



Framing disease: The example of female hypoactive sexual desire disorder[☆]

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ABSTRACT

Disease classification is an important part in the process of medicalisation and one important tool by which medical authority is exerted. The demand for, or proposal of a diagnosis may be the first step in casting life's experiences as medical in nature. Aronowitz has written about how diagnoses result from social framing mechanisms (2008) and consensus (2001), while Brown (1995) has demonstrated a complex range of interactions between lay and professionals, institutions and industries which underpin disease discovery. In any case, there are numerous social factors which shape the diagnosis, and in turn, provide a mechanism by which medicalisation can be enacted. Focussing on diagnostic classification provides an important perspective on the human condition and its relationship to medicine.

To illustrate how layers of social meaning may be concealed in a diagnosis, this paper uses as heuristic the relatively obscure diagnosis of Female Hyposexual Desire Disorder which is currently surfacing in medical and marketing literature as a frequent disorder worthy of concern. I describe how this diagnosis embodies long-standing fascination with female libido, a contemporary focus on female hypersexuality, and commercial interest of the pharmaceutical industry and its medical allies to reify low sexual urge as a pathological disorder in women.

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Medicalisation is one of only a few sociological terms which has managed to integrate itself into popular and medical parlance (Furedi, 2006). This process by which medical authority or explanations infuse banal social experiences of everyday life has infused scholarly literature since the early 1970s (Zola, Conrad and Schneider are amongst the seminal writers in this area). Medicalisation is frequently, although not invariably, enabled by diagnostic categories. The demand for, or proposal of a diagnosis may be the first step in casting life's experiences as medical in nature.

It is with this thought in mind that analysis of diagnosis becomes a useful activity. The fact that there is a diagnosis for this or for that condition validates the fact that medical attention is warranted, a treatment justified, and an identity consolidated. It positions the condition in the medical arena, and starts the ball rolling.

Aronowitz (2008) has written about how diagnoses result from social framing mechanisms and consensus (Aronowitz, 2001), while Brown (1995) has demonstrated a complex range of interactions between lay and professionals, institutions and industries which underpin disease discovery. In any case, there are numerous

social factors which shape the diagnosis, and in turn, provide a mechanism by which medicalisation can be enacted.

Focussing on diagnostic classification provides an important perspective on the human condition and its relationship to medicine. Diagnoses are the classificatory tools of medicine; they can conceal conflict and multiplicity beneath layers of obscure representation, "making it appear that science describes nature (and nature alone) and that politics is about social power (and social power alone)" (Bowker & Star, 1999, p. 46). Exploring the specific role that diagnosis plays in medicalisation provides a more finely-grained analysis of medical authority than focussing on medicalisation only. Disease labelling is but one of the many ways by which medicalisation takes place. Further, the classification of the disease plays a substantive role outside of the identification of recognised sickness: identifying deviance, disciplining practitioners, setting research agendas and distributing resources (Rosenberg, 2002). And diagnoses hide both agendas and ideologies. As one example, the disease category of "Female Hypoactive Sexual Desire Disorder" (FSDD), its genesis and detection fingers the presence of powerful stakeholders and andocentric, heterosexual definitions of normal sexuality. It is not that female sexuality has not already been studied within the context of medicalisation (see, for example, Tiefer, 1996). This case study serves as a useful heuristic for understanding how classificatory systems describe 'realities' which merit further critical scrutiny.

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In the pages which follow, and after a short introduction, I will explore the layers of meaning which are embodied in the diagnosis of FHSDD, using some of the social framing mechanisms that Arownowitz (2008) has identified. Starting with the socio-cultural framing of sexuality, and particularly female sexuality, I will demonstrate how fascination with normative sexuality and the presumption of its immutable presence is unchallenged and untested in medicine. I will then discuss the development of screening tools for the disease, which I present as technological mechanisms for reinforcing the presence of the diagnosis. And finally, I will discuss the internal and internal dynamics of consumption which constitute FHSDD as a diagnostic category. The prevalent use of the hypersexualised female in all forms of media present a fantasy of constant desire and sexual fulfilment, and underlines the inadequacy of the consumer. A consumer solution is promoted by the pharmaceutical industry, in the exercise of disease-branding: marketing the diagnosis in order to create demand for its cure.

Background

The matter of female libido, or at least of the association of gender with libido, is one which has preoccupied scholars for centuries. Whilst a historical survey is impossible within the scope of this paper, a bouquet of examples from various eras illustrates this fascination. History is a useful tool for identifying social mores, as temporal distance is also a critical distance, highlighting the oddities in ways of thinking that are too deeply embedded to be visible in contemporary practices (Martin, 1997).

The oft-cited myth of Tiresias, as recounted by Ovid, is a useful starting point. Tiresias was called upon by the gods Jupiter and Juno to settle their argument about whether the sexual pleasure of man or woman was greatest. He was appointed to “arbitrate this jocular dispute” because he had “known both Venuses,” (p. 105) having lived 7 years as a woman, after having been born a man. He agreed with Jupiter: women have more pleasure, he maintained. Tiresias’ decision was not without consequence: Juno blinded him for his taking Jupiter’s side. To palliate his loss of sight, Jupiter gave him the ability to know the future (Ovid, 1985).

While mediaeval writers sought to demonstrate that organs and orgasms of men and women reflected one another, the pudenda responding like the penis during coitus, renaissance doctors struggled to make physiological sense of female orgasm. Women were variably cast as passionless, or as insatiable libidinal beasts, filling medical and philosophical texts as concern about sexual difference served as a proxy for anxiety about power and position in the public sphere (Laqueur, 1990).

In Victorian times, medicine, concerned about sexual excesses, took responsibility for education about sexuality, seeking both to explain and modulate the place of desire in woman’s social role, and to link it with the production of healthy off-spring. Some authors argued that female passion had a physiological link to conception, a position which Dr George Napheys (1871) refuted in his late nineteenth century guidebook for women. He argued nonetheless that the “disposition” of the woman at the time of conception had a formative effect on the physical and emotional formation of the foetus and described three levels of sexuality in women. There are those that have generally little or no sexual feeling, he wrote; a second group, probably slightly greater than the previous, who are “more or less subject to strong passion;” and finally, the “vast majority of women in whom the sexual appetite is as moderate as all other appetites” (p. 74).

Another popular medical writer, Dr Hollick, acknowledged a wide difference between the two sexes “as to the manner in which the imagination acts, owing to the difference in their characters and

organization” (Hollick, 1902, p. 395). **Woman, in addition to her desire to please, also has an innate sentiment of shame which can lead to prudery if dominant.** But he also cautioned that when “the [woman’s] temperament is warm, and the sexual instinct unusually strong... indulgence is imperatively needed, and if it cannot be had the most injurious consequences may take place” indicating the possibility of miscarriage and “partial derangement” (p. 389). Dr Melendy (1904) (a female doctor), on the other hand, cautioned that in the sexual union, the wife should “not be overtaxed beyond her natural desire” should the couple be in pursuit of a high spiritual life (p. 310).

Although medical guides and handbooks addressed the matter of female sexual desire, pathologisation of low libido only surfaced in the last quarter of the 20th century; it was the contrary behaviour, excessive female desire, that preoccupied medicine at the beginning of that century (Lunbeck, 1987). It was not until 1980 that the DSM-III (American Psychiatric Association, 1980) introduced a diagnosis of “inhibited sexual desire,” a condition reported as being more common in females, and described as the: “Persistent and pervasive inhibition of sexual desire. The judgment of inhibition is made by the clinician’s taking into account factors that affect sexual desire such as age, sex, health, intensity and frequency of sexual desire, and the context of the individual’s life. In actual practice this diagnosis will rarely be made unless the lack of desire is a source of distress to either the individual or his or her partner.” (p. 278). In 1987, the DSM-III-R (American Psychiatric Association, 1987) recast the diagnosis as “hyposexual desire disorder,” described now as: “Persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age, sex, and the context of the person’s life.” (p. 293). In parallel, “Inhibited sexual desire” figured in the ICD-9 (World Health Organisation, 1977), however, “hypoactive sexual desire” was not introduced until the next revision of the ICD in 1994 (World Health Organisation, 1994).

Framing

Social and structural

The diagnosis of FHSDD relies on the untested assumption that all humans are endowed with demonstrable sexual urges and that their absence constitutes a pathological condition. This constitutes the fundamental structural frame to buttress the pathologisation of low or non-existent sexual desire. Masters and Johnson presented sexuality as “a drive of biologic origin deeply integrated into the condition of human existence” an important cornerstone, argues Tiefer (Tiefer, 1996) to the development of alleged universal, biological, sexual norms.

A facile evolutionary argument supporting this assumption is that sexual urges are a biological necessity for the survival of the species. However, I use the word facile advisedly. That homosexuality challenges this assumption is the easiest rejoinder. Whilst homosexuality continues to present collective challenges to a heterosexually-dominant classificatory society, its non-reproductive sexual urges are no longer contained in the DSM, enunciating clearly that evolution doesn’t determine what medicine chooses to classify.

As a result of this presumption, there has been little contemporary scholarly discussion of asexuality in terms other than medical. Being captured by medicine defuses threats to the assumptions that serve as its foundation. Medicine is simultaneously the explanation and the discipliner. Its classificatory status announces *The Way Things Are*, and thwarts challenges. As Hacking (2001) has written, “the idea of nature has served as a way to disguise ideology, to appear to be perfectly neutral. No study of

classification can escape the obligation to examine the roots of this idea... no study of the word 'natural' can fail to touch on that other great ideological word, 'real' (p. 7).

Kaplan (1977) is cited (in Sills et al., 2005) as one of the earliest contemporary medical researchers to discuss the low sexual urge in terms of pathology, building on the interest in sexuality promoted by the work of Masters and Johnson. Whilst she acknowledged that there is no definition of normal sexual urge, she pointed out that the sex therapy literature failed to address matters of sexual desire. She presented low urge as a problem requiring extensive therapy, and associated it with a fear of love, success and of pleasure. In the same year, Lief (1977) reported that inhibited sexual desire affected 37% of women in one sample, and was amongst the most difficult sexual dysfunctions to treat. Kaplan and Lief's interest in the issue of sexual desire as an area of therapeutic interest was enabled by the sexual liberation movement of the previous decade and its anti-taboo approach to speaking of sex.

More recent medical work tends to be epidemiological in nature, confirming prevalence, incidence and associations (always, however, performing a reproduction of asexuality-as-pathology by confirming FSHDD a thing to be counted). Bogaert (2004)—on the basis of pre-existing data from the UK National Survey of Sexual Attitudes and Lifestyles—reported that **one percent of the population claimed to have no sexual attraction to members of either sex**. He identified a number of associated and predictive features of asexuality, including gender (mainly women), religiosity, short stature, low education, low socioeconomic status, and poor health.

In counter-distinction to this epidemiological approach to understanding asexuality, identity-based discussions take a different tack. A number of **Internet communities have sprung up to offer a community for individuals who identify as asexual**. Virtual communities in a general sense provide a sanctuary for alternative and stigmatized groups. Notable for their genesis in medical-lay discord about diagnosis, these groups may, on the one hand, provide support for illnesses that medicine does not sanction (For example, see Dumit (2006) on Medically Unexplained Symptoms; Ware (1992) on chronic fatigue; or Charland (2004) on psychiatric disorders); or, on the other, reject diagnostic classification, seeking to redefine what medicine perceives as disease in other terms (for example, see Fox, Ward, and O'Rourke (2005) work on the pro-anorexia movement; or St-Onge, Provencher, and Ouellet (2005) team on psychosis).

Scherrer (2008) studied participants in the *Asexual Visibility and Education Network* and concluded, among other things, that the language to define and the space to be asexual offered by the virtual community enabled individuals to define an essential identity based on the absence of sexual drive. She also suggested that asexuality has had far less attention paid to it than other sexual identities. Possibly as a result of its *lack* of behaviour and desire, it does not draw attraction to itself, and has not historically been perceived as morally or legally wrong (Bogaert, 2004). Her respondents, for the most part, saw asexuality as aproblematic, and naturalised it as a way of being, rather than as an ontological illness.

Prause and Graham (2007) surveyed the sexuality of 1146 students and identified 41 (who identified as asexual). Of these, 63.4% ($n = 26$) were women. This subset (both men and women) attributed both benefits and drawbacks to asexuality. Benefits included avoiding intimate relationship problems, having lower health risks and social pressures, and having more free time. Drawbacks on the other hand, were potential partner relationship problems, thinking something is wrong, negative public perception, and missing positive aspects of sex. Prause and Graham also write that asexual individuals may feel pressure to conform to the normative expectation of sexuality, a social expectation which goes beyond the control of the individual (p. 353). However, the existence

of the diagnostic category, more than the lack of sexual drive itself may provide a shove towards the illness. Because personal distress is a diagnostic criterion for FHSDD, and because distress results from worry that asexuality may be a medical problem, "then the psychiatric diagnosis implying abnormality may exacerbate concerns in an asexual individual" (Prause & Graham, 2007, p. 353).

Social theory provides a perspective which challenges the problematising of essentialised sexuality. In both queer and feminist theory, gender and sexuality are cast as products of social and historical context rather than of immutable biological states. Trends in social theory conceptualize these categories as plural, provisional and situated (Richardson, 2007), providing space for asexuality as a normal form of sexuality.

The "Boston Marriage," or romantic but asexual relationships between lesbians, has a long historical, but unacknowledged tradition (Rothblum & Brehony, 1993). Boston marriages challenge the idea that sexual activity defines relationships. Women in such relationships may or may not previously have had sexual relations between themselves or with others, but do no longer. In all other ways but sexual, their relationship resembles those of other lesbian couples. However, importantly, the fact of their asexuality is neither acknowledged nor broadcast. To do so would be both a political and social liability.

Naomi McCormick (in Rothblum & Brehony, 1993) sees the demand for sexual pleasure as proxy for partnership as a reflection of an androcentric approach to sexuality. "It is entirely possible" she writes:

that many passionate female friendships enjoyed by our foremothers excluded mutual genital stimulation that people expect before categorizing a relationship as sexual or erotic. The absence of genital juxtaposition hardly drains a relationship of passion or importance (p. 6).

Jagose (2003) echoes McCormick's comments: "That such happy, well-matched couples can be so easily drawn into the jurisdiction of pathological dysfunction suggests something of the weird morphing effect of the medical/therapeutic industries on the cultural status or value of sexual desire. Not in itself necessarily desirable, desire is instead compulsory. **It turns out to be banally more like the Brussels sprouts of childhood, something that is good for us and that we must have whether we like it or not.**"

This contextualisation is muted in the assumptions underpinning the diagnosis of FHSDD. That hyposexuality is seen to be a medical problem further reinforces the taboos around discussing love without sex. The authors of "Boston Marriages" pointed out that many members of the lesbian community kept their asexuality hidden, because being "out" as lesbians required them to be a model of normative lesbian relationships (Rothblum & Brehony, 1993).

The diagnosis of FHSDD, however, disregards the historical and social context of sexuality; rather it focuses on clinical detail about attitudes towards sex. The tools of diagnosis constitute a second important framing mechanism in creating the classification itself.

Technological change

Technology frames disease categories by capturing the conditions the categories describe in objective and immutable descriptors. As a simple example, the emergence of overweight as a disease could only take place in the presence of scales and "desirable weight" charts (Jutel, 2006). Yet, even as scales became a standard feature of the medical rooms, and a range of weight classification systems became both available and implemented, technological refinement (in the form of epidemiological fine-tuning) constantly changed categorical boundaries. From 1942 to 2000, no fewer than

eighteen different ideal/desirable/normal/suggested/acceptable or other categorical formulations for weight were implemented by a range of official classificatory documents, according to Kuczmarski and Flegal (2000). A weight considered “ideal” in 1942 (say, 1m70 and 73 kg) would have been “desirable” in 1959, “acceptable” in 1985, and “overweight” in 2000. Technological tools (scales, manometer, thermometer, ECG, and so on), which Rosenberg (2002) refers to as “instruments of specificity” and include any one of a number of instruments capable of capturing observed phenomena in objective units, provide a way to characterize, and indeed name, a condition.

There is a technology of FHSDD which is similarly generative. As with the diagnosis of overweight, in the absence of mechanism for assessing its presence, FHSDD cannot establish an epidemiological existence. Powerful interests, I will argue, are at play in the rush to develop the tools to establish the existence of FHSDD, not the least of which are those which figure on the panel of the **International Consensus Development Conference on Female Sexual Dysfunction whose authoritative professional status enables its recommendations to serve as mandates**. The preliminary meetings to develop the consensus conference were **organised and financed by the pharmaceutical industry**, was comprised of a group equally balanced between pharmaceutical representatives and researchers either experienced or interested in working collaboratively with the industry (Moynihan, 2003).

This group identified the penury of studies investigating female sexual dysfunction and the **barrier presented by the absence of diagnostic frameworks** (Basson et al., 2000). This call to action was supported by grants from Eli Lilly, Pentech, Pfizer, Proctor and Gamble, Schering-Lough, Solway Pharmaceuticals, TAP Pharmaceuticals and Zonagen, just as its 19 authors acknowledged financial or other relationships with 24 listed pharmaceutical companies. The findings of this committee were that urgent investigation was required to develop new classifications and definitions of sexual dysfunction.

The first specific instrument for assessing FHSDD or its response to various treatments was developed by Sills et al. and presented in 2005. Entitled the validated Sexual Interest and Desire Inventory-Female (SIDI-F), the work was both funded and copyrighted by the pharmaceutical company Boehringer Ingelheim and undertaken by its scientists (Sills et al., 2005). I will detail overleaf, Boehringer Ingelheim’s interest in FHSDD. Sills et al. tested the 17-item rating scale on women previously diagnosed with FHSDD by an experienced clinician. His pilot study tested the tool on nine participants without the disorder, and 12 with. He concluded that the scale could be used to discriminate between participants diagnosed with HSDD and those without a clinical diagnosis, but does not provide data from the pilot. The main study only tests women with the disorder, failing to validate sensitivity in a second independent group of patients, limiting the predictive value of the instrument.

However a recent publication purports to supersede the SIDI-F. It is a streamlined survey tool which, its authors argue, enables non-specialists to deal with the **fraught problem of female sexual function. They describe a “growing need for simple diagnostic instruments that can be used in everyday practice by clinicians who are not specialists or experts in FSD”** (Clayton et al., 2009, p. 731).

The decreased sexual desire screener (DSDS) (Clayton et al., 2009) is designed by its researchers to provide a very brief tool that can be used by non-specialists to diagnosis what the authors believe is a very prevalent condition amongst women. The tool has two parts. The woman is initially presented with a set of four questions. If she answers all of these *affirmatively*, then she will answer a second set of questions. If she answers all of these *negatively* the clinician can confirm the diagnosis of FSDDD. The **simplicity of the diagnostic procedure is beguiling**, but both the

nature of the questions and the relationship of the researchers to the commercial players in the sexual dysfunction industry give pause.

- In the past, was your level of sexual desire/interest good and satisfying to you?
- Has there been a decrease in your level of sexual desire/interest?
- Are you bothered by your decreased level of sexual desire/interest?
- Would you like your level of sexual desire/interest to increase?

A fifth question rules out other causes for the decreased sexual interest (relationship problems, systemic illness, recent obstetric or gynaecological events, stress or fatigue). Then, clinicians who are not specialists or experts in the field of female sexual dysfunction reviewed the responses and determined whether the individuals met the criteria for generalised, acquired FHSDD. Subsequently, expert clinicians conducted a standard diagnostic interview with each participant. Results of the interview and those of the DSDS were then compared to validate the diagnostic ability of the tool. **However, both the predictive value of this tool and the interests of the researcher who developed it must be questioned.**

Predictive value reflects the probability that the tool will correctly and predictably identify the presence of the condition. This means that its use will not identify individuals who do not have the disorder as having it. Intuitively, one (or at least this author and her friends) senses that the four questions that comprise the DSDS are most likely to result in an affirmative response from many women, and that the confirming set of questions will also result in a likely negative response, which would result in a positive diagnosis. The fact that the study was validated in a population with a high prevalence of the disorder limits its ability to project across a general population.

The interests of the researcher are also important to describe. Anita Clayton is a consultant for Boehringer Ingelheim, whose relationship to FHSDD we will discuss in greater depth in the next section. Whilst we cannot judge how, or even if these interests influence the development of the screener, the relationship of the researcher to this specific pharmaceutical company must be noted. In the pages to come, I will explore how the commodification of sexuality by pharmaceutical companies such as Boehringer Ingelheim is at the base of a particular dynamic of consumption, which is enabled by research such as this.

Dynamics of consumption

When Aronowitz writes about the dynamics of consumption, he describes how the effective manipulation of consumer need results in a negative effect on physical and mental health, resulting in identification of a problem as medical in nature. In the case of female sexuality, the commercial dynamic is two-fold. It presents the sexual female both as commodity and as consumer. The dual burden of consumer longing and disease classification is not unprecedented. The nineteenth century disease of kleptomania was one which typified women as simultaneously consumers of, and consumed by, shopping (Roberts, 1998).

FHSDD contains a similar two-way street of commodity culture, in which longing for spontaneous hypersexuality is marketed, then pathologised and re-presented with its concomitant cure similarly available as a consumer item. The pharmaceutical industry acts as “an engine of medicalisation” (Conrad, 2005), transforming longing into disease. Classification (diagnosis) confirms the presumed ontological, already-always-there nature of the illness.

FHSDD's presence in commodity culture is anchored in the sale of sexuality, and the public discourse which surrounds female hypersexuality in product sales. From music videos to milk advertisement, the display of the female body in sexually provocative and enticingly erotic postures is common currency (Reichert & Lambiase, 2003). This positions hypersexuality as a female norm. Women are supposed to like having sex, or being sexy. Not wanting sex is not normal. So, just as readers buy their *Woman's Weeklies* and *Woman's Days*, following the thousand little rules for achieving a bikini body in time for summer, they are simultaneously taking surveys about what turns them on; how to make *him* (not her) happy in bed; and figuring out just how often they should be having sex (if they're normal, that is) and what kind. The vexed question of "Just how often are normal people having sex?" surfaces in publications from *Glamour* to *New Scientist*, and figures in self-screening tools about longevity, happiness and relationship health.

This might be the pursuit of what Cushman argues is a great consumer yearning, emerging from the transformation of the bounded, restricted Victorian self into the empty post-World War II self-contained individual. This "empty self" finds its fulfilment in consumption and acquisition, with sexuality as a prevalent theme. Glorified sexual images whose primary intent is to sell products, present at the same time a mandate to be sexy, to have sex, and to desire sexual connection (Kilbourne, 2003).

Sex sells magazines (clothes, cosmetics, cars, music, tooth paste and myriad other items), but the reciprocal to that equation is also true: magazines, clothes, cosmetics, cars, music and tooth paste sell sex. The fantasy of constant desire and sexual fulfilment captured in advertising serves as a perpetual punctuation of the inadequacy of the consumer (Kilbourne, 2003). It is a distortion of reality, presenting sexuality as it should be, in the eyes of able marketers, but not as it is. The consumer then seeks to attain normality as it is portrayed in the imaginary. The transformation of longing into pathology is being ably managed by a number of players in the pharmaceutical industry creating a second tier in the commercial dynamic that generates FHSDD as a diagnostic category (Tiefer, 2006).

The story of FHSDD is one which is infused by the efforts of the pharmaceutical industry to establish the existence of female sexual dysfunction, in order to market the cure. But, we'll start with the cure, to understand where the stakes are driven, and how the commercial interest is promoted. It hinges around the medication Flibanserin, patented in 2006 as treatment for FSHDD (Borsini & Evans, 2006).

The primary component of Flibanserin, a compound called BIMT 17, was initially investigated as a potential anti-depressant, appearing in the psychopharmacology literature for the first time in 1997 (Borsini et al., 1997), after animal studies a few years earlier (Borsini et al., 1995). The first author of these articles is a staff scientist for Boehringer Ingelheim and his work describes the substance as having a faster possible onset of therapeutic action than other established therapeutic options for depression. Later media reports about the compound reveal that during early phase studies of its anti-depressant activity, researchers monitored anticipated side-effects of decreased libido, and observed, rather than the expected decrease, an increase (Carey, 2006). There is no published research heralding this finding. However, by December 2006, Borsini et al. from Canada had filed a US patent application on behalf of Boehringer Ingelheim for a "Method of treating female hypoactive sexual desire disorder with Flibanserin" (Borsini & Evans, 2006).

Boehringer Ingelheim (BI) launched a media campaign proclaiming the importance of Flibanserin and the severity of FHSDD. On 31 Oct 2008, BI released a press release touting that "the largest study of its kind reveals low sexual desire is most common female sexual problem" (Meyer-Kleinmann, 2008a) They cite Shifren,

Monz, Russo, Segreti, and Johannes (2008) cross-sectional survey of 31,581 female respondents reported that 38.7% of women experienced low desire. The science behind the report seems clear. The sample size is exceptional, the *p*-values and confidence intervals stringent, the scale used to determine FHSDD validated.

However, closer scrutiny points out that the study was funded by Boehringer Ingelheim, that the principle author on this paper receives consulting fees from Boehringer Ingelheim, that the second and third authors were employed by Boehringer Ingelheim at the time of the research, and that the remaining authors "performed work related to this article under a research contract with BI and their employer" (Shifren et al., 2008, p. 970). The scale used to validate the condition was developed outside of BI, but by researchers funded by a different pharmaceutical industry player (P&G) (Derogatis, Rosen, Leiblum, Burnett, & Heiman, 2002) with a similar interest in promoting female sexual distress, given its commitment to Intrinsic, a transdermal testosterone patch for the treatment of FHSDD (Procter & Gamble Pharmaceuticals UK Ltd., 2009).

Buttressed by science (that the pharmaceutical industry itself has funded and organised) Boehringer Ingelheim set forth on an awareness campaign to highlight the frequency, under-diagnosis and consequences of FHSDD (see Meyer-Kleinmann's press release, 2008b). The company prepared an information sheet describing an unreferenced frequency of "up to one in five women" and promoting a new diagnostic tool comprising only five questions, and taking no more than 15 min (Boehringer Ingelheim GmbH, 2008). This is the DSDS referred to above, developed and validated by Anita Clayton and her team. As we have pointed out Dr. Clayton is a consultant to, funded by, and on the advisory board of Boehringer Ingelheim. Her article reporting on the validation of the DSDS was not published until March 2009 in the *Journal of Sexual Medicine*. Boehringer Ingelheim's announcement circumvents the publication of the actual study, however, the journal publishing this article is an ally of the pharmaceutical industry. It features professional endorsements on its website from Pfizer and Bayer (<http://jssm.issir.org/>) and no others. Regardless of what aims the researchers espoused in undertaking the development of this screening tool – be it to support the industry's interest, or something else – the outcome would clearly appear to benefit Boehringer Ingelheim. This makes the industry's support of the work a logical step in their commercial strategy.

Of course, Clayton is not the only researcher in this area with strong ties to industry. The medical opinion leaders in the discussion of FHSDD are, for the most part, affiliated with Boehringer Ingelheim, or with related industrial players. From the consensus writers in 1999, who originally set the scene, to the authors of recent reviews of the condition and the expert clinicians developing tools, most have an affiliation with Boehringer Ingelheim either through funding of the studies being reported, or in a consultant role (Clayton et al., 2009; Shifren et al., 2008; Sills et al., 2005 and so on). Boehringer Ingelheim is not alone in funding the tools and providing cures for female sexual dysfunction. I have previously mentioned Procter and Gamble, but also Pfizer (and perhaps others) have a vested interest in the development of other treatments for female sexual dysfunction.

The consumer dynamic is clearly complex. It involves an initial and pervasive representation to the consumer of sexuality as a means of escape from the real conditions of existence; sexuality circulates as an attainable promise that must be eternally deferred in order for the promise to be unendingly remade (Brady, 2007). On the one hand consumer culture is based on perpetuating feelings of sexual inadequacy; on the other, the industry has recognised an opportunity for exploitation, and has designed and presented a remedy: also for sale.

Discussion

Mirowsky and Ross (1989) have compared **diagnoses to constellations in the sky**, comprised of stars which are truly present, but which we assemble in the recognisable patterns to which we attach meaning. The process by which we construct diseases from symptoms provides insight into how we reflect upon the array of things which are before us: dysfunctional and otherwise. A collective cultural position determines which symptoms we will see, which we will brush off as insignificant, and how we make sense of what is there.

Diagnoses facilitate medicalisation, but are not its only tool. Through their semantic presence, they order and allocate authority: determining first that a given condition can and should be considered by medicine, as opposed to another social authority; and secondly, which specialism should be “in charge.” The ability to assign a diagnosis sets the doctor apart from the lay person and other professionals, confirming the medical practitioner’s greater knowledge and status, as well as medicine’s authority (Freidson, 1972).

FHSDD is a vivid example of how the convergence of social circumstances leads first to the identification of a particular condition as problematic, and second to its embodiment in a diagnostic framework. In this case, the disease category is relatively transparent, but no less controlling. A quick analysis of the disease would simply highlight the role that “Big Pharma” plays in promoting diagnoses. The notion of disease mongering, that was introduced by Lynn Payer (1992) in the early 90s, “trying to convince essentially well people that they are sick, or slightly sick people that they are very sick” (p. 5) has resulted in intense discussion around the ways that this industry influences medical and lay education, diagnostic categories, publication practices, and doctor patient relationship (see Conrad & Leiter, 2008; Moncrieff, Hopker, & Thomas, 2005; Moynihan & Henry, 2006; Wolinsky, 2005; Woloshin & Schwartz, 2006) and has drawn science away from the interests of human health (Abraham, 2008).

Notwithstanding, it would be simplistic to argue that FHSDD is simply the creation of the pharmaceutical industry, a perfect example of disease mongering. Without minimising the role of the industry in the promotion and expansion of this diagnosis, I maintain that the industry cannot conjure a classification out of thin air.

A particular social context must provide the back drop for the disease-branding that Boehringer Ingelheim is undertaking with FHSDD. In this case, an age-old angst over women’s sexuality, overlaid by the commodification of sexuality provides a frame in which the industry can get to work and drive for public and professional recognition of this disorder, rather than leaving it hidden in the pages of the DSM or the ICD, pulled out and dusted off only for the odd idiosyncratic case. In the case of FHSDD, the pharmaceutical industry alone could not make the diagnosis a wider concern if, for example, female sexuality were still generally taken as woman’s duty to her spouse and nation. Imagine for a moment if those who provided advice to young married women still believed today, as did J.A Stewart in 1814, providing “advice previous to matrimony,” that “the tumult of passion will necessarily subside” (Stewart, 1814, p. 540). The very first questions of Clayton’s DSDS screening tool would, in that context, make no sense. Rather than capturing a picture of pathology, they would be describing the normal state of affairs. Yes, my level of desire used to be good. Yes, my level desire is lower than it was. Yes, my passion has subsided...

Whilst Stewart doesn’t incriminate passion as deviant, by the turn of the next century, female hypersexuality figured large in psychiatric medicine as an ailment, rather than a desirable characteristic. Psychiatrists used the term “psychopathic” to describe

women who engaged in sexual activity beyond the bounds of what genteel society felt was moral (Lunbeck, 1987). Such women were cast as sexual predators who sought to entrap young men through their “uncontrolled sex impulses” in stark contrast with the medical concern over female sexuality today.

For FHSDD to exist, sexuality must be a desired female attribute, women capable of indulging their impulses without recrimination. Perpetual reminders of both of these factors serve to reposition the self as one who can have FHSDD. The transformation from the dangerous Victorian self, whose sexual and aggressive impulses had to be controlled by state and church to the self-expressive, consuming and indulgent self is an important pre-requisite to any commercial strategy using inadequate sexuality as foundation (Cushman, 1990). Cushman rightly maintains that understanding the configuration of the self and its temporal context provides insights on “the illnesses that plague it, and the activities responsible for healing it” (p. 600).

It is also important to note that changing attitudes towards sexuality equally go beyond commodity culture. Both the study and embodiment of sexuality have endured significant changes in the last century. In addition to commodification of sexual images, technological shifts have transformed definitions of intimacy and relationships (cybersex, phonesex and email affairs); postmodern narratives reposition attitudes towards sex as “knowing” and public; sexism is now disguised in stylized female exhibitionism; social configurations capture angst about class, status, race and gender; and new pursuits of intimate relationships alter what we mean by sexual pleasure, love, and commitment (Attwood, 2006).

Knowing what consumers feel and believe is an important foundation to any branding campaign, and Boehringer Ingelheim’s intimate involvement in the promotion, identification and cure of FHSDD is an exercise in disease-branding. This approach markets, not the therapy, rather the awareness of the condition that the therapy is supposed to cure. An effective disease-branding strategy results in sufficient public awareness such that intervention is no longer required: the patient and doctor are vigilant monitors of the potential for diagnosis (Parry, 2007).

Understanding the diagnosis and its genesis provides another angle for understanding the medicalisation of women’s sexuality. First, the mechanisms which frame this diagnostic label, as described above, are firmly grounded in a social context which must be acknowledged. The diagnosis enables the expansion of medical authority and its agents (or “engines”). Second, the FHSDD label fulfils the potent social roles one expects of a diagnosis. It legitimises deviance, defines normality, creates identity, and enables access to treatment (Jutel, 2009). Finally, however, it reinforces an inadequately challenged combination of assumptions and observations about sexual function which consequently serve as a basis for commercial exploitation and disease promotion.

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