

A Bibliography of 27 Counter-Narrative Sources
Prepared for the FDA Advisory Committee Hearing on Flibanserin
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Introduction: Counter-Narratives

While the New View Flibanserin Planning Group (of which we are part) was preparing fact-sheets and presentations for the June 18, 2010 FDA Advisory Committee Hearing on Flibanserin, a new brain drug developed by Boehringer-Ingelheim to “treat” “hypoactive sexual desire disorder,” we became irritated with the dominant narrative that B-I was using to promote their claims

- HSDD is a real medical condition, not new, not disease-mongering
- HSDD is highly prevalent and causes huge distress, not rare or accepted as passing or part of life
- Desire is in the brain, not the culture, not the relationship
- Sexual desire is a concept everyone agrees upon and can easily recognize, as opposed to a veritable Tower of Babble of options
- HSDD is a brain abnormality, not a neuroscientific fantasy

And on and on.

In the New View Campaign we knew of lots of research that ran counter to the B-I narrative, and we decided to compile just the tip of the counter-narrative iceberg - 25 papers that we could easily abstract (it turned out to be 27!). We mainly wanted to use empirical studies in which women’s actual and diverse voices were heard reflecting on sexuality and sexual problems, but a few theoretical papers crept into the mix.

Herewith, in alphabetical order, the tip of the counter-narrative iceberg.

Empirical Sources:

1) Ahlborg, Tone , Dahlöf, Lars-Gösta and Hallberg, Lillemor R-M. (2005) Quality of the intimate and sexual relationship in first-time parents six months after delivery. *Journal of Sex Research*, 42: 2, 167 - 174

820 Swedish first-time parents completed a questionnaire in 2002 which aimed to describe the quality of the intimate relationship among parents six months after the birth of their first child. The survey included questions about relationship satisfaction, communication, and expression of affection, sensuality and sexuality. The results show that both mothers and fathers were somewhat discontented with the relationship sexuality.

However, the results also reveal that most parents were happy with the

overall relationship. Couples with high levels of communication reported higher levels of several dimensions of intimacy, including dyadic consensus and satisfaction. This study stressed that low sexual desire in women was usually caused by large amounts of stress and fatigue, and that sensual activity between partners could awaken sexual desire.

2) Bachmann G. (2006) Female sexuality and sexual dysfunction: Are we stuck on the learning curve? *Journal of Sexual Medicine*, 3: 639 - 645.

1946 physicians and other health professionals completed a survey in 2004 which aimed to study the knowledge, attitudes, and practices of medical professionals regarding FSD. Although most clinicians recognized the high prevalence of FSD, many had little knowledge of women's sexual health, rarely initiated discussions of sexual function with their patients, and did not evaluate their patients for FSD. Physicians estimated a greater prevalence of FSD than what is shown in the literature, with 85% recognizing HSDD as a medical disorder. That being said, only 25% of survey participants routinely performed a comprehensive diagnostic work up of HSDD on their patients. This might be due to limited knowledge and comfort in the subject or the fact that 86% of participants rated the current available treatment options as fair (41%) or poor (45%). The author recommends that health care professionals be better trained to "recognize the unique and multifaceted nature of sexual disorders in women, which may stem from any combination of physical, psychological, and relationship factors, and encouraged to take a proactive approach to their detection and evaluation" (643).

3) Bancroft, J, Loftus, J, & Long, J S. (2003) □Distress about sex: A national survey of women in heterosexual relationships. *Archives of Sexual Behavior*, 32: 193-208

Telephone interviews were conducted in 2000 with 987 White or African American women aged 20 – 65 years, living for at least 6 months in a heterosexual relationship. The women were asked questions about their overall physical and mental health, sexual activity, self esteem, and their level of sexual distress. A total of 24.4% of women reported marked distress about their sexual relationship and/or their own sexuality. The best predictors of sexual distress were general emotional well-being and emotional relationship with their partner during sexual activity. Physical aspects of sexual response in women, including sexual arousal, vaginal lubrication, and orgasm were poor predictors of sexual distress. In general, the predictors did *not* fit well with the *DSM-IV* criteria for the diagnosis of sexual dysfunction in women. The conclusions emphasize the psychological and social issues that contribute to sexual distress in women and propose

that we further examine the distinction between “dysfunction” and “reaction to circumstances.”

4) Cacchioni, Thea. (2007) Heterosexuality and ‘the Labour of Love’: A Contribution to Recent Debates on Female Sexual Dysfunction. *Sexualities*, 10(3): 299–320

Interviews were conducted in Vancouver in 2003 with 31 women, 21 to 62, from varying nationalities and ethnicities, who reported sexual problems such as lack of interest, lack of pleasure, and pain. Most were heterosexual, with children, and 2/3 were in long-term relationships. Participants described strong wishes to be “normal,” and fit in to a climate where sex was supposed to be “exciting” and “romantic.” The author identified three strategies participants used to conform to standard heterosexual practices, including changing their own mental and physical responses through treatment or study, faking what they thought was normal, or avoiding sex altogether. Women with abuse histories or financial dependence were more likely to conform to “heteronormative” practices. Other women successfully shifted their goals to de-prioritize, reframe or rescript sex in their relationships, often by changing primary partners. The paper challenges the medicalization of “female sexual dysfunction” as reinforcing social pressures rather than supporting sexual liberation and shows how women struggle within and against current norms.

5) Carvalheira AA, Brotto LA, and Leal I. (2010) Women’s motivations for sex: Exploring the Diagnostic and Statistical Manual, Fourth Edition, Text Revision criteria for hypoactive sexual desire and female sexual arousal disorders. *Journal of Sexual Medicine*, 7:1454–1463.

3,687 Portuguese women completed a web-based survey exploring women’s motivation to engage in sexual activity, frequency and predictors of sexual fantasies, sexual, arousal, recognition of sexual arousal, and association between relationship duration and these variables. What is important to note from this article are the women's responses pertaining to partner stimulation. A majority (72.1%) of women who found it difficult to get sexually aroused would have liked to receive more effective stimulation from a sexual partner. 56% of women who could easily become sexually aroused reported the same wish. The article proposes that “it is possible that in the vast majority of cases in which a clinician would administer a diagnosis of FSAD, that if more effective stimulation were applied, arousal may not be impaired, and the FSAD diagnosis would not be given” (1461).

6) Carvalho J, and Nobre P. (2010) Sexual desire in women: An integrative approach regarding psychological, medical, and relationship dimensions. *Journal of Sexual Medicine*, 7:1807–1815.

237 Portuguese women answered mailed questionnaires in 2007 which aimed to understand how psychological, medical, and relationship factors interact in sexual interest. Results showed that cognitive factors mediated the relationship between certain variables and sexual desire. For instance, conservative sexual beliefs indirectly affected sexual desire by diminishing erotic thoughts. Absence of erotic thoughts (e.g., “that turns me on”) and failure/disengagement sexual thoughts (e.g., “when will this be over?”) reduced sexual desire. Previous studies showed that negative emotions like guilt and anger tend to distract women from sexual stimuli. This “suggests the need to better understand the impact of different emotions on female desire” (1813). This study supports a biopsychosocial approach to the assessment and treatment of sexual desire difficulties because research on the “interaction between predictors can explain, in a more comprehensive way, how each factor affects sexual desire in women” (1814).

7) DeLamater, John D. and Sill, Morgan. (2005) 'Sexual desire in later life', *Journal of Sex Research*, 42: 2, 138 — 149

This study takes a biopsychosocial approach to understanding sexual desire in men and women over the age of 45. The results are from a survey of 1,348 men and women in 1999 that included measures of diverse biological, psychological, and social factors that may influence sexual functioning. Variables included age, illness and medication use; attitudes, expectations, and knowledge; and presence or absence of a sexual partner, quality of relationship, education and household income. The authors conclude that the principal influences on strength of sexual desire among women are age, the importance of sex to the person, and the presence of a sexual partner. Attitudes were more significant influences on sexual desire than biomedical factors. One of the key findings in the research was that a woman’s sexual desire is more attuned to her relationship context than is a man’s. The results of this study “provide little support for an exclusively medical model of sexuality among the aging.” (148)

8) Dennerstein, L., Hayes, R., Sand, M., and Lehert, P. (2009) Attitudes toward and frequency of partner interactions among women reporting decreased sexual desire. *Journal of Sexual Medicine*, 6:1668–1673.

1402 U.S., German and Italian women who were 18-65, in a relationship, and bothered by decreased sexual desire completed a face-to-face questionnaire which assessed sexual interest and attitudes towards partner interactions. Results showed that higher levels of sexual interest

were associated with “increased frequency of a woman caressing her partner, telling her partner how she was feeling, sharing daily life activities with her partner, as well as reduced frequency of avoiding her partner’s sexual advances, or considering a separation from her partner” (1671). While these findings reveal the correlation between attitudes towards partner interactions and sexual interest, they failed to prove causality due to the cross sectional nature of the study. We need research that examines the causal direction between relationship quality and sexual interest, since logically the direction could be either way.

9) Graham, C. A., Sanders, S. A., Milhausen, R. R., & McBride, K. R. (2004) □Turning on and turning off: A focus group study of the factors that affect women's sexual arousal. *Archives of Sexual Behavior*, 33, 527-538

Nine focus groups included 80 women ages 18 – 84 were conducted in 2003. Each group had of 12 women from various demographic backgrounds, as well as two focus groups of lesbian/bisexual women and one group of African American women. The participants described a wide range of physical, cognitive/emotional, and behavioral cues to arousal. The relationship between sexual interest (desire) and sexual arousal was complex; sexual interest was reported as sometimes preceding arousal, but at other times following it. Many women were unable to differentiate between arousal and interest. Factors that contributed to enhanced or reduced arousal included feelings about one’s body, concerns about reputation, risks of negative consequences, feeling desired and accepted by a sexual partner, feeling “used” by a sexual partner, and negative mood. The data in this study supports a growing concern that current models of sexual arousal and sexual dysfunction may be too genitally focused and minimize the wide variety of factors that can affect arousal.

10) Goberna, J., Francés, L., Paulí, A., Barluenga, A., and Gascón, E. (2009) Sexual experiences during the climacteric years: What do women think about it? *Maturitas*, 62: 47–52.

Eighteen volunteers attending a health education program for menopausal women participated in focus groups for this study. In the focus groups, women discussed the climacteric stage of life and self reassertion, burden of biological factors in their lives, their journey through sexual life, and the importance of social/family factors with regards to sexual experience. The women in this study acknowledged that physical differences come with aging and menopause, but stated that biological factors had less influence on their sexual lives than did upbringing and psychosocial aspects. In this study, social, family, and structural factors had the greatest impact on sexual experience later in life. Tiredness, lack of intimacy and a reduced

living space that is often shared with parents or grownup children were also strong determinants of free expression of sexuality. The women said they felt calmer and more mature; they had become able to enjoy a “kind of sexuality in which the sexual desire characteristic of youth had been replaced by more rational sexual behavior” (51).

11) King, Michael, Holt, Victoria, and Nazareth, Irwin (2007) Women's views of their sexual difficulties: Agreement and disagreement with clinical diagnoses. *Archives of Sexual Behavior*, 36: 281-288.

This study sought to compare the ICD-10 diagnosis of sexual dysfunction with whether or not women perceived they had a sexual problem, their views on its origins, and its impact on their life. In London, 401 women aged 18 – 75 answered a questionnaire which contained diagnostic material from the BSFQ as well as open ended questions about their thoughts on sexual dysfunction. Based on reported symptoms and behavior, 38% of women had at least one ICD-10 diagnosis of sexual dysfunction. Prevalence fell to 18% in women who also perceived they had a problem and to 6% in women who regarded the problem as moderate or severe. The disjunction between medical diagnosis and women’s perceived sexual problems was the most extreme for sexual arousal disorder and lack or loss of sexual desire. Emotional and relationship difficulties were most often cited as causes for sexual dysfunction. This study concludes that “defining sexual problems is subjective and depends on the values, wishes, and sexual knowledge of the woman and her partner.” (287)

12) Hayes, R.D., Dennerstein, L., Bennett, C.M., Sidat, M., Gurrin, L.C., and Fairley, C.K. (2008) Risk factors for female sexual dysfunction in the general population: Exploring factors associated with low sexual function and sexual distress. *Journal of Sexual Medicine*, 5: 1681–1693.

1002 Australian women aged 20 – 70 completed a questionnaire comprised of multiple choice and open ended questions regarding their sexual behavior related to physiological, psychological and relationship factors. Results showed that duration of relationships was closely related to decreased sexual desire. Relationship factors were more important to low desire than age or menopause, whereas physiological and psychological factors were more important to low genital arousal and low orgasmic function. Sexual distress was strongly associated with both psychological and relationship factors. Intriguingly, “women who placed greater importance on sex in their lives were less likely to experience low desire, low arousal, and low orgasmic function,” (1691). The authors suggest more research is needed to determine the underlying reasons for this.

13) Hayes, R.D., Dennerstein, L., Bennett, C.M., and Fairley, C.K. (2008) What is the "true" prevalence of female sexual dysfunctions and does the way we assess these conditions have an impact? *Journal of Sexual Medicine*, 5:777–787.

A mailed survey was completed by 356 Australian women aged 20 – 70. The study compared various instruments that measure HSDD, sexual arousal disorder, orgasmic disorder, and dyspareunia. There was a large variance in prevalence rates using the different methods; the prevalence for HSDD varied from 32% to 58%, for example. This study provides evidence that the different instruments currently used to assess FSD can produce substantially different prevalence estimates. Predictive risk factors also varied with the instrument used. The authors note that as our understanding of these conditions evolve, so should the clinical definitions of FSD.

14) Kleinplatz, P. J., Ménard, A. D., Paquet, M.P., Paradis, N., Campbell, M., Zuccarino, D., Mehak, L. (2009) The components of optimal sexuality: A portrait of "great sex." *The Canadian Journal of Human Sexuality*, 18, 1; Research Library: 1-13

Telephone interviews were conducted in 2009 with 64 men and women – including 25 individuals over the age of 60 who reported having been in relationships of 25 years or longer and had experienced "great sex," 20 sex therapists, and 19 members of sexual minority groups. Volunteers were recruited through announcements posted in community groups and on email listservs. Participants were asked to distinguish between "very good" and "great" sex and discuss the common features of their best sexual experiences. Content analysis identified eight major themes: being present, connection, deep sexual and erotic intimacy, extraordinary communication, interpersonal risk-taking and exploration, authenticity, vulnerability and transcendence. Two minor components were identified: intense physical sensation and desire. These physical elements were mentioned only by a minority of participants and were not especially emphasized. The study conclusions stress that "normal" sexual functioning is not necessary to experience optimal sexuality and that clinicians have much to learn regarding optimal sexuality and sexual dysfunction.

15) Koch, Patricia Barthalow, Mansfield, Phyllis Kernoff, Thureau, Debra and Carey, Molly (2005) "Feeling frumpy": The relationships between body image and sexual response changes in midlife women', *Journal of Sex Research*, 42: 3, 215 – 223

This study focuses on data from the 1993 U.S. Midlife Women's Health Survey, which contained a section on body image. 307 women's responses

were analyzed with regards to body image, sexual response, and sexual satisfaction. The study demonstrated that body image has a significant impact on sexual desire, orgasm, enjoyment, and frequency of sexual activity, but not with sexual satisfaction. The majority of the women reported that they were sexually satisfied in their relationships, even though many reported sexual responsiveness and activity declines. Lessened sexual responsiveness generally did not concern most of the older women. "Older women's sexual satisfaction seems to be influenced more by contextual factors than bodily responses." (221) The study suggests that "in order to understand aging women's sexuality, we should place more emphasis on the sociocultural effects of aging (e.g., impacting body image) and the contextual features of women's lives (e.g., relationships)." (221)

16) Meston, CM, and Buss, DM. (2007) Why humans have sex. *Archives of Sexual Behavior*, 36, 477-507.

444 men and women from Texas aged 17 to 52 were asked the following open-ended prompt, "Please list all of the reasons you can think of why you, or someone you have known, has engaged in sexual intercourse in the past." 237 distinct reasons were gathered, and 1,549 other participants rated how frequently each of the reasons led them to have sex in the past. Further analysis classified the answers under four overriding factors: physical reasons, goal attainment, emotional reasons, and insecurity. The data reveal significant gender differences in reasons for having sex. Men more frequently cited physical desirability and pure availability while women cited more emotional motivations for having sex. The conclusions of the study emphasize that "human sexuality is motivated by a complex and multifaceted psychology. Efforts to reduce sexual motivation to a small number of variables are doomed to fail." (502)

17) Miller, S. Andrea and Byers, E. Sandra. (2004) 'Actual and desired duration of foreplay and intercourse: Discordance and misperceptions within heterosexual couples', *Journal of Sex Research*, 41: 3, 301 — 309

152 heterosexual couples aged 21 to 77 completed and returned a mailed questionnaire which sought to understand perceptions about male and female sexual scripts. The survey asked individuals about their actual and ideal duration of foreplay and intercourse, as well as their perceptions of their partners' desires and their beliefs about most men and women. The results showed that while men desire a longer duration of intercourse, there were no gender differences with regards to duration of foreplay. Both men's and women's perceptions of their partners' ideal duration of foreplay and intercourse were found to be more strongly related to their own sexual stereotypes than to their partners' self-reported sexual desires, suggesting

that people rely on sexual stereotypes when estimating their partners' ideal sexual scripts. The research also revealed that the differences between actual and desired durations of foreplay and intercourse were not associated with sexual satisfaction, which led to the study conclusion that quality is better than quantity.

18) Nicholls, Leanne. (2008) Putting the New View classifications scheme to an empirical test. *Feminism and Psychology*, 18: 4, 515-526.

An open ended questionnaire designed to collect heterosexual women's accounts of their sexual difficulties was completed by 49 London women. The women's responses were compared to the *New View Classification Scheme for Women's Sexual Problems*, which includes four categories: sexual problems due to socio-cultural, political, or economic factors; sexual problems relating to partner and relationship; sexual problems due to psychological factors; and sexual problems due to medical factors. 20% of responses could be classified as contextual/external, 65% as relational, 8% as psychological, and 7% as biological. The responses "suggest that the New View classification scheme for women's sexual problems does provide a valid framework for understanding sexual difficulties from women's points of view." (521) The significant importance placed on relational and contextual issues provides evidence to support that these should be seen as a priority in conducting a full assessment for either research or clinical purposes.

19) Nicolson, P, Burr, J (2003) What is 'normal' about women's (hetero)sexual desire and orgasm?: a report of an in-depth interview study. *Social Science & Medicine*, 57, 1735–1745

In-depth interviews with 33 women between 19 and 60 years of age explored respondents' sexual development and experiences. The women expressed their views of female sexuality with regard to sexual "norms" in place by society. Their reflections revealed a large difference between their constructed views of men's and women's sexuality. They described men's sexuality as "active, needy and demanding" and described their own sexuality as "active but different, and ambivalent to sexual intercourse" (1743). They said that for women, orgasm is not the primary outcome of sexual intercourse and penetrative sexual intercourse is not the only form of sex. This study suggests that many women place *themselves* in a dysfunctional category based on what is currently considered "normal" by society. Furthermore, "the potential of women's sexual fulfillment is yet to be realized through the clinical literature which remains deeply embedded in a predominately male, patriarchal and commercially centered view" (1744).

20) Sand M., and Fisher, M.A. (2007) Women's endorsement of models of female sexual response: The nurses' sexuality study. *Journal of Sexual Medicine*, 4: 708–719.

A random sample of 113 registered nurses completed a mailed questionnaire which assessed women's perceptions of the fit of their sexual experience with current models of female response. Women with FSFI scores in the sexually functional range were significantly more likely to endorse the linear Masters and Johnson or Kaplan models of female sexual response. They indicated that they engaged in sexual activity for the physical sexual experience. Women who were classified as sexually dysfunctional were more likely to endorse the circular Basson model and reported non-sexual and emotional reasons for engaging in sex. These results show that Basson's model "provides an expansion of, and further depth into, the earlier models that may be particularly relevant to women who experience sexual and emotional relationship dissatisfaction" (717). The authors conclude that none of the current models of sexual response can be considered a normative description.

21) Sanders, Stephanie A., Hill, Brandon J., Yarber, William L., Graham, Cynthia A., Crosby, Richard A., and Milhausen, Robin R. (2010) Misclassification bias: diversity in conceptualizations about having 'had sex.' *Sexual Health*, 7: 31–34

A telephone survey was conducted with 486 male and female Indiana residents aged 18-96. "Participants were given a list of 14 specific behavioral items and asked, for each one, 'Would you say you 'had sex' with someone if the most intimate behavior you engaged in was.....'" (32) The responses indicate that there is no universal consensus on which behaviors constitute "having sex." Therefore, it is likely that people across gender and age groups may use varying criteria to answer questions about how many partners they "had sex" with or how many times they "had sex." "The current study adds to a growing body of literature exploring the constructed meaning of language related to sexuality... The results provide empirical evidence supporting the need to use behavior-specific terminology in sexual history taking, sex research, sexual health promotion, and sex education." (34).

22) Schalet, A (2000) Raging hormones, Regulated Love: Adolescent sexuality and the constitution of the modern individual in the United States and the Netherlands. *Body and Society*, 6, 75-105.

Interviews were conducted in 1991/92 with Dutch and American parents of 16 year olds. "The American parents describe adolescent sexuality as a biologically driven, individually based activity which causes disruption to the teenager as well as to the family. The Dutch parents, by contrast,

emphasize the love relationships and social responsibility of teenagers which make their sexuality a 'normal' phenomenon." (P.76) Consequently, "whereas 12 out of 17 Dutch parents say they would permit their 16-year-olds to sleep together with a girl- or boyfriend in the home, 13 out of 14 American parents say they would not." (P 76)

American parents view teens as immature and not capable of "real" relationships or responsible behavior. They put teen sex in the same category as drug experimentation. Are these differences in outlook related to the higher incidence of youth HIV-AIDS and teen pregnancy in the US? Are they connected to the absence of comprehensive sex ed in the US and the greater anxiety about sexual performance?

23) Seal, BN, Bradford, A, and Meston, CM (2009) The association between body esteem and sexual desire among college women. *Archives of Sexual Behavior*, 38: 866-872

85 sexually active college women participated in this study, which studied the link between physical self esteem and sexual responses. Participants completed a questionnaire in a laboratory setting that included the Female Sexual Function Index, the Body Esteem Scale, and a baseline sexual arousal scale. They then read an erotic story and filled out a second sexual arousal rating scale. Body esteem was positively related to sexual desire, including desire to erotica as well as desire in real life situations. The answers relating to body characteristics that are most likely to be under public scrutiny (sexual attractiveness and weight concerns) were particularly linked to sexual desire. This study reinforces the importance of considering body image in conceptualizing women's sexuality, and "leads one to question whether women with low body esteem might be particularly prone to difficulties with sexual response." (871)

Theoretical Sources:

24) Basson, Rosemary. (2006) Sexual desire and arousal disorders in women. *The New England Journal of Medicine*, 354: 1497-1506

In this paper, psychiatrist Rosemary Basson highlights physiologic, cognitive and emotional factors influencing sexual desire and arousal, including distractions, expectations of a negative experience, sexual anxiety, fatigue, depression and mental health, positive self-image, and positive feelings for the partner. She recommends that evaluation of women with desire and arousal disorders should start with a detailed sexual history of both partners, an assessment of the woman's mental health, feelings about the relationship, medical history, and thoughts and emotions during sexual activity. She also proposes a "combination of cognitive behavioral therapy and sex therapy focused on altering maladaptive thoughts, unreasonable expectations, and misinformation about women's sexuality, as well as

discussing strategies for improving the couple's closeness and communication and enhancing erotic stimulation." (1505) She would *not* recommend "any pharmacologic therapy, pending the availability (and longer-term) data in support of such treatment." (1505)

25) Brotto, Lori A. (2010) The DSM diagnostic criteria for Hypoactive Sexual Desire Disorder in women. *Archives of Sexual Behavior*, 39:221–239.

Brotto offers an overview of research on sexual desire. She also critiques prior and current diagnoses of HSDD in editions of the DSM, and she proposes new criteria for consideration in DSM-V. Currently, the two criteria for diagnosing HSDD are "(1) persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity which causes (2) marked distress or interpersonal difficulty" (221). It is very important to note that distress was not assessed in the most cited studies that report the prevalence of low sexual desire in women to be 43%. In studies where distress was measured, the prevalence of low sexual desire with accompanied distress was much lower (between 9 and 26%). The variability in prevalence rates in these studies makes identifying a single prevalence difficult and inaccurate (224). The article also discusses the various definitions of sexual desire found in the literature, and notes a disparity between the DSM definition of desire and how women themselves describe it. She emphasizes that due to the variance in the literature, women's sexuality and desire are far from fully understood. She mentions that studies have shown significant confusion in understanding untriggered versus responsive desire, and that often times, desire and arousal overlap. Brotto recommends merging sexual desire and arousal disorders into one category, revising the criteria in the definition of low sexual desire, and using a multi-faceted approach to diagnosis which recognizes varying degrees of and causes of low sexual desire.

26) Wood, J., Koch, P., & Mansfield, P. (2006) Women's sexual desire: A feminist critique. *Journal of Sex Research*, 43: 236-244.

This essay offers a critical feminist analysis of the biomedical conceptualizations of women's sexual desire. It criticizes the use of male models as the standard for women and the use of a linear model of sexual response. It states that we limit our knowledge of women's sexuality by focusing on a narrow biomedical model. The essay argues that "the biomedical view of sexual desire promotes concern over what constitutes "normal" versus "abnormal" and "high" versus "low" levels of desire." (239) It cautions clinicians against this model because the created "normal" levels of desire might make women perceive they have a problem when they are perfectly fine. It goes on to advise that in the future, research on women's

sexuality focus more on qualitative analysis and biopsychosocial models to better understand women's sexuality from all angles.

27) Vanwesenbeeck, Ine. (2009) Doing Gender in Sex and Sex Research. *Archives of Sexual Behavior*, 38:883–898.

Based on her 2008 IASR Presidential Address, Dutch researcher Ine Vanwesenbeeck reviews the state of gender research in sexology and concludes that there is too much simplistic sex differences research. She is convinced that, "the ambiguity in the evaluation of women's sexuality [the sexual double standard] ...may, as a matter of fact, cause ambiguous, confused sexual behavior and experience. Detrimental effects of the sexual double standard for women's as well as men's sexual experience have been described and empirically confirmed by many," (888). She emphasizes that there is a lot of societal pressure to express gender norms which can lead to negative emotional and behavioral outcomes. These "restrictive gender norms, which undermine women's power, competence, and agency, help account for women's higher rates of depression, poorer standardized scores on a variety of psychological outcomes, and higher discontent with sex" (888). She also mentions that habitual outer body-monitoring due to low self esteem can distract women from internal bodily cues and hinder their sexual satisfaction.