A New View of Women's Sexual Problems

for FDA Advisory Committee Hearing on Intrinsa, December 2, 2004

Problems with Medicalizing
Sex and Menopause

Problem 1: Is menopause a state of hormone deficiency? Only if you are trapped in the medical model.

The idea that menopause is a state of hormone deficiency began in the US, according to menopause educator Vicki Meyer (2003) (who calls it "propaganda"), but it is accepted now in most medical discussions of women's lives worldwide. It's almost as if doctors and medical researchers cannot think of menopause in any way other than a "loss" of this and a "decline" of that.

In "Medicalized menopause, US style," Meyer reviews the paltry scientific information behind the view that physical changes associated with the end of menstruation serve only to increase the risk for diseases and lower the quality of life. Like other menopause educators, Meyer offers a "Health Perspective" as an antidote to the "Medical perspective," and argues that menopause is a normal health enhancing physical process, and that what are usually called "symptoms" are the body's appropriate response to changing hormone levels. As hormone levels change, the body changes - in menopause, as in puberty and pregnancy.

Giving women hormonal medicines as a routine and automatic reaction to menopause makes as little sense as trying to "correct" the hormonal state of a pregnant women to prevent her from gaining weight or of a pubertal girl to prevent her from developing breasts and pubic hair.

Just as women vary enormously in their physical responses to the hormonal changes of pregnancy and puberty, they will vary enormously in their physical responses to the hormonal changes of menopause. Variety seems to be the way of biology.

It is not difficult, however, to pathologize women, to make them feel that their bodily changes and responses are wrong, defective, inadequate or in need of treatment. For 40 years, menopause was regarded as an "estrogen deficiency disease" and women were routinely treated with estrogen to "replace" the deficiency. This approach was ultimately shown to be harmful and dangerous and nowadays women are warned to take estrogen for only brief periods of time.

Now it seems that we are entering a phase of public messages claiming that it is wonderful to have 30 year old testosterone levels and "deficient" is to have 60 year old testosterone levels. Menopause is coming to be regarded as a "testosterone deficiency disease" and this is a sad and dangerous turn of events.

Meyer, V (2003) Medicalized menopause, US style. Health Care for Women International, 24: 822-830.

Problem 2: Is there a universal sexual response for women? Only if you are trapped in the medical model.

And what is "hypoactive sexual desire disorder," anyway?

The term comes from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* and dates back to a radical revision in 1980 that changed the manual from a 52 page list of mental problems to a 494 page list (the current edition, 1994, is 886 pages).

Did hundreds of new mental conditions suddenly appear?

Probably not. Rather, the revised 1980 version included new details and ways of listing many familiar behavioral and emotional patterns. In the sexuality section, a brand new list of individual disorders of desire, excitement (arousal), orgasm, and pain appeared, including "inhibited sexual desire" (changed in 1987 to "hypoactive sexual desire disorder").

The basis for this particular list was arbitrary, based on laboratory measures of volunteers' sexual activity combined with clinical experience with people's sexual complaints. But, sexual complaints relating to romance, intimacy, cooperation, sensuality, body acceptance, and pleasure, just to name a few, while known, didn't make it to the level of official "diagnoses." The psychiatrists chose to stick to the basic reproductive sexual script and proclaimed that regular performance was "sexually normal" and anything else was a problem.

As a consequence, the list of sexual disorders used today overemphasizes genital responses and the performance of sexual intercourse, and shortchanges the more humanistic and emotional aspects of lovemaking. Many sexuality scholars and clinicians have criticized this medical model over the years, but it continues to dominate medical sex research.

Fast forward to a new interest in profitable sex drugs by the pharmaceutical industry in the 1990s, and the official medical emphasis on physical arousal and intercourse performance provided a readymade marketing opportunity for drugs with genital effects. Performance can always be improved, and, more important, people can always be led to feel deficient in their performance. As with standards for appearance, sexual standards can be continuously raised to provide a permanent market for quick-fix promises.

The only way to resist the explosion of sexual drugs with their performance-is-the-most-important-thing philosophy is to recognize that the medical model is the wrong model for sex. Yes, the body is important to sex, but only as the executor of a cultural and personal message. It's the same with dance. Doctors can fix ankles, but they can't say what a normal dance is. Classifying normal sexual function is a doomed enterprise – but Big Pharma is hoping the public won't notice.

Tiefer L (2004) Sex is Not a Natural Act, and other essays, 2nd edition. Boulder: Westview Press.

Kaschak E. & Tiefer L. (Eds) (2001) A New View of Women's Sexual Problems, Binghamton, NY: The Haworth Press.