CHLOË TAYLOR

Female Sexual Dysfunction, Feminist Sexology, and the Psychiatry of the Normal

> It is really weird that doctors should be the reigning experts on sex.
> —Leonore Tiefer[1]

THE FIRST VOLUME of Michel Foucault's *The History of Sexuality* provides a compelling and influential critique of the "sciences of sex." In this work, Foucault suggests that there is little that is scientific about the disciplines of psychoanalysis, psychiatry, and sexology that emerged in the nineteenth and twentieth centuries.[2] In each case, Foucault argues that the authority of science is exploited to facilitate the regulation of sexuality in a biopolitical era in which the sex life of the population has become a crucial political stake.[3] Sex, according to Foucault, is managed by doctors not so much to cure health problems as to enforce social norms, and sexual science does not provide the truth of sex or make people healthy, but naturalizes the monogamous, heterosexual, nuclear family.[4]

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1. Leonore Tiefer, *Sex Is Not a Natural Act and Other Essays* (Cambridge, MA: Westview Press, 2004), 180.
2. Michel Foucault, *The History of Sexuality: An Introduction* (New York: Vintage, 1978).
3. Michel Foucault, *The History of Sexuality*: 133–160. See also Michel Foucault, *Psychiatric Power: Lectures at the Collège de France 1973–1974* (New York: Palgrave-MacMillan, 2006) and Michel Foucault, *Abnormal: Lectures at the Collège de France 1974–1975* (New York: Picador, 2003).
4. This is not to say that for Foucault doctors do not ever cure health problems or that their intentions are not to cure health problems. However, Foucault

Feminism has also posed powerful critiques of the sexual sciences. As Janice Irvine notes, feminist epistemology has rejected the purported neutrality of science, especially of the sciences that claim knowledge about sex and gender.[5] Feminist and queer political theorists and activists have, moreover, "underscored the hollowness of solutions based on techniques" that are favored by sexologists; teaching men skills to resist premature ejaculation or to better stimulate their wives' clitorises are not adequate resolutions to widespread and profound dissatisfactions with sex, gender, and marriage in a heterosexist and patriarchal society.[6] As Irvine writes,

> Feminism and lesbian/gay liberation … challenged power inequalities between men and women and questioned the very concepts of maleness and femaleness, masculinity and femininity.… They presented alternatives to tradition and to expert power and authority. Therein lay their threat to American sexology.[7]

Given this antagonistic relationship, combining feminism and sexology has proved controversial. The work of feminist sexologist Shere Hite in the 1970s and 1980s was critiqued by sexologists and feminists alike: sexologists complained that the 1976 *Hite Report* was political and thus undermined the scientific prestige of sexology, while feminists criticized Hite for aspiring to a masculine scientific authority.[8] Describing the relationship between feminism and sexology, Irvine notes that "the incompatibility of their concerns — science and market, on the one hand, versus

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shows that what we consider "healthy" is thoroughly political and that the effect of doctors' practices is normalizing whatever their intentions may be. For two recent Foucauldian studies of the ways that medical and sexual science function to sexually normalize individuals and populations, see Ladelle McWhorter, *Bodies and Pleasures: Foucault and the Politics of Sexual Normalization* (Bloomington: Indiana University Press, 1999); and Ladelle McWhorter, *Racism and Sexual Oppression in Anglo-America: A Genealogy* (Bloomington: Indiana University Press, 2009).

5. Janice Irvine, *Disorders of Desire: Sexuality and Gender in Modern American Sexology*, rev. ed. (1990; repr., Philadelphia, PA: Temple University Press, 2005), 101.
6. Ibid.
7. Ibid.
8. Ibid., 117.

progressive political change, on the other — led … to a contentious and emotionally charged history."[9]

Drawing on both Foucauldian and feminist perspectives, this article explores a new chapter in this history, examining self-described feminist sexologists' responses to the psychiatric diagnoses of Female Sexual Dysfunction (FSD). While psychologists had pathologized female sexuality under the label of frigidity since the nineteenth century, sexual dysfunctions were relatively marginal in the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published in 1952. In the DSM-1, frigidity (like impotence) was a subcategory of "Psychophysiological autonomic and visceral disorders," which were themselves part of a larger group of "Disorders of psychogenic origin or without clearly defined physical cause or structural change in the brain." Each new edition of the DSM has given sexual dysfunctions a more prominent place, however, and has tended to proliferate their number — although the DSM-5 in fact merged five types of female sexual dysfunction into three. As Leonore Tiefer notes, not only have more sexual dysfunctions been named, but they have moved from being symptoms of disorders to being disorders themselves.[10] In the DSM-5, released in 2013, sexual dysfunctions are a category of their own, and FSD is divided into the following disorders: Female Orgasmic Disorder, Female Sexual Interest/Arousal Disorder, and Genito-Pelvic Pain/Penetration Disorder.[11]

Of these, Female Sexual Interest/Arousal Disorder, formerly known as Inhibited Sexual Desire or Hypoactive Sexual Desire Disorder, was by the late 1980s "the most common presenting problem, constituting half of all diagnoses," and is diagnosed more frequently in women than the parallel disorder in men.[12] According to the National Health and Social Life Survey, published in 1999, 32 percent of women and 15 percent of men have Hypoactive Sexual Desire Disorder.[13] In turn, Female Orgas-

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9. Ibid., 100.
10. Leonore Tiefer, "Gender and Meaning in the Nomenclature of Sexual Dysfunctions," in *Sex Is Not a Natural Act*: 131–138.
11. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, fifth ed. (Arlington, VA: American Psychiatric Publishing, 2013): 429–40.
12. Irvine, *Disorders of Desire*, 165.
13. Edward Laumann, Anthony Paik, and Raymond Rosen, "Sexual Dysfunction in the United States: Prevalence and Predictors," *Journal of the American Medical Association* 281, no. 6 (1999): 537–44.

mic Disorder "includes any difficulty or delay in reaching orgasm that causes the woman personal distress," even, judging from case studies, if the "difficulty" is that she cannot orgasm from vaginal penetration.[14] A woman may be treated for this disorder if she is does not orgasm from a "sufficient" amount of stimulation, although what constitutes "sufficient" is highly subjective.[15] A woman may likewise be treated for FSD if she experiences pain during intercourse or clenches her vaginal muscles in a manner that makes penetration difficult.

"Personal distress" is the marker for whether a woman is sexually disordered in each of the categories of FSD: a woman can be treated for FSD if she experiences "a lack of sexual desire that causes [her] distress," or if "the problem causes clinically significant distress or impairment."[16] Importantly, the DSM-5 specifies that sexual dysfunction refers to symptoms that are "not better explained" by "severe relationship distress (e.g., partner violence), or other significant stressors," but repeatedly lists as a "specifier" of FSD "relationship factors (e.g., poor communication, discrepancies in desire for sexual activity)."[17] The implication seems to be that if a woman has difficulty with penetration, orgasm, or arousal because of partner violence, she is not disordered, but she may be disordered if her difficulties result from "discrepancies in desire" between herself and her partner that endure for at least six months. Tellingly, one of the symptoms of Female Sexual Interest/Arousal Disorder is that the woman is "typically unreceptive to a partner's attempts to initiate."[18] Thus a woman may be pathologized by psychiatry if she regularly declines sex with her partner over an extended period.

Importantly, in many of the case studies recounted in the literature, the distress on the woman's part is a response to a relationship in turmoil. As Irvine writes, "An angry and dissatisfied partner is often the impetus for someone to seek professional treatment for [Inhibited

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14. Jennifer Berman, Laura Berman, and Elisabeth Bumiller, *For Women Only: A Revolutionary Guide to Reclaiming Your Sex Life*, rev. ed. (1999; repr., New York: Henry Holt, 2005), 70. As noted below, the DSM-5 explicitly states that a woman who requires clitoral stimulation to orgasm should not be diagnosed with FSD, but case studies show that doctors disregard this caution.
15. Ibid.
16. Ibid.
17. *Diagnostic and Statistical Manual of Mental Disorders,* fifth ed., 429–30, 431.
18. Ibid., 433.

Sexual Desire Disorder]."[19] A woman may in fact not feel troubled by her decreased postpartum or postmenopausal libido, for instance, but consults a doctor about it because of a frustrated husband. Women are diagnosed and treated as sexually disordered because they have sex-related marital tensions, even if they are personally well adjusted to their sexual response. Much of the problem with FSD seems to arise from lack of education, rather than from something aberrant about the women; for instance, although this goes directly against a caution expressed in the DSM-5, many of the couples discussed in the clinical literature appear ignorant of the fact that most women do not orgasm from intercourse, and yet this does not prevent doctors from treating the women as disordered, prescribing them testosterone, and subjecting them to surgeries.[20] Although sexologists since William H. Masters and Virginia E. Johnson (who began work on sexual dysfunctions in 1957) note that a large part of their job is pedagogical, women today are still being treated for mental health problems in cases where sexual education seems more in order.[21]

According to a frequently cited report from the National Health and Social Life Survey, published in the *Journal of the American Medical Association*, FSD was found to be widespread, affecting "43 percent of American women, young and old … —a significantly higher percentage than that of men, who suffer [from Male Sexual Dysfunction] at a rate of 31 percent."[22] Numbers are even higher in older women: "more than half the women over age 40 in the United States have sexual complaints."[23] As in these examples, the literature on FSD moves fluidly

19. Irvine, *Disorders of Desire*, 172.
20. See page 430 of the DSM-5 for a clear caution that many women do not orgasm from vaginal penetration and require clitoral stimulation and that women who do not orgasm from intercourse should not be diagnosed with FSD. See Berman, Berman, and Bumiller, *For Women Only*; and *Orgasm Inc. The Strange Science of Female Pleasure*, directed by Liz Canner (Astrea Media, 2009) for examples of women nevertheless being treated for FSD—including surgical treatment—because they do not orgasm from intercourse and are unaware that this is statistically normal.
21. See Irvine, *Disorders of Desire*, 144; and Tiefer, *Sex Is Not a Natural Act*, 140. It is difficult to ascertain how many women are currently being treated for FSD. The medical literature claims that it is being "under-diagnosed" but does not say how many women are currently being treated. See Keith Montgomery, "Sexual Desire Disorders," in *Psychiatry* 5, no. 6 (2008): 50–55.
22. Berman, Berman, and Bumiller, *For Women Only*, xiii.
23. Ibid.

between writing about sexual "complaints," "sexual dysfunctions," and "disorders," implying that any dissatisfaction on a woman's part may indicate a psychiatric problem with the woman and not with her lover or the societal fantasies of female sexuality that she is trying to live up to.

In this article I will engage with the contemporary literature on FSD in three ways. First, I will critically examine the writings of three influential feminist sexologists — Drs. Jennifer and Laura Berman and Dr. Leonore Tiefer — as they approach the diagnosis and treatment of FSD. While the Bermans and Tiefer each present their sexological approach as "revolutionary," "new," and "feminist," I will suggest that they in fact have familiar — albeit opposed — visions of female sexuality and of sex. While I will be almost entirely critical of the work of Jennifer and Laura Berman, there are a number of helpful arguments and insights in the work of Tiefer that coexist with the aspects of her work that I will problematize.

Second, this article will argue that what is most worrisome about the diagnosis and treatment of FSD is not that it is an instance of psychiatry passing off political, moral, or social norms as science (after all, if we follow Foucault, this characterizes all psychiatric practice); rather what is most disturbing is that the diagnosis and treatment of FSD is indicative of a new stage in psychiatry's expanding grip over ever-larger numbers of people. When Foucault argued that psychiatry widened its net in the late nineteenth century in order to target not only the pathological but the abnormal, the abnormal individuals in question were still ostensibly both morally and statistically uncommon for any given condition. Each abnormal group (agoraphobics, masochists, antivivisectionists, homosexuals) was small compared to the "normal" group to which they were opposed, even if, when taken as a group, abnormals make up a large group, far larger than the pathological; indeed, we are all more or less abnormal in some way or another, and thus we are all potential targets for psychiatric power. The transition from a psychiatry of the pathological to a psychiatry of the abnormal thus represented a significant coup on the part of psychiatry.[24] Abnormal individuals were targeted for their moral aberrations, but these moral aberrations had to be conflated with statistical irregularities for scientists to deem them

24. See Foucault, *Abnormal: Lectures at the Collège de France.*

unnatural and thus "unhealthy" and to present their moral indictment as medical science. Now, however, psychiatry has taken on an even more ambitious project, targeting individuals as disordered who do not *even* stray from an ostensible statistical norm. The medicalization of women's sexual dissatisfaction is a case in point.

Third, by way of conclusion, I will draw on feminist and Foucauldian insights in order to indicate some alternatives to sexological approaches to women's widespread sexual dissatisfaction.

THE BERMANS' NOT SO "REVOLUTIONARY GUIDE TO RECLAIMING YOUR SEX LIFE"

Laura Berman is a professor of gynecology and psychiatry at the Feinberg School of Medicine at Northwestern University and runs the "spa-like" Berman Center in Chicago, where women can be treated for sexual complaints and "menopause management."[25] Her sister, Jennifer Berman, is a urologist and runs the Female Sexual Medicine Center at UCLA. To give some sense of the scope of the sisters' influence: they are the hosts of *Berman and Berman* on the Discovery Health Channel; they appear regularly on *Good Morning America*; they have both appeared on *Oprah*, and they write for newspapers and magazines such as *USA Today*, *Ladies' Home Journal*, *Chicago Sun-Times*, *New York Times*, and *Cosmopolitan*, in addition to running their centers.

Together, the Berman sisters offer treatments ranging from the psychological to the surgical, including "sex therapy, couples therapy, educational counseling, medical treatment, and surgery … and gynecological physical therapy."[26] According to the introduction to their book *For Women Only*, the Berman sisters, taking up "where Masters and Johnson left off," have

> adapted the more sophisticated technology of our day to evaluate women.… pH probes to measure lubrication; a balloon device to evaluate the ability of the vagina to relax and dilate; vibratory and heat and cold sensation measures of the external and internal

25. Berman, Berman, and Bumiller, *For Women Only*, xi.
26. Ibid. xiii.

> genitalia; and high frequency Doppler imaging, or ultrasound, to measure blood flow to the vagina and clitoris during arousal.[27]

Conversely, Leonore Tiefer has described these medical tests as a "fascinating combination of science and mumbo-jumbo," since "most of the tests have no valid norms at the present time, so there is no way to know what the measurements mean."[28]

Both Berman sisters advocate a "mind/body" approach to what they call "female sexual dysfunctions," combining psychological examinations and counseling with physical examinations, pharmaceuticals, and surgery. They write that "psychotherapy is the foundation for all successful treatment of sexual dysfunction and will likely remain so," but *For Women Only* devotes far more pages to advertisement-like information on drugs than on describing psychotherapeutic treatments, and almost every case history they recount is resolved in part through a Viagra or testosterone prescription.[29] At the end of the only case history in which Viagra was not helpful, the Berman sisters add a eulogy to pharmaceuticals, as if to appease their funder, Pfizer:

> Drugs to treat sexual dysfunction, like sildenafil [Viagra] and testosterone, have made the job of the sex therapist much easier. Much of our work in the past was focused on the grieving over the loss of sexual function that we now know may be medically based. Today, as we are better able to tend to the physical problems, sex therapy is more successful.[30]

The Bermans also include a long defense of hormone treatments for the "management" of menopause, and they argue that the benefits of hormone treatment outweigh the health risks. "No woman," they write, "should have to suffer through the sexual and emotional side effects of menopause because of unrealistic fears about her health."[31]

Despite being snugly in bed with the pharmaceutical industry, the Bermans present their book as a feminist revolution, and describe their task of medically resolving current levels of female sexual dissatisfaction

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27. Ibid. xv.
28. Tiefer, *Sex Is Not a Natural Act*, 265.
29. Berman, Berman, and Bumiller, *For Women Only*, 128.
30. Ibid., 132.
31. Ibid., 109.

as a feminist goal: "We are in an era of women's sexual health — perhaps feminism's next frontier."[32] For too long, the Bermans suggest, women have suffered from sexual dissatisfaction in silence; finally, there are doctors — and pharmaceutical companies — who will listen to their complaints. The Bermans have made a fortune as the self-described "pioneers" of this frontier.

The Bermans argue that it is "important that women be made to feel entitled to their sexual response," and they reprimand male doctors who are dismissive of women's sexual complaints.[33] They note that while nerve-sparing surgeries for prostate cancer were developed in the 1970s so that men could retain erectile function postsurgery, no similar nerve-sparing techniques have been developed for female genital operations, reflecting the lower value attributed to female sexual pleasure by the male-dominated medical establishment. "In women, we are perhaps at least a half-century behind," they write. "Incredibly, we know less about female pelvic anatomy than we did thirty years ago about male genital anatomy."[34] To their credit, Jennifer Berman is working to bridge this gap. The Bermans are also highly critical of cosmetic genital surgeries, which often result in diminished sexual sensitivity.[35]

This is the extent of the Berman sisters' feminism, however, and in the majority of their case studies it becomes clear that women's sexuality is medicalized by the Bermans not so much because they want the women themselves to feel entitled to their sexuality, but because those women's husbands feel entitled to more and "better" sex from their wives. The Berman sisters initially state that a woman's "problem must cause her personal distress. If it's bothering only her partner, then by definition she does not have sexual dysfunction."[36] It becomes clear in reading their book, however, and especially in the chapter called "Partners," that the female distress in question is usually a response to male

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32. Ibid., xvi.
33. Ibid., 12.
34. Ibid., 124.
35. Ibid., 16, 41. For an excellent recent article on vulvar pain and cosmetic vulvar surgeries, see Christine Labuski, "Vulnerable Vulvas: Female Genital Integrity in Health and Dis-ease," in *Feminist Studies* 39, no. 1 (2013): 248–276. (Winner of the Claire Goldberg Moses award for theoretical innovation.)
36. Ibid., 68.

dissatisfaction and that women are treated as disordered because infrequent sex or sex in which they do not orgasm is angering their husbands. Following a traumatic childbirth, for instance, Sarah "found it difficult to become aroused and reach orgasm with intercourse":

> Sarah had lost all interest in sex, but she was willing to be sexual for the sake of intimacy, which she still enjoyed. Her husband, Benjamin, however, had a hard time not taking it personally that she couldn't have an orgasm, and began to fixate on the problem, bringing it up in and out of the bedroom. But all the time and effort he was spending on her arousal only made her more anxious and less likely to become aroused at all. He started to feel inadequate as a result and began to find it difficult to maintain his erection. They had gone on this way for years, and now were close to a separation.[37]

Sarah is treated with pharmaceuticals and therapy.

Similarly, we read of "Ann and Charles, a couple in their seventies," who "came in seeking therapy at the husband's insistence." As the Bermans explain,

> Charles had always been physically active and had a number of infidelities over the years. Ann had responded by creating her own world of friends and social connections and separating her life from his. But now her husband's medical problems had curtailed his sports and social activities and made it impossible for him to drive. Suddenly dependent, Charles wanted to build an intimate relationship with his wife. He was still able to have sex. And, he said, he was lonely.[38]

Ann was not "at all sure that she wanted to reconnect with her husband. After nearly a half century of living a parallel life, *she was satisfied*."[39] Ann was postmenopausal, was not on hormone replacement treatment, had an active social life, and was wary of becoming intimate with her husband given his history of infidelities. Indeed, at the time that they came to the Bermans' clinic, "Charles had told Ann that he was so frustrated by her attitude that he was thinking of finding another sexual

37. Ibid., 172.
38. Ibid., 173.
39. Ibid., my emphasis.

partner to meet his needs."[40] Although, like Sarah, Ann is not "personally distressed" by her low libido, she is a candidate for FSD treatment in the Bermans' book.

Next we hear of "Ellen, a professional woman in her late fifties. She, too, came to see us because of a husband unhappy over her loss of libido":

> Although Ellen said she had never considered herself a person with an enormous sex drive … she said she had had a satisfying sexual relationship with her husband for most of their marriage. But as she reached menopause in her mid-fifties, she began to notice a gradual waning of interest. Over the past year, she said, it had become especially pronounced. Sex, she said, "is fine, it's nice, it's a nice thing to do. And once I get going, I'm definitely orgasmic." But she just wasn't interested, beyond the need for intimacy and warmth.
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> Her husband, however, had a strong sex drive and was as interested as he had always been.… Although the two were still having sex on average twice a week, a rate many other couples young or old would welcome, Ellen said she was only participating because her husband wanted it and she needed to feel close to him.[41]

Thus, although the couple was still having sex regularly, "Ellen's husband was increasingly unhappy about her lack of interest."[42] The Bermans' preferred treatment was to prescribe Ellen testosterone in addition to psychotherapy.

Finally, the Bermans describe the case of Debra, a mother with four children between the ages of one and eight, as follows:

> Debra's lovemaking with her husband had dropped from four or five nights a week to one or two, hardly a bad average for a couple with a houseful of children, but not at all what her husband wanted. Debra tried consoling herself that things would eventually improve: "I had heard that after having children, your sex drive goes down. I just chalked it up to stress. I figured maybe after the kids were grown and gone, it would be better again. I just didn't put too much priority in it."
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> Debra's loss of libido was highly frustrating for Scott. At 35, he was not ready to give up his sex life with the hope that it might

40. Ibid.
41. Ibid., 174–75.
42. Ibid., 176.

> improve in a decade. He felt unwanted, rejected, and angry. "It was excuse after excuse," he said. At times he worried that there was something physically wrong with Debra and urged her to speak to her gynecologist. Debra refused, saying she was too embarrassed. Other times Scott wondered if his wife might be having an affair. "It's probably the first thing that comes into a guy's head," he said. "But she told me it wasn't me, it was her."[43]

Few of us probably see Debra as dysfunctional, just as I doubt we would see Sarah, Ann, or Ellen as dysfunctional. Scott, on the other hand, could be seen as obnoxious in his suspicion that "there was something physically wrong" with his wife or she was being unfaithful just because she was not having sex with him more than twice a week. Unfortunately, the Berman sisters validated his opinion since they not only prescribed Viagra and testosterone cream to Debra but referred her to a psychotherapist for psychological treatment. As with Sarah, Ann, and Ellen, Debra was not distressed by her low libido, but only by her husband's anger and suspicions. As she said, sex was not a priority for her at this time. Debra did not want help having more sex; she notes that she pretended to be asleep when her husband came to bed, hoping to avoid sex, and sought medical advice only at her husband's insistence. Physical examination at the Bermans' clinic showed that Debra had nothing wrong with her physiologically and that her hormone levels were normal. She easily had an orgasm in their clinic. She is nevertheless presented in the Bermans' book as a case of a woman with FSD and was treated both pharmaceutically and psychologically. Reading the Bermans' case studies, it becomes clear that the medical treatment of FSD aims less to assuage female sexual dissatisfaction than to accommodate *men's* sexual expectations. Far from being "feminism's next frontier," the medical treatment of FSD, as with the medical management of menopause, subjects women to health risks and disciplinary treatments in order to accommodate men and to maintain heterosexual marriages.

Almost every case the Berman sisters describe is a married woman, and only one lesbian appears in a case history. Her case, as Tiefer points out, is granted one page out of two hundred and forty-six; although critical of this fact, Tiefer, too, primarily discusses heterosexual women and

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43. Ibid., 166.

reports exceedingly low numbers of gay couples or individuals seeking her services.[44] The irony is not lost that, although it seems to be predominantly married heterosexual people complaining about sexual dysfunction and showing up at sexologists' clinics, the Bermans assure readers that (heterosexual) married sex is better. Depending on a methodologically problematic study, wherein single people were interviewed alone while married people were interviewed in their spouses' presence, the Bermans conclude that "the findings are essentially correct that married women overall are sexually more satisfied with their lives than singles."[45] In their chapter titled "Sexuality Through the Life Cycle," the female is described moving from infancy through childhood and adolescence, through young adulthood and into marriage, pregnancy and childbirth, parenthood, and then into "The Golden Years." Alternative paths are not considered. A woman who does not get married to a man and experience pregnancy, childbirth, and parenthood is not progressing through the life cycle described by the Bermans.

The Bermans not only take heterosexuality for granted in their book but also assume sex to mean intercourse. Only in their discussion of "The Golden Years" and in their section on men who cannot have erections due to prostate surgery do the Bermans discuss nonpenetrative forms of sex, such as "very erotic noninsertive sex" (VENIS). Adjusting emotionally to this kind of sex is compared to adjusting to the death of a loved one, and Viagra is advocated as a first recourse.[46] In "The Golden Years," the Bermans tell us, "All couples, but especially older couples, can give each other sexual pleasure and orgasms through all sorts of activities that don't require erections, even when their range of motions has decreased. Lesbians will certainly attest to this."[47] This is one of the few references to lesbians in the book, and, interestingly, it is to compare them to "impotent" men wounded by prostate surgeries. (We might be reminded of Aristotle, who also identified women—although not just lesbians—with "mutilated" men.)[48]

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44. Tiefer, *Sex Is Not a Natural Act*, 267, 196.
45. Berman, Berman, and Bumiller, *For Women Only*, 150.
46. Ibid., 181.
47. Ibid., 162.
48. Aristotle, *Generation of Animals*, trans. A. L. Peck (Boston: Harvard University Press, 1943).

When treating sexual dysfunction in younger couples, intercourse rather than VENIS is taken as the unquestioned goal. Laura Berman has couples refrain from intercourse in order to perform sexual exercises, with each new exercise "progressing" toward that pinnacle of achievement that is vaginal-penile penetration: "Each week, as long as all was going well, Laura gave them assignments that moved them gradually closer to sexual intercourse, including 'imitating' intercourse."[49] All forms of sex other than intercourse are taken to be mere stages along the way to the ultimate act.

We therefore see that when it comes to enabling women to "reclaim their sex lives," the Berman solution involves lots of prescriptions and a psychiatric management of wives. Marriages are preserved and wives are pharmaceutically transformed to conform to their husbands' expectations and to a teleological and phallocentric understanding of sex. Far from this resonating as feminist, the Berman world of doped wives and happy husbands recalls nothing so much as *The Stepford Wives*.

In *Sex Is Not a Natural Act*, Leonore Tiefer provides the following overview of feminist critiques of sexology:

> Margaret Jackson argued that the role of sexology all along has been to normalize and universalize "the coital imperative" and "the primacy of penetration" in order to undermine women's resistance to compulsory heterosexuality. Similarly, Mariana Valverde argued that sexologists' role as marriage reformers in the twentieth century led them to insist that women, like men, have sexual needs and desires and that, conveniently, women's sexual needs and desires were just like men's, albeit a bit slower. Janice Irvine, in her extended analysis of the history of sexology in the United States, likewise has argued that sexologists' primary concern has been for their own professional status and legitimacy and that this emphasis has required strategies and alliances that have time and again co-opted any interests they may have had in women's self-determination.[50]

Irvine, like Mariana Valverde and, more recently, Ladelle McWhorter, observes that sexology has been "a profession committed to rehabilitating

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49. Berman, Berman, and Bumiller, *For Women Only*, 144–45.
50. Tiefer, *Sex Is Not a Natural Act*, 138.

[heterosexual] marriages through better sex."[51] Intervening in the "crisis in marriage" that threatens "the family" has been the fundamental justification for sexological research since Alfred Kinsey's foundational work in the 1940s and 1950s and appears to be a crucial component of securing research funding and institutional support for this field of study.[52] As the preceding discussion has shown, these feminist critiques of sexology—although written primarily in the 1980s and 1990s—apply to Laura and Jennifer Berman's work. Far from being revolutionary or feminist, the Bermans' sexological practice repeats the patterns of a conservative and patriarchal discipline that has proved impervious to feminist critique.

LEONORE TIEFER'S NOT SO "NEW VIEW" OF WOMEN'S SEXUALITY

Leonore Tiefer is a professor of psychiatry at the New York University School of Medicine and has a private sex-therapy practice in Manhattan. She is the main spokesperson in the feminist movement resisting the medicalization of women's sexuality and is featured in two recent documentary films about FSD.[53] With Ellyn Kaschak, she is the coeditor of *A New View of Women's Sexual Problems*.[54] In her own collection, *Sex Is Not a Natural Act and Other Essays*, Tiefer argues repeatedly that sex is "socially constructed" and frequently uses Foucault's name when she says this.[55] This volume is full of useful information and compelling criticisms of the medicalization of sex. In the final section of this article I will examine some aspects of her work that are especially helpful in theorizing feminist alternatives to sexology. In this section, however, I want to question the purported "novelty" of Tiefer's view of female

51. Irvine, *Disorders of Desire*, 117. See also Mariana Valverde, *Sex, Power, and Pleasure* (Toronto: Women's Press, 1985); and McWhorter, *Racism and Sexual Oppression*.
52. Alfred Kinsey, *Sexual Behavior in the Human Male* (Philadelphia: Saunders, 1948); Alfred Kinsey, *Sexual Behavior in the Human Female* (Philadelphia: Saunders, 1953).
53. *Pharma Sutra*, directed by Marion Gruner and Robin Benger (Cogent/Benger, 2008); *Orgasm Inc.*, directed by Canner.
54. Ellyn Kaschak and Leonore Tiefer, eds., *A New View of Women's Sexual Problems* (New York: Haworth Press, 2001).
55. Tiefer, *Sex Is Not a Natural Act*, 17, 20, 131.

sexuality ("a new view") and the ways in which her arguments remain prone to both Foucauldian and feminist critique.

In *The History of Sexuality*, Foucault famously problematizes what he calls "the repressive hypothesis."[56] He insists that far from sex being something that interacts with power primarily through censorship and silencing, "modern man" is a sexually "confessing animal."[57] Undeniably, the modern West is characterized by an unprecedented cacophony of discourses on sex, ranging from relentless media stories to the development of academic disciplines and medical subspecialities whose raison d'être is to write and speak about sex. According to Foucault, we nevertheless persist in thinking that we cannot talk about sex because this self-deception provides a liberatory excuse to talk *even more* about sex, and we want that excuse because we are titillated by our own sexual discourses.

The repressive hypothesis is worrisome for at least two reasons. First, by positing sex as repressed and thus largely unconscious, complex, and mysterious, it has come to seem imperative that we have experts to receive and interpret our confessions. Thus we think that consulting psychiatrists, psychologists, and sexologists is good for our psycho-sexual health, as these experts help us to overcome our inhibitions, understand our libidos, and become healthy and happy sexual subjects. Thus the repressive hypothesis encourages us to put ourselves under the authority of sexual scientists. However the task of these experts is not only to cure us of medical ills, Foucault argues, but to assimilate us into socio-sexual norms and to pathologize us insofar as we fail to conform. While Foucault's primary example of this is the psychiatric taxonomization of perversion, we can also see this imposition of socio-sexual norms in the medical management of wives: the Bermans treat women as sexually dysfunctional if they are not satisfying their husbands' desires.

A second problem with the repressive hypothesis is that it misunderstands how power works and thus prevents us from effectively resisting it. The repressive hypothesis presumes that power is negative, or that power censors and forbids. On the contrary, modern power is positive or constitutive of the kinds of subjects that we are. Thus, for Foucault, the

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56. Foucault, *The History of Sexuality*, 17–49.
57. Ibid., 59.

sexual sciences do not so much say no to homosexuality as they produce heterosexuality as a norm and constitute homosexual subjects as aberrant. Likewise, the sexual sciences do not so much repress female sexuality as they construct it to accommodate heteronormative masculine desires. Foucault is known as a "social constructivist" because he argues that power *makes* subjects rather than repressing them.

Although Tiefer purportedly follows Foucault in being a social constructivist, she in fact subscribes to the repressive hypothesis and, thus, falls prey to the pitfalls of the hypothesis described above. Throughout her book, Tiefer insists that sex, frank conversation about sex, sex education, and sex research are censored, forbidden, underfunded, treated with moral disapprobation, and ridiculed.[58] So difficult do we find it to talk about sex, Tiefer claims, that half of her job is just getting clients to "talk calmly and frankly about their sex lives" without becoming tongue-tied or giggly.[59] In particular, "women's sexuality has been repressed, suppressed, and oppressed."[60] Of a forty-five-minute sexological interview, Tiefer writes, "Since this is Nicole's only opportunity (maybe in her whole life) for an extensive sex discussion with a person comfortable talking about sex, the brevity is a tragic tease."[61] So sexually repressed are we, this statement suggests, that the only way we are likely to have a frank conversation about sex in our entire lives is by hiring a professional such as herself with whom to have it. From these passages we see that however often she says that sex is "socially constructed," Tiefer also assumes that there is something — sexuality, and women's sexuality in particular — that exists prediscursively in order to be repressed, censored, or silenced. Although she thinks that reading more books about sex and watching more sex videos will help, it seems that the best cure for sexual repression is to speak to a sexual scientist. Thus, having only a forty-five-minute interview with a sexologist in a lifetime is "tragic."

While Tiefer consistently assumes sexuality, and female sexuality in particular, to be something that already exists, albeit repressed, she is clear that another, alien sexuality has been imposed on women by a patriarchal society. Repudiating her doctoral experiments on rodents,

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58. Tiefer, *Sex Is Not a Natural Act*, xi, xii, xiv, 8, 15, 110.
59. Ibid., xiv.
60. Ibid., 139.
61. Ibid., 265.

she notes, "Writings from the women's movement convinced me that the primary influences on women's sexuality are cultural norms internalized by women, reinforced by institutions and enacted in significant relationships. Hamsters had taught me nothing about social norms."[62] Hamsters and other nonhuman animals are horribly victimized by academics in vain: as Tiefer argues, since these animals are not subjected to the same processes of socio-sexual normalization that we are, they can teach us nothing about our own sexuality. Tiefer thus rejects the medical approach to sex favored by Masters and Johnson and the Bermans that assumes statistical surveys and laboratory observations of sex acts will tell us the truth about mammalian sexuality. In fact, these studies — at least those done with human subjects — only tell us about the effects of sexual socialization, not timeless truths about how sex is and ought to be.

Tiefer argues that, beyond misinterpreting social sexual conditioning as biological fact, the sexual sciences are actively constructing and shaping female and male sexuality in new ways. Masters and Johnson, the Bermans, and the DSM are engaged, she believes, in replacing an old set of social constructions with a new one. Tiefer notes that Masters and Johnson's human sexual response cycle, proposed in their 1966 book *Human Sexual Response*, is "social construction in action" as is "the Viagra phenomenon."[63] Indeed, although "sex role socialization introduces fundamental gender differences and inequalities into adult sexual experience," Tiefer thinks that Masters and Johnson, the DSM, and the Bermans all assume that women and men are sexually the same; more importantly, Tiefer thinks that Masters and Johnson, the DSM, and the Bermans *actively construct* women and men to be sexually the same. She observes that Masters and Johnson selected women for their studies who were atypical in their culturally "masculine" sexuality: the women were unusually interested in improving coital technique, as demonstrated by the fact that they were eager to be involved in Masters and Johnson's studies at all; they were sexually uninhibited enough to have sex in a laboratory (Masters and Johnson had initially hired prostitutes for their studies, thinking no "normal" women would want to

62. Ibid., xiii.
63. Ibid., x, 61.

participate); and they had histories of orgasms from both masturbation and intercourse. The scientists then generalized from results using these atypical subjects to form their theories about female sexuality generally, thus producing a distinctly masculinized female sexuality as the norm that all women must live up to or be deemed "inadequate."[64] According to Tiefer's trenchant and largely astute criticism, the DSM and the Bermans carry on this tradition of assimilating women into a masculinized construction of female sexuality by pathologizing women who do not conform to masculine norms. Tiefer criticizes the DSM for presupposing that disorders of female sexuality will fall into the same categories of disorder as male sexuality and will be genital focused and coitus focused. She argues that this version of sexology, "with its alleged gender equity, disguises and trivializes social reality, that is, gender inequality, and thus makes it all the harder for women to become sexually equal in fact."[65]

Tiefer argues that even as the DSM constructs a masculinized version of female sexuality, like the work of Masters and Johnson and the Bermans, it ignores "*women's actual sexual voices*" or the "sexual concerns that women talk about, as we know these from popular surveys, questionnaire studies, political writings, and fiction."[66] For instance, "There's nothing in the DSM about emotion or communication, whole-body experience, danger and taboo, commitment, attraction, sexual knowledge, safety, respect, feelings about bodies, breast cycles, pregnancy, contraception or getting old."[67] Or again, "There's nothing about love, gentleness, kissing, passion … communication, emotional involvement … and the like."[68] If we listen to "*women's actual sexual voices*," Tiefer suggests, we will realize that women are less focused on the "sensate" aspects of sex than men, are less concerned with genitals, performance, and orgasm, and care more about the emotional aspects of sex. For most women, Tiefer writes, sex should "consummate a bond" and 77 percent of women want more "tenderness" in sex.[69]

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64. See Irvine, *Disorders of Desire*, 62.
65. Tiefer, *Sex Is Not a Natural Act*, 58.
66. Ibid., 136. Italics in original.
67. Ibid.
68. Ibid., 194.
69. Ibid., 184.

At times Tiefer acknowledges that "*women's actual sexual voices*" and the concerns they raise are themselves the products of social construction, but she does not criticize these social constructions of female sexuality in the same way or to the same extent that she criticizes the constructions of female sexuality that she sees occurring in current medical practice. And yet, if Masters and Johnson, the DSM, and the Bermans are constructing women to be like men sexually, Tiefer should recognize that there is another patriarchal tradition at work that constructs women to be different from men. The emotional communication and tenderness during sex that Tiefer believes women need may indeed be an outcome of a patriarchal tradition that valorizes women's other-orientedness: women's survival has been made dependent on their relationships, abilities to secure love, and communication skills. Similarly, while the DSM may ignore women's anxieties about aging bodies, it can be argued that it is a society that values women exclusively for their appearance and youth that produced this anxiety in the first place. Thus, it is not clear why it would be preferable if the DSM did include what Tiefer calls "*women's actual sexual voices*" in its categories of dysfunction. Would this not further pathologize women both for the way they are currently constructed as feminine *and* for the ways that they thus fall short of masculine norms? Since both women's current experiences of sexuality and the model that Masters and Johnson, the DSM, and the Bermans promote are patriarchal constructions, why would it be better for the doctors and their manuals to mention one set of constructs rather than the other?

In fact, far from seeing all patriarchal constructs of female sexuality as equally pernicious and in need of resistance and critique, Tiefer argues that the old constructs (women as different from men) need to be accommodated and written into the medical understanding of sexuality, while the new constructs (women as the same as men) need to be rejected. For instance, Tiefer approvingly describes sex therapies that would redefine sexual scripts so that they include more verbal communication and tenderness, thus defining the sexual script on (some) women's terms. Tiefer writes, "Such a redefinition requires appreciating the deep gender differences in sexual socialization in our society and rejecting the notion that sex-as-usual represents the interests of all men and

women."[70] Similarly, Tiefer would like sex therapy to "stress emotional homework assignments (heavy on loving communication, eye contact, expression of feelings, and the like)," since this is what (some) women want.[71] Tiefer's sex therapy would "be designed to evaluate a couple's emotional knowledge, comfort, and connectedness during sex instead of their satisfaction with the performance of various sex acts."[72] However, if (some) women's current desires for communication, emotional knowledge, and tenderness during sex are themselves constructs of femininity that have catered to an older patriarchal regime, why must we "appreciate" them and "define" our sexual scripts according to them? As Sandra Bartky has discussed, heterosexual feminine sexual desires may also be masochistic, but this does not mean that feminism needs to construct sexual scripts to conform to these women's desires to be humiliated and dominated by men.[73] However much Tiefer speaks of "social construction," her failure to call into question and incite our resistance to these more deeply entrenched constructs of femininity suggests that she views these constructs as unproblematic, natural, or inevitable. Indeed, Tiefer ignores the fact that female sexuality is not univocal and that some women actually prefer well-performed sex acts that lead to orgasm over kisses and pillow-talk about feelings and commitment. The voices of the women willing to participate in Masters and Johnson's studies — sexually experienced sex enthusiasts, eager to improve their coital and orgasmic techniques under bright lights with cameras rolling — were, like it or not, "*women's actual sexual voices*" too.

Thomas Laqueur argues that from antiquity until the modern era in Western science, female and male bodies were understood as isomorphic.[74] Anatomical drawings were designed to emphasize the similarities between the bodies of women and men rather than their differences. It was only in the eighteenth century that biologists began to emphasize the anatomical differences between the sexes, using a "two-sex" model,

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70. Ibid., 184.
71. Ibid.
72. Ibid., 185.
73. Sandra Bartky, "Feminine Masochism and the Politics of Personal Transformation" in *Femininity and Domination: Studies in the Phenomenology of Oppression* (New York and London: Routledge, 1990): 45–62.
74. Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, MA: Harvard University Press, 1990).

that entrenched the allegedly natural sexual differences between women and men that also justified keeping women in their place. While the Bermans, like anatomists prior to the eighteenth century, provide drawings of the human body that stress the similarities between female and male anatomies, Tiefer's book is closer to the vision of doctors using the "two-sex" model in that it is illustrated with pictures that represent female and male sexuality as radically opposed. In what Tiefer dubs "The Best Feminist Sex Cartoon in the World," we see female Viagra supplements, which are not made up of sildenafil but "Talkra" (which "revives flagging interest in what she has to say"), "Lovra" ("dramatically enhances the most basic act of all"), "Anniversra" ("rekindles a passionate drive to remember birthdays, anniversaries, etc."), "Respectra" ("reawakens a pounding, throbbing desire to think of her as a human being"), and "Flattra" ("stimulates the urge to give compliments").[75] Another cartoon, called "Fantasies Enable Many True Human Females to Cope More Satisfactorily with Their Lives," shows a bestial, beer can-wielding, balding, hairy, cigar-smoking man with an erect penis protruding from his boxer shorts approaching a smiling, shut-eyed woman who (as a heart-shaped bubble tells us) is imagining a well-groomed man shown from the waist up offering her flowers.[76] Women don't want penises (or anything from the waist down), the cartoon suggests; they want flowers. A third cartoon reproduced by Tiefer depicts the "Female Sexual Dysfunction Marathon," with male competitors representing pumps, sprays, pills, patches, salves, supplements, gels, creams, and capsules cheered on by other men representing Colgate Palmolive, Bayer, Pfizer, and other pharmaceutical companies. Two women stand at the sidelines holding signs that read "respect talk sincerity flattery" and "love and tenderness."[77]

Although Tiefer's feminist politics are clearly anathema to the eighteenth and nineteenth-century biologists described by Laqueur, and although she argues that the differences between women and men are social rather than biological facts, her view is hardly as new as she claims it is, and ultimately reiterates without problematizing the common trope that women and men are sexually different and that men want sex while women want love and commitment. If women want sex at all, Tiefer and

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75. Tiefer, *Sex Is Not a Natural Act*, 170.
76. Ibid., 174.
77. Ibid., 243.

the "new view" collective suggest that it is not so much for orgasms, however, but for spiritual connectedness with their partners: authors anthologized in Kaschak and Tiefer's *A New View of Women's Sexual Problems* critique "the orgasmocentric construction of sexual satisfaction," and advocate couples counseling to improve relationships rather than finding new sexual partners.[78] Tiefer and her followers thus remain true to the sexological tradition of preserving heterosexual marriages; they do so not so much by improving sexual technique so that women have more orgasms, but by reassuring women (and men) that women don't care much about orgasms anyway. Women just want love. Although Tiefer describes her approach as the "new view" and "postmodern," ultimately she provides a more sophisticated ("social constructivist") version of the sexual dichotomy espoused both by eighteenth and nineteenth-century biologists as well as the contemporary "men are from Mars, women are from Venus" mainstream.[79] While the pharmaceutical industry and the Bermans' ideas about sexuality may be a masculinist social construction in which female sexuality is like male sexuality, only weaker and inferior (and thus more statistically prone to dysfunction), the vision of female sexuality that Tiefer defends is just as normalizing and has just as much of a sexist history behind it as the vision of sexuality that she resists. Arguably, it is because Tiefer remains embedded in the disciplinary practice of sexology that she, like the Bermans — and despite her best (feminist, Foucauldian) intentions — continues to be complicit in sexual normalization, the repressive hypothesis, and the authority of sexual "experts" such as herself.

The following section considers how the notion of normalcy and practices of normalization are at work in the sexological treatment of FSD.

A PSYCHIATRY OF THE NORMAL

Laura and Jennifer Berman tell us that "Am I normal?" is one of the most frequently asked questions that they are posed.[80] Tiefer notes that the most common question that she is asked is: "Is my partner normal?"[81]

78. Kaschak and Tiefer, *A New View*, 74, 49.
79. Tiefer, *Sex Is Not a Natural Act*, 39.
80. Berman, Berman, and Bumiller, *For Women Only*, xiii.
81. Tiefer, *Sex Is Not a Natural Act*, 6.

She observes that in sex therapy, normalcy "typically is something couples fight over and accuse each other about. 'You're not normal,' 'No, you're not normal.'"[82] Tiefer writes that "the public seemed to acquire an insatiable appetite for information to answer the question, 'Am I normal?'" and that she is regularly expected to be a "normality referee."[83] Psychiatrists, it seems, are our recognized authorities on normalcy, and normal is what people want their sex lives to be. What this presupposes is that psychiatry has an expertise in normalcy and treats abnormalities. In his 1975–1976 lecture series *Abnormal*, Foucault argues that psychiatry shifted in the late nineteenth century from treating pathologies, or mental illnesses, to treating abnormalities. Although psychiatry had established itself as an authoritative discipline through its similarity to medicine, about one hundred and twenty years ago it "dispensed with illness," thus broadening its web of control.[84] The pathological, after all, were a small group compared to the abnormal. What I argue is that today psychiatry has moved, not merely beyond the pathological, but beyond the abnormal as well. It is not accurate to say that psychiatry dispenses with its previous targets as it shifts its focus. Rather, psychiatry maintains its grip on the pathological and the abnormal even as it casts its net wider, taking the normal into its domain.

The question of normalcy is particularly apparent in the case of the Bermans and other doctors treating women for FSD, since they uncritically cite the National Health and Social Life survey's statistic that 43 percent of US women are affected by FSD and that "more than half" of US women over forty are sexually "disordered," even while treating FSD as a psychiatric problem. These numbers suggest that FSD is in fact statistically *normal* and that, among mature women, FSD actually characterizes the majority. Thus the question arises as to whether FSD is abnormal in some *other* way — such as ideologically — or how, if it is not abnormal at all, it can be a psychiatric disorder.

The Bermans are inconsistent with respect to how they measure normalcy and about whether they think FSD makes a person abnormal. In their discussion of testosterone treatments for women, they note,

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82. Ibid., 181.
83. Ibid., 14, 181.
84. Foucault, *History of Sexuality*, 308.

> The normal range for total testosterone is usually 14 to 76 nanograms per deciliter, although Dr. Susan Rako, the author of *The Hormone of Desire*… sets normal at 20 to 50 nanograms per deciliter. We agree with her, and think that anything below 20 nanograms per deciliter is too low, indicating that testosterone therapy should be considered.[85]

Although it is within the normal range to have a total testosterone count anywhere between 14 and 76 nanograms per deciliter, the Bermans advocate the narrower range of 20 to 50 nanograms per deciliter as "normal." This means that women should be neither at the low end of the spectrum, in which case they may have low libidos, nor at the high end, in which case they might be physically masculinized. This seems to entail a contrast between what is statistically common (anywhere between 14 and 76 nanograms per deciliter) and what is considered optimal (20 to 50 nanograms per deciliter), with the word "normal" being reserved for the ideal rather than the commonplace.

The Bermans write scathingly of doctors who tell women that decreased libido is "a normal part of aging" and are critical of drug companies that have been slower to "recognize female sexual dysfunction as a medical problem" than they were to treat male erectile dysfunction.[86] Lower sex drive, according to the Bermans, is *not* to be accepted as "normal" after menopause or at any other life stage, and not even after hysterectomies or other pelvic surgeries. In this case, the Berman's use of the term "normal" clearly refers to neither a statistical nor even a biological norm, but to an ideological norm. The ideology in question *could* be feminist: all women, whatever their age, are entitled to sexual desire, arousal, and pleasure, and no doctor should invoke normalcy or aging to convince them otherwise. On the other hand, it could be patriarchal: all women, whatever their stage in life, should desire intercourse, should be aroused easily, and should orgasm. In other words, all women should be making themselves sexually available (to their husbands) and loving it, whatever drugs this takes to achieve. Far from feminist, in this reading the ideological norm in question is a medical construction of female sexuality tailored to appeal to modern, Western, heterosexual men, for

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85. Berman, Berman, and Bumiller, *For Women Only*, 115.
86. Ibid., xiv.

whom women who *don't* want sex and *don't* orgasm are more threatening than women who do.

Likewise, treatment for FSD is described by the Bermans as a normalization of women who had previously been abnormal: of one successful case, they write, "Her relationship with her husband improved. Her newfound desires also made her feel less isolated and more like other women around her. 'Now I feel like I think like most of my friends,' she said." According to the Bermans, FSD is not to be accepted as normal, then, and treating FSD will make women feel more normal with their partners and peer group. This implies that FSD is abnormal and that treating it normalizes women, regardless of the statistics.[87] Ironically, the Bermans also tell their readers that women who come to their offices are "relieved to learn that many other women share the very same problems, that they are not abnormal or alone." "Our goal is to assure them of their normalcy," they write. Indeed: "we prefer the term 'female sexual dissatisfaction' when we talk to our patients. It seems too much of a stigma to label someone as dysfunctional when so many women suffer from these complaints."[88]

This brings us back to the question: if FSD is a commonplace sexual dissatisfaction on the part of (heterosexual) women, how is it a psychiatric disorder? The answer is surely that it is aberrant with respect to a social fantasy, and Foucault is therefore right when he argues that doctors are practicing social hygiene.[89] Nevertheless, in the cases that Foucault discusses, even if it were an aberration from a social fantasy that truly concerned the doctors, their patients were statistically abnormal, or were at least discussed as though they were, as in the case of the masturbating children who so concerned nineteenth-century doctors. Although tacitly recognized, the near-universality of childhood masturbation could

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87. Foucault's distinction between "normation" and "normalization," developed in Lecture 3 of *Security, Territory, Population*, may be useful here. See Michel Foucault, *Security, Territory, Population: Lectures at the Collège de France: 1977–78* (New York: Picador, 2009), 83–91.
88. Ibid., 118, 1, 64, 68.
89. See Foucault, *The History of Sexuality*; Foucault *Abnormal*; Michel Foucault, "Confinement, Psychiatry, Prison," in *Michel Foucault: Politics, Philosophy, Culture: Interviews and Other Writings, 1977–1984*, ed. Lawrence D. Kritzman (New York: Routledge, 1988), 178–210; Michel Foucault, *History of Madness* (1961; repr., New York: Routledge, 2006); Foucault, *Psychiatric Power*.

not be invoked at the time since, in the nineteenth and for most of the twentieth century, the two senses of abnormal — statistical and ideological — were conflated, or those targeted for disciplinary transformation were perceived as abnormal in both senses. Indeed, this is perhaps why masturbation was ultimately abandoned as a psychiatric concern: however useful the pathologization of masturbation was to psychiatric power, the myth of its abnormality could not be sustained. Now, however, the case of FSD shows that the abnormal may be openly abandoned in the statistical sense, and psychiatrists are taking on targets that can only be defined as abnormal in an ideological sense. Women's sexual dissatisfaction is not rare, nor is there any attempt to disguise it as such; on the contrary, it is now the very *prevalence* of so-called female sexual dysfunction that is unabashedly broadcasted in order to stress the urgent need for medical treatment.

As feminists such as Tiefer and documentaries such as *Pharma Sutra* and *Orgasm Inc.* have demonstrated for a decade, FSD, like Male Sexual Dysfunction, is pathologized in order to patent the drugs developed to treat it. There are enormous financial incentives to medicalize these conditions precisely because they are commonplace, and the market for these drugs is thus large. The diagnosis is not about illness or abnormality; it is about making large numbers of people *think* that they are ill or abnormal so that corporations can profit. At the same time one does not want to pathologize or render sexual dysfunction so abnormal that patients will be afraid to admit that they need treatment. One must walk the thin line of abnormalizing these symptoms just enough to make people want the drugs, but not so much that they are ashamed to ask for them. While this cynical view regarding the financial stakes in pathologizing sexual dissatisfaction has been espoused before, what I find also troubling is that this financial incentive has been instrumental in a new shift in the history of psychiatry. Now that psychiatrists are funded for their research almost exclusively by pharmaceutical companies, they have new economic stakes in pathologizing groups of individuals that are increasingly large and thus increasingly normal. Just as in the late nineteenth century, psychiatry expanded its net to colonize the abnormal, in the twentieth century, it took on a new and even more

expansive target: the statistically normal.[90] In each case, psychiatry does not so much give up its previous targets as amass new ones, and it has taken ever more audacious targets each time.

This argument about the pathologization of the normal is similar to Susan Bordo's argument about anorexia as a "crystallization of culture" and Cressida Heyes's argument that there is no "bright line" between Body Dysmorphic Disorder and "normal" feminine preoccupations with physical appearance.[91] Both authors show that the pathological is on a hazy continuum with the banal, and the enforcement of the norm produces its abnormal other. Typical feminine behavior is pathologized when taken to an extreme, and the pathological is not so much opposed to the norm as the norm exaggerated. With the case of FSD, however, it seems that feminine comportment does not even need to be taken to an extreme to be pathologized. The women treated are not sex-phobic women, after all, but postmenopausal and postpartum women who are experiencing decreased libidos, and the majority of women who do not orgasm from intercourse. With the psychiatry of the normal, it is not just that the line between the normal and the abnormal is an indistinct and moving target, or that skewed norms are themselves producing

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90. Janice Irvine's study of the emergence of sexology in the works of Kinsey (1948, 1953) and Masters and Johnson (1966, 1970, 1974) shows that high rates of divorce and otherwise unhappy marriages were invoked to justify the scientific study of sex. Masters and Johnson, who focused on "marital units" rather than individuals in their sex therapies, claimed that half of marriages were sexually dysfunctional (Irvine, *Disorders of Desire*, 148). From its inception, therefore, sexology justified its existence by way of the widespread nature of the social problem that it purported to address. Importantly, however, Kinsey would not attribute the cause of sexual problems to pathology, but to a lack of sexual education. Thus, with Kinsey's work, we cannot yet say that the normal is being pathologized. The shift to pathologizing sex seems to have occurred with the publication of Masters and Johnson's *Human Sexual Inadequacy* (1970). In this work, Masters and Johnson build on their previous study, *Human Sexual Response* (1966), to identify categories of sexual dysfunction corresponding with each stage of their Human Sexual Response Cycle. The DSM account of sexual dysfunction builds on the work of Masters and Johnson.

91. Susan Bordo, "Anorexia Nervosa: Psychopathology as the Crystallization of Culture," in *Unbearable Weight: Feminism, Western Culture, and the Body* (Berkeley: University of California Press, 1993), 139–64; Cressida Heyes, "Diagnosing Culture: Body Dysmorphic Disorder and Cosmetic Surgery," *Body and Society* 15, no. 4 (2009): 73–93.

pathologies, but that no abnormality need even exist since the mundane itself has been psychiatrized.

CONCLUSIONS: FOUCAULDIAN-FEMINIST ALTERNATIVES TO SEXOLOGY

Although Tiefer borrows heavily from Foucault when she says that sexuality is socially constructed, she is in fact not adequately Foucauldian insofar as she expresses a repressive view of the relationship between sex and power. While Tiefer may not have grasped the consequences of Foucault's argument regarding the constitutive rather than repressive nature of power, there are at least four moments in Tiefer's texts that I think are usefully Foucauldian and helpful for theorizing feminist alternatives to sexological approaches to women's sexual dissatisfaction.

The first of these moments is Tiefer's historicization and critique of the preoccupation with normalcy and with sexual normalcy in particular. While Foucault provides a genealogy of the shift from thinking of most sex acts as sinful to seeing them as abnormal and cause for psychiatric concern, Tiefer sees the medical discourses on abnormality as taking up where religious discourses on sin left off. She distinguishes between six uses of the term "normal" and criticizes the conflation of these uses. Tiefer problematizes the presumed connection between abnormality and pathology and argues that the concern with abnormality is not ultimately about health, but about social conformity.

The second Foucauldian moment in Tiefer's work is her observation that in sexological writings, pleasure has been forgotten. The medical discourses on sexual dysfunction focus on performance and genital mechanics, including orgasm, but are silent about pleasure. For men, sexual function in the medical literature is about getting a "normal" erection and sustaining it for a "normal" amount of time before ejaculating. For women, it is about feeling a "normal" amount of desire and responding "normally" to sexual stimulation (arousal and orgasm). Doctors speak of Hypoactive Sexual Desire Disorder and Sexual Arousal Disorder, but say nothing of pleasure dysfunctions. "Personal distress" and pain are viewed as signs of a disorder, but their opposite, pleasure, is nowhere to be seen. In an interview, Foucault similarly argued that we have focused so much on desire that no one knows what pleasure is

anymore.[92] We know from his writing that Foucault included himself in this statement.[93] Tiefer suggests that we shift our focus of attention from desire and performance to pleasure, and Foucault makes a parallel argument, suggesting that bodies and pleasures, rather than sex/desire, might be the "rallying point" for resisting sexual normalization.[94] Tiefer, unlike Foucault, is usefully attentive to gender when she discusses pleasure. She observes,

> An early 90s U.S. probability sample survey conducted in Chicago asks one question about sexual problems experienced in the past 12 months, and about twice as many women (27 to 17 percent, younger to older) as men (10 to 6 percent) reported that sex was not pleasurable. However, unlike the results about arousal and orgasm, these provocative findings on pleasure were not further analyzed.[95]

Thus a second point we might take from Tiefer and Foucault is that we need to think less about performance and desire and more about pleasure. In particular, we should be concerned with why many women are not finding sex pleasurable.

Third, Tiefer argues that we should replace the medical approach to sexuality with an aesthetic approach. Rather than sex being something that we consult a psychiatric manual about, Tiefer suggests that sex could be thought of as an artistic endeavor. She writes,

> Open a textbook on human sexuality, and nine times out of ten it will begin with a chapter on anatomy and physiology.... Open a textbook of music, in contrast, and you will not find chapters on the bones, nerves, blood vessels, and muscles of the fingers (for playing the piano), the hands (to play cymbals or cello), or even the mouth or throat (for flute or singing). And what about the physiology of hearing or of the sense of rhythm? Why don't music texts start with biology? Isn't biology as fundamental to music as it is to sexuality?[96]

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92. Michel Foucault, "On the Genealogy of Ethics," in *Michel Foucault, Beyond Structuralism and Hermeneutics*, ed. Hubert Dreyfus and Paul Rabinow (Chicago: University of Chicago Press, 1993), 243.
93. See Michel Foucault, "An Ethics of Pleasure," in *Foucault Live: Collected Interviews 1961–1984* (New York: University of Columbia Press, 1996), 378.
94. Foucault, *The History of Sexuality*, 157.
95. Tiefer, *Sex Is Not a Natural Act*, 209.
96. Ibid., 2.

The reason sexuality textbooks begin with biology, while textbooks on music do not, is that we think of sex as a "natural" act, whereas we think of music as artistic or as a creative human endeavor. However, Tiefer argues, human sexuality is a thoroughly cultural phenomenon and, like music, is a way in which we can express ourselves creatively. Foucault also contrasts the sexual science approach to sexuality with an aesthetic model, first in the *ars erotica* (erotic art) comparison of the first volume of *The History of Sexuality* and later in his discussions of the aesthetics of the self.[97] These examples are meant to show that we could approach our lives, including our sex lives, as works of art, rather than as objects of knowledge for the biological and psychological sciences. Approaching sex aesthetically would be a way out of the normalizing discourses of the psychological sciences, since art does not aspire to normalcy. For Foucault, an artist would only make art in order to transform herself or to become other than what she is: "The transformation of one's self … is, I think, something rather close to the aesthetic experience. Why should a painter work if he is not transformed by his own painting?"[98] If we approached our sex lives aesthetically, it would not be to prove our normalcy. Rather, a sexual aesthetic could be about transforming ourselves, using sexual practices and pleasures to become other than what we are. An aesthetic approach to sex might undo the disciplining (including the gendering) of our sex lives and enable us to experience new bodies and new pleasures, or to become new bodies of pleasure.

While the notion of an aesthetic approach to sex is helpful, I want to raise two qualifying criticisms of these last claims. First, much as Sandra Bartky argues that gender, although performative, is too coercive to be understood as aesthetic self-expression, so also we must worry about describing sex in these terms. Bartky writes,

> In the language of fashion magazines and cosmetic ads, making up is typically portrayed as an aesthetic activity in which a woman can express her individuality. In reality … making up … is a highly stylized activity that gives little reign to self-expression. Furthermore … the

97. Foucault, *The History of Sexuality*, 57–58; Michel Foucault, *The Use of Pleasure* (New York: Vintage, 1985); Michel Foucault, *The Care of the Self* (New York: Vintage, 1986); Michel Foucault, "An Aesthetics of Existence," in *Michel Foucault: Politics*, 47–53.

98. Foucault, "An Ethics of Pleasure," 379.

> woman who chooses not to wear cosmetics at all faces sanctions of a sort which will never be applied to someone who chooses not to paint a watercolor.[99]

This is not dissimilar to Judith Butler's discussion of the performative nature of gender:

> The act that gender is … is clearly not one's act alone. Surely there are nuanced and individual ways of *doing* one's gender, but *that* one does it, and that one does it *in accord with* certain sanctions and proscriptions, is clearly not a fully individual matter.[100]

The theater analogy is common in sexological writings — as in the frequent use of the term "sexual scripts" — but, as with gender, it is important to note that sex being theatrical or performative does not mean that it is mere aesthetic self-expression; we must remember the constraints under which these theatrical performances take place, the overwhelming conformity of the performances, and the sanctions that arise from transgressive performances. Like gender, sex may be a set of acts that we perform amid threats of violence and the risk of social illegibility should we stray too far from the script. The potential for aesthetic self-expression is extremely limited under these conditions, even if, as Butler writes, the body "is not passively scripted with cultural codes."[101] A feminist goal should be to help create a world in which sex *could* be explored by everyone as aesthetic self-expression, and yet we should not assume that this is already the case.

Second, an aesthetic and self-transformative approach to sex, insofar as it is currently possible, may not be appealing to everyone, including many women who are currently being diagnosed with FSD. Rather than seeing sex as a site for endless self-transformation, many people may be happy with their sex lives as they are, may like their routines, may be busy with other projects, or may not consider sex to be an important, interesting, or safe aspect of their lives that they want to develop.

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99. Sandra Bartky, "Foucault, Femininity, and the Modernization of Patriarchal Power," in her *Femininity and Domination: Studies in the Phenomenology of Oppression* (New York: Routledge, 1990), 71.
100. Judith Butler, "Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory," *Theatre Journal* 40, no. 4 (1988): 525. Italics in original.
101. Ibid., 526.

A feminist approach to women's sexuality should be accepting of these facts.

This brings me to the fourth moment in Foucault's and Tiefer's work that I think is useful for feminism: while both Tiefer and Foucault propose an aesthetic rather than a medical approach to sex, neither prescribes it. The overwhelming message of the first volume of *The History of Sexuality* is that our current fascination with sex is problematic and contingent. In *The Use of Pleasure*, Foucault repeatedly notes that the ancient Greeks did not share our keen interest in sex and thought that food was a much more interesting pleasure to problematize.[102] Similarly, Tiefer stresses that

> sexuality is an option in life, although one wouldn't think so to listen to many "experts" talk. If someone wants to have a long and lively sexual life—and believe me, *I don't care* whether anyone does or does not want to and I am making no recommendations—but a person who does want to needs to learn about sexuality and take time to practice.[103]

Like musical ability, Tiefer argues that sex may be a talent that some people have and others lack.[104] If one does not have a talent for sex, it is no more terrible than if one does not have a talent for music. There are other fulfilling pursuits in life, and sexuality should be no more privileged a pursuit than any other. Indeed, one of Tiefer's reasons for rejecting the health model for sexuality is that she does not think we need to be sexual to be healthy. The contingency of thinking that sex is and should be significant to everyone's lives is an important message for feminism to convey. It is with this decentering of sex, along with their critique of normalcy, their turn from desire to pleasure, and their turn from medicine (though not necessarily to art), that I think both Tiefer and Foucault provide resources for developing non-normalizing alternatives to sexology. Foucault, unfortunately, offers these critiques without paying any particular attention to gender, while Tiefer, also unfortunately, offers these critiques from within the practice of sex therapy—which she advocates—and the hypothesis of sexual repression, which is at odds

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102. Foucault, *The Use of Pleasure*, 114.
103. Tiefer, *Sex Is Not a Natural Act*, 145. Italics in original.
104. Ibid., 156.

with her critique of the medicalization of sex. Rather than medicalizing sex, Foucault and Tiefer support an aestheticization of sex, while Tiefer continues to argue for "feminist sex therapy."[105] Given my rejection of sexual therapy and the qualifying criticisms that I have raised with respect to the idea of an aesthetics of sex, I am less inclined to argue for either a "new" form of sex therapy or an aestheticization of sex than for a feminist politics of sex. As this article has suggested, such a feminist politics of sex would be desexualizing in so far as it would not see sex as central to everyone's life and identity, and it would advocate the cultivation of pleasures (sexual or otherwise) rather than normalcy.

105. Tiefer, "Towards a Feminist Sex Therapy," in *Sex Is Not a Natural Act*: 147–158.