Stony Brook University

The Medicalization of Gender and Sexuality:

Women's Responses to "Female Sexual Dysfunction"

A Dissertation Presented

by

Amy Braksmajer

to

The Graduate School

in Partial Fulfillment of the

Requirements

for the Degree of

Doctor of Philosophy

in

Sociology

Stony Brook University

December 2013

Stony Brook University

The Graduate School

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Abstract of the Dissertation

The Medicalization of Gender and Sexuality:

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Scholarly interest in the social construction of female sexual dysfunction has tended to focus on the medicalization of women's sexual desires and behaviors, which can be traced back to the early 1970's with the publication of Masters and Johnson's Human Sexual Inadequacy. Not much is known, however, in regards to the ways in which women make sense of sexual problems as "dysfunctions", or the ways in which medical interpretations of these problems affect the ways in which women experience gender, sexuality, and their bodies.

In this qualitative study, I am interested in understanding: a) how, and to what degree, women come to view their sexual problems as sexual dysfunctions; and b) how the medicalization of female sexual dysfunction – or lack of it - affects women's gendered and sexual identities and practices. To do so, I conducted a comparative qualitative study of three populations: women with sexual pain, including (but not limited to) women with vulvodynia (a condition causing pain during penetrative intercourse), women with hypoactive sexual desire disorder (commonly understood as low libido), and women with anorgasmia (the inability to achieve orgasm).

I first examine the ways in which women are expected to achieve normative gender via sexual activity and/or feeling, as well as the consequences of the inability or disinclination to engage in such activity for women's sense of themselves as gendered beings. Next, I elucidate the causal narratives women used to explain their sexual problems, as well as the strategies used to address them. Finally, I examine the ways in which both women and their physicians lay claims to bodily expertise in regards to sexual difficulties, paying particular attention to the delegitimation of women's experiences and strategies of resistance. In doing so, I hope to contribute to the literature on the ways in which gendered sexuality is constructed by examining what happens when sexual experience is medically pathologized, as well as the means by which women attempt to restore their sexual capabilities.

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ACKNOWLEDGMENTS

I wish to express thanks to the members of my committee: Michael Kimmel, Cathy Marrone, Eileen Otis, and Lisa Diedrich for their helpful comments and ongoing support. As a leading scholar in gender studies, Michael Kimmel's assistance was invaluable in contributing to my understanding of masculinity and femininity, and the ways in which the two are co-constructed. Cathy Marrone, who was always available to discuss my work, provided generous feedback with kindness and good humor. Eileen Otis' careful reading helped me to sharpen my focus and critically engage with the ideas presented in this dissertation. Finally, in sharing her knowledge of issues relating to women's health more broadly, Lisa Diedrich helped to provide a useful context within which to situate my work.

This dissertation would also not have been possible without the support of the women who took the time to speak with me so that I may learn from their experiences. Their intimate knowledge, and their unflagging courage in the face of sexual difficulties gave me tremendous insights into the ways in which medicalization affects real women in real situations. I hope that this work does them justice; they deserve nothing less.

Furthermore, I would like to acknowledge the feminist scholars that came before me and laid the foundation for this work. In particular, I would like to acknowledge Leonore Tiefer, whose groundbreaking work paved the way for my initial interest in this field, as well as provided a starting point for scholarly inquiry. Her passionate activism and keen insights have proven to be an inspiration.

I would also like to express thanks to my mother and father, who instilled in me a love of learning, a thirst for reading, and a commitment to social justice. Thanks also to Misty Curreli, Sonja Gschossman, Rachel Kalish, Saul Braksmajer, Kim Lehnert, and Marie Bances for keeping me sane throughout the process. Finally, to Michael Restivo – my friend, my editor, my partner. I couldn't have done it without you.

CHAPTER 1: INTRODUCTION

The American Psychiatric Association's Diagnostic and Statistics Manual of Mental Disorders (DSM), the most widely used system for classifying men and women's sexual problems, defines female sexual dysfunction as "disturbances in sexual desire and in the psychophysiological changes that characterize the sexual response cycle and cause marked distress and interpersonal difficulty." (American Psychiatric Association, 2000). The DSM-V, released in 2013, identifies three major categories of dysfunctions: sexual interest/arousal disorders, orgasmic disorders, and genito-pelvic pain/penetration disorders Laumann, Paik, and Rosen (1999) put the prevalence of female sexual dysfunction at 43% – almost half of all women; notwithstanding strong critiques of the study's methodology (Bancroft 2003), it has been cited over 1,800 times in the medical and psychological literature to date. Furthermore, popular media outlets have been quick to disseminate these findings. Oprah Winfrey has declared that women are suffering from a "secret epidemic" of sexual problems. But is this true? What is the nature of this epidemic, and how has it come to be defined as such? Most importantly, how are women responding to it?

While much of the existing literature on the medicalization of female sexuality is theoretical in nature – or, alternatively, studies of the pharmaceutical and medical construction of "female sexual dysfunction" - there have been relatively few empirical studies examining the effects of this phenomenon on women themselves. Little is known, for example, about how women make practical sense of sexual problems as "dysfunctions" or the ways in which medical – or non-medical - interpretations of these problems affect how women experience gender, sexuality, and their bodies.

In this qualitative study, I am interested in understanding: a) how, and to what degree, women come to view their sexual problems as sexual dysfunctions; and b) how the medicalization of female sexual dysfunction – or lack of it - affects women's gendered and sexual identities and practices. To do so, I conducted a comparative qualitative study of three populations: women with sexual pain, including (but not limited to) women with vulvodynia (a condition causing pain during penetrative intercourse), women with hypoactive sexual desire

disorder (commonly understood as low libido), and women with anorgasmia (the inability to achieve orgasm). I first examine the ways in which women are expected to achieve normative gender via sexual activity and/or feeling, as well as the consequences of the inability or disinclination to engage in such activity for women's sense of themselves as gendered beings. Next, I elucidate the causal narratives women used to explain their sexual problems, as well as the strategies used to address them. Finally, I examine the ways in which both women and their physicians lay claims to bodily expertise in regards to sexual difficulties, paying particular attention to the delegitimation of women's experiences and strategies of resistance.

In doing so, I hope to contribute to the literature regarding the ways in which gendered sexuality is constructed by examining what happens when normative sexuality "fails" and sexual experience is pathologized. I also hope to offer a lens into how medicalization is implicated in the construction of gender and sexual identities, as well as how cultural tropes regarding gender and sexuality come to influence the process of medicalization itself. Finally, taking a Foucauldian feminist approach, I hope to add to discussions of biopower, resistance, and the production of the sexually dysfunctional subject.

Background and Significance

Definition of Medicalization

Zola (1972) has defined medicalization as the process by which aspects of everyday life come to defined as health issues, to be diagnosed and treated by physicians. Conrad (2013) suggests that medicalization takes four primary forms:

1. The regulation of deviant behaviors (e.g., alcoholism, ADHD, homosexuality). In this instance, what was once "bad" or morally reprehensible is now "unhealthy".
2. The regulation of natural life events (e.g., childbirth, menopause). In this instance, the life course is subjected to rationalized control.
3. The resolution of problems in everyday living (shyness, normal sadness). In this instance, problems once associated with the human condition become illnesses to be cured.

4. The enhancement of healthy people (e.g., via cosmetic surgery, cognitive enhancements). In this instance, individuals seek to exceed normal biological limits, becoming "more than human".

Morgan (1998) outlines three requirements for medicalization; first, the topic or process must be understood in medical terms and through dominant medical discourse/paradigms. Second, medical authorities must be seen as the primary authorities regarding the topic or process, having both the authoritative knowledge regarding the medically defined problem and control over the means to apply that knowledge. Third, there must be widespread individual and group acceptance of the dominant conception of medicalization, as well as active participation in its macro- and micro-institutions.

While early formulations of medicalization suggested that it was a top-down process, in which the medical profession exercised control over disempowered patients who lacked agency, more recent work has focused on the role of social interest groups and market interests (e.g., the actions of consumers and pharmaceutical companies) in driving medicalization (Riska, 2010). Furthermore, as Halfmann (2011) and Conrad (2013) point out, medicalization is not an either-or proposition; rather, medicalization may occur by degrees, and medicalization and demedicalization may take place simultaneously.

In recent years, scholarship has focused on the concept of biomedicalization, which draws on this original conception of medicalization but differs in several key points. Biomedicalization is characterized by: a) an intensified focus on health (in addition to illness and injury) as well as optimization and enhancement of the physical body; b) increased efforts towards elaborating risk and engaging in preventive surveillance (e.g., genetic testing for risk of breast cancer); c) the technoscientization of biomedical practices, where interventions for treatment and enhancement are characterized by an increasing reliance on technology; d)transformations of biomedical knowledge production, information management, distribution, and consumption; and e) the development of technoscientific illness identities. Whereas medicalization focuses on control of the unruly body, biomedicalization focuses on its transformation (Clarke 2010).

Medicalization, however, is not restricted to biomedicine; rather, psychology has also played a role in the transformation of deviance to illness. While most literature on

medicalization focuses on the control or transformation of the physical body, a frequently cited example of demedicalization is that of homosexuality, which was removed from the DSM in 1973. This suggests that medicalization may, in fact, include psychologization, although the literature is largely inconsistent on this score. Of note, however, biomedicalization and psychologization have several factors in common: a) both encompass conceptions of health (i.e., "mental health/illness" vs. "physical health/illness"); b) both act as sources of biopower, in which individuals are encouraged to engage in self-surveillance and/or control or alter the self in response to bodily experiences that are seen as problematic; and c) in both cases, individuals subject themselves to the authority of medical knowledge via reliance on medical expertise. In addition, the lines between psychology and biomedicine have long been blurred; for example, as I explain in Chapter 6, OB-GYN specialists explicitly allied themselves with the mental health profession after World War II, while biopsychosocial models of health and illness emphasize the interrelation of biological, psychological, and social factors in fostering health and illness. Thus, I argue that medicalization actually consists of two interconnected strands, biomedicalization and psychologization; while the former may or may not be taking precedence over the latter in the 21st century – even psychological processes are being increasingly defined as products of neurobiology - it is important that we continue to take seriously the role of psychology in the pathologization of individual experience.

Critiques of Medicalization

It has been argued that medicine has become a (purportedly value-free) replacement for religion as a source of social control, securing adherence to social norms and maintaining social order (Zola, 1972; Foucault 1978). As Foucault has pointed out, this control is not coercive; rather, it functions by convincing individuals of the appropriateness of the medical standard, so that potential patients willingly take up these standards as their own. Foucault has also noted the disciplinary power of medicine, which is rooted in its ability to monitor, observe, measure, and compare to established standards of behavior and feeling. With medicalization, difference is positioned as pathology, and stigmatized or otherwise undesirable bodily conditions are posited as being subject to change with the proper medical treatment, which physicians and other practitioners have the power to provide. Physicians have become the cultural arbiters of

normality who are able to deem who is pathological and who is not. Even if a particular individual is not considered pathological, all people are deemed *potentially* pathological, as medicine and public health uses the language of risk management and prevention to regulate behavior while increasing surveillance over populations in order to monitor these risks. In addition, it has become a moral imperative to be healthy; to fulfill this imperative, individuals become voluntarily self-governing in the quest for health and wellness.

Medicalization often leads to the neglect the underlying social causes of suffering by depoliticizing and individualizing negative bodily experiences. In regards to depoliticization, medical discourses reduce the degree to which individuals understand their emotions, behavior, or bodily feelings as due to unequal power relations. For example a contributor to women's experience of premenstrual distress may be a reaction to the "double shift" of paid work and childcare, or gendered relationship dynamics. Thus, medicalization serves to reinforce patients' accommodation to their social worlds. At the same time, individualization locates problems within individual bodies, rather than their social contexts.

With medicalization, it is assumed that all bodies function in the same way regardless of cultural norms; thus, treatments of illness take on a "one size fits all" process of bodily normalization. In this way, Marshall (2010) argues, bodies become fragmented into functional anatomies; no longer is health defined by conceptions of "normal" and "abnormal", but in terms of "functional" and "dysfunctional." She goes on to point out that functionality is measurable and standardized, as normality cannot be; furthermore, the discourse of functionality "disassembles the body and materializes it around discrete functional subsystems, such as genetic, hormonal, neurochemical, and vascular systems." Furthermore, Marshall suggests that this view of the body is at the root of what she calls "the pharmaceutical imagination", in which drugs become the preferred means by which medicalized conditions are treated.

Medicalization and Gender

A significant amount of scholarship has centered on women's experiences of medicalization; these discussions have largely focused on women's reproductive health. For example, childbirth has been largely medicalized; it used to take place at home, often with the help of a midwife, but it now almost exclusively performed in hospitals. This can be attributed to

the expanding medical profession, medicine's pursuit of professionalization, and physician's growing monopoly over healing from the 17th to the 19th centuries (Cahill 2001). Medical schools were closed to women, and female healers lost legitimacy in the face of "scientific" medicine. Some authors have suggested that the medicalization of childbirth results in passivity and loss of control on the part of the patient, as she becomes dependent on the physician to carry her through a safe pregnancy and birth (Brubaker and Dillaway 2009; Cahill, 2001). Women, on their own, are seen as deficient in that they cannot engage in their natural bodily processes on their own; rather, in order to help fulfill their gendered role, they must rely on medical processes.

The medicalization of menopause is another example of how gendered life processes have been medicalized. Menopausal women are seen to be deficient in comparison to pre-menopausal bodies , which serve as a standard for womanhood. McCrea (1983) identified four themes that pervade medical definitions of menopause: 1) that women's potential and function are biologically destined; 2) women's worth is determined by fecundity and attractiveness; 3) rejection of the feminine role will bring physical and emotional havoc; and 4) aging women are useless and repulsive. In the 1960's, writers pointed out that estrogen deficiencies effectively transformed women into men:

> "As estrogen is shut off, a woman becomes as close as she can to being a man. Increased facial hair, deepened voice, obesity, and decline of breasts and female genitalia all contribute to a masculine appearance. Not really a man but no longer a functional woman, these individuals live in a world of intersex. Having outlived their ovaries, they have outlived their usefulness as human beings." (quoted in McCrea, 1983)

More recently, women have been told that estrogen deficiencies can lead to a myriad of health problems, including osteoporosis, heart disease, and Alzheimer's; furthermore, they have been told that menopause is a threat to their quality of life (Meyer 2003). Such a deficiency can be remedied by hormone replacement therapy, which has been marketed as a way to "stay feminine forever" (McCream, 1983) by helping women to maintain sexual interest, remain sexually attractive, and resist problematic changes in mood. Furthermore, Ramirez (2006) found that for women in Oaxaca, Mexico, HRT was being promoted as a way to prevent the potential dissolution of the nuclear family, as menopause was seen to affect family well-being; thus, HRT

was seen as a way for women to fulfill their caring feminine role. Hormone therapy has been critiqued in that it increases the likelihood of breast cancer and other diseases; regardless, medicalization is a means by which women can retain their ability to achieve gendered ideals of behavior and appearance.

Women's experiences of menstruation have also been medicalized. Pre-menstrual distress, at one point dismissed by the medical profession, became legitimized once categorized as "pre-menstrual syndrome" in 1953. Symptoms were thus given the status of a "real" physiological complaint, which is not always unwelcome to women suffering from such distress (Lee 2002). Premenstrual distress was further medicalized by the introduction of Late Luteal Phase Disorder to the DSM III-R in 1987, which was replaced by Premenstrual Dysphoric Disorder in the DSM-IV. This was the case even though there is no "proof" of a menstrual cycle-related condition that could be characterized as an illness (Offman and Kleinplatz 2004). The construction of PMS as a medical label reflects cultural assumptions about the role and behavior of women (Offman et. al, 2004). In the case of PMS, the "normal" woman is constructed in comparison with her "abnormal" and "unhealthy" other, who openly expresses negative emotions and experiences either changes in mood or negative affect. The media often presents PMS as a medical label that explains almost every fluctuating disturbance of a woman's well-being in the reproductive years Offman et al. 2004). In addition, Markens (1996) found that in popular magazines, physicians are often used as "experts" to give credence to PMS as a legitimate topic, while women's experiential accounts are used to further provide authenticity to medical narratives. Finally, in regards to remedies, the focus is usually placed on women's individual bodies and lifestyles, rather than social/structural factors that might have contributed to distress, such as the competing demands of work and home.

Women also look to medicine to help achieve cultural ideals of beauty; breast implants are one example. This no longer stops at the visible or public body; recently, there has been a steady increase in female genital cosmetic surgeries. There is no official data regarding the number of women who undergo these procedures each year, but it has been estimated that it is the fastest growing plastic surgery sector in the United States. It includes procedures like labiaplasty (designed to reduce the inner labia and make them symmetrical), vaginoplasty (designed to tighten the vagina, often after childbirth), and hymenoplasty (designed to "restore"

the hymen). Even though many physicians claim that these procedures increase women's sexual pleasure, possible risks from genital procedures are painful scarring or nerve damage that could result in loss of sensation or hypersensitivity to pain. The increase in genital cosmetic surgeries means that genital diversity is being pathologized. All women's genitals are different, but now this difference is seen as abnormal and requiring repair. Furthermore, in the case of vaginoplasties, the typical condition of a woman's genitals after childbirth has been designated "dysfunctional". The idea of surgery to improve women's genitalia is not new; it has been long been seen as a way to resolve problems of a psychological or sexual nature (Braun 2010). Psychological distress, however, is being caused in this case by cultural standards of feminine beauty, which women turn to medicine to achieve.

While most of the attention given to medicalization and gender has focused on the experiences of women, men's experiences have also been increasingly medicalized in recent years. Some writers have suggested that, just as women undergo menopause, men undergo an analogous process known as andropause, purportedly caused by a decrease of testosterone with age. Testosterone replacement therapy is on the rise, despite the dearth of studies about its risks and benefits (Szymczak and Conrad 2006). In addition, the medicalization of impotence and the construction of "erectile dysfunction" set new behavioral standards for men and marks countless male bodies in need of repair (Loe 2006). Failure of the penetrative male body reflects a failure of masculinity, which drugs such as Viagra can restore. These drugs recast the aging male body as something that is perfectible, subject to self-control, and endlessly virile (Marshall 2006). In these ways, some scholars believe, conceptions of ideal masculinity have been commodified (Loe, 2006).

At times, medicalization of a particular condition comes to directly define one's gender, as in the case of intersexuality and transgenderism. In looking for the causes of intersexuality, medicine pathologizes the intersexual body and routinely intervenes, even though the majority of intersexual children do not require gender assignment for their physiological health (Preves 2002). Instead, physicians, who subscribe to the notion that there are only two "natural" sexes, justify intervening on the grounds gender assignment is psychologically necessary if the child is to become a functioning, well-adjusted adult. Physicians use the length of the penis to help decide whether to refashion the intersexual child as a boy or a girl, sometimes prioritizing this

over chromosomal sex. If the child is to become a girl, the "clitoris" is trimmed back, even though this often results in a loss of sensation. Thus, penis size (a marker of masculinity) becomes the standard against which true sex – and, by extension, gender - is measured. Later, the gendered body is further produced by the administering of hormones at puberty. As in the case of the conditions mentioned above, medicalization individualizes intersexuality by deeming the intersexual body problematic, rather than the social order that creates the gender binary (Preves, 2002).

In regards to transgenderism, gender variance has been classified as Gender Identity Disorder in the DSM, becoming a psychological condition that justifies gender reassignment surgery. This surgery is used to refashion individuals so that their bodies reflect what they feel is their "true" gender, revealed by identification with and expressions of gender-coded behaviors not typically associated with one's birth sex (Currah, Green and Stryker 2009). Those who wish to have this surgery or take hormones must be first examined by a medical professional, who can establish the presence of Gender Identity Disorder. In this way, gender nonconformists become patients to treat; again, rather than examine the social system that pathologizes gender nonconformity, the medicalization of transgender locates the "problem" within the individual psyche. It is important to point out that transgender individuals often resist the pathologization of gender identity, while depending on medicine to alter their bodies so that they can conform to the gender to which they feel they belong; in either case, medicine is the means by which gender is created.

The Medicalization of Female Sexuality

With the advent of companionate marriage in the early 20th century, women were transformed from beings that were not expected to enjoy or desire the sexual act beyond its procreative nature to those who were expected to enjoy sexual intercourse (within the marriage relationship) as one of the best, most pleasurable, and most important experiences known (Clark, 1937; Rossiter, 1939). Instructional sex manuals of the time encouraged constant self-surveillance regarding proper sexual technique, feelings, and response. These posited sexual activity as a fundamental and necessary means of cementing heterosexual relationships (Jackson and Scott 1997). It is in this context that the definitions of normal sexuality took on additional importance, and sexual problems became vital to diagnose and treat.

During the first half of the 20th century, psychoanalysts dominated the field of sex therapy. Treatments for "frigidity" (which could encompass anything from lack of sexual desire to the inability to achieve a vaginal orgasm in coitus) were largely based in talk therapy. Such therapy was meant resolve unresolved childhood conflicts in regards to one's relationships with one's parents, including conflicts about gender roles. Sexual problems were seen as manifestations of a broader psychopathology that needed to be addressed in order for the sexual symptoms to be resolved.

During this time, sexologists struggled to establish themselves as a distinct discipline; in order to do this, they had to distinguish themselves from psychoanalysts. Their critiques of psychoanalysis to treat sexual problems were twofold: first, they asserted that talk therapy based in psychoanalytic theory was slow, expensive, and not very successful. Secondly, and perhaps more importantly, they critiqued psychoanalytic models as being either untestable or without empirical support (Morrow 1994). By doing so, they paved the way for what they considered more scientific and objective explorations of sexual functioning, based on physiology.

Masters and Johnson, who regularly invoked medical authority when discussing their research, were the first sexologists to popularize the physiological study of human sexuality. They began their studies in 1954, observing and recording the physical details of human sexual response (derived from masturbation and coitus) in scientific laboratory conditions. By 1965, they had collected data from 382 women and 312 men, encompassing approximately 10,000

episodes of sexual activity (Masters and Johnson 1966). Based on this research, they published *Human Sexual Response* in 1966, in which they proposed that human sexual response could be divided into four linear and sequential stages: excitement, plateau, orgasm, and resolution. These were seen as natural outcomes of "effective sexual stimulation." In relying on physiology to describe this sexual response, Masters and Johnson were able to claim that it was natural, universal, and largely reflexive; it is important to note that Masters and Johnson did not speak of "a" sexual response cycle but only of "the" sexual response cycle that was shared by men and women alike (Tiefer 1995).

Sexual problems were those that interfered with any of the four stages of sexual response that Masters and Johnson had outlined as the norm. Masters and Johnson viewed sexual difficulties as a major problem; they frequently stated that at least half the married couples in the United States suffered from sexual problems, and that failures of sex could seriously damage intimate relationships (Irvine 1990). Masters and Johnson quoted Nizer as saying, "the greatest single cause for family-unit destruction and divorce in this country is a fundamental sexual inadequacy within the marital unit." To address this problem, Masters and Johnson published *Human Sexual Inadequacy* in 1970, which was the first comprehensive account of treatment modalities for female sexual problems, such as orgasmic dysfunctions, vaginismus, and dyspareunia.

In allying themselves with a medical model, they were able to locate sexual problems in a model where immediate solutions were easily attainable (Irvine, 1990). "Normal" sexual response could be achieved by anybody with the application of the proper techniques, which were largely behavioral in nature (e.g.,. the "squeeze" technique for premature ejaculation, or directed masturbation for female orgasmic problems). Along with sexual advice and basic sex education, these techniques were meant to help couples unlearn the "bad sexual habits" that led to their particular dysfunctions (Irvine, 1990).

Both *Human Sexual Response* and *Human Sexual Inadequacy* became best sellers and were translated into more than thirty languages. With the rise in popularity of Masters and Johnson's work, it became legitimate to seek treatment for sexual problems (Irvine, 1990). In response to this growing demand, there was sharp increase in the number of sex therapists

throughout the 1970s, most of whom based their clinical work on Masters and Johnson's therapeutic modalities.

Masters and Johnson's work, however, did not account for sexual desire. In response to this omission, Helen Singer Kaplan - another major figure in the development of sex therapy - collapsed Masters and Johnson's four-stage response cycle into two components, arousal and orgasm, and added sexual desire as a third component in 1977. A psychiatrist, Kaplan's sex therapy program synthesized Masters and Johnson's behavioral treatment models with psychoanalysis, and was based on the belief that sexual difficulties stemmed from either remote or immediate psychological determinants (Irvine, 1990). She did, however, continue to outline what she considered to be the physiological bases of desire, arousal, and orgasm, claiming that the control of desire was related to levels of testosterone (or, as she put it, "the libido hormone") (Tyler 2009) and that desire was the result of "the physical activation of a specific neural system in the brain" (Kaplan 1979).

The Diagnostic and Statistical Manual of Mental Disorders' classification of sexual dysfunctions is largely based on Masters and Johnson and Kaplan's models of sexual response. The first edition of the DSM, released in 1952, did not list sexual disorders at all; instead, they considered such disorders symptoms of other psychiatric disorders. The second edition, released in 1968, listed dyspareunia and impotence as forms of psychosomatic disorders, psychiatric conditions that manifested themselves in physical symptoms. Kaplan served on the task force on sexual dysfunctions for the DSM-III, released in 1980, which was the first to list sexual disorders by name. For women, these included inhibited sexual desire, inhibited sexual excitement (based on a lack of physiological arousal), inhibited female orgasm, functional dyspareunia, and functional vaginismus. Since then, the number of categories and diagnostic criteria of female sexual dysfunction in the DSM have changed with each edition, although in each case interference with the "complete sexual response cycle" is held as a constant basis for diagnosis.

The (Re)Medicalization of Female Sexual (Dys)function

Tiefer (2002), has argued that the medicalization of female sexual dysfunctions has undergone a dramatic shift, thanks to the deregulation of the pharmaceutical industry and the and the increasingly cultural belief that idealized sexual bodies can be easily be attained via

pharmaceutical intervention. She traces the history of the development of female sexual dysfunction as a medically treatable disorder over a period of years, beginning with a pharmaceutical industry-sponsored conference in 1997 where participants gathered to learn about the physiology of women's sexual functioning, as well as potential treatments for sexual difficulties. The definition of female sexual dysfunction, however, remained unclear.

In order to remedy this problem, a closed-door, industry-sponsored consensus conference was held in 1998. The goal of the conference was for the participants to develop a classification system that would include both psychologically- and biologically-based disorders and that would "parallel the clinical and basic science developments for men" (Basson et al. 2000). The majority of conference presentations focused on biomedical aspects of sexual dysfunction, including reviews of genital physiology and clinical trials of medical treatments (Hartley 2003), and the conference's final report placed an emphasis on the possible biomedical causes of sexual dysfunction, Other industry-funded conferences and continuing medical education workshops on female sexual dysfunction soon followed (Tiefer 2006).

The success of pharmaceutical approaches in treating men with erectile dysfunction (i.e., Viagra) led the pharmaceutical industry to attempt to invent and market similar drugs for women. Clinical trials of Viagra in women, meant to target "female sexual arousal disorder"- specifically, "vaginal engorgement and clitoral erectile insufficiency syndromes" (Marshall, 2009) - did not demonstrate any difference over placebo, and such trials were largely halted by Pfizer in 2004. Since then, most industry efforts have attempted to develop a drug that would enhance female sexual desire; for example, in 2010, Boehringer Ingelheim attempted to gain FDA approval for Flibanserin, a nonhormonal treatment meant to treat low libido in premenopausal women. This treatment, however, was rejected by the FDA, which claimed that the risks of such treatments outweighed the benefits. Even without FDA approval for treatments aimed at women with sexual dysfunction, and the lack of clinical trials establishing effectiveness of drugs designed for men with erectile dysfunction in women, doctors often prescribe these and similar drugs (e.g., Viagra, Cialis, testosterone) off-label to women who present with sexual problems in the clinical setting (Hartley and Tiefer 2003).

This new pharmacological approach to female sexual dysfunction has been aided by publicity created by the mass media. For example, beginning in 2001, Drs. Laura and Jennifer

Berman (one a sex therapist, the other a urologist) have become increasingly visible in popular publications, talk and other television shows as promoting a predominantly biomedical perspective on women's sexual problems, even as they claim to integrate the strengths of psychotherapy with the forefront of women's sexual medicine (Hartley, 2006). In the absence of alternative frameworks regarding sexuality, audiences rely on professional "experts" to tell them what and how to think about their sexual problems. This is especially the case given that sexual problems are often shrouded in embarrassment and discomfort, giving women few other outlets to explore these issues. When these problems are framed as biomedical in nature by the mass media, women may look to pharmaceutical agents for their cure.

CHAPTER 2: METHODS

This study draws upon a long tradition of feminist work examining women's lived experience of illness, as well as studies examining the ways in which women come to form gendered and sexual subjectivities. As such, feminist epistemologies, as well as the use of feminist methods to collect, analyze, and interpret data, was at the forefront of the research strategy described below. Feminist epistemologies: a) privilege women's lived experience as a central point of analysis; and b) accept women's stories of their lives as legitimate sources of knowledge (Campbell and Wasco, 2000). In doing this research, I was primarily interested not in an "objective" truth, but in how women conceived of their experiences in a broad sense. See **Table 1** for a summary of research questions and hypotheses.

Method

This study took place in two phases. In the first phase, I recruited and interviewed a sample of women diagnosed with vulvodynia, a condition that causes pain upon attempted vaginal entry and/or tenderness to pressure within the vaginal vestibule that either prevents or impedes sexual intercourse. In the second phase, I expanded my sample to include women with sexual pain (regardless of diagnosis), low libido, and/or anorgasmia. Please see Appendix A for a list of participants and their characteristics.

I will discuss the recruitment strategy, sample, and data collection strategy for each phase below; this will be followed by a discussion of my overall analysis strategy. This research was approved by Stony Brook University's Office of Research Compliance for Human Subjects.

Phase 1

Phase 1: Recruitment. Recruitment for this phase took place from 2007 – 2008. Subjects were primarily recruited via the National Vulvodynia Association's e-mail listserv for New York State. The National Vulvodynia Association is a patient support and advocacy group, which encourages a biomedical interpretation of sexual pain for its members and engages in physician education surrounding these matters. Thus, the experiences of these women represents a

Table 1: Research questions and hypotheses

Research Questions	Hypotheses
How do sexual difficulties affect women's gendered and sexual identities and practices?	1. Women with sexual difficulties will experience a sense of gender failure or inadequacy in the face of sexual problems due to the inability to fulfill prescribed roles in intimate relationships. 2. The degree to which women experience gender inadequacy will differ according to sexual identity and relationship status. 3. In regards to sexual practices, all women will experience internal and external pressure to engage in sexual activity/have orgasms in order to maintain intimate relationships, regardless of the perceived etiology of sexual problems, as reflected in prior research. Women with sexual pain, however, will be most able to resist sexual activity or participate in alternative sexual behaviors to the exclusion of intercourse.
How, and to what degree, do women come to understand sexual problems as medical phenomena/sexual dysfunctions (i.e., at what point do women come to believe that sexual problems equal pathology?)	1. Women will negotiate between a wide range of competing discourses surrounding female sexual difficulties, including biomedical, psychological, social, and political discourses, and adopt elements from all of them to form comprehensive causal narratives. 2. Women's understanding of their sexual difficulties as medical phenomena will occur along a continuum, with sexual pain being the most medicalized and anorgasmia being the least medicalized. 3. Mirroring hypothesis #2, women with sexual pain will be the most likely to adopt biomedical strategies to discipline their bodies, while women with anorgasmia will be the least likely to do so.
What are the micro-interactional processes that contribute to the medicalization (or lack thereof) of women's sexual difficulties?	1. The experiences of women with sexual pain will be dismissed/ delegitimized by biomedical practitioners, the experiences of women with low libido will be taken seriously by these practitioners. 2. Women with sexual pain will fight for medicalization vis-à-vis biomedical practitioners in response to delegitimation.

completely biomedicalized perspective, in which women willingly adopt – and, by supporting the National Vulvodynia, attempt to fight for – this perspective on their sexual difficulty.

Subjects were also recruited via several Yahoo e-mail listservs, including the following:

- http://health.groups.yahoo.com/group/vv-vvs/
- http://health.groups.yahoo.com/group/eovv/

- http://health.groups.yahoo.com/group/VulvarDisorders/
- http://health.groups.yahoo.com/group/vulvodynia-support/
- http://health.groups.yahoo.com/group/vulvodynia_vulvarpain/

Posted study information invited women with vulvodynia to take part in confidential, face-to-face qualitative interviews, which would last from 90 – 120 minutes and which would take place in locations suggested by subjects. No compensation was offered. In order to be included, subjects had to: a) be a woman over the age of 18; b) have been diagnosed with vulvar vestibulitis or vulvodynia; c) be fluent in English; and d) be able to provide informed consent. While study information was posted to the New York listserv, I did receive requests to participate in this study from women across the country; furthermore, I also received requests to participate from several women residing in other countries (e.g., Australia, Germany, Sweden). Given my belief that social context influences the lived experience of sexual pain, I chose to further restrict my sample to women residing in the United States.

Phase 1: Data Collection. As previously mentioned, subjects resided in locations across the United States; thus, subjects were either interviewed via phone or in person. Prior to the interview, following the obtaining of informed consent, subjects filled out a demographic questionnaire, which included questions regarding age, race/ethnicity, highest education completed, household income, relationship status, sexual orientation, length of time experiencing symptoms, and whether they had received a formal diagnosis of vulvodynia. Interviews, which were semi-structured and open-ended, lasted anywhere from 40 minutes to over three hours. Interview questions changed according to the requirements of the interview and the topics brought up by respondents, but generally covered topics relating to the history of their experiences with the condition, interactions with physicians and other healthcare providers, interactions with intimate partners, sexual practices, and sexual identity (see Appendix B for Phase 1 interview schedule). Interviews were conducted until data saturation had been reached, with special attention paid to the discovery of variation in the sample according to demographic characteristics.

Phase 2

Phase 2: Recruitment. Recruitment for this phase took place from 2011-2012. Subjects were recruited utilizing a broad array of methods:

a) Flyers with study information and a contact e-mail were posted in conspicuous areas at Stony Brook-affiliated OB-GYN and Family Medicine practice locations (five in total).

b) Flyers with study information and a contact e-mail were posted throughout the Stony Brook University West Campus, as well as the Health Sciences Center.

c) Study information was listed in a "Campus Announcements" e-mail listserv distributed to employees of Stony Brook University Medical Center.

d) Study information was listed in the Village Voice's classified advertisement section.

e) A call for study participation was posted among subgroups of the popular website, www.reddit.com (e.g., r/TwoXChromosomes, r/Sex, r/DeadBedrooms, r/LGBT, r/Samplesize). This website was chosen due to its broad reach; it has been estimated that, in 2011, approximately 35million unique visitors frequented this site, representing a wide range of sociodemographic groups[1].

Posted study information invited women with sexual difficulties to take part in confidential, face-to-face qualitative interviews, which would last from 90 – 120 minutes and which would take place in locations suggested by subjects. In lieu of compensation, women were entered into a lottery for a $150 Amazon gift card. In order to participate, women must have: a) experienced low libido, anorgasmia, and/or sexual pain for six months or longer; b) been over 18; c) been fluent in English; and e) been able to provide informed consent. Again, as I received widespread interest regarding this study, I chose to restrict my sample to those residing in the United States.

Phase 2: Data Collection. Subjects were primarily interviewed via Skype or in person at a location of the subject's choice. Three women were interviewed via instant messaging, as they did not have access to Skype and could not meet in person. Prior to the interview, following the obtaining of informed consent, subjects filled out a demographic questionnaire, which included questions regarding age, race, highest education completed, annual household income, relationship status, and sexual orientation. Interviews, which were semi-structured and

open-ended, lasted from 45 minutes to 2 hours. Again, the interview questions changed according to the requirements of the interview and the topics brought up by respondents, but generally covered topics relating to: a) the physical and emotional experience of the woman's sexual difficulty; b) negotiation with biomedical, psychological, cultural, and political discourses regarding the sexual difficulty in question; c) sources of information regarding sexuality in general and sexual difficulties in particular; d) doctor-patient relations, especially as they relate to physician responses to reported difficulties and the process of receiving (or not receiving) a medical diagnosis; e) intimate relationships, particularly the responses of partners to sexual difficulties; f) ways of dealing with/managing sexual difficulties in the context of a sexual encounter; g) sexual and gender identity, including how women maintain these identities in the face of sexual difficulties; and h) meanings subjects give to sexual problems, sexual behaviors, sexual performance, and relationships (see Appendix C for Phase 2 interview schedule). Again, interviews were conducted until data saturation had been reached, with special attention paid to the discovery of variation in the sample according to demographic characteristics.

Sample

Phase 1: Sample. This sample consisted of 23 women diagnosed with vulvodynia. All but one subject was Caucasian; in addition, while income ranged from approximately $5,000 (in the case of several students) to approximately $150,000, the average income was approximately $85,000. A significant number of women refused to answer this question, however; as it is possible that women with lower incomes were more likely to do so, these figures may belie the nature of this sample. This sample was also problematic in that all but two subjects were heterosexual. While this may reflect the possibility of greater distress regarding sexual pain among heterosexual women, given the activity it impeded (i.e., penetrative vaginal intercourse), this limited my ability to explore the ways in which sexual identity impacted queer women's experiences with this condition. 19 were in committed relationships at the time of the study. Finally, the ages of the women in this sample ranged from 20 to 60, with the average age being 33.

Phase 2: Sample. The sample for Study 2 consisted of a) 7 women with anorgasmia alone; b) 17 women with low libido alone; c) 9 women with sexual pain (largely undiagnosed)

alone; and d) 11 women with some combination of these three conditions (mostly low libido combined with anorgasmia). The sample for Study 2 was somewhat more diverse than that of Study 1, likely reflecting the broader recruitment strategy. In regards to race/ethnicity, nine participants were women of color; while this was an improvement over the Phase 1 sample, this sample was still predominantly Caucasian. This sample was also more diverse in regards to sexual orientation/identity. While most non-heterosexual women identified as bisexual (n = 7), 2 women identified as pansexual, 2 identified as lesbians, and one identified as asexual. Approximately half (n = 23) were in committed romantic relationships at the time of the interview; ages ranged from 18 – 60, while the average age was 28.

Given the fact that many subjects were college-aged, women's level of education may not be a reliable indicator of social class. However, of those women who did not identify as current students (n = 45), the majority had bachelor's or master's degrees. The measurement of income in this study continued to be problematic, as: a) college-aged women were not always aware of their household income; and b) some college-aged women only mentioned their own earned income, irrespective of their household income. Reported income, however, ranged from $2,000 to over $150,000, with the average income reported being $48,000.

Data Analysis

Interviews were audiotaped with the participant's permission for later transcription and narrative analysis. All interviews were transcribed verbatim. Each transcript was carefully reviewed, line by line, for salient/ recurrent themes and vital concepts; preliminary analyses of these themes served as a basis for refinement of the interview schedule. Sensitizing concepts, drawn from the literature, generated an initial set of inductive codes (e.g., "Gender Identity", "Interactions with Professionals"), which were iteratively refined, added to, and discarded as coding progressed. Central to these efforts was the "lumping" and "splitting" of codes to produce precise categories. At the conclusion of analysis, the final codebook contained 15 higher-level codes and more than 500 subcodes (see Appendix D for codebook). Memos, in which I reflected on the data collected and analyzed, were similarly coded for easy retrieval.

Answers to questions were compared between transcripts to identify overall recurring themes across narratives. Then, transcripts were viewed as a whole to in order to identify

unifying themes and concepts. In order to compare themes between sociodemographic groups, transcripts were grouped into sets and analyzed for within-group and between-group variation. Simple text queries allowed for the discovery of specific content within and between transcripts, while case queries allowed for frequency counts of themes according to sociodemographic groups. Finally, matrix queries allowed for the identifications of patterns within the data. All analyses were conducted using NVivo v. 8.0.

A Note on Reflexivity

My approach to research was not independent of my social position. Feminist standpoint theory suggests that social location shapes and limits what we know, so that knowledge is achieved from a particular standpoint (Intemann, 2010); thus, as a white, heterosexual, middle-class woman, I brought my own normative assumptions to bear on the relationship between gender and sexuality, as well as the relationship between these factors and medicalization. Standpoint theory also suggests that the standpoints of oppressed groups are particularly useful, given that the members of such groups are required to be conscious of the perspectives of those in power as well as their own. Therein lies one of the drawbacks of this sample: while more heterogeneous than many other studies of women's experiences of sexuality and/or the lived experience of illness, there were fewer women of color, non-heterosexually identified women, and socioeconomically disadvantaged women participating in this research than I would have preferred. The reason for this is unknown, although Cannon et al. (1991; cited in Campbell and Wasco, 2000) suggest that it is typically white, middle class individuals who tend to volunteer for in-depth, self-reflective qualitative studies. I would also suggest that this may be due to the ways in which female sexual problems are conceptualized, as will be discussed later in this work. While reflexivity regarding these issues may overcome some of the disadvantages incurred by my limited sample, it is especially important for me to acknowledge that my findings are in no way meant to represent all women.

Furthermore, as a woman who at one point experienced sexual pain, which is now cured, I made myself and my own body a starting point for inquiry (Devault, 1996); in doing so, I allowed my own life experiences shape the way in which I collected my data and interpreted the results. Some may see this as a drawback of my research, while others might see it as an

advantage, particularly due to the fact that acknowledging my own pain to the women I studied allowed me to foster a nonhierarchical relationship between myself and the women I spoke to. I hope that, by discussing my own experiences and knowledge with them (after interviewing them, of course), they were able to learn from me and ask me questions, just as I learned from them. In any case, I believe that a constant reflexivity on my part regarding the ways in which my position as "knower" affected my research was the only way to – if not completely overcome – minimize the effect of my privilege as researcher on the work presented here.

CHAPTER 3: GENDER EXPECTATIONS AND FEMININE PERFORMANCE

As discussed in Chapter 1, gender is not static; rather, it is a process, situated in interactions with others who are alert to its production. Women engage in activities in light of normative expectations of the attitudes and behaviors appropriate for their sex. These enactments, although they take work to achieve, then serve as signs of women's essential female natures. Thus, gender is not something one *is*, but something one *does*. All women are accountable to others for their gendered performances; as West and Zimmerman (1987) note, to do gender is "not always to live up to normative conceptions of femininity or masculinity; it is to engage in behavior at the risk of gender assessment." Furthermore, it is questionable as to whether women *can* live up to these normative expectations; rather, they serve as a benchmark which women constantly struggle to attain.

One way in which women "do" gender is through sexuality, in which women strive to achieve femininity via their bodily practices and desires, which are then taken as evidence of women's natural sexual inclinations. Many theories of gender performance implicitly take all claims to inclusion in the category feminine as equal; it is possible, however, that women tend to privilege sexual function, along with reproduction, as bases for inclusion in normative femininity, as they relate to what is taken to be a biological grounding for claims to sex/gender. Butler (1990) notes that that gender becomes culturally intelligible through a "heterosexual matrix" that generates a series of ideal relations between biological sex, gender, and sexual desires and practices. Sexual desires are said to follow naturally from gender, just as gender is said to follow naturally from biological sex, so that to be biologically female means to be feminine, express desire for men, and (perhaps) participate in the enactment of heterosexual practices such as penetrative intercourse (i.e., deploying "sex organs" in culturally intelligible ways). Thus, sexual performance may figure more centrally in gender identity compared to many other forms of gender enactment. Of those asked about the importance of sexuality to women's gender identity (n = 25), almost all expressed the opinion that it was, in fact, important. One woman with low libido, Jill, made the connection between gender performativity and sexual

performance explicit: "I think in both cases, sexual performance is a big part of gender for people. So if you're not sexually performing, you're failing at performing your gender."

Given that sexuality is seen as important to maintaining women's gender identities, women with sexual problems often experience a sense of gender failure. In this study, almost half of the subjects that discussed the effects of their experiences on their gender identity discussed it in terms of loss. This finding is similar to that of Kaler (2006), who, in a study of 90 women suffering from vulvar pain, found that women with such pain perceived themselves as effectively degendered, their identities as women shattered because they could no longer participate in heterosexual penetrative intercourse. The failure to engage in intercourse – to live up to the "coital imperative", as will be discussed below - led these women to question the meaning of their bodies, their genitals, and their sexual/gendered selves. This loss of womanhood was reinforced by participants' perceived inability to perform a woman's role within particular relationships, as well as the inability to relate to other women who did not experience sexual pain. Ayling and Ussher (2008) also found that women understood vulvar pain as degendering due to a conflation of femininity and receptive sexuality. Finally, Lavie and Willig (2005) found that the inability to achieve orgasm was also linked to feeling like "less of a woman", and that orgasm was a symbol of femininity.

Due to the non-comparative nature of existing studies, however, these authors were not able to assess how experiences of gender loss might vary among women with a range of sexual problems. They thus oversimplify the phenomenon of gender loss. For example, in this study, half of women with sexual pain, approximately a third of women with low libido, and only one woman with anorgasmia reported a perceived loss of gender due to their experiences.[1] Why these differences? How might the process of degendering and/or maintaining gender change according to the sexual problem experienced?

Furthermore, these studies suffer from a lack of diversity in regards to sexual orientation/identity. This is problematic in that queer women's experiences of heteronormative sexual and relational scripts may be quite distinct from that of heterosexual women. Thus,

1 In regards to the effect of particular conditions on gender identity, women with multiple conditions were largely omitted from the analyses presented in this chapter. This is due to the impossibility of determining which of the conditions mentioned contributed to gender loss. In all other instances, these women were counted in the total denominator.

sexual minorities might experience gender loss differently compared to straight women, if they do so at all. This is borne out by this study: of 28 women who suffered gender loss, almost all were heterosexual. This might be expected in regards to sexual pain, in that the coital imperative may not hold as much purchase among queer women. But what about the effects of low libido or anorgasmia on gender identity? In what ways is sexual orientation linked to the maintenance of gender identity among women with sexual problems?

Finally, relationship status has not been explored as an analytical category. If gender is performed in interaction with others who are attuned to this performance – including relationship partners – then it makes intuitive sense to examine whether the presence of such partners affects women's sense of gender. Women who do not have partners – or, alternatively, have casual sex partners but are not in a committed relationship – may need to perform gender in different ways than women who are in such relationships, and might suffer from gender loss differently. For example, single women might place more emphasis on orgasms during sexual encounters, rather than on maintaining an emotional relationship with one's partner.

In this chapter, I argue that women with "problematic" sexualities experience difficulties in performing gender in interaction – that is, "doing" gender. I further argue that – to paraphrase Foucault's statement in the History of Sexuality - there is a proliferation of discourses dictating the ways in which women can and should be sexual and that the current overarching hegemonic sexual script continues to dictate a *receptive, compulsory, partnered* sexuality. In short, women are required to be constantly receptive to their partner's sexual advances with corresponding desire, constantly responsive to those sexual activities (whether in terms of arousal or orgasm), and (if heterosexual) able to participate in penetrative intercourse in the confines of a committed relationship. While some acts and feelings take precedence over others in producing the "successful" sexual encounter, all contribute to feelings of gender loss to varying degrees when absent.

I also argue that it is this failure to do gender in the sexual realm that leads to feelings of gender loss for many women. This occurs for two primary reasons: a) failure to adhere to gendered sexual scripts regarding appropriate behaviors and feelings during sexual interactions; and b) failure to engage in sexual care work, which is a key aspect of these hegemonic sexual scripts. This sexual care work, with which women prioritize male sexual pleasure, exchange

physical intimacy for emotional intimacy, and fulfill what they see as their sexual "obligation" or "duty", is naturalized and seen as part of who women *are*, not what they *do*; thus, when the "doing" of such work is threatened by sexual difficulties, women's gender identities come under assault.

Failure to Adhere to Sexual Scripts

Failure to Adhere to Sexual Scripts: Sexual Agency. Sexual situations carry with them their own specific rules of gendered behavior and feeling that are in line with cultural expectations about the importance of sexual activity (especially vaginal intercourse) and the meaning of such activity to the achievement of femininity. These and other cultural norms regarding sex are subsumed within what Gagnon and Simon (1973) refer to as sexual scripts, which dictate expectations about who will do what, to whom, in what circumstances, at what time, and in what sequence during a sexual encounter, as well as what feelings and motives are appropriate to the event. Cultural scripts, one type of sexual script, provide larger frameworks through which sex is experienced; they are instructions regarding how one should or should not behave sexually. While scripting theory has been critiqued for its failure to take into consideration relations of power and inequality, which help to dictate the ways in which dominant sexual scripts are taken up and reproduced. Beres (2013) suggests that cultural sexual scripts are manifestations of Foucauldian discourses that "make available particular subject positions for actors to take up and open up particular spaces for action."

These discourses – and, therefore, cultural scripts regarding female sexuality - are far from unambiguous. Several women in this study acknowledged what one subject referred to as the "tight-rope" of female sexual expectations – that is, that women are simultaneously expected to be sexual and not sexual.

> Yeah, I think that, the whole concept of what women's sexuality should be, for so long, has been defined as, it should be what your man wants. I think, again, the whole slut and prude dynamic of, if she rejects you, she's a prude, if she is jumping into bed with you, she's a slut. If she makes you work for it, she's a tease. You know, there's a lot of derogatory words that we assign to women's sexual behavior that, if we really look at it objectively, should just be considered normal human sexual behavior. (Jocelyn; low libido)

Traditionally, women have been expected to be less interested in sex than men, and stereotypes of women's lack of interest abound (e.g., "Not tonight, dear – I have a headache!") Approximately one in five women discussed these expectations. As Jill, a woman with low libido, noted, "It seems like that's a lot more acceptable. It's more OK if two women aren't having sex together. [Why?] I think just because women, in general, are expected to have less of a sex drive. So it's like 'Two women together? They're not going to have sex. They're going to have cats.'"

At the same time, permissive discourses celebrate free sexual expression for men and women, legitimating women's sexual desires and agency while simultaneously providing new obligations for them to fulfill. Women are now expected to have and enjoy sex; for example, Lavie-Ajayi (2005) found that women's magazines encourage women to achieve orgasm because it simultaneously demonstrates their pleasure and their liberation. This is a key aspect of a neoliberal; post-feminist sensibility, in which: a) discourses of choice, rationality, autonomy, and individualism abound; b)sexual practices are positioned as freely chosen even as they mean increased surveillance, self-monitoring, and self-discipline; c) sexual empowerment used to sell/advertise a wide range of consumer goods; and d) the body is presented as a woman's source of power (Gill, 2007, 2008, 2012). Burkett and Hamilton (2012) point out that this leads to an "awkward blend of feminist and anti-feminist elements in which women view themselves as empowered yet continue to reproduce the terms of heterosexuality set by heteronormative discourses." Thus, in the postfeminist framework, the fulfillment of sexual obligations (as discussed below) is represented as a sign of an active, agentic sexuality:

> I mean, I tend to think that I have fairly empowered, evolved friends, but I have a lot of brilliant friends that have low self-esteem when it comes to sex, and they feel like if they have sex, and they express themselves in that way, then, you know, they're gonna be somehow fulfilled or completed, or on an equal level with men. And as they have defined equality. .. "I have power because I have sex with you." This is all we talk about, my girlfriends and I. You know, we live not only in a post-feminist era, but in a post-post-feminist era, where the idea of female empowerment is so nebulous. (Sarah, pain)

We see, then, that sexual agency is a prominent feature of the post-feminist sexual script, yet it remains difficult for women to achieve. Moreover, there is no room for those women who cannot participate in what is increasingly seen as an emancipatory act. This was discussed by one woman, who recounted a conversation she had with a feminist roommate:

> If a woman wants to walk around showing everything off, and telling men that she wants to have sex with them, being very active, that's completely fine, and my roommate did not feel that was the case right now as far as women being able to express their sexuality…Homosexual or being bisexual. It was mostly giving women the opportunity to be sexual. Whether it's "Have sex with as many women as you want," or, "Have sex with as many men or women as you want," we never touched on exclusively women going out there and standing up for themselves, being like "I don't want to have sex." That was never touched on. (Karen, low libido)

Thus, women were not uncritical of these ideas. For the most part, however, the "right to choose" to be sexual and the claiming of power via sexual autonomy were seen as contributing to feelings of gender loss when these were unachievable.

> The more I see it, the more I realize that being sexually desirable and desiring that sort of activity can be beneficial to representing womanhood. From my perspective, being sexually active and being sexually powerful is a positive thing, and women who are highly sexually active are viewed as empowered and a positive representation of womanhood. [Given all that...and given your low desire...how do you feel about yourself as a woman?] I don't feel very womanly or feminine! (Kirsten, anorgasmia and low libido)

In contrast, three women stated that their sexual difficulties, in fact, upheld their gender identities due to the fact that women were not traditionally expected to be sexual in the first place:

> I think it's liking sex a lot isn't...almost isn't feminine, if that makes sense. It's like, how if you have a voracious appetite for sex it would be a masculine quality in a woman in our society. So being...liking and wanting sex is somehow a masculine quality. Which now that I think about it makes no sense but I feel like that is the truth in our society. Not being able to have sex or not liking it because of

> whatever dysfunction you have is not masculine. So if a woman were to have some degree of sexual dysfunction and not like sex as much, well liking sex too much isn't womanly to begin with. (Vanessa, anorgasmia)

In short, the relationship between sexual agency, traditional conceptions of female sexuality, and gender performativity are complex and cannot be reduced to the assumption that adherence to traditional gender norms will inevitably result in a feeling of gender loss when women experience sexual difficulties. While I do not argue that abdication of the agentic script is desirable, I caution that such a script is not unproblematic and its effects must be explored further in future work.

Failure to Adhere to Sexual Scripts: The Coital Imperative. The obligation for intercourse is important given what has been referred to as the coital imperative (Gavey, McPhillips and Braun 1999), which defines penetrative heterosexual intercourse as real sex to the exclusion or detriment of alternative sexual behaviors. Vaginal intercourse is thus the most normal form of intercourse; it ranks high in a hierarchy of sexual behaviors, which grant those who practice it respectability, legality, and certified mental and physical health (Rubin 1984). One third of women spoke of the obligation for and importance of intercourse, at times contextualizing the act within their committed relationships; unsurprisingly, most of these were in committed heterosexual relationships.

> I mean, look, there are many levels of having sex. There are many acts, there are many experiences related to sex. I think what I'm talking about is penetration, as far as having sex. And to me, that defines my ability to have, you know, that happen is sex to me for this. I guess that's how I'm conceptualizing it…. I felt so much pressure. At that time, I was reading like Cosmopolitan, all those magazines, and what does it talk about? All it talks about is having sex which includes penetration. (Debbie, pain)

Interestingly, two lesbians, who were in relationships with women, noted the importance of penetrative intercourse in their sexual interactions. One cited pleasure as the reason for her privileging of intercourse, while the other cited her partner's need to be dominant in the sexual interaction, indicating the possibility that penetrative intercourse might signify an eroticized power dynamic in which to be penetrated is to be submissive (taking on the traditional feminine

role) even in the absence of a heterosexual partner. However, of the women that both adhered to the notion that penetrative intercourse was important or obligatory and experienced a sense of gender loss, all were heterosexual and suffered from sexual pain. Thus, gender loss in this instance may reflect the struggles they had experienced in attempting to fulfill this particular sexual imperative.

Failure to Adhere to Sexual Scripts: The Orgasmic Imperative. Bejin (1986) argues that there exists an orgasmic imperative where, "all individuals capable of achieving at will…that acme of sexual enjoyment that is today called 'orgasm' may be considered to be in good sexual health." Similarly, Potts (2000) points out that the ability to have orgasms defines one as not only a sexually healthy human being, but a complete one; in turn, the lack of orgasm is marked as dysfunctional, abnormal, or undesirable. Not just any orgasm will do; several women in this study made it clear that only certain kinds of orgasms would suffice. Orgasms were, at times, rated according to type, for example: partnered vs. solo orgasms, or clitoral vs. vaginal. For example, when asked if she had orgasms, Anya, a woman with pain, responded, "Yeah. Yeah. Not vaginal orgasms but clitoris. But not like, the other ones. I've never had that. I still feel like that that's normal and I don't have normal sexual experience." As this demonstrates, several women who volunteered to participate in this study stated that they had anorgasmia, but defined this as not being able to have orgasms when having sex with a partner or when having penetrative intercourse. This suggests that, for at least some women, the ability to have orgasms is partner-centered as well. One possible reason for this is that women may see orgasms as required to reassure their partner about their sexual prowess; while this motive will be discussed in greater detail below, it is important to point out that women are thus responsible for helping to construct and maintain their partner's masculinity, as well as their own femininity.

Similarly, orgasms also had to surpass a certain thresholds before they could be seen as "true" orgasms – i.e., they were also rated in regards to quality (i.e., length and strength). As Erica, a woman with anorgasmia, stated, "My orgasms are usually like three seconds long. The longest I experienced was the one I gave myself when I was 14, I believe. That was the longest one. But with my partners, it hasn't been more than like three seconds. I think I read somewhere that it was supposed to be about eight seconds." This suggests that women engaged in careful

self-surveillance even at the height of pleasure, for fear of not measuring up to normative sexual expectations.

These findings notwithstanding, more than half of those mentioning the importance of orgasm stated that, in fact, there was no such pressure or obligation to have orgasms, and only one woman with anorgasmia reported feeling a sense of gender loss in response to her experiences. As one woman with anorgasmia and low libido, Jen, noted: "I think this is probably the least amount of pressure for sex in terms of being able to reach orgasm, it's probably one of the lowest. Then libido is around there, just because a lot of women are able to orgasm, and even if they can't, they fake it sometimes, because that's what they do, and I feel like we don't have pressure to do that." This lack of pressure to have orgasms may be because failure to achieve orgasm does not necessarily interfere with the obligation to engage in partnered sex. It also may be that female pleasure continues to be omitted from the conventional heterosexual sexual script; interestingly, a greater percentage of non-heterosexual women felt that orgasm was important, compared to heterosexual women.

Alternatively, it could mean that women's constructions of pleasure extend beyond orgasm, as mentioned by Liz, who had anorgasmia and low libido: "I don't think so just because I never went into the relationship expecting orgasms and, granted, the few times that it's happened it's been really great, but I'm usually happy just having sex and feeling really good having sex and not necessarily orgasming… Obviously for me having an orgasm is pretty much like one out of 10 on the sex importance scale. I don't know if it is for other women." This is supported by the work of Nicolson and Burr (2003) who found that women often defined female sexual pleasure as involving sensuality, physical affection, and emotional connection; while orgasm could be an important outcome of sexual activity, it did not have to be.

Failure to Adhere to Sexual Scripts: The Desire Imperative? In contrast to the coital imperative, there is a dearth of sociological literature regarding corresponding obligations for women to experience particular levels of desire. In addition, no women in this study directly cited a "desire imperative", or the importance of desire to sexual interactions. However, such an imperative may be assumed from the intense amount of time and energy – not to mention of money – that has been spent by pharmaceutical companies to create a "cure" for low desire among women, as detailed in Chapter 1. This indicates that desire is required, but not taken for

granted as coitus is – in other words, there is a popular perception that many women need help in achieving the proper levels of feminine desire.

However, desire in and of itself is not what is required here. Rather, it is desire that is responsive to a partner's – ideally a man's – desires. As one woman noted:

> Sexual desire for women in society is a really complicated place...For me, I had a lot of ideas of feminine sexuality as a receptive sexuality. I think that's like the mode in which women in our society are kind of expected to express their desire. They're like, "I am so receptive to sex right now! You have no idea how much sex I would just receive!"….I feel like a lot of what society thinks about female sexuality and female desire is that it's something that they put a high value on but it has to stay within this certain sphere. Female sexuality is totally great and awesome and everybody finds it really desirable and women are super sexy and sex with women is super sexy. But women have to kind of stay there and sit there and be sexy for when somebody wants them. (Jill, low libido)

Thus, the imperative for desire does not exist in its own right as a symbolic representation of womanhood, as coitus does. Nor is it seen as optional, as orgasm is. Instead, I argue that the imperative for desire, which pharmaceutical companies promote in an effort to sell libido-enhancing drugs, originates in the obligation of women to perform sexual care work – that is, it is directly related to the ability of women to be sexually responsive to their partners in an effort to demonstrate emotion and maintain relationships.

Importance of "Sexual Care Work" to being a Woman

An important, yet undertheorized aspect of gendered sexual scripts is the performance of sexual care work. Care work has been defined as work undertaken for the well-being of others, which is often based on sustained personal interaction and is (at least in part) motivated by altruism (England, 2005). Care work, paid or unpaid, is typically associated with women; thus, care work is a core aspect of "doing gender." Discussions of care work in the literature largely focus on commodified care work; that is, care work that is undertaken for monetary compensation. In contrast, Lynch (2007) proposes a theory of "love labor"; that is, care work that is undertaken in order to sustain interdependent relationships. Altruistic and emotionally driven, this type of care work: a) often has little marginal gain for the carer, and in fact may cost

them socially, emotionally, or financially; b) is characterized by a strong sense of mutuality; and c) not only consists of a set of tasks, but a set of affective orientations to the cared-for person; that is, feelings and ways of regarding the other (Lynch, 2007).

Discussions of unpaid care work performed by women usually center on childrearing, performing other household tasks, or caring for the health of others. I argue that care work (i.e., "love labor") in the realm of the sexual is a key part of the bodily enactment of femininity – an enactment that is then essentialized and placed within the realm of the biological. This labor is intimately linked to bodily self-discipline and a feminine ethics of care and self-sacrifice (Graham 1983) that serves to reinforce hegemonic gender norms and is key to disciplining women's gendered sexual identities. Women are often expected to sacrifice for the good of their partners or their families; thus, when a woman does so by engaging in sexual activity for the sake of maintaining her relationship, it is an additional signifier of femininity that may be seen as compensation for the loss incurred by having a sexual difficulty. Such care work – which is ideally, but not always able to be invisible - is not seen as work; rather, it is seen as a reflection of what women are, not what they do in production of a gendered self.

This concept builds on the work of and Duncombe and Marsden (1996), who suggest that women in long-term sexual relationship must engage in emotion work (i.e., ""management of feeling to create a publicly observable facial or bodily display in private setting,") in order to bring their sexual feelings into line with how sex "should" be experienced. Similarly, Elliott and Umberson (2008), discuss the ways in which married men and women conceptualize sexual difference (generally in terms of women's "innately" lower libido), as well as perform emotion work in the sexual encounter in order to negotiate these differences and maintain their intimate relationships. They also briefly discuss women's occasional resentment of performing such work, as well as some women's characterization of sexual activity itself as "work" – part of the "third shift" (i.e., the emotion work that follows paid employment and household work; Hochschild, 1997) and/or an "obligation".

This study differs from Elliott and Umbermann's work in regards to several key elements. First, their article only focused on differences in desire, while this study focuses on a wider range of sexual difficulties. Second, the authors point out that a certain degree of difference between men's and women's desire was expected by their participants, and thought to be reflective of

men's and women's innate sexual natures. They did not discuss, however, what would happen when women's low desire pushed beyond the lower bounds of "normality" – that is, when the difference was perceived as pathological. Third, as the authors note, their sample was limited to couples who were married seven years or more, and these couples indicated a high level of marital quality; thus, they were not able to determine the ways in which couples who were together for shorter periods of time were able to negotiate this sexual conflict. It is plausible, for example, that relationships in which women had very different levels of desire than their partners and/or could not perform sexual emotion work might dissolve before the seven-year mark was reached. Fourth, the authors did not discuss the ways in which women performed emotion work in order to bring themselves into line with sexual expectations; I will discuss these in Chapter 5.

Finally, and most curiously, issues related to power were largely omitted from Elliott and Umbermann's work. For example, the authors discussed the efforts of both women and men to alter their sexual desires in order to bring them more in line with what the other required; thus, women worked to be more receptive to their partners' advances and/or initiate sexual activity more often. However, while the authors briefly mention that women are held accountable for emotion work in ways that men are not, and that women were aware of this difference, they do not explore this point in depth. Nor do they fully acknowledge that the pressure to sexually comply with a partner is stronger for women then for men and do not discuss the implications for "doing" femininity, even if they do frame their discussion in regards to "doing gender." In other words, women have more at stake, they are held accountable to a greater degree, and the failure to sexually comply signifies failure to enact gender norms in ways that men do not experience.

For example, women who will not or cannot engage in sexual care work are often singled out for additional warnings regarding dangers to the well-being of the self, partners, and relationships. In a study of the representations of women's sexuality in magazines aimed at middle-aged women, Clarke (2009) found declines in sex were portrayed as a warning of trouble within marriage; furthermore, an unwillingness to engage in sexual activity was assumed to mirror women's entire attitudes towards their husbands. Women were encouraged demonstrate not only a desire to engage in sexual activity, but to provide different varieties of sex in order to retain their husbands' interests. Sexuality was also seen as owed to partners, often in response to proper relationship behavior on the part of others – part of the bargain women took on when they

agreed to marry. In addition, women are, at times, warned that they are responsible for maintaining their male partners' emotional well-being; for example, a recent opinion column published in the Wall Street Journal stated:

> "Men tend to express feelings with actions, not words. Unlike a lot of women, they probably don't have heart-to-heart chats with everyone from their best friend to the bus driver, and they often limit hugs and physical affection to their immediate family. No wonder they miss sex when it disappears. It's a way for them to be aggressive and manly but also tender and vulnerable. "For some men, sex may be their primary way of communicating and expressing intimacy," says Justin Lehmiller, a Harvard University social psychologist who studies sexuality. Taking away sex "takes away their primary emotional outlet." (Bernstein, 2013)

Thus, this column suggests that if women do not have sex with their male partners, these partners will not be able to express positive emotions of care and connection - not just in regards to their relationships (although that is certainly one aspect of the threat), but in regards to anything else. It goes on to note that "orgasm causes the brain to release oxytocin and vasopressin, the "feel-good" hormones that promote attachment." In addition to the assumption that orgasms are best when taking place via partnered sex, this scientific-sounding language – rooting the good of the relationship in bodily responses, rather than social contexts – makes a direct link between having unwanted sex and ensuring attachment and intimacy. Messages such as these are key examples of the ways in which sexual obligations are constructed and communicated to women with sexual difficulties.

Sex as Obligation. In turn, women often internalize these messages; for example, echoing the findings of Elliott and Umbermann, many subjects were cognizant of an obligation for partnered sexuality, speaking of sexual activity or proper sexual feeling (i.e., desire) to be an obligation within past or current relationships. Women used terms such as "obligation", "my duty", "a requirement", "supposed to", "fulfill the expectation/my end of the bargain", and "my responsibility". As Adrienne, a woman experiencing sexual pain, put it, "I guess because part of the role of a woman is to be able to have sex. You know, a man needs that. Like, you don't wanna think that that's all there is to a relationship, but for a man, I think it is a pretty big part. And it's part of your job. It's part of what you bring to a relationship is sex. And I think not

being able to, you just kind of feel, “All right, I don’t have this to bring to the table. Why even bother?’”

As is evident in this response, this obligation is often perceived as a necessary response to men’s sexual needs, consistent with studies that have addressed sexual scripts regarding male sexuality. However, heterosexual and non-heterosexual women cited the obligation for sex in approximately equal proportions, raising the possibility that the obligation is an inherent property of the intimate relationship, and not necessarily tied to the gender of one’s partner. This is also suggested by the fact that a significant majority of those discussing this obligation were currently in a relationship. While women did not speak of a corresponding obligation for desire, the obligation for partnered sex ensures that regardless of desire, women felt compelled to participate. This is evidenced by the fact that approximately a third of women with sexual pain and half of women with low libido spoke of the obligation for partnered sex, compared to one woman with anorgasmia.

Sex as Work. At times, women explicitly described sexual activity as work or a chore. Caitlyn, who experienced all three sexual difficulties, said, “A lot of people my age think of it as, people my age who are mothers, mostly think of it sometimes as a chore. Not always, but sometimes it's a chore or a responsibility. And so that kind of takes the enjoyment out of it, you know? [What makes it a chore?] They feel like it's something they need to do as a wife, to make sure their husband is satisfied and it's part of their duties, and so they don't necessarily want to do it but it's on their list of things to do, you know?” About a third of women with low libido considered sex to be work, compared to almost no women with sexual pain or anorgasmia.. This may be because women with low libido found sexual activity to be drudgery and/or mundane, as opposed to women with anorgasmia (who, as mentioned above, might experience other feelings of pleasure above and beyond those provided by orgasm) or sexual pain (for whom sexual interactions might be too fraught with anxiety or distress to characterize as work). Unsurprisingly, women in relationships considered sex to be a chore about twice as frequently as did single women; this may be tied to the aforementioned sense of duty or obligation women in relationships felt to fulfill their partners’ sexual needs. Notably, only heterosexual women felt this way; thus, while some queer women might have viewed sex as an obligation, this obligation may not have been as onerous as it was for straight women.

Sex as Relational. Almost all women spoke of sexuality as something to be enjoyed or experienced in some other relational sense (e.g., as "a bond", "emotional, " love", "a gift", "intimacy", "mutuality", "a necessary part of a relationship", or "about pleasing a partner"). Even when there was no explicit sense of obligation, for these women, sexual activity was an important way to enhance emotional connections, care for one's partner, and maintain relationships. Gavey suggests that normative heterosexual relationships involve an "economy of sex" in which women exchange sex for love and emotional intimacy (Gavey, 2005); this was borne out by this study, as Rachel, a woman with low libido, made clear: "I felt, obviously, a little bit disgusted that everything had turned into currency in our relationship. But, I don't know. I said to myself, well then that's what it is, it's currency. It's a form of exchange, it's a requirement." In this way, female sexual compliance is normalized 'in the name of love' and being accommodating to unwanted sex is seen as 'normal' behavior for women who love their partners (Burkett and Hamilton, 2012).

In contrast, only one third of women spoke of sexuality as a source of pleasure or happiness (e.g., "a culmination", "fulfillment", "fun", ""happy", "pleasurable"). Queer women were three times as likely to cite pleasure as a core aspect of sexual activity compared to straight women; this, in addition to the fact that more queer women experienced the orgasmic imperative in comparison to heterosexual women, indicates that queer women are more likely to have sex for pleasure's sake in and of itself.

Care Work and Gender Identity. Women spoke of the effects of the failure to engage in care work on their gender identities:

> Sexy means sexual. Sexy is sexual. But feminine…no. [Does woman, in general, mean sexual?] No. [Have you felt differently about yourself as a woman, knowing that you can't, or it's difficult for you to have intercourse?] Mm-hmm. [Even though woman does not equal sexual?] Ohhh…you're bad. (laughs) Um…yeah. Yeah. Um…I'm inadequate, as a woman. Guess, like a woman is sexual, too. Uh, you know, you're supposed to be able to fulfill your husband's needs. Yeah. And, and…that's kind of one of our jobs. (Emma, pain)

Nearly half of women with sexual pain expressed that the failure to engage in care work made them feel as if they were less of a woman, compared to a third of women with low libido

and one woman with anorgasmia. This indicates that while many women felt that intercourse was key to engaging in this care work, the fact that a significant number of women with low libido – who, presumably, were not prevented from engaging in intercourse – felt this way indicates that sexual care work encompasses, but does not equal, the fulfillment of the coital imperative. That women with anorgasmia did not equate loss of gender to failure to engage in care work is not surprising, given that the women's orgasms were not seen as required to sexually satisfy one's partner. As Susie, who experienced all three sexual difficulties, put it:

> I feel like I just totally fell off. I went from normal, even maybe more, I had a very healthy, I guess, sexual drive and now it's like nothing. [That affects how you feel about yourself as a woman?] Yeah. I think so. I feel like I can't, I'm not…Like I cannot fulfill my role as a woman, as a wife. **[**What about the lack of orgasms? Does that affect how you feel about yourself as a woman?] Not so much I feel like because I didn't have orgasms when I was having more sex and I still had a lot of sex so...

When asked to identify the condition that had the most significant impact on their lives, women with multiple conditions rarely mentioned anorgasmia. Rather, they generally cited low libido as most important, reflecting a focus on their partner's needs, rather than their own:

> [Lack of orgasm] hasn't really been a problem for me, because I'm the type of person who likes to satisfy my partner. It's not about me getting satisfied. It's just about me being able to satisfy my partner. My lack of orgasms, I would say, are not very important. The lack of desire. It's more important than the orgasm. If I do not have that desire to be sexually intimate with somebody, maybe that person who I'm with is going to be affected in some way. They're gonna be like, "I don't want to be with somebody like you." I think that's more important. (Erica, anorgasmia)

Interestingly, these findings did not differ by relationship status, indicating that women had internalized their obligations even when they were not required to fulfill them in the immediate sense.

Preventative/Compensatory Care Work. In order to counteract their failure to properly perform gendered sexuality, subjects often went to great lengths to engage in preventative or

compensatory sexual care work – sexual activities or interactions meant to mitigate the effects of sexual difficulties on gender loss. This was often done at great cost to the women themselves. For example, more than half of women with sexual pain would continue to engage in sexual intercourse, regardless of the (sometimes excruciating) pain this caused. Most did this out of the aforementioned sense of obligation, as Eileen, a woman with sexual pain, made clear: "And at that point, we still had sex quite a bit. And I just dealt with the pain (laughs), which was horrible, but I guess I – to me, being a wife involves having sex with your husband. And I felt like I would be letting him down – this is me, not him speaking. I felt like I would be letting him down if I wasn't able to do that with him. So I kind of just stayed quiet, didn't tell him about the pain, and just kind of lived with it."

While less than half of women with gender loss engaged in painful intercourse, two thirds of women without gender loss did so. This suggests that this form of compensatory care work was successful, at least in part, in ameliorating the effects of sexual difficulties on women's gender identities. In short, women who continued to have sex in spite of pain may never have lost – or may have regained – their sense of gender by engaging in this feminine act (i.e., being a receptive partner in penetrative intercourse) for a feminine motive (i.e., care work). Women in committed relationships were twice as likely to continue to engage in intercourse in the face of sexual pain than were single women; this makes sense in that women restrict this kind of care work to those with whom women had already built an intimate relationship.

Similarly, women engaged in sexual activity when they did not desire to, in order to please their partners. In half of all cases, as well as half of women with low libido, subjects acquiesced to sexual activity by totally focusing on their partner's sexual needs to the exclusion of their own, either by engaging in intercourse or (more often) focusing on their partner by performing fellatio. In this instance, fellatio was seen as a way to satisfy one's partner without investing too much of the self in the sexual activity:

> [And you were saying that most of the time you give him oral sex?] That, that could happen a lot. Yeah. That, you know, that might be one out of every two or three days of being together. Or sometimes one every two days. And I have to admit, there are times I do that when maybe I'm not totally, just because I want to – I feel the need that I have to sometimes do things to keep things going, relationship-wise. That there might be a time that I – I mean, I really do enjoy it,

> but there's definitely times when I, you know, I'm just tired, I'd rather go to sleep. But…it's just frustrating me. (Maria, pain)

As a whole, women engaged in unwanted sexual activity regardless of the degree to which they experienced gender loss, which may suggest that all women, regardless of threats to gender, were able to engage in this form of care work. Nor did these results differ by sexual orientation, indicating the perceived need to perform compensatory care work is not necessarily tied to the gender of one's partner. However, most women who engaged in unwanted sexual activity were in relationships, which, as in the case of sexual pain, indicates a greater willingness to engage in compensatory/preventative care work with intimate partners as opposed to casual ones.

In the sense that faking orgasm is primarily engaged in in order to spare a partner's feelings and thus maintain relationships, it may also be perceived as sexual care work. Two thirds of women with anorgasmia did, in fact, fake their orgasms for this purpose. As Amy, a woman with anorgasmia, put it:.

> When she would make love to me, because when a woman makes love to a woman, there's no real...Like a feeling comes over you when they're being, when you realize that they are reacting to what you are doing and it's pleasuring them and they're getting wet or they're going to come or their body cringes. It excites you. I felt like I have to show her that I'm reacting that way, like if I don't get wet, I get nervous. Like, "Shit she's going to feel like I'm not attracted to her." Or if my body doesn't cringe, she's not going to think that what she's doing is good enough and she's going to feel bad. This is huge problem. She's going to feel bad or she's not going to get excited because I didn't get excited. You know what I mean?

Faking orgasm is not only a form of care work, but a gender performance in its own right. Roberts et al. (1995) point out that the construction of men's desire as a strong biological drive positions women as the recipient of such desire, thus requiring women's bodies to be responsive to men's "technique" and "work, reinforcing a binary in which men are active and women are passive. Furthermore, this suggests that women's orgasms are not natural, as men's are; rather, it takes a man's technique to bring them out. Thus, by performing orgasm (i.e., making orgasm

"visible"), women also (paradoxically, actively) perform receptivity and passivity, key aspects of traditional femininity. While several women indicated the pressure to fake orgasm with a female partner, indicating the strength of these cultural messages and the internalization of the traditionally feminine perspective, this kind of sexual care work is most often focused on the satisfaction or ego reassurance of a male partner.

Similarly, several women with low libido reported feeling pressure to fake desire or enthusiasm for sexual activity, most often – but not always - in response to their partner's advances:

> He's, he just, usually we're doing something, we're watching TV and a lot of times, I feel really bad because I want to keep watching and he'll start to kiss me or something to try to distract me. He enjoys distracting me to see how long I can hold out watching the TV show. But the thing is, I'm not interested enough for it to be fun. Because, if I wanted to, I could just keep watching the TV show, but I feel bad. So, I distract myself on purpose to make him feel better. And I know that is not leading anywhere. (Rosa, low libido)

While faking orgasm positions women as passive recipients of a partner's technique, women were expected to be receptive to their partner's efforts to "awaken" their desire; thus, faking desire in response to a partner's advances is a gender performance in its own right. At times, however, partners were disappointed if women did not initiate sexual activity, indicating the adoption of alternative discourses that position women as autonomous sexual beings, as described above. That women were required to perform sexual autonomy – a contradiction in terms - does not invalidate the idea of gender performance; rather, that women are expected to perform both autonomy and passivity indicates the conflicted messages regarding female sexuality indicated in the previous sections.

The idea of sex as care work presents a problem for current conceptions of female sexual dysfunction. In the academic and medical literature – for example, in the Diagnostic and Statistical Manual, 4th Edition – it has been standard to consider women as having a sexual dysfunction only if the condition causes them "marked distress or interpersonal difficulty" (American Psychiatric Association, 2000). Of the women in this study who stated that their experiences were a "problem", most (75%) reported that their experience was a problem

primarily in relation to their partner, as opposed to a problem in and of itself. Sonja, a woman with anorgasmia and low libido, said, "Nothing else about it really impacts my life too much because if it was just me, I wouldn't care. But the fact that it affects other people now, I almost feel bad, responsible, that I'm bringing stress or something into someone else's life. Someone that I care about is becoming upset because of something that's happening to me." Women, then, are deemed pathological if they can no longer engage in sexual activity with a partner, which in turn causes them distress primarily due to sexual scripts that dictate such activity. It is not enough to say that women who are not distressed are not pathologized – one must examine the roots of this distress and determine the extent to which it exacerbated by cultural expectations regarding female sexuality in partnered relationships.

Retaining/Supporting Gender Identity

Approximately half of women experiencing sexual difficulties also experienced gender loss. What of women who did not? Reasons given for the lack of gender loss were varied, and included: a) being female was not important to the subject's identity; b) the subject felt as if there was more to being a woman than one's sexual capabilities; and that d) the subject felt as if they were less of a person, rather than less of a woman, as Amy, a woman with anorgasmia, stated: "I think sexuality, I feel, is, or at least I've been told, I guess, yeah, because I've been taught it or told it or seen it, that I feel that sexuality and being sexual is part of being a human. It is part of the human experience. It does make, it makes me feel like I'm missing out. It makes me feel...I guess it does make me feel, in a way, like less of a person."

However, one third of women who reported maintaining gender identity often expressed reasons that remained consistent with the aforementioned theories of gender loss. For example, several women, including Sophia, a woman with sexual pain, reported that they did not experience gender loss because they could perform feminine care work in other ways: "So to some regards, when you are walking around, you can't wear your dungarees, and you can't feel sexy, because your vagina's burning, we identify. But not 100%, because we can still clean the house and cook and, do you understand? And do what we gotta do." Other women noted that their gender remained intact due to the fact that either their partner did not need sex or they were not in a romantic relationship. Two women saw the experience was common or "normal", and

one woman explicitly stated that their gender identity was not affected by sexual pain because she engaged in intercourse regardless of the pain, as discussed above.

As previously, mentioned, queer women suffered less from gender loss than did heterosexual women; one third of straight women asserted that their experiences had no effect on their gender identities, compared with two thirds of queer women. This suggests that obligations for partnered sexuality are, perhaps, weaker among non-heterosexual women. This supports the work of van Rosmalen-Nooijens et al. (2008), who found that experiencing a low frequency of sexual activity did not affect the satisfaction that lesbian women had with their intimate relationships. In addition, there may be less of an obligation for particular sexual acts, such as penetrative intercourse, in queer relationships:

> I feel like if I'm going to characterize sex with men vs. women that it is more directed, in the sense – my own feeling about it is that it is very phallocentric. I did very much feel that. I'd feel that it is kind of about the guy getting up and then you have a certain amount of time to do stuff, and then you know. (laughs) And then it's over. It does feel like there's a very specific beginning, middle, and end kind of thing. But I do feel a lot less pressure around that, because I do feel like the amorphousness of sex acts between women is actually, for me has been actually really liberating and really cool to me, in the sense of, like, I don't feel like there's any prescripted [sic] thing. (Maya, pain)

It may also indicate that queer women's gender identities do not centrally revolve around sexual performance. As Maya put it, her struggle with gender identity and sexuality centered on her sexual orientation, not her sexual capacities; thus, she had experienced what it meant to question "normal" female sexuality and was the better for it:

> I think that a lot of straight women probably, with this condition, may, since they are stuck in the confines of a straight relationship, are probably self-blaming as I did, and they're probably not having had other aspects of their life challenged in such a personal way that they actually dig deep internally to try to figure out what this stuff means, and how to articulate it to other people. So I feel like I've actually been quite – I actually think being gay is a blessing, in a big way. I think it's actually a gift now. I didn't for many years. But I think it actually, if you want it to, can set you up with an alternate perspective that really kind of allows

> you to view the world through a different lens that kind of is more illuminating and less restricting.

However, as noted above, gender loss was still present among some queer women. As one woman, self-consciously identifying herself as the "feminine" actor during her sexual interactions with women, stated:

> For the most part, the ways that I thought about my sexuality I was more feminine partner in the act for whatever sense of that - I don't even know what that means really - but of the dynamic… A lot of how I defined gender was, for myself, was "In sex, I'm going to be the" - I'm using a lot of artistic metaphors here - "you know, like the raw block of stone that they chisel into something," right? "I don't feel like I'm a workable medium," to continue the metaphor. So if that form of femininity isn't going to work for me now, if that womanness isn't how I'm going to be a woman, what is? That's kind of what I'm trying to explore. (Jill, low libido)

As indicated above, this may occur more frequently in regards to a failure to fulfill the orgasmic imperative. When asked how she thought partners would react if she decided not to worry about orgasms, Erica, a woman with anorgasmia, noted: "I don't think they would like it at all. Because I think, especially when it comes to lesbian relationships, it's more of a relationship where there has to be a satisfaction between both people. It's not like heterosexuals, where it's all about the guy. I think that she would care about me being satisfied. If not, then she will think that it's her fault." Thus, future research should further explore the experience of sexual difficulties among queer women to identify specific forms of acquiescence and resistance to gendered sexual norms.

Conclusion: "Broken" Women

Several studies have shown that women with sexual dysfunction often position themselves as "defective" women (Connor, Robinson and Wieling 2008). Lavie and Willig (2005) found that women with anorgasmia saw their inability to achieve orgasm as a defect and a sign of inferiority. Similarly, Ayling (2008) found that women with vulvar pain saw themselves as "worthless", "broken", and "dysfunctional". Many women in this study utilized similar

metaphors. Of the women in this study, one in five literally used the word "broken" to describe themselves, their vaginas, their gender, and their sexuality. Yvonne, a woman with anorgasmia, said, "At that point I was 19, had started having intercourse, been with a few partners, and just thought it should have happened at least once. Especially after trying myself, it was just not there. Something was missing. [I felt] a little bit broken. [Broken?] I guess that was a joke I had with the few friends that I would tell. I said that I had a broken vagina." Women also portrayed themselves as a machine that no longer able to perform its designed function, as Maya, a woman with sexual pain, illustrated: "[What does "broken" mean?] Something that doesn't function. Something that's out of place that, you know, maybe the parts exist but they're split in half. Literally doesn't function. Or maybe a car with a flat tire. It still goes, but it's not really, like (laughs). It's kind of broken. And that's maybe a more accurate analogy. You're just kind of limping along, as opposed to smooth sailing." At times, women's friends and families reinforced these notions:

> I actually lost a friend – well, I was gonna say I lost a friend over this…And what happened was that we're in a bar, and I got a tattoo last year, and this was maybe right after or right before I got it, 'cause I was talking about, "Oh, I can get a tattoo like this. I can get a tattoo like this." And my friend just kind of blurted out, like, "You should get one of a vagina that says 'Doesn't Work." So, and I actually punched him…But I was so angry. Like, and I was embarrassed, 'cause I lost my shit. We're at a booth at a bar with eight friends, and I just started punching. (Ilana, pain)

This reflects the work of Emily Martin (1994), who suggested that female bodies are often understood as disciplined machines ; as a machine, the body is composed of multiple interrelated parts that may break down. This conceptualization of the vagina as a "broken" body part indicates its objectification; here, the vagina is almost disembodied, no longer a part of them

Almost a third of women with sexual pain or low libido felt as if they were broken or malfunctioning , compared to one woman with anorgasmia. Furthermore, of the women who felt as if they were broken or malfunctioning, almost all were heterosexual. It may be that "brokenness" is linked to the lack of desire or ability to fulfill the coital imperative. This is reflected in the response of Melissa, a woman with sexual pain, who noted that intercourse was

something that the female body was designed for: "It makes me feel much less feminine. Less womanly. Less…yeah, I mean, again, the knee-jerk response is there's this primal, like, I'm not enough of a woman because I can't do this service. Or, not service, I can't do this thing that I'm built to do." Thus, women again positioned receptive sexuality – particularly, the ability to engage in penetrative intercourse, which was positioned as a "service" (i.e., labor) - as central to constituting gender. In contrast, women did not necessarily expect to have orgasms, and a lack of orgasm was not seen as central to the maintenance of relationships; thus, failure to have them did not represent a failure of an essential bodily function.

The central questions of this thesis are these: If women are "broken", in what ways to they seek to become "repaired"? Who do they turn to in order to "fix" them? If they cannot fulfill their sexual obligations, who do they call upon for help? When do they turn to medicine to fulfill this function? If they do, under what circumstances do relationships with their "fixers" take hold? I turn to these questions in the next chapter.

CHAPTER 4: THE MEDICALIZATION OF SEXUAL DIFFICULTIES: CAUSAL ATTRIBUTIONS

Humans are sense-making creatures. Like all people, including all those confronted with bodily experiences of unknown origin, women with anorgasmia, low libido, and sexual pain feel the need to explain, understand, and make sense of these experiences in the context of their life histories, popular discourses, and interactions with others. Thus, as in the case of those with illness, women with sexual difficulties "make meaning" of their problematic bodies through the use of narratives that give coherence to the distinctive events and long-term course of suffering (Kleinman, 1990). One vital aspect of the process of constructing illness narratives is the adoption of explanatory models of illness (Kleinman, 1980), which help people to recognize, explain, and respond to illnesses and their symptoms. These models attempt to address questions regarding: a) etiology; b) time and mode of onset of symptoms; c) pathophysiology; d) course of sickness; and e) treatment. Through the construction of such models, individuals are able to reformulate and/or reestablish and reaffirm who they are in the wake of sexual difficulties.

Williams and Healy (2001), however, have suggested that this term "explanatory model" is too fixed to adequately convey illness attributions' fluid and dynamic nature. Rather, particular causal attributions may exist alongside or be supplanted by others, forming a complex map of possibilities that provide a framework for sense-making on the one hand and have the possibility to lead to disorder and uncertainty, on the other. In the case of sexual difficulties, given their uncertain positioning vis-à-vis medicalization, this may mean that varied configurations of medicalized and non-medicalized explanations of bodily experiences coalesce, break apart, and reform to create a shifting tapestry of meaning. What these varied explanations have in common, however, is that each reflects different assumptions regarding male and female sexuality and bodily functioning. For example, men's sexuality is often represented as uncomplicated, hydraulic, and straightforward; in contrast, women's sexuality is represented in the popular media as more complex (Fishman, 2002; Zilbergeld, 1978): "The male sexual brain is like a single toggle switch, whereas the female sexual brain is like the cockpit of an F1 fighter

jet," Gaddam said. "There are tons of dials and instruments, and there's sophisticated calibration going on." (Landau, 2011)

These representations were echoed by the women in this study. Jill, a woman with low libido, said, "Well, you know, women have this entirely different sexuality than men with parts that are confusing. And so, we have to have hours and hours of foreplay and romantic movies in order to get women to feel in the mood. Men, you just press a button on the penis." Thus, women's explanatory maps for sexual difficulties may be more complex than men's due to the way male and female sexuality are constructed. If women's sexuality is thought to be influenced by biological, psychological, and social factors, any one of these could be construed as an explanation for sexual difficulties; in contrast, while men's sexuality may be just as complex, its construction as simple lends itself to simple, biological causal attributions for erectile dysfunction.

One way in which individuals make sense out of explanatory maps, solidifying them into explanatory models, is through the adoption of illness identities - understandings of self and affiliation with others on the basis of shared symptoms and suffering (Barker 2002) which unify heterogeneous sets of symptoms into a single defined illness (Barker 2002, 2011). As Angel (2012) notes, the term "female sexual dysfunction" has been increasingly cited in medical and scientific journals over the last several decades, moving from an umbrella term encompassing various dysfunctions occurring in females to a unique condition in and of itself. This transformation, which accelerated after the development of Viagra, suggests a single (biological) causal pathway for these diverse sexual difficulties that are akin to men's, which may help to pave the way for women's receptivity to a "female Viagra" once developed.

Feminist authors have suggested that women's vulnerability to the authority of medicine may lead to the increasing adoption of medicalized explanations for sexual difficulties and/or sexually dysfunctional illness identities. To date, however, most studies of women's causal attributions regarding sexual difficulties suggest that women most often attribute their sexual problems to relational, contextual, or emotional factors, rather than individual psychological or medical factors (Nicholls 2008; King, Holt, and Nazareth, 2007; Sims and Meana, 2010). Such studies do not, however: a) differentiate between the types of difficulties experienced; b) explore underlying assumptions regarding sexuality and the body that help to create explanatory maps of

illness; and b) explain the ways in which these maps contribute to the formation of gendered illness identities. I address these questions in this chapter, with an eye to understanding the degree to which women medicalize their experiences on a conceptual level, separate from practice (which will be addressed in Chapter 5). Addressing these questions will allow for further explorations of the tensions between complex cultural understandings of female sexuality and pharmaceutical/medical attempts to create the sexually dysfunctional subject.

Understandings of Sexual Difficulties: The Process of Formation

The meanings of bodily sensations were often elusive and difficult to capture for the women in this study. When attempting to explain why they were experiencing their sexual difficulties, 19% of the women in this study could not identify a cause. Instead, these women were lost in a mire of uncertainty, which caused additional distress – as Sarah, a woman with sexual pain, noted: "There are certain things you can do to protect yourself from certain diseases, preventative care, good eating prevents diabetes onset, what have you. With this, it just seemed like it was just, you have it. There's like some nebulous – it's almost like those old theories of, of public health disease transmission, the humors and the miasma, where it's "It's in the air." But no, it's in your vagina! Where does it come from?"

Most women, however, had one or more hypotheses as to why their difficulties were occurring. Not only did the women in this study cite a wide range of causes for their sexual difficulties but – reflecting the findings of Williams and Healy (2001) - a large majority cited multiple potential causes, reflecting: a) the complexity and conflicting nature of discourses available to them; and b) women's uncertainty in navigating this conceptual terrain. Often, they quickly moved between alternative attributions, suggesting first one, then another, of a range of available attributions without necessarily prioritizing any of them. In doing so, women attempted to make sense of their experiences using bits and pieces of things they heard (e.g., from popular media sources or medical/scientific authorities) but did not necessarily fully comprehend.

> [Now, you said that you had thought that it was a biological thing. What does that mean exactly?] Oh, just that there was something biologically wrong with my

> vagina or hormones possibly, the biological factors that comes into account when having an orgasm. I think there are four steps of arousal. I don't remember what they are necessarily but just involving hormones stimulation and just maybe I have a hypo sensitive vagina. Maybe the nerves aren't as sensitive to touch or maybe they're extra sensitive, I don't know if I'm using the right language. (Yvonne, anorgasmia)

Of the 24 women who discussed how they decided on their particular constellation of potential causes, 42% did so by process of elimination; that is, they ruled out each one that did not apply to their situation until they were left with a handful of possible alternatives:

> I was thinking that this was something that could play into it because it has a lot of stance in other places in my life. This is just something I assume attributes to it because other things, they just don't make sense. I've taken out variables, I've added variables, I've tried to see if anything does affect it that I can change currently. Anything that has been able to, such as, change in partner, change in relationship, change in time period of a relationship. Anything of those I've tried different things. (Jen, anorgasmia and low libido)

Thus, women's causal narratives changed as their experiences - their biographies – did. Thus, women did not only contextualize their sexual difficulties in their life stories, but revised them and reformulated them as time went on.

In the following sections, I will describe the various attributions that constituted women's explanatory maps, as well as the ways in which these attributions may or may not have reflected women's understandings of gendered bodies and sexualities. This will provide a foundation for later discussions of identity formation in the context of medicalization.

The Adoption of Medicalized Causal Attributions

Medicalized attributions were frequently cited by the women in this study. Most cited biomedical causes, psychological causes, or both as possibilities. Taryn, who experienced sexual pain and anorgasmia, made this explicit in her discussion of pain, saying that the cause either had to be biomedical ("physical") or psychological ("mental"): "[What did you read on sites like WebMD?] That it's kind of two fold. There is the physical, like you need to actually physically

stretch things out because you have a small vagina, or you have that condition where you just kind of clamp down because of mental emotional blocks or whatever. I don't know which one I have. [But you think it's one of those things?] Yes." Four-fifths of women with pain and low libido cited biomedical ("physical") reasons for their experiences, compared to one third of women with anorgasmia. Similarly, approximately two thirds of women with sexual pain and with low libido cited psychological causes, while only slightly more than one third of women with anorgasmia did so. Thus, while all three groups of women medicalized their experiences to some extent, this was far more common among women with low libido and sexual pain.

21% of women rejected mind-body dualism in favor of a holistic model in which their sexual difficulties were not biomedical or psychological but encompassed both. Similar proportions of women with sexual pain, low libido felt this way (18% and 23%, respectively) while almost no women with anorgasmia did:

> Does anyone know? You know, you're not even having sex right now. It's bothering you maybe every couple of months, where you have this weird episode. And then I realize, oh, you know, I'm, I'm stressed out about something. Is that related? I just don't really understand. I don't really understand if there is a connection between the physical experience and some sort of, like, neural pathway. I mean, I don't know. Your body is connected to your emotions. I mean, when we have things – when we get in an argument, we have a stomachache. Well, we could have a stomachache. There are certain, you know, pathways that manifest those emotions in you. So I really, I just don't know. I don't know what it is! And I, and I wonder if there is some emotional connection. (Sarah, pain)

Again, however, even in embracing both sides of the mind-body dichotomy, the dichotomy remained intact – in these instances, social causes were still excluded in favor of medicalized attributions.

Both psychological and biomedical attributions are composed of multiple discourses in their own right. Below, I will describe each of these discourses in an attempt to complicate notions of what it means to medicalize bodily experiences, and will attempt to analyze which apply to particular difficulties. It is these discourses, along with competing non-medicalized

discourses, that are suppressed by the efforts of pharmaceutical companies to find "one-size-fits-all" solutions to sexual problems.

Medicalization: Biomedical Attributions

Medications. Interestingly, iatrogenic reasons – particularly the use of medications -were the most frequently offered explanations for sexual difficulties in among women who cited a physical reason for their experiences (43%). This was most common among women with low libido (42%), although it was present in women with other conditions as well (27% of women with pain and 12% of women with anorgasmia). Thus, the medicalization of other bodily/emotional experiences (e.g., depression) could be seen as causing sexual difficulties in and of themselves; this problematizes the idea that additional medicalization is necessary to treat women's sexual problems, in that biomedical solutions are at least partly responsible for the problems in the first place.

Birth control was the most frequently named culprit for sexual difficulties among women with low libido although several women with sexual pain and/or anorgasmia cited this as a problem, as well. Cecilia, how experienced low libido, said, "It is quite possible that there is a genetic, physical, mechanical part to [low libido]. It is quite possible...For the first 12 years of being married I was on Norplant birth control, the arm injections. Then I was on an IUD for about five years, then maybe for a year or so I was on the pill, and now I'm off of it." Thus, women felt as if their hormones were being altered for the worse as a result of the use of contraceptives, a medicalized way of controlling conception.

In addition to hormonal problems caused by medications, 20% of women who cited physical causes spoke of hormones in general terms; most of these experienced low libido. However, when including the effects of birth control, more than a third of all women felt that hormones were at least in part responsible for their experiences, as Olivia – who had low libido – believed: I just don't really have a high libido at all. I'm thinking there's some dysfunction going on. There might be. **[**What do you mean by dysfunction?] Like if I have weird...low hormones or something that normally are supposed to cause you to have some motivation to have sex. It's actually most of the time I don't want to have sex. I think it's hormones." Similarly, in a study of women suffering from chronic pelvic pain, Grace and MacBride-Stewart (2007) found that

women often blamed "out of whack" hormone levels for their experiences, suggesting the centrality of hormones in understanding difficulties relating to reproduction and sexuality. Hormones in and of themselves are signifiers of – and supposedly partially constitutive of - biological sex differences, which has implications for gender identity (Roberts, 2002). Hormonal inputs help to sexually differentiate the fetus *in utero* and contribute to the development of sexed bodies through, among other things, secondary sex characteristics such as breasts and facial hair. Hormones are also tied to sexuality, in that testosterone is linked to libido in both men and women; men's "innately" greater sex drive is often popularly attributed to greater amounts of testosterone. It makes sense, then, that many women assign blame for their sexual difficulties – particularly those involving libido – on problems with hormones; such attributions reflect existing presuppositions regarding sexed bodies.

Other Biomedical Causes. Other, less frequently mentioned physical causes – all of which were for sexual pain - included: a) physiological problems (i.e., those having to do with the physical structure of the body, such as small/short vagina or a tilted uterus; 12%); b) systemic physical problems (12%); c) allergies (to semen and/or condoms) (10%); d) problems with lubrication (10%); e) yeast infection (8%); and f) neurochemistry (8%). As discussed above, these explanations reflect women's complex explanatory maps; even when difficulties were defined as biomedical in origin, there was not one consistent narrative that was available to the women in this study.

Medicalization: Psychological Attributions

Just as in the case of biomedical causal attributions there was a wide range of psychological causal attributions noted, including: a) sex-specific anxiety; b) generalized anxiety or depression; c) sexual repression; and d) trust issues. In addition, similar to biomedical causal attributions, many (although not all) psychological attributions reflected women's understandings of gender and sexuality – or, alternatively, reflected a consciousness and/or critique of societal pressures and conflicts surrounding these issues.

Mental Health (General). Of women with psychological causal attributions, 27% cited other mental health (e.g., depression, anxiety) issues as the reason for their experiences. Women with low libido (23%) were twice as likely to cite general mental health issues as a cause of their

experiences compared with women with anorgasmia and women with sexual pain. This may be tied to the way that depression has been characterized by medical professionals and the pharmaceutical industry over the years, as manifesting as a loss of interest in life itself.

This explanation, however, was tied to yet another iatrogenic (i.e., biomedical) cause cited by several women: - antidepressants - which were often thought to cause low libido and anorgasmia above and beyond that caused by depression itself. Karen (who experienced low libido) said, "I have been on different types of medications. They have intensified my lack of sexual desire. I was put on anti- depressants, bi- polar medication, and anti- anxiety medication. I went from being able to tolerate being touched. To not being able to be touched. Appalled by a man touching me in any romantic way. " This is a prime example of the ways in which biomedical and psychological explanations for sexual difficulties may exist in the same explanatory map, as well as the ways in which illness identities unify a number of disparate symptoms into a single explanatory model. Of note, women are diagnosed with depression and anxiety at higher rates than are men, suggesting that depression is itself a gendered condition (Johnson et al., 2004); as psychological explanations for sexual difficulties may likewise be gendered, as will be discussed below, this facilitates the incorporation of such explanations into this prior illness identity.

Sex-Specific Anxiety. One third of women who believed that their experiences were due to psychological factors cited sex-specific anxiety. Many were women with sexual pain who were fearful of painful intercourse, even as they attempted to have intercourse in spite of the pain in an attempt to perform sexual care work as described in Chapter 3. Anxiety was seen as contributing to a never-ending cycle in which pain caused anxiety, which presaged further pain; this was also seen to contribute to low libido, as women like Melissa desired sexual activity less as they increasingly anticipated pain: I was constantly waiting to have it hurt. I just, I couldn't focus. I couldn't not focus on it hurting. And I was prepared for it to hurt, so it always hurt."

A common theme in the scientific literature is that underlying most sexual pain is vaginismus (i.e., an involuntary tightening of the vaginal muscles often attributed to psychological trauma and/or anxiety surrounding sexual activity). While vaginismus in the case of prior exposure to pain is understandable on its face, there is also a historical association between sexual difficulties, including vaginismus, and feminine anxiety regarding sexual

activity. For example, in marital advice literature from the early-to-mid 20th centuries, sexual difficulties (including vaginismus) were often associated with the "horrors of the wedding night"; in this literature, men were advised to approach their brides delicately upon defloration or face the lifelong consequences of sexual trauma. (Clark, 1937; Rossiter, 1952; Rutgers, 1940). Today, although it is not framed as a manifestation of traditional femininity, scientific literature that cites emotional aversion, feelings of threat, avoidant behavior, and fear of pain (Watts and Nettle, 2010) draws upon this history.

Sexual Trauma. Similarly, therapeutic discourse exists in which other forms of sexual trauma (e.g., rape, sexual abuse) are often assumed to cause longstanding emotional scars, leading to a wide range of sexual difficulties (Zwickl & Merriman 2010). Thus, one out of ten women with psychological causal attributions cited sexual trauma due to rape or sexual abuse as a reason for their experiences. Crystal, who experienced anorgasmia, believed this to be true, stating, "I said, 'The statistics of women who can't have an orgasm are like, I don't know, what was it, 33 percent…. I said, "I'm in one of them.' I told him what had happened to me in the past about being assaulted." An additional 15%, however, noted that while sexual trauma was not a cause of their own sexual difficulties, they understood that it might be in others. Karen, who experienced low libido, made sure to clarify this belief: "I never experienced sexual abuse and I figured that was probably what you are going to jump at because I've heard that just from reading is kind of a cause of weird sexual things. But no sexual abuse." One quarter of women with anorgasmia cited sexual trauma as a possible cause of sexual difficulties, for themselves or others, compared to 16% and 12% of low libido and sexual pain, respectively.

Clearly, the language of sexual trauma held some purchase with these women, even in cases where they felt that the cause did not apply to them personally. While I do not mean to deny or minimize the very real pain that women who have been sexually abused or raped experience, it is important to separate out these experiences from the discourses that help women to understand and interpret what has happened to them. The strength of this discourse, as will be seen in Chapter 6, often led medical practitioners to disbelieve women with sexual pain who claimed to not have a history of trauma, and even led women to scour their own memories for signs of repressed memories of abuse. Therefore, these discourses may serve as a space for delegitimation as well as support.

Trust Issues. 15% of women who believed that their difficulties were attributable to psychological causes felt that trust or intimacy issues were at the root of their experiences. Thus, the reluctance to make themselves emotionally vulnerable was seen as a hindrance to women with sexual difficulties:

> I have continually throughout the five or six years that I've experienced this gone online to look things up. You know, female orgasmic disorder. I looked in the DSM-IV. I've found a little description there. Nothing that's ever resulted in anything… [what did you find exactly in the DSM-IV? What did it tell you?] Just a female's inability to have an orgasm. I think it actually did say something about usually linked to relationship. What's the word? Problems with relationships. Problems with intimacy. (Yvonne, anorgasmia)

Female sexuality is commonly associated with emotion and intimate relationships in the popular imagination; for example, women are often assumed to have difficulty in engaging in casual sexual encounters, as there is seen to be an emotional requirement that must be fulfilled before such activity can occur. This understanding of female sexuality led women to believe that a problem with sexual functioning must be due to a problem with the ability to emotionally engage with one's partner. At times, women connected this with having a poor father figure:

> My mom and dad were always together but my dad had a lot of personal demons that he never really confronted and he chose to self-medicate using alcohol. It made things very, very complicated. He and I had a very difficult relationship. It was very adversarial. I never really had an opportunity to understand what a healthy male-female relationship could be about. I always say that because of my relationship with my father, you know, it kind of set the course for the way that things are now. (Cara, anorgasmia)

Of note, one quarter of women with anorgasmia reported this, compared with 12% of women with low libido and no women with sexual pain. While most women suggested that a poor relationship with their father caused their fear of intimacy with men, this particular attribution also evokes psychological discourses of female sexuality that date back to the early-to-mid-20th century. Freud, for example, suggested that frigidity – in this case, the failure to have a vaginal orgasm – was due in part to the woman's failure to shift her libidinal

attachment from her mother to her father (Gerhard, 2000). Thus, a disordered relationship with one's father might be seen to set up the stage for difficulties in achieving orgasm later in life.

Need to "Relax". Approximately a quarter of women with psychological causal attributions cited the need to relax or "let go" as the reason for their sexual difficulties. This was three times more likely among women with anorgasmia (29%) compared to women with low libido or sexual pain, although Emma, who experienced sexual pain, poignantly expressed this sentiment: "I definitely felt, is it me? Am I – whatever frigid means? Yeah, I'm too uptight. I'm not relaxed enough. I mean, we've never had, like, free and easy sex, ever. You know, where you're just having fun, and romping. It just doesn't, I've never had that." Not only did this put the responsibility for sexual difficulties on women's shoulders, but it evoked the expectations that: a) women should be "up for" and properly responsive to sexual activity, lest she be considered "uptight", "frigid", or a "prude"; and b) women's sexuality is largely passive, rather than active. This last is seen in the way in which relaxing – which evokes lying back and letting the sexual activity happen to her, rather than participating as an active agent – is seen as the means to achieve orgasm.

Sexual Repression. Finally, the aforementioned idea of "relaxing" is often tied in the popular imagination to letting go of sexual repression, interpreted as a "hang-up" (i.e., an internal process that could, perhaps, be treated by psychotherapy). One in five women with psychological causal attributions claimed that their sexuality had been repressed in some way; this was most common among women with anorgasmia (24%) compared to women with low libido (15%) and women with sexual pain (almost none). Many, like Rosa (who experienced low libido), claimed that this was due to the taboo nature of sexuality, particularly for women: "You don't even hear sex mentioned in that, because it's so implicit, you cannot bring that up. It's very taboo, and it's very annoying that it is. [Where does low desire fit into all of that?]. I think I know where it fits in. It's something to do with my brain processing it as a taboo thing. I think it's shutting down my physical reaction, because I'm so worried about it." Women in this case are critically engaging with the double bind of conflicting messages surrounding their obligation to engage in sexual activity on the one hand, and admonitions against agentic female sexuality on the other. Again, these women blamed themselves for their inability to resolve these messages, internalizing the critique and framing it as a psychological difficulty to be overcome.

The Adoption of Non-Medicalized Causal Attributions

In addition to psychological and/or biomedical causes, nearly all women with anorgasmia and low libido, and more than half of women with sexual pain, also cited non-medicalized explanations for their experiences. Three quarters espoused both medicalized and non-medicalized causes simultaneously, which indicates that while medicalized explanations may be extremely popular, these represent only one facet of women's complex explanatory maps. Furthermore, many of these social attributions reflected a consciousness of inequalities regarding gendered obligations and treatment within intimate relationships. That women continued to hold up the achievement of sexual norms as the ideal indicates that this resistance was not complete; however, this societal critique may be seen as a first step in resistance to medicalization.

Body Image. Echoing a recent review of 57 studies conducted by Woertman and van den Brink (2012) that found that positive feelings about one's body and/or appearance were associated with fewer sexual difficulties, many women cited poor body image. One third of women with low libido cited body image (appearance in particular) as a reason, compared to 12% of women with anorgasmia and/or sexual pain. This may be due to increased feelings of self-consciousness during sexual activity and/or the fear of negative responses from sexual partners, which takes them "out of the sexual moment":

> And there's perhaps another mental level for me, where attractive is also attached to "being in your own body," in a sensual awareness of one's own body and its potential. That sex is an embodied experience, one that's hard to really enjoy without that internal pleasure-in-the-body -- and if I don't like my body, if I'm self-conscious about it, then it's very hard to just accept all the input that I might get from it during sex. So that's another part of the "I just don't feel sexy/sexual" thing. (Cecilia, low libido)

In this case, women acknowledged that social expectations regarding female sexuality may have been internalized in such a way that they interfered with their ability to desire their partner; thus, their sexual difficulties again lay at the juncture between social (i.e., the

unreasonable beauty standards that society holds up as ideal for women to achieve) and the psychological.

"In My Own Head." 14% of women attributed their experiences to "being in their own head" to an excessive degree; twice as many women with anorgasmia felt this way compared to women with low libido, while almost no women with sexual pain did so. In this case, women felt the need to "be in the moment' of sexual activity, sensually aware, almost unconsciously so; thus, the active mind was identified as an enemy. Often, this was tied to women's anxieties regarding their sexual performance:

> When somebody is making love to me, I'm so worried about how they're feeling as opposed to how I'm feeling. I'm always worried, "Are they having a good time?" Then I think, for those five seconds that I don't think about it, I enjoy it and then I worry about them again…. Maybe I need to immerse myself more. I don't know. [What do you mean, immerse yourself?] Like, immerse myself in the experience, you know, like, instead of worrying about how she's feeling based upon what I'm doing, or how she's feeling based upon how I'm reacting to her. You know, instead of worrying about all of that, just immerse myself in this feels good. But again, I can't say that I've never tried that before, or I can't say that there's never been times where I'm just like, just stop thinking, you know, like, but that, I don't know how to shut off my brain. (Amy, anorgasmia)

That this could also be seen as a difficulty induced by the perceived need for sexual care work is illustrated in the quote above; thus, women were conscious of how sexual obligations might actually interfere with the sexual functioning that such obligations required. Rather than blaming these obligations for their sexual difficulties, however, women blamed themselves; i.e., their inability to "shut their brain off." This is an example of women individualizing and depoliticizing what may otherwise be seen as a social cause; as discussed in Chapter 1, this is a key aspect of medicalization, which takes social norms and expectations and locates the onus for these in the (pathologized) bodies of women.

Partners. Almost half of all women felt that their partners contributed to their experiences; this was evenly distributed among all conditions. This occurred in a number of ways, including: a) wanting to be with a different partner (n = 8) b) lack of attraction (n = 4); c) having an inexperienced partner (n = 2); d) having a partner with a large penis, causing pain (n =

4); and e) their partner's inability to fulfill traditional gender roles, which located the problem in their partner's lack of masculinity, rather than in their own loss of femininity. Among issues relating to women's partners, however, the most common was their partner's perceived sexual selfishness and/or sexual mistreatment (n = 9):

> I wanted him to kiss me, and I wanted him to mean all the things that he was saying, but it was quite obvious that he wanted sex and nothing that came along with it. My body was dry; I was literally not producing any body secretions. And he was treating me like a faucet that you can just turn on and turn off and all the emotions that come with sex and a desire to be with someone were just not there. There's no kissing, no touching in the right spots... it was just like, flip over, put it this way, do that way, and I literally had bruises on my knees, I did not even want to be in the situation whatsoever. I described it to my best friend because I had spoken to her about it as if my vagina literally had thorns growing out rejecting him. Because I had this brand new realization about who I am and what I mean to myself and I'm strong. And there he was, just taking it from me. And my body had no physical reaction to it except for it did not want it. (Lauren, low libido)

In this instance, low desire was directly seen as the bodily manifestation of resistance to sexual objectification and mistreatment. While this woman felt as if her power was being taken from her, her vagina – here almost conceived of as a separate entity – defended her against her partner's actions. As such, her vagina was a source of strength and defiance.

Relationships. One in five women cited aspects of the relationship as the reason for their sexual difficulties; similar proportions of these experienced sexual pain, low libido, and/or anorgasmia. Two thirds of these women framed this in general terms, as Ilana, who experienced sexual pain, did: " I mean, I guess – it boils down to, like, he was hot. I thought – I just, I thought the potential for him to, like, for us to open up to each other, and it just kept on not happening. And I was, like, "OK. This is how it's how it's gonna be." We're not gonna open up to each other emotionally, which means that sex is not ever gonna be really comfortable to me." Again, this reflects gendered understandings of female sexuality being dependent on such relationships and their attendant emotions. In this case, however, sexual difficulties were not attributed to an inability to engage in intimate relationships (as in the case of those who felt that they were fearful emotional of intimacy); rather, their problems were reflective of the

unsatisfactory nature of the relationship itself. Thus, women were able to locate the problem outside the self.

Stress Due to External Causes. Women cited stress as a cause of their sexual difficulties in 22% of cases. This was most common among women with low libido (31%), and much less so among women with sexual pain (15%) and anorgasmia (6%). This stress was attributed to the daily demands these women had to face. As Jen, who experienced anorgasmia and low libido, put it, "It's a lot of hours after my day has been done. I think that the stress that manifests in my mind from my days is not prepared for something that...I don't know why it's not prepared for it, but it's just maybe it doesn't feel my body is ready, or...I'm not sure." An additional 10% did not specifically mention stress, but cited either their demands of child care or busy lives as a reason for their experiences. Again, most of these women – like Liz, who also struggled with anorgasmia – experienced low libido: "For me, personally, I can understand being in a relationship for six years. You have other things to do, you know? Sometimes, especially, when you're out of college, you have a job, you have responsibilities now. You can't have sex all the time. Yeah. It's almost like, "Oh," shrug your shoulders like, "I guess this is life for us now." For the women in this study, it was not the de-sexualization of their roles that contributed to women's sexual difficulties, but the stress and/or difficulties incurred in trying to live out these roles (Bellamy et al, 2013). Women's responsibility for the lion's work and childcare, as well as the emotional well-being of their families, created a context in which sexual care work was extremely difficult to enact. This may explain women's characterization of sex as "work" or a chore", as discussed in Chapter 3; it was one more thing that women had to do as part of the "third shift" (Hochschild 2001).

Failure to Know One's Body. Some women (11%) felt that their experiences were due to the fact that they were not familiar with their bodies; thus, once they had explored their bodies' capabilities, they would be able to experience normative sexuality. As Erica, who experienced anorgasmia, noted, "I think that maybe it's because I need to explore myself a little bit more…. It's just the fact that I need to take some time and really see what I like." Although "failure to know one's body" was not often cited, when it was, it was largely among women who experienced anorgasmia or low libido.

Demonstrated in the landmark text Our Bodies, Ourselves and the self-discovery workshops of Betty Dodson, these discourses were created as an explicit counterpoint to those of medical institutions, who were perceived to devalue women's knowledge and constrain their sexual and reproductive bodies. The rhetoric of agency and control in regards to the achievement of female orgasm continues today in popular messages centered on agency, liberation, and empowerment that manifest themselves under a postfeminist guise of "sex positivity". Cecelia, who experienced low libido, said, "I have been tempted to go invest in a Betty Dodson workshop for sex therapy, but I don't know that I'm really ready to do that on a weekly basis. [What would you expect to happen in a Betty Dodson workshop?] Oh, gosh. People sitting around in robes until they get naked. I've seen the vagina galleries from some of her workshops, so it's much more, 'Get comfortable with your own body,' and, 'Let's all sit in a circle and masturbate, and then talk about the experience.'"

This attribution is an agentic attribution, tied to the postfeminist sexual scripts discussed in Chapter 3; even so, it places the responsibility for having an orgasm squarely on women's shoulders. It may be true that if a woman cannot have an orgasm, she is seen as unskilled or inexperienced, rather than medically or psychologically pathological. However, it is then up to the woman to develop herself in the sexual sense. If that is thought not to have happened, then women may be blamed for not investing their time, energy, and efforts into cultivating their ability to orgasm and/or feel desire. This will be discussed further in Chapter 5, when discussing the strategies utilized by women with anorgasmia and the discourses surrounding them.

Normalizing the Experience. Finally, a quarter of all women saw their experiences as normal or natural. Nearly half of women with low libido felt that their experiences were natural or normal, while women with anorgasmia and sexual pain felt this way less often (18% and 12%, respectively). Rachel, who experienced low libido, asserted, "I think it's normal. It's so different between everyone, that it's much more a subjective term than people want to believe. [Laughs]" Similarly, many women felt that this experience was a natural occurrence in all long-term couples. This echoes the findings of Sims and Meana (2010), who found that institutionalization of their relationships, over-familiarity with their partners, and the de-sexualization of their roles (i.e., transitioning from sexual being to wife, mother, and professional) all contributed to a lack of desire among married women. In normalizing the experience, these women acknowledged the

wide range of women's sexual expression and asserted their right to experience their bodily sensations without judgment. This, then, was the one discourse that did not pathologize women's sexual experiences, but asserted the individuality of each woman – or, as one Sonja, who experienced anorgasmia and low libido, put it, "my homeostasis for me." Thus, this may be seen as a mark of resistance to medicalization.

Summary of Causal Explanations by Condition

See Table 1 for a rank-ordered list of the top causal attributions by condition. Contrary to expectations, women's top attribution for sexual pain was their partner. Some of this may be explained by the fact that women's with sexual pain often cited their partner's penis size as the cause of their difficulties. Thus, their partners may have represented a secondary, more immediate cause of their pain, rather the pain's underlying origin. Furthermore, as discussed above, many of these women – such as Debbie, who experienced sexual pain - coupled partner-specific causal attributions with others, which were usually biomedical or psychological in nature: "**[**What do you attribute the dissipation of the pain to?] The reduction of stress. It's weird. Because I always wondered to myself, was my body trying to tell me when I got involved with this guy, that this is a bad thing to do, and I wasn't reading into it? But then, I do know, for a fact, that the pill did cause the pain. Even in future relationships, even with my current husband, initially I tried to go back on the pill and I couldn't, because the pain came right back."

Sex-specific anxiety (a psychological cause) was the next most common attribution for pain, followed by medications (a biomedical cause), indicating women with sexual pain frequently adopt medicalized explanations for their experiences. Similarly, medications were the most cited attribution for low libido. However, the remaining causal attributions of low libido were non-medicalized in nature. Finally, women anorgasmia with most often cited psychological and/or non-medical causes for their distress.

Table 2: Top 5 Causal Explanations by Condition

Sexual Pain		Low Libido		Anorgasmia	
1. Partner	39%	1. Medications	42%	1. Partner	47%
2. Sex-Specific Anxiety	30%	2. Normal or Natural	42%	2. Normal or Natural	29%
3. Medications	27%	3. Body Image	38%	3. Need to Relax	29%
4. Normal or Natural	15%	4. Partner	35%	4. In Own Head	29%
5. Stress	15%	5. Stress	31%	5. Need to Know Own Body	29%

It is apparent that female sexual difficulties have not been medicalized to the same degree, or in the same ways. While men may have one or two primary explanatory models to explain their sexual difficulties, women do not have one primary model on which to draw. It is possible, then, that women are not merely passive recipients of medical discourses of sexual difficulties; rather, due to the wide variety of competing cultural discourses surrounding women's sexuality, the choice of medical causal attributions is not inevitable. These discourses reflect agency and constraint in that women can choose among these discourses, but are restricted to those discourses available to them.

The Construction of a Sexually Dysfunctional Identity[2]

Given the wide variation of etiological explanations for their sexual difficulties, to what extent did women identify themselves as sexually dysfunctional? In other words, did women adopt this particular illness identity, solidifying their causal map into one medicalized attribution model? To answer this question, it is first necessary to examine the ways in which women defined what this term meant, as well as its significance to them. The women in this study

2 After the first round of interviews that I conducted, the construction of sexually dysfunctional identities arose as a salient theme; thus, during the second round of interviews, I routinely asked women regarding their experiences in this regard. This section specifically reflects the views of the women who were asked these questions, including all women with low libido and anorgasmia and 9 women with sexual pain.

understood the term in a number of ways, including: a) something that primarily happened to older women; b) anorgasmia; c) low libido; d) sexual pain; e) the inability to engage in sexual activity, particularly penetrative sexual activity; or f) a change in an individual's sexual capacities over time Just as particular causal attributions reflected gendered assumptions regarding men's and women's sexual bodies, however, so too did understandings of sexual dysfunction. This was reflected in the fact that sexual dysfunction was most often defined as erectile dysfunction – that is, something that happened to men - as Eileen, who experienced sexual pain, admitted: "I knew that, um…males experienced sexual dysfunction, 'cause I knew about, you know…pre-ejaculation, and erectile dysfunction, those types of things. But I never knew that females could experience sexual dysfunction. Um, I just, I guess I just thought that it was supposed to work. And that, yeah. I didn't even think that there was a possibility." Even when female sexual dysfunction was spoken of, it was often juxtaposed with erectile dysfunction; thus, just femininity takes on meaning in relation to masculinity, female sexual dysfunction only took on meaning in comparison to its male counterpart. For example, as one woman pointed out, if male sexual dysfunction is defined as the failure to achieve and maintain an erection, female sexual dysfunction must, by extension, reflect a failure to be heterosexually responsive:

> It seems equated with erectile dysfunction, which is weird because erectile dysfunction doesn't even necessarily imply sexual dysfunction. But when you think of the word "dysfunction" in a sexual context, it seems to be like, "My penis is broken."[Laughter] As if there's nothing else to sex than that. So sexual dysfunction - female sexual dysfunction -- I guess what it means would be like, "She's sexually unresponsive," because I think that's kind of where female sexuality is placed. Their sexual function is responding, so if you're sexually dysfunctional, you're not responding, I guess. (Jill, low libido)

Another example of this may be seen in regards to the differing causal attributions assigned to male and female sexual dysfunction. Male sexual dysfunction was often thought of as a physical, not psychological problem, possibly due to the dominance of Viagra and "erectile dysfunction" in the popular imagination. In contrast, the women in this study acknowledged popular assumptions that women's sexual difficulties were largely due to emotional factors:

> I think that a man's sexual problem is only considered physical. It's not considered, like maybe he emotionally can't get hard because he was molested as a child, or he is not attracted to women and he can't tell himself that he's attracted to men, he can't admit that to himself. But we never think of a man's sexual problem as emotional. We always think about it as physical. Whereas a woman, we only think of her sexual problems as emotional, that a woman does not want to have sex because she's a prude, because of this, because of that. It's never, she physically is not enjoying it. (Amy, anorgasmia)

This quote reflects an additional assumption regarding men's and women's sexual natures; as Grace points out, "men unproblematically always want sex; willingness to perform is not the problem, the physicality of the erection is the problem." In contrast, women can engage in sexual activity any time they want to – their physical bodies always allow them to be receptive - but they do not desire to/they cannot enjoy it due to their faulty psychology.

Given these understandings of sexual dysfunction, it is not surprising that most of the women in this study did not believe that they, in fact, were sexually dysfunctional. Only 20% of women with low libido or anorgasmia believed that they had a sexual dysfunction; furthermore, while of the nine women with pain who were were asked questions regarding the formation of a sexually dysfunctional illness identity, only one identified as sexually dysfunctional. Those who assigned themselves a sexually dysfunctional label, for the most part, felt that their problem was biomedical in nature; this may reflect an equation of sexual dysfunction with erectile dysfunction, which these woman felt was biologically caused. When asked whether she thought she had a sexual dysfunction, Amy, who experienced anorgasmia, said no: " I just always thought that it was mental. I never thought about it like that." In contrast, Olivia, who experienced low libido, stated, "I just don't really have a high libido at all. I'm thinking there's some dysfunction going on. There might be. [What do you mean by dysfunction?] Like if I have weird...low hormones or something that normally are supposed to cause you to have some motivation to have sex."

Why did women with pain, who insisted that their pain was physical and not psychological in nature, biomedicalize their condition yet not think of it as a sexual dysfunction? This may be due to the adoption of vulvodynia, rather than "sexual dysfunction" per se, as an illness identity. Illness identities are formed in part through the efforts of support organizations

such as the National Vulvodynia Association (NVA), as well as self-help literature disseminated by such organizations (Barker 2002); while most of the women in this study came to the NVA upon being diagnosed with vulvodynia by a medical practitioner, others joined after searching for their symptoms on the Internet, in an effort to discover more information regarding their experiences. Women who were recruited via the National Vulvodynia Association's listserv did not, for the most part, discuss the possibility of having a sexual dysfunction; thus, it is impossible to speculate as to whether one illness identity supplanted the other. However, given that: a) "research update" newsletters frequently discuss studies relating to sexual dysfunction; b) press releases, at times, contrast vulvodynia to male sexual dysfunction ("Unfortunately, unlike male sexual dysfunction, armed with champion Bob Dole and constant television ads, vulvodynia has yet to become an acceptable topic for mainstream media.; www.nva.org, 2009), it is possible that a vulvodynia diagnosis and a sexually dysfunctional illness identity can coexist.

Of note, there is no unified explanation for vulvodynia or any universally accepted treatment; thus – as in the case of low libido and anorgasmia - the process of developing sexually dysfunctional illness identities may be accelerated by the development of a "female Viagra." This reflects pharmaceutical determinism, a cultural logic by which the existence of an officially approved medical condition lends credence to the biomedical existence of the condition, and the he biological mechanism by which the medication acts becomes the biological mechanism by which the condition is caused (Barker, 2011). Such logic helps to transform a complex, fluid explanatory map into a fixed explanatory model. The existence of Viagra helped to create "erectile dysfunction" as an illness condition; as there is no such medication for female sexual difficulties, women do not uniformly define themselves as sexually dysfunctional. Creating a medication to treat female sexual dysfunction would lend itself to the conception of a single disease entity, rather than a disparate collection of symptoms - and, in turn, a medicalized illness identity.

Given that a female Viagra does not yet exist, how do women cope with their sexual difficulties? How do their coping mechanisms reflect the degree to which women take up medicalization, as well as the ways in which women draw upon assumptions of gendered sexuality? Finally, how do women respond to the possibility of the development of a female Viagra? I will address these questions in the next chapter.

CHAPTER 5: THE PROCESS OF MEDICALIZATION: MANIFESTATIONS OF BIOPOWER

As discussed in Chapter 4, women adopted narratives that attributed the causes of their sexual difficulties to medical problems in varying degrees; furthermore, these narratives often existed alongside other, non-medicalized narratives, resulting in a complex, fluid, and dynamic web of meaning. Medicalization, however, also takes place through practical action; i.e., strategies of self-surveillance and self-regulation that individuals adopt in the quest to become the ideal subject – or, in the case of women with sexual difficulties, the "normal" subject. Gavey (1993) refers to the "tyranny of inferred normality" in heteronormative discourse; women with sexual dysfunction draw on this, as well as conversations with other women in order to order to assess their own sexual performance, and often find themselves lacking. For example, Hinchliff (2009) found that women with sexual desire loss spoke of how they felt as if they were "abnormal" and "freaks" compared to women that had a "normal" sexual drive. Driven by self-doubt, these women invoked imagined or real others in order to self-regulate their sexual performance, much as they might for other forms of gendered performance (e.g., appearance, comportment).

Medicine is an important site of normalization, as it both pathologizes abnormal sexuality – drawing on (and driving) women's self-doubts about their performance of gender - and provides techniques that help reconstruct a semblance of normalcy. As such, Foucault's theory of biopower (1977) provides a useful analytic lens through which scholars may understand the forces that help to construct the sexually normal body, Biopower, which facilitates bodily manipulation, control, and transformation, consists of two facets: biopolitics, meant to regulate and control populations, and anatomo-politics, which consists of a set of diverse techniques meant to produce the "docile body"; i.e., a body that is disciplined and (by extension) subjugated (Rodrigues, 2012). Docile bodies are not merely produced by institutional control; rather, power is embodied through behavioral norms and processes of self-governance (i.e., "technologies of the self"), leading to "a kind of alliance between personal objectives and ambitions and institutionally or socially prized goals or activities" (Rose, 1990; quoted in Shim, 2010). Thus,

the sexual body represents a point of contact at which techniques of domination and techniques of the self interact to produce the subject (Burchell, 1996). Such an approach does not preclude autonomy and agency, a common critique of Foucault's early work; however, individuals act through the discourses available to them (i.e., those described in Chapter 4) and are thus both constrained and produced by them.

The strategies that women undertake in order to self-monitor and self-discipline the sexual body, particularly in relation to medicalization, have been undertheorized in the literature. One oft-cited work by Cacchioni (2007) examines the various types of disciplinary work (i.e., "sex work") women with sexual difficulties carry out in order manage their sexual behaviors and activities. Three types of sex work were identified: a) performance work, in which women with sexual difficulties "faked" the appropriate sexual response; b) avoidance work, in which women avoided sexual situations or avoided relationships that would lead to such situations; and c) discipline work, which referred to sex work aimed at changing one's own as well as one's partner's bodily and mental responses to sexual practices in an effort to bring them in line with normative expectations regarding sexual activity. While Cacchioni includes in her study a breakdown of various strategies that women with sexual difficulties used to discipline their bodies into achieving proper sexual response, she does not focus on the important role of medicine, including medical techniques and language, in normalizing sexual performance. Furthermore, this work omits a theoretical analysis of power relations that facilitate the adoption of particular strategies and preclude others.

In this chapter, I argue that that through the alteration of the physical body (in the case of pain); the alteration of the inner self via emotion work (in the case of low libido), and through the practical adoption of post-feminist discourses surrounding masturbation/sex toys (in the case of orgasm), women subject themselves to – or, alternatively, attempt to resist - biopower. In regards to sexual pain, women with sexual pain subject themselves to the clinical gaze and the authority of biomedical knowledge in the name of sexual health; in this way, the painful vagina became a problem to be medically managed and transformed into a "useful" and "improved" vagina, capable of giving and taking pleasure in penetrative intercourse. (Rodrigues, 2012). In this case, the standard of behavior is not merely to be penetrated; women must instead learn to *enjoy* penetration; as such, the experience of pleasure cannot be separated from the operations of

power, which creates a responsive (not merely receptive) sexual body. This power operates on and through heterosexuality, as women are expected to thrill in response to the skillful orchestrations of their male partners. That power is productive of pleasure does not rob it of its disciplinary nature; rather, it is through the generation of pleasure that power becomes most effective, as individuals more willingly subject themselves to its disciplinary nature.

In turn, women with low libido attempted to transform their inner responses in order to bring them in line with ideal conceptions of female desire via emotion work. As discussed in Chapter 3, Hochschild defines emotion work or emotion management as the "management of feeling to create a publicly observable facial or bodily display in private setting," which takes two primary forms: surface acting and deep acting. Surface acting refers to what is commonly known as "faking it"; that is, pretending to feel what one does not, in actuality, feel. In contrast, "deep acting" refers to emotion work that is intended to alter the individual's feeling about a given situation in order to bring it in line with perceived emotional obligations towards others (i.e., "feeling rules"). This emotion work, like other forms of emotion work intended to maintain relationships, may be seen as a key aspect of sexual care work that facilitates the constitution of gender as discussed in Chapter 3. The enactment of gender, in this case, is rooted in the appropriate emotional response, just as the enactment of gender in the case of sexual pain is rooted in the physical body. Eliott and Umberson (2008) and Duncombe and Marsden (1996) have previously suggested that women in long-term sexual relationship engage in emotion work in order to bring their sexual feelings into line with how sex "should" be experienced. For the most part, however, these authors do not discuss the specific strategies women utilized in order to do so, not how power relations structure the ways in which these take place.

Furthermore, in regards to the negotiation of sexual difficulties, placing emotion work in the context of medicalization allows us to see these strategies as manifestations of biopower. An analogous process may be seen in the case of depression. While biomedical treatments for depression are widely used, so too are cognitive and/or behavioral interventions meant to alter one's dysfunctional thinking patterns and bring them into line with an "emotionally healthy" ideal. Individuals with depression engage in self-surveillance (e.g., keeping mood diaries in which they record how they feel on a given day, along with the dysfunctional thoughts that led to such feelings) and self-regulation (e.g., countering negative thoughts with positive ones,

exercising, taking antidepressants). In short, the ways in which sexual feeling rules are constructed, internalized, and enacted, as well as the relationship between emotion work and biopower, have been undertheorized; these questions will be addressed below.

Finally, women with anorgasmia drew upon feminist discourses that positioned masturbation as emancipatory and the route to sexual pleasure. While these feminist discourses have often positioned themselves counter to the regulating and normalizing power of medical institutions, it is important to note that constant efforts to improve the ability to orgasm and subject the (pre-)orgasmic body to self-surveillance in the guide of "knowing oneself", are still disciplinary in nature. As such, they are manifestations of biopower – which, again, reflects a tie between power and the increase of pleasure. Thus, while strategies for overcoming anorgasmia may be forms of resistance to medicalization in some respects, they share with medicalized strategies the desire for the creation of the optimal sexual body – and the negation of self-doubt brought about by perceived inadequacies in gender performance.

Consulting Professionals

Women's adoption to medical explanations for their sexual difficulties is reflected in part by the degree to which they consulted biomedical or mental health professionals in order to diagnose and/or treat their condition. While women may have consulted physicians in accordance to the degree to which they medicalized their experience, the converse may also be true in that women, originally unsure of the reasons for their experiences, have medicalized their difficulties upon receiving a diagnosis from a medical practitioner. Thus, causality regarding medicalization is not unidirectional; rather, I suggest medicalization occurs in a mutually reinforcing process such that biomedical causal narratives, often formed by exposure to media messages and feedback from intimate partners/peers/family, lead to consultations with medical providers, who in turn reinforce or fail to reinforce such narratives.

Sexual pain prompted more women to consult biomedical professionals compared to women with other difficulties; in turn, while several women with low libido and/or anorgasmia consulted a mental health professional, almost no women with sexual pain did so. These findings are consistent with those discussed in Chapter 4. For example, women with anorgasmia, who were least likely to medicalize their experiences on a conceptual level, were also the least

likely to consult physicians or talk about their feelings regarding diagnosis and/or treatment. They were also unlikely to consult psychologists. These women were no less likely to engage in discipline work than women with low libido or women with sexual pain, however; these strategies, however, were more traditionally in line with the advice of the self-styled "sex experts" commonly found in popular media aimed at women (e.g., *Cosmopolitan* magazine).

In turn, women with sexual pain, who were the most likely to adhere to biomedical causal narratives, were also the most likely to consult biomedical professionals – possibly because pain is associated with a wide range of injuries and diseases, for which biomedical consultation is appropriate. They were also the least likely to consult psychologists, even though the second most common causal narrative that they adopted was that of sex-specific anxiety. As such anxiety was most often attributed to the pain itself, however, it makes intuitive sense that they would not consult a psychologist for diagnosis and/or treatment. In fact, as will be seen in the next chapter, women with sexual pain fiercely resisted any implication that their pain was psychological in origin, as they felt that such an implication delegitimized their experiences.

While some women with low libido consulted medical professionals regarding their experiences, 50% of these women did so in order to discover whether their medications were interfering with their sexual desire; once the possibility of iatrogenic (i.e., due to medical treatment) causes was eliminated, women were slightly less likely to consult biomedical professionals as they were to consult psychological ones. However, of the small percentage of women who went to psychologists in order to receive a diagnosis or receive treatment, most discussed their sexual difficulties with psychologists as part of a regular consultation; thus, it is unclear as to whether they would have done so expressly for the purpose of addressing their sexual difficulty.

Examining the reasons why women chose not to consult professionals provides greater insights into the degree to which women medicalized their condition. Of 37 women who gave reasons for not consulting a biomedical or mental health practitioner, approximately half noted that it was because the sexual difficulty did not present a problem; this was cited most often among women with low libido (38%), followed by women with anorgasmia (24%) and women with pain (12%). Thus, even if women adopted medicalized causal narratives for their sexual difficulties, this did not always translate into practical action, for reasons relating to the

presence/absence of gender loss as suggested in Chapter 3. In addition, women were not always *able* to translate their narratives into action, as the second most frequently cited reason for not consulting a professional (predominantly mentioned in relation to physicians), was that these professionals would not be able to fix the problem.

Interestingly, of the 10 women who did not consult medical professionals due to their belief that the professional could not help them, approximately two thirds had low libido. Thus, women with low libido, while somewhat willing to consult biomedical professionals in order to understand their experiences, were unsure as to the utility of doing so; as indicated above, they framed this uncertainty in terms of the lack of a "miracle pill", in the vein of Viagra. Furthermore, while some may have thought their experiences were problematic and were psychological in origin, they were not necessarily eager to consult mental health professionals specifically to address their condition. Reasons for this varied, including not knowing how to find a therapist who would be comfortable discussing sexuality, embarrassment, discouragement from partner, and wishing to explore non-medicalized strategies before seeking out professional help. Thus, while women with sexual pain sought out professional medicalization, women with low libido were much more hesitant about this process.

Finally, not all women were able to consult medical professionals – or utilize the medicalized strategies suggested by these professionals - due to issues relating to cost and/or lack of health insurance (i.e., lack of access to care). In other words, if women wished to consult physicians, they often had to be willing – and able – to expend a great deal of personal resources in order to do so. Julia, who experienced sexual pain, struggled with this: "Ultimately it helped me really focus what I place such value on, and how much I placed on my own...it really helped me hone in my sexual peace with my sexuality into... You'd have to basically almost say, "How much is it worth to me, literally out of my pocket?" You really literally had to put a dollar amount on it, because you have to put in thousands of dollars treating it. You really have to say, put a financial commitment on it."

Thus, low-income women or women without insurance did not have access to medicalized strategies to the same degree as those with more financial resources, leading to potential inequities in the experience of sexual pain. Such women at times became reliant on intimate partners and family members to help pay for the exorbitant costs of treatment.

> I mean I was making, like, I mean I was making poverty wages on RI, but my family, they were helping me, um, and I think I didn't really question it, because I felt like I was in pain. I was suffering. I, I couldn't have any pride about it. I just couldn't. [How much a year would you say goes into non-covered expenses?] I mean, I wanna say it was, like…god, it was thousands. $11,000, $12,000. It was high. I think there was one year that I think I made – oh, my God, I think I made about $15,000, and I think my medical expenses were $13,000 or something. I mean, really – it was too close. It was humiliatingly close. (Diane, pain)

This dependency may be problematic in respect to intimate power relations, increasing women's vulnerability and positioning them as dependent vis-à-vis intimate partners and others.

Regardless of whether they consulted medical or mental health professionals in order to deal with their sexual difficulties, women monitored, assessed, regulated, and disciplined their bodies in a number of ways in order to achieve the ideal sexual self. The strategies women used to do so will be described below.

Strategies Adopted: Summary

Although women often attempted multiple strategies to address their sexual difficulties, either consecutively or simultaneously, women with sexual pain were more likely to adopt medical strategies in order to deal with their experiences than women with anorgasmia. Greater proportions of women with sexual pain resorted to biomedical strategies (e.g., drugs, surgery, alternative medicine) to overcome their difficulties compared to women with the other two conditions (79%, compared with approximately half of women with low libido and one woman with anorgasmia). In contrast, greater proportions of women with low libido (38%) resorted to psychological strategies (e.g., relaxing, improving body image), compared to less than a quarter of women with sexual pain and anorgasmia. Finally, approximately half of women with low libido and sexual pain resorted to non-medicalized strategies (e.g., masturbating, sex toys, instructing one's partner), while three quarters of women with anorgasmia did so. Non-medicalized strategies, however, often existed alongside medicalized ones, particularly among women with sexual pain; the former were used to cope with the condition in the moment, while the latter were utilized in a quest to find an ultimate solution for the difficulty in question. See Table 1 for a list of the top three specific strategies by condition.

Table 3: Top 3 Strategies By Condition

Sexual Pain		Low Libido		Anorgasmia	
Medications (starting, stopping, or changing)	76%	"Fake it until you make it"	46%	Masturbate	29%
Physical Therapy/ Biofeedback	45%	Drugs or Alcohol	23%	Instruct Partner / Sex Toys (With Partner)	18% (each)
Lubricant	39%	Pornography	19%	"Relax"	12% (n = 2)

Note: Columns do not add up to 100%, as many women used multiple strategies simultaneously.

Strategies Adopted: Sexual Pain

Among the dyspareunic women in this study, this transformation of the sexual self was considered possible primarily through the deployment of technological interventions (i.e., pharmaceuticals, surgery), which were accessible via biomedicine. I will discuss each of these interventions below.

Medications. A number of different medications were tried by women with sexual pain, including: a) antidepressants; b) lidocaine ; b) treatments for yeast; d) estrogen cream ; e) steroids; f) antihistamines; g) Botox; h) anti-seizure medications (e.g., Neurontin) ; i) capsaicin; j) antibiotics; and k) interferon shots. As will be discussed in Chapter 6, this reflects the difficulties inherent in receiving a diagnosis for sexual pain, as well as the medical profession's uncertainty regarding how to treat it. Often, physicians tried one biomedical strategy after another in a futile effort to stem the pain.

Interestingly, given that psychological attributions were roundly rejected by women with sexual pain (as will be discussed in the next chapter), the most common medications taken were anti-depressants. These, however, were not seen as treating psychological symptoms; rather, they were seen to affect the nerve pathways by which pain was transmitted. That anti-depressants remained symbolic of psychological dysfunction, however, was reflected in

media messages regarding their use for sexual pain – messages that were acknowledged, and resented, by the women in this study:

> I know that there was one episode of Sex in the City where Charlotte went to her gynecologist and actually had either vulvodynia or vestibulitis. I'm not really sure which one. And the, in the show, the gynecologist was like, "Oh, here, take these antidepressants and you'll feel better." And that was kind of it, and there was, I think Charlotte made a comment, like, "My vagina is depressed" or something. And it was kind of over. Like, they didn't, I don't think that they portrayed it accurately. It's not something where you can just take a pill for a couple days and you're fine. (Eileen, pain)

As will be seen in the next chapter, the association of femaleness, chronic pain, and psychopathology, had major implications for the ways in which women responded to medicalization. Women, however, also protested the representation of biomedical solutions as a quick fix to their difficulties. By extension, this may be seen as a larger critique of the popular portrayal of biomedicine as the source of quick, easy solutions to problematic bodily experiences; as I will argue in the next chapter, this may be due to disillusionment with the medical profession, not to lack of initial faith in the power of biomedicine to solve sexual difficulties.

Lidocaine, the second most popular medication used, was not meant to cure sexual pain; rather, it was used to numb the vulvar vestibule in order to permit vaginal intercourse. As in the case of many of the other strategies presented in this chapter, the use of Lidocaine was specifically meant to override the body's inability to be penetrated, rather than to make sexual activity pleasurable for women with pain. Use of lidocaine often precluded other forms of sexual activity, such as cunnilingus, that might have been more pleasurable. Furthermore, some women, like Carolyn, were concerned that the Lidocaine would render them totally incapable of clitoral pleasure: "When I was with a man, it was much more on my mind. Like I think I tried the Lidocaine, which was retarded. That was, you know, one of the suggestions was, like, "Oh, put anesthetic on yourself." [Why "retarded?"] Well, first of all, you can't control the path of the ointment, right? So you're gonna end up, you know, you freeze off your clit, too. That's completely, like it ruins everything. Goes from, like, bad to worse." That so many women used

Lidocaine in this way, regardless of these potential drawbacks, indicates the strength of the perceived obligation to perform sexual care work irrespective of women's own pleasure. Again, sexual activity was primarily for the benefit of one's partner/maintenance of relationships; gender recovery centered upon that, not on the ability to be pleasured. Furthermore, this indicates the secondary importance of alternative sexual behaviors to women with sexual pain, as well as the phallocentric nature of normative sexuality. Finally, this reveals the medical profession's prioritization of intercourse over orgasm, which perpetuates masculine sexual privilege.

The third most commonly utilized treatment, yeast medications, were usually the front line of sexual pain treatment. Many women were only familiar with the idea of vulvar or vaginal discomfort in regards to yeast infections; furthermore, many physicians prescribed such medications when first consulted. This, at times, led to long courses of antifungal treatment:

> They gave me, he gave me all these creams. I mean, I was, I was going back there, probably…every couple months, because I was, "This isn't working." Then they'd give me something else. "This isn't working." Um…[And were they seeing yeast at this point?] Um…no, actual – I think it – the, at one point, maybe he did. But it wasn't, um…he said, he said something the level wasn't anything abnormal? He kept treating me for it! So I don't really know what they were thinking. (Christina, pain)

This may be due to the difficulties physicians experienced in diagnosing the causes of sexual pain. As indicated above, and as will be discussed in the next chapter, physicians often treated women with particular medications even in the face of contradictory evidence, so sure they were in their power to diagnose – or, perhaps, so unwilling they were to admit uncertainty or failure. Several women, however, felt that yeast treatments exacerbated the pain:

> But I was, I was being told, um, that I had BV, that I had yeast. Um…And I would treat them with, what they told me to use. Um…And…At a certain point, I – at a certain point, I realized that I was going in and reporting pain, and they were saying there's no infection. So then, it kind of became a pain issue. And the only thing in there that seems sort of significant treatment-wise was that one of the topical medications they gave me, something called Terazol, I had a bad reaction to, and it seemed to go downhill from there.(Diane, pain)

As this suggests, many medications, particularly antidepressants and anti-seizure medications, often had onerous side effects. These included weight gain, "brain fog", extreme fatigue, vaginal burning, and non-penetrative vaginal pain, as Maria discovered: "I put on probably ten pounds with the amitriptyline, and I – I had such a hard time waking up. I could not believe how – I had the lowest dose, 10 milligrams, once a day (laughs). That thing knocks you out! It's horrible. And I used it up until about 6 months ago. I used it for three years." These side effects, at times, prevented women from adopting these strategies and/or led to their abandonment once tried. Women, however, did not abandon the idea of biomedical solutions as a whole; in addition, many women continued to take particular medications even in the face of side effects, reflecting their dedication to bodily discipline in the face of pain. This also indicates the nature of medical authority, which will be further discussed in the next chapter; as physicians were seen as experts, women adhered to their recommendations even when these recommendations led to extreme physical discomfort.

Physical Therapy. Many women with sexual pain engaged in physical therapy, either with a physical therapist or at home; this course of treatment was often – but not always – recommended by physicians. Physical therapy typically took the form of massage (both internal and external) and/or strengthening exercises, including Kegel exercises to strengthen vaginal muscles. Kegel exercises also had the added benefit of training the vaginal muscles to relax, as women were instructed in gaining control of these muscles and/or developing consciousness of when they were tightening unnecessarily. Biofeedback - meant to assist women in regaining control of their pelvic floor musculature - often helped in this regard. Women undergoing biofeedback undergo an initial computerized electromyographic assessment of pelvic floor muscles in the medical practitioner's office; following this, they are provided with portable home trainer biofeedback devices (to be inserted in the vagina) and instructed in biofeedback-assisted pelvic floor muscle rehabilitation exercises. With biofeedback, women – and their medical practitioners - can see their level of vaginal muscular tension on a screen, which aids in evaluating their progress (Figure 1).

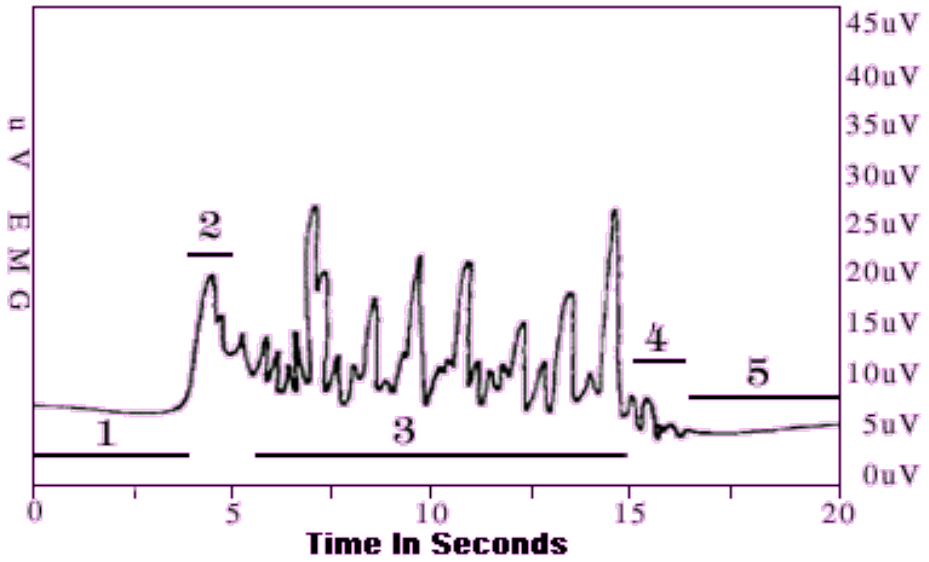

Figure 1: Pelvic EMG activity for typical vulvar vestibulitis

(Taken from White et al. (1997))

Melanie described this process:

> So, then we did a series of biofeedback exercises in correspondence with actual physical stretching, and the biofeedback is like, she would hook up three sensors or whatever they are called. Three different parts of my pelvic floor muscles, specific parts on the exterior of my vagina and rectum, and then that would hook up to a biofeedback program that would monitor the level of the muscle. And then we would exercises with Kegel exercises, and I could see the muscle expand and contract, and there was also one attached to my abs, because usually a lot of times we need to engage your abs, but you are not supposed to.

Like many other medical visualization techniques (e.g., ultrasounds during pregnancy), biofeedback acts as a technology of self-surveillance that facilitates the objectification of the body and makes it available to vigilant self-assessment. While women could perform physical therapy exercises at home, along with biofeedback, women also demonstrated their improvement in the physician's/physical therapist's office; as such, through biofeedback, medical practitioners were given the power to judge the degree to which women were or were not compliant with the prescribed course of treatment.

While biofeedback thus informed women – and their medical practitioners - as to whether their efforts were bearing fruit, it also provided biomedical legitimacy to women's experiences by presenting evidence that there was, in fact, a medical problem to be solved:

> And it was really interesting to see sort of a, for the first time ever, a tangible representation of my pelvic floor muscles. I was actually for the first – he showed me, he's like, "This is what a normal person would be, and this is where you're tracking, and you're way under that. So your pelvic floor is, your muscles are not strong. There is a problem." And that was actually kind of, that was kind of a huge relief to me, 'cause it was like here's somebody who, you know, he has his theories, and I can't remember exactly why all this stuff is, but here's something that seems to start to make some sense to me, that is non-invasive, that is showing me that I do have an overall problem in that area, and that this may be a way to help sort of work on fixing that. (Maya, pain)

Thus, visibility legitimated their experiences in ways that subjective reports of pain could not. As a lack of visible signs or symptoms often led to the dismissal of women's complaints of pain by physicians, as will be discussed in the next chapter, this visibility was welcomed by the women in this study.

Just as medications were often accompanied by distressing side effects, biofeedback was not without problems in this regard. For example, two women accompanied biofeedback with an electrical STIM unit, which was designed to send currents through the skin via electrodes with the intention of targeting and relaxing muscles. Unsurprisingly, this was painful:

> And then the other, I guess, it's not actually part of biofeedback, but the STIM machine – I don't know if anybody else has talked to you about that. It's the same thing, it hooks up to the same sensor and it, it's a battery, and it sends an electrical shock through the sensor and it fatigues your muscles. And, um…she usually does that before biofeedback, to kind of like fatigue your muscles, that when you do biofeedback, your muscle tone might be lower. Kinda like help your body kind of realize what it means to relax. And the first time I did that, I wasn't aware of what it was going to feel like. And it hurt a lot (laughs). It was awful, you know, that she would shock inside of you. It was, I don't know, it floored me. I was so upset. Since then, I've gotten used to it, and it doesn't hurt anymore, and it's been really great and helpful, but that first time was just…terrible. (Eileen, pain)

Again, this reflects the lengths women with sexual pain would go through in order to discipline their bodies and achieve the ability to engage in penetrative intercourse.

Finally, at-home physical therapy often involved the use of dilators, which took the form of graduated cylinders that were used to slowly stretch open the vaginal opening, in order to make the vagina more amenable to penetration. Women also used dildos for this purpose; while this may be seen as a non-medical strategy, the fact that it was often recommended by physical therapists brings it into the realm of the medical:

> I practiced with a dildo. The original one that I bought was way too big for what I could handle. And I was doing it more – it was also my approach. I was doing it as, "I must get through this pain." Whereas this other dildo was a lot smaller, for one. But also, and I actually worked with my healer, talking about it, which was to think about it more as like, you know, the act of penetration or, you know, removal in a much gentler capacity. And also to sort of, you know, there's no need to rush into anything. I don't have to shove it in to myself. Like, it was more about, you know, I can put it in a little, does that hurt, see how it feels, pull it back out. It was a much slower process. There was no need to, yeah. So it was, you know, how do I feel about it? And I found that I actually, I really liked masturbating with it. Yeah, so that was a first, so that was, like, "Wow, ok." That was the first time I was, like, I could actually enjoy this, and that was good. (Maya, pain)

In this case, women consciously caused themselves pain in order to accustom themselves to penetration. As such, women were literally disciplining their bodies into submission to the coital imperative with pseudo-penises, training themselves to not feel pain – and, eventually, feel pleasure – through the reenactment of normative sexual activity. At times, this association was made clear in the recommendations of physicians, as Emily pointed out: "I have dilators, and I, there's, you know, that set of four – there's, like, four of them. And I have this one that's really huge, and that's the one I always use. And it's getting much, much easier. And _____ was, like, "Just get a vibrator and use that instead. I'm fine with that. Just get something in there and get off, whatever." But I, it's totally nonsexual to me." Thus, while the presumed association between bodily self-discipline and sexual pleasure was not always explicitly noted, it was at times made clear in the medical encounter.

Lubrication. Lubricant was the third most common strategy used to combat sexual pain, and the most common non-medical strategy used for this purpose. This strategy was either used as a front-line strategy, before medicalized options were pursued, and/or in conjunction with such options. This is consistent with the work of Sutton et al. (2011), who found that women with dyspareunia reported greater frequency of lubricant use during sexual activity over the last year. Vaginal dryness, of course, may lead to increased friction during penetrative intercourse and thus increase one's pain, rendering lubricant a sensible sexual strategy. Genital "wetness" may be symbolic, however, in that it signifies female arousal in response to sexual activity; thus, the presence of vaginal dryness may be stigmatizing to women with sexual pain (Sutton et al. 2011). Therefore, lubrication may be seen as a non-medical strategy that addresses a biological deficiency. Doesn't its status as a "medical" strategy depend on how women understood it?

Surgery. While surgery was not popular among women with sexual pain, its unique character makes it worthwhile to mention here. This surgery typically took the form of an excision of the vulvar vestibule; most often, this was seen as a last-ditch effort when all other strategies had failed. Dana recalled: "So he gave me a couple of choices for treatments, besides what I've already tried…And then the other choice was surgery, and by this point, it was, like, 3 years. I was just ready, because it's either, he told me it's either you try and numb the pain forever, because they're nerve endings, and they're not just gonna go away by themselves. They're not just gonna, you know, they're not just gonna dull. You have to keep dulling the pain forever, or you remove the nerve endings." Surgery, however, was risky; as several women noted, it was permanent in nature, was not guaranteed to provide a solution, and might instead make the pain worse. Furthermore, the symbolic nature of cutting into the vagina/vulva was problematic for at least one woman, who likened the surgery to female genital cutting:

> I remember, my friend Christy in grad school did this ethnographic research in a cheese stand in Washington DC, and she used to (laughs) have to cut cheese with a wire – you know those cheese cutting wires? And I actually had this horrible nightmare where they took this cheese cuter to my vagina and sliced off my labia. Yeah. So I remember waking, being so angry, so upset about the possibility of genital mutilation that…So even though, you know, I mean I occasionally look at my vagina with a mirror, but it does mean something to me to alter myself physically to the point that, you know, even my subconscious was kind of going crazy about the thoughts of this. …I mean, part of me was sort of, like, part of it

> very much was a feminist part of me saying, crying out against the patriarchy, when this dr.'s telling me, you know, "Don't care – " He's, like, "It's your vagina? What are you worried about?" I was, like, "It's my fucking body, dude." And again, I just kept being struck by – yeah, it is kind of like female genital mutilation. You know, it's like, ok, so you don't have a problem with, you know, things happening to your penis, apparently, but, you know…So that part of it to me was very, you know – to me, it did invoke some kind of mutilation. Because it is a mutilation. (Maya, pain)

For this woman, altering the body in pursuit of pain-free penetrative intercourse was likened to an act of violence perpetuated by patriarchal institutions claiming the best for women; as such, it took on the symbolism associated with female circumcision, which circulates as a figuration of female powerlessness in Western culture.

> While the recovery of normative gender and sexuality via vestibulectomy has not been explored in the literature, one may liken such surgery to female genital cosmetic surgeries such as vaginoplasties which are often positioned in the popular media as a means to enhance women's sexual pleasure, as well as save relationships threatened by problematic sexual bodies (Braun 2005). In both cases, the ideal of female sexual embodiment cannot be achieved without the ultimate in medical intervention: the sexual body is, quite literally, in the physician's hands. Furthermore, in both cases, the female genitals are positioned as inherently "wrong", and the flaws of the vulva and/or vagina requires their (partial) removal. Thus, the fulfillment of the coital imperative requires the building of a "better" vagina – one that can accommodate, and take pleasure from, a penis.

Strategies: Low Libido

In contrast to women with sexual pain, women with low libido were not reliant on medicalized strategies; instead, they engaged in emotion work, either immediately prior to sexual activity or in the sexual moment. Strategies used engage in emotion will be described below.

"Fake It Until You Make It". As discussed in Chapter 3, many women with low libido had sex when they did not want to in order to perform sexual care work. Interestingly, however, almost half of women with low libido revealed that having sex before experiencing desire did, in

fact, help to *induce* desire. Erin described how pleasure seemed to follow, rather than precede, sexual activity:

> We have a good time during sex, it just sometimes feels like we decide first and then follow through rather than have it be like "Oh, we're all hot for each other" and it's an inevitable consequence….I've had that advice given to me by friends before. I remember talking with an old friend about somehow when I wasn't in the mood. It's like, as long as you really don't feel strongly against having sex - sometimes if you just go with it, you'll find you're very happy to and your brain's very happy to catch up.

This supports the work of Basson (2000a), who has suggested that women's sexual response often differs from that of men's in that it is primarily responsive rather than spontaneous; thus, the problem with current definitions of female sexual dysfunction lie in the assumption that models of female sexual desire and arousal mirror those of men. Thus, Basson proposed the lack of "receptivity" to be included as a diagnostic criterion for female sexual dysfunction in the DSM-V – a recommendation that was taken up by the manual's authors. Receptivity, in this case, refers to the "'willingness to proceed [with sexual activity] despite absence of sexual desire at that instant." (Basson, 2002) Other scholars, however, have critiqued this concept in that it prioritizes male sexual demands and promotes coercive sex in heterosexual relationships (Tyler, 2009). That this strategy was undertaken as part of sexual care work for many women seems to reinforce Tyler's critique: while the induction of desire may have been one aspect of "fake it 'til you make it", it could not be separated from other, more problematic motivations. Furthermore, an emphasis on receptivity naturalizes social and cultural expectations regarding passive female sexuality, suggesting again that women must rely on a partner in order to become desirous of or take pleasure in sexual activity.

This also inverts Hochschild's assumption that emotion necessarily precedes bodily expression or physiological responses. While this is certainly not a new idea – William James, a psychologist, suggested in 1884 that feedback from physiological responses are processed by the brain in such a way to produce emotion – the embodied, corporeal construction of emotion has been little discussed in the sociological literature on emotional labor. One exception may be seen in the work of Otis (2012), who notes the existence of culturally prescribed "body rules" that

help to regulate the ways in which bodily displays express particular relationships with others. In turn, these rule help to reconstruct the relationship between one's body and one's emotions. Thus, body rules dictating the proper expression of normative sexuality in a relationship with an intimate partner – that of the desirous subject – in fact help to produce that desire. Women, then, are aware of expectations regarding feminine sexuality and consciously undertake their enactment – which are then assumed to stem from natural, biological differences between the sexes.

Drugs or Alcohol. Women often made a conscious effort to "relax" in order to overcome whatever mental barriers they thought they had devised against pleasurable sexual activity and/or desire – lowering inhibitions that could be seen as products of socialization. In some cases, women partook in drugs or alcohol in order to achieve the desired effect.

> We have tried watching porn, to see if I can get in to the mood, but the only thing that ever really worked was just me smoking weed, and then I feel ready to go, whether I wanted to previously or not…If I was drunk or high or both, I would be a lot more horny, or I would be horny, and willing to have sex and whatever than if I was sober. It's like we would go out to parties with our friends, and then we would come home, and I will be all over him. And so, of course, he is not going to like pass off the chance. At parties, too, I think I would be a little more like touchy feel or comfortable with kissing him or talking about having sex. (Janet, low libido)

This strategy has problematic implications for public health in that the regular use of alcohol of drugs to induce desire may impede negotiation regarding condom use, render women vulnerable to sexual coercion, and confuse women's judgment regarding sexual partners. While women with low libido did not explicitly discuss this, Ilana, who experienced sexual pain, noted that smoking marijuana eased hesitations regarding her partner and/or the sexual situation: "I would definitely say I would feel less pain if I was high, just 'cause there would be less anything. Like, less hesitation at all. But…[And that's connected to the pain?] Well, just in the sense that, uh, if I'm having sex with someone, and for whatever reasons I have any sort of reservations or, like, hesitation about the situation, like, sure. I think it would hurt more. Um, but yeah. If I'm stoned, you know, that kind of gets pushed to the background…" Furthermore, if taken to extremes, reliance on intoxicating substances to produce desired effects on sexuality may

contribute to alcohol or drug dependence. Thus, such a strategy, while possibly effective in the short term, may have detrimental effects on women's health more generally.

Pornography. The third most common strategy used to increase desire among women with low libido was pornography. Women such as Angie watched internet videos, read pornographic literature, or listened to sexually-oriented audio in an effort to fuel the imagination and enhance their arousal: "I think watching porn actually is very stimulating, just depending on what type of porn. I would go through stages where I would watch it and I would not let him know I was watching it and then we would have good sex. Then I would lose interest again, then kind of go back to it again." For the most part, women attempted this of their own volition; several, however, noted that this strategy was suggested by their partners, who may have drawn on their knowledge of what aroused *them* in order to do so:

> One time he downloaded, when we went through the porn thing, he download all different types of porn. He was like, "Alright, I want you to watch all these different ones. Tell me which one you like." Then he was like, "Alright, well, if you don't like any of these, you look up what you like and then just let me know." He downloaded really typical stuff… So he would download stuff like that, anything he could think of, he's very creative. So anything that was very categorizable, I guess. That's something he would have downloaded, he had a nice variety, some really dirty stuff, and I'm not very dirty at all. He had this silly soft porn you would see on at 11:00 clock at night on Cinemax. He had some of those and I was like, "This dude is terrible!" (Janet, low libido)

Only one woman discussed pornography targeted towards women, and no women did so in regards to feminist pornography; rather, as is evidenced above they were expected or expected themselves to become aroused in response to traditional pornography, with its emphasis on normative feminine appearance and phallocentric sexual activity. While the woman above criticized this type of pornography, it is questionable as to the degree women more generally internalized norms of sexual behavior (e.g., focusing on male pleasure, visibly demonstrating desire/orgasm) derived from such movies. Thus, in addition to altering their sexual subjectivities, pornography may have acted as an additional site of sexual socialization for women with low libido.

Strategies: Anorgasmia

Pornography, however, was not the only site of sexual socialization that women with sexual difficulties encountered. In contrast to women with sexual pain and women with low libido (who attempted to alter the physical body and/or their inner desires), women with anorgasmia – perhaps the least likely to medicalize their experiences - often drew upon feminist discourses of sexual self-fulfillment and body knowledge that date back to the second-wave feminist movement, as discussed in Chapter 4. The primary strategy employed by women with anorgasmia, masturbation/"getting to know one's body" capitalizes on these discourses, as well as post-feminist discourses regarding sexual empowerment via the use of consumer goods, in the effort to create the orgasmic subject.

Masturbation. Many scholars claim that masturbation remains a taboo act, particularly for women. (Kaestle and Allen, 2011). In contrast, however, Attwood (2005) takes note of a "post-feminist sexuality in which the key sign is masturbation as a symbol of active female sexuality." Masturbation, then, is seen as the key to unlocking the secrets of the body, the first indication of sexual awakening:

> One thing that I've definitely been doing is paying more attention to myself in a sense that I never really ever masturbate or do anything like that. I only am sexual when I'm having sex with my boyfriend, so having stuff where I'm paying attention to myself, or just exploring it. I never really touched myself growing up, so getting to know myself, and my body, and my physiology better has helped a lot in terms of me feeling comfortable during sex to try something that might feel good, even though I might think that it's a little bit weird. (Josette, anorgasmia and low libido)

The above quote echoes the work of Kaestle and Allen (2011), who, in a study of 72 undergraduate students, found that while female students discussing masturbation often cited taboos regarding its performance, 16% of women associated masturbation with developing familiarity with one's body and learning its likes and dislikes, which would presumably lead to an increase in pleasure. Even this was tied, however, to inducing pleasure in partnered sexual activity rather as an end in and of itself, as Josette went on to say: "I know that if I were to get more comfortable with myself by myself, then I would more likely be able to say this is what I

want. He would be more likely to give me what I want, which would more likely get me to have more fun."

Given these associations, it perhaps not surprising that masturbation has often been prescribed as a treatment for anorgasmic women as part of sex therapy, including feminist sex therapy (Tiefer 1994; Kaestle and Allen, 2011); these women are at times described in the literature as "pre-orgasmic," suggesting that all women are capable of such experiences. This is mirrored in self-help literature, as well; Sex for Dummies, 3rd Edition, states that ""Ninety-five percent of women who aren't having orgasms are actually pre-orgasmic: they are capable of orgasm, but they need help learning how to achieve orgasm. Because every woman is different, there are no perfect tips on reaching the perfect female orgasm. Learning what gives you an orgasm, followed by what gives you a fabulous orgasm, is part of the overall procedure of becoming orgasmic." These messages are echoed in women's magazines such as *Cosmopolitan*, which describe absence of orgasms as a common phenomenon, while at the same time implying that women who cannot have them could do so if they only tried harder. As one advice columnist noted, "I believe and cannot see any reason why every woman, *if she really wants to* [emphasis added], cannot achieve orgasm. It depends upon how we feel about ourselves as women." (Cosmopolitan 1981; quoted in Lavie-Ajayi, 2009). While such messages may be encouraging to women who doubt their bodies' orgasmic capability, they: both reify the idea that sexual pleasure equals orgasm and position the reader as sexually naïve, immature, and less than knowledgeable regarding the most rudimentary aspects of sexuality, unable to discover pleasure without the assistance of the literature in question (Machin, 2003). Moreover, they suggest that failure to achieve orgasm is the fault of the reader, who is not trying hard enough to achieve normative sexuality.

Related to the above is the use of sex toys for masturbatory purposes. Devices such as the "Rabbit" vibrator entered into the American consciousness via *Sex and the City,* promoting the concept that the use of sex toys was an acceptable route to pleasure (Attwood, 2005), and sex toy shops aimed at women at times explicitly identify as feminist in their mission statements (Loe, 1998-1999). This commodification of feminism is reflective of the post-feminist neoliberal ethic discussed in Chapter 3, which encourages sexual empowerment via consumption and positions the fulfillment of sexual obligations (here, the orgasmic imperative) as a sign of

free, agentic sexuality. Just as I would not advocate the abdication of the sexually agentic script, as I discussed in Chapter 3, I do not suggest that women should not engage in masturbation in order to discover their body's capabilities and/or experience pleasure. I do argue, however, that one must examine the discourses surrounding masturbation and sexual agency in order to determine the degree to which such discourses present obligations for women with sexual difficulties – i.e., to what extant sexual agency is, in fact, agentic.

Instruct Partner/ Use Sex Toys With Partner. As previously mentioned, Cacchioni's definition of discipline work encompasses the disciplining of one's partner in order to achieve the optimal sexual response. Again, once women knew how to achieve pleasure in partnered sexual activity, they would be able to tell their partners how to please them, reinforcing the idea that it is a male partner's responsibility to "give" women pleasure:

> I have this notion that I didn't know how it was supposed to feel, but when I did...let them touch me. I would let them be really aggressive with how they start…I didn't know how it was supposed to feel. I was like be like basically directing them to apply more pressure, or be more effective with their style. It was not...I didn't know what the outcome was supposed to be, or what it was supposed to feel like, so...[Then why direct them to be more aggressive?] Because I thought that nothing was happening with the light stuff. Like happening...and I heard like in reference to like orgasm and climax, but I didn't know what orgasms feel like. I'm like, "I'm not feeling anything with like this little bit." I don't know anything about my anatomy, so I don't really know what I should tell you... Testing more and testing heavier, maybe that will bring about this "thing" that's supposed to happen, but I don't even know what that is. [OK, and did it ever...] No.(Julia, pain)

As is evident from the quote above, masturbation and/or instructing one's partner in the appropriate sexual techniques were not successful in achieving the desired effect. Similarly, the use of sex toys with a partner, consistent with the commodification of the feminist liberatory ethic described above, were not effective in inducing orgasm, although they did at times increase women's non-orgasmic pleasure. Thus, counter to the sex-positive liberatory ethic of "any woman can!", the women in this study could not achieve normative sexuality, defined here as orgasm.

"Relax". Another strategy, "relaxing", was used to quiet the overactive mind (seen as a distraction) and focus on feelings of pleasure. Vanessa, who experienced anorgasmia, described this strategy: "It wasn't really until a new relationship, where a new partner took a lot of time to help me explore, to be really relaxed about it, to help me to... I almost see it as you direct yourself down a path of relaxation, and focus, and not pressuring yourself. Knowing that you're safe even though there's scary feelings. Learning to do that, helped me to achieve orgasm." As this quote indicates, however, a key aspect of relaxation was to eliminate the self-induced pressure to have an orgasm. Thus, while this strategy could be seen as disciplinary in that it was meant to assist in achieving normative sexual feelings, it was the only strategy that was rooted in the rejection of normativity and/or obligations to a partner.

As Armstrong and Murphy (2011) point out, resistance to and subjection to disciplinary power may take the same forms; therefore, it is a mistake to think that resistance equals rejection of medicalized technologies and subordination and acceptance equals domination. They go on to note the importance of distinguishing between behavioral resistance (i.e., resistance to a medical strategy) and rejection of the discourses within which such strategies are embedded. This was demonstrated by the women I spoke to, as strategies to address anorgasmia simultaneously demonstrated elements of resistance and subjection to self-surveillance and self-discipline. This is similar to the findings described in Chapter 3, in which postfeminist discourses held both the promise of agency and the constraint of sexual obligation. As in that case, I do not advocate for the abdication of feminist discourses vis-à-vis the cultivation of sexual pleasure; I do, however, wish to problematize them, opening up a space for critical discussion.

Do We Need a Female Viagra?

In interviews with women with low libido and anorgasmia, some expressed opinions regarding the development of a "female Viagra" that addressed their particular sexual difficulty. These women at times expressed frustration that such a medication had not yet been invented, tying this to a societal disinterest in women's sexuality. Naomi, who experienced sexual pain, was one of these women: "Now that I'm in my 30s, and a lot of my friends are in their 30s, I find that women are thinking about their own bodies. People talk about using vibrators, openly, and people talk about getting what they need or desire. I don't know that society at large cares about

that. They care about if a man can get it up and if he needs Viagra. That's not important, seemingly, our feelings on sex and how we enjoy sex is not important to the perception of how sex is sold in this country."

While there are a multitude of discourses that are concerned with the proper enactment of women's sexuality, as described above and in Chapter 3, this woman did not acknowledge these discourses as enabling the ability of women to "talk about getting what they need or desire." Thus, to paraphrase Foucault (1977), women often claim that their sexuality is ignored, while dismissing the proliferation of discourses that both constrain and enable their sexual possibilities. Similarly, while efforts to develop a female Viagra have existed since the late 1990's, when the male version proved to be so phenomenally successful, several women stated that a female Viagra did not yet exist because "no one care[d] enough" to develop one:

> I started talking to my doctor about the low desire and I mentioned, "Why is it considered a medical problem for men but not for women?" She said that it was considered a medical problem for women, but when I asked her, "Is there a drug like Viagra for it?" She said, "Not really. There are some hormonal things. There's some herbal supplements on the market, but there are no good studies done on them. "I'm like, "Why are there no good studies done on them?" The obvious answer is that no one cares enough. Or that no women want to participate in because no women think they have it. Because I had only recently even discovered that it was possible for us to have it, sexual dysfunction. (Rosa, low libido)

Thus, the medicalization of female sexuality in the form of Viagra would then be seen as an example of the medical establishment "finally" giving women's sexuality its proper due. Of note, however, is the suggestion that women do not wish to participate in clinical trials of a female Viagra, since they do not yet know they have a sexual dysfunction. Thus, as discussed in Chapter 4, the development of a sexually dysfunctional illness identity was dependent – as least in part – on the development of pharmaceutical technologies (what Barker [2011] referred to as pharmaceutical determinism). It is the medicine that dictates the creation of an illness, rather than the other way around.

Regardless of this, however, only one third of women with low libido and two women with anorgasmia stated that they would use a "female Viagra" if offered; this difference may be

due to factors described in previous chapters (e.g., the comparative importance of the desire imperative, lack of orgasm not being seen as a problem, lack of orgasm not being seen as a biomedical condition). While several women noted that they would take such a drug out of sheer curiosity, several others noted that they would only do so for the sake of an intimate relationship or in response to pressure from a partner – reflecting the imperative to perform sexual care work. Karen, who experienced low libido, stated, "I honestly don't even know if I would take it, unless I started dating a heterosexual male that I really, really, really liked and could see myself marrying, because that's just something that I think is fair, to try to do that." In contrast, 15% of women stated that they would not wish to take a female Viagra. Josette, who experienced anorgasmia and low libido, noted that "I feel like I should be happy with myself the way that I am", while several others noted that their sexual difficulty did not present a problem.

Finally, Angie, who experienced low libido, expressed concerns regarding potential side effects, including hypersexuality[3]: "I don't hold out for a pill, basically. I don't think there's anything out there right now. If there was, how much would you have to take it and how frequent? Then at what level of sexual craziness are you going to be at, all the time?" Another woman spoke of her fear of others *perceiving* her as hypersexual if she took such a drug:

> I think the doctors. I just don't like the idea of being viewed as hypersexual. When Marcello would call me a slut, I would always get very defensive about that, and that is not something I want to be called. It's not that I feel like taking a medication would be slutty to say, but I just don't want to think of myself as putting so much emphasis on sex. That also goes along with what I was saying before: that I am 20, it's not something that I'm serious about. If there is a medication, forget about other women; If I'm getting married and I get into an issue, then I'll put more thought into it. (Yvonne, anorgasmia)

This suggests that marketing for a female Viagra would have to contend with the competing discourses surrounding women's sexuality discussed in Chapter 3; that is, women are expected to be sexually agentic and expressive on one hand – but not *too* much, lest they violate traditional femininity. Only by overcoming these contradictions can they hope to find a market.

3 Hypersexuality, of course, has been medicalized as well, codified in International Classification of Diseases (ICD-10) of the World Health Organization as nymphomania. Interestingly, nymphomania was tied in the 1950's to frigidity, as women engaged in sex with man after man in the search to find the elusive vaginal orgasm.

Pharmaceutical companies themselves, however, may struggle with the same double bind, as made clear by a recent article in the New York Times that, addressing the development of libido-enhancing drugs, discussed industry fears of creating the hypersexual woman:

> More than one adviser to the industry told me that companies worried about the prospect that their study results would be too strong, that the F.D.A. would reject an application out of concern that a chemical would lead to female excesses, crazed binges of infidelity, societal splintering. "You want your effects to be good but not too good," Andrew Goldstein, who is conducting the study in Washington, told me. "There was a lot of discussion about it by the experts in the room," he said, recalling his involvement with the development of Flibanserin, "the need to show that you're not turning women into nymphomaniacs." (Bergner, 2013)

Thus, such companies are actively debating the degree to which women should be allowed to be sexual. In contrast to Viagra, which supposedly allows men to act out their already-existing desires, the desire of women must be carefully controlled in order to prevent "societal splintering". (Presumably, the makers of Viagra were not concerned with men's infidelity tearing asunder the fabric of society, or the fact that many men, including younger men, use Viagra recreationally). This, then, is a perfect example of the ways in which medicalization attempts to control female sexuality in such a way that the double bind, discussed in Chapter 3 is preserved. In other words, women should be just sexual enough to please their sexual partners in monogamous (not adulterous or casual) relationships, but not so much that they be considered promiscuous or desirous of sex for its own sake.

What of a "female Viagra" to address sexual pain? Recently, the FDA approved Opshena, a drug to treat sexual pain in menopausal women due to "vulvo-vaginal atrophy" caused by decreased levels of estrogen. Osphena works by mimicking estrogen and carries with it the same serious risks that estrogen does (e.g., cancer, blood clots, strokes) (www.osphena.com). Furthermore, in clinical trials, other side effects emerged; for example, women taking the drug had twice the rate of urinary tract infections, three times the rate of hot flashes, and 14 times the rate of yeast infections (Newsweek, 2013). Thus, it is debatable as to whether the drug's promise outweighs its perils. In addition to Osphena's health risks, however, the process by which the drug was approved by the FDA and brought to market may also be seen

as problematic. Not only were the trials that led to the drug's approval funded by the pharmaceutical company that developed the drug, Shionogi Inc., but their lead authors hold multiple consultancies, speaker's bureau affiliations, and board memberships with pharmaceutical companies, including Shionogi. (Newsweek, 2013). It remains to be seen as to how Osphena will be marketed to older women with sexual pain; for example, will marketing messages focus on the maintenance of heterosexual relationships? In what ways will such messages continue to promote the importance of penetrative sexual activity? It also remains to be seen as to how women with sexual pain will receive the drug. Will they accept the drug unquestioningly, or will there be resistance? These questions may serve as a fruitful area of inquiry for future research.

Even prior to Osphena's release, women with dyspareunia were the most likely to biomedicalize their sexual difficulties, as is indicated above. Their ability to do so, however, was dependent on whether or not they were able to receive a biomedical diagnosis. Such diagnoses, however, were difficult to obtain, as physicians delegitimized their subjective bodily expertise and assigned them causal narratives that were psychological in nature. Therein lies a curious paradox: how is it that women with sexual pain were most likely to utilize biomedicine, yet were all too frequently dismissed by biomedical gatekeepers? Why did these women fight for recognition, and what implications does this have for the experience of gender in the medical and/or sexual encounter? I discuss these questions in the next chapter.

CHAPTER 6: THE MEDICALIZATION OF SEXUAL DIFFICULTIES: DELEGITIMATION IN THE MEDICAL ENCOUNTER

As discussed in the previous chapters, women with sexual pain were most likely to assign biomedical labels to their experiences and/or engage in biomedical strategies. Their ability to do so was dependent in part on whether or not they were able to receive a biomedical diagnosis. While many of the women in this study with sexual pain were ultimately diagnosed with and treated for vulvodynia – a chronic pain syndrome that occurs without an identifiable cause or visible pathology – the path towards diagnosis and treatment was characterized by confusion, uncertainty, and delegitimation on the part of medical practitioners. Women with sexual pain were evaluated/assessed by physicians in accordance with normative gender expectations in regards to sexuality and the purportedly psychological origins of illness; it is women's consciousness of this forms the basis for resistance and pursuit of biomedicalization.

Much of the early literature on medicalization suggested a top-down process in which medical institutions exert their influence over passive, uncritical, disempowered consumers, As discussed in Chapter 1, however, much of the recent literature on medicalization has focused on the role of activist groups and consumers in creating a demand for medicalization. In the case of female sexual difficulties, this may be understood in the context of women's health movements, which are largely what Brown et al. (2004) refer to as embodied health movements– that is, movements that challenge hegemonic ideas regarding disease etiology, treatment, and prevention. Through such health movements, women have: a) challenged the authority of medical experts, as well as the dominance of the medical system (Starr 1982); b) altered hegemonic meanings given to health conditions in an attempt to ameliorate stigma (e.g., HIV/AIDS) (Ley 2006); c) fought for the demystification and democratization of medicine, as well as equalize physician-patient relationships (Sulik 2011); and d) fought for increased federal funding and research for diseases primarily affecting women (e.g., breast cancer).

In doing so, women's health movements have typically taken one of four stances vis-à-vis medicalization: resistance against totalizing medicalization (e.g., in the cases of pregnancy and/or body size); fighting for clear demedicalization (e.g., in the case of menstruation);

demanding access to medicalization (e.g., in the case of effective birth control methods); and fighting for a shift in medicalization – i.e. a transformation of medicalization, in which conceptions of an illness or disease process shifts from psychologization to biomedicalization. This last stance is significant, given that early feminist critics of the medical establishment were particularly critical of psychiatry, psychoanalysis in particular, in regards to its role in perpetuating gender bias. (Angel 2012) It is also significant in that, as discussed in previous chapters, psychological explanations for bodily conditions are often gendered. Even in cases where disease etiology is clear, women's symptoms are often assumed to be psychological in origin. For example, in a study of 120 general practitioners who assessed constructed case histories that were identical except in regards to gender, physicians who thought the symptoms belonged to women were more likely to believe that they were emotional in origin (Colameco et al., 1983). Similarly, studies have shown that women with chest pain are less likely to be admitted to the hospital than are men, and are more likely to be given sedatives (i.e., an anti-anxiety treatment) to treat pain as opposed to men, who are more likely to be given narcotics. (Hoffman and Tarzian, 2001)

It is in part through the biomedicalization of sexual pain, as well as resistance to delegitimizing psychological narratives, that the women in this study sought to reconstruct their gender identity. First, biomedicalization held the promise of a cure, which in and of itself would allow them to engage in sexual care work and help them to reconstitute their "failed" gender. Furthermore, in privileging their lived experiences and subjective knowledge, as well as claiming the right to biomedicalization in the face of delegitimation, the women in this study consciously claimed power by positioning themselves as experts on their own bodies. Paradoxically, however, these women simultaneously denied their physician's expertise while seeking the legitimation of the medical establishment. Thus, the relationship between patient experience and medicalization in regards to female sexual difficulties is ambivalent and complex.

In this chapter, I will explore the ways in which medical interactions regarding sexual pain are gendered, and how this gendering leads to the dismissal of women's bodily experiences. In addition, I will explore the ways in which resistance to this gendering paradoxically subjects women to the disciplinary power of medicine in the name of resistance to patriarchy. In doing so I will illustrate that, while many studies regarding women's experience of chronic illness position

women's lived experiences as counter to the hegemony of biomedicine (Hyde 2011), they can, at times, coincide. It follows, then – as will be discussed below - that women with sexual pain may be more vulnerable to the efforts of pharmaceutical companies proposing a "cure" for sexual dysfunction.

The Hope of Medicalization

Women with sexual pain who consulted medical professionals often saw them as experts at first, trusting them to know what was best. This was especially the case for women who consulted gynecologists, as they were seen as specialists in regards to women's genitals and/or sexual well-being.

> And especially a gynecologist. I mean, this is a, um…it's not like I went in there and I had, um…like, you know, and he listened to my heart, and he was, like, "Oh, I think you might have a heart palpitation" or something. You know? I mean, this was, this is like their specialty, and they still didn't know what it was. So I'm kind of, like, "Well – " I mean, it's not like I went in there with some problem that was unrelated to that, where I could see they would be, like, "We don't know what that is." Like, they could miss it. But when you're going into a gynecologist with a problem with your vagina, how can they not know what it is? (Christina, pain)

Women with sexual pain overwhelmingly felt that a diagnosis would be beneficial to them; of women with pain who discussed the significance of diagnosis, 85% did so in positive terms. Reasons given for this were varied. Not only did women feel that a diagnosis facilitated treatment, but they felt as if diagnosis reduced the uncertainty associated with the competing causal narratives described in Chapter 4. Without an authoritative explanation for their experiences, women such as Eileen could only feel as if there were something inherently wrong with them: "I think earlier, um, maybe before I didn't have a diagnosis or before I started the physical therapy, I think I really did feel like there's just something wrong with me. And that I was the only one that experienced that. And then I, I think then I felt like, um…that there was just quote-unquote something wrong with me. And that there was something wrong with my body, 'cause I wasn't able to have sex. " Ironically, being told that their bodies were medically

"wrong" led women to feel as if their bodies were no longer inherently wrong or flawed. Blame and responsibility for the body's wrongness, as well as the stigma associated with not being normal was removed from the shoulders of these women. As such stigma was associated with gender loss, as we have seen in Chapter 3, it is possible that recovering a sense of normalcy via diagnosis was associated with the amelioration of gender loss among women with sexual pain.

Several women with sexual pain mentioned that a diagnosis would excuse their reluctance to have sex; this is consistent with Parson's (1951) sick role theory, which suggests that individuals that are considered "sick" are excused from their normal social roles, removing their responsibilities, duties, and expectations. Thus, physicians had the power to legitimize women's failure to "do gender" in the sexual sphere.

> I think I did get to a point, and it's, I'll tell you – once I got the diagnosis, it was like doctor's orders, don't do it if it hurts, you know. It was, like, "Oh, my God. The doctor told me I can say no." That was wonderful.... Before the diagnosis, we were more intimate, I would say, and definitely more involved sexually. Um, you know, with the whole, all the alternatives, and sex as well. Or intercourse, whatever. And I think being told that I couldn't, I shouldn't, it's, I don't know. It just, like, was liberating for me. And that's really sad, 'cause here we are, you know, and I actually could. I don't know if that was necessary for me to have that freedom. Like, for 20 years, I felt obligated, and then all of a sudden, I was being told not to if it hurts. You know, I went for it. (Emma, pain)

Here, then, was proof that women could not perform their sexual duties – proof that their own subjective feelings could not provide. As the inability to provide sexual care work also contributed to feelings of gender loss, it is possible that diagnosis provided the power to resist feelings of gender loss due to this inability. Diagnosis also contributed to a greater sense of power within intimate relationships: the power to refuse sexual activity in the face of pressure to perform such activity. This power, however, was indirect in that it was not their own; rather, they wielded the power of legitimacy provided by their medical practitioners.

Encountering Delegitimizing Narratives

Problems of Diagnosis. Many of the medical professionals that women with sexual pain consulted, however, were actually unable to come to a diagnosis. Regardless of this, physicians

were reluctant to admit their uncertainty, perhaps due to a cultural privileging of medical knowledge and the "expert" status of physicians. Approximately half of women with sexual pain spoke of consulting a physician for diagnosis at one point or another, only to be told that there was nothing organically wrong with them:

> I just remember, I guess when I started thinking I had yeast infections, and going and they were telling me, "No, you don't have a yeast infection. And there's nothing wrong with you." And…you know, made me feel like it was in my head. [And how did they do that?] By just telling me, "No, there's nothing wrong with you." I'm like, "But I, I'm feeling these things." "But no, there's nothing wrong with you. We can't find anything, there's nothing wrong with you. Hormonally, there's nothing wrong with you…you know, you don't have an infection." Didn't at all try and find any other answers. Never asked any other questions. I was always giving information. They weren't asking questions. That frustrated me. (Maria, pain)

As such, physicians engaged in "normalizing" discourses, which attempted to reassure patients while at the same time not truly addressing women's concerns (Salmon, 2007):

> You know I went to the doctors and they just ignored me. Or told me that it was normal, and everything was fine. That I would just have to get used to it and so on and so forth. [So, they said it was normal and what did they think caused it?] They didn't really give me an explanation. At one point, they said something along the lines of like, "Your cervix had this traumatic experience. Maybe it's like your cervix is in a different position now and you have to find ways that will not bump it, a certain way." But there was no way that I could not, it's there. [Laughs] That didn't help. I don't know, that was useless to me, their advice. (Naomi, pain)

In other cases, confronted with the inability to diagnose and/or treat sexual pain, many physicians dismissed women's knowledge in favor of their own expertise.

> [It was] your typical 15-minute doctor-patient quick, – quick dip, quick stick, whatever, let's test you for all of these STDs, and maybe you have gonorrhea. And a lot of assumptions. And I was not sexually active at the time. In fact, I had never even had sex in 2003. So I was, what, 25. I'm totally a late bloomer. So he made a lot of assumptions, and was not – and did not believe that I had never had

> sex. That was the first thing that was very upsetting to me in this encounter. He thought, , I was trying to hide something He just kept asking me, he said, "You've never – " , first I said, "Well, maybe I have, a yeast infection." And he said, "Well, let's talk about your sexual activity." And I said, "Well, I'm not sexually active, so there's nothing to talk about." And he said, "Well, what do you mean?" And I said, "I've never had sex." … And he said, "OK. Well, I need to ask you some questions anyway." As though I were kind of, the naïve, innocent girl who really doesn't know, well, , if the penis is over here, then that's definitely sex. Or, , maybe you think it's not, but it is. I just was pissed off at him. So, so he took me through, a series of very rudimentary seventh-grade health-type questions. "Well, have you done this?" "No." "Well, have you done this?" "Well, yes, but not recently." "OK, well, I guess really you haven't had sex." (Sarah, pain)

As is evidenced above, physicians often came with assumptions regarding patients' gendered sexuality that echoed the findings related in Chapter 3. Women were expected to be sexual – so much so that claims of virginity were held in doubt by Sarah's physician. Women were not expected to be *too* sexual, however, as Sarah's later experiences with another physician made clear: "And he's like, "Well, you know, does your partner have a really large penis?" And I said, "No, I don't think so." And he's, like, "Well, have you seen a lot of penises? I mean, with all due respect." In this instance, Sarah was assumed to not have "seen a lot of penises"; therefore, her claims to bodily expertise could be called into question. However, if she had encountered many penises, then she would have been suspect as a sexually promiscuous woman.

Similarly, physician tested women for "common" sources of sexual pain, such as yeast infections or sexually transmitted infections, even in the face of contradictory evidence and/or women's subjective claims.

> They examined me, and they basically said that I had chlamydia, [laughs] and I said, "That's impossible." I guess, OK, it could have been possible, but I'm like, "It's really not possible, I really don't think so." I explained how the pain started, and they said, "It sounds like chlamydia. We're going to take a culture. We're going to test it, but in the interim, before the culture comes back, we're going to give you oral medication for chlamydia. We're treating you for chlamydia." [Even though they hadn't gotten the results.] Yes… I thought I had some terrible disease. I was so scared, but I knew I didn't have chlamydia because it didn't make sense…But I took the medication because, again, I felt like, "OK, they're the doctor. It's a pill. Maybe it will help me." (Debbie, pain)

Most distressingly to the women interviewed, physicians dismissed women's problematic bodily experiences by suggesting that they were "in their head," – i.e., psychosomatic. Referring to another physician, Debbie continued:

> At that time, and this doctor specifically, they don't realize, and I know that he didn't realize how painful it was for me. My reaction was very extreme, and it was very hard for me, and I was in tears and in a lot of pain. Then, I know when he came back to me, I was dressed. My mom was in the room, and he basically said, "There's absolutely nothing wrong with you. You're fine. You're healthy." I remember what he said. He said, "I recommend you see a psychologist because this is in your head, and you need to work that out."

While 24% of women reported that medical professionals implied that their experiences were psychosomatic in origin, the phrase "all in your head" was also used in several cases as a framework to interpret other, more general delegitimizing messages.

> The first doctor, she was treating me and she was fine, but then she was treating me and it didn't seem to be getting better. So I kept coming back, and she would just, like, do a culture, check for bacteria, for yeast, and then it would be fine, because I didn't have any of those things. And she'd just say, "You shouldn't have any pain. You should be fine." That's what she would say to me. Like, basically saying, "I can't find anything wrong with you. You shouldn't have any pain. You're making this up." Kind of. [Did she say that, or that was the impression?] No, that's the impression she gave me. But she did say, "You shouldn't have pain." Like, she told me, "You shouldn't have pain, from what your tests are showing me." (Dana, pain)

In total, almost half of women with sexual pain either used the term "all in my head" or made other references to "being crazy" when discussing their experiences, either with physicians or more generally. As discussed in the introduction to this chapter, as well as Chapter 4, this reflects women's conceptions of female sexual difficulties being psychological in origin, as well as the larger dismissal of women's symptoms as psychologically based by physicians treating medically unexplained pain. The history of the dismissal of women's complaints is not limited to such pain, however; rather, gynecologic complaints as a whole have traditionally been delegitimized. Zetka (2008) describes the ways in which OB-GYN specialists, in an effort to

stave off claims on professional turf by pelvic surgeons, explicitly allied themselves with the mental health profession after World War II. Thus, women's physical complaints such as dysmenorrhea, infertility, and even morning sickness were often thought to be due to rejections of the traditional feminine role or other psychological and/or emotional disturbances, particularly when physicians experienced diagnostic difficulties.

Jordana, acknowledging this history, noted, " Up until about 50 years ago, they just thought it was something mean women got. Mean women, like angry women. It's really, really funny, because when I yell at my kids...They're 11 and 13 so there's a little bit of yelling that goes on in this house. I've noticed that I tighten up, vaginally. It's unbelievable. They used to think it was just angry women." Even though psychoanalysis eventually fell out of favor as the predominant psychological approach to addressing gynecological complaints, however, the connection between such complaints and presumed psychopathology remains. Similarly, although medically un explained sexual pain is no longer explicitly associated with rejection of the feminine role, it is interesting that some physicians associated particular personality types with medically unexplained sexual pain – specifically, women who do not live up to traditional feminine standards of behavior. Sarah recalled: "I thought, 'What bizarre epidemiological condition is this?' Oh – I know what he said. He said, 'It tends to affect women who are very successful, Type-A personalities.'"

The women in this study reported that physicians suggested – and, at times, insisted - that they must have been sexually traumatized, drawing on the discourses described in Chapter 4. Women resisted this, for the most part; however, some women questioned themselves as to whether or not they had been abused. In this way, they substituted the physician's "expert" knowledge for their own.

> He kept basically asking me, not in those words, but, like, "Have you ever been sexually abused? Have you ever – is that what this is about?" And I was, like, "Not that I can think of…" You know? And I felt like he kept asking me that question. And that made me really uncomfortable. [What about that made you uncomfortable?] That he thought that that's what was causing this. The pain. [It bothered you that he thought that at all, or that he kept asking you, or what…?] I guess both a little bit, but that he kept asking me bothered me also. As if there must have been something to cause this, and, um…and, I mean, I told you about the things that I thought could be involved psychologically, and there could be

> other things. And maybe I was and I just don't remember. But I really don't, you know, think that that was something that happened. (Amanda, pain)

A third historically gendered trope related to gynecological pathology/psychopathology – hysteria – was explicitly referenced by 20% of women with sexual pain:

> Well, because, you know, they're making it to be very emotional. It just plays into all the other stereotypes about women being dramatic and emotional, and "Oh honey, you're just stressed out." Like, my 70-some year old elderly doctor in Georgia saying, "We need to quiet your nerves, darling." Like, women at the turn of the century, they used to put them in inpatient units for being hysterical, when maybe there was something legitimately wrong. Like your husband was cheating with the next-door neighbor. Or, like, childbirth fucking hurts, and, you know, we don't have drugs for you. (Sarah, pain)

Hysteria, thought to be epidemic in the late 19th/early 20th centuries, was a catch-all term that referred to a range of possible symptoms, including muscular aches, depression, nervousness menstrual irregularities, and debilitating weakness. While the concept of hysteria has been attributed to Hippocrates, who thought it due to uterine disturbances, it was only in the 19th century that it became attributed to: a) disordered sexuality, primarily sexual dissatisfaction/frustration and lack of vaginal orgasm derived via penetrative intercourse; and/or b) the stresses of modern civilization (Ehrenreich and English,1978; Maines, 1999). Women were thought of as invalids, constantly needing a physician's care; they never died from their complaints, but they also never recovered from them, thus making them perfect patients from the physician's point of view.

Traditionally, hysteria was associated with manipulative attempts to gain sympathy from physicians and loved ones (Showalter, 1993). That this is still common today was reflected in the reports of approximately one third of women with sexual pain, who – like Debbie - noted that they felt as if their physician did not believe them when they said they were in pain: "I guess that's the theme, it's not the domestic violence that wasn't believed, but this physical condition, I wasn't believed initially. I don't know. I guess the importance is that you're validated. Your experience as a person is validated, and when somebody says; not even just one person, but when numerous people say to you, outright blatantly say "I don't believe you!", that

sort of invalidates the experience." The association between hysterical pain and the manipulative quest for sympathy also draws upon psychoanalytic theory from the mid-20th century. Munch (2004) quotes a gynecology textbook from 1971 that states "many women, wittingly or unwittingly, exaggerate the severity of their complaints to gratify neurotic desires". Thus, physicians at one time were explicitly taught to disbelieve and dismiss the illness claims of female patients.

While hysteria represents a specific historical construction of disease, the term also currently refers to exaggerated or uncontrollable emotionality. Women have traditionally been assumed to be emotionally labile; thus, stereotypes regarding the emotional nature of women may thus be used to dismiss genuine distress and/or the pain itself.

> The physiatrist comes in from the other room, and she's, like…you know, "What are you doing? I have patients in there, and you're freaking out my other patients, that you're crying. Stop being melodramatic. You're really, this is not appropriate." I'm, like, "Excuse me…." I totally told her off, which surprised me. I was, like, "Excuse me, I'm in pain. I come here for treatment for my pain. If I'm in pain, I'm gonna cry." And she's, like, "You know, this is really inappropriate. This is my office." Oh, and then she pulls the heat blanket off of me. She actually interrupts treatment to yell at me. She pulls the blanket off of me, and she was, like, "You know, big person. Don't cry." …[Later] I got this letter from her in the mail that was, like, "I think you'd be better off with a physical therapy establishment that gives more individualized care. And you probably are very emotionally unstable, and you need help." (Ilana, pain)

In a study of 21 general practitioners, Mik-Meyer and Obling (2012) found that the legitimacy of claims by patients that present with medically unexplained symptoms were influenced by the degree to which they displayed problematic personality traits. This is echoed by the findings above: women who were seen as emotionally "difficult" are more easily seen as hysterical and, therefore, not legitimate in their claims.

Biomedical professionals, invalidated the experiences of women with sexual pain in other ways, as well. Four women recalled their physician telling them that their fears regarding their pain were unfounded, given that the vagina was designed to stretch – i.e., accommodate a penis.

Their bodies were assumed to be the natural conduit of heterosexual activity; in this framework, pain was incomprehensible:

> She was just, this doctor was so mean to me. Because, I don't know why. It just, I feel like it's 'cause I was younger, and they just, like, had better things to do. It was kind of, ''cause they would, they also dealt with, you know, pregnant women and stuff. They just didn't want to deal with this. And she just…she did a test, and was, like, "Your skin's fine. It's…I don't see any bacteria and your skin's very – " I don't know. She was saying that it's, like, stretchable, like it should be fine. And she's just, like, "It just must be in your head." I don't know. That's just what she said. (Dana, pain)

In addition, several women with sexual pain perceived that their physicians invalidated them via the treatments they suggested, some of which suggested psychosomatic causes for their experiences in and of themselves. For example, three women noted that their physician told them to get drunk before having intercourse, as this would aid in their relaxation. As Maya recalled, "I did go to my gynecologist, and I said, you know, "I'm having a really hard time having sex." And she was just saying, "You're just nervous. You're tensing up. Get drunk." And so I was told to, like, drink more before having sex. She was, like, she said, "Have some glasses of wine, relax, you're not relaxed. You're tense." So I was basically fobbed off as it being psychological."

Other physicians, while taking the condition itself seriously, dismissed the concerns of women regarding treatments, which could be invasive (i.e., vestibulectomy). Later in her interview, Maya described an experience that she had with another physician::

> He was recommending surgery for me, and I had said, "I would like to see slides of women pre- and post-surgery, so I can see what it looks like." And said that I was the only patient in his years of being a doctor that had ever asked him to see photographs of what their vagina would look like after, post-surgery of vestibulitis. And so, you know, he was, like, "Well, basically, we will cut off this area of your vaginal entryway. We will take the interior vagina, pull it out, down, and sew it down." And I was, like, "Jesus! No!" And I remember him saying, I remember saying to him, like, "It's important to me about what it looks like." Then this comment, he's, like, something, he's, like, "Look at my wife's picture over there. She's had plastic surgery, but that was her face." It was stuff like that

that was just, like, and I was, like, “Well, I care about what my vagina looks like.” And he’s, like, “Well, who’s gonna see it?”

Thus, not only were women with sexual pain invalidated in ways that were specifically tied to physician’s assumptions regarding gendered psychopathology, but were rooted in dismissal regarding women’s legitimate concerns regarding symptoms and treatment. These women, however, were relatively privileged in that they were largely white and middle-to-upper class. Marginalized groups continue to have a different relationship with medicalization, medical power relations, and bodily expertise compared to white, middle-class, highly educated women. Debbie recognized this: “But how am I with my doctors? I think I'm much more commanding. I'm not afraid of them. I can explain to them in great detail what's going on with my body and some other things that I think may be contributing factors to it. Does it help that they know that I'm highly educated? Probably. I just feel like I command the show, and I tell them what's going on with me, and then, respectfully hear what they say” Medical professionals may thus be quicker to dismiss claims of sexual difficulties made by women of color and/or working-class women. In a study of 52 welfare officers and 41 welfare clients that examined the ways in which gender and class intersect in the negotiation of illness, Mik-Meyer (2011) found that women who were poorly educated were more likely to be described as suffering from psychological problems than men or more highly educated women.

Furthermore, particular legitimizing diagnoses, such as vulvodynia, are more often associated with white, middle-class women, as Jordana’s words made clear: “There for a while, I was saying, "Maybe I abused that thing." I did! I was like, "Maybe I abused it." He's like, "Look, there are hookers up on 42nd Street who have a lot more sex than you do." It's like, "And they don't get vulvodynia." I'm like, "They're underreported, because they're not white, middle class women. They probably all have it. We just don't know.” Studies show that show that sexual health discourses aimed at women of color focus primarily on the prevention of sexually transmitted infections, while discourses concerned with the attainment of pleasure remain underemphasized, including in the sexual dysfunction literature (Linwood, 2004). Thus, even when working-class women or women of color experience sexual pain, they may be more likely to be dismissed by physicians. This is supported by the work of Bell (2010), who has suggested that socioeconomic disparities in regards to the medicalization of infertility continues to exist

regardless of whether access to care is equalized (e.g., through health insurance). This is due to medicine's role as a gatekeeper, determining who is fit to mother depending on hegemonic ideals of motherhood: middle-class white women are positioned as infertile, while poor women of color are viewed as excessively fertile. Similarly, medicine helps to determine who norms regarding sexual function apply to

Thus, the ability to medicalize sexual pain may be limited by social location, as marginalized women: a) are not acknowledged as legitimate sufferers of sexual pain from the outset; b) do not have the material resources with which to seek out medical practitioners that acknowledge their suffering; and c) do not necessarily possess the cultural capital required to assert themselves vis-à-vis physicians. Such women therefore are less likely to be medicalized (i.e., granted legitimacy by physicians), and are less able to exert agency in the pursuit of medicalization. Differential access to treatment, in these instances, is a product of social inequity, above and beyond dismissal by physicians.

Resistance

Women Claiming Expertise. Feminist writers have claimed that through medicalization, women often substitute their "authentic" knowledge of their own bodies with the knowledge of the medical profession (Bransen, 1992). While this may be true in many instances, it is not automatic. As Lorentzen (2008) points out, women may describe medical interactions as problematic when physicians attempt to assert truth claims about their experiences or appropriate gendered embodiment that are demeaning or dismissive of women's experiential knowledge. As such, women like Jordana privileged their own bodily knowledge: "I was having urethral pains and I'm like, "My urethra hurts." And she's like, "How do you know your urethra hurts?" I'm like, "Because I'm a 41-42 year old woman. I know where my urethra is. I've had two C-sections, you can't tell me I don't know where my urethra is." This is similar to the findings of Peters (1998), who found that patients contrasted their infallible knowledge of their own symptoms to physicians' indirect knowledge of their experiences.

Practical Resistance. In the face of rejection and/or dismissal, women with sexual pain, including Maria often consulted numerous physicians in search of a diagnosis: "Nobody was giving me any answers. So that…that was frustrating. I probably saw, like, maybe…I don't

know, four or five different urologists in those years." The women in this study saw this pattern of health care utilization, often referred to as "doctor shopping" in the literature, as empowering in its own right. As medical consumers, rather than disempowered patients, women were able to determine where their health care dollars were spent. This was seen as advocating for one's own well-being. Christina asserted, "I think you have to really be an advocate for yourself. And if you don't find a doctor that works for you, you gotta move on. I would never, I would not think twice about switching doctors, ever, or getting a second opinion or a third opinion. I would not, and I wouldn't feel bad about it at all. About anything. Any kind of problem, or any kind of doctor at all." It is important to note, however, that "doctor shopping" has at times been associated in the scientific literature with hypochondriasis in and of itself (Kaestner, 1976). Thus, even as women may see this as a form of resistance, physicians may view this as further evidence for the dismissal of women's symptoms.

Another form of practical resistance was reflected in the fact that approximately one third of women with sexual pain noted that they had sought out a female physician. The majority of women who did so claimed that male physicians were more insulting, demeaning, condescending, or dismissive – or, alternatively, have women's best interests at heart:

> You know, they don't have vaginas, so…they don't know what having a vagina's like. Gynecology is about feeling what's happening in the vagina and making it feel appropriate, or good. You know? Like, so….they're already at a disadvantage, right? So I don't know. Why do they want to be looking at vaginas all day. It sounds kind of weird. But basically, just my experience with male doctors as gynecologists, it's like, they don't really seem to have my being as their first thought in their mind. Dr. Ledger, for example, was way more concerned with the research study that the patient's individual well-being, in my experience. And the other male dr. I saw was, like, "Oh! Well, just get surgery!" And, like, didn't take a moment to put himself in my shoes. Which it might have been easier for him to do if he had had the body part that I was so concerned about. (Ilana, pain)

As noted above, a preference for a female physician may be linked to expectations of empathy. Such physicians, being women, might be slower to engage in stereotypical gender-based dismissal of women's pain.

Finally, women often sent medical professionals biomedical information gleaned from other sources that supported their position. Women often relied on the Internet in order to formulate contradictory truth claims with which to counter their physicians:

> Well, I went back to her, and I had, I written out the things about, you know, the, the tests you can get done, with your urine, see how much, you know, calcium oxalates in your urine. And I showed her a bunch of these things, and she basically said, you know, "I have only one other patient that has this, and she's on amitriptyline, and you know, there's nothing that – none – the stuff you're talking about is not real science." And she basically deflated everything that I showed her. (Maria, pain)

Much has been written regarding the "Googling" patient; with the advent of the Internet, as Broom (2005) points out, there has been much speculation regarding the deprofessionalization of medicine, which is accompanied by the demystification of medical expertise and lay skepticism regarding health professionals. Broom goes on to note, however, that while some physicians welcome the Internet-informed patient, challenges to professional authority are often met with further resistance, as seen above.

Biomedicalization and Feminism. Feminism was often conceived of as resistance to patriarchy, or a way to counter gender discrimination. Not only did the women in this study believe that men's illnesses and/or pain were taken more seriously than that of women, they noted that men's bodies were deemed more worthy of biomedical intervention than the bodies of women. This was often explicitly tied to perceptions of male domination of the medical establishment, as well as male control of the medical gaze. Thus, men were seen as the arbiters of legitimacy, the authors of the dismissal that these women were attempting to combat:

> What I keep saying, like all the time – whenever I'm frustrated that doctors don't have a better handle, basically that there's no cure for this. Um…like when like, I've said this like a million times, but yeah. If this happened to penises, there'd be a cure for it…If this happened to men, there would be a cure for it. Because the establishment, the medical establishment is run by men, even though more and more women are becoming doctors. I'm not sure why, but it's still definitely male-dominated. And diseases are defined by men, and drugs that come out are the ones that men find useful and not the ones that women find useful. You

> know? It's just men who decide what's legitimate and what's not legitimate. (Ilana, pain)

Similarly, the women in this study drew on feminist rhetoric to counter the dismissal they experienced by physicians, as well as a lack of diagnosis and/or treatment:

> We need to see commercials about it! I mean, seriously. But there's not gonna be any commercials until there's some treatment. I mean, you know, a treatment that you can ask your doctor about. Won't that be a revolution. And a revelation. Both. [You're using the term revolution…] It is a revolution! […and you were talking before about legislation. Do you think this is a political issue?] No, I think it had to be brought into the political limelight, just to get funding and stuff like that. I think it had to be. And I think it is a revolution. I think it's time that women can be valuable enough to claim a disease and to claim that yes, it does affect the whole family. And something other than cancer, or whatever else. (Shoshana, pain)

> I think it just needs to be treated and taken seriously, and maybe more money put into it. [Do you think this is a political issue?] Not necessarily a political issue, but I think that it's a women's issue, definitely. Women's issues, the personal is political. [Laughs]…I think that it's a women's issue, and I think that it affects many women. That's what the research says. Because of that, it needs to be addressed, and I'm not necessarily saying politically, but it can be incorporated into healthcare, women's issues, or anything. Just like, and I'll say it again, the whole Viagra thing. Why is that so important? Why are women's sexual health issues not as important as men's sexual health issues? (Debbie, pain)

By calling for a "revolution", as well as noting that "the personal is political", women explicitly allied themselves with the second-wave feminist movement, as well as women's health activism more broadly. Ironically, subjecting themselves to the disciplinary power of medicine in in an attempt to regain normative heterosexual functioning was viewed as resistance to patriarchy.

In resisting dismissal by physicians, many of the women in this study explicitly allied themselves with the women's health movement in order to claim access to biomedicalization, as described above. Riska (2009) refers to as the "empowerment" version of the medicalization thesis, as opposed to repressive medicalization that positions women as the victims of medicine.

I argue, however, that – just as in the case of postfeminist, "agentic" sexual norms - empowerment and subordination may coexist, leading to a complex relationship between women and the medicalization of sexual difficulties. In short, women challenging the authority of physicians are still privileging their cultural authority by demanding that they take the conditions seriously

Furthermore, feminist rhetoric may be co-opted in the name of market interests ("our bodies, our sales", perhaps). For example, pharmaceutical marketing for fibromyalgia often co-opts this rhetoric in order to further sales.. In an study that included the examination of a marketing campaign for Lyrica, a drug meant to treat fibromyalgia, Barker (2011) found that commercials prominently featured the message that "it's not all in your head" – i.e., that fibromyalgia was a "real" illness, not a psychosomatic one. Similarly, Jennifer and Laura Berman, a urologist and psychologist that have built their careers on becoming the go-to media "experts" on female sexual dysfunction, say in their book, For Women Only: A Revolutionary Guide to Overcoming Sexual Dysfunction and Reclaiming Your Sex Life (2001): "We hope that this book will serve as an antidote to what women have heard for decades. The problem is not just in your head. You are not crazy…We are beginning to recognize female sexual dysfunction as a medical problem."

Finally, critiques of medicalization in the popular and scientific literature have been viewed delegitimizing in and of themselves. For example, the National Vulvodynia Association called for signatures for a petition meant to "raise awareness about the importance of women's sexual health, and to advocate at the federal level for effective treatment solutions for women suffering from disorders that affect their sexual health and relationships." In an e-mail to members, they note:

> "The legitimacy of disorders that affect a woman's ability to engage in and enjoy intimacy continues to be questioned, as recently as this past week in a major news article. ISSWSH plans to use this petition in its efforts to legitimize this issue and to voice the needs and concerns of millions of afflicted women that deserve a long-overdue and appropriate research effort to identify effective treatment strategies that will improve all aspects of their health and well-being, including their sexual health." (NVA, 2013)

The news article in question was one critiquing the medicalization of sexuality and sexual pain, discussing the development and approval of Osphena, the drug discussed in Chapter 5. This article noted the drug's side effects, as well as the industry ties of the authors of the studies evaluating its effectiveness, as described above. Thus, those who attempt to critique medicalization – regardless of their feminist identification, in many cases- are positioned as against the interests of women, denying them relief.

Consequences for Gender Reconstruction

This chapter is ultimately a story about the power of recognition. Receiving a diagnosis had the potential to ameliorate gender loss among women with sexual pain; however, physicians often denied them access to such diagnoses. In response to gendered delegitimation on the part of medical practitioners, women with sexual pain fought for medicalization by laying claims to expertise that were rooted in their bodily experiences. As such, it was the process of *not* receiving a diagnosis, rather than receiving one, which had the greatest implications for the women in this study. It would be inaccurate, however, to say that physicians refused to medicalize women's experiences; rather, women and their doctors differed in regards to the kind of medicalization they engaged in; i.e., the former biomedicalized their experiences, while the latter psychologized them. In doing so, physicians drew upon a long history of assigning psychopathology to women with gynecological complaints, as well as medically unexplained pain. By treating the processes of biomedicalization and psychologization the same, scholars may miss out on key gender insights.

These women's claims to recognition represent a paradox in regards to agency and empowerment. While they fight for recognition, such recognition requires ceding control to the medical establishment. Any claims to the desire for political action takes place not in relation to absolving women of the requirement for heterosexual activity; rather, these claims center on facilitating research that will allow them to engage in such activity. The lack of treatment for sexual problems, rather than the requirements of heterosexuality, are seen as a product of patriarchy and gender inequity.

In the next and final chapter, I will continue to explore women's conceptions regarding differences in the ways in which male and female sexual dysfunctions are broadly constructed

and treated by the medical profession. I will address perceived differences in male and female sexual difficulties, the construction of sexually dysfunctional identities, and the significance of proposed pharmaceutical interventions (i.e., "female Viagra") as detailed in Chapter 1. In doing so, I will provide a starting point for future discussions regarding the comparative significance of female sexual difficulties in the Viagra age.

CHAPTER 7: CONCLUSION

In conclusion, this work makes clear the reciprocal relationship of gender and sexuality and medicalization for women with sexual difficulties, as well as the ways in which these meld to form the sexually dysfunctional identity First, I found that gender loss resulting from sexual difficulties is exacerbated by: a) the inability to live up to postfeminist messages regarding the centrality of sexual activity to self-actualization and empowerment; b) the inability to fulfill coital, orgasmic, and desire imperatives within sexual relationships; and c) the inability to perform sexual care work. These contribute to women's sense of themselves as "broken", leaving them open and vulnerable to pharmaceutical and medical efforts to "fix" them.

Second, I found that women's understandings of their sexual difficulties are disjointed and incomplete, forming a causal map that shifts and changes according to women's life histories. I argue that, without a unified illness identity, which may be facilitated by the development of pharmaceuticals (via "pharmaceutical determinism") as well as organizations/self-help movements dedicated to the definition and treatment of sexual difficulties, it is difficult to resolve the conflicting and complex facets of women's causal maps. The attraction of medicalization – particularly in its power to diagnose pathology - is that it promises to provide a clear-cut answer to the uncertainty and confusion inherent in these maps.

Third, I argue that strategies to address sexual difficulties are examples of the subjection of the self to biopower, I suggest that these strategies take three forms: a)the alteration of the physical body (in the case of pain); the alteration of the inner self via emotion work (in the case of low libido), and through the practical adoption of post-feminist discourses surrounding masturbation/sex toys (in the case of orgasm). I also suggest that, even as the latter may be seen as liberatory/a form of resistance, it may also be seen as an acceptance of the need to self-discipline the sexual body.

Finally, I demonstrate how women's encounters with medical professionals are major sites of contestation for claims of bodily expertise. Women discussed their systematic dismissed by physicians, who chose to psychologize the suffering of women with sexual pain rather than biomedicalize it. In turn, the rhetoric of women's self-help movements are used to counter this

delegitimation, leading to a paradoxical dynamic in which women lay claim to normative implications of sexual pathology in the name of resistance to patriarchy.

Please see Figure 1 for a hypothesized model by which the medicalization of sexual dysfunction takes place. While this work addresses some of the ways in which medicalization took place for the women in this sample, several others remain to be explored (e.g., media effects on women's understandings of female sexual dysfunction). As will be discussed later in this conclusion, these areas would benefit from further research; however, this model may serve as a starting point for future discussions of the contributors to – and consequences of – the medicalization of women's sexual problems.

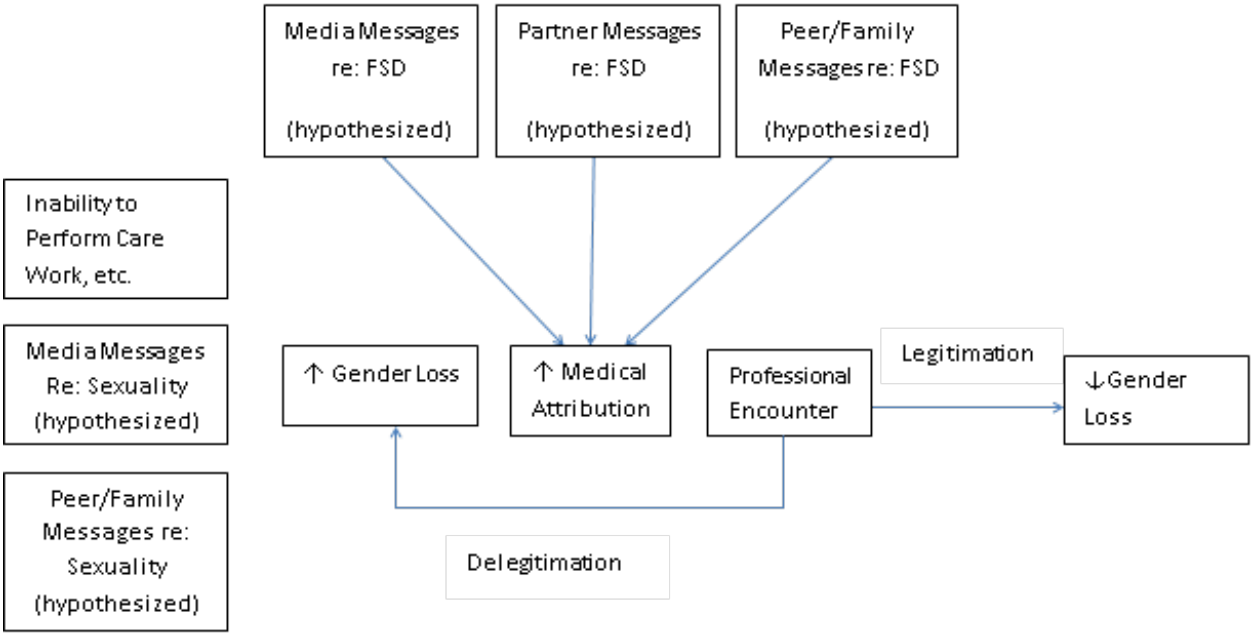

Figure 2: Hypothesized Model of FSD Medicalization

There are several implications of this work for understandings of gender and sexuality in a broader sense. Regardless of whether women have a sexual difficulty or not, almost all are obligated to perform receptive sexuality, particularly when in committed relationships; furthermore, sexual care work is a key obligation of the "third shift" (i.e., emotional work meant to maintain intimate relationships; Hochschild, 1997). This work also reinforces the central role of sexuality in constituting gender. Finally, of central interest in this work is the productive tension between feminist agency/resistance and disciplinary power. Women are not merely

cultural dupes, as much work on the medicalization of sexual difficulties seems to suggest; on the other hand, the means of resistance that women are able to undertake are not unproblematic themselves. This work complicates the idea that postfeminist rhetoric regarding sexuality is necessarily empowering; for example, this rhetoric implies that sexuality is a key arena of empowerment, leaving those who cannot or will not enact such norms as disempowered by default. Similarly, rhetoric adopted from the women's health movement may be seen as both resistance to disempowerment on the part of physicians and subjection of the self to normative sexual ideals. When considering these points, it is important to again keep in mind that feelings of empowerment and being empowered - that is, able to act with sexual self-determination - are not necessarily the same thing (Gavey, 2012).

There are also implications of this work for theories of medicalization. Not only is medicalization not one unified process – rather, there are many forms of medicalization, which differ according to social location, including gender. This work also reinforces the idea that medicalization often takes place "from the ground up", a point that scholars of the medicalization of female sexual dysfunction often gloss over, with their focus on institutional practices. On the other hand, women's reactions to medicalization are often ambivalent – not wholly accepting nor wholly resistant – and the degree to which a sexual difficulty is medicalized depends on a multitude of factors (e.g., micro-level interactions with physicians, the degree to which the difficulty is medicalized in popular discourse).

Is medicalization wholly negative? Notwithstanding the fact that medicalization encourages or structures particular sexual subjectivities, a more productive way of understanding medicalization is that it both empowers and constrains (Sulik 2009). For example, the medicalization of some aspects of reproduction (e.g., childbirth) may be seen as constraining, but the medicalization of fertility control (e.g., the birth control pill) may be seen as essential to freeing women from unwanted childbearing. Similarly, medicalization and technology may be seen as facilitating relief from pain and suffering – who would not want pain to be relieved? It is important to remember, however, that even as medicalization carries its own benefits, these benefits do not mean that medicine is not disciplinary, or that it is advisable to ignore the negative implications of medicalization. As such, medicalization is multisided and complex in its own right.

Erectile Dysfunction and Female Sexual Dysfunction: Parallel Disorders?

By examining the history of the development of biomedical understandings of erectile dysfunction, we can gain some valuable insights into the ways in which the medicalization of female sexual dysfunction may occur. For example, with the rise of psychoanalysis, which reached its heyday in the 1950s, physicians largely abandoned the problem of male sexual dysfunction to the realm of psychology; in 1952, impotence was listed in the American Psychological Association's Diagnostic and Statistical Manual as psychologically based (McLaren, 2007).

During the 1970's and 1980's, however, the medicalization of impotence began in earnest, moving away from its prior "psychologization". For example, surgeons from the 1970s began to implant surgical rods into the penises of impotent men, and also promoted the use of penile inflators. 1982, the International Society for Impotence Research was founded, largely dominated by urologists; in 1984, the first "World Meeting on Impotence" was held, and in 1992, the National Institutes of Health sponsored a Consensus Development Conference on Impotence. (Tiefer, 1994). Urologists' efforts included persuading the public that impotence was due to physical causes, particularly vascular obstructions. (McLaren, 2007).

These claims were taken up by the media; by the end of the 1980's, most reports cited that in 90% of the cases, the causes of impotence were physiological, mechanical, and could therefore be treated (McLaren, 2007). For example, the *Wall Street Journal* featured a front-page article that claimed that new research suggested that impotence was largely organic, while *Time* magazine devoted an entire issue to the topic that repeated the assertion that psychological factors were irrelevant to impotence as a whole (Tiefer, 1994). Repeated claims of "It's not all in your head" revealed the about-face that conceptions of impotence had taken since the mid-20th century, as well as the threat to masculinity that psychological explanations had foregrounded. Prior to 1993, surveys had indicated that 10 percent of men suffered from the inability to achieve an erection. During that year, however, one study suggested that half of men over 40 had experienced impotence of some sort (McLaren, 2007). By the mid-1990's, *Business Week* estimated that American men were spending $600 to $700 million annually on biomedical treatments for impotence, which by this time included vasodilator injections.

In 1998, Viagra became the first oral medication approved by the United States Food and Drug Administration approved for the treatment of erectile dysfunction (Fishman and Mamo, 2001). The term "erectile dysfunction" was readily embraced by marketers of the drug, as it not only emphasized the biomedical, physiological nature of impotence but also established itself as a scientifically based treatment. "Erectile dysfunction" also did not carry the same stigma that "impotence" had, with its connotations of failed masculinity; rather, the cause of impotence was now seen as strictly mechanical and therefore outside of men's control.

The medicalization of female sexual dysfunction seems to be following this trajectory; however, it has been stymied by the pharmaceutical industry's inability to create a drug that would address female sexual complaints. On the other hand, as seen in Chapters 4 and 5, women were ambivalent regarding whether they would actually take drugs designed to treat their sexual difficulties, as well as whether they would consider themselves sexually dysfunctional. While this is likely to be due in part to the contested biomedicalization of women's sexual difficulties – after all, these difficulties have not been completely established in the popular imagination or in professional practice as biomedical problems – it may also be due in part to the different ways in which men and women relate to their sexuality. As indicated in Chapter 4, female sexual dysfunction and erectile dysfunction are constructed in relation to each other. Women's obligations for receptive sexuality are primarily intelligible in relation to men's obligations for strong, penetrative erections and active sexual drive. Men's sexuality is seen as simple, rational, and biologically-driven: men are sexually stimulated, leading to erections; erections lead to penetration; penetration leads to orgasm; orgasms lead to detumescence. Thus, men's sexual problems are assumed to be responsive to simple, mechanical solutions (i.e., Viagra). In turn, women's sexuality, as indicated in this work, is seen as irrational, emotionally-driven and complex. This reflects underlying societal assumptions regarding men and women's gendered natures. By attempting to create a female Viagra, pharmaceutical companies and the medical establishment are attempting to rationalize female sexuality, making it amenable to standardization, measurement, evaluation, and improvement.

Furthermore, the penis and the vulva/vagina hold different meanings in Western society. Erections – and penises more generally - are unique signifiers of masculinity, representing potency, virility, and power. In addition, Potts (2000) suggests that there is in fact a synecdochal

relationship between a man and his penis, so that the part (the penis) comes to represent the whole (the man). Thus, phallocentric sexuality and sexual performance becomes a proving ground for masculinity (Loe, 2001). This takes on special significance in relation to contemporary crises of masculinity, which leave men searching for the meaning of manhood, unsure as to their societal roles (Kimmel 1996). What was once hard, competitive, controlled, enduring and active has become seen as soft, emasculated, almost feminized (Potts, 2000). As such, sexuality remains a key site for men to assert their status *as men:*

> I feel there is a certain urgency, or with men's sexual issues men are supposed to like sex more than women, and being able to have an erection, and sex a lady is a part of a man's masculinity. A woman's femininity, I feel like, I almost feel like a woman's femininity is more like a puzzle where there's all these pieces on the table and you can have most of the puzzle pieces and you can still tell what it is. With a man's masculinity, it's almost like there is a power where there is...it seems almost more fragile. (Vanessa, anorgasmia)

By locating sexual difficulties within the body, individualizing and depoliticizing them (Loe, 2001). Viagra and similar drugs are then positioned as the solution to masculinity in crisis. As Bob Guccione, founder and publisher of *Penthouse* magazine stated, "Feminism has emasculated the American male, and that emasculation has led to physical problems. This pill will take the pressure off men. It will lead to new relationships and undercut the feminist agenda." (quoted in Handy, 1998)

In contrast, while vaginal sexuality may also a proving ground for femininity, it acts in that way as a reflection of woman's capacity to reproduce and/or make herself sexually available to men. For example, in s study of the relationship between vaginas and female gender identity, Braun and Wilkinson (2005) found that women indeed made a connection between the two, stating that all women had vaginas and that having a vagina was central to womanhood. However, when exploring the specific ways in which this took place, these authors found that the vagina was linked to identity through what it enabled these women to do: namely, be penetrated and have children. Thus, the vulva/vagina is not prized for its own sake or represented as a source of power.

Given that women are often defined in relation to intimate others, however, this threat to self may indeed be significant. For example, the women in this study at times noted reluctance to take a "female Viagra" unless it were for the sake of an intimate partner, reflecting women's need to perform sexual care work rather than foster their sexual capacities for their own sake. As one woman noted:

> A guy who's not in a relationship who's having some sort of sexual problem, they would be like, "Oh, no. How will he do things?" [laughing] Like what he's expected to go do. Go do sex with things. That's how he gets the relationship, I guess, by going and presenting his sexual prowess and ability. Then, the girl goes, "Ah yes, OK." Whereas the girl, she wasn't going to be displaying that anyway outside a relationship, so they're like, "It's not a problem." Then, when she's in a relationship, "It's a problem," but it's only a problem in the sense, that, "Well, if they're in a relationship they should be having sex."…Whereas, if a guy in the relationship has a low sex drive, they're like, "Well, what's the issue? It's not like she was going to want to have sex anyway." It's a problem for him because he's not doing the manly thing by having sex, but it's not a problem for the relationship as much. (Jill, low libido)

Promotional materials for Viagra, Cialis , and similar drugs often suggest that such drugs are tools to fix relationships "broken" by erectile dysfunction. (Potts and Grace, 2004); thus, erectile dysfunction is popularly constructed as a coupled phenomenon (Fishman and Mamo, 2001). Similarly, in a study of 33 men with erectile difficulties, Grace et al. (2006) found that men were concerned for the pleasure of their female partners and discussed their fears of lost intimacy stemming from their inability to achieve an erection. At first glance, this seems to reflect what the women in this study experienced here; i.e., the need to perform sexual care work. In addition, men's care work was dependent on being the active partner, "performing" hegemonic masculinity just as women's care work was dependent on performing receptive, hegemonic femininity. As previously mentioned, however, the requirements for men and women to perform sexual care work are quite different. Women are seen as the ones responsible for maintaining emotional relationships with others; this responsibility is naturalized and seen as a sign of biologically-based femininity. Thus, while men may regret the perceived loss of intimacy caused by erectile dysfunction, women may be more threatened by it.

Limitations

There are several limitations to this study, primarily in regards to the relative lack of diversity of the study sample. First, the majority of women in this study were under the age of 40; this is problematic in that medical/pharmaceutical efforts to address sexual problems in women may, in fact, be primarily targeted towards menopausal or postmenopausal women (see the discussion in Chapter 5 of Osphena, for example). Similarly, Shifren (2009) notes that one-fifth of all the prescriptions of testosterone products approved for men are actually written (off-label) for women in order to treat low libido. That I did not encounter similar findings may be an artifact of my study sample, as testosterone supplementation is most often suggested as a treatment for low libido among menopausal women. Finally, Marshall (2011) has suggested that both men and women are now expected to engage in sexual activity throughout the lifespan, with sexual function being associated with vitality, activity, and health; in this way, thus, this limitation is an important one to address in future work.

A second limitation of this study is my sample's relative lack of socioeconomic and racial diversity, as discussed in Chapter 2. While the sample was indeed more diverse than many other studies on this topic, which tend to focus on straight, middle-class white women, I was not able to perform a truly intersectional analysis. This is problematic, not least due to the fact that sexual difficulties are diagnosed and treated differently among women of color and working-class women compared to white, middle-class women. As previously discussed in this work, working-class women may not have the financial means or the time to seek out medical treatment of sexual difficulties – in short, to treat the body as a project. In addition, women of color may be less likely to be diagnosed with a sexual difficulty. Mulholland (2007), for example, who describes the racialization and ethnicization of sexuality and sexual problems among sex therapists, notes that certain races and ethnicities (e.g., African ethnicities) are automatically assumed to be sexually active and/or assertive; in these populations, sexual difficulties (other than sexually transmitted infections) remain outside the realm of possibility. This is directly attributable to centuries of racialized discourse in which black women's bodies have been hypersexualized. On the other hand, sexual difficulties are at times seen as inherent to Asian and Middle Eastern women, who are perceived to be oppressed by patriarchal cultural norms; as such, gender inequities and sexual ignorance seen to result in reduced libido. In this

case, there is an insistence on societal causes of sexual problems - but in a racist, not emancipatory way. As white, Western women are represented in popular discourse as living in bastions of sexual freedom, how could sexual difficulties be seen as anything other than medical/psychological?

Future Directions

Several areas may serve as a fruitful area of inquiry for future research. First, with new pharmaceutical developments come new opportunities for research and scholarship. For example, it may be interesting to see the ways in which discourses regarding female sexual dysfunction are produced and circulated. As Angel (2012) points out, activists' focus on pharmaceutical and medico-scientific developments glosses over the impact of cultural resources such as women's magazines and self-help books; these resources suggests a wide range of potential etiologies for FSD, leading to the confused explanatory maps described in Chapter 4. Lavie-Ajayi and Joffe (2009), for example, point out that magazines construct women's sexual difficulties as due to repression or other psychological factors while at the same time telling women not to expect an orgasm every time they have sex. Thus, a content analysis of such literature may help to elucidate the ways in which women are socialized into accepting medicalized accounts of sexual difficulties.

Second, future work can also explore the micro-level interactions help to facilitate the acceptance of medicalized accounts of sexual difficulties, such as interactions with intimate partners. As previously discussed, to do gender is to be accountable to others - to be vulnerable to gender assessment. While gender assessments regarding non-sexual feminine performance (i.e., childbearing, appearance) are quite frequently performed by peers, family members, and other individuals women encounter in their daily lives, their capacity to perform sexual care work is most frequently assessed by intimate partners. Thus, there is a possibility that the attitude of intimate partners regarding sexual difficulties has a large impact in regards to the degree that women experience gender loss. This is also suggested by the fact that, as mentioned in Chapter 3, many women considered sexual difficulties to be a problem if and only if they were a problem for their partners.

Similarly, the medicalization of sexual difficulties occurs in the spaces between women and to whom they are accountable in performing gender. In other words, women's experiences of medicalization play out in specific exchanges with particular others and in particular situations – in short, are produced within the context of social relationships. Medical discourses are contested, negotiated, and adopted through interaction; thus, women's interactions with intimate partners influence how medicalization occurs prior to interactions with medical professionals. For example, a study conducted by Mooney-Somers, Perz and Ussher (2008) found that the responses of women's partners play a role in the construction of premenstrual distress as "PMS", often labeling all negative emotions and behaviors as signs of the condition. Furthermore, in a study of how women's interactions with partners affected women's experiences with menopause, some women noted that partners monitored their symptoms – including negative emotional expressions - and viewed menopause as something that needed to be controlled, preferably by biomedical means (Dillaway, 2008).

Fourth, future research should further examine the use of feminist tropes as a means of decreasing women's resistance to medicalization. For example, Braun (2009) examines the ways in which the rhetoric of "choice" and "agency" are utilized in professional and media discourses surrounding female genital cosmetic surgery (e.g., labiaplasty). In these ways, feminism is used for the purposes of self-objectification, self-surveillance, and subjugation to normative ideas of what bodies are supposed to be like – in short, decidedly non-feminist ends. It remains to be seen if such rhetoric is used in pharmaceutical marketing now that drugs are being developed for the treatment of female sexual dysfunction.

Fifth, more efforts should be undertaken to examine individuals' differential access to medicalization, as well as the individuals towards whom medicalization most often targeted ; i.e., the ways in which medicalization shapes the experiences of women in various social locations. A truly intersectional analysis – one that accounts for multiple, interacting sources of subordination/oppression – would help to illustrate the means by which women of color and economically disadvantaged women negotiate and come to terms with sexual difficulties.

Resistance to Medicalization

Finally, research should explore means of resistance towards sexual normativity in the context of medicalization. For example, the New View Campaign is an activist movement countering the medicalization of women's sexual difficulties by the pharmaceutical industry. Since 2000, the campaign has engaged in numerous activities in furtherance of their mission, including op-eds in major newspapers, conference presentations, activist events, continuing education for physicians and nurses, and scholarly articles. These activities also include the creation of a manifesto that outlines a new classification of women's sexual problems; this classification not only addresses biomedically- and psychologically-based causes of sexual difficulties, but addresses difficulties rooted in sociocultural, political, and economic factors, as well as factors relating to intimate partners and relationships. Thus, the New View campaign has opened a critical space in which issues relating to the medicalization of female sexual difficulties may be addressed and challenged head-on.

Resistance to medicalization may take many forms. For example, it may manifest itself as acknowledgement of the social causes that contribute to female sexual difficulties. Women's experiences of gendered sexuality play out in specific exchanges with particular others and in specific situations – in short, are produced within the context of social relationships. Individualizing sexual problems removes them from their social contexts, locating the pathology within the person (Keystone and Carolan, 1998) Furthermore, these specific encounters are imbued with differences of relative power – differences that in large part stem from traditional conceptions of properly enacted femininity. Medical models ignore issues regarding these dysfunctions' political and cultural dimensions, such as power differences in heterosexual relationships, the narrow sexual scripts that women internalize in regards to properly enacted heterosexuality, and gender inequalities (Drew 2003).

Furthermore, as feminist scholars have noted, medicalized models of sexual dysfunction - based as they are on a universalistic norm of physiological response - ignore differences among women that impact their sexual functioning. As Tiefer (2002) notes, "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." Thus, resistance to sexual normativity could take the form of acceptance of sexual diversity in behavior, not just orientation or identity. As reflected in Chapter 3, it is possible that marginalized groups (e.g., LGBT-identified women) may be better able to resist this form of sexual normativity. Such women already know what it means to grapple with societal expectations regarding gendered sexuality, and may be aware of the ways in which such expectations may be inverted. As mentioned in Chapter 2, standpoint theory suggests that the standpoints of oppressed groups are epistemically privileged, given that the members of such groups are required to be conscious of the perspectives of those in power as well as their own. Thus, the celebration of gender and sexual diversity in a general sense may lead to a resistance to pathologization of sexual diversity in regards to sexual performance. I conclude this work with the words of Cecilia, a woman experiencing low libido, who demonstrates the ways in which such resistance could be articulated:

> I don't know that I believe in sexual dysfunction. I believe in a huge variety of sexual natural behavior, all the way from people who are just not interested in sex. They're asexual, perfectly naturally. For them, a fulfilling sex life is a life of not having sex...to people who like a wide variety of things. It's not a spectrum. It's a galaxy. For me, getting to know your own sexuality and finding a way to enjoy that and be honest with it, and find someone who will collaborate. Finding some way to be honest about what it is you really like. That's true sexual function.

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APPENDIX A: PARTICIPANT CHARACTERISTICS

Table 4: Participant characteristics

	Age	Condition	Education	Income	Race/ Ethnicity	Relationship Status	Sexual Identity
Adrienne	18-35	Pain	Bachelor's	Don't Know/ Refused	Caucasian	Single	Heterosexual
Amanda	18-35	Pain	Graduate	$40,001-$50,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Amy	18-35	Anorgasmia	Bachelor's	Above $100,000	Caucasian	Single	Bisexual
Andrea	18-35	Pain	Some College	$35,001-$40,000	Hispanic	In a Relationship/ Partnered	Heterosexual
Angie	35	Low Libido	Bachelor's	$35,001-$40,000	Caucasian	Single	Heterosexual
Anna	18-35	Pain	Graduate	$50,001-$75,000	Caucasian	Married	Heterosexual
Anya	18-35	Pain	Some College	Don't Know/ Refused	Caucasian	Single	Heterosexual
Becky	18-35	Pain	Graduate	Above $100,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Bridget	18-35	Pain	Associate's	$50,001-$75,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Caitlyn	18-35	All 3	Graduate	Don't Know/ Refused	Asian	Married	Heterosexual
Cara	35	Anorgasmia	Graduate	Above $100,000	African-American	Married	Heterosexual
Carolyn	18-35	Anorgasmia/ Pain	Some College	$0-$5,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Cathy	18-35	Low Libido	Some College	$5,001-$10,000	Caucasian	In a Relationship/ Partnered	Heterosexual

	Age	Condition	Education	Income	Race/ Ethnicity	Relationship Status	Sexual Identity
Cecilia	35	Low Libido	Graduate	$50,001-$75,000	Caucasian	Single	Heterosexual
Christina	18-35	Pain	Bachelor's	$40,001-$50,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Crystal	35	Anorgasmia	Bachelor's	$50,001-$75,000	Caucasian	Single	Heterosexual
Dana	18-35	Pain	Some College	$0-$5,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Deanna	35	Pain	Graduate	Above $100,000	Caucasian	Married	Heterosexual
Debbie	18-35	Pain	Graduate	Above $100,000	Caucasian	Married	Heterosexual
Diane	35	Pain	Graduate	Above $100,000	Caucasian	Single	Heterosexual
Eileen	18-35	Pain	Bachelor's	$30,001-$35,000	Caucasian	Married	Heterosexual
Emily	18-35	Low Libido	Bachelor's	$25,001-$30,000	Caucasian	Single	Lesbian
Emma	35	Pain	Graduate	$75,001-$100,000	Caucasian	Married	Heterosexual
Erica	18-35	Anorgasmia	Bachelor's	Don’t Know/ Refused	Hispanic	Single	Lesbian
Erin	18-35	Low Libido	Graduate	$20,001-$25,000	Caucasian	In a Relationship/ Partnered	Lesbian
Gina	35	Low Libido	Graduate	Don’t Know/ Refused	Caucasian	In a Relationship/ Partnered	Heterosexual
Ilana	18-35	Pain	Bachelor's	$40,001-$50,000	Caucasian	Single	Heterosexual
Janet	18-35	Low Libido	Some College	$15,001-$20,000	Caucasian	In a Relationship/ Partnered	Bisexual
Jen	18-35	Anorgasmia/ Low Libido	Some College	$5,001-$10,000	Caucasian	In a Relationship/ Partnered	Heterosexual

	Age	Condition	Education	Income	Race/ Ethnicity	Relationship Status	Sexual Identity
Jessica	18-35	Anorgasmia	Some College	Don’t Know/ Refused	Caucasian	Single	Bisexual
Jill	18-35	Low Libido	Bachelor's	$15,001-$20,000	Caucasian	In a Relationship/ Partnered	Bisexual
Jo	35	Anorgasmia/ Low Libido	Bachelor's	$40,001-$50,000	Hispanic	Married	Heterosexual
Jocelyn	18-35	Low Libido	Bachelor's	$50,001-$75,000	Caucasian	In a Relationship/ Partnered	Bisexual
Jodi	18-35	Low Libido	Bachelor's	$40,001-$50,000	Caucasian	Married	Heterosexual
Jordana	35	Pain	Bachelor's	$75,001-$100,000	Caucasian	Married	Heterosexual
Josette	18-35	Anorgasmia/ Low Libido	Bachelor's	$10,001-$15,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Julia	18-35	Pain	Bachelor's	$10,001-$15,000	More Than 1 Race	In a Relationship/ Partnered	Heterosexual
Karen	18-35	Low Libido	Graduate	$35,001-$40,000	Caucasian	Single	Other
Kate	18-35	Low Libido	Bachelor's	$75,001-$100,000	Caucasian	Single	Heterosexual
Kim	18-35	Low Libido	Vocational	$20,001-$25,000	More Than 1	Single	Heterosexual
Kirsten	18-35	Anorgasmia/ Low Libido	Bachelor's	Don’t Know/ Refused	Caucasian	In a Relationship/ Partnered	Heterosexual
Lauren	18-35	Low Libido	Associate's	$30,001-$35,000	Caucasian	Single	Heterosexual
Linda	35	Low Libido/ Pain	Some College	$35,001-$40,000	Caucasian	Married	Heterosexual
Liz	18-35	Anorgasmia/ Low Libido	Bachelor's	$35,001-$40,000	Asian	In a Relationship/ Partnered	Heterosexual
Lucy	18-35	Pain	Bachelor's	$15,001-$20,000	Caucasian	In a Relationship/ Partnered	Other

	Age	Condition	Education	Income	Race/ Ethnicity	Relationship Status	Sexual Identity
Maria	35	Pain	Unassigned	Don’t Know/ Refused	Caucasian	In a Relationship/ Partnered	Heterosexual
Maya	18-35	Pain	Graduate	Above $100,000	Caucasian	Single	Lesbian
Melanie	18-35	Pain	Bachelor's	Above $100,000	Caucasian	Married	Heterosexual
Melissa	18-35	Pain	Bachelor's	$25,001-$30,000	Caucasian	Single	Heterosexual
Michelle	18-35	Pain	Unassigned	Don’t Know/ Refused	Caucasian	In a Relationship/ Partnered	Lesbian
Naomi	18-35	Pain	Graduate	$40,001-$50,000	Caucasian	Married	Bisexual
Olivia	18-35	Low Libido	Some College	Above $100,000	Caucasian	In a Relationship/ Partnered	Other
Patricia	18-35	Pain	Graduate	$75,001-$100,000	Caucasian	Married	Heterosexual
Rachel	18-35	Low Libido	Bachelor's	$0-$5,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Rosa	18-35	Low Libido	Some College	Above $100,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Sarah	18-35	Pain	Bachelor's	$50,001-$75,000	Caucasian	Single	Heterosexual
Shana	35	Pain	Bachelor's	$75,001-$100,000	Caucasian	Married	Heterosexual
Sonja	18-35	Anorgasmia/ Low Libido	Some College	$15,001-$20,000	Caucasian	In a Relationship/ Partnered	Heterosexual
Sophia	35	Pain	High School	Above $100,000	Caucasian	Single	Heterosexual
Susie	18-35	All 3	Some College	$20,001-$25,000	Hispanic	In a Relationship/ Partnered	Heterosexual
Taryn	18-35	Anorgasmia/ Pain	Graduate	Don’t Know/ Refused	Caucasian	In a Relationship/ Partnered	Heterosexual

	Age	Condition	Education	Income	Race/ Ethnicity	Relationship Status	Sexual Identity
Vanessa	18-35	Anorgasmia	Graduate	$5,001-$10,000	Caucasian	In a Relationship/ Partnered	Other
Yvonne	18-35	Anorgasmia	High School	Above $100,000	Caucasian	Single	Heterosexual

APPENDIX B: INTERVIEW GUIDE (PHASE 1)

- How would you describe your pain to someone who hasn't experienced it?
- Are there any occurrences in your past that you feel affected your experiences with or attitudes towards/feelings about vulvodynia?
- Tell me about your experiences with vulvodynia, starting from the time you started to experience symptoms.
- In regards to your vulvar vestibulitis, how have physicians responded?
- Have you ever had any relationships, long-term or otherwise, where vulvar pain has been an issue you dealt with as a couple? How have partners responded to your condition? Are you able to discuss sexual issues with your partner openly?
- How have you dealt/would you deal with meeting new partners and dating while living with vulvar pain? How do you manage new sexual encounters?
- Have you been able to talk to your friends and family about your pain? What have you told them? What has been the response?
- Where did you learn about sex from growing up? From whom? What were the messages you received?
- If you have a question about sex now, where do you go to find out the answers? Internet? TV? Magazines? Doctors? Why? What are the differences in the messages you get from each source?
- Have you seen information about/representations of vulvodynia in the media? How was it portrayed?
- How is sexual dysfunction talked about in our society, if at all?
- How do you define "sex"? What behaviors/emotions/attitudes does it entail?
- How much does sex matter to you, personally? How much do you think it matters for a person's life, in general/what place should it have? How important is sex for a healthy relationship? (What is a healthy relationship?) For a healthy self? Personal identity? Explain why.

- What do you think a good sex life entails?

- What makes someone an attractive sexual partner? What makes someone "good in bed"? Do you feel like a good sexual partner? Why or why not?

- How has vulvodynia affected your identity? Your sense of yourself as a woman/sexual being?

- Describe how you feel about your body. Has vulvodynia changed how you feel about your body? If so, how? Do you like your body? Why/why not?

- How do you think society shapes the experiences of women with vulvodynia?

APPENDIX C: INTERVIEW GUIDE (PHASE 2)

- Tell me about what you're experiencing. When did you first become conscious of this? Has it always been the same?

- (If multiple issues) Which came first? Do they affect each other? How? Which is most significant to you? Why?

- Put yourself in your shoes when you started to experience/first became aware of X. what did you notice was happening?

- How did you feel about it? What about now? Do you feel that it is a problem for you? Why/why not?

- (If not a problem): Did you ever think it was? Why/Why not? If so, what changed? How did that change? What prompted the change?

- Before you ever experienced X, had you ever… heard/read about women who had experienced X? What about afterwards?

- Women have told me that they understand their experiences with X in a lot of different ways. What do you think causes X? Why?

- Walk me through how you have dealt with X, from when you first started experiencing it until now.

- Have you ever gone to a professional (e.g., physician, psychologist, sex therapist, other) to talk to them about X? Why? What prompted you?

- In regards to X, how did the (1^{st}, 2^{nd}, 3^{rd}) professional respond? How did you feel about the doctor's opinion? Do you feel heard when you speak to your doctor about this?

- Have you gotten a medical diagnosis? How has the diagnosis changed things for you, if at all?

- Probe: Do you think you have a good relationship? Why or why not? What does it mean to you to have a "good relationship?" (NOTE: REPEAT ALL QUESTIONS FOR THE CURRENT/LAST RELATIONSHIP)

- What happens when your partner approaches you for sex? Do you ever feel pressured to engage in sexual activity? Do you engage in sex even if you don't want to? (If anorgasmia) Do you ever fake orgasm?

- How did your partner respond to your experiences? Does/did your partner think it's a problem? What does he/she think are the causes? What does he/she think you should do about it?

- What were the effects of X on your relationship?

- How have you managed/how do you plan to manage sexual encounters with new partners (if not in a long-term relationship)?

- How do you define "sex"? What does sex mean/represent to you?

- When you think of "normal" libido/sex/orgasmic capability, what do you think of? Why? Do you think other people think there is a normal? How important is "normal" sexual activity/feelings to being a woman in our society? To you?

- How do you feel about yourself as a woman? Has X affected the way you feel about it? Why?

- (For lesbians/bisexuals): Do you think your sexual orientation has affected the way you see X? How? How do you think your experience with X would be different if you were dating a man vs. a woman?

- Do you think your experience is common? Do any other women that you know have similar issues? In regards to sexuality, how do you think you compare to other women you know?

- What does the term "sexual dysfunction" mean to you? Have you ever thought that your experiences with X are due to a "sexual dysfunction"? Why or why not?

- If someone came up with a female Viagra, would you take it?

- What do you think are the differences between men's sexual problems and women's sexual problems?

APPENDIX D: CODEBOOK

- All In My Head
    - Frigidity
    - Hysteria
- Messages Received about Sexuality (General)
    - Sex is Bad, Shameful, Negative, Etc.
    - Everyone Having Sex
    - Gendered Messages
    - Sex and Relationships
        - Sex Equals Love
        - Sex is An Important Part of a Relationship
        - Sex is For Marriage
    - Sex Is Good
    - Sex Equals Fun, Happiness, etc.
    - Sex Is Healthy
    - Sex is Not Shameful, Wrong
    - Sex is Sacred, Something God Wants
    - Should Be Having Sex
    - Intercourse is Important
- Experience of Condition
    - Anorgasmia
        - Clitoral Orgasms Not Enough
        - Don't know What Orgasm Is
        - Little Orgasms Not Enough
        - Solo Orgasms Not Enough
    - Low Libido
        - Desire is Fragile
        - Don't Even Masturbate
        - Don't Think About It
        - Enjoy Sex Once Started, But Don't Want It
        - Going Through the Motions
        - Lose Drive Over Time
        - Never Felt Desire
        - Shut Down
    - Pain
- Expertise
    - Doctor Claiming Expertise
    - Doctor Not Having the Answers

        - Don't Trust Doctor
        - Trust Doctor
        - Doctor as Researcher
        - Subject As expert
- Gender Identity
    - Characteristics of Women with Condition
    - Effects of Condition on Gender Identity
        - Ambivalent
        - Less of a Woman or Inadequacy as Woman
            - Can't Do Care Work
            - Can't Perform Femininity (General)
            - Lack of Empowerment
            - Not Normal Or Like Other Women
            - Other
        - No Effect
            - Being Female Not Important to ID
            - Can Still Perform Femininity
            - Husband Doesn't Need It or No Relationship
            - Still Had Sex
            - Less of a Person, not Less of a Woman
            - More to Being a Woman Than Sexuality
            - Normal or Common
            - Shouldn't Define Your Gender
            - Other
        - Upholds Gender Identity
    - Importance of Sexuality to Being a Woman
        - Don't Know
        - Important
        - Not Important
- Information About Condition (Received from Peers, Family, Mass Media)
    - Cause
        - Biomedical Issue
            - General
            - Hormones
            - Medication
                - Antidepressants
                - Birth Control
            - Vulvodynia
            - Other
        - Stress

        - Partner Issue
        - Psychological Issue
        - Relationship Issue
        - Other
    - Dismissed It
    - Experience is Common or Normal
    - How to Fix Problem
        - Be Romantic
        - Biomedical
            - Antidepressants
            - Do Something With Birth Control
            - Female Viagra
            - HRT
            - Treat Yeast
        - Diet
        - Fake it Till You Make It
        - Faking Orgasms
        - Get to Know Body
        - Herbal
        - Lube
        - Need to Go to Professional
        - Other
        - Physical Therapy
        - Relationship
        - Relax
        - Surgery
        - Vibrator
    - Problem for Men, Not Women
- Interactions With Professionals
    - Interaction with Other Professional
        - Invalidation or Validation
            - Reaction to Invalidation
        - Professional's Response - Other
        - Reason for Going or Planning to Go
        - Reason for Not Going
        - Suggested Treatments
            - Get to Know Body
            - Other
            - See biomed doctor
            - Sexual
    - Interaction with Physical Therapist
        - Invalidation or Validation

            - Reaction to Invalidation
        - Physical Therapist's Response - Other
        - Reaction to Physical Therapist's Opinion
        - Reason for Going or Planning to Go
        - Reason for Not Going
        - Suggested Causes
            - Biomedical
            - Psychological
        - Suggested Treatments
            - Biofeedback
            - Dilators
            - Exercise
            - In-Office
            - Kegels
            - Massage
            - other
            - Sexual
- Interaction with Psychologist or Psychiatrist
    - Invalidation or Validation
        - Reaction to Invalidation
    - Psychologist's Reponse - Other
    - Reaction To Psychologist's Opinion
    - Reason for Going or Planning To Go
        - Coping With Condition
        - Find Reason for Condition
        - Fix Problem
        - Need To Talk To Someone (General)
        - Other
        - Part of Regular Therapy
    - Reason for Not Going or Not Talking About It
        - Didn't Think It Was a Mental Problem
        - Not a Problem
        - Other
    - Suggested Causes
        - Abuse
        - Biomedical
        - Normal
        - Other
        - Psychological
    - Suggested Treatments
        - Fix Relationship

                - Mechanical - e.g., Positions, Lubricant
                - Other
                - See Biomedical Professional
                - Sexual
- Interaction with Sex Therapist
    - Reaction to Sex Therapist's Opinion
    - Reasons for Going or Planning to Go
    - Reasons for Not Going
        - Don't Know Any or Don't Know What they Do
        - Not a Problem
        - Other
    - Suggested Causes
        - Mechanical
        - Psychological
        - Relationship
    - Suggested Treatments
        - Work on Relationship
- Interactions With Biomedical Professionals
    - Diagnosis
        - Feelings About Diagnosis
            - Ambivalent Re Diagnosis
            - Diagnosis is a Bad Thing
            - Diagnosis is a Good Thing
        - Q-Tip Method
        - Self-Diagnosed
            - Birth Control
            - Other
            - Vulvodynia
            - Yeast
        - Visibility
    - Doctor Shopping
    - Doctors Don't Care About Sexuality
    - Doctor's Response - Other
        - Might Not Go Away
        - Other
        - Should Have Sex
    - Invalidation
        - Didn't Believe Me
        - Didn't Care
        - Dismissed Concerns
        - Dismissed Feelings

        - Dismissing Patient's Knowledge
        - In Your Head
        - Nothing Wrong With You
    - Reaction to Invalidation
    - Validation
        - Believed Me
        - Cared
        - Listened
        - Took Time To Explain
    - Male vs. Female Doctor
    - Reaction to Doctor's Opinion
        - Agreed
        - Disagreed
    - Reasons for Going
        - Find Reason for Condition
        - Fix the Problem
        - Other
        - Part of a regular checkup
        - Patner's Request
    - Reasons for Not Going or Talking About It
        - Doctor Can't Do Anything
        - Don't Like Doctors
        - Don't Think It's Biomedical
        - Not a Problem
        - Other
        - Uncomfortable
    - Suggested Causes
        - Abuse or Rape
        - Biomedical
            - Bacterial Vaginosis
            - Hormones
            - Medication
            - Other
            - STD
            - Vulvodynia
            - Caused By Genes
            - Caused By Medication
            - Caused By Nerve Dysfunction
            - Caused by Pelvic Floor Dysfunction
            - Caused By Tight Muscles
            - Other

        - Yeast
    - Don't Know
    - Normal or Natural
    - Other
    - Psychological
    - Too Tight
- Suggested Treatments
    - Biomedical
        - Biomedical - Drugs
        - Antibiotics
        - Antidepressants
        - Antihistamines
        - Botox
        - Estrogen Cream
        - Hormones - Other
        - interferon shot
        - lidocaine
        - Neurontin - Anti-Seizure
        - Other
        - Steroids
        - Stopping or Switching Birth Control
        - Yeast Medicine
        - Biomedical - Surgery
    - Diet
    - Mechanical
    - Other
    - Physical Therapy
        - Biofeedback Exercises
        - Dilators
    - Vulvar Care
- Personal Opinion Regarding Cause
    - Both Biomedical and Psychological
    - Don't Know
    - Need to Know Own Body
    - Normal or natural
        - General
        - Inexperience
    - Other
    - Other Sexual Condition
    - Busy Lives
    - Children

- Biomedical
    - Allergy
    - General Biological (vague)
    - hormones
    - Medications
        - Antidepressants
        - Birth Control
        - Other
    - Neurochemistry
    - Other Condition
    - Systemic
    - Yeast
    - Childbirth
    - Lubrication
    - Other
    - Physiological
    - Psychological
        - Depression or Generalized Anxiety
        - Father Figure
        - General
        - In own head too much
        - Need to Relax or Let Go
        - Other
        - Repression
        - Sex-Specific Anxiety
            - Fear of Pain
            - General
        - Sexual Trauma
        - Trauma Related
        - Trust Issues
    - Social (Macro)
    - Social (Micro)
        - Partner
            - Atttraction
            - Don't Have the Right Person
            - Inexperienced
            - Not Fulfilling Gender Roles
            - Other
            - Sexually Selfish
            - Too Big
            - Treated Poorly

                - Relationship
                    - General
                    - Long Term Couples Lose Desire
            - Body Image
            - Stress
        - Deciding About Cause
            - Exposure to Trusted Sources
            - Never Told It was Physical By a Doctor
            - Other
            - Pain is Real
            - Process of Ruling Things Out
- Problem vs Not A Problem
    - Is a Problem
        - Is a Problem Because of Partner or Relationship
    - Most Significant Condition
    - Not a Problem
- Relationships
    - Communication
    - Dating
        - Avoidance
            - Fear of Rejection
        - Benefits of Condition
        - Hooking Up
    - Disclosure
        - Ethics
        - Never told partner
    - Future of Relationship
        - Fear of Dissolution
        - Fear of Infidelity
    - Threat to Partner's Masculinity
    - Partner Wants to Please Subject
    - Partner's Expectations Regarding Sex
    - Partner's Opinion Regarding Cause
        - Don't Know
        - Just the Way I Am
        - Mechanical (e.g.., lubrication)
        - Need to Understand Own Body
        - Other
        - Biomedical
            - Medication
            - Physiological
        - Psychological

    - Relationship
    - Self
- Partner's Opinion Regarding Treatment
    - Biomedical
        - Change Birth Control
    - Doesn't Know
    - Fix Body Image
    - Get to Know Own Body
    - Mechanical - e.g., positions, lubricant
    - Other
    - Partner Trying Harder
    - Relax
    - See biomed doctor
    - See psychologist or psychiatrist
    - See Sex Therapist
- Partner's Response Towards Condition
    - Other
    - Sees it as a Challenge
    - She Needs to Be Working On It
    - Supportive or Understanding (Overall)
        - General
        - Partner Doesn't Want to Cause Pain
    - Unsupportive (Overall)
        - Angry
        - Comparisons to Other Women
        - Didn't Care
        - Frustrated
        - negative expression
        - Other
        - Pressure to Have Sex or Perform
        - Rejected Subject
        - Threatening to Leave
        - Upset (Other)
- Power Difference
- Reaction to Partner's Feelings and Opinions
    - Didn't Believe Reassurance
    - Other
    - Stay with Partner Because He Puts Up With It
- Reassuring Partner
- Relationship Quality
    - Actual Dissolution (past relationships)

        - Impacted Negatively
            - Conflict
            - Actual Infidelity
        - No Effect on Relationship
    - Attitudes Towards Partner's ED
        - Blamed Self
        - Judged Masculinity
        - Medicalized It
        - Other
        - Psychologized It
        - Would Accept It
- Sexual Attitudes
    - Definition of Sex
        - Other
        - Sex Is Intercourse
    - Gender and Sexuality
        - Evolutionary Pysch and Bio
        - Feminism and Sexuality
        - Men's vs. Women's Sexuality
            - Different Performances
            - Men Identify With their Sexuality
            - Men Need Intercourse
            - Men Need to Have Orgasms
            - Men Need to Have Sex
            - Men's Sex Doesn't Have to Be Emotional
            - Men's Sexuality is Simple
            - Other
        - No One Wants to Talk About Female Sexuality
        - Sex as Empowerment or Agency
        - Walking A Fine Line
        - Women Not Supposed To Be Sexual
        - Women Not Expected To Be Sexual
        - Women Supposed to Be Sexual
    - Neutral Meanings
        - Receptivity
        - Sex As Adult
        - Sex as Letting Go
        - Sex As Natural
        - Other
        - Sex as Human
        - Sex as Reproduction
        - Sex as Vulnerability

    - Sex as Work
- Normal Sexuality
    - Definition of Normal
        - Actual Capacity or Frequency
        - Behaviors
        - Dictionary Definitions
    - No Normal
    - Who defines normal
        - Couple
        - Media
        - Other
        - Past Self
        - Society (general)
- Positive Meanings
    - Sex as Culmination
    - Sex as fulfillment
    - Sex as Fun
    - Sex as Happiness
    - Sex as Pleasurable
- Sex and Relationships
    - Sex as Bond
    - Sex as Emotional
        - Sex as Love
    - Sex as Gift
    - Sex as Intimacy
    - Sex as Mutuality
    - Sex as Necessary Part of Relationship
    - Sex as Pleasing Partner
- Sex as Healthy
- Sex Is Important
    - Importance of Partnered Sex In General
        - Not Important
    - Importance of Desire
        - Not Important
    - Importance of Intercourse
        - Not Important
    - Importance of Orgasm
        - Orgasm not Important
- Sex or Feeling as Obligation or Duty
- Sexual Expectations
    - Pressure to Perform

        - Sex Should be Easy
        - Should Know How to Do This
        - Subject's Expectations Re Sex
- Sexual Dysfunction
    - Definition of Sexual Dysfunction
        - Erectile Dysfunction
        - General
        - Individual
        - Lack of Orgasm
        - Low Desire
        - Other
        - Pain
        - Unable to Have Intercourse
    - Female Viagra
        - Ambivalent About Taking It
        - General
        - Would Take It
        - Wouldn't Take It
    - Having a Sexual Dysfunction
        - Don't Have One
        - Don't Know
        - Have One
    - Male vs Female Sexual Problems
        - Significance Is Different
        - Men's are More Visible
        - Men's are Physical, Women's Are Psych
        - No Difference
        - Other
    - Other
    - Something That Happens to Older Women
- Sexual Identity
    - Asexuality
        - Compared to Other Sexual Orientations
        - Forming Identity
        - I'm Not Alone
        - Other
        - There's Nothing Wrong With Me
    - Feeling Less Sexually Attractive
    - Less of A Sexual Being
    - No Effect
    - Other
    - Queerness

        - Being With Women vs. Being With Men
        - Effect on Perception of Condition
        - Other
        - Penetrative Sex Is Still Important
        - Societal Expectations
- Strategies
    - Accept It
    - Avoid Sex
        - Avoid Physical Affection
        - General
        - Refuse Sex
    - Biomedicalized
        - Alternative Medicine
            - Acupuncture
            - Herbal Supplements
            - Hypnosis
            - Meditation
            - Other
            - Yoga
        - Biomedical - Drugs
            - Antibiotics
            - Antidepressants
            - Antihistamines
            - Botox
            - estrogen cream
            - Hormones - Other
            - interferon shot
            - lidocaine
            - Neurontin - Anti-Seizure
            - Other
            - Side Effects
            - Steroids
            - Yeast Medicine
        - Biomedical - Surgery
        - Diet
        - Physical Therapy
            - Biofeedback
            - Dilators
            - Side effects
        - Stopping or Switching Birth Control
    - Didn't Want to Try

        - Diet
        - Drugs
        - Other
        - Physical Therapy
        - Sexual
        - Surgery
            - FGM
- Faking vs. Not Faking
    - Can't or Won't Fake
    - Fake Desire or Enthusiasm
    - Fake Orgasm
    - Need To Prove It to Him
- Have Sex Though It Hurts
    - Guilt, Sense of Obligation
    - Maybe It Will Be Better
    - Other
    - Pain is Tolerable
    - Partner Didn't Care, Pressure from Partner
    - Want to Please Partner
- Have Sex When Don't Want To
    - Do It Until You Get Into It
    - Guilt, Sense of Obligation
    - Other Reason
    - Pressure From Partner
    - Want to Please Partner
- Relationship-Oriented
    - Compensate - Non-Sexual
    - Work on Relationship
- Sexual Strategies
    - Alternative Behaviors
        - Anal
        - BDSM
        - Cunnilingus
        - Manual
        - Other Partner
        - Fantasy
        - Focus on Partner
        - Get to Know Own Body or Masturbate
        - Instruct Partner
        - Lube
        - Other

                - Pornography
                - Positions
                - Sex Toys (With Others)
                - Try New Things
        - Other
        - Psychologized
        - Drugs or Alcohol
        - Improve Feeling Sexy
        - Relax
        - Vulvar Care
- Talking About Experiences With Others
    - Comparisons With Other Women (Negative)
        - Negative
        - Positive
        - Don't Compare Self To Other Women
    - Disclosure
        - Others' Reactions
    - Don't Want to Talk About It
    - Internet Forums
    - Support Groups