

Key Concepts in
Medical
Sociology

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THIRD EDITION

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PART I

SOCIAL PATTERNING OF HEALTH

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Sexuality

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Sexuality typically refers to sexual acts and to sexual orientation and/or sexual identity. Sexuality is both private and ubiquitous, important to well-being and potentially risky.

Understanding the social implications of sexuality, including its relationship to health, can be confusing. While medical definitions are usually clear there is often confusion in everyday life about the difference between sex, gender and sexuality. Sex is usually based on medical assessment of a baby's genitals, whereas gender is usually used to denote the social implications of being either female or male (see the entry on 'gender'), and sexuality refers to an individual's sexual preferences/identity. There is added complexity in relation to individuals who consider themselves to be of the opposite gender to that which is usually linked to the sex they were assigned at birth, but this is a matter of gender and not sexuality and therefore will not be dealt with in this entry.

Here, we will focus on sex and sexuality especially in relation to health and illness. Diseases resulting from, or assumed to be related to, sexual behaviour have long been a medical concern, and, since the mid-20th century, the fields of health education and later health promotion have focused on attempting to encourage sexual health. First, however, it is necessary to offer further context and some caveats.

Sexuality includes both the capacity for sexual feelings and an individual's sexual orientation or preferences. However, these two aspects are not preconditions for each other. It is possible to identify as heterosexual, homosexual or bisexual, but have no desire for, or even experience of, sex, or as asexual and yet engage in sexual acts or to have same-sex sexual relations but not define oneself as homosexual. The definition of 'natural' sexuality is no longer based on religious teachings, although these still circulate, but on biological assumptions that predominate in modern societies. The underlying assumption here is that human sexuality is driven by genes and hormones, and by an innate desire to

perpetuate the species – hence the longstanding definition of heterosexuality as normal. However, since the 1970s sociologists have challenged this essentialist view and criticized the assumption that ‘natural’ sexuality untouched by culture is possible. They argue that people become sexual in specific contexts and that our biographies shape our sexual preferences and practices (Scott and Jackson, 2020). If we look at sexuality historically we find significant differences; for example in medieval Western Europe women were often thought to be full of carnal lust whereas in the Victorian period, in Britain, they were often defined as asexual (Acton, 1865). Likewise, if we take a cross-cultural perspective, we find a wide range of practices which could be, but are not necessarily, viewed as sexual (Herdt, 1981).

Until relatively recently sex was viewed in Western culture as a private matter, only acceptable within marriage, linked to reproduction, and with male heterosexual desire shaping sexual practice. This produced an understanding of sexuality that was both sexist and heterosexist (Scott and Jackson, 2020). Psychoanalysis and related theories, which developed in the early 20th century, argued that attempts to ‘repress’ these ‘natural’ sexual urges created problems within the individual psyche, and this thinking influenced the liberation movements of the 1960s.

There are three main strands of explanation in the sociology of sexuality: social interactionism, post-structuralism (primarily shaped by the work of Michael Foucault) and Queer theory – which in turn draws on post-structuralism as well as psychoanalysis and feminism. Feminist work has also been very important. Feminists have drawn on all three kinds of explanation in order to account for the interrelationship between sexuality and gender. In brief, interactionist sociologists argue that there is no innate sexuality; rather, ‘being sexual’ and ‘doing sex’ are learnt through the sexual meanings and conventions within social interaction. Feminist interactionist sociologists (Jackson and Scott, 2010) have argued that because children generally develop a sense of their gender before they have access to sexual knowledge they come to understand sexuality through social definitions of gender, which in turn shape our understanding of differences between male and female sexuality. For interactionists sexuality is not fixed, but evolves in relation to biography and cultural context. Foucault (1981 [1978]) argued against the widespread view that sexuality was repressed in the 19th century. Rather, he claimed that sexuality as we now know it was brought into being through the *classification* of various forms of sexual expression, as normal or perverse, and through the *production* of sexuality as an aspect of our inner being. For Foucault, discourses around sexuality encompass aspects of both regulation and liberation, and there is no linear movement from the former to the latter as modernity progresses. Queer theorists stress the importance of individual sexual identity and the range of potential sexual identities. They also argue for the disruption of the binary between heterosexuality and homosexuality (Seidman, 1997). For them ‘Queerness’ is constituted as marginal, in relation to the heterosexual norm, and therefore all non-normative sexualities come under the umbrella of ‘Queer’.

In order to fully understand sexuality sociologically, we need to explore how it is affected by various social factors. These factors include the interrelationship of social structures, other social divisions and positions, everyday social and sexual practices, as well as the meanings attached to sexuality within cultural discourses and individual subjectivities. Sociological and *some* everyday accounts of sexuality do focus on its social construction, but essentialist explanations have not disappeared. Indeed, they have seen a revival. As sexuality has become ever more closely linked to individual identities it has also been increasingly understood as a fundamental aspect of the self. Also, developments in genetics and neuroscience have led to attempts to find a 'gay' gene and a 'gay' brain. Some lesbians and gay men do indeed understand their sexuality as a fundamental aspect of their biology, whereas others draw more on biographical and cultural explanations and/or see it as a matter of collective identity. The sociological questions, in this context, are: why are some explanations more dominant/acceptable at any given time? What are their implications? Why is heterosexuality still relatively unproblematized? Sociologists are also interested in understanding what we might call the 'specialness' of sex – the way it is seen as a central aspect of everyday life *and* raised above the quotidian. Recent sociological research into asexuality has argued that sex is not at all important for some people (Scott et al., 2014). The case has also been made that a great deal of sexual activity is neither risky nor exotic, but rather mundane, every day and possibly marginal (Jackson and Scott, 2010).

As noted above, sex has been related to health as well as to sickness. Modern medicine, while defining 'normal' sex as a natural biological function, classified homosexuality and many other sexual practices as perversions. It is worthy of note that homosexuality was only finally removed from the World Health Organization's International Classification of Diseases in 1990. Treatment regimens were devised for 'sexual deviants' aimed at curing them through a variety of means – castration, aversion therapy, Electroconvulsive therapy (ECT), drugs and psychotherapy – at different points in time from the late 19th century onwards. It is significant that psychological and psychotherapeutic interventions have, in more recent years, shifted from 'treating' homosexuality towards supporting lesbians and gay men who are suffering from mental health problems, primarily as a result of continuing discrimination and abuse. Such research as there is, on the general health of lesbian and gay individuals, suggests poorer overall health, particularly in relation to mental health, than the heterosexual population (Meads et al., 2012).

The so-called 'liberation' of sex and sexuality in the 1960s, epitomized by legal changes regarding homosexuality and abortion, was, from the start, countered by crises and panics about, for example, gay sexual behaviour and teenage pregnancy. These concerns became entangled with changing ideas about risk and danger. Previous perceptions of a world fraught with hazards, which humans could do little about, had shifted towards an increased expectation that

we would/should be able to obviate risks. Expectations grew that this would be done through scientific and social developments, coupled with management of individual behaviour (Gabe, 1995).

This focus on risk was clearly played out in relation to HIV/AIDS in the 1980s and 1990s. HIV was seen as a problem of (not just for) gay men because the initial spread in the Global North was through the gay community. There was a backlash against homosexuals for allegedly causing the pandemic through 'casual' sex. Sociological and anthropological research countered some of these assumptions and ensured that epidemiologists and public health professionals were better informed about the social contexts of HIV transmission (Bloor, 1995). It was widely assumed that the gay community should be targeted with information. However, this completely missed the many men who identified as heterosexual but sometimes had sex with men and who would be much less likely to go to the places where information and support were available (Deverel and Prout, 1999). It was also generally assumed that gay men who had high numbers of sexual partners were most at risk of becoming infected. However, as Hunt et al. (1991) showed, gay men tended to be more willing to use condoms with casual partners than within an established relationship, even if one, or both, partners was/were non-monogamous.

Sex can be viewed and/or experienced as problematic throughout the life-course. There are currently public health concerns about the sexual behaviour of midlife and older heterosexuals. The incidence of sexually transmitted infections (STIs) has increased in this age group as a result of the breakdown of long-term relationships and the opening up of opportunities through internet dating (Dalrymple et al., 2016). Children and young people have also been a major focus of anxiety in relation to sexual risk. In this context there has been much debate about sex education (Buston et al., 2001), with more liberal opinions in tension with the view that children should be protected from too much sexual knowledge. Sociologists have argued that keeping children in ignorance, or only teaching them the 'facts', fails to prepare them to deal with sex and relationships (Jackson and Scott, 2015). Such 'protection' potentially puts young people at risk of abuse and STIs and, in the case of girls, of sexual coercion and pregnancy.

As contraception made it possible to separate heterosex from reproduction, and as gay and queer sexualities became more visible, a shift occurred in our understanding of what sex is for. Sexual activity is increasingly seen as being for leisure and pleasure, reinforcing the view that good sex is healthy and can improve one's life and well-being. However, not having 'good' sex is increasingly seen as a personal failing and something to be rectified. Also, while in the past sexual competence was seen to be primarily an issue for men, the increases in women's autonomy and the options available to them have encouraged a greater focus on female pleasure but also raised expectations of their performance. In this context the options for improving the situation are both personal (for example, partner change and self-help manuals) *and* professional (for

example, therapy, counselling and pharmaceuticals). Drugs, such as Viagra, are used to sustain male sexual performance, while the search for a safe equivalent for women continues. The way in which Viagra works means that, once again women are expected to be available to respond at the appropriate moment, thus rendering equality in the practice of sexuality problematic – another example of the non-linear process of social change in relation to sexuality (Potts et al., 2003).

The liberalization of sexuality carries a contradictory kernel of anxiety. There is a struggle between the desire for sex to be liberated from normative constraints while at the same time redefining what is seen as normal, to widen the range of socially acceptable sexual expression. A good example of this latter move is the legalization of gay marriage which, besides increasing equality, has the effect of rendering gay relationships more respectable without actually unsettling heterosexuality (Richardson, 2004).

Tensions between sex as healthy and sex as risky continue to play out in the media, within health promotion and in personal relationships. For sociologists, however, sex is neither intrinsically good nor bad, healthy nor unhealthy. What *is* of sociological interest are the particular ways in which sex acts, sexual relations and sexual identities are socially ordered and the continuities and changes in these over time. Specifically, in relation to the relationship between sexuality and health, more sociological research is needed on: sex and sexuality in later life; the relationship between sexual identity and sexual experiences; the mental health and general health status of the wider population of LGBTQ+ individuals plus continued critical analysis of the field of sexual health promotion.

See also: Ageing and the Lifecourse; Gender; Risk.

REFERENCES

- Acton, W. (1865) *The Functions and Disorders of the Re-productive Organs in Youth, in Adult Age, and in Advanced Life, Considered in their Physiological, Social, and Moral Relations*. Held by the British Library, London.
- Bloor, M. (1995) *The Sociology of HIV Transmission*. London: SAGE.
- Buston, K., Wight, D. and Scott, S. (2001) 'Difficulty and diversity: the context and practice of sex education', *British Journal of the Sociology of Education*, 22 (3): 352–368.
- Dalrymple, J., Booth, J., Flowers, P. et al. (2016) 'Socio-cultural influences upon knowledge of sexually transmitted infections: a qualitative study with heterosexual middle-aged adults in Scotland', *Reproductive Health Matters*, 24 (48): 34–42.
- Deverel, K. and Prout, A. (1999) 'Sexuality, diversity and community: the experience of MESMAC', in R. Parker and P. Aggleton (eds), *Culture, Society and Sexuality: A Reader*. London: UCL Press.
- Foucault, M. (1981 [1978]) *The History of Sexuality, Volume One*. London: Pelican.
- Gabe, J. (ed.) (1995) *Medicine, Health and Risk: Sociological Approaches*. Oxford: Blackwell.

- Gagnon, J. and Simon, W. (2004) *Sexual Conduct*, 2nd edn. New Brunswick, NJ: Aldine Transaction.
- Herd, G. (1981) *Guardians of the Flutes*. New York: McGraw Hill.
- Hunt, A.J., Davies, P.M., Weatherburn, P. et al. (1991) 'Changes in sexual behaviour in a large cohort of homosexually active men in England and Wales 1988–1989', *British Medical Journal*, 302: 505–506.
- Jackson, S. and Scott, S. (2010) 'Rehabilitating interactionism for a feminist sociology of sexuality', *Sociology*, 44 (5): 811–826.
- Jackson, S. and Scott, S. (2015) 'A history of researching childhood and sexuality: continuities and discontinuities', in E. Renold, J. Ringrose and R.D. Egan (eds), *Children, Sexuality and Sexualisation*. London: Palgrave.
- Meads, C., Camona, C. and Kelly, M.P. (2012) 'Lesbian, gay and bisexual people's health in the UK: a theoretical critique and systematic review', *Diversity and Equality in Health and Care*, 9: 19–32.
- Potts, A., Gavey, N., Grace, V.M. and Vares, T. (2003) 'The downside of Viagra: women's experiences and concerns', *Sociology of Health & Illness*, 25 (7): 697–719.
- Richardson, D. (2004) 'Locating sexualities: from here to normality', *Sexualities*, 7 (4): 391–411.
- Scott, S. and Jackson, S. (2020) 'Sexuality', in G. Payne and E. Harrison (eds), *Social Divisions: Inequality and Diversity in Britain*. Bristol: Policy Press.
- Scott, S., McDonnell, L. and Dawson, M. (2014) 'Asexual lives: social relationships and intimate encounters', *Discover Society*, Issue 9, 3 June. Online: <https://discoversociety.org/2014/06/03/asexual-lives-social-relationships-and-intimate-encounters/>
- Seidman, S. (1997) *Difference Troubles: Queering Social Theory and Sexual Politics*. Cambridge: Cambridge University Press.

SUGGESTED FURTHER READING

- Parker, R.G., Aggleton, P. and Thomas, F. (eds) (2015) *Culture, Health and Sexuality: An Introduction*. London: Routledge.

This collection explores a range of topics relating to social and cultural aspects of sexuality and sexual health: sex and gender, sexual diversity, sex work, migration and sexual violence. It includes conceptual and empirical material and is global in its scope.

- Jackson, S. and Scott, S. (2010) *Theorizing Sexuality*. Maidenhead: Open University Press.

This book provides an overview of the field of sexuality and develops a feminist sociological position in evaluating debates and theories in relation to the wider development of modernity. It considers the biographical, interactional and institutional contexts of our sexual lives as well as examining the cultural meanings and everyday practices of sexuality.

- Kneale, D., Becares, L. and Weeks, H. (2020) 'How are LGBTQ+ people faring during the COVID-19 pandemic?' *Discover Society: Covid-19 Chronicles*, 7 May. Online: <https://discoversociety.org/2020/05/07/how-are-lgbtq-people-faring-during-the-covid-19-pandemic/>

This short article argues that the restrictions relating to the COVID-19 pandemic are likely to exacerbate existing health inequalities for LGBTQ+ people. While there is a paucity of research, what does exist suggests that LGBTQ+ individuals may have higher levels of chronic illness, which could lead to poorer outcomes for those infected with the virus.

- Mercer, C.H., Tanton, C., Prah, P. et al. (2013) 'Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)', *The Lancet*, 382 (9907): 1781–1794.

This article discusses the findings from the best available large-scale longitudinal overview relating to sexuality in Britain, providing useful background and context for reading more in-depth and specific studies. The survey does cover sexual health in relation to sexual orientation but there is still a lack of information about the wider health status of LGBQ individuals.