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Medicalizations and Demedicalizations of Sexuality Therapies

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This article complicates recent discussions about the expanding zones and influences of medicalization and biomedicalization on sexuality and sex therapy by contextualizing them with competing nonmedicalizing trends. These latter developments include an escalating non-expert commercial sexuality sector on the Internet, as well as a long history of anarchic and democratizing social politics, such as “the counterculture” and “free love movements.” What these nonmedicalizing trends have in common is the view of sexual problems and solutions as far broader than sexual dysfunctions and sex therapies, a belief in the social determinants of individuals’ sexual experiences, and a deep concern regarding the socially harmful consequences of medicalization. With the quantity of sexuality information and advice available to the public through the Internet only likely to expand, a long era of clashing claims about relations between sexuality and health and about the role of expertise in sexual life can be foreseen.

The Current Picture

The “medicalization of sex” is a phrase that has been used, often critically, to describe recent decades’ focus on biomedical language, explanations, and solutions to address what are often psychological, relational, and social conditions and problems of sexuality (Tiefer, 2004). This trend seems currently on the upswing, although the phrase can refer to theory and practice in any historical period wherein conceptual and practical hegemony is granted to medical personnel and their zones of expertise and license.

Currently, medicalization prevails throughout health care, especially women’s health care, and has been traced to a variety of long-term cultural drivers, such as the 20th century’s growing enchantment with reductionist biomedical research and new health care technologies and an overreliance on professional experts to solve many life problems (Moynihan & Cassels, 2005; Wright & Cummings, 2005). Anthropologists and sociologists have long offered critical analyses of medicalization rooted in their concern for social determinants and social meanings of health and illness (Mishler et al., 1981). In recent years, however, critique has focused on the aggressive role of hospitals and the pharmaceutical industry in promoting unnecessary treatments, tests, and diagnoses as a way to sell medicines and medical services (Moynihan & Cassels, 2005; Welch, Schwartz, & Woloshin, 2011).

In the field of sexology, medicalization can be seen in the growing authority over sexual matters given to medical experts in the past two centuries, but especially in the growing visibility of a new cadre of “sexual medicine” specialists backed by the pharmaceutical industry in the past two decades (Tiefer, 2004). Experts live not only in the world of bricks and mortar, but in cyberspace. As the Internet has grown as a source of information and products for sexuality, both individual and corporate medical entrepreneurs are represented by Web sites and blogs touting their expertise and their products’ effectiveness to solve sexual problems.

However, this dominance has current challengers wherein new communication technologies, such as cable television, smart phones, and the Internet, are being used to offer alternative metaphors and practices to medicalization. Other examples can be found in history. This article examines some historical and contemporary challenges to the medicalization of sexuality therapies.

What Are Sex Therapies?

If asked, “What is sex therapy?,” many would think of Masters and Johnson (1970) and their behavioral...
psychotherapy for couples, or of Viagra and the new world of sexual medicines. “Sex therapy” is actually an amorphous category more familiar in the popular press than as a professional term, but both the Masters and Johnson (1970) couple-focused treatment approach and sexuopharmaceuticals have been publicized and popularized by the media, professionals, and rafts of textbooks for several decades. They are defined as the go-to (although competing) treatments for “sexual dysfunctions” (i.e., deficiencies of arousal and orgasm in the so-called universal “human sexual response cycle” first described by Masters and Johnson, 1966, over four decades ago).

However, asking “What are sex therapies?” directs the question away from sexual dysfunctions to the much broader category of sexual problems and discontented and to a far-flung world of interventions. Shifting the lens produces a list that includes Masters and Johnson and Viagra, but also includes ancient love potions, bloodletting, 19th century masturbation control devices, female genital mutilation surgeries, sessions in Wilhelm Reich’s orgone accumulator (Turner, 2011), community-based sex education offerings, sacred sexuality tantric education, open marriage, mandatory pre-marital counseling, campaigns against sexual violence, 1980s New York City bodysex weekend workshops, challenges to religious fundamentalism, and 21st century YouTube kissing advice videos, just to name a few.

The contemporary official discourse of sex therapy, in other words, results from experts’ and media’s focus on a certain kind of understanding of sexual problems and a specific range of relevant remedies. It focuses on problems as deficiencies in assumed “natural” functions (i.e., those that have been medically classified and vetted) while minimizing other kinds of sexual problems and interventions not regarded as backed by scientific evidence or as requiring professional assistance. These “other” kinds of sexual problems and dissatisfaction (e.g., disapproval of one’s weight or sexual preference and consequential discomfort with nudity or self-disclosure) may be further marginalized by being called “political.”

Determining which kinds of sexual problems are regarded as “important” and “real” is central in the debate over medicalization. By emphasizing biological aspects of sexual experience, experts bias the public’s understanding of sexuality and underestimate the role of social conditions and expectations in constructing sexual experience (Tiefer, 1996). Medical authorities might insist that they are not minimizing problems such as sexual compatibility, comfort, tenderness, or technique simply because they focus on topics they are expert on, such as blood flow, hormones, and neurotransmitters, but a political analysis argues otherwise. The prestige of the medical voice in the current atmosphere inevitably sidelines and marginalizes competing points of view (Caplan & Cosgrove, 2004).

The effort by the World Health Organization (WHO) in 2002 to define sexual health offers an alternative view:

Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.1

Medicalizations and Demedicalizations

In the view of one of its most prolific analysts, medicalization refers to the shifting of social and behavioral problem definition and management into the medical domain (e.g., from drunkenness to alcoholism or from shyness to social anxiety; Conrad, 2007). It involves the triumph of a hegemonic medical model, nomenclatures, research, and teaching, and it involves the geometric expansion of medical institutions, money, and health media. According to sociologists, medicalization became one of the defining social processes of the 20th century as the cultural and institutional authority of medicine expanded (Starr, 1982).

In this sense of the term, the medicalization of sexuality locates sexual problems and interventions within a professionalized framework of diagnoses and therapies, identifies health-trained personnel (not just physicians) as sexuality experts, foregrounds traditional medical emphases of individual factors and universal processes as the important axes for understanding, and anoints biomedical strategies as the favored interventions (Tiefer, 1996, 1997, 2001, 2004). The current wave of highly advertised sexuopharmaceuticals and sexual medicine clinics clearly celebrates and promotes the new slate of biomedical assessments and interventions, but it is important to emphasize that medicalization is about a medical model mindset that can be implemented by diagnosis-driven psychotherapies as easily as biotherapies.

A recent and broader perspective, referred to as “biomedicalization” (Clarke, Mamo, Fosket, Fishman, & Shim, 2010), went beyond the increasing availability and popularization of medical experts, theories, and

1See http://www.who.int/topics/sexual_health/en/.

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treatments to emphasize the expanding roles of technoscience and commercialization in shaping the public’s self-understandings and choices. The commercial promotion of “newer and better” treatments and diagnostic machines feeds into a culture already obsessed with what Robert Crawford (1980) called healthism: “a preoccupation with personal health as a primary, often the primary, focus for the definition of well-being” (p. 386). Biomedicalization encourages the public to view any life experience (e.g., pregnancy, sleep, menstruation, love, hobbies, and moods) as a potential matter of health versus illness, normality versus abnormality (Nye, 2003). Keeping track of one’s health score on so many aspects of everyday life requires constant self-scrutiny, and creates a population of “worried well” people (Barsky, 1988).

The biomedicalization of sexuality, then, refers to how sexual activity and experience are surveilled and self-disciplined by a public trained to think in terms of sexual norms: proper sex versus sexual perversions, inadequacies versus excesses (i.e., to automatically judge sexual fantasies, desires, object choices, activities, and identities—their own and others—as normal or unhealthy).

Viewing sexuality as a matter of health and illness, with authority in the hands of medical experts, however, while a dominant cultural trend that is clearly enhanced by mass media and the prevailing medicalized thinking, has not gone unchallenged. One important source of critique comes from what might be called the “alternative sexualities communities.” More or less organized around the normalization and even the celebration of sexual and gender diversity, various social utopians, open marriage, sex radical, or free sex groups strive to de-pathologize identities and practices that sexual medicine experts classify as disordered or “queer” (e.g., ambiguous gender expressions, nudism, asexuality, sexual practices involving fetishes, domination or pain, public sex, multi-partner sex, polyamory, sexual practices derived from Eastern philosophies, masturbation as a primary sexual outlet, and substance-enhanced sexual experiences).

Until recently, members of these communities met and wrote in secrecy or anonymity because their practices and philosophies were often illegal and widely condemned. However, in recent years, alternative newspapers and magazines, network television talk shows, the Internet, cable TV (including reality shows), sex “expos,” and sex toy stores have made diverse sexual ideas and practices increasingly well known, if not always highlighting the philosophy and community behind the practices (Gamson, 1999). Celebrating sexual diversity is often in direct confrontation with a norms-based medical model of sex, and as this movement grows, the challenge to medicalization grows with it.

In addition to the explicit opposition to medical model thinking and the denigration of sexuality experts as “the sex police,” there is a growing collection of professionals, other than mainstream health professionals, who offer sexuality advice and treatment (e.g., experts on nutrition, detoxification, yoga, prayer, hypnosis, massage, vitamin injections, and pelvic floor function, not to mention devotees of Primal “Scream” Therapy or other healing ritual therapies). However, practitioners of various alternative and complementary “nonstandard” therapies frequently strive for professional status (and remuneration) and use quasi medical model language (e.g., expert, normal, healthy, and pathology) and individualized interventions, so we do not consider them here as contributing nonprofessional challenges to medicalization.

There is, however, a nonprofessional aspect to much sexuality education and advice over the centuries that can be viewed as part of the critique of medicalization. Many cultures, especially non-Western and non-industrialized cultures, incorporate aspects of sexual training and initiation into traditional rites and relationships between children and adults.2 “How-to” sexuality education is often culturally normative. Another prime source of nonprofessional sexuality training, of course, comes from the hands-on worlds of prostitution and pornography. In his recent biography of Masters and Johnson, Thomas Maier (2009) described how St. Louis prostitutes were initially sought out as sex educators for the research team because of their presumed knowledge of techniques of stimulation. Masters and Johnson’s use of nonprofessional sexual surrogates for nonpartnered patients was one of the most famous aspects of their early counseling program.

Nina Hartley (1999) is only one of many who used pornography in a self-directed study program to overcome sexual inhibitions due to “negative conditioning” (p. 203). Nonprofessional sexual self-help books are replete with non-pathologizing recommendations to view pornography for remedial education, enhancement, or improved sexual adjustment. Similarly, sex advice has been a mainstay of women’s and sex-oriented magazines, and in many cases, the advisors are chatty nonprofessionals. De-professionalization has escalated with the post-1960s decline in obscenity prosecution and the subsequent rise in sex accessory stores offering technique-oriented workshops. The authority for the advice in these instances comes, in large or whole part, from outside the medical model, and as they grow in popularity, the demedicalization trend expands.

### History of Sex Therapies

#### Before Sexual Science

In ancient times, and in many parts of the world even today, sexual life was largely regulated by religious and political, not medical, dicta, although doctors were

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2See [http://www2.hu-berlin.de/sexology/GESUND/ARCHIV/GUS/GUSVOLIICH7.HTM](http://www2.hu-berlin.de/sexology/GESUND/ARCHIV/GUS/GUSVOLIICH7.HTM).
called on for obvious physical problems of reproduction or venereal diseases. People who were dissatisfied with their love lives and might want enhanced sexual performance or experience could turn to a variety of spiritual, physical, and interpersonal experts. We know from myths, legends, and ancient texts that magical remedies such as prayer, herbal concoctions, and the casting of spells and charms have been in widespread use to modify sexual experiences (McLaren, 2007).

Millenia of “lovesickness” or “love melancholy” provide an example of how the twin deviations of sexual excess and deficiency have long drawn the attention of experts (Duffin, 2005). This “condition” was known in ancient Greek, Roman, Arabic, medieval, and Renaissance philosophy and medical texts, and numerous paintings depicted lovesick women and girls with their physicians. Baths, bleeding, distraction, and satisfying sexual intercourse were all recommended as treatments, depending on the expert’s ideas about etiology (i.e., Was it largely in the head, the heart, the genitals, or the humors?). Duffin (2005) claimed the condition disappeared due to the rise of a positive attitude toward sex and love in the 20th century. However, searching the Internet for “love-sickness” identifies numerous contemporary books that link this “problem” to physical, psychological, or social causes (i.e., obsessions, neurotransmitters, evolution, or cultural traditions prohibiting free partner choice).

The forthcoming edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (5th ed.) will probably list hypersexual disorder3 in the appendix with language which will reframe some elements of the old lovesickness in modern scientific terminology. Both the lovesickness and hypersexuality designations reflect a core element of medicalization—the presumed validity of a norm designated by experts along with the advisability of “treatment” for norm deviations. As a thought experiment, imagine a model that did not regard lovesickness as a condition or disorder but, rather, as a personality trait (“Oh, that’s just Joanie, she’s always mooning over some guy or other”), the vicissitudes of youth (“I can hardly wait for Aaron to get past this moony phase”), or a particular subcultural expression (“Oh, those lovesick Italians!”). The essence of non-medicalized approaches is the embrace of diversity as the result of culture, psychology, life stage, or social context.

Post-Enlightenment Sexual Radicalism

The Enlightenment produced a new cultural focus on the power of science and human reason to improve society. Social reforms of the 19th century included better industrial working conditions, public education, and the abolition of slavery. Prostitution, masturbation, nymphomania, and venereal diseases were the primary sexual interests of social reformers. Medical experts condemned these as deviant sexual practices and recommended both physical and psychosocial treatments including isolation, punishment, retraining, and various biological purges and genital surgeries (Money, 1998).

However, the 19th century also saw a proliferation of nonmedical theories and reformist sex experiments purported to enhance sexual experiences for ordinary people. Marriage reform, utopian communities, and “free love” movements were known in many parts of Europe and the United States (Sears, 1977). These social experiments offer examples of manipulating social arrangements to enlarge opportunities for sexual satisfaction—a public health approach to preventing sexual problems through social engineering. Social engineering, of course, can be “sex-positive” or “sex-negative” (i.e., designed to foster lots of good sex or, conversely, to dissuade and inhibit sexual expression, as is found in much traditional and fundamentalist religious teaching).

Early Sexual Science

Throughout the 19th century, theorists and governmental authorities increasingly viewed the old sexual heresies as forms of medical deviation. Although censorship was strong due to the U.S. Comstock laws of 1873 prohibiting obscene, lewd, or lascivious information, some medically oriented books and those by clergy were permitted (Sears, 1977). Medical authors elaborated on a few case-studies and ideas about “sexual instincts” or “sexual impulses” (Weeks, 1985).

Sexuality study and theory grew in the 20th century, although censorship prevented social science research and nonmedical or nonclerical books for many years (Bullough, 2008; Weeks, 1981). In the turn-of-the-century Progressive, Communist, and Socialist atmosphere, sexual problems were often blamed on destructive social forces, and enjoyment of sexual life was thought to require sweeping cultural changes in sex roles, public education, religiosity, and political freedoms. Some authors advised that social improvements alone could generate good sex lives, whereas others predicted a permanent need for the kind of individual unblocking offered by the new psychoanalysis (Hall, 2011).

However, widespread use of traditional elixirs, potions, and nostrums for sexual ills continued alongside the nonmedical new sexual politics. Emerging wonder sciences, such as endocrinology and radiology, contributed new biotechnologies. “Organotherapy” (i.e., the use of extracts of every conceivable bodily tissue), for example, became a fin de siècle panacea for virtually every disorder, and treatment with a new discovery, radium, in creams, baths, and potions was offered for

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sexual problems (Sengoopta, 2003). The enthusiasm that greeted these developments continued as uncritical technology worship throughout 20th century medicine, paving the way for the contemporary medicalization of everyday life (Grimes, 1993).

Robinson (1976) observed that prior to the 20th century, medical writings about sex chiefly focused on problems of excess (lust, self-abuse, and deviant desires), but that in the 20th century, they shifted to problems of weakness—inadequate arousal, desire, and inability to perform properly. Consequently, medical interventions in the 20th century were more likely to be psychoeducational, therapeutic stimulants, and psychotherapeutic unblockers than restrainers and inhibitors.

Beyond Advice Manuals: Mid-Century Sex Advice in Theaters, Movies, Newspapers, and Magazines

Sex advice manuals by clerics and doctors around the turn of the 20th century were flowery and euphemistic texts about love and marriage (Kent, 1979), but, increasingly, professional sex books offered explicit advice about normal relationships, psychology, and medical recommendations (Hall, 1991).

Sober advice columns in newspapers and magazines competed for the public’s sexual attention with new popular entertainments such as vaudeville, burlesque, and blues, with their sexual innuendo and suggestive dances. Silent and talking films depicting sexual expressions and transgressions were watched by ever-larger audiences (Williams, 2008). Cultural studies scholars have barely begun to examine the sexual discourses embedded in these new entertainments, and we are far from unpacking their “advice” about sexual life. Nevertheless, social, biological, and psychological remedies are all clearly present. Many films and songs illustrated people changing their sex lives simply by changing partners or improving techniques, but there could also be subtleties in the messages of the arts. A 1920s song by Sophie Tucker, the “red hot mama” of vaudeville, for example, called “Vitamins, Hormones, and Pills,” refers to “injections” that men get to “warm up the cold ones, make young ones of the old ones.”

Although the song criticizes doctors, and Tucker’s own preferred recommendations were “dining, dancing, and romancing to stir up a lady’s affection,” we can assume members of the audience took note of the new medical options.

Postwar Sex Therapies

The modern era of sex therapies is often said to have begun with the medical work of Masters and Johnson in mid-century America (Robinson, 1976). Masters and Johnson used their 1950s and 1960s genital and nongenital physiology research to describe a normative sexual response cycle, and labeled deviations in arousal or orgasm as sexual dysfunctions. They developed a psychotherapy program for couples that combined sex education, communication skills, behavioral homework, and cognitive reframing. Numerous medical schools established sex therapy clinics and training programs in the 1970s in psychiatry departments. Although the approach was largely psychological, it emphasized the cardinal elements of medicalization: norms, expertise, and classification.

A less well known “humanistic sex therapy” approach (Irvine, 1990/2005; Tiefer, 2006) integrated Californian sexual counterculture together with the new medical sex therapy. In the 1960s, the “human potential movement” popularized experiential practices such as sensitivity training, encounter groups, gestalt therapy, and bodywork, which were developed in 1920s Europe and brought to the United States by immigrants and refugees (Moss, 2001). Humanism-derived sex therapies included group treatment for couples and individuals (Barbach, 1975), structured group work to enhance the experience of couples with and without sexual problems (LoPiccolo & Miller, 1975), the use of surrogate partners for single patients (Wolfe, 1973), and the practices of nudism, body imagery work, and sexually touching clients (Hartman & Fithian, 1974).

Not calling itself “sex therapy,” physical bodywork practices developed by Rolf, Feldenkrais, Reich, Alexander, and others also addressed sexual blocks.

Some of these humanistic contributions embraced aspects of a medical model (pathologies, experts, and treatments), whereas others clearly did not. In some group therapy and sex enhancement workshops, for example, major goals were “empowerment” via peer exchange and “authenticity” in self-disclosure and body acceptance. As sex therapy professionalized, however, elements of humanistic practice (e.g., directed masturbation practices) became techniques within a medical model of symptom removal, rather than optional elements of sexual growth in a nonmedical project.

Medical Sex Therapies During the 1980s and 1990s

Beginning in the mid-1980s, urologists became interested in men’s erections (Wagner & Kaplan, 1993). Their surgery-based specialty needed to evolve in order to cope with a reduced need for kidney and benign prostate surgeries, and a path to sexual medicine was opened by the increased acceptability of nonpsychiatric physicians investigating sexual topics (Tiefer, 1994, 2004). Urologists’ sex therapies included off-label medications, permanent surgical implants, penile blood vessel surgeries, and drugs injected into...
the penis. Patients’ sex partners were not routinely consulted, and the focus was on the penis as a biomechanical mechanism.

Things changed dramatically with governmental approval of sildenafil citrate (Viagra) in 1998. Primary care physicians, as well as urologists, now had a medication to prescribe for erectile dysfunction and less incentive to refer patients for psychosexual therapy or to look for nonmedical alternatives. Following Viagra’s enormous media attention, and capitalizing on the biological zeitgeist of molecular biology and Human Genome Project promises, sex clinics offering medical interventions opened in major cities.

At the end of the 1990s, numerous journals and professional associations, initially organized by urologists, replaced impotence with sexual medicine in their names to advertise expertise in women’s and men’s sexual dysfunctions. The new focus on sexual pharmaceuticals spurred by Viagra became evident in conference programs, sponsorship and exhibit areas, medical education, and sex research. This phase of sexual medicalization followed the general move of the pharmaceutical industry and medicine into “lifestyle” areas (Elliott, 2003)—a ready-made opportunity for sexual topics. Medical advertising, public relations, celebrity spokespeople, and direct-to-consumer pharmaceutical advertising all played important roles in shifting public preferences toward medical solutions and “healthist” self-surveillance. Nevertheless, other influences on public opinion were growing at the same time.

Books, Films, TV Shows, and HIV Education as Sex Therapies

Sexual advice books were available throughout the 20th century, as we have noted, but their visibility zoomed after the decline in obscenity prosecution, the publicity about Masters and Johnson, the “hippie” sexual revolution of the 1960s and 1970s, and the explosion of convenient bookstore chains like Barnes & Noble. For Yourself: The Fulfillment of Female Sexuality (Barbach, 1975), The Joy of Sex (Comforth, 1972), and Male Sexuality (Zilbergeld, 1978) were examples of bestsellers that combined anatomical and psychological sex education, behavioral suggestions, and humanistic sex therapy elements. Most used medicalizing language and health and function rhetoric to legitimize sexual complaints and help-seeking. Consequently, it may be that by their very frankness, these bestselling texts paradoxically increased self-consciousness about norms and sexual performance standards. In recent decades, the demedicalization trend noted earlier has allowed popular books by celebrities to proliferate. They offer advice based on assumed personal sexual success and insight, common sense, and random professional sources. All kinds of people are designated sex experts now that censorship of sexuality information is dead.

Explicit sex films had been privately produced since the dawn of filmmaking, and became available to the public in movie theaters in the 1970s and then in the home due to the video cassette tape industry in the 1980s. Many have argued that each advance in video technology has been a response to public demand for explicit sexual materials (Arlidge, 2002). Mark Schoen, a sex education filmmaker, said that, for years, his films were only available for professional trainings at conferences and colleges (often viewed in marathon sessions called “sexual attitude restructuring” sessions), but that the very same films began to be sold to the public on videocassette in the 1980s. Then, he said, ordinary people used them to enhance their sex lives and address problems. The marketing of these films initially used healthist medicalized language but, over time, came to emphasize non-medical sexual goals of entertainment, pleasure-seeking, curiosity, and self-improvement.

Around the same time, people began to be able to access cable television shows with nude striptease and bawdy talk, and even network daytime television talk shows featured frank sexual topics and controversies. Although the topics were often handled by the hosts and audiences as freak displays, the discussions were doubtful sources of nonmedical sexual ideas and information (Abt & Seesholtz, 1994). The current wave of “reality” television shows continues the sexual boundary breaking. Deborah Lupton (1994) argued that the discursive limits imposed by the structure of the shows served “to disempower and punish the more extreme representatives of sexual plurality” (p. 62). This is probably true, and at the same time, alternative sexualities were demystified in these genres by exposure and familiarization.

With the rise of HIV and AIDS, much sex counseling and education became pathology-oriented preventive risk-reduction. However, a few programs emphasized nonmedical issues of eroticism and pleasure. Joseph Kramer, a gay San Francisco massage therapist, began a series of community workshops in 1984 called “Celebrating the Body Erotic,” which taught erotic techniques to increase sexual intensity and pleasure without the exchange of bodily fluids. Kramer’s approach involving touch and breathing was too spiritual for some, whereas others would later adapt aspects to a “safer sex” sex education approach called “outercourse” (Cobb, 1997). Kramer’s work is a bridge from the humanistic sex therapies to the Eastern-derived sex therapies (“Tantra”) of the current alternative sex movement.

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6See http://www.youtube.com/watch?v=oxRsGTKUfJU.
7See http://donshewey.com/sex_articles/body_electric.html.
Conclusion: The Internet and the Future of Medicalizations and Nonmedicalizations

The Internet is the epitome of postmodern indiscriminacy. It has increased access to pro-medical, as well as anti-medical and nonmedical, sexual theories and therapies, putting practitioners of alternative sex practices and owners of sex toy stores on an equal footing with physicians and other professional experts. Searching online for sexual advice, enhancement, entertainment, or remedy can instantly lead to explicit videos, surgeries, supplements, medical treatments, instructional videos, sex coaching, or weekend workshops, all seemingly on a level playing field. In 2010, YouTube announced that every minute, 35 hr of video are uploaded to their site (it is geometrically more by now), and it is likely that a large proportion of that focuses on sexuality.

However, it is not only the Internet that has blurred lines between different types of expertise and different sources of information. Sexual coaches, for example, like sexual surrogates in the pre-AIDS 1970s, engage in bodywork interactions (more or less erotic) with their clients/patients/students for the purpose of what is, in the context of this article, sex therapy, or in the context of many state laws, prostitution. In another boundary-leap, Annie Sprinkle, well known for performances featuring sexual subjects and nudity, was a recent New York Times book review author (see Sprinkle, 2011). The book was a memoir about a man’s life as a prostitution customer, and Annie established her credentials “as someone who has had sex of one sort or another with more than 3,000 Johns myself” (Sprinkle, 2011). This recalls Masters and Johnson’s public use of prostitutes as expert informants in the early days of their sex research—a tactic they later jettisoned, however, out of concern for propriety and legitimacy (Maier, 2009). No letters to the editor were published that complained about the propriety of a New York Times review by Annie Sprinkle.

It remains to be seen how much the new democratization of information on the Internet will disrupt the mindset that views sexual life through the lens of health and illness. Sexuality tradeshows featuring erotic performers and products, and also including professional therapists with advanced degrees and professional standards, are growing in popularity around the world. Does the presence of members of both groups enhance the overall credibility of the convention? How consumers and professionals understand the clash of ideas and models urgently needs to be studied.

Some cultural critics argue that sex has already become unmoored from social contexts and conventions, and has become a normless search for desire for its own sake, orgasm on its own terms (Baumann, 1998). However, satisfaction is more elusive without norms, especially when expectations are high, and in such an environment, sexual discontent will become universal and therapies infinite. Certainly, the marketplace is ever at work creating new objects for desire, new foci for dissatisfaction, and new commodities and services as solutions.

However, as the growth of alternative sexualities expands, the paradigm of problems and therapies may shift away from medicalization and biomedicization toward a multisexualities diversity model. Society and individuals will continue to need various kinds of help, but perhaps in the next era they won’t turn—or first turn—to medicine or a model centered on health or illness to lead the way.

References


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9Just Google “sex coach” to see what I mean.