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**A CRITICAL DISCOURSE ANALYSIS OF HERBAL SEXUAL MEDICINE WEBSITES MARKETING TO  
WOMEN**

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## ABSTRACT

An area attracting increased attention from the 'profit driven' commercial drug industry is the potentially lucrative medication market for female sexual problems. In the absence of an approved pharmaceutical drug, numerous internet based herbal sexual medicine (HSM) companies are targeting this market. Very little has been known about the marketing messages that HSM companies are sending out to women via the internet.

This research delivered a critical analysis of the marketing messages of five prominent internet based HSM companies: Zestra; Femvigor; Hersolution; Vigorelle, and; Provestra. The analysis revealed three main discursive themes forming the basis of the marketing strategy. In the first theme, the HSM websites presented a medicalised view of women's sexuality and sexual problems, this framing implicated all women as being sexually dysfunctional and requiring biologically based sexual medication. In the second theme, stereotypical gender constructions were used in the HSM websites to portray women's sexuality as inadequate compared to men's, whilst emphasising the importance of sex for men and the necessity for women to fulfil men's sexual needs in order to maintain intimate relationships. This again led to the conclusion that women needed to consume sexual medication. In the third theme, the HSM websites capitalised on the current western societal emphasis placed on the importance of sex for health. In conjunction with the portrayal of the importance of sex was a call for women to act responsibly concerning their health. Being 'responsible' for sexual health, was portrayed in the HSM websites as consuming sexual medicine.

The critical analysis of the HSM websites ultimately revealed that the marketers of HSMs had researched and identified potential issues that could make women anxious about their sexual problems. They appeared to emphasise these problematic issues in an attempt to increase a women's anxiety about her sexual concerns, with the aim of manipulating women into purchasing sexual medication. These findings add considerable evidence to suggest that HSM companies are involved in the disease-mongering of female sexual problems.

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## CHAPTER 1

### BACKGROUND TO THE RESEARCH

#### Disease-mongering of women's sexual problems

For any business a key strategy is to sell a product to the widest possible market. The commercial drug industry is no exception. In fact, in an attempt to expand markets, medication producers now spend more on marketing than on research and development (Angell, 2004; Gagnon & Lexchin, 2008). It is also no secret that commercial drug companies contract marketing agencies with expertises in condition branding, whose skills include fostering the creation of new medical disorders and dysfunctions (Parry, 2003). This situation has raised serious concern from academics, amongst others, that contemporary understandings of health and illness are being underwritten by marketing departments concerned with profit rather than a primary interest in people's health. According to Moynihan and Cassels, "drug company marketing is creating new ideas about health and illness in order to sell medication" (2005, p. xiv). Furthermore, drug companies are also expanding their markets by marketing medication to an increasingly wide range of human anxieties and dissatisfactions (Applbaum, 2006). These unethical practices of manipulating markets in order to sell more medication, has led to the serious accusation that the commercial drug industry is involved in disease-mongering (Moynihan & Cassels, 2005; Moynihan, Heath, & Henry, 2002).

The commercial sexual medicine industry has been accused of disease-mongering for its unethical role in actively campaigning for female sexual problems to be redefined and understood as female sexual dysfunctions (FSDs) (Angell, 2004; Conrad, 2007; Moynihan & Henry, 2006; Tiefer, 2004). This promotion of female sexual problems as biologically based sexual dysfunctions is said to have moved female sexual problems into the medical domain therefore creating a potentially lucrative market for women's sexual medicine. Having been involved in unethical disease-mongering in order to build a market for women's sexual medicine, there is now a concern that the marketing practices will also employ disease mongering tactics in order to manipulate women into consuming sexual medicine (Hartley & Tiefer, 2003a; Moynihan & Cassels, 2005). Consequently this research aims to deliver a

critical analysis of the marketing messages of commercial businesses that sell sexual medication to women.

### Creating a market for women's sexual medicine

In contemporary western society the market for sexual medicines has undergone significant change. In an expanding commercialised health market, sexual medications include not only pharmaceutical drugs but also a range of non prescription medicines such as herbal sexual medicines (HSMs). Sexual medications are not only available by prescription from a doctor but are also widely available 'over the counter', and perhaps of most significance is their availability from the internet (Conrad & Leiter, 2004). Sexual medicines are now advertised and sold not only to treat sexual functioning problems but also to enhance people's sexual performance (Harmon, 2005). Sexual medicines are also being marketed to, and consumed by people of all ages (Katz & Marshall, 2003).

The normalisation of sexual medicine, the expansion of the sexual medicine market, and the general commercialisation of sexuality are credited by many scholars, to have been significantly influenced by the 1998 introduction of the pharmaceutical drug Viagra (Tiefer, 2006b). In the early days it was marketed primarily to older men with physical problems such as diabetes or prostate cancer that resulted in erectile problems (Loe, 2004). However seeing the potential profitability, within a short time, Pfizer Pharmaceuticals began a global marketing campaign to expand its market (Tiefer, 2006a). Those that tracked the marketing observed, within a few short years the marketing strategy was shifting from a focus on older men with medical problems to a much broader and younger age group (Lexchin, 2006), who might just want a boost in sexual performance (Conrad & Leiter, 2004). Through its marketing it is believed that Viagra transformed how society thinks about its sexual problems (Cacchioni, 2007). Sexual problems which were once thought of as a normal part of ageing, or as having social origins, are now more commonly understood as biological dysfunctions requiring biological medications (Loe, 2004; Tiefer, 1995). Viagra's highly influential marketing was also noted for its divisive promotion of traditional normative heterosexuality and masculinity discourses (Fishman & Mamo, 2001), with a particular emphasis placed upon men's erectile performance as an indicator of masculinity (Loe, 2004). Two researchers, Cecilia Åsberg and Ericka Johnson, analysed the way masculinity was presented on Pfizer's website in Sweden, and described what they called the



construction of the 'Swedish Viagra man' (Åsberg & Johnson, 2009). Here masculinity was portrayed as quintessentially to have 'potency' and always be 'ready for sex'. The site also tapped extensively into national imagery of the rugged outdoor life as a symbol of masculinity. 'Viagra', the researchers observed, 'realigns a man to his natural virility' (Åsberg & Johnson, 2009, p. 11). Consequently, Viagra marketing is also said to have created an atmosphere of increasing self-scrutiny, anxiety and uncertainty over appropriate standards for sexual behaviour (Tiefer, 2008). In addition, the clinical and market success of Viagra was pivotal in creating new institutional structures and health promotion discourses around sexual health and in constructing ageing bodies as sites of biomedical intervention (Marshall, 2010). This highly successful marketing campaign has resulted in annual sales of 1.6 billion a year for Pfizer (Tuller, 2004).

The financial success of Viagra, combined with its cultural impact on normalising the idea of sexual medication, is said to have created tremendous incentives for the pharmaceutical industry to develop a market for female sexual medicine (Leland, 2000). In fact, the pharmaceutical industry is largely believed to have spent millions of dollars in grooming this market (Hartley, 2006). This occurred through an active campaign to transform the understanding of women's sexual problems into sexual dysfunctions. Investigative health journalist Ray Moynihan has spent the past decade investigating this issue. Over this time he has observed the unethical involvement of the pharmaceutical industry in pushing its agenda for developing a market for women's sexual medication. He noted that the pharmaceutical industry was directly involved in funding medical research, and paying key medical opinion leaders to shape how women's sexual problems are understood (Moynihan, 2003). Consequently, a very narrow biomedical understanding of female sexual problems has been promoted in western society. Furthermore, women's sexual problems have been relabelled and redefined as female sexual dysfunctions (FSD), with the key aspect of women's sexual dysfunction said to be a lack of sexual desire, referred to as hypoactive sexual desire disorder (HSDD) (Wood, Koch, & Mansfield, 2006).

In addition, pharmaceutical industry funded and influenced research informed society that half of all women are suffering from FSD and are in urgent need of treatment (Hartley & Tiefer, 2003a). Moynihan provides the following summation of the pharmaceutical industry's involvement in developing a market for FSD:

*“Looking back over the past decade, it has become clear that drug companies have not simply sponsored the science of this new condition [FSD]; on occasions they have helped to construct it. Corporate employees have worked with paid key opinion leaders to help develop the disease entity; they have run prevalence surveys to portray it as widespread; and they helped create the measurement and diagnostic instruments to persuade women that their sexual difficulties deserve a medical label and treatment” (Moynihan, 2010, p. 698).*

Undoubtedly this pharmaceutical influence has developed a market for women’s sexual medications (Tiefer, 2000). It has also led to a critique that the pharmaceutical industry is implicated in medicalising women’s sexual problems for profit in a classic case of disease mongering (Angell, 2004; Conrad, 2007; Moynihan & Henry, 2006; Tiefer, 2004).

#### Herbal sexual medicine for women

In conjunction with developing a market for FSD, the pharmaceutical industry also turned their attention to creating a Viagra equivalent for women (Hartley & Tiefer, 2003a; Leland, 2000; Moynihan, 2003). Consequently, a vast variety of products, including pills, patches, creams, sprays, are continually being developed and tested by over a dozen pharmaceutical companies (Enserink, 2005). However, because of issues relating to appropriateness, effectiveness and safety, as well as vocal feminist opposition to the medicalisation of women’s sexual problems, pharmaceutical regulatory agencies around the world have been cautious to approve pharmaceutical drugs for FSD. Of particular significance, and perhaps setting the precedent for other countries, is the fact that the American Food and Drug authority (FDA) is yet to approve any pharmaceutical agent for the treatment of FSD.

Currently, the only products for women’s sexual problems, or medically defined FSDs, that are widely available, marketed, and consumed are herbal sexual medicines (HSM) (Mazaro Costa, Andersen, Hachul, & Tufik, , 2010). HSM’s are a mix of herbs and nutrients that are claimed to be effective in treating FSD as well as increasing women’s desire and enjoyment of sex (Provestra, 2011). These HSM’s do not have to adhere to the same regulatory jurisdiction as pharmaceuticals (Hartley, 2006). Because of this current situation, many pharmaceutical, nutraceutical and other opportunistic business companies, have turned to manufacturing HSM’s for the lucrative women’s sexual medicine market (Clewell

et al., 2010) . Consequently, HSMs are now widely available over the counter at chemists and health food shops. However, their presence is particularly apparent on the internet with websites marketing and selling HSM directly to women (Ferguson, Hosmane, & Heiman, 2010; Kenyon, Button, Perella, McKeown, & Holt, 2006). There are no empirical studies reporting on the prevalence of women's consumption of internet-based HSM's. However, anecdotal evidence suggests it is significant. For example Avlimil, a HSM product sold on the internet, reported sales of 200,000 packages in its first month on the market (Pokorny, 2004). Also indicating a significant amount of consumption is the significant number of websites found on the internet selling HSM. A website search, using the popular search engine Google, under the terms 'herbal sexual medicine' and 'female sexual dysfunction' returns over 3 million hits, and provides links to innumerable websites marketing and selling women's HSM.

It is also likely that HSM use is consistent with the general trend in western society of tremendous growth in the use of herbal medicines (Ervin, Wright, Wang, & Kennedy-Stephenson, 2004). That HSM is implicated in this trend is also bolstered by the fact that herbal medicines are significantly used by women of the "ageing baby boomer" generation (see, e.g., Marinac et al., 2007; Timbo, Ross, McCarthy, & Lin, 2006). In terms of indicators to suggest that women could be consuming HSM specifically via the internet, one only has to look at the increasing role of the internet in people's healthcare (Conrad & Stults, 2010). The internet is now one of the most readily accessible and comprehensive methods for accessing health information and treatments by the public (Ayantunde, Welch, & Parsons, 2007; Fox & Jones, 2009). As well as searching for conventional health information, a US study found that 30 per cent of internet users search for information on 'alternative therapies' such as herbal medicines (Fox, 2005). Based on the current increased societal trends of herbal medicine use, the utilisation of the internet in health care, and the medicalisation of sexual problems, combined with the fact that no pharmaceutical drug has been approved for FSD, it is reasonable to assume that a significant amount of internet based HSM's are being consumed by women.

#### A critique of women's sexual problems

Feminist scholars have long observed that sexuality, especially but not exclusively women's sexuality, is as much a matter of politics as biology (Snitow, Stansell, & Thompson, 1983;

Vance, 1984). In western society, women's sexual problems have been shaped by powerful groups, particularly religion and medicine, within a context of gender inequality (Ehrenreich, Hess, & Jacobs, 1986; Fine, 1988; Rich, 1980; Tiefer, 1995). While the oppressive influence of religion still lingers on, it is the medical establishment, continued gender inequality and societal pressure for people to be sexually healthy that are believed to be most influential in shaping contemporary understandings of women's sexual problems (Hinchliff, Gott, & Wylie, 2009; Ussher, 2006).

Contemporary understandings of women's sexual problems are based upon a relationship with medicine that dates back to the late 19<sup>th</sup> century (Nicolson & Burr, 2003). This 'orthodox scientific sexology' has been identified as especially powerful due to its connection with biomedical understandings of our bodies that are considered authoritative in that they prescribe what is 'normal' and 'healthy' when it comes to sex (Potts, 2002). What counts as appropriate sex for women has been largely determined, therefore, by clinicians and sexologists and problematic sex positioned as deviations from these norms (see Nicolson, 1993; Potts, 2002; Ussher & Baker, 1993 for more information). Central to the medical understanding of female sexual problems is biological determinism. This theory sees sexual biology as providing nature's direction for women's sexuality (Kaplan, 1979). Here women's sexuality, and sexual desire, is thought of as driven by a biological imperative to reproduce or to perpetuate our genes. A facile evolutionary argument used to support this assumption is that women's sexual desire is a biological necessity for the survival of the species. This perspective posits female sexual desire as intrinsic, natural and universal (Tolman & Diamond, 2001).

Underpinned by biological determinism, is the seminal publication of *Disorders of desire* (Kaplan, 1979). This highly influential work marked the initial comprehensive theorising of sexual desire, or rather a lack of sexual desire as being dysfunctional, in modern sexology (Irvine & Arvine, 1990). Kaplan proposed that normal sexual response consisted of three discrete phases that proceeded in a linear fashion: desire, arousal, and orgasm (Meston, 2001). Kaplan also outlined what she believed to be the physiological bases of desire, arousal and orgasm. Her claim was that the physiological basis of sexual desire resided mainly in the brain and that the control of desire related to levels of testosterone or "the libido hormone" (Kaplan, 1979, p.14). This reinforced commonly held notions that sexual desire was an innate biological drive, present in all healthy human

beings (Tyler, 2009). Inversely, this also set the foundations for low sexual desire to be seen as medically problematic and requiring treatment.

Biological determinism and Kaplan's theory of sexual response have also formed the basis of how women's sexual problems are defined as a disorder, in the *Diagnostic and Statistical Manual* (DSM). The DSM is the principle tool for diagnosing sexual problems as well as informing research studies. Within the DSM a women's lack of sexual desire is labelled as Hypoactive Sexual Desire Disorder (HSDD) and defined as "persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity" that causes "marked distress or interpersonal difficulty" (American Psychiatric Association, 2000).

The majority of medical research into women's sexual problems is firmly entrenched in the biomedical paradigm (Wood, et al., 2006). Perhaps the most significant research that has contributed to the public understanding of female sexual problems is the widely cited, yet vastly contentious, study by Laumann, Paik and Rosen (1999). This study attempted to measure the prevalence and predictors of sexual dysfunction among men and women. It concluded that 43% of women had some form of sexual dysfunction with 22% of women reporting low sexual desire symptoms, meeting the criteria for HSDD. The authors concluded "the results indicate that sexual dysfunction is an important public health concern" (Laumann, Paik, & Rosen, 1999). Others have been quick to use these results, to proclaim that women's low sexual desire constitutes a "modern day epidemic-level sex problem" (Pierce, 2000, p. 257). In addition, the overall statistic '43%' has been used to emphasise the prevalence of physiological sexual problems for women and the urgent need for treatments (Hartley & Tiefer, 2003a). The pharmaceutical industry and sexual medical profession maintains that FSD is a 'real problem' that needs to be taken seriously and treated effectively with biological medicine. They maintain that women's sexual problems such as a lack of sexual desire have historically been misunderstood, under-diagnosed, under-treated, and that increased medication use is in the interests of women's health (Berman, Berman, Toler, Gill, & Haughie, 2003).

Feminist scholars, however, have been critical of the promotion of medication for women's sexual problems. They argue that female sexual dysfunction is an invented disease that serves commercial and professional interests rather than the interests of women. This was noted in the previous section, whereby the pharmaceutical industry was using the power and influence of the medical establishment to promote an understanding of

women's sexual problems as biological medical dysfunctions, in its attempt to create a market for medications (Marshall, 2009; Marshall & Katz, 2002; Tiefer, 2000).

Feminist scholars have pointed out that biomedical theory, definitions and research all work to medicalise women's sexual problems. Medicine provides a 'set of truths' telling people what is 'normal' when it comes to female sexual functioning (or dysfunction) (Ussher, 2006; Wood, et al., 2006). If a woman does not fit the norm she is labeled pathological or dysfunctional (Wood, et al., 2006). Feminists within a constructionist view, point out that there is no universal blueprint of normal sexuality, and women experience their sexuality in many different ways (Tiefer, 1987). Feminists point out that a biological deterministic perspective locates women's sexual problems as residing in an individual woman's body, prioritising the physical aspects of sexual problems over other possible causes (Plummer, 2003). Critics argue this is a reductionist approach to understanding women's sexual problems and overlooks important contextual factors (McCormick, 1994; Tiefer, 1995, 2000). In contrast to a strict biomedical perspective, feminists highlight that sexual problems do not occur in a vacuum. Instead they refer to qualitative research showing that social, psychological and interpersonal factors (e.g. relationship quality with partner; low levels of social support; spousal health problems) impact women's sexual experiences of sexual problems equally if not more than, biological aspects (Goberna, Francés, Paulí, Barluenga, & Gascón, 2009; Hess et al., 2009; Wood, et al., 2006). As well as overlooking social issues involved with female sexual problems, a biomedical understanding is criticised for the fact that it obscures the reality that women's sexual problems involve cultural and political factors as well as physical factors (Bass, 2001; Mamo & Fishman, 2001; Snitow, et al., 1983; Tiefer, 1995; Vance, 1984).

A highly significant cultural and political factor involved in women's sexuality and sexual problems is the fact that men and women do not have equal political sexual power or, often, personal sexual power (e.g., Kramarae & Spender, 1992). Sexual gender inequality is not always easily recognised because it is woven deep into the social fabric of society. People are often unaware of sexual gender inequality because of entrenched stereotyped assumptions about men's and women's essential sexual natures. Feminists argue that the constructed act of sex between a man and a woman (heterosex) is orientated to privilege a male version of sex (Jackson, 1984; Kilmartin, 1999; Ussher, 2005). This is because the main

act of heterosex is penetration of the vagina by the penis, referred to as coitus. Numerous studies have been conducted which clearly show that not all women desire or even enjoy coital sex (Hinchliff, et al., 2009). It is said that coitus is reinforced in society as the sexual norm because of the 'male sexual drive' discourse (Hollway, 1984), whereby men are supposedly being driven by an insatiable biological 'need' for coital sex for its own sake (Weeks, 1986). Subsequently, coitus is seen as an entitlement and right for men (Wilkinson & Kitzinger, 1994). This has led to what is referred to as the "Coital imperative" (McPhillips, Braun, & Gavey, 2001; Potts, 2002), which posits that 'real sex' equals coitus. Heterosex is also significantly related to sexual performance, whereby orgasm becomes the indicator of a successful sexual encounter. Again this is said to be orientated towards privileging a male version of sex (Jackson, 1984; Kilmartin, 1999). Popular discourses describe men as being biologically predisposed to 'performance' orientated sex. Moreover, sexual ability, performance and competence are said to be linked to masculine discourses of accomplishment, self esteem, and identity. The notion of male sexuality as (inherently) performance-orientated has been challenged by many (Kilmartin, 1999; Seidler, 1989; Tiefer, 1995).

On the other hand, popular discourses of women's sexuality portray women as having lower sex drives and not being as 'naturally' sexual as men (Roberts, Kippax, Waldby, & Crawford, 1995). This understanding of women's sexuality is said to be constructed within the heterosexual norm and in relation to men's sexual drive, expectations and needs, and subsequently positions women's sexuality as inadequate or dysfunctional (Jackson, 1984; Kilmartin, 1999; Ussher, 2005). It is argued that if heterosexual activity were redefined (not so much emphasis placed on coitus and sexual performance), sexual problems, as understood, might not be problems at all (Hinchliff, et al., 2009).

Women's sexual problems are also affected by cultural expectations of what it means to be a heterosexual woman. Discourses of femininity are said to position the 'good' women as caring and nurturing in relation to men (Gavey, McPhillips, & Braun, 1999; Ussher, 1997; Weeks, 1986). Consequently part of being a 'good' woman is to accommodate men's 'insatiable' biological sexual needs (Nicolson & Burr, 2003; Potts, 2002). So while not having coital sex, not desiring coitus and not orgasming may not be of particularly high importance for women (Lavie-Ajayi, 2005), it is still seen as necessary for the sake of men. As an example, Nicholson and Burr (2003) found that within heterosexual intercourse

women are relatively indifferent about achieving orgasm for their own enjoyment but they still regarded orgasm as important for the satisfaction of their male partners, presumably as a signifier of his sexual performance. This has led to the criticism that female sexuality has been seen essentially as a response to male sexuality (Nicolson & Burr, 2003). Qualitative research also indicates that these normative beliefs and understandings of heterosexuality and gender can lead to significant distress for some women (Meadows, 1997). Research shows that when a women perceives she cannot fulfil normative function of heterosexuality and femininity, she may judge herself as 'inadequate' through a process of reflexive self positioning (Ayling & Ussher, 2008). This process takes place at an intrapersonal level, identified by Foucault (1977) as internalised self-policing whereby individuals constantly appraise their performance against cultural ideals. Falling short of these ideals can lead to feelings of inferiority and inadequacy, which could potentially lead to self-pathologisation and seeking treatment (Nicolson, 1993, p. 57).

Research by Kaler (2006), based on the experiences of women who live with chronic vulval pain (and subsequent sexual desire loss), examined the ways in which women's experience of sexual problems intersected with dominant discourses of heterosexuality and gender. Women who were unable to perform coitus, considered themselves to be failures as women, and women who were not really women. Women also spoke of isolation, feelings of sexual inadequacy, a loss of femininity, guilt, shame, loss of self esteem, and diminished confidence (Kaler, 2006). In another similar study by Ayling and Ussher (2008), women's experiences of vulvodynia (and subsequent sexual desire loss) found that most women took up positions of 'inadequate women' and 'inadequate sexual partner' when they were unable to regularly engage in coitus. They interpreted this as affecting their ability to satisfy their partners sexually resulting in feelings of shame, guilt, and a decreased desire for sexual contact. From this perspective, a woman's experience of her sexual desire being problematic might be understood to emerge within her simultaneous negotiation of dominant discourses of heterosexuality, femininity and masculinity.

As well as a narrow biomedical understanding, and gender inequality affecting understandings of women's sexual problems there is increasing societal pressure to be sexually healthy. Over the past two decades, in western, predominantly middle class locales, sex is increasingly "talked of in the idiom of health promotion and lifestyle choices"(Jackson



& Scott, 1997, pp. 557-558). In relation to looking after our health, sex is increasingly viewed as being integral to our psychological development, personal growth, emotional satisfaction and physical health (Cacchioni, 2007). It has also been observed that there is a particular emphasis on the promotion of sexual activity in later life as part of an ageing-well philosophy (Katz & Marshall, 2003). Whereby, an emphasis is placed on the importance of continued sexual activity across the lifespan, and links sexual function with overall health (Marshall, 2009). So while historically sexual decline in both men and women was assumed to be an inevitable consequence of growing older, this assumption has now being reversed (Marshall, 2010). Furthermore, waning sexual capacities associated with normal ageing are now increasingly pathologised as sexual dysfunctions that require corrective self care practices, including medications (Marshall & Katz, 2002; Marshall, 2009).

The understanding of the benefits of sex for health is largely due to a number of scientific studies, which have identified health benefits of regular sexual activity, ranging from increased life-span and decreased risk of certain types of cancer to immunity from colds. These scientific and medical findings have been widely reported in western media outlets, as evidence for the health benefits of sex. The 'sex for health' discourse has also been promoted by commercial and public health promotion. Health promotion discourses have embraced language such as 'empowerment' to encourage individuals to take responsibility for their sexual health as part of their commitment to the collective health of the population (Marshall, 2002). In this way sexual function has become part of a wider 'moral obligation' requiring individuals to monitor their own health and engage in significant amounts of 'self-work' to maximise their health and well-being (Clarke, Shim, Mamo, Fosket, & Fishman, 2003). The 'sex for health' discourse has been noted for its consequences for individuals. Although this 'sex for health' discourse may serve to de-stigmatise sexual activity for some, it may also increase pressure on others to be sexually active and may contribute to the pathologisation of people who abstain from sex or engage in sex infrequently. Alternatively it may encourage individuals to seek medication treatment if their level of sexual activity does not meet expectations (Marshall & Katz, 2002; Marshall, 2009).

This section explores the argument that women's sexual problems are influenced by more than simply biology. While physical occurrences may take place in the body, how a

woman experiences these depends on the discourses available to her. As this section shows powerful institutions such as medicine, patriarchal dominance and health promotion emanate discursive norms about sexual biology, gender, and sexual health and dominate how women's sexual problems are experienced. Feminists argue how these powerful institutions and norms operate in a self serving manner often to the detriment of women's sexuality. In fact these dominant discourses have been noted as significant factors in explaining why women can become anxious and distressed about sexual problems. Because women's sexual problems are socially constructed, medication becomes questionable. While medication may cause physiological change, it cannot change the cultural, social and political conditions that oppress women's sexuality.

#### About this research

This research presents a feminist position, whereby it is argued that far from being of unalloyed benefit to women, medication for women's sexual problems serves rather to reinforce their subjugation by medical hegemony, patriarchal dominance, sexual health promotion, and their exploitation by the commercial health industry. Therefore, this research echoes the call to resist the increasing use of medications for female sexual problems for example, (Drew, 2003; Kaschak & Tiefer, 2002; Nicolson & Burr, 2003; Potts, Gavey, Grace, & Vares, 2003).

Currently in western society it is not only the pharmaceutical industry that is pushing medications. Increasingly, commercial businesses are becoming involved in healthcare and marketing medications. Seeing a gap in the market with the absence of any pharmacological drug for women's sexual problems, commercial businesses are marketing and selling herbal sexual medications to women. As mentioned there is particular concern that women's understanding of sexual problems is now vulnerable to commercial marketing departments looking to enlarge the sexual medication market. There is also concern that the marketing practices will employ disease-mongering tactics in order to manipulate women into consuming sexual medicine (Hartley & Tiefer, 2003b; Moynihan & Cassels, 2005). Of specific concern is that HSM marketing might draw on already oppressive, anxiety creating discourses in order to manipulate women into consuming sexual medicine.

Currently, very little is known about the marketing messages HSM companies are sending out to women via the internet, and because of concerns with disease-mongering of women's sexual problems, this research aims to deliver a critical analysis of the marketing messages of internet based herbal sexual medicine marketing. To help fulfil this aim the following questions will be asked of the websites:

- What are the dominant discourses in HSM websites?
- How do HSM websites frame women's sexual problems and sexual medicine?
- What marketing techniques are HSM websites utilising in their attempt to sell sexual medicine?
- How might the HSM websites be contributing to the oppression of women and their sexuality?

## CHAPTER 2

### METHODOLOGY

#### Sample

The aim of this research was to give critical consideration to the marketing of herbal sexual medicine (HSM) websites targeting women. As mentioned in the previous chapter, a website search, using the popular search engine *Google*, under a combination of different terms including 'herbal medicine' or 'herbal sexual medicine' and 'sexual problems' or 'female sexual dysfunction' returns millions of hits, and provides links to innumerable websites marketing and selling women's HSM.

In considering which of these websites would be most suitable for this research, the following considerations were employed: I looked for websites that frequently showed up at the front of various websites searches; The websites had to be exclusively selling herbal sexual medicine to women; I also looked for websites that were specifically targeting the treatment of 'sexual dysfunctions' as opposed to sexual enhancement; further consideration was also given to how well constructed the websites were, whereby it was assumed that websites that had clearly spent significant money constructing its website belonged to larger and potentially more profitable businesses; Finally, the websites selected for the study had to provide enough relevant data for analysis. Through this process, Five websites stood out as clearly meeting these guidelines and were included in the study sample, they were: [www.zestra.com](http://www.zestra.com), [www.femvigor.com](http://www.femvigor.com), [www.hersolution.com](http://www.hersolution.com), [www.vigorelle.com](http://www.vigorelle.com), [www.provestra.com](http://www.provestra.com).

To secure a hardcopy of the websites, and for practical reasons relating to analysing the websites, software was used to download the websites from the internet. The software used to download the websites was WinHTrack Website Copier. A total of 68 pages from the five websites were downloaded February 1, 2011.

#### Analysis

The method used to analyse the marketing of HSM websites drew considerably from critical discursive analysis (CDA). Consistent with CDA, this method of analysis is best

described as an approach towards analysis rather than a step-by-step method (Huckin, 2002). This approach is characterised by being overtly political. As Thomas Huckin (2002) notes “the main purpose of CDA is to understand how people are manipulated by public discourse and thereby subjected to abuses of power” (p.162). My position in this thesis is that women’s sexuality and in particular, women’s sexual problems, are being defined and shaped by dominant discourses and institutions. Of particular focus is a concern that HSM businesses are attempting to influence women’s understanding of their sexuality as problematic and requiring medication. I take a feminist activist position and oppose women’s sexuality being constructed in a problematic way to sell medication. Therefore, this analysis is focused on demonstrating how HSM businesses are attempting to manipulate women for profit. What follows is that the methodology used in this research is not a ‘discovery’ mechanism per se rather, it serves to confirm, explain, and enrich this initial insight and to communicate this insight in detailed fashion to others.

As well as being overtly political, a key focus of CDA and this research analysis is taking a critical approach. The notion of being critical, according to Ruth Wodak, is to be understood as “having distance to the data, embedding the data in the social, taking a political stance explicitly, and a focus on self-reflection as scholars doing research”(in Wodak & Meyer, 2009, p. 9). In accordance to taking a critical approach I have not simply analysed the discursive content of the websites on face value, instead I have endeavoured to read the discursive content of the websites on three different but integrated levels. The discourse is analysed on its textual content; on the discursive practices of the websites, i.e. how the discourse is positioning the reader; and within its social, political, historical and commercial context. In addition to being critical of the context surrounding the content of the websites, I have also attempted to put critical consideration into possible effects of the websites on its readers.

As well as being critical, a systematic approach to the analysis of the data also played a central role in the analysis. A systematic approach was considered important as a way of being thorough and rigorous toward gaining a meaningful insight into the data, whilst maintaining the academic integrity of the analysis. This systematic approach to analysing the data began with an initial reading of the websites. The main intention of proceeding this way was to make sure that I read and looked at all of the material on the websites gaining a thorough account of the content. In addition, I wanted to gain an impression of how these

websites might be read by a lay reader. Following this initial reading, I went back through the websites and recorded notes on the general themes and visual representations in the websites. I recorded this in tables for clarity. The tables were divided into the following categories: A description of the HSP's; colours and imagery on the websites; packaging of the HSM's; marketing slogans; what is FSD; causes of FSD; symptoms of FSD; medication outcomes and barriers to using sexual medicines. This basic website data provided a valuable overview of the websites and reference resource.

After an initial orientating reading and recording of the websites, I then approached the websites more critically. This involved reading and re-reading each of the websites several times. As I proceeded through the websites I made notes and comments about the content.

In addition I continually referred to relevant literature and theory to help with an in-depth understanding of the text. As part of the analytic approach I continually asked questions of the text such as: What does this mean in western society? What is this discourse doing? Why is this being referred to? What are the possible implications of this discourse, etc. From this process several important ideas common to all the HSM websites began to develop. From this point I started the initial writing up of the analysis. I constantly referred back to the data, further unpacking these websites and gained a more developed understanding of the content.

The data collection, analysis and writing of the results were not exclusive activities. Instead, the methodological analysis occurred in an oscillatory way. After lengthy consideration and development of the main ideas three main themes were identified. The first was the considerable focus in the websites to portray women's sexual problems as 'biomedically sexually dysfunctional' requiring medication. A second theme was how the websites created an 'illusion of female sexual liberation' in its attempt to convince women to purchase HSM. The third theme was the portrayal of HSM as 'a requirement for women's sexual health'. The analysis in the following section will expand and exemplify these themes.

Although this CDA-informed methodology is appropriate for my research, there are criticisms of a CDA approach. These criticisms are worth addressing as it helps to further illuminate my application of this methodology. CDA has been criticised for being a matter of interpretation. For instance, Widdowson argues that critical discourse analysts confirm their

own values, that CDA is merely a subjective process (Widdowson, 2004). However, any account of a social phenomena or situation inevitably reflects the researcher's own partial understandings and special interests. This research does not aim to provide one knowledge or truth, as this would deny the diversity of viewpoints and experiences of others who are involved in the subject of the study. So while it could be said that the findings of the analysis in this research are partial and relative (related to my world view and value systems), it can be said that all arguments are subject to their own deconstructive readings and counter-interpretations. Moreover, since complete neutrality is impossible, Stephanie Taylor suggests "the researchers' influence must be taken into account and even utilised" to some extent (in Wetherell, Taylor, & Yates, 2001, p. 17). To ensure I am aware of potential ethical complexities my research takes into account the influence and relevance of my own identity, understandings and special interests.

## CHAPTER 3

### FINDINGS

The critical analysis of the herbal sexual medicine (HSM) websites, [www.zestra.com](http://www.zestra.com), [www.femvigor.com](http://www.femvigor.com), [www.hersolution.com](http://www.hersolution.com), [www.vigorelle.com](http://www.vigorelle.com), [www.provestra.com](http://www.provestra.com), revealed three main themes that formed the basis of the marketing strategy to manipulate female readers to consume sexual medication. I have labelled these themes 'Biomedically sexually dysfunctional', 'An illusion of female sexual liberation', and 'A requirement for women's sexual health'. In the first section 'Biomedically sexually dysfunctional', I argue that the HSM websites draw upon the authority of medicine to present a medicalised view of women's sexual problems. This framing implicates women as having problematic biological sexual dysfunctions requiring biologically based HSMs. Next, I argue that these websites promote discourses of female sexual liberation whilst simultaneously portraying a male orientated version of women's sexuality and reinforcing patriarchal norms. Finally, I argue that the HSM websites draw upon dominant societal discourses of 'sex for health' and 'health responsibility' as a way to make HSM a requirement for healthy responsible women. In outlining these themes, I draw on exemplary texts and discuss how each theme attempts to manipulate women into consuming sexual medication.

#### Biomedically sexually dysfunctional

As part of their marketing strategy HSM websites portray a medicalised version of women's sexual problems in order to appropriate sexual medication. This is achieved in the websites by consistently drawing upon medical and biological discourses to portray female sexuality as dysfunctional and requiring medication. Biological discourses were utilised to frame sexual problems as biological imbalances located solely within a women's body, while medical rhetoric was employed in order to reframe sexual problems as female sexual dysfunctions (FSD), affecting most women. In close conjunction with medicalising women's



sexual problems to sell medication, was a supplementary marketing ploy to draw upon the power and authority of the ‘medical establishment’ to legitimate FSD as ‘serious’ concern and HSM as an ‘effective’ and ‘appropriate’ treatment.

It is well known that the medical profession gained great influence and authority in the first three quarters of the twentieth century, attaining both a professional dominance (Freidson, 1970) and cultural authority (Starr, 1982). As a way of employing this power and authority the HSM websites displayed numerous visual images of supposed Doctors, identifiable by their symbolic white coats and accompanying stethoscope, for example:

*Image 1.*



*(Provestra, Femvigor, Vigorelle, Hersolution)*

These visual images were accompanied by testimonials about FSD and HSM. These testimonials worked to establish that: Doctors are the qualified authority on women’s sexuality; that women’s sexual problems are a ‘serious’ medical problem; and that HSM is an ‘effective’ and ‘appropriate’ treatment. For example:

*“As a doctor, my many years of research and direct clinical work with patients have allowed me to understand human sexuality... Provestra offers a new and exciting break through for women suffering from symptoms of female sexual dysfunction such as low or no sex drive as well as a lack of confidence associated with these feelings...Dr. Michael Carter” (Provestra)*

And:

*“As a doctor, I regularly speak to female patients who are plagued with a combination of overwhelming responsibilities, stress, and even medications that have had a terrible impact on their libido, often manifesting into more serious problems like*

*vaginal dryness and inability to achieve orgasm...finally, a formulation of scientifically proven ingredients , in an easy-to-take once a day supplement that targets all of the systems that are critical in maintaining healthy and satisfying sexual performance...As a doctor, I would definitely recommend Provestra to any of my female patients looking to enhance their Libido and sexual pleasure” ...Dr. Alexis Vazquez (Provestra)*

The numerous visual images of Doctors, combined with their accompanying testimonials are seemingly employed in the websites to create a sense of authority and legitimacy around the topic of women’s sexual problems and sexual medication. In addition, the visual images and testimonials also worked to set an ‘authoritative discursive tone’ throughout the websites. Furthermore, because of the ‘authoritative discursive tone’ in the websites, at times it is ambiguous as to whether it was a Doctor or the HSM Company being represented. Certainly, the HSM websites are written as if speaking with a ‘medical voice’, and thus the websites are arguably ‘claiming conferred authority to further the ends of the marketing exercise. The ‘authoritative discursive tone’ also enabled messages about women’s sexual problems to be delivered as if they were uncontested facts. For example:

*“Women of all age’s encounter periods of low libido at some or the other point in their lives...This is referred to as Female Sexual Dysfunction” (Femvigor).*

The use of Doctors’ images and testimonials was also part of a larger attempt to portray a medicalised version of female sexual problems. In particular Medical terminology was frequently used throughout the websites. In particular, medical labels were used to describe women’s sexual experiences. For example, not feeling like having sex was referred to as Hypoactive sexual desire disorder:

*“Otherwise known as hypoactive sexual desire disorder or HSDD, this is a common sexual dysfunction found in women.” (Hersolution)*

Difficulties with orgasm were referred to as anorgasmia:

*“The inability to orgasm is called anorgasmia. This is common sexual dysfunction to women in their late 20s-40s” (Provestra)*

The sexual medicine term FSD was employed throughout the HSM websites to refer to a variety of women's sexual problems. In the following passage, a lack of sexual arousal, vaginal dryness, or any sexual concern was referred to as FSD:

*"Women of all ages encounter periods of low libido at some or the other point in their lives. Most of the time, it is accompanied by vaginal dryness. This is referred to as **Female Sexual Dysfunction** or simply **FSD**" (Femvigor)*

In the above passages, the underlining of the word 'common' and 'all ages', is added into the text to show how the HSM websites consistently portrayed FSD as effecting a significant proportion of women, regardless of age. The framing of dysfunctional sex occurring at any stage of a women's life seems to have particular implications for older women. As Marshall (2010) explains, "while historically sexual decline in both men and women was assumed to be an inevitable consequence of growing older, this assumption has now been reversed" (Marshall, 2010, p. 4). As a way of reinforcing the message that FSD was common to women of all ages, the websites drew upon the contentious research of Laumann et al (1999), to proclaim that FSD was at seemingly epidemic levels (Tiefer, 2001). For example:

*"According to the Journal of the American Medical Association, a whopping 43% of women report dealing with sexual dysfunction" (Provestra)*

The referencing of a medical journal in the above passage was also another example of how medical authority was drawn upon in the websites to legitimate FSD as a real and serious concern for all women. The use of medical terminology in the HSM websites is divisive because it discursively moves sexual problems into a medical domain, in an apparent attempt to legitimate sexual problems as 'serious' dysfunctional concerns. Medical terminology also sets the stage in the websites to portray sexual problems or 'so called' sexual dysfunctions as biologically based. For example:

*"...if your suffering with low libido, you need more than a bubble bath and a romance novel to get you in the mood, because low libido is often an issue of physical health...not mental health" (Femvigor)*

And:

*“You can’t just talk yourself into wanting sex” (Hersolution)*

Prior to the influence of Viagra, sexual problems were largely believed to be the result of relational or psychological issues. By portraying sexual problems as biologically based dysfunctions, HSM websites further reinforce the increasingly popular notion that sexual problems are located in the physical body. This is significant as it shifts the treatment of sexual problems from talking based therapies such as counselling and psychology to treatments that target the physiology of the body. This transformation of people’s understanding of sexual problems is said to be essential for drug companies trying to sell biologically based treatments (Moynihan, 2003). In considering the implications of this shift Marshall (2009) suggests that this may relieve women of one sought of moral responsibility, for their sexual problems, by suggesting ‘it’s not all in your head’, however, another kind of moral responsibility replaces it as individuals are made responsible for their own preventative and rehabilitative care (Marshall, 2009).

Consistent with framing sexual problems as biological dysfunctions, was a biomedical explanation given as the primary reason to explain FSD. FSD was said to be the result of three main physiological bodily changes in hormones, nutrients and estrogens. For example:

*“[sexual dysfunctions are] an imbalance of the hormones and nutrients associated with all aspects of the female reproductive system” (Provestra)*

And:

*“It is becoming more and more common for women to be literally overloaded with estrogens – and this is a key cause of loss of interest in and enjoyment of sex.”  
(HerSolution)*

There was also a particular focus on women experiencing menopause, as being particularly susceptible to problematic biological changes that caused FSD:

*“[Menopause] this is simply something that cannot be avoided. Hormones which are mainly responsible for arousal are depleted. It can cause the vaginal wall to dry out making sex painful” (Zestra)*

And:

*“[In reference to menopause] the bad news is that, sometimes, our bodies don’t respond the way they used to. That’s because declining levels of the estrogen lead to decreased vaginal lubrication & less vaginal elasticity, & lower androgens can diminish desire and arousal” (Zestra)*

The underlining of the words *imbalance*, *overloaded*, *depleted*, *declining* and *decreased* was added into the passages to highlight the consistent negative metaphorical framing that seems designed to further problematise female sexuality. The negative metaphorical portrayal also seemed to be working to evoke a ‘body-as-machine’ metaphor. Whereby, words such as ‘depleted’ and ‘declining’ portray the human body in mechanical terms. The ‘body as machine’ metaphor arguably legitimises a proposed medication regime: whereby a mechanical fault has developed; mechanical faults can usually be fixed; and in this case with HSM (Coupland & Williams, 2002).

The changes in hormones, nutrients and estrogens were said to result in ‘symptoms’ of FSD such as low libido, vaginal dryness, and difficulties achieving orgasm. For example:

*“Lack of desire, vaginal dryness, difficulty reaching orgasm...these are just a few of the very common symptoms of FSD experienced by half of all women” (Hersolution)*

Passages like this work to reinforce low sexual desire, vaginal dryness, and difficulty reaching orgasm as something that is dysfunctional and subsequently problematic, no matter what age or stage of life a woman is at. The portrayal of these symptoms being dysfunctional draws upon the dominant biomedical understanding of ‘normal’ sexual functioning. This biomedical understanding is based on the ‘human sexual response cycle’ (HSRC) (Masters & Johnson, 1966). In this model sexual functioning is said to follow a linear process whereby arousal, leads to lubrication, followed by orgasm. In medical discourse, deviation from the normal sexual response cycle constitutes a sexual dysfunction (Winton, 2001). The HSRC has been criticised for being based on a supposed male model of sexual functioning. Furthermore, it is said to reduce sexuality to mechanical functioning whereby sexual response occurs and proceeds in discrete stages (Potts, 2002). However, research indicates that women do not distinguish between “desire” and “arousal,” or between subjective and physiological arousal; yet the procession of physiological arousal by desire is

proclaimed to be central to sexual functioning (Kaschak & Tiefer, 2002). In addition, not only does female sexual response not always follow a linear progression through discrete stages, it does not always cumulate in orgasm (Tiefer, 1995). However, portrayed in the websites, and consistent with the HSRC model, any sexual experience that does *not* include orgasm is deemed dysfunctional. For example:

*“The inability to reach orgasm is called anorgasmia. This is common to women who are in their late 20s to 40s... If you’re having problems achieving an orgasm one reason is your not simply up to it. The lack of desire to perform sex is one of the major reasons why women never get an orgasm. One way of going around this is by taking female libido enhancement pills like Provestra (Provestra)*

In the HSM websites, as we have seen, a medicalised story portrays women’s sexuality as dysfunctional and their sexual problems, as biologically based. What of course follows in this story is that problematic biological dysfunctions require biologically based HSM:

*“What needs to be done is to choose something that works on your hormones and corrects this condition at the roots. Femvigor arouses the estrogen activity in your body and effectively works up your sexual desire. This is the only pill in the market that intensively tackles dryness of vagina” (Femvigor)*

HSMs market themselves as the ‘logical’ choice as they restore biological imbalances and return the body back to a ‘normal’ sexual state:

*“Sexual health scientists have created solutions for women who are suffering from a lack of desire with products like hersolution- a blend of herbals, nutrients, and aphrodisiacs that work to restore the hormonal, nutritional, and stress induced imbalances that could be shutting down your bodys ability to desire and enjoy sex.” (Hersolution)*

The power and cultural authority of the medical profession is again drawn upon, this time to legitimate and endorse HSM as an ‘effective’ and ‘appropriate treatment for FSD:

*“Femvigor is a doctor approved capsule that effectively helps to overcome Female Sexual Dysfunction. The potent ingredients of FemVigor ensures that a dry vagina and a low libido are a thing of the past” (Femvigor)*

In a further example, of how the websites draw on the power and authority of the medical establishment, combined with their attempt to medicalise women’s sexual problems, instructions for using HSM employ a well known medical script:

*‘Take two capsule’s in a day, 1 capsule in the morning and 1 prior to bedtime’ and to ‘follow a regular course to ensure permanent relief from symptoms of female sexual dysfunction’ (Femvigor)*

While the packaging of HSMs strongly resembled prescription medicine. For example the Hersolution product was in pill form, packaged in punch out containers, and in prescription style boxes:

*Image 2.*



### Summary

As has been demonstrated the HSM websites, presented a medicalised view of women’s sexuality and sexual problems, that was reinforced visually and textually by the power and cultural authority of the medical establishment. In particular the websites drew on selective biomedical discourses to frame women’s sexual problems as biologically based dysfunctions. These biologically based dysfunctions were described as ‘break-downs’ of the body, due to ‘hormone imbalances’ and ‘estrogen deficiencies’. By reducing sexual problems

down to a identified biological origin this suggests they can be fixed solely with the intervention of medication, in this case HSM. The consequence of this biological dysfunction was framed in the websites as affecting a women's 'supposed 'normal' sexual functioning. What were described as symptoms of this biological dysfunction, and indicative of FSD, was said to primarily be a lack of sexual desire/libido, inadequate vaginal lubrication, and orgasm deficiencies. The message to the reader is that if you are experiencing any of these symptoms you have medically diagnosed FSD. As was noted these 'symptoms' portray a narrow version of 'normal' and unrealistic version women's sexual functioning. However, this serves the marketing purpose as it implicates any woman who does not fulfil this narrow version of 'normal' sexual functioning as biologically dysfunctional and requiring medication. Furthermore, the websites presented a plethora of contributory factors for FSD, portraying women as being at 'high risk' of developing FSD. Combined with references to 'epidemic' level statistics, the HSM websites work to suggest that the majority of women are suffering from highly problematic FSD. This medicalised biological framing of women's sexuality and sexual problems is undoubtedly a marketing attempt to manipulate women into believing they have FSD, in order to expand the market for HSM.

This ethically dubious marketing strategy, portraying women's sexuality in medical terms and sexual problems as biological dysfunctions in order to sell medications, has several additional implications.

The HSM websites promotion of a biomedical view of women's sexual problems is also significant for what it ignores or perhaps intentionally masks. By highlighting the biological explanations, women's sexual problems are isolated from their broader context. What is excluded is social, cultural, and political causes of women's sexual problems, that Tiefer et al (2002) notes are the more likely cause of the problem. For example, there is no consideration of how sexual functioning is generally located within a relationship context, and that relationship problems are almost certain to effect sexual functioning (McHugh, 2006). Furthermore, a biological explanation also ignores that sexual problems are caused from anxiety and distress from not being able to conform to cultural norms of sexual function. In this way the HSM websites are depoliticising women's sexual problems by focusing attention on biological explanations for women's sexual problems.

The portrayals of symptoms of sexual dysfunction were in accordance with the dominant biomedical HSRC model. Consistent with this model, symptoms of sexual



dysfunction were described as: a lack of desire to have sex, inadequate genital lubrication, and infrequency or difficulties attaining orgasm. Tiefer (2001) argues that the prevailing biomedical model of sexuality promotes the idea of a universal 'normal' female sexuality in which successful sexual experience is one where the women experiences "desire for sex, genital arousal, a timely orgasm, and the ability to enjoy vaginal penetration" (p.90). As mentioned in the analysis this narrow and mechanical view of women's sexual functioning is not compatible with all women's experiences. Furthermore, a biomedical model of sexuality relies on the concept of 'normal' sexual function to the exclusion of cultural variation in sexuality. For example, the biomedical model rarely focuses on socio-cultural factors, such as the influence of religious scripts on sexuality (Tiefer, 2001). Therefore, the HSM website promotion of a biomedical model of 'normal' sexual functioning is promoting a homogenised perspective of women's sexual experiences. Consequently sexual diversity is marginalised in the websites.

By framing women's sexual problems as biological dysfunctions occurring for a majority of women, and portraying a narrow version of 'normal' sexual function, the HSM websites are attempting to persuade women to reinterpret their sexuality as a problematic bodily dysfunction. This is significant, as studies have shown that women who perceive their sexuality as a biological dysfunctional are said to experience considerable distress. For example, Kaler (2006) in a study of women's experience of vulva pain, found that medical discourses locating women's sexual problems as disorders within the body resulted in women referring to themselves as "defective," or that their body "betrayed" them (p.65). In a study of women with sexual desire loss, subjects expressed feelings of being "not normal" or different from other women, or even as being less of a women. These women experienced themselves as inadequate, and located the "problem" of low sexual desire within their own bodies, as opposed to within the relationship or cultural expectations (Hinchliff, Gott & Wylie, 2009). Because a biomedical understanding is said to create significant distress in women, it seems likely that the HSM websites promotion of women's sexual problems as biological dysfunctions is also an attempt to evoke distressing feelings, presumably to encourage and manipulate them into purchasing sexual medication.

## An illusion of female sexual liberation

On the surface the HSM websites consistently used discourses of women's sexual equality, agency and empowerment, to portray an impression that HSM businesses are strong advocates for female sexual liberation. These discourses also worked to portray both the availability of HSM's on the market, and women being able to choose to treat and enhance their sexuality through medication, as indicators of sexual liberation.

The discourses that built this story of sexual liberation were as follows. A particularly divisive discourse of sexual equality worked to portray the use of HSM as a signifier of women's struggle against sexual oppression. This discourse usually began with references to how women's sexual desires and pleasures have historically been oppressed, for example:

*"Womens sexuality was once a taboo subject. If we weren't satisfied, the "solution" was quite resignation" (Zestra)*

Along with highlighting the historical oppression of women's sexuality, was the claim that women, in fact, have equal sexual desires and needs as men, for example:

*"We are pretty comfortable with the idea that a man needs sex... It doesn't need to be a secret anymore: women need sex too. More important, women need to feel the desire for sex" (Provestra)*

In accordance with an acknowledgment of the oppression of women's sexual desire and enjoyment, and that all women deserve more, was an appeal to the notion that women's sexual problems have not received the same amount of attention as men's sexual problems, for example:

*"More women suffer from sexual dysfunction than men (43%). Yet we aren't talking about it. While ads for Viagra and Cialis are ubiquitous these days – we hear almost nothing about female sexual dysfunction. The social constructs that govern this are obvious (suppression of women's sexuality)" (Provestra)*

What seamlessly followed in this theme was the inevitable claim that the oppression of women's sexuality also extended to include the oppression of effective treatments for women's low sexual desire, for example:

*"Men have Viagra what do women have? Most men already have a solution to their sexual problems" (FemVigor)*

In this way, HSM's frame themselves as a solution to this oppression and inequality, for example:

*"But no longer! Easy-to-use, topically applied Zestra – created specifically for women's sexual pleasure- has improved sex for so many women! ...women everywhere (are) reclaiming their sexual satisfaction..." (Zestra)*

The emphasis placed here on women 'reclaiming' their sexual satisfaction was consistent with a discourse promoting female sexual agency that pervaded the websites. This discourse of sexual agency ran parallel to the discourse of equality, whereby it also seemed to be 'working' to will women on towards a sense of female 'liberation' and 'empowerment', through purchasing and using HSM. The call to empowerment included the notion that sexually, 'all' women are 'deserving' of more, for example:

*"you no longer have to silently suffer with low sexual desire" ... "Every woman deserves a passionate sex life, filled with intense desire, uninhibited pleasure, exquisite sensations, and easily achieved orgasms" (Provestra)*

And women were told to take control of their sexual agency:

*"Isn't it time to put yourself first?" (Provestra), and to, "Take ownership of your sexuality"(Zestra)*

It is significant to note, that this appeal to female sexual liberation appeared to be the central marketing message used by the HSM businesses. This was evidenced by the fact that appeals to sexual liberation were frequently used in headings and were given central importance in most of the websites advertising slogans. For example:

*"No more shame. No more pressure. Just pleasure, on YOUR terms!" (Hersolution)*

And:

*“Spontaneous desire and exquisite sexual pleasure on YOUR terms. No pressure. No obligations” (Provestra)*

That this message of female sexual liberation was found to be so prevalent in the websites and used in such a manipulative manner (persuading women to purchasing HSM) is evidence of a concerted marketing strategy.

Incorporating discourses of female empowerment, and notions of female sexual liberation to promote products targeted at women, has been acknowledged as a growing trend within contemporary western advertising (for example, Gill, 2008; Heath & Potter, 2005; Lazar, 2006)

Specifically, this marketing strategy seems to align female HSM’s, with the power and energy of the feminist sexual liberation movement of the 70s and 80s. In addition, this marketing strategy attempts to position women who consume sexual medicine as empowered and liberated, thereby drawing upon popular feminist ideals and rhetoric. However, the crux of this marketing seems to be, that the feminist sexual liberation movement resulted in arguably more choices for women and as a result women now have more choices about their sexuality, including the choice to purchase and use sexual medication.

As well as identifying the manipulative nature of the female sexual liberation discourses to sell HSM, I would also argue that a portrayal of female sexual liberation is simply an illusion, and there is a disjunction between the explicit and implicit message in these websites. A critical reading of the websites reveals that the implicit message is one that emphasises a male-dominated version of how women’s sexuality should be, whilst reinforcing patriarchal norms. Furthermore, it would appear that women are not free to choose, as women are told they should take sexual medicine for the sake of their relationship and ultimately for the benefit of men. The following sections exemplify and deconstruct this implicit message.

#### Normative heterosexuality, gender stereotypes, and patriarchal dominance

The HSM websites portrayed what is arguably a traditional and certainly dominant version of ‘normal’ sexuality. This normal version of sexuality, also referred to as

heterosexuality, is characterised as sexual activity that exclusively happens between a man and a woman, involves a man's penis penetrating a woman's vagina, and ideally as something that occurs in monogamous relationship. It has been noted that this heterosexual script holds a privileged position in society, whereby it is taken for granted and unquestioned (Johnson, 2005). However, feminists have critiqued this dominant sexual script, and have questioned the taken for granted nature of heterosexuality. For example, Adrienne Rich (1980) argued that heterosexuality is not an innate in human beings; instead it is a socially constructed idea. In addition, feminist scholars criticise this dominant version of sexuality by noting that it offers women a limited definition of appropriate sex, limiting women's ability to choose their own sexual preferences, whilst reinforcing traditional gender constructions that privilege a male version of sexuality (for example, Fine, 1988; S. Jackson, 1996).

An emphasis on the privileging of heterosexuality came through particularly strongly in the visual images used in the HSM websites. The reader is persistently presented with images of 'successful' heterosexual couples on almost every page of every website, and in some cases several times per page, for example:

*Image 3.*



In addition to privileging heterosexual monogamy, these images also worked to associate heterosexual monogamy with 'great sex'. The heterosexual monogamous couple were frequently portrayed displaying facial expressions and body gestures suggestive of highly successful sexual encounters, for example:

*Image 4.*



*(Hersolution)*

Relating a discourse of 'great sex' exclusively to heterosexual relationships is a finding acknowledged by several researchers. Researchers such as Farvid and Braun (2006) and, Menard and Kleinplatz (2008) have found that 'great sex' is portrayed in popular women's magazines as something that can only occur within the context of an intimate, caring and long-term heterosexual relationship.

In the context of the website data, gathered for this research, marketing sexual medicine to women with an emphasis and reinforcement of heterosexuality can be seen as divisive. The constant bombardment of these images and frequent reference to women's sexuality in terms of heterosexuality means the websites do a number of things. The reader is given a narrow sexual script that sex is something that occurs exclusively between a man and women, and ideally in a relationship. This results in a normalisation of heterosexuality and "renders any alternative sexuality 'other' and marginal" (Jackson, 1999, p. 163). The overwhelming reinforcement of heterosexuality also sends a message that a heterosexual relationship is the goal to which all women should aspire, with the further insinuation that men are the underlying source of women's fulfilment, security and happiness.

The exclusive privileging and subsequent normalising, of heterosexuality also works in the websites to seamlessly promote hetero-sex as the normal version of sex. As mentioned in the previous chapter, successful hetero-sex revolves exclusively around coitus, as the main event of sex. The centrality of coitus based hetero-sex is also reinforced by what is absent from these websites, for example, there is no mention of foreplay or any other forms of sexual activity. This privileging of hetero-sex has several implications, as Farvid and Braun (2006) note, in that it privileges technical and mechanical aspects of sex, at the expense of emotional and contextual dimensions. Furthermore, the privileging of coitus sends a message that only a man can sexually satisfy a woman through vaginal penetration, therefore constructing men as necessary for women's sexual fulfilment. In addition, this focus on coital hetero-sex demotes sexual practices such as kissing, touching, and oral sex to

simply 'foreplay', or not 'real sex' (Cocchoni, 2007). This is significant as evidence indicates that women often find these other sexual activities at least as, if not more, pleasurable than coitus (Gavey, McPhillips, & Braun, 1999; Ussher, 1997). Thus in effect, these websites are promoting a very narrow version of successful hetero-sex that critics argue prioritises masculine sexuality and male sexual desire (e.g., Ussher, 1997).

The establishment and reinforcement of heterosexuality and hetero-sex also facilitates traditional stereotypical understandings of gender to operate. This is very important in the context of HSM websites, as it appears that stereotypical gender constructions about men's and women's sexual behaviour, beliefs and values are being used in a manipulative and devise manner to ultimately promote the use of sexual medicine. Within the HSM websites, sex was represented as being very important to men, as something that men are always willing and able to engage in 'anytime,' and something that men always want. In contrast, women were portrayed in a stereotypical fashion whereby women have a lower sex drive and are not as naturally sexual as men (Roberts, et al., 1995). For example:

*"While men seem to enjoy it more because they seem to be almost always in the mood for sex, for women, it sometimes is just not the case" (Provestra)*

Also:

*"While he has been waiting for it all day, you just cannot seem to get into the scene" (Provestra)*

And:

*"...men reach their climax faster than women" (Femvigor)*

These passages draw upon the common and normative idea that men are continually ready for sex, based on a traditional male stereotype of men supposedly being more naturally sexual with a greater sex drive (Weeks, 1986). By depicting men as more 'naturally sexual' Jackson (1984) notes that this privileges male sexuality and works to position sex as the man's domain. It has also been noted that this discourse also positions women as needing to accommodate men's natural and normal 'insatiable' sexual needs (Nicolson & Burr, 2003; Potts, 2002). Here, the reader is told about men's sexuality, presumably to modify their

sexual behaviour to satisfy men's natural sexual urges. Consequently, rather than men modifying their sexual technique to arouse their female partners adequately, women are instead instructed by HSM websites to find ways to speed up to have sex on men's terms. In the HSM websites the consequence of not being able to meet men's sexual needs because of low sexual desire was portrayed as vastly problematic. One such problem was that women's low sexual desire would affect womanhood and femininity:

*"feeling unfeminine & undesirable" (Provestra)*

And:

*"...feeling like less of a woman" (Hersolution)*

In these passages women's femininity is associated with desiring and having sex. This is consistent with Holland et al (1991) noting that when a woman does not desire sex she is often defined as unfeminine. The male bias in this construction is clearly obvious, whereby women's femininity is constructed in relation to men's needs and wants. As well as being a problem for stereotypical constructions of femininity, women's low sexual desire was also portrayed as vastly problematic for men:

*"The lack of sexual drive is the most common among the three sexual complaints by women as well as their partners" (Femvigor)*

There was considerable emphasis placed on how a woman's low sexual desire affected men. One such example, which strongly resembled a patriarchal position, was that a male partner would not receive sexual appreciation:

*"Losing the appetite for sex can be a limiting factor in expressing one's appreciation of their partner" (Hersolution)*

Also not desiring sex was portrayed as affecting a man's ego:

*"Sometimes this [women's low sexual desire] can lead to low self confidence of their partners making them ponder if they are still attractive or not anymore" (Provestra)*

As well as affecting a man's emotional well being:



*“lack of desire, unresponsiveness or inability to orgasm can leave partners feeling distant or unloved or blamed. The resulting resentments can easily turn into major problems” (Vigorelle)*

Men’s emotional vulnerability to a woman lacking sexual desire or not being able to perform adequately was portrayed as resulting from a need for a man to maintain his masculinity. This is exemplified in the following revealing passage:

*“What makes a great lover? A super-responsive partner! A big part of a man’s self-image is tied to his sexual prowess – that is, how well can he thrill and satisfy his partner? As you experience the deeper sensations possible with Vigorelle for women, your man will be delighted to know you are swept away with his lovemaking. As you climax more frequently and more explosively, he’ll have the powerful feeling of being a great lover and the confidence that he satisfies you completely. Naturally your eagerness for more sex and greater frequency will delight him, too. There’s no better way to make a man feel masculine and accomplished in the bedroom than to truly enjoy sex with him.”*  
(Vigorelle)

Kilmartin (1999) has suggested that hetero-sex ‘has been a major way for men to demonstrate their masculinity’ (p.185), and thus feelings of sexual inadequacy can place that masculinity in jeopardy. It would appear the HSM websites draw upon this popular discourse, whereby women are told they should desire sex and orgasm in order to satisfy their male partner’s ego and to enhance men’s feelings of sexual competency. Ultimately women’s sexual pleasure is orientated towards men:

*“There’s probably nothing better you can do for your man than crave and delight in sex with him!” (Vigorelle)*

The portrayal of men’s vulnerable ego, the importance of sex for maintaining their masculinity, and men’s insatiable sexual drive all work to evoke another popular notion of femininity referred to as the ‘good women’. The expectation of being a ‘good women’ requires women to be nurturing, caring, and doing things for others (Finch, 1983). When applied to sex the notion of a ‘good women’ is said to be a woman who is sexually passive or receptive, responsive to men’s sexual needs as well as caring and nurturing in relation to

men (Ussher, 1997; Gavey & McPhillips, 1999; Weeks, 1986). These discourses of femininity, which is apparent in the HSM websites, are said to place the responsibility for men's sexual and emotional needs on women (Gill, 2009). For example:

*“Only if we're being honest, nobody is really happy. You're not happy with yourself, feeling like less of a woman. And you feel guilty, ashamed knowing that your partner isn't satisfied either. He's feeling neglected...Unwanted. But what can you do?”*  
(Hersolution)

Cacchioni (2007) notes that one consequence of femininity constructions such as the 'good women' is that they coincide with what she terms 'Sex work'. 'Sex work' refers to the unacknowledged effort and the continuing monitoring which women are expected to devote to managing their own and their partner's, sexual desires and activities. The portrayal of traditional discourses of femininity in the HSM websites also extended to include the idea that the primary goal of a woman is to be in a relationship with a man (Stoppard, 2010). This discourse worked in conjunction with the mentioned masculinity discourses to promote the idea that a woman needs to have sex in order to maintain a relationship with a man. This finding is consistent with previous research (e.g. Menard & Kleinplatz, 2008), noting that sex for women is constructed as a way to maintain their relationships, and women needed to learn to 'do' sex well to achieve this goal. For example:

*“sex can be the fuel that keeps the flame of a relationship burning”* (Hersolution)

And:

*“Nothing places the spark back into a relationship faster than a night of pure passion. Couples who enjoy regular sex are most likely to stay in the relationship. More often than not, a cold relationship is one where couples no longer enjoy sex with each other”* (Hersolution)

As well as a portrayal of the benefits of sex for a woman's relationship, it is also noted that 'great sex' was also emphasised as an important way for a woman to maintain a relationship with a man:

*“But perhaps the most important way to stay connected to your partner is to have great sex” (Hersolution)*

And:

*“Beter sex, better relationship!” (Vigorelle)*

The implication is easy to see here, if women keep their male partners sexually satisfied, then they keep the relationship steady. The emphasis placed on the importance of sex for a relationship clearly works to further position a lack of sexual desire and sexual performance as problematic. This was also represented visually whereby the apparent absence of sex or women’s sexual performance issues led to a dejected looking man and a worried looking woman, who has been framed in the text as being concerned for her relationship:

*Image 5.*



*(Vigorelle)*

The Manipulative and divisive nature of these discourses was revealed through critically analysing the HSM websites and identifying stereotypical gender constructions. What became clear was that these gender constructions were ultimately working in the websites to promote sexual medicine to women. The following passages example this:

In order for a woman to meet the stereotypical construction of a man’s superior sex drive and performance she needs to use sexual medicine:

*“[by using Vigorelle] get turned on right away” and “speed arousal and time to climax” (Vigorelle)*

Because of men's fragile ego and potential feelings of inadequacy, women should seek to relieve this uncertainty by taking sexual medication, to make women perform better and reassure a man that he matches a heterosexual 'sexual ideal' and that he is sexually adequate:

*"Bringing Vigorelle into your sex life shows your partner how willing you are to totally, completely enjoy him" ... "Delight your partner with your new enthusiasm for more sex" (Vigorelle)*

And:

*"Not only wild success in the bedroom, but also an overall improvement in their relationships! Men love a women who shares deep sexual intimacy...and who is totally aroused and satisfied by him! Add a little vigorelle, and give him the credit. Its a win win" (Vigorelle)*

And by having more medicated sex for the sake of your man a women will be more feminine:

*"Feel utterly feminine, sexual and desirable again!" (Provestra)*

Image 6.



*(Vigorelle)*

And help women achieve their ultimate sexual goal of maintaining a relationship:

*"Love what it does for your relationship" (Provestra)*

And,

*“This [Hersolution] probably saved our marriage, thanks from both of us”  
(Hersolution)*

In this analysis, the critical reading of the HSM websites revealed they consistently reinforced patriarchal dominance. Consistent with this was that women use of sexual medicine seemed to reinforce patriarchal dominance. For example:

*“gift your partner the new YOU!” ( Femvigor)*

This was also visually portrayed:

*Image 7:*



*(Hersolution)*

*“my husband loves that I pounce on him for sex now” (Hersolution)*

And:

*“for those times we need to take it up a notch, libido enhancement pills like her solution can be the solution women have always been looking for.” (Hersolution)*

The following supposed testimonial on the Femvigor website perhaps best highlights the patriarchal dominance in the HSM websites:

*“...my wife used to get irritated quickly after the birth of our baby girl. She did not take active part in sexual activity and I did not know the reason. I spoke to one of my female friends about my wife and she answered my questions. In a few days, I ordered FemVigor from this site and urged her to use it. She is back to her ravishing form since then. I’am pleased with this change...” Andrew, 34, Wales, UK (Femvigor)*

## Summary

On the surface the HSM websites consistently draw upon discourses of women's sexual equality, agency and empowerment, giving an impression of advocating for female sexual liberation. However, I argue that this is no more than a popular marketing ploy attempting to align its product with a fashionable, but limited, interpretation of feminism in order to sell more products. The analysis revealed that there was in fact an implicit contradictory script running parallel to that of women's empowerment and liberation. This implicit script drew upon stereotypical male-dominated gender norms to frame women's sexuality in terms of men's wants, needs and desires. Any sense of women's empowerment was undermined by an implicit message that a woman needed to use sexual medication to fulfil her primary role of providing pleasure to the man, whilst maintaining the relationship. Ultimately this served to reduce any sense that it is legitimate for a woman to express her own sexual preferences and concerns. By continuously reinforcing these gender scripts the HSM websites naturalise and normalise these supposed sexual behaviour differences between men and women, therefore making these gender differences appear unquestionable, and potentially unchangeable. This encourages these gender differences to be accepted, and promotes the agenda for sexual medication to be taken, rather than resisted or challenged. The representations of these supposed gender differences as 'normal' also camouflage and naturalise that these gender constructions ultimately work to disempower and oppress women. Any recognition that women may not desire sex that is centred on male desires, or that women are pressured into having sex on men's terms, of course was not mentioned. Therefore the HSM websites were strongly reinforcing patriarchal male dominance. This finding is consistent with other forms of feminist media analysis that have demonstrated a disjunction between surface and implicit messages (McCracken, 1993). For example, Machin and Thornborrow's (2003) interpretation of women in women's magazines noted women were constructed as having agency, power and confidence to get what they want, while simultaneously being positioned as driven by a need to please a man' (p.465). These findings are also consistent with previous research demonstrating that popular media representations continue to maintain 'patriarchal standards for women's sexuality' (Durham, 1998).

Of particular importance to this analysis of HSM websites is the acknowledgment by

researchers that a women's experience of sexual problems might be understood to emerge within her simultaneous negotiation of dominant discourses of heterosexuality, femininity and masculinity. When a women perceives she cannot fulfil normative function of heterosexuality and femininity, she may judge herself as 'inadequate' through a process of reflexive self-positioning (Ayling & Ussher, 2008). This process is said to take place at an intrapersonal level, identified by Foucault (1977) as internalised self-policing whereby individuals constantly appraise their performance against cultural ideals. Falling short of these ideals can lead to feelings of inferiority and inadequacy (O'Grady, 2005), 2005), which Nicolson notes could potentially lead to self-pathologisation and seeking treatment (Nicolson, 1993). As an example, research by both Kaler (2006) and Katz (1996), based on the experiences of women who live with chronic vulva pain (and subsequent sexual desire loss), examined the ways in which women's experience of such pain intersected with dominant discourses of heterosexuality and gender. Women who were unable to perform coitus, considered themselves to be failures as women, and women who were not really women (Kaler, 2006). Women also spoke of isolation, feelings of sexual inadequacy, a loss of femininity, guilt, shame, loss of self esteem, and diminished confidence. In a similar study, Ayling & Ussher (2008) found that women used dominant discursive constructions of "successful" heterosexuality as reference points for their experience of sexual problems. They found that most women took up positions of "inadequate women" and "inadequate sexual partner" when they were unable to regularly engage in coitus. They interpreted not being able to perform coitus as affecting their ability to satisfy their partners sexually, resulting in feelings of shame, guilt, and a decreased desire for sexual contact. A study by Cacchoni (2007) also found that the male sexual drive discourse was evident in the majority of female participant's accounts of why they were distressed about sexual difficulties (p. 316). Loe (2001) also notes, the availability of sexual medications, may offer women a tool in which to manage heterosexual conformity and to preserve notions of femininity and masculinity.

Considering the analysis, and from a critical perspective it appears the websites are manipulating this situation. The fact that male-dominated stereotypical gender discourses such as the 'male sex drive', combined with a narrow and perhaps unrealistic or unobtainable portrayal of successful female sexuality, are continuously reiterated in the HSM websites, is highly suggestive they could be actively building a sense of inferiority,

inadequacy and anxiety presumably as a way of manipulating women into purchasing sexual medication to 'cure' these feelings. As feminists might argue without these stereotypical male dominated sexual gender constructions the need for sexual medicine disappears.

### A requirement for women's sexual health

In western society being healthy has become a matter of orthodoxy. Surveys show that health is rated as the greatest source of happiness in life and the most important quality to preserve, western people think about health more than about romance, work, money, or any other single topic, and that guilty feelings closely follow failure to comply with principles of healthy living (Barsky, 1988). The analysis of the HSM websites revealed how the importance of health for people, and the negative feelings associated with being unhealthy, were used to market sexual medication.

In looking to exploit this contemporary scenario, the HSM websites frequently portrayed sex as a vastly important health promoting activity. Whereby, high levels of sexual performance were extolled as being particularly healthy. Through a significant emphasis placed on the importance of sex for a healthy lifestyle, and through a direct call to take responsibility for one's sexual health, the HSM websites appear to be working to position sexual medicine as a requirement for every 'healthy' woman.

The health benefits of sex described on the HSM websites are perhaps best characterised by their wide ranging nature. For example, the health benefits of sex were said to include a wide range of physical and psychological benefits:

*“Improved sexual function and positive intimate relationships have been linked to improvements in overall health, wellness, decreased disease, decreased medication requirements, lowered stress and decreased chronic medical disease. Those who have some positive sexual connections and increased intimacy can expect to live longer happier lives – sexual hormones can boost immunity, promote longevity and in some cases have been linked with lowered rates of depression and anxiety (Hersolution)*



The public awareness of the health benefits of sex are said to be largely promoted by widespread reporting by western media outlets on a number of scientific medical studies (Keller & Brown, 2002). These studies have identified various health benefits of regular sexual activity, ranging from increased life-span and decreased risk of certain types of cancer to immunity from colds. Here the HSM websites are utilising the popular contemporary promotion of the medical and psychological benefits of sex. In addition to the promotion of sex for health it has also been observed that there is a particular emphasis on the promotion of sexual activity in later life as part of an aging well philosophy (Katz & Marshall, 2003). As part of this philosophy it is said that anti-decline discourses have emerged which extol the benefits of maintaining sexual function (Potts, Grace, Vares, & Gavey, 2006). These anti-decline narratives appeared in the HSM websites, whereby the benefits of sex for ageing included:

*“Regular sex will help you live longer” (Zestra)*

And sex was claimed to:

*“Make you feel younger” (Provestra)*

The portrayal of the benefits of sex for women however, encompassed far more than simply physical and psychological health benefits. Health benefits of sex were extended to include a more general sense of wellbeing, where sex was considered important because:

*“The fact is a better sex life can help you lead a more balanced, well-rounded, enjoyable existence” (Provestra)*

And:

*“Sex is important to happiness and quality of life” (Vigorelle)*

In addition to a focus on the broad ranging benefits of sex for health and wellbeing, was an emphasis placed on sexual performance being particularly healthy. This is consistent with an acknowledgment that sexual health has become increasingly focused on sexual desire and performance (Giarni, 2002). For example:

*“The more you have it [sex] the healthier you will feel” (Femvigor)*

And in relation to orgasm:

*“Orgasm, for sexual wellness” (Zestra)*

And also:

*“Passionate sex = passion for life: when your sex life is fulfilling, you’ll feel incredible both in and out of the bedroom” (Vigorelle)*

While not having impulsive arousal was deemed unhealthy:

*“not being in the mood for sex is just not healthy” (HerSolution)*

In the HSM websites, this broadening and all encompassing sense of health and wellbeing seemingly worked to extend the parameters of the benefits of sex. The take home message to the reader about sex and health is clear: Regardless of age, being a healthy woman requires sex, and the more you have it and the better it is, the healthy you are likely to be. The wide range of benefits of sex also worked to create a sense of the importance of sex for a women’s health. An appeal to the importance of sex for health was also overtly portrayed in the websites:

*“...a fulfilling sex life is the utmost importance for a healthy lifestyle” (Provestra).*

And:

*“[because]a fulfilling sex life is of the utmost importance for any human being man or women.” (Provestra)*

Cacchioni (2007) referred this broadening and importance placed on the health of sex as the ‘healthicization of sex’, whereby sex is increasingly being represented as integral to women’s psychological development, personal growth, emotional satisfaction and physical health.

It has been observed that looking after one’s health has become somewhat of a requirement in contemporary western society. Individuals are required to monitor their own health and engage in significant amounts of ‘self-work’ to maximise their health and well-being (Clarke, et al., 2003); and terms such as ‘health maintenance’ and ‘healthy living’ highlighting the mandate for work and attention toward attaining and maintaining health (Clarke et al., 2003). Nikolas Rose has described this health promotion as a “Will to Health”, whereby every citizen must now become an active partner in the drive for health, accepting

their own responsibility for securing their own wellbeing (Rose, 2000). This is also described by Foucault (1990) as the dictum to 'care for the self'. The HSM websites work to utilise this mandate of being responsible for looking after one's health. By inducing women to take responsibility for their sexual health, the HSM websites emphasise the seriousness of sexual health:

*"You need to take a serious, reflective look at how you can look to begin achieving a healthy balance in your life" (Femvigor)*

While being responsible with your sexual health takes commitment:

*"If your committed about having a healthy sex life you need to make sure you are aware of everything out there that will aid you" (Zestra)*

In another example of an appeal to women to take responsibility, they were urged to take 'ownership' of their sexual health:

*"With all the natural ebbs and flows, it helps to take ownership of your sexual health" (Zestra)*

In the following passage, a sense of responsibility was promoted by an appeal to the 'right thing to do':

*"Don't rob yourself of an active, fulfilling, healthy sex life. (Hersolution)*

And in a final appeal to take responsibility women were called to action:

*"Isn't it time to discover the healthy, vibrant women you can be?" (Provestra)*

In their attempt to challenge women into a sense of responsibility for their sexual health, the HSM websites appear to be deliberately creating a sense of pressure on its readers. This can be seen in the following passage:

*"It doesn't matter how busy you are, how tired you are, how many kids you might have...how you might feel about the way you look. The fact is a better sex life can help you lead a more balanced, well-rounded, enjoyable existence" (Provestra)*

The considerable emphasis placed on the importance of sex for a women's health and general wellbeing, as well as the direct appeal for women to take 'responsibility' for their sexual health portrays HSM as a necessary requirement, was reiterated in passages that emphasised the importance of sexual medication for health care. For example:

*"...prerequisite for health" (Zestra)*

Consistent with the broad portrayal of sex for health, HSM was promoted as critical for healthy sexual performance:

*"Critical for healthy sexual performance" (Provestra)*

In an appeal to the benefits of HSM for healthy ageing:

*"Feel sexy and feel alive again! (Hersolution)*

And:

*"Femvigor makes you feel young and ready for more" (Femvigor)*

Whereby taking HSM for sexual health is what a responsible woman should do:

*"A daily supplement of provestra offers you a quick and simple way to begin achieving "healthy" balance in your life. A very reasonable investment in your sexual health" (Provestra)*

### Summary

The critical analysis of the HSM websites revealed that there was a particularly strong emphasis placed on the importance of sexual health. As mentioned, this emphasis is consistent with a western societal trend whereby looking after one's health has become an imperative, and sex is increasingly promoted and perceived as playing a role in a healthy lifestyle regime. The analysis showed the HSM websites marketing attempt to capitalise on this trend. This was exemplified in the websites portrayal of a significant and vast array of health and wellbeing benefits from sex which in turn, worked to emphasise the importance of sex for a women's health and put pressure on women to be sexually active. It is also important to note many of the health and wellbeing benefits were framed in such a way as to appeal to older women through their 'sex for health' marketing. Also significant was the

emphasis placed on high levels of sexual performance being portrayed as particularly healthy. Again this appears designed to deliberately put pressure on women, by implying that 'optimal' sexual health is achieved through high levels of sexual performance. Unpacking this marketing further, it appears the intended underlying message is, if you are not having frequent sex and achieving high levels of sexual performance then your health is in jeopardy. Considering, they are targeting older women, who are perhaps having less sex and with less focus on performance, then there is the potential that this message may cause anxiety about meeting 'sexual health' norms. As intended by the marketing, this scenario also creates a potential demand for sexual medication, whereby women turn to medication in order to enhance their sexuality, in order to meet the requirements of the 'sex for health discourse'. This finding is consistent with Gupta's (2011) notion that the 'sex for health' discourse may increase pressure on people to be sexually active and may serve to pathologise people who abstain from sex or engage in sex infrequently, and lead them to seek treatment.

The HSM websites also drew upon another dominant cultural discourse, of 'the responsibility people have to their health'. This discourse uses emotive language suggesting women need to be 'serious', 'committed' and take 'ownership' of their sexual health. This can be seen as an attempt to evoke feelings of guilt for women who were not being responsible for their sexual health. This also evokes negative emotions, such as anxiety, about the crucial responsibility an individual has to their health. This again has the potential to create pressure for a woman, and appears to be a marketing strategy in order to manipulate women into consuming HSM.

As has been demonstrated, the HSM websites, as part of their marketing strategy, draw upon a dominant 'sex for health' discourse combined with a 'responsibility for health' discourse to potentially create negative feelings such as anxiety and guilt in women about their sexual health. This strategy is employed as a way to manipulate women into purchasing sexual medication. Furthermore, this marketing strategy appears to be directly targeting the distress women can experience from their sexual problems. For example, in a study of women's perceptions of their sexual problems, Cacchioni (2007) found discourses of healthification were evident in the majority of participant's accounts of why women were distressed about sexual difficulties (p. 316). This is significant because Cacchioni's work suggests that the 'sex for health' discourse is encouraging some women to experience their

sexuality as distressing and to engage in significant amounts of self-work to alter their sexual functioning. Therefore by targeting the 'sex for health' discourse and the 'responsibility for health' discourse the HSM websites are again directly utilising dominant discourses which cause women to experience their sexuality as problematic and distressing.

## CHAPTER 4

### DISCUSSION

As mentioned in the background to this research, the profit-seeking commercial drug industry, with its strategic marketing practices, is increasingly involved in promoting medication. Scholars have raised concerns that the commercial drug industry is participating in unethical marketing practices in their attempt to expand markets for their products (Moynihan & Cassels, 2005; Moynihan, et al., 2002). This has led to accusations of disease-mongering (Conrad, 2007; Moynihan & Cassels, 2005; Moynihan, et al., 2002; Tiefer, 2004). One area attracting increased attention from the commercial drug industry, is the potentially large medication market for female sexual problems. However, due to considerable opposition from feminists, and issues relating to appropriateness of proposed drugs, so far no pharmaceutical drug has been approved for treating female sexual problems. Currently, filling this potentially lucrative gap in the market are numerous internet based herbal sexual medicine (HSM) companies. Very little has been known about the marketing messages HSM companies are sending out to women via the internet, and because of concerns with disease-mongering of women's sexual problems, this research delivered a critical analysis of the marketing messages of internet based HSM companies.

To help meet the aim of this research a sample of five prominent HSM websites were selected and subjected to a systematic critical analysis. While this sample was small, the websites were carefully selected to provide a representative and significant amount of relevant data. This website data revealed a pervasively similar approach in both the discursive representations of women's sexual problems and the marketing of HSM, suggesting that this is characteristic of HSM websites in general.

This analysis revealed three main discursive themes forming the basis of the marketing strategy. While these themes were distinctive and clearly the main marketing strategies, it is important to note that these themes were interrelated and at times crossed over one another. It is also relevant to note that there were less prominent discursive themes in the websites, such as alternative medicine discourses that appeared to play a role in HSM marketing that were not addressed in this research. The first theme identified in the

analysis was how the HSM websites, presented a medicalised view of women's sexuality and sexual problems, that was reinforced visually and textually by the power and cultural authority of the medical establishment. Through their use of influential biomedical rhetoric the HSM websites worked to frame women's sexual problems as biologically based FSDs, while simultaneously portraying a narrow version of adequate sexual functioning. This framing implicated all women as being sexually dysfunctional and requiring biologically based sexual medication. It has been demonstrated that the portrayal of women's sexuality as dysfunctional leads to feelings of shame and inadequacy for women (Lavie & Willig, 2005; Nicolson & Burr, 2003). As part of their marketing strategy, it is likely the HSM websites are intentionally framing women's sexuality as dysfunctional to evoke negative feelings as a way of manipulating women into purchasing sexual medication. Secondly, stereotypical gender constructions were used in the HSM websites to portray women's sexuality as inadequate compared to men's, whilst emphasising the importance of sex for men and the necessity for women to fulfil men's sexual needs in order to maintain intimate relationships. If a man was not sexually fulfilled the insinuation made in the websites was that a women would not be able to maintain a relationship. This again led to the conclusion that women needed to consume sexual medication, and again appeared to be attempting to provoke negative emotions in the reader in order to manipulate them into purchasing sexual medication. Thirdly, the HSM websites capitalised on the current western societal emphasis placed on the importance of sex for health. In the websites the benefits of sex for health were portrayed as extensive and vitally important to women of all ages. In conjunction with the portrayal of the importance of sex was a call for women to act responsibly concerning their health. Being 'responsible' was portrayed in the HSM websites as consuming sexual medicine. This marketing strategy functioned to potentially evoke feelings of anxiety and guilt for a woman about their sexual adequacy and sexual health. Consequently, the intention of the marketing again seemed clear, whereby negative feelings were being evoked in an attempt to manipulate the reader into purchasing sexual medication.

As Ray Moynihan (2005) pointed out, disease-mongering is about enlarging the market by all possible means. The critical analysis presented here reveals how HSM websites attempt to enlarge potential medication markets for HSM products by implicating all women as sexually dysfunctional. Leonore Tiefer (2006) also notes that disease-mongering is a process that encourages the conversion of socially-created anxiety into



medical diagnosis suitable for pharmacological treatment. The use of these discourses is important because they are already said to be creating considerable anxiety with women and making their sexuality problematic (Ayling & Ussher, 2008; Cacchioni, 2007; Kaler, 2006). In the HSM websites it became apparent that the marketers of HSMs had researched and identified potential issues that could make women anxious about their sexual problems. They appeared to emphasise these problematic issues in an attempt to increase a women's anxiety about her sexual concerns, with the aim of manipulating women into purchasing sexual medication. These findings add considerable evidence to suggest that HSM companies are involved in the disease-mongering of female sexual problems.

While it would be tempting to conclude that the HSM websites are conclusively involved in disease-mongering, there are additional factors to consider. It seems important to note that the content of these websites does not emerge in a social, discursive, or ideological vacuum. Instead, it arises out of, and reflects, contemporary discourses of gender, gender relations, medicine, health and sexuality. The privileging of hegemonic male sexuality, a dominant biological understanding of sex, and sexual health discourses, are pervasive norms in western society (Kaschak & Tiefer, 2002). Therefore it is unclear to what extent these websites are divisively drawing upon these discourses to sell medications, or to what extent they are simply echoing commonly held societal beliefs. However, it is important to reiterate that HSM websites are commercial businesses, where the bottom line is profit. Further, it cannot be assumed that the marketing messages in the HSM websites have a direct impact on women as this study has not involved women directly and therefore is not able to assess if the discourses in HSM marketing directly affect women's decision to use such medication. On a similar note, Rose (2007, p. 701) also urges caution over the tendency to imply that people are passive recipients of marketing messages, arguing that "although drug companies use techniques of modern marketing, they do not seek to dupe an essentially submissive audience". Therefore it is too simple to see people as passive beings, acted upon by the marketing devices of commercial business who invent medical conditions and manipulate individuals into identifying with them' (Rose, 2006, p. 480).

A further concern of this research was to give critical consideration to whether these HSM websites might be contributing to the oppression of women and their sexuality. As

mentioned, dominant scripts in society portray women's sexual problems as biological dysfunctions, detrimental to men, and compromising to women's health. These privileged scripts are said to be the cause of considerable anxiety for women when they attempt to understand their sexual problems. The analysis revealed that, as part of their marketing strategy, HSM companies look to exploit this anxiety by emphasising, and in some cases expanding upon, these dominant scripts in their attempt to manipulate women into consuming sexual medicine. As is the intention of these websites, this increased emphasis has the potential to create more anxiety for women and make their sexual problems even more problematic.

Rhetorical and stereotypical discourses associated with these dominant scripts were also identified in the analysis. As mentioned throughout this research, many of these discourses have been acknowledged by feminist scholars as being oppressive towards women and their sexuality. Discourses such as 'the superior male sex drive', 'the privileging of heterosexual coitus' and 'the importance of sex for men' work to position men as more naturally sexual, and sex as a man's domain. In contrast women's sexuality was portrayed as 'deficient' whilst sex was a way for women to maintain a relationship with a man. These discourses marginalise any woman who does not fit into or chooses not to adhere to, this narrow male dominated portrayal of sex, therefore limiting women's ability to choose their own sexual preferences, and consequently stifling sexual diversity, whilst reinforcing patriarchal dominance. By reiterating these stereotypical discourses the HSM websites contribute to making them appear like 'universal truths' or 'just the way things are', therefore making these discourses appear as though they are unchangeable. Considering these discourses are contributing to women's perceptions of their sexuality being problematic, if it is perceived that these discourses are unchangeable it is possible this will only add to women's experience of their sexuality as problematic, and possibly be detrimental to resolving a women's issues.

In the HSM websites, women's sexual problems were also reduced to biological determinants located in the body. This simplified version of the world individualises women's sexual problems. Scholars argue that placing the locus of sexual control solely upon the shoulders of the individual complaining of an issue removes sexuality from its natural realm of shared experience and places it once again into an isolated and thereby often untreatable position (Cohen, 2005; Pacey, 2008). Furthermore, by locating sexual

problems as existing solely in a women's body, the HSM websites distract attention away from the social conditions leading to sexual problems. In this way the HSM websites can be seen to de-politicise women's sexual problems, ignoring the fact that whether sexual problems for any individual is problematic or not depends both on individual and societal definitions of sexual problems and on an unspecified number of variable and contingent social, economic, cultural, political, relational, and individual factors. According to Janet Walker , "it would be against the interest of the drug companies to admit any possibility that social change is what is required to relieve some of the symptoms depicted" (Walker, 1993, p. 31). It is not the intended objective of this research to question the legitimacy of women's sexual experience of their sexual problems, or to suggest that sexual medication does not relieve distressing symptoms. Furthermore it is acknowledged that many women sincerely feel they would be happier with medically improved sex lives and express satisfaction with the results of medical treatment (Braun, 2005). However I have endeavoured to demonstrate that sexual problems and medication use is about context. Women's sexual problems are more than simply about biology, they are socially created and like all things are vulnerable to institutions of power who look to manipulate understandings for their own gain. The context of HSM is one where HSM companies utilise discourses in society which oppress women's sexuality and cause considerable distress in an attempt to expand the market to provide medication to. As revealed in the analysis of the HSM websites sexual medicine consumption was portrayed as being in accordance with popular notions of feminism. Medication was portrayed as signifier of liberation, implying the ability to choose to use sexual medication was of itself, a signifier of empowerment. However a critical analysis revealed that HSM websites are disempowering women through contributing to the disease-mongering of female sexual problems and reinforcing oppression.

There is a wide variety of prescription pills, injections, creams, patches, inhalants, and mechanical devices being developed or undergoing clinical trials for FSD (Enserink, 2005). Thus while there are currently no pharmaceutical drugs approved for FSD, it is anticipated that because of the pharmaceutical industries vested interests, and their ongoing push, approval is likely. Once approved, it is expected that a massive global marketing campaign for female sexual medications will begin (Tiefer, 2006a). In addition, Moynihan and Henry (2005) also note that "the coming years will bear greater witness to the corporate sponsored creation of disease" (p.426). Considering this potential scenario, as

well as the potentially negative implications for women demonstrated in this research, hopefully the coming years will also bear witness to a much more vigorous effort to understand and challenge the corporate involvement in women's sexuality.

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