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Low Desire, Trauma, and Femininity in the DSM-5: A Case for Sequelae

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Abstract

The recently released *DSM-5* (2013) includes a new sexual dysfunction: Female Sexual Interest/Arousal Disorder (FSIAD). For the first time, the low sexual desire disorders are split along gender lines, and lack of sexual 'receptivity' is offered as a criterion for diagnosis in women only. Although 'severe relationship distress' or other 'significant stressors' are to be considered during evaluation for FSIAD, the patient's trauma history is not evaluated as part of the protocol. The presence of violence or distress can potentially elicit a differential diagnosis, but what constitutes 'severity' is not articulated either, except to designate 'partner violence' as the primary example. Thus, *past* relational violence, sexual abuse, and trauma are not explicitly considered—nor is the vast spectrum of gendered violations that many women describe experiencing on a regular basis. I examine potential problems with separating the trauma diagnoses (i.e., Posttraumatic Stress Disorder, Depersonalization/Derealization Disorder, and other Trauma- and Stressor-Related or Dissociative Disorders) from FSIAD in the *DSM-5*. Drawing on interviews with low-desiring women who describe being violated, I elaborate how this diagnostic separation may be re-traumatizing for women who have experienced such violence and have low sexual desire as a result. I also question the utility of framing psychological disorders and symptoms as 'comorbid' (i.e., concomitant but unrelated) and argue instead for more thorough etiological or 'sequelic' investigations of low desire.

Keywords: Female Sexual Interest/Arousal Disorder (FSIAD), Posttraumatic Stress Disorder (PTSD), trauma, violence, desire, gender

Concerns regarding the medicalization and psychiatric diagnosing of 'normal human variation'—specifically as these diagnoses pertain to sexuality, desire, gender identity, and other individual sexual behaviors and expressions—are well-documented (for examples, see Boyle, 1993; Moynihan, 2005; Moynihan & Mintzes, 2010; Tiefer, 1995, 1996, 2001). In this article, I draw attention to the implications of a specific diagnosis, one that is new to the *DSM-5*: Female Sexual Interest/Arousal Disorder or FSIAD. FSIAD replaced the DSM-IV diagnosis of Hypoactive Sexual Desire Disorder (HSDD) in Women and also incorporated another DSM-IV diagnosis, Female Sexual Arousal Disorder (FSAD). This new disorder is only diagnosed in women, and its introduction is worth examining, as—according to recent research—around a third of women in the U.S. lack interest in sex or experience distress due to their low sexual desire (Laumann, Paik, & Rosen, 1999; West, et al., 2008) and thus may be potential candidates for diagnosis with FSIAD.

I have articulated critiques of FSIAD on several bases elsewhere (Spurgas 2013a, 2013b). First, female receptivity is prescribed in the diagnosis, via its foundation within the 'alternative female sexual response model' (Basson, 2000, 2001). The 'alternative female sexual response model' as described originally by Rosemary Basson argues that women have naturally lower sex drives than men do, that they are more often motivated to engage in sex because of perceived possible 'incentives' or 'rewards' to do so (e.g., fostering relational harmony or intimacy or pleasing a partner), that they experience subjective arousal (i.e., in the form of rational motivations to have sex) that is often out of sync with their physical or genital arousal (i.e., discordance), and that they are not driven to reach orgasm in the same way men are. For Basson and her followers, this indicated that the traditional Human Sexual Response Cycle (HSRC) model of sexuality (as described by Masters and Johnson, 1966), with its emphasis on sexual

release, does not accurately describe women's experiences of sex, and that a new model, specifically for women, was required. This new model—in opposition to the linear and 'male-focused' HSRC—made uniquely feminine 'receptivity' or 'responsive desire' its cornerstone. Prior to the publication of the *DSM-5*, Lori Brotto (2010) described how some of the tenets of the alternative female sexual response model would be included in the new female-specific low desire diagnosis in an article in the *Archives of Sexual Behavior*.

Brotto (2010), a member of the *DSM-5*'s work group on sexual and gender identity disorders and one of the primary authors of the FSIAD diagnosis, has argued that the term 'interest' is a better descriptor than 'desire' for women, as many women do not experience spontaneous or 'untriggered' sexual desire. Instead, she states, they may become physically aroused (e.g., upon receiving sexual overtures from an interested partner) and then become 'interested' in having sex as a result. Thus, Brotto (2010) argues that 'if one adopts the view that sexual desire is triggered, then a more appropriate determination of low desire would be the woman who never experiences sexual desire at any point during a sexual encounter—before or *after* experiencing sexual arousal' (p. 226, italics in original).[1]

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[1] Brotto (2010) sometimes refers to the 'alternative sexual response cycle' in non-gendered terms in her article, and engages with critiques of a linear model of desire on the basis that 'the Masters and Johnson model purports that women *(and men)* first experience sexual desire before experiencing sexual arousal [which she argues, along with Basson, is untrue]' (p. 226, italics added). Although she includes the parenthetical caveat that men, as well as women, may experience 'responsive desire,' her model of sexual responsiveness in this article is based on Basson's (2000, 2001) model of responsiveness, which Basson defines as applying specifically to women. In addition, up until the last few years, research on sexual responsiveness was uniquely conducted on women. Thus, there is a problematic slippage between: 1.) an *empirical* lack of evidence to support responsiveness in men, and 2.) a *theoretical* instantiation of uniquely female responsive desire. As I will argue, the existence of two separate low desire diagnoses in the *DSM-5*, one for men and one for women, with correspondingly gendered language in each (e.g., an emphasis on receptivity and responsiveness in FSIAD), discursively and diagnostically produces masculine and feminine desire, and male and female sexuality, as very different.

The diagnostic institution of 'interest' and 'arousal' and the concomitant removal of 'desire' under the terms of FSIAD (but not for the male diagnosis of Male Hypoactive Sexual Desire Disorder or MHSDD) indicate the *DSM-5* sexual and gender identity disorders workgroup's belief that an 'incentive-motivation' (Laan & Both, 2008) model of sexuality or 'motivational theory of desire' (Brotto, 2010) is applicable to women uniquely (or, at least, primarily). The language of the diagnosis (and its absence from the language of the corresponding diagnosis for men, MHSDD) also implies their belief that women are more sexually receptive than men—or, that healthy, sexually functional females are characterized by 'responsive desire' to their partners. The full FSIAD entry subsumes the following criteria:

> Lack of, or significantly reduced, sexual interest/arousal as manifested by at least three of the following indicators: 1. absent/reduced *interest* in sexual activity, 2. absent/reduced sexual/erotic thoughts or fantasies, 3. no/reduced initiation of sexual activity and typically *unreceptive to a partner's attempts to initiate,* 4. absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75%-100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts), 5. absent/reduced sexual *interest/arousal* in response to any internal or external sexual/erotic cues (i.e. written, verbal, visual), and 6. absent/reduced genital or nongenital sensations during sexual activity in almost all or all (approximately 75%-100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts) (APA, 2013, p. 433, italics added).

Many heterosexist assumptions are spelled out directly in the language of the FSIAD diagnosis in the *DSM-5*, and the presumed difference between masculine and feminine desire is particularly evident when comparing FSIAD to MHSDD (for men, desire and arousal disorders

were retained as separate entities). The only definitional criterion for MHSDD is: 'persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity' (APA, 2013, p. 440). The terms 'interest' and 'responsiveness' are not used in the MHSDD 'Diagnostic Criteria' at all, whereas in the section entitled 'Diagnostic Features' (which directly follows the 'Diagnostic Criteria' for all diagnoses in the *DSM-5*) in the entry for FSIAD, 'responsiveness' and 'interest' are articulated throughout:

> …sexual interest/arousal disorder may be expressed as a lack of *interest* in sexual activity, an absence of erotic or sexual thoughts, and *reluctance* to initiate sexual activity and *respond* to a partner's sexual *invitations*…(APA, 2013, p. 433, italics added).

Here, it is very clear that it is expected that women often won't feel sexual until their [male] partner 'invites' them to 'respond with desire.' In contrast, in the MHSDD diagnosis, sexual 'receptivity' or 'responsiveness' to a partner's advances are not discussed in the beginning of the entry in either the 'Diagnostic Criteria' or the 'Diagnostic Features' sections, and are instead not mentioned at all until much later in the entry, in the 'Associated Features Supporting Diagnosis' section. Once these constructs are mentioned, it is with a caveat or qualifier regarding men's situational *preference* for their partner to initiate sex (thus, responsiveness is not framed as a core component of male sexuality):

> *Although men are more likely to initiate sexual activity*, and thus low desire may be characterized by a pattern of non-initiation, many men may *prefer* to have their partner initiate sexual activity. *In such situations*, the man's lack of receptivity to a partner's initiation should be considered when evaluating low desire (APA, 2013, p. 441, italics added).

In these excerpts from the diagnostic terminology, there is no mistaking how the sexual difference discourse of the alternative female sexual response model has been imported into the diagnosis. It is without question that men's and women's sexual dysfunctions—and thus their normal or functional states, as counterparts—are framed as not only disparate, but opposed, with women posited as inherently more sexually receptive, and as a corollary, more discordant or dissociative (as will be explained below). This notion of women's naturally discordant state is also articulated in the diagnosis through numerous references to experimental psychological research which utilizes vaginal photoplethysmography. Some of this is the same experimental research used to instantiate the transition from female 'desire' to 'interest/arousal' in Brotto (2010).

The framework for FSIAD thus also shares common assumptions with experimental psychological research that purports that women's subjective sexual desire is naturally detached from their objective physical genital response (for examples, see Chivers, 2010; Chivers & Bailey, 2005; Chivers, Seto & Blanchard, 2007; Chivers, Seto, Lalumière, Laan, & Grimbos, 2010). In multiple places throughout the FSIAD diagnostic entry, the powerful influences of notions of female receptivity and responsiveness, in line with the alternative female sexual response model, and also of female discordance, in line with the suppositions of vaginal photoplethysmographic research, are evident. The relevance of these constructs and model is based on the belief that women (whether they are diagnosed with FSIAD or not) are naturally discordant, or that their sexual minds and bodies are disconnected. This same research suggests that men are naturally more 'in tune' with or perceptive of their own subjective desire and that this desire is physically expressed through their objective genital response—that is, that men are more sexually 'concordant' than women (Chivers, Seto, & Blanchard, 2007; Chivers, et al.,

2010). The notion that even women without sexual arousal concerns often cannot get an accurate 'read' on their own physiological excitement is espoused in this research, as is the notion that most women are more likely than men to be physiologically sexually responsive whenever presented with sexual stimuli (as operationalized by vaginal lubrication and vasocongestion). Research based on comparing objective genital response to subjective psychological arousal (or subjective perceptions of objective arousal) via photoplethysmographic measure while subjects watch pornography suggests that women are less 'category-specific' (Chivers, Seto, & Blanchard, 2007) or 'target-specific' (Brotto, 2010) than are men—men are more likely to be physically aroused by 'targets' of 'their preferred gender' (Chivers, Seto, & Blanchard, 2007, p. 1109) based on their stated sexual orientation, whereas women are more likely to be physically aroused based on the general 'sexual nature of the stimulus' rather than by the gender of the 'target' (Brotto, 2010, p. 224) as would be expected based on their stated sexual orientation. This general state of female arousal, regardless of subjective experience of desire or perception of genital arousal, is highlighted under 'Diagnostic Features' for FSIAD in the *DSM-5* when the authors state: '…physiological measures of genital sexual response do not differentiate women who report sexual arousal concerns from those who do not…' and under 'Risk and Prognostic Factors' when the work group writes: 'Psychophysiological research using vaginal photoplethysmography has not found [objectively measured] differences between women with and without perceived lack of genital arousal' (APA, 2013, p. 435). In these statements, we see evidence of the framing of female sexuality as based in a mind-body disconnect, and the positing that women are innately or neurobiologically dissociative.[2] Although this supposition is not

[2] According to Chivers et al. (2010) female discordance may be the result of an evolutionary adaptation designed to help women make more evolutionarily sound choices regarding whom

spelled out directly in the *DSM-5* entry for FSIAD, it is promulgated in the research that the FSIAD authors reference, and thus it is of concern regarding the diagnosis itself. As I will argue, dissociation may very well be part of some women's experience of sex; what is problematic is the idea that dissociation is somehow inherently or naturally female, rather than a consequence of the gendered violence and pursuant trauma that women experience disproportionately around the world today.

In this essay, I analyze possible negative effects of the FSIAD diagnosis on low-desiring women who have sex with men, effects which may be particularly deleterious for women who have experienced sexual and gendered violence and, in some cases, corresponding trauma, over the course of their lives. The relationship or comorbidity among FSIAD and the Trauma- or Stressor-Related and Dissociative Disorders in the *DSM-5* is not adequately theorized nor accounted for in the current diagnostic protocol, and thus how trauma may potentially be related to low desire is not discussed. I argue that the new diagnosis may, in effect, be iatrogenically *re-traumatizing* for some low-desiring women, due to the fact that the current diagnostic protocol may lead to clinicians missing important historic traumas that women have experienced, and as such may lead to the continuation of a pattern of women being unable to integrate and respond to experiences of sexual violation. Although this clinical re-traumatization is obviously not of the

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they mate with: 'Unlike men…concordance is not necessary for women to engage in sexual intercourse. In fact, the more conservative sexual strategy (in terms of greater choosiness regarding sexual partners, having fewer sexual partners and longer term relationships) adopted by many women might be compromised by high concordance (see Symons, 1979). From this perspective, partial independence of psychological and genital processes may aid female sexual decision-making by reducing arousal-dependent appraisal of suitable mates…' (p. 50). Graham (2010), the other primary author of the FSIAD diagnosis cites this research, and Brotto (2010) herself cites other research by Chivers and her colleagues (e.g., Chivers, Seto, & Blanchard, 2007). This incorporation demonstrates how the evolutionary psychology perspective (e.g., Symons, 1979, cited in the excerpt above) on sexual difference in regards to concordance is also fundamentally intertwined with the FSIAD diagnosis.

same magnitude as actual sexual and gendered interpersonal violence, foreclosing an analysis of the relationship between trauma and low desire via the FSIAD protocol may set up women who have previously been the victims of traumatic sexual violence to be further traumatized in the future.

Importantly, while 'severe relationship distress (e.g., partner violence)'[3] is listed as a circumstance that might preclude diagnosis with FSIAD in Criterion D, neither Posttraumatic Stress Disorder (PTSD) nor Depersonalization/Derealization Disorder are listed as potentially comorbid at the end of the diagnostic entry. In the *DSM-5*, PTSD is characterized by symptoms of intrusion, dissociation, avoidance, hyperarousal, and other negative alterations in mood and cognition following exposure to a 'traumatic event,' which may include 'actual or threatened death, serious injury, or sexual violence' (APA, 2013, p. 271). Depersonalization/Derealization Disorder is characterized by experiences of 'unreality' and 'detachment' with respect to either one's own 'thoughts, feelings, sensations, body, or actions' or to one's surroundings (APA, 2013, p. 302), and these symptoms are reportedly found in the 'aftermath of trauma' (APA, 2013, p. 291). That neither of these disorders are listed as comorbid with FSIAD is remarkable, as, in the cases of PTSD, Depersonalization/Derealization Disorder, and other Trauma- and Stressor-Related and Dissociative Disorders, sexual violence is cited as a quintessential 'traumatic event' which might elicit these symptoms. The authors of the *DSM-5* never define 'trauma' explicitly, but in the Introduction to the chapter on Trauma- and Stressor-Related Disorders, they mention 'clinical distress following exposure to catastrophic or aversive events'

[3] That this violence must characterize the *current* relationship is tacit in the diagnosis, which I elaborate below.

and state that 'psychological distress following exposure to a traumatic or stressful event is quite variable' (APA, 2013, p. 265). Judith Herman (1992) has further elucidated trauma as involving the overwhelming experience, witnessing, or threat of physical or psychological terror, injury, harm, and concomitant loss of control or feelings of powerlessness. It is worth noting that even in clinical expositions, a clear definition of 'trauma' remains elusive, as the experience is clearly subjective, volatile, nebulous, and persists in a shifting taxonomy of symptoms, as a syndrome.

The possibility that sexual arousal and interest problems might be part of this systemic chain of traumatic sequelae or a syndromic network is not outlined anywhere in the current *DSM-5*. Thus, although assessing the possible presence of 'clear and present' severe relationship distress when diagnosing FSIAD may be a step in the right direction for responsible treatment, this criterion does not go far enough in accounting for external, environmental-structural, or inter-relational stressors that might influence low desire, particularly in women who have been subjected to sexual and gendered violence in the past or throughout their lives, as part of a pattern. This type of violence is not always traumatic for women (according to current clinical definitions of 'trauma'); but, in their naming of sexual violence as one of the most common traumatic events that individuals experience, the authors of the *DSM-5* imply that, in many cases, exposure to this type of violence is, in fact, traumatic for those who endure or witness it. The spectrum of gendered and sexualized violations that women experience—from childhood sexual abuse to relationship violence to street harassment to the daily experience of living in fear that any of these potentially traumatic incidents *may occur at any time*—must be accounted for when diagnosing FSIAD. This is particularly important as women are disproportionately affected by intimate partner violence, sexual violence, and stalking: nearly 1 in 5 women in the United States report experiencing rape at some time in their lives, 13% report experiencing other forms of

sexual coercion, and 1 in 4 report being the victims of relationship violence (Centers for Disease Control, 2012, 2014). In this essay, I utilize qualitative interview data gathered from research conducted with low-desiring women to assess the link between low desire and the experience of sexual and gendered violence (which, in some cases, is associated with trauma).

From 2011-2014, I conducted a series of in-depth interviews with women from diverse racial, ethnic, and sexual orientation backgrounds regarding their sexual histories and experiences of low desire. All participants were between the ages of 18 and 55 (all but three were under the age of 40) and resided in the New York/New Jersey area (except for one Canadian citizen, who was interviewed via Skype). Participants responded to flyers posted in coffee shops, grocery stores, universities, and health and medical clinics around New York City, and additional participants were contacted via snowball sample of the original participants. For this larger project, I ultimately interviewed 37 women[4] who had experienced low desire at some point in their lives, who had at some point been sexually involved with men, and the majority of whom had experienced sexual and gendered violence and, in some cases, corresponding trauma. As I conducted interviews it became apparent that almost all of the women who self-selected for participation in the study due to their experience of low desire had also experienced sexual or gendered violence in some form or another during the course of their lives. I emphasize this because experience of violence (and potential pursuant trauma) was *not* a prerequisite criterion

[4] It is important to note that all of the participants in my study were cisgendered women (they identify as women and had been assigned a female sex designation at birth), and the men they described having sex with were cisgendered men—although many currently identify as queer, and many are no longer in heterosexual relationships. Previous or current sexual relations with cisgendered men was an important variable, as this study examines the role of heteronormativity and patriarchal violence in low-desiring women's experiences of their own femininity, and as it paid particular attention to experiences in early and present-day sexual, romantic, emotional, and familial relationships with men. This research thus contributes to the burgeoning field of critical heterosexuality studies (Fischer, 2013).

for participation in the study, yet it is clearly linked with low desire, at least for the women in my small sample[5].

Here, through select personal experience narratives drawn from this data, I illuminate the complex ways that low desire, lack of interest, arousal troubles, sexual and gendered violence, fear, and trauma come together for women. This analysis indicates that in order to effectively care for women with sexual interest and arousal problems, clinicians must first fully explore their patients' possible traumatic histories and other gendered relational experiences that may have negatively affected these women's sexualities and desire patterns. Thus, more thorough etiological investigations of low sexual interest/arousal are in order. It seems that 'etiology' has become a dirty word in our post-Freudian psychological health climate, but a renewed attention to the frameworks of traumatic *syndrome* and *sequelae*—including for mental health concerns which are always relational, always political, and often experienced differently based on gender and other social variables—are necessary from an ethical and feminist standpoint. Attention to psychic history and trauma need not be delimited by Oedipal frameworks nor the rigid categories associated with traditional Freudian psychoanalysis; this attention may be more in line with the

[5] Although I did not ask my participants whether or not they had ever been diagnosed with any Trauma- or Stressor-Related or Dissociative Disorder, many described experiencing the types of gendered and sexual violence and abuse which in many cases do result in trauma (Herman, 1992), and some mentioned PTSD or described symptoms consistent with a diagnosis (it was unclear whether or not these individuals had received a clinical diagnosis from a practitioner). Many participants used terms such as 'traumatic,' 'violent,' 'violating,' 'coercive,' and 'abusive' to described previous sexual experiences, and did not clearly distinguish among these terms. They also used this language to describe the development of their own sexualities, femininities, and experiences of 'living as women in the world.' Thus, in keeping with the colloquial and loose way these terms were used by my participants at the expense of precise medical or legal terminology, I focus on the pervasive experience of gendered violence and sexual transgressions while acknowledging that these result in clinical trauma for some, but not all, women. I do not suggest that every participant in my study fits the criteria for diagnosis with PTSD or any other Trauma- or Stressor-Related or Dissociative Disorder.

types of psychoanalytic endeavors put forth by feminist and other relational analysts (for an example, see Benjamin, 1988) and thus consider affective, material, sociorelational patterns that deeply affect our psychic lives. In this vein, we may also usefully reattend to and reconceptualize the *psychosomatic*—another seemingly dirty word in our current neurobiological and cognitive-behavioral milieu.

I call for a renewed attention to feminist analyses of trauma and PTSD (Brison, 2008; Brown, 1991; Herman, 1992) and to a complex/developmental trauma framework (van der Kolk, 2005)—specifically for women and other individuals who disproportionately experience sexual and gendered violence. In clinical terms, I call for a deep and honest reconsideration of the vast scope of 'specifiers' that Graham (2010) has articulated regarding desire problems, including partner, relationship, individual vulnerability, cultural, religious, and medical factors. Importantly, it must be stated that my analysis here is *not* a call for further 'medicalization' or diagnosis of women's desire troubles[6]—but it is an acknowledgment of two things: 1.) receiving help for problems which have negatively impacted our mental and physical health is already a firmly medicalized (and individualized) endeavor and one that often relies on navigating *DSM* diagnoses, and 2.) there is a rich history of recuperation, reclamation, and strategic subversion of the language of dysfunction and disorder via powerful social movements which turn diagnoses against themselves and effectively queer them, particularly as these movements have grappled with and made use of the sex, gender, and sexuality diagnoses through the various incarnations

[6] I acknowledge that my incorporation of a feminist psychoanalytic framework cannot be fully divorced from a medical framework. A feminist psychoanalytic therapeutic encounter between a clinician and patient, in accordance with the way I discuss that encounter, would involve a more thorough accounting of history, power, interpersonal relationships, and the sociopolitical context in which diagnoses are made, though, and would thus eschew some of the most glaring problems with 'medicalization' that I cite here (this is in line with the type of 'feminist therapy theory' espoused by Brown, 1991, among others).

of the *DSM*. We must navigate medical discourses and institutions even as we politicize and resist the experiences and relationships they diagnose and disorder. It is necessary to attend to the gendered political implications of FSIAD and the relational, non-medical reasons why women might have low desire, while simultaneously acknowledging that sexual problems are currently dealt with in the medical realm. In light of this, that realm is a good place from which to begin to do this work—whether our goals are ultimately reformist or revolutionary.

Female Sexual Interest/Arousal Disorder: Prescribing female receptivity in the DSM-5

Since its initial publication in 1952, the DSM has consistently included at least one diagnosis for sexual difficulties. Over the last sixty years, the sexual diagnoses expanded to include arousal, orgasm, desire, and pain disorders, in line with the Human Sexual Response Cycle as outlined by Masters and Johnson (1966). Although sexual troubles such as 'frigidity' were arguably always pathologized and feminized under the various diagnoses, the language of the desire disorders themselves has remained gender-neutral since the institution of the first desire disorder, Inhibited Sexual Desire (ISD), in 1987—that is, until the publication of the latest version.

In light of the 'receptivity' or 'responsiveness' criterion included in FSIAD, an analysis of the aspects of the diagnosis that will be particularly troublesome for trauma survivors is paramount. In the 'Differential Diagnosis' section for FSIAD, 'severe relationship distress, such as intimate partner violence' is listed as a circumstance that would cause a clinician to consider *not* diagnosing a woman's low desire as evidence of FSIAD. Non-sexual issues such as 'significant stressors' are mentioned in the terminology of both MHSDD and FSIAD in Criterion D (the presence of which would require consideration of a differential diagnosis or no diagnosis at all), but throughout the majority of the entry for FSIAD, 'relationship or interpersonal distress'

is listed as *associated* ('comorbid') with low desire, or, more frequently, low desire is cited as a *cause* of relationship distress, as it is in the following passage: 'Distress may be experienced as a result of the lack of sexual interest/arousal or as a result of [the lack of interest/arousal's] significant interference in a woman's life and well-being' (APA, 2013, p. 434). It is unclear how this lack of sexual interest/arousal might specifically interfere in the diagnosee's 'life and well-being,' but, as low desire is spelled out as a relational problem in Criterion A3 (as it may be associated with a woman's lack of receptivity to her initiating partner), this framing begs the question of whether or how her partner's sexual satisfaction contributes to a diagnosee's quality of life and well-being. Given the way relationality is taken into account in the diagnosis, it seems plausible that, in some cases, the interference in a diagnosed woman's life quality could be a result of her *partner's* dissatisfaction, which might create a problem with relational discord. Further down in the diagnostic entry, the notion of distress is mentioned again in the 'Functional Consequences of FSIAD' section: 'Difficulties in sexual interest/arousal are often associated with decreased relationship satisfaction' (APA, 2013, p. 436), and, again, in the 'Comorbidity' section. In all of these examples, it seems curious that relationship or interpersonal distress is articulated as 'associated with,' 'comorbid with,' and 'resulting' from low desire, but it is never assessed as a possible *cause* of low desire.

In addition, only '*severe* relationship distress,' such as 'partner violence' is mentioned as a possible trauma-related reason to not diagnose a woman with FSIAD. But, it is unclear how 'severity' will be measured as a factor that may lead to a differential diagnosis[7]. It is also striking

[7] This lack of clarity around 'severity' begs the questions: Is clear-cut physical violence or brutality at the hands of a present partner the only legitimate form of '*severe* relationship distress' that might factor into a reconsideration of the diagnosis? Are other kinds of distress legitimate? Just how distressing must these factors be to sensibly or *legitimately* affect a

that the experience of violence that must warrant a differential diagnosis is tacitly defined as contemporary, current violence, while the possibility of earlier traumatic experiences or histories of abuse are not accounted for. A larger discussion around the murky terrain between coercion and consent is never taken up, and the hyperbolization and hypostatization of 'severe relationship distress' and its equation with intimate partner violence or abuse is problematic; feminist clinicians and researchers (for recent examples, see Christianson [2014] and Tolman, Spencer, Rosen-Reynoso, & Porche [2003]) have suggested that there is indeed a very grey area in terms of what is consensual—let alone what is *desirable* or worthy of *interest*—when it comes to sexual relations, including heterosexual intercourse (which is the type of sex that is implied in both of these heteronormative diagnoses [MHSDD and FSIAD]).

Some therapists, such as Kleinplatz (2011) and Tyler (2009), have argued that building the notion of female receptivity into the FSIAD diagnosis as a normative construct may be harmful to women, particularly those who have experienced sexual and gendered violence. Illuminating the stories of women who have undergone treatment for sexual dysfunction is thus a powerful way to demonstrate potential problems with the diagnosis. Two of the women I interviewed had been treated in a program designed to help women overcome female sexual dysfunctions, including vestibular vulvodynia, Genito-Pelvic Pain/Penetration Disorder, and comorbid Hypoactive Sexual Desire Disorder in Women (their treatment was prior to the publication of the *DSM-5* and the institution of FSIAD). As only two of my participants had undergone this type of treatment, these results are in no way generalizable. But, their stories do highlight some of the biggest problems with the receptivity criterion and associated aspects of FSIAD, and, as these women are both survivors of sexual and gendered violence and both

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woman's responsive desire? What if the violence is distressing to her, but not to her initiating partner? And: who will be making the call?

identify as low-desiring (or did at the time of their treatment), their narratives help us explore the relationship between low desire, physical pain, and the experience of violence, and warn of problems with diagnosing FSIAD in women with this particular set of experiences. In North America, one way that women are increasingly encouraged to learn how to 'get back in touch' with their body's 'natural' state of arousal is through Mindfulness-based Cognitive Behavioral Therapy or MCBT (Brotto, 2011; Brotto, Basson & Luria, 2008; Brotto, Krychman & Jacobson, 2008)—a type of cognitive behavioral therapy that incorporates the Buddhist technique of meditative mindfulness to help women stay 'focused' and 'present' during a sexual encounter. The treatment programs my participants had been through involved the use of MCBT among other techniques. One of these participants, Astrid, had deep criticisms of the program, and specifically of the alternative female sexual response model:

> They explained that in the course of a normal relationship—a heterosexual relationship just understood—that, at first, both the man and the woman might experience this 'spontaneous desire' for sex with each other, but as time would go on, the man might still experience that, but the woman would no longer experience the spontaneous desire… what she would experience instead would be sort of a willingness to engage in sex. So, for reasons of increasing the intimacy levels or whatever—like, 'we get to cuddle at the end' and stuff—we [the treatment program participants] would have been willing to respond to the advances of our husbands or the men in our lives, and that this is kind of how normal relationships go…in the beginning, you have mutual desire that's like, you see each other and you desire each other, but as things go on the guy still has that but the lady doesn't have that anymore, and so she's like more willing to be seduced…[later in the course of the program] the men [male partners] were given a chance to talk about how frustrated they were [about their partners' lack of desire], then they were educated in this

> 'response cycle' thing, that we had also been taught about: 'Well, you might feel spontaneous desire for her, but she may need to be coaxed into it' kind of thing.

Kelly, another participant who had been treated in a program designed to help alleviate her vaginal pain and low desire, stated:

> The idea was [to use MCBT] so that I could continue to have sex, which is kind of weird because if I didn't want to have sex [Kelly explained that she was not interested in sex at all during this time], why am I doing exercises so I can continue doing it? So that was kind of strange…and *male-focused*! Because if I wasn't enjoying sex at the time, then it's something that I'm doing almost just so that my boyfriend can still have sex with me, it wasn't something that would help me with my *own* pleasure…

In both Astrid's and Kelly's comments, the heteronormative bias of the alternative female sexual response model for women is clear[8]. It is also clear how, through these treatment programs, women were taught what the normative framework for women's desire is—a framework that is based on receptivity, responsiveness, and a willingness to be seduced or coaxed into sex by an initiating male partner. These participants were also taught that the kind of sex they were *not* going to naturally or spontaneously desire, but also that they should be receptive to engaging in for their male partner's benefit, likely involved penetrative intercourse with a focus on male pleasure. Thus, women were not only taught what their own desire should feel like, but what

[8] I do not suggest that the human sexual response cycle (HSRC) as articulated by Masters and Johnson (1966) is more appropriate for women (or men) than the alternative female sexual response model, only that the alternative female sexual response model does not offer a true or viable alternative to the HSRC and thus does not account for the diversity of human desire, which, in many cases, is not sexually dimorphic (as *either* essentialist model purports). Masters' and Johnson's HSRC has been critiqued at length elsewhere (for examples, see Tiefer 1995, 1996, 2001), and both Angel (2013) and I (Spurgas 2013a,b) have elucidated how some of these feminist critiques and the alternative female sexual response model itself unfortunately reinscribe binary, gendered, and rigid frameworks for sexual desire.

kind of sex they were meant to be engaging in, and for whose enjoyment. These normative assumptions pose particular problems for survivors of sexual and gendered violence, which both Astrid and Kelly were. In the remainder of this essay, I present participants' narratives to shed light on how gendered violence and pursuant trauma have informed their senses of their own femininity, and their experiences of sex throughout their lives—experiences which emphasize the gendering of sexuality and of desire itself. Immediately below, I allow women's stories to briefly speak back to the alternative female sexual response model, with its emphasis on arousal preceding desire.

Desire, arousal, interest: Linkages and lacunae among embodied sexual states

In order to gain insight about the new DSM-5 diagnosis of Female Sexual Interest/Arousal Disorder (FSIAD), to better understand the transition away from Hypoactive Desire Disorder (HSDD) in Women, and also to gain a clearer understanding of the female-specificity of the new diagnosis, I asked my participants about how their desire, arousal, and interest link up (or do not). Although most of the women I interviewed were not aware of the content of the newest edition of the *DSM*, they were very much aware of scientific tropes about female receptivity, responsiveness, and passivity. They also had complex thoughts about the notion of a feminine disconnect among cognitive, emotional, and embodied states, and they were able to articulate very clearly the (important) place of desire in their own sexual lives.

Most of the low-desiring women I interviewed stated that sex just doesn't really 'work' if they are not 'into it.' For many of them, the alternative female sexual response model (including its emphasis on arousal preceding desire) did not make sense for them experientially, nor did they identify with it. The idea of cognitively or rationally inducing a sense of being receptive or

'in the present' (such as would be induced via MCBT), in order to mobilize a physical response and thus go forward with a sex act, also made some participants distinctly uncomfortable. It raised concerns about coercion versus consent. This sentiment is articulated succinctly by Annie, who is also a survivor of sexual abuse:

> I feel like if I'm not really into it, it doesn't usually work that well, like I'll have a harder time getting wet and actually aroused and excited…that [experiencing physical arousal before desire] has happened to me before —but *it's not really my preference*.

The desire to be in control of the terms of sex, of not wanting physical arousal to guide a sexual experience, was expressed by many participants—both sexual abuse survivors and women who had not experienced sexual abuse. Throughout my interviews, the notion that it is possible for arousal to precede desire, or for the two to feel 'conflated' (in line with the alternative female sexual response model as articulated by Basson [2001], Brotto [2010], and Graham [2010], among others), was a possible trajectory. But, almost all participants stated that they did not enjoy sex nearly as much when arousal preceded a clear sense of desire, and that sex was much more enjoyable when they felt a true longing, wanting, or desire for their partner. This notion is expounded by Marianne:

> The physical desire is always there [Marianne describes generally having a lot of spontaneous desire], but mentally and emotionally I shut down…so physically I'm like 'Yes, please, let's go to bed together' and I can feel my body heating up, I can feel all of the sexual cues kicking in…but emotionally I cannot handle it, and so I stop it…or if I do go through with it, I am not comfortable, I am not enjoying it.

Molly expresses a similar sentiment about not enjoying sex if she is not truly desiring of, engaged with, and emotionally connected to her partner:

> A lot of times I feel very dissociated, like my body is turned on, but my mind is not. So physically I have a reaction, like I get wet and—but mentally I don't feel like I am really there. My body is showing all the signs of being turned on, but I don't *feel* turned on…so a lot of times I kind of just go 'Well, I'm wet, might as well have sex,' and it's okay, but it is not that much fun…even with him [a partner that she trusts] there have been times where I have gone, in my head, 'Why am I doing this?'—where I have felt really disconnected and thought 'I don't want to do this anymore'…and that is what started to get me really turned off, that feeling of like my body responding, when my mind is not…that is a turnoff because I feel like it kind of increases the dissociative state…I know that your body can respond at times, even when you are being *forced* to do things…I don't know if that's what happened with [the man who abused her as a child], I don't remember, but sometimes I wonder if that's where some of that comes from, in terms of *getting turned on physically but not feeling good about that unless my mind is incorporated*.

Molly's and Marianne's stories of emotional disconnection and dissociation, outlined above, are examples of why the diagnostic logic of *arousal determining desire* (or even simply being conflated with desire, with the constructs being brought together diagnostically) appears to exemplify a strange sanctioning of blurred consent. This logic also seems to sanction a medicalized supporting of one partner's sexual wishes governing, defining, or taking precedent over another's, which is potentially dangerous for women—particularly in that so many women have experienced abuse, rape, or other forms of sexual violence (or will at some point during their lives). These types of potentially coercive experiences range from overt violent infractions by strangers on the street to less clearly defined situations in which consent was not adequately

acquired from an intimate partner, date, acquaintance, or friend—or, instead, in which women were pressured to have sex that they 'consented' to by not explicitly saying 'no,' but did not feel comfortable with and thus did not feel was truly consensual. If low-desiring women (who are in some cases also victims of gendered violence) are keenly aware of the possibility and common experience of dissociating during sex, of experiencing depersonalization and derealization in a sexual moment, then it seems questionable to promote mindfulness as a remedy for low desire. In this context, mindfulness functions as a cognitive-behavioral prescription for women to overcome a mental state of not being fully 'into it' and an injunction to 'follow the lead' of their own aroused body—or worse, an aroused partner.

The everyday nature of gendered violence

The stories these low-desiring women told illuminated how gendered violence runs the gamut from more casual, everyday violations and microaggressions—which many women understand as 'normal' because of how common they are (Sociologists for Women in Society, 2014)—to more clear-cut and obvious forms of sexual violence, including childhood sexual abuse and 'stranger rape.' Even women in this study who had not been the victims of rape or sexual abuse described being violated in other ways. Valdivia describes the everyday, quotidian, almost banal experience of gendered violence, and explains how she experiences this as a perpetual potential threat, as a constant nagging at her body and psyche, and as a pervasive ambiance of insistent inquiry as to whether or not she will give consent—concomitant with a tangible, felt disregard for her answer. She frames this foreclosure of consent as a deep, constitutive aspect of her own experience of femininity, and something that she learned and has lived from a very young age:

> One of my first sexual experiences was when I was 13, my first French kiss, it was a super big deal, it was this intrusion of bodies, there was a tongue involved, there was groping involved, and it was definitely sexual even if it wasn't called that. And I remember that this person didn't *ask* me…that's the thing, consent has only made its way into my life very recently. And consent is a thing that is so nebulous, surprisingly enough, it is frightening to me how nebulous it is…I can't think of anything sexier than consent at this point. But that French kiss began a long career of non-consent…

In light of Valdivia's comments, it is also important to note that some low-desiring survivors of sexual abuse describe providing a service—not to their abusers, but to a society which relies on imagery and narratives of supposedly 'valid' or 'real' sexual abuse in order to excuse everyday, mundane, and casualized aggressions toward women. Within this framework, as long as we have so-called 'legitimate' victims of abuse, who have suffered at the hands of 'authentic' criminals who are pathological and ill, individuals who enact violence all the time in more quotidian ways can be absolved. Here, we have evidence of an affective economy in which one type of violence is authenticated, and can thus be made to excuse other types. This material-discursive system—as it makes it appear as though child sexual abuse and 'stranger' rape are idiosyncratic and isolated occurrences—simultaneously exotifies and fetishizes these more obvious and clear-cut violences, making it seem as though these do not happen every day, as well. This heteropatriarchal economy of violence legitimation (that the authors of the FSIAD diagnosis draw upon) obscures the fact that even these more extreme forms of obvious and clear-cut violence are actually part of the quotidian landscape of many women's lives, as much as the 'less

extreme,' casual, everyday violations and microagressions are also a part of this gendered landscape[9].

Most of the low-desiring women I interviewed had experienced gendered violence, sexual coercion, and, in some cases, pursuant trauma, at some point in their lives. Several had experienced sexual molestation or abuse at very early ages, but many had not experienced childhood sexual abuse. Almost all of the women I spoke with described the larger, pervasive milieu in which their sexualities had developed as 'violent,' 'violating,' 'traumatic,' 'traumatizing,' or 'abusive,' though, and they spoke of cultural expectations of (hetero)sexuality which are bound up with masculine aggression as regularly excusing violence and harassment of women, and of women's bodies being violated in a variety of ways in everyday life and spaces. Sexual incursions could also happen closer to home, and many women described having sex with male partners with whom they did *not* feel they had particularly intentional sex lives. This notion illustrates the murky terrain of consent versus coercion and of intentionality versus haphazardness within mundane, banal forms of sexual intimacy—a realm that we do not generally associate with violation or coercion, unless in the 'extreme' forms of domestic or intimate partner violence. Regina sums up this sentiment about the murkiness of consent/coercion within intimate relationships, when I asked her if any sexual experience happened to her in her life that she thinks may have contributed to her low desire:

> I don't think so, other than the history of having not wanted to have sex with my partner but doing it anyway, on just kind of a daily level…and certainly 'consenting' the entire time, *but doing so very reluctantly*…

Regina's statement makes it clear that what happens in the bedroom is not as far from what

[9] Feminist scholars, including popular writer Rebecca Solnit (2014), have made similar points about economies of violence within heteropatriarchal societies.

happens on the street as people often like to think. Evie extends this idea to street harassment and other forms of violence that women endure in non-intimate spaces:

> As sexually objectified people, we kind of channel these things—violations, traumas—through our sexual activities—but at the same time it is so taboo to talk about it! You can't have conversations like this—even though they are so part of our everyday lives! It's almost a way to squash it, and not give women the power or control over the things that happen to them, because it's not 'cool' to talk about it…I think that what happens is because these things are so normalized in our culture but not acknowledged—like the attacks, constant hollering [on the street, out in the world], the fact that one in three women get raped in their lives, these statistics, women are subject to sexual violence whether it is physical or emotional in nature—but at the same time, our society refuses to acknowledge it as a real problem and so it's not 'cool' to talk about being a rape victim, like things get really 'heavy.' And it is very serious, but it becomes this thing where people don't feel comfortable talking about it in everyday life even though it is part of our everyday life.

Evie's powerful statement elucidates the way sexual coercion and gendered violence are insidious and become hidden by cultural discourses that silence them, and which are even muted in our sex lives. She points to an idea that is subsequently perpetuated when discussions of sexual violence are framed as too 'intense'—the notion that women should take the blame for these violations in the form of their own shame, or, alternately, that women should 'lighten up' about them. Many participants articulated similar thoughts, and some also expressed this notion of 'voicelessness' in terms of silence and dissociation during actual sexual acts, or in regards to speaking about the violence they have endured over the course of their lives. Many women

described feeling voiceless not only in cultural representations and conversations about violence against women, but also when they were actually having sex, and in their intimate relationships. This theme is expressed by Elizabeth, who experienced sexual abuse as a child:

> I find it very hard to speak up for myself when it comes to sex. It's harder than fighting with my landlord! I can fight with my landlord like it's nobody's business, but I feel like—I don't feel like—or I feel like I have that option [to say 'no' to sex] but *I have watched myself not take it* in sexual situations.

Many other participants expressed similar notions, and also associated it with the sentiment Evie expressed about the everyday cultural silencing of women's stories about sexual and gendered violence. They talked about how women don't communicate enough—with their partners and with each other—about their sex lives, including the potentially traumatic aspects. These participants elucidated how women are socialized to *shut up* about sex—including about infractions against their bodies. It is also important to note that this experience of 'voicelessness' is consistent with Depersonalization/Derealization Disorder, in that it involves a sense of detachment from one's own thoughts, feelings, sensations, body, or actions (depersonalization), which is formally related to trauma as a Dissociative Disorder in the *DSM-5*. These women's descriptions of their experiences of normalized sexual violence and, in some cases, pursuant trauma—or even more prosaic descriptions of the opacity of consent/coercion that they have experienced in their everyday lives and sexual relationships—shed much light on why many of them express the need to feel safe, comfortable, and trusting in order to be able to 'lose themselves' in a sexual experience. The women I interviewed were very aware of the role of gendered violence in their lack of desire, and of the violation of women's bodies as a cultural trope and as a material reality. Ultimately, many placed utmost importance on negotiation,

intentionality, consent, trust, and safety during any sexual encounter, as a way to safeguard against pervasive gendered violence.

The agency of the skin, embodied knowledge, and the effects of gendered violence on sexuality

The low-desiring participants in this study were quite clear that regardless of any other biological or social factors, their experiences of sexual and gendered violence had deeply influenced their experiences of sex, and the substance of and their ability to pursue their own desires. Molly again discusses her experience of childhood sexual abuse:

> I remember very little, and a lot of what I feel about it is more like muscle memory—there are times where I will have a very physical reaction, or feel something physical, but I'm not able to say 'Okay, I feel this because he did this specific thing to me'…it's frustrating to not be able to say 'I know that this happened, and I know that that happened, and that that other thing happened'…and then certain weird things can trigger sort of a flashback…it's like the stuff that I can't deal with in my head comes out in my body.

What Molly is describing is exactly in line with Criterion B3 of the diagnostic definition for Posttraumatic Stress Disorder or PTSD (i.e., 'flashbacks'). It warrants mentioning that Molly is likely a candidate for diagnosis with PTSD, but she initially came to me to participate in a study about low desire. What she describes regarding 'muscle memory' and 'stuff she can't deal with in her head coming out in her body' is also consistent with somatization[10]. Her earlier

[10] 'Somatization,' or the conversion of anxiety or trauma into physical symptoms, does *not* fit with definitional criteria for Somatic Symptom and Related Disorders as they appear in the *DSM-5*. Psychologists, psychiatrists, and psychoanalysts have long been interested in the

descriptions of dissociating during sex are clearly in line with Depersonalization/Derealization Disorder, as well.

Some participants who experience pain upon penetration had similarly sophisticated analyses of how the experience of violation has affected their sexual bodies. Sarah discussed how her chronic pain condition, which is not specifically vaginal but which does make penetration uncomfortable for her, has deeply affected her desire to have sex (or rather, to avoid it)—with men, particularly. She explains how her body has become so accustomed to experiencing pain that she almost automatically 'shuts down,' often before the experience has even begun, in anticipation. Regina, who experiences pain upon penetration, described a similar phenomenon, and stated that her (male) partners were not as understanding about it as she wished they had been:

> Usually, I would pretend like it didn't hurt…I even went to a physical therapist, she gave me these dildo-looking things—you go up in size to stretch and things like that and I did find that if I used that the day before, or a couple of hours before I was going to have sex, then that did help things…and then we kind of made it part of our thing, that I would do this, or maybe take a bath to relax things…but this all gets to be very mechanical, it is not the playful spontaneous sex that is fun and enjoyable, it starts to be like 'Okay, how can we get it so that Regina's vagina does not revolt?' Like every time we had sex, I had all these chores to do in order to be able to *have* sex…

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physical manifestation of repressed desires and traumatic experiences, as earlier explorations of hysteria clearly demonstrate (Breuer & Freud, 1955; Freud, 1963). But, although Molly's description here may have been in line with Somatoform Disorders as they appeared in earlier versions of the *DSM*, including in the *DSM-IV*, the *DSM-5* in general marks a shift away from psychosomatic explanations of trauma and psychic life, and a concomitant move toward cognitive-behavioral explanations (these shifts apply to Somatic Symptom and Related Disorders as well as to FSIAD). I would like to thank an anonymous reviewer of an earlier version of this essay for pointing this out.

This notion of her body 'revolting' against penetration is one that other participants with vaginal pain expressed. Maya, who has not been diagnosed with any physical dysfunction, but who has begun to experience more intense vaginal pain in the context of her marriage, described her thoughts on the etiology of the problem:

> It was always a little bit painful, but now it is just excruciatingly painful and I think it is because I am totally not into it… I find that I am shutting myself off…it's like physical—but I would imagine that it is totally linked to the psychological. I have told myself that I don't want to do this anymore, and because of that, my body is devising ways of making it easier for me to prove that I cannot do it. And I am totally not feeling pain because I want to feel pain, I just feel pain, but I wonder about the psychosomatic aspect of it, that maybe it's just, my body saying 'Okay, well your mind doesn't want to do it, so we don't want to do it either'…

Both Kelly and Astrid shared similar sentiments about the possibility of a psychophysiological materialization of their trauma and concomitant lack of desire *as pain*. Astrid's story, articulated below, is particularly alarming in regard to these themes. She describes her body as waging war against a *way of being sexual* that she could simply no longer tolerate:

> I think my body stepped in where my mind wasn't willing to step in or was incapable of stepping in at the time and said 'This isn't right, I don't want to be submitted to this practice of being receptive to this kind of abusive treatment'—I think that my body just said 'No!' and sort of drew a line in the sand…this 'disorder'—it changed everything for me, it made it impossible for me to continue to engage in this sort of dysfunctional relationship where I traded sex for security at the expense of my own identity and my own politics…I feel like my nonconsensual sex turned from only an emotionally painful

> sex into also a physically painful sex and that that became a physically *impossible* sex over time to the point where I was no longer able to engage in that abusive, nonconsensual sex, just because my body made it impossible…

In light of a discussion of somatic symptomology, these stories are particularly powerful. These participants' words provide a sobering counter-narrative to the tales evolutionary psychology, experimental vaginal photoplethysmographic research, FSIAD, and the alternative female sexual response model tell about the embodied 'truth' of female desire. Rather than the female lubrication-swelling response being an indication of a woman's evolved physical proclivity to become aroused, here, we have accounts of the body shutting down as a form of embodied *revolt* or *resistance*. As we have moved away from psychosomatic medicine and into the terrain of purported neurologically based differences with 'organic' etiologies and hormonal and evolutionary bases, these narratives may seem anachronistic or even anathema. They certainly feel out of place in our current neoliberal, biomedical, technoscientific moment, including within the larger cognitive-behavioral shift of the *DSM-5*. But these accounts beg the question of the psychosomatic, the somatoform; they hearken back to Breuer's encounters with Anna O., to Freud's with Dora, and to psychoanalytic conceptualizations which might have previously been framed as frigidity, hysteria, or other 'peculiarly feminine neuroses' of enigmatic, perplexing women of times past (Breuer & Freud, 1955; Freud, 1963). But much has also been written about embodied phenomena, experiences, processes, and practices as political acts, as forms of revolt or resistance, and as reclamations of bodies and identities which have been colonized and oppressed (Bordo, 1993; Cixous, 2004). With this in mind, might we consider certain manifestations of low desire among women, and their physiological effects, as potentially political, subversive, or even as insurrectionary?

Beyond comorbidity: The case for sequelae

Some scientists and clinicians, today as in the past, have argued that women's sexuality is inherently complex, responsive, and dissociative, while men's sexuality is direct, initiating, and concordant. Although the researchers and clinicians I interrogate here suggest this in different ways, and to different extents, the designers of the FSIAD diagnosis in the *DSM-5* (Brotto, 2010; Graham, 2010) rely on research conducted to support the alternative female sexual response model (Basson 2000, 2001), and both FSIAD and the alternative female sexual response model are presented within a gendered framework in which objective bodily response is measured against subjective psychological desire (Chivers, 2010; Chivers & Bailey, 2005; Chivers, Seto & Blanchard, 2007; Chivers, et al., 2010). This last domain of scientific inquiry, in which men's and women's mental perceptions are measured against their embodied responses, seems to sustain a search for the 'truth' of sexual difference, and continues a project in which female sexual credibility and the legitimacy of female desire are persistently questioned. Taken together, all of this research and diagnostic framing suggests that male sexuality and female sexuality are quite different, and none of it theorizes this difference, analyzes the interpersonal, environmental, and social reasons for this difference, or considers the consequences of continuing this pursuit of sexual difference in regards to desire[11].

At least for the low-desiring women I interviewed for this project, it may be true that women's sexualities are complex—and, in some cases, characterized by dissociation. But, these

[11] An important exception to this lack of theorization is Chivers & Bailey (2005) and Chivers, et al. (2010), who suggest that female mind-body discordance and the ease with which women are posited to become objectively sexually stimulated could potentially be the result of evolutionary adaptations in ancestral females that have evolved to protect the vagina from tearing during rape, in line with the tenets of evolutionary psychology (e.g., as it is epitomized by Symons, 1979).

interviews make it clear that this complexity is primarily due to sociorelational, environmental, and psychostructural factors, including sexual and gendered violence and subsequent experiences of trauma—which are completely elided in much of the scientific research on and clinical framing of sexual desire. Not only this, but trauma and low desire are held apart discursively in the *DSM-5* and in the research that supports it. What violence may potentially be enacted—discursively and materially—when the influence of gendered and sexualized violations on desire is not explored, theorized, and politicized? Why is trauma not fully taken into account in the FSIAD diagnosis? Why must we hold onto a model of comorbidity rather than moving fully toward etiological investigations, which might include ontologies of symptomology, syndrome, and sequelae, and which would account for the co-occurrence and complex development of trauma which influences desire (or its lack)? In her argument for the lumping of Female Sexual Arousal Disorder (FSAD) with HSDD in Women (what would become the new FSIAD diagnosis), Graham (2010) called for an increased attention to 'specifiers' for women's sexual concerns (e.g., 'individual vulnerability factors' including 'history of abuse experiences'), as I discussed previously. But many of these specifiers did not make it into the *DSM-5* criteria for FSIAD, and thus we see a continued reluctance to engage with etiology, and with the notions of syndrome and sequelae, in favor of a neurobiologized and cognitive-behavioral 'snapshot' model of mental health or illness.

The inclusion of Posttraumatic Stress Disorder (PTSD) in the *DSM-III* in 1980 marked the first time that environmental, social, and political traumas were explicitly taken into account in a diagnosis. Trauma- and Stressor-Related and Dissociative Disorders continue to be the only diagnostic groupings in the *DSM-5* which are configured outside of an individualizing and increasingly neurobiologizing model of mental pathology, and which instead take into account

external, historical events as constitutive of disorder patterns themselves. Although PTSD was originally based on the experience of 'shell shock' among male war veterans, research by feminist clinicians and scholars has illuminated how so much of the trauma that women (and other disproportionately traumatized populations) live through is not 'outside the range' of everyday human experience (Brison, 2008; Brown, 1991)—but it is related to sexual and gendered violence that is rarely confronted or interrogated in a patriarchal and heterosexist milieu. This dull trauma that results from mundane violence is not glamorous or exotic; rather, it is so insidious precisely because it is so routine, so *familiar*. But, as Herman (1992) and Leys (2000) have emphasized, discussions of trauma have fallen in and out of vogue over the course of the history of the *DSM* and in the history of psychology, more generally. Arguments have been made for a more in-depth, complex, developmental, and potentially etiological investigation of trauma (van der Kolk, 2005; van der Kolk & van der Hart, 1995), but more recent configurations of psychopathology have generally not taken this complexity into account. That PTSD is more prevalent in women and that women tend to experience PTSD for longer durations than men do is acknowledged in the *DSM-5*, under 'Gender-Related Diagnostic Issues' regarding PTSD, as is the fact that 'at least some of the increased risk for PTSD in females appears to be attributable to a greater likelihood of exposure to traumatic events, such as rape, and other forms of interpersonal violence' (APA, 2013, p. 278). Trauma- and Stressor-Related Disorders, Dissociative Identity Disorders, Somatic Symptom and Related Disorders, depression, and a variety of other diagnoses are acknowledged as more likely to affect women, and all of these disorders are understood as expressing a high degree of comorbidity with each other. Concomitantly, comorbidity among low sexual interest/arousal and depression, anxiety, thyroid problems, current physical and sexual abuse in adulthood, substance use, and other medical

factors are accounted for in the FSIAD diagnosis. Given the acknowledgment of comorbidity in these two very separate regards, the absence of FSIAD as comorbid with these others gendered diagnoses and the absence of trauma as comorbid with FSIAD are glaring. These lacunae are evidence of the vacuousness of the concept of comorbidity.

Rather than either reassessing its value or reconceptualizing 'comorbidity,' I propose that the complex and developmental etiology of low desire in women—which cannot be disentangled from the everyday experience of sexual and gendered violence and pursuant trauma—be taken more seriously instead. The reality of widespread violence against women and the words of my participants (which, although part of a small-sample study, suggest a possible link between low desire and the experience of gendered violence and pursuant trauma among some women) indicate the necessity of a new clinical orientation to the assessment and treatment of low female desire. The medical and ethical implications of this are clear, and I argue that they should include: 1.) discussing sexual history, including traumatic history, thoroughly during any FSIAD intake in light of the lack of specifiers in the diagnostic entry, 2.) de-individualizing what are clearly relational sexual problems (but which are, as of now, discussed in relational terms disproportionately when a woman's 'receptivity' is in question), and 3.) more adequately conceptualizing etiology, with a renewed emphasis on symptomology, syndrome, and sequelae—which are always sociopolitical, inter-relational, and based in gendered and sexualized structural-environmental realities involving unequal distributions of power. In undertaking this new orientation to treatment and care, we would responsibly set up a new protocol for understanding how the phenomena that disorders reflect both correlate and present in patients, and importantly, in larger populations.

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