

Concept Paper

# Medicalization of Sexuality and Trans Situations: Evolutions and Transformations

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**Abstract:** This article explores the evolution of the definition and the process of medicalization of sexuality during the second half of the 20th century. After a review and discussion of the notion of medicalization, the application of this notion to a few examples is discussed, including the emergence of sexuality, the demedicalization of homosexuality, the treatment of “sexual disorders”, the prevention of HIV infection, and the gender-affirmation pathways for transgender and gender diverse (TGD) people. The analysis of these situations—in the light of the notion of medicalization—allows us to better understand the multiple facets of this notion. In particular, we observe processes of medicalization and demedicalization, depathologization, and pharmacologization. The notion of medicalization of sexuality appears here as a useful concept for understanding the conceptualization and treatment of diversities in the field of sexuality and gender.

**Keywords:** medicalization; sexuality; social control; pharmacologization

## 1. Introduction

Since the release in 1998 of new pharmacological treatments for male erectile dysfunction, and, more recently, the release of some pharmacological treatments for women’s sexual problems and disorders, there has been a renewal and reformulation of the issues and controversies regarding the medicalization of sexuality. The questions raised by the “medicalization of sexuality” lead to a renewal of the general questions about the medicalization of society in general, which has already been conceptualized in the work of Conrad [1] and others who have developed other notions, such as “biomedicalization” [2]. As historian Olivier Faure has already noted, “the term medicalization refers to multiple realities, has different origins and gives rise to opposing interpretations. Much more than an object of consensus, the notion of medicalization is an inexhaustible source of debate among historians, which makes it rich, but also ambiguous” [3]. The situation observed by Faure with regard to historians applies perfectly to sociology, anthropology, and science and technology studies (STS) in which this work is situated.

Attitudes towards the issue of the so-called medicalization of sexuality are not univocal. Depending on the professional position, the personal conceptions, and the professional interests that one defends and tries to promote, the question of medicalization is not approached in the same way. Everyone may consider the legitimacy of the use of this concept differently, the positive aspects or, conversely, the negative or problematic aspects. The different evaluations of the dimensions and values associated with the processes of medicalization vary also according to the objects under study: male and female ‘sexual disorders’, HIV prevention techniques, and treatments aimed at facilitating the gender affirmation process for transgender and gender diverse (TGD) people. These different evaluations and their possible designation as forms of “medicalization” of sexuality or gender issues vary according to the historical moments and the actors involved in these processes. In the examples that will be discussed in this work, violent controversies that opposed actors involved at different levels were observed, either, on the one hand, between different professional groups involved in a given situation, or, on the other, an opposition



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between differently positioned groups regarding a specific condition, i.e., medical doctors and groups of patients, users of care, and consumers. It is, therefore, the understanding and discussion of the fundamentally controversial nature of medicalization processes that makes them interesting and that will be the central focus of the present work.

## 2. Materials and Methods

The reflection carried out in this article on the question of the medicalization of sexuality has its origins works carried out by the author on the use of drugs to treat “sexual disorders” in men [4] and women [5], on the evolution of HIV prevention with the arrival of effective retroviral drugs [6], and on the questions of medicalization and depathologization of medical treatments concerning gender affirmation pathways [7]. This article proposes a theoretical and political reflection on the qualification of different situations as medicalization and the consequences that this designation entails on a practical and political level. It is based on research performed in Europe, North America, and Brazil.

## 3. State of the Art

The problem of the “medicalization of sexuality” is the subject of several controversies that oppose health professionals and health care users, sometimes organized into patient and consumer associations that play an increasingly important role in health and health care issues. The question concerns different objects and gives rise to contradictory views concerning the evolution of sexuality, the transformations that are undergoing under the influence of the pharmaceutical industry and medicine, the coherence and even the ethics of professional interventions, and, last but not least, the participation of consumers’ and patients’ associations.

The use of the term “medicalization” in current debates and controversies about sexuality is, thus, embedded in the social world, and these debates are embedded on the different representations of sexuality and gender held by different groups with different professional and ideological views and objectives. The examples discussed in this paper demonstrate that the actors currently involved in social and political debates about sexuality use the same term “medicalization” with different meanings and representations. The use of this term in the social world is, therefore, different from that observed in the academic world, particularly in sociology and history. However, health professionals use some kind of common sense meaning of the term medicalization which may be somewhat different from its academic definitions. We can, therefore, speak of a “common sense” of the professionals. If there is a plurality of understandings of the professional common sense of medicalization, this is because it is (1) based on different representations of sexuality that refer to a plurality of professional or ideological objectives, as well as to personal subjective positions, and (2) related to the implications of medical and pharmacological treatments for the conditions that fall under the jurisdiction of these professions. Psychologists dealing with “sexual problems” and “impotence” will not have the same representation compared to urologists dealing with “erectile dysfunction” and will not use the same approaches, tools, techniques, and pharmaceutical products.

Thus, not only do these different representations of sexuality conveyed by professionals allow us to understand the dividing lines that have emerged in the debates on the medicalization of sexuality, but they also reveal the blind spots in each of these conceptions of medicalization. For example, there is rarely mention of the “medicalization of sexuality” in the context of HIV prevention, even though this field of activity involves both changes in sexual behavior and medicalized interventions of various kinds (prevention, recommendations, treatment, etc.) that are grounded on medical and public health knowledge, whereas the field of the disorders of sexual function is saturated with controversies around the medicalization of sexuality, including pros and cons. The field of treatment for gender affirmation is more often described and discussed as a process of “pathologization” and “de-pathologization” which excludes a critique of the concept of medicalization.

The study of “medicalization of sexuality”, as a system of polarized representations, must be based on a socio-historical analysis of the field of sexuality and the care of which it is the object in the Western world. “Sexuality” is being understood here as the field of words and concepts that define and represent it. This is why, in the present work, even if our initial reflection on the medicalization of sexuality started in the field of ‘sexual disorders’, we considered it fundamental to test the ideas developed in this field in other areas that were not immediately analyzed from the angle of medicalization. The approach developed in this article is based on the work by the French sociologist Robert Castel (1933–2013) in which he considered that, in order to understand the contemporary mental health system, it was necessary to include “the whole range of practices and theories”, starting from the practices of prison psychiatric hospitalization, to the prescription of psychotropic drugs, to the different psychotherapies, and to the practices of personal development and psycho-corporal approaches, which were very much in vogue at the beginning of the 1980s and were carried by an ideology of contestation of the “psy” system [8]. Castel demonstrated that a unifying logic was underlying all of these apparently opposed practices and discourses. The ambition and the aim of this paper are to describe the underlying and unifying logic of medicalization in those situations that are analyzed beyond apparent controversies. In this perspective, this work is different from the work published by Ortega and Zorzanelli, in which these authors discuss the fluidity and potential inaccuracy of this concept [9].

#### 4. The Medicalization of Sexuality: Conceptual Approaches

The expression “medicalization of sexuality” tends to give some substance to the idea that there is an essence of sexuality outside the field of medicalization, and that medicalization would have distorted the very essence of “sexuality”. However, an analysis of the history of sexuality since the middle of the 19th century shows that the destiny of sexuality has been inseparably linked to developments in science and medicine and to different medical and psychological approaches. In this perspective, to speak of “medicalization of sexuality” would almost be a pleonasm, insofar as the concept of sexuality appears in the register of physiology and medicine (outside of medicine, there is no “sexuality”). It would be also to ignore that the term “sexuality” is already in itself a historically dated representation of a set of phenomena designated under other terms in the course of history [10]. Michel Foucault has clearly shown how the term “flesh” was used in early Christian pastoral care to address the phenomena currently designated under the definition of sexuality, while referring to a different “experience” and *episteme* [11]. Medicalization then unfolded from the different “foci” of the medical disciplines, each one responsible in its own way for dealing with one of the problems posed by sexual conduct, whether conjugal or non-reproductive and “perverse”. More recently, the French historian Alain Corbin has analyzed the phenomena of “sexual life” in the period between the middle of the eighteenth and the nineteenth centuries before the term “sexuality” appeared in the language of physiology and medicine in English and French languages. Corbin, thus, highlights another form of medical understanding of sexuality in which medicine appears to be responsible for a “just measure of pleasure”, set aside from questions of procreation, and supports the idea of the necessity of a “moderate” sexual pleasure for the “harmony of couples” and the good health and well-being of individuals [12].

However, if we should take for granted that modern sexuality has indeed developed in a scientific and medical context, the term medicalization, as used by sociologists and historians who have been interested in this question, allows us to understand the genesis and the social, political, and psychological implications that have presided over the elaboration of medical representations of sexuality. Georges Lanteri Laura has approached this question from the angle of “the medical appropriation of sexuality”, highlighting that the implantation of sexuality in the field of medicine is the result of a historical process based on the pre-constructions operated by the dominant ideology and the penalization of certain behavior (male homosexuality constituted the paradigm of these approaches) [13]. Thomas Szasz has shown, from the example of masturbation, how the medicalization of sexuality

has consisted in a progressive appropriation by medicine of behavior and personalities previously treated by religion or by justice [14]. Arnold Davidson has developed the notion of a “style of reasoning” applied to psychiatry and medicine. The development of different and divergent representations of sexuality, elaborated according to the division of tasks between somatic medicine (such as urology and venereology) and psychiatry, makes it possible to explain how the question of sex inscribed in the body has been transferred to that of the personality and subjectivity of the perpetrators of deviant behavior [10].

Other sociologists, within the framework of sociology of deviance, have understood the process of medicalization in a dynamic form by situating the institution of medicine in relation to other institutions that play a central role in the social world and in the management of the body and behavior: the religious institution and the legal institution. In this perspective, the process of medicalization appears as the object and the result of a conflict between the medical institution and these other institutions, which has as its goal the designation of phenomena and the definition of legitimate response to them. Thinking about medicalization within the framework of sociology of deviance implies a decentering of the conceptions of medicine and its social role, of the conceptions of illness, and of the role and social status attributed to those living with an illness.

In this context, Peter Conrad has defined “medicalization as a process by which everyday life problems come to be defined as medical problems, most often in terms of diseases or disorders” [15]. From a sociohistorical perspective, Conrad and Schneider introduce the idea that medicalization is a form of designation that historically replaces other forms of designation of deviance established by other institutions of social regulation and control. They explain the processes by which Western society has transformed a number of conditions and behaviors “negatively condemned by society” into forms of disease [16]. The “unnatural acts” initially treated as sins in the religious context were transformed into crimes or offences in the judicial context, and then, more recently, into diseases to be treated in the medical register, before leaving the field of pathology and being constructed as a form of social identity and participation in a “community” [17]. Conrad and Schneider, thus, highlight a form of circulation, historically determined, of the processes of designation of deviance, which makes it possible to change the representations and meanings attributed to “deviant” behaviors, as well as the forms of social treatment that are intended for them. A profound transformation of the ideology and functioning of modern society has driven the way in which social behaviors are interpreted. Thomas Szasz has described the following in his work: “With the transformation of the religious conception of man into a scientific one—particularly through psychiatry—which developed systematically during the 19th century, there was a radical shift from the view of man as a responsible agent acting in and on the world to a reactive organism that is acted upon by biological and social ‘forces’” [18].

The work of the North American sexologist Leonore Tiefer occupies a singular place insofar as she attempts to situate herself on a double slope as a conceptualizer of the notion of medicalization of sexuality and by engaging in critical debates from a position opposed to what she considers as an inappropriate form of medicalization of sexuality. Tiefer makes a double distinction. First, she analyzes the “medicalization of sexuality” and the “medicalized construction of sexuality” separately. “The first implies that there is an *a priori* field of behavior and problems—sexuality—that is placed in the register of medicine during the historical and social process of medicalization. The second implies that modern medical cosmology (what Foucault has called the *archaeology of the clinic*) has invented a sexuality in its own image” [19]. Second, on the basis of this conceptual distinction, Tiefer also differentiates the analysis of appropriate forms of medicalization of sexuality from that of the excessive medicalization of sexuality. The medicalization of sexuality then concerns the understanding and management of patients with erectile dysfunction, low desire disorders, premature ejaculation, and sexual pain, whereas the over-medicalization of sexuality is defined as an excess of medical diagnosis, recourse to medical or surgical treatments, and the search for exclusive medical causes of sexual problems. Tiefer takes the

perspective of a clinical sexologist who defends a specific approach to “sexual disorders” by contrasting “good” and “bad” forms of medicalization of sexuality and by privileging the psycho-social dimensions of sexuality that constitute her own professional object. Gori and Del Volgo follow the same perspective by denouncing the “medicalization of existence” or the “bio-medicalization of the human being” from the point of view of psychoanalysis, thus *de facto* excluding psychoanalysis from the field of medicalization and from the field of questionable medicalization [20].

Overall, the medicalization of sexuality is, thus, thought to be the result of a relatively complex historical and sociological process that does not consist in the simple medical appropriation of the natural phenomenon of sexuality. It consists much more in the reinterpretation of previously existing modes of representation and designation of deviance, such as the religious and the legal by the medical-scientific apparatus.

The study of the medicalization of sexuality, thus, lies first and foremost in the deciphering of the way in which sexuality is constructed and represented in a context marked by the emergence of modern medicine, the development of biological and medical sciences, the organization of the medical profession and health professions, and the development of public health. The medical representation of sexuality has been developed in relation to other ways of designating phenomena related to reproduction, eroticism, marital relations, and social deviance, which are situated in the moral, religious, and legal registers. It consists of, above all, the definition of a set of norms opposing the “normal” functioning of sexual function and activity to its less frequent forms, thus transforming them into pathological forms. The pathologization of behavior and subjectivity is one of the central forms of medicalization. This model of medicalization is based on a binary opposition between the normal and the abnormal, the legal and the illegal, and the common and the uncommon, which rejects conceptions based on the idea of a continuum of behavior, activities, thoughts, fantasies, and emotions.

Secondly, the study of medicalization lies in the analysis of the transformations of representations of sexuality under the effect of the neurological, physiological, hormonal, and pharmaceutical research developed since the end of the 20th century and that calls into question the primacy of psycho-social explanations of sexuality. This new focus on the pharmacological treatment of “sexual disorders” and the emergence of sexual medicine [21,22] have the effect of obscuring situations in which it is rather a lack of medical development that is at stake. Interventions developed in the field of HIV-AIDS prevention are not often represented as a form of “medicalization of sexuality”, whereas patients’ associations demand the development of effective treatments and vaccines and greater accessibility to the populations concerned in a situation of extremely limited access to these treatments in many regions of the world. In this case, what is criticized is the lack of available medical treatments and the difficulties of access to these treatments, whereas in the field of “sexual disorders”, it is the process of over-medicalization or the non-necessary use of pharmacological products that is at stake. The multiplicity of these ways of assessing the “medicalization of sexuality” confirms that these phenomena are the subject of very different and even opposing representations.

## 5. Male and Female “Sexual Disorders”: The Arrival of Pharmacological Treatments

### 5.1. Medicalization and Over-Medicalization

In the field of sexology and sexual medicine, the expression “medicalization of sexuality” is currently used and claimed in various ways. Medical doctors and researchers who, often in association with the pharmaceutical industry, develop and promote new drugs and treatments, use it in a positive sense. In this posture, medicalization is seen as an important advance of scientific medicine (evidence-based medicine) in a field that is still insufficiently explored and, in full development, that of sexual medicine. In this first sense, the term medicalization of sexuality is, therefore, synonymous with progress [23]. The term is used by others, notably sexologists, sex therapists, and psychotherapists who are not part of the medical profession, in a critical and pejorative sense, and consists of criticism



of the transformations of representations of sexuality and of the medical, psychological, and sexological practices that are caused in this context. They perceive a transformation of the characteristics of female sexuality, mainly [19], and, secondarily, a reduction of male sexuality to the sole sexual function (erection, ejaculation, and orgasm) under the influence of the strategic orientations of the pharmaceutical industry. In this second sense, the medicalization of sexuality is considered more as a process that is highly problematic. A distinction can be made between the proponents of this second view. Some denounce medicalization in itself, as well as the domination of medicine and the imposition of a biologicistic representation of sexuality that takes little account of the elements of social and psychological context that are consubstantial to the idea of sexuality which emerged at the beginning of the 20th century [4]. Others, while not questioning the legitimacy of medicalization (as a medical approach to these problems), criticize the phenomena of *over-medicalization* of sexuality that is occurring with the bio-medical management of women's sexual difficulties and disorders [24]. They consider it inappropriate or excessive to treat these problems through the exclusive use of pharmacological products.

### 5.2. Pharmacological Treatments for Male Impotence

The medicalization of male impotence is a phenomenon that dates back to the dawn of sexual medicine [21]. This contemporary form of medicalization of male impotence is based on a process that began in the early 1980s with scientific discoveries and, in particular, the discovery of the effects of Papaverine on erection by the French urologist Ronald Virag. Then, a group of urologists from Boston University undertook to reconceptualize male impotence in the field of organic medicine, away from the psychological and psychoanalytic conceptions that had prevailed during the previous decades, and distanced themselves from the surgical approach (applied to the insertion of penile prostheses), which was then central in urology. Armed with the new concepts (*erectile dysfunction* instead of *impotence*) and new criteria of severity and frequency of occurrence of the condition, these same urologists occupied the field of epidemiology and established data showing a much higher prevalence than that which was commonly accepted until then. The development of the sildenafil molecule, for which Pfizer pharmaceutical company filed a patent in 1993, opened up perspectives and possibilities for research funding that led to the development of an instrument for evaluating the effects of treatment and aiding diagnosis and the conduct of clinical trials demonstrating the tolerance and efficacy of the drug. The development of evaluation questionnaires and clinical trials marked the entry of the pharmaceutical industry into the field of impotence and its association with researchers and physicians who had been working on impotence for many years. The process of organicist reconceptualization of male impotence was not, however, to be total. In their initial ambition, these urologists would have willingly abandoned the psychogenic hypothesis to impose the organic theory, as evidenced by the publications in the early 1990s, which placed strong emphasis on organic etiologies and related risk factors. Their own clinical trials led them to requalify their statement and to recognize the presence of an irreducible form of psychogenic etiology "in most men", which remained accessible to the new treatment. The presence of psychosocial etiological risk factors was finally recognized, as a way of not cutting itself off from a large part of the market [4]. Is erectile dysfunction different from impotence? The term impotence is now considered pejorative and potentially offensive. It is also considered inappropriate in that it can encompass the entire cycle of a man's sexual response, whereas the term "erectile dysfunction" takes into account only the erectile mechanism, as only one part of this cycle and the only target of treatment. Furthermore, impotence, as a pathology, only concerns the severe forms, i.e., "primary"; episodes of secondary, transient, or situational impotence are considered "the limit of normal sexual functioning". The new concepts of erectile dysfunction innovate by establishing a continuum of degrees of severity (from the mildest to the most severe) and by including all men with a lesser degree of this dysfunction in the field of pathology. The etiology of impotence is considered to be mainly psychogenic, whereas that of erectile

dysfunction is mainly organic. Erectile dysfunction is, thus, distinguished from impotence by a reduction of its domain to erection and organic etiology and by an increase of the total prevalence by including the mildest forms alongside its moderate and severe forms [4].

If scientists and physicians (and mainly urologists) have played a fundamental role in this conceptual evolution of male impotence, the pharmaceutical industry has very quickly set up a drug and new treatments for this new clinical entity. The pharmaceutical industry then contributed to the diffusion of these ideas and their transformation. By choosing to designate the whole situation as an “effective and well-tolerated treatment for a duly listed disease”, the pharmaceutical industry was facing the regulatory bodies of drug distribution, which further contributed to the evolution of ideas and located the problem of ‘sexual disorders’ on a public health level.

The introduction of Viagra in 1998 led to intense media campaigns in the developed world. Viagra—Viagra is understood here as a discursive device, a “Viagra culture” [24] and not only as a drug—was constructed as a symbol of a new sexual revolution, which countered the sexual pessimism developed all along the early years of the epidemics of HIV infection. Viagra represents a sexual world much different from the world that was constructed in the rhetoric of AIDS [25], in which it is a matter of “restoring a natural and normal sexuality” instead of trying to reduce anal sexual practices, promiscuity, and multiple partnership considered as risk factors. From this perspective, the Viagra discourse is aimed at a different segment of the population, men over forty in a stable heterosexual relationship and practicing penile—vaginal penetration, and is aimed at the “restauration” of this practice within the context of the married heterosexual couple. Generally speaking, it is a rediscovery of the sexuality of older heterosexual people and marital sexuality, a sexuality that had been forgotten in the context of the fight against the HIV infection because it was perceived as not being at risk of contamination. Viagra is constructed as a drug that must be prescribed by a doctor to treat a disease: erectile dysfunction. It is the clinical model of communication between the doctor and the patient that predominates, even if Viagra is the subject of an intense media campaign that occupies the public space. Here, the pharmaceutical industry addresses consumers directly, at the same time as it addresses doctors through the channels of professional communication. Advertising propaganda, thus, functions on both sides. The public dimension of Viagra’s advertising communication suggests that its influence goes far beyond the strict framework of the population; it is supposed to address and opens up possibilities of use to other groups of the population who are more engaged in “recreational” sexual activities than are concerned with restoring a “natural sexuality”.

## 6. Homosexuality: Medicalization and de-Medicalization

Homosexuality is also part of an evolution that has consisted in recognizing the legitimacy and normality of non-reproductive sexual practices and non-marital activities. Homosexuality began as a form of “unnatural” sexuality, and, until recently, was considered a crime or at least an offence in a number of European countries and a mental disorder. Within each of these categorizations, the status of homosexuality has followed particular destinies, taking on specific meanings according to the times and contexts and becoming subject to different punishments or penalties [26]. More recently, the medical fate of homosexuality has undergone important changes. Homosexuality, considered as a mental disorder, was excluded from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973 following discussions between gay organizations and representatives of the different trends of American psychiatry: “By deciding to exclude homosexuality from the nomenclature, the American Psychiatric Association not only placed itself in opposition to the systematic models of formal and informal exclusion that prevented the complete integration of homosexuals into social life, but also deprived civil society of an ideological justification for a certain number of its discriminatory practices” [16]. The exclusion of homosexuality from the field of mental disorders testifies to the anchoring and political function of this medical discipline, its submission to ideological influences and the *zeitgeist*,

and its function of legitimizing social norms and prejudices. A few years after leaving the field of psychiatry and mental illness, homosexuality entered the field of medicalization again through the HIV-AIDS epidemic, becoming the first visible figure of this disease [27] in the form of a “lifestyle” that could cause a serious illness: the so-called “gay cancer”. The “lifestyle” hypothesis was the first attempt to explain HIV-AIDS in the early 1980s before the discovery of the acquired immune deficiency virus [28]. But beyond the representation of AIDS in the guise of male homosexuality, it is the entire so-called “recreational” non-reproductive sexual life, “promiscuity”, and “multi-partnering” that have fallen into the net of medicalized pathologization.

### **7. Public Health Responses to the HIV Epidemic: The Pathologization of “Deviant” Behavior**

The HIV social and political responses, including HIV prevention, grew out of the first responses to the epidemic among gay men and is one of the most important forms of medicalization of sexuality that has taken place in the 20th century on a global scale. The main objective of the fight against HIV-AIDS has been (and still is) to “change sexual behavior” and to develop “protected” sexual practices, i.e., to avoid transmission of the virus by using condoms during sexual relations (anal, genital, and oral). It is, therefore, a behavioral change effort based on scientific and medical rationality and public health lessons. The *AIDS system* [29] has become part of the public health field, working with “risk groups” and deploying methods of social communication, education, and counseling. Sexual behaviors began to be assessed in terms of their potential risk of infection, distinguishing between high-risk, low-risk, and very high-risk behaviors. A hierarchy of behaviors was established, distinguishing between genital, oral, and anal sex according to risk exposure, and between monogamy and multi-partnership according to the same criteria. As a result, the meanings of sexual activity and sexual relationships have changed and love has come to be seen as “a risk factor” insofar as one does not feel the need to protect oneself from someone one loves [30].

In the past, multi-partnership was seen as a moral issue related to infidelity, whereas at the times of HIV-AIDS multi-partnering has become a “risk factor”. Much attention had been paid to gay men and not at all to lesbians, as they were assumed not to be at risk of HIV infection. In this perspective, there was a sustained interest in anal practices (insertive and receptive) considered as “higher-risk” sexual practices. This stigmatization of anal sexual behavior and the attempt to reduce them are parallel to the decriminalization of sodomy by the United States Supreme Court in 2003. While attempts were made to reduce anal practices in the name of health, legal and criminal prosecution of those who were alleged to engage in them had been stopped.

Minority behaviors considered deviant, such as sex work and group sex, have become public health issues [31]. The logic of public health does not overlap with that of legality, nor with that of morality. Moral issues are translated into health problems. The fight against HIV infection has focused on young people and multi-partners and has neglected the elderly and married heterosexual and monogamous couples who are considered less exposed to risk. From this perspective, the “fight against AIDS” has taken less account of issues of contraception and procreation and has often failed to consider the links and contradictions between the various forms of “protection” for sexual relations, especially heterosexual relations. There was a strong contrast between the Global North and its focus on Gay and Bisexual men and Intravenous Drug Users (IVDU) and the high prevalence of HIV infection among heterosexual women and men in countries from the Global South, such as Brazil for example [32]. We can, thus, see how the contours of risky sexuality and its health framework have been redrawn by implicitly excluding the most common form of sexual behavior from the field of risky sexuality and from public health interventions and recommendations [33]. However, the history of the medicalization of sexuality from the perspective of AIDS is not yet complete. Current developments in HIV prevention policies, which fall within the paradigm of risk reduction, reflect a shift in this medicalization with



the use of pre-exposure and post-exposure antiretroviral pharmacological treatments and male circumcision [34].

### 8. HIV Prevention as a Form of Biomedicalization of Sexual Activity

The introduction of new efficient drugs available for HIV prevention and treatment has created a situation in which the potential exposure to the risk of HIV infection becomes a medical condition in itself, which can be treated medically with these new drugs. The exposure to the risk of HIV infection—whether situational or behavioral—becomes itself available to chemotherapy in replacement of (or in “combination” with) behavioral approaches. There is a shift from a situation in which behavioral modifications were the only possibility to prevent the occurrence of HIV infection towards a situation in which these behavioral modifications will no longer be necessary thanks to the use of pharmacological medication. This kind of transformation of therapeutic devices into prevention tools is not unique and specific to HIV-AIDS. Based on her work in the field of breast cancer prevention, Fosket has developed the notion of “chemoprevention” in which the risk of breast cancer is treated as a disease: “Chemoprevention is based on the concept that biologically active compounds can be administered not only as tumor-destroying chemotherapy but also as tumor-preventing chemotherapy. (. . . ) Drugs developed as treatments for health problems given instead to healthy populations as a way to stay healthy highlight the intense biomedicalization of society such that technoscientific biomedical interventions are increasingly normalized as part of everyday life” [35]. Fosket demonstrates how chemoprevention, which remains controversial, is developed in combination with and/or in replacement of other more traditional preventive approaches, such as surveillance, self-examination, and early response, which are behavioral practices.

The approach developed in the field of cancer treatment and prevention presents a strong analogy to understand the important changes occurring in the field of HIV-AIDS prevention. The concept of Pre-exposure Prophylaxis (PrEP), which refers to the act of using a drug designed for the treatment of HIV infection to prevent the occurrence of the infection, reflects this evolution. Risk exposure and risk behavior become conditions that can be—and need to be—treated biomedically, using the same drugs that are used to treat patients who are already infected to HIV. However, these drugs do not have the function to treat these behaviors; they prevent the occurrence of some adverse potential consequences of such behaviors without the possibility to reduce or suppress their occurrence [36]. The treatment becomes prevention: “Treatment as Prevention” (TasP) replaces the obligation to engage in sexual behavior change among those who have already been infected by HIV, which is now considered to have been a failure by most of the advocates of the biomedicalization of HIV prevention [37].

The discovery of the relative protective effect of biomedical (pharmaceutical) and surgical approaches (ART and male circumcision) is now a motivation for the adoption of new health behavior and adherence to medical prescriptions, and for a reduction in the effort expended on education on sexual behavior change, which is now considered less necessary. This relative reduction in educational efforts, with the increased emphasis on awareness of risk situations, is associated with the use of bio-medical methods. In any event, the promoters of this new pharmacological HIV prevention strategy consider that biomedical recommendations are easier to adopt rather than the long-term modification of sexual behavior, and that adherence to biomedical prescriptions will provoke a reduction of the social and individual control exerted on sexual conducts, thanks to the shift to adherence to pharmacological prescriptions.

The situation that is currently developing around responses to HIV infection is part of a long history of the medicalization of sexuality in the twentieth century that has seen the setting of the behavioral approaches and their progressive abandonment, be they psychosocial, psychotherapeutic, or sexological, in favor of methods based on the use of medication. For example, the development of hormonal oral contraception, considered to be highly effective, has, in most industrialized countries, replaced behavioral methods,

such as *coitus interruptus* and male condom, which are located at the very moment of the actual sexual interaction. The widespread use of hormonal contraception, presented as a ‘magic bullet’ and endowed with total efficacy in the prevention of unplanned pregnancies, is actually disconnected from the moment of the sexual interaction and placed under the control of women. It has been proven over time to have important limitations. Undesirable side effects linked to the regular ingestion of hormones were reported and provoked controversy. Recent surveys demonstrated that the use of hormonal contraception did not eradicate the occurrence of unplanned pregnancies and, consequently, abortion [38]. In the domain of “sexual disorders”, there has been an extensive movement pertaining to the pharmacologization of sexuality since the introduction of Viagra, building on the idea of the abandonment of the psychogenesis of “sexual disorders” and the potential for their psychotherapeutic treatment. As in the domain of contraception, after the euphoria of the possibility of completely restoring male sexual function, there was a redeployment of psychotherapeutic responses complementary to, or independent of, the use of these drugs [39]. It can, therefore, be seen that psychosocial and behavioral approaches were initially put in place as a first step towards achieving certain health goals, with the objective of changing people’s behaviors and cognition. These treatments and approaches had limitations, as much in the prevention of HIV as in the domains of contraception and the prevention of abortion and sexual dysfunction. One must also note that the development of biomedicalized measures and tools remain constructed on the ground of disciplinary conducts. The major change in this regard is the shift from the discipline related to sexual behavior to a discipline related to health behavior (use of medication and circumcision). Biomedicalization and the development of biopolitics cannot be effective without the sustained use of some disciplinary approaches, be they focused on sexual behavior or on health-oriented behavior.

The case of HIV prevention illustrates the migrations of the medicalization of sexuality, initially between the use of educational and preventive methods based on risk awareness and the application of complex body techniques and, in a second phase, a return to approaches rooted in the bio-medical model based on the persuasion and adherence of individuals in the perspective of population management.

### 9. “Trans” Situations: Between Medicalization and Depathologization

The question of the coverage and reimbursement of gender affirmation pathways in health insurance systems is central to the conceptual thinking and policy development of user associations, health professionals, and international organizations. The WHO’s ICD-10, the major international classification of diseases, was used as a reference by the majority of the world’s states [40]. This issue is taken into account in the work of the groups responsible for revising the ICD-10 and, in particular, chapter F 64, which includes “gender identity disorders” and “transsexualism”, and to the same extent by the international “Task Force” responsible for revising the DSM-IV into the DSM-5 [41]. Finally, it should be noted that almost the same experts have been appointed to address gender identity disorders in both groups. They are the US psychiatrist Jack Drescher and the Dutch clinical psychologist Peggy Cohen-Kettenis, whose legitimacy in dealing with these issues is unquestionable both in terms of their clinical practice and in view of their impressive lists of publications on the subject. Both of these authors have already published extensive reviews of their work on the DSM-5 Task Force [42,43] and ICD-11 revision process, and it can be assumed that they draw on this prior work for their interventions in the WHO working group.

From the outset, these two experts stated that the main challenge of the revision of ICD 10 was to be able to reconcile the avoidance of stigmatization while protecting the modalities of access to care, insofar as this access is dependent, in the majority of WHO member states, on the existence of a recognized and codified condition. It was, therefore, necessary to maintain a nosographic category allowing access to care and health insurance systems while limiting the effects of stigmatization and the consequences on the mental health of trans people, such as internalized transphobia. The definition and maintenance of

such a nosographic category are, thus, the result of decisions that go beyond the simple medical or psychiatric space to take into account in a decisive way the psycho-social consequences of the very establishment of the diagnosis and to allow access to care and its coverage by health insurance systems. Thus, the definition of a nosographic category depends as much, if not more, on the responses that societies provide to conditions than on the strictly medical dimensions of the problems and disorders in question. Since the ICD is a classification of somatic and psychiatric disorders, it would have been possible to classify “gender identity disorders” and “transsexualism” outside of psychiatric mental disorders and, for example, among endocrine disorders or neurological disorders. One could also redefine “gender identity disorders” along the lines of sleep disorders or in the pregnancy register [44]. Furthermore, the ICD has a “Z” category that would have allowed “gender identity disorders” to be coded as “factors influencing health status and reasons for seeking health services,” which would make it possible to avoid specifying these disorders in a pathological register while maintaining the possibility of their management and coverage in the health care systems.

The logic of the ICD-10, thus, allows for more room for maneuver than the DSM-5. If the WHO would have decided in the last instance not to exclude “gender identity disorders” from the register of diseases, the possibilities offered would have been numerous to maintain the place of “transsexualism” in the register of conditions without maintaining its definition as a general pathology on the one hand, or even psychiatric on the other.

The potential demedicalization of the trans situations and “gender identity disorders”—if it is desirable for some—appears, however, difficult to achieve at the general level. The first demand is for the depsychiatrization of these conditions, but apparently in the discussions that have taken place in the framework of the DSM-IV Task Force, this possibility has not been put on the agenda. The experts are moving towards a definition of these disorders under the term “gender dysphoria” (after a first proposal made in 2010 to use the term “gender incongruence”). However, Heino Meyer-Balhbarg warns policy makers that any new definition of these disorders cannot be based on scientific grounds alone and must be in compromise with the claims and needs of people with gender identity variants [45]. The ICD offers broader possibilities for the depsychiatrization of “transsexualism” and reclassification of this condition under a new name, but the experts, concerned with reducing the harmful effects of stigmatization, did not envisage removing this category completely from the field of pathologies, which would have the effect of depriving the persons concerned of quality care and of coverage by health insurance systems.

In the discussions that developed around the development of erectile dysfunction drugs, it was hypothesized that the medicalization of ‘sexual disorders’ had come under the control of the pharmaceutical industry and was, thus, a result of the pharmacologization of “sexual disorders” [46]. With transgenderism and diverse expressions of gender identifications, it is much more the economics of health and health insurance systems that contribute to the maintenance of minority identities in the register of medicalization. The total depathologization of “transsexualism” does not seem possible for the moment insofar as it would imply an exclusion of the assumed responsibility of health insurance systems, which is wished neither by the doctors nor by the representatives of the trans associations. Non-medical factors, thus, contribute to keeping the trans situations within the bounds of medicalization. The situation of transsexualism, thus, opens up a renewal of the questioning of medicalization by revealing the non-medical factors that are at work in the construction of medical categories and definitions. Finally, the WHO working group proposed the creation of a new category “problems related to sexual health” in which “gender incongruence” would be included as a way of excluding the trans situations from the realm of a psychiatric (mental disorder) category and the subcategory of paraphilic disorders. The creation of this new category is a half-way process toward depathologization. It is certainly a way of excluding the trans situations from the field of psychiatric disorders while maintaining these situations in the field of registered response to a medical condition, allowing its full or partial coverage by local insurance companies and social

security systems. Ironically, at a time in history where transgender and gender diverse situations are moving away from any reference to a sexual etiology and paraphilia (as it was the case in previous medical and psychiatric classifications), the WHO created a new category of “conditions related to sexual health” in order to depathologize these situations. The sexual dimension of transgender identities and situations makes a kind of unexpected comeback. Including transgender and gender diverse situations in the realm of sexual health helps to remove these situations from the field of psychiatry and, at the same time, brings them back in the extended field of sexuality [47].

## 10. Conclusions

The various forms of the medicalization of sexuality and gender that have been discussed in this article (responses to the HIV-AIDS epidemic, conceptions of homosexuality, treatments for “sexual disorders”, and gender affirmative pathways for transgender and gender diverse situations) have appeared at different times in the history of the 20th century. Each of these approaches represents a particular form of medicalization, that is, a form of medicalized representation of sexuality or gender identity issues which has social, political, economic, medical, and subjective implications. Some of these situations are denounced by groups of actors involved in these issues (feminist organizations, gay organizations, and transgender and gender diverse organizations), others are considered acceptable and even sometimes necessary (HIV prevention), and some are not considered to fall within the scope of the medicalization of sexuality and therefore exempt from criticism.

The medicalization of sexuality takes the form of interventions, planned within the medical framework, on situations qualified as sexual, and on the actors involved in them, which can take the form of clinical and therapeutic interventions, but can also be outside the narrow framework of medical practices and preventive, psychotherapeutic, or educational interventions which are oriented through a medical perspective. These interventions can take place within a medical framework in the strict sense of the word, or in partnership with public health, health education, or criminal justice institutions. The anchoring of these practices in the dichotomy of normality/pathology established by medicine orients the objectives of these practices and interventions in the direction of restoring or enhancing supposedly reduced sexual activities, which are considered as normal, or in the direction of reducing or repressing physical or mental sexual activities considered, either from a strict medical point of view or from a legal and moral point of view, as deviant or excessive.

These analyses demonstrate that medicalization is a very complex process. Moreover, medicalization has numerous ramifications and, primarily, the movement of medicalization/demmedicalization has been observed regarding the depsychiatrization of homosexuality. There is also a possibility to try to depathologize a situation, such as the medical pathways of gender affirmation among trans people, and not demmedicalize, i.e., not removing medical interventions and participation of members of the medical profession. The medicalization of sexuality was first framed and organized around the distinction and separation between procreative and non-procreative activities, which provided the onset of the concept of sexuality to establish a discourse and a practice [9]. Then, since the beginning of the 20th century, the organizing principle of the medicalized representation of sexuality has gradually changed by recognizing the legitimacy of non-procreative activities. In its contemporary meaning, the terms “sexuality” and sexual no longer necessarily include procreative functions in their normal course. The pathologization of these terms now focuses on the difficulties in developing and maintaining an erotic life, which is a guarantee of satisfactory sexual health and well-being. While medicalization initially consisted of the medical appropriation of a field of human activity, more recent developments show how health has progressively become the foundation and justification of individual and collective moral values [48].

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