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Feminist Sexology and Activism: Challenges to the Medicalisation of Sex

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Within a culture that is heavily dependent on psychological, psychiatric and medical concepts to explain the 'human condition' (Rose, 2006), it may be difficult to imagine what Tiefer (1996) describes as a 'postmedicalisation' era. 'Medicalisation' refers to the reconstruction of a concept specifically within medical terms (Conrad, 2004). For example, the range of physical and emotional experiences that can coincide with menstruation were reframed as 'Premenstrual Tension' (PMT) in 1931, then 'Premenstrual Syndrome' (PMS) (Ussher, 2003) before the pathologisation of 'Late Luteal Phase Dysphoric Disorder (LLPDD) (Caplan, McCurdy-Myers & Gans, 1992) and the DSM-5 proposal for 'Premenstrual Dysphoric Disorder' (PMDD) (American Psychiatric Association [APA], 2011a). The application of biomedical understanding to sexuality brings with it 'binarized thinking' of healthy and unhealthy or normal and abnormal, "…that delimit the existence of alternative conceptualizations" (Potts, 2002, p.3). This categorization of sex is framed as scientific, objective and based on physiology. However, as Ussher (1997) argues, "…clear ideological judgments about 'sex' and the status of 'woman' and 'man' underpin these supposedly objective systems of classification" (p.265). The medicalisation of sex therefore, "…profoundly shapes the popular view of sexuality, despite a culture full of diverse sexual voices" (Tiefer, 2001, p.65). This 'cacophony' of sexual diversity (Plummer, 1995) gets overlooked due to the prominence of biomedical discourse (Potts, 2002; Tiefer, 2004; Ussher, 1997) that conveys sexuality as universal, innate and biological (Groneman, 2011). The medicalization of sex promotes, '…the illusion that sexual problems are medical problems' (Szasz, 1991, p.34).

Medicalization historically coincides with contextual transitions. However, as Conrad (2004) argues, "These factors, rather than being explanatory, set the context in which medicalization occurs" (p.159). In 1966 Masters and Johnson published an overwhelmingly influential book describing the *Human Sexual Response Cycle*, which positioned sex as a purely biological phenomenon and overlooked "…that the ultimate organ of human sexuality is not the genital but the mind" (Szasz, 1980, p.152). This model was a result of interviews as well as laboratory observations of over 10,000 orgasms, which resulted in the production of (what they considered) four distinct and 'universal' stages of sex (Weeks, 1993). Reducing sex to its biological functions and bodily components 'open[ed] the door for medicalisation' (Tiefer, 1996, para. 30). Any divergence from this cycle therefore represented a sexual 'dysfunction' (Potts et. al. 2004), as described in Masters and Johnson's subsequent publication, *Human Sexual Inadequacy* (1970), which heavily influenced the *DSM-III* (American Psychiatric Association *[DSM-III],* 1980; Potts, 2002; Tiefer, 2001). In the 1980's the extensive expansion of the DSM Sexual and Gender Identity Disorders Section coincided with crises of legitimacy for both the psychiatric and sexology professions, who were being challenged by feminists, gay rights activists and the anti-psychiatry

movement (Mayes & Horowtiz, 2005). The amalgamation of sexology and psychiatry was a convenient response to increasing criticisms and enabled health insurance reimbursement in the U.S. as well as the introduction of 'sexuopharmacology' (Tiefer, 2001, p.39).

Sexuopharmacology

The collision of biomedical and consumerist discourses (Marshall, 2011) incorporates providers (e.g. hospitals), payers (e.g. insurance companies) and consumers (e.g. patients), which creates a context where financial and corporate interests influence the structure of services and framing of diagnoses (Conrad, 2004). This 'medical marketplace' (Conrad, 2004) assumes that psychological problems have a physiological basis and that pharmaceutical treatments can produce psychological benefits (Marshall, 2011). This is problematic, as it is in the pharmaceutical companies' financial interest to "increase their market share and maximize shareholder value" (Rose, 2006, p.466), thereby promoting an increase in diagnosis, and disorders. It is also in the financial interest of the APA, as the DSM is a million-dollar moneymaker for the organization (Caplan, 1995). 'Direct-to-consumer' advertising in the U.S. has assisted in the marketing of drugs in a way that also reshapes the patient's experience in medical and DSM terms, while promoting a specific drug as 'treatment' (Rose, 2006). The pharmaceutical industry has been very successful in inserting itself into the psychiatric process, with a reported 638% increase in the drug market in the U.S. between 1990 and 2000 and a generated income of close to $19 billion, whereas the U.K. witnessed a four-fold increase in tranquilizer prescriptions between 1960 and 1980 (Rose, 2006).

Viagra

The DSM describes a 'healthy' sexual experience focused around heterosexual penetration (Potts et al. 2004), based on the 'Human Sexual Response Cycle' (Masters & Johnson, 1966). Any deviation from this model is therefore pathologised, particularly if it impedes penetration in some way (such as the DSM-5 proposals for 'Penetration Disorder', see APA, 2011b). The pharmaceutical treatment for erectile difficulties in the form of Viagra, illustrates that the 'pharmaceutical imagination' is equally phallocentric and heteronormative (Marshall, 2011). However, Viagra has experienced vast financial success resulting in more than 17 million prescriptions since its release in 1998 (Moyihan, 2003), and generated an income of more than $1.5 billion within its first year on the medical market (Conrad, 2004). However, men have been found to counter the narrow and medicalised discourses distributed by drug companies, by emphasizing fewer erections as synonymous with aging and not pathological or 'disordered' (Potts et al. 2004). Also, while Viagra enjoys financial success, reports on the 'effectiveness' of the drug use the International Index of Erectile Function (IIEF) and pay little attention to its effect on relationships (Potts et al. 2004) not to mention its abuses, such as the reported use in Libya as an aid in war rape (MacAskill, 2011). Potts et al. (2003) reported findings from interviews of partners who described a range of negative aspects from introducing Viagra into their sexual experience. These included prolonged intercourse, which resulted in pain and discomfort, such as irritation and tearing of the vaginal wall. They also described how their sexual experience focused more on penetration and other forms of sexual activity

decreased, as well as an increase in pressure to have sex or an increase in 'unwanted sex' (Walker, 1997).

Female Sexual Dysfunction

The role of the pharmaceutical industry in the medical construction and pathologisation of 'Female Sexual Dysfunction' (FSD) is well documented (e.g. Monyihan, 2003; Tiefer, 2004). The aggressive marketing strategy by drug companies looking to profit from FSD was inspired by the financial 'success' of Viagra. This initiated a frantic 'race' to find the female equivalent with hopes of equally impressive profits, which was in part influenced by the deceptively high estimates of potential 'sufferers' of FSD (Canner, 2008). The construction of FSD as a reified mental disorder was consolidated at a meeting of researchers and pharmaceutical representatives. The Co-Chair stated that only researchers, "…who have experience with, or special interest in working collaboratively with the drug industry have been invited" to this crucial meeting on FSD (Moynihan, 2003, p.45). The medical market also 'aggressively' promoted other forms of 'treatment' such as genital surgery, which can result in a loss of sensation and chronic pain, and in some cases be life threatening (Canner, 2008). However, the search for the female equivalent proved more complicated due to the difficulty in ascertaining female sexual pleasure without the overt physiological response that can be easily assessed for 'effectiveness' with 'Erectile Dysfunction' (Moynihan, 2003). Despite the unconvincing results of research into the 'female Viagra' that resulted in the U.S. Food and Drug Administration (FDA) rejecting Proctor & Gamble's 'Intrinsa' drug, it went on to be accepted in the E.U. and is being sold online (Canner, 2008).

Surgical and pharmaceutical treatments are not new in the 'treatment' of sexual problems. Clitoridectomy, ovariectomy, (hetero)sexual intercourse and pregnancy have all been 'treatments' for female 'frigidity' and the 'dormant' 'wandering womb' (Bullough, 1994; Potts, 2002; Ussher, 1997; Ussher, 1991). Also, Neurosene was prescribed in the 1940s to 'treat' 'nymphomania', a diagnosis of 'excessive' female sexuality satirically defined by Kinsey (1953, cited in Groneman, 2011) as 'someone who has more sex than you do.' Possible loss of sensation is a reported risk of genital surgery used on infants classed as intersex (those defined by medical professionals as having 'abnormal' genitalia, although others have highlighted the social constructions of sex, e.g. Kitzinger, 1999). All treatments, whether for FSD, ED or Intersex all prioritise heterosexual and penetrative intercourse despite the potential consequences. For example, Reis (2011) describes the use of Fetaldex (dexamethasone) to reduce the size of the clitoris of individuals with a diagnosis of Congenital Adrenal Hyperplasia (CAH). This reduction is aimed to 'feminise' the external genitalia of these individuals and disregards genital diversity to maintain the gender binary. This drug has been prescribed to 600 women in New York in the first 8 weeks of pregnancy despite no clinical trials done on a similar population (due to ethical issues of experimental drugs on pregnant women). Reported side effects of dexamethasone include increased risk of stillbirth and cognitive impairment (e.g. Wolkowitz et al, 1990; Dreger, 2010).

Demedicalization

It's therefore extremely important to question these processes of medicalisation, and expose the mechanisms going on 'behind the scenes' such as Canner's (2008) illuminating documentary on the orgasm industry, or 'Orgasm Inc'. It's also imperative that academics and activists voice concerns as this plays a pivotal role in 'demedicalisation' (Conrad & Angell, 2004). While some diagnoses become unpathologised over time such as masturbation (Hunt, 1998) and oral intercourse (Potts, 2002), others require social intervention. The removal of homosexuality from the DSM (APA, 1974) and the subsequent condemnation of 'conversion' therapies (APA, 2000) have been described as 'symbolic victories' in demedicalisation (Conrad & Angell, 2004). However, the demedicalisation of a concept does not prevent it from being 'remedicalised' (Rose, 2006). For example, Quinsey (2010) contributes to the DSM-5 special issue on the Sexual and Gender Identity Disorders section and states that any behaviour, which doesn't function to reproduce the species, could potentially be considered 'pathological'. Conrad & Angell (2004) assert that the introduction of 'Childhood Gender Identity Disorder' in the DSM in 1980 could be viewed as potentially remedicalising homosexuality. Zucker (2006), who is Head of the GID Clinic in Toronto and Chair of the DSM-5 Sexual and Gender Identity Disorders Work Group, emphasizes the association between childhood GID and homosexuality. He also describes the 'prevention' of homosexuality and transsexualism as rationales for therapeutic intervention. This has resulted in an accumulation of academic and clinical criticism (Burke, 1996; Wilson, 2000; Wren, 2002; Menvielle & Tuerk, 2002; Hird, 2003; Langer & Martin, 2004; Lev, 2005; Bryant, 2008; Burleton, 2008; Choe, 2008; Queerty, 2009; Hegarty, 2009) as well as protests in the UK (Tosh, 2011a; 2011b; 2011c; In press) and Canada (Wingerson, 2009).

Protests and academic criticisms also played an important role in keeping out a range of controversial diagnoses in the 1987 DSM-III-R. These protests targeted the inclusion of 'Self-Defeating Personality Disorder' (Caplan & Gans, 1991), 'Late Luteal Phase Dysmorphic Disorder' (Caplan, McCurdy-Myers & Gans, 1992) and 'Paraphilic Coercive Disorder' (Tiefer, 2001). Tiefer (2011) lists critique, resistance and transformation as aspects of activism, which are important to avoid a 'medical monopolization' (Conrad, 2004) on gender and sexuality. As Tiefer (1996) states, "The medical model of sex is not the only game in town" (p.253).

Conclusions

Discussions around contemporary hegemonic sexual discourses on whether sexology and psychiatry are 'remedicalising' (Kleinplatz, 2001; Nicolson & Burr, 2003) or 'overmedicalising' (Tiefer, 1996) sex are abundant. Concerns over the increasing involvement of the pharmaceutical industry in funding and defining sexual 'dysfunctions' while providing a medical 'cure' (Tiefer, 2004; Moyihan, 2003) show that the 'postmedicalisation' era (Tiefer, 1996) is a distant aim and that feminist and LGBTQI activism are as important now as they were in the 1970s (e.g. APA, 1974). If this is the 'second sexual revolution' based on the medicalisation of sex "…from the Victorian era to the Viagra era" (Cacchioni, 2010, para. 2) then it is one that requires a vociferous feminist and critical presence.

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