

**A NEW VIEW**  
of  
**WOMEN'S SEXUAL PROBLEMS**

*A Teaching Manual*

by

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# TO THE WORKSHOP LEADER OR INSTRUCTOR

## WHO ARE WE?

This manual was put together by a team from "The Campaign for a New View of Women's Sexual Problems." We are a diverse, grassroots group of feminist social scientists, sex educators, therapists, sex researchers, physicians, and activists who have been working and thinking together about the medicalization of women's sexuality since 1999.

As you will see from our Manifesto in the Resources section of this manual, we became concerned in the late '90s that, while women's education, reproductive rights, and political emancipation were increasing around the world, a pseudo-feminist medical perspective on women's sexuality was also gaining strength. This medical model seemed to assert that women are entitled to a sexuality identical to men, with the same sexual "dysfunctions," and that doctors are the best people to help women with their sexual problems. These claims seemed wrong to us. We could see that behind the scenes, medicalization was being actively promoted by a pharmaceutical industry that foresaw megamillion dollar profits coming from a marketing campaign for women like that used to sell Viagra to men.

Our group is confident that medicalizing women's sexual problems will not benefit the vast majority of women around the world. Many different types of research have repeatedly shown that women's sexual emancipation and enjoyment are linked to increased individual, interpersonal, and institutional empowerment, not to new consumer products and advertising campaigns. So we decided to form ourselves into a movement and take action.

## WHAT HAVE WE ACCOMPLISHED?

This is a true grassroots campaign, with no money other than donations, no office, and no staff. Nevertheless, we have managed to accomplish quite a lot.

- We have a *website*, [www.fsd-alert.org](http://www.fsd-alert.org), with lots of information for students, consumers, and professionals.
- We held a Boston *press conference* to release our Manifesto on October 25, 2000 (Manifesto is in this manual's Resources)
- We published a *book* that includes the Manifesto, North American and International commentaries, and several articles about important current issues in women's sexualities (Kaschak, Ellyn & Tiefer, Leonore (Eds) (2001) *A New View of Women's Sexual Problems* (Binghamton, NY: Haworth Press).
- We held a *conference* in San Francisco in March, 2002, called "*The new 'female sexual dysfunction': promises, prescriptions, and profits*" and 140 people attended.

- We *publicly challenged* Big Pharma and its medical spokespeople at medical, sexological, and social science conferences in the US, Canada, France, England, Italy, Germany, Croatia, India, Uganda, and Japan, and all without taking a nickel of drug industry money.
- We *published our manifesto* in US and UK professional sexology journals. It has been translated into Dutch and is in press in the Dutch sexological journal, and the same effort is underway in Germany.
- We received *media attention*, especially following a prominent January, 2003 article in the British Medical Journal, "*The making of a disease: female sexual dysfunction*" (reprinted in this manual's Resources)
- And now we have this *manual* of activities for workshops and classes that we hope will facilitate a broader understanding of sexuality and of how medicalization is changing both our sexual experiences and our ideas about sex.

## **GOALS AND OBJECTIVES OF THE NEW VIEW WORKSHOPS**

The medical model promotes the idea that all women want the same things out of sex, with routine orgasmic genital function as the centerpiece and physical malfunctions the main source of difficulty. It tells women there is something wrong with them whenever they experience a pattern of sexual desire, arousal, or orgasm defined by experts as "abnormal."

The "New View," by contrast, emphasizes sexual diversity, social context, education, empowerment, and attention to the way sexual norms are constructed by the media and opinion leaders. We hope workshop participants will understand our position that loss or absence of sexual desire, arousal, and orgasm may or may not be a tiny problem or the main problem or any problem at all for a particular woman. It all depends on her social context, as do all sorts of sexual difficulties, disappointments, and dissatisfactions. And whereas physical causes of sexual problems can certainly exist, they are hardly the lion's share of the situation.

### **PRIMARY WORKSHOP GOAL:**

Participants will understand the "New View" approach to women's sexualities and sexual problems.

### **WORKSHOP OBJECTIVES:**

- Analyze cultural, economic and political forces that shape women's sexual expectations and experiences.
- Examine how medical models of health and normalcy affect thinking about sexuality and sexual problems.

- Examine how the current marketing of drugs affects professional responses to women's sexual problems.
- Use the World Association of Sexology's Declaration of Sexual Rights to examine women's diverse sexual situations.
- Consider how to apply the New View approach in a variety of educational and clinical situations.

## **DESIGNING A WORKSHOP**

There are 12 activities in this manual, dealing with medical and "New View" models of sexuality, taking various time allotments, and using a broad range of methods. We suggest you examine ALL the activities and select those most valuable for your group and situation. The amount of time needed will depend on your style and on the group.

We have presented the activities in the manual in a logical order for involving the participants and introducing ideas of increasing sophistication. We think activities 1, 4, and 5 are central to every New View workshop. Activities 1, 2, 3, and 4 involve thinking about women's real world sexual problems. Activity 5 presents the New View campaign. Activities 6, 7, 8, 9, and 10 offer various ways to get across the social context aspects of "new view" messages. Activities 11 and 12 allow participants to practice applying the New View.

Here are the approximate time allotments for each activity. You can make any exercise longer or shorter by extending or limiting discussion:

<b><u>Number of minutes</u></b>	<b><u>Activity</u></b>
5-10 .....	#1, 5
10-20.....	#2, 3, 4
25-30.....	#6, 7, 8, 9, 10
30-35 .....	#11, 12

In a **ONE or 1 1/2 HOUR WORKSHOP**, we recommend you include activities: 1, 4, 5, and 11; also select *one* from 6, 7, 8, 9, and 10.

In a **THREE HOUR OR HALF DAY WORKSHOP**, we recommend you include activities: 1, 2, 3, 4, 5, and 11; also, select *two* from 6, 7, 8, 9, and 10.

In a **SIX HOUR OR FULL DAY WORKSHOP**, you can include all the activities.

In a **CLASSROOM** situation, the instructor can omit activity 1, but we recommend going through the rest systematically as time permits, with the activities adapted to class size and student comfort level.

## HANDOUTS

In addition to the specific *Handouts* you need for the activities you are facilitating, we recommend you make copies of the following for each workshop participant or student:

- Mini-lecture: The New View Campaign.....p. 13
- Guidelines for Implementing a New View.....p. 41
- Selected Resources.....p. 47-49
- New View Manifesto.....APPENDIX
- Any articles important for your participants.....APPENDIX

## JOIN OUR CAMPAIGN

We welcome your feedback about this manual, the activities, and the New View campaign. You can contact us at the address listed on the title page. If you are interested in joining the campaign, we welcome your endorsement of our manifesto, your financial support of our activities, and your interest in carrying the ideas to the public and other educational settings.

Ultimately, we would like to see "New View" ideas presented in all educational and professional materials about sexuality that deal with women's sexual problems.



Cartoon by Marian Henley, "Maxine's Viagra Supplements," published in *Ms.*, October/November 1999. Maxine!Comix © Marian Henley. Reprinted by permission of the artist.

## ACTIVITY 1

### **ATTITUDES ABOUT WOMEN'S SEXUAL PROBLEMS**

#### **OBJECTIVES:**

Participants will:

1. Express gut feelings about women's sexual problems.
2. Begin to reflect on women's point-of-view of women's sexual problems.

#### **MATERIALS:**

- Flipchart, newsprint, magic markers.

#### **PROCEDURE:**

1. Explain that the purpose of this exercise is to get at gut feelings about women's sexual problems. You will read out a sentence stem - and they are to write down the FIRST thought that comes to mind that will finish the sentence. There is NO right answer except the uncensored thought that comes to mind. No one will know what others write, unless they choose to share it with the group.
2. Read each of the following sentence stems, jotting it on the newsprint as you repeat it:
  - a. Women's sexual problems are.....
  - b. Most doctors think that women's sexual problems are.....
  - c. When it comes to women's sexual problems, the media.....
  - d. For the health insurance industry, women's sexual problems are ....
  - e. Adolescents' sexual problems are....
3. Ask for volunteers to read their completion of the first sentence stem. After several contributions, ask for responses to each of the other sentence stems.

#### ***Discussion Questions:***

- a. What did this exercise reveal?
- b. How do you feel about these issues?





## ACTIVITY 2

### **WOMEN'S SEXUAL PROBLEMS: WHAT'S YOUR OPINION?**

#### **OBJECTIVES:**

Participants will

1. Examine some of their opinions about current issues in sexuality education and therapy.
2. Identify some of the issues important for a New View of women's sexual problems.

#### **MATERIALS:**

- Signs labeled: **STRONGLY AGREE, AGREE, NOT SURE, DISAGREE, STRONGLY DISAGREE.**
- *Educator Resource: WHAT'S YOUR OPINION?*

#### **PROCEDURE:**

1. Place the signs in a continuum on the wall. Ask participants to stand. Explain that you will read a statement and they are to take a position near one of the signs reflecting their opinion of the statement. (Strongly Agree, Agree, Not Sure, Disagree, Strongly Disagree).
2. Once they are gathered near the signs, participants should discuss their choice with others who have the same opinion about the statement.
3. After one or two minutes, ask people by the different signs to explain their choices. Give participants at each position a chance to speak.
4. Repeat this process with 5 or 6 statements from the list, then have participants return to their chairs.

#### ***Discussion Questions:***

- a. What are some of the social forces that create sexual problems for women?
- b. What questions did this exercise raise for you?

***WHAT'S YOUR OPINION?***

1. Women's sexual emancipation has increased almost everywhere.
2. Female sexual development is a lifelong process in which many changes in sexual orientation are possible.
3. STDs play an important role in disorders of desire, vaginismus, and sexual aversion .
4. Love and intimacy are more important for understanding women's than men's sexuality.
5. Most sex education emphasizes problems and risks rather than pleasure and intimacy.
6. Orgasm is essential for sexual satisfaction.
7. The lack of affordable counseling forces people to choose drug treatments for their personal and relationship problems.
8. If a couple has a good sexual relationship, time pressures from work or family won't interfere.
9. Most people think sex therapy is a joke rather than a useful investment for couples.
10. It is a myth that satisfying sexuality comes naturally to most people.
11. Most couples are able to talk with each other about their sexual feelings and wishes.
12. The advice about sexual life in popular magazines is helpful to many readers.
13. Newspaper articles overemphasize the role of hormones in sexual life.
14. People are brainwashed by drug ads to minimize the dangers and side-effects of prescription drugs.

## ACTIVITY 3

### WOMEN'S SEXUAL PROBLEMS: KEY FACTS

#### OBJECTIVES:

Participants will

1. Examine some of the factors affecting women's sexuality.
2. Identify key facts regarding the social context of women's sexual life in the U.S.

#### MATERIALS:

- *Handout: WOMEN'S SEXUAL PROBLEMS: KEY FACTS*
- *Handout: WOMEN'S SEXUAL PROBLEMS: ANSWERS*

#### PROCEDURE:

1. Distribute the *Handout: WOMEN'S SEXUAL PROBLEMS: KEY FACTS*
2. Note that they'll have a chance to examine some of the *Key Facts about Women's Sexual Problems*. Ask them to work in pairs to complete the *Handout*.
3. As pairs complete their *Handout*, give them the *Handout: ANSWERS* so they can check their responses. When all are finished, discuss any questions participants have.

#### *Discussion Questions:*

- a. What are some of the non-medical problems that affect women's sexuality?
- b. In your opinion, are the conditions supporting women's sexual lives improving in the U.S. today?

***Handout:***

***KEY FACTS ABOUT WOMEN'S SEXUAL PROBLEMS***

Put a T (true) or F (false) in front of each statement.

- \_\_\_ 1. There is a strong correlation between women's subjective reports of sexual arousal and measures of genital excitement.
- \_\_\_ 2. The human sexual response cycle model is based on research with a representative sample of the U.S. population.
- \_\_\_ 3. The Masters and Johnson model is based on the assumption that orgasm is the (only) goal of "effective sexual stimulation."
- \_\_\_ 4. Medicalization is a process of social control that reframes human behaviors as a medical discourse. For example, pregnancy, alcohol use.
- \_\_\_ 5. Recent research leads to a view of sexual orientation as being biologically determined.
- \_\_\_ 6. During Congressional committee discussion regarding the abstinence provision of the Administration's Welfare Bill, members voted to require that sexuality education funded by this bill be scientifically accurate.
- \_\_\_ 7. About 50% of women who report being raped and/or physically abused since they were 18 were victimized by someone with whom they were in a relationship.
- \_\_\_ 8. 86% of all U.S. counties have no abortion provider.
- \_\_\_ 9. Almost all health plans cover drugs like Viagra, while fewer than 80% fund oral contraception.
- \_\_\_ 10. Lesbian women are more likely to have cervical and breast cancer screenings and be tested for sexually transmitted infection.
- \_\_\_ 11. Between 50% and 80% of adolescent girls are dissatisfied with their bodies.
- \_\_\_ 12. Depression has a more important effect on female sexuality than age.
- \_\_\_ 13. Women are more prone to sexual problems at certain times of life such as after childbirth and during menopause.

- \_\_\_\_\_ 14. Abortion is the only medical procedure with a “conscience clause” that allows a medical provider to refuse to care for a patient.
- \_\_\_\_\_ 15. Researchers have found that testosterone improves women’s sexual response.
- \_\_\_\_\_ 16. Having an orgasm is always one of the top 3 items women associate with satisfying sex.
- \_\_\_\_\_ 17. By the late 1990s, urologists emerged as the primary specialists of care for the patients with sexual dysfunction
- \_\_\_\_\_ 18. The American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV) acknowledges the importance of both acute and chronic Sexually Transmitted Diseases on women’s sexual problems.
- \_\_\_\_\_ 19. Criteria for normal sexual functioning emphasize objective, mechanical and physiological indices rather than women’s subjective experience.
- \_\_\_\_\_ 20. Sexual dysfunctions in older women appear to be more due to social and psychological than physical factors.

## ***Handout: WOMEN'S SEXUAL PROBLEMS - ANSWERS***

1. **FALSE.** Since the 1970s, many studies have shown that genital arousal is a poor predictor of subjective arousal in women. Factors other than genital temperature or tingling matter when women report how turned on they are. *Laan, E. International Study for the Study of Women's Sexual Health (ISSWSH), Vancouver, 2002.*
2. **FALSE.** In fact, Masters and Johnson made no effort to study sexual physiology and subjectivity in a representative sample. Subjects in their study were required to have a "positive history of masturbatory and coital orgasmic experience" before being accepted. *Tiefer, L. (1995) Ch. 4 in Sex is Not a Natural Act (Westview).*
3. **TRUE.** For their physiological research, *Masters, W.H & Johnson V.E, (1966) Human Sexual Response* (Little, Brown and Co.), rejected subjects whose primary sexual techniques were not orgasm oriented. *Tiefer, L. Ch. 4 in Sex is Not a Natural Act (Westview).*
4. **TRUE.** The medicalization of sexuality is a process of defining normal and deviant sexual interests and activities in terms of alleged sexual health and illness. It is promoted by industry, media, health experts, and profoundly influences the popular view of sexuality. *Kaschak E. & Tiefer, L., (Eds) (2001) A New View of Women's Sexual Problems (Haworth) p. 64.*
5. **FALSE.** Although this topic is complex, recent research suggests that sexual orientation is determined by many influences. Growing evidence indicates that women's sexuality and sexual orientation are significantly capable of change over the lifetime. *Garnets, L.D. & Peplau, L. A. in Kaschak, E. & Tiefer, L., p.115 - 121.*
6. **FALSE.** Some Congressional Committee members preparing Welfare Bill re-authorization sought to require that the abstinence-only education provided by the bill be medically and scientifically accurate. They were defeated. *For full discussion, see Abstinence-Only Education? A Joint Statement prepared by the National Coalition Against Censorship. (www.NCAC.org).*
7. **FALSE.** Of women who reported being raped and/or physically assaulted since the age of 18, 76% were victimized by a current or former husband, cohabitating partner, date or boyfriend. *Prevalence Incidence Consequences of Violence Against Women: Findings from the National Violence Against Women Survey, U.S. Department of Justice, November, 1998.*
8. **TRUE.** And 95% of rural U.S. counties have no abortion providers. Only 15% of chief residents in family medicine programs had clinical experience providing abortions while the number of U.S. hospitals providing abortions decreased by 18% between 1992 and 1996. *Henshaw, S.K. "Abortion Incidence and Services in the U.S. 1995-1996." Family Planning Perspectives, 30:6, 1998.*
9. **TRUE.** A recent Kaiser Family Foundation survey of about 3,300 employers, from Fortune 500 companies to smaller firms, found that 99 percent of health plans cover

prescription drugs like Viagra, while 78% fund oral contraception. *Reuters, 09.1.02.*

10. **FALSE.** Lesbians are **less** likely to seek health care because of the discomfort of coming out to health care providers. Also, lesbians are at higher risk of breast, cervical and ovarian cancers because they are less likely to have children by age 30. *www. maurnerproject.org/facts.html.*
11. **TRUE.** And the self-reported dieting in 12-17 year olds is 30-70%. In industrialized countries, body image is probably the most important component of an adolescent girl's self-esteem. *Cash, T. & Pruzinsky, T. (Eds). Body Image: A handbook of theory, research, and clinical practice. (2002), p. 74. (Guilford).*
12. **TRUE.** *AAMFT Consumer Update on Female Sexual Problems.*
13. **TRUE.** *AAMFT Consumer Update on Female Sexual Problems.*
14. **TRUE.** *http://www.repro-activist.org/AAP/publica\_resources/fact\_sheets/shortage/provider.htm.*
15. **FALSE.** The relationship between testosterone and women's sexuality is very complex. *Basson, R. (2002) Androgens and women's sexuality: Scientific, clinical and regulatory perspectives. Presented at International Society for the Study of Women's Sexual Health (ISSWSH), Vancouver, October, 2002.*
16. **FALSE.** In recent research by Ellison and Zilbergeld, the top 3 items a large sample of American women associated with satisfying sex were feeling close to partner before sex, emotional closeness after sexual activity, and feeling loved. *Ellison, C.R. (2000). Women's Sexualities. Generations of Women Share Intimate Secrets of Sexual Self-Acceptance. (New Harbinger Publications).*
17. **TRUE.** Initial concern about "sexual dysfunction" focused on erectile issues, addressed by urologists. By the 1990s urologists were opening clinics for women's sexual problems. *Candib, L.M. in Kaschak, E. & Tiefer, L., p. 10.*
18. **FALSE.** The DSM-IV gives virtually no recognition to the role sexually transmitted diseases may play in disorders of desire, vaginismus, or sexual aversion. *Firestein, B. A. in Kaschak, E. & Tiefer, L., p. 28.*
19. **TRUE.** Thus, sexual problems are identified in terms of deviations from normative heterosexual, performance standards with no emphasis on the intrapsychic, relational or socio-cultural contexts in which problems are diagnosed and treated. *Kleinplatz, P. J. in Kaschak, E. & Tiefer, L., p. 127.*
20. **TRUE.** *Laumann, E. and 5 colleagues. The impact of biological aging effects on the reporting of sexual dysfunctions in women aged 40-80 years: Results of an international survey. ISSWSH, Vancouver, October, 2002..*





## ACTIVITY 4

### WHAT ARE WOMEN'S SEXUAL PROBLEMS?

#### **OBJECTIVES:**

Participants will

1. Identify the sexual problems they are aware of that affect women.
2. Examine the relevance of a medical model for addressing the problems they have identified

#### **MATERIALS:**

- Flipchart, magic markers and masking tape.

#### **PROCEDURE:**

1. Explain that you'd like to make a list of all the sexual problems common to women. Ask participants to identify any problems they know of.
2. As participants call out, list on the newsprint. Tape all sheets where they are easily seen.
3. Once all items are listed, ask participants to jot down the 3 problems they consider to be most common.
4. Explain that we will identify the most common problems by tabulating. Each person will have 3 (only) "votes." As you go through the list of "women's sexual problems," they are to raise their hands when you come to one of the three they have selected.
5. Once you have tabulated, use a fresh sheet of newsprint to list the problem with the most votes, second most, etc.

#### *Discussion Questions:*

- a. Would the list be different if you had been identifying the sexual problems for women in Saudi Arabia? lesbian women? adolescent women?
- b. What are the causes of the problems you have rated "most important"?
- c. Which of these problems would be addressed by a medical approach?



## ACTIVITY 5

### **MINI-LECTURE: THE NEW VIEW CAMPAIGN**

**The "New View" of women's sexual problems is:**

**... a position paper (the manifesto):**

You will find the "new view" position paper in the Resources section of this workshop manual. It was written by a group of feminist clinicians and social scientists and released at a press conference in Boston on October 25, 2000.

**... an educational campaign:**

The educational campaign is a movement to inform journalists, students, professionals and the public about the diversity of women's sexual lives and sexual problems. There is no one-size-fits-all description of sexual function, sexual normalcy, or sexual problems.

**... an activist campaign:**

The activist campaign is a movement to challenge the role of the pharmaceutical industry in creating new sexual disorders, controlling research and professional education, and overselling medical treatments.

**... a point of view about the causes of women's sexual problems:**

The "new view" point of view is that most of women's sexual problems result from political and relationship, rather than medical, causes. This has been documented in surveys, case studies, and sex research over the past decades.

The mini-lecture on "the new view" can emphasize any or all of these 4 elements, depending on participants' interests. The workshop leader will find supportive information on the "new view" website: <http://www.fsd-alert.org>, and the book edited by Ellyn Kaschak and Leonore Tiefer, *A New View of Women's Sexual Problems*. (Haworth, 2001).



## ACTIVITY 6

### SEXUALITY, 1950 - 2000: CHANGES IN SEXUAL ATTITUDES, VALUES, BELIEFS, & BEHAVIORS

#### OBJECTIVES:

Participants will

1. Identify important sex-related events affecting women's sexuality over the past fifty years.
2. Discuss the impact of these events on women's experience of themselves.

#### MATERIALS:

- *Educator Resource: EVENTS THAT SUPPORTED or UNDERMINED a NEW VIEW PERSPECTIVE OF WOMEN'S SEXUALITY, 1950-2000.*
- Roll of paper, taped to wall and labeled:

##### Support a New View

1950 \_\_\_\_\_ 1960 \_\_\_\_\_ 1970 \_\_\_\_\_ 1980 \_\_\_\_\_ 1990 \_\_\_\_\_ 2000

##### Undermine a New View

- Magic markers.

#### PROCEDURE:

1. Ask participants to think of events - scientific, political, legal, pop-culture - that have had an impact on women's sexuality during the last fifty or so years. They should decide whether the impact has been **Supportive** of the New View approach or **Undermines** the New View Approach.
2. As they call them out, jot events in the appropriate place on the timeline. **Supportive** events above the line, **Undermining** events below the line.

3. If participants do not mention them, you may want to add one or two items at a time from the *Educator Resource* to stimulate further discussion.
4. After ten minutes or so of listing items, ask participants to discuss the timeline:

***Discussion Questions:***

- a. Overall, have these events improved women's lives?
- b. Which events have had the greatest impact?
- c. What generalizations can you make about changes during the past fifty years?

*Educator Resource*

**A FEW EVENTS THAT SUPPORTED or UNDERMINED  
A NEW VIEW PERSPECTIVE OF WOMEN'S SEXUALITY  
1950 - 2000**

**SUPPORTIVE**

**UNDERMINING**

1953	<i>Second Sex</i> in English <i>Kinsey Report</i> on Women	
1960	FDA approves contraceptive pill	
1965	<i>Griswold v. CT</i> supports privacy	
1960s	on - Gradual Gay & Lesbian liberation	
1970	<i>Masters &amp; Johnson</i> - <i>Human Sexual Inadequacy</i>	<i>Everything You Always Wanted to Know..</i>
1972	Title IX ERA Passes Congress	ERA Fails to pass in states
1973	<i>Roe v. Wade</i> legalizes abortion	
1975	UN Decade of Woman begins	
1976	Hite Report on Women	
1977		Hyde Amendment denies Federal Funding for Abortions; by 2000 only 18 states provide funding for poor women.
1978	National Coalition Against Domestic Violence formed	
1979	UN Convention on Elimination of all forms of discrimination against women.	
1980	EEOC lists sexual harassment as form of sex discrimination	
		AIDS epidemic begins
1986		Commission on Obscenity/Pornography
1991	Office of Women's Health	Supreme Court upholds Gag Rule vs abortion counseling.
1990s	UN Conferences on Reproductive and Human Rights	
1992	Year of Woman - increased legislation on women's issues	
1996		Defense of Marriage Bill Welfare Reform funds Abstinence-Only education
1997		FDA - Direct to Consumer ads permitted less regulation of the drug industry





## ACTIVITY 7

### **MIXED MESSAGES: LIVING IN A SEXUALLY CONFUSING SOCIETY**

#### **OBJECTIVE:**

Participants will

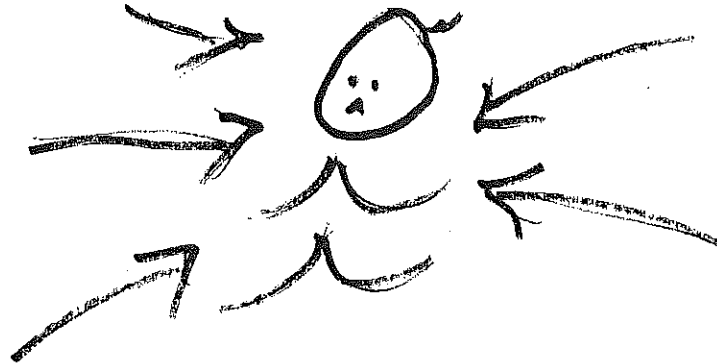
1. Examine the contradictory messages about sex women and men receive from various important sources.
2. Consider how these confusing messages may contribute to women's sexual problems.

#### **MATERIALS:**

- *Handout: MIXED MESSAGES: LIVING IN A SEXUALLY CONFUSING SOCIETY.*
- Easel with newsprint, magic markers.

#### **PROCEDURE:**

1. Draw a stick figure on the newsprint and ask participants to brainstorm the sources of sexual messages. As they call them out, write them around the stick figure:



2. Ask them whether each source currently supports positive sexual development or discourages it - and why. Put a + or a - by each; a ? if there is disagreement among participants. Take no more than 5 minutes for this.

3. Distribute the *Handout: MIXED MESSAGES: LIVING IN A SEXUALLY CONFUSING SOCIETY*. Ask participants to jot down the major messages they personally have gotten/are getting from each source.
4. Ask participants to find a partner and discuss their jottings. Of course, they do NOT have to reveal ANYTHING they choose to keep private. Explain you will give each partner 3 minutes to talk while the other LISTENS attentively; then you will announce time and the second partner will talk. Finally, you will give 2 minutes for them to discuss their findings together.
5. Bring the whole group together.

*Discussion Questions:*

- a. Were there any surprising insights you had as you did the exercise?
  - b. As you imagine an adolescent navigating such messages, what might be helpful?
  - c. Which of these messages might be significantly different for:
    - 1) People of color.
    - 2) Gay/Lesbian/Bisexual/Transgender people.
    - 3) Older people.
6. Closure: How can this exercise be useful to individuals?

***Handout: MIXED MESSAGES -  
LIVING IN A SEXUALLY CONFUSING SOCIETY***

**Directions:**

1. Under each item, write a major "message" about sexuality that has affected you from that source.
2. Draw a line from each source to "ME" - make the line thick or thin depending on the importance of that source for your sexuality today.

**FRIENDS**

**WORK**

**SCHOOL SEX ED**

**PARENTS/  
FAMILY**

**ETHNIC BACKGROUND**

**ME**

**RELIGION**

**ADVERTISEMENTS**

**PARTNER(S)**

**LIFE EXPERIENCES**

**MUSIC/TV/VIDEOS**

**BOOKS/MAGAZINES**



## ACTIVITY 8

### **MANY MEANINGS: HOW IDEOLOGY AFFECTS SEXUALITY**

#### **OBJECTIVES:**

Participants will:

1. Examine four major sexual ideologies.
2. Evaluate how sexual ideologies affect personal or professional approaches to sexual issues.

#### **MATERIALS:**

- *Handout: FOUR MAJOR SEXUAL IDEOLOGIES.*
- *Handout: ATTITUDES, VALUES, BELIEFS.*
- Slips of paper each with one ideology printed on it: *Religious/Traditional, Relational/Therapeutic, Biological/Evolutionary, Social/Cultural.*

1. Ask participants to examine the *Handout: FOUR MAJOR SEXUAL IDEOLOGIES* and rank them from 1 - the **most** similar to their own point of view to 4 - the **least** like their own point of view.
2. Put 1, 2, 3, 4 on newsprint and, as you record the responses, ask participants, "Who put #1 as the ideology closest to their own? # 2? #3? #4?"

#### *Discussion Questions:*

- a. Do the people you work with as a professional have beliefs that are similar or different from your own?
  - b. How might that affect your ability to communicate with them on sexual issues?
3. Explain that they are going to have a chance to think about the importance of a person's sexual ideology in their attitudes towards a variety of sexual behaviors. Divide participants at random into four groups and use the slips to assign each group an ideology.
  4. Distribute *Handout: ATTITUDES, VALUES, BELIEFS*. Acknowledge that many people have beliefs in two or more of the ideologies and that people with

the same ideology will differ from each other. Nevertheless their group should hypothesize how people with the ideology on their slip of paper would most likely view the issues raised on the worksheet.

4. After 15 minutes, ask for reports from the groups, addressing the following questions.

*Discussion Questions:*

- a. How did you feel examining the beliefs of the ideology you were assigned?
  - b. How does the ideology you were assigned affect how a person might deal with women's sexual problems?
  - c. How might knowledge of a client or student's ideology affect how you work with that individual?
6. Closure: What thoughts do you have following this exercise?

## ***Handout: ATTITUDES, VALUES, BELIEFS***

Sexual Ideology You Are Examining \_\_\_\_\_

Describe, to the best of your knowledge, how people with this ideology might view:

1. Sexual pleasure:
  
2. HIV/AIDS:
  
3. Sexuality education in elementary school:
  
4. Viagra:
  
5. Spanking as part of sexual script:
  
6. Adolescent sexual intercourse:
  
7. Monogamy:
  
8. Masturbation:
  
9. Insurance coverage for sex therapists:
  
10. "Sex in the City":

## ***Handout: FOUR MAJOR SEXUAL IDEOLOGIES***

### **1. RELIGIOUS/TRADITIONAL**

Sexuality is primarily a moral issue. People are often tempted by selfish impulses and peer, consumer culture, or media pressures. A good sexual life will result from adhering to traditional family and religious values that emphasize responsibility and fidelity. Some religions are far more conservative than others - but all believe that sexual activities and restraints are related to spiritual authenticity and religious doctrine and practice. E.g., Kissing often signifies union of the souls; kissing is a public sign of private feelings.

### **2. RELATIONAL/THERAPEUTIC**

Sexuality is primarily a matter of individuality and couple communication and cooperation. It is a "natural" drive and expression, shaped by learning and cultural influence. Sexual activities can profoundly enrich health and intimacy as people share vulnerability. Diverse sexual activities allow couples to grow together and express different aspects of their personalities. Many sexual problems grow out of psychological wounds. E.g., Kissing expresses intimacy; feelings about kissing can be related to feelings about cleanliness.

### **3. BIOLOGICAL/EVOLUTIONARY**

Sexual desires and behaviors are the result of evolutionary pressures and developed to serve the ends of reproduction and reproductive fitness. Even at the present time, sexual drive, many gender differences, and attractiveness patterns are hard-wired and controlled by biological factors such as hormones. Sexual problems are frequently caused by physiological factors. E.g., The pleasures of erotic kissing may be linked to infant suckling since the mouth and brain are organized for these connections.

### **4. SOCIAL/CULTURAL**

Sexual desires and behaviors are constructed by culture and subcultural values. They derive from larger issues like how the culture views pleasure and different parts of the body, and the emphasis on relationships vs. individualism. Gender and age differences in sexuality are usually crucial to sexual values. Each group socializes its members through various systems of sexual control including criminal justice, education, and medical institutions. E.g., Kissing is taught as part of the sexual script by movies; kissing patterns relate to cultural issues of personal space or bodily taboos.



## ACTIVITY 9

### *SEXUAL RIGHTS: EXPLORING DIVERSITY*

#### **OBJECTIVES:**

Participants will:

1. Examine the *Declaration of Sexual Rights* developed by the World Association of Sexology.
2. Make and discuss hypotheses about the sexual rights of women with varied identities.

#### **MATERIALS:**

- *Handout: DECLARATION OF SEXUAL RIGHTS.*
- 3" x 5" Identity Cards, each with one of the following written on it:  
African-American, Latina, Asian-American, Catholic, Jewish, Protestant, lesbian, heterosexual, adolescent, elderly, wealthy, school dropout, physically handicapped, developmentally delayed, mentally ill,

#### **PROCEDURE:**

1. Divide participants into pairs and have each pair draw one of the Identity Cards. Give each pair a copy of the *Handout: DECLARATION OF SEXUAL RIGHTS.*
2. Note that for the purposes of the exercise, they will have only this single identity to focus on as they think about a woman's sexual rights as these have been described in the *Declaration of Sexual Rights* adopted by the World Association of Sexology in Hong Kong in 1998.
3. Ask them to guess the degree to which women with the identity that is on their card have each of the listed sexual rights. Acknowledge that, of course, they are making outrageous generalizations - but give it a try. By each right, they are to put:  
0 - women with this identity **rarely** have this right.  
1 - women with this identity **sometimes** have this right.  
2 - women with this identity **usually** have this right.  
3 - women with this identity **almost always** have this right.

4. When all pairs are finished their ratings, discuss:

*Discussion Questions:*

- a. Are there any of the listed rights that you think are NOT important for women?
  - b. What insights did you have as you did the exercise?
  - c. What changes would be necessary for women to move toward having more of these rights?
5. In small groups, not all the Identity Cards will be distributed. If time allows, read some of the unused Identity Cards and ask for quick responses about the Sexual Rights of women with these identities.

## ***Handout: DECLARATION OF SEXUAL RIGHTS***

Adopted by the World Association for Sexology, Hong Kong, 1999.

1. **The right to sexual freedom.** Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation, and abuse at any time and situations in life.
2. **The right to sexual autonomy, sexual integrity, and safety of the sexual body.** This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.
3. **The right to sexual privacy.** This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual rights of others.
4. **The right to sexual equality.** This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.
5. **The right to sexual pleasure.** Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well being.
6. **The right to emotional sexual expression.** Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.
7. **The right to sexually associate freely.** This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.
8. **The right to make free and responsible reproductive choices.** This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.
9. **The right to sexual information based upon scientific inquiry.** This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.
10. **The right to comprehensive sexuality education.** This is a lifelong process from birth throughout the lifecycle and should involve all social institutions.
11. **The right to sexual health care.** Sexual health care should be available for prevention and treatment of all sexual concerns, problems, and disorders.

***Sexual Rights are Fundamental and Universal Human Rights***



## ACTIVITY 10

### **CONSUMER BEWARE! HOW DRUG COMPANIES - MISREPRESENT PROBLEMS AND SELL SOLUTIONS**

#### **OBJECTIVES:**

Participants will:

1. Identify ways drug companies operate to promote their products.
2. Examine a press release promoting a new product claiming to increase women's sexual pleasure.
3. Identify the biases of different groups regarding pharmaceutical advertisements.

#### **MATERIALS:**

- **Handout: CONSUMER BEWARE:  
MARKETING STRATEGIES OF DRUG COMPANIES.**
- **Handout: ANSWERS: CONSUMER BEWARE**
- **Handout: ADVERTISEMENT FOR ZESTRA.**
- 3" x 5" Identity Cards labeled:
  - Journalists**
  - Zestra salespeople**
  - Pfizer salespeople** (Zestra's chief competitor, maker of Viagra)
  - Consumer Rights Advocates** (concerned about safety, pricing, evidence, overmedication)

#### **PROCEDURE:**

1. Explain that the release of Viagra in 1998 was a watershed moment for sexual ideas and practices. The new sexuo-pharmaceuticals will change gender relations, sexual expectations, sexual scripts, definitions of health, and older life sexuality. These drugs have both benefits and liabilities. It is important for all citizens and consumers to understand how the new drugs are actively promoted by "interested groups" within society.

society.

2. Distribute the *Handout: CONSUMER BEWARE!* Ask participants to work in pairs, quickly deciding whether each statement is True or False.
3. As each pair finishes the *Handout*, distribute the *Handout: ANSWERS* and let pairs correct their own answers.
4. Bring whole group together for discussion.

***Discussion Questions:***

- a. Which facts presented here are the most important for thinking about women's sexual problems?
  - b. What can be done to help women be less vulnerable to the marketing strategies of drug companies?
5. Distribute the *Handout: ADVERTISEMENT FOR ZESTRA* and divide participants, at random, into four groups. Have someone in each group pick an Identity Card for the group.
  6. Explain that each group, after reading the press release for Zestra, is to write a one paragraph advocacy statement from the point-of-view of the people named on their card. They will have ten minutes to complete their statements.
  7. After ten minutes, ask a representative from each group to stand and read the group's statement.

***Discussion Questions:***

- a. How did you feel when you read the Zestra press release?
- b. How does the marketplace for sexual products look after this exercise?
- c. How might this exercise make people better consumers?

***Handout: CONSUMER BEWARE -  
DRUG COMPANY MARKETING STRATEGIES***

Make a guess! Put a T (true) or F (false) in front of each statement.

- \_\_\_ 1. Medicalization is a social process that reframes human behaviors in medical language. (For example, pregnancy, alcohol use, classroom misbehavior, pre-menstrual experience.)
- \_\_\_ 2. A review of articles on blood pressure medications found that 50% of authors of articles that favored particular drugs had financial relations with the manufacturers vs. 37% of authors who produced unfavorable results.
- \_\_\_ 3. Drug companies influence the information that health care practitioners receive through selective funding of research and publication, funding conferences and lectures, and personal visits from gift-bearing representatives,
- \_\_\_ 4. During the 2002 election the pharmaceutical industry launched an advertising blitz in support of Republican candidates.
- \_\_\_ 5. Drug makers spent nearly \$5.5 billion marketing to doctors and hospitals in 2001 up from \$3 billion in 1996.
- \_\_\_ 6 The cost per prescription in the U.S. has tripled since 1991.
- \_\_\_ 7. Last year the drug industry earned 2 times after tax profit compared to other Fortune 500 companies.
- \_\_\_ 8. Drug companies employ more people in marketing than they do in research and development.
- \_\_\_ 9. More than 100,000 Americans die each year from adverse reactions to prescription drugs that have been approved by the FDA.
- \_\_\_ 10. In 1997 Congress approved the FDA Modernization Act that increased prohibitions against manufacturers disseminating information about unapproved uses of drugs when safety and efficacy are uncertain.
- \_\_\_ 11. U.S. and New Zealand are the only countries that permit direct marketing of drugs to consumers.
- \_\_\_ 12. The great majority of physicians report that drug representatives have little influence on their prescribing habits.

- \_\_\_\_\_ 13. The AMA (American Medical Association) generates \$20 million annually by selling detailed personal and professional information on doctors to the pharmaceutical industry.
- \_\_\_\_\_ 14. A recent study of research on secondhand smoke found that 94% of authors with a connection to the tobacco industry concluded that passive smoking is not harmful, while only 13% of authors without a link to the industry came to the same conclusion.
- \_\_\_\_\_ 15. Allergan plans to market Botox as aggressively as Pfizer marketed Viagra.
- \_\_\_\_\_ 16. There is a pretty direct correlation between how much a product is promoted through the media and future sales.
- \_\_\_\_\_ 17. A growing percentage of patients who talk to the doctors about Viagra are between 65 and 75.
- \_\_\_\_\_ 18. Most the clinical research conducted for drug companies is done by the nation's universities.



## ***Handout: ANSWERS - CONSUMER BEWARE!***

1. **TRUE.**
2. **FALSE.** In fact, 96% of authors of articles that favored particular drugs had financial relations with the manufacturers vs. 37% who produced unfavorable results. *New England Journal of Medicine, 1998.*
3. **TRUE.** "Much of this influence is subtle, insidious and often inaccurate." *The truth about HRT, p. 12. National Women's Health Network, 2002, Prima Publishing.*
4. **TRUE.** According to the Wall Street Journal at least \$16 million was spent on an advertising campaign led by United Seniors Association, a group with ties to Pharmaceutical Research and Manufacturers of America, Pfizer, and other drug companies. *www.nofreelunch.org, November 5, 2002.*
5. **TRUE.** *Research firm, IMS Heath, New Jersey Star Ledger, September 4, 2002.*
6. **FALSE.** Per prescription costs have only **doubled** in the past ten years! *www.Graypanthers.org.*
7. **FALSE.** In fact, last year drug companies earned **four** times after tax profit compared to other Fortune 500 companies. *www.Graypanthers.org.*
8. **TRUE.** Since 1995, Research and Development of U.S. brand name drug companies have decreased by 2%, while marketing staff have increased by 59%. Currently, 22% of staff are employed in research and development, while 39% are in marketing. *www.nofreelunch.org quoting research by Sager and Socolar.*
9. **TRUE.** More than 100,000 Americans die each year from adverse reactions to prescription drugs that have been approved by the FDA. Drug reactions are the nation's fourth leading cause of death. *The American Prospect, August 13, 2001.*
10. **FALSE.** The FDA Modernization Act **abolished** long-standing prohibitions against manufacturers disseminating information about unapproved uses of drugs **even when safety and efficacy are uncertain.** *The American Prospect, August 13, 2001.*
11. **TRUE.** *www.nofreelunch.org.*
12. **FALSE.** In a study by Avorn, et al, 46% of physicians reported that drug representatives are moderately to very important in influencing their prescribing habits. *American Journal of Medicine, 1982.*
13. **TRUE.** *New York Times, November 16, 2000.*

14. **TRUE.** This according to a 1998 analysis of 15 years of review papers on secondhand smoke by researchers at the University of California. *Chronicle of Higher Education, February 8, 2002.*
15. **TRUE.** *Atlanta Business Chronicle, April 26, 2002.*
16. **TRUE.** *Atlantic Business Chronicle, April 26, 2002.*
17. **FALSE.** Since Pfizer is choosing younger and healthier pitchmen for its Viagra ads, a growing percentage of patients who talk to their doctors about Viagra are between 40 and 59. *New York Times, February 13, 2002.*
18. **FALSE.** In the early 1990's, about 75 percent of the drug industry's clinical research dollars went to universities. By 2000, just 34 percent went to academic institutions, while the rest went to investigators working under the direction of either a private research firm or pharmaceutical companies. *New York Times, November 22, 2002.*

## ***Handout: ADVERTISEMENT FOR ZESTRA***

Authentic Press Release from QualiLife Pharmaceuticals, Inc. [edited for length]

CHARLESTON, SC --Aug 5, 2002 -- QualiLife Pharmaceuticals, Inc. announces increased access to Zestra™, the only topically applied consumer product which has been clinically-proven to increase female sexual pleasure in double-blind, placebo-controlled crossover clinical studies conducted by independent sexual medicine experts.

Zestra™ for Women - The Proven Solution for Better Sex

Beginning with Pfizer's introduction of Viagra™ for men in 1998, global pharmaceutical and consumer product companies have been racing to develop a product to enhance female sexual pleasure. Better sex is an important quality of life issue for many women and couples alike which until now, has been largely unsatisfied.

Increasing Female Sexual Pleasure

Zestra™ was designed by pharmaceutical scientists and sexual health researchers with a single purpose in mind -- to produce highly pleasurable effects for women during vaginal intercourse. Zestra™ was first made available for purchase from the official Zestra™ website during the June 2002 American Urological Association conference.

Zestra™ - The Women's Personal Care Product Unlike Anything Before

While numerous "novelty-type" creams, gels, and lotions have continued to surface over the past few years - most contain menthol, which is classified as an "irritant" (Remington's Pharmaceutical Sciences 18th Edition). The (patent pending) blend of botanical oils and extracts in Zestra™ were specifically chosen because they safely and naturally increase female sexual pleasure without the use of irritating chemical substances or artificial ingredients.

Where Can I Purchase Zestra™?

In addition to websites [www.zestraforwomen.com](http://www.zestraforwomen.com), [www.newshe.com](http://www.newshe.com), and [www.sexualhealth.com](http://www.sexualhealth.com), you'll also find Zestra™ available from local healthcare professionals and female sexual health centers in your area.



## ACTIVITY 11

### ***THE NEW VIEW IN ACTION: GUIDELINES FOR PUTTING IT INTO PRACTICE***

#### **OBJECTIVES:**

Participants will:

1. Examine Guidelines recommended for applying A New View of Women's Sexual Problems.
2. Identify women's sexual problems in a real-life scenario.

#### **MATERIALS:**

- *Handout: GUIDELINES FOR IMPLEMENTING A NEW VIEW.*
- *Handout: AMY'S STORY - A SEXUAL PROBLEM CASE STUDY.*

#### **PROCEDURE:**

1. Distribute the *Handout: GUIDELINES FOR IMPLEMENTING A NEW VIEW.* Review each **Guideline**. If the group is small enough, you might have participants each read a **Guideline** and comment on its importance. If the group is large, the educator may need to read the **Guidelines**, commenting and questioning to reinforce the points.

##### ***Discussion questions:***

- a. Are there **Guidelines** you would not want to use?
  - b. Which **Guidelines** would be most difficult to apply?
  - c. Are there **Guidelines** you would recommend adding to the list?
2. Distribute *Handout: AMY'S STORY* and read the directions. Read the story aloud as participants decide how to rank the characters. Be sure everyone has completed their ranking before dividing into small groups.

3. Depending on size of workshop, divide participants into groups of 5 to 8 and instruct them to try to reach agreement on the ranking. Explain they will have 10 minutes to reason with each other.
4. After ten minutes, stop the action and ask someone from each group to stand and report their ranking. Jot the rank next to names on the newsprint.

*Discussion Questions:* (These will vary depending on the reported results.)

- a. What were the major differences in who people in the group “blamed” for the situation?
- b. Did anyone feel particularly angry with one of the characters? If so, why?
- c. Is there any character whose behavior would have improved if they had been educated about a New View?
- d. How does this scenario illustrate the complexity of women’s sexual problems?

*Handout:*

***GUIDELINES FOR IMPLEMENTING A NEW VIEW  
OF WOMEN'S SEXUAL PROBLEMS***

**ENCOURAGE WOMEN TO:**

1. Find their own ways of saying, "Sex is more than intercourse. It's more than physical. It's part of your personality. It expresses your culture. It involves all of you -- body, senses, emotions, thoughts, memories, meanings, relationships."
2. Create their own sexual scripts and define their own sexual problems rather than deferring to medical authorities or media experts.
3. Be aware of how social inequalities can produce and maintain sexual problems.
4. Appreciate changes in the physical sexual responses over the lifespan.
5. Acknowledge differences among women, and recognize the struggle of all women, including lesbian women, to be sexually self-determining.
6. Teach women to inhabit their bodies rather than regarding them as objects and to acknowledge that no one is perfect or sexually perfect.
7. Educate women to be critical of media messages about women's sexuality.
8. Understand that since we live in a culture with deep contradictions, it makes sense to be more light-hearted about sex.
9. Recognize that everyone has experienced sexual rejection and disappointment
10. See the connection between the personal and the political in all aspects of sexuality and share New View concepts with colleagues.

## ***Handout: AMY'S STORY - A SEXUAL PROBLEM CASE STUDY***

When she was growing up, Amy Martin's mother and father were affectionate with each other and their 3 children, but they never mentioned topics like sexuality or masturbation, and left sex education to the school. The weekly newspaper in Amy's town published warning articles about "pedophiles" and "sex offenders," although Amy couldn't get anyone to explain to her what a "sex offender" actually did. Her father stopped helping with Amy's bath after reading about incest and hearing how some fathers in their community had been reported to the authorities.

In the first grade, Amy's class was visited by a policewoman who explained how children should never let adults touch them in the wrong places. Afterwards, Amy didn't want to help her mother change her brother's diapers. In the second grade, Amy's elementary school eliminated the kids' pretend-play dress-up box, following a parent's complaint that cross-gender clothes could foster gender insecurity.

In 4th grade, the girls in Amy's class saw a hygiene film about menstruation. Amy's best friend Joellen got her period in 5th grade and Joellen's mother showed them the different kinds of sanitary pads. Amy started checking herself when she urinated to see if there was blood. She was too embarrassed to ask her mother, and the topic never came up. In the 5th grade, a boy named Billy grabbed Amy and said he liked her "boobies" and wanted to "take off her clothes" and "do it" with her. Amy told her teacher, and Billy got into a lot of trouble. Amy got her first menstrual period soon after that and wondered if it was Billy's fault. For a while she thought she was pregnant because her body began feeling different.

At the end of the 6th grade, Amy's class had a lesson on HIV and AIDS that made her cry because you could die like the children in Africa. Her mother said she was too young to get AIDS, but when Amy had cramps with her period, she got scared again until Joellen told her that lots of girls got cramps.

In junior high, Amy started reading Seventeen magazine but it seemed to be all about how to get a boy to like you. Even though Joellen said kissing was fun, Amy told herself that being popular was stupid. There were class discussions about how girls should say no, but a lot of girls just rolled their eyes, and Joellen said that saying no took a lot of work. Amy joined the Virgins Club, which really pleased her parents.

Joellen dated a lot in high school and talked about sex, but Amy couldn't imagine doing it and avoided parties. Joellen got her a date for the junior prom, but the kissing and touching afterwards made her heart pound so much she got nauseous and frightened. Her date invited her to go to the movies, but when the same thing happened after a



couple of kisses in the theater, Amy decided that to stay a virgin, she'd better not date any more until she was sure she was in love.

When Amy was 30, she and her husband of 2 years, Mark, came to see a psychotherapist about their sexual problems. They had met in college, fallen in love and rapidly become engaged. There had been several brief, tense sexual encounters, but Amy didn't want to have intercourse before marriage and Mark agreed. They spent time during their engagement cuddling affectionately, although it made Amy worry that Mark would want to have intercourse.

Amy and Mark tried to have intercourse on their wedding night and during their honeymoon, but Amy said that everything hurt, so each encounter was brief and ended with Amy crying and Mark feeling guilty. Amy had some bleeding at one point, and assumed that intercourse had occurred, but Mark said no. He got angry that Amy had "tricked" him, and began questioning her closely about her sexual history. He told her he thought she was frigid, but apologized later.

Amy visited her gynecologist after the honeymoon. She cried throughout her first pelvic exam. The doctor said he couldn't look inside her vagina because she was so tense, and couldn't tell if her hymen was still there, but he said that the hymen didn't matter and Amy's vulva looked normal. He encouraged her to keep trying, and to come back in a few months if she was "still a virgin." There wasn't time for questions, and Amy wasn't sure what to ask, anyway. She was glad to be normal, but worried that the exam was incomplete.

Over the next few months, Mark and Amy had sporadic sexual encounters, each time ending with tears and apologies. Amy started having stomach pains and cried often at work. After about six months, without any discussion, they stopped all sexual relations. Amy didn't find anything in women's magazines that sounded like her problem, and never got answers from columnists. Mark went online for advice, getting his search engine to pursue "virgin wives" and "women's sexual problems," but he got confused by all the pornography and all the information. Finally, Mark confided in his uncle, a pediatrician, and got the name of a psychotherapist who saw couples.

\* \* \* \* \*

Various factors and individuals have contributed to Amy and Mark's sexual unhappiness. Rank them on a scale of 1 to 6, with 1 being MOST contributory and responsible for the sexual problems, 6 being the LEAST contributory and responsible.

\_\_\_\_ Amy's Parents    \_\_\_\_ Amy    \_\_\_\_ Mark

\_\_\_\_ School system & teachers    \_\_\_\_ Gynecologist    \_\_\_\_ Media



## ACTIVITY 12

### ***IMPLEMENTING THE NEW VIEW CAMPAIGN - RESPONDING IN VARIED SITUATIONS***

#### **OBJECTIVES:**

Participants will

1. Examine how issues challenging the New View come up in different situations.
2. Rehearse presenting New View ideas in different situations.

#### **MATERIALS:**

- Easel, newsprint, magic markers.
- ***Handout: WHAT WOULD YOU SAY?***

#### **PROCEDURE:**

1. Explain that the purpose of this exercise is to review the aspects of the New View and imagine how a person might promote them in various situations
2. Demonstrate by using an example. Say, "Suppose someone said that women should have a choice about how to treat their sexual problems; new products offer a choice." How, given New View principles, might you respond? Jot participant responses on newsprint.

#### ***Discussion Questions:***

- a. How is the word "choice" being used in this example?
  - b. What concerns would you have about women using new pharmaceutical products to address sexual problems?
3. Distribute the ***Handout: WHAT WOULD YOU SAY?*** Divide participants, at random, into small groups and ask each group to write brief New View responses .
  4. After about 15 minutes, bring groups together and discuss their responses.

## *Handout: WHAT WOULD YOU SAY?*

Given what you now know about women's sexual problems, how might you respond to each of the following commonly heard statements?

1. Research has shown that almost half all women suffer from sexual dysfunctions.

Your response \_\_\_\_\_

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2. In the wake of Viagra, science about women's sexual problems is becoming legitimate.

Your response \_\_\_\_\_

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3. There's no harm to just trying a new blood flow pill or hormone gel for low sexual desire.

Your response \_\_\_\_\_

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4. Women will enjoy sex more if they pay more attention to the arousal of their genital organs.

Your response \_\_\_\_\_

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# RESOURCES

## IN THIS MANUAL

The New View Manifesto and several published articles about the medicalization of women's sexual problems have been reprinted in an APPENDIX at the end of this resources section.

## OTHER RESOURCES

### WEBSITES

The New View Website:

- [www.fsd-alert.org](http://www.fsd-alert.org)

Other websites that challenge the pharmaceutical industry:

- [www.nofreelunch.org](http://www.nofreelunch.org)
- [www.familiesusa.org](http://www.familiesusa.org)
- [www.graypanthers.org](http://www.graypanthers.org)
- [www.citizen.org](http://www.citizen.org)

Other websites that promote a progressive view of women's health:

- [www.womenshealthnetwork.org](http://www.womenshealthnetwork.org)
- [www.ourbodiesourselves.org](http://www.ourbodiesourselves.org)
- [www.cwhn.ca](http://www.cwhn.ca) (Canadian Women's Health Network)

Other websites that provide noncommercial sexuality information:

[www.siecus.org](http://www.siecus.org) (with links to many others)

## PUBLICATIONS

- Kaschak, E. & Tiefer, L. (Eds) (2001) *A New View of Women's Sexual Problems* (Haworth) .See, also, review by Nathan, Debbie, *The Right Way to Have Sex*, in *The Nation*, November 18, 2002, p.18.
- Barbach, L. (1975) *For Yourself: The fulfillment of female sexuality*, (Anchor).
- Burnham, J.C. (1987) *How Superstition Won and Science Lost: Popularizing science and health in the United States*. (Rutgers University).
- Brumberg, J. J. (1997) *The Body Project: An intimate history of American girls*. (Random House).
- Cooney, S. (1994) *The Menopause Industry* (Hunter House).
- Dodson, B. (1997) *Sex for One: The Joy of Self-Loving* (Crown).
- Dodson, B. (2002) *Orgasms for Two*. (Harmony Books)
- Ellison, C.E. (2000) *Women's Sexualities: Generations of women share intimate secrets of sexual self-acceptance*. (New Harbinger).
- Hall, M. (1998) *The Lesbian Love Companion*. (Harper).
- Hochschild, A. (1989) *The Second Shift: Working parents and the revolution at home*. (Viking).
- Levine, J. (2002) *Harmful to Minors: The perils of protecting children from sex*. (University of Minnesota).
- McLaren, A. (1999) *Twentieth-Century Sexuality: A history*. (Blackwell).
- Parker, R. G. & Gagnon, J. H. (Eds.) (1995) *Conceiving Sexuality: Approaches to sex research in a postmodern world*. Routledge.
- Payer, L. (1992) *Disease-Mongers: How doctors, drug companies and insurers are making you feel sick*. (John Wiley & Sons).
- Melville, A. & Johnson, C. (1982) *Cured to Death: The effects of prescription drugs*. (Secker & Warburg, London).
- Sherwin, S. et al. (1998) *The Politics of Women's Health* (Temple).

- Tolman, D. L. (2002) *Dilemmas of Desire: Teenage girls talk about sexuality* (Harvard).
- Vance, C. (Ed) (1984) *Pleasure and Danger: Exploring female sexuality* (Routledge, Kegan-Paul).
- Wingood, G. M. & DiClemente, R. J. (Eds) (2002) *Handbook of Women's Sexual and Reproductive Health* (Kluwer).

## EDUCATIONAL VIDEOS

(Each video is available from New View Campaign for a \$100 tax-deductible contribution; they may also be available from the producers.)

### **Bill Moyers' "Now" 11/22/02, PBS**

18 minute segment on relationship between advertising industry and clinical trials for new drugs.

### **"Prime Time" 2/21/02, ABC**

8 minute segment, including undercover work, on how pharmaceutical companies influence doctors' prescribing practices

### **Peter Jennings Reporting, "Bitter Medicine: Pills, Profit, and the Public Health", 5/29/02, ABC**

1 hour program reviewing many aspects of current pharm. industry: R&D costs, ads, patents, tax money aiding research, suppressing unfavorable clinical trial results, etc.

### **Sex-TV "Female Sexual Dysfunction" 10/2000, Canadian TV**

20 minute examination of the new "FSD" - treatments, criticism, patients' views

### **"Second Sexual Revolution: Sex pills and love potions", 7/3/01, British documentary made for the Learning Channel**

1 hour program reviewing many aspects of new ED and FSD treatments and critiques

### **60 Minutes Australia: "Not Tonight, Dear" 11/01**

15 minute examination of the new "FSD"- treatments, criticism, patients' views

## APPENDIX

1. Campaign Manifesto, "*A New View of Women's Sexual Problems*," by the Working Group on a New View, October 14, 2000.
2. Tiefer, L and Tavris, C. *Viagra for Women is the Wrong Way to Go*. L.A. Times, October 2, 1999.
3. Tiefer, L. *The Medicalization of Women's Sexuality*. American Journal of Nursing, December, 2000.
4. Rosen, R. *Orgasms for Sale*. San Francisco Chronicle, April 30, 2001
5. Chalker, R. *Feminists' Contributions to the "Real" Sexual Revolution* The National Women's Health Network News, January, 2002.
6. Shah, S. *The Orgasm Industry: Drug Companies Search for a Female Viagra*. The Progressive, October, 2001.
7. Moynihan, R. *The Making of a Disease: Female Sexual Dysfunction*. British Medical Journal, January 4, 2003, v.326, p.45-47.
8. Greer, G. *A Woman's Duty Is Not Only to Have the Sex She Doesn't Really Want, but to Enjoy It*. London Times, January 9, 2003.



*The MANIFESTO of the Campaign for a New View of Women's Sexual Problems*

*(October, 2000):*

**A New View of Women's Sexual Problems**

by **The Working Group on A New View of Women's Sexual Problems**<sup>1</sup>

**Introduction**

In recent years, publicity about new treatments for men's erection problems has focused attention on women's sexuality and provoked a competitive commercial hunt for "the female Viagra." But women's sexual problems differ from men's in basic ways which are not being examined or addressed.

We believe that a fundamental barrier to understanding women's sexuality is the medical classification scheme in current use, developed by the American Psychiatric Association (APA) for its Diagnostic and Statistical Manual of Disorders (DSM) in 1980, and revised in 1987 and 1994.<sup>2</sup> It divides (both men's and) women's sexual problems into four categories of sexual "dysfunction": sexual desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders. These "dysfunctions" are disturbances in an assumed universal physiological sexual response pattern ("normal function") originally described by Masters and Johnson in the

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<sup>1</sup> Linda Alperstein, M.S.W., Assoc. Clin. Prof., Psychiatry, University of California at San Francisco; Psychotherapy Practice, San Francisco, CA, Carol Ellison, Ph.D., Author; Psychotherapy Practice, Oakland, CA, Jennifer R. Fishman, B.A., Doctoral Candidate, Department of Social and Behavioral Science, UCSF, CA, Marny Hall, Ph.D., Author; Psychotherapy Practice, San Francisco, CA, Lisa Handwerker, Ph.D., M.P.H., Institute for the Study of Social Change, University of California at Berkeley, CA, Heather Hartley, Ph.D., Ass't Professor, Sociology, Portland State University, OR, Ellyn Kaschak, Ph.D., Professor, Psychology, San Jose State University, CA, Peggy J. Kleinplatz, Ph.D., School of Psychology, Univ. of Ottawa, Ontario, Canada, Meika Loe, M.A., Doctoral Candidate, Women's Studies Emphasis, Sociology, University of California at Santa Barbara, CA, Laura Mamo, B. A., Doctoral Candidate, Department of Soc. and Behav. Sci., UCSF, CA, Carol Tavris, Ph.D., Social Psychologist; Independent Scholar, Los Angeles, CA, Leonore Tiefer, Ph.D., Assoc. Clin. Professor, Psychiatry, New York University School of Medicine and Albert Einstein College of Medicine, NY

<sup>2</sup> American Psychiatric Association (1980, 1987, 1994). Diagnostic and Statistical Manual of Mental Disorders, 3rd, 3rd-revised, and 4th editions. Washington, DC: APA.

1960s<sup>3</sup>. This universal pattern begins, in theory, with sexual drive, and proceeds sequentially through the stages of desire, arousal, and orgasm.

In recent decades, the shortcomings of the framework, as it applies to women, have been amply documented.<sup>4</sup> The three most serious distortions produced by a framework that reduces sexual problems to disorders of physiological function, comparable to breathing or digestive disorders, are:

1) A false notion of sexual equivalency between men and women. Because the early researchers emphasized similarities in men's and women's physiological responses during sexual activities, they concluded that sexual disorders must also be similar. Few investigators asked women to describe their experiences from their own points of view. When such studies were done, it became apparent that women and men differ in many crucial ways. Women's accounts do not fit neatly into the Masters and Johnson model; for example, women generally do not separate "desire" from "arousal," women care less about physical than subjective arousal, and women's sexual complaints frequently focus on "difficulties" that are absent from the DSM.<sup>5</sup>

Furthermore, an emphasis on genital and physiological similarities between men and women ignores the implications of inequalities related to gender, social class, ethnicity, sexual orientation, etc. Social, political, and economic conditions, including widespread sexual violence, limit women's access to sexual health, pleasure, and satisfaction in many parts of the world. Women's social environments thus can prevent the expression of biological capacities, a reality entirely ignored by the strictly physiological framing of sexual dysfunctions.

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<sup>3</sup> Masters, W. H. & Johnson, V. E. (1966) Human Sexual Response. Boston: Little, Brown, and Co.; Masters, W.H. & Johnson, V. E. (1970) Human Sexual Inadequacy. Boston: Little, Brown, and Co.

<sup>4</sup> e.g., Tiefer, L. (1991) Historical, scientific, clinical and feminist criticisms of "the Human Sexual Response Cycle" model. Annual Review of Sex Research, 2, 1-23; Basson, R. (2000) The female sexual response revisited. J. Society Obstetrics and Gynaecology of Canada, 22, 383-387.

<sup>5</sup> Frank, E., Anderson, C., & Rubinstein, D. (1978) Frequency of Sexual dysfunction in "Normal" couples. New England Journal of Medicine, 299, 111-115; Hite, S. (1976) The Hite Report: A nationwide study on female sexuality. NY: Macmillan; Ellison, C. (2000) Women's Sexualities: Generations of women share intimate secrets of sexual self-acceptance. Oakland, CA: New Harbinger.

2) The erasure of the relational context of sexuality. The American Psychiatric Association's DSM approach bypasses relational aspects of women's sexuality, which often lie at the root of sexual satisfactions and problems--e.g., desires for intimacy, wishes to please a partner, or, in some cases, wishes to avoid offending, losing, or angering a partner. The DSM takes an exclusively individual approach to sex, and assumes that if the sexual parts work, there is no problem; and if the parts don't work, there is a problem. But many women do not define their sexual difficulties this way. The DSM's reduction of "normal sexual function" to physiology implies, incorrectly, that one can measure and treat genital and physical difficulties without regard to the relationship in which sex occurs.

3) The levelling of differences among women. 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.

Because there are no magic bullets for the socio-cultural, political, psychological, social or relational bases of women's sexual problems, pharmaceutical companies are supporting research and public relations programs focused on fixing the body, especially the genitals. The infusion of industry funding into sex research and the incessant media publicity about "breakthrough" treatments have put physical problems in the spotlight and isolated them from broader contexts. Factors that are far more often sources of women's sexual complaints--relational and cultural conflicts, for example, or sexual ignorance or fear--are downplayed and dismissed. Lumped into the catchall category of "psychogenic causes," such factors go unstudied and unaddressed. Women with these problems are being excluded from clinical trials on new drugs, and yet, if current marketing patterns with men are indicative, such drugs will be aggressively advertised for all women's sexual dissatisfactions.

A corrective approach is desperately needed. We propose a new and more useful classification of women's sexual problems, one that gives appropriate priority to individual distress and inhibition arising within a broader framework of cultural and relational factors. We

challenge the cultural assumptions embedded in the DSM and the reductionist research and marketing program of the pharmaceutical industry. We call for research and services driven not by commercial interests, but by women's own needs and sexual realities.

### **Sexual Health and Sexual Rights: International Views**

To move away from the DSM's genital and mechanical blueprint of women's sexual problems, we turned for guidance to international documents. In 1974, the World Health Organization held a unique conference on the training needs for sexual health workers. The report noted: "A growing body of knowledge indicates that problems in human sexuality are more pervasive and more important to the well-being and health of individuals in many cultures than has previously been recognized." The report emphasized the importance of taking a positive approach to human sexuality and the enhancement of relationships. It offered a broad definition of "sexual health" as "the integration of the somatic, emotional, intellectual, and social aspects of sexual being."<sup>6</sup>

In 1999, the World Association of Sexology, meeting in Hong Kong, adopted a Declaration of Sexual Rights.<sup>7</sup> "In order to assure that human beings and societies develop healthy sexuality," the Declaration stated, "the following sexual rights must be recognized, promoted, respected, and defended":

- The right to sexual freedom, excluding all forms of sexual coercion, exploitation and abuse;
- The right to sexual autonomy and safety of the sexual body;

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<sup>6</sup> WHO Technical Report, series Nr. 572, 1975. Full text available on the website <http://www.sexology.cjb.net>.

<sup>7</sup> Full text available on the website listed in footnote 6 and also on the World Association of Sexology website <http://www.tc.umn.edu/~colem001/was/wdeclara.htm>. It is published in E.M.L.Ng, J.J. Borrás-Valls, M. Pérez-Conchillo and E.Coleman (Eds.) (2000) Sexuality in the New Millennium. Bologna, Editrice Compositori.

- The right to sexual pleasure, which is a source of physical, psychological, intellectual and spiritual well-being;
- The right to sexual information...generated through unencumbered yet scientifically ethical inquiry;
- The right to comprehensive sexuality education;
- The right to sexual health care, which should be available for prevention and treatment of all sexual concerns, problems, and disorders.

### **Women's Sexual Problems: A New Classification**

Sexual problems, which The Working Group on A New View of Women's Sexual Problems defines as discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience, may arise in one or more of the following interrelated aspects of women's sexual lives.

#### **I. SEXUAL PROBLEMS DUE TO SOCIO-CULTURAL, POLITICAL, OR ECONOMIC FACTORS**

A. Ignorance and anxiety due to inadequate sex education, lack of access to health services, or other social constraints:

1. Lack of vocabulary to describe subjective or physical experience.
2. Lack of information about human sexual biology and life-stage changes.
3. Lack of information about how gender roles influence men's and women's sexual expectations, beliefs, and behaviors.
4. Inadequate access to information and services for contraception and abortion, STD prevention and treatment, sexual trauma, and domestic violence.

B. Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality, including:

1. Anxiety or shame about one's body, sexual attractiveness, or sexual responses.

2. Confusion or shame about one's sexual orientation or identity, or about sexual fantasies and desires.

C. Inhibitions due to conflict between the sexual norms of one's subculture or culture of origin and those of the dominant culture.

D. Lack of interest, fatigue, or lack of time due to family and work obligations.

## **II. SEXUAL PROBLEMS RELATING TO PARTNER AND RELATIONSHIP**

A. Inhibition, avoidance, or distress arising from betrayal, dislike, or fear of partner, partner's abuse or couple's unequal power, or arising from partner's negative patterns of communication.

B. Discrepancies in desire for sexual activity or in preferences for various sexual activities.

C. Ignorance or inhibition about communicating preferences or initiating, pacing, or shaping sexual activities.

D. Loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, e.g., infertility or the death of a child.

E. Inhibitions in arousal or spontaneity due to partner's health status or sexual problems.

## **III. SEXUAL PROBLEMS DUE TO PSYCHOLOGICAL FACTORS**

A. Sexual aversion, mistrust, or inhibition of sexual pleasure due to:

1. Past experiences of physical, sexual, or emotional abuse.

2. General personality problems with attachment, rejection, co-operation, or entitlement.

3. Depression or anxiety.

B. Sexual inhibition due to fear of sexual acts or of their possible consequences, e.g., pain during intercourse, pregnancy, sexually transmitted disease, loss of partner, loss of reputation.

#### **IV. SEXUAL PROBLEMS DUE TO MEDICAL FACTORS**

Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes. Such problems can arise from:

- A. Numerous local or systemic medical conditions affecting neurological, neurovascular, circulatory, endocrine or other systems of the body;
- B. Pregnancy, sexually transmitted diseases, or other sex-related conditions.
- C. Side effects of many drugs, medications, or medical treatments.
- D. Iatrogenic conditions.

#### **Conclusion**

This document is designed for researchers desiring to investigate women's sexual problems, for educators teaching about women and sexuality, for medical and nonmedical clinicians planning to help women with their sexual lives, and for a public that needs a framework for understanding a rapidly changing and centrally important area of life.

October 25, 2000

(unchanged)

# Viagra for Women Is the Wrong Rx



Prescribing a pill for loss of sexual interest in women masks the true causes—and only benefits drug companies.

By LEONORE TIEFER  
and CAROL TAVRIS

Viagra is doing so well for men—especially for men in the pharmaceutical industry—that legions of sexologists and urologists are trying to find a way to market it to women.

If men have erectile dysfunction, though, what do women have? There must be something comparable. It's only fair. Accordingly, a new category of disorder is now being promoted, "female sexual dysfunction," or FSD.

At the Boston University School of Medicine, urologist Irwin Goldstein is planning a conference on FSD, to be held in Boston this weekend. The program has many well-known speakers from the world of sexology who will be paid by Pfizer and other drug companies to give their talks. The payment is indirect, of course; it comes in the form of "unrestricted educational grants" to the host institution. Two sessions are scheduled to discuss the creation of a new society—probably a Society for the Study of Female Sexual Dysfunction, modeled on the pharmaceutical industry-funded Society for the Study of Impotence. There's even a session on "how to run a drug trial," which is most unusual at a scientific meeting.

Whose interests would be served by the Boston meeting and this new organization? Which points of view will be present and which will be absent? Which groups of people interested in and knowledgeable about women's sexuality will be present and which will be absent?

Organizers of the meeting have invited people from many "health care disciplines." No invitations, however, were sent to researchers in women's studies or gender studies, social psychology, sociology or anthropology, gay and lesbian studies, history or cultural studies. Thus, people who have social, psychological or cultural perspectives on sexuality will not be heard at this conference on "female sexual dysfunction."

The audience therefore will not learn that the very notion of "normal" functioning, let alone definitions of "dysfunctioning," are culturally and socially determined. They are not analogous to medical conditions or diseases like arthritis or gout. The audience will not be required to think about questions like: Who decides what's normal? Who decides what is a "dysfunction" and what kind of treatment is appropriate?

If this new "disorder" takes off, an-

other big step will have been taken in the ongoing medicalization of life's ordinary problems. It will work like this: Drug companies will pay for endless studies of minute components of the genitalia. Data will be presented at expensive meetings (in exotic places) underwritten by drug companies and published in new books and journals, supported by drug company ads.

Health and medical journalists will report on the new disorders of genital function and herald the new treatments. The dire new statistics about Americans' sexual unhappiness will be trumpeted on the front pages of newspapers and discussed on TV talk shows.

Epidemiological studies about FSD will be paid for by drug companies to create and identify new markets. Urgent government and commercially funded conferences will be held to decide how best to deal with the new problem. And the answer will be, of course, taking an expensive pill—and taking it permanently because drugs don't teach anyone how to kiss, how to talk or how to listen.

**'Loss of sexual interest more likely results from emotional conflicts with the partner, lack of sex education . . . shame, fear of pregnancy, fatigue, depression or internalized cultural or religious prohibitions.'**

The manifesto for the new medical approach to female sexuality appeared in the September issue of *Urology*: "Female sexual dysfunction: Incidence, pathophysiology, evaluation, and treatment options," by the unflagging Irwin Goldstein and two women who work with him (who have been on TV touting the virtues of Viagra for women based on their very limited work). The article begins, "Female sexual dysfunction is age-related, progressive and highly prevalent, affecting 30%-50% of women."

Yikes! It's "progressive"! This means the older a woman is, the more "dysfunctional" her sexual response is likely to be.

Never mind that surveys since Kinsey have found just the opposite: As women get older, most become more

comfortable with sex and more satisfied.

Loss of sexual interest more likely results from emotional conflicts with the partner, lack of sex education, the partner's poor technique or lack of sensitivity to the woman's needs, the partner's premature ejaculation, the woman's self-consciousness about her body, consequences of trauma, psychological inhibitions or shame, fear of pregnancy, fatigue, depression or internalized cultural or religious prohibitions.

Could these old-fashioned, low-tech causes of FSD explain why the first published studies of Viagra on women have had such poor results? Such negative findings will not, of course, daunt the medicalizers or be discussed much at Goldstein's conference. Instead, as the conference material promises, we will hear about how feeding rabbits a high cholesterol diet causes their clitoral blood vessels to clog up, and how this research provides a great comparison for women.

Frankly, we won't pay much attention until they come up with a female rabbit who complains, "I don't feel sexy tonight, Peter; 36 of our kids pestered me for attention all day, and besides, my thighs are too fat."

*Leonore Tiefer is a sex researcher and therapist; Carol Tavriss is a social psychologist.*



By Leonore Tiefer, PhD

## The Medicalization of Women's Sexuality

*There's a new market, but who will benefit?*

This past year the pharmaceutical industry has shown extraordinary interest in women's sexuality. Months of publicity promoted cover stories that asked, "Where Is Women's Viagra?" while behind the scenes major drug companies sponsored closed meetings to develop new dysfunction lists and questionnaires; they currently have under development more than a dozen drugs targeting "FSD" ("female sexual dysfunction").

In May the Food and Drug Administration drafted guidelines for FSD drug trials that take a mechanical view of sexuality modeled on research into male erectile dysfunction. Women with relationship difficulties or mood problems or who are taking medications that interfere with sexual function will be excluded. Who'll be left? The clinical trial endpoint will be increased orgasm frequency, although research indicates women care more about pleasure and intimacy.

This latest phase in the medicalization of women's bodies would be funny if it weren't so annoying. It distorts feminists' 1970s rediscovery of clitoral sensitivity into sham disorders such as "clitoral insufficiency syndrome." It treats women's insistence on equal sexual opportunity as if this means simply equal numbers of sexual

events ("Honey, was that a complete event or just a partial?"). It shifts the spotlight from women's educational and supportive groups to urologists' high-tech measurements of genital blood flow.

The shift is the result of many factors, including

- pharmaceutical manufacturers with huge marketing budgets that promote blockbuster "lifestyle" drugs, and entrepreneurial urologists and hospitals that view sex clinics as a growth area.
- health journalists, who focus on physiology and medical treatments.
- federal funding that

ignores sex research unrelated to public health problems such as STDs or teen pregnancy prevention.

- a lack of community- and school-based sex education that leaves the public anxious and embarrassed about discussing sexuality; those who search find only sensational magazine articles ("50 Ways to Drive Your Man Wild in Bed"), or Internet sites offering anonymous drug purchase opportunities and questionable "information," and generic "ask your doctor" advice.
- heavily promoted drugs (such as selective serotonin reuptake inhibitors) that often interfere with sexual response, and physicians who remain uncomfortable discussing "outercourse" forms of arousal and pleasure.
- an epidemic of "couple stress" that's resulted from increased work hours and "second-shift" resentment, and unchanged high expectations of sexuality.

• ignorance, embarrassment, and fear of rejection that inhibit conversation between lovers about sexual experience, desires, and feelings.

I'm sure you can add to this list. No one factor is responsible, and so there is no simple way to resist the medicalization steamroller. The most important protective element, I believe, is comprehensive sexuality education, beginning in preschool and continuing throughout life.

The Netherlands provides one model, including TV programs on topics such as gender identity, life cycle changes, and safer sex. In the United States, by contrast, children and adolescents learn about sexuality in schools that are gagged by "abstinence-only" restrictions. Television stations won't accept condom ads. Conservatives condemn sex education as harmful. Adult learning is limited to sensational talk shows, gimmicky magazine articles, and drug company literature in physicians' waiting rooms.

We need an atmosphere that allows people to reflect on their sexuality. Nurses can help create a movement to "take back" women's sexuality from the urologists and the pharmaceutical companies, one based on the feminist movement to reclaim women's sexuality a generation ago. In settings from schools to hospitals to clinics, you can encourage open communication among caregivers and patients and discourage reliance on drugs.

To challenge the new FSD model, we need multidisciplinary research, comprehensive sex education, and accessible health services. Sexuality is too beautiful and varied to waste. ▼



*Leonore Tiefer, clinical psychologist and sexologist, is a clinical associate professor of psychiatry at New York University Medical Center and author of *Sex Is Not a Natural Act and Other Essays* (Westview, 1995). For more information on her current campaign, "A New View of Women's Sexual Problems," send an e-mail to [LTiefer@mindspring.com](mailto:LTiefer@mindspring.com).*

# Orgasms for sale

**D**O YOU SUFFER from Female Sexual Dysfunction Disorder? The pharmaceutical industry

certainly hopes so. Ever since Viagra put pistols in the pockets of millions of American men, drug companies have raced to discover the next blockbuster sex-enhancing drug that will "cure" your problem and enhance your sexual satisfaction.

In case you're wondering, Female Sexual Dysfunction Disorder is an umbrella term that includes low libido, painful sex, limited sexual-arousal and difficulty in achieving orgasm.

Some would say it's an invented medical disorder. In 1999, a landmark study published in the prestigious *Journal of American Medicine* found that 43 percent of American women of all ages felt they suffered from one



RUTH  
ROSEN

of these sexual problems. Think about this finding: If nearly half of American women believe they experience some kind of sexual difficulty, is there really a pandemic problem, or have we defined "normal female sexuality" in such a way that half of American women do not recognize it as their own experience?

Leone Tiefer, Ph.D., an associate clinical professor of psychiatry at NYU's School of Medicine and Albert Einstein College of Medicine, has launched an educational campaign to expose the drug industry's fast-track research effort to profit from women's pervasive sense of sexual inadequacy. In her view, which is shared by the National Women's Health Network, feminist writers Barbara Ehrenreich and Susan Faludi, and hundreds of

health-care providers, the trend toward pill-pushing tends to mask the subtle emotional, social and cultural context in which women's sexual experiences take place.

According to Tiefer, this new grass-roots movement wants "to show how the recent rush to solve women's sexual problems — which are suddenly drastic and widespread — is a rush led by drug companies eager to reap financial success in finding and marketing a female Viagra."

A well-respected scholar, Tiefer readily acknowledges that many physical problems do, in fact, inhibit sexual response — among them, spinal cord injuries, anti-depressant and cholesterol-lowering medicines, and multiple sclerosis. What most concerns her is that the global pharmaceutical industry is building a market for sexual drugs by creating a need that must be filled through direct marketing to women. What further outrages her is that medicalizing women's sexual problems misinforms them about the safety and effective-

ness of medicinal "quick fixes."

The potential for profits is certainly enormous. Ever since Pfizer Inc. released that little blue diamond pill in 1998, which netted the pharmaceutical company \$1.3 billion in sales in 2000, pharmaceutical companies have tested various pills and potions that they hope to market as a cure for women's "sexual dysfunctions."

So far, the FDA has approved only one product, called EROS-CTD (clinical therapy device), that acts like a vacuum pump on the clitoris. Some doctors, however, are prescribing Viagra to their female patients. Still others are offering testosterone to postmenopausal women, which sometimes enhances the libido, but also raises the risk of liver and heart disease and can produce unpleasant side effects, such as the sprouting of male facial hair. In stores that stock supplements, new over-the-counter aphrodisiacs, with names like Niagara and Rendezvous, have suddenly appeared as "life-enhancing" supplements. Tiefer asks us to consider why half

of the female population may experience less sexual satisfaction than the self-absorbed young women who have turned HBO's "Sex and the City" into such a hit series. Among these, she suggests, is our abysmal lack of sexual education, which prevents girls from learning about their sexuality; our culture's celebration of thin, flawless, female celebrities, which makes many ordinary women ashamed of their aging faces and bodies; and the frantic, stressed-out nature of working mothers' lives. Oh yes, and don't forget to add the bewildering fact that women's anatomy still remains a great mystery to some men.

It won't be long before some drug company markets a pill that promises to deliver us sexual nirvana. It may even rebalance hormones or biochemistry in ways that offer renewed passion and vitality. Every woman should of course choose her own destiny, but as with all purchases, let the buyer beware.

Ruth Rosen is a *Chronicle* editorial writer.

# Feminist Contributions to the *Real* Sexual Revolution

by Rebecca Chalker

The sexual revolution of the 1960s is referred to as *the* sexual revolution, but there have been others in the 20th century. The first such revolution occurred in the 1920s when women in large numbers began going to universities and trade schools, earning their own money, and thus achieved emancipation from family control.

The second sexual revolution occurred in the 1960s. In the 1950s, the Kinsey Reports provided the opportunity for a wider public discussion of sexuality, and the media quickly discovered a public hunger for information on sexuality. Thus in the mid-1960s, Masters and Johnson were able to promote their theories about human sexual response.

The mass marketing of the Pill and wider availability of other forms of contraception allowed heterosexual women and men the opportunity to have sex without fear of pregnancy. Some feminists have argued that while contraception protected women from pregnancy, it primarily made sex

more available to men.

The third, and what I call the *real* sexual revolution, began in 1968 with the foundation of the second wave of feminism, the Stonewall rebellion in 1969 and activism that grew out of the abortion-rights and anti-Vietnam War movements. This revolution spawned many significant developments:

- Feminists began writing sex-advice books. Barbara Seaman wrote *Free and Female* in 1972, and Shere Hite published *The Hite Report on Female Sexuality*, the first volume in her monumental trilogy.
- Feminists and progressive sexologists sought to redefine sex as far more than intercourse, taking the focus off of the "intercourse script" and promoting both pleasure and orgasm as legitimate goals of sexual activity.
- Feminists popularized and normalized masturbation for women. In her book, *Liberated Masturbation* (since republished as *Sex for One*), Betty Dodson revived and popularized the use of vibrators for masturbation and partner sex. And in *For Herself*, Lonnie Barbach promoted vibrator use as a means of helping women discover their orgasmic potential.
- The Federation of Feminist Women Health Centers redefined the clitoris according to modern anatomical standards. This revealed that the clitoral system is as extensive as the penis and perhaps even more powerful.
- Lesbians came into their own, providing new models of discovering sexual pleasure for all women.
- Dr. Beverly Whipple (of G-spot fame) did groundbreaking research into female ejaculation in the 1980s, bringing this subject out of the closet and promoting the idea that it is a normal component of female sexual response. In the late 1980s, feminists began documenting this phenomenon on video, revealing a wide range of women's ejaculatory experiences.
- Leonore Tiefer critiqued Masters and Johnson's four-phased sexual response cycle and found their research to be fraudulent. In addition, Jo-Ann Lulan proposed a more realistic sexual response model that begins with willingness and ends with pleasure.
- Feminists opened women-oriented sex boutiques, the most well known of which are Eve's Garden (New York City), Good Vibrations (San Francisco Bay area), Grand Opening! (Boston) and Toys in Babeland (Seattle and New York City).
- Tired of male-oriented pornography, feminists began to write and film their own erotica.
- In the late 1980s and early '90s, feminists ascended to leadership positions in mainstream sexology organizations. Debra Haffner became president of the Sexuality Information and Education Council of the U.S., and Naomi McCormick was the first "out" feminist president of the Society for the Scientific Study of Sexuality.

NATIONAL WOMEN'S HEALTH NETWORK

January/February 2001

- Most recently, feminists are seeking to counter the aggressive movement to medicalize women's sexuality by reducing sexual problems to dysfunctions of "hydraulics," and seeking to "fix" them with Viagra and other drugs. A group of feminist sexual activists, led by Leonore Tiefer, asserts that women's sexuality is a complex phenomenon that includes socio-cultural, psychological, relational, even political issues that have been dismissed, unstudied and unaddressed.

The third sexual revolution has yet to be widely acknowledged, but clearly its roots are quite different from those of the '60s revolution. The important changes noted in this presentation represent the first steps in transforming the longstanding and deeply entrenched, male-centered heterosexual model of sexuality and in constructing a new model that includes women's needs and preferences.

*Rebecca Chalker is Adjunct Professor of Women's Studies at Pace University in New York City, where she teaches a course she developed entitled "Historical and Modern Sexual Revolutions." She is also the author of numerous books and articles, including The Clitoral Truth (see review, page 8).*

# The Orgasm Industry

## Drug Companies Search for a Female Viagra



**By Sonia Shah**

**Illustrations by Kathryn Rathke**

Since the launch of Pfizer's tremendously popular erectile-dysfunction drug Viagra in May 1998, pharmaceutical companies have scrambled to find the next big sex drug—for women this time. Start-up pharmaceutical companies and enterprising physicians have jumped into the fray to treat what they see as an underserved market of tens of millions of sexually dysfunctional women.

Feminists tend to bristle at the term "dysfunctional" but acknowledge that many women don't enjoy

sex. Some feminists say that women should welcome drug industry products that may provide some relief to

those in desperate need of sexual help. Others argue that such products will stigmatize female sexuality and drive women to pop a pill when what they really need are better relation-

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*Sonia Shah is a freelance writer and former editor at South End Press.*

ships and more sex education.

"No potion or pill will show you where your clitoris is," says sex writer Susie Bright. "No cream will enlighten you as to your unconscious erotic imagination."

Never mind the ongoing epidemic of sexual violence, spotty

access to contraception,

and the fact that most women with sexual difficulties say they are too busy and too stressed

out to have sex. Pill-pushers with their eyes on the bottom line are eager to gear women up for high-tech sex with new creams, gels, and other products.

While ten million men around the world take Viagra, earning Pfizer \$1.3 billion last year, the market for a prescription sex drug for women may be even bigger. According to a much-cited February 1999 article in *JAMA: The Journal of the American Medical Association*, 43 percent of all women suffer from sexual dysfunction, as opposed to just 31 percent of all men.

In April 2000, the Food and Drug Administration approved the first product to treat female sexual dysfunction, which it defines as decreased sexual desire, decreased sexual arousal, pain during intercourse, or inability to climax. The FDA-approved product, called EROS, is manufactured by Urometrics, based in St. Paul, Minnesota. It's a glorified vibrator that applies suction to the clitoris. It costs \$359 and is sold by prescription only.

Dozens of other products to alleviate female sexual dysfunction, including body creams and even a remote-control device, are currently in clinical trials. Some of these products may make it to market as early as

2004, say drug company spokespersons.

Nastech, a nasal drug company, recently started the second of three Food and Drug Administration-required phases of clinical trials for its apomorphine hydrochloride product for women, which is designed to improve blood flow and lubricating secretions in female genitals.

Apomorphine hydrochloride belongs to the family of morphine-derived drugs that includes codeine. The product

would come in a small vial with a nasal spray applicator,

which women would spritz into their nostrils about twenty minutes before having sex.

The company expects to bring the prescription nasal spray to market within a few years.

BioSante Pharmaceuticals expects results from Phase 2 clinical trials of its female sex drug, LibiGel, by this fall. Women would rub LibiGel onto their shoulders or arms, releasing libido-increasing testosterone into their bodies for up to twenty-four hours. According to BioSante, as women age, their testosterone levels go down, and women who've undergone total hysterectomies have 50 percent lower testosterone levels. Studies show that testosterone-replacement therapy can boost sexual desire, according to a company press release. LibiGel may hit the market in four years, BioSante's CEO Stephen M. Simes says, and would cost about \$1,000 a year for daily therapy, a sum BioSante expects insurance companies to cover.

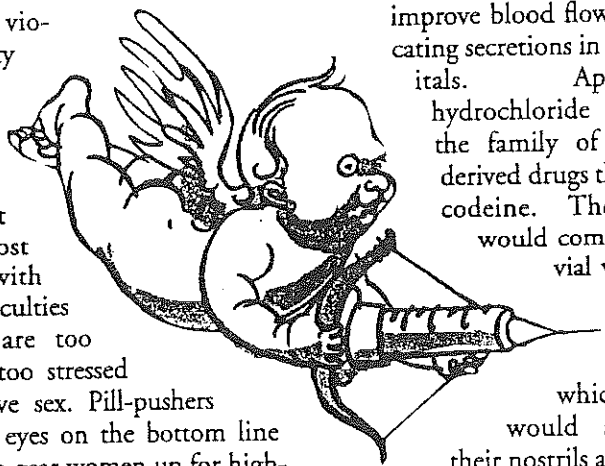
"Just like men who take Viagra who don't have erectile dysfunction, there are individuals who will want to have an orgasm on demand," says North Carolina pain specialist Dr. Stuart Meloy. In January, Meloy was issued a patent for a remote-con-

trolled neural-stimulation device to trigger orgasms. Three years ago, Meloy, like other pain specialists, noticed that a surgically implanted neural stimulation device routinely used to alleviate chronic pain sometimes triggered orgasms instead. He considered it a "funny, unwanted side effect," he says, until he realized that "this unwanted side effect was something that may be quite desirable in another clinical setting." Meloy expects to start clinical trials in the near future.

But who will want to spend \$15,000 on a surgical procedure to have push-button orgasms? There are about 23,000 women with orgasmic dysfunction who are not responsive to simpler therapies, Meloy estimates, and CNN pollsters reported that 59 percent of women would want to have Meloy's device implanted in them. "Frankly, for that individual who has the cash in hand, it is kind of on par with cosmetic surgery," he says.

Feminists publicized and politicized women's raw deal in bed decades before drug companies began researching their corporate solutions to the problem. But the women's sexual health movement, with its self-help books, sex-toy shops, sex therapists, and masturbation workshops has never been particularly profitable. The ultimate solution to women's sexual problems, say some, is more time, less stress, better education, and attentive partners—hardly the stuff of glossy brochures for thousand-dollar prescription treatments.

"Women really want a sense of self-empowerment and self-efficacy," says Leonore Tiefer, feminist sex therapist and professor of urology and psychiatry at Albert Einstein College of Medicine. "They don't just want products to choose from." The search for a female Viagra, Tiefer says, exploits for profit "the lack of sex education and sexual freedom we have in this country."



Such products may help a small fraction of women, the National Women's Health Network program director Amy Allina told me, but "in the context of today's health care system structured around profit and patentable products, many women may be sold drugs that they don't need and that can hurt them" with the side effects.

To make it big, drug companies need to mass-market their prescription sex products. Pfizer doesn't market Viagra exclusively to the 5 percent of the U.S. male population that suffers from erectile dysfunction. Pfizer sells Viagra by selling romance.

Urometrics, the maker of EROS, plans to run spots on radio stations and in print media in ten cities around the country, says the company's public relations spokesperson, Saunya Peterson. Both LibiGel and Nastech's nasal spray are also likely to be advertised directly to consumers, the companies say. "Like Viagra, this

**"If I have a headache, it may have some larger social cause, but in the meantime I'm going to take aspirin."**

is something consumers will be hearing about directly," says Matthew Haines, director of corporate communications at Nastech.

"Their marketing implies that you can passively sit back and let the 'chemical' do the work for you," says Bright. "But we already have powerful sexual [chemicals] in our bodies. They're called hormones."

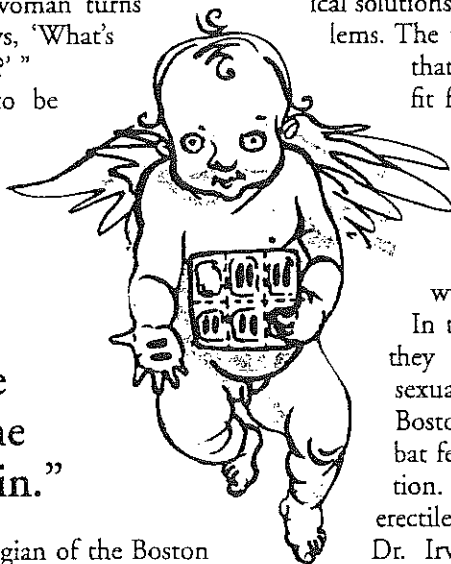
"We are all susceptible to promises that things will be made better," says Carol Ellison, a sex therapist who surveyed 2,632 U.S. women about their sex lives for her book, *Women's Sexualities: Generations of Women Share Intimate Secrets of Sexual Self-Acceptance* (New Harbinger Publications, 2000). She found that women

want more free time, less stress, and loving relationships to feel good in bed. But if that's the case, why would women seek medical solutions for nonmedical problems?

"Women are very anxious to improve their sex lives," says Tiefer. "The illusion of sex that is promoted by the entertainment media is that sex is just one big orgasmic scream after another, but that is not what most people's experience is like."

Women who turn to sex drugs may be more than disappointed. Says Ellison: "When a drug doesn't solve your problem of low sexual desire, which is based on your partner not helping out with the kids or taking time to feel close to you before sex, then the woman turns around and says, 'What's wrong with me?'"

"We need to be cautioning the public right now,"



says Judy Norsigian of the Boston Women's Health Book Collective.

Others, such as Pulitzer Prize-winning writer Natalie Angier, author of *Women: An Intimate Geography* (Anchor Books, 2000), say that women need as much information and support for having orgasmic sex as possible, whether from a friend or a drug-company ad on television. If a product could help even a small fraction of women, she says, it's worth it, given women's widespread trouble with achieving orgasms.

"Most women, if not all women, are capable of learning how to become readily orgasmic," says Angier. When feminists say that women's sexuality is more about intimacy than orgasm,

"you end up with a lot of dissatisfied women."

Cultural critic Ellen Willis agrees. "If people are sexually unhappy, anything that helps them is fine," she says. Sex drugs should be seen as "one more resource in dealing with sexual problems. If I have a headache, it may have some larger social cause, but in the meantime I'm going to take aspirin."

The race to find the female Viagra started in 1998, the year Viagra was released. Two tele-genic sisters—urologist Jennifer Berman and sex therapist Laura Berman—spearheaded a popular crusade urging women to consider medical solutions to their sexual problems. The two were "convinced

that women could benefit from the same medical attention to sexual problems that was given to men," they write on their web site,

[www.newshe.com](http://www.newshe.com).

In the summer of 1998, they founded a women's sexual health clinic at Boston University to combat female sexual dysfunction. With their mentor, erectile dysfunction pioneer Dr. Irwin Goldstein, they organized the first ever conference on female sexual dysfunction a few months later. Their quest transformed them into the darlings of the sex-drug industry, and the Bermans were soon giving a paid lecture about new sex treatments on an industry-sponsored yacht trip. They also appeared on a raft of television and radio programs, including *The Oprah Winfrey Show* and *Good Morning America*, explaining how women could combat the female sexual dysfunction epidemic.

Meanwhile, University of Chicago sociologist Edward O. Laumann, author of a well-respected survey of sexual practices in the United States,

reanalyzed data from his influential 1992 survey to look specifically at sexual dysfunction, a topic he previously covered only briefly. In February 1999, Laumann and his co-author, clinical psychologist Raymond C. Rosen, released their reanalysis in *JAMA*, one of the nation's foremost medical journals. "The results indicate that sexual dysfunction is an important public health concern," they wrote, coming up with the 43 percent figure for female sexual dysfunction.

Without Laumann's claim, female sexual dysfunction may have become another of hundreds of obscure medical syndromes and conditions. "Because it was published in *JAMA*, was based on a well-known survey, and there's so much interest in women's sexuality and drug treatment, it has attained this status [as] the most accurate figure we have," says the Kinsey Institute's Cynthia Graham.

But critics question whether Laumann's characterization of so many women as dysfunctional is really accurate. "Women may be saying they have these symptoms," says Graham, "but they may not consider it a problem."

Graham's point cuts to the heart of the notoriously murky world of sex research. What is a sexual problem and what isn't? Who decides? Who talks truthfully to researchers about their sexual lives and why?

Most well-known studies of sexual practices—such as those by zoologist Alfred C. Kinsey in 1948 and 1953, Masters and Johnson in 1966, and Shere Hite in 1976—are based on what volunteers chose to tell researchers. But in 1992, Laumann set out to find out what randomly selected ordinary Americans did in bed. The large majority of the 3,159 people his researchers spoke to in ninety minute face-to-face interviews were found to "feel loved, satisfied, and even thrilled by their sex partners," as Laumann and his co-authors

wrote in *The Social Organization of Sexuality* (University of Chicago, 1994).

Sometime before 1998, Laumann became a consultant for Pfizer. He teamed up with Rosen, another Pfizer consultant. Rosen urged Laumann to showcase his data on sexual dysfunction in a medical journal where physicians would be more apt to see it, Laumann says. So Laumann reanalyzed his data and came to a different conclusion. In 1994, Laumann wrote, "comparatively few [men and women] are made to feel sad or afraid or guilty in their sex lives." But in his February 1999 *JAMA* article, he unveiled an epidemic of female sexual dysfunction.

Today, Laumann tries to distance himself from the conclusions in his article. "I've been somewhat annoyed that, because this study was published in a medical journal, it has been spun in a very medical direction," he says.

As Laumann puts it, the article shows that most of the women characterized as having female sexual dysfunction may simply be experiencing "normal responses to the challenges



of life." Just more than half of the women characterized as suffering from female sexual dysfunction were those who reported a lack of interest in sex for a period of several months or more over the last twelve months. Another third or so reported arousal problems, that is, they reported having trouble lubricating for a period of several months or more in the past

twelve months.

"If you have any kind of life at all," says Laumann, "you are going to have these problems" at some point. Plus, aside from lubrication problems, which many women remedy by using over-the-counter lubricating jellies, most of the other female sexual dysfunction symptoms decrease as women age, Laumann says.

The number of women who truly need medical intervention in their sex lives is probably tiny, Laumann says. "The vast bulk of the 43 percent are probably suffering from social stresses," he says.

Laumann says that corporate interests had nothing to do with the conclusions of his article for *JAMA*. "We were writing for doctors," he says, "so an interpretive spin was simply not possible."

As sex research becomes more beholden to the pharmaceutical industry, Tiefer says, there is a vested interest in painting a picture of sick women in need of new drug treatments. "Profitability motives" are driving research on female sexual dysfunction, she says.

In the past, medical experts condemned women's sexualities as hysterical, nymphomaniacal, or frigid. Today, according to Laumann's own admission, healthy women in normal life circumstances acquire a medical label of "dysfunctional." Laumann and physicians such as the Bermans consider the classification of normal female sexuality as

dysfunctional a step in the right direction. At least now, they say, people are talking openly about women's sex lives.

And that's the irony. Feminists have been whispering, joking, yelling, and agitating about female sexuality for at least three decades. Now that a lucrative market is in view, the experts and entrepreneurs may deign to listen. ♦

# The making of a disease: female sexual dysfunction

Ray Moynihan

Is a new disorder being identified to meet unmet needs or to build markets for new medications?

The corporate sponsored creation of a disease is not a new phenomenon,<sup>1</sup> but the making of female sexual dysfunction is the freshest, clearest example we have. A cohort of researchers with close ties to drug companies are working with colleagues in the pharmaceutical industry to develop and define a new category of human illness at meetings heavily sponsored by companies racing to develop new drugs. The most recent gathering, featured Pfizer as chief sponsor and Pfizer-friendly researchers as chief speakers. The venue? The Pfizer Foundation Hall for Humanism in Medicine at New York University Medical School.

Since the launch of sildenafil (Viagra) in 1998, more than 17 million men have had prescriptions written for it as a treatment for erectile dysfunction, with Pfizer reporting sales in 2001 of \$1.5bn.<sup>2</sup> The emerging competitors, Bayer's vardenafil and Lilly-ICOS's tadalafil, are likewise expected to have annual markets in excess of \$1bn each.

To build similar markets for drugs among women, companies first require a clearly defined medical diagnosis with measurable characteristics to facilitate credible clinical trials. Over the past six years the pharmaceutical industry has funded, and its representatives have in some cases attended, a series of meetings to come up with just such a definition (table).

## Defining the new disorder

In a ground breaking gathering in May 1997, clinicians, researchers, and drug company representatives met for two days at a Cape Cod hotel "to discuss the future direction of clinical trials" in this area, against a backdrop of "widespread lack of agreement about the definition" of female sexual dysfunction.<sup>3</sup>

In response to an email inquiry about the Cape Cod meeting, co-chair Raymond Rosen wrote: "The meeting is completely supported by pharmaceutical companies, and approximately half of the audience will be pharmaceutical representatives. The goal is to foster active and positive collaboration between the two groups. Only investigators who have experience with, or special interest in working collaboratively with the drug industry have been invited." The subsequent publication of the meeting's presentations and discussions acknowledged sponsorship from nine drug companies.<sup>3</sup>

Eighteen months later, in October 1998, the first international consensus development conference on female sexual dysfunction took place in Boston under "closed session" deliberations.<sup>4</sup> Participants for this multidisciplinary meeting were hand picked by a group from the American Foundation for Urologic Disease on the basis of their research or clinical expertise and their positions as "thought leaders." Working with existing classification systems, including the American manual of psychiatric disorders (*Diagnostic and Statistical Manual of*

## Summary points

Researchers with close ties to drug companies are defining and classifying a new medical disorder at company sponsored meetings

The corporate sponsored definitions of "female sexual dysfunction" are being criticised as misleading and potentially dangerous

Commonly cited prevalence estimates, which indicate that 43% of women have "female sexual dysfunction," are described as exaggerated and are being questioned by leading researchers

Controversy surrounds current attempts to medicalise sexual problems and establish "normative data" for a range of physiological measurements of female sexual response

The role of drug companies in the construction of new conditions, disorders, and diseases needs more public scrutiny

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*Mental Disorders*, 4th edition), participants produced a new definition and classification featuring disorders of desire, arousal, orgasm, and pain, to be used in "medical and mental health settings."<sup>4</sup>

Publication of the proceedings of the consensus conference disclosed support from eight pharmaceutical companies and showed that 18 of the 19 authors of the new definition had financial interests or other relationships with a total of 22 drug companies.<sup>4</sup>

In October 1999 the Boston University School of Medicine hosted a further conference, which was supported by 16 companies. In a response to a question from a speaker at the conference, a show of hands at one session revealed that around half of the participants were connected to the drug industry.<sup>5</sup> In 2000 and 2001, the newly formed Female Sexual Function Forum hosted annual conferences in Boston supported each time by more than 20 companies, with Pfizer as a key sponsor. Interviewed just before Christmas 2002, Pfizer's Urology Group's leader, Dr Michael Sweeney, said the company had played a passive role in sponsoring a series of discussions about the disorder, simply providing unrestricted grants in response to requests from physicians.

On the international stage, female sexual dysfunction was discussed as part of the first international consultation on erectile dysfunction in Paris in 1999, hosted chiefly by urology associations and sponsored heavily by pharmaceutical companies. A second meeting is planned for Paris in June 2003, with one aim being the adoption of an "internationally accepted instrument for assessment of sexual function."<sup>6</sup>



All three Boston meetings (1999-2001) were chaired by Dr Irwin Goldstein, professor of urology and gynaecology at Boston University School of Medicine, who is also a key figure at the international gatherings. Originally trained as an engineer, Goldstein has widened his focus in recent years from male to female sexual dysfunction. A regular speaker at meetings funded by industry and a consultant and lecturer for virtually every pharmaceutical company, he is a passionate advocate for building a new discipline of sexual medicine, because, as he told the recent New York gathering, in this emerging field "there is such joy in treating these people successfully."

### Difficulties become dysfunctions become disease

One of the milestones in the making of the new disorder was a *JAMA* article in February 1999 titled "Sexual dysfunction in the United States: prevalence and predictors."<sup>7</sup> The authors, two of whom belatedly disclosed close links to Pfizer,<sup>7</sup> said that for women aged 18-59, the "total prevalence of sexual dysfunction" was 43%, a figure now widely cited in both the scientific and lay media.<sup>8,9</sup>

As an example, in November last year a Californian firm offering "business intelligence" announced that "43% of all women over 18 experience sexual dysfunction ... Greater public awareness and acceptance of SD [sexual dysfunction] as a common and treatable disease will heavily influence market growth, predominantly for women." In August, a company advertising trials of a new drug for "female sexual arousal disorder" prominently cited the figure in its press release. Dr Sweeney told me that 40% of women have the dysfunction in one form or another, "but not all have the most severe form of the disease."

Serious questions hang over the 43% figure, obtained when University of Chicago sociology professor Ed Laumann and colleagues reanalysed a slice of data from a 1992 survey. About 1500 women were asked to answer yes or no to whether they had experienced any of seven problems, for two months or more, during the previous year, including a lack of desire for sex, anxiety about sexual performance, and difficulties with lubrication. If the women answered yes to just one of the seven questions, they were included in a group characterised as having sexual dysfunction.

Drug company sponsored meetings to define new disorder

Year	Meeting and host	No of company sponsors*
1997	Sexual function assessment in clinical trials—Cape Cod conference	9
1998	International consensus development conference on female sexual dysfunction: definitions and classifications—American Foundation for Urologic Disease, Boston	8
1999	Perspectives in the management of female sexual dysfunction—Boston University School of Medicine	16
2000	Female sexual function forum—Boston University School of Medicine	22
2001	Annual meeting of the female sexual function forum, Boston	22
2002	The new view "female sexual dysfunction": promises, prescriptions, and profits, San Francisco	0
2002	Annual meeting of the International Society for the Study of Women's Sexual Health, Vancouver	15
2003	International consultation on erectile and sexual dysfunctions—to endorse instruments for assessment of sexual function, Paris	Currently seeking sponsors

\*A very small minority of sponsors were not drug companies.

The *JAMA* article stated that its data were "not equivalent to clinical diagnosis," yet this caveat is now regularly overlooked, and leading sex researchers have raised serious concerns about the figure's constant misuse.<sup>10</sup>

One of those concerned is Dr Sandra Leiblum, professor of psychiatry at Robert Wood Johnson Medical School and a clinical psychologist. She believes real dysfunction is much less prevalent than 43%, and that the figure has contributed to an overmedicalisation of women's sexuality, where changes in sexual desire are the norm. "I think there is dissatisfaction and perhaps disinterest among a lot of women, but that doesn't mean they have a disease," she said during an interview at the recent New York educational workshop.

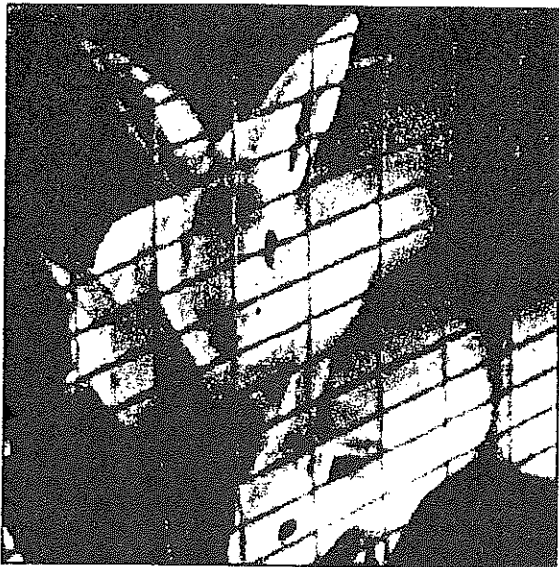
The director of the Kinsey Institute at Indiana University, Dr John Bancroft, believes the term "dysfunction" is highly misleading, and he is one of several researchers critical of the corporate sponsored 1998 definition.<sup>11</sup> He argues that an inhibition of sexual desire is in many situations a healthy and functional response for women faced with stress, tiredness, or threatening patterns of behaviour from their partners.<sup>10</sup> "The danger of portraying sexual difficulties as a dysfunction is that it is likely to encourage doctors to prescribe drugs to change sexual function—when the attention should be paid to other aspects of the woman's life. It's also likely to make women think they have a malfunction when they do not," he said during a telephone interview. In response, Laumann defends his use of the term "dysfunction" but concedes that many women among his 43% are "perfectly normal" and that a lot of their problems "arise out of perfectly reasonable responses of the human organism to challenges and stress."

New York University's clinical associate professor of psychiatry, Dr Leonore Tiefer, contends that the medical model itself is severely limited for dealing with problems of sexuality because of its mind-body split, biological reductionism, focus on diseases rather than people, and reliance on norms.<sup>12</sup> She claims pharmacological research runs the risk of oversimplifying the sexual difficulties of both men and women because it "promotes genital function as the centrepiece of sexuality and ignores everything else"<sup>13</sup>

### What is healthy and what is sick?

While the measurement of sexual problems in men has focused almost exclusively on erections, female sexual responses have proved much more difficult to quantify, creating problems for researchers testing pharmacological therapies. In recent years, however, a host of new methods have been identified, and some clinicians now recommend, along with a physical and psychosocial examination, a comprehensive evaluation that can include the measurement of hormonal profiles, vaginal pH, and genital vibratory perception thresholds, as well as the use of ultrasonography to measure clitoral, labial, urethral, vaginal, and uterine blood flow. In 1999, Dr Jennifer Berman, assistant professor of urology at the University of California, Los Angeles, wrote "Normative data are being gathered for comparison to determine what normal physiologic responses are for women in particular age groups."<sup>14</sup>

Studies by Berman, Goldstein, and others have used those physiological measurements to test the effects of



DR. JASPER A. SROBNER

Fluffy bunnies are used as models for "female sexual dysfunction"

sildenafil on women with "female sexual arousal disorder."<sup>14</sup> In October 2002, Berman presented results from another study of sildenafil, conducted with three authors from Pfizer, at a conference where the company was chief sponsor.<sup>15</sup> Last month she told me: "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."

On the basis of studies of the genitalia of female New Zealand White rabbits, Goldstein and colleagues have developed animal models of "vaginal engorgement insufficiency and clitoral erectile insufficiency."<sup>16</sup> Using data from studies comparing the testosterone levels of "normal" women with the levels of his patients, he told the December meeting in New York that women with "female sexual dysfunction" might have a "specific defect in steroid synthesis."

Goldstein regularly cites the 43% prevalence figure and dismisses suggestions from his colleague Dr Leiblum that it may indicate the prevalence of difficulties rather than real dysfunction: "I love psychologists but they don't deal with evidence." Asked during a break in the New York gathering about criticisms that medicine may not be best equipped to deal with sexual problems, Goldstein's replied: "Who's best equipped to deal with it? The horticulturists? It's a form of medicine. I think physicians are most appropriate." He added that he worked within a "mind-body relationships" framework and a multidisciplinary team that includes psychologists and nurses.

The pharmaceutical industry's role in helping build the science of this new disorder has been "paramount," according to Goldstein, and he rejects suggestions that closeness between drug companies and academic researchers may be inappropriate. Asked whether marketing campaigns worth hundreds of millions of dollars may ultimately tend to amplify particular views of sexual difficulties and promote certain therapeutic options over others, he said: "I'm an academic clinical doctor. That's a question for some philosopher."

### Another view of women's problems

In contrast to the definition driven by Goldstein and others, Tiefer and colleagues are promoting a women-

centred definition of sexual problems: "discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience," with four categories of causes: sociocultural, political, or economic; relationship related; psychological; and medical.<sup>3</sup> "Sex is like dancing," Tiefer told me during an interview in her Manhattan office, "If you break an ankle while you're dancing you go to a doctor. But your doctor doesn't take a dance history and wouldn't advise you whether your dancing is normal. The medical model is about defining what's healthy and what's sick—but sex isn't like that."

The potential benefits of this current medicalisation campaign are a more humanised doctor-patient relationship, effective and safe new drugs, and increased public and research attention to the complexity of female sexual problems. The potential risk, in a process so heavily sponsored by drug companies, is that the complex social, personal, and physical causes of sexual difficulties—and the range of solutions to them—will be swept away in the rush to diagnose, label, and prescribe. Perhaps the greatest concern comes from the flip side of inflated estimates of disease prevalence—the ever-narrowing definitions of "normal" which help turn the complaints of the healthy into the conditions of the sick.

These revelations about female sexual dysfunction should spark a more widespread and rigorous investigation into the role of drug companies in defining and promoting new diseases and disorders.

Thanks for comments on early drafts to medicalisation-watcher and drug policy analyst Alan Cassals and to sociology lecturer Jo Ellins, who is working on a doctoral thesis on "lifestyle" drugs.

Competing interests: None declared.

- 1 Moynihan R, Heath L, Henry D. Selling sickness: the pharmaceutical industry and disease mongering. *BMJ* 2002;324:886-91.
- 2 Pfizer. Annual report 2001. [www.pfizer.com/pfizerinc/investing/annual/2001/p2001ar21.html](http://www.pfizer.com/pfizerinc/investing/annual/2001/p2001ar21.html) (accessed 12 Dec 2002).
- 3 Special supplement. *Int J Impotence Res* 1998;10(suppl 2):S1-142. (The Cape Cod conference: sexual function assessment in clinical trials, 30-31 May, 1997, Hyannis, Massachusetts, USA.)
- 4 Basson R, Berman J, Burnett A, Derogatis L, Ferguson D, Fourcroy J, et al. Report of the international consensus development conference on female sexual dysfunction: definitions and classifications. *Urology* 2000;163:888-93.
- 5 Kaschak E, Tiefer L, eds. *A new view of women's sexual problems*. Binghamton, NY: Haworth Press, 2001:70.
- 6 Second international consultation on erectile and sexual dysfunctions. Paris, June 28-July 3, 2003. [www.congress-urology.org/index.htm](http://www.congress-urology.org/index.htm) (accessed 12 Dec 2002).
- 7 Lautmann E, Paik A, Rosen R. Sexual dysfunction in the United States: prevalence and predictors [published erratum appears in *JAMA* 1999;281:1174]. *JAMA* 1999;281:537-44.
- 8 Berman J, Berman L, Goldstein I. Female sexual dysfunction: incidence, pathophysiology, evaluation, and treatment options. *Urology* 1999;54:385-91.
- 9 Cooke R. There's gold in them there pills. *Observer* 2002 October 27.
- 10 Bancroft J. The medicalization of female sexual dysfunction: the need for caution. *Arch Sex Behav* 2002;31:451-5.
- 11 Segraves R, ed. Historical and international context of nosology of female sexual disorders. *J Sex Marital Therapy* 2001;27(2):81-245.
- 12 Tiefer L. The medicalization of sexuality: conceptual, normative, and professional issues. *Annu Rev Sex Res* 1996;7:252-82.
- 13 Tiefer L. Sexology and the pharmaceutical industry: the threat of co-optation. *J Sex Res* 2000;37:273-83.
- 14 Berman J, Berman L, Lin H, Flaherty E, Lahey N, Goldstein I, et al. Effect of sildenafil on subjective and physiologic parameters of the female sexual response in women with sexual arousal disorder. *J Sex Marital Therapy* 2001;27:411-20.
- 15 Berman J, Berman L, Toler S, Gill J, Haughey S. Efficacy and tolerability of sildenafil citrate in women with sexual arousal disorder: a double-blind, placebo-controlled study [abstract]. Annual meeting of the International Society for the Study of Women's Sexual Health, October 10-13, 2002:49.
- 16 Park K, Goldstein I, Andry C, Siroky M, Krane R, Azadzi K. Vasculogenic female sexual dysfunction: the hemodynamic basis for vaginal engorgement insufficiency and clitoral erectile insufficiency. *Int J Impotence Res* 1997;9:27-37.

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## **A woman's duty is not only to have the sex she doesn't really want, but to enjoy it**

Germaine Greer

London Times online

<http://www.timesonline.co.uk/printFriendly/0,,1-152-537048,00.html>

Ever since Queen Victoria died, men have been trying to tame the female orgasm. As long ago as 1913 Alfred Adler published his conclusion that 80 per cent of women were sexually non-responsive. In those days they would have been called frigid; these days we say they suffer from female sexual dysfunction (FSD).

Generations of sex manuals have endeavoured to teach husbands to reduce their wives to gibbering ecstasy, to no avail. In 1975 Kinsey reckoned that 75 per cent of women did not often reach orgasm through conventional intercourse. The Holy Grail of sexual chivalry was the multiple orgasm; the only good orgasm was the vaginal orgasm, which turned out to be more like the snark, because nobody could prove it existed. Men were urged to make love more creatively, varying positions and using instruments, pornography, roleplay and various pharmaceutical products, from Spanish Fly to yohimbine, to heighten women's arousal. A woman's orgasm came to be more eagerly sought by a lover than his own. The harder men tried, the more pressure women felt to produce the requisite moans so they could both get some sleep. Faking it became a necessary part of sexual etiquette.

Part of the sexologists' problem in quantifying female sexual response is that they were looking for the same intense, short-lived and localised orgasm as could be observed in men. We now know that the clitoris is not a magic button but the summit of a dense network of neural pathways linking it to the organs. We know better than to belittle the clitoral orgasm, but we also know that the point of travelling is not necessarily to arrive. In love-making sleeping in each other's arms is at least as important as the orgasm, especially if it is to be followed in short order by detumescence, back-turning and snoring. As the late Peggy Lee unforgettably sang, "Is that all there is, my friends? Let's keep dancing."

Failure to be excited is only to be expected if what is on offer is unexciting. No sex rather than bad sex should be an option, but in the post-millennial world the unresponsive woman is dysfunctional and will be treated. Her lack of genuine passion will be corrected by charging her up with synthetic

passion, otherwise known as Viagra. Her duty is not only to have the sex she doesn't really want, but to enjoy it.

The principal publicists for FSD, and Viagra as the treatment for it, have been Drs Laura and Jennifer R. Berman, directors of the UCLA Female Sexual Medicine Centre which has reported on a Viagra trial. It is also running trials of lasofoxiphenone and alprostadil as treatments for "female sexual arousal disorder", which with "hypoactive sexual desire disorder", "sexual aversion disorder", "female orgasmic disorder", and "sexual pain disorders" makes up the spectrum of FSD.

The focus of much of this work is the postmenopausal woman, who is already assumed to be suffering from one deficiency disease that is to be treated with oestrogen. Oestrogen facilitates intercourse by improving lubrication, but does not replace lost libido. Something else had to be found and women have been ordered to find it in the bathroom cupboard.

When boys sneer at a girl who won't join in sex games on the back seat of the school bus, and call her frigid, it hurts; she wonders whether her revulsion means that something might be wrong with her. A woman who begins to dislike the sex on offer within an adult relationship, which may well be lukewarm and mechanical, and is told that the problem is hers and that it is called FSD, is being manipulated in the same way. The difference is that this pseudo-medical concern is presented to her as pro-feminist, caring, empowering, and all that jazz. Co-option of feminist rhetoric has been a problem ever since a cigarette was sold to women who had "come a long way baby". The sanctimonious claptrap that will be used to sell Viagra to women will argue that sexual satisfaction is a human right that Pfizer is nobly concerned to restore to women, as it has to the men who are already providing the company with a billion dollars of profit every year.

As women's orgasmic potency is adversely affected by insecurity, knowledge that the man in one's life has to take Viagra to get it up will hardly enhance female sexual response. A loving husband might also be abashed to discover that his wife is yelping beneath him not because his penis is a joy to her but because she took a pill or is using an electronic implant. How different is taking Viagra from popping amyl nitrate or snorting cocaine to enhance sexual response? The only difference between Viagra and Suregasm or Nymphomax or Zestra is that Viagra works, but the evidence is scantier and softer than it has any right to be, given Pfizer's massive resources.

## THE AUTHORS

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