Female Sexual Dysfunction: History, Critiques and New Directions

by Whitney F. Mollenhauer

28 January 2011

Although the term “female sexual dysfunction” is fairly new, the medicalization of women's sexuality is not. As early as the sixteenth century, diagnosis of nymphomania was not uncommon, and the Victorian era saw a dramatic increase in the numbers of women with this “medical condition” (Groneman 1994). A canonical 1973 review of gynecology textbooks documented the profession's reliance on cultural views of women as “frigid,” and of sex and sexual pleasure as male-centered; the authors suggest that gynecology may be “medicine practiced on women for the benefit of men” (Scully & Bart 2003: 14). While this is an oversimplification, this statement calls attention to the material and cultural biases that inform how biomedicine treats women's sexuality. Cultural and material influences on medical knowledge dominate current literature on the medicalization of female sexual dysfunction (FSD). In the twenty-first century the pertinent influences include consumerism, privatization of medical research, and “Viagra culture.” This paper will review both feminist critiques and sociological studies of the medicalization of sex and especially female sexual dysfunction.

A study of the medicalization of FSD must begin with that of erectile dysfunction (ED). Urologists' study of men's sexual problems received little support from the profession as a whole, but gained greater legitimacy following a conference on ED sponsored by the National Institutes of Health in 1992 (Tiefer 2003). This institutional acknowledgment of the medical nature of ED, as well as urologists' history of working with industry, paved the way for the development of medical treatments for sexual dysfunctions. After Viagra was FDA approved in 1998 and proved to be hugely profitable, the Boston University School of Medicine held a continuing medical education (CME) conference in 1999 entitled, “New Perspectives in the Management of Female Sexual Dysfunction.” Urologists now turned to FSD as the next probable source of research funding from pharmaceutical companies. As of 1998, the only diagnosis of FSD to be found was in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM); the categorization found in the DSM was then revised by a group of sex researchers and clinicians, most of whom had ties to the pharmaceutical industry. The revision

allowed the DSM's categorization of sexual disorders of arousal, desire, orgasm and pain to be usable for physicians treating patients for FSD (Hartley & Tiefer 2003).

As the medical profession was seeing women's sexual problems in a new light, so was the American public. In 1999 the Journal of the American Medical Association published a study on the prevalence of sexual dysfunction; the major finding reported was that 31% of men and 43% of women experience sexual dysfunction (Laumann, Paik, & Rosen). The popular media immediately picked up on the "43%" statistic and dramatically emphasized that millions of women were suffering from FSD (Hartley & Tiefer 2003).

Medicalization involves changing understandings about the etiology of a condition as well as its treatment. One of the first strategies to treat FSD was off-label use of Viagra. Since Viagra had been successful in increasing blood flow in men's genitals, it was believed that it might do the same for women, improving arousal and orgasm frequency. Androgen and testosterone hormone therapies are also under development; though none are currently approved in the U.S., such treatments have been approved in Europe and Australia (Hartley 2006). The only FDA approved treatment for FSD is the Eros device, which is designed to increase blood flow to the clitoris by applying a gentle vacuum action (Fishman & Mamo 2001). Another medical treatment for FSD is labiplasty. Considered a form of 'cosmetic' surgery, this treatment may involve reducing the size of the labia, exposing more of the clitoris, or tightening the vaginal opening or muscles (Braun 2005). This is seen as improving sexual response through both physiological effects and through psychological effects from improved body image.

The preceding overview of types of treatments under development for FSD is important for understanding some of the critiques of its medicalization. Feminist critiques criticize the forms of power used in medicalization and emphasize the blindspots of medical discourse and its socially embedded nature.

One such critique regards the assumption that women's sexual response is similar to men's. A reflection of this can be seen in off-label use of Viagra to treat FSD; this relies on a male-based model that states that correcting problems with blood flow will then correct problems with arousal, and thereby correct problems with achieving orgasm. The assumption of male-female sexual equivalence is largely informed by the human sexual response cycle (HSRC) from the work of William Masters and Virginia Johnson; in this model, sexual response necessarily culminates in orgasm. This implies that any sexual experience that does *not* include orgasm is abnormal. Although many women frequently experience intercourse without orgasm, because the DSM categorization is based on the HSRC, these women would automatically be considered to have FSD (Tiefer 1995). Not only does female sexual response not always culminate in orgasm, but the role of desire in female response is often different from its role for men. Many women do not distinguish between “desire” and “arousal,” or between subjective and physiological arousal; yet the precession of physiological arousal by desire is central to DSM categorization of sexual disorders (Tiefer, Hall & Tavris 2002).

Current trends in medicalization of FSD also tend to favor male experience and male bodies. Clinicians tend to recommend that their female patients experiencing sexual dysfunction should engage in various kinds of work—focusing, exercising, reading books—to improve their sexual experience that emphasizes coitus, instead of helping the female patient redefine a healthy sex life as what comes naturally to them, even if it does not involve coitus or orgasm through penetration (Cacchioni 2007). Furthermore, it is the female body that is pathologized when sex does not proceed according to medical models, and it is the female body that risks iatrogenic effects from surgical or hormone treatments (Drew 2003). It is female experiences of sexuality that are ignored in the construction of the scientific (Tiefer et al. 2002). Thus it is the female body that suffers in order to maintain hegemonic conceptions of healthy sex that privilege male pleasure.

Scholars have often criticized the inability of a medical discourse of female sexual problems to

address a number of important aspects of sexuality. The overly genital focus of medical discourse ignores psychological and especially socio-cultural factors that play an important role in sexual response. The diversity of human sexual experience is reduced to one narrow sexual script, and differences due to religion or socioeconomic status are treated as problematic or dysfunctional, since the human body is perceived as having one “natural” sexual process that maps onto all bodies. Moreover, although sex is generally considered to be something that happens between two people, medical discourse locates sexuality within the individual, ignoring relationship context; however, relationship problems are almost certain to affect sexual functioning in ways that medical approaches cannot treat. (McHugh 2006)

The framing of sexual problems in biomedical terms belies the social embeddedness of such views of proper sexual functioning (Marshall 2002). Female complaints of infrequent orgasm through coitus only make sense in a culture that sees sex as phallocentric and relegates clitoral stimulation to mere 'foreplay' that is optional before the 'main event.' This maps onto arguments regarding inappropriate assumptions of male/female sexual equivalence; only in cultures that take male sexual experience to be the norm would sex be expected to culminate in orgasm every time (Drew 2003). Perhaps most importantly, a focus on medical causes and treatments for women's sexual problems tends to ignore or mask socio-cultural factors that are more likely to be the cause of the problem, such as ignorance due to limited sex education, or anxiety and distress from inability to conform to cultural norms of appearance or behavior (Tiefer et al. 2002).

Four major themes emerge from the current literature on the medicalization of sexual problems and of FSD in particular: the influence of privatization and commercialization; the influence of direct-to-consumer (DTC) advertising in the creation of markets; the power of medicalization to reify and modify cultural discourses on gender and aging; and the formation of gendered identities by patients with FSD. These four themes illuminate the macro-level forces that cause medicalization and shape its current forms, as well as the ways in which medicalization influences the social construction of gender.

Although the logic and ethics of science and medicine were once ideally considered at odds with profit and industry, the boundary between these two frameworks has blurred. Continuing Medical Education conferences are generally put on by medical schools, but are heavily funded through "unrestricted education grants' from pharmaceutical companies. Although these companies cannot dictate how these funds are used or the content of the conferences, "there might be explicit or implicit expectations of eventual repayment through increased prescription of the manufacturer's drugs" (Fishman 2004: 196). At these industry-sponsored conferences, companies may provide material, including presentations and visual aids that tend to promote a certain model of disease and treatment involving pharmaceuticals made by the company. (Hartley 2003).

Many of the more prominent presentations at CME conferences are given by researchers with ties to the pharmaceutical industry. Since their research is funded by the pharmaceutical industry, these presenters tend to emphasize aspects of the disease that may be susceptible to pharmaceutical intervention (Fishman 2004). Since the approval and phenomenal success of Viagra, researchers have seen increased funding from the pharmaceutical industry for research in very specific areas. Those conducting research on female arousal and desire have seen increased funding, but not for research on sexual pain disorders. Clinicians conducting research on female sexual problems have also seen increased funding for studies focusing on physiological causes, but not those focusing on psychological causes (Hartley 2003)

Commercialization has also spread to areas of health care that insurance companies do not consider "medically necessary," such as Viagra and cosmetic surgery. Private markets have sprung up around these treatments, and these markets are heavily influenced by DTC advertising and popular media (Conrad 2004). Viagra ads, for example, have "enlightened" men who had ED but "[didn't] even know it" (Marshall 2002). More and more patients seek out their doctors to request specific drugs they have heard about (Marshall 2010; Conrad 2004). DTC advertising constitutes an important source of

information for individuals seeking symptom relief (Hartley & Tiefer 2003).

As pharmaceutical companies developed and began testing products to treat FSD, they conducted public relations campaigns to disseminate knowledge of these technological advances through the mass media. Although neither Viagra nor hormone therapy has been FDA approved for the treatment of FSD, these treatments have been successfully promoted by celebrity "sexperts" Laura and Jennifer Berman. Funded by pharmaceutical companies, these women started a website, published a book, and made numerous TV appearances promoting a medicalized view of women's sexual problems, and emphasizing the usefulness of off-label prescriptions of Viagra and Androgel (a testosterone cream) in treating FSD (Fishman 2004; Hartley 2006). Because off-label uses are restricted from DTC advertising, strategic alliances between pharmaceutical companies and clinicians using mass media are important in creating markets for treatments prior to their approval.

Both scholars and critics of medicalization point out the power of medicalization to both reify and modify cultural discourses surrounding gender and sexuality. The characterization of ED and problems with women's arousal and orgasm in intercourse as dysfunctional begs the question of what normal function these problems impede. The answer seems to be penetrative intercourse within a heterosexual relationship, since many forms of sexual pleasure exist that do not require orgasm or penetration. Medicalized models of sexual problems draw upon assumptions of ever-present male libido and a receptive vagina in their construction of dysfunction (Marshall 2002). Viagra is seen as a successful treatment because it restores the penis to its erect state—further treatment to increase desire is not needed, since it is already assumed to exist and its consummation is simply impeded by constricted blood vessels to the penis. Also, the Eros device for women is prescribed for use prior to intercourse (not as a means to orgasm by itself), relegating the clitoris to mere foreplay, reifying popular discourse of coitus as the key act (Fishman & Mamo 2001).

Both popular and medical discourses surrounding women's sexual problems are a powerful force

on identity formation. One study of women suffering from vulvar pain, classified as a genital pain disorder, showed that inasmuch as their condition prevented heterosexual intercourse, these women felt like "failed" or "unreal" women. Medical discourse of sexual problems locates disorders and sexuality within the body; as a result, the women in this study often referred to themselves as "defective," or that their body "betrayed" them. Even though these women were able to give and receive other kinds of sexual pleasure, they saw themselves as not sexual, or as "inauthentic sexual objects;" this perfectly illustrates the privileging of coitus in discourses about sex (Kaler 2006: 65).

Subjects in a study of women with sexual desire loss expressed similar feelings of being "not normal" or different from other women, or even as being less of a woman. These women experienced themselves as inadequate wives, and located the "problem" of low sexual desire within their own bodies, as opposed to within the relationship or cultural expectations (Hinchliff, Gott & Wylie 2009). Pharmaceutical companies profit when such feelings of discomfort to spur people to action, turning them into patient consumers of pharmaceutical treatments.

Although literature on the medicalization of FSD has further elaborated theories of medicalization and sexuality that were developed in ED literature, this area of study is still fairly new to medical sociology. Although many questions remain unanswered, I emphasize the need for further research in three areas: medicalization of pain disorders, diversity of experience, and agency and social change.

While pharmaceutical companies have been keen on cashing in on feelings of sexual inadequacy due to disorders of desire, arousal, and orgasm, little attention has been paid to sexual pain disorders (Hartley 2003). Disruption of normative heterosexual intercourse due to pain is highly distressing to women (Tiefer 2005; Kaler 2006; Cacchioni 2007). Studies informed by feminist theory and historical context may be useful in understanding why sexual pain disorders have received less attention, as well as understanding opportunities for empowerment through medicalization.

Diversity of experience is another issue that must be addressed in FSD medicalization literature. The 1999 JAMA article indicated that sexual experience varies according to social factors such as race and socioeconomic status (Laumann et al.). This makes sense in light of the fact that healthicization is a largely middle-class phenomenon (Cacchioni 2007). Furthermore, these race and socioeconomic are known to affect numerous health outcomes. More research is needed to help us understand the mechanisms by which these social factors affect the prevalence of FSD. We also know that the sexuality of some groups (e.g. white, middle-class) has historically been privileged over that of other groups (e.g. black, Asian, Jew, poor and working class). How are these groups differently affected by trends medicalizing sexual problems? How do individuals experiencing FSD as a result of other diseases (AIDS, cancer, depression) interpret their sexuality and their bodily experience? How do men whose partners have FSD come to understand the problem? Do they experience changes in interpretations of masculinity and sexuality, similar to the women in Kaler's study (2006)?

Possibilities for agency and social change are important in discussions of medicalization. In particular, feminist critiques of medicalization emphasize the power of medical gaze in disciplining women's bodies; yet women can also function as agents, using medicine for personal empowerment, "to prevent suffering and enhance well-being" (Purdy 2001:258). Although medical views of "normal" sexual behavior are undoubtedly flawed and tend to marginalize women's experience, many women sincerely feel they would be happier with medically improved sex lives and express satisfaction with the results of medical treatment (Braun 2005). Through medical treatment, women may be able to resist views of women as sexual objects and begin to experience themselves as sexual subjects. Women's role as agents was briefly touched on in studies by Kaler and Cacchioni, but a more in-depth treatment of the subject is needed (2006; 2007).

Members of the Working Group for A New View of Women's Sexual Problems were moderately successful in preventing the rapid medicalization of women's sexual problems; their success—or lack

thereof—should be further examined to understand possibilities for social change. The New View group consisted of clinicians and scholars; but we do not know to what degree they benefited from more grassroots activities. And while the new classification for sexual problems they proposed is critical of the current DSM classification, it also incorporates current medical views of FSD as having bodily causes such as endocrine and circulatory issues—similar to current views on "androgen deficiency syndrome" or constricted arteries in genital regions. The New View classification also draws on human rights documents from the World Health Organization and the World Association of Sexology (The Working Group on A New View of Women's Sexual Problems 2001). Addressing this group's degree of success and their use of extant frameworks in two different fields (human rights and sexology) will lead to greater understandings of whether and how de-medicalization can be effected. These issues of social change, agency and diversity are central in the field of medical sociology, and as such, must be addressed in future FSD medicalization research. A focus on these topics will elaborate theories of gender and sexualities within medical sociology, as well as within the broader discipline.

References

Braun, Virginia. 2005. "In Search of (Better) Sexual Pleasure: Female Genital 'Cosmetic' Surgery." *Sexualities.* 8(4): 407-424.

Cacchioni, Thea. 2007. "Heterosexuality and 'the Labour of Love': A Contribution to Recent Debates on Female Sexual Dysfunction." *Sexualities.* 10(3): 299-320.

Conrad, Peter and Valerie Leiter. 2004. "Medicalization, Markets and Consumers." *Journal of Health and Social Behavior.* 45: 158-176.

Drew, Jennifer. 2003. "The myth of female sexual dysfunction and its medicalization." *Sexualities, Evolution & Gender.* 5(2): 89-96.

Fishman, Jennifer R. 2004. "Manufacturing Desire: The Commodification of Female Sexual Dysfunction. *Social Studies of Science.* 34(2): 187-218.

Fishman, Jennifer R. and Laura Mamo. 2001. "What's in a Disorder: A Cultural Analysis of Medical and Pharmaceutical Constructions of Male and Female Sexual Dysfunction." Pp. 179-193 in *A New View of Women's Sexual Problems*, edited by Ellyn Kaschak and Leonore Tiefer. Binghamton, NY: Haworth Press.

Groneman, Carol. 1994. "Nymphomania: The Historical Construction of Female Sexuality." *Signs*. 19(2): 337-367.

Hartley, Heather. 2003. "'Big Pharma' in our Bedrooms: An Analysis of the Medicalization of Women's Sexual Problems." Pp. 89-129 in Advances in Gender Research, vol. 7, Gender Perspectives on Health and Medicine: Key Themes, edited by Marcia Texler Segal, Vasilikie Demos, with Jennie Jacobs Kronenfeld. Boston, MA: Elsevier.

(----.) 2006. "The 'Pinking' of Viagra Culture: Drug Industry Efforts to Create and Repackage Sex Drugs for Women." *Sexualities*. 9(3): 363-378.

Hartley, Heather and Leonore Tiefer. 2003. "Taking a Biological Turn: The Push for a 'Female Viagra' and the Medicalization of Women's Sexual Problems." *Women's Studies Quarterly*. 31(1): 42-54.

Hinchliff, Sharron, Merryn Gott and Kevan Wylie. 2009. "Holding onto Womanhood: A Qualitative Study of Heterosexual Women with Sexual Desire Loss." *Health*. 13(4): 449-465.

Kaler, Amy. 2005. "Classifying Pain: What's at Stake for Women with Dyspareunia." *Archives of Sexual Behavior.* 34(1): 34-36.

(----.) 2006. "Unreal Women: Sex, Gender, Identity and the Lived Experience of Vulvar Pain." *Feminist Review*. 82: 50-75.

Laumann, Edward O., Anthony Paik and Raymond C. Rosen. 1999. "Sexual Dysfunction in the United States: Prevalence and Predictors." *Journal of the American Medical Association*. 281(6): 537-544.

Marshall, Barbara L. 2002. "'Hard Science': Gendered Constructions of Sexual Dysfunction in the 'Viagra Age'." *Sexualitites* 5(2): 131-158.

(----.) 2010. "Science, Medicine, and Virility Surveillance: 'Sexy Seniors' in the Pharmaceutical Imagination." *Sociology of Health & Illness*. 32(2): 211-224.

McHugh, Maureen C. 2006. "What Do Women Want? A New View of Women's Sexual Problems." *Sex Roles*. 54: 361-369.

Moynihan, Ray. 2003. "The Making of a Disease: Female Sexual Dysfunction." *British Medical Journal*. 326: (45-47).

Purdy, Laura. 2001. "Medicalization, Medical Necessity, and Feminist Medicine." *Bioethics*. 15(3): 248-261.

Scully, Diana and Pauline Bart. 2003. "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks." *Feminism Psychology.* 13(1): 11-16.

Tiefer, Leonore. 1995. *Sex is Not a Natural Act and Other Essays*. Boulder, CO: Westview Press.

(----.) 2003. "Female Sexual Dysfunction (FSD): Witnessing Social Construction in Action." *Sexualities, Evolution & Gender*. 5(1): 33-36.

(----.) 2005. "Dyspareunia is the Only Valid Sexual Dysfunction and Certainly the Only Important One." *Archives of Sexual Behavior*. 34(1): 49-51.

Tiefer, Leonore, Marny Hall and Carol Tavris. 2002. "Beyond Dysfunction: A New View of Women's Sexual Problems." *Journal of Sex & Marital Therapy*. 28: 225-232.

The Working Group for A New View of Women's Sexual Problems. 2001. "A New View of Women's Sexual Problems." Pp. 1- 8 in *A New View of Women's Sexual Problems*, edited by Ellyn Kaschak and Leonore Tiefer. Binghamton, NY: Haworth Press.