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EDITORIAL

Pharmacotherapy for women: Will we, won't we, should we?

Suppose somebody offered you a bag of Magic Beans that promised to solve all sexual problems. Would you believe it? Would you trade your best cow for them? Would you eat the beans? Or, perhaps most importantly, do you believe enough in Magic Beans to go searching for them yourself?

Despite the best scientific and marketing efforts by Proctor and Gamble, their moderately magical bean—a testosterone patch for oophorectomized women with hypoactive sexual desire disorder (HSDD)—was recently rejected by the U.S. Food and Drug Administration. The demurral was ostensibly based on concerns about safety and efficacy alone. But we would submit that, perhaps, the outcome arose in part from a disbelief in magic beans, or an unwillingness to make them available to women. This is odd, since men are so well supplied with magic beans these days.

Obviously we're talking about the possibility of pharmacotherapy for women's sexuality, whether for treatment of sexual dysfunction or enhancement of sexual pleasure. There appears to be a considerable degree of ambivalence, overt and covert, conscious and unconscious, and even hostility towards those advocating research and development of such medications.

It's important to remember that there have always been aids, supplements, nostrums, spells, and formulas intended to enhance the sexual appetites and satisfaction of women and men both. Is there something particularly objectionable about creating medications whose chemical properties will be precisely known, to be marketed and marked up (for a profit)? Obviously there is a problem here, for purists, moralists, some feminists, social conservatives, and potentially countless others. As sex therapists, though, what do we think, even assuming there *are* or *could be* magic beans?

Whether we view HSDD—or indeed any unwanted change in a woman's typical sexual response—as a complaint, a dysfunction, an adaptation to circumstances, or a transient phase of life, as sex therapists we know how hard it is to stoke up sexual interest when it has vanished or was never there. Some might argue, so what? Lack of sexual interest isn't life threatening. How then does it qualify as a medical condition?

Perhaps the problem is that, regardless, it *may* be treatable by medical means. The purist will complain that the lack of symmetry—no medical condition, so no medical intervention—disqualifies women's sexual response issues from such pharmacological relief as might eventually be available. This point of view raises two

Correspondence to: Sandra Leiblum, Dept. of Psychiatry, University of Medicine and Denistry of New Jersey, Robert Wood Johnson Medical School. E-mail: leiblum@cmhc.umdnj.edu

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objections. First, why should HSDD be any different from, say, headaches? In both cases the etiology can be either obscure or complex: they both can be attributed to an admixture of psychological and physiological components. We don't pathologize headaches, however. We merely take the aspirin and get on with it. How is HSDD different, exactly?

The answer, and our second objection to the purists' slant, is that women's sexual problems are overwhelmingly *dyadic*. They occur in a particular context with a particular partner. The idea of treating the woman alone carries the implication that she is the problem: it is her pathology, not that of the relationship. As clinicians we know unequivocally that this is not the case. So how could we, as clinicians, be behind magic beans?

Above all we're pragmatists. We know that a single magic bean is not going to solve the entire problem. You need a whole bag. We admit we're willing to exploit whatever will help us help the relationship. Just as we would not hesitate to prescribe antidepressants for one partner alone, we would not hesitate to prescribe testosterone if one partner might benefit from it. Obviously, there are safety concerns about the long-term use of *any* pharmaceutical or hormonal intervention. But this concern speaks to a need for *more* research in this area, rather than less.

The larger concern in this discourse is the fear that our field is in danger of being co-opted by "big pharma" and commercial interests. We agree that this is a genuine and realistic concern. However, to simply express righteous indignation seems to us to be of limited utility. Rather, if the needed research is to occur, we must work with, rather than in isolation from or opposition to, the pharmacological industry. Obviously, as sex therapists, we cannot command the resources to engage in crucial research. And it is clear that, regarding the pharmaceutical companies, they need us as much as we need them—whether it be to educate them about the complexity of sexual dissatisfaction or disorders, to design the most meaningful outcome studies, or to interpret the resulting data.

In summary, we find no advantage in taking a principled stand against pharmacological research and treatment for women's sexual complaints. We are simply in the process of working out a necessary *modus vivendi* among all of the players—patients, clinicians, researchers, and pharmaceutical companies. At this stage it is counterproductive to raise objections based on hypothetical problems. The fact is, we need the whole bag of magic beans. That said, at this moment, we are not sure that any magic bean at all will be forthcoming any time soon.

SANDRA R. LEIBLUM, PH.D.
North American Editor, Sex and Relationship Therapy

Derek Hill and Richard Orr have resigned from the Editorial Board now that they have retired from clinical practice. We would like to thank them both for their important contribution to clinical practice in the UK and for their contribution to SRT. We wish them well in their future years and hope they will remain active readers of the journal.