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THE CHALLENGES OF SEXOLOGY IN ARGENTINA

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ABSTRACT. This article inquires into the origins and present dynamics of sexology in Argentina, with the aim of discussing its prevailing approaches and shedding light on some of the field's tensions and challenges. Findings are based on empirical research that used both *secondary sources* (i.e., course outlines, conference programs, and affiliation and accreditation rules of professional associations and curriculum vitae of well-known sexologists) and *qualitative data* gathered in interviews with key actors in the field (sexual therapists, sex educators, and other professionals dealing with sexuality issues who do not acknowledge themselves as sexologists). The text also maps professional organizations and training options, explores potential tensions in the field (i.e., the relation between those providing sexual counseling and sex education), and addresses two main issues: the increasing medicalization of the field stimulated by the Viagra phenomenon and the gender power imbalance between professions (most physicians working as sexologists are male, while most psychologists and psychoanalysts are female). It is our hypothesis that both sexologists' profile (mainly male physicians) and the nature of the demands they face (their clients are basically middle-class couples or individuals seeking to improve their sexual lives) may explain their lack of familiarity and/or interest regarding the gender perspective and nonhegemonic sexualities. The fact that there has not been an evident generational renovation as well as sexologists' small amount of interaction with nongovernmental and governmental actors regarding public policies on sexuality-related issues (i.e., decriminalization of abortion, sex education in schools) seem to indicate that the field is facing challenges other than increasing medicalization that threatens the power and prestige of these specialists.

KEYWORDS. Sexology, Argentina, medicalization, gender perspective

INTRODUCTION

Sexology is a specific field of knowledge and practices (whether educational and/or therapeutic) focused on sexuality. Its origins date back to the second half of the 19th century, and since then, sexology has been practiced by professionals from different medical and nonmedical disciplines (Béjin, 1985a, 1985b; Bullough, 1994; Giami, de Colomby, & Groupe-Euro-Sexo, 2006; Irvine, 2005; Kontula, 2011). Its development and consolidation can be considered part of the medicalization process, an international tendency characterized by the fact that some sexual practices and states are defined as "health problems" that need to be solved by "treatment"—whether the application of techniques, expertise, and/or pharmaceutical drugs (Conrad, 2007; Tiefer, 1996).

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The concept of medicalization was created by social scientists to explain how medical knowledge is applied to a series of behaviors over which medicine exerts control, although those behaviors are not self-evidently a field of medicine intervention (Conrad, 1992; White, 2002; Zola, 1972). The dramatic growth in the number of categories of mental illness as explained in the various versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a primary area of alleged medicalization. For instance, the current version (DSM-Fourth Edition) includes "erectile dysfunction" and "premature ejaculation" in the list of so-called "sexual disorders." Many socially unacceptable behaviors have been medicalized and assigned disease terms in the 20th century, while some behaviors previously considered medical problems have become more acceptable and been de-medicalized (e.g., homosexuality, masturbation). Experts argue that from the 1980s onward and due to HIV/AIDS, sexuality has been profoundly remedicalized (Vance, 1991). At present, the medicalization of sexuality is basically related to the development of surgical interventions (Rosen & Leiblum, 1995; Tiefer, 1994) and a variety of drugs for sexual dysfunctions (i.e., sildenafil has become "the treatment" for lack of erection; Giami, 2011).

Contrary to traditional biomedical perspectives, which tend to consider sexuality as universal and immutable, a social constructionist perspective of sexuality states that even though sex "feels private," sexuality is socially embedded (Ross & Rapp, 1983). Kinship and family systems, sexual regulations and definitions of communities, national and world systems—each and all simultaneously—set the external limits on sexual experience and shape individual and group behavior (Ross & Rapp). In some cultures, ideologies of sexuality stress female resistance, male aggression, and mutual antagonism in the sex act; in others, they stress reciprocity and mutual pleasure (Dixon-Mueller, 1993).

This approach recognizes that women's and men's bodies play a key role in their sexuality but also looks carefully at the specific historical and cultural contexts to gain an understanding of how specific meanings and beliefs about sexuality (for instance, ideals regarding virginity) are generated, adopted, and adapted (Dixon-Mueller, 1993). It incorporates collective and individual beliefs about the nature of the body, about what is considered erotic or offensive, and about what and with whom it is appropriate or inappropriate for men and women (according to their age and other characteristics) to do or to say about sexuality. Central to this perspective is the idea of gender and sexuality as "interlocking domains" (Dixon-Mueller).

Scott's (1986) definition of gender as a constitutive element of social relationships based on perceived differences between the sexes and as a primary way of signifying relationships of power has been widely accepted by academia and other relevant stakeholders (health and rights advocates, governmental agencies, UN agencies, etc.). Although often used interchangeably, sex and gender are in fact distinct terms. A person's sex is biologically determined as female or male according to certain identifiable physical features. However, these biological differences cannot explain why women have less access to power and lower status than men do. To understand and challenge the cultural value placed on someone's biological sex, and unequal power hierarchies, we need the relational concept of gender (Reeves & Baden, 2000). Gender refers to the economic, social, and cultural attributes and opportunities associated with being male or female in a particular social setting at a particular point in time (World Health Organization [WHO], 2001). Society prescribes specific roles for girls and boys and women and men, and values them differently. In almost all societies girls and women are valued less compared with boys and men (Bourdieu, 2001). This unequal value is the source of discrimination and oppression for women and accounts for the inferior status given to women in society.

As other "master statuses" (i.e., age, race, class), gender organizes a person's understanding of the social world and, particularly, his or her very understanding of sexuality (Laumann, Gagnon, Michael, & Michaels, 1994). In other words, ideas about what constitutes the essence of "maleness" and "femaleness" are expressed in sexual norms and ideologies (Fausto-Sterling,

2000). One of them is the "double sexual standard," in which men initiate sexual life earlier than women, are more oriented to the enjoyment of the physical aspects of sex, have more sexual partners, and are more likely to have sex outside marriage. Another is the dual female stereotype (bad girl/whore; good girl/*madonna*) that depicts "good women" as those who are ignorant about sex and passive in sexual interactions (Weiss & Rao Gupta, 1998; Zeidenstein & Moore, 1996). Men, in contrast, are expected to be experts in sexuality and have no problem asking for and finding pleasure in sex. In addition, issues of sexual diversity and inequality linked to sexual orientation and gender identity also need to be taken into account in contexts that "combine institutionalized patriarchy and heterosexism, as well as the pathologizing of non-normative sexual and gender behaviors and identities" (Gamson & Moon, 2004).

In Argentina, as in many other countries in the North and the South, socio-anthropological and psychosocial studies triggered by HIV/AIDS in the last decades of the 20th century have provided a huge amount of knowledge on human sexuality regarding people with diverse sexual orientations (Gogna, Pecheny, Ibarlucía, Manzelli, & Barrón López, 2009; Grimberg, 2002; Kornblit, Mendes Diz, & Di Leo, 2004). Likewise, social sciences studies on a variety of sexual and reproductive health and rights issues have supplied evidence on women and teenagers' sexual practices, ideals, and norms (Gogna, 2005; Jones, 2010; Pantelides & Manzelli, 2003; Sikos, 2000; Weller, 1999).

Nevertheless, the knowledge on sexual conduct, expectations, and/or fantasies produced by social scientists has had little or no impact on the perspectives of most clinical sexologists. It is our hypothesis that both sexologists' profile (mainly male physicians) and the nature of the demands they face (their clients are basically middle-class couples or individuals seeking to improve their sexual lives) may explain their scarce contact with local literature on sexual and reproductive health and rights issues. It is interesting to note that 15 years ago, professionals from the same generation but with backgrounds in psychology or psychoanalysis created the Psychoanalysis and Gender Forum, a multidisciplinary space for the discussion of gendered research findings in various fields. Its founders have also played a key role in debates on sexuality-related issues such as the decriminalization of abortion, the egalitarian marriage, the trafficking of women, and sex education in schools. Many of them also have a clinical practice in which they provide services mainly to middle-class patients. Yet they seem to have a greater interest and commitment with current debates in the public sphere. We believe that the fact that the forum was founded mainly by feminist women may explain that people trained in the same university (mainly the University of Buenos Aires) have, despite some initial common interests, adopted such diverse professional routes. To expand our argument, the article will focus on two dimensions: (a) sexologists' perspectives on medicalization of sexuality, and (b) their familiarity (or not) with gender—a key dimension regarding sexual ideals and behaviors.

In the first part, we describe the methodological strategy of the study. In the second part, we provide a brief history and an analysis of the process by which sexology constituted itself as a field in Argentina. Afterward, we analyze the perspectives of sexologists regarding the increasing medicalization of the field brought about by sildenafil, which—unlike other issues—alarms both medical and nonmedical clinical sexologists. We then focus on sex education and sexologists' familiarity (or not) with the gender perspective, a key dimension of human sexuality. Finally we enumerate some of the challenges our interviewees acknowledged and others that, as outsiders, we foresee as crucial for the evolution of the field.

MATERIALS AND METHODS

Our description and analysis come from the results of a three-step study that was carried out in 2007–2008 as part of a broader project: "Sexuality, Science, and Profession in Latin

America: Argentina, Brasil, Chile, Colombia, México, Perú" coordinated by the CLAM (Latin American Center for Sexuality and Human Rights) and Inserm Institut National de la Santé et de la Recherche Médicale (Russo & Giami, 2011).

First, we drew a map of the field of sexology in Argentina to identify the main associations, training institutions, courses, regular meetings and publications, and key professionals. To build this map, we applied the following research techniques: (a) an Internet search of personal or institutional Web pages and of courses related to sexuality/sexology at various careers at universities (medicine, psychology, etc.); (b) the analysis of secondary sources (content analysis of programs, review of sexology associations' affiliation and accreditation norms and of professionals' curriculum vitae); (c) virtual exchange with university teachers and key informants of the field; and (d) six exploratory interviews with some of the "pioneers."

Second, we conducted 12 semistructured interviews with relevant stakeholders in the field (in some cases, a second interview with a so-called pioneer). Interviewees were selected purposely to cover different profiles in terms of undergraduate training, area of specialty, geographical jurisdiction, and gender. The purposeful sample was made up of six men and six women; four were physicians and eight were nonmedical professionals (among them, four psychologists). Regarding area of specialization, four were educational sexologists, five were clinical sexologists, and three were specialists in both areas.

Thirdly, to broaden our view on the professional role of sexuality specialists, we interviewed another five professionals who address sexuality issues—and often interact with well-known sexologists—but who do not acknowledge themselves as such, nor do they consider themselves part of the field of sexology. We interviewed a psychoanalyst and physician, a urologist, a gynecologist, a psychoanalyst, and a psychologist specialized in sex therapies.[1]

[1]See detail of interviewed informants' sample in Table 1.

BRIEF HISTORY OF THE FIELD

'At the Beginning, It Was Psychoanalysis'

The first antecedents of sexology in Argentina date back to the 1950s and are related to sex education initiatives such as the "Escuela para Padres" (School for Parents), founded by psychoanalyst Eva Giberti in 1957.[2] What started as group meetings with mothers who came to her looking for help to raise their children then grew to incorporate fathers and teachers, and finally became a national movement that went on until the beginning of the 1970s. The experience had a significant presence in the mass media, and professionals from different specializations became part of it. This made it possible to cover several issues, which went from learning problems to odontopediatrics, including children psychoanalysis and relationships among family members.

Giberti, who currently leads a public program assisting victims of sexual violence, is still perceived by the general public as one of the main divulgators of psychoanalysis[3] since she made its concepts popular by talking about sexuality issues in ways that were culturally acceptable for the large middle-class sector of the Argentine society during the 1960s (Plotkin, 2003). Paradoxically, despite having acted as a hinge between both fields, she is neither acknowledged as "one of them" by sexologists nor by orthodox psychoanalysts (mainly, those gathered in the Argentine Psychoanalytic Association).

Then Doctors Arrived: Sex Education

In the early 1960s,public hospitals and the School of Medicine at the University of Buenos Aires started to offer sexology courses. Professors were gynecologists and obstetricians working in the family planning field. In 1967, a group of obstetricians and gynecologists founded the

[2]In regard to the role of Eva Giberti on sex education and the outreach of psychoanalysis in Argentina, see Cosse (2006, pp. 43–48) and Plotkin (2003, pp. 169–175).

[3]In Argentina, the teaching of psychology has been dominated by a psychoanalytic approach, which many times reinforces traditional points of view on female sexuality (Plotkin, 2003).

TABLE 1. Key Informants Interviewed

	Genre	Original Profession	Specialization in Sexuality	Institution	Area of Activity
1	F	Biology teacher	Sex education specialist	ASEL	Entre Ríos Province
2	M	Gynecologist physician	Clinical sexologist	CIPRESS - ASEL	Entre Ríos Province
3	F	Biologist and biological sciences teacher	Sexual educator	SOCOSEX	Córdoba Province
4	M	Bachelor in Social Communication licensee	Sexual educator	AASES	Buenos Aires Province
5	M	Gynecologist physician	Couples psychotherapist and specialist in clinical sexology and sex education	SOCOSEX	Córdoba Province
6	F	Psychologist	Clinical sexologist and sexual educator	ARESS, Kinsey Institute	Santa Fe Province
7	F	Bachelor in Eugenesys and Humanism[1]	Therapist, gerontologist, clinical sexologist, and education sexologist	FESEA	Buenos Aires City
8	M	Psychologist	Clinical sexologist	SASH	Buenos Aires Province
9	M	Psychiatrist, physician, and psychoanalyst	Clinical sexologist	CETIS	Buenos Aires City
10	M	Psychiatrist and physician	Clinical sexologist	SASH	Buenos Aires City
11	F	Social psychologist	Educational sexologist	AASES	Buenos Aires Province
12	F	Psychologist	Clinical sexologist	SASH and FLASSES	Río Negro Province, Buenos Aires City
13	M	Urologist physician	Andrologist	Hospital Italiano and PROCREARTE Red de Medicina Reproductiva y Molecular	Buenos Aires City
14	F	Gynecologist, physician, and obstetrician	Physician specialist in gynecological endocrinology	SAEGRE	Buenos Aires City
15	M	Psychiatrist and physician	Psychoanalyst with genre perspective, male sexuality	Psychoanalysis and genre forum	Buenos Aires City
16	F	Psychologist	Heterodox psychotherapy; sexual issues.	Sexuality Studies Group (IGG/UBA)	Buenos Aires City
17	F	Psychologist	Psychoanalyst with genre perspective, women	World Federation for Mental Health Psychoanalysis and Genre Forum	Buenos Aires City
18	F	Psychologist	Clinical sexologist	CEPAS	Mendoza Province
19	F	Bachelor of Obstetrics	Sexual educator	IPESS	Buenos Aires City
20	M	Physician specialized in psychiatry	Sexologist	AISM and SASH	Buenos Aires City

[1]The Bachelorship in Eugenesys and Humanism was a career offered by the Universidad del Museo Social Argentino, closed in the 1980s.

AASES = Asociación Argentina de Sexología y Educadores Sexuales (Argentine Society of Sexology and Sexual Education); AISM = Academia Internacional de Sexología Médica (International Academy of Medical Sexology); ARESS = Asociación Rosarina de Educación Sexual y Sexología (Sexual Education and Sexology Rosarian Association); ASEL = Asociación Sexológica del Litoral (Sexology Association of the Litoral); CEPAS = Centro de Educación, Pareja y Asistencia a la Sexualidad (Education, Couples, and Sexuality Assistance Center); CETIS = Centro de Terapia e Investigación en Sexualidad (Sexuality Therapy and Research Center); CIPRESS = Centro Interdisciplinario de Prevención de Enfermedades de Transmisión Sexual y Sida (Interdisciplinary Center for the Prevention of Sexually Transmitted Diseases and AIDS); FESEA = Federación Sexológica Argentina (Argentine Federation of Sexology); FLASSES = Federación Latinoamericana de Sociedades de Sexología y Educación Sexual (Latin American Federation of Sexological Societies and Sexual Education Associations); IIGG/UBA = Instituto de Investigaciones Gino Germani/Universidad de Buenos Aires (Research Institute Gino Germani/Buenos Aires University); IPESS = Instituto de Prevención y Educación en Salud y Sexualidad (Institute for Health and Sexuality Prevention and Education); SOCOSEX = Sociedad Cordobesa de Sexología (Sexology Society of Córdoba); SAEGRE = Sociedad Argentina de Endocrinología Ginecológica y Reproductiva (Argentine Society of Gynecological and Reproductive Endocrinology); SASH = Sociedad Argentina de Sexualidad Humana (Argentine Society of Human Sexuality).

"Asociación Argentina de Protección Familiar" (Argentine Association for Family Protection), as a branch of the International Planned Parenthood Federation. The first professional associations of sexologists also date back to those days. The pioneer associations were the "Sociedad Argentina de Sexología y Educación Sexual" (Argentine Society of Sexology and Sex Education), organized by Dr. Armando Domenech, and the "Escuela Argentina de Sexología" (Argentine School of Sexology), created by the gynecologist and psychologist Héctor Segú, where several educators and sex therapists were trained (Flores Colombino, 1980; Fridman, 2007).

International support was also crucial for the development of sex education initiatives. The Sweden International Development Agency, for instance, granted scholarships for sex education training to many Latin American professionals at the beginning of the 1960s. In 1975, a group of them founded the "Comité Regional de Educación Sexual para América Latina y el Caribe" (Latin American and Caribbean Regional Committee for Sex Education), which would play a crucial role in the training of sex educators in the region and particularly in Argentina (Aller Atucha, Bianco Colmenares, & Rada Cadenas, 1994).

Toward 1976, a group of young physicians and psychologists from Rosario, the second main city of Argentina, founded the "Asociación Rosarina de Educación Sexual" (then "Asociación Rosarina de Educación Sexual y Sexología" [Sex Education and Sexology Rosarian Association]), probably the first institution specifically devoted to sex education in the country. It is worth noting that some of the founders were at this time coping with the disappearance of loved ones due to the terror policy implemented by the military dictatorship that ruled Argentina during March 1976 to December 1983.

Sex Therapy

It was in the 1980s, when the cognitive-behavioral approaches started to compete with psychoanalysis (for a long time perceived as *the* only appropriate approach to sexuality issues), that sexological therapies as we now know them started to flourish. Psychologists Laura Caldiz, María Luisa Lerer, and Mirta Granero, psychiatrist León Gindín and gynecologist Héctor Segú were their main promoters. Even thought the majority of pioneers acknowledge having been greatly influenced by psychoanalysis, they adopted a clinical approach of sexuality based on the work of Masters and Johnson (1966, 1970) and Kaplan (1974, 1979). The efficacy of these classic models to modify behaviors and thoughts identified as "dysfunctional" is the main reason clinical sexologists give to explain why they gave up psychodynamic approaches that focus on the long-term historical causes of "sexuality-related problems." It is also important to take into account that the majority of "pioneer" sexologists in Argentina belong to a generation that was educated before the outreach of gender studies (which date from the end of the 1980s), and their professional interventions have been oriented to solve "problems" quickly centering on symptoms, two factors that explain why they have not been too involved in a gender approach. Yet, some members of the "psy" field have been very permeable to the gender perspective. We attribute this to two factors: first, the fact that they have a more "intellectual profile" (than a professional one), and second, the influence exercised by the feminist activism.[4]

The Institutionalization Process

Both in the country and in the region, the field of sexology tended toward institutionalization during the 1980s. Many professional societies and training institutions were created or consolidated. In 1980, the "Federación

[4]Fifteen years ago, a small group of professionals (Irene Meler, Mabel Burin, Martha Rosenberg, Juan Carlos Volnovich, among others) created the Psychoanalysis and Gender Forum, which organizes roundtables and conferences every month to discuss papers or topics considered relevant (i.e., the gender division of labor, sex work, child abuse, gender violence, etc.). Some of them are clearly identified with current social debates (i.e., Rosenberg is a feminist very active in the campaign for the decriminalization of abortion).

Latinoamericana de Sociedades de Sexología y Educación Sexual" (Latin American Federation of Sexology and Sexual Education Societies) was created; and that same year, Caldiz and Gindín created the "Centro de Educación Terapia e Investigación en Sexualidad" (Sex Education, Therapy, and Research Center), a private institution devoted for 20 years to the training of physicians and psychologists as specialists in clinical sexology. In 1982, they founded the "Sociedad Argentina de Sexualidad Humana" (SASH; Argentine Society of Human Sexuality), which is today the main sexology association in Argentina; in 1983, the "Instituto Kinsey" (Kinsey Institute) was created in Rosario.

The institutionalization and expansion process began as soon as the most repressive phase of the 1976–1983 dictatorship started to decline after the defeat in the war of Malvinas (Falklands) and benefited from the return to a democratic regime in 1983. As the debate on issues related to sexuality expanded to include a wider audience, the newly graduated specialists set up their private offices and assistance centers in Buenos Aires and other cities. Most periodic events of the sexological field started during this period (for instance, SASH regular meetings started in 1986), and a diversity of clinical sexology courses were opened at the newly found institutions.

The boost that clinical sexology had in the 1980s had a new momentum at the end of the 1990s with the global launching of sildenafil (known by its commercial name, Viagra) for the treatment of erectile dysfunction by Pfizer laboratory. There was a consensus among our interviewees regarding the fact that the appearance of sildenafil has increased the "medicalization" of sexuality, as well as the predominance of physicians (psychiatrists and urologists) to the detriment of other professionals in the field (e.g., psychologists, who are not authorized to prescribe medication).

In this context of growing medicalization of sexuality, sexual medicine became more visible as a medical branch devoted to research and treatment of sexual dysfunctions and is now perceived by health professionals as a specialization outside the field of sexology. In 1990, Buenos Aires was the venue of the 1st Congress of the "Sociedad Latinoamericana de Impotencia Sexual" (SLAI; Latin American Society of Sexual Impotence), regional chapter of the International Society for Impotence Research. Three Argentine urologists (Edgardo Becher, Gustavo Álvarez, and Juan Carlos Speranza) were among this society's founders, and Speranza was the president of the SLAI between 1991 and 1993 (Mazza, n.d.). In 2004, Buenos Aires hosted the 11th Sexual Medicine World Congress, organized by the International Society for Sexual and Impotence Research, presided by Edgardo Becher. These events reflected the advance of "more traditional physicians" (mainly specialists in urology) over colleagues with a certified training in sexology and, occasionally, a psychoanalytic background, generating new tensions in the field.

RESULTS

The Broad Picture: Visible and Invisible Tensions

The field has two distinct branches. The clinical one deals with so-called "sexual problems" of individuals and couples, both in its organic and its psychological dimensions. Medical trends deal with sexual problems considering them as mainly or exclusively related to an organic origin, while psychological perspectives tend to focus on psychoemotional dimensions. Because both trends are oriented to "problem solving," they can be considered as "repairing" interventions on sexuality.

It is important to note the overlap between professions and sex/gender. Seventy-eight percent of male sexologists are physicians, and 80% of female sexologists are psychologists or have a nonmedical background. This gender division of the sexological work reproduces other well-known dualisms (hard and soft sciences, masculine–feminine, objective–subjective; Oakley, 2000) and brings tension (whether acknowledged or not) to the field. This sex ratio between physicians and psychologists is common in other countries' fields (Giami & de Colomby, 2003).

In the educational branch (commonly known as sex education), in turn, there is a multiplicity of actors. On the one hand, a variety of professionals (teachers, psychologists, social scientists, social psychologists, nurses, and midwives) are allowed to be trained as sex educators. On the other hand, sex education activities are also developed by interdisciplinary teams (at schools, hospitals, community settings) or by secondary school teachers trained by the Integral Sex Education training program of the Ministry of Education. In addition, for a long time (the sex education law dates back to 2006), sex education was mainly the realm of nongovernmental organizations (feminist, women health advocates, lesbian, gay, transgender, and bisexual organizations, related to HIV prevention and care, etc.). Thus, sex education feeds from practices and knowledge coming from very diverse disciplines, pedagogies, and political experiences. Moreover, this heterodox background makes sex educators more prone to interdisciplinary work and potentially more open to social science notions and tools (in particular, to gender perspective and to feminist pedagogy) compared with clinical sexologists. In addition, their interventions mainly target more diverse audiences: children and teenagers from all social classes and backgrounds.[5]

The coexistence of this variety of actors is not always peaceful. There are tensions arising from the gender division of professional work but also from the fact that while only physicians and psychologists are authorized to receive training and to practice clinical sexology, many doctors who carry out educational activities have not been trained as sex educators.

The Medicalization of Sexuality: An Undesirable Trend?

Both sexologists with a medical and a psychological background expressed their concern about the growing "medicalization of sexuality" (Tiefer, 1996), understood as the increasing use of drugs and surgical procedures to solve "sexual problems." While the former regret the increasing power of urologists and other specialists they considered as "outsiders" to the field, the latter feel disappointed by the fact that a drug is discouraging sexual therapies with a comprehensive approach of these problems.

> It is as if clinical sexologists did not grow in their management of therapy, and today they fix it a lot with medication. (. . .) For me sexology is not that. It sounds perfect to me that the patient can be helped by medication and sometimes we ask doctors to prescribe it, but not in this way. (Female psychologist, clinical sexologist, and sexual educator)

From this perspective, the main arguments against the "medicalization trend," taken as dominant inside the field of sexology, are based on the notion that emotional factors and affection are also related to sexual problems and that these cannot be dealt with exclusively by means of medication. Unlike medical treatments that focus on the organic problem, sexual therapies—they state—work on the subjectivity of the patient. The majority of interviewees pointed at "problems in relationships" mostly in a generic way (gender power imbalance was hardly ever mentioned), patients' fears, anxieties, stress, etc.

A small number of physicians also expressed their concern about the use of medication as the key element of treatments. These sexologists argued that drugs must only be prescribed in specific cases, as one of many therapeutic options. Far from being a self-criticism to their own practice, what they question is the "business" around sexual health. Even at the expense of generating iatrogenic effects on the patients—some interviewees maintain—private medical institutions (perceived as external to the field of sexology) indiscriminately use the same method for different problems (i.e., absence of desire, erectile dysfunction, premature ejaculation) and promote the use of certain drugs for long periods of time due to an illegitimate interest.

[5]Because sexology is underdeveloped in public hospitals, clinical sexologists tend to work mainly with middle- and upper-class sectors privately.

> They treat a difficulty in the erection and the disorders of ejaculatory control with the same product, and they inject everyone with a vasodilator in the penis, but this means tying them to a medication which they have to buy every month. On the one hand there is all this 'sexual health business' which, well . . . , it also exists in other specializations, obviously, but I know this better because it is closer to me. There are almost 30% of patients that I see, who come to me with previous therapeutic experiences which were absolutely disastrous. (Male physician, clinical sexologist, and sexual educator)

The medicalization process seems irreversible for most sexologists. Sexology consultation has dramatically changed—they state—because most men who consult due to erectile dysfunction know about sildenafil or have used it already. In this case, the professional can only indicate the best conditions to increase the effectiveness of the medication.

What Has Gender to Do With It?

As Giami (2007) pointed out, the definition and treatment of sexual dysfunctions reflects the permanence of traditional gender representations in the way mainstream sexology conceives male and female sexuality in Argentina. The focus on sildenafil to treat the erectile dysfunction assumes an organic, biochemical male sexuality, free of any other relational aspect, and reinforces the idea that the male performance is related almost exclusively to the functioning of the sexual organ (Bozon, 2002; Rohden, 2009). From the beginning of the 20th century, the issue of male sexual performance worked as a mandate under many "scientific" discourses (medical, but also psychological) because it was considered the manifestation of an intrinsic natural instinct in men (Laumann & Gagnon, 1995). Association of sexual performance (expressed by erection and/or ejaculation at the appropriate moment) with virility and normality underlined these discourses (Haavio-Manila, Kontula, & Rotkirch, 2002; Heilborn, Aquino, Bozon, & Knauth, 2006). Recent developments regarding male sexuality in medicine and pharmacology focus on erectile function and ejaculation. The psychic, psychosocial, and relational aspects of sexuality are limited to factors that can affect sexual function in the form of stress, depression, or anxiety. Instead, in the case of women's sexuality, current investigations deal mainly with desire (or its weakness) and stimulation and consider psychological, emotional, and relational issues as key aspects. The expectation for the arrival of the "female Viagra" (a testosterone patch) and flibanserine (not approved by the U.S. Food and Drug Administration), which aims at treating the so-called "hypoactive sexual desire disorder," reflects the persistence of the idea that female sexuality is influenced by the relational aspect (Russo, 2009).

Our document analysis revealed a scarce presence of the gender perspective in sexologists' "official positions." Only 5 out of the 12 sexology organizations identified in our mapping publicly expressed their commitment to this approach among their goals (see Table 1). Out of the 22 training programs in sexology we had access to, 18 included gender-related issues in their curricula, mainly in one unit. The word "gender" was also infrequent in the programs and abstracts of sexology meetings (workshops and conferences) reviewed for the 2003–2007 period (i.e., only one roundtable on "gender and power," four papers that included the word "gender" in its titles—mainly in roundtables about sex education). In other words, gender is not conceived as a transversal approach to the different issues sexology tends to deal with by the majority of professionals and associations in the field.

In turn, interview data revealed that references to the gender perspective were used as a sign of professional updating and political correctness rather than as evidence of a genuine commitment to the issue.

> Feminist movements have had a great influence and some people from these movements have made greats efforts to encourage the gender perspective. Thus, we are careful when speaking to say 'she' and 'he'

> all the time. (Male social scientist, sexual educator)

It is difficult to know if this type of statement reflects a growing social acceptance of gender-based equality as a desirable horizon or simply cosmetic changes in discourse. It was quite evident that many of the male referents could not explain what this perspective consisted of or how they incorporated it to their professional practice or to training courses. Moreover, it was not uncommon for interviewees to confuse the concept of gender with the numeric predominance of women in certain jobs or academic fields.

> Certainly, there is [gender perspective] because 80% of physicians and medical students are women. Now, all my attending are females. Does this ring a bell for you? And they are better students. Males have more skills for surgery and technical staff. The world will have to cope with it. They have to accept it. Women have dominated psychology for a long time. The gender perspective is strong in psychology. (Male psychiatrist and clinical sexologist)

Out of 12 interviewees, only 3 female sexologists (2 psychologists and 1 social psychologist) showed familiarity with the "gender perspective" and criticized the fact that most of their colleagues only tended to differentiate between female and male problems and were "gender-blind" (WHO, 2001) to inequality and power relations. Testimonies indicated that most professionals were unaware of the fact that gender stereotypes, power asymmetries or sexist mandates are key factors in some of the sexuality-related problems they attempt to solve.

DISCUSSION

Contemporary sexology was born in the 1960s with the aim of addressing and "fixing" dysfunctional sexual performance (Béjin, 1985a). Argentina followed this trend in its own way, probably due to a strange combination of cultural and social influences. On the one hand, it is a country in which the Catholic Church has traditionally exercised a strong pressure on public matters, particularly in two crucial areas: education and sexual and reproductive health and rights. On the other hand, psychoanalysis—and to some extent other psychological therapies—have had an early and widespread social acceptance.

As seen elsewhere, the field has experienced a variety of tensions. One of them is the power imbalance between biomedicine and other professional backgrounds (mainly psychology), which also reflects a gender division of labor: Most physicians working as sexologists are male, while most psychologists and psychoanalysts are female. Most recently, in the times of Viagra, clinical sexologists have seen their prestige and income threatened by the increasing influence of urologists (mainly male).

Paraphrasing some interviewees, there is an ongoing conflict ("medicalization" vs. "humanization" of sexology) that develops itself in two frontlines. One of them is the confrontation between those who propose a comprehensive (psycho-physic) approach of sexual problems and those who fall into the category now called "sexual medicine" (seen by most sexologists as a specialization external to the field and personified mainly by urologists). The other conflict within the field of sexology takes place among those physician-sexologists more prone to the adoption of pharmacological treatments (and, in general, with closer relationships with laboratories) and those who defend sexual therapies as a warranty of a "humanized" type of care that better addresses patient subjectivity.

From a critical point of view, it is worth pointing out that sexology as a field has not incorporated, neither in theoretical nor in practical terms, some of the premises and concerns of pioneer Eva Giberti or feminist psychologists such as Maria Luisa Lerer and Laura Caldiz. The former—as well as her partner Florencio Escardó—reached wide audiences in the 1960s and clearly had the intention of affecting the way in which parents raised their children or couples solved their conflicts. Giberti, who was never considered a member of the sexological field, later became a mentor of study groups on eroticism (in Spanish, *Erótica)* and

is now the visible head of a national public program assisting victims of sexual violence. Lerer and Caldiz, in turn, took advantage of the "democratic boom" (in the 1980s) to influence with their gender perspective the way in which women approached and conceived sexuality.[6] It is impossible for us to say if these professionals "fought a battle they lost" or if they were not interested in playing a key role in mainstream sexology, because our study did not address this particular question. All we know is that they all made important contributions to the development of the field but never occupied the center of the scene or did so only for a brief time.

Summing up, most therapeutic approaches in Argentina—whether medical or "psy"—are based on and tend to encourage stereotypes of male and female sexuality that reinforce gender inequalities and oppressive mandates for both women and men. Something similar happens with the educational trend, in which the focus on heterosexuality prevails in sexual education and sexual health prevention strategies. Interviews with sex educators revealed that the majority where not familiar or concerned with gender, sexual diversity, and sexual rights issues. Some of them manifested their disappointment for not having been consulted as experts regarding the implementation of the 2006 Comprehensive Sex Education Law. In fact, sex educators were not the main actors in the process leading to the sanction of this law in which feminists, popular educators, and sexual diversity and youth activists interacted with legislators and politicians.

CONCLUSION

Seen from a historical perspective, the field of sexology seems to have lost the innovative quality, the dynamics, and the richness that it originally had in the early 1980s. To some extent, one can state that sexology has not escaped a wider process of impoverishment of the political and intellectual debate in the country. Nevertheless, the lack of a generational renovation and the inability to interact with governmental initiatives indicates that the field has other problems than the "empowerment of urologists." As some interviewees highlighted, pending tasks for this professional community are: to promote a wide discussion regarding the midterm and long-term consequences of the medicalization of sexual dysfunctions and to review and update both their theoretical backgrounds and methodological approaches.

Despite the fragmentation of the field and some of its drawbacks, within both trends of sexology, we encountered committed and creative professionals interested in contributing their expertise and experience to deal with some pending tasks—for instance, the implementation of sex education programs at schools and communities; the prevention of sexual and gender violence and the provision of integral and sensitive care to victims; the promotion of greater social respect regarding sexual diversity, etc.

If sexologists somehow manage to embrace new perspectives that make them more "attractive partners" for other relevant governmental and nongovernmental stakeholders in the sexuality/reproductive health and rights arena, they will have taken a step forward in the direction the pioneers imagined more than half a century ago.

[6]Lerer's *La sexualidad femenina* (*Female Sexuality*) was one of the best-sellers of the mid 1980s.

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