

FACT SHEET

HSDD

Problem #1: HSDD is NOT a disease; it is an ambiguous, highly contested diagnosis.

- The Working Committee on Sexual Disorders for the forthcoming DSM-5 has recommended to delete HSDD because of scientific weakness (APA 2010).
- There is no empirical evidence to suggest that a “normal” level of sexual desire exists against which hyposexual desire can be measured (Brotto 2010).
- “There is a great deal of ambiguity and variation regarding the conceptualization, definition, operationalization, and application (in research and practice) of the term “sexual desire” (Wood Mansfield & Koch 2006, 236).
- Although the current official definition of HSDD requires the presence of “distress,” independent (non-pharma) funded epidemiology indicates that “less than half” of women and men reporting sexual dysfunction on surveys “experience that it is accompanied by personal distress” (Lewis et al. 2004, 59).
- What is determined “normal” with regards to sexuality is strongly linked to the cultural setting: era, location, class, ethnicity, sexual identity, etc. Historically, women were pathologized for exhibiting too much sexual desire. Since the ‘sexual revolution,’ standards of “normalcy” have reversed. These too will ebb and flow (Jutel 2010).

Problem #2: There are multiple sources of sexual desire; desire is shaped by psycho-social and interpersonal factors; variation is normal.

- The neuroscience model used by Boehringer Ingelheim (B-I) is speculative and hypothetical. There are no studies on neurotransmitter abnormalities in women with desire complaints.
- There is overwhelming research consensus that psycho-social and interpersonal factors are the main causes of reduced sexual desire, including anxiety about sexual attractiveness, body image, and aging; confusion or shame about sexual orientation or fantasies; fatigue, stress, depression; experiences of sexual trauma and violence; relationship problems and length of relationship (Brotto 2010).
- When premenopausal women were asked about the causes of their lost desire, they listed psychosocial and interpersonal factors overwhelmingly, and over one third blamed another sex problem (pain, anorgasmia) (Maserejian et al. 2009).
- There is debate over the origins of women’s sexual desire, spontaneous vs. responsive, but all are considered “normal” (Meana 2010).

Problem #3: The assessment instruments used to formulate Boehringer Ingelheim’s claims about sexual desire and distress were developed by industry funded researchers. This is a conflict of interest.

- The screening tool recommended for HSDD was developed by B-I consultants. It was validated only in a small group with pre-identified sexual problems and has limited predictive value (Clayton et al. 2009).
- This HSDD brief symptom checklist screening tool can easily be abused as it tempts clinicians to abbreviate patient interviews and histories, omitting key elements of patient history; it also encourages stigmatizing self-diagnosis.
- The screening tool omits all assessment of non-clinical relational, cultural and situational factors which contribute to issues of desire. This will misinform the public about the true complexity of human sexual desire.

References

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