The Medicalization of Sexuality: Disease, Dysfunction and ‘Normality’

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“We have reached [...] the end of the body as we knew it. In its place [...] is the profitable body, one that can and should constantly be improved.”¹ This is how Hans Baer, Merrill Singer and Ida Susser describe the way medicalization has changed the ways the human body is viewed. Medicalization is a process whereby “medical authority or explanations infuse [...] social experiences of everyday life.”² It is how human conditions and problems come to be defined and treated as medical conditions, and thus become the subject of medical study, diagnosis, prevention, or treatment.³ The process can be seen in anthropological and sociological terms as the domination of ‘normal’ life events and processes by medicine, spreading the jurisdiction over which it has control and authority.⁴

Medicalization can be driven by new scientific evidence, technology, or social situations. In the case of sexuality, the invention of Viagra, an erectile dysfunction (ED) drug, marked the early successful pharmaceutical intervention of a sexual ‘problem’.⁵ Since then a growing trend initiated by pharmaceutical companies and perpetuated by the media, has been to view sexuality as something that can and should be maintained throughout life, something that can be achieved through biomedical control.⁶ This paper aims to investigate the ways in which the biomedical industry has medicalised sexuality and sexual fulfilment. To do this, three main issues will be analysed. First, an analysis of the ways in which medicalization is enacted by classifying behaviours, or lack thereof, as ‘dysfunction’ or ‘disease’ which creates a new standard of ‘normal’, thereby exerting control over the sexuality of individuals. Next, the norm of sexual fulfilment as it is embodied through female genital cosmetic surgery (FGCS) and hormone replacement therapy (HRT) to treat female hypoactive sexuality disorder (FSDD). Finally, the ‘new sexual revolution’ will be discussed as aging adults are continuing sexually into later life.

³ Ibid.
⁴ Ibid.
through medical intervention using HRT. It is important to understand how the classification of something as a disease creates a ripple effect in how society responds to this new ‘diagnosis’.

**The Process of Medicalization**

The medicalization of sex and sexuality has existed since early in the 19th century, through the creation of diagnostic categories defining acceptable sexual behavior according to Victorian attitudes. The resulting sexual norms can be understood through Foucault’s theory on surveillance and control. Foucault argued that the liberalization of sexuality through open discussion brought sexuality into the public sphere of discourse and surveillance, where it could then be studied and categorized on a scientific basis and therefore subject to control by the state and other institutions. Control is exerted first through public health interventions via medical professionals and secondly through self-regulation based on comparison to the norms created. Norms therefore act as a standard for which the medical community and individuals can compare themselves in their sexual health and gratification. If a person’s experience doesn’t meet these standards, feelings of inadequacy can ensue in which intervention is subsequently sought. The obsession with sexual gratification has turned ‘celibacy into the new deviance’, whereby any deviation from a ‘normal’ sexual experience in which gratification is reached is seen as needing medical treatment. In addition to this, the medical community is increasingly putting satisfying sex lives at the center of achieving a healthy, balanced lifestyle. What gets lost in this process is the highly variable nature of sexuality. Disease classification and diagnosis is a fundamental tool through which medical authority is exerted over sexuality.

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7 It is important to note that some of the literature differentiates between medicalization and biomedicalization, the latter being characterized as having increased penetration and cooperation with science and industry (Marshall 2012). For the sake of my paper here, the term medicalization will be used to refer to both the traditional definition of medicalization and the novel differentiation for biomedicalization as multiple authors reviewed use the terms interchangeably.


9 Ibid.


15 Jutel, “Framing Disease,” 1084-1090.
Medicalization is also tightly tied to consumerism through the capitalist nature of the pharmaceutical industry. Aronowitz describes the interrelationships between dynamics of consumption and the resulting impacts on physical and mental health via the manipulation of consumer needs. The pharmaceutical industry perpetuates feelings of inadequacy in terms of sexual fulfillment and function in order to present the problem as medical in nature, with a ready-made cure. Conrad has even gone so far as to call the pharmaceutical industry an “engine of medicalization” as they profit from the creation of new illnesses that they can then treat.

The role of media is also significant in reproducing those feelings of inadequacy in “the social construction of ideas about appearance, health, illness and sexuality.” In the new format of sexuality, people are seen to have a “right and duty to achieve and give maximum satisfaction in their sexual relationships.” Put in simpler terms, not having gratifying physical sex, posed in the form of penetration, is a new form of deviance, “sexual pleasure […] is, socioculturally, almost mandatory.” The process of medicalization relies on a consumer system in which the mass media, societal norms, and the medical community perpetuate the perception that people are defective in some way, and that biomedicine will continually facilitate the ‘curing’ of these ailments.

Female Sexual Dysfunction

One of the norms that women are being pressured into fulfilling avows that penetrative sex and orgasm are the epitome of ‘sexual gratification’, where sexual fulfillment is understood to be available to all. The diagnosis of sexual dysfunction in women has increased due to women’s feelings of abnormality in terms of their sex lives as a result of not living up to these standards. Female sexual dysfunction (FSD) and

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16 Ibid.
22 Ibid., 417.
23 Ibid., 419.
female hypoactive sexual desire disorder (FSDD) are two examples of diagnosed conditions in which females have a ‘lack of desire’.\textsuperscript{26} FSD is a classification of female sexual problems, specifically concerning orgasm, whereas FSDD is a more specific diagnosis in which a woman has “inhibited sexual desire,” implying that there is an innate sexual urge in all humans caused by hormones that is somehow being disrupted in these individuals.\textsuperscript{27}

FSDD and FSD are both treated with HRT, which supplements a lack of naturally occurring hormones.\textsuperscript{28} HRT is based on the biomedical understanding that lack of sexual arousal is due to a hormonal imbalance of estrogen, progesterone and testosterone.\textsuperscript{29} A major assumption made by the biomedical industry is that there is a way to physiologically quantify something as highly variable as sexual pleasure.\textsuperscript{30} Firstly, there is a wide range of hormonal levels with which people can function sexually.\textsuperscript{31} Secondly, the quantification of a highly individual and qualitative trait demonstrates a disregard or misunderstanding by the medical community of the lived sexual experiences of both men and women.

What is largely being ignored in this discourse is whether the normalized ideals of sexual gratification are at all reflective of women’s experiences. Findings from Nicholson and Burr demonstrate from qualitative interviews that women felt the underlying existence of a standard of normality that they or their partner used as a comparison.\textsuperscript{32} But most of the women agreed that ‘normal sexuality’ has more to do with popular belief and media than actual experiences of women. Based on these interviews, women described many different ‘types’ of sex that varied from the penetrative and negated the orgasm as being the predominant aim of sex.\textsuperscript{33} This demonstrates that although women are aware of the standard of orgasmic, penetrative sex, they can and do achieve sexual fulfillment in a multitude of other ways.\textsuperscript{34}

An emerging trend within the last ten years to deal with the pressure of adhering to the ‘normal’ sexual trajectory is female genital cosmetic surgery (FGCS).\textsuperscript{35} Some people may feel extreme anxiety if they do not achieve sexual fulfilment within society’s norms, leading them to

\textsuperscript{26} Nicolson and Burr, “What is ‘Normal,’” 1735-1745; Jutel, “Framing Disease,” 1084-1090.
\textsuperscript{27} Jutel, “Framing Disease,” 1084-1090; Nicholson and Burr 2003).
\textsuperscript{28} Jutel, “Framing Disease,” 1084-1090.
\textsuperscript{29} Ibid.
\textsuperscript{31} Ibid.
\textsuperscript{32} Nicolson and Burr, “What is ‘Normal,’” 1735-1745.
\textsuperscript{33} Ibid.
\textsuperscript{34} Nicolson and Burr, “What is ‘Normal,’” 1735-1745.
the extreme of surgical modification of the genitalia. FGCS is a cosmetic surgery that can be performed for purely aesthetic reasons, or to increase pleasure. This can be accomplished through labiaplasty, liposuction, vaginal tightening, G-spot amplification and clitoral repositioning. Although this may seem like an extreme measure to undertake for the sake of sexual pleasure, surgeons are doing up to forty procedures a month and are expecting these numbers to increase due to such positive feedback. Another major reason women undergo FGCS is insecurity due to the aesthetics of their genitalia. Many women interviewed by Braun admitted that they often found it difficult participating in certain sexual acts, such as cunnilingus, due to the fact that they felt there was something wrong with the way their genitalia looked. The post-operative genitalia had minimized labia minora and resembled a pre-pubescent aesthetic often seen among adult film actresses. This procedure in particular is completely external and doesn’t directly increase the sexual pleasure or stimulation of the women, unlike in other procedures. But it is responsible for giving the patient increased confidence about their genitalia, which often lead to a better sex life. What is happening here is the surgical homogenization of female genitalia to fit a particular “playboy” aesthetic that men find attractive. The individuality of women’s bodies and sexuality is being overturned in favour of conforming to heteronormative ideals of what men find attractive and what women should engage in sexually and enjoy. Increased sexual function is achieved through these procedures, allowing the women to achieve sexual gratification within strict normalized bounds. The concept of sexual pleasure has become a mandatory ideal for women to achieve, despite the evidence that the majority of women find pleasure in alternative ways to penetrative, orgasmic sex.

**Sexuality and Aging**

Interest and ability to engage in sexual intercourse decreases with age in both men and women, but is more pronounced in women after menopause. This is a natural phenomenon due to hormonal changes that result in decreased libido, inability to maintain an erection and difficulty in having sex for both men and women. People are living longer and with the commercialization of Viagra came the era of ‘new aging’ in which

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38 Ibid.
39 Ibid.
40 Ibid.
42 Ibid.
getting older didn’t have the same negative implications that it used to.\textsuperscript{43} Using HRT and a myriad of other drugs and procedures meant that the elderly could reduce the negative effects of aging, including sexuality. In addition to this was the decades old assertion that sex was beneficial to a person’s health.\textsuperscript{44} Therefore, if aging comes with serious health implications, participating in healthy activities such as sex is encouraged and applauded.

One of the biggest purported benefits of adhering to the new aging process is its positive effect on other health issues.\textsuperscript{45} Between the ages of 35-60 women go through menopause, which is defined as a “sex-linked, female dominant, endocrine deficiency disease with specific symptoms and signs which should be investigated and managed in a very careful and considered fashion for the remainder of a woman’s life.”\textsuperscript{46} Menopause is treated with HRT and once prescribed is recommended to be continued for the rest of a woman’s natural life.\textsuperscript{47} The scientific literature from Wylie \textit{et al.} (2010) positions HRT for menopause as a cure all for female aging.

Klein and Dumble (1994) question whether physicians are critically examining the effectiveness of using HRT as a ‘treatment’ when they are recommending HRT to all women over a certain age. Treating women with HRT does reduce the risk of developing osteoporosis and cardiovascular disease, which are major side effects of decreased hormone levels due to menopause.\textsuperscript{48} However, the beneficial risk reduction disappears as soon as a woman stops taking HRT and the massive side effects of HRT itself cause many women to do just this.\textsuperscript{49} HRT was initially marketed in the 1960-70s as estrogen replacement therapy (ERT) and as a ‘cure all’ for aging, but was later taken off the market for serious side effects including cancer and death.\textsuperscript{50} HRT is essentially the same product modified slightly to make it moderately safer and is once more being marketed as a way to stay young and sexual.\textsuperscript{51} This is representative of the view that identity in terms of femininity and masculinity are intrinsically linked to physical sexuality and sexual function.\textsuperscript{52}

The issue for aging males is classified as male sexual dysfunction.

\textsuperscript{43} Marshall, “Medicalization and the Refashioning,” 337.
\textsuperscript{44} Wylie \textit{et al.}, “Androgens, Health and Sexuality,” 275-289.
\textsuperscript{46} Ibid., 328 (author’s emphasis).
\textsuperscript{47} Klein and Dumble, “Disempowering Midlife Women,” 327-343.
\textsuperscript{48} Wylie \textit{et al.}, “Androgens, Health and Sexuality,” 275-289.
\textsuperscript{49} Ibid.
\textsuperscript{50} Klein and Dumble, “Disempowering Midlife Women,” 327-343.
\textsuperscript{51} Ibid.
\textsuperscript{52} Ibid.
with several sub-categories, the most prevalent being testosterone deficiency syndrome (TDS). TDS is defined as “a clinical and biochemical syndrome associated with advancing age; it is characterized by a deficiency in serum testosterone levels (below the young healthy adult male reference range).” The definition is important in that it identifies that the dysfunction exists because hormone levels are being compared to that of a young, healthy, virile male, which an aging man is not. There are very few other health implications to sexual dysfunction disorders in men so the majority of HRT is for the treatment of reduced sexual function or desire at the behest of the patient himself.

This introduces the question of the ‘decline narrative’ versus the ‘progress narrative’. The decline narrative is “when changes associated with getting older are constructed in negative terms through tropes of ‘diminishment’ and ‘reduction’” and is associated with comparisons to a more youthful state in their lives. Whereas the progress narrative is “that youthful sex may […] still be their reference point when discussing sexuality, but they relay an account of sex improving with age and experience” in a multitude of ways. Based on this premise, Potts et al. (2006) conducted qualitative interviews with aging men to assess their views on sexuality. The resounding response from these men was that sex to them wasn’t synonymous with penetrative sex and that alternative forms of sexual fulfillment through other forms of intimacy were often more important as age progressed from youth. This demonstrates that there are alternative routes to sex don’t require men to be physically sexual for life.

Conclusion
The medicalization of sexuality is an increasingly important topic as more aspects of sexual health and fulfillment are being incorporated into the biomedical sphere. The aim of this paper was to investigate the medicalization of several aspects of sexuality through the existing literature from scientific, sociological and anthropological perspectives. This amalgamation of perspectives allowed for a better understanding of the mechanisms through which medicalization occurs and how it is enacted in society.

Medicalization is enacted within society through media

54 Ibid., 282 (my emphasis).
57 Ibid.
59 Potts et al., “‘Sex for Life’?” 306-329.
representations, the medical community itself and societal norms that instil a sense of inadequacy that can then be incorporated into a medical context of disease or dysfunction. This was framed in terms of Foucault’s theory of surveillance and control as well as through dynamics of consumption. Several case studies were discussed which represented existing forms of medicalised sexuality. FSDD and FGCS were based upon hegemonic standards of sexuality whereby not having fulfilling sex was deviant. Menopause and TDS were examples of the medicalization of aging sexuality, in which HRT was based upon the decline narrative of aging as a dysfunction.

The overarching implication of the medicalization of sexuality is that ‘sexual health’ has become synonymous with ‘sexual pleasure’. Health is defined by Baer, Singer and Susser as “access to and control over the basic material and non-material resources that sustain and promote life at a high level of individual and group satisfaction. It is not some absolute state of being but an elastic concept that must be evaluated in a larger socio-cultural and political economic context.” Disease is viewed as “as a disruptive event that in some way or another threatens the flow or quality of life and potentially, the identity of the sufferer. Disease must be understood as being as much social as it is biological” whereas medical dysfunction is “the state of being unable to function in a normal way.” These definitions highlight the individuality of health whereby ill-health, disease or dysfunction may be different for every single person and involve multiple interacting factors. Different individual baselines of ‘normal’ make it difficult to determine the boundary between individual variation and an actual state of disease or dysfunction.

Bibliography


60 Baer, Singer and Susser, Medical Anthropology, 5.
61 Ibid., 6-7.


