COMMENTARY

The pink Viagra story

We have the drug, but what's the disease?

Leonore Tiefer

> Ever since Viagra put a spring in the step of millions of impotent men after coming onto the market in March, attention has been focused on the more mysterious key to sexual gratification among women.
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> *Sunday Times*, 19 July 1998

Another way to put this would be, 'Ever since Viagra proved to the pharmaceutical industry that contemporary sexual confusions and dissatisfactions could be medicalized and marketed (to the sweet cash-register ring of billions of dollars and euros), companies have been searching for some way to make women into sex-problem consumer-patients.' News media around the world have tirelessly chronicled the 'hunt for the female Viagra', which, as of the date of writing (June 2003), still lacks a definitive quarry.

The problem has been that before pink Viagras or other such products could be tested, approved and sold to the public, there had to be clarity on exactly what disease or disorder the drug would be treating. And despite huge industry expense and the involvement of multitudes of doctors, marketers and health journalists, there has been no consensus on a targetable women's sexual disorder that could work for the industry in the same way that men's erectile dysfunction had. Clarifying women's sexual function and dysfunction has become not only complicated, but contentious, and therein lies an interesting story about sexuality, medicalization, globalization and feminism.

Sexual options become more interesting every day. Now we have reality shows on television that not only showcase sexual attractiveness, but feature real (maybe) longing, lust, pursuit, rejection and jealousy along with the endless expanses of flesh. For seemingly insatiable audiences of men and women, gay and straight, old and young, mass media offer a continuous Roman orgy. Background social shifts such as increased longevity, a new freedom of choice about relationships, and new goals for recreation and physical well-being set the stage for changes in sexual life. Publicity about HIV–AIDS and campaigns against international sexual trafficking make the public aware of how diverse and driven sexual life can be. And then there are the ever-present stories about celebrities' sexual lives which have filled the press since the time of penny papers. Results of social-science surveys, perhaps stimulated by publicity about new drugs and the apparent primacy of sexual life for the ubiquitous celebrities, show that ordinary people expect more in the way of perfect performance from their sexual lives than they used to.

Ironically, all this sexuality promotion coexists with only the most rudimentary sexuality education in most regions, save Scandinavia and Northern Europe. The idea of comprehensive sexuality education that would include an understanding of identities, bodies and relationships; introduce cross-cultural variation; and dispassionately describe value systems, is certainly lacking in both the USA and the UK. People are somehow supposed to be able to figure out the vicissitudes of sexual life from their own experience, the teachings of family and other authorities, and the hyped and confusing messages from the media. Good luck.

Midwifing 'female sexual dysfunction'

The dilemmas and anxieties of contemporary sexual life create a variety of markets, not least of which is a medical market for obtaining sexual information and managing sexual uncertainty and dissatisfaction. As women's sexual entitlement (at least in industrialized nations) grew through the 1970s and 1980s, women were freer to pursue sex. But what sex would they pursue? What forms would satisfaction take?

Orgasm had widely become the presumed measure of women's satisfaction in both feminist writing and sex research by the middle 1970s. Revoking Freud's dismissal of clitoral pleasure was a major feminist triumph and segued into the assumption that orgasm should be as important and valued for women as it is for men. Some feminists argued that orgasm could become a new tyranny and source of pressure, but sexual self-determination without goalposts was too anarchic to become popular. By the late 1990s, physicians gathered at meetings sponsored by the pharmaceutical industry to discuss the complaints they were hearing from women about low sexual interest and difficulty with arousal and orgasm. In some cases, these seemed to be women with a history of disease or medical treatment (surgery, chemotherapy) who felt newly emboldened to raise sexual complaints and newly hopeful about medical remedies. In most cases, however, these were women whose complaints lacked identifiable medical causes, whose expectations had been raised by the media, who had partners who expected more from them, and who turned for advice and relief to physicians as a result of 'disease awareness campaigns' that suggested doctors had something to offer in the way of sexual health.

Instead of taking the new public interest in women's sexual life as an opportunity for collaborative research with feminist scholars, social scientists and relationship experts, however, leading physicians and sexologists allowed themselves to be drawn into a narrowly focused industry-dominated perspective whose sole purpose was developing a medical–sexual rhetoric suited for new diagnoses and new drugs. By 1998, experts in secret industry-sponsored meetings were refining a list of sexual disorders for women – too little desire, problems with arousal and orgasm, pain; basically the same list as for men – that made sex into a medical function like digestion, and opened the gates to over-the-counter and prescription-only products. The list of disorders became a new problem, 'female sexual dysfunction', and journalists began to follow the story of the search for its treatments with article like 'Rx for Sex', 'The science of "O"', 'Designing women', and 'The search for the Lady Viagra'.[1]

Unexpectedly, however, there were problems in the drug development process, and, after five years of intense effort, surprised physicians and researchers are now saying that women's sexual function and satisfaction are mysterious, complicated, and certainly different from men's.[2] The favourite slide at sexology conferences around the world these days shows two metal boxes, one with a single up-and-down switch, and the other with many knobs and buttons of different shapes and sizes. The first box is labelled 'The Man', and the second 'The Woman'. Does this sound familiar? 'What DO women want?'

The stumbling block turned out to involve both diagnosis and new drug evaluation. The drug evaluation problem was what measure of outcome to use in clinical trials for women. For erectile problems in men, drug companies basically just asked, 'is it harder?' and 'does it last longer?' The answers were quantifiable and statistics could be used to show whether drugs 'worked' or not. But as women lack a penis or other visible sign of sexual functioning, their sexual satisfactions turned out to be more difficult to measure. Should success of a drug for women be gauged by more orgasms? More sexual encounters? Higher self-reported arousal or pleasure?

The US Food and Drug Administration says it will reject purely physical measures like genital temperature and blood flow in assessing drug trial results. But it will also reject purely subjective measures like 'enjoys sex more'. The smart money is on statistically validated questionnaires that combine event-counting and subjective assessment. The first drug consistently and reliably to reduce 'sexual distress' in women with defined complaints of sexual arousal or desire will probably be approved to treat 'female sexual dysfunction'.

Yet the bigger problem has turned out to be channelling women's sexual complaints into specific diagnoses – hence the many knobs and buttons. It turns out that the list of sexual disorders for women developed in the industry-sponsored meetings – too little desire, problems with arousal and orgasm, pain – don't work too well. There are no unambiguous biological measures to slot women into one category or another, and women's own descriptions of arousal and desire often overlap. Many women report several complaints. Moreover, although drugs tested so far frequently affect genital measures of blood flow, they don't improve sexual distress and satisfaction ratings. This has led to scientists' epiphany that women's sexual lives are contextualized – that is, that sexual experience depends as much or more on social context (relationship, cultural background, past sexual experiences) as on genital functioning. This is news?

Backlash against big Pharma

The explanation that 'women are different' has both advantages and disadvantages for progressive sexual medicine. Looking at social context could bring awareness and attention to issues of sexual abuse and assault, insecure body image, anxiety and depression, lack of sexual knowledge and access to reproductive health care, and the many ways in which male supremacy still thrives in sexual life. Improving these 'contextual' matters will unquestionably improve women's sexual opportunities for pleasure and satisfaction. I suspect clinical trials repeatedly report equivalent responses to placebos as to active drugs because of the sex education and encouragement that are part of the trial.[3] I would think a doctor with a clipboard cooing, 'Gee, that's great, let's see how you do next week', could go a long way in correcting a disadvantageous context – at least temporarily.

Eventually, researchers might recognize that sexual life is contextualized for both men and women, and that men are not simply sexual robots. Men's social privilege allows their context to be invisible, like being a fish in water or a rich shopper in Saks Fifth Avenue. Cultural entitlements for men to be sexual and scripts that call for men to initiate sexual encounters favour men's arousal. Similarly, the 'coital imperative' and the active role men take in sex make it likely that men will regularly experience pleasure and orgasm in their encounters. Men aren't simply lucky in their biology; they have the context going for them.

The disadvantage of the new 'women are different' rhetoric, of course, is that it naturalizes the categories of 'men' and 'women', produces endless ghastly sociobiologizing, and may never lead physicians and researchers to the awareness that sexual life is contextualized for everyone. Women's sexuality can be ghettoized by any theory, and I can imagine a generation of experts in new women's sexual health centres teach-

ing the 'men are from Mars, women are from Venus' philosophy that women's sexuality is relational and contextual and touchy-feely. That would be terrible.

The global pharmaceutical industry is extremely large, wealthy and powerful. A temporary delay in developing the perfect outcome measure for drug trials or in creating workable diagnostic categories for recruiting patients for those trials may be no more than just a temporary delay. It may be – it probably will be – that, in a year or two, female arousal and desire drugs will be as widely available and as widely praised as Viagra and the Viagra wannabes now emerging from Lilly and Bayer. But the search for the pink Viagra is occurring just as a new backlash against the global pharmaceutical industry is picking up steam. Editorials in medical journals (for example, 'Is Academic Medicine For Sale', in the 2000 *New England Journal of Medicine*) and entire issues of the *British Medical Journal* (for example, 13 April 2002 on 'Too Much Medicine' and 31 May 2003 on 'No Free Lunch') indicate that aspects of the medical community are opposed to excessive pharmaceutical industry involvement in advertisement, medical research, training, organizations, publications and continuing education.[4]

This backlash dovetails with the analysis and critique of 'medicalization' over the past several decades within sociology, the women's health movement, the 'anti-psychiatry' movement, and, newly, from cultural historians examining the social construction of illness and disease. All these scholars argue that the medical model, with its hallmark elements of mind–body dualism, universalism, individualism and biological reduction, is not well suited to many of the challenges of contemporary life and suffering. Yet, at the same time, patient advocacy groups are clamouring for medical legitimacy, increased funding and research, and, above all, new drug treatments. And the drug industry continues to expand.

Allying with the backlash, I convened a 'Campaign for a New View of Women's Sexual Problems' in 2000 to provide a feminist anti-medicalization perspective in the debate about 'female sexual dysfunction'.[5] Salvation is in the struggle, they say, but I still think I'll live to see that pink pill.

Notes

1. Many 'pink Viagra' stories, especially ones including criticism, are listed on and linked to www.fsd-alert.org/press.html.
2. Mary Duenwald, 'Effort to Make Sex Drug for Women Challenges Experts', *New York Times*, 25 March 2003, p. F5.
3. A recent American Urological Association conference abstract (May 2003) reported that a cream for FSD improved things 50–60 per cent depending on dose, but that the placebo improved things 54 per cent. A high placebo rate is also found in the erectile dysfunction literature.
4. Links to medical literature publications on the backlash against the pharmaceutical industry can be found in section IV on www.fsd-alert.org/links.html.
5. http://www.fsd-alert.org.