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PEER REVIEWED SUBMISSION

The Medicalization of Sex Therapy: Better Living Through Chemistry?

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ABSTRACT

This article will address several of the ethical dilemmas that surround the increasing role of the use of medical and pharmaceutical technologies in the treatment of sexual dysfunction. Highlighted will be both the benefits, as well as the costs, of such innovations with a focus on whether or not our current efforts are leading us in a direction that helps to promote a greater sexual happiness and satisfaction among the patients we serve.

Key Words: medicalization; sex therapy; ethics; death anxiety

The treatment of sexual dysfunction has changed a great deal since the 1960s when William Masters and Virginia Johnson gave birth to the field of sex therapy. With the publication of their groundbreaking text, *Human Sexual Inadequacy* (Masters and Johnson, 1970), the active pursuit of the treatment for a variety of sexual maladies began in earnest. As is the case with most clinical interventions, these changes have brought both positive and negative features to this field. While many of these changes have been vigorously debated in the clinical literature, such discussions have rarely been in the forefront of our ethical conversation. Indeed, the ethical dilemmas facing the field of sex therapy have faced little scrutiny and scant serious attention in recent literature (Lyman, 2001). This article will address several of the ethical dilemmas that surround the increasing role of the use of medical and pharmaceutical technologies in the treatment of sexual dysfunction. Highlighted will be both the benefits, as well as the costs, of such innovations with a focus on whether or not our current efforts are leading us in a direction that helps to promote a greater sexual happiness and satisfaction among the patients we serve.

When we speak of the *medicalization* of sex therapy, we are referring to the increased emphasis on medical approaches to the conceptualization and treatment of sexual problems. Recent years have seen the sex therapy field shift from a primarily psychological treatment approach to a more medically focused form of assessment and treatment. Obviously, this shift in perspective has had a profound effect on the manner in which sexuality in general, and patient care in particular, are understood and managed. Several authors have commented that the field of sex therapy has become increasingly enamored with a more medicalized view of sexuality and the treatment of sexual problems (Tiefer, 1995; Szasz, 1980). Although this shift in focus has certainly been welcomed for offering patients a wider range of treatment options, these advances have brought with them some significant concerns.

Without doubt, the most striking illustration of this trend towards medicalization has been the introduction of sildenafil citrate Viagra™ in 1998, followed by the release of its pharmaceutical cousins, Levitra™and Cialis™ (Watter, 2001). Since the advent of Viagra™, more men have been encouraged to seek treatment for concerns regarding erectile functioning than ever before. Indeed, not only have large numbers of men sought out such treatment, but also many have found relief from a condition that had confounded them for years. The success of Viagra™ has resulted in an increased interest in pharmaceutical research in an effort to uncover other potential uses for the drug, as well as the development of other drugs that may be of value in alleviating some of the sexual distress experienced by men and women.

However, such progress predictably comes with a price. In a recent essay, Paul reminds us

> …the increasingly rapid translation of technology to the public results in access to technology before its consequences can be fully recognized. Coupled with what are often less-than-conclusive claims about benefits and about who will gain those benefits, these issues pose additional challenges to ethical decision making (2011, 17).

Specifically, while the potential benefits of a drug such as sildenafil citrate have been touted in both the popular and professional literature, the cost (beyond the financial) has received far less attention. Marino (2009) reminds us that all progress paves over some bit of knowledge or washes away some valuable aspect of practice. That is, with each new technological advance a field inevitably loses some of the art attached to its craft. This concern was echoed in a recent *New York Times* article by Ofri (2011). The ethical concern here is the reality that as the use of technology increases, the risk of becoming progressively distant from patients increases as well. The unfortunate result is that many physicians are spending much less time discussing sexual concerns with their patients and, instead, dismiss them with a hastily taken sex history and a quickly written prescription (Watter, in press).

This prospect creates an ethical conundrum for both patients and physicians. While the availability of medical options for the

treatment of sexual dysfunction has many potential benefits, their emergence on the scene may reinforce the counterproductive and reductionist notion that sex is merely a mechanical process. For many years, sex therapists have attempted to move patients (especially male patients) away from a limiting one-dimensional view of sex as a purely goal-directed genital experience. However, the popularity and easy availability of pharmaceutical interventions have perhaps led patients, and physicians, to assume that sexual problems are simplistic, one-dimensional, and amenable to a "quick fix." The exuberance over the pill as a "simple solution" has great appeal, but overlooks the complexities of the human sexual condition. Tiefer (1995) points out that, "The primary disadvantage of medicalization is that it denies, obscures, and ignores the social causes of whatever problem is under study." She further states that the emphasis on medical treatments and physical causes often allows us to avoid psychological treatments such as marital and/or sex therapy, even though these are precisely the treatments that may be most likely to address the problem adequately. For example, most sex therapists with clinical experience know that simply relieving a symptom may not genuinely improve the person's sexual life. The man with erectile dysfunction who receives a prescription for Viagra™ from his physician may no longer suffer from the inability to achieve or maintain an erection. However, if his relationship with his partner is problematic and this remains unaddressed, his sexual life will likely not improve. The risk inherent in this technological advance is that patients will quickly be handed prescriptions for oral medications, penile injections, or some other medical intervention, and simply be sent on their way without the benefit of an adequate assessment of the situation. Therefore, if sex therapy practices are allowed to turn in this direction, our patients may not be well served by our well intentioned, yet limited interventions.

This concern is not unique to the sex therapy field. The trend toward the medicalization of patient care has created disquiet in other areas of healthcare as well. According to Hartocollis (2010), several medical schools in the United States have begun to make significant changes in their curricula as they have become increasingly concerned that they are producing physicians who have come to view patients as "diseases" as opposed to whole beings. The fear has been that our medical schools are creating practitioners who behave more like technicians than healers. Similarly, the trend toward what has become known as Evidenced-Based Practice, while having certain advantages, has created apprehension that such an inclination will diminish our ability to view people as complex emotional individuals, and result in a focus that overlooks the human aspects of the situation and attends only on the pathology or "disease."

Noteworthy is that the concerns regarding the medicalization of sex therapy are not limited to our clinical interventions. There is also an unease regarding the medical model and its influence on how sexuality, and sexual diversity, may be viewed. For example, viewing sexuality through the lens of the medical model predisposes us to conceptualize atypical sexual behavior as *pathological*. Consider the case of low sexual desire. Complaints regarding low sexual desire are among the most common seen in sex therapy practice. Typically, these cases present as problematic inasmuch as the higher drive partner is dissatisfied with the amount of sexual initiative or receptive behavior of his/her partner. Often, the therapist will seek a cause or explanation for this "problem" and recommend some strategy for treatment of this "disease." Indeed, recent efforts in the pharmaceutical industry have focused extensively (albeit without success) on the development of a medication to "treat" such a disorder (Wilson, 2010). While such efforts may, indeed, improve patient care and outcomes, the question remains as to whether such efforts will ultimately benefit the patient. Bancroft (1991), Brown and Sollod (1988), and Szasz (1980) all point out that if such desire cases are viewed as disease states, sex therapists are then "obligated" to provide some type of treatment. The ethical concern here is whether our own values and moral judgments are influencing our determination of what is pathological as opposed to what may be an otherwise healthy variation in sexual interest.

Most ethicists are keenly aware of the importance of recognizing how values and moral judgments can easily infiltrate realm of clinical decision-making. However, given the fact that sexual discussions are still so often a source of discomfort for a number of clinicians, many of the subtle judgments and biases of our clinical decisions in sex therapy remain largely unexamined. For example, what is the underlying message and appeal of a medication such as Viagra™? A cursory first glance may suggest that the answer here is obvious—the message is that erectile ability can be easily restored and men and their partners need not suffer the frustrations and embarrassments that often accompany erectile failure. However, there is another, perhaps more subtle (and perhaps even dangerous), message that is implicitly communicated, especially with regard to the sexuality of aging patients.

In a recent *New York Times* article, Ellin (2011) discussed a potentially problematic trend toward an increase in cosmetic surgery for Americans over the age of 65. Ellin reports that according to the American Society for Aesthetic Plastic Surgery, in 2010 there were 84,685 cosmetic surgical procedures among patients age 65 and older. This number includes 26,635 face-lifts; 24,783 cosmetic eyelid operations; 6,469 liposuctions; 5,874 breast reductions; 3,875 forehead lifts; 3,339 breast lifts; and 2,414 breast augmentations. All indications suggest that this trend is likely to continue as more and more older Americans live longer, healthier lives.

On the one hand, there should be little reason for concern. If competent adults chose to engage in procedures that they believe will improve their physical appearance and enhance their lives, why would anyone object? In some ways, such practices are entirely consistent with a culture that values and rewards physical attractiveness. While some would object on the grounds that such behavior reinforces a shallow and shortsighted view of what creates life satisfaction and happiness, we have a long history of advocating that people should be autonomous in their decision-making, and have the right to make healthcare choices (within reason) for themselves. Therefore, the "harm" may not be in allowing such practices, but rather in restricting the autonomy of healthcare consumers.

However, such a position, while certainly having merit, may still be problematic. Ethically, the fact that a given intervention may adequately address a presenting problem does not necessarily mean that the intervention is actually good for the patient. Dobken (2010) reminds us that if an action does not advance the care of the patient, then the action is simply not justified. The concern of several ethicists is the increase in cosmetic surgery among the

elderly may, indeed, be a collusive effort between physicians and patients to deny the reality of the aging process. While some may advocate that practices that allow a person to feel more youthful are beneficial and not harmful, others see a concern that we attempt to present an unrealistic (and perhaps unfair) picture to patients that reinforces the notion that youth is "good" and aging is "bad." Clearly, one could interpret the usage of Viagra™ and the other sexual medications similarly.

Yalom (2008) advances this concern a step further. He suggests we have an irrational belief that life is a perpetual upward spiral. We often believe that life should just get "better and better" and it is incumbent upon us that we do all within our power to thwart (deny) the inevitability of an eventual physical decline. In other words, Yalom proffers the notion that much of our anti-aging attitude and behavior is rooted in an existential anxiety regarding death. He suggests that many humans are so terrified at the prospect of death, or running out of time, that we will utilize a set of irrational and delusional of beliefs and actions that represent the (often futile) attempt to assuage our fears of our eventual (and inevitable) decline.

In describing the relationship between sex and death, Yalom offers the following:

> …another death-anxiety emollient—the power of sexuality—kicked in. Sex, the vital life force, often counters thoughts of death. I've encountered many instances of this mechanism: the patient with a severe coronary who was so sexually driven that in an ambulance carrying him to the emergency room, he attempted to grope an ambulance attendant; or the widow who felt overcome with sexual feelings while driving to her husband's funeral; or the elderly widower, terrified by death, who became uncharacteristically sexually driven and had so many sexual affairs with women in his retirement community and created such divisiveness that the management demanded he seek psychiatric consultation. Still another elderly woman, after her twin sister ad died from a stroke, became so overcome with multiple orgasms while using a vibrator that she feared she too would suffer a stroke. Worried lest her daughters discover the vibrator next to her body, she decided to dispose of it (2008, 212-213).

If we look at medications such as Viagra™ through this lens, we are ethically required to examine the question of whether such interventions truly benefit our patients. As we look beyond the rudimentary observation of people will be happy if their aging penises function like the penis of their youth, we are left asking ourselves if we are assisting in creating an unrealistic expectation that human beings can "cheat" death. Rather than supporting our patients in the acceptance of natural aging and the reality that all life comes to an end, we may enable the continuation of the false notion that bodies need not age, sexual functioning need not change, and human life need not eventually end. Perhaps we as healthcare professionals should be more cognizant of the importance of assisting our patients deal with the reality of existence and the quest to find pleasure and enjoyment in the aging process and the natural course of events.

Such questions are clearly complex and require further discussion and debate. However, such questions are also somewhat threatening and are often avoided. The existential fear of death exists to some degree in us all. The value placed on youth and physical enhancements has become so widely accepted that we often fail to notice its pervasive influence on daily living generally, and sexuality in particular. However, we are reminded by Paul, "The most pressing issue for bioethicists may not be in the content of moral discourse, but rather in the way we engage in it. Fundamentally a discipline based in dialogue, bioethics depends on participation—on the articulation of values and principles and the willingness to deliberate with those who disagree" (2011, 17). As ethicists, we need to be willing to examine the underlying, subtle costs of even our most popular interventions. While the medicalization of sex therapy has clearly benefitted many, there are others who are being less well served by this trend. It is our obligation to not allow these patients to become lost in our enthusiasm for the "quick-fix."

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Acknowledgements:
The author wishes to thank Peggy J. Kleinplatz, Ph.D. for her suggestions on earlier drafts of this article.

Competing Interests: *None.*

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Date of Publication: *November 22, 2012*