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Publication Date

2011-05-01

**SOCIOLOGICAL THEORIES OF AND RESEARCH ON SEXUAL PROBLEMS: A REVIEW OF
THE LITERATURE**

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Key Words

Sexuality, sexual desire, sexual dysfunction, women, biopsychosocial

Abstract

This review considers the literature on sexual problems, with a focus on the most prevalent sexual dysfunction among women – low sexual desire disorder. I first discuss the debates over the definition of Hypoactive Sexual Desire Disorder (HSDD) and then I consider the extent and nature of low sexual desire among women. Next I provide an overview of the underlying mechanisms that are said to account for HSDD. I end the review with a discussion of avenues for future work on sexual problems by sociologists.

INTRODUCTION

Sociologists of sexuality have recently turned their attention to the study of sexual problems. Their work has been influenced by and has influenced discussions of sexual problems and dysfunctions outside academia. A noteworthy example is the inclusion of sociologists in recent debates about the legitimacy and treatment of sexual dysfunctions in women. In June 2010, the U.S. Food and Drug Administration (FDA) Reproductive Drugs Advisory Committee voted unanimously to recommend against approval of flibanserin – a drug to treat female sexual dysfunction. Whereas pharmaceutical therapies for male sexual dysfunction have been on the market for over 10 years, flibanserin would have been the first drug approved by the FDA for sexual dysfunction in women. Flibanserin was originally developed as an antidepressant medication but was not found to be effective for depression. It was thus later marketed as a sexual therapy. The drug manufacturer, Boehringer Ingelheim, asserts that hypoactive sexual desire disorder in women is caused by neurotransmitter abnormalities in the brain and can be treated with flibanserin, which targets serotonin receptors (Boehringer Ingelheim 2010). Opposition against approving flibanserin was mounted by the New View Campaign, a group formed in 2000 to challenge the medicalization of women's sexuality. During the FDA hearings, New View supporters opposed the pharmaceutical company's claims of drug safety, questioned the legitimacy of the 'hypoactive sexual desire disorder' (HSDD) diagnosis, and argued for situating women's sexual desire in psychosociocultural context that pays attention to lifestyle and cultural diversity (New View Campaign 2010). The FDA committee based their decision to not approve the

drug on the lack of drug efficacy and the risk of side effects. Boehringer Ingelheim issued a press-release in October 2010 announcing its decision to discontinue its development of flibanserin for the treatment of HSDD (Ingelheim 2010).

Sociologists working in the area of sexuality are not peripheral to these debates over sexual problems. In fact, one of the six speakers allowed to present arguments against approving flibanserin was a sociologist (Thea Cacchioni). As well, Edward Laumann and his colleagues have collected substantial data on sexual dysfunctions over the years (Laumann et al 2008, Laumann et al 2009, Laumann et al 2005, Laumann et al 1999). Their major finding – 43% of American women experience sexual dysfunction compared with 34% of men (Laumann et al 1999) – is the most cited national prevalence rate of sexual dysfunctions and is often used to legitimate the use of pharmaceutical treatments for sexual dysfunction. Heather Hartley, another sociologist, has written about the ‘pinking’ of Viagra culture and the medicalization of female sexual problems (Hartley 2006). Overall, the most significant contribution that sociologists of sexuality have made to the study of sexual problems is the call for an alternative view to the prevailing biomedical view of sexuality. Sociologists have acknowledged the importance of psychosocial influences on sexuality.

This review considers the literature on sexual problems, with a focus on the most prevalent sexual dysfunction among women – low sexual desire. I will attempt (a) to show the debates surrounding the definition of female sexual dysfunction; (b) to identify the psychosocial correlates and underlying mechanisms of female sexual problems; (c) to explore how sociological work contributes to a biopsychosocial

perspective; and (d) to suggest directions for future sociological research on female sexual problems. I limit my scope to the theoretical underpinnings and empirical research on female sexual dysfunctions and I will exclude other important topics in the sociological literature on sexuality. Two sociological review essays that are particularly noteworthy in tackling interesting topics in sexuality are Arlene Stein's (1989) exploration of the sociological and postmodern challenges to a drive theory of sexuality and Gamson and Moon's (2004) review on the relationships between sexuality and globalization, intersectionality, and queer studies.

DEFINING LOW FEMALE SEXUAL DESIRE

An issue of contention among researchers has been how to define sexual problems among women. There are differing beliefs about what constitutes sexual problems. Those who advocate leaving the scope fairly wide open prefer to talk about 'sexual problems', whereas those who want more definitional certainty prefer to use 'sexual dysfunctions'. Most psychologists use the criteria for sexual dysfunction as found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1994), whereas there is no formal standard among sociologists as to what constitutes female sexual dysfunction. Sociologist Laumann and colleagues (1999) have developed survey questions that approximate the DSM definition. The New View Campaign (Tiefer 2002), a group of interdisciplinary researchers, argue against the narrow definition of sexual dysfunction in the DSM and prefer to think about 'sexual problems' among women. In fact, the New View collective puts forth the idea that women should define for themselves what constitutes a sexual problem.

The Diagnostic and Statistical Manual of Mental Disorders

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) classifies sexual dysfunctions, for both males and females, as disorders relating to: (1) desire, (2) arousal, (3) orgasm, and (4) sexual pain (American Psychiatric Association 1994). The DSM diagnostic system is modeled after the sexual response cycle first conceptualized by sexologists Masters and Johnson (1966), and later refined by Kaplan (1977, 1979). The latter focused on a three-phase model of the female sexual response cycle that includes desire, arousal and orgasm. The most recent edition of the DSM (DSM-IV-TR) (American Psychiatric Association 2000) classifies sexual dysfunctions into the following categories: Sexual Desire Disorders, Sexual Arousal Disorders, Orgasmic Disorders, Sexual Pain Disorders, Sexual Dysfunction due to a General Medical Condition, Substance-Induced Sexual Dysfunction, and Sexual Dysfunction Not Otherwise Specified. Sexually related personal distress is a requirement for a diagnosis of female sexual dysfunction. It should be noted that this classification system is based entirely on clinical phenomenology and has no basis in pathophysiology or etiology (DeRogatis & Burnett 2008). As well, due to limited normative data, there are no clear criteria that distinguish normal from abnormal experiences, and thus a disorder diagnosis is based solely on clinical judgment (Segraves & Woodard 2006).

The DSM-IV-TR defines hypoactive sexual desire disorder (HSDD) as “persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity” that causes “marked distress or interpersonal difficulty.” HSDD syndrome is further defined by the following subtypes: psychogenic or psychogenic/biogenic; lifelong or acquired; and generalized or situational. A clinician is instructed to take into account

factors that affect sexual functioning, such as age and the context of the person's life, when assessing whether a woman suffers from HSDD. Also, the lack of sexual desire must not be "better accounted for by another Axis 1 disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance or a general medical condition." Davis et al. (2004) recommend that a clinical assessment of hypoactive sexual desire disorder should include completing a medical history (to identify possible iron deficiency, thyroid disease and galactorrhea), a general physical examination, a gynecological examination (with attention to signs of vaginal atrophy and evidence of infection), and a sexual and psychosocial history.

Critics of the DSM diagnostic system charge that it is overly genital and neglects issues of relationship and social context, is based on flawed research (Hartley & Tiefer 2003), and pathologizes women who fall short of performing according to a genital, orgasmic norm (Ogden 2002). Marshall (2002) notes that the 'function' that 'sexual function' threatens is penile-vaginal intercourse among heterosexuals. 'Functional' is thus understood as 'successful' intercourse. Others charge that the American Psychological Association, the organization that produces the DSM, receives substantial drug funding from the pharmaceutical industry and thus may be compromised by conflicts of interest (Cosgrove et al 2008). Most importantly, DeRogatis and Burnett (2008) note that other important influences that can have an impact on a practitioner's diagnosis of a sexual dysfunction are missing (e.g., menopausal status, partner's sexual health, premorbid sexual function, and depression) and thus can obscure an appropriate diagnosis. Other social, economic, and political factors that can affect sexual desire include sexual violence and lack of access to sexual medicine or education (Tiefer et al

2002). In regards to the DSM categories of sexual desire disorders specifically, the two common critiques center on the use of the male model as the standard and the use of a linear model of sexual response (Leiblum 2002).

Currently there is discussion about changing the definitions of female sexual dysfunction in the influential DSM-IV. A working group for the American Psychiatric Association has called for a variety of revisions to the fifth edition of the DSM, which is to be released in 2015. These proposed revisions have been published in *Archives of Sexual Behavior*, a primarily psychology-focused journal. Both Brotto (2010) and Graham (2010) argue that the diagnostic criteria for Hypoactive Sexual Desire Disorder (HSDD) and Female Sexual Arousal Disorder (FSAD) should be combined as there is significant overlap between desire and arousal. They propose a new diagnostic disorder to replace HSDD and FSAD – Sexual Interest/Arousal Disorder. The following criteria are suggested:

“(1) absent/reduced interest in sexual activity (preserving the DSM-IV definition); (2) absent/reduced sexual or erotic thoughts or fantasies (preserving and expanding the DSM-IV definition); (3) does not initiate sexual activity and is not receptive to a partner’s initiation; (4) absent/reduced sexual excitement/pleasure during sexual activity, and (5) desire is not triggered by any erotic stimulus” (Brotto 2010:235).

A diagnosis would require that the symptoms cause clinically significant distress or impairment and be present for more than six months. Furthermore, the following specifiers would be included: (1) lifelong or acquired; (2) generalized or situational; (3) partner factors (e.g., partner’s sexual problems, partner’s health status); (4) relationship factors (e.g., poor communication, relationship discord, discrepancies in desire for sexual activity); (5) individual vulnerability factors (e.g., depression or anxiety, poor body image, history of abuse experience); (6) cultural/religious factors

(e.g., inhibitions related to prohibitions against sexual activity), and (7) medical factors (e.g., illness/medications).

Pharmaceutical researchers oppose this revision because they argue that desire and arousal disorders do not overlap (Fabre & Smith 2010). They cite clinical findings that show investigative drugs have different effects on desire and arousal disorders and that depression affects experiences of desire and arousal differently. Likewise, Derogatis (2010) argues that desire and arousal disorders do not overlap and cautions making revisions to the DSM without having empirical evidence to support this claim. Changes to the DSM categories of female sexual dysfunction will have far-reaching and profound clinical effects, given that the two categories that could be amended – hypoactive sexual desire disorder and female sexual arousal disorder – represent the two most highly prevalent categories of female sexual dysfunctions (Derogatis 2010).

Operationalizing the DSM-IV Definitions in Social Science Research

In recent years sociologist Laumann and colleagues (Laumann, Das and Waite 2008; Laumann, Paik and Rosen 1999; Nicolosi et al. 2006) have developed a sexual dysfunction survey instrument that operationalizes the definition of sexual dysfunction found in the DSM. Laumann, Paik and Rosen's (1999) important findings on sexual dysfunction in America have been cited considerably and the survey instrument is used extensively for epidemiologic purposes by non-sociologists. Laumann et al. define female sexual dysfunction as the following experiences that occur with moderate or higher frequency: (1) lack of interest in sex; (2) lubrication difficulties; (3) climaxing too early; (4) inability to achieve orgasm; (5) sex not pleasurable; (6) pain during sexual intercourse; and (7) anxiety about performance.

DeRogatis and Burnett (2008) believe that any new diagnostic system for sexual dysfunctions should include measurements of severity and duration of sexual problems. Laumann and colleagues have refined their survey questions accordingly over the years. In an article published in 1999, Laumann, Paik, and Rosen measured neither the severity nor the duration of the sexual problems experienced by women. In this study seven dichotomous response items were listed and respondents were asked if they had experienced the problem in the past 12 months. In contrast, later studies (Laumann et al. 2009; Nicolosi et al. 2006) asked about the severity of sexual dysfunctions that had occurred for at least two months in the past year. Respondents who indicated they had experienced a sexual problem were then asked to specify if they experienced it “occasionally,” “sometimes” or “frequently.” Although DeRogatis and Burnett (2008) suggest duration be recorded in months or years, Laumann and colleagues have not yet added a survey question that asks for the length of time during which the sexual problem has lasted.

The New View Approach

Opposition to rigid definitions of sexual dysfunction has been lodged by an interdisciplinary group of researchers who support a “new view” of sexual problems. Led by Leonore Tiefer, a clinical professor in psychiatry, The Working Group on A New View of Women’s Sexual Problems was developed in 2000 to offer both a critique of the prevailing medical model of women’s sexual problems and an alternative perspective. New View supporters argue that the DSM-IV diagnostic definitions have a medical emphasis on sexual physiology and performance (McHugh 2006). Unlike the narrow

definition of sexual dysfunctions based on the DSM-IV diagnostic criteria, New View researchers define sexual problems as “discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience” (Tiefer 2002:130). This definition is grounded in sexual rights literature, for example a 1974 World Health Organization document and a 1999 World Association of Sexology list of sexual rights, with the intent of highlighting the rights to sexual education, pleasure, and self-determination (Hartley & Tiefer 2003). New View researchers base their sexual problems classification scheme on the work of feminist researchers who use a biopsychosocial model and who argue that women’s sexual problems are primarily due to sociopolitical and relationship factors (Tiefer 2002). They argue that both sexual responses and problems involve a complex interplay between biological, sensual, emotional, cognitive, spiritual, relational, and cultural elements (Ogden 2002). The New View Campaign argues that a medical perspective on women’s sexuality is problematic because: (a) it erases differences among women and ignores the inequalities created by gender, race, class, and sexual orientation; (b) it views male and female sexuality as equivalent; and (c) it markets pharmaceutical interventions for women’s sexual problems (McHugh 2006). Others, who are opposed to a classification system, argue that these systems are a tool for the medicalization of female sexuality. For example, Moynihan (2003), in a controversial article published in the *British Medical Journal*, claims that female sexual dysfunction is not a medical condition and is, instead, a concept that has been deliberately developed by pharmaceutical companies to gain profits from pharmaceutical interventions. Hartley and Tiefer (2003) identify medicalization as a “process that organizes a broad and ever growing range of behaviors and aspects of everyday life into categories of health and

illness” (p. 43). Citing second-wave feminist scholars, they argue that medicalization creates misinformation and distracts attention away from social and cultural explanations for behaviors, and it is promoted by those interested in expanding medical domains for professional and economic interests.

PREVALENCE

Epidemiological research on the prevalence, predictors and outcomes of sexual dysfunction in women was lacking prior to the mid 1990s. Interestingly, it would be the work of a sociologist and his colleagues (Laumann et al 1999) who would offer this comprehensive national data.

Sexual Dysfunction Prevalence Rates

Laumann and colleagues (1999) have argued that sexual dysfunction is a public health concern that not only affects one’s sexual life but also one’s quality of life. Using population-based data from the National Health and Social Life Survey conducted in 1992, they found that 43% of American women, between the ages of 18-59 years, suffer from sexual dysfunction. DeRogatis and Burnett (2008) caution that this prevalence rate was determined by a survey instrument and not a clinical diagnosis, and that respondents were not asked about any distress related to their experience of sexual dysfunction. Among middle-age and older women, between the ages of 40-80 years, who completed a telephone survey, 33% suffered from lack of sexual interest and 23% from lubrication difficulties (Laumann et al 2009). A national probability sample of older adults, between 57 to 85 years of age, finds that about half of the female respondents report at least one bothersome sexual problem (Lindau et al 2007). International prevalence rates vary

substantially – women living in New Zealand were most likely (57%) and women in Canada were least likely (28%) to report suffering from at least one sexual dysfunction (Nicolosi et al 2006). Prevalence rates of female dysfunction are highly variable. Lewis and associates (cited in DeRogatis & Burnett 2008) have found prevalence rates of low sexual interest among women ranging from 17% to 55% and arousal/lubrication disorder rates that range between 8% and 28%.

Among the various sexual dysfunctions, lack of sexual interest is often the most common problem in women. In the National Health and Social Life Survey (Laumann et al 1999), between 27-32% of women aged 18-59 who had been sexually active during the past year answered “yes” to the question: “During the last 12 months has there been a period of several months or more when you lacked desire for sex?” International findings show similar results: In the Global Study of Sexual Attitudes and Behaviors (GSSAB), 26 to 43% of the 13,882 women surveyed in 29 countries said that they lacked interest in sex. In other epidemiologic studies examining low sexual desire among women, prevalence was about 36% (Rosen et al 2009, Shifren et al 2008).

Sociologist Laumann and colleagues (1999) received wide attention for their unexpected finding that sexual dysfunction is more prevalent for women (43%) than men (31%). Psychologist Bancroft and sociologists Loftus and Long (2003a) question whether their use of the term *dysfunction* is appropriate: Is the absence or reduction of sexual interest “dysfunctional” or adaptive? Bancroft, Loftus and Long support the latter view and see reductions in sexual interest as often healthy adaptive responses to adverse conditions. They argue that current surveys that assess epidemiologic prevalence of ‘dysfunction’ are “hazardous” (p. 204) because they do not distinguish between genuine

dysfunction and a healthy adaptive response. Furthermore, they argue, the ‘43-31’ study, as it’s often referred to, is vague about the time period covered (respondents were asked if they had experienced sexual difficulties “for several months or longer” in the previous year) and did not assess if the sexual problems caused distress in the respondents (Bancroft et al 2003b).

Hartley and Tiefer (2003) raise the concern over how sexual dysfunction research is taken up in popular and professional media. For example, they argue that although Laumann and colleagues note in their paper that the prevalence of women’s sexual problems varies by race, age, marital status, history of sexual abuse, economic location, and level of education, these socio-cultural predictors were glossed over in the media. By linking sexual problems with physiology only, a message is conveyed that female sexual dysfunction is highly prevalent and in urgent need of pharmaceutical intervention.

A CONCEPTUAL FRAME FOR RESEARCH ON LOW SEXUAL DESIRE IN WOMEN

The biopsychosocial model was first developed by George Engel as a response to the biomedical model of disease research, which he deemed reductionist and predicated on a mind-body dualism. Missing from the biomedical model, Engel argues, are psychological and social dimensions of illness (Engel 1980). His biopsychosocial model is based on a systems theory approach in which disease is understood as arising from complex interactions of multiple systems. Explanations are hierarchical in nature and can range from sub-atomic to socio-cultural. For example, depression is a syndrome that is the product of a constellation of social, familial, cognitive, and biochemical processes

(Searight 1994). Other disorders that are influenced by psychosocial factors include musculoskeletal disorders, cardiovascular disease, and environmental illness (Arnetz 1996). In contrast, adherents to the biomedical model argue that illness is caused solely by physical factors.

Fremont and Bird (1999) assert that both medical and sociological researchers are responsible for the lack of integration of a biopsychosocial approach into their research. On the one hand, social scientists criticize medical researchers for failing to include how social context can impact illness. The result of this exclusion is that biomedical research offers very little guidance on the psychosocial elements of prevention efforts that aim to change the health beliefs, attitudes, and behaviors of those at risk of suffering from chronic diseases (Havelka et al 2009). Sociological research, on the other hand, rarely includes biological measures to examine physiologic mechanisms. This is a particularly important omission as it doesn't allow sociologists to substantiate or rule out physiologic explanations put forth by biomedical researchers (Fremont & Bird 1999).

Biopsychosocial research reveals more complex relationships by linking psychosocial and biological factors to health problems. However, by no means has a biopsychosocial model replaced the biomedical model in disease research; in fact, the biomedical model continues to be structurally rooted in professional and research institutions (Lindau et al 2003).

Several issues with the biopsychosocial approach have arisen in recent years. The strongest opposition to the approach centers on its methodological shortcomings. The first challenge associated with using interdisciplinary factors in a biopsychosocial model is the lack of a common system of concepts (Havelka et al 2009). For example, a study

incorporating biopsychosocial factors may use psychological, medical, and sociological concepts and terminology, which could lead to difficulties in analyzing and interpreting findings.

Another drawback of a biopsychosocial approach is the complex research design required for collecting such rich data. Schubert (2010) recommends that a well-designed biopsychosocial study include repeated measures gained from various sources (biological, psychological, and social) and that the data be analyzed using time-series analysis so that 'intra-individual biopsychosocial relations' can be identified. Additionally, he calls for the use of qualitative methods, such as interviews and hermeneutic analysis, to capture the subjective experiences of individuals.

Under the biopsychosocial model, phenomenon is best understood by incorporating a variety of perspectives. Opponents of interdisciplinary research argue that, in some cases, the use of a single perspective is the preferred course of action. Ghaemi (2009) points to the case of peptic ulcer disease as an instance where biological reductionism was warranted: whereas it was long believed that peptic ulcers were a psychosomatic illness, they are now believed to be caused by a bacteria. However, sociologists Link and Phelan (cited in Fremont & Bird 1999) caution against focusing mainly on physiologic mechanisms because it can cause one to lose sight of the larger social context and social causes of a phenomenon.

Another criticism of the biopsychosocial approach is related to the analysis of complex data. A challenge that arises if we are to follow Engel's call to consider the entire system – including molecular and cellular levels and psychological and social

levels – is that of understanding complex cause and effect relationships between factors.

Schubert (2010) explains, in the context of illness:

“Circular causality between these different biopsychosocial levels results in the emergence of complex psychophysiological phenomena such as coupling and decoupling between psychological and physiological variables; psychophysiological feedback mechanisms; bidirectional cause–effect relations between psychological and physiological variables; and stress-related transitions from normal to disease-related dynamic ordering” (p. 389).

Ghaemi (2009), a psychiatrist, is opposed to using a biopsychosocial approach because “... prioritization happens on the run, with each person’s own preferences, and the model devolves into mere eclecticism, passing for sophistication” (p. 4). It may be true that biopsychosocial work requires data collection and analysis expertise that exceed those of researchers specialized in one discipline (Garland & Howard 2009). For example, it is probably beyond the capabilities of most sociologists to analyze highly-technical DNA microassays or for most molecular biologists to analyze hierarchical linear modeling of social data. Disciplinary boundaries must be breached if we are to fully embrace the possibilities of a holistic scientific exploration of sexuality. However, it should be noted, sociologists have much expertise to offer an interdisciplinary team doing biopsychosocial research on sexuality. Arnetz (1996) argues that the statistical analysis routinely used in most research are appropriate only for simple single-cause models. Quantitative sociologists are skilled in using non-linear models and structural analysis to understand multidisciplinary and multi-causal mechanisms.

In recent years, a biomedical approach has been applied to a host of sexual problems, most notably to sexual dysfunction (Rowland 2007). Tiefer (2001) argues that the prevailing biomedical model of sexuality promotes the idea of a ‘normal’ female sexuality in which successful sexual experience is one where the woman experiences

“desire (vaguely indicated as being ‘for sex’), genital arousal, a timely orgasm, and the ability to enjoy vaginal penetration” (p. 90). Missing from such a conception, she argues, is a focus on the psychosocial elements of sex, including sexual motives, scripts, sensuality, communication, pleasure and emotionality. She insists, furthermore, that a biomedical model of sexuality relies on the concept of ‘normal’ sexual function to the exclusion of discussion and research on cultural variation in sexuality. For example, the biomedical model rarely focuses on socio-cultural factors, such as the influence of religious scripts on sexuality. A biomedical approach assumes an underlying pathophysiology whereby problems require fixing through surgical or pharmaceutical treatments. The consequences of biased biomedical research are the medicalization of complex sexual experiences and the aggressive promotion by pharmaceutical companies of drugs to fix these medical problems. Tiefer (2006) provides an excellent review of the rise in the use of pharmaceuticals to treat sexual dysfunction in men. Whereas the predominant biomedical approach to treating sexual problems is the use of pharmaceuticals, a biopsychosocial model recommends a range of treatments with the aim of improving both sexual functioning and sexual satisfaction (Rowland 2007).

Proponents of a biopsychosocial approach to sexuality argue that sexuality is a multidimensional phenomenon that has biologic, psychosocial, and cultural aspects and thus requires a holistic approach (Berg 2001; Clayton 2007; McCarthy and Thestrup 2009; Parish et al. 2007). As well, whereas the biomedical model focuses upon the individual and his/her sexual functioning, a biopsychosocial approach is interested in the interpersonal factors inherent in dyads and larger social networks in which the individual belongs (Lindau et al 2003, Rosen & Barsky 2006).

Like the biomedical literature on sexuality, biopsychosocial research also focuses primarily on sexual dysfunction (Althof et al. 2005; Berg 2001; Bitzer et al. 2008; Brotto et al. 2010; Laan and Both 2008; McCabe et al. 2010; McCarthy and Thestrup 2009; Meana et al. 1997; Rosen and Barsky 2006; Wood, Koch and Mansfield 2006). This focus on sexual health problems is not surprising given that the biopsychosocial model was first developed to assess and treat health issues and disease. Other sexuality-related topics tackled by biopsychosocial researchers are sexual response (Mansfield et al 2000), adolescent sexual behavior (Rossi 1997), sexuality among the elderly (DeLamater et al 2008, Johnson 1998), timing of first sexual intercourse (Meschke 2000), sexual assault (Chivers-Wilson 2006), sexuality and chronic illness (Jensen 1992), and HIV risk behaviors (Stein et al 2009).

Evidence Linking Biopsychosocial Correlates to Low Sexual Desire in Women

A biopsychosocial model is predicated on the belief that sexual problems among women have a multi-causal explanation. Relevant biopsychosocial factors can include: “(i) patient variables such as performance anxiety and depression; (ii) partner variables such as poor mental or physical health and partner disinterest; (iii) interpersonal nonsexual variables such as quality of the overall relationship; (iv) interpersonal sexual variables such as the interval of abstinence and sexual scripts; and (v) contextual variables such as current life stresses with money or children” (Althof et al 2005:798).

If, as biopsychosocial researchers argue, sexual problems are influenced by a combination of biological, psychological and social factors, which correlates have found to be of particular importance? In recent years Laumann and colleagues have collected

both national and international data on sexual dysfunction among women (Laumann et al. 2009; Laumann et al. 2005; Laumann, Paik and Rosen 1999; Lindau et al. 2007; Parish et al. 2007). Among American women ages 18-59 years, the biopsychosocial correlates of sexual dysfunction are: (1) age (a decrease in sexual problems with age); (2) educational attainment; (3) emotional problems or stress; (4) poor health; (5) socioeconomic status; and (6) sexual victimization (Laumann et al 1999).

Laumann, Glasser et al. (2009), in a study of American women aged 40-80 years, find that 22% have experienced an inability to reach orgasm, 29% lack sexual interest, and 11% do not find sex pleasurable. Data on physical health show that lower than average level of physical activity is associated with a lack of sexual interest. As well depression is strongly correlated with a number of sexual problems among women in the United States.

Recent literature has produced new explanations for sexual problems among elderly women. Among women ages 57-85 years, Lindau and colleagues (2007) find physical health is more strongly associated with sexual dysfunction than is age alone. Women who rate their health as being fair or poor have a higher prevalence of sexual problems, including pain and lack of pleasure, than do women who rate their health as being excellent, very good, or good. The most common sexual problems cited by women are lack of interest in sex, difficulty with lubrication, inability to climax, finding sex not pleasurable, and pain during sex.

Laumann, Das et al. (2008) examine three sets of biopsychosocial risk factors, in addition to a basic set of demographic indicators, for sexual problems among older women: (1) sexual or partnership experiences; (2) mental health; and (3) physical health.

These researchers analyze the same dataset on elderly Americans as Lindau and colleagues (2007) and find negative mental health is the strongest correlate of sexual problems among elderly women (Laumann et al 2008). However, that is not the complete story. Surprisingly, there is no correlation between biological age and more sexual problems among women, suggesting that there is no inevitable decline in sexual function with age. Instead, sexual problems among elderly women are a response to life stressors. Health conditions, such as any lifetime history of STDs, lower urinary tract syndrome, and self-rated physical health, strongly affect the likelihood of sexual problems among women. Poor mental health, measured as depression and anxiety, is also associated with women's reports of sexual problems. Relationship dissatisfaction is positively associated with sexual problems among women. Thus, the findings show that sexual problems among older women are correlated with all three categories of factors.

The New View of sexual problems, based on a biopsychosocial model, argues that there are four categories of causes of sexual problems: (1) socio-cultural, political, or economic factors; (2) partner and relationship factors; (3) psychological factors; and (4) medical factors (The Working Group for A New View of Women's Sexual Problems 2002). The first and second categories of sexual problems are the most relevant to sociologists. The first category includes structural factors such as inadequate sex education, lack of access to contraception, abortion, and STD care, and lack of time due to family or work obligations. The second category includes sexual problems caused by partner's abuse, discrepancies in desire for sexual activity, conflicts over commonplace issues, and partner's health status.

Nicholls (2008) tested the utility of the New View classification system by assessing whether women's own accounts of sexual difficulty correspond with the scheme. Forty-nine women were interviewed and these women came up with 108 issues related to sexual difficulties. Of these issues, 98 percent could be classified by the New View scheme. The majority (65%) of the issues were classified as resulting from partner or relationship, 20 percent as relating to contextual/external (e.g. sociocultural, political or economic), 8 percent as resulting from psychological factors, and 7 percent as resulting from medical/biological factors. Nicholls argues that this research supports New View claims that, although individual (psychological and medical) factors play an important role in sexual problems, women's sexual difficulties are best understood primarily in relation to context and relationships. Thus, the New View perspective advocates exploring contextual themes (e.g., sexual violence and the effect of media images on sexuality) and relationship topics (e.g., aim to please a partner or avoid losing a partner on sexual desire) as primary influences of sexual problems among women.

MECHANISMS OF INFLUENCE

In the following I consider the debates over causal explanations of low sexual desire among women.

The Role of Sex Steroids

Most biomedical work on female sexual dysfunction is based on sex therapist and psychologist Helen Singer Kaplan's (1979) publication *Disorders of Desire*. In it she proposed a "triphasic" model of human sexual response (desire, arousal and orgasm) that

consisted of specific discrete phases that were experienced in a certain order. Kaplan claimed that the physiological basis of sexual desire resided mainly in the brain and that the level of desire exhibited was related to levels of testosterone circulating in the body. Janata & Kingsburg (cited in Tyler 2009) note that this explanation of sexual desire plays into common notions of sexual desire as an innate biological drive inherent in all healthy individuals. Kaplan's work is the basis for the DSM-IV criteria for desire disorders. The diagnostic category assumes that "all humans are endowed with demonstrable sexual urges and that their absence constitutes a pathological condition" (Jutel 2010:1085).

The role of sex steroids in sexual drive has been studied. One argument is that the impact of estrogen on the sexual drive of women appears to be indirect. As Leiblum (2002) explains, "the estrogen loss associated with menopause is a major cause of vaginal atrophy and hot flushes—the former contributing to dyspareunia, the latter to nocturnal awakening—both of which diminish female sexual desire" (p. 64). Another argument considers a more direct impact of sex steroids on sexual drive - women are most likely to initiate sex during the mid-point of their menstrual cycle when estrogen and androgen levels peak. Other studies suggest that androgen deficiency is related to diminished sexual interest among pre-menopausal, menopausal and post-menopausal women (Davis et al 1995, Guay 2001, Sherwin et al 1985). Several female life experiences (e.g., hormonal contraceptives, postpartum states and lactation, and oophorectomy and hysterectomy) may also uniquely affect sexual desire (Warnock 2002). Many researchers agree that adequate levels of free testosterone are necessary for stimulating sexual interest but "while testosterone fuels the flames of desire, psychological factors determine the intensity and direction of the flame" (Leiblum 2002:65). These psychological factors

include habit, circumstance, expectation and conditioning. Other research has also shown that physical factors, including menstrual phase (Hendricks 1994) and physical fatigue due to recent childbirth (Hyde et al 1998), can affect feelings of sexual desire among women.

Wallen (2000) notes that women are capable of experiencing as much pleasure from sexual intercourse as are men, insofar as women are capable of experiencing multiple orgasms. The more important gender difference in sexual desire is thus not the strength of the sex drive but the regularity of the sex drive. Most men experience continuous intense sexual drive, whereas women appear to have cycles of desire. Women experience more variability in sexual desire across a month than do men. The increase in sexual desire among women coincides with the high spikes in testosterone during the middle of the menstrual cycle, whereas men appear to have more consistent levels of sexual interest across a month.

Receptivity

Rosemary Basson (2000) suggests that Kaplan's linear model of sexual response fits male sexuality but is less useful in understanding female sexuality. Women are much more likely to be motivated to participate in sexual activity by intimacy, pleasure and partnership issues rather than by biological urges. In fact, many women do not experience sexual desire at the start of a sexual experience. Instead, a woman chooses to respond to positive sexual stimuli as a way to ignite sexual desire. Basson (2002) describes sexual receptivity as the "willingness to proceed [with sexual activity] despite absence of sexual desire at that instant" (p. 294). It should be noted that sexual arousal and responsive desire are nearly indistinguishable in this model (Segraves & Woodard 2006). Basson's

concept of receptivity implies that “women may not consciously experience desire internally but that it can be awakened by a partner and by the experience of arousal” (Leiblum 2002:60). The important aspect of this concept is the willingness and ability to find and respond to sexual stimuli.

Tyler (2009) argues against the use of Basson’s receptivity model of sexual desire on the grounds that it undermines women’s sexual autonomy and their ability to refuse unwanted sexual activity. The model doesn’t allow for women to refuse unwanted heterosexual intercourse in committed relationships and revives the “sleeping beauty model of women’s sexuality” (p. 44).

Dual Control Model

Much of the literature on sexual dysfunctions is predicated on the belief that sexual issues are distressing. For example, the DSM-IV criteria for the diagnosis of sexual dysfunction in women includes personal distress about sex. Psychologist and sociologists Bancroft, Loftus and Long (2003a) conducted a telephone survey of 987 White and Black/African American women, ages 20-65 years old, and who had lived for at least 6 months in a heterosexual relationship, to explore whether physical aspects of sexual response were predictors of sexual distress. Surprisingly, these physical aspects (including arousal, vaginal lubrication, and orgasm) were poor predictors of sexual distress, whereas general emotional well-being and emotional relationship with the partner during sexual activity were very good predictors. These authors argue that the absence or reduction of sexual interest or response should not necessarily be considered dysfunctional or maladaptive. Instead, inhibition of sexual response can in fact be an adaptive mechanism (Bancroft & Janssen 2000). According to Bancroft, Loftus, and

Long (2003a), a reduction in sexual interest is an understandable response to adverse conditions in a relationship or in an individual's general life situation. If a woman is faced with these sexual difficulties, her case should be viewed through three conceptual "windows": (1) evaluate her current relationship situation and her life situation generally; (2) consider her sexual history; and (3) look at whether there are physical, pharmacological, or hormonal effects, which might be challenging her sexual response system. The authors note that it is feasible to consider problems explained through the second and third windows as "sexual dysfunctions".

Social Stress Theory

Here I track the work done by sociologist Edward Laumann on female sexual dysfunction. In a 1999 article that analyzes data from the National Health and Social Life Survey, a probability sample study of sexual behavior in a demographically representative cohort of US adults, Laumann and colleagues (1999) explore the predictors associated with sexual dysfunction. The strongest predictors of sexual difficulties were age, poor health and lifestyle, nonmarital status, low educational attainment and minority status. Their underlying theory is that emotional and stress-related problems generate elevated risk of experiencing sexual difficulty. They use a social stress theory that views social conditions as a cause of stress for members of disadvantaged social groups (Aneshensel et al 1991). This stress, in turn, can cause disease, or in terms of sexuality, sexual dysfunction.

In terms of differentials in sexual experience based on age, the authors assert that young women are more likely to experience sexual problems than older women because

younger women more often experience stressful sexual encounters. Stress is associated with younger women having unstable sexual relationships – they are more likely to be single, have higher rates of partner turnover, and periodic spells of sexual inactivity than their older peers. Other factors, such as poor health, nonmarital status, low educational attainment and minority status, also increase one's risk of experiencing sexual dysfunction because they are related to physically and emotionally stressful lifestyles and experiences. Other sources of stress, which affect sexual problems in the present, include a history of child-adult contact or forced sex, and deterioration in social status. The authors clearly state that they believe both physiological and psychological statuses are independent factors that affect sexual functioning.

While the Global Survey of Sexual Attitudes and Behaviors (GSSAB) provides prevalence rates of sexual dysfunction of women aged 40-80 years in five Anglophone countries (the United States, Canada, the United Kingdom, Australia, and New Zealand), the study provides no answers as to why there are national differences in the prevalence rates (Nicolosi et al 2006). The study did not investigate if the differences are due to genetic predisposition, health factors, cultural perception or socioeconomic situation. Likewise, data from the GSSAB on older women, between the ages of 40-80 years old, living in the United States, provide little information on the underlying mechanisms of sexual dysfunction (Laumann et al 2009). The authors speculate that depression plays a large role in sexual dysfunction among older individuals, but they do not include data to substantiate the connection. Kennedy et al. (1999), instead, have found that a well-recognized symptom of depression among adult women is decreased sexual interest. In their study of sexual dysfunction among individuals with major depressive disorder, half

the women subjects reported decreased sexual interest prior to treatment. The authors suggest that women with depression are more likely to suffer difficulties with the early stages of sexual activity (i.e., desire and arousal) than women that are not depressed. As well, treating depression has shown to improve women's sexual dysfunction. Piazza et al. (1997) compared depressed women before and after treatment with anti-depressant medication (sertraline or paroxetine) and found that women reported significant improvements in sex drive and psychological arousal after six weeks of treatment.

Sexual Drive

Much of the literature on sexual desire tends to focus on the prevalence and frequency of sexual thoughts and behaviors across different groups, and less on the meaning and subjective quality of sexual desires (Tolman & Diamond 2001) and the "intrapsychic landscapes" that evoke sexual excitement (Simon 2003). As Simon explains,

"[T]he question of what creates sexual excitement, how it is rooted not in our bodies but in our lives, has only been considered in the most superficial ways. In other words, we have been encouraged to avert our attention from the creation of the erotic, the creation of the sexual meanings, sexual motives, and sexual priorities. The naturalization of sex rendered such concerns unnecessary: as an expression of the natural it was alleged to be there at the very beginning – that it came as standard equipment with the body" (p. 25).

It was sociologists, Stein (1989) says, who first began to question Freud's assertion that sexuality was an instinctual drive and who explored the variation in sexual behavior exhibited across cultures. Stein argues that although Freud differentiated between 'instincts' (which are biological) and 'drive' (which is psychically and culturally shaped), overall his libido theory viewed the sexual drive as fixed and existing prior to society.

Criticisms of an essentialist drive approach are: (1) it is deemed a reductionist method that takes the complexity of the world and reduces it to supposed constituent units; and (2) it is deterministic and argues actions are caused by 'inner propulsions', such as genes, hormones, or the unconscious (Weeks 2003). An essentialist approach cannot account for the social organization and the changing meanings associated with sexuality. Instead, non-essentialists view sexuality as a product of social and historical forces. Traditionally, sociologists opposed to essentialist models of sexuality have fallen into two camps: (1) structural functionalists who argue that social norms structure sexual behavior; and (2) symbolic interactionists who argue that sexual meanings are negotiated through social interaction.

A great deal of the postwar functionalist literature on sexuality is based on a drive model derived from psychoanalysis, which saw sexuality as being a natural impulse. Postwar functionalists believed that social institutions - the family primarily - developed social norms to hold sexual impulses in check. The goal of socialization, they argued, was to maintain the integrity of the family system (Stein 1989). One was labeled a deviant if they bucked these sexual norms around procreative heterosexuality. Stein explains that the functionalist model developed by sociologists downplayed the extent to which sexuality is socially constructed and instead primarily explored the relationship between sexuality and social structure.

Sexual Scripts

Challenges to postwar functionalist models, in the 1960s and 1970s, came from symbolic interactionists who believed that culture, not nature, primarily determined

sexual patterns. Whereas functionalists viewed sex as a natural drive that has to be curbed by learning and enacting sexual roles within the family, symbolic interactionists argued that sex was socially constructed and subject to sociocultural molding. Stein (1989) details the shift in focus from social norms to situations in which individuals engage with sexual scripts. Contrary to the idea that individuals passively adhere to social norms, symbolic interactionists argued that individuals actively negotiate and acquire scripts in everyday interaction. John Gagnon and William Simon's groundbreaking book, *Sexual Conduct* (1973), was the first to describe and theorize how sex is a product of social forces and how sexual meanings originate in social interactions. The authors argue that there are no essential human sexual drives and that individuals come to define something as 'sexual' based on definitions or scripts that circulate in the social world. These scripts set the parameters for an individual's choices and actions. A variety of scripts coexist at any one time, thus we can and usually are surrounded by contradictory definitions of the 'sexual'. Many sociologists have applied this theory to their work, resulting in the theory having "a kind of monopoly status within the field" (Green 2008).

Gagnon and Simon's scripting theory is weakened by several limitations: (a) it doesn't explain where cultural scenarios originate (Stein 1989); (b) it doesn't detail why some cultural scenarios are followed while others are ignored; (c) it offers weak explanations about the structuring of sexual desire (Epstein 1991); (d) it is difficult to study scripts directly (Laumann et al 1994) and to study interactions between the cultural, interpersonal and intrapsychic (Whittier & Melendez 2004); (e) given its emphasis on variability, it has limited explanatory and predictive power (DeLamater & Hyde 1998);

and (f) it undertheorizes ambivalence and disidentification with intrapsychic scripts (Moon 2008).

Erotic Habitus

Scripting theory has previously been used to explain how social structures and location affect sexual action and fantasy. It does not, however, clarify why or how individuals acquire and enact particular scripts. Green (2008) critiques scripting theory for (1) understudying the role of psychodynamic processes in the development of sexual desire, and (2) failing to provide a macro-level analysis of the structural sources of sexual ideation, i.e., how race, class, ethnicity and age affect sexual desire. Building upon Boudieu's work on the relationship of psyche to society, Green proposes a new line of theorizing on the sociology of desire that links social structure to unconscious processes. Central to his approach is the concept *erotic habitus*. He wishes to extend scripting theory to ask why and how individuals choose between scripts.

Bourdieu sought, with his theory of practice rooted in the principle of "embodiment", to explain social action, whereas Green, using Bourdieu's insights, attempts to explain sexual action. The habitus is a concept that describes how the social world becomes inscribed on the mind via symbolic force. Green (2008) explains,

"For Bourdieu, social structures are not simply external to the individual, but, rather, occupy a somatic relationship to the self. This relationship develops out of a process whereby social structures are 'deposited' in the unconscious via 'symbolic force,' materializing in a set of 'embodied' inclinations, dispositions, schemes of actions and appreciations captured in the concept, 'habitus'" (p. 599).

Furthermore,

"Bourdieu believed that human beings were constitutionally docile, symbolically absorptive, and prime for cultural construction, most especially in early life. Nevertheless, saturated in physical and social worlds mediated through symbolic systems, humans soak up their symbolic environments in such a way that they do not perceive the socialization process itself but, rather, misrecognize their identities, dispositions, inclinations, tastes, material and cultural orientations, and even bodily structures (e.g., its particular height, weight, shape, and density), as a function of their 'nature'" (p. 609).

Green uses Bourdieu's concept of the habitus to explore the area where social structure and the unconscious meet. The 'erotic habitus' is a socially constituted psychological mechanism whereby objects and their relations are introjected and become stabilized as psychic structures. The result is a deeply socialized intrapsychic life filled with 'libidinal investment' in the form of sexual desire. 'Erotic work', Green says, is the process whereby these internalized unconscious schemes of erotic habitus are transformed into conscious sexual fantasy. He notes that erotic work will reveal sociohistorical patterning because differently located individuals in social space will have distinct experiences of the external world and thus have distinct group erotic habitus. He explains the relationship between the erotic habitus and improvising sexual scripts:

"[T]he erotic habitus should not be regarded as determinative of sexual fantasy, but rather, as a socially structured set of erotic dispositions, schemes of perceptions and appreciations that interface with more idiosyncratic, biographical, and psychological factors to make certain objects *more or less likely* to be focal points of arousal. In this sense, the erotic habitus provides a rough template of objects and erotic dispositions from which individuals consciously improvise a sexual script. Moreover, even as the erotic habitus materializes early in psychological life, it is not to be conceived as an ossified psychic structure but, rather, subject to change over time as individuals have new experiences that reconstitute self-concept and the self's location in social space" (p. 615).

While the erotic habitus orients sexual desires to the social world, it does not determine their precise expression. Ultimately, Green argues, scripting and embodiment theories should be used together for developing a sociology of desire. Erotic habitus shows how underlying schemes of perception and inclinations are imbued with erotic salience, while scripting processes organize these schemes into intelligible, conscious sexual fantasies.

BRIDGES INTO FUTURE RESEARCH

In the future sociologists might contribute more substantially to the following two areas: (1) applying theories and empirical research on sexual dysfunctions to populations of women that hitherto have not been studied; and (2) monitoring and suggesting appropriate interventions for female sexual problems.

An interesting shift in sexual dysfunction research has been to explore sexual dysfunction among women in same-sex relationships. Nichols (2004) explores low frequency of sexual activity in same-sex couples. She finds no statistically-significant differences in sexual frequency between lesbians and heterosexual women, thus finding no support for the notion of 'lesbian bed death'. The non-clinical based study, undertaken by a private practice agency specializing in work with sexual minorities, surveyed 104 self-identified lesbians and 89 heterosexual women. Other study data suggest that lesbians report significantly fewer sexual problems than heterosexual women, including less pain with vaginal entry, fewer orgasm problems, and less trouble lubricating. As well, lesbians engage in sex that lasted longer, including non-genital as well as genitally-focused acts, in more varied sexual acts, and in sexual acts that more reliably resulted in orgasm. Nichols concludes that previous findings on low sexual frequency among

lesbians obscured other important components of sex between women. For example, her study can shed light on sex that is tailored to the sexual needs of women; “one might reconceptualize the female sexual response as slower out of the gate, so to speak, requiring more time, variety, and imagination—but ultimately full of passion” (Nichols 2004:369).

Likewise, Iasenza (2008) critiques the idea of ‘lesbian bed death’ and the underlying theory that all lesbian women “are shaped by gender scripts that train women to be sexually receptive/responsive rather than active” (p. 539) and that “two women in a relationship are logically destined to be platonic partners because there is no man around to get sex started” (ibid). She applies a New View approach to the study of low sexual desire among lesbian women and cites case studies of female clients with whom she’s worked. She suggests that sexual desire among women in same-sex relationships can be impacted by experiences of homophobia, being closeted at work, and low self-esteem. She asserts that sexual problems usually have their sources in context and relationships.

Research by Laumann et al. (1999) on sexual dysfunctions has become widely-cited and known as the ‘43-31’ study, where more women (43%) than men (31%) are said to suffer from sexual dysfunction. They have emphasized the strong association between sexual dysfunction and impaired quality of life and have called sexual dysfunction a significant health problem. Furthermore, they argue that sexual dysfunction is strongly associated with low wellbeing among women, and thus it would be beneficial to focus on developing appropriate therapies to assist women who suffer from sexual dysfunctions. Although they note that “service delivery efforts should be augmented to target high-risk populations” (p. 544), they do not identify which therapies or

interventions should be used. In a later article, Laumann and others frame sexual dysfunction as an important issue because it is a barrier to satisfying sexual life for middle-aged and elderly men and women (Nicolosi et al 2006). Wright, Wright et al. (2007) emphasize the deleterious consequences of sexual dysfunction for another population - people with serious mental illness. Sexual dysfunction, they argue, is associated with problems in maintaining relationships and social isolation, which affect their ability to gain critical social support from sexual partners.

Currently there are three major forms of treatment for sexual dysfunction available to health practitioners: psychological, hormonal, and use of psychopharmacological agents. However, there is no standard approved treatment for low sexual desire in women, no clear guidelines on the safe use of non-approved treatments (Segraves & Woodard 2006), and no products that have US Food and Drug Administration (FDA) approval to treat hypoactive sexual desire disorder (HSDD) in women. The case study presented at the beginning of this article explores a pharmacological therapy to alleviate symptoms associated with diminished sex desire among women. Sociologist Heather Hartley (2006) has written about the 'hunt for the Pink Viagra' in which the drug industry has put substantial effort and funds into creating and expanding a market for sex drugs for women. She charts how pharmaceutical company, Pfizer, did clinical trials of Viagra in women to alleviate symptoms related to the condition 'Female Sexual Arousal Disorder' (FSAD). When Viagra was shown to be no more effective in enhancing arousal in women than a placebo, the focus of pharmaceutical interventions shifted to the use of testosterone and to the condition 'Hypoactive Sexual Desire Disorder' (HSDD). Hartley argues that this shift in focus from

FSAD to HSDD illustrates the ‘disease mongering’ tactics of the drug industry and “seems to indicate an effort to match up some drug (*any drug?*) with some subcomponent (*any subcomponent?*) of the DSM classification” (p. 367). A second method of expanding a market for sex drugs for women is through the use of off-label prescription of men’s sex drugs to women. While none of the drugs approved by the Federal Drug Administration (FDA) as treatments for men’s sexual problems – e.g., Viagra, Levitra, Cialis, AndroGel, and Testim – have been sufficiently tested in women, increasingly doctors are giving women ‘off-label’ prescriptions. Once a drug has been approved for sale for one purpose, physicians are permitted to prescribe it for any other purpose that, in their profession judgment, is both safe and effective.

Medical sociologist, Annemarie Jutel, argues that female Hypoactive Sexual Desire Disorder (HSDD) is central to the project of reifying low sexual desire as a pathological disorder in women (2010). Supporting the development and diagnosis of HSDD are the pharmaceutical industry and its medical allies for commercial gain related to marketing a cure. Jutel provides a revealing look at the development and marketing of Flibanserin as a therapy for HSDD, which included a new diagnostic tool to measure and screen for HSDD. She goes beyond the argument that HSDD is simply the creation of the pharmaceutical industry and instead argues that a particular social context must provide the back drop for such a development. She explains:

“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...” (p. 1089).

Whereas excessive female desire preoccupied medicine at the beginning of the 20th century, low sexual desire surfaced in the last quarter of that century. We can trace the

formal pathologisation of low libido to 1980, when a diagnosis of “inhibited sexual desire” was defined in the DSM. As a reminder, HSDD, as defined in the DSM-IV, assumes sexual urges are inherent in all humans and that the absence of sexual urges constitutes a pathological condition. The second element within the social context, which allows for the development of pharmaceutical therapies of HSDD, is the commodification of sexuality. Here, a “spontaneous hypersexuality is marketed, then pathologised and re-presented with its concomitant cure similarly available as a consumer item” (Jutel 2010:1087).

While the New View researchers do not focus on treatment interventions for women’s sexual problems, they support the use of psychotherapy, couples therapy, and other appropriate interventions, including medical treatment (Hartley & Tiefer 2003). Their larger aims, rather, are to raise awareness about the multiple causes of sexual problems and to reconceptualize sexual distress as being situated in a larger political context. They do hope, however, that by addressing larger issues, such as political equality, women’s emancipation and entitlement, sex education, and health care access, they can help to prevent many sexual problems.

CONCLUSION

I have shown that sexuality scholars from a variety of disciplines have debated over the definitions, prevalence, correlates, and underlying mechanisms of female sexual dysfunction, specifically low sexual desire. Sociologists have been at the forefront in both researching female sexual dysfunction and critiquing the medicalization of female sexuality. While there have been calls for viewing sexual problems using an

interdisciplinary lens, this review has shown that the biopsychosocial model is still in its infancy. Green (2008) has begun the effort to bridge psychoanalysis and sociology but I argue that he undertheorizes the role of physiological responses in developing an erotic habitus. How might the neurochemical changes associated with sex and orgasm affect one's sexuality and sexual predilection? A convincing biopsychosocial model needs to explain the psychological and physiological processes at work when one is engaged with the social order.

ACKNOWLEDGEMENTS

Research for the review was supported, in part, by an NIH Research Grant (T32 MH015722) funded by the National Institute of Mental Health and the National Institute on Drug Abuse.

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