Social Science & Medicine 70 (2010) 1084–1090

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

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

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ARTICLE INFO

Article history:
Available online 28 January 2010

Keywords:
Sexuality
Gender
Pharmaceutical industry
Sociology of diagnosis
Medicalisation

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.

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.

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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.

☆ I would like to thank Drs Anita Brady, Douglas Booth and Joel Lexchin for their feedback at various stages in the preparation of this manuscript.

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doi:10.1016/j.socscimed.2009.11.040

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 Aronowitz (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 evolutional 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