

SEXUAL HEALTH

Fact sheet 18

Sexual dysfunction and the medicalisation of sex

Sexual dysfunction (SD) is believed by some researchers to be common, occurring in one form or another in between one-third and one-half of all women and just under one-third of all men, throughout or at stages in their lives (10, 17, 31).

What is consistent across studies, however, is that sexual dysfunction is more prevalent among women than among men In a U.S.-based population study, sexual dysfunction was prevalent in 43% of women and 31% of men (17).

There is no question that real sexual dysfunction exists; what is in question is the extent of it:

Serious questions hang over the 43% figure (from) University of Chicago sociology professor Ed Laumann and colleagues The JAMA article stated that its data were "not equivalent to

Some researchers ... are questioning to what extent the spectrum of sexual experience is being skewed so that once 'normal' behaviours or expectations have been redefined into conditions that require treatment.



clinical diagnosis,” yet this caveat is now regularly overlooked, and leading sex researchers have raised serious concerns about the figure’s constant misuse (22).

Significant concerns exist around the efficacy and even safety of some SD treatments being offered in the marketplace.

A global study of sexual behaviour and dysfunctions after age 40, conducted in 2004 and involving 27 500 men and women across 29 countries, found that ‘Overall, 28% of the men and 39% of the women said that they are affected by at least one sexual dysfunction’ (25). Early ejaculation in men, and lack of sexual interest in women, were the most commonly reported sexual problems.

Some recent research, however, questions the prevalence of erectile dysfunction (ED) in men—raising concerns that could apply to other types of sexual dysfunction.

Only when the ED results in distress, can it be considered a clinically relevant condition. It has been shown in a number of studies that a subset of 30–70% of men with ED suffer distress from having ED. Thus, it appears that the prevalence of ED requiring clinical attention is in the range of 3–7%, and is therefore about 10-fold less than what has

been communicated in several publications on ED (19).

Many researchers are unhappy about the connections between some investigators into sexual dysfunction and pharmaceutical interests.

Difficulties become dysfunctions become disease ... in November (2002) a Californian firm offering “business intelligence” announced that “43% of all women over 18 experience sexual dysfunction” The 43% figure (is based on) ... About 1500 women (answering) yes or no to whether they had experienced any of seven problems, for two months or more, during the previous year If the women answered yes to just one of the seven questions, they were included in a group characterised as having sexual dysfunction (22).

The real number of people experiencing sexual dysfunction is difficult to determine, skewed as it may be by:

- concerns over whether or not a condition is a dysfunction if it does not cause distress (4, 19)
- research issues around levels of reporting, taboo, and reliability of personal recollection (17)
- suggestions that normal variations of female sexual desire, as Beutel et al (2007) (4) wrote, ‘... are medicalized to the benefits of pharmaceutical

companies investing heavily in new markets for sexually enhancing drugs' (see also 17)

Much sexual dysfunction literature deals with reductions in sexual behaviour as people age. Again, there is room for concern about the research in this area. A significant study conducted by the American Association of Retired Persons (AARP) in 1999 and repeated in 2004 revealed that:

Over 60 percent of those over age 70 with partners reported engaging in sexual touching or caressing at least once a week and reported a high level of satisfaction with their sex lives. Older adult couples did engage less often in sexual intercourse, self-stimulation, and oral sex than middle-aged adults did; however, more than 30 percent of those over age 70 reported having intercourse at least once a week (AARP, 2005) [33].

Such information, when coupled with other issues around sexual dysfunction research—the prevalence of commercial interests, small sample sizes in some research, failure to account for differences between the responses of single individuals and those people in partnerships, failure to account for the wide variety of sexual

activities, and a willingness to assign the term 'dysfunction' on very small levels of reporting—should lead to healthy skepticism about the degree to which levels of participation in sexual behaviours are declared to be outside a norm.

Clearly more research is needed, without ties to pharmaceutical companies, featuring larger and more inclusive samples, and accounting for a wider diversity of sexual behaviour than that which

currently over-emphasises heterosexual penile-vaginal penetrative sex above other forms of sexual activity.

Sexual dysfunction

Sexual dysfunction in all genders may be characterised by hyper- or hyposexuality; that is, lack

of arousal or orgasm need not be the defining parameter although much of the literature refers exclusively to conditions of hyposexuality.

Hyposexual dysfunctions include (10, 17):

- inhibited orgasm (male and female)
- inhibited sexual excitement (that is, lack of erection for men, lack of arousal for women)
- functional dyspareunia (painful sex)

Treatments for female sexual dysfunction are highly desired by pharmaceutical companies; female 'viagra' is a much sought-after prize.

- inhibited sexual desire (that is, sex not pleasurable and sex not important)
- premature ejaculation
- functional vaginismus (sudden tensing of vaginal muscles, outside the control of the woman).

It is worth noting, however, that:

As sexual functions, experience and satisfaction vary widely among individuals and couple relationships, a requirement for a psychiatric diagnosis is always that the sexual dysfunction 'causes marked distress or interpersonal difficulty' (5).

Hypersexual dysfunctions include behaviours prompted by psychological causes, such as various paraphilias. Some hypersexualities arise from physiological causes, such as priapism, while others appear following such catastrophic events as severe brain injury.

Sexual dysfunction differences between men and women

Researchers typically differentiate between male and female sexual dysfunction and many researchers focus on one or other of these genders. (Note that there seems to be little published on 'normal' homosexual and 'normal' transgender sexual behaviour; the focus in research around these people is often on promiscuity, drug use, conversion therapy, surgical issues and so on).

Much has been written suggesting that men are more interested in sex, while women are more interested in intimacy in its larger sense. However, some researchers recently have begun questioning the ways in which survey questions are couched, hypotheses set and results interpreted.

How should we interpret the finding that women appear less interested in sex than men? One possibility is that researchers have inadvertently used male standards (e.g., penile penetration and orgasm) to evaluate women's sexual experiences and consequently ignored activities, such as intimate kissing, cuddling, and touching that may be uniquely important to women's erotic lives (26).

There also is a growing rift between researchers whose results seemingly indicate growing sexual dysfunction in women and those who assert that much research is skewed to create, or erroneously emphasise, a problem with a view to possible commercial advantages (3, 22, 35).

It is interesting to note, as well, that women are often seen as the 'seat of the problem'; they are 'hysterical' or 'frail' or 'corrupting'.

A marked distinction has existed with respect to the perceived responsibility of men and women for sexual health—women have consistently been seen as

“reservoirs of infection”. In 1962, health promotion materials that targeted men could say that “a girl may be perfectly clean ... and yet have in her body millions of the invisible germs of gonorrhoea or syphilis, or perhaps both”. Even in the late 20th century, the United Kingdom’s proposed national screening program for Chlamydia trachomatis suggested that only women be tested (14).

Erectile dysfunction

Male erectile dysfunction has received more attention than any other area of sexual dysfunction. This focus in part may be because there has been an assumption that male dysfunction is easier to ‘treat’ than is female dysfunction:

The initial privileging, or medicalising, of male sexual difficulties by sex researchers studying the impact of drugs on sexual behaviour, indicates the operation ... of a cultural assumption that male sexuality is straight forward and uncomplicated (to study and treat), whereas female sexuality is complex and mysterious (27).

Skultety points out that:

Erectile dysfunction has received the most attention in both the media and in the research

literature ... [even though] The most common sexual dysfunction for all the male samples was early ejaculation, although age was not a significant factor (33).

Erectile dysfunction has been put as high as 30.8 per cent in men aged 50–59, 55.1 per cent in those aged 60–69, and 53.4 per cent in those aged 70–79 (5); however, others have expressed concern over these numbers and suggest they may be inflated (19).

Kubin goes on to state that the distress caused by erectile dysfunction is clinically more important than ED per se (19).

Ejaculatory and orgasmic disorders

Men also experience ejaculatory disorders with the most common being premature ejaculation (where orgasm is reached sooner than desired by either the man, or woman, or both).

Among the disorders of ejaculation, premature ejaculation was reported by 14% (of respondents), remaining fairly constant across the life span (up to 18% by 70–80 years). Above the age of 50 years, reduced semen or no ejaculation, however, were reported by an increasing proportion of men (from 46% from 50 to 59 years to 74% by 70–80 years). Ejaculation problems were

considered only slightly bothersome, independently of age (5).

To date, ejaculatory problems have not been well-defined or studied (5), although they are beginning to attract attention from pharmaceutical companies (30).

Sexual dysfunction treatments

Viagra

Perhaps the most significant new element around male sexual dysfunction has been the introduction of Sildenafil, marketed as Viagra, a pharmaceutical solution to erectile problems. Viagra was first released in 1998 in the United States of America (15); by 2007, it had estimated sales of \$1.8 billion in 2007 (by way of example, it sold in 2000 at an average wholesale price of \$8.75 US dollars) (11, 18).

There is no question that there was a demand for the drug:

The introduction of Viagra™ essentially quadrupled the market for treatment of ED (in dollar sales) in the United States in eight months (18).

As reported by Rosen and Bachmann (2008), both men and women valued the new medication:

Not surprisingly, the 2005 (American Association of Retired Persons—AARP) survey found that the use

of sex-enhancing agents and medications (e.g., PDE-5 inhibitors) among men was twice as high in 2004 as in 1999. Of note, this use of ED medications had resulted in a sexual “reawakening” for many of the women in the survey, with women in all age groups reporting an enhancement of their own sexual satisfaction as a result of their partners’ use of ED medications (AARP, 2005) (29).

Much of the success of Viagra may be attributed to clever marketing: *... Pfizer transformed Viagra from an effective product for erectile dysfunction (ED) due to medical problems ... into a drug that “normal” men can use to enhance their ability to achieve an erection and to maintain it (in a “harder state”) for a longer period of time (20).*

An estimated 23 million men received 123 million prescriptions for Viagra, Cialis and Levitra; thus ‘... a sexual problem that once involved the shared interests and expertise of sex therapists and physicians/urologists has now become the near-exclusive domain of the medical profession’ (30).

Questions have arisen for others, however, around the effect of Viagra on the lives of the men using it, and on the lives of their partners.

Potts et al (2003) (27) found levels of distress and dissatisfaction among

women whose partners had begun using Viagra, with reports that it can lead to:

- a risk of expectation that sex will happen solely because the pill has been taken, along with an increasing failure to consult about or negotiate over whether or not sex is 'on the agenda'
- instances of women being compelled or forced to have intercourse, both because of the newly-recovered capacity of the male to sustain an erection, but also because of claims from men about the potential waste of money if sex is not forthcoming after taking a tablet
- increased focus on penetrative sex, often to the exclusion of foreplay and of other forms of sexual behaviour that may be more gratifying for women
- prolonged duration of penetrative sex, sometimes beyond that which the woman might enjoy, and on occasion to her physical detriment, with injury occurring
- a reduction in personal intimacy that some women felt had arrived in latter years, with renewed male focus on penile-vaginal intercourse

Viagra clearly is not entirely a boon for everyone operating in the heterosexual arena.

Furthermore, it is important to note Skultety's statement in her work on couples in later life, when she writes: 'Studies of sexual activity and aging should not limit their definition of sex to intercourse because many couples are regularly engaging in other meaningful sexual activities' (33).

Much of the literature around homosexual use of Viagra™ refers to 'misuse' of it as a recreational drug, often in conjunction with methamphetamine. More credible research that examines the sexual lives of homosexuals in ways that do not treat them or their behaviours as marginalised, semi-criminal or unreservedly promiscuous is needed to get a clearer picture of their experiences with sexuality and aging, and normal sexual function and sexual dysfunction.

Other medications

These chemical compounds/medications are either under investigation for the creation of new drugs, or on the market in the United States, or Europe (30):

- Melanocortin agonist bremelanotide—being investigated as a treatment for male and female sexual desire and arousal
- agents that affect serotonergic, dopaminergic, nitergic, vipergic and GABAergic systems, all of which are involved in sexual response

- Dapoxetine and Intrinsa—for ejaculatory, arousal and desire disorders in either or both men and women.

Commercial erectile dysfunction enterprises

Sex clinics with a strong commercial focus and large advertising budgets have opened for business in Australia, and other countries, in the last decade. Many medical practitioners, family planning clinics, other legitimate sexology practices and even governments are expressing concerns about the treatment, medications and methodologies used by these enterprises.

Professor David Handelsman, head of andrology at Concord Hospital's ANZAC Research Institute is on record about one such Australian clinic, saying its '... advertising was pernicious and destructive, and its claims for efficacy for its erectile dysfunction treatments were a carefully constructed legal fiction' (6).

David Malouf, vice-president of the Urological Society of Australia and New Zealand stated that the company '... displayed serious inappropriate clinical practice' (6).

It should be noted that these companies do not necessarily prescribe Viagra, but instead '... provide compound formulations. What you have are a number of

drugs that have been available for different indications for 30 to 50 years. They are off-patent medications, so those medications are fully registered. A couple of them are then put together and it is that compound which is provided under an individual prescription for the patient ... medications like phentolamine, apomorphine, clomipramine' (32).

One Australian-based company also is coming under scrutiny in relation to the sexualisation of children in the media, because of its advertisements in prominent public places, asking questions such as 'do you want longer lasting sex?' in large black typefaces.

Psycho-social models

The medical/psycho-medical approach to sexual dysfunction typically sees individuals seeking help through their general practitioner (GP) and proceeding through various medical specialities to an end result of drug treatment; there often is a disease model in use (30).

Psycho-social models may see individuals seeking help through their GPs, other specialists, counsellors and others (30).

Sexologists and practitioners of psycho-social approaches are arguing now that the psycho-medical/disease model does not account adequately for (30, 35):

- sexual politics (feminism, gay and lesbian rights)
- multiculturalism
- sexual diversity and individualism
- the complexities of relationships
- personal psychologies

Tiefer goes so far as to state that: 'Clinical sexology research and practice are in danger of being captured by commercial interests, chiefly the global pharmaceutical industry' (35). She adds that the 'mass media and the public may have succumbed to a myth of objective science and prematurely relinquished non-medical and non-scientific sources of knowledge about bodies, relationships and personal well-being'.

Female sexual dysfunction

The holy grail of pharmaceutical companies producing drugs around sexual dysfunction is treatments for both real, and possibly 'manufactured', problems experienced by women.

Pfizer, the world's larger pharmaceutical company, was the main promoter of (female sexual dysfunction) from 1997 to 2004, when its quest to have Viagra approved to treat "female sexual arousal disorder" ended because of consistently poor clinical-trial results (35).

Drugs are not the only medical option available to women, or their doctors (14):

Gynaecological surgery is also being harnessed to enhance female sexual pleasure and improve aesthetics So far, genital enhancement—the so called "designer vagina"—has had little impact in the United Kingdom, but it is routinely advertised in America. Procedures include:

- *Liposuction of oversized vulvas*
- *Labiaplasty to "aesthetically modify" the labia*
- *Clitoral repositioning*
- *Tightening of vaginal muscles and support tissues*
- *Reduction by laser of redundant vaginal mucosa.*

The medicalisation of sexual dysfunction

Disease-mongering is defined as 'trying to convince essentially well people that they are sick, or slightly sick people that they are very ill' (35):

... the taxonomy by which sexual behaviour is defined was invented a century earlier (than 1963), when a new breed of sexologists created diagnostic categories such as homosexual and heterosexual, hysteria and nymphomania, and a host of arcane paraphilias. These

labels served to define what was normal and acceptable and what was not, distinguishing “perversions” from “acceptable” heterosexual, procreative, and monogamous sex. The long tradition of representing illness as a punishment for sin was continued when sexual behaviour was medicalised and transformed into morbidity (14).

‘Lifestyle drugs’ are a growth area, and focus on ‘... what until recently have been regarded as the natural results of ageing or as part of the normal range of human emotions’ (20). Many of the ‘problems’ that lifestyle drugs target are those that people self-diagnose, such as obesity or hair loss, and for which they try to find solutions outside themselves.

The message is ... *that everyone, whatever their age, can use a little enhancement; and any deviation from perfect erectile function means a diagnosis of ED and treatment with Viagra (20).*

In America, consumers are the direct target of advertising, where in other countries, only the medical profession is subjected to marketing around medications; research has found that such consumer-directed advertising is leading “... patients to ask their doctors for specific drugs in ways that

effectively encourage doctors to grant these requests” (21).

Medicalisation causes concern because it narrows treatment options, often ignores ranges of normalcy, redefines the higher and lower end of the spectrum of normalcy so that it comes to be regarded as dysfunction, and tends to serve vested commercial interests over patient interests (20, 23, 30).

Medicalisation also can create problems where none existed before, or cause a small problem to be escalated into a larger one; as Hart and Wellings (2002) reported, ‘... our obsession with sexual gratification has undoubtedly increased people’s expectations, and it may have increased people’s feelings of inadequacies. Although many men with erectile dysfunction daily thank Pfizer for their efforts, others who once thought their low libido was “normal” and acceptable now feel dissatisfied with their sexual lives’ (14).

Not all aspects of sexual medicine are negative, as Rowland (2007) points out (30). Many individuals benefit from the drugs administered, and from other factors. The table below shows Rowland’s take on the benefits and liabilities for patients in this area:

Positive	Negative
Clear entry point into the health system	Entry point likely to bias/limit the options
Destigmatisation of the condition through depersonalisation	Not a cure, just a treatment
Increased treatment options	Dependency on the medication for sexual response
Demonstrated efficacy	Address physiological but not psychological or relational components
Easy and accessible solutions	Non-responders and adherence issues
Third-party reimbursement	

Pharmaceutical interests

The construction of sexual dysfunction, and its relationship to the pharmaceutical industry, treads an historical path that can be traced from a meeting in 1997, sponsored by pharmaceutical companies and to which 'Only investigators who have experience with, or special interest in working collaboratively with drug companies have been invited' (22). A conference took place in Boston in 1998, at which '... 18 of the 19 authors ... had financial interests or other relationships with a total of 22 drug companies' (22).

Other groups are responding against the medicalisation of (particularly women's) sexuality. Two New View Campaigns, convened in 2000, first challenged the 'tidal wave of over-promoted sexuality drugs' post-Viagra and, second, conducted a theoretical critique to '... educate journalists, the public, and the sexological community, focusing on the weaknesses of the prevailing sexual dysfunction model and nomenclature as bases for sexuality research, education and therapy' (35).

... (Dr Leonore Tiefer) and colleagues are promoting a women-centred definition of sexual problems: "discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience," with four categories of causes: "sociocultural, political, or economic; relationship related; psychological; and medical" (22).

Some of the objectives of the campaigns are to achieve a 'more humanised doctor-patient relationships, effective and safe new drugs, and increased public and research attention to the complexity of female problems'. Advocates of the campaign express concern that the risk of failure around these efforts will see '... the ever-narrowing definitions of "normal" which help turn the complaints of the healthy into the conditions of the sick' (22).

Rowland (2007) also points out that “new journals have been founded, new professional societies have been established, new research funds have been invested” (sic) and sexual medicine has emerged. The question remains whether all these developments really signify a huge new development in the field of sexology, or whether they just reflect the effort of some medical disciplines (e.g., urology, obstetrics, and gynecology) to get “a bigger piece of the pie.” (2).

Some researchers and commentators are stating that the very diagnosis, terminology, and measurements around sexual function and dysfunction are vague, imprecise and inadequately defined (2). In particular reference to women:

Critics ... have challenged the validity of (the DSM categories of sexual dysfunction) model, its applicability to women, and its use as a basis for clinical assessment. They have also faulted the DSM for ignoring the relationship context of sexuality for women (proposing instead) a new “woman-centered” view of women’s sexual problems that gives prominence to partner and relationship factors that affect women’s sexual experiences, and also to social, cultural, and economic factors that influence the quality of women’s sexual lives (26).

One clear factor that is emerging in commentaries from critics of the pharmaceutical company-sponsored research is the neglect in that research of the social aspects of sexuality: relationships, sociological factors, culture, ignorance and fear, and lack of partners (34).

Another factor in relation to sexual functioning among one particular group—the elderly—is that their living arrangements may ‘... constitute another barrier to engaging in sexual activity for many older couples. Many long-term-care facilities do not allow couples to share a room and do not provide locations where older adults could have privacy to be intimate with a partner many staff had negative attitudes about sexual activity in old aged and discouraged the expression of sexuality in these environments’ (33). Living with adult children also can pose considerable difficulties for older people striving to maintain a sexual life (33); access to privacy, issues about partners who may not be spousal, and negative attitudes about the expression of sexuality among older people may be a bigger problem than any physical shortcoming.

Andropause—the new growth area?

Women’s sexual health, and both real and constructed dysfunction around it, are not the only issue in medicalisation. Viagra and its

competitors are but one locus of the medicalisation of male sexuality; andropause is the new centre of attention.

Currently, older men are being prescribed testosterone replacement therapy for a set of vague symptoms, often referred to as andropause, male menopause, the male climacteric, or androgen

deficiency in aging men (ADAM) ... Despite the widespread use of testosterone replacement therapy, there is a dearth of information and clinical studies about its risks and benefits (8).

Conrad also suggests that men, too, want to 'resist the aging process' and so 'collude' in turning normalcy into pathology.

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