

Gender differences and the medicalization of sexuality in the creation of sexual dysfunctions diagnosis

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ABSTRACT

The article aims to analyze critically the most important and updated contributions focused on the recent stage of the medicalization of sexuality. Most works center on the production of the category and the diagnosis of “sexual dysfunction,” considering either the masculine case (more largely studied via “erectile dysfunction”), or the feminine case (in many cases translated into the idea of a supposed complexity of women’s sexuality). The perspective I utilize has as a reference the social studies of science and, in particular, the contributions of anthropology and history of medicine. In addition, it incorporates the matrix of the gender and science studies that have produced a powerful critical view of the scientific production of the two last centuries, revealing how the gender conditioners have crossed the relation between knowledge production and social context.

Keywords: Sexuality; Medicalization; Gender; Sexual Dysfunction

RESUMO

O objetivo do artigo é analisar criticamente as contribuições internacionais mais importantes e atuais que têm tomado a etapa recente da medicalização da sexualidade como tema de pesquisa. A maioria dos trabalhos centra-se na produção da categoria e do diagnóstico de "disfunção sexual", seja considerando o caso masculino, mais amplamente estudado pela via da "disfunção erétil", seja o caso feminino, muitas vezes traduzido pela ideia de uma suposta complexidade da sexualidade das mulheres. A perspectiva que utilizo tem como referência os estudos sociais da ciência e, especialmente, as contribuições da antropologia e da história da medicina. Além disso, incorpora a matriz dos estudos de gênero e ciência que tem produzido uma poderosa visão crítica da produção científica dos dois últimos séculos, revelando como os condicionantes de gênero têm atravessado a relação entre produção do conhecimento e contexto social.

Palavras-chave: sexualidade; medicalização; gênero; disfunção sexual.

I

In the last few years, the avalanche of news regarding sexual dysfunctions and, above all, its broad definition and the range of treatments available has become really apparent. Since the launching of Viagra, in 1998, we have seen the consolidation of new era in the process of medicalization of sexuality guided for the most part by the pharmaceutical industry. Numerous people make use of the innovative technologies related to sexual performance. They are hit by the constant normative discourse regarding sex expressed, for example, in the notion of “sexual health,” which was already been officially denied by the World Health Organization¹.

However, it is also worth noting that there is a relative scarcity in terms of the undertaking of scientific work addressing this phenomenon in large proportion worldwide, especially considering the field of collective health. Perhaps, this reflects certain reluctance in the field about considering sexuality as a legitimate domain for investigation, especially when it refers, in a stereotypical manner, to the so-called “normal” sexuality, defined within the parameters of a heterosexual couple. The sex promoted by Viagra is the type focused on the idea of satisfaction and strategically separated from the historical constraints related to the sexual practice, such as in the case of unwanted pregnancy and of sexually transmitted diseases.² Therefore, we depart from the plane of the studies about reproduction and birth control as well as of sexually transmitted diseases (STDs) and HIV/AIDS which have produced a robust structure for the analysis of the interface between sexuality and health.

The goal of this article is a critical analysis of the most important and current international contributions that has marked the recent phase of medicalization as a research subject. This medicalization is understood here as a very broad and complex phenomenon that encompasses definitions of medical terms defining deviant behavior as well as scientific discoveries that legitimize them, and proposed treatments and the dense net of social interests, both political and economic that are at play.³ It also includes more specific questions regarding the process of de-medicalization involving the loss of power that were once the strict realm of doctors to the pharmaceutical industry or the broadening of a collection of professionals destined to treat sexuality.⁴ In a general manner, the works available belong to the category of science social studies. The majority is focused on the production of the category and the diagnostic of “sexual dysfunction,” whether in the male case, vastly studied via the “erectile dysfunction,” or in the female case, many times through the idea of supposedly complex nature of women’s sexuality.

The perspective utilized here also owes to the social studies of science and, especially the contributions of anthropology and the history of medicine. However, a more accurate reflexion of the case in question is built upon the incorporation of the matrix of gender studies and science, which has produced a critical view of the scientific production in the last two centuries, revealing how gender conditioning has permeated the production of knowledge and the social context.⁵

In this sense, a phenomenon as complex as the recent medicalization of sexuality around the idea of sexual dysfunction can only be investigated in the light of the interaction of the multiple actors in the scene, such as researchers, clinicians, the pharmaceutical industry, the media and consumers and the

¹ Alain GIAMI, 2002.

² Fabiola ROHDEN and Igor TORRES, 2006.

³ Peter CONRAD, 1992; Charles E. ROSEMBERG, 2002,

⁴ GIAMI, 2004; Leonore TIEFER, 2004 e 2006^a.

⁵ Anne FAUSTO-STERLING, 2000; Ludmilla JORDANOVA, 1989; Londa SCHIEBINGER, 2001; Cynthia Eagle RUSSET, 1995; Ornella MOSCUCCI, 1996; Sandra HARDING, 1986; Ruth BLEIER, 1997; Ruth HUBBARD, 1990.

intense interplay of interests and outlook of the world involved in the discourse that is being produced. Elements such as scientific legitimacy, economic and political motivations, professional disputes and gender relations comprise a game of tensions, which also produces unexpected results.⁶

Next, I will introduce a panorama of the field of sexology in the XX century which provides context for the most recent picture of the medicalization of sexuality followed by a discussion about the creation of the categories “male sexual dysfunction” and “female sexual dysfunction.”

II

The history of intervention around sex and even the creation of sexuality as a category and autonomous domain have been well mapped. In addition to the classical and seminal work by Michel Foucault,⁷ we add the contributions of Jeffrey Weeks, Thomas Laqueur, Vern Bullough, Anthony Giddens, Carol Groneman and Michel Bozon,⁸ to name a few. These bodies of work share a common arena where sexuality is perceived as socially constructed phenomenon toward which a series of competing discourses converge. Although, it is common to cite the origin of the promotion of sexuality in the medical interest in the so-called sexual perversions during the second half of the XX century,⁹ lesser attention has been given to the trajectory of the studies around sex, or to what came to constitute the field of sexology, in the XX century.

The basic reference, in this case, is the classic work of André Béjin¹⁰ and his hypothesis that sexology has two beginnings. The first sexology would be the one produced in the second half of the XIX century, a period during which reference works such as *Psychoatitia Sexualis*, edited by Heinrich Kann in 1844 and another volume with the same title published by Krafft-Ebing in 1886. This “proto-sexology” was focused on nosography, in contrast with the therapeutic approach, which would concentrate on venereal diseases, the psychopathology of sexuality and on Eugenics. The second branch of sexology came to be in the 1920’s, marked by the work of Wilhelm Reich who started publishing about the function of orgasm in that period. Finally, the edition of the first study by Alfred Kinsey, in 1948, helped to cement orgasms a central issue in the new sexology¹¹.

According to Béjin,¹² proto-sexology concentrated itself in the difficulties relating to the working of the reproductive sexuality, such as sexually transmitted diseases, “sexual aberrations” and contraceptive techniques. It was not concerned in separating itself from other branches of medicine, such as psychiatry, legal medicine or urology. Now the current sexology seeks to constantly mar its autonomy in face of other disciplines, especially through the affirmation of a particular object, orgasm, for instance, and its essential norm, the “ideal orgasm.” In addition, proto-sexology main focus was abnormalities and not on the so-called “normal” sexuality, heterosexual and reproductive. The science that studies orgasm, on the other hand, first established the norm of what is considered ideal orgasm minus the abnormalities, which it would be willing to treat. It is noteworthy that the modern sexologists do not translate these abnormalities in terms of “aberrations.” Instead, they substitute the separation between normality and abnormality within a spectrum of dysfunctionality. As Béjin

⁶Nelly OUDSHOORN, 1994; Marianne Van Den WJINGAARD, 1997; Jennifer R. FISHMAN, 2004..

⁷FOUCAULT, 1988.

⁸WEEKS, 1985; LACQUEUR, 1992; BULLOUGH, 1994; GIDDENS, 1993; GRONEMAN, 2001; BOZON, 2002.

⁹WEEKS, 1985.

¹⁰BÉJIN, 1987a and 1987b.

¹¹BÉJIN, 1987a.

¹²BÉJIN, 1987a.

remarks, “if we face the demanding norm of celestial orgasms, we will find out that we are all “sexually dysfunctional.”¹³

The author¹⁴ also points out that the creation of an increasing “clientele” for contemporary sexologists who have come a long way from their pioneers that only treated the “perverted” and the carriers of venereal diseases. This movement has propelled the creation of institutions of specialized teaching and the establishment of clinics for specific treatments. Furthermore, while the proto-sexology had developed its etiology summarily, allowing room for only one control *a posteriori* and repressive, articulating with prisons and asylums, the new sexology refines its etiology and develops means of control *a priori e a posteriori*, translated in the orgasm therapies and prophylaxis of sexual dysfunctions. A pedagogical function then entered the scene.

In a way, this panorama designed by Béjin described in depth in the book *Disorders of Desire* by Janice Irvine.¹⁵ The author shows how the field of sexology was constituted in the United States of America between the decades 1940 and 1980, emphasizing the multidisciplinary aspects, pursuit and controversy. Focusing mainly on the work of Kinsey, it reveals the impasses of the process of professionalization, cultural legitimization and the creation of a market around sex. The political tensions and the variation of historical and cultural contexts strongly influenced the development of research, interventions and the acceptance of new references about sexuality. Besides that, it directed the debates around the distinction between “scientific sexology,” the main focus of this work based on the parameters of the scientific methodology and on the practices of the medical authorities, and “humanist sexology,” more rooted in the psychological wisdom and centered in the acknowledgment of sexuality as the focus of personal realization, self-knowledge and individual satisfaction, which had a big impact starting in the 1970s.

According to Irvine,¹⁶ sexology underwent a process of rapid institutionalization in the XX century. In 1907, the German doctor Iwan Bloch was already proclaiming a formal definition of sexology as the study of sexual life of the individual from the standpoint of medicine and the social sciences. In 1919, Magnus Hirschfeld founded the first institute of sexology that was heard of in Berlin, reaffirming the centrality of Germany in this field of study during that period. In fact, in the beginning of the century one could count on the great works of Richard von Krafft-Ebing, Havelock Ellis and Sigmund Freud, all of them contributed to establishing the foundation of thought about sexuality in the modern world and were fundamental in conferring scientific legitimacy to this field. There was a significant diversity of theories and methods and a tension between the natural and social sciences translated in the polemic question of whether sexuality was inherent or acquired, although there was already an emphasis on biology. It is important to add that in the first decades of the XX century, sex becomes an increasing point of interest, not only on the part of doctors, but also jurists, legislators, Eugenists, feminists and social reformers.

Having in mind this background, it makes it easier to understand the great impact of Kinsey’s work, which signaled a new chapter in sexual research. It was precisely a scientist, a biologist that brought a new foundation to the scientific study of sex, regarded as a natural phenomenon. For Kinsey, the most recurring theme in terms of sexual practice would be what is considered natural; therefore, it should be studied by science and promoted or permitted by society. The great problem is that by focusing only

¹³ BÉJIN, 1987^a, P. 228.

¹⁴ BÉJIN, 1987^a.

¹⁵ IRVINE, 2005.

¹⁶ IRVINE, 2005, p 5-6.

on the physiological aspects of sex and overlooking social influences, Kinsey could not realize how much of his research findings were the result of social conditioning, for example, that women had a lower interest in sex or were less “capable” of having sex. His findings and his interpretations reproduced the marital and heterosexual “normality” of white middle-class America. His researches were financed between 1947 and 1954 by the Committee for Research in Problems of Sex, founded in 1921 with the financial backing from the Rockefeller Foundation aimed above mostly to biomedical research, and especially, to studies on hormones and sexuality. In 1948, *Sexual Behavior in Human Male* is published, compiling information collected from 5,300 interviews with men and he becomes a scientific authority on sexuality of the north America men and turning sex into a legitimate subject of investigation and treatment. *The Sexual Behavior in Human Female*, published in 1953, and containing information from 5,940 interviews with women, is not received the same way. It seems that the general public and the institutions were not ready for Kinsey’s presentation on the sexual behavior of American women, who were more liberal then they were assumed to be. This is the explanation used to justify the loss of financing for his researches in the following year and also for his public condemnation by the American Medical Association.¹⁷

It is interesting that Kinsey, based on the results of his researches, was able to demonstrate the fluidity of sexual behavior, attesting for example, to the possibility of homosexual practices by any individual. But, as far as women go, although Kinsey made an effort to reveal their “concrete” behavior (highlighting, for example, the importance of the clitoris and the masturbation and questioning the vaginal orgasm) in contrast with the current suppositions and their similarities with men, the idea that women are less inclined to sex prevailed. By emphasizing that the biological aspects of sexuality connected to our mammalian origins, Kinsey affirmed that the sexual capacity of the individual depended on the morphologic structure and on the metabolic capacity, on the organs used for touching the surface of the body, the hormones and the nerves. He believed that women were less capable. In fact, his conclusion that women were less capable of enjoying sex resulted from his research findings in which women declared they had sex less often and experienced fewer orgasms. Kinsey rejected socio-cultural explanations for the differences between men and women. For him, the fact the women were “less inclined” to sex had less to do the moral and social conventions and more with a loss of interest in anything erotic related to some internal mechanism that functioned differently in men and women. He dedicated himself to searching for the roots of this difference in nerves and in hormones, but didn’t find anything conclusive. What grabs the attention is his refusal to consider cultural determination that, at least since the XX century, prescribed a model of womanhood based on restricting sex to procreation. Moreover, he also promoted an idea that would become common in later studies stating that women had a more complex sexuality, with sexual practices that lead to orgasm less frequently (the great measure of sexual satisfaction to be pursued at any cost) and therefore, more difficult to be researched.¹⁸

Another important chapter in the history of sexology was the publication of *Human Sexual Response*, in 1966, by William Masters and Virginia Johnson, work that consolidated the alignment of sexology with medicine. Masters was an established gynecologist who became respected for moving from research with animals to human sexuality and, strategically, enlisting the help of a woman, the psychologist Johnson. It is evident that the book relied on medical authority and in its strategies to promote it, as well as in the emphasis on scientific research. Aside from that, this work offers a database on 694 individuals researched through observations in laboratory, among prostitutes and “respectable” voluntaries, and it was central in establishing a new legitimate sexual therapy. According

¹⁷ IRVINE, 2005, cap. 1.

¹⁸ IRVINE, 2005, cap. 1.

to Irvine,¹⁹ the great novelty was the idea that the promotion of the idea that the doctor would extend his power of treatment and healing to the domain of sexuality, even going against alternative approaches prescribed in traditional marriage manuals, for example. In the social context marked by the big transformations of 1960s, a newly proposed sexual therapy was very well received. In 1970, they published *Human Sexual Inadequacy*, based on their analysis of 510 white, well educated and upper-middle-class, a demographic that was also more likely to accept the services of sexual therapy. Again, the emphasis is on the physiological aspects of sexuality and on the universality of the human body. Their most notable contribution was the elaboration of a model of the cycle of sexual response that would become a parameter for the modern research and sexual therapy, serving even as a basis for the classification of sexual deviations in the *Diagnostic and Statistic Manual of Mental Disorders III and IV (DSM-III and DSM IV)*.²⁰ This cycle was composed by the following phases: desire, arousal, orgasm and resolution. If for Kinsey the natural aspect of sex was what people said they were doing, for Masters and Johnson it was represented by the physiological responses observed in laboratory and that constitute a new standard of sex to be aspired to through sexual therapy. Their findings and the promotion that they had in the field were fundamental to the establishment of a new clinic market in the treatment of sexuality.²¹

Using the panorama designed by Irvine²², during the 1970s, what comes to the fore ground is not the production of a new great study, but the consolidation of two new categories related to the general notion of sexual dysfunction, but rather the concept of “sexual addiction,” and especially the “hypoactive sexual desire,” which had a longer repercussion. While the first afflicted primarily men, the second afflicted mainly women. If until the end of the decade the most common demand for sexual therapy came from “easy cases” related to “ignorance” or lack of information on the part of the patients in terms of sexual exercise and healed through Masters and Johnson’s behaviorist methods, later new difficulties surfaced. The new complaints had to do with sexual boredom, low libido, aversion and sexual phobia. It is in this context that the notion of inhibited sexual desire or hypoactive, as Harold Leif defined in 1977, corresponds to a chronic failure to initiate or respond to sexual stimuli.²³ In the 1980s, sexual therapists affirmed that this was the main problem reported by the patients, constituting half of the diagnosis and also the most difficult one to treat.²⁴ In 1980, the American Psychiatric Association acknowledged the hypoactive desire as clinical entity and it included it in the DSM-III. Besides disputes in the field, a vision centering sexual desire as a biological impulse remains strong and it gains new interest with the investigations focused on the brain and in the hormones.²⁵

Jane Russo²⁶ contextualizes this phenomenon within a more general process of the medicalization of sexuality in the nosography of contemporary psychiatry. The DSM-III marked the passage between two different approaches: one that sees mental disorders as psycho-social and another that sees it as strictly biological. Psychiatry and Neuroscience have played a major role in the trajectory of re-biologization of humans and guided a new version of the manual that, among other things, abandoned the old hierarchy between organic and non-organic disorders in favor of a more general perspective in which all mental disorders have a biological base. In regards to sexuality, the author says that there has been an increase not only in the number of disorders and deviances, but also the creation of new entities. In

¹⁹ IRVINE, 2005, cap. 2.

²⁰ Jane RUSSO, 2004; Jane RUSSO e Ana Tereza VENÂNCIO, 2006.

²¹ IRVINE, 2005, cap 2.

²² IRVINE, 2005, cap. 7.

²³ IRVINE, 2005, p. 165.

²⁴ IRVINE, 2005, p. 165.

²⁵ IRVINE, 2005, p. cap 7.

²⁶ RUSSO, 2004.

the DSM-I (edited in 1952) there was a category for Sexual Deviance, within the Sociopathic Personality Disorder, in the group of Personality Disorders. In the DSM II (edited in 1968), the Sexual Deviances are still in the Personality Disorder and other Non-Psychotic Mental Disorders group, but there were already nine categories listed (Homosexuality, Fetishism, Pedophilia, Transvestism, Exhibitionism, Voyeurism, Sadism, Masochism, and other sexual deviances). While in the DSM-II (1980), Sexual Deviances were removed from the Personality Disorders and were incorporated in a group called Psychosexual Disorders with 22 items subdivided into four categories: Gender Identity Disorder, Paraphilia, Psychosexual Dysfunctions, and other Psychosexual Disorders. Psychosexual Disorders include the following: Inhibited Sexual Desire, Inhibited Sexual Arousal, Inhibited Female Orgasm, Inhibit Male Orgasm, Premature Ejaculation, Functional Dyspareunia, Functional Vaginismus, Atypical Psychosexual Disorder. In the DSM-IV (published in 1994), Sexual and Gender Identity Disorder are grouped together with the Sexual Dysfunctions, Paraphylia and Gender Identity Disorder. The Disorders, in turn, are subdivided in Sexual Desire Disorders (Hypoactive Sexual Desire Disorder, Sexual Aversion Disorder, Female Sexual Arousal Disorder, Male Erectile Disorder), Orgasmic Disorders (Female Orgasmic Disorder, Male Orgasmic Disorder, Premature Ejaculation), Sexual Pain Disorder, (Dyspareunia, Vaginismus) and Sexual Disorder due to General Medical Condition. The author argues that one can notice the automatization process of sexuality as a subject, at the same time that there is an expansion of the concept of dysfunction reaching the so-called normal sexuality. A typical example of this trend would be the use of, in the DSM-IV, disturbances associated with the cycle of sexual response (based on the definition by Masters and Johnson) and with pain in intercourse, with each phase having its own correspondent disorders.²⁷

This new chart of official classification of sexual disorders is part of a broader and more general context. It was also used as a foundation for a more an “accurate” definition of the possible sexual problems afflicting the common individual. In addition, it legitimized the promotion and commercialization of a new and broad range of treatments, starting with the so-called erectile dysfunction.

III

Barbara Marshall and Stephen Katz²⁸ argued that in the XX century, the process of medicalization was focused on men and circumscribed male sexuality to erectile dysfunction. Through a general problematization that links sexuality and age as fundamental dimensions to the modern subject, it is worth noting the importance of cultures and life styles prevalent in the end of last century, such as the emphasis on health, on activities and on staying young to a process which will produce a vast field of studies and interventions around the penetrative capacity of the masculine organ. To begin with, erectile dysfunction is defined exactly in function of the (in)capacity to penetrate a vagina, thus marking the heterosexual inclination of those definitions. The great novelty of the XX century, according to the authors, was the shift that happened going from the admission of the decline of sexual life in the course of time, when there was even a certain pejorative suspicion regarding sex in the old age, to a period when one is expected to perform well sexually until the end of life. Moreover, sexual activity is portrayed as a necessary condition for a healthy life and the erectile capacity defines male virility during the whole life span of men.²⁹

²⁷ RUSSO, 2004, p. 106-107.

²⁸ MARSHALL and KATZ, 2002.

²⁹ MARSHALL and KATZ, 2002; MARSHALL, 2006.

The ascension of erectile dysfunction comes from ancient concerns with impotence, which was mostly approached as a problem of psychological origins, including in the works of Masters and Johnson. Until the 1980's, it was a common belief that the fear of impotence was what caused impotence and that the treatment should include therapy and counseling, even in conjunction with hormonal treatments, prosthesis and vitamin supplements. During this period, urological research in the field started to deliver innovative results, such as the "live" demonstration by Doctor Giles Brindley at a congress, in 1983, through the injection of phenoxybenzamine in his own penis leading to an erection – this fact was widely reported in the literature. New discoveries, such as the intracavernous injection of papaverine contributed to the transformation of the erection into an eminent physiological event in detriment to its psychological aspects. Therefore, impotence became a disorder with organic causes and that is how it should be treated as such. An important development was the *Consensus Development Conference on Impotence* that took place in 1992, organized by the American National Institute of Health. Among its recommendations contained in its final document was the substitution of the term "impotence" for "erectile dysfunction," in order to characterize the incapacity of obtaining and/or maintaining an erection enough for a satisfactory sexual performance. In addition, it also promoted the idea that it is an organic disease that is treatable and it is also a matter of public health. It was instrumental to have the epidemiological data in order to address it as a public health issue. The most cited study was the *Massachusetts Male Ageing Survey (MMAS)*³⁰ that interviewed 1,700 men between the ages of 40 and 70 years of age in the area of Boston between 1987 and 1989. The study found that 525 of the men had some degree of erectile dysfunction, defined as the inability to obtain and maintain an erection strong enough to perform sexual intercourse. Despite being criticized,³¹ the study, which widened the concept of the disease through the idea of stages insofar as it being a progressive disorder, prevailed. It was cited and served to create the notion of the risks and the responsibilities that should be carried by the individuals thus promoting the idea of constant vigilance and the consumption of products to guarantee erectile health, the symbol of masculinity and physical and emotional health.³²

It is exactly in this context that we watch the launching of Viagra (sildenafil citrate) produced by Pfizer and aimed at facilitating and maintaining an erection, which illustrates the development of a molecular science of sexuality.³³ Viagra has been a success in commercial terms, a blockbuster, and a drug that rakes in at least one billion dollars yearly.³⁴ It is important to mention that it is precisely the construction of Viagra as a medication to treat a disease and not to be used as an aphrodisiac, as observed by Alain Giami.³⁵ Viagra was approved for consumption by the Food and Drug Administration (FDA) in the United States in 1998. Shortly after that, the first studies financed by Pfizer were published, confirming the efficacy of the medication and how well it was tolerated. The foundation of these studies was the *International Index of Erectile Function (IIEF)* elaborated in 1997 with 15 questions destined to examine the erectile function and do away with the difficulties in establishing a diagnostic of dysfunction and evaluate the result of the trials with new medicines.³⁶

An important facet of this process is the degree of institutionalization that the field was acquiring with the evident predominance of urologists. In 1982, the International Society for Impotence Research (ISIR) is created, aimed at the scientific study of erection and its functional mechanisms, with its

³⁰ H.A. FELDMAN et al, 1994.

³¹ Joel LEXCHIN, 2006.

³² MARSHALL and KATZ, 2002, p. 54-59; GIAMI, 2004; TIEFER, 2006a.

³³ MARSHALL and KATZ, 2002, p. 60.

³⁴ TIEFER, 2006a, p. 279.

³⁵ GIAMI, 2004.

³⁶ GIAMI, 2004.

official publication called the *International Journal of Impotence Research* starting in 1989. In 2000, the Society changed its name to International Society for Sexual and Impotence Research (ISSIR), leaving an obvious opening to the inclusion of other aspects of male sexuality and also female sexuality. According to Giami,³⁷ this was a strategy to broaden the limits of intervention with sexual activity on a global scale, departing from the confines of erectile dysfunction. In 1999, the International Consultation about Erectile Dysfunction was organized in Paris under the auspice of the World Health Organization and the International Urology Society. The conference was sponsored by the pharmaceutical industry and it marked the process of internationalization of the medicalization of impotence and the alliance between the urologists and the pharmaceutical industry. Similarly, the World Association of Sexology (WAS) conference that happened in Paris in 2001, translates, still according to Giami,³⁸ into the entrance of the pharmaceutical industry and the urologists into the world of sexology, which was traditionally fragmented between doctors and non-doctors and between issues of sexual education and prevention, besides the treatment of sexual disorders. According to Leonore Tiefer,³⁹ the process of medicalization of sexuality goes beyond the phase of creation of systems of classification and enters the stage of institutionalization and professionalization of “sexual medicine” with the support of organizations, conferences, training centers, scientific journals, clinics and medical departments. This new branch of sexual medicine went side by side with the “sexual pharmacology.”

In an article entitled “Bigger and Better: How Pfizer Redefined Erectile Dysfunction,” Joel Lexchin⁴⁰ problematizes the strategies adopted by the pharmaceutical industry to promote Viagra. The main argument is that it was necessary, on the one hand, to transform erectile dysfunction into a problem that may afflict any man, at any time in his life, and that there was a medicine already available to solve or to prevent this difficulty. In this sense, Viagra integrated the broader collection of life style drugs or comfort medications, destined to enhance individual performance; a market clearly in expansion. Viagra’s success came exactly from that, according to Lexchin.⁴¹ If it had been restricted to the treatment of erectile dysfunction associated with organic causes it would have been a business failure in terms of sales. On the other hand, Pfizer also worked to promote the idea of erectile dysfunction as an acceptable subject in public discourse, which also led to a higher demand for treatment.⁴²

Meika Loe⁴³ makes another interesting argument. She argues that Viagra is a cultural and material technology that is related with the construction of a new possibility of intervention with the male body, in contrast with the traditional history of medical intervention with women’s bodies. This has become possible thanks to the propagation of an idea of masculinity in crisis, illustrated above all by the metaphor of erection. The idea that the erection, symbol of virility and masculine identity, is effectively unstable, subject to many types of misfortune, seems to gain more and more notoriety. It is precisely to combat this lack of control or unpredictability of the male body that the industry offers a cure like Viagra, capable of fulfilling the expectation of a better performance always.⁴⁴

Furthermore, there is the history of Viagra advertisement campaigns in several countries, which clearly shows how the medicine has been converted into something destined to improve the sexual performance without any restriction and without being destined to a specific group. It was initially

³⁷ GIAMI, 2004, p. 14.

³⁸ GIAMI, 2004, p. 16.

³⁹ TIEFER, 2006a, p. 275.

⁴⁰ LEXCHIN, 2006.

⁴¹ LEXCHIN, 2006, p. 1.

⁴² LEXCHIN, 2006.

⁴³ LOE, 2001

⁴⁴ Victoria GRACE e al, 2006.

geared to an older public and in the context of a heterosexual union, but it started being offered to younger and younger men and it started to be featured without a presumable partner.⁴⁵ What was behind this commercial trajectory was the creation of a feeling of masculine vulnerability that led to the search for control and enhancement of potency and of sexuality in general.⁴⁶

It is important to mention that the physical and mental instability have been frequently associated more with female bodies, governed by variable hormonal cycles and by different stages linked to the reproductive life, which also justifies the sexual instability of women.⁴⁷ The novelty is that now this representation has also reached the male body and it threatens the notion that men are “naturally” potent. It is also worth noting that, while female sexuality has historically focused on and encapsulated by reproduction, male sexuality is viewed obliquely through the penetration in sexual intercourse.

In this sense, Loe⁴⁸ suggests that the development of technologies associated to reproduction and, especially, the contraceptive pill, in the middle of the XX century, were precursors of a new pharmacology of sex. The same thread connected the pill, which liberated women’s sexuality from its reproductive consequences, and Viagra, which supposedly guarantees male sexual satisfaction. Furthermore, Alain Giami and Brenda Spencer⁴⁹ argue in favor of three models of sexuality that characterize the last decades: liberated sexuality, in the context of the pill; protected sexuality, to the extent of the HIV/AIDS epidemic and condom use; and functional sexuality, in light of the medications for sexual dysfunction.

In this regard, we are already referring to an analysis that takes into consideration the medicalization of the female sexuality in the context of the new era of sexual dysfunctions. Tiefer,⁵⁰ openly demonstrates a “feminist sensibility,” when she presents the context for the construction of Viagra as a cultural phenomenon in the field of “Viagra Studies.”⁵¹ She points out that, besides the issue of pharmaceutical industry and the creation of the sexual drugs, there are two other central themes which are the search for a “Pink Viagra” and the explosion in the rise of clinics to treat female sexual dysfunction. The author refers to the creation of the female sexual dysfunction as a classic case of a tactic promoting a new disease by the pharmaceutical industry and other agents of the medicalization, such as journalist, health professionals, advertisement agencies, public relations agencies, etc. According to Tiefer,⁵² since at least 1997, North American urologists were already working on the category “female sexual dysfunction,” referring to aspects of genital pathophysiology similar to the erectile dysfunction. In this year, the *Sexual Function Assessment in Clinical Trial* happened, sponsored by the pharmaceutical industry, during which they proclaimed the need for a better definition of the female sexual dysfunction. In 1998, the year when Viagra was officially launched and the moment when the journalists had already started talking about the “Pink Viagra,” Doctor Irwin Goldstein, urology leader in the Boston Group that studied erectile dysfunction, opened the first Sexual Health Clinic for Women. Still, in this year, the first *International Consensus Development Conference on Female Sexual Dysfunction* also happened in Boston. In the following years, new conferences happened and as of the year 2002 they became international and happened yearly. In 2000, the Female Sexual Function Forum is created, renamed for the International Society for the Study of Women’s Sexual Health

⁴⁵ MARSHALL and KATZ, 2002, p. 61.

⁴⁶ Tiina VARES e Virginia BRAUN, 2006.

⁴⁷ ROHDEN, 2001.

⁴⁸ LOE, 2001, p. 101.

⁴⁹ GIAMI and SPENCER, 2004.

⁵⁰ TIEFER, 2006a.

⁵¹ Annie POTTS and Leonore TIEFER, 2006.

⁵² TIEFER, 2006b.

(ISSWSH) in 2001.⁵³ Another important milestone was the article entitled “Sexual Dysfunction in the United States: Prevalence and Predictors,” by Edward Laumann, Anthony Paik and Raymond Rosen, published in the *Journal of the American Medical Association* (JAMA) in 1999,⁵⁴ based on a re-analysis of the data from the survey with 1,500 women who responded positively to any of the problems cited, such as loss of desire, anxiety about sexual performance or difficulties with lubrication. In this work, the researchers affirmed that for women between the ages of 18 and 59 the total prevalence of sexual dysfunction was 43%. As it occurred in the case of erectile dysfunction, this number became insistently cited in the literature that promoted the disease.⁵⁵

What we see through the creation of a diagnostic for female sexual dysfunction is an even more refined process of articulation between several actors culminating in the formation of a new and vast market. This is the argument proposed by Jennifer Fishman⁵⁶ regarding the commoditization of the female sexual dysfunction from the perspective of someone who notices an intricate web of relations mapped out in a field which congregates several points, such as business, science, medicine and governmental regulation. The author reveals, in particular, how the researcher play a key role as mediators between the producers, meaning, the pharmaceutical industries, and its consumers, in other words, the clinicians and their patients who consume these new drugs. The symbolic capitalism of these scientists, the majority of whom are doctors and psychologists holding jobs at medical schools, is an important currency in the course of promoting a new market, not only to test the scientific legitimacy of the products submitted to approval by the regulatory agencies, but also to help confirm a parallel market through off-label prescriptions of products yet to be approved. Through the educational conferences sponsored by the industries, the researchers share information which will be, in turn, prescribed at the doctor’s office. As a result, the moment that the drugs being promoted by the big companies are approved, there is already a broad market for it. This process starts with the classifications and the diagnostics; at the same time as the disease, the treatment for it and the population that can be treated are "created."

In the case of the female sexual dysfunction, this process starts with the prescription of Viagra as well as of testosterone, approved in the United States for the treatment of male sexual dysfunctions. It is worth noting a curious slip as in what would be applicable to men, would also be applicable for women.⁵⁷ In the conferences of medical education researched by Fishman,⁵⁸ this was common standard. Moreover, what also contributes to the increase in the prescriptions is the transformation of some researchers into celebrities. The most known case in the field of sexual dysfunction is that of the two researchers linked to Irwin Goldstein, the urologist Jennifer Berman and her sister, the psychologist Laura Berman. In addition, beside opening a clinic for treatment of this dysfunction at the University of Los Angeles (UCLA), the two are featured in a television show, have a website and books dedicated to promote this subject and to popularize these so called treatments with off-label drugs, especially Viagra and testosterone.⁵⁹

It is estimated that around one billion and seven hundred million dollars is spent yearly in the search for a market for the treatment of women’s sexual problems. Several companies have invested in a series of products, starting with Viagra, tested in women by Pfizer between 1997 and 2004 when the laboratory

⁵³ TIEFER, 2006b; Ray MOYNIHAN, 2003; Heather HARTLEY, 2006.

⁵⁴ LAUMANN, PAIK and ROSEN, 1999.

⁵⁵ MOYNIHAN, 2003; HARTLEY, 2006.

⁵⁶ FISHMAN, 2004.

⁵⁷ LOE, 2004, cap. 5.

⁵⁸ FISHMAN, 2004.

⁵⁹ MOYNIHAN, 2003; FISHMAN, 2004; HARTLEY, 2006.

admitted that clinical trials did not show satisfactory results. Comparatively, in the field of erectile dysfunction, the female sexuality seems to have made the work of the researchers harder because it has been more difficult to quantify female sexual response as well as to conduct trials of efficient pharmaceutical therapies.⁶⁰ Currently the FDA has only approved one stimulant for the clitoris called EROS-CTD.⁶¹ A new turning point in the history of the female sexual dysfunction is the investment from Procter & Gamble laboratory on a testosterone patch called Intrinsa and recommended for the treatment of hypoactive sexual desire disorder, which had not been approved by the FDA in the United States in 2004, but was approved for use in European Community in 2006.⁶² Intrinsa, and the fact that at least seven big pharmaceutical companies are testing products with testosterone for women indicates a change in the referential regarding the treatment of female sexual dysfunction disorder, and the focus shifted from problems with sexual arousal to be viewed as disorders associated with sexual desire. Hartley⁶³ asks provocatively if women's problems have changed or if this transformation in the field reflects a strategy by the pharmaceutical industries to search a drug with some subcomponent that will correspond with the disorders in the DSM. The new tactics of promotion at work affirm that Viagra has failed women because female sexuality is much more complex than male's. Leaving aside the mechanisms or arousal, it would be necessary to resort to the "desire hormone," testosterone. As confirmed by medical literature, the Hypoactive Sexual Desire Disorder is a product of the Androgen Insufficiency Syndrome, which has justified the long and polemic history of hormonal replacement therapy for women. According to Hartley,⁶⁴ it is interesting that, despite the known risks posed by these therapies, the fragility of the data about the efficacy of treatments and, specially, the demonstration that there was no connection between low sex drive and low levels of testosterone, the pharmaceutical investments continued to increase as well as the number of clinicians that prescribed these drugs to women.

IV

The conclusion we arrive in analyzing the trajectory of the construction of masculine and feminine sexual dysfunction, beyond the general considerations regarding the complex process of medicalization of society, is that such trajectory is marked by gender stereotypes that are present in the preconceptions held by the researchers as far as what is re-transmitted to society during the stage of promotion of a new diagnostic and treatment. We notice the model of sexuality and also masculine identity widespread in the age of erectile dysfunction and Viagra centers on potency. Although, we have recently started to see discussions about masculine desire and even about the use of drugs to "treat" the dysfunction, what remains is a reduction of the sexual experience and of men's subjectivity to the anatomic and physiological erection norm, in the vast majority perceived in the context of heterosexual relations.

This centrality on the anatomic and physiological and consequently its circumscription to sexuality to its genital function guided the first pharmaceutical attempts in the treatment of female sexual dysfunction, illustrated above all by the use of Viagra. Here we see it clearly the reduction of the female sexuality to the model conceived as masculine, in which arousal would be the central point. With the failure of this treatment, the attention goes back to the desire stage and the new hope to combat the hypoactive sexual desire in women is nothing more than testosterone, a hormone that since

⁶⁰ MOYNIHAN, 2003 and 2005.

⁶¹ HARTLEY, 2006.

⁶² EUROPEAN MEDICINES AGENCY, 2007.

⁶³ HARTLEY, 2006, p. 367.

⁶⁴ HARTLEY, 2006, p. 367.

its discovery has been conceived as eminently masculine, in contrast with estrogen, seen as feminine.⁶⁵ Therefore, in this new stage, in order to have a satisfactory sexuality women have to resort to what physically and symbolically represents a process of masculinization. Only by resembling the economy of a masculine body, can women get closer to the widespread sexual satisfaction. Finally, what we see is that women's sexuality is treated beyond reproduction; it seems to be a reduction, in different ways, of the female sexuality to a supposed masculine model.

It is interesting that we find the formation of groups posing resistance to the new medicalization of female sexuality in contrast to the absence of manifestations regarding the men's. This has to do with the "Campaign for a New View of Women's Sexual Problems," headed by Leonore Tiefer, who promotes a critical theory as an alternative to the medical model of sexual problems as well as a constant vigilance of the web of the professionals and the industries that promote new drugs to treat female sexual dysfunction.⁶⁶ The campaign proposes a more constructionist approach and a politic of sexuality, alerting against defining a "normal" sexuality, and it also defends an alternative system of classification that takes into consideration the social, relational, psychological, medical and organic of diseases. Tiefer⁶⁷ specially criticizes the false notion of the sexual equivalence between men and women, derived from early researches about sex that registered their similar physiological responses during sexual activity. Furthermore, it alerts that few researches encouraged women to describe their experiences from their point of view, which if it had been the case, it would have made the differences evident. Women, for example, would not make a distinction between desire and arousal, as expressed in the Masters and Johnson; they would be less used to physical arousal and more subjective and their complaints more focused on "difficulties" not present in the DSM.

Despite the critical relevance of the aspects raised by Tiefer and by the "Campaign for a New View," a question remains. The doubt is if the new model proposed does not end up reifying certain gender norms. The idea that female sexuality is more complex, that women are more permeable to the subjective and emotional aspects, that physical arousal is secondary, may be once more reinforcing a certain image of feminine associated with representations inherited from at least the XX century, of a radical contrast between genders that conceals broader political tensions.

In closing, it is important to say that the literature analyzed has worked expansively on the milestones of investigation of the process of medicalization of society and of sexuality. It is an important collection of articles that calls the attention to the dimension of gender in the determination of medical and cultural produced models. There is also an increasing investment in a critique of the movement of construction of new sexual norms based on the compulsory notion of an enhanced performance. The challenge that remains is how to exactly articulate these three dimensions which, together, will enable a deeper understanding of this new era of discourse and practice that have been constituted around sex.

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⁶⁵ OUDSHOORN, 1994.

⁶⁶ TIEFER, 2004 e 2006b; HARTLEY, 2006; MOYNIHAN, 2003.

⁶⁷ TIEFER, 2004, p. 252.

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