abandon her own sexual needs” (Ohl 2007). Religious background and family values may also influence an individual’s attitude toward sex, fostering feelings of guilt and shame in instances of diversion from these values, further inhibiting the individual (Ohl 2007). Partner performance and technique, especially premature ejaculation or as an attempted enactment of pornographic scenarios, may also contribute to the woman’s discomfort (Millheiser 2013). Additionally, the lack of education provided about female sexual capacity (in contrast with the prominence of male sexual education) will lead to women “suffer[ing] in silence [...] not knowing any better” (Angel 2010). FSD arises from the way in which society, although evolving, is still male-oriented. Religious, familial, and cultural values, the prevalence of male sexual education versus the blatant lack of female sexual education - all serve to emphasize and enforce a male-centric society.

Of course, men are also victims of sexual dysfunction, with about 31% of men reported to be impotent (Millheiser 2013). But unlike for women, medical remedies have been developed for men: there are seven FDA approved drugs, most notably Viagra, targeting male sexual dysfunction compared to various FDA approved “treatments” for FSD that perform either unreliably or not at all, often with negative side effects (Millheiser 2013). The introduction of drugs such as Viagra increased the “mismatch” in sexual capacity between the genders to extremes. Older men were able to experience a renaissance of their sexuality, while many of their female partners experienced an age-appropriate decrease in their sex drive. As a result, this mismatch became a contributing factor to the rise in infidelity and divorce rates, especially in the United States (Millheiser 2013). Distress caused by FSD and interpersonal issues occurring because of FSD are also reported to lead to anxiety disorder, depression, cardiovascular concerns, and other sexual disorders listed in the DSM-V. Individuals without health care are unable to receive help for these issues, further impeding the individual’s health and her future relationships (Mayo Clinic 2015).

Scholars disagree, however, about Female Sexual Dysfunction

as a medical condition, much less a social phenomenon. Due to the intertwined nature of the medical and pharmaceutical industries, some suggest that FSD is over-medicalized. Journalist Ray Moynihan, for instance, even suggests the pharmaceutical industry “sponsored” and “constructed” the dysfunction, influencing and manipulating the medical perception of FSD (Hutchison 2010). The hype surrounding FSD has led critics, such as Doctor Marcia Angell, to warn that, “doctors may be pathologizing normal ups and downs of libido in response to the industry’s illusion of an epidemic” (Hutchison 2010). Others, such as Dr. Sandy Goldbeck-Wood, argue that the pharmaceutical industry’s over-involvement in research for FSD should be questioned, but that “the reality of these disorders and the distress they cause, should not” (Jervis 2014). Dr. Bat Sheva Marcus of the Medical Center of Female Sexuality agrees that claiming women are complaining about their sex lives simply because “pharmaceutical companies told them to is really insulting to women” (Ellin 2012). Sheryl Kingsberg, Chief of Behavioral Medicine at the University Hospitals Case Medical Center, additionally counters that diagnoses develop only with enough evidence to indicate a genuine syndrome. She adds that refusing to validate a condition with a label would do “these women a disservice” (Hutchison 2010). The debate continues with the fact that women may potentially interpret a normal part of the sexual cycle (such as a decrease in libido following a pregnancy) as a symptom of a disorder, but that does not mean that the dysfunction does not exist (Jervis 2014).

Regardless of the academic debates concerning the legitimacy of Female Sexual Dysfunction, multitudes of women resort to over-the-counter products (lubricants, arousal gels, oils, nutritional supplements, vibrators), testosterone patches, hormone therapy, etc. in the absence of a reliable government-approved medication (Ellin 2012). The effectiveness of these products and treatments, however, is limited. Some create secondary conditions, ranging from minor side-effects (acne, facial hair) to major conditions (anxiety, depression, cardiovascular disease, breast cancer), while others are proven to be “equally as effective as a placebo” (Jio 2009). As a response to these problems surrounding FSD and to the lack of genuine solutions, Sprout Pharmaceuticals has taken the initiative to create “a little pink pill:” Flibanserin (Silverman 2015). If approved, it would be “the first drug of its kind on the market” (Schiavocampo, Jesko, and Effron 2014).

Sprout Pharmaceuticals developed Flibanserin to bridge the disparity between men's and women's viable solutions to sexual dysfunction, giving females the opportunity to enjoy and "become equal members of their sex life as men have become with the products available" (Schiavocampo et al. 2014). The drug would serve as a non-hormonal supplement, taken daily in the evenings (Schiavocampo et al. 2014). Unlike male potency medication, which mechanically increases blood flow to the genital area, Flibanserin targets the brain and increases noradrenaline and dopamine to "rebalance the imbalance of brain chemicals associated with acquired hypoactive sexual desire disorder or low sexual interest," as simply increasing blood flow to the vaginal area would not elevate or generate arousal for women (Jio 2009). After the Food and Drug Administration's rejection of the drug in 2010 and again in 2013, Sprout formed a coalition with seventeen women's and consumer advocacy organizations, launching an internet campaign called "Even the Score." To this day, Even the Score pressures the FDA to approve more drugs targeting FSD, and now a number of lawmakers are contacting the FDA to support the campaign (Silverman 2015).

Despite the seemingly controversial nature of the situation, the FDA may have legitimate reasons to continuously reject Flibanserin. FSD is vastly different from male impotence, as female sexuality is centered most prominently in the brain (Schiavocampo et al. 2014). Female sexual desire is a complex interplay between hormones, brain chemistry, stimulus, and culture - a combination that may be much more difficult to manage than a quick-fix pill can accommodate (Kaplan 2015). As a result, defining "sexual enhancement" for women is extremely intricate, especially when women vary in terms of what excites them (Ellin 2012). This brings into question whether medication such as Flibanserin is even necessary - whether the implementation of the drug should follow a societal change involving deeper knowledge of and a wider perspective on female sexuality (Kaplan 2015). As writer Amanda Marcotte states, female sexuality is often overlooked. Altering the social conception of female sexual capacity, although challenging, will perhaps serve as a greater and longer-lasting improvement than the temporary and convenient effects of medication (Kaplan 2015). In a sense, this approach would "even the score" not with the medications available, but with the knowledge foundation that females will have access to about their own bodies and sexual capacity.

This spills into the concrete reasons the Food and Drug Administration repeatedly rejected Flibanserin. The FDA's most recent rejection of the drug was explained on the basis that the drug displayed only "modest" benefits in "increasing sexual satisfaction," and that these "modest" benefits failed to outweigh the negative aspects of the drug (Silverman 2015). Although the manufacturers argue that Flibanserin demonstrated a statistically significant improvement during clinical trials, the drug continues to generate skepticism from various consumer and women's health groups. The drug has to be ingested on a daily, long-term basis (compared to male sexual dysfunction pills taken on an "as-needed basis"), and there are obvious risks when tampering with the central nervous system (Silverman 2015). Additionally, fifteen percent of the women participating in the clinical trials dropped out because of the side effects, which include nausea, dizziness, drowsiness, and anxiety. The FDA determined that these side effects, which include driving impairment, pose a potential danger to women (Schiavocampo et al. 2014).

Flibanserin positively affected the sex lives of women in clinical trials (Schiavocampo et al. 2014). However, the media coverage of the heated debate between Flibanserin advocates, the FDA, members of the Even the Score campaign and its critics, further magnify the issue, increasing awareness of Female Sexual Dysfunction and the "little pink pill" (Silverman 2015). The increased awareness itself may raise the rate of individuals identifying with FSD, potentially causing the previously stated 40% to rise, and amplifying the negative consequences of the social issue (Kaplan 2015). According to Tammy Nelson, a sex and relationship therapist in Connecticut, Flibanserin tries to fix a problem that is extremely difficult to even define. Flibanserin exploits the "desire [to fix FSD] by selling women products that may not be the best thing for [their] bodies and may not work" (Ellin 2012). Flibanserin *might* be a potential, reliable solution to FSD, but medication will not improve the negative consequences of the Female Sexual Dysfunction issue unless the socio-cultural issues of FSD are addressed first.

Additionally, public awareness of Flibanserin initiated a controversy with heavy overtones of sexism (Schiavocampo et al. 2014). The FDA's rejections of Flibanserin frustrated advocates, leading to assertions that the lack of approved treatments for women with FSD reflects the FDA's "persistent gender inequality" (Kaplan 2015). Critics of the FDA's rejections further reveal that Viagra, although it possessed similar side

effects to Flibanserin (with the addition of dangerous four-hour erections), was approved “on a fast-track status” (Kaplan 2015). However, critics of the Even the Score campaign, such as Ray Moynihan and Doctor Marcia Angell, as well as supporters of the FDA rejection argue that accusing the agency of promoting sexism was “at best a misunderstanding and at worst a ploy” to pressure the FDA to overlook the drug’s flaws (Schiavocampo et al. 2014). They argue that Flibanserin was disapproved “because of science, not sexism,” and that to claim gender bias as the reason for the drug’s failed approval is a “disservice to women” (Kaplan 2015). Regardless of these specific points made about the reasoning behind the disapproval of Flibanserin, debates are still ongoing about the FDA’s supposed sexism.

Women’s sexual issues can potentially be resolved primarily through a renaissance in education regarding female sexual capacity (Hunter 2014). Sexual health is an integral component of an individual’s health and not a simple lifestyle choice. Sexual difficulties have a negative influence upon women’s quality of life, overall well being, and relationship satisfaction, increasing infidelity and divorce rates. The lack of reliable solutions for Female Sexual Dysfunction, especially when compared to the abundance of resources for male sexual issues, amplifies the negative consequences of FSD, and promotes social perceptions of sexism, mistaken or otherwise. Thus decreasing the percentage of women affected by the Female Sexual Dysfunction, and remaking our social conception of female sexuality, ultimately promotes a happier, healthier society.

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