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Title:	The medicalization of sexuality: Conceptual, normative, and professional issues.
Authors:	Tiefer, Leonore
Source:	Annual Review of Sex Research; 1996, Vol. 7, p252, 30p
Document Type:	Article
Subject Terms:	*SEX
Abstract:	Discusses the medicalization and overmedicalization of sexuality, the latter, defined as the excessive use of medical and surgical treatments for sexual problems. How medicalization influences and constructs sexuality; Medical way of knowing sexuality.
Full Text Word Count:	12638
ISSN:	1053-2528
Accession Number:	9705250164
Persistent link to this record:	http://search.ebscohost.com.lp.hscl.ufl.edu/login.aspx?direct=true&db=aph&AN=9705250164&site=ehost-live
Cut and Paste:	The medicalization of sexuality: Conceptual, normative, and professional issues.
Database:	Academic Search Premier

THE MEDICALIZATION OF SEXUALITY: CONCEPTUAL, NORMATIVE, AND PROFESSIONAL ISSUES

Sexuality . . . is a potentiality organized by disciplinary practices. (Turner, 1995, p. 233)

It is indisputable that the leading physicians, psychiatrists, and sexologists are unanimous in their assertion that the proper and natural performance of the sexual act, especially when consummated with mutual satisfaction, is not only highly beneficial, but in some cases essential, to the general health and well-being of the individuals concerned. (from a 1933 patent application for a penile splint with clitoral stimulator) (Levins, 1996, p. 122)

The fact that physicians are willing to manage or deal with a problematic form of behavior leads to the illogical conclusion that the behavior must be an illness. (Friedson, 1970, p. 251)

A growing chorus of sexologists, myself included, have written recently about "the medicalization of sexuality" as it affects the contemporary understanding and management of patients with erectile dysfunction, low desire, premature ejaculation, and sexual pain (Bancroft, 1989; Bass, 1995; Rosen & Beck, 1988; Rosen & Leiblum, 1996a, 1995b, Schiavi, 1996; Schover & Leiblum, 1994; Tiefer 1986, 1994a, 1995). These authors all complain, in one way or another, about the problems inherent in the "overmedicalization" of sexuality, which we might define as excessive medical diagnostic workups, excessive use of medical and surgical treatments, and excessive claims about the medical causes of sexual problems.

It may be that this period of overmedicalization is self-correcting. Bancroft seemed to think that such things go in cycles, or at least he did in 1982:

Medical fashions come and go and the treatment of erectile impotence is no exception. In the 20s and 30s, physicians and surgeons looked for physical causes and tried out methods of treatment, most of which now seem absurd. Since that time there has been a widely held view that 90-95% of cases of impotence are psychologically determined. Where this figure came from was never clear, but it has entered into medical folklore. In the past 5 years or so, the pendulum has been swinging back. Physical causes and methods of treatment are receiving increasing attention. (Bancroft, 1982, p. 353)

By 1989 the swinging pendulum was looking more like a steamroller, given the way penile implants and intracavernosal injections were being used for the treatment of erectile dysfunction, and Bancroft was now writing about a "surgical `take over bid`":

We have here a classic example of the medicalization of health care . . . any evidence of physical

damage or disease is regarded as sufficient explanation for the erectile failure . . . we are seeing an approach to the management of erectile dysfunction which neglects the role of psychological processes. (Bancroft, 1989,pp.23-24)

Well, the pendulum has not yet begun to swing back, and it is already late in 1996. Furthermore, oral medications for erectile problems are on the horizon and drugs are increasingly being prescribed for desire and orgasm disorders. This is not a situation which predicts a diminution of medicalization in the near future. It may be that psychiatry has seen regular oscillation between biomedical and psychosocial emphases, but the trends which support the medicalization of sexuality seem more unidirectional.

Sexologists need to examine the present medicalization and overmedicalization of sexuality because we may have some influence on these trends with a clearer understanding of their conceptual, professional, and social underpinnings. Moreover, we must acknowledge that medicalization is not just something being done to sexology. For decades many sexologists have participated in the process of medicalizing sexuality, and we must examine our own role in order to understand the complete picture (Irvine, 1990). Sexuality is available to be overmedicalized largely because it has already been medicalized. The fundamental flaws in a medical model of sexuality will not be corrected even if the pendulum does swing back from current excesses.

In the present essay I will review the medicalization of sexuality from several points of view. A general introduction to the topic will be followed by a closer examination of the medical way of knowing sexuality (epistemology and basic science), the medical way of doing sexology (clinical management strategies and the professional setting), and sexual medicine and morality. Then I turn to aspects of late 20th century sexuality which have been conducive to medicalization and overmedicalization, and describe what some changing professional realities within medicine portend for sexology. Finally, I will outline a "postmedicalization" epistemology and pragmatics of sexuality which may serve as a partial blueprint for the future. The medical model of sex is not the only game in town. We can, if we wish, find new allies and ideas for building a fresh sexuality model in some of the current, exciting sexuality scholarship in the social sciences and humanities (cf. Parker & Gagnon, 1995; Tiefer, 1994b).

What is Medicalization?

Medicalization is a major social and intellectual trend whereby medicine, with its distinctive ways of thinking, its models, metaphors, values, agents, and institutions, comes to exercise practical and theoretical authority over particular areas of life. Medicalization relocates activities or experiences (e.g., crimes, habits, or changes in physical or intellectual ability) from categories such as social deviance or ordinary aging to categories of medical expertise and dominion (Conrad & Schneider, 1980). Much of Western society is already medicalized insofar as medical standards dominate huge chunks of everyday life: notions of appropriate behavior and feeling, gender identity, relationships, recreational pursuits, having and raising children, food choices, menstruation, pregnancy,

menopause, etc. (Crawford, 1980).

Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "threat" it. (Conrad, 1992, p. 211)

Medicalization influences and constructs sexuality insofar as its conceptual assumptions and agents currently affect every nook and cranny of sexuality theory, research, legislation, education, employment, information, and assistance to people with sexual problems.(n1) Most of this essay will be devoted to spelling out the details of just how sexological thinking is dominated by the medical model.

Overall, many sexologists, including physicians such as Bancroft and most of the critics of overmedicalization, probably view the medicalization of sexuality as an initially benign development carried to excess and only now poised to do more harm than good. They subscribe to many elements of medical-model thinking and celebrate how the normative influence of medicalization has humanized areas of social deviance (e.g., drunkenness, insanity, rebelliousness) previously subject only to public cruelty or censure (Conrad & Schneider, 1980). They embrace what we might call a "weak" critique of medicalization.

Other sexologists, however, including myself and many who emphasize political and humanistic aspects of sexuality, see the medicalization of sexuality as largely inappropriate and always potentially dangerous--the incursion of an individualized, evolution-derived, biologically based, disease and malfunction model into what is better seen as a fundamentally relational, socially constructed sector of life. This critique emphasizes medicalization as a cosmology about the body and pathology which has gradually been permeating society since the late 18th-century Enlightenment (Frank, 1990, Jewson, 1976). We might consider this the "strong" critique of medicalization, and it is the perspective which shapes this essay.

The Medical Way of Knowing Sexuality

Medicine is a culture, a profession, a body of knowledge, and a way of knowing that has evolved in conjunction with technology and social values over the past several centuries. It employs a scientific, biological, "naturalized" view of the body and of health, "the medical model," that emerged in the late 18th century (Duden, 1991; Gordon, 1988).

Some sociologists and anthropologists have criticized the attempt to identify "core characteristics" of modern medicine as "almost as reductionist as the medical understanding it seeks to interrogate," (Atkinson, 1995, p. 29), and some medical practitioners, who define their viewpoint as more "nonreductionistic, holistic and contextual" than the medical model (Bloch, 1983, p. 5), might vociferously resist recognizing themselves in this essay.

It certainly is true that some areas of medicine are more strongly characterized by traditional medical model thinking than others, urology and gynecology more than family practice or psychiatry, for example, which helps explain why the medicalization (and overmedicalization) of sexuality are more apparent in some areas than others. Nevertheless, discussing basic themes is useful because many elements in "the" medical model permeate both professional and lay thinking and practice regarding sexuality.

Mind-Body Dualism

Mind-body dualism is one of the pillars of the medical model. The persisting separation of mind and body in medicine is reflected in the contemporary doctor's efforts to identify, separately, organic and psychogenic components of complaints and diseases, which has become standard modus operandi with sexual complaints. In fact, the DSM-IV (American Psychiatric Association, 1994) instructs a mental health clinician to first eliminate the possibility of a physiological, medical, substance abuse, or medication condition before assessing any psychological or psychosocial issues (Wylie, 1995).

In the nonpsychiatric physician's office, an increasingly common resource for people with sexual complaints, "real" disease (i.e., demonstrable biological pathology) is pursued first, and, when found, increases the doctor's time and interest in the patient (Kirmayer, 1988; McDaniel, Campbell, & Seaburn, 1995). There are many things to talk about: What will the next test be?; What are the options for treatment? If "nothing" is found, often the patient is told that "nothing" can be done, at least not by this physician.

The separable biological body (sans mind) lends itself to the image of "the body as a complex machine, of disease as the consequence of the breakdown of the machine, and of the doctor's task as repair of the machine" (Engel, 1977, p. 131; also Osherson & AmaraSingham, 1981). The body-as-mindless-machine metaphor is central to the medicalization of sexuality. It contributes an emphasis on sexual dysfunction as disturbance in sexual performance, it defines proper sexual function as dictated by the body's proper physiological function, it endorses the separate specialist evaluation of physical causes of sexual problems, and it is the essential underpinning for an explosion of basic physiological research.

Numerous attempts have been made by psychologists and sexologists to challenge the mind-body split when it comes to sexuality. "It is naive to classify a sexual problem as either organic or nonorganic," wrote Wincze in 1982 (p. 257), and probably someone or other every 6 months since. But thus far no model of sexuality in a unitary "body-mind," or in the relationship, or in the culture, has successfully competed with the prevailing medical model, which locates certain aspects of sexuality firmly in the mind and others firmly in the body.

Objective, Universal, Body

In the medical model, the separation of mind from body produces a universalized body governed by empirical laws and processes that work independently of social life, culture and history (Wright, 1982/1994). People have culture; bodies have physiology. There are several important consequences for sexology in this principle (e.g., the growing use of medical technologies, the questions that won't go away ["where exactly is a woman's orgasm?"], the persistent biological reductionism of research, and the attraction to transcultural concepts and categories such as "the human sexual response cycle"). In fact, some might say that sexology has had a major role in perpetuating the belief that there is a bodily sexuality which can be known, a belief which leads directly to a central tenet of overmedicalization, the idea that fixing the body's sexuality is a benefit in and of itself.

Technology seems to allow a body to be known directly, without distortions introduced by a person's psychology or culture, just as the positivistic model of science seemed to allow the natural world to be known directly, without cultural or historical prejudices. Doctors had long been skeptical about the reliability of patients' descriptions of their bodily experiences, suspecting that patients often misrepresented their experiences because of ignorance, miscommunication, or even a deliberate wish to mislead. They were delighted when technology allowed them to tap the objective, scientific, "truth" of the body directly (Reiser, 1978). The thermometer, invented in the mid-19th century, produced measurements thought to be beyond the patient's will and independent of all external circumstances, a paradigm for the explosion of chemical, electronic, and radiologic diagnostic tools in use today.

The wish to know the body's sexuality directly and the belief that there is a bodily sexuality which can be known contribute to the overuse of diagnostic technology in sexology today. The numerous technologies currently used to assess men's erections (e.g., nocturnal tumescence monitors, penile vascular ultrasounds, nerve conduction tests) assume that "erection" is a bodily function with objective norms and standards. The symbolic power of medical science is demonstrated when "normal" test results are used to prove to skeptical men that their erectile function is normal, because "technology doesn't lie" (Tiefer & Melman, 1989). The fact that technological facts often prove no such thing to many patients testifies to their incomplete medical model indoctrination, and presages the inability of many men to "follow simple instructions" in terms of erectile dysfunction treatment (Schuetz-Mueller, Tiefer, & Melman, 1995).

Duden (1991) described how reading the words of an 18th century German doctor shocked her into realizing that taking "the body for granted as an unchanging biological reality" (p. 3) is a fairly recent proposition. Modern education allows us to do this because our view of the body derives from the type of universalizing, unchanging image presented in textbooks and anatomical atlases. Patients often have different views, however.

One patient of the German doctor reported how the "wind" in her womb generated by an episode of sexual intercourse had "gone out through her ears" (Duden, 1991, p. 109). This is like Freud's patients whose neurosis-generated anesthetics corresponded to no known anatomical possibilities. Interpreting and understanding experiences of the body which do not correspond to our

professional, mechanistic, mind-body dualism takes more than a simple factual correction offered in a doctor's office. Perhaps this is one reason why many patients with sexual complaints are not currently being helped.

Debates within sexology which take the universal body for granted are common. Consider, for example, the perennial question of women's orgasm. Is there one type or more than one? Are multiple orgasms all "real" orgasms? Are orgasms "in" the clitoris, the vagina, the "urethral sponge," the "G spot," or some combination? The modern medical cosmology takes as an article of faith that all bodies have the same basic capacities and functions (we're not talking about Olympic skills on the balance beam here), thus perpetuating the search for the universal physiological bases of sexual experience.

Naturalism

Despite the fact that natural is "perhaps the most complex word in the language" (Williams, 1976/1983, p. 219), the naturalistic view of sexuality is practically a mantra within sexology.(n2) In the tradition of early sex reformer-physicians, such as Havelock Ellis and Magnus Hirschfeld, the zoologist Kinsey viewed sexuality as an objective (reliably measurable), material (bodily), transhistorical product of mammalian evolution (Kinsey, Pomeroy, & Martin, 1948; Robinson, 1976; Weeks, 1985). Kinsey's was the first Rockefeller-funded project on human sexuality following decades of sex research studying only animals' mating behaviors. The focus on animals had come about because the original 1920s Committee for Research in Problems of Sex was fearful of social ridicule associated with public discussion of human sexuality, but it also fit the naturalistic assumption of significant mammalian sexual uniformities (Tiefer, 1988).

Contemporary sexology has yet to come to terms with the legacy of decades of "basic" sex research on animals, such as hamsters, rats, rabbits, cats, dogs, and laboratory monkeys. Within sexology, mating behaviors of animals and sexual activities of people have been similarly described, measured, and theorized (Katchadourian, 1979), paving the way for the excesses of contemporary sociobiology. The medicalized language of contemporary sexology is the clinical language of sexual naturalism, wherein sexuality is a function of the body, like "excretion and respiration" (Kaplan, 1974, p. 2), which evolved through natural selection. To view sexuality as a function of the body is to open the door for medicalization.(n3)

Universalized Bodily Sexuality

Masters and Johnson's (1966) human sexual response cycle epitomizes the medicalized sexuality of universal human capacities, tendencies, and functions. They observed and reported a supposedly orderly and invariant sequence of neurogenital physical changes (vasocongestion, myotonia, and orgasm) which they claimed was the result of "a drive of biologic origin deeply integrated into the condition of human existence" (p. 127). Kaplan (1974) agreed that the universal sexual pattern was derived from evolution, "the object of which is to prepare the bodies of two mates for reproductive

union" (p. 5).

This combination of assumptions and observations generated alleged universal, biological, sexual norms which have formed the backbone of contemporary sexology. My analysis of their work suggested that the so-called universal backbone consisted far more of assumptions than observations, however, because Masters' and Johnson's subject selection criteria and research conduct ensured similar responses from their research participants (Tiefer, 1991a). The sexual body did not speak directly to Masters and Johnson. Rather, they coached the people whose bodies were being measured and carefully selected research participants whose sexual styles would conform to the measurements they wanted to get. The important thing about "the human sexual response cycle" is the way it so perfectly filled a social and professional need for a bodily, biological, universal, natural sexuality that, 3 decades later, it continues to be sexual dogma and to completely dominate our field.

The current diagnostic manual of the American Psychiatric Association (APA) relies foursquare on these universalized biological norms: "A sexual dysfunction is characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse" (American Psychiatric Association, 1994, p. 493). As we will see later, diagnoses are central to medical management, and the normative APA list of sexual dysfunctions (together with its lists of paraphilias and gender identity disorders) thus provides an essential element for a medicalized clinical sexology.

Individualism

In biomedicine, illness is something an individual gets. A family can be in a car accident, but it will be Jim's broken bones or Jean's whiplash. The individualism of medicine rests on the image of disease being in the body. "The body-centered, body-limited medical model has been and remains today the defining paradigm for our professional and philosophical conceptions of health" (Wright, 1982/1994, p. 46).

Even in psychiatry, the individualism of the medical model persists. The APA's "official" list of mental disorders announces at the outset, "each of the mental disorders is conceptualized as a . . . pattern that occurs in an individual" (American Psychiatric Association, 1994, p. xxi, emphasis added). This individualism includes all the sexual dysfunctions and sexual disorders listed in the psychiatric manual. Only a person can have a sexual problem. Schnarch (1991) disputes this when he insists, "sexual dysfunction is not a disease process.... [This] perpetuates the misguided notion that sexual dysfunction and disinterest reside within a single individual" (p. 224), but his family systems model has less chance than David against Goliath at the moment.

The only couple-diagnosed sexual complaint in widespread use is the notion of "desire discrepancy," (Zilbergeld & Ellison, 1980) and even that is used only in desperation, when individual diagnoses seem inappropriate (Leiblum & Rosen, 1988, p. 8). Verhulst and Heiman's

(1988) suggestions of problems in synchronization or coordination of sexual rhythms, or Levay and Kagle's (1977) notions of deficiencies in pleasure, intimacy, and cooperation (which they called "ego" deficiencies but which could be adapted for couple assessment), seem to bounce off the individualistic medical model without making a dent. Although we showed years ago that wives and husbands tell different stories about presumably joint, shared, sexual problems, the inclusion of partners never became routine in assessments of men's sexual problems (Tiefer & Melman, 1983).

A Coalition on Family Diagnosis formed in 1987 to petition the American Psychiatric Association to add "relational diagnoses" to its next edition (Kaslow, 1996). Such diagnoses (e.g., "relationship conflict" or "chaotic enmeshment") would use as their starting point "what symptoms can tell us about the interaction among family members" (p. 7) rather than always and only what symptoms signify about an individual person. This politicking resulted only in the blandest of relational diagnoses ("partner relational problem," "sibling relational problem") being listed in a catchall category at the end of the manual, "Other conditions that may be a focus of clinical attention" (American Psychiatric Association, 1994, pp. 680-681). In the medical model, individuals have sexual problems, and so individuals are referred, evaluated, and treated.

Biological Reductionism

Another pillar of the medical model, biological reductionism, is the idea that medical phenomena can ultimately and with greatest precision and generalizability be understood via research on their constituent biological elements (e.g., biochemical or neurophysiological processes) (Engel, 1977). Research on the smallest units is "basic" research, and discoveries made at the molecular level are assumed to have clinical consequences at the molar level. Likewise, clinical interventions at the molar level are assumed to require research at the molecular level. An immensely active program of "basic" research on the physiology and biochemistry of the penis, for example, is claimed not only germane but necessary to help men with sexual problems (Furrow & Wagner, 1989). One can only assume that this philosophy will result in an ever-growing literature on the connection to sexuality of every possible biological element.

Sherif (1979), by contrast, argued that physiology and biochemistry are defined as basic, "not because they can necessarily tell us more about a human individual than religious history or sociology, but because physiology and biochemistry are more prestigious" (p. 100) due to the successful promotion of reductionistic ideas and the power of technical language to intimidate the uninitiated. Thus, proponents of the medical model hold that scientific research discovers basic physiology which can beneficently be applied to individuals' medical problems, whereas critics of medicalization claim that scientists aggressively promote basic research for personal ends while using social need as justification (Nelkin, 1987).

Have the disciplines which work with molecular units in sexuality actually been of use? Although we definitely understand the physiology of the penis better than we did a decade ago, and although it is possible that such research may have contributed to pharmacological treatments for erections,

most current injection therapies were accidental by-products of drugs already in use for other purposes, and it seems that the same is true for the oral medications now on the horizon (Rosen, 1996; Wagner & Kaplan, 1993).

It seems heretical to challenge the validity or utility of basic research, especially medical research. It is almost a commandment that we can only cure cancer (or anything else) when we understand the most elementary properties of cells and how they interact with each other. But radical geneticist Lewontin (1993) argues that "we have become so used to the atomistic machine view of the world that originated with Descartes that we have forgotten that it is a metaphor" (p. 15). Many aspects of life "cannot be broken into independent parts to be studied in isolation, and it is pure ideology to suppose that [they] can" (p. 15). Sexologists need to evaluate whether and to what extent basic biological research contributes to effective sexuality interventions before we continue unthinkingly to endorse its importance.

Reified Diseases

When Engel (1979) indicated that "the biomedical model is disease-centered" (p. 260), he made the important point that, in the medical model, diseases, in contrast with people, are the focus of interest.

Patients have the rather naive view that when they are sick and go to doctors, the doctors are trying to find what the matter is. That is not the case. Doctors are trying to find out whether a disease is present. (Cassell, 1986, p. 26)

Reification is most prominent in those situations when a patient is referred to a specialist because of one particular problem and will not be seen again once that problem is diagnosed and ameliorated. In such situations, "the assumption is [made] that diseases are real entities, and the [doctor's job is to] ascertain the presence or absence of a specific disease in any particular case" (Mishler, 1981a, p. 145). Reification results in the attitude, for example, that because premature ejaculation can be effectively altered by medications, that premature ejaculation is a condition which can be described and treated without knowing anything about the culture, life circumstances, or individual history of the person so diagnosed. If the patient fails to comply with the prescription regimen, that failure is not the fault of incorrect diagnosis or treatment, but is a failure due to "nonmedical" psychological, cultural, or relationship factors!

Sexologists play into this reification, albeit unwittingly, when a urological or gynecological consultation is sought for expert biomedical knowledge of specific organ systems. The referral may be made to "rule out" physical pathology before psychological therapy can commence, or the referral may be made because psychological therapy is not progressing satisfactorily. In either case, the specialist's exclusive focus on ascertaining the presence or absence of disease can seem straightforward and appropriate. However, diagnostic evaluations are done on people, not organs; they are conducted by people, not robots or machines; and they are conducted in an atmosphere of

information and expectations provided by popular media. The patients have problems they want solved, and the specialists are in the business of solving problems. The specialist gives the problem a diagnosis with which s/he is familiar, and often offers a trial of medical treatment. Why should this surprise us? A pre-existing framework has taken over, and the result is the kind of overmedicalization sexologists are complaining about.

Referral to a specialist physician to "rule out" organic problems is an example of how the clinical sexologist often subscribes to a medicalized model of sexuality. Such referrals would be far less common if sexologists believed in the inextricability of mind and body, privileged sociocultural variables over biological ones in the causation and maintenance of sexual problems, construed sexual problems as fundamentally couples' problems, and ignored so-called universal sexual norms.

The conceptual alternative to reification is to view diseases as labels which arise in culture rather than "in" the body. Premature ejaculation is obviously influenced by cultural values (relating to gender, pleasure, and sexual scripts), and medication might sometimes be an appropriate element in a treatment plan. A nonmedical way to view premature ejaculation or any other sexual complaint is as a discrepancy from the normative sexual script which might be appropriately addressed by script changes, attitude changes, medications, psychotherapy, education, etc. Under certain circumstances, drugs or other mechanical interventions may be helpful, but universal diseases will not be the objects of treatment.

Conclusion: The Medical Way of Knowing

There is a vigorous debate ongoing in contemporary psychology over whether clinical psychologists should strive to obtain prescription privileges. Protagonists argue that because medication is effective in the treatment of psychological disorders, and jobs are awarded to candidates with the broadest range of effective treatments at their disposal, psychology must rise to the challenge of mastering the necessary knowledge and skills (e.g., DeLeon & Wiggins, 1996). Antagonists argue that the effectiveness of medications is exaggerated, but, at any rate, that effectiveness is beside the point (Hayes & Heiby, 1996). They suggest that "the medicalization of psychology would [cause]...an irreversible qualitative shift in the discipline . . . [and would impose] an alien biomedical model" (p. 202). That is, prescription privileges would not merely add biological assessment and treatment devices to the practice of clinical psychology, but would alter many peculiarly psychological ways of thinking about human behavior and problems. In my lengthy exegesis on elements of the medical model, I have attempted to examine medical ways of knowing so that understanding biological assessment and treatment in sexology would not similarly be oversimplified or merely regarded as an "addition."

The Medical Way of Doing Sexology

Conceptual assumptions are not listed in medical textbooks as a code of principles for beginners to memorize. Rather, they are deeply embedded in everyday practices (Gordon, 1988). How do the

roles and activities of sexologists, medical personnel, and patients incorporate and promote the medical model principles of mind-body dualism, body universality and objectivity, individualism, biological reductionism, and reified disease?

Diagnosis

Doing medicine centers around diagnosis (Atkinson, 1995). Diagnosis plays a role in modern medical practice not unlike that of orgasm in modern sexual practice--it legitimates the activity, it displaces other purposes, one "reaches" it after focused effort, participants feel socially lost without it, efforts toward it can persist long after common sense might dictate halting, and it operates as both verb and noun!

Diagnosis is both a process of assigning a disease label and the label itself (Blaxter, 1978).

From diagnosis, which gives a name to the patient's ailment, the thinking goes chronologically backward to decide about pathogenesis and etiology of the ailment. From diagnosis also, the thinking goes chronologically forward to predict prognosis and to choose therapy.... The taxonomy used for diagnosis will thus inevitably establish the patterns in which clinicians observe, think, remember and act. (A. R. Feinstein, *Clinical Judgment*, 1967, p. 73, quoted by Mishler, 1981a, p. 144, my emphasis)

Were it not for the legitimacy offered by the formal diagnosis of erectile dysfunction/impotence, which sexologists have contributed to in countless ways, the current diagnostic overmedicalization would not be possible. For example, franchised "Impotence Centers of America" around the United States advertise widely and provide a standard diagnostic workup for a standard fee (\$550 as of September, 1996), regardless of medical, psychological, or relationship history. What could be more mechanistic? I wonder how men and their sexual partners experience such a check-up, and how it will be used in-, say, pre-nuptial and divorce agreements. The universalized concept of the erection legitimates this enterprise.

Decades of social science analysis has reframed medical diagnoses, especially in the case of mental conditions, as "labelling," concluding that the clinical gaze, purportedly objective, biological, and scientific, often simply reproduces sociocultural values in medical language (Brown, 1995). In sexual science Kinsey noted the irony of producing "scientific classifications . . . nearly identical with theologic classifications and with moral pronouncements of the English common law of the 15th century" (Kinsey et al., 1948, p. 202). Kinsey was particularly concerned with the unacknowledged cultural norms about sexual deviance at the heart of the clinical gaze. As a feminist, I have described how what seem superficially to be purely biological sexual dysfunction diagnoses can perpetuate the social devaluing of women's sexual interests (Tiefer, 1995). The franchising of Impotence Centers will push women's sexual concerns further to the periphery as phallic function continues to be the centerpiece of sexuality.

Technology

On each occasion that "the body is transformed into a series of signs and representations by means of a complex array of technologies of inspection," the mystique of the medical model is promoted (Atkinson, 1995, p. 62). But, technology only measures what experts have already decided was worth measuring, and even then, the numerical and radiographic outputs of machines must be interpreted. Nonspecialists often are so dazzled by technology that they fail to notice how many ambiguous layers of human opinion and thought are involved.

Clinical sexology and sex research have used technology as a "sexological lie detector," hoping to circumvent self-report and get the body to directly reveal its deviant sexual interests (Rosen & Beck, 1988, p. 221). Yet, the use of such technologies often raises more questions than it answers. In fact, several articles in each issue of this very periodical, now in its 7th year of publication, are devoted to attempts to untangle and unravel complex methodologies--what did we study? what did we find? what did we omit? Patients (and research participants), with values and beliefs, think and feel throughout technological processes, and constantly interpret the meaning of the tests and technicians' behaviors (Gerteis, Edgman Levitan, Daley, & Delbanco, 1993). Yet this is rarely acknowledged, and its consequences are unknown. Sexologists are as attracted as others by the elusive "objective technology" which will allow us to get directly at sexual "truth."

Perfectibility and Risk Reduction

The contemporary medical model fosters dependence on experts through the discourse of risk reduction and the allure of perfect health (Barsky, 1988; Lupton, 1995). Because, it is alleged, small problems unattended to will eventually become larger and more difficult to fix, early detection of disease is touted as a moral responsibility, and people who feel perfectly well are encouraged to worry about their health and to visit doctors "routinely." The discourse of "risk" offers optimism in that one can reduce risk through responsible action, yet at the same time it fosters anxiety.

The allure of perfect sexuality is part of the current overmedicalization. For reasons to be discussed in a later section, most people have good reason to be anxious about their sexual adequacy in contemporary times. Standards are high and inadequacy is highly stigmatized. Dependence on medical experts in this anxious time is maintained by promoting freedom from worry through accurate medical check-ups and effective medical treatments. One of the primary results of advertising the prevalence of sexual problems is to maintain social anxiety and to increase the public's demand for appropriate services. If the advertisement further insists that sexual problems are largely medical, the public will demand and flock to medical experts.

Patient-Doctor Encounter

Sexual medicalization occurs in the intimacy of the patient-doctor relationship as doctors'

knowledge, authority, and communication strategies allow them to control encounters with patients and to keep discussion focused on biomedical concerns. Todd (1989), for example, demonstrated how gynecologist-patient conversations inexorably become dialogues focused on biology and body parts regardless of patients' worries and concerns about any other related issues.

Balint (1957) first pointed out how patients initially tell about personal worries and troubled relationships and report vague and unfocused complaints, and that then, together, the patient and doctor "negotiate" an illness and proceed with a conventional diagnostic workup (Ransom, 1983). Through routine steps practiced over many years, the physician attends to and selects a subset of symptoms that will allow him or her to match the patients problems to a particular symptom cluster or syndrome representing a specific disease. Thus, the patient's illness is "diagnosed." (Mishler, 1981b, p. 8)

There have been no similar studies describing and documenting how sexual worries and concerns become transformed into formal sexual dysfunction diagnoses, yet I certainly have seen this process (and facilitated it) innumerable times working in a hospital-based sexual dysfunction clinic. The more routinized the encounter or pressured the time frame (check-lists handed out by the receptionist, brochures in the waiting room describing specific dysfunctions and treatments, residents prepared to deal with a narrow spectrum of sexual topics), the more likely each patient's concern will acquire a medical label and workup. Third-party reimbursement constraints further promote this process. Because sexual disclosures and frank discussion are so unfamiliar and uncomfortable, both doctor and patient probably welcome the manageability offered by medical sexuality designations.

Bodies in Sex Research

Sexuality as bodily performance characterizes more than clinical sexology; behavioral sex research in general has adopted a detached, individualizing gaze (DiMauro, 1995). As we have seen, American sex research focused on animals for several decades to avoid accusations of sexual "prurience." When it became possible to study people's sexual experience in a "scientific" way, the quantitative survey tabulating acts and attitudes became the paradigm.

Sexual meanings as they are shaped in cultural context have been largely ignored, a situation now much regretted in AIDS research (Giami & Dowsett, 1996). Because questions about homosexuality focused on acts taking place between same-sex partners, significant cultural differences in meaning were ignored. It now seems that those meanings make an enormous difference in public health campaigns, and that the emphasis on objectivity, individualism, and generalizable results in behavioral sex research has been short-sighted in the case of AIDS prevention (Daniel & Parker, 1993).

Is there any way to get sexual meanings into the explosion of research on the penis discussed earlier? Can sex research study multiple, interpersonally constructed meanings of erection instead

of always and only construing sexual erections of the penis as a universal, biological function? When I argued at the NIH Consensus Conference on Impotence that "different men and different couples expect and rely on different degrees and durations of penile rigidity to accomplish their sexual goals," and that, therefore, there could be no "standard normal erection," this view fell outside the biomedical lens (Tiefer, 1992). Medicine currently views erection as a universal means to an end determined by evolution, not by culture and choice.

This narrow view of erection promotes biological reductionism. The first issue of *The International Journal of Impotence Research*, for example, announced that it would be "concentrating our interest on the normal and pathological function of a single organ" and that "basic" research would occupy much of the publication space (Furlow & Wagner, 1989, p. iii). Similarly, in a recent urologic overview it was asserted

It is only in the last decade that the rigors of a more scientific approach to this dysfunction of the corporeal cavernosal tissue have begun to unlock some of the causes of and treatment for this disorder. (Lewis, 1995, p. 63, emphasis added)

With no concept of erection save the biomedical one, we can foresee the next decade full of (a) biological discoveries leading to increased penile testing for physiological abnormalities, (b) increasingly sophisticated (read: expensive) technology to measure and treat penile physiology, (c) increased demand for medical remedies to treat the physiological abnormalities (as well as the iatrogenic consequences of both treatments and evaluations), and (d) increased publicity about "risks" of penile dysfunction and the need for early detection. One would have to speculate as well that it is only a matter of time before some version of this biomedical explosion becomes available for women's sexuality.

Sexual Medicine and Morality

The old-fashioned view of scientific objectivity leads some to believe that nature is indifferent to good and bad, to human values and morality in general (Gordon, 1988). Yet, medicine is actually a deeply moral exercise, a factor which is especially important in politically contested zones such as sexual behavior. From the perspective of medical sociology and cultural studies, medicalization is one of the primary ideologies of social regulation, and thus the assumptions and practices of sexology not only guide professional work but have broad social consequences. If we sexologists ever saw ourselves as neutral and value free, that epoch is over. Now the question is: Are the values of medicalization the ones sexologists want to transmit?

Norms and Normativity

The central moral component in the biomedical model is the health norm, the demarcation between good and bad in the world of medicine. Diagnostics searches for abnormalities; assessment technology calibrates deflections from standard values; benign variation from a health norm is a

contradiction in terms. "All commentators agree that the concept of disease as deviation from a biological norm dominates medical thinking and practice at the present time" (Mishler, 1981b, p. 4).

The idea of objective standards for health developed after the 18th century as the establishment of clinics and hospitals and systematic procedures of record-keeping allowed the collection and classification of health information (Lupton, 1994). The comparison of any one individual's condition with generalized norms gradually replaced more idiosyncratic conceptions of health and dysfunction (Armstrong, 1983).

Objective standards for healthy sexual behavior and experience have been the provenance of sexology, the science of sexuality. But are sexual norms the result of scientific laboratory and clinical work, or are they, to repeat Kinsey's ironic language, "scientific classifications . . . nearly identical with theologic classifications and with moral pronouncements of the English common law of the fifteenth century" (Kinsey et al., 1948, p. 202)?

Sex reformers over the century have sought to use scientific authority to overcome sexual prejudice. Two years after Nazis burned the magnificent collections in his Berlin Sexology Institute, for example, Magnus Hirschfeld could insist, "I believe in Science, and I am convinced that Science, and above all the natural sciences, must bring to mankind, not only truth but with truth, Justice, Liberty and Peace" (Hirschfeld, 1935, quoted in Weeks, 1985, p. 71). Reformers like Havelock Ellis and Hirschfeld believed they could use medical science to argue that masturbation, sex for pleasure, oral-genital activities, sexual fantasy, and homosexuality were not sinful, were not sick, but in fact were healthy and normal. But, how do you prove health claims such as those? Can it be that our current period of overmedicalization is the ultimate result of sexologists' well-intentioned complicity with the medical model which began almost a century ago?

Proper Physical Function

In the medical model, each part of the body has a proper function, thought of as its natural function, shaped by evolution over millennia and discoverable by basic scientific research. This medical body is now highly sophisticated and finely tuned, like a symphony orchestra or an orbiting satellite, its components interdependent and necessary for survival and health.

The meaning of "proper function" has special normative implications regarding sexuality (Macklin, 1987). Because medicine views the functional body as ideally designed by nature for evolution's purposes (i.e., survival and reproduction), uses of body parts in ways "contrary" to nature, that is, contrary to evolutionary intention, can easily be criticized. Thus, ironically, although Kinsey, Hirschfeld, and other reformers used the rhetoric of natural sexuality to combat social disapproval, the meaning of naturalism in the medical model ("according to evolution's design") gives all justifying authority to evolution, and thus can actually perpetuate criticism of many "unnatural" forms of sexuality.

The Moral Imperative of Health

The third important moral element in the medical model is that being healthy has become a matter of orthodoxy. Surveys show that health is rated the greatest source of happiness in life and the most important quality to preserve, that Americans think about health more than about romance, work, money, sex, or any other single topic, and that guilty feelings closely follow failure to comply with principles of healthy living (Barsky, 1988). Mass media promote health information over every airwave and on every newsstand, informing, reminding, advising, and chastising, just in case the topic should ever slip from consciousness.

The ideology of healthy living has acquired the status of a moral code, with public "signs" of unhealthy living (e.g., being obese, cigarette smoking, letting a child or pet eat something from the floor) being severely stigmatized. The fact that many, if not all, such habits were sources of moral censure long before they became medicalized illuminates how "sin becomes sickness," how diagnostic labels import social values (Conrad & Schneider, 1980).

As the imperative of sexual adequacy has grown over the 20th century, being sexually "normal" has become regarded as a matter of physical and mental health. The viewpoint that sexuality is a universal evolutionary drive which will be expressed (normally or abnormally) or repressed can probably be credited to the Freudian revolution, but it is the overall medicalization of everyday life that has made being sexual (in the proper way) so important to the contemporary person's own sense of health.

The imperative to be healthy produces the final moral element in the biomedical model: the sense of shame a person acquires along with an unhealthy or abnormal condition. Becoming ill is often regarded as a person's fault, as evidence of an unhealthy life (or "lifestyle"), because biomedical norms have taken so much from centuries of Judeo-Christian beliefs about sin and retribution (Seymour, 1989). "Causal responsibility and moral blameworthiness have become interchangeable terms of discourse" (Smiley, 1992, p. 13).

This is the exact opposite of the initial theory of medicalization, which proposed that a person would be exonerated from blame if a condition were labeled a sickness, because medical conditions were supposedly due to factors beyond a person's control: alcoholism rather than drunkenness, hyperactivity rather than disobedience, mental illness rather than criminality or foolishness (Conrad & Schneider, 1980). However, as an increasing number of conditions (e.g., cardiovascular illness, backaches, dental diseases, cancer) are said to be preventable through healthy living, the expanse of moral exculpation shrinks (Barsky, 1988). "Healthy living," of course, being still as much a moral as a scientific term, we see the paradox of medicalization during the AIDS epidemic: You are regarded in a humanitarian way when you are sick with AIDS only if you acquired the condition through "no fault of your own," (i.e., proper living) (Patton, 1996).

Even with conditions not flagrantly moralized, more than simply a medical label is now required to

avoid shame for being sick. When physical examination and medical technology uncover physical abnormalities, a condition is thought "real" and "in the body," (i.e., not just reliant on self-report), and thus a patient will more likely be relieved of blame for his or her condition (Kirmayer, 1988). Proof of genetic determinism offers an especially strong moral escape valve, one reason for the breakneck search for genetic origins of socially stigmatized behaviors, such as homosexuality and mental illness (Nelkin & Lindee, 1995).

Thus, the medical model has many moral elements, and medicalization is deeply connected to social regulation of right and wrong. For the purposes of evaluating the medicalization of sexuality, it is important to realize how medicine currently influences the determination of sexual values. Where do we get sexual norms? From evolution? From cultural standards dressed up in biological language? Is it appropriate for people to feel unhealthy if they don't "do" sex in some prescribed way? Once we relinquish the Enlightenment belief that "nature" can speak directly to us, it seems inevitable that we must look elsewhere for our values than to medicine (Weeks, 1995).

Sexuality in the Late 20th Century United States

Sexual life during the 20th century was ripe for medicalization because of important social changes affecting sexuality, on the one hand, and people's dearth of resources and skills for understanding sexuality on the other (Tiefer, 1994b). Changes in gender roles, marriage, and views of women's sexuality have augmented the importance of sexual adequacy. In most parts of the industrialized world, the old economic and patriarchal system of marriage has gradually yielded to a more egalitarian and companionate ethic which valued personal, emotional, and sexual satisfaction. In addition, liberalized laws have permitted more open display and discussion of sexual topics, and many commercial enterprises, chief among them mass and entertainment media, have raised the noise level about sexuality to a cacophony.

On the other hand, a continuing heritage of guilt and confusion from repressive religious and family sexual messages, the absence of candid sexual conversation among peers, and the lack of useful sex education have all contributed to making people ill-at-ease and ill-informed about many aspects of sexuality, despite the din all around them. Sex is far more often joked about than talked about. Periodic moral panics about sexual disease and sexual crimes (especially against children) serve to give a face to the pervasive sexual uncertainty and worry.

Under these circumstances, people are secretive and insecure about their sexual feelings and problems, and are attracted to authorities who promise definitive, objective knowledge. Although the public's level of trust is declining, doctors continue to have great cultural authority, and there is a clear lack of alternative sources of expertise and confidential advice.

Media, Sexualization, and Medicalization

News media heavily promote the message that "going to the doctor" is the correct course of action

for sexual worries; their advice, also, seems objective and authoritative. In general, the media favor medicalized sex because they can take advantage of the public's great interest in the subject while avoiding any taint of obscenity or pornography.

A full discussion of the many and varied kinds of media accounts of sexuality is greatly needed. Communications media have used sexual stories and images to attract readers and sell products since the town crier and the earliest graphic artist! Since mid-19th century improvements in the printing press, however, each new technological development in mass media seems to have provided a geometric increase in opportunities to teach, to scandalize, and to sell to a public perpetually fascinated by sexual subjects. Each time we seem to have reached the saturation point, another sexual topic emerges in a new communications medium.

I wish we had effective ways to study the impact on people's and couples' sexual scripts of television talk shows, sex advice magazine articles, personals ads, X-rated and non-X-rated films, weight-loss and deodorant ads, home videos, titillating clothing or perfume ads, and internet sexuality chatrooms. I can only speculate that the constant bombardment of sexual messages leaves no person's sexual life unaffected. One consequence of the dominance of biomedical thinking in sexology and the universal, naturalized sexuality it promotes is deficiency in our methodologies for understanding the impact of television talk shows or decades of advertisements for hygiene products.

Health media promote a medicalized sexuality by overemphasizing sexual problems as matters of sexual disease and dysfunction. In discussing erectile problems, for example, Jane Brody and other "Personal Health" columnists of The New York Times repeatedly mention contributions of physical medical factors such as diabetes and medications, while omitting factors such as escalating performance standards (Brody, 1995a, 1995b, Blakeslee, 1993). In fact, by insisting that, "if nothing interferes with the erectile response, men can remain potent and capable of enjoying sexual intercourse into their 90s," Brody (1995a, p. C9), citing no research other than the usual, "experts have found," herself contributes to a preposterous standard.

The health and science media legitimize and model medical thinking and conduct by quoting medical experts, using medical terminology, and swiftly and enthusiastically publicizing new medical devices and pharmaceuticals (Parlee, 1987).

Media and the numbers game. One of the most important ways in which the news media medicalize sexuality is by disseminating epidemiological information which exaggerates the prevalence of medical factors. In 1988, for example, Brody's column began with what has become the mantra of the overmedicalization of erectile dysfunction, "Less than a decade ago, more than 90% of impotence cases were attributed to emotional inhibitions . . . but . . . experts say that more than half, and perhaps as many as three fourths of impotency cases have a physical basis" (Brody, 1988, p. B4). By 1995, her influential column read

Perhaps the most important development in the treatment of erectile dysfunction has been the nearly complete reversal of the long-held belief that in 80% of cases the problem was due to psychological factors. It is now recognized that about 70% to 80% of cases have a physical cause . . . and that emotional factors like anxiety about sexual performance, undue stress or guilt are common causes of impotence only among the relatively few young men with erectile dysfunction. (Brody, 1995a, p. C9)

Unnamed experts and uncited research are credited with generating a major shift in knowledge about sexual problems. This climate of conviction built throughout the 1980s, as articles on the front page of *The Wall Street Journal* and in national and regional magazines all claimed that "new research" showed that "impotence" was "almost always" organic (Blaun, 1987; Stipp, 1987; Toufexis, 1988).

The steps by which this "shift" came about require more detail than can be provided here, but they involved significant publicity regarding particular research and commercial developments. As with Masters and Johnson's research, the media are very interested in medical sexual developments, and publicity is easy to obtain. In no case, however, was there reported or can I or anyone else locate the sort of epidemiological research which would justify the prevalence claims which were made.

Medicalized Claims-Making

Medicalization proceeds in stages and involves competitive claimsmaking (Conrad & Schneider, 1980). Once some behavior has been labelled deviant or undesirable, it only becomes accepted as a medical problem if the public and members of other professional communities become persuaded that the behavior is a matter of health and disease and relates to norms of biological functioning. The media's readiness to publicize claims about the medical etiology of erectile dysfunction gave credibility to what would otherwise have been transparently self-serving claims made by urologists, penile prosthesis manufacturers, or pharmaceutical companies.

The claims about medical origins for sexual problems were institutionalized in the current edition of the American Psychiatric Association's diagnostic manual. Seven new diagnoses were added to the latest edition to cover "sexual dysfunctions due to a general medical condition" (American Psychiatric Association, 1994, pp. 515-518). In order now to make a proper differential diagnosis, the clinician is obligated to fully investigate any possible relationship between sexual problems and medical conditions. "A careful and comprehensive assessment of multiple factors is necessary to make this judgment" despite the fact that "there are no infallible guidelines for determining whether the relationship between the sexual dysfunction and the general medical condition is etiological" (both quotes, American Psychiatric Association, p. 515). Mandatory medical consultations for lack of sexual desire, erectile problems and dyspareunia will predictably result in overmedicalized treatment and a variety of iatrogenic effects.

Changing Professional Realities

Economic and political developments are transforming the professional practice of medicine as dramatically as technology transformed medical theory and treatment. Changes in the conditions and climate of medicine will profoundly influence clinical sexology as well (e.g., corporatization of health care delivery, competition from "alternative" health care providers, changes in specialization patterns and special interest organizations, the increasing delegation of aspects of work to less costly providers, and the growing domination of pharmacology in medical care) (Hafferty & Salloway, 1993; Shore & Beigel, 1996).

Some political influences can already be seen. Since 1980, the American Psychiatric Association's classification system has had a medicalizing impact on sexology in several ways: It has influenced how the federal government funds sex research (Persons, 1986), it has affected the third party reimbursement of clinical sex treatment (Kiesler & Morton, 1988), and its tremendous cultural authority has dominated much of sex education and discussion of sexual behavior in the courts. In these ways at least, the narrow, biological, performance orientation which dominates the conceptualization of sexuality in the APA classification system will continue to medicalize the construction and management of sexuality, unless some alternative perspective is offered.

Practice Guidelines

The expanding role of practice guidelines within medicine has particular implications for clinical sexology and for our discussion of medicalization (Woolf, 1990, 1992, 1993). Woolf reviewed the increasing prominence of practice guidelines in recent years as a result of rising health care costs, large variations in practice, and reports of inappropriate care. He described how medical and surgical traditions of informal consensus are giving way to more formal processes whereby scientific evidence (in the form of published data) and expert opinions are presented at brief conferences and compiled into expert reports which specify guidelines to be used in the care of particular conditions or when employing particular procedures. Finally, he reviewed the evidence of how guidelines are influencing clinician behavior, clinical outcomes, legislation, and malpractice coverage.

To my knowledge there are no practice guidelines yet developed for any sexual problems, but we are coming close in at least one of the more medicalized sexual areas. In 1992 there was a government-sponsored "consensus development conference" on "impotence."⁽ⁿ⁴⁾ The scientific evidence prepared for the conference was compiled in a 1986-1992 bibliography of 956 items (Beratan, 1992). Of the 19 database search strategies described, only 3 included anything clearly sexological (e.g., "psychosexual disorders" or "libido"). All the others had to do with "penis," "impotence," "erection," various diseases (e.g., diabetes), or medical treatments.

The 21 "experts" appearing at the conference and allotted 20 minutes each included 5 sexologists (Althof, H. S. Kaplan, Masters, Osborne, and Tiefer), one epidemiologist (McKinley), and 15 urologists or basic scientists whose research focused on the biology of the penis. Three highly published urologists (Lue, Goldstein, and Morales) gave a total of 8 of the 27 presentations. The

panel chosen to prepare the report consisted of 14 members, including 6 urologists and 1 sexologist (Zitrin). There were no participants from any social science or humanities discipline.

Consequently, the report is suffused with a medical model orientation which reifies "impotence" and discusses details of physiology endlessly and with great sophistication and detail. However, it throws psychological factors into long lists of "risk factors" such as "lack of sexual knowledge, poor sexual techniques, inadequate interpersonal relationships or their deterioration" (Impotence, 1992, p. 11). The report mentions the partner only briefly and discusses nothing about differences among partners. It deals with erectile troubles as an individual man's problem, and recommends that diagnostic evaluations be multidisciplinary, "when available" (p. 13). In other words, this report represents a "consensus" from the traditional medical model point of view.

I suggested to Arnold Melman, co-editor of International Journal of Impotence Research that the final report be published in his journal, along with comments from a range of respondents. I provided a list of 31 sexologists (covering six countries), but only 14 of them chose to write a comment.(n5) In addition, there are comments from 18 urologists. These commentaries provide a dramatic illustration of the differences between the two groups' views of sex, erections, men, couples, treatment, nomenclature, and, of course, the consensus development conference report itself. To oversimplify only slightly, the urologists loved it and the sexologists said it was seriously incomplete. This provides a worrisome note as we enter the era of practice guidelines.

The fact that so few sexologists participated in the consensus development conference occurred because no sexologists participated in the planning for the conference (Impotence, 1992, pp. 32-33). The topics, speakers, and time allotment were not truly multidisciplinary and thus represent another example (along with the DSM) of the institutionalization of medicalization, the final stage of the sociological process outlined by Conrad and Schneider (1980). However it has come about, sexologists have yielded authority over erectile dysfunction to urologists. For the moment.

Postmedicalization

In the hundred-year period from the 1860s through the 1960s much of what was published on sexuality was authored by "medical authorities," who wrote from the perspective of a biological and gender imperative....These medical authorities who theorized about sex increasingly came to be known as sexologists.... Over the past 10 or 15 years ... scholars in history, other social sciences, literature and the humanistic disciplines have begun to study sex and gender from radically different viewpoints, and new theoretical perspectives have been developed by such individual theorists as Michel Foucault, by feminist thinkers, and by gay studies specialists; the study of sexuality will never be the same. (rout, 1992, pp. 1-2)

Sexologists have been intimately involved in the medicalization of sexuality. Irvine (1990) argued that sexologists were attracted to conceptualizing sexuality within a medical model because of our needs for respectability, professional legitimacy, and financial opportunity. I agree, but would also

direct attention to our moral and political goals. Many sexual researchers and reformers have been attracted to the naturalistic and normative elements of the medical way of thinking because they believed that these would offer moral legitimacy for variations in sexual behavior, sex education, liberalization of obscenity laws, contraception and abortion, and sexuality research. Hirschfeld's commitment to the promise "that Science, . . . must bring to mankind . . . Truth, Justice, Liberty and Peace" (Hirschfeld, 1935, quoted in Weeks, 1985, p. 71) is still widely shared within sexology, but the redemption of sexuality from a repressive and conservative discourse by the bright, shining beam of medical science has proved elusive.

Fout (1992) offered us the kinship of "history, other social sciences, literature and the humanistic disciplines" as companions to our medical science in a joint investigative effort (p. 2).⁽ⁿ⁶⁾ This may seem an unwieldy, and to some, an impossible, mix. Certainly, one cannot simply add a few historical and sociological insights to traditional medical-model thinking (Clark, 1993; Tiefer, 1991b). Rather, I am suggesting a transformative synthesis, such as has been offered by research in medical sociology and medical anthropology on healing and normality (e.g., Lupton, 1994; Turner, 1995), and by research in cultural studies and history of diverse meanings of the body (e.g., Csordas, 1994). These lines of scholarship offer in common a challenge and alternative to "medicocentric" discussions of sexuality. Sexologists looking to rescue sexuality from medicalization cannot expect to conduct business as usual either in the lab, the library, the consulting room, or the conference auditorium with these new allies. Naturalistic sexuality will have to yield to a more inclusive, more postmodern, playing field.

But, hey, what else is a new millennium for?

(n1) A distinction can be made between "the medicalization of sexuality" and "the medicalized construction of sexuality." The former implies an already-existing domain of behavior or problems, sexuality, which comes to be located under the medical rubric by a social process, medicalization. The latter implies that the modern medical cosmology (what Foucault and others have called "the clinical gaze") creates a sexuality in its own image. In this paper I will connate the two meanings and use "medicalization" to refer to both.

(n2) when I took a workshop with Masters and Johnson in St. Louis in 1975, they used the phrase "sex is a natural act" so many times, I had a t-shirt made with that phrase printed on the back.

(n3) Although Helen S. Kaplan is regarded as bringing psychological sophistication to Masters and Johnson's work, she often promoted a medicalized view of sexology, as when she referred to sexology as "a biological discipline...[which is] basically much simpler than neurology or cardiology" (Wagner & Kaplan, 1993, pp. 3-4).

(n4) I spoke as an "expert" on the subject of "nomenclature" at this conference, and strongly advocated the use of erectile dysfunction instead of impotence to describe the condition under study, citing sexologists' complaints about the imprecision and stigmatizing effects of the term

impotence. Ironically, although the final report supported my position in its first paragraph, the report was still titled, "Impotence," and it was that term that appeared in all the publicity about the conference (Impotence, 1992).

(n5) The complete NIH report together with the commentaries are published as Volume 5, Number 4, December 1993, of the International Journal of Impotence Research.

(n6) Actually, I think he rather envisions replacement rather than companionship, but I hope we can win him over, as regular reading of his journal, *The Journal of the History of Sexuality*, should persuade many clinical sexologists of the virtues of greater exposure to "the new theoretical perspectives."

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