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## Sexually “Broken”: The Rhetorical Production of The Distressed Nonsexual in The Flibanserin Debate & Beyond

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## **Abstract**

Using a Foucauldian-influenced approach to discourse and power, this thesis analyzes the production of nonsexualities, such as the lack of sexual desire, in the contemporary United States. In psychiatric discourse, the distressed nonsexual subject is produced as the patient with Hypoactive Sexual Desire Disorder (HSDD). This discursive formation was put to use in the debate surrounding pharmaceutical drug flibanserin (Addyi) in order to secure its approval by the FDA in 2015. I posit that, by emphasizing the distress of the HSDD patient experience, the rhetoric of pro-flibanserin advocacy succeeded in producing an ethical exigency, arguing that it would be cruel for the FDA to reject the drug. Centrally, its support for this claim relies upon the construction of an ideal (hetero)sexual marriage and problematizing nonsexuality as a threat to love. Flibanserin's rhetorical support depended, then, upon casting nonsexuality in the role of a destructive enemy force. As a counter-discourse, the discourse of the asexual community—which produces “asexuality” as a sexual orientation—codifies a point of resistance to these claims.

*Sexually “Broken”: The Rhetorical Production of The Distressed Nonsexual in The Flibanserin*

*Debate & Beyond*

by

H. Helene Thompson

B.A. Southwestern University, 2015

Thesis

Submitted in partial fulfillment of the requirements for the Degree of Master of Arts in

Communication and Rhetorical Studies

Syracuse University

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# Table of Contents

Chapter 1: Introduction .....	1
Medical Rhetoric.....	4
Asexuality Studies .....	5
Sexuality & Sexual Norms .....	8
Object One: HSDD and the Flibanserin Hearing .....	9
Object Two: Asexuality and the Asexual Community .....	11
Onward: A Summary of Purpose .....	15
Chapter 2: Broken .....	16
A Breaking Point.....	16
The Emergence of HSDD .....	18
The Development of Flibanserin.....	22
Dueling Feminisms in the Flibanserin Debate.....	26
Even the Score (Pro-Flibanserin).....	26
The New View Campaign (Anti-Flibanserin) .....	29
The 2015 FDA Hearing .....	34
Heterosexual, Monogamous, Stable Marriage .....	36
The Distressed Woman .....	40
She Is Broken.....	44
What a Wife Should Want .....	46
Duty Sex .....	50
No Other Option for an Unmet Need .....	56
Conclusion.....	60
Epilogue.....	62
Chapter 3: Mended .....	65
New Orientations.....	65
Emergence of the Asexual Community.....	66
Asexual Community Demographics & Lexicon .....	67
Demographics .....	67
A Sexual Orientation .....	69
Some Do, Some Don't.....	71
Aces with Multiple Orientations .....	72

Asexual Narratives of Distress .....	74
Asexual Narratives of Medicalization .....	77
Asexual Accounts of HSDD .....	79
Asexual Accounts of Flibanserin .....	81
Asexuals in Love .....	83
Narratives of Relationship Tensions .....	84
Positive Narratives of Nonsexual Love.....	87
Conclusion.....	88
Chapter 4: To Freely Give Zero Fucks.....	91
The Distressed Nonsexual Subject(s) .....	92
Future Directions .....	96
The Repressive Hypothesis .....	98
References .....	101
Vita .....	121

## Chapter 1: Introduction

“You’re the only one who took the asexual literature,” a man says of the small green parade flyer. “I avoided it like the plague. I thought, that’s scary.”

Later, a fellow parade participant says, “You’re polluting my mind,” and hands the flyer back. “You know what, I totally respect you though. Just give us twenty feet, okay?”

Another more bluntly proclaims, “I pity your poor soul.”

These responses of disgust and pity directed at asexual participants in the San Francisco Pride Parade represent just some of the stigma demonstrated in the 2011 documentary *(A)sexual*. In the context of the film, these responses, including the pity response, is framed at odds with the goals of the pride participants—to inform and promote acceptance of asexuality as nothing more and nothing less than another sexual orientation. By contrast, the pity response would also later be deliberately, intentionally invoked by proponents of flibanserin, a new medication to treat Hyposexual Desire Disorder, as a part of a broader rhetorical strategy to sway an ambivalent Food and Drug Administration.

Is low sexual desire or any other “absent” experience of sexuality a condition worthy of pity? How should it be conceptualized? As an identity? As a medical disorder? Either? Both? Does it need to be cured? *Can* it be cured? Is it wrong to attempt a cure, or is it more wrong to withhold the option? These are questions that have circulated in relation to asexuality-as-identity and HSDD-as-diagnosis both, two very different discursively-produced ways of understanding an overlapping range of experience. However, the salience of these questions

raised its stakes with the recent development of flibanserin (Addyi), a pharmaceutical drug for HSDD in premenopausal women, ultimately leading to its approval by the FDA in the year 2015.

Taking this recent debate as a case study, I am pursuing the following primary questions. How have nonsexualities been rhetorically produced as a medical problem in the modern United States? How has the uptake of this understanding been contested, in official contexts? Outside of those official contexts, how has the medicalization of nonsexuality been taken up or renegotiated by the asexual community? These questions are guided by a broader investment in the rhetoric of medicine, wherein lines between “hard fact” and “persuasion” begin to blur.

Feminist and queer theory are also important antecedents to this study for their problematizing of sexual norms and critiques of the family. As a continuation of those traditions, this particular case study contributes to current theorizing on sexuality by posing a challenge to an exclusive emphasis on negative, juridical power (power in terms of laws and prohibition). Further, this thesis introduces asexuality to studies of medical rhetoric and contributes to theorization of the sexual norms which produce the nonsexual subject’s distress.

Although beyond the scope of the present analysis, the category of “distress” also holds contested salience in broader disability activism (see Mulvany 2000; Anderson et al. 2012; Spandler et al. 2015). Is medical “correction” enabling, in part for a resolution of pain and distress, or is the reliance on medical intervention and a deficit model complicit with oppression of disabled people? No certain answers are offered here, although the contested medicalization of nonsexualities will reflect some parallels to that debate.

Before I proceed, I will note here how I am using certain terminology. By nonsexualities, I am referring to a range of possible “abnormal” (non)-experiences of sexuality, such as keeping



celibacy, a disinterest in sex, and experiencing any of a range of (what are medically understood as) sexual “dysfunctions.” “Nonsexualities” will serve as my umbrella term for any experience of absence, lack, “low”ness, or negation with regards to human sexuality, intentionally broad to address a range of distinct but interrelated discursive phenomenon. In other words, nonsexualities may or may not be diagnosed as HSDD or become identified as asexuality based on which discourse is brought to bear as a lens for interpretation. I am using this term not to imply that there is any true essential experience “outside” or “before” the discourse is applied, but rather, to isolate and condense a range of components that the two objects share in common between them. This serves the convenience of future reference, as this more broadly-defined umbrella allows me to reserve the term “asexual” as a self-chosen designation describing an identity rather than a discrete, specific kind of experience or behavior.

In delving into medical discourse and medical conceptualizations of nonsexuality, I will be primarily analyzing the diagnostic category of Hypoactive Sexual Desire Disorder (HSDD). To a lesser extent, Female Sexual Dysfunction (FSD) and Female Sexual Interest/Arousal Disorder (FSIAD) are relevant as well. Each of these diagnostic labels shares overlapping criteria, though their exact definitions and names have been a matter of frequent revision.

Lastly, the term “asexuality” is here being used exclusively to refer to a voluntarily-applied identity label, conceptualized as a sexual orientation, like bisexuality or heterosexuality. This may not be the only way that the word “asexual” has been used in the English language in reference to humans or human sexuality. Nonetheless, it is the focus of how this particular analysis will proceed, in reference to the emergence of the self-identified asexual community as a counter-discourse to medicalization.

## Medical Rhetoric

In the year 2000, sex researcher Leonore Tiefer warned us that sexology was in danger of “co-optation” by the pharmaceutical industry. I regret to reply that this warning may have been too little, too late. Although I believe the 2015 FDA approval of flibanserin marks a significant step in that history, the relationship between sex, gender, and the medical field at large extends far back before the turn of the millennium. Feminists and gender scholars have already set ample precedent for analyzing medical discourse, especially gendered medical discourse, as rhetorical and loaded with value judgements. One of the groundbreaking texts here is *Women and Madness* by Phyllis Chesler (1972), who put forth a feminist criticism of contemporary psychology. More recent scholarship includes documenting the medicalization of infertility (Jensen 2015), a rhetorical history of “hysteria” (Koerber 2018), the rhetoric of midwifery (Lay 2000), the pathologization of abortion (Stoermer 2015), and the absurdity of nymphomania and its breadth of diagnostic criteria, even noting some doctor’s attribution of it to frigidity(!) as a suspected cause (Groneman 1994).

In order to approach medical diagnoses such as female HSDD and FSD as cultural phenomena with a social history, it makes sense to trace their roots according to feminist scholarship on the medicalization of female sexual refusal and the figure of the unmarried women. Chesler (1972) stands as, again, one of the early writers on gender and frigidity, arguing that “most clinicians have tried to help their female patients... by counseling a joyous and/or philosophical acceptance of the female role as envisioned and enforced by men” (47). Scholars such as Margolin (2017) have already argued that the various historical definitions of

“frigidity” as a medical term share a misogynist common thread, as part of (or positioned in contrast to) a patriarchal construction of ideal/“normal” female sexuality in mid-twentieth century medical discourse. Similarly, Giami (2015) argues that the classifications of sexual disorders may be understood as “representations of contemporary sexuality and gender relations.” The specific diagnoses of HSDD and FSD and their histories have been analyzed before (Cacchioni 2007; Jutel 2010; Angel 2010), but rarely have these conversations taken asexuality into consideration in earnest—and where they have, they have not specifically addressed the flibanserin debate (Chasin 2017; Hinterliter 2013).

Conversely, the recent scholarship on the rhetoric of the flibanserin debate has not adequately addressed the response of the asexual community as an overlooked resource for the opposition, although scholars do offer salient critiques of strategies of flibanserin advocacy. Judy Segal (2015) critiques pro-flibanserin advocacy as “faux feminism;” likewise, scholars have cited it as an example of overmedicalization (Chanska and Grunt-Mejer 2016), of “choice” rhetoric as a tool of neoliberalism (Rutherford 2018), and of heteronormative futurity (Floore 2018). In the aftermath of the approval, Segal has argued that the case had already been won from the beginning, in part because the axiom that “sex is health” is seldom questioned (2018, 475).

### **Asexuality Studies**

Segal’s point may be true in dominant medical discourse. However, the claim that “sex is health” is *frequently* questioned within the small, niche area of discourse that is the asexual community, as has been well-accounted for in asexuality studies. By “asexuality studies” I am

referring to a recent, small but growing body of scholarship explicitly spotlighting asexuality and other nonsexualities in light of the emergence of an asexual community: a community of people that explicitly self-describe their sexual orientations in terms of “asexuality,” “the asexual spectrum,” or “the asexual umbrella.” In relation to the emergence of this community, scholars who devote attention to it have regularly negotiated its place in relation to contemporary discourses of health, both technical and popular. Among sexologists, some already do study and advocate in favor of accepting asexuality as a healthy status (Brotto and Yule 2017; Conley-Fonda and Leisher 2018), which sometimes has involved contrasting asexuality against diagnoses such as HSDD and FSIAD (Hinterliter 2013; Stelman and Hertlein 2016; Chasin 2017). In gender and sexuality studies, scholars have begun to document the representation of asexuality in fictional media, wherein asexuality is regularly disparaged and pathologized. In one memorable example, the protagonist of *House, M.D.* declares that anyone who doesn’t want sex is either “sick, dead, or lying” (Gupta and Cerankowski 2018, 21; Sinwell 2014). Explorations of the conditions that led to the formation of the asexual community and the political salience of asexuality frames the identity in terms of resistance to pathologizing societal norms (Przybylo 2011; Chasin 2015; Gupta 2017).

Scholars in asexual studies have even critiqued discourses of nonsexuality in other, more explicitly critical, political rhetoric. Examples of this include feminist rhetoric of sexual liberation (Milks 2014), feminist and queer scholars’ rejection of the possibility of a lesbian asexuality (Gupta 2013), and the use of the term “asexual” to describe a denial of agency central to the Black female stereotype of the Mammy (Owen 2018). In an article that addresses asexuality’s “implications for theory and practice,” Cerankowski and Milks (2010) carefully respond to

Michael Warner's assertion that gay men "cannot be expected to live asexual lives." As they acknowledge, the context of this quote clearly indicates that Warner is addressing the punitive pressure on gay men in public life, but they also invite theorists to consider how an asexual gay man would "fit into this rubric of queer politics" his claim implies. Is asexuality necessarily only assimilationist, or is there room for theorizing a queer asexuality as well? The existing work on these intersections brings important insights. However, owing to the prominence of medicalization, perhaps the most salient of these intersections for the purposes of my own analysis is the intersection of asexuality and disability.

As asexuality scholarship has established, the discourses of asexual advocacy and disability rights viewed in tandem poses both affordances and tensions. For instance, Cuthbert's sociological interviews of disabled asexuals reports on interviewee's concerns about the intersections of disability and asexuality in their personal lives, including some informants' fears that their disability may make the asexual community "look bad" or that being openly "out" may "confirm the stereotype" that intertwines normative health with normative sexuality (2017, 251). In these ways, disabled asexuals may worry about stigma within and without the ace community that could leverage them against asexuality's "validity" as an acceptable, "healthy" identity. More broadly, asexual scholarship has addressed the rhetoric of mutual foreclosure between asexuality and disability (Kim 2014; Gupta 2014; Lund and Johnson 2015; Cuthbert 2017)—what Eunjung Kim calls "the tendency to deny any connection out of fear that the stigma associated with one might attach to the other" (2011, 480).

For the most part, these critical interventions in asexuality studies derive from such disciplines as women's and gender studies, critical race studies, and disability studies.

Asexuality has yet to be approached explicitly in terms of communication and rhetoric per se. Accordingly, this project introduces a rhetorical perspective to asexuality studies as much as it introduces asexuality to the study of rhetoric.

### **Sexuality & Sexual Norms**

It is from both within and without this field asexuality studies that scholars have theorized a crucial concept that influences my approach to this project—a concept that has gone by many names. Among asexual scholars, the terms in use have included “compulsory sexuality,” in direct reference to Adrienne Rich’s “compulsory heterosexuality” (1980). Compulsory sexuality is defined variously as “the pervasive cultural assumption... that everyone is defined by some kind of sexual attraction,” (Emens 2018), “the privileging of sexuality and the marginalizing of nonsexuality,” (Gupta 2017), or “the social expectation that sexuality is a universal norm” that all must adhere to (Przybylo 2016). Further definitions describe it as “the assumption that all people are sexual,” those norms and practices that marginalize nonsexualities and “compel people to experience themselves as desiring subjects,” or the construction of sexuality, sex, and orgasm as “health-promoting” aspects of a whole and healed selfhood (Gupta 2015, Barounis 2014). Similar concepts have gone by the name of sex-normativity or sexual-normativity (Gupta 2013; Carrigan 2011). Outside of asexuality studies, researchers writing on sex advice books and sex manuals have used the terms “the sexual imperative” and “the coital imperative” to describe presenting an absence of sexual activity in a couple’s relationship as a problem warranting the manuals’ proffered “solutions” (Barker et al. 2018; see also Neuhaus 2000 on “the importance of being orgasmic”).

Together, all of these terms (compulsory sexuality, sex-normativity, the sexual imperative) can be contrasted against what Fahs (2014) calls “freedom from” sexual coercion, as contrasted with “freedom to” sexual expression. In other words: to take on this concept is to take seriously the idea of power as “productive” in a Foucauldian sense.

### **Object One: HSDD and the Flibanserin Hearing**

To answer my research questions, I am using the flibanserin debate as a case study. Flibanserin, branded as Addyi, refers to a pharmaceutical drug intended for the treatment of Hypoactive Sexual Desire Disorder (HSDD) in premenopausal women. Flibanserin was only recently approved by the FDA in 2015, after two previous rejections on the basis of efficacy and safety. My first research object encompasses four primary sites of discourse in the debate: the two FDA hearings themselves (held in 2010 and 2015), the website for the Even the Score campaign (advocating in favor of flibanserin), and materials from the New View Campaign (advocating against).

Tracing a genealogy of frigidity and sexual disorders and the trajectory of flibanserin in particular, I approach these materials with a method patterned after Foucauldian analytics. For this purpose, I am looking to Michel Foucault’s larger project and approach to discourse—as exemplified in his work on the conceptualization of “madness,” the changes in the understandings and practices of criminal punishment, and the “explosion” of Victorian discourse on sexuality. One of Foucault’s interests lay in the way discourses circulate and codify ways of understanding and behaving, or relations of communication, knowledge, and power. To study these, he developed an analytics of power which considers the emergences of discourses,

their circulation, and the consequences of that circulation. In *The History of Sexuality*, Foucault asks, “What were the effects of power generated by what was said? What are the links between these discourses, these effects of power, and the pleasures that were invested by them? What knowledge (savoir) was formed as a result of this linkage?” (1990, 11). A Foucauldian discourse analysis charts discursive formations, or recurring regularities in the discourse, and how multiple components of a discourse are articulated to each other. This involves inquiring as to how subjects—or types of people, like “the madman” or “the homosexual”—become “known” in the discourse, in conjunction with how power is at work, as both a determiner and an outcome of how these subjects are understood.

The questions to orient this discourse analysis, then, lead with, “In a specific type of discourse on sex [...] what were the most immediate, the most local power relations at work? How did they make possible these kinds of discourses, and conversely, how were these discourses used to support power relations?” (Foucault 1990, 97). Power, here, refers to “a complex strategical situation in a particular society” which enables and is enabled by discourse (93). In other words, power is not a thing which is “had,” nor a strictly juridical force of negation and restriction, but a network of relations among people that makes certain practices possible, as encoded by how those things are talked about, a discourse.

With that said, power relations are not wholly deterministic. A Foucauldian conceptualization of power also acknowledges that “Where there is power, there is resistance,” (95). Power relations depend upon points of resistance to play the role of adversary, target, and more, inscribed in them as an irreducible opposite (95-96). When points of resistance are strategically codified, this is what makes revolution possible.



In medical discourse, there are select keywords that prominently figure in the construction of nonsexuality and how it is understood via diagnostic categories, or pathologized subject positions. The primary keywords in the flibanserin debate, specifically, are “distress” and “desire,” owing to a diagnostic category that directly figures *low sexual desire* as pathological when the patient regards that experience as a source of *distress*.

Because “distress” features among the DSM diagnostic criteria for HSDD, distress became an important keyword in the debate about whether or not “low or absent sexual desire” is a *serious* enough problem—and a medical enough problem—to warrant a pill for it. The debate over this question includes both third-party discussion of and first-person narratives of women who would qualify for the prescription of the drug flibanserin due to meeting the clinical criteria for Hypoactive Sexual Desire Disorder/Female Sexual Dysfunction. Accordingly, among the pro-flibanserin advocates, this discourse presents a singular understanding of a particular type of nonsexual subject: the distressed female subject who does not experience sexual desire. This discourse can be broken down into three main sub-formations: accounts of the nonsexual subject, accounts of her distress, and a pronouncement of the right solution to that distress.

### **Object Two: Asexuality and the Asexual Community**

A distinctly different discourse circulates within the asexual community, which operates on its own quite different production of the nonsexual subject and, I argue, is crucial to more completely understanding the fuller debate and how the proponents won. That is, the success of flibanserin at FDA hearing to prevent its eventual approval can be attributed in part to their

rhetorical production of the nonsexual subject and the opponents' inattention to disputing that production with an alternative. As a basis of contrast, I will analyze the discourse of the asexual community, which circulates its own production of the nonsexual subject, the subject's distress, and its solution.

In my use of the term here, "asexual" refers to a voluntarily-applied sexual identity, conceptualized both as a sexual orientation unto itself and as a "spectrum," which individuals may identify with for a range of reasons. This will be explored in more detail in the corresponding chapter, but for the sake of introduction, asexual identity may be understood as describing a "lack" or "absence" with regard to some aspect of sexuality. For instance, "no sexual attraction to any gender" is a commonly-offered definition, although even this may be considered an oversimplification and does not account for all who share the identity.

The corresponding chapter will present a discourse analysis of asexual community subject formation as a counter-discourse, which is to say, a discourse positioning itself directly counter to other productions of nonsexuality (such as HSDD). To locate asexual community discourse, I am drawing on personal narratives and didactic rhetoric from vernacular, popular, and non-academic sources including the Asexual Visibility and Education Network (AVEN), the available Asexual Community Census data, and the short list of vernacular asexuality books written by asexual authors (chiefly *The Invisible Orientation* by Julie Sondra Decker).

In order to form and grow its membership, the asexual community has engaged in practices of "consciousness raising," or the sharing of personal experiences as a means of restructuring of one's worldview (see Campbell 1999, 2002). Prototypical consciousness raising centers on personal narratives and makes the "personal political," illuminating that individual

problems may not be as unique or isolated of cases as they may have seemed. Identifying the strategy of consciousness-raising does not necessarily assume that there was always already a “true” consciousness to be raised. Rather, as a rhetorical process, it produces new frames for personal experience—in this case, the experience of “distress.” For the asexual community, consciousness raising has involved fostering the realization that one is “not alone” in the experience of nonsexuality, arguing that the absence of sexuality is nothing to be ashamed of, and advocating for more widespread acceptance of asexuality-as-identity.

A history of the development of the asexual (or “ace”) communities begins in the 1990s and early 2000s, via online websites hosted on such places as Yahoo groups, LiveJournal, and later, the Asexual Visibility and Education Network (AVEN). Owing to small numbers across a wide geographic distribution, the ace community as it is understood today remains a highly (though not exclusively) digital one, with an over 33% majority discovering the concept of asexual identity via online sources (Decker 2015; Bauer et al. 2016). A complete “history of asexuality” might reach back much farther, incorporating such brief acknowledgements as found within the Kinsey model and all mentions of asexuality in political movements such as radical feminism. With that said, for my purposes here I am focusing specifically on the contemporary, identity-based community organizing around “asexuality”-as-identity, as conceived of not by theorists or sexologists but by those who identify with it personally.

With this background established, I conduct a narrative analysis of asexual community discourse that mirrors the “distress” criterion for HSDD so heavily discussed by flibanserin proponents: the recurring self-describing as “broken.” This issue intertwines with the community discourse on pathologization and the question of a “cure,” as recurring objects of

concern. The flibanserin debate itself started to garner attention from the asexual community in the year 2015, most likely due to increased press coverage. In response, the asexual community debated the potential impact for asexual women—that is, whether or not HSDD and asexuality should be seen as two distinct phenomenon or, instead, different superficial descriptions for the same basic experiences, whether or not the criterion of “distress” is a sufficient distinguishing factor, and whether or not this drug should be regarded as a threat to the asexual community.

The term “asexuality” itself may not refer to a diagnosis, at least not in ace community usage, but the experiences that attract individuals to the label may overlap with the diagnostic criteria for various different disorders, including the aforementioned HSDD. This reason alone makes the flibanserin debate highly relevant to the concerns of the ace community. However, it is not the only reason. The ace community disproportionately shares other characteristics of the target demographic that flibanserin is intended for with regard to age, nationality, and gender. According to a recent community census, the ace community is disproportionately young (a majority under age 30), disproportionately citizens of the United States, and both disproportionately women (in gender identity) *and* disproportionately people whose assigned sex at birth was female (Bauer et al. 2018). This makes the asexual community already disproportionately relevant for any issues concerning the health of American premenopausal women (and “female bodies” according to a medical model of physical sex); flibanserin is targeted at exactly this same demographic.

At the intersection of all these factors, the asexual community demonstrates a highly salient alternative production of the nonsexual subject, an alternative construction of distress,

and an alternative solution, illuminating a range of rhetorical possibilities overlooked at the flibanserin hearing.

### **Onward: A Summary of Purpose**

In analyzing these objects, I am pursuing the following questions: How have nonsexualities been rhetorically produced as a medical problem in the modern United States? How has the uptake of this understanding been contested, in official contexts? Outside of those official contexts, how has the medicalization of nonsexuality been taken up or renegotiated by the asexual community?

For the drug flibanserin, intended to treat a form of nonsexuality, I posit that the rhetoric of flibanserin advocacy succeeded with the 2015 approval by producing an ethical exigency, arguing that it would be cruel for the FDA to reject it again. Centrally, its support for this claim relies upon the construction of an ideal (hetero)sexual marriage and problematizing nonsexuality as a threat to love. Flibanserin's rhetorical support depended, then, upon casting nonsexuality in the role of a destructive enemy force. As a counter-discourse, the discourse of the asexual community, which produces "asexuality" as a sexual orientation, codifies a point of resistance to these claims.

## *Chapter 2: Broken*

### The Rhetorical Production of the Distressed Nonsexual Subject in the Flibanserin Debate

#### **A Breaking Point**

It is not every day that the Journal of the American Medical Association publishes an article about rhetoric. Yet for Steven Woloshin and Lisa Schwartz (2016), the commentary was called for: after the FDA had already rejected the experimental drug flibanserin twice in years past, the 2015 decision to approve it came as enough of a surprise that, as medical professionals, they were compelled to ask, “What changed?” According to them, “Nothing about efficacy.” If anything, the new data pointed toward another dangerous drug interaction—one which even caused a severe drop in blood pressure for one trial participant, who lost consciousness and became unresponsive. Yet on this third and final appeal, the drug was approved by the FDA. In Woloshin and Schwartz’s article, they credited a promotional advocacy campaign and an overwhelming wave of rhetoric as the best explanation for the result.

In the field of rhetorical studies, several scholars have already criticized pro-flibanserin advocacy as deceptive and unethical rhetoric (Segal 2015; Chanska and Grunt-Mejer 2016; Gellad et al. 2015; Segal 2018). After the FDA decision, Judy Segal (2018) argued that the third attempt to win FDA approval had already won before it even began, primarily based on the discourse of the 2014 Patient-Focused Drug Development Meeting and the FDA’s own subsequent summary. She bases this claim on the clear evidence that even before the 2015 trial, the FDA already expressed a willingness to understand the HSDD patient as person with a

disorder and therefore in need of a drug. That is, they accepted it as a medical problem warranting a *pharmaceutical* response—while dismissing the objections of critics who suggested alternative conceptualizations (such as a culturally-induced anxiety, to be addressed with therapy). While Segal's and other critical analyses present many legitimate criticisms of the drug and the rhetoric of its advocates, to argue that “the case for approving flibanserin had been won before Sprout even submitted its application” is to write off the possibility of any other outcome.

On the contrary, I argue that the power relations enmeshed in the flibanserin case also contain their own potential points of resistance. The regularities in its discourse are “bound up more with circumstances than necessities, more arbitrary than self-evident, more a matter of complex, but temporary, historical circumstances” than with the inevitable (Foucault 2013, 156). As specious and scientifically ill-supported as the pro-flibanserin rhetoric was (and is), it benefited from a *strong, coherent narrative*, producing a clear singular problem with a clear singular response. In doing so, it relied upon universalizing claims that in other contexts have been disputed and disrupted. While prior scholarship on the flibanserin debate has justly highlighted concerning aspects of pro-flibanserin rhetoric, including the lies and the corporate misappropriation of feminist language, none of these have adequately addressed the proponents' central linchpin, simultaneously its biggest strength and its biggest vulnerability: the construction of sex as always, universally, inherently necessary for a happy romantic relationship.

In this chapter, I trace the emergence of Hyposexual Desire Disorder and the development of the drug approved to treat it, provide an overview of dueling feminist rhetorics

on opposing sides of the debate, and, chiefly, analyze the discourse of the decisive 2015 FDA hearing at which the drug flibanserin was approved. Within this discourse, proponent speakers issued sweeping, generalizing claims to knowing the nonsexual subject as an HSDD patient, biologically “broken,” in desperate need of pharmaceutical treatment. I argue that this subject construction, in addition to universalizing claims on the vital place of sex in marriage, was key to the drug’s eventual approval. When approached according to a Foucauldian analytics, these truth claims must be questioned on the level of both their tactical productivity and their strategical integration with regard to power, bearing consequences well beyond flibanserin for answering: What were the effects of power generated by what was said—and what was not?

In this chapter, I argue one of the most important effects of what was said was its production of a distressed nonsexual subject and its ethic of sexual obligation. First, I trace the discursive emergence of HSDD as a diagnostic category, followed by the development of flibanserin as a drug to treat it. As an introduction to the terrain of the flibanserin debate, I lay out the general rhetorical strategies of a proponent group, Even the Score, and an opponent group, the New View Campaign. From here, my analysis focuses in on the discourse of the decisive 2015 FDA hearing and the formation of a subject who is heterosexually married, greatly distressed by low desire, unable to fulfill a role she is expected to fulfill, and facing no other option for an unmet need.

### **The Emergence of HSDD**

The phrase “hypoactive sexual desire” to name a type of pathology was first proposed by Helen Singer Kaplan in 1977, during the same decade of “sexual liberation” discourse in



which Foucault published his *History of Sexuality*. In Kaplan's account, she explains both why she believes hypoactive sexual desire merits further study and how the matter came to her attention in the first place. Her interest in "low sexual desire" as a psychological problem emerged while studying "failures in sex therapy": the patient records on those who had undergone psychosexual therapy and nonetheless "failed" to "improve."<sup>1</sup> Nonetheless, Kaplan recounts that low sexual desire has been a significant contributing factor in "failure" and therefore suggests it is worthy of closer scrutiny, especially because such an experience "may be extremely distressful to patients and their partners." Kaplan goes on to compare desire for sex to appetite for food, in that it is possible both to have too much or too little, despite the plainly apparent fact that consuming too little in the way of calories has a much more drastic impact on an individual's health. What constitutes a "healthy" appetite may presumably be that which enables appropriate life-sustaining nutrition; by contrast, by what measure may we determine "normal" or "healthy" sexual desire? Kaplan herself acknowledges yet hesitates to provide a clear answer on this question. Outright, she states, "we do not know exactly what normal sexual desire is," yet she claims to avoid this conundrum by focusing exclusively only on "severe forms" at the margins (Kaplan 1977, 4-5).

As she outlines the details and manifestations of low desire, Kaplan also makes moves to explain what hypoactive sexual desire is not. For instance, low desire is considered situational and not pathological in the context of "becoming disillusioned" with a partner or developing interest in "someone other than the spouse." These do not qualify as hypoactive sexual desire, on her terms, for no reason given other than that they are simply normal.

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<sup>1</sup> Note that an operational definition for "failure" is not provided in the text.

Additionally, she defines low desire as a mental, psychological condition, *not* to be confused with physical capacity.

In fact Kaplan takes pains to explain that, despite hypoactive desire, some patients can and do have sex with their partners, on account of “fear of loss of the partner.” In her summary, “It is not uncommon for the partner of the low-libido patient to react with an obsessive concern about the situation and with severe depression, rage, and despair. A lack of sexual desire by one partner frequently precipitates the termination of a relationship” (Kaplan 1977, 6). Note despite the use of the word “obsessive” here by a psychological professional, the partner’s concern is clearly not aberrant in her eyes or even worthy of explanation. The problem, in Kaplan’s eyes, lies in the “lacking” individual, who she warns clinicians must be on the lookout for, because “there is a great deal of denial in this population” and “a person often denies that there is anything wrong because he or she does not want to make love.” Kaplan, of course, believes otherwise. An official diagnostic category reflecting this concept, under the name “Inhibited Sexual Desire,” was first added to the third edition of the Diagnostic and Statistical Manual (DSM-III) in 1980, later to be renamed Hypoactive Sexual Desire Disorder in the 1987 revision, and would continue to undergo alterations of terminology (Hinderliter 2013).

It was not until 1994, with the publication of the DSM-IV, that a criterion was added to HSDD that “the disturbance causes marked distress or interpersonal difficulty” (Hinterliter 2013). The word “distress” would continue to remain important, as would the acknowledgement of its “interpersonal” dimension, in that HSDD was diagnosed of the individual yet observed in the context of relationships. According to Andrew Hinderliter (2013), the APA added this criterion to over half the diagnoses listed in the DSM-IV in response to

studies which “had found rates of psychopathology in the general population that many felt to be too high.” One such recipient of this modification, then, was the diagnosis of HSDD, and although its exact wording would later be revised, this “distress” criterion would go on to become an important part of the discourse asserting the category’s legitimacy.

Despite following a different trajectory, this criterion places HSDD in a comparable situation to that of the history of homosexuality in the DSM, which was also once qualified with “distress.” As detailed by Jack Drescher (2015), this history begins with the very first edition of the DSM (DSM-I), published in 1952, listing “homosexuality” as a type of “sociopathy personality disturbance,” and although that definition would change, “homosexuality” per se would not be removed from subsequent editions until 1973. However, in its place, the DSM-II 6<sup>th</sup> printing included a “compromise” of sorts between those in the field who wanted it to be removed entirely and those affirmed its status as pathological: a new diagnosis labeled as “Sexual Orientation Disturbance (SOD),” which “regarded homosexuality as an illness if an individual with same-sex *attractions found them distressing and wanted to change*” (emphasis added) (571). SOD would later be renamed “Ego Dystonic Homosexuality” in 1980, and it would not be removed completely from the DSM until the revision released in 1987. As this poignant example demonstrates, the “distress” criterion in DSM classifications may sometimes be worthy of close scrutiny as either reflective of or a facilitation of the enforcement of arbitrary cultural norms. Therefore, although HSDD is technically limited to those who are “distressed” by low desire, this historical example shows that a “distress” criterion is not enough to separate a diagnostic category from cultural values or make “treatment” always the ethical response.

Sexual dysfunctions such as HSDD these would later experience a revival in interest after the licensing of Viagra in 1998, allowing for an understanding of and greater emphasis on sexual problems as biomedical in nature (Hartley 2006; Tiefer 2006; Angel 2010). The first instrument, or assessment method, for female HSDD was developed in 2005, labeled as the Sexual Interest and Desire Inventory-Female (SIDI-F) and funded by pharmaceutical company Boehringer Ingelheim (Sills et al. 2005; see Jutel 2010). A few years later, in 2009, the SIDI-F would be joined by Decreased Sexual Desire Screener (DSDS), also funded by Boehringer Ingelheim (Clayton et al. 2009).

Today, the DSM-5 (2013) has split HSDD by gender, creating separate listings for “Male Hypoactive Sexual Desire Disorder” and “Female Sexual Interest/Arousal Disorder.” Despite the dissimilar terminology, a note in the description for FSIAD indicates that male HSDD is considered the male equivalent of the same. The indication for flibanserin, however, still officially remains “female HSDD.” The current definition of Female Sexual Interest/Arousal Disorder in the DSM-5 (2013) is rife with exclusions and acknowledgements, not unlike those offered by Kaplan in 1977. With that said, its diagnostic criteria might be condensed into the following summary: at least six months of absent/reduced sexual 1) interest, 2) thoughts/fantasies, 3) initiation/receptiveness, 4) excitement/pleasure, 5) responsiveness, or 6) sensations—at least three out of these six—plus the experience of “clinically significant distress” at these symptoms.

### **The Development of Flibanserin**

Despite the fact that “female HSDD” no longer officially existed on the books after 2013, in 2015 a drug known as flibanserin (Addyi) was approved to treat it. As I will argue, the rhetoric of pro-flibanserin advocacy involved the production of a distressed nonsexual subject, which the anti-flibanserin advocacy neglected to adequately counter, even as almost every other point and claim in the debate was heavily contested. With so much in question, I am therefore writing this section to serve as a brief introduction to the most basic “facts” of the case: its origins, its prior rejections by the FDA, its efficacy, and its side effects.

A brief technical history of flibanserin begins with its origins as a drug being investigated for a different diagnosis altogether. Originally, one of its compounds, BIMT 17, was initially being researched for its potential as an antidepressant (Borsini et al. 1997; see also Jutel 2010). Early studies as to its actual effects was never officially published. However, evidentially the preliminary investigations suggested a different direction, as informally hailed in popular media reports, relaying that even though antidepressants are associated with a decrease in libido, researchers observed “rather than the expected decrease, an increase” (Jutel 2010). By the end of 2002, the pharmaceutical company Boehringer Ingelheim had filed a patent for flibanserin specifically as a method of treatment for Hypoactive Sexual Desire Disorder, and this patent was approved in 2006 (Borsini and Evans 2006).

Subsequently, the drug was tested more deliberately as a treatment for HSDD. The promising potential of flibanserin, however, would not pan out for Boehringer Ingelheim so easily. After the first NDA (New Drug Application) for flibanserin was filed, the FDA’s Advisory Committee for Reproductive Health Drugs met for a hearing in June of 2010 and voted 11 to 0

that the overall risk/benefit profile of flibanserin had not been proved acceptable. The drug was rejected.

After Boehringer Inegelhiem's failure to get the drug approved, the company officially halted development, but subsequently, another company called Sprout Pharmaceuticals, Inc. acquired the rights to flibanserin, and it filed a second New Drug Application with the FDA in 2013, this time with additional data (Burger 2010; News-Medical 2013). For the second time, the application was rejected for similar reasons as to the first: an unconvincing risk/benefit profile.

In each of these cases, the committee affirmed the reality and validity of HSDD as a condition that needed better treatment options, but they interpreted clinical trials as not supplying enough evidence in flibanserin's favor. How exactly to evaluate and interpret the results of those clinical trials, primarily conducted by Boehringer Ingelheim employees, was and remains a highly contested matter, in part owing to the ambiguity in evaluative notions of "effective enough" and "safe enough," but also owing to factors like multiple different efficacy measures, which makes even summarizing the results a complicated undertaking.

Is flibanserin "effective"? Yes and no. Different trials found varying results along different measures. Most recently, the main three drug trials ("Violet," "Begonia," and "Daisy") were conducted by researchers who, as the conflict of interest sections note, either received funding from Boehringer Ingelheim or were listed as BI full-time employees. Although as mentioned there were multiple measures, the trials may be summarized as demonstrating one half additional "satisfying sexual event" per month over placebo. A systematic review by

Jaspers et al. (2016), in the JAMA medical journal, summarizes the quality of evidence for its effectiveness as “very low.”

Today, as a result of the data gathered from these clinical trials, the side effects (or “adverse reactions”) officially listed on the Addyi (flibanserin) label are dizziness, somnolence (sleepiness), nausea, fatigue, insomnia, and dry mouth. The label also includes a boxed warning<sup>2</sup> that patients using the drug are not to consume alcohol, that the drug should not be taken alongside (strong or moderate) CYP3A4 inhibitors, and that it should not be taken by patients who have hepatic impairment. For each of these contraindications, the box explains, hepatic impairment, strong/moderate CYP3A4 inhibitors, and alcohol consumption can all increase the risk of hypotension (low blood pressure) and syncope (fainting). Note also, for reference, that oral contraceptives are considered weak CYP3A4 inhibitors, which raised questions as to whether or not the distinction between moderate and weak classes makes this fact irrelevant or whether or not a potential drug interaction between flibanserin and contraceptives deserved to be taken into account as well. Of these three official contraindications, the restriction on alcohol consumption is paired with the most detailed warning to prescribers, instructing them to assess the likelihood that the patient will actually abstain from alcohol and to advise them about the importance of heeding this warning.

2010: rejected. 2013: rejected. 2015: approved. Looking at the rhetoric of the proponents and opponents in the debate, I want to answer: What changed? Why did flibanserin get approved in the end? I argue it was not because of any change in the clinical data but

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<sup>2</sup> A boxed warning, or “black box warning,” is a severe warning label required by the FDA in certain cases—for instance, when there is a serious risk of adverse reaction.

instead because of a more developed rhetorical strategy that produced the distressed nonsexual subject as someone in dire need of a drug, any drug at all, no matter how modest the chances that it might increase desire. In the process, this rhetoric cultivated a sense of urgency to which the opposition at the hearing supplied no adequately convincing alternative. To make this argument, I will first provide an overview of the rhetorical strategies of the advocacy and opposition in the debate and explain how these strategies directly countered each other, as background leading up to the 2015 hearing. This overview will not be comprehensive, but rather, will provide a brief sketch of two different activists groups on opposing sides of the debate: Even the Score and the New View Campaign.

### **Dueling Feminisms in the Flibanserin Debate**

#### *Even the Score (Pro-Flibanserin)*

In 2014, a coalition joining together under the name of Even the Score began to respond to the ongoing flibanserin debate. Even the Score's campaign website describes itself as "a campaign for women's sexual health equity" formed out of a need to "level the playing field" with regard to the treatment of "sexual dysfunction." The name "Even the Score" itself refers to one of the organization's foundational claims: that there is an "uneven score," favoring men over women, with regard to the treatment of sexual dysfunction. According to Even the Score's count, prior to the summer of 2015, the US FDA had approved 26 drugs for male sexual dysfunctions and 0 for female sexual dysfunctions. Their campaign goals, accordingly, were to educate on the prevalence of women with sexual disorders (read: HSDD especially), advocate



against gender bias with regard to the FDA approval and rejection of sexual dysfunction treatments, and support the women affected.

The claim to an uneven “score” was just one of three essential claims made by Even the Score in regards to the flibanserin debate. First, foundationally, they affirmed the prevalence and scientific validity of HSDD. Even the Score’s 2014 iteration of its website prominently features the claim that 43% of women “suffer from sexual dysfunction,” with a footnote that simply cites the source as “FDA.gov.” More specifically, it says that 1 in 10 women suffer from HSDD, in contradiction with the DSM’s own note that the exact prevalence of HSDD remains unknown. These points bolster a sense of medical exigency, calling for a medical response.

Second, the campaign argued that there remains an inadequate status quo in terms of treatment options. Talk therapy, according to Even the Score, is not always enough. Sometimes sexual dysfunction is biological in origin and calls for a pharmaceutical response, i.e., a drug. At that time, they argued, that the lack of approved medications on the market for women’s sexual dysfunction should be understood as a component of gender inequality, and more specifically, they alleged that the previous two rejections of flibanserin may have been motivated by gender bias. In Even the Score’s narrative of events, the FDA has been unjustly obstructing women’s sexual health by denying treatments for women’s sexual dysfunction while holding treatments for male sexual dysfunction to a lighter standard. For instance, on their webpage entitled “The Problem,” they contrast Viagra against unnamed treatments for female sexual dysfunction:

The FDA approved the first drug for the treatment of men’s sexual dysfunction decades ago. Viagra, a household name, was approved in 1998. Sixteen years later, women are

still waiting for an FDA-approved solution of their own and they stand ready to support decision-makers and regulators who prioritize woman's health issues such as this one.

With such a drastic contrast, they constructed an account of FDA track record as disproportionately favoring men over women.

Third, they championed flibanserin as a worthy treatment for HSDD and more than deserving of an FDA approval, as supported by rhetoric invoking liberal values of equality, rights, progress, and freedom of choice. This same rhetoric, alongside the contrast with Viagra (as above), is further dramatized by a parody video published by Even The Score in 2014 entitled "What the F\*\*k?! – Hilarious Parody of Viagra Video." Weighing in on the flibanserin debate, but not acknowledging it by name, a blonde white woman in a seaside setting addresses a male viewership while lounging on a bed in a pink dress. Her speaking voice switches between two voices—a husky, "sexy" advertisement voice juxtaposed with a more natural sarcastic voice—as she describes a vast disparity between the medical options available to men (i.e. Viagra) versus women. Eventually she objects, "What the [censor bleep]? Are we really so far behind that we don't think women have the right to sexual desire?" The rhetorical question draws on a long tradition of social movement rhetoric to frame the current lack of HSDD drugs as "so far behind" a projection of linear progress and "sexual desire" as something we should recognize women's "right to," as a metaphorical application of legalistic/social movement language. The spokeswoman adds, with heavy-handed emphasis on the innuendo, "Yet again, we come second." As she concludes her main speech, she declares that "Women deserve better," the selfsame words which hover as a hashtag in the corner of the frame, as an invitation to further engagement on Twitter.

Despite the campaign's general commitment to "sexual dysfunction" issues, a casual perusal of their website will reveal a narrower focus on the diagnosis of HSDD, specifically, alongside ardent expressions of support for the drug flibanserin. This much can be seen on their FAQ page, which includes an answer to the question "What is HSDD?"—but *no other* introductory question-and-answer pair for any other sexual dysfunction diagnosis, such as vaginismus or female orgasmic disorder. This same FAQ implicitly acknowledges the campaign's primary focus on the flibanserin debate with another question: "Will Even the Score continue to exist after achieving the first-ever treatment for HSDD?" In context, the language here clearly uses "treatment" to mean "drug," as a way of implicitly discounting the relevance or efficacy of other existing treatments. As their answer attests, "Approval of a first-ever drug to treat women's most common sexual dysfunction will represent a huge step forward in our fight. But there is still a long way to go before we achieve true gender equity in sexual health – and Even the Score will be there every step of the way." As of approximately 2018, the website is now defunct, and the campaign appears to be no longer active.

As an advocacy group with representatives attending the FDA hearing, Even the Score set the tone for pro-flibanserin rhetoric, and several the above claims (ex. 26 to 0) were repeated at the hearing by those in support of approval.

### *The New View Campaign (Anti-Flibanserin)*

Eventually standing in opposition to Even the Score and flibanserin, the New View Campaign was founded in 2000. By 2014, the NVC had already played an active role in multiple issues in the realm of sexuality, ranging from organizing a street demonstration against female

genital cosmetic surgery, organizing an art exhibit in celebration of body diversity, and speaking out at FDA hearings in opposition to Intrinsa, a testosterone transdermal patch previously proposed for the treatment of FSD (female sexual dysfunction). The NVC would go on to oppose flibanserin as well, on the basis of “challenging the medicalization of sex.” In fact, the NVC had even participated in the 2010 flibanserin hearing, before the drug had been acquired by Sprout and before Even the Score had been formed. In the NVC’s account, Sprout (and before them, Boehringer Ingelheim) was the villain of the piece, not the FDA, and the FDA should stay the course with another rejection. Their strategy did not showcase the same slick consistency of Even the Score but can be roughly sorted in to three main categories: disputes of technical claims, attacking credibility, and gesturing to alternatives.

Steeping their claims in feminist rhetoric of a very different kind opposite Even the Score, they directly countered many of the claims made by flibanserin advocates and presented their own picture of Sprout as attempting to control women’s sexualities, only in it for the profit. For example, they challenged the “uneven score” or tally foundational to the Even the Score campaign as a bogus claim. As they also pointed out, while there was (at the time) no US-approved drug for female HSDD, there was (and is) no approved drug for male HSDD either—no drugs for *any* gender targeting “low desire” as a symptom. By the NVC’s count, there are instead only eight drugs approved for male sexual dysfunctions, and all of these are for the physical problem of erectile dysfunction, exclusively, as spelled out on the #DontNeedDrugsToScore campaign flyer jointly produced with Pharmed Out. As for where Even the Score gets its numbers from, the flyer alleges, “the ‘26 drugs’ have never been disclosed,” casting the claim as clearly suspect.

This allegation represents just one of many technical claims they made or disputed in response to pro-flibanserin advocacy. The NVC put together numerous “fact sheets” working to provide detailed counterpoints like the above and to point out faulty aspects of the clinical studies. For example, they point toward an aspect of the clinical trial design that may be likely to raise the placebo effect: the trial explicitly included a requirement to engage in sexual activity once a month, thus functionally dissuading individual outcomes involving less than one sexual event per month—holding women to a requirement to consciously try to have sex in order to remain in the trial, which the NVC suspects may have artificially inflated the results.

Secondly, another important prong to the NVC’s anti-flibanserin campaign was to attack the credibility of both Even the Score and Sprout Pharmaceuticals, impugning their motivations as financially motivated and exploitative. The NVC alleged that Even the Score and, relatedly, an organization involved with research on “female sexual dysfunction,” the International Society for the Study of Women’s Sexual Health (ISSWSH), were funded by the pharmaceutical industry and therefore far less credible. Both these groups, during the debate, repeated the statistic that “43% of women suffer from some form of sexual dysfunction,” which NVC labels as an outright lie. More specifically, the NVC sources the original claim to a 1994 study that “asked women a set of yes/no questions about sexual issues but did not inquire about distress,” not originally intended to stand in as a representation of “sexual dysfunction” or its prevalence as a whole. More broadly, they positioned Sprout’s efforts to win approval for flibanserin as a case of corporate corruption, pushing a faulty, unnecessary drug instead of being truly interested in women’s wellbeing.

The NVC devoted much of its attention to these two aspects of its strategy, debunking claims and attacking credibility, but it also interwove a third general component, gesturing to alternatives. As an aspect of Sprout's duplicity, the NVC harbored concerns that direct-to-consumer marketing could heighten or incite distress where there was none/less before, thereby drumming up more demand. In general, the NVC was much more inclined to characterize HSDD and other sexual problems as culturally, socially, and psychologically influenced. As contrasted with flibanserin' advocates emphasis on a biological etiology of low desire, the NVC raises the question of "what's sexually 'normal'?" and insists that "'normal' standards are strongly influenced by consumer culture" and changing social norms, which can lead to women to worry that their experiences are more abnormal than they really are. These various influences, in their eyes, included a broad range rather than conforming to a condensable narrative. With respects to flibanserin, this meant that a drug would not make sense as the appropriate form of treatment.

On the other hand, what *do* they suggest? The suggestions proffered are as similarly broad and vague as the causes, to the point of ambivalence as to whether low desire should be accepted as-is or instead corrected by other means. The NVC documents "Counter Narratives" and "Alternative Treatments" showcase extensive examples of this. For instance, the document entitled "Counter Narratives" begins with a section on "efficacy of diverse psychological treatments," largely psychological, therapeutic, and mindfulness-based treatments for "sexual difficulties" and "sexual dysfunction," despite a brief acknowledgement in another section on HSDD that "desire for sex and sexual fantasy are not universal experiences."

The shorter and more concise “Alternative Treatments” document emphasizes the comparable benefits and lack of side effects offered by “non-medical interventions.” Here “non-medical” implicitly means “non-pharmaceutical,” given that the very next point states “alternative treatments can be psychological, educational, psychophysical, or spiritual.” Listed below with implicit endorsement are couples counseling, sex therapy, cognitive-behavioral therapy, mindfulness training, physical therapy, tantra, yoga, sex education, and healthy relationship education. These are listed but not explored in further detail. The final “issue” raised on the “Alternative Treatments” factsheet is the issue of *prevention* of sexual disorders, before they can emerge to begin with. The NVC argues that not enough research has been done on this area and, in this section, implicitly communicates an association between sexual dysfunction and older age. For instance, they accuse direct-to-consumer advertising as promising “lifelong youthful sexual function” and glossing over “real and expected life conditions” (such as “changes post-menopause”). Here “sexual function” and its higher end of the range is clearly being associated with “youthfulness,” which provides a “natural” explanation for the older nonsexual subject, but *not* for the younger one. These two “fact sheets” are linked on the NVC’s “FDA 2014” webpage on the flibanserin debate, where the NVC’s outlook is summarized with bullet points that include “the failure of studies to study [sic] alternative, nonmedical causes of, and interventions for, women’s sexual complaints” and “the continuing confusion of ‘FSD’ terminology that actually reflects genuine diversity in women’s sexual experiences and problems.”

Between these two points, the NVC presents an ambivalent perspective on nonsexualities—potentially simply a part of “diversity,” potentially also a “sexual complaint”

calling for alternative “interventions” like yoga or therapy. These proffered options listed under the header of “Alternative Treatments” largely consist of, put simply, things that “already exist,” although access or quality in specific cases might be in question. However, the pro-flibanserin advocates argued that these existing options were proven in some cases ineffective, powerfully refuting the NVC’s point in such a way as would prove decisive to the entire case a whole.

### **The 2015 FDA Hearing**

After two prior rejections, the outcome of the 2015 FDA hearing on flibanserin was not a given. It was rhetoric, not clinical data, that made the difference. More specifically, though, it was rhetoric that created a sense of ethical urgency so strong that the committee was moved *to disregard* the clinical data; the distress of the nonsexual subject was discursively produced as too great to refuse patients the option they were begging for, no matter how little promise it held.

As the voting rationale statements given by the committee clearly show, the FDA committees’ perspective on flibanserin remained wary of an unsatisfactory risk/benefit profile after both the 2010 and 2015 hearings. At the June 2010 hearing, the FDA committee voted “No,” 10 to 1, on the question of whether or not the Applicant (Boehringer Ingelheim Pharmaceuticals) had proved enough evidence that the drug was effective, and they also voted “No” 11 to 0 on the question of whether or not the Applicant had demonstrated an acceptable risk/benefit profile. In other words, their ruling asserted that the current data didn’t make flibanserin look effective enough or safe enough. This wariness would remain at the next



hearing. In 2015, the committee voted on the question, “Is the overall benefit/risk profile of flibanserin acceptable to support approval for HSDD in premenopausal women?” and selected from three different choices—A) Yes, with labeling alone to manage the risks, B) Yes, but only if certain risk management options beyond labeling are implemented, and C) No. Of these three choices, not one member voted for A. Instead, a majority of 18 voted B, against 6 for C. As the voter rationale elaborates, the committee shared a drastically changed perspective on the *worth* of the drug even as strong reservations about its efficacy and safety remained.

From these votes and their stated rationale, it is clear that whatever the new clinical trials demonstrated, they did not fully assuage the concerns of the FDA about flibanserin’s relative risk/benefit profile, which is why we must look beyond the numbers to identify what made this approval possible. Based on the testimony delivered at that 2015 hearing, I argue that speakers in favor of flibanserin succeeded in persuading the committee with their construction of the distressed nonsexual subject, weaving a narrative which the opposition neglected to fully counter with any of its own. Pro-flibanserin advocacy drew heavily on personal and professional testimony of unbearable emotional distress, attributed to the experience of low sexual desire. In attempting to counter their case, the opposition at the hearing may have made some points worthy of consideration, but what they neglected to do at the hearing itself was offer any alternative account—anything to *disprove* the cries of “no other option”—for how to ethically respond to that distress. In order to prove this argument, I will analyze how the proponent effort thus constructed the distressed nonsexual subject as in need of pharmaceutical rescue. Below, I have broken the discourse apart into 1) the centrality of heterosexual, monogamous, stable marriage, 2) the discursive formation of distress, 3) the

figurative language of the nonsexual subject as “broken,” 4) the truth claims on the universal indispensability of sex is marriage, 5) the object of “duty sex” or marital sexual obligation, and, finally, 5) the narrative of no other treatment option, allowing advocates to construct a rejection of flibanserin as ethically unconscionable.

### *Heterosexual, Monogamous, Stable Marriage*

The production of the nonsexual subject by advocates at the hearing involved disproportionate, intentional attention to heterosexual, monogamous, stable marriage. This move appeared to serve at least four purposes. First, the affirmation of a stable and loving relationship could dismiss alternative explanations of low desire. Second, personal narratives were able to reflect deliberate clinical trial criteria designed for homogeneity. Third, a marriage provided a context for low desire to emerge as relevant and provoke distress. Fourth, the reverence granted to marriage and long-term relationships (especially both in combination) may have preempted counterarguments that mismatches in sexual desire are best resolved with separation.

A narrative of the nonsexual subject as a patient with HSDD begins with establishing an otherwise inexplicable case of low desire. From the beginning of the category’s inclusion in the DSM, the definitional construction of HSDD has positioned it as last-resort diagnosis, one that can be precluded by alternative explanations (such as other medical conditions or relationship troubles). For the pro-flibanserin speakers, then, it was important to assert the inapplicability of *other* explanations for low desire, such as losing interest in a particular partner.

Thus, across examples in the hearing, the women who delivered their personal narratives of HSDD (and the spouses, doctors, and activists who testified on their behalf) drew attention to their status as married women in long-term, monogamous, heterosexual marriages. We see women mentioning husbands and men mentioning wives, often with a mention of how many years they had been married, but never, not once, any women with wives. The word “partner” was regularly used by doctors, professionals, and clinicians, leaving marital status unspecified, but there were no clear examples of explicitly unmarried heterosexuals, much less non-heterosexuals. In fact, not one of the speakers at the hearing even used the words “girlfriend” or “boyfriend” at all. In the debate at the hearing, there were only partners, husbands, and wives. I found no explicitly-acknowledged instances of women in relationships with women—or any other form of nonnormative relationships—being discussed explicitly as *examples* of HSDD patients, either in the first- or third-person narratives.

This focus on the normative was not just a fixture of the personal testimony but also a deliberate aspect of the clinical study design, as well. The sole appearance of the term “homosexual women” in the official transcript comes from the mention of them as having *not* been enrolled in any of the clinical trials (FDA 2015, 128). As acknowledged by David Portman, acting as an industry presenter at the hearing, the “key inclusion criteria” for the three main clinical trials included the criterion that subjects had to be “in a stable monogamous, heterosexual relationship for at least 1 year,” thereby excluding polyamorous women, women partnered with women, and women in shorter or more recent relationships (151). Ostensibly we can reason that the “stable” relationship criterion was selected in order to rule out “instability” in a sexual relationship or relationship status as an alternative means (other than

HSDD) to explain variations in sex drive, as well as to preserve the integrity of the study by attempting to select against changes in relationship status during the trial period itself. As for the exclusion of women in non-heterosexual relationships, specifically, these were excluded “to increase the uniformity of the study population” according to researchers, which in the published text itself is acknowledged as a limitation of the studies (Katz et al. 2013).

Whether this uniformity of the heterosexual wife in pro-flibanserin testimony is merely incidental, or whether it is understood as an appeal to ethos and the construction of the normative patient as personally credible, the would-be sexual relationship in the form of heterosexual marriage also served an even more important role in the hearing discourse: accounting for the impact of HSDD. For although only women with HSDD (not men with HSDD) were discussed in the hearing as patients with the potential to be prescribed flibanserin, advocates were completely frank in contextualizing HSDD as something affecting not one person, but (at least) two people: the woman *and* her sexual partner, most typically in the form of a husband.

At this point it is worth mentioning that nothing in the HSDD diagnostic criteria officially requires that it only be diagnosed in the context of a monogamous long-term sexual relationship—or even any sexual relationship at all, nor is that the absent desire necessarily restricted to *interpersonal* desire. In fact this breadth is even implicitly acknowledged by clinical trial design, which does count a desire for masturbation as a type of desire that counts toward drug efficacy. Additionally, on a similar note, even if sexual desire is directed at another person, there is nothing in the diagnostic criteria technically requiring that said desire be acted upon or satisfied; in other words, unreciprocated desire for non-partners could technically (by these

criteria) be taken as evidence of disorder remission. And yet, for the purposes of both clinical trial data as well as in pro-flibanserin hearing testimony, the women represented were overwhelmingly married women, exclusively. The word “masturbation” or its variants do not even appear in the 2015 hearing transcript at all.<sup>3</sup>

Additionally, the HSDD-diagnosed woman in second- and first-person personal testimony accounted for her heterosexual relationships as, regularly, a driving force in their distress. In other words, the unreciprocated desires of a (male) partner provided a context to provoke distress and was willingly proffered as a reason to intensify the view women’s low sexual desire as deserving of intervention and sympathy. In fact, at one point a speaker even addresses the *men* of the committee (not the women), asking them whether they would want “an answer for her” if their own wives (“wives” was the exact word used, exhibiting an assumption of both heterosexuality and marriage) were “afflicted” with the same (non-)experience (329). Evidently, the women on the committee (of which there were multiple) were assumed *not* to have wives (or female partners), demonstrating the heteronormativity that pervaded the proceeding.

Lastly, the recurring foregrounding of long-term marriages (ex. specifying how many years the couple had been together) suggests one last rhetorically strategic utility—preempting or discouraging a response of “Why can’t they just go their separate ways?” as an alternative, non-pharmaceutical solution to the problem. In the context of a promise of fidelity in the form of marriage, and a long established one at that, the suggestion of separation or divorce could

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<sup>3</sup> There is one instance of this in the 2010 hearing, solely to explain that this was counted toward the efficacy measures of the clinical trials.

even come off as dismissive or callous, leaving less rhetorical room for a mismatched desire to be framed as an issue of mere incompatibility. And if that point of contention does become a basis of divorce, as was alluded to as a possibility by some speakers, this was understandably framed as a saddening, regrettable state of affairs, something to be prevented, if possible, by medicating the wife.

### *The Distressed Woman*

In addition to the appeals to the normativity of patient marriages, speakers emphasized the great distress they associated with the experience of low desire. As mentioned, “distress” is one of the criteria of an HSDD diagnosis. Distress alone is not necessarily a sickness, but distress can be a disabling experience—and emphasizing distress also emphasized the urgency of a solution.

One way this argument was strengthened was by naming sacrifices made to attend the hearing, thereby asserting how important this issue was to the speakers. For instance, Kelli Stoup began her speaking time with this stirring message:

You don't know me, but I'm a very private person. To stand up here in front of a room full of people who are looking at everything that I do and everything that I say [...] is humiliating [...] I am a private person, but I am willing to stand here and speak about this. I am passionate about this and willing to speak on behalf of those who cannot be here (275).

Consider also the testimony of Katherine Campbell, whose travel expenses were covered by Sprout Pharmaceuticals—as she noted, in defense of this fact, “I hope everyone understands

that my husband and I do not have money set aside to fly back and forth to DC so that I can talk about how much sex we're not having" (260).<sup>4</sup> Nonetheless, Campbell defends her personal credibility as compensation: "I have no hidden motives or agendas... I'm simply an intelligent, fully-grown woman who knows her body better than anyone else." Attending this hearing was so important to her, she even disclosed that she was missing her own son's first birthday in order to be there.

Campbell's contribution to the hearing heavily emphasized intelligence, autonomy, and patient's own clarity of judgement: "the millions of other women I have to represent today who are looking to the FDA for a solution [...] are smart, modern women who are a hundred percent capable of knowing their own bodies and making good decisions. We want and deserve options" (261). In the same vein, she responded to the concerns about flibanserin's side effects by saying, "It feels like a slap in the face. I'm basically being told that I'm not smart enough to stop taking something if it isn't working or if the side effects are unbearable" (262). Despite this emphasis on autonomy, she also concludes by returning to a reference to her marriage and the emphasis on distress:

As a woman who truly has HSDD, is premenopausal, is in a committed relationship, and is in complete distress, I am pleading for help for an option. And when you hear me, I hope you see not just me, but all the women this disorder is hurting (262).

Among professional speakers, this distress was magnified through breadth of relevance, emphasizing to the committee why it was both severely important and a matter of *health*, not

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<sup>4</sup> While this is a very sensible reason to accept Sprout's money, left unanswered is the question of who might possibly cover the travel expenses of those on the opposing side.

to be dismissed as a matter of petty overreaction or personal preference. Such moves induct the women's distress into *scientia sexualis* while also contributing a greater sense of moral urgency to the call for a treatment option. HSDD patient distress was characterized as an issue of "quality of life," of "a woman's wellbeing," and for "mental health" by figures ranging from the president of the American Sexual Health Association, the CEO of the National Association of Nurse Practitioners in Women's Health, and doctors David Portman, Christina Chang, and Marianne Brandon. Sex educator Sue Goldstein described patient's sexual problems as "wreaking havoc on their lives" (238), and Doctor David Portman, agreeing that acquired HSDD patients are "incredibly bothered and distressed" (62), elaborated that the evidence on flibanserin "demonstrates positive impact on many different aspects of distress such as guilt, inferiority, and embarrassment, the essence of HSDD and its impact on quality of life" (71). The essence of HSDD that impacts quality of life, he says, essentially lies in varied forms of shame; with this shame treated as an inherent aspect of HSDD, the medical approach then calls for removing that shame biologically. This shame, in doctors' repeated references to "quality of life," emerges in the context of and has a negative impact on "her partner" and "relationships."

Given this fixed recurring variable, women described their nonsexualities as objects at odds with their ability to maintain a happy marriage. They turned their blame inwards in the search for the resolution to the distress, all the while trying to assure their partners or husbands that they didn't mean to make them feel rejected. In husbands' personal testimony, likewise, they told of feeling rejected and confused, suspecting that their wives no longer loved them, for instance, or that they might be having affairs. In dismissing these alternative



explanations, speakers again located patient's low sexual desire as an innate problem of biology.

Although much of the discussion of distress makes no claims to any specific etiology beyond "biology," pro-flibanserin testimony at the hearing did not bother to affirm a variety of personal perspectives on long-term low desire. Instead, it embraced a slippage between "desire" and "health" as much as "low desire" and "distress," implicating low desire as inherently distressing and unhealthy unto itself. In other words, pro-flibanserin discourse at the hearing refused to recognize even the mere possibility of contented, non-distressed nonsexualities. Personal experiences or behaviors such as low desire or sexual inactivity must always be distressful, always a problem, always worthy of intervention.

This argument is clearest in two remarks from Doctor David Portman, a paid consultant of Sprout. In one instance, he contrasted patients with acquired HSDD (having little to no satisfying sex) against "healthy sex lives," thereby constructing celibacy as an unhealthy sex life. Then, further, he explicitly made a claim to emotional distress as an appropriate, innate, and inevitable response to infrequent sexual activity. That is, he claimed to *know distress* by *knowing infrequent sex* when he issued the following reminder, while discussing the clinical trial measures of "satisfying sexual events":

Here, you see that while there were some women—you mentioned the average 1 of 2 to 3, and that's largely driven by the mean, but you see that close to half or over half were having 2 [events] or less. And you have to remember that this population, these are 36-year-old women. And we could look at normative data from either the Kinsey

Institute or other organizations, *but certainly 2 events per month is clearly a sign of distress.* (124-5, emphasis added)

According to this claim, which appears to go unchallenged by other speakers, infrequent sex—when deemed infrequent enough to be considered nonnormative—is *itself* “clearly a sign of distress.” Portman treats this equivalency as safe to presume even without asking an individual for their own perception. This is a sentiment not too dissimilar to that of Helen Singer Kaplan, the psychologist credited with first theorizing HSDD in the 1970s, who wrote that clinicians should be watchful for hypoactive sexual desire because the patient in question “often denies that there is anything wrong.”

Despite (or because of) the emphasis on a causal relationship between nonsexuality and distress, then, the discourse of pro-flibanserin advocates readily produces one as interchangeable or inextricably bound with the other. This point, it must be noted, rejects a model of nonsexual subjects as split between those who might desire treatment and those who do not need it. The discursive equivalence of nonsexuality and distress claims knowledge of the latter by measuring the former, ensuring a reciprocal effect of power and knowledge that incites the desire for treatment. This relationship is further dramatized in the example below.

### *She Is Broken*

With distress naturalized as the only conceivable or appropriate response to low desire, nonsexuality becomes intelligible only as a problem. Consider the most overt example of this: a recurring metaphor that dramatizes sexual desire as essential functioning by labeling the undesiring woman as “broken.” In a narrative delivered by gynecologist Alyse Kelly-Jones, she

recounts, “The first thing my patient said to me as I walked into the exam room was, ‘I feel like I’m dead inside.’ She was broken” (297). Another gynecologist, Julianne Adams Birt, recounts a similar and even more poignant encounter with a woman with low sexual desire: “one of my dearest patients came running up to me. She was sobbing. She was sobbing. She embraces me and she says, ‘Dr. Birt, where are you going? What am I going to do now? Who’s going to fix me?’” (308). In the personal testimony of HSDD patient Kelli Stoup, self-described “very private person,” she declares her humiliation at sharing in front of others “that I am broken and cannot be fixed, that I could go without sex for the rest of my life, that I have zero interest in sex,” which is why there needs to be a FDA-approved medication available for “when a woman like myself gets up the courage to go to a doctor and admit that she is broken” (275-7). In these accounts, the “brokenness” of the women described is clearly not located in the shame-response but in the biological fact of low desire. As contrasted with the brokenness of low desire, sex educator Sue Goldstein asks the FDA to approve flibanserin in order to “allow women to feel whole again” (239).

In addition to labeling nondesiring women as broken, pro-flibanserin speakers further emphasized the severity of HSDD in terms of losing something vitally important as an individual woman. A clear picture is painted by Doctor Sheryl Kingsberg, a paid consultant to Sprout, who, based on a professed 25 years of experience, describes “the prototypical HSDD patient” as someone who has not only suffered but has “lost a sense of self” and “wants to feel normal again,” where normality implicitly involves persistent and active sexual desire (50-2).

Further, these patients “want their femininity back” (52), an assertion which intertwines adult femininity with sexual desire—or rather, *heterosexual* desire, *in women*, presumably,

unless we would like to read this statement according to the (unlikely) interpretation that male sexual desire would also be regarded as feminine. What this construction of sexual desire might possibly mean for queerer forms of sexuality and gender expression remains unclear.

From here, Kingsberg tells a story of encountering a stylized self-portrait drawn by a woman with HSDD: “In it, she had drawn no breasts, no hair, and no hands. That is a self-image of a woman who is profoundly distressed, a woman who’s lost her sense of self” (52). This quote includes the full extent of the details that he shares in this anecdote, which does not include an artist’s statement or any mention of a conversation with the artist herself to confirm her intentions. With how the anecdote is framed, those intentions and the meaning of the piece are simply presumed on the basis that she is an HSDD patient, as though the diagnosis means all her art must be read through that diagnosis, reducing all her artistic expression to the disorder. Kingsberg does not elaborate on the reasoning for this interpretation of artistic symbolism. She simply includes the anecdote to further the repeated narrative of dramatic, relationship-killing, self-annihilative distress, folded in as yet another iteration of the same foregone conclusion: nonsexuality as disturbing and pathological.

### *What a Wife Should Want*

Further, for flibanserin advocates, women’s nonsexuality-as-pathology warrants treatment because it goes against the mandates of marriage. For speakers in favor of flibanserin, sex and sexual desire together are granted an essential status as indispensable ingredients not just to a happy individual, but to a happy marriage. Statements to this effect are framed in no unclear terms: as universals, true for everyone. A marriage without active mutual

sexual desire, by contrast, must necessarily be insufficient and likely to end because of it. For example, consider how Doctor Julianne Birt described herself as, over the past 10 years, listening—“listening to women who stress, they stress over the fact that their marriages or their relationships, as we heard from some other persons today, they may be ending soon. They don't have a way to engage in intercourse again” (309). Within this context, the second statement is clearly attributional. They don't “have a way” (read: feel the desire) to have intercourse; they *want to want to*, but they don't want to, and the stress they feel over that fact relates to their beliefs about what makes for a suitable romantic partner.

These very beliefs are more explicitly affirmed by others, such as Erica Palim and Barbara Gattuso, who declare that “an active sex life is an important, healthy, and natural part of a loving relationship” and “sex is a very, very important part of any healthy marriage” (306; 267). There is never any hedging or qualifying that the same should not apply to everyone. They are presented, instead, as the universal *truth* of sex, love, and marriage.

With sex described as essential to a “healthy” marriage, the objects of nonsexuality and marriage are figured, metaphorically, as antagonistic forces. Kelli Stoup, for instance, recounts her words to her OBGYN, “I have no libido, and it's killing my marriage” (276). The marriage itself takes on a metaphorical life of its own, not as a relationship which can involve challenges and incompatibilities between two people, but as its own being which can suffer and must be kept alive. A patient named Vicki Lofthus attributes HSDD as the reason why “my marriage has suffered greatly, so much so that the conversation of divorce is on the table” (269).

With this preface, finally, husbands return to the picture as individual beings as opposed to fixed and static forces merely being alluded to. She continues, “My husband has a difficult

time understanding my struggle with this disorder. He still takes my avoidance of sex personally, thinking I don't love him anymore and there is something wrong with him, which is farthest from the truth." In this poignant account, Lofthus' husband does not believe that his wife loves him anymore despite her protestations that she does—and here at no point is the husband positioned as needing to be changed or made to understand, because that might involve affirming the validity of nonsexual romantic love, which would then challenge the other supporters' assertions that sex is a very, very important, healthy, vital, and natural part of a loving and healthy marriage which in its absence must be biologically restored. Likewise, Kelli Stoup prefaces "[HSDD] has caused strife in my marriage" before saying "My husband knows I love him, but he continually feels rejected and knows when we do have sex, it's because I know he needs it and is what a husband and wife should want to do" (277). Here, her account repeats the moving story of the husband who feels rejected, but is not characterized as needing to change his thoughts, beliefs, attitudes, or behaviors in anyway, followed by Stoup's universalized assertion as to what a husband and wife "should" want.

Another personal narrative, delivered by HSDD patient Amanda Parrish, dramatizes this conflict even further:

A silent wall of shame grew between us, shame of guilt on my part for not wanting to have sex with a man whom I loved, and hurt on his part wondering what he was doing wrong. Often pretending to be asleep before he came to bed, we suffered separately in silence, seriously threatening our relationship (257-8).

In her case, she recounts, she was lucky to get the chance to participate in the clinical trials for flibanserin, which she describes as "relationship saving," but the trial eventually came to an

end, “leaving me with no medical option, and life returned to uncertainty and distress.” The saving of relationships, further, she describes as “lifesaving” (260), and Lori Weinstein similarly extends the effects of flibanserin to “the potential to.... create happy couples, which undergird happy families” (244). Ergo, to value happy families is to approve flibanserin.

At no point are the pro-flibanserin advocates recorded as challenging these beliefs. Instead, the distress itself (as a response) is cited as evidence that the distress-response is justified. Doctor Barb Dupree is quoted as outright refusing the thought of challenging this maxim, declaring, “It doesn't occur to me to say, ‘nothing is wrong with your sex drive.’ If nothing were wrong, they wouldn't be in my office asking, sometimes pleading for help” (332).

Only once, and briefly, does the opposition at the hearing question this construction of the nonsexual subject and nonsexual marriage at all. Alessandra Hirsch, project manager at Pharmed Out, includes toward the end of a string of points the offhand assertion that “Couples should talk about and negotiate disparate levels of libido in the same way they do other issues. Such conversations, essential to women's rights and safety, ensure that we are in relationships where it's okay for a woman not to have sex when she doesn't want to” (287). This conditional “when” is not elaborated upon or granted emphasis as a point unto its own, but rather, folded into a broader and more ambiguous point about communication and “conversations.” Her “when” does not clearly specify that this idea should hold true even when that “when” becomes “always.” Without this level of specification, this phrasing leaves it easy to pass up the significance of this brief line and interpret the “when” as an *exception* to a more normative, consistent pattern, instead of potentially a consistent rule unto its own.

For or against, I found no instances at the 2015 FDA hearing of a speaker personally testifying to enjoying a satisfying nonsexual marriage or romantic partnership without distress. Such testimony might have disrupted the universalizing truth claims of advocacy rhetoric, lending it rhetorical affordances for the opposition. Yet opposition speakers at the hearing demonstrated no awareness of or attempt to produce such a subjectivity as a part of their rhetorical strategy. To the extent that the opposition discussed marriage and relationships at all, it was to offer the alternative narratives of “communication” or alternative treatments such as therapy (287; 315). As much as the hearing opposition directly challenged many specific statements, such as the “26 to 0” count contrasting approved drugs for men against approved drugs for women, it left untouched the discursive object of marriage as necessarily only loving or healthy when consistently, actively sexual.

### *Duty Sex*

There are clear implications to acknowledging a nonsexual subjectivity while claiming that a loving marriage *must* feature sex. At this point is important to return some of the specificity of HSDD diagnostic criteria in order to analyze another, less-emphasized component of the discourse—both in what is said and what is not. Recall that HSDD, as a diagnosis, does *not* involve physical incapacity for sex as one of its components. Patients with HSDD can and do have sex, which is acknowledged in some parts of the hearing. Among these acknowledgements, speakers reference an ongoing reality of women acting on a sense of sexual obligation.



These references appear in both personal and professional testimony. Doctor David Portman, in his narrative of the typical HSDD patients, said of their romantic relationships that “they either didn't participate [in sex] at all, or it was less than half the time, and almost always out of a sense of obligation” (126). Personal narratives affirm this sense—as in the case of Sue Goldstein, who described her goals for treatment as “No more avoiding sex or having duty sex” (238), and, even more dramatically, Kelli Stoup testified that when she has sex with her husband, “it's because I know he needs it” (277). This second assertion frames sex as a *need*, not a want, that a wife is obligated to fulfill. In the personal narrative of Amanda Parrish, as well, “if I don't have the desire to have sex, I will either opt out or simply oblige, which shortchanges us both” (259). This same discursive object of “duty sex” and sexual obligation have been analyzed in Ashline and McKay's (2017) article on the 2014 FDA public meeting on Female Sexual Dysfunction; its presence here can be read as a straightforward recirculation of the same. These narratives might raise thorny but productive questions for feminists as to the meaning of consent—for instance, as to what extent “sex without desire,” “unwanted sex,” and “sexual violence” may or may not be distinguished from each other (see Walker 1997; Bay-Cheng and Eliseo-Arras 2008; Conroy et al. 2015; Bailey 2018; Darden et al. 2019), to what extent this might challenge models of consent which rely on an implicit expectation of desire as a part of the sex it defines as ethical, or how to negotiate the competing frames of “sexual freedom” and “sexual needs” (Fahs 2014). Arguably, some feminist definitions of rape *would* include “duty sex,” or sex by acquiescence (Basile 1999). Introducing this ethical framing would have problematized the proponents' construction of sex as too important for the married woman to refuse. These questions are not explored by the speakers at the hearing, however.

The above narratives are important because they reference instances where—at least temporarily—a husband’s sexual desires were prioritized as a consequence of women’s low sexual desire being problematized. Indeed, critical analysis of that preceding 2014 meeting also found that patients were openly defining “SSE”s (or “satisfying sexual events,” nominally—one of the flibanserin trial endpoints) *in terms of male pleasure* and making sure her *husband felt successful* (Segal 2018; Ashline and McKay 2017).

The only suggestion that men’s behavior, instead, could ever be problematized (in the context of these tensions) did not come from the intervention of anti-flibanserin speakers there to oppose the drug. Instead, it was a question asked by a skeptical committee member—in the form of the highly dubious move to question flibanersin’s potential as a “date rape” drug. Diane Aronson, patient representative and voting committee member, was the sole speaker to ask, “One thing I worry about is because of the indication of this drug, could it be thought of as like a date rape drug? That’s my worry, is about the sleepiness or the hypotension” (210).

This question was met with not just a rebuttal but with offense from two out of the three speakers who responded to it, casting the mere thought as both inaccurate and insulting. Marianne Brandon, one of the professional psychologists, commented, “I have worked with multiple women who’ve received date rape drugs and been raped. And I feel like it’s disrespectful to compare the two. What these women tell me is they can’t move their body, they’re confused, they’ve lost their memory” (223). Thus comprises her rebuttal: a single, delimited, exclusive narrative of what deserves to be called rape. This very limited range of possibilities reflects the overly narrow definition that has been critiqued by feminists such as Basile (1999), a definition that excludes long-term marital abuse from the definition of rape.

Because this is the entirety of what Brandon has to say about how rape happens or is experienced, with no word on other possibilities, this response forecloses rather than addresses any other narratives of sexual coercion which might be more relevant to flibanserin's evaluation.

The second speaker to respond to this concern (in conjunction with another), HSDD patient Amanda Parrish answered also with indignation, saying:

For the record, I am a woman, not a mouse. I would not take four times the intended dose, and quite frankly I was offended that this would be compared to a date rape drug. I love sex with my husband, but if I don't have the desire to have sex, *I will either opt out or simply oblige*, which shortchanges us both. Much like even though I love steak, I'm not going to eat one if I'm not hungry. I want to want my husband. It is that simple. I implore you to approve flibanserin, understanding that although it may not work for everyone, it certainly worked for me and thousands of other women. For us, flibanserin is a lifesaving, relationship saving, and life changing drug. Thank you. (259, emphasis added)

In the same breath, the speaker both rejects the possibility of comparing flibanserin to a date rape drug while also casually affirming marital sex without desire. Because these are not regarded as a contradiction, her testimony furthers the delimitation of sexual violence to a singular narrative of physically-forcible rape by a prospective date, never the manipulation of a beloved longterm partner.

A third speaker, sponsored presenter Josephine Torrente, also made the more pertinent point that flibanserin is too slow-acting to for the "date rape drug" comparison to hold water.

Flibanserin is to be taken daily and does not have immediate onset, does not cause immobility, and does not cause amnesia. Hence she concluded, “so this is really just a sedative effect, no advantage to using this over a Benadryl-type product” (405), which thoroughly dispels the analogy to something much more powerful and fast-acting like the conventional “date rape drug.” Flibanserin taken daily will still take weeks to be effective (if at all), and its gains are only seen in the long-run, whereas (speakers implicated) the “date rape” suspicion is one solely associated with short-term use causing immobility and amnesia and taking effect within hours. So no, flibanserin could not rightly be compared to a date rape drug.

What was not addressed, on either side, was the specter of *marital rape* (as opposed to “date rape”) or any other form of sexual abuse over the *long term*, as opposed to the short term. Terms like “marital rape,” “sexual abuse,” or “coercion” do not appear in the hearing transcript at all, nor do any references to interpersonal abuse—not even from the opposition or critics of the drug. There are no discussions of “consent” with regards to sex at all, only “informed consent” with regard to medication. This absence marks a subtle but significant shift away from the language of the 2010 hearing, five years prior. For by comparison, even the slightest, most indirect acknowledgements in the previous hearing make that absence all the more palpable—highlighting how opponents and proponents both backed away from the specter of coercion in the subsequent trial.

Consider two examples from the 2010 transcript, one from a critic and one from a proponent, as a basis of comparison. The first, from filmmaker Liz Canner, stands as the sole instance within the transcript I found that acknowledges the very concept of sexual violence at all, and that is in the form of accusing Boehringer Ingelheim (previous owner of the rights to

flibanserin) of “promot[ing] a definition of HSDD as a neurological problem, underemphasizing the role of nonmedical factors in a woman's sex life, such as relationship issues and past sexual abuse” (237). In this statement, note that sexual abuse is qualified as *past* sexual abuse. Such an experience is floated as a potential factor in low desire's etiology, as occurring in the past; conversely, the reverse is not explored. That is, Canner (and all other speakers, by their silence) express no thoughts, not even speculative ones, on any relationship between low desire and a vulnerability to *ongoing* or *future* sexual abuse.

This possibility is demonstrated, though not named as such (not even by other speakers in response), by the personal narrative delivered by pro-flibanserin HSDD patient Kim Whittemore. Quoted below, her story of unwanted sex in marriage—compared to the than the vaguer allusions the 2015 personal narratives—is delivered in a far more gut-wrenching, viscerally disturbing form:

I became less and less interested in lovemaking and sex. After 18 months, it became increasingly uncomfortable and then downright painful. I did almost anything to avoid even the most gentle and innocuous expressions of affection for fear that it might excite and arouse my husband and force the dutiful, yet despised act of intercourse or bring on another argument about my disregard for his needs, and, ultimately, my loathing of sex. I was almost always reduced to tears if we did have sex and tears after arguments if we didn't (252).

Thus Whittemore constructs a narrative of uncomfortable, painful, unwanted sexual experiences and her struggle with a marital obligation—avoiding affection for fear it might “force the dutiful, yet despised act”—that moved her to tears, either from the experience itself

or from the arguments between herself and her husband over her reluctance. She does not further give a name to this pattern of treatment in her marriage. That said, it seems to bear a (more violently conflicted) resemblance to later 2015 hearing speaker's (much lighter) allusions to "obliging" with "duty sex" in deference to a husband's "needs."

By comparison to 2010, the 2015 transcript shows both sides stepping back from the specter of coercion. The pro-flibanserin speakers of the later trial seem to have granted it only much briefer, less visceral acknowledgement, and the anti-flibanserin speakers—despite an explicitly feminist orientation in some cases—did not discuss (or offer any alternative framing of) "duty sex" at all. It took a committee member herself to raise the specter of coercion by asking about flibanserin's comparability to a "date rape drug," and this concern, owing to her poor phrasing, was quickly and indignantly dismissed. Without opposition to push the issue, the object of duty sex and long-term coercion was thus allowed to recede from hearing discourse unchallenged.

#### *No Other Option for an Unmet Need*

Alongside establishing the problem in the form of long-term marriages without sex or with unwanted duty sex and locating the problem in the distressed nonsexual subject as a broken woman to be fixed, the final, essential component in the strategy was to cinch the conviction that these women had no other options—that in their efforts to fix this problem, *nothing else was working*. Professionals Christina Chang and Lynn Barclay, for instance, used the term "unmet need" to describe the current state of HSDD treatment (204; 264). Other

professionals metaphorized this lack as a toolbox or toolkit lacking anything within. As Doctor Barb Depree put it, “There's not a lot in my toolkit to respond to these women” (332).

Urologist Ashley Tapscott similarly contrasted her options for male patients and female patients in a more extensive manner, alongside more rhetoric of personal choice:

With regards to my male patients, I have many well-established tools for treatment. I have guidelines. I have approved medications. This allows me to treat these males with conditions causing severe bother and distress, like Peyronie's Disease. In fact, this condition, Peyronie's Disease, or penile curvature, was so bothersome that the FDA, physicians and men were willing to assume serious risk, including penile fracture, to have a choice in treating that disease. [...] For my female patients, I have an empty toolbox (303).

In this comparison, Tapscott contrasted female HSDD with Peyronie's Disease, a dysfunction that is similar (in that it is a sexual dysfunction that can interfere with sex, potentially making sex painful) yet also different, in that it is caused by a known physical mechanism (scar tissue) and is not considered a psychological disorder. By contrast, HSDD is a question of psychological desire, and its origins, causes, or functioning (in the sense of “how it works”) are not well-known. At present (as well as at Tapscott's time of speaking), there are no approved medications for male HSDD. Nonetheless, the comparison of treatment options for two different kinds of diagnoses is compelling. Even more dramatically than in the first telling, Tapscott also demonstrated this same lack of options by saying, “I want you to hear the options [for HSDD] that I tell my patients,” and immediately following this point, the transcript has simply recorded the words “(Silent pause)” (304).

This absence of approved options does not mean the absence of action, however. In the context of unmet need, Doctor Sheryl Kingsberg recounted what HSDD patients may resort to, saying,

Far too often, what's happening is that these women turn to the internet or in the back of a magazine. They have no other option. In fact, in a study that sought to better understand the healthcare utilization by women with HSDD, we learned that more than half will turn to the internet or magazine articles (51-2).

What advice or directive do the internet or these magazines supply? She does not specify, instead seeming to play on the lack of professional, medical credentials that popular and vernacular media sources represent. This reiteration of “no other options,” also affirmed by patient testimony recounting how other attempts at treatment had failed them, formed an indispensable part of the push for flibanserin’s approval, as can be seen in the rationale given by the committee members after the final vote.

In the voter’s rationale, unmet need and the absence of any other approved drug for the same condition featured as a prominent deciding factor toward voting B (“Yes, but only if certain risk management options beyond labeling are implemented”) as opposed to C (“No”).

Consider the following excerpts from among the stated voter rationale:

Walid Gellad: “I voted B also. Just to say a few things, I think if this were the seventh drug in the class, I think it'd be a very different discussion” (430).

Lorenzo Leggio: “I voted B as well... I took under serious consideration the fact that it's another first drug... the first drug ever” (434-5).



Amy Whitaker: “I voted B as well. I think it's exciting that we'll have a drug in the armamentarium for the treatment of HSDD, although I think we all wish that it was a drug that was a better one...” (450).

Til Sturmer: “I voted B. I was on the fence here, I have to admit... The reason to vote B and not C is that there is clearly an unmet need, and there is proven potential benefit” (451).

Tobias Gerhard: “I also voted B, very difficult B, definitely between B and C... I think quantifying the risk in real-world settings, including in realistic situations with real-world use of alcohol and so on, is absolutely critical... because, currently, the risk side isn't quantified sufficiently to really allow informed benefit/risk decisions, but the unmet need seems to be so strong that even for a drug with rather modest benefit...” (455-6).

As these answers show, the importance of approving a *first* drug to meet an *unmet need* figured as a crucial part of the approval, even as the committee almost unanimously reiterated shared concerns about the drug's risks. In fact, this degree of consensus was noted by Chairperson Vivian Lewis at the end, who concluded, “So thank you all, a remarkable agreement between the B's and C's actually at this point—I don't think I've ever seen that before—in terms of the rationale for the vote” (459).

While the final vote might be dismissed as a foregone conclusion of Sprout's corporate lobbying power, the on-record voting rationale at this hearing makes it possible to identify two additional, rhetorical factors in why the proponents succeeded. First, we can see that the committee voted in the drug's favor even in spite of concerns that the drug was risky and not very effective, ergo convincing them of this was not enough. Second, the opposition's

arguments were scattered and lacked a consistent, powerful throughline—making only small points by impugning Sprout’s corporate credibility by reminding the FDA of their history of deception, questioning the 26 to 0 tally, and so on. And thirdly, most importantly, it did not challenge the most compelling part of the advocate’s discourse, the distressed nonsexual subject and the unmet need. In other words, the opposition did not sufficiently argue that the nonsexual subject’s distress could already be assuaged in other, more effective ways than flibanserin. It did not convincingly present any alternative to the women for whom nothing else had worked, allowing committee members to feel that another rejection would amount to ignoring the cry for help.

## **Conclusion**

The discourse that won flibanserin’s approval by the FDA succeeded because of its production of the distressed nonsexual subject as an HSDD patient with an unmet need for pharmaceutical treatment. The manner in which the proponents made their case did not involve carefully hedged qualifications of idiosyncratic, individual responses to nonsexualities, nor did any of the pro-flibanserin speakers affirm that it would be equally legitimate to regard low desire with acceptance rather than distress. Individual distress, where cited, was folded into claim to universality of sex as imperative. The nonsexual subject was not just distressed, but her distress was presented as the *only conceivable* response to nonsexuality. In the context of heterosexual marriage, a husband’s sexual desires were implicitly and explicitly prioritized to the point of frank acknowledgement of marital sexual obligation and “duty sex.” Speakers lamented unwanted sex only in that the nonsexual spouses in question were figured as

biologically lacking and as causing their husbands undue embarrassment. Sex with her husband is “what a wife should want,” ergo there needs to be a drug to make that sure she does.

Even though the FDA committee retained concerns about the drug’s safety and efficacy, especially the risk it posed when taken with alcohol, the advocates persuaded the majority that, even so, something was better than nothing. For, otherwise, married women would remain “broken,” obliging their husbands with duty sex instead of participating enthusiastically enough to convince those men they truly loved them. The opposition, meanwhile, in suggesting alternatives such as sex education and talk therapy, appeared to join with the proponents in viewing low desire as a potential problem in need of treatment, offering only the barest of acknowledgement that a woman’s “no” ought to be respected. Given this rhetorical landscape at the hearing, even setting aside the proponents’ greater numbers, it would not have made sense for the committee *not* to approve the drug.

This was not an inevitable outcome: embedded within this discourse, there are certain affordances, points of resistance and exploitable contradictions, as will be further explored in third chapter. The success of proponent rhetoric depended in no small degree on the claim that the nonsexual subject, the HSDD patient, *cannot* be happy while her desire remains low. At the hearing itself, however, the opposition speakers posited alternative solutions that had already been tried and found ineffective for some patients, which is why “a different treatment, just not this one” was too weak a move to carry the day. For the hearing opposition to counter the pro-flibanserin arguments more effectively might have required presenting a different trajectory, a different narrative, for the distressed nonsexual subject.

## Epilogue

Although Even the Score and the New View Campaign are no longer active, this is not the end of the story. As of this year, flibanserin (Addyi) has been newly approved in the nation of Canada, expanding its market and potential subscribers (Kirkey 2018). Financially, in the U.S., flibanserin has not done well—perhaps because it was initially priced at \$800 a month, or perhaps because it is completely contraindicated with alcohol, or perhaps for both of these reasons and more (Koons 2018). In response, Sprout has recently launched a covert new marketing campaign to boost prescription rates.

For Hers (forhers.com) is perhaps one of the most nondescript titles possible for a pharmaceutical drug promotional site, and there is a reason for that: Ostensibly, it is not a promotional site at all. For Hers presents itself as an all-purpose one-stop-shop for supporting women in their care of the self. On its current landing page, you will find a welcome message that bears a striking resemblance to the rhetoric of Even the Score: “Let’s level the healthcare playing field, shall we?” The site’s main sections are its blog posts (“Learn”) and its products (“Shop”), the latter of which are divided into four main categories: skin, sex, hair, and wellbeing. Styled as a slick, modern advocate of women’s autonomy (“Your body, your control”), For Hers promises effective, quality products in each of these categories. Their offerings range from acne treatment, vitamins, thinning hair treatment, shampoo, high blood pressure treatment... and a prescription treatment for low sexual desire, Addyi, the sole product on the site paired with a registered trademark symbol. A small asterisk marks prescription products (like Addyi) which require a consultation with a physician. Yet the website

is formatted like any other online shopping website, encouraging consumers to approach the product assortment as they would any other trip to the grocery store or beauty salon.

In conjunction with this naturalizing format, downplaying the role that doctors are meant to play in issuing prescriptions, For Hers' "Learn" tab directs the viewer to their "educational" articles on an assortment of women's health topics. These articles, covering a range of topics that mirrors the product assortment, include some on low desire and, of course, flibanserin, the only drug here mentioned by name. The former, an article on "low desire," features header phrases such as "Before You Say No," "When You Say No," and "If You Say No Often;" its advice includes, "Ask yourself, 'Is there something I need/want that would make me desire sex?'"

The discursive directive to *desire* "desire" disciplines the nonsexual subject to think of themselves as lacking and broken, their nonsexualities a problem to be interrogated. This pressure was suspected, but not successfully articulated, by flibanserin's opponents, fearing that a flibanserin mass-marketing campaign might itself elevate distress. In 2010, for example, at the first FDA hearing on flibanserin, academic gender scholar Thea Cacchioni questioned whether the marketing of flibanserin might create a self-fulfilling prophecy. In some respects, this phrasing might grant the marketers too much credit—for the discourse of nonsexuality as pathological deficiency has long preceded the development of flibanserin itself. What Cacchioni calls the "self-fulfilling prophecy," or more precisely, the discourse which makes female low desire intelligible only as brokenness, was and is already circulating. What has occurred with the FDA approval of flibanserin, rather, is a newfound corporate financial incentive toward the circulation of such a discourse, a pathological deficit-model of women's low sexual desire.

Regardless of the merits of the diagnosis itself, however, the advocacy rhetoric at the hearing was made possible not just by Sprout as a corporation, but also the more local power relation in the form of heterosexual marriage. How does a such a power relation “make possible” this discourse, “and conversely, how were these discourses used to support power relations?” (Foucault 1990, 97). Heterosexual marriage invoked by hearing speakers as a basis of credibility, stability, and context for sex, taking the long-term commitment of these relationships as a precondition for their argument. Yet in their accounts of “duty sex” and sexual obligation, flibanserin advocates did not just argue that the FDA should approve a drug for HSDD. They also argued that a wife should discipline herself in any way possible to have sex that satisfies and proves her love to her husband, assuaging any insecurities or anger that sexual refusal incites in him, regardless of her own sexual preference. In other words, this specific discourse on sex takes poses an ethical frame which elides consent, constructing unwanted sex as not just acceptable but even, sometimes, “obligated” and necessary. It condemns exclusively one element of unwanted sex in marriage, and that is a wife’s unwanted, rather than a husband’s determination to have sex with her regardless. What this means, then, is that this formation of pro-flibanserin discourse supports a specific power relation in the form of marital rape.

### *Chapter 3: Mended*

#### The Rhetorical Production of Distress and the Nonsexual Subject in the Asexual Community

##### **New Orientations**

In the previous chapter, I analyzed the pro-flibanserin advocacy's production of a nonsexual subject, distressed by a pathologized experience of "low sexual desire" in the context of marriage and "duty sex." The rhetorical force of these arguments at the hearing depended upon an unquestioned positioning of nonsexuality as itself a problem to be resolved. As a case in point, in this chapter I analyze a counter-discourse circulating in the context of the asexual community, where the production of the distressed nonsexual subject structures a completely different mode of response. That is, instead of framing the distressed nonsexual subject as a patient in need of a "medical option," this counter-discourse produces the distressed nonsexual subject as an asexual person in need of community, acceptance, and a shift in consciousness.

As I will show, asexual community discourse produces the "asexual" in a way that overlaps with but also diverges from the construction of the HSDD patient. In asexual discourse, an asexual is a person who does not experience sexual attraction, sexual desire, or some other aspect of sexuality. An asexual may be initially distressed at this (non)-experience, owing to widely-circulated discourses of sexuality, and may feel that they are "broken." This distress may be alleviated by learning of "asexuality" as a concept—and encountering the validation thereof as acceptable in its own right. In offering this validation, asexual discourse diverges from pro-flibanserin discourse on two points. First, it challenges or qualifies, to some degree, the medicalization of nonsexuality and talk of a cure. Second, it asserts an

understanding of love, including romantic love, that has the potential to be compatible with nonsexuality, rather than solely negated, threatened, or “killed” by it. In the chapter as follows, I trace the emergence of the asexual communities online, both chronologically and with a general sketch of community demographics and lexicon. My main analysis concerns asexual narratives, specifically asexual narratives of distress, discourse on (and critique of) medicalization, accounts of asexuals in love, and asexual responses to HSDD and flibanserin. By analyzing this discourse, I point out sites of convergence and divergence with the discourse of the flibanserin hearing, indicating how the opposition could have rhetorically strengthened its argument by drawing on these narratives and bringing asexual voices to the hearing floor.

### **Emergence of the Asexual Community**

Although recognition and discussion of “asexuality” extends back further than the age of the internet, both sexologically and in activist discourse (Kinsey 1948; Storms 1980; Fahs 2010), the internet has played a significant role in the formation of contemporary asexual communities. A history of “asexual” as a *community* begins in the late 1990s, online, with the publication of an online article entitled “My Life as an Amoeba” (see Hinterliter 2009). The article included a self-description as “asexual” and had an open comment section, allowing readers to respond, share, and communicate with each other. This comment section itself is what Hinterliter calls “the first online ‘asexual community.’”

Perhaps due to the influence of this article, a similar naming convention was reflected in the Yahoo! Group “Haven for the Human Amoeba” (HHA), formed in 2000. Like the article, HHA’s name conceptualized nonsexuality through an analogy to unicellular organisms, i.e. those



not associated with sexual reproduction. Thus, the amoeba represents the “absence” of sexuality.

From here, the term “asexual” as a type of human subject began to come into use and circulate in a more organized form. Around this same time, a student named David Jay used his university account to create the Asexual Visibility and Education Network (AVEN). The first, early iteration of the site included little more than a definition of asexual—as “a person who is attracted to neither gender,” although this wording was subsequently adjusted to avoid presuming a binary. Today, the internet continues to play a large role for the asexual community, commonly referred to as the “ace” community for short (Bauer et al. 2016).

### **Asexual Community Demographics & Lexicon**

Who is the ace community? This section introduces a brief description of its demographics, its lexicon, its production of asexuality as a “sexual orientation,” and the compatibility of asexuality with other orientational identity terms.

#### *Demographics*

For the past few years, an independent team has been organizing an Asexual Community Survey (also known as the Asexual Census) to collect demographic information within the community. Viewed in the context of the flibanserin debate, these results indicate more than one parallel to the target group for flibanserin: in age, nationality, race, and gender. A 60.4% majority of survey respondents reported their nationality as from the United States, vastly outpacing the second and third place rankings of the UK at 10.1% and Canada at 7.4%

(Bauer et al. 2018). Respondents' ages ranged from 13 to 75, but they skewed young: 86% of ace respondents were age 30 or younger, with a mean of 23. This places the community disproportionately *within* the same age bracket as “premenopausal women,” the target population for flibanserin. A majority of respondents self-described as White (77.2%), which was also true of the test subjects in the flibanserin trials (DeRogatis et al. 2012; Katz et al. 2013; Simon et al. 2014).

Gender presents a slightly more complicated picture. On the one hand, 63% of aces surveyed identify as women (Bauer et al. 2016). It would be a mistake, however, to assume that the remainder identifies as men. When presented with the options of “man” or “woman,” 26% of aces surveyed responded with “None of the above.” Those who selected this option were subsequently offered a more fine-grained list of gender labels—and of these, the most commonly selected included “non-binary,” “agender,” and “genderqueer.” Thus, people of nonbinary genders *outnumber men* in the ace community. It might be noted here, however, that gender identity alone is not what might be relevant to the prescription of flibanserin in a medical context. Because medical discourses tend to disregard gender identity and focus on assigned sex at birth, I will also note here the proportion of aces who might be designated “female” under the medical gaze, as pertains to FSAID and the flibanserin debate.<sup>5</sup> Of the ace respondents to the community survey, 89.3% had been assigned female at birth. Thus, from either perspective, gender identity or assigned sex, the community is still majority “female.”

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<sup>5</sup> Note the published articles and the representatives at the hearing did not specify whether or not trial participants were exclusively cisgender, unlike the noting of heterosexuality. Cisgender alignment between assigned sex at birth and gender identity there went unmarked and presumed, as it so often does in circumstances where transgender issues are not broached specifically.

Wherever issues concern disproportionately young American women, the ace community is disproportionately relevant as well. Yet in the ace community, nonsexuality and low desire for sex are *not* themselves parsed as dysfunctional or disordered.

### *A Sexual Orientation*

In both casual and educational asexual discourse, “asexuality” is implicitly and explicitly described as a “sexual orientation.” One of the ways this occurs is through outright referring to as such, but asexuality also is further aligned with the language of sexual orientation discourse through two other formations. Mimicking the discourse of LGBT rights, members of the asexual community sometimes employ a “coming out” metaphor, which aligns their experience with those oppressed on the basis of sexual orientation (see McLean 2007; Bobker 2015; van den Berg 2016). Additionally, asexual discourse sometimes borrows the emphasis on sexual orientation as “not a choice,” invoking biological essentialism and the belief that sexual minorities are “born this way” (see Johnston 2015).

This language appears in *The Invisible Orientation* by Julie Sondra Decker, sections of the Asexuality Archive website, the Asexual Outreach website, and various AVEN forum threads. In *The Invisible Orientation*, under the headline “Should I Come Out?” Decker explains,

Most people do feel like sexual orientation is an important part of their lives, and they feel it's important to include their loved ones in their realization. Some asexual people who come out enjoy a self-affirming experience and believe they're contributing to asexual visibility through disclosing their orientation. However, it's not necessary to come out if you aren't ready or you aren't comfortable. (2014, 143)

Here, “coming out” is clearly being used to mean the same thing as disclosing an asexual identity. In a different section, she also invokes the “closet” metaphor as well, saying that a punitive attitude on the subject, or that which blame aces for the consequences of coming out, “is more or less advocating asexual people staying in the closet” (Decker 2014, 67). Similar language is used at Asexuality Archive, which recounts that “Coming out is an important part of the asexual experience,” but also “Some decide to remain in the closet” (2012) .

For some aces, the motivation to come out is the shift in relationship to the self and is something to share stories about and advice on how to do. As Langevin wrote at the Asexual Outreach blog, “I distinctly remember the first time I came out as asexual... For the first time, I had shared an identity that deeply resonated with me and it felt like a first step toward being open and honest about myself” (Langevin 2016). AVEN threads on the subject abound, with titles like “Coming out to your parents” (2013), “How to Come Out as Ace?” (2015), and “Experiences of coming out as Asexual” (2019).

Additionally, it is commonplace for asexual community definitions of asexuality to emphasize that it is “not a choice,” as contrasted with celibacy and in line with a view of sexual orientation as innate and involuntary. See for example the AVEN “Overview” page, where it says, “Unlike celibacy, which is a choice to abstain from sexual activity, asexuality is an intrinsic part of who we are, just like other sexual orientations.” Asexual activists such as Decker and Jay take care to make the same distinction—not the same as celibacy, not a choice.

This invocation of “sexual orientation” and the clear influence of LGBT discourse may raise questions as to the relationships between these communities. Although this has been a controversial question in asexual discourse since approximately the community’s inception, to

chart the development of that debate and its common arguments lies far outside the scope of this project.

### *Some Do, Some Don't*

In some respects, however, the asexual community and the asexual subject defy simple summaries or a singular narrative. Introductory resources such as [WhatIsAsexuality.com](http://WhatIsAsexuality.com) and others make sure to address common questions by affirming that there is no one singular answer that covers every asexual person's preference or experience, otherwise summed up as "some do, some don't." This particular section from the aforementioned site conveys the spirit:

Many questions people have about asexuality can be answered with the same phrase: "Some Do, Some Don't." Do asexuals date? Some do, some don't. Do asexuals fall in love? Some do, some don't. Do asexuals have sex? Some do, some don't. Do asexuals masturbate? Some do, some don't. Do asexuals like pepperoni pizza? Some do, some don't. We are all individuals, with our own individual preferences and personalities, and it is generally impossible to make blanket statements about us. ("What Is Asexuality?" 2014)

Thus, the asexual community here and elsewhere explicitly acknowledges (rather than precludes) that asexuals may or may not be interested in romantic relationships. Admittedly this constitutes a break from wider sexual orientation discourse, which typically talks of "whom one is interested in partnering with" as a subcategory of "whom one is attracted to." How can the category of the former be *larger* than the category of the latter? Asexual discourse resolves this ostensible contradiction in a number of ways, such as "romantic orientation." In doing so, it

both challenges sexual orientation discourse but also draws on orientational language to resolve that source of tension.

### *Aces with Multiple Orientations*

In the asexual community, sexual orientation is defined as the realm of describing patterns of “sexual attraction,” not just attraction at large. This specificity allows for asexual discourse to make a distinction between “sexual attraction,” “romantic attraction,” and many others (see *Asexuality: A Brief Introduction*). Some aces also use this distinction to then label themselves according to a parallel notion of “romantic orientation.” In fact, this is even a prevalent enough model in the ace community to be featured in the asexual community census, under the questions “Which (if any) of the following romantic orientation labels do you identify with?” and “Which of the following groups are you romantically attracted to?” (Bauer et al. 2018). Romantic orientation is just the tip of the iceberg with regards to idiosyncratic community lexicon that can make asexual community discourse seem overwrought and dizzyingly opaque to the unacquainted. For this reason, I will restrict the scope of this section to cover just one other formation in the community’s production of asexuality: the language of the spectrum.

“Asexuality” has been produced not as just one singular identity, but also in terms of “the asexual spectrum” or “the asexual umbrella.” The idea of the “asexual spectrum” is represented in the black, gray, and white stripes of the asexual flag, as inspired by the AVEN triangle, itself a reference to the Storms model (Storms 1980). This concept was incorporated into the AVEN site design early on in its existence, but it was not for a few years until after its

founding, in 2006, that AVEN forum user KSpaz first coined “Gray-A,” or gray-asexuality, in reference to the triangle. In their words: “Is there really a line at which point you are asexual? According to our logo there isn’t. Just fuzziness.” This concept, representing the “fuzziness” via the analogy to the gray in between a gradient between white and black, was not the first proposal of its kind—preceded by “semisexuality,” discussed on an AVEN thread in 2003. However, “Gray-A” was the name that stuck. Years later, the gray-asexual label is still in circulation as a type of identity on the asexual spectrum. A commonly cited treatise on the label, a post on The Asexual Agenda entitled “Many ways to be between” presents a definition of gray-asexual as “someone who finds asexuality to be a useful idea, in the sense that it approaches a self-description, even if it does not quite fit.” Gray-asexuality is represented by one of the stripes in the official asexual flag that was designed in 2010, cementing its status as an “official” part of asexual community discourse (“The Ace Flag: A History and Celebration” 2018). Thus, from very early on asexuality was conceptualized not just as one singular label or experience unto itself but also as a “spectrum.” Despite the linearity of the representation, the AVEN triangle and the “spectrum” metaphor did at least suggest a model of asexuality which does not commit to a strict binary (asexual vs. not), instead accommodating more of a “range” of nonsexualities.

The objects of “gray-asexuality” and “romantic orientation” provide, then, two explanations—though not all, and not an exhaustive account—for how there can be members of the asexual community who identify with multiple orientation labels. As elaborated under “Aces with non-ace orientations,” there were “many” ace respondents who simultaneously identify also as “straight, gay, lesbian, bisexual, or pansexual” (Miller 2018). What this means

for the purposes of this analysis is that, although there are certainly aces who prefer to stay single, asexuality and singleness are not synonymous; the asexual discourse includes at least two different frames for conceptualizing individuals on the asexual spectrum as potentially interested in and compatible with others as partners. Accordingly, it should not be presumed that issues arising in the context of romantic relationships or long-term partnerships are irrelevant to the asexual community.

### **Asexual Narratives of Distress**

What makes asexual discourse pertinent for analyzing flibanserin discourse is not just the experience of “low desire,” but also the experience of distress over low desire. Like the production of the HSDD patient, asexual personal narratives (as a genre) commonly detail or make reference to strong sentiments of negative self-regard. Unlike in HSDD narratives, however, this distress is given a completely different framing. Typically, asexual narratives of distress involve two main beats: the damage of internalizing cultural messages about (non)sexuality, followed by the articulation of an alternative frame in the form of asexuality, often described as a kind of “revelation.”

Part one, the internalized cultural messages, is attributed the responsibility for making aces feel distressed. As Julie Sondra Decker describes part of the impetus for her introductory book, *The Invisible Orientation: An Introduction to Asexuality*: “The average asexual person spends too many of their formative years hearing explicit and implicit negative messages about lack of sexual attraction or interest. It doesn't take much to severely warp an impressionable, still-forming young mind” (Decker 2015, xiv). In this frame, those “negative messages”



becoming a polluting force, “warping” the young nonsexual subject toward a negative self-regard. This negative self-regard is commonly metaphorized in asexual narratives in terms of feeling “broken.” In a personal narrative posted to independent online publication *The Asexual*, Tawny Rose Case wrote, “I spent a lot of time feeling alone and broken, wondering why the swell of hormones all my peers were experiencing weren’t driving me to chase after anyone” (Case 2018). In the comparatively more mainstream outlet *The Atlantic*, David Jay was quoted as saying, initially, “I just assumed I was broken” (Hills 2012). On the “What Is Asexuality?” webpage of Resources for Ace Survivors, a resource site for asexual survivors of sexual violence, the team argues against a remedial outlook on asexuality by saying, “Most asexual people are happy that way; we only tend to try to ‘fix’ ourselves because we are so often told that we are somehow ‘broken’” (Elizabeth 2015). On the AVEN forum, threads on the topic abound, with titles such as “I’m not broken” (2015) and “I Don’t Want Sex and That’s Okay?” (2012). In the latter thread, user posts not only include the “broken” personal narrative in multiple iterations, but some users even reference it as something “most” aces experience and is a “stereotypical” reaction (here clearly meaning “typical,” standard).

Part two, the second stage of asexual narratives of distress, highlights the revelation of asexuality-as-identity. In their accounts, asexuals thus position a discourse of acceptance as a sorely needed intervention allowing for a reconceptualization of the self. That is to say, asexuality-as-identity creates the *potential* for the nonsexual subject to transition from “broken” to “not broken,” from deficient to affirmed. The pattern to these narratives is summarized in Julie Decker’s words, “Finding a name for one’s experiences—and realizing that it isn’t a sickness or a disorder or a hurdle to leap—is usually a self-affirming experience”

(Decker 2015, 11). The practice of facilitating or encouraging this realization can be considered a form of consciousness raising. According to Karlyn Kohrs Campbell, consciousness raising involves “creat[ing] awareness (through shared experiences)” that what were once thought to be “personal deficiencies and individual problems” are, instead, a site of common ground—and that the problem lies in the political “reality structure” rather than the individual (Campbell 1999, 128-132). Alternatively, this may be phrased as a disruption of the intelligibility of sexual discourse.

In “discovering” asexuality, nonsexual subjects are enabled to make sense of their nonsexualities in a whole new way. From the aforementioned 2015 AVEN thread, consider this quote from a post by LunaBetula, saying, “I am new to the world of asexuality, but after feeling broken for so many years, it feels nice to know I'm not and I'm not alone.” This same timeline is tellingly indicated by the title of a 2014 AVEN thread, “What did you think was ‘wrong’ with you before you knew the word asexual?” In an article by Tara Willis, being introduced to asexual discourse is even framed as “liberation”: “I feel this story needs to be told because the feeling of relief and liberation the community has given to me is something I did not expect in life,” as contrasted against a lifelong struggle with suicidal ideation (Willis 2017). It is the encounter with and knowledge of this discourse (of asexuality) and this community (of fellow asexual people) which, in some narratives, assuages the distress of the nonsexual subject.

This affirmational revelation is described powerfully by Case (2018) when she describes her encounter with asexual discourse via an online documentary, watching the film furtively while her roommate was away:

Flash forward a few years, and I'm graduated, sitting on my couch in my first apartment, flicking through Netflix while I wait for my roommate to come home. She is an out-and-proud bisexual, which I find inspiring, but still do not connect with my own identity. In my mind I am still straight, broken, and in hiding. My eyes catch on to something on the screen — a documentary. *(A)sexual*: "Not everybody's doing it." It's won some awards, and, at the time, it's only about a year old. My eyes whip to the clock on the wall — I have enough time before my roommate will be home from work. I hesitate for just a second, and then I press play. Two hours later, I'm in tears on my couch, and my narrative has shifted again. I'm not broken.

In this personal narrative, the teller is moved to tears, not out of brokenness, but out of a radical "shift" in narrative; asexual discourse opens new possibilities, simply by providing an alternative framework for making nonsexualities intelligible as something other than "broken." Thus, again and again, asexual personal narratives repeat this refrain as the refrain of revelation, of self-acceptance, of rejecting the discursively-produced subjectivity they had known before: I'm not broken. I'm not broken. I'm not broken.

### **Asexual Narratives of Medicalization**

The source of the "broken" feeling, in asexual accounts, is attributed to multiple sources, and one of these is medicalization. Medicalization of asexuality, as an object of discourse, appears or is challenged in informal personal narratives and introductory educational materials, like *The Invisible Orientation* and Asexuality Archive. While medical accounts of nonsexual experiences are not always outright rejected in ace discourse, and the exact

relationship between asexuality and medical sexology is contested, a medical approach to asexuality is frequently challenged or framed as invalidation. For instance, when the Asexual Census asked about experiences of invalidation from others, “Nearly half of the ace respondents (45.4%) reported experiencing others attempting or suggesting ways to fix or cure them because of their sexual and/or romantic orientation” (Bauer et al. 2018). This statistic is listed under the category header of “Negative Experiences,” alongside others like “verbal harassment” and “familial rejection,” indicating how the pursuit of a “cure” is understood as negative. On the AVEN forums, over the years members have created threads with titles such as “Is there a ‘cure’?” (2015) “Is there actually a cure?” (2009) and “Magic pill to make you sexual?” (2008). Members disagree over whether or not such a “cure” would be worth it, whether or not asexuality can be “cured” at all, or whether or not such framing even makes sense. One AVEN member quips, “That’s like asking if there’s a cure for having blue eyes.”

In introductory materials directed outward from the community, the more consistent message is that medicalization is the wrong approach. In Decker’s *The Invisible Orientation*, she includes three entire sections presenting variations on this theme. These include the section “Asexuality is a Healthy Status,” among the “What is it?” sections, and then two other sections under the heading of “The Many Myths of Asexuality”: “Do Asexual People have a Physical or Hormonal Problem?” and “Should Asexual People Get Therapy to Be Fixed?” Decker’s answer to these questions bears a resemblance to the much more succinct answer presented on Asexuality Archive, which has a page dedicated to answering “Is There a Cure for Asexuality?” with simply the lines “Asexuality is not a disease, so, no. There isn’t a cure because there’s nothing to be cured.” This comprises the entirety of the page’s answer. The same sentiment

appears on another of the website's pages, entitled "Myths, Misconceptions and Other Things That Are Just Plain Wrong," affirming "asexuality is not a physical ailment. There's no pill that'll make an asexual start experiencing sexual attraction. It would be like there being a pill that would turn a gay person straight."

### *Asexual Accounts of HSDD*

Unlike the flibanserin hearing's total silence on asexuality, asexual discourse does include some occasional, scattered, somewhat ambivalent acknowledgement of HSDD, the psychological diagnosis. Primarily, this takes the form of distinguishing HSDD as a medical object from asexuality as an identity object. A page on Asexuality Archive discusses this issue at length, with a marked ambivalence, both using the DSM to affirm asexuality but also using asexual discourse to critique the DSM's definition. The webpage, entitled "Asexuality in the DSM-5," begins with the sentence, "Asexuality is OFFICIALLY not a disorder, according to the APA" and proceeds to discuss and unpack the explicit exception written into the DSM definitions of FSIAD and male HSDD: "If a lifelong lack of sexual desire is better explained by one's self-identification as 'asexual,' then a diagnosis of female sexual interest/arousal disorder would not be made" and "If the man's low desire is explained by self-identification as an asexual, then a diagnosis of male hypoactive sexual desire disorder is not made." Yet, as the page argues, "this is not enough." Or rather, while this exception in the DSM may make a convenient reference in an argument over whether or not asexuality "is just HSDD," the exception language may not actually be strong enough in other contexts. The Asexuality Archive page lists four problems: 1) the use of "scare quotes" (like so), which the author views as

delegitimizing, 2) the “self-identification” aspect of the exception (“You can’t self-identify as asexual if you’ve never heard of asexuality”), 3) the exception is noted only in the longer version of the DSM but *not* in the shorter “desk reference” version, *and* it is only presented separately, further down from the diagnostic criteria, making it easy to miss or overlook, and 4) the criterion of “clinically significant distress” is not sufficiently distinguishing. It severely neglects to account for social factors that are commonly recounted as a part of the asexual experience. As the article argues, “Repeatedly being told that you’re broken can cause ‘clinically significant distress.’”

This degree of wariness or suspicion toward the APA’s language is not uncommon but is also contested and not a matter of complete consensus within asexual discourse. Some, like Michael Paramo (2017) in an article on the popular journal *The Asexual*, are willing to straightforwardly refer to HSDD as pathologizing—“Under the dictation of HSDD, my body was inherently problematized.” Others provide different readings. For example, one AVEN thread on the subject, “issues with hypoactive sexual desire disorder criteria” (2017), begins with a post saying, “I don’t think the current criteria is good enough to protect asexuals from what’s basically conversion therapy, especially people who are questioning or unaware of their asexuality.” Another member disagrees and affirms the validity of HSDD as a legitimate diagnosis, while positioning asexuality as easy to distinguish: “the difference is that an asexual generally has no interest in changing their sexuality.” Yet still others doubt the validity of the diagnosis as a whole, and one poster even shared a personal narrative of personal distress and attempts to change themselves through the medical establishment, which is positioned as a past mistake and an example of wrongful mistreatment:

When I was young I was married. My husband had a very hard time with me not wanting sex. That began FOUR YEARS of therapists, doctors, and medical visits. I was blamed for not being a "good wife." My husband was encouraged to "take it" from me. It was horrible! Was I distressed? Hell yes I was "distressed"!!

### *Asexual Accounts of Flibanserin*

I found no evidence to suggest that the asexual community was ever contacted by the FDA, the New View Campaign (anti-flibanserin), or any other official, professional, or activist group involved in the decisive flibanserin hearing. With that said, some information about it did eventually trickle down to AVEN and the asexual blogosphere in the latter stages, primarily through journalist news outlets. Sometime before the 2015 hearing, AVEN organized a small online petition under the headline "Tell the FDA: Disinterest in Sex Shouldn't Be Treated With A Pill." The full text of the petition includes citations and a references full of sexological and sociological sources, raising concerns "about the 'disease' that this drug seeks to treat." The petition presents several points in the case against flibanserin, some of them similar to those of the New View Campaign, but what distinguished it was its last and final point: that marketing this drug "will encourage misdiagnosis and mistreatment of people on the asexual spectrum."

After the approval, ace bloggers continued to write about their dismay and objections, continuing to highlight the cultural aspect of "distress" and the sense that asexuality was being pathologized. It was not until this point that finally, after the fact, someone outside of the asexual community with an official role in relation to flibanserin finally acknowledged the community's concerns—if only to dismiss them as irrelevant. It took a journalistic media

publication reaching out for comment for Sprout to finally release a statement on the matter, which included the line, “Asexual individuals are not distressed, and therefore would not be a candidate for treatment with Addyi.” On tumblr, the Ace Flibanserin Task Force responded with a post that begins, “Here’s the problem: Unfortunately, some aces are distressed about being ace and/or about having low sexual desire.”

Elsewhere, on Wordpress blogs, the tone was similarly apprehensive. A blogger named Sennkestra has released multiple “drug watch” posts announcing developments in Sprout’s marketing scheme for Addyi, such as the short-lived “Find My Spark.” As further discussed in the comment section of that post (2017), the “Find My Spark” website included a “my sexual health quiz” for visitors to self-evaluate for FSD (Female Sexual Dysfunction). According to these ace bloggers’ attempts to test the quiz, selecting “very satisfied with my sex life” in combination with “no sexual activity” & sexual disinterest options returned results encouraging them to think of themselves as having a problem—indicating that nonsexuality itself overrode the absence of distress in the coding of the evaluation. Sennkestra also posted more recently with a “mini update” (2018), celebrating that the prior “Find My Spark” initiative had died but that Sprout was up to more objectionable activity: promoting a telemedicine portal for prescriptions and launching a second “suspicious new marketing campaign,” For Hers. On the former, Sennkestra wrote, their site “encourages women to bypass their usual physician to speak to a sprout-recommended telemedicine provider,” who, it is discussed, might be less likely to encourage any other response and more likely to simply prescribe Addyi.



In these responses, from AVEN to Tumblr to Wordpress, flibanserin is positioned as threatening to the asexual community, as pathologizing low sexual desire in and of itself, and as ignoring or even contributing to the cause of distress.

### **Asexuals in Love**

Distress, of course, is not all that appears in asexual narratives. In response to popular associations between sex and romance, asexual discourse takes pains to affirm that asexuality is no universal barrier to romance, arguing that nonsexual love is legitimate and that not all asexual people are uninterested in romantic relationships.

Consider, for instance, these excerpts from the AVEN “Relationship FAQ” page or the book *Asexuality: A Brief Introduction*. In the latter, the author presents “Common Questions About Asexuality” answers the question “Can asexuals fall in love?” with “Although asexual people do not experience sexual attraction, that does not necessarily mean that they do not experience romantic emotions. As most people know, love does not equal sex, so it’s possible to fall in love with someone and not be interested in having sex with them.” This same separation is repeated in the section “A Bit of Attraction,” which includes the line “Love and sex are different things,” in context simply meaning that they can be experienced separately. In the section dispelling “Myths,” one such myth is that statement that “Asexual people can’t fall in love,” which the author corrects by explaining that there are asexual people who “feel the full range of romantic emotions” and there are also asexual people who do not, which leads into a discussion of “romantic orientation.”

Similarly, the AVEN FAQ on Relationships includes the question “Why do asexuals want romantic relationships, anyway?”—answered with “Many asexual people still desire deep personal connections through romantic love, and experience romantic attraction to other people.” Another part of the FAQ, “For Asexuals,” includes “My partner is pressuring me to do sexual things that I don't want to do. How do I resolve this tension?” The very first sentence of the FAQ's response begins, “You have no obligation to do things you don't want to do, even to please your partner,” thereby explicitly rejecting the concept of sexual obligation. With that said, a sense of sexual obligation and conflicts over sex in romantic relationships are a recurring object of discussion in how the asexuality community.

### *Narratives of Relationship Tensions*

For the asexuality community, romantic relationships can be a fraught subject, mirroring what was said in the flibanserin hearing about a sense of sexual obligation as a site of distress. In some personal narratives, aces may become resigned to either negotiating “compromise” or else facing a lack of intimate relationships in life. The notion of “compromise” with regard to sexual consent can be extremely ethically fraught, which has been acknowledged and discussed by aces before. For example, this topic has been treated in a polemical post entitled “Why I Won't Sexually Compromise: Asexuality and Relationship Expectations” (2014), in which the author Stormy explores the rhetoric of “compromise” in relation to a personal narrative of sexual violence. One line in particular out of this post bears a striking resemblance to one of the narratives from Chapter 2. Speaking of a former partner, Stormy wrote, “I deserve not to spend my nights in tears because some woman insisted she doesn't need consent from me.” The

statement bears a striking resemblance to another by Kim Whitemore, given at the 2010 FDA hearing, relaying her “dutiful” sexual experiences and how she was “almost always reduced to tears” (252). Unlike the discourse of the flibanserin hearings, however, there are sites of asexual discourse in which such a relationship is recognized as unethical and exploitative.

With that said, compromise is nonetheless a prevalent frame for aces and intimacy. This tension is highlighted in the personal narratives delivered through the documentary *(A)sexual* (2011). Although the film features the contented singlehood of Julie Decker, it does conclude with David Jay reflecting on a reluctant change in perspective with regards to relationships. Earlier in the film, we were introduced to Jay’s close friends, one of whom was in a romantic relationship with another man but nonetheless openly discussed the possibility of the three of them (herself, her partner, and her friend Jay) raising a child together. At the time, Jay seemed contented with his social network and community connections. As the film tells us, however, two years later, life circumstances had shifted, and many of these close friends had moved away or drifted apart from him. Visibly distraught, he narrates how this forced him to realize that the kinds of relationships that he most desired and were most ideal to him were not relationship that he “can depend on” or “raise a kid in.” As a consequence, he says he has become more interested in pursuing a romantic relationship and thinking through an inner renegotiation of his boundaries in order to ensure a mutual prioritization. In his words, “Sex is how we take relationships seriously,” and “It is really... kind of... disheartening for me to feel like I might need to have sex just because that’s the only way to... access the kind of intimacy that I want to access.”

In this presentation of an asexual personal narrative, Jay's experiences lead him to believe that he might not be able to bring his ideal relationships (close friendships, nonsexual romance, or something that straddles the line) into reality. He is disheartened, facing what he believes is a choice between either sacrificing his sexual preferences or else sacrificing a chance at love. It is personal narratives like these that demonstrate another way in which asexual distress can arise: not just in the medicalization of the individual, as wrong for lacking some aspect of sexuality, but also in the perception of the individual as romantically or emotionally *undesirable*. As these narratives show, in some cases, aces may be deprioritized by others unless they make more of an effort to assimilate into more normative models of committed partnership.

What the film does not show, regrettably, is that Jay did not remain as doomed to resignation as the documentary's narrative would make it seem. Several years later, in 2017, Jay published an article revealing that he is, in fact, getting to live his dream of raising a child: "My Path To Becoming A Third Parent." In the article, Jay the commitment he has formed with Avary and Zeke, a heterosexual couple who planned to have a baby together. Jay is not partnered with either of them on a romantic level—in fact, he does have a partner of his own, who is uninterested in children. At the same time, he is open about being "deeply wired for parenting," and Zeke and Avary have invited him to have a role in the rearing of their child. Despite the willingness of all parties, the idea of a three-parent team is foreign and unscripted to them, which makes having a frank conversation about actual expectations difficult:

How, exactly, to have that discussion is still a mystery to all of us, but we start to stumble our way through. I draw a line in the air. "On this end," I say, "the baby starts

crying and I give her back.” I move my hand two arm lengths over. “And on this end we are equal coparents. I live with you, we equally share expenses, I’m bottle feeding at 4 a.m. Show me the range that you’re interested in discussing.” (Jay 2017)

In Jay’s account, he acknowledges the centrality of “queer couples” as the reason why third parent adoption has been made legal in the state of California, describes the research and planning that went into the arrangement with reverence to that legacy, and describes one of the reasons why three parents are better than two: more adults to take shifts during the night means shorter shifts and more sleep for all.

#### *Positive Narratives of Nonsexual Love*

In contrast to narratives of relationship tensions, the asexual community also invites and creates more positive narratives of nonsexual romantic love. These narratives, “proving” that such relationships are possible, could have been invoked to disrupt the flibanserin proponents’ production of sex as universally indispensable for a loving marriage. The affirmation of love without sex outright contradicts that discursive formation, making it potentially salient as a source of counterarguments. For a small selection of examples, consider the AVEN thread entitled “The Good Partner Thread” (2012), whose first post by AVEN user Lady Girl explains, “I think we're all VERY aware of the difficulties a ‘mixed’ relationship can cause (if not, there's plenty of threads for those posts). So let's hear some of the good stuff (good stuff ONLY please).”

In this thread, members offer real (not just hypothetical) examples of loving romantic relationships that, contrary to the successful pro-flibanserin discourse, present a picture of

happiness and love without sex. Posters replied to the thread writing in about their asexual partners, describing their favorite qualities about them and telling stories that present the “mixed” relationship in a positive light. Individual asexuals are described by their partners as, “extremely and passionately loyal,” “amazingly thoughtful and romantic,” and “a wonderful cook.” In some personal narratives, an asexual husband is credited with bringing the spouse tea in bed, in one example, and spending birthday money on a loved one rather than himself, in another. These reflections feed into conclusions about the posters’ satisfaction and gratitude for the relationship: “Definitely an absolute keeper.” “I never thought I could enjoy a relationship this much.” “I have truly never been happier in my life.” In fact, one contributor to the thread, *gablesgirl22*, even *credits* asexuality for making a better relationship possible:

I love that my husband can experience intimacy through our companionship on a level that is unreal. It creates this space that is almost unheard of, and our friendship is what everyone comments on all the time. It's awesome, and I don't think it would be possible to this degree if he wasn't an ace :)

Granted, this is not necessarily a widespread perspective. As the first post of the thread even acknowledges, these are not the usual approaches to commentary on “mixed” relationships, which are openly acknowledged to have their “difficulties.” The congregation of these more positive narratives in the context of the ace community, however, might have lent the potential to be disruptive to the pro-flibanserine truth claims about the place of sex in marriage.

## **Conclusion**

In this chapter, I have analyzed asexual community discourse and its own production of the distressed nonsexual subject, with reference to how this production both aligns with and challenges the production of the distressed nonsexual subject at the flibanserin hearing. Like the HSDD patients in the flibanserin trials and flibanserin hearing, members of the asexual community are majority young, American, and female (both in gender and assigned sex). Like the HSDD patients, those in the asexual community may pursue romantic relationships, in which sex is a point of tension, and may experience distress over their absence of sexual desire. Yet the discourse of asexual community creates a completely different narrative, attributing that distress to cultural norms, interpersonal conflict, and false consciousness, rather than an innate medical brokenness in the individual. Additionally, the invocation of “sexual orientation” language brings with it the ethical frame which says a sexual orientation is not a problem to be fixed or changed. Asexual narratives show that asexual identity cannot be easily distinguished or disentangled from HSDD using the mere criterion of “distress” or feelings of “brokenness,” as these experiences are familiar narratives in the asexual community as well. Consequently, I argue that the asexual community’s production of the distressed nonsexual subject illuminates the gaps in the opposition rhetoric at the flibanserin hearing.

More broadly, asexual community practices of consciousness raising challenge vastly pervasive formations in the discourse of sexuality. Asexuality disrupts the binary of “straight sex” versus “queer sex,” destabilizes platitudes like “we are all sexual beings,” and exposes in “sexual obligation” discourse the sexual imperative, inverting traditional models of sexual repression. Asexual consciousness raising alleviates individual shame, and at the same time, it represents a radical departure from the “reality structure” of much of the discourse on sex,

love, and intimacy. Contrary to the formation circulating through the flibanserin hearing that sex is universally “an important, healthy, and natural part of a loving relationship,” asexual discourse decouples sex from love, arguing for a more diverse breadth of what it means to have a “loving relationship.” Conversely, sexual obligation becomes a frame to be rejected, problematized by personal narratives which expose its support of sexual exploitation.



## Chapter 4: To Freely Give Zero Fucks

At the the 2014 FDA Patient-Focused Meeting, Judy Segal observed an overwhelming lack of equivocation about framing nonsexuality as a medical experience. Contrasting that framing against her own speculations, she wrote,

All of their experiences were coded as symptoms. That is, women experiencing low sexual interest/arousal/desire were already constituted as people with a disease rather than as, for example, people with unresolved relationship issues or a history of sexual repression or a life-with-work-and-children that left little energy for sex. (Segal 2018, 470)

These alternative etiologies of low sexual desire—relationship issues, sexual repression, capitalist exploitation—bear an almost one-to-one resemblance to the “Myths of Asexuality” presented and contradicted in Julie Decker’s *The Invisible Orientation*. Under that heading, Decker lists subsections in the form of questions: “Have asexual people just not met the right person?” “Are asexual people repressed, boring, or dispassionate?” “Are asexual people too distracted by their busy lives?” For Decker, an asexual activist, each question represents a “myth” to be discounted, an inapplicable or inappropriate way of making sense of asexuality. In other words, asexual discourse disputes the foregrounding of these kinds of etiologies as a form of invalidation, a reinscription of universal sexuality (merely disrupted, repressed, or hidden, as opposed to *absent*). While Segal’s proposed alternatives may well be applicable in some cases, her suggestions are telling in that she names three etiologies in the form of *problems*—relationship problems, psychological problems, energy problems—while making no move to

recognize any possibility of nonsexuality as acceptable in its own right. Even in rejecting the framing of nonsexuality as a “symptom,” or medical problem, she nonetheless retains the framing of nonsexuality as a problem of some other kind.

Segal’s criticism can be taken as largely representative of the opposition speakers at the flibanserin hearing: questioning the specifically “medical” framing while *holding to* the production of low sexual desire *as a problem*. That is, although they challenged the specific phrasing and main goals of the flibanserin proponents, they also implicitly accepted its foundations. For this reason, I see Segal’s argument that “the case for approving flibanserin had already been won before Sprout submitted its application” as overdetermined and under-attentive to points of resistance.

### **The Distressed Nonsexual Subject(s)**

In the previous two chapters, I have argued that proponents of flibanserin produced a clearer, stronger narrative of the distressed nonsexual subject than did their opponents, and that asexual discourse indicates untapped affordances for reframing the debate. The FDA committee’s decision at the close of the hearing should not be taken as simply a foregone conclusion. While there is no saying for sure how the course of the debate could have been altered, I argue that asexual discourse throws into relief what was absent from the opponent’s rhetoric at the hearing, codifying certain points of resistance.

The medical discourse on nonsexuality, especially that of the flibanserin proponents, produces distressed nonsexuality as HSDD. This diagnostic category of HSDD explicitly includes a “distress” criterion added as part of sweeping changes to the DSM made in the 1990s. My

argument has been that this “distress” criterion should not be taken as ideologically neutral; a Foucauldian analytics takes desires (and distress) as discursively constructed, as we might easily conclude of the selfsame criterion present in the 1974 version’s “Sexual Orientation Disturbance” and 1980’s “Ego Dystonic Homosexuality” (Drescher 2015).

In the flibanserin debate specifically, proponents invoked a “truth” of sex as essential to a woman’s sense of self and the maintenance of healthy, loving relationships, allowing for its absence to render her “broken.” Low sexual desire was produced as an inherently distressing, *destructive* force, “killing” happy marriages. Sex was spoken of as “what a wife should want,” framing “duty sex” as a begrudging but necessary obligation. The medicalizing discourse of nonsexuality calls for a disciplining of the self, to inhabit the sick role, to seek treatment, to attempt to medically, literally *produce* desire, at any cost.

The distress of low desire, proponents argued, might possibly be alleviated by a pill, and for some women this distress is so great as to be worth the side effects and low efficacy. Within this discourse, the production of the status quo and “lack of a medical option” as a state of “unmet need,” winning FDA approval by framing another rejection as a form of cruel indifference and neglect. Although the opposition recognized something amiss with this construction, its response did neither rhetorically refute nonsexuality-as-problem nor introduced any personal narratives of happy nonsexual marriage.

Nonsexuality is produced differently enough to be instructive for comparison in asexual discourse, the discourse of the asexual community and asexuality-as-identity. Under this discourse, nonsexualities such as a lack of sexual attraction are produced as “asexuality,” a sexual orientation. Because of its integration into broader a discourse of sexual orientation,

under which sexuality is “innate,” “not a choice,” and something to be accepted as-is, communities engage in a practice of consciousness-raising, framing negative self-perception of one’s asexuality as, conversely, a kind of false consciousness. This much is demonstrated in personal narratives of distress prior to asexual identification, wherein distress over nonsexuality is framed as societal, cultural, and ideological—borne of powerful but mistaken beliefs. While the initial distress is figured similarly to the distress of HSDD patient narratives (up to and including the language of “brokenness”), for aces the narrative takes a completely different trajectory: Instead of concluding on the need for “treatment,” the turning point in the story takes the form of “discovering” asexuality. Discovering asexuality may not prevent all future distress, but it does, in these narratives, wholly restructure the conception of the self in a more accepting way. In other words, although they were already thoroughly (painful) aware of their own nonsexualities, the effect produced by asexual discourse is to restructure its intelligibility as something natural, acceptable, and even a source of community rather than pain and isolation. Relatedly, the invocation of “sexual orientation” discourse, both by name and through the “closet” metaphor borrowed from LGBT lexicon, invokes a completely different ethics than the production of HSDD, instead framing the medical response as inappropriate and malicious. The ethical response, instead, is to challenge the source of distress.

That source of distress in asexual discourse has not been given any one particular name. With that said, it is clearly not as naturalized as it is in medical discourse. Instead, it is framed as a misunderstanding—deliberate or not—of “culture” or “society,” a misapprehension, an overgeneralized belief about the nature of human sexuality. In some accounts, this same concept has gone under the name of “compulsory sexuality” or “sex-

normativity.” Compulsory sexuality creates distress by producing sexuality as “natural” part of what it means to be “human,” its absence explicable only in pathology or repression, which imposes on the nonsexual subject a sense of inner “brokenness.” This distress can only be alleviated by challenging compulsory sexuality.

Another point of departure from the flibanserin hearing lies with the sticky quandary of conflict in “mixed” romantic relationships. By mixed relationships, I am referring to romantic relationships between either an HSDD patient and a “healthy” partner or an asexual partner and a partner who is not asexual. Both discourses acknowledge that conflict over mismatched levels of sexual desire can arise in these relationships. Unlike the pro-flibanserin formation of “duty sex” and sexual obligation, however, asexual discourse features a range of ambivalent-to-negative perspectives on what is called “compromise.” In some sites of ace discourse, “compromise” is even framed or described as violating and unethical.

Further, unlike in the flibanserin hearing, asexual discourse fosters (comparatively) less silence on the topic of sexual violence from intimate partners, which asexuality-as-identity should not be mistaken for an immunity to. In fact, this topic is even considered salient enough to be included on the community census. According to those numbers, of the 44% of aces who reported some form of nonconsensual sex, sexual assault, or sexual coercion, 48% described their perpetrator as an intimate partner (Bauer et al. 2018). The asexual community has also produced initiatives like Resources for Ace Survivors, a project supporting asexual spectrum survivors and victims of sexual violence. Meanwhile, I found no acknowledgement of intimate partner abuse against HSDD patients among pro-flibanserin advocacy. If anything, the pro-

flibanserin speakers were successful in deeming the entire specter of sexual abuse to be irrelevant.

Was the case for approving flibanserin already won from the start? Structurally, Sprout had the advantage, with the financial resources and public relations team to curry favor with large women's organizations and bring many speakers to the floor, and corporations *do* tend to get their drugs approved with the FDA more often than not (Goldacre 2014). What invites room for doubt is the prior two rejections, creating precedent in which the opposition had been successful, and the ambivalence expressed by the 2015 committee. Would Sprout still have won if, for instance, the opposition had brought any asexual people or any narratives of happy nonsexual love to the hearing floor? Possibly. I suspect, however, that this could have at least forced a shift in the discourse *away* from the universalizing language, backing off of generalizations about "what a wife should want" to instead hedge around "what some wives want to want." With the final committee vote so hesitant and ambivalent as it was, such a destabilization of the proponents' strategy might well have tipped the scales in the end. I raise this point not to claim any certainty toward alternate outcomes but rather to challenge the idea that *the way things are* must *necessarily* be so.

### **Future Directions**

This analysis highlights how a particular feminist effort, the New View Campaign, could have altered the course of the hearing if it had partnered with an asexual organization, such as AVEN or Asexual Outreach, in order to introduce asexual counternarratives. More broadly, though, it invites attention to this case not just as a medicalization of sex, but as a discourse on

“the truth of sex.” What were the effects of power generated by what was said? At the FDA hearings and beyond, Sprout Pharmaceuticals, Even the Score, and their organizational allies circulated a discourse of sexual obligation: that sexual refusal, especially within heterosexual marriage, must operate on only a limited scale or else become unacceptable, for it is the wife’s “duty” to have sex. The essence of a happy, healthy marriage, they have argued, *depends upon* active sexuality.

On any given discourse of sex, Foucault would ask, “What were the most immediate, the most local power relations at work? How did they make possible these kinds of discourses, and conversely, how were these discourses used to support power relations?” (1990, 97). While the New View Campaign rightly identified the corporate profit motive and industry investment in the debate, funding speakers to overwhelm the hearings and financing their own astroturf organization to promote their message, the most *local* power relation making this discourse possible (and conversely, that the discourse was used to support) takes the form of the married couple. Contrasted the struggling sexless marriage against the loving sexual marriage, it extols sex as “important,” “healthy,” “natural” part of “a loving relationship.” What is constructed, then, is an ideal of a “loving relationship” which demands sex as essential to love—a manifestation of compulsory sexuality.

Identifying hegemonic discourses of compulsory sexuality poses implications for feminist activism, disability studies, queer theory, and critical scholarship more broadly with regard to the critique of sexual norms. In the case of disability studies, as Karen Cuthbert notes, “Asexuality appears occasionally within this literature, but only as an oppressive mantle to be shrugged off”—and conversely, positive agency is framed in terms of sex (2017, 242). For this

reason, scholars of asexuality studies have critiqued critical/activist rhetoric which positions asexuality solely as ideologically threatening—a construct appearing in rhetorics of sexual liberation (Milks 2014), queer readings (Gupta 2013), race studies (Owen 2014; Owen 2018), and disability advocacy (Kim 2011; Kim 2014; Gupta 2014; Lund and Johnson 2015; Cuthbert 2017). As demonstrated in the previous chapters and their conclusions, heteronormative discourse can include a celebration of sex and enforce distress for the nonsexual subject. Taking this construction seriously as an element of heteronormative force relations would mean disposing with the framing of agency in terms of sex and its endorsement of the repressive hypothesis.

### **The Repressive Hypothesis**

The repressive hypothesis is a term used by Michel Foucault to discuss a particular way of approaching sexual norms as “one great central mechanism destined to say no,” a view of power entirely focused on negation (1990, 12). Accordingly, a recognition of such power calls for the imperative “breaking of a secret,” to speak and rupture the (presumed) silence—which Foucault, rather than endorsing transformative, instead questions as “partak[ing] of the injunction by which discourse is provoked” (34-5). That is, the injunction to proclaim the truth of sex is perpetuated, not disrupted, by the repressive hypothesis and its implications. An approach of this kind would have nothing in its toolkit to critique the discourse of the filibanserin hearing, in which the truth of sex was proclaimed to be its utter necessity in heterosexual marriage. This particular case study is dramatically demonstrative of why “repression” cannot be the only name for the pathologization of sexuality. As Foucault argued,



“We must not think that by saying yes to sex, one says no to power... It is the agency of sex that we must break away from” (157).

I am arguing that a rejection of the repressive hypothesis, in light of the medicalization of nonsexuality, means that the use of the name “asexual” for a hegemonic figure is not a neutral choice. That is, carries its own political implications. This argument has been made powerfully by Ianna Hawkins Owen on the subject of antiblack racial stereotypes and the conventional way of describing the “Mammy” as an “asexual” figure. In Owen’s words, “Interrogation from an asexual standpoint reveals that the labeling and positioning of the mammy's asexuality is problematic because the white male's alleged desire is centered, not the black subject's” (2014, 123). This critique highlights that in deeming the stereotype an “asexual” one, “asexuality” then becomes conflated with a lack of agency, constraining what the exercise of sexual agency can look like. Hence, Owen calls for racial-sexual critiques which “make space for black women to each wonder about her own life, to desire in unimaginable ways, and to freely give zero fucks, literally” (2018, 77).

In specific types of discourse on sex, in a specific form of extortion of truth, appearing contemporarily and in specific places, low sexual desire has been pathologized—made adversarial to actually inclusive love, marriage, and the family. These amount to conservative efforts to *enforce* (certain forms of) sexuality, not just repress it. For this reason, it is possible to identify a construct of “asexuality” that is not solely repressive, conservative, or hegemonic, but rather is itself a target of hegemonic forces. From asexual communities we hear voices struggling with identity, rejecting previous identity categories, and re-framing the experience of

“distress,” pointing us toward a broader critique of society and the discursive production of (non)sexuality.

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## Vita

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