PSYCHOLOGY REVIVALS

Psychological Perspectives on Sexual Problems

New Directions in Theory and Practice

Edited by
Jane M. Ussher and Christine D. Baker

Psychology Revivals

Psychological Perspectives on Sexual Problems

Sexuality has always been conceptualised as a potential problem. The regulation of sexuality and the distinction between normality (healthy sexuality) and abnormality (sexual problem) have a long history, in which psychologists have been deeply involved. Yet all attempts to develop a single psychology of sexual problems are fraught with difficulties. There has also been much criticism of the idea of a psychology of sexuality, and of dysfunction, particularly from authorities in psychoanalysis and feminism.

In *Psychological Perspectives on Sexual Problems*, originally published in 1993, these controversies and debates are critically examined, while also addressing the need for individuals with difficulties associated with sexuality to receive help.

Psychological theories associated with sexuality and sexual problems are examined, along with examples of positive and empowering practice with groups of individuals whose sexuality is often marginalised by psychologists. These include people with learning difficulties or physical disabilities, sex offenders, injecting drug users, gay men with AIDS and women with eating disorders.

Psychological Perspectives on Sexual Problems was the first book to integrate critical theory and current clinical practice. It offered a radical new approach to the psychology of sexuality at the time. Today it can be read in its historical context.

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Introduction

Sexuality: whose problem?

Sexuality has always been conceptualised as a potential problem. The regulation of sexuality and the careful distinction between normality (healthy sexuality) and abnormality (problem) has a long and chequered history. Yet throughout history, and across different cultures, the definition of exactly *what* is problematic about sex is clearly not invariant. Nor is the identity of the multitude of experts who pronounce and proclaim on the rights and wrongs of sex. For, whilst psychologists may now have confidently adopted the mantle of authority, attempting to understand the significance of sex, uncover the aetiology of problems, and prescribe appropriate cures, this is a relatively recent phenomenon. Prior to the 'psychiatrisation of sex' (Foucault, 1979) in the eighteenth century, and the subsequent development of sexology in the early twentieth century, the notion of psychological explanation or intervention in the private arena of sex was unheard of. If considered at all, sex was simply a biological drive; or, in theological doctrine, a licentious lust stimulated by the devil. That which crossed the boundaries of the current orthodoxy, be it manifestations of homosexual desire in a heterosexually orientated culture, women manifesting desire for men outside the bounds of wedlock, sex during menstruation, during old age, or within families, would undoubtedly have been contained and controlled, but certainly not 'cured'.

Today we don't punish, or segregate, or enforce abstinence upon those who stray from the path of sexual normality (except in the case of sex offenders, who are chastised most severely for their crime). Instead we offer understanding, scientifically validated explanations, and a wide range of medical and psychological interventions for sexual distress, dysfunction, or deviancy. We are careful what we 'treat': for example, homosexuality is no longer framed as illness.[1] We may even go as far as to contest the very notion of a sexual problem as deviation from normality, with our reams of statistics which show sexual difficulties to be the norm. The era of psychologist[2] as sex expert appears to have arrived.

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Yet any attempt to identify a simple and unitary 'psychology of sexual problems', to evolve *one* successful paradigm applicable to all, is doomed to failure. There is no one view. Any serious scholar attempting to unearth common threads of argument between the many theorists, researchers, and clinicians may be forgiven for concluding that there is little agreement between protagonists in this debate about definitions of sexuality (never mind what constitutes a sexual problem), about causes of difficulty, and about the right of professionals to intervene. Psychological textbooks on sexuality may appear to belie this fact, presenting sex, sexual problems, and psychological intervention in a straightforward and unproblematic way. In these texts, the problems of men and women are conveniently separated, their common dysfunctions listed, epidemiological statistics cited, and the current theories and therapies clearly elucidated. This is not that type of book. The contradictions and inconsistencies within the psychology of sexual problems are tackled head on, with no flinching, and any notion of an anodyne analysis rejected out of hand.

Yet to cast an eye over what is the current *Zeitgeist* in this field is to reach the inevitable conclusion that the psychology of sexual problems, whatever that is, is in the doldrums. Even a leading expert in the field, a proponent of the psychological approach, has said as much (Bancroft, 1989). Practices evolved many decades ago (e.g. Kinsey; Masters and Johnson) appear to be still adopted unproblematically, as if the difference between the sexual climate of the 1960s and that of the 1990s had little bearing on sexuality or on intervention; as if the nature of relationships, and the demands made upon them, had not changed over the decades, to the extent that there is no longer a clear blue-print mapping out our expectations and behaviour; as if the stimulus–response view of sex, however enlightened it appeared at the time (particularly in the insistence on the existence of female desire and orgasm), could not be improved upon; as if sexuality, and therefore sexual problems, could be framed in an unproblematic way, without reference to culture, to history, to the dominant (and often oppressive) discourses of sexuality which permeate our society; as if the critiques and reformulations of sexuality which have taken place over the last three decades did not exist. If we still rigidly adopted Kraepelin's[3] taxonomies in psychiatry, there would be cause for complaint. Is this not what will be happening in the field of sexuality if we do not re-evaluate our current practices?

Yet outside psychology the debate on sexuality has been raging for many years, untouched by lack of interest and disavowal on the part of the sex experts. How can this be? How can the debates raging in fields such as philosophy, history, literary theory, psychoanalysis, or feminism fail to touch the very people who offer direct analysis and solace to those who find their sexuality problematic, those who have turned to the

experts for help? Is there any common ground to be found between those who pronounce, for example, on the efficacy of the Masters and Johnson 'stop/start' technique for treating male premature ejaculation, or the need to introduce vaginal dilators gradually to treat female vaginismus, and, alternatively, those who focus on the belief that the penis signifies the phallus, the all-powerful, condemning women (the penis-less) to a secondary sexuality, an eternal lack, and men to grandiose and mistaken beliefs that the phallus is theirs – when it is not? Is there any common ground between those who advocate rational clinical treatments for sexual problems, and those who would deconstruct the whole notion of dysfunction, seeing it as yet another strand in regulation of the body, the pathologization of normality, or part of the discourse which maintains the pre-eminence of patriarchal heterosexuality? We think that there is.

The aim of this book is to provoke. Equally, we want to promote a glasnost between those whose work directly involves research and intervention in the arena of sexuality and those who would deconstruct, criticise, and reframe any understanding of sexuality outside the dominant discourse of psychology. These are not traditionally happy bedfellows (sic). The debates tend to occupy separate spheres: two circles which never meet, two worlds apparently without a common thread. This is wrong. There is common ground, yet also need for debate, so that integration can occur, and progress be made in both theory and practice. The post-structuralist deconstructions, the psychoanalytic accounts, the feminist or social constructionist analysis could be said to have had little or no impact outside the hallowed walls of academia, and certainly appear to have had little impact on clinical practice as yet. The applicability of these analyses to the reality of sexuality for individual men and women, often in severe distress, is unclear. Yet conversely, sexuality and sexual problems appear to be framed in an uncritical, decontextualised way within the psychology of human sexuality. Can a meeting of the two create a catalyst which will create fusion?

A MEETING OF TWO MINDS

The genesis of this book is in a meeting of two minds wherein very different perspectives and beliefs dwell. Yet reconciliation of views was reached. One is a practising clinician, daily dealing with the reality of sexual difficulty in women and men, using a range of clinical tools to provide amelioration of distress, and finding much success. The other is a lapsed clinician, research and critical theory having been adopted as a means of understanding sexuality, in the face of disenchantment with clinical practice, critiques of the psychology of sexuality being adopted in its stead.

What became clear was that despite appearances, there was much common ground. On the one hand, whilst tried and tested interventions

for sexual difficulties were clearly efficacious for the clinician, underlying each therapeutic encounter was a basic questioning of the dominant discourses of sexuality current in our culture: a questioning of the association of sex with penetrative heterosexual intercourse; of the belief that anything else is secondary, or deviant; that failure to achieve penetration is evidence of dysfunction. Premises at the centre of the apparently contradictory critiques had permeated clinical practice.

For example, a woman presented with vaginismus. She had been referred by her GP, having been married for a number of years without ever having achieved penetrative sex with her husband. Perhaps clearly a case for intervention. But the marriage was a success, the couple having adopted a wide sexual repertoire, and both were sexually satisfied. It was only because the woman was unable to perform the 'normal' female function of accepting the erect male member into her vagina and thereby achieving pleasure that therapy was sought. After much discussion it became clear that neither partner was greatly dissatisfied, and a description of the accepted treatment for such 'dysfunction' was greeted with horror. No therapy was carried out. The woman was reassured that she should continue to enjoy her sexuality, her relationship, and not worry about the absence of intercourse, for, as she did not want children and both parties were happy, she did not have a problem.[4]

This is certainly not the oppressive model of sex therapy represented in many critiques (see Jeffreys, 1990). It is positive practice, acknowledging that sexuality is a complex, multifaceted phenomenon, wherein sexual intercourse is neither necessary nor sufficient for satisfaction; where sensuality is as important as genital sexuality, and where the cultural definitions of what it is to be 'normally' sexual are integrated into clinical practice. At the same time, the lapsed clinician recognised that theoretical critiques on their own are not enough; that the reality of distress, despair, and disenchantment in the realm of sexuality must be recognised, and then addressed. Deconstruction is only the first step; on its own it is not enough.

What we need is a new psychology of sexuality, which does not operate within narrow parameters, defining its modus operandi at the outset, without reference to the needs of individuals or the multiplicity of sexuality in its many forms. We need to acknowledge that sexuality is not a unitary entity, something to be pinned down, categorised, and analysed, or something which can be experienced in an unproblematic way. The very contradictions inherent within sexuality affect us all: the impossibility of desire,[5] the negative construction of both female and male sexuality in our cultural discourse, the all-pervasive representation of the all-sexual person in popular discourse, which contrasts sharply with the reality of many people's lives.[6] Sexuality cannot be separated from the self, it cannot be conceived of in a vacuum. To understand

sexuality we must understand relationships, individual identity, and the pressures which impact upon the individual, be they conscious or unconscious: the pressure to perform, the pressure to be normal, the pressure to be sexual, as well as the difficulty in resolving unconscious desire and conflict. We must also address the question of who has the right to be sexual (or the right *not* to be sexual), and in what way, and who has the right to help, should they so desire. People with disabilities, those who are lesbian or gay, those who commit sexual crimes, may be seen as being outside the psychologist's remit, their sexuality something which is inherently private, because positioned as different or deviant. We do not agree.

This book attempts to address many of these issues and illustrate the influence of these different discourses on individuals with very different experiences. We want to present the critiques, for they have uncovered much that is wrong with current theory and practice. Yet it is important not merely to pay lip service to a progressive discourse, and so we also acknowledge the need for psychology to help those in distress, to attempt to uncover practices which will be ameliorative and empowering. So we have chosen to include contributions from clinicians working in disparate fields in order to illustrate the ways in which progressive practice can evolve. Work with women and men, both heterosexual and homosexual, work with those who have a physical disability, a learning difficulty, those affected by AIDS or drug use, women with eating disorders, those who are sex offenders: analyses of discourses of sexuality associated with each group uncover many common themes, yet each uniquely offers an insight into sexuality. Other areas of work could have been included, but short of producing an encyclopaedia, we have had to limit ourselves to these examples.[7] Some of the contributions may appear contradictory, but as this reflects the current psychological discourse on sexuality, it is important to allow these different voices to be heard. We may not both agree with every contributor in this volume, but we are here not to censor, but to provoke and promote discussion, and to strive for the beginnings of a revolutionary approach to the psychology of sexuality that moves out of the doldrums and into the twenty-first century.

NOTES

1 This applies to the official psychological discourse in Great Britain. In many countries homosexuality is still deemed an illness, and lesbians and gay men subjected to aversion therapy. One might also argue that many individual practitioners in Britain still regard homosexuality as illness.

2 Or psychiatrist: much of the research and theory in the field of sexuality has been developed by psychiatrists. In this instance, as we are discussing the psychology of sexual problems, we are looking at the psychological approach, rather than the specific professional background of the expert.

3 The nineteenth-century German psychiatrist who first classified schizophrenia.
4 A man referred for therapy because he could not sustain an erection for an extended period, yet could satisfy himself and his partner through other means, could be seen to be equally oppressed by a repressive and outmoded model of sexualiy.
5 In the psychoanalytic view desire is always impossible because unconscious and because sexuality is split, so the object of desire can never be achieved. See Frosh in this volume; Mitchell and Rose 1982.
6 For example, the image of the all-orgasmic man or woman in magazines and newspapers. See Nicolson in this volume.
7 What we most regret not including is a contribution on working with individuals from different ethnic or cultural backgrounds. Is it a reflection of the paucity of work in this area or of the pressures impinging on those who carry out clinical practice in this field that our efforts were in vain?

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Part I

Theory: deconstructing sexology, reconstructing sexuality

The three chapters in this first section represent a critical perspective, taking issue with traditional psychological conceptualisations of female and male sexuality. Whilst the approach of the early twentieth-century sexologists has been consigned to history by modern sex therapists, it is seen as having laid the foundations for a reductionist view of sexuality and sexual problems, which still exists today. Thus, by deconstructing sexology, by refusing to conceive of sexuality as an unproblematic pre-given entity, the flaws in much of our current theories and therapies can be exposed. However, this is only the first step in reconstructing a positive and empowering psychology of sexuality, and these three authors lay the theoretical foundations for the clinical considerations later in this volume.

The first chapter, by Jane Ussher, takes the notion of a sexual problem, and places it in historical context, whilst critically evaluating the current research and theory on female sexual problems. Ussher argues that current psychological therapies and practices potentially act to oppress women, through conceiving of sexuality in a reductionist manner, either as a dysfunction or as an easily manipulated experimental variable. The second chapter, by Stephen Frosh, examines masculine sexuality, whilst addressing the question 'why do men sexually abuse children?'. From a psychoanalytic perspective, Frosh argues that masculine sexuality, as it is presently constructed, is an almost impossible conundrum. The third chapter, by Paula Nicolson, examines the infiltration of sexology into popular discourse, whilst asking the question 'why do women refer themselves for sex therapy?'. Women's sexual passivity is seen as being reified within dominant psychological discourses associated with sexuality, then internalised by women, who see and believe.

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Chapter 1

The construction of female sexual problems

Regulating sex, regulating woman

Jane M. Ussher

INTRODUCTION

To be woman[1] is to be sexual. Yet, paradoxically, woman is also asexual, her sexuality a lack, invisible, a liability, defined always in relation to men, conceived of within a patriarchal prism which confines and distorts experience. The construction of femininity is closely tied to the construction of sexuality, and as sexuality is regulated so are women.

Psychological discourse[2] on the subject of women's sexuality reflects this conundrum. Women are defined by their sexuality within psychology as other, as labile, as unequal to men,[3] often completely absent from the psychological agenda, for fear that they might contaminate the results of experimental research.[4] Yet, at the same time, women's sexuality is ignored or marginalised within psychology or conceived of only as problem. For, in stark contrast to disciplines such as history (Foucault, 1979; Weeks, 1990), psychoanalysis (Freud, 1895; Klein, 1952; Lacan, 1977; Irigaray, 1986), literary theory, or film theory (Rose, 1986), psychology has largely neglected any analysis of female sexuality, except as a dysfunction to be placed under the positivistic microscope.[5] In either case, in this heterosexually orientated discourse, woman's sexuality is positioned as passive, as problematic, but always seen in relation to men.

The central thesis of this chapter is that the psychological discourse on the subject of female sexual dysfunction occupies a central position in the regulation of women,[6] both because the limited, fragmented, and one-dimensional view of sexuality offered within psychology may be internalised by women, who subsequently experience their own sexuality as negative, and because the psychological discourse reinforces the positioning of woman's sexuality as liability within wider cultural discourse. Psychological theory and therapy are proffered by their protagonists as objective, rational, and scientifically validated, whilst in reality they operate within a specific ideological framework, which is both biased and short-sighted – denying the existence of alternative or competing discourses of sexuality (such as the cultural, social, or historical) – and thus is ultimately flawed.

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Yet the conundrum feminists are faced with is that many women *do* experience difficulty and discontent associated with their sexuality, and turn to psychologists for help. Problems do exist – and, whilst they are certainly framed by the current discourse, for the individual women they are real. So psychology *may* have a place in providing some explanation and intervention for difficulties – if it can move away from a position in which female sexuality is either ignored or seen as a potential root for pathology.

HISTORY OF PSYCHOLOGY AND SEXUAL PROBLEMS

Theological doctrine

In order to understand the current psychological discourse associated with women's sexual problems, it is essential to have some understanding of the historical context which has led to our present practices and prejudices. From a Foucauldian standpoint, the roots of our current conceptions of sexual problems are seen as necessarily grounded in the past, as understandings of what is positioned as normal and abnormal sexuality, and therefore what constitutes a 'problem', are not historically or culturally invariant. The framing of female sexuality as problematic or as invisible is not confined to twentieth-century psychology.

Prior to the 'age of enlightenment' in the eighteenth century, sexuality was understood within the boundaries of theology, as a moral construct, where the teachings of the church served to define what was and what was not 'normal' sexual behaviour (Weeks, 1990). The most commonly accepted view was that sexuality was a biological, instinctive drive that was essentially male, directed at the passive, if seductive, female. Man was driven, woman received. Man's unholy desires, as the theologians clearly deemed them, were invariably attributed to the fatal attraction of the female, his impulses driving him to sow his seed, often forcing him to act against the doctrines of the Christian church. Control was deemed imperative, and was achieved through castigation of female sexuality. For, as psychiatric historians have argued, the collapse of feudalism potentially heralded a move away from theological control of mind and body and thus:

> it became increasingly imperative to the Church to start an anti-erotic movement, which meant that women, the stimulants of men's licentiousness, were made suspect . . . they [were seen as] carriers of the devil.
>
> (Alexander and Selesnick, 1966: 67)

Thus, whilst men were positioned as the active driving force, the 'naturally' sexual beings, women were seen to be playing a key role in

arousing male desire. Woman's sexuality was therefore both fatal and flawed – paradoxically framed either as absent, within the archetype of the asexual pure Madonna, or as all-encompassing and dangerously omnipotent, an image represented most clearly by the witch or the whore (Ussher, 1991). The other side of this essentialist coin is that *normal* sexuality was seen as an 'instinct for reproduction' (Weeks, 1990: 143), firmly contained within marriage, the individual ultimately motivated by the desire to bear children. Both views clearly locate sexuality in the heterosexual act of intercourse. In its other forms it was invisible or, if acknowledged, perverse and therefore condemned.

Nineteenth-century science

The eighteenth and nineteenth centuries saw the establishment of the (male) expert who assumed the legitimacy which allowed him to pronounce upon the rights and wrongs of sexuality: what Foucault (1979) has termed the psychiatrisation of sex. Psychiatry was used to define the boundaries of normality and abnormality, effectively prescribing sexuality for both men and women. When previously those who were intent on preserving the institutions of the family and patriarchal power might have used theological discourse to curb and control women's supposedly abhorrent sexuality, in the nineteenth century they turned to science. So, in the same way as woman's unhappiness or despair was couched within psychiatric nosology (Showalter, 1987; Ussher, 1991), so was her sexuality. And, whilst many of the new 'disorders', such as masturbation, nymphomania, frigidity, homosexuality (termed 'inversion'), and a host of other 'minor perversions', were categories of illness which could be applied to men or women, female sexuality was undoubtedly more carefully scrutinised and controlled. For, after the eighteenth century:

> the female body was analysed – qualified and disqualified – as being thoroughly saturated with sexuality; whereby it was integrated into the sphere of medical practices, by reason of a pathology intrinsic to it. (Foucault, 1967)

Sexuality was reduced to what Foucault has termed 'aberrations, perversions, exceptional oddities, pathological abatements, and morbid aggravations' (1979: 53), most clearly exemplified in Krafft-Ebing's 1890 encyclopaedia which detailed the 'various psycho-pathological manifestations of sexual life' through the use of individual case histories. Sexuality outside the strictly prescribed bounds of normality was perceived to be the root cause of pathology, of madness, for, as Henry Maudsley (1873: 83) commented, 'we have to note, indeed, to note and bear in mind how often sexual feelings arise and display themselves in all

sorts of insanity': an insanity which women were deemed to be more prone to experience (Ussher, 1991).

Within the scientific discourse the individual was clearly the focus of attention, social or historical context ignored. Sexual problems or deviancies (often seen as synonymous) were either deemed to have arisen from innate biological factors or were believed to be manifestations of some degenerative process (Bancroft, 1974). Yet there was also a school of thought which saw dysfunction as having been acquired through learning or childhood experiences: a foretaste of the split between the expert positions of today.

These different aetiological theories clearly had different implications for treatment, which at the essentialist extreme could be crude and disfiguring. For example, many women were subjected to Mitchell's rest cure, which involved enforced bed-rest in a darkened room with no stimulation and forced feeding of gruel, for disorders of hysteria and masturbation, both thought to be connected to an over-active sexuality (Tissot, 1769). Equally, ovariectomy was regularly offered for a host of female complaints, including nymphomania (Szasz, 1981). Its pioneer, Robert Battey, claimed:

> I have hoped through the intervention of the great nervous revolution which ordinarily accompanies the climacteric, to uproot and remove serious sexual disorders and reestablish general health.[7]

A treatment which literally removed the offending organ at the root of women's sexual dysfunction, clitoridectomy, was pioneered by the medic Issac Baker Brown for the 'sexual perversion of masturbation', but was thought to be efficacious in treating a host of other female complaints. Clitoridectomy exemplifies the contradiction wherein female sexuality is seen as the root of a host of pathologies, yet at the same time is denied or disregarded. For this barbaric surgery (with no proven efficacy), whilst offered as a panacea for a host of 'female complaints', was at the same time not expected to have any great effect on a woman's mood or self-esteem, as it was believed that it was 'irrelevant to a woman's feeling whether she had sex organs or not' (Barker-Benfield, 1976: 125). It implies that the very existence of the female sexual organs could only have a detrimental effect on the woman's psyche.

Yet the era of the 'little knife' as an antidote to dysfunctional or deviant sexuality was short lived, for, at the beginning of the twentieth century, psychological techniques were introduced.[8] As early as 1895 Schrenck-Notzing advocated psychological methods to 'create series of habits by means of direct persuasion, acts, imitation and admiration' (Bancroft, 1974: 23), using this technique primarily to 'treat' homosexuality. Yet it was in the early twentieth century that the research of the sexologists and the new therapeutic techniques of the psychologists really came into their

own. Women's sexuality was finally bracketed, controlled, and – if problematic – able to be cured.

Twentieth-century sexology

In the early twentieth century the rapidly burgeoning discipline of sexology, which formed the foundation of our current psychological theories and practices, was dominated by the work of Havelock Ellis and Sigmund Freud. Both were initially vilified for their supposedly 'incorrect' or 'hazardous' theories (Weeks, 1990: 142), but were subsequently influential in analysing and proposing treatment of so-called 'normal' sexual difficulties. On the subject of women they were less than objective – despite their adoption of the mantle of neutral scientist.[9]

Ellis advocated and celebrated as 'natural' the traditional gender roles laid down for men and women, categorically stating that 'woman breeds and tends; man provides'.[10] In this view, women were designed with reproduction in mind, with female sexual pleasure (Ellis did at least acknowledge the existence of female orgasm) serving evolutionary ends in ensuring copulation. That female orgasm could exist outside a sexual relationship with a man was inconceivable: women were believed to become aroused only following 'the stimulation of the male at the right moment.[11]

It is not surprising then that the lesbian presented a particular challenge to Ellis's theory, for, as Jeffrey Weeks explains:

> Whilst he [Ellis] recognised the legitimacy of female homosexuality (his wife was a lesbian) he obviously found it difficult to conceptualise in terms of his sexual theories . . . it was as if he could only conceptualise lesbianism as a masculinization of the woman, whereas today many tend to see female homosexuality as the ultimate in female autonomy from men.
>
> (Weeks, 1990: 147)

As an inherent 'abnormality', female inversion (lesbianism) was reduced to hormonal imbalances or irregularities: a distortion of the *normal* 'courtship' ritual of the male wooing the female – an unwelcome challenge to the firmly held notion of the secondary nature of female sexuality. Yet, whilst he was convinced of the naturalness of the heterosexual (and it was assumed male-dominated) union, Ellis was not reactionary in his support of expression of active female sexuality, within marriage, unlike his Victorian predecessors. Believing that individuals were potentially 'polysexual', he advocated marriage predominantly as a keystone of social policy, which in Ellis's view should be egalitarian, moving away from the traditional model within which women's rights were ignored: certainly a radical view in its time.

Whilst Ellis, with his emphasis on a continuum between normality and abnormality, his potentially positive view of sexuality, and his acknowledgement of the existence of female pleasure, provided a benchmark for researchers and clinicians of the twentieth century, Freud was equally if not more influential. Freud finally moved the analysis of sexuality from the biological to the psychological arena. For, whilst the belief in a biological sexual drive was still present in his theorising, sexuality was conceived of as a socially located instinct, with central aspects repressed as a result of cultural norms and mores.

Freud's postulations on the subject of female sexuality have presented succeeding generations of scholars with ammunition for either a complete disavowal of psychoanalytic theories on the grounds of misogyny (e.g. Figes, 1970) or its adoption as the mainstay of a feminist re-analysis of women's sexuality and psyche (e.g. Mitchell and Rose, 1982: Irigaray, 1988). In arguing for a basic bisexuality which is only socially channelled into heterosexuality, Freud drew attention to the large element of repression in all sexuality. Through the experience of childhood, girl children came to experience their sexuality as a lack, their non-possession of a penis as a loss. Always seen in relation to men, following the Oedipal stage of development, women's sexuality was essentially castrated, the physical reality of the 'inferior' organs sentencing women to a lifetime of neurosis and unresolved conflict – which could be resolved only through psychoanalysis or through symbolic acquisition of the phallus following childbirth.

Recent feminist analyses (e.g. Mitchell, 1974) have rejected the view that Freud was misogynistic, arguing that in positioning woman's sexuality as castrated or as a lack, he was merely *reflecting* the dominant cultural discourse, rather than prescribing it. However, Freud's influence in laying the foundations of the late twentieth-century psychological discourse on female sexuality cannot be underestimated. With Ellis, he established once and for all the legitimacy of the scientific analysis of sexuality[12] – and reinforced the association between pathology and sexuality (Breuer and Freud 1895: 246). Both reaffirmed the right of the (male) expert to pronounce upon the subject of female sexuality, the right to frame it within a psychological prism.

PSYCHOLOGY AND THE PROBLEM OF FEMALE SEXUALITY

Women's sexuality under the microscope

In the late twentieth century the dominant discourse of psychology and psychiatry, if it considers women's sexuality at all, classifies it clearly, concisely, and clinically. 'Normal' female sexuality is certainly marginal-

ised or ignored, for, as one commentator noted, 'the issue of female sexuality has been a puzzlement to male social scientists and they have usually elected to ignore it' (Plummer, 1984: 227).

The same could be said of clinicians. For, whilst the categorisation of male sexual problems is seen as relatively straightforward, with attention generally being focused on performance-related problems, such as premature or retarded ejaculation, or erectile dysfunction, as Cole (1988a: 35) comments:

> sexual disorders in women, with the possible exception of vaginismus . . . are by their very nature less easily categorized because of the more complex nature of women's sexual responses.

So clinicians often ignore the sexual problems of women.

A further difficulty which psychologists face is that of quantifying the extent of sexual problems in women. The activity of arriving at accurate epidemiological statistics is fraught with difficulty, for sexuality remains an aspect of experience positioned very much in the private domain, and thus is rarely discussed by clinicians (Ussher, 1990) or by individuals who might experience difficulty (Friedman *et al.*, 1986). The two avenues of study for those collecting statistics are studies of clinic attenders or general surveys of the population, and, whilst questions have been raised in relation to the representative nature of the samples of women used and the validity and reliability of the results presented (Bancroft, 1983), prevalence rates are certainly high.

Quantifying sexual dysfunction

The female sexual problems which have been categorised are generally described thus:

a) anorgasmia
b) inhibited sexual desire/general sexual dysfunction
c) vaginismus and dyspareunia.

The host of disorders and minor perversions floridly described in the nineteenth-century literature have been reduced to these supposedly more objectively defined categories – apparently afflicting large numbers of women. For example, examining clinic attenders, Masters and Johnson (1966) reported that out of a sample of 342 women 91 per cent experienced orgasmic dysfunction and 9 per cent suffered from vaginismus or dyspareunia. Similarly, Bancroft and Coles (1976) in analysis of 102 women who attended a sex-therapy clinic over a three-year period claimed that 62 per cent of women experienced general sexual problems, 18 per cent were anorgasmic, and 12 per cent suffered from vaginismus or

dyspareunia. Mears (1978) reported that out of 1330 clinic attenders 51 per cent experienced general sexual dysfunction, 22 per cent were anorgasmic, and 15 per cent suffered from vaginismus or dyspareunia.

When more general populations of women are questioned, such as through a sexual survey,[13] similarly high rates of problems are suggested. On the subject of anorgasmia in women the estimates range from Hite (1976) who claimed 29 per cent of 3000 women respondents never or almost never achieved orgasm, to Garde and Lunde (1980) who claimed only 4 per cent of their sample of 225 women were anorgasmic. Others report 19 per cent (Chester and Walker, 1980), 15 per cent (Frank *et al.*, 1978), 7 per cent (Hunt, 1974), 5 per cent (Pietropinto and Simenauer, 1977), and 4 per cent (Saunders, 1985) to be anorgasmic. Vaginismus is reported to affect between 1 and 4 per cent of women (Pasini, 1977; Catalan *et al.*, 1981), but exact figures are unknown.

Yet, despite the apparent certainty provided by the statistics, categorisation and diagnosis of sexual problems are far from incontrovertible. Firstly, the notion of dysfunction has been contested. One recent author has argued that 'identifying the absence of orgasm in a woman as "dysfunctional" is not only intellectually unacceptable but it can also be therapeutically counterproductive' (Cole, 1988a: 41) – thus challenging many of the theories and treatments currently directed at large numbers of women. Secondly, the type of difficulty necessary for diagnosis is not clear cut. For example, within current psychological discourse a problem is invariably defined as that which is related to pleasure or performance in sexual intercourse. Thus anorgasmia is diagnosed if a woman cannot achieve orgasm through intercourse, but not if she cannot achieve orgasm through masturbation, clearly defining orgasm during vaginal penetration as the normal experience for women. A woman's ability (or unwillingness) to give herself autonomous pleasure is not deemed an issue for the sex experts, unless she is being taught to masturbate as part of a programme of therapy. However, different surveys suggest that strikingly large numbers of women rarely or never achieve 'unassisted' orgasm during intercourse – up to 80 per cent in one study (Saunders, 1985),[14] suggesting that 'anorgasmia' may be experienced by a majority of women, thus challenging the notion of its being pathological. Yet, if Kinsey *et al.*'s (1948) estimate that three-quarters of men ejaculate (and therefore terminate intercourse) after only two minutes of penetration is in any way representative, perhaps it is not too surprising that women are anorgasmic without what is euphemistically termed 'assistance' (clitoral stimulation).

The dysfunction termed 'inhibited sexual desire', the general lack of interest in sex which is supposedly more common in women than in men (Hawton, 1985; Cole and Dryden, 1988), is equally problematic. The manifestations of this 'disorder' include lack of sexual appetite, boredom,