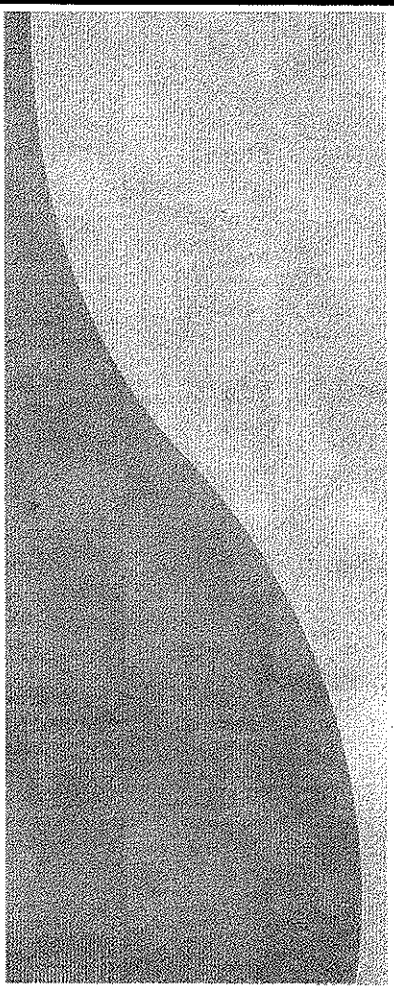

SEXUALITIES

IDENTITIES, BEHAVIORS, AND SOCIETY

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1.6 THE SOCIAL ORIGINS OF SEXUAL DEVELOPMENT

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THE SEXUAL TRADITION

The most important set of images for sex or eroticism in the modern West, either for scientists or in conventional educated speech, derives from the language of psychoanalysis. It would be difficult to overstate the coercive power of Freud's innovative verbal reformulations of a whole range of early conceptualizations about the role of sexuality in its biological, personal, and societal contexts. In an important sense Freud remains the superego of nearly all researchers into the sexual, since we must in some measure either conform to or rebel against his body of ideas. As with most great innovators, Freud began with the available set of contemporary ideas that were part of the heritage of the eighteenth and nineteenth centuries. It is difficult for those in the 1970s, for whom Freud is received wisdom and whose conservative postures are now most evident and emphasized, to recognize his role as a radical theorist of sexuality as well as representing a force for sociopolitical liberalism. The emphasis on the instinctual basis for the experience of the sexual and the universality of man's sexual experience, though possibly wrong in fact and theory, served to introduce a great change in sexual values at the turn of the century. Perhaps more important, by asserting the universality of the human experience, Freud significantly helped erode the dubious anthropology that imperial Europe used to describe its colonial subjects. The Freudian codification provided for modern, educated, Western man a set of verbal categories through which he might describe his internal states, explain the origins of his sexual proclivities, describe his own and others' motives, and ultimately reanalyze literature, histories, and societies as well as individual lives. The cultural assimilation of much of psychoanalytic theory, especially on a popular level, resides in its essential continuity with popular wisdom about the instinctive nature of sexuality. This version of sexuality as an innate and dangerous instinct is shared not only by the man in the street, but also by psychological theorists deeply opposed to Freudian thought, as well as by sociologists whose rejection of analytic theory is nearly total. Hence the language of Kingsley Davis:

> The development and maintenance of a stable competitive order with respect to sex is extremely difficult because sexual desire itself is inherently unstable and anarchic. Erotic relations are subject to constant danger—a change of whim, a loss of interest, a third party, a misunderstanding. Competition for the same sexual object inflames passions, and stirs conflicts; failure injures ones self-esteem. The intertwining of sex and society is a fertile ground for paranoia, for homicide and suicide.[1]

The seventeenth-century political image of the individual against the state is translated by the Romantic tradition into a contest between the individual and his culture. The Hobbesian contest between natural instinct and imposed constraint was moved by Freud (as well as many other post-Romantic innovators) from the arena of the state, power conflicts, and the social contract to the arena of the mind, sexuality, and the parent-child contract. The sexual instinct presses against cultural controls, pleasure contests with reality, as the sociocultural forces in the form of parents (Leviathan writ small) block, shape, and organize the sexual drive and convert it from lust to love, from societal destruction to social service.

This tradition is surely present in Freud with his emphasis on a drive model of development, a libidinal thrust that sequentially organizes intra- and extrapsychic life as well as the very meaning of the parts of the body. This direct relation between the external signs of physiological events and necessary motiva-

tional and cognitive states is a given for nearly all students of sexual behavior, whose frequent error is to confuse the outcomes of sexual learning with their apparent origins.

The Freudian or Kinseyian traditions share the prevailing image of the sexual drive as a basic biological mandate that presses against and must be controlled by the cultural and social matrix. This drive reduction model of sexual behavior as mediated by cultural and social controls is preeminent in "sexological" literature. Explanations of sexual behavior that flow from this model are relatively simple. The sex drive is thought to exist at some constant level in any cohort of the population, with rising and falling levels in the individual's life cycle. It presses for expression, and in the absence of controls, which exist either in laws and mores or in appropriate internalized repressions learned in early socialization, there will be outbreaks of "abnormal sexual activity." In the more primitive versions of this drive theory, there is a remarkable congruence between the potentiating mechanisms for specifically sexual and generally sinful behavior. The organism is inherently sexual (sinful) and its behavior is controlled by the presence of inhibitory training and channeling, internalized injunctions, and the absence of temptation. If these mechanisms fail, there will certainly be sexual misconduct (sin). More sophisticated models can be found in functional theories in sociology or in revisionist psychoanalytic models, but fundamental to each is a drive reduction notion that sees sex as having necessary collective and individual consequences because of its biological origins.

What is truly innovative about Freud's thought is not his utilization of prior constructs about sexuality and the nature of man, but his placement of these ideas about sexuality at the center of human concerns, beginning in infancy, an essential to normal human development. As Erik Erikson has observed, prior to Freud, "sexology" tended to see sexuality as suddenly appearing with the onset of adolescence.[2] From Erikson's point of view, Freud's discovery of infantile and childhood expressions of sexuality was a crucial part of his contribution. Libido—the generation of psychosexual energies—was viewed after Freud as a fundamental element of the human experience from its very inception, beginning at the latest with birth and possibly prior to birth. Libido was conceived as something essential to the organism, representing a kind of constitutional factor with which forms of social life at all levels of sociocultural organization and development, as well as personality structure at each point in the individual life cycle, had to cope.

In Freud's view the human infant and child behaved in ways that were intrinsically sexual and these early behaviors remained in effective and influential continuity with later forms of psychosexual development.[3] Implicit in this view was the assumption that the relations between available sexual energies and emergent motives and attachments would be complex but direct. In some aspects of psychoanalytic thinking, both adolescent and adult sexuality were viewed as being in some measure a reenactment of sexual commitments developed, learned, or acquired during infancy and childhood.[4]

From the vantage point of the late twentieth century, it is apparent that this point of view presents both an epistemological and a sociolinguistic problem. Freud's descriptive language for sexuality was the language of adults describing their current and childhood "sexual" experience (as transmuted through psychoanalytic interviews), which was then imposed upon the "apparent" behavior and "assumed" responses, feelings, and cognitions of infants and children. Acts and feelings are described as sexual, not because of the child's sense of the experience, but because of the meanings attached to those acts by adult observers or interpreters whose only available language is that of adult sexual experience.

It is important to note here the extraordinary difficulties of all developmental research in getting accurate data and also that research on infancy and childhood through adulthood faces a problem which most of the psychoanalytic literature obscures. Part of the problem is faulty recall, some of which is locatable in the problem of inaccurate memories, but another source of error is located in the existentialist insight that instead of the past determining the character of the present, the present significantly reshapes the past as we reconstruct our biographies in an effort to bring them into greater congruence with our current identities, roles, situations, and available vocabular-

ies. Indeed, the role of the analyst in providing an alternative self-conception for patients by creating a new vocabulary of motives is central to the therapeutic impulse and opposed to the gathering of accurate information about the past.

The other major problem of data quality control results from attempting to gather data either from children who are, because of their stage of development, ill-equipped to report on their internal states or from adults who were asked to report about periods in their life when complex vocabularies for internal states did not exist for them.[5] How can the researcher determine what is being felt or thought when the researcher is confronted with organisms whose restricted language skills may preclude certain feelings and thoughts? The child in this situation possesses internal states that in a verbal sense are meaningless and that will begin to be named and organized only during later development. The adult loses access to that inchoate period of his own experience by learning new ways of attributing meaning to experiences. The organism cannot hold onto both sets of experiences at once. Indeed, this may be the central meaning of development, that the acquisition of new categories for experience erase the past. Opie and Opie report that adolescents quickly forget childhood games. How much more quickly do we forget earlier and more diffuse experiences?[6]

The assumption of an identity between perception based upon a adult terminology for the description of a child's behavior and the meaning of that behavior for the child must be treated with extreme caution. The dilemma is in distinguishing between the sources of specific actions, gestures, and bodily movements and the ways in which they are labeled as sexual at various stages of development. For the infant touching his penis, the activity cannot be sexual in the same sense as adult masturbation but is merely a diffusely pleasurable activity, like many other activities. Only through maturing and learning these adult labels for his experience and activity can the child come to masturbate in the adult sense of that word. The complexity of adult masturbation as an act is enormous, requiring the close coordination of physical, psychological, and social resources, all of which change dynamically after puberty. It is through the developmental process of converting external labels into internal capacities for naming that activities become more precisely defined and linked to a structure of sociocultural expectations and needs that define what is sexual. The naive external observer of this behavior often imputes to the child the complex set of motivational states that are generally associated (often wrongly) with physically homologous adult activities.

In the Freudian schema, this gap between observer and observed, between the language of adult experience and the lived experience of the child is bridged by locating an instinctual sexual energy source within the infant. The child is seen as possessed of certain emergent sexual characteristics that express themselves regardless of parental action systems. These actions of the child are viewed as being rooted in the constitutional nature of the organism. Consequent upon this primitive Freudian position is an over generalized presumption that all contacts with or stimulation of the end organs of the infant have a protosexual or completely sexual meaning.

To suggest that infant or childhood experience, even that which is identified as genital, is prototypical of or determines adult patterns is to credit the biological organism with more wisdom than we normally do in other areas where the biological and sociocultural intersect. Undeniably, what we conventionally describe as sexual behavior is rooted in biological capacities and processes, but no more than other forms of behavior. Admitting the existence of a biological substrate for sex in no way allows a greater degree of biological determinism than is true of other areas of corresponding intersection. Indeed, the reverse is more likely to be true: the sexual area may be precisely that realm wherein the superordinate position of the sociocultural over the biological level is most complete.[7]

The unproven assumption in psychoanalytic theory (and much conventional wisdom) of the "power" of the psychosexual drive as a fixed biological attribute may prove to be the major obstacle to the understanding of psychosexual development. In its more specific psychoanalytic formulation, we find little evidence to suggest that such a "drive" need find expression in specific sexual acts or categories of sexual acts.[8] Similarly, we must call into question the even more dubious assumption that there are innate sexual

capacities or specific experiences that tend to translate immediately into a kind of universal wisdom, that sexuality possesses a magical ability allowing biological drives to seek direct expression in psychosocial and social ways that we do not expect in other biologically rooted behaviors. This assumption can be seen in the psychoanalytic literature, for example, in which the child who views the "primal scene" is seen on some primitive level as intuiting its sexual character. Also, the term *latency,* in its usage by psychoanalytic theorists, suggests a period of integration by the child of prior intrinsically sexual experiences and reactions; on this level, adolescence is reduced to little more than the management or organization on a manifest level of the commitments and styles already prefigured, if not preformed, in infancy and childhood experience.

In contradistinction to this tradition, we have adopted the view that the point at which the individual begins to respond in intrinsically sexual ways, particularly in terms of socially available or defined outlets and objects, reflects a discontinuity with previous "sexual experience" (however that might be defined). Further, at this point in the developmental process, both seemingly sexual and seemingly nonsexual elements "contend" for influence in complex ways that in no respect assure priority for experiences that are apparently sexual in character and occur earlier in the life cycle.

Essential to our perspective is the assumption that with the beginnings of adolescence—and with the increasing acknowledgement by the surrounding social world of an individual's sexual capacity—many novel factors come into play, and an overemphasis upon a search for continuity with infant and childhood experiences may be dangerously misleading. In particular, it may be a costly mistake to be overimpressed with preadolescent behaviors that appear to be manifestly sexual. In general, it is possible that much of the power of sexuality may be a function of the fact that it has been defined as powerful or dangerous. But this overenriched conception of sexual behavior (to the degree that it is possessed by any individual) must largely follow upon considerable training in an adult language that includes an overdetermined conception of sexuality. Thus it does not necessarily follow that the untrained infant or child will respond as powerfully or as complexly to his own seemingly sexual behaviors as an adult observer.

We must also question the prevailing image of the sexual component in human experience as that of an intense drive stemming from the biological substratum that constrains the individual to seek sexual gratification either directly or indirectly. This is clearly present in the Freudian tradition. A similar position is observable in more sociological writings. This is apparent, for example, in the thinking of sociologists for whom sex is also a high intensity, societal constant that must be properly channeled lest it find expression in behaviors which threaten the maintenance of collective life.[9]

Our sense of the available data suggests a somewhat different picture of human sexuality, one of generally lower levels of intensity or, at least, greater variability in intensity. There are numerous social situations in which the reduction and even elimination of sexual activity is managed by greatly disparate populations of biologically normal males and females with little evidence of corollary or compensatory intensification in other spheres of life.[10] It is possible that, given the historical nature of human societies, we are victim to the needs of earlier social orders. For earlier societies it may not have been a need to constrain severely the powerful sexual impulse in order to maintain social stability or limit inherently antisocial force, but rather a matter of having to invent an importance for sexuality. This would not only assure a high level of reproductive activity but also provide socially available rewards unlimited by natural resources, rewards that promote conforming behavior in sectors of social life far more important than the sexual. Part of the legacy of Freud is that we have all become adept at seeking out the sexual ingredient in many forms of nonsexual behavior and symbolism. We are suggesting what is in essence the insight of Kenneth Burke: it is just as plausible to examine sexual behavior for its capacity to express and serve nonsexual motives as the reverse.[11]

A major flaw in the psychoanalytic tradition is that psychosexual development, while a universal component in the human experience, certainly does not occur with universal modalities. Even ignoring the striking forms of cross-cultural variability, we can observe

striking differences within our own population, differences that appear to require not a unitary description of psychosexual development but descriptions of different developmental processes characterizing different segments of the population.[12] The most evident of these are the large number of important differences between observable male and female patterns of sexual behavior.[13] This particular difference may in some respects be partly attributable to the role played by the biological substratum. We have to account not only for the gross physiological differences and the different roles in the reproductive process that follow from these physiological differences, but must also consider differences in hormone functions at particular ages.[14] However, while our knowledge of many of the salient physiological and physiochemical processes involved is far from complete, there is still little immediate justification for asserting a direct casual link between these processes and specific differential patterns of sexual development observed in our society. The work of Masters and Johnson, for example, clearly points to far greater orgasmic capacities on the part of females than males; however, their concept of orgasm as a physiological process would hardly be a basis for accurately predicting rates of sexual behavior.[15] Similarly, within each sex, important distinctions must be made for various socioeconomic status groups whose patterns of sexual development will vary considerably, more impressively for males than for females.[16] And with reference to socioeconomic status differences, the link to the biological level appears even more tenuous, unless one is willing to invoke the relatively unfashionable conceptual equipment of Social Darwinism. These differences, then, not only suggest the importance of sociocultural elements and social structure, but also stand as a warning against too uncritical an acceptance of unqualified generalizations about psychosexual development.

Scripts and the Attribution of Meaning

The term *script* might properly be invoked to describe virtually all human behavior in the sense that there is very little that can in a full measure be called spontaneous. Ironically, the current vogue of using "encounter groups" to facilitate "spontaneous" behavior can be defined as learning the appropriate script for spontaneous behavior. Indeed, the sense of the *internal rehearsal* consistent with both psychoanalytic and symbolic interactionist theory suggests just such scripting of all but the most routinized behavior.

It is the result of our collective blindness to or ineptitude in locating and defining these scripts that has allowed the prepotence of a biological mandate in the explanation of sexual behavior. (This possibly occurs precisely because the notion of such a biological mandate is a common element within the sexual scripts of Western societies.) Without the proper elements of a script that defines the situation, names the actors, and plots the behavior, nothing sexual is likely to happen. One can easily conceive of numerous social situations in which all or almost all of the ingredients of a sexual event are present but that remain nonsexual in that not even sexual arousal occurs. Thus, combining such elements as desire, privacy, and a physically attractive person of the appropriate sex, the probability of something sexual happening will, under normal circumstances, remain exceedingly small until either one or both actors organize these behaviors into an appropriate script.

Elements of such scripting occur across many aspects of the sexual situation. Scripts are involved in learning the meaning of internal states, organizing the sequences of specifically sexual acts, decoding novel situations, setting the limits on sexual responses, and linking meanings from nonsexual aspects of life to specifically sexual experience. These would at first seem only to be versions of the old sociological saw that nothing occurs internally that does not occur in the external social world. But it is more than this in two ways. Using this model the process of sexual learning can be specified without depending on nonbehavioral elements, and doing this reorders the sources of meaning for phenomena and the ways in which we think about the sexual experience.

This can be exemplified even more dramatically. Take an ordinary middle-class male, detach him from his regular social location, and place him for some business or professional reason in a large, relatively anonymous hotel. One might even endow him with an interest in sexual adventure. Upon returning to the

hotel at night, he opens his hotel door and there in the shaft of light from the hall-way, he observes a nearly nude, extremely attractive female. One may assume that his initial reaction will *not* be one of sexual arousal. A few men—the slightly more paranoid—might begin to cast about for signs of their wife's lawyer or a private detective. Most, however, would simply beat a hasty and profoundly embarrassed retreat. Even back in the hall and with a moment's reflection to establish the correctness of the room number, the next impulse would still *not* be one of sexual arousal or activity but most probably a trip to the lobby to seek clarification—via the affectively neutral telephone. What is lacking in this situation is an effective sexual script that would allow him to define the female as a potentially erotic actor (the mere fact of her being attractive or nearly nude is not sufficient) and the situation as potentially sexual. If these two definitional elements did exist, much of what might follow can be predicted with fair accuracy. But without such a script, little by way of sexual activity or even sexual arousal will transpire.

Our use of the term *script* with reference to the sexual has two major dimensions. One deals with the external, the interpersonal—the script as the organization of mutually shared conventions that allows two or more actors to participate in a complex act involving mutual dependence. The second deals with the internal, the intrapsychic, the motivational elements that produce arousal or at least a commitment to the activity.

At the level of convention is that large class of gestures, both verbal and nonverbal, that are mutually accessible. Routinized language, the sequence of petting behaviors among adolescents and adults, the conventional styles establishing sexual willingness are all parts of culturally shared, external routines. These are the strategies involved in the "doing" of sex, concrete and continuous elements of what a culture agrees is sexual. They are assembled, learned over time, reflecting—as will be clear in subsequent chapters—general patterns of stages of development. This relatively stylized behavior, however, tells us little of the meaning it has for its participants. The same sequence of acts may have different meanings for both different pairs of actors or the participants in the same act. This is the world where sexual activity can be expressive of love or rage, the will to power or the will to self-degradation, where the behavioral is experienced through the symbolic.

On the level of internal experience, it is apparent from the work of Schachter and others that the meaning attributed to many states of physiological arousal depends upon the situation in which they are experienced.[17] In this way, meaning is attributed to the interior of the body by many of the same rules as it is to an exterior experience, depending on a vocabulary of motives that makes the biological into a meaningful psychological experience. This phenomena is well understood in research in drug effects, with the meaning of the drug experience being dependent on mood, situation of use, prior history of the user, and the like, rather than what is spuriously referred to as the drug effect. This is apparent in the effects of all of the so-called mind-altering drugs including marijuana. The differing reports on the internal effects of LSD-25 lysergic acid (good trips, psychomimetic experiences, paranoid trips, art nouveau hallucinations, meetings with God) seem more attributable to the person-situation effect than to the drug. This is observable in young adolescents when they are required to learn what the feelings they have with reference to early post-pubertal sexual arousal "mean." Events variously categorized as anxiety, nausea, fear are reported which are later finally categorized as (or dismissed, even though they still occur) sexual excitement. A vast number of physiological events get reported to the central nervous system, but of this number only a small proportion are attended to in any single moment. (How many persons, for instance, experience their toes curl or the anal sphincter twitch at the moment of orgasm?) It is this small proportion that is recognized as the internal correlates or internal "meanings" of the experience. In this case, the meaning is a consensual experience with various elements brought together to be the appropriate behaviors that will elicit the internal correlates or consequences of the external behaviors.

Scripting also occurs not only in the making of meaningful interior states, but in providing the ordering of bodily activities that will release these internal biological states. Here scripts are the mechanisms

through which biological events can be potentiated. An example from the adult world is most apt in revealing this process. If one examines the assembly of events that are the physical elements of the current script in the United States for adolescent or adult heterosexual behavior that leads to coitus, it is clear that there is a progression from hugging and kissing, to petting above the waist, to hand-genital contacts (sometimes mouth-genital contacts) and finally to coitus. There is some variation about these acts in timing (both in order and duration), but roughly this is—at the physical level—what normal heterosexual activity is. Prior to or in the course of this sequence of physical acts, sexual arousal occurs, and in some cases orgasm results for one or both of the two persons involved. What is misleading in this physical description is that it sounds as if one were rubbing two sticks together to produce fire; that is, if only enough body heat is generated, orgasm occurs. However, orgasm is not only a physical event, but also the outcome of a combination of both biological and, more importantly, social psychological factors. Unless the two people involved recognize that the physical events outlined are sexual and are embedded in a sexual situation, there will not be the potentiation of the physiological concomitants that Masters and Johnson have demonstrated as necessary in the production of sexual excitement and the orgasmic cycle.[18] The social meaning given to the physical acts releases biological events. Most of the physical acts described in the foregoing sexual sequence occur in many other situations—the palpation of the breast for cancer, the gynecological examination, the insertion of tampons, mouth-to-mouth resuscitation—all involve homologous physical events. But the social situation and the actors are not defined as sexual or potentially sexual, and the introduction of a sexual element is seen as a violation of the expected social arrangements. The social-psychological meaning of sexual events must be learned because they supply the channels through which biology is expressed. In some cases, the system of naming must exist for the event to occur; in others, portions of the event that are biologically necessary are never observed in the psychological field of the participating persons.

The term *script* (or *scripted behavior*) immediately suggests the dramatic, which is appropriate; but it also suggests the conventional dramatic narrative form, which more often than not is inappropriate. The latter tendency is reinforced by our most general conception of the sex act itself, which is seen as a dramatic event with continuous cumulative action. This is suggested, for example, by the language of Masters and Johnson—"arousal, plateau, climax, and resolution"—a conception resembling somewhat an Aristotelian notion of the dramatic or the design for a nineteenth-century symphony. However, the sources of arousal, passion or excitement (the recognition of a sexual possibility), as well as the way the event is experienced (if, indeed, an event follows), derive from a complicated set of layered symbolic meanings that are not only difficult to comprehend from the observed behavior, but also may not be shared by the participants. Even where there is minimal sharing of elements of a script by persons acting toward each other (which, while not necessary, clearly facilitates execution of the acts with mutual satisfaction), they may be organized in different ways and invoked at different times.

The same overt gesture may have both a different meaning and/or play a different role in organizing the sexual "performance." The identical gesture undertaken during sexual activity may be read by one participant with a content that might resemble that of Sade or Sacher-Mosoch, while the other participant reads content from *Love Story.*

Elements entering into the performance may be both relatively remote to the erotic (or what is conventionally defined as remote to the erotic), as well as the immediately and intrinsically erotic. Moreover, the logic of organization may more closely follow the nonnarrative qualities of modern poetry, the surrealistic tradition, or the theater of the absurd than conventional narrative modes. The sexual provides us with a situation where the mere invocation of some powerfully organizing metaphor links behavior to whole universes of meaning; a situation where the power of a metaphorically enriched gesture, act, characteristic, object, or posture cannot be determined by the relative frequency with which it occurs; such organizing metaphors need only be suggested for their effects to be realized.

An example of this may be seen in Jerzy N. Kosinski's novel *Steps,*[19] where our nameless hero finds

himself looking down upon a fellow office worker (female) whom he has long desired sexually and who is in a posture of unrestrained sexual accessibility. Though it is a moment he has long desired, he finds himself unable to become aroused. He then recalls the moment of his initial sexual interest; a moment in which, while watching her in the act of filing papers with uplifted arms, he catches a fleeing glimpse of her bra. This trivial image, originally arousing, remains arousing and our hero goes on to complete the act. It is that image (and what it links to) that both names her as an erotic object in terms of his sense of the erotic and names also what he is about to do to her. Though the image need only be briefly suggested (both in its origins and subsequent utilization), and though it may remain unknown to the behaviorist observer, it becomes critical to the performance. Its meanings could be multiple. For example, that the sexual becomes erotically enriched when it is hidden, latent, denied, or when it is essentially violative (deriving from unintended exposure). It also legitimates the appropriate name for the behavior. Consider the possible "labels" our hero could have invoked that could have been applied to the behavior, each with its own powerful and powerfully distinct associations—making love, making out, fucking, screwing, humping, doing, raping.

The erotic component we can assume is minimally necessary if sexual activity is to occur; that is its very importance. (A dramatic exception, of course, are many women whose participation in sexual activity has often—historically, possibly more often than not—had little to do with their own sense of the erotic.) On the other hand, a preoccupation with the erotic may reach obsessive proportions without overt sexual behavior necessarily following. Thus, like the biological component, it can be described as simultaneously being of critical importance and also insufficient by itself to be either fully descriptive or predictive of actual sexual careers.

While the importance of the erotic can be asserted, it may be the most difficult to elaborate, as a concern for the erotic—the acquisition of sexual culture—is possibly the least well understood or attended aspect of sexual behavior. We know very little about how it is acquired or, for that matter, the ways in which it influences both our sexual and nonsexual lives. Persistence of concepts such as libido or the sex drive obviate need for this knowledge. For those who hold these or comparable positions, the body is frequently seen as being both wise and articulate; recognizing and speaking a compelling language. Still others have assumed, in too unexamined a way, a direct link between collective sexual cultures and private sexual cultures, despite the fact that for many what is collectively defined as erotic may not be associated with sexual response or that much that the collectivity defines as non- or even anti-erotic may become part of the private sexual culture of a given individual; for example, various kinds of full and partial fetishisms. As a result, much of the research on responses to erotic materials often begins with the dubious assumption that experimental stimuli are recognizable in terms of a conventional social definition.[20]

One thing that is clear is that for contemporary society erotic imagery or metaphors are for the most part discontinuously or only latently a part of the images or metaphors of nonsexual identity or social life. (The exceptions are those social roles that are specifically assumed to have a "known" erotic aspect, such as the prostitute, the homosexual, the stewardess, or the divorcee, all of whom we tend to see as either fully erotic or unusually erotic to the point where we have difficulty seeing them in anything but erotic terms.) Thus, for conventional actors in relatively conventional settings, the invocation of the erotic, necessary for sexual arousal, frequently requires a series of rituals of transformation before the participants or the setting license (as it were) the sexual moment. For example, much of precoital petting or foreplay may serve less as facilitators of a physiological process, than as elements in a ritual drama that allow one or both actors to rename themselves, their partners, as well as various parts of the body in terms of the "special" purpose. The intrusion of nonerotic, manifest meanings to images—that is, parts of the body or other role commitments of one or another of the actors is experienced as disruptive of sexual interest or capacity, if only because such commitments are rarely predictive of sexual role needs. For most, as a

consequence, the sexual flourishes best in a sheltered and, in some sense, isolated universe, a landscape denuded of all but the most relevant aspects of identity.

At the same time, the larger part of identity and sense of the rest of social life frequently intrude in an indirect way. The elaboration of the erotic or its direct expression is often constrained by an anticipation of an anticipated return to that larger social role, that more continuous sense of self. For some this may involve merely the insulation of silence; for others, symbolic reinterpretation and condensation—for example, an intensity of pressure that allows the actor to represent by that gesture either passion (or the message that uncharacteristic behavior is thereby explained), or love and affection (that the actor is the same as he or she is in their more conventional mode of relating), or sadistic aggression (illuminating a complicated fantasy rehearsed and experienced sufficiently that the gesture successfully evokes most of the emotional density generated by a long and frequently complicated scenario).

Beyond the very general level, however, little can be said. Important questions dealing not only with origins but careers have yet to be even examined provisionally. Where do such images come from? In terms of what sexual and nonsexual experiences do their meanings change? Is there need for elaboration? These, and many more, are the questions that we may have to examine before sexual activity, which all too often can be described as a "dumb-show" for its participants, becomes something other than a dumb-show for behavioral science.

NOTES

1. Kingsley Davis, "Sexual Behavior," in *Contemporary Social Problems* eds. R. K. Merton and R. Nishet (New York: Harcourt Brace Jovanovich, 1971), p. 317.

2. E. H. Erikson, *Childhood and Society,* 2nd ed. (New York: Norton, 1963).

3. Sigmund Freud, "Three Essays on Sexuality," *Complete Psychological Works,* vol. 7 (London: Hogarth, 1953), pp. 135–245. Also, E. Jones, "Freud's Conception of Libido," in *Human Sexual Behavior: A Book of Readings,* ed. Bernhardt Lieberman (New York: John Wiley & Sons, Inc., 1971), pp. 42–60; P. Chodoff, "Critique of Freud's Theory of Infantile Sexuality," *American Journal of Psychiatry* 123 (1966): 507–18.

4. Sigmund Freud, *A General Introduction to Psychoanalysis* (New York: Liveright, 1935), pp. 283–84.

5. E. Schachtel, *Metamorphosis* (New York: Basic Books, 1959).

6. There is a body of evidence that among young children there is a large amount of game and folklore material that is rapidly forgotten after puberty. A certain amount of this material is sexual, but the folklorists who work with children usually fail to keep records of this, or if they do so, do not publish it. An interesting aspect of this material is its eternal character—that is, it is passed on from generation to generation. For example, children in England are currently singing a recognizable variant of a song about Bonaparte popular in the early nineteenth century. See Iona Opie and Peter Opie, *The Lore and Language of School Children* (London: Oxford Press, 1959), pp. 98–99.

7. Even on the level of organismic needs and gratification, the linking of these to the sexual or protosexual may be too limited, too simple. Robert White has argued cogently that during infancy and early childhood an emergent commitment to "competence" may rival sensual expressions of the pleasure principle in organizing the young organism's activities, as the child "sacrifices" immediate sensual gratification in order to develop and experience his or her own competence. See "Psychosexual Development and Competence," *The Nebraska Symposium on Motivation* (Lincoln, University of Nebraska Press, 1960).

8. Frank A. Beach, "Characteristics of Masculine 'Sex Drive'," *The Nebraska Symposium on Motivation* (Lincoln: University of Nebraska Press, 1956).

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CHAPTER TWO

CONTEMPORARY INTERROGATIONS

Classical studies of sexuality focused on how we got to be sexual in the first place, what we did sexually, and what was normal and what was not. Contemporary inquiries question all three of these, further complicating the questions we raise and making the search for easy answers virtually impossible.

In the 1990s, John Gagnon was part of a research team at the University of Chicago that undertook a more comprehensive survey of American's sexual behavior than had ever been done in our history, outdoing the Kinsey study in both reach and scope. The team found that Americans had less sex than we had previously thought and the most surprising finding was that Kinsey's original estimates of homosexuality were dramatically inflated. The results of the new survey indicated that only about 4–5 percent of American men and about 1–2 percent of American women identified as homosexual.

These findings caused a significant controversy. Some thought the numbers were low because people were far more circumspect than researchers thought and likely to be dishonest in conversations with sex researchers. Others found the numbers too high and the dissemination of information about sex to be an invitation to perversion.

But most contemporary discussion about sex research has been about the criteria that the researchers used—and the limits of that type of research in the first place. Jonathan Katz makes clear that the terms "homosexual" and "heterosexual" used as nouns to describe discrete and identifiable identities (not as adjectives describing behaviors) is as recent as the turn of the last century, so applying them to historical cases may be inaccurate. Biologist Anne Fausto-Sterling suggests that a simple binary model of two sexes fails to adequately capture the full range of humans as biological creatures, with dramatic implications for sexualities. And Suzanne Kessler makes it clear that it is often doctors, not individuals, who decide biological sex based on their assumptions of what would make a person happiest. What you see is not always what you are, or will become.

Leonore Tiefer in one selection, and Julia Ericksen and Sally Steffen in another, get inside the famous sex surveys of the twentieth century, offering powerful critiques both of what was included and what was left out.

2.1 THE FIVE SEXES

Why Male and Female Are Not Enough

Anne Fausto-Sterling

In 1843 Levi Suydam, a twenty-three-year-old resident of Salisbury, Connecticut, asked the town board of selectmen to validate his right to vote as a Whig in a hotly contested local election. The request raised a flurry of objections from the opposition party, for reasons that must be rare in the annals of American democracy: it was said that Suydam was more female than male and thus (some eighty years before suffrage was extended to women) could not be allowed to cast a ballot. To settle the dispute a physician, one William James Barry, was brought in to examine Suydam. And, presumably upon encountering a phallus, the good doctor declared the prospective voter male. With Suydam safely in their column the Whigs won the election by a majority of one.

Barry's diagnosis, however, turned out to be somewhat premature. Within a few days he discovered that, phallus notwithstanding, Suydam menstruated regularly and had a vaginal opening. Both his/her physique and his/her mental predispositions were more complex than was first suspected. S/he had narrow shoulders and broad hips and felt occasional sexual yearnings for women. Suydam's "feminine propensities, such as a fondness for gay colors, for pieces of calico, comparing and placing them together, and an aversion for bodily labor, and an inability to perform the same, were remarked by many," Barry later wrote. It is not clear whether Suydam lost or retained the vote, or whether the election results were reversed.

Western culture is deeply committed to the idea that there are only two sexes. Even language refuses other possibilities; thus to write about Levi Suydam I have had to invent conventions—*S/he* and *his/her*—to denote someone who is clearly neither male nor female or who is perhaps both sexes at once. Legally, too, every adult is either man or woman, and the difference, of course, is not trivial. For Suydam it meant the franchise; today it means being available for, or exempt from, draft registration, as well as being subject, in various ways, to a number of laws governing marriage, the family and human intimacy. In many parts of the United States, for instance, two people legally registered as men cannot have sexual relations without violating anti-sodomy statutes.

But if the state and the legal system have an interest in maintaining a two-party sexual system, they are in defiance of nature. For biologically speaking, there are many gradations running from female to male; and depending on how one calls the shots, one can argue that along that spectrum lie at least five sexes—and perhaps even more.

For some time medical investigators have recognized the concept of the intersexual body. But the standard medical literature uses the term *intersex* as a catch-all for three major subgroups with some mixture of male and female characteristics: the so-called true hermaphrodites, whom I call herms, who possess one testis and one ovary the (sperm- and egg-producing vessels, or gonads); the male pseudohermaphrodites (the "merms"), who have testes and some aspects of the female genitalia but no ovaries; and the female pseudohermaphrodites the ("ferms"), who have ovaries and some aspects of the male genitalia but lack testes. Each of those categories is in itself complex; the percentage of male and female characteristics, for instance, can vary enormously among members of the same subgroup. Moreover, the inner lives of the people in each subgroup—their special needs and their problems, attractions and repulsions—have gone unexplored by science. But on the basis of what is known about them I suggest that the three intersexes, herm, merm and ferm, deserve to be considered additional sexes each in its own right. Indeed, I would

argue further that sex is a vast, infinitely malleable continuum that defies the constraints of even five categories.

Not surprisingly, it is extremely difficult to estimate the frequency of intersexuality, much less the frequency of each of the three additional sexes: it is not the sort of information one volunteers on a job application. The psychologist John Money of Johns Hopkins University, a specialist in the study of congenital sexual-organ defects, suggests intersexuals may constitute as many as 4 percent of births. As I point out to my students at Brown University, in a student body of about 6,000 that fraction, if correct, implies there may be as many as 240 intersexuals on campus—surely enough to form a minority caucus of some kind.

In reality though, few such students would make it as far as Brown in sexually diverse form. Recent advances in physiology and surgical technology now enable physicians to catch most intersexuals at the moment of birth. Almost at once such infants are entered into a program of hormonal and surgical management so that they can slip quietly into society as "normal" heterosexual males or females. I emphasize that the motive is in no way conspiratorial. The aims of the policy are genuinely humanitarian, reflecting the wish that people be able to "fit in" both physically and psychologically. In the medical community, however, the assumptions behind that wish—that there be only two sexes, that heterosexuality alone is normal, that there is one true model of psychological health—have gone virtually unexamined.

The word *hermaphrodite* comes from the Greek names Hermes, variously known as the messenger of the gods, the patron of music, the controller of dreams or the protector of livestock, and Aphrodite, the goddess of sexual love and beauty. According to Greek mythology, those two gods parented Hermaphroditus, who at age fifteen became half male and half female when his body fused with the body of a nymph he fell in love with. In some true hermaphrodites the testis and the ovary grow separately but bilaterally; in others they grow together within the same organ, forming an ovo-testis. Not infrequently, at least one of the gonads functions quite well, producing either sperm cells or eggs, as well as functional levels of the sex hormones—androgens or estrogens. Although in theory it might be possible for a true hermaphrodite to become both father and mother to a child, in practice the appropriate ducts and tubes are not configured so that egg and sperm can meet.

In contrast with the true hermaphrodites, the pseudo-hermaphrodites possess two gonads of the same kind along with the usual male (XY) or female (XX) chromosomal makeup. But their external genitalia and secondary sex characteristics do not match their chromosomes. Thus merms have testes and XY chromosomes, yet they also have a vagina and a clitoris, and at puberty they often develop breasts. They do not menstruate, however. Ferms have ovaries, two X chromosomes and sometimes a uterus, but they also have at least partly masculine external genitalia. Without medical intervention they can develop beards, deep voices and adult-size penises.

No classification scheme could more than suggest the variety of sexual anatomy encountered in clinical practice. In 1969, for example, two French investigators, Paul Guinet of the Endocrine Clinic in Lyons and Jacques Decourt of the Endocrine Clinic in Paris, described ninety-eight cases of true hermaphroditism—again, signifying people with both ovarian and testicular tissue—solely according to the appearance of the external genitalia and the accompanying ducts. In some cases the people exhibited strongly feminine development. They had separate openings for the vagina and the urethra, a cleft vulva defined by both the large and the small labia, or vaginal lips, and at puberty they developed breasts and usually began to menstruate. It was the oversize and sexually alert clitoris, which threatened sometimes at puberty to grow into a penis, that usually impelled them to seek medical attention. Members of another group also had breasts and a feminine body type, and they menstruated. But their labia were at least partly fused, forming an incomplete scrotum. The phallus (here an embryological term for a structure that during usual development goes on to form either a clitoris or a penis) was between 1.5 and 2.8 inches long; nevertheless, they urinated through a urethra that opened into or near the vagina.

By far the most frequent form of true hermaphrodite encountered by Guinet and Decourt—55 percent—appeared to have a more masculine physique.

In such people the urethra runs either through or near the phallus, which looks more like a penis than a clitoris. Any menstrual blood exits periodically during urination. But in spite of the relatively male appearance of the genitalia, breasts appear at puberty. It is possible that a sample larger than ninety-eight so-called true hermaphrodites would yield even more contrasts and subtleties. Suffice it to say that the varieties are so diverse that it is possible to know which parts are present and what is attached to what only after exploratory surgery.

The embryological origins of human hermaphrodites clearly fit what is known about male and female sexual development. The embryonic gonad generally chooses early in development to follow either a male or a female sexual pathway; for the ovo-testis, however, that choice is fudged. Similarly, the embryonic phallus most often ends up as a clitoris or a penis, but the existence of intermediate states comes as no surprise to the embryologist. There are also uro-genital swellings in the embryo that usually either stay open and become the vaginal labia or fuse and become a scrotum. In some hermaphrodites, though, the choice of opening or closing is ambivalent. Finally, all mammalian embryos have structures that can become the female uterus and the fallopian tubes, as well as structures that can become part of the male sperm-transport system. Typically either the male or the female set of those primordial genital organs degenerates, and the remaining structures achieve their sex-appropriate future. In hermaphrodites both sets of organs develop to varying degrees.

Intersexuality itself is old news. Hermaphrodites, for instance, are often featured in stories about human origins. Early biblical scholars believed Adam began life as a hermaphrodite and later divided into two people—a male and a female—after falling from grace. According to Plato there once were three sexes—male, female and hermaphrodite—but the third sex was lost with time.

Both the Talmud and the Tosefta, the Jewish books of law, list extensive regulations for people of mixed sex. The Tosefta expressly forbids hermaphrodites to inherit their fathers' estates (like daughters), to seclude themselves with women (like sons) or to shave (like men). When hermaphrodites menstruate they must be isolated from men (like women); they are disqualified from serving as witnesses or as priests (like women), but the laws of pederasty apply to them.

In Europe a pattern emerged by the end of the Middle Ages that, in a sense, has lasted to the present day: hermaphrodites were compelled to choose an established gender role and stick with it. The penalty for transgression was often death. Thus in the 1600s a Scottish hermaphrodite living as a woman was buried alive after impregnating his/her master's daughter.

For questions of inheritance, legitimacy, paternity, succession to title and eligibility for certain professions to be determined, modern Anglo-Saxon legal systems require that newborns be registered as either male or female. In the U.S. today sex determination is governed by state laws. Illinois permits adults to change the sex recorded on their birth certificates should a physician attest to having performed the appropriate surgery. The New York Academy of Medicine, on the other hand, has taken an opposite view. In spite of surgical alterations of the external genitalia, the academy argued in 1966, the chromosomal sex remains the same. By that measure, a person's wish to conceal his or her original sex cannot outweigh the public interest in protection against fraud.

During this century the medical community has completed what the legal world began—the complete erasure of any form of embodied sex that does not conform to a male-female, heterosexual pattern. Ironically, a more sophisticated knowledge of the complexity of sexual systems has led to the repression of such intricacy.

In 1937 the urologist Hugh H. Young of Johns Hopkins University published a volume titled *Genital Abnormalities, Hermaphroditism and Related Adrenal Diseases.* The book is remarkable for its erudition, scientific insight and open-mindedness. In it Young drew together a wealth of carefully documented case histories to demonstrate and study the medical treatment of such "accidents of birth." Young did not pass judgment on the people he studied, nor did he attempt to coerce into treatment those intersexuals who rejected that option. And he showed unusual even-handedness in referring to those people who had had sexual experiences as both men and women as "practicing hermaphrodites."

One of Young's more interesting cases was a hermaphrodite named Emma who had grown up as a female. Emma had both a penis-size clitoris and a vagina, which made it possible for him/her to have "normal" heterosexual sex with both men and women. As a teenager Emma had had sex with a number of girls to whom s/he was deeply attracted; but at the age of nineteen s/he had married a man. Unfortunately, he had given Emma little sexual pleasure (though *he* had had no complaints), and so throughout that marriage and subsequent ones Emma had kept girlfriends on the side. With some frequency s/he had pleasurable sex with them. Young describes his subject as appearing "to be quite content and even happy." In conversation Emma occasionally told him of his/her wish to be a man, a circumstance Young said would be relatively easy to bring about. But Emma's reply strikes a heroic blow for self-interest:

> Would you have to remove that vagina? I don't know about that because that's my meal ticket. If you did that, I would have to quit my husband and go to work, so I think I'll keep it and stay as I am. My husband supports me well, and even though I don't have any sexual pleasure with him, I do have lots with my girlfriends.

Yet even as Young was illuminating intersexuality with the light of scientific reason, he was beginning its suppression. For his book is also an extended treatise on the most modern surgical and hormonal methods of changing intersexuals into either males or females. Young may have differed from his successors in being less judgmental and controlling of the patients and their families, but he nonetheless supplied the foundation on which current intervention practices were built.

By 1969, when the English physicians Christopher J. Dewhurst and Ronald R. Gordon wrote *The Intersexual Disorders*, medical and surgical approaches to intersexuality had neared a state of rigid uniformity. It is hardly surprising that such a hardening of opinion took place in the era of the feminine mystique—of the post-Second World War flight to the suburbs and the strict division of family roles according to sex. That the medical consensus was not quite universal (or perhaps that it seemed poised to break apart again) can be gleaned from the near-hysterical tone of Dewhurst and Gordon's book, which contrasts markedly with the calm reason of Young's founding work. Consider their opening description of an intersexual newborn:

> One can only attempt to imagine the anguish of the parents. That a newborn should have a deformity . . . [affecting] so fundamental an issue as the very sex of the child . . . is a tragic event which immediately conjures up visions of a hopeless psychological misfit doomed to live always as a sexual freak in loneliness and frustration.

Dewhurst and Gordon warned that such a miserable fate would, indeed, be a baby's lot should the case be improperly managed; "but fortunately," they wrote, "with correct management the outlook is infinitely better than the poor parents—emotionally stunned by the event—or indeed anyone without special knowledge could ever imagine."

Scientific dogma has held fast to the assumption that without medical care hermaphrodites are doomed to a life of misery. Yet there are few empirical studies to back up that assumption, and some of the same research gathered to build a case for medical treatment contradicts it. Francies Benton, another of Young's practicing hermaphrodites, "had not worried over his condition, did not wish to be changed, and was enjoying life." The same could be said of Emma, the opportunistic hausfrau. Even Dewhurst and Gordon, adamant about the psychological importance of treating intersexuals at the infant stage, acknowledged great success in "changing the sex" of older patients. They reported on twenty cases of children reclassified into a different sex after the supposedly critical age of eighteen months. They asserted that all the reclassifications were "successful," and they wondered then whether reregistration could be "recommended more readily than [had] been suggested so far."

The treatment of intersexuality in this century provides a clear example of what the French historian Michel Foucault has called biopower. The knowledge developed in biochemistry, embryology, endocrinology, psychology and surgery has enabled physicians to control the very sex of the human body. The multiple contradictions in that kind of power call for some scrutiny. On the one hand, the medical "man-

agement" of intersexuality certainly developed as part of an attempt to free people from perceived psychological pain (though whether the pain was the patient's, the parents' of the physician's is unclear). And if one accepts the assumption that in a sex-divided culture people can realize their greatest potential for happiness and productivity only if they are sure they belong to one of only two acknowledged sexes, modern medicine has been extremely successful.

On the other hand, the same medical accomplishments can be read not as progress but as a mode of discipline. Hermaphrodites have unruly bodies. They do not fall naturally into a binary classification; only a surgical shoehorn can put them there. But why should we care if a "woman," defined as one who has breasts, a vagina, a uterus and ovaries and who menstruates, also has a clitoris large enough to penetrate the vagina of another woman? Why should we care if there are people whose biological equipment enables them to have sex "naturally" with both men and women? The answers seem to lie in a cultural need to maintain clear distinctions between the sexes. Society mandates the control of intersexual bodies because they blur and bridge the great divide. Inasmuch as hermaphrodites literally embody both sexes, they challenge traditional beliefs about sexual difference: they possess the irritating ability to live sometimes as one sex and sometimes the other, and they raise the specter of homosexuality.

But what if things were altogether different? Imagine a world in which the same knowledge that has enabled medicine to intervene in the management of intersexual patients has been placed at the service of multiple sexualities. Imagine that the sexes have multiplied beyond currently imaginable limits. It would have to be a world of shared powers. Patient and physician, parent and child, male and female, heterosexual and homosexual—all those oppositions and others would have to be dissolved as sources of division. A new ethic of medical treatment would arise, one that would permit ambiguity in a culture that had overcome sexual division. The central mission of medical treatment would be to preserve life. Thus hermaphrodites would be concerned primarily not about whether they can conform to society but about whether they might develop potentially life-threatening conditions—hernias, gonadal tumors, salt imbalance caused by adrenal malfunction—that sometimes accompany hermaphroditic development. In my ideal world medical intervention for intersexuals would take place only rarely before the age of reason; subsequent treatment would be a cooperative venture between physician, patient and other advisers trained in issues of gender multiplicity.

I do not pretend that the transition to my utopia would be smooth. Sex, even the supposedly "normal," heterosexual kind, continues to cause untold anxieties in Western society. And certainly a culture that has yet to come to grips—religiously and, in some states, legally—with the ancient and relatively uncomplicated reality of homosexual love will not readily embrace intersexuality. No doubt the most troublesome arena by far would be the rearing of children. Parents, at least since the Victorian era, have fretted, sometimes to the point of outright denial, over the fact that their children are sexual beings.

All that and more amply explains why intersexual children are generally squeezed into one of the two prevailing sexual categories. But what would be the psychological consequences of taking the alternative road—raising children as unabashed intersexuals? On the surface that tack seems fraught with peril. What, for example, would happen to the intersexual child amid the unrelenting cruelty of the school yard? When the time came to shower in gym class, what horrors and humiliations would await the intersexual as his/her anatomy was displayed in all its nontraditional glory? In whose gym class would s/he register to begin with? What bathroom would s/he use? And how on earth would Mom and Dad help shepherd him/her through the mine field of puberty?

In the past thirty years those questions have been ignored, as the scientific community has, with remarkable unanimity, avoided contemplating the alternative route of unimpeded intersexuality. But modern investigators tend to overlook a substantial body of case histories, most of them compiled between 1930 and 1960, before surgical intervention became rampant. Almost without exception, those reports describe children who grew up knowing they were intersexual (though they did not advertise it) and adjusted to their unusual sta-

ties. Some of the studies are richly detailed—described at the level of gym-class showering (which most intersexuals avoided without incident); in any event, there is not a psychotic or a suicide in the lot.

Still, the nuances of socialization among intersexuals cry out for more sophisticated analysis. Clearly, before my vision of sexual multiplicity can be realized, the first openly intersexual children and their parents will have to be brave pioneers who will bear the brunt of society's growing pains. But in the long view—though it could take generations to achieve—the prize might be a society in which sexuality is something to be celebrated for its subtleties and not something to be feared or ridiculed.

2.4 Historical, Scientific, Clinical, and Feminist Criticisms of "The Human Sexual Response Cycle" Model

Leonore Tiefer

> The sexuality that is measured is taken to be the definition of sexuality itself.
>
> —*Lionel Trilling*

The Human Sexual Response Cycle Metaphor: A Universal Machine Without a Motor

The idea of the the human sexual response cycle (HSRC) by that name was initially introduced by William Masters and Virginia Johnson (1966) to describe the sequence of physiological changes they observed and measured during laboratory-performed sexual activities such as masturbation and coitus. The goal of their research was to answer the question: "What physical reactions develop as the human male and female respond to effective sexual stimulation?" (Masters and Johnson, 1966, p. 4). Although they coined terms for their four stages, it appears that the metaphor of "the" overall sexual "cycle" was assumed from the very outset. They wrote: "A more concise picture of physiologic reaction to sexual stimuli may be presented by dividing *the human male's and female's cycles* of sexual response into four separate phases. . . . This arbitrary four-part division of *the sexual response cycle* provides an effective framework for detailed description of physiological variants in sexual reaction" (p. 4, emphasis added).

The cycle metaphor indicates that Masters and Johnson envisioned sexual response from the start as a built-in, orderly sequence of events that would tend to repeat itself. The idea of a four-stage cycle brings to mind examples such as the four seasons of the annual calendar or the four-stroke internal combustion engine. Whether the cycle is designed by human agency or "nature," once begun it cycles independently of its origins, perhaps with some variability, but without reorganization or added stages, and the same cycle applies to everyone.

The idea of a sexual response cycle has some history, although its precursors focused heavily on an element omitted from the HSRC—the idea of sexual drive. In his intellectual history of modern sexology, Paul Robinson (1976) saw the origin of Masters and Johnson's four-stage HSRC in Havelock Ellis's theme of "tumescence and detumescence."[1]

But the language of tumescence and detumescence was popular even prior to Ellis. In his analysis of Freud's theory of the libido, Frank Sulloway (1979) discussed nineteenth-century German and Austrian sexological ideas in circulation while Freud was writing. Sulloway pointed out that many sexological terms associated with Freud, such as *libido* and *erotogenic zones,* were in widespread use in European medical writings by the turn of the century, and he credited Albert Moll (then "possibly the best-known authority on sexual pathology in all of Europe" though "an obscure figure today") with originating a theory of two sexual drives—one of attraction and the other of detumescence (Sulloway, 1979, p. 302).

It is significant that, despite this long heritage of sexologic theorizing about sexual "energy," Masters and Johnson's model of sexual response did not include initiating components. Their omission of sexual drive, libido, desire, passion, and the like would return to haunt clinical sexology in the 1970s. Actually, in avoiding discussion of sexual drive, Masters

and Johnson were following a trend peculiar to sexologists (in contrast to psychiatrists and psychoanalysts) during the twentieth century. Perhaps because of the history of elaborate but vague nineteenth-century writings, perhaps because of the subjective connotations to *desire,* talk of sex drive seemed to cause nothing but confusion for modern sexual scientists interested in operational definitions. Kinsey used the term only in passing, and meant by it "sexual capacity," the capacity to respond to stimulation with physical arousal (e.g., Kinsey, Pomeroy, Martin, and Gebhard, 1953, p. 102). Sexologists could compare individuals and groups in terms of this hypothetical internal mechanism, capacity, by looking at their frequencies of sexual behavior, thresholds for response, and so on with no reference to internal experience.

Frank Beach (1956), writing during the time Masters and Johnson were beginning their physiological observations, argued that talking about sex *drive* is usually circular and unproductive and approvingly noted that even Kinsey "equates sexual drive with frequency of orgasm." Beach suggested that sexual *drive* had nothing to do with "genuine biological or tissue needs" and that the concept should be replaced by sexual *appetite,* which is "a product of experience, . . . [with] little or no relation to biological or physiological needs" (Beach, 1956, p. 4). Although the concept of appetite never caught on in sexology, the recent rediscovery of "desire" indicates that ignoring the issue of initiation of sexual behaviors did not solve the problem.

By omitting the concept of drive from their model, Masters and Johnson eliminated an element of sexuality that is notoriously variable within populations and succeeded in proposing a universal model seemingly without much variability. In what I think is the only reference to sexual drive in their text, Masters and Johnson indicated their belief that the sexual response cycle was actually an inborn drive to orgasm: "The cycle of sexual response, with orgasm as the ultimate point in progression, generally is believed to develop from a drive of biologic origin deeply integrated into the condition of human existence" (Masters and Johnson, 1966, p. 127). The cycle of sexual response, then, reflects the operation of an inborn program, like the workings of a mechanical clock. As long as the "effective sexual stimulation" (i.e., energy source) continues, the cycle proceeds through its set sequence.

Scientific Criticisms of the HSRC Model

Masters and Johnson proposed a universal model for sexual response. At no point did they talk of "a" human sexual response cycle, but only of "the" human sexual response cycle. The critique of the HSRC model begins with a discussion of the generalizability of Masters and Johnson's research results. Analysis of their work shows that the existence of the HSRC was assumed before the research began and that this assumption guided subject selection and research methods.

Subject Selection Biases: Orgasm with Coital and Masturbatory Experience

In a passage buried four pages from the end of their text, Masters and Johnson revealed that for their research they had established "a *requirement* that there be a positive history of masturbatory and coital orgasmic experience before any study subject [could be] accepted into the program" (Masters and Johnson, 1966, p. 311, emphasis added). This requirement in and of itself would seem to invalidate any notion that the HSRC is universal. It indicates that Masters and Johnson's research was designed to identify physiological functions of subjects who had experienced *particular,* preselected sexual responses. That is, rather than the HSRC being the best-fit model chosen to accommodate the results of their research, the HSRC actually guided the selection of subjects for the research.

Two popularizations of Masters and Johnson's physiological research commented on this element of subject selection but disregarded its implications for HSRC generalizability:

> Men and women unable to respond sexually and to reach orgasm were also weeded out. Since this was to be a study of sexual responses, those unable to respond could contribute little to it. (Brecher and Brecher, 1966, p. 54)

> If you are going to find out what happens, obviously you must work with those to whom it happens. (Lehrman, 1970, p. 170)

"Unable to respond"? If you want to study human singing behaviors, do you only select international recording artists? One could just as easily argue that there are many sexually active and sexually responsive men and women who do not regularly experience orgasm during masturbation and/or coitus whose patterns of physiological arousal and subjective pleasure were deliberately excluded from the sample. No research was undertaken to investigate "human" sexual physiology and subjectivity, only to measure the responses of an easily orgasmic sample. The "discovery" of the HSRC was a self-fulfilling prophecy, with the research subjects selected so as to compress diversity. The HSRC cannot be universalized to the general population.

The apparently identical performance requirements for male and female research subjects masked the bias of real-world gender differences in masturbatory experience. Masters and Johnson began their physiological research in 1954. In 1953, the Kinsey group had reported that only "58 percent of the females" in their sample had been "masturbating to orgasm at some time in their lives" (Kinsey, Pomeroy, Martin, and Gebhard, 1953, p. 143). Married women, the predominant subjects in Masters and Johnson's research, had even lower masturbatory frequencies than divorced or single women. This contrasts with the 92 percent incidence of men with masturbatory experience reported by the same researchers (Kinsey, Pomeroy, and Martin, 1948, p. 339). Masters and Johnson had to find men and women with similar sexual patterns despite having been raised in dissimilar sociosexual worlds. Obviously, because of this requirement the women research participants were less representative than the men.

Subject Selection Biases: Class Differences

Just as Masters and Johnson chose subjects with certain types of sexual experiences, they deliberately chose subjects who did not represent a cross-section of socioeconomic backgrounds. They wrote: "As discussed, the sample was weighted *purposely* toward higher than average intelligence levels and socioeconomic backgrounds. *Further selectivity* was established . . . to determine willingness to participate, facility of sexual responsiveness, and ability to communicate finite details of sexual reaction" Masters and Johnson, 1966, p. 12, emphasis added). Masters and Johnson's popularizers disparaged the possible bias introduced by this selectivity with such comments as, "The higher than average educational level of the women volunteers is hardly likely to affect the acidity of their vaginal fluids" (Brecher and Brecher, 1966, p. 60).

But one cannot simply dismiss possible class differences in physiology with an assertion that there are none. *Could* differences in social location affect the physiology of sexuality? The irony of assuming that physiology is universal and therefore that class differences make no difference is that no one conducts research that asks the question.

In fact, Kinsey and his colleagues had shown wide differences between members (especially males) of different socioeconomic classes with regard to incidence and prevalence of masturbation, premarital sexual activities, petting (including breast stimulation), sex with prostitutes, positions used in intercourse, oral-genital sex, and even nocturnal emissions. For example, "There are 10 to 12 times as frequent nocturnal emissions among males of the upper educational classes as there are among males of the lower classes" (Kinsey, Pomeroy, and Martin, 1948, p. 345). Kinsey noted, "It is particularly interesting to find that there are [great] differences between educational levels in regard to nocturnal emissions—a type of sexual outlet which one might suppose would represent involuntary behavior" (p. 343). Given this finding, doesn't it seem possible, even likely, that numerous physiological details might indeed relate to differences in sexual habits? Kinsey also mentioned class differences in latency to male orgasm (p. 580). The more the variation in physiological details among subjects from different socioeconomic backgrounds, the less the HSRC is appropriate as a universal norm.

Subject Selection Biases: Sexual Enthusiasm

Masters and Johnson concluded their physiological research text as follows: "Through the years of research exposure, the one factor in sexuality that consistently has been present among members of the

study-subject population has been a basic interest in and desire for effectiveness of sexual performance. *This one factor may represent the major area of difference between the research study subjects and the general population*" (Masters and Johnson, 1966, p. 315, emphasis added).

Masters and Johnson do not explain what they mean by their comment that "the general population" might not share the enthusiasm for sexual performance of their research subjects and do not speculate at all on the possible impact of this comment on the generalizability of their results. Whereas at first it may seem reasonable to assume that everyone has "a basic interest in and desire for effectiveness of sexual performance," on closer examination the phrase "*effectiveness* of sexual *performance*" seems not so much to characterize everyone as to identify devotees of a particular sexual style.

We get some small idea of Masters and Johnson's research subjects from the four profiles given in Chapter 19 of *Human Sexual Response* (1966). These profiled subjects were selected by the authors from the 382 women and 312 men who participated in their study. The two women described had masturbated regularly (beginning at ages ten and fifteen, respectively), had begun having intercourse in adolescence (at ages fifteen and seventeen), and were almost always orgasmic and occasionally multiorgasmic in the laboratory. For the first woman, twenty-six and currently unmarried, it was explicitly stated that "sexual activity [was] a major factor in [her] life" (Masters and Johnson, 1966, p. 304) and that she became a research subject because of "financial demand and sexual tension" (p. 305). No comparable information was given about the second woman, who was thirty-one and married, but she and her husband had "stated categorically" that they had "found [research participation] of significant importance in their marriage" (p. 307).

The unmarried male subject, age twenty-seven, was described as having had adolescent onset of masturbation, petting, and heterosexual intercourse as well as four reported homosexual experiences at different points in his life. The married man, age thirty-four, had had little sexual experience until age twenty-five. He and his wife of six years had joined the research program "hoping to acquire knowledge to enhance the sexual component of their marriage" (Masters and Johnson, 1966, p. 311). The researchers noted, "[His] wife has stated repeatedly that subsequent to [research project] participation her husband has been infinitely more effective both in stimulating and satisfying her sexual tensions. He in turn finds her sexually responsive without reservation. Her freedom and security of response are particularly pleasing to him" (p. 311).

Every discussion of sex research methodology emphasizes the effects of volunteer bias and bemoans the reliance on samples of convenience that characterizes its research literature (e.g., Green and Wiener, 1980). Masters and Johnson make no attempt to compare their research subjects with any other research sample, saying, "There are no established norms for male and female sexuality in our society . . . [and] there is no scale with which to measure or evaluate the sexuality of the male and female study-subject population" (Masters and Johnson, 1966, p. 302). Although there may not be "norms," there are other sex research surveys of attitudes and behavior. For example, volunteers for sex research are usually shown to be more liberal in their attitudes than socioeconomically comparable nonvolunteer groups (Hoch, Safir, Peres, and Shepher, 1981; Clement, 1990).

How might the sample's interest in "effective sexual performance" have affected Masters and Johnson's research and their description of the HSRC? The answer relates both to the consequences of ego-investment in sexual performance and to the impact of specialization in a sexual style focused on orgasm, and we don't know what such consequences might be. I cannot specify the effect of this sexually skewed sample any more than I could guess what might be the consequences for research on singing of only studying stars of the Metropolitan Opera. The point is that the subject group was exceptional, and only by *assuming* HSRC universality can we generalize its results to others.

Experimenter Bias in the Sexuality Laboratory

Masters and Johnson made no secret of the fact that subjects volunteering for their research underwent a period of adjustment, or a "controlled orientation program," as they called it (Masters and Johnson, 1966,

p. 22). This "period of training" helped the subjects "gain confidence in their ability to respond successfully while subjected to a variety of recording devices" (p. 23). Such a training period provided an opportunity for numerous kinds of "experimenter biases," as they are known in social psychology research, wherein the expectations of the experimenters are communicated to the subjects and have an effect on their behavior (Rosenthal, 1966). The fact that Masters and Johnson repeatedly referred to episodes of sexual activity with orgasm as "successes" and those without orgasm or without rigid erection or rapid ejaculation as "failures" (e.g., Masters and Johnson, 1966, p. 313) makes it seem highly likely that their performance standards were communicated to their subjects. Moreover, they were candid about their role as sex therapists for their subjects: "When female orgasmic or male ejaculatory failures develop in the laboratory, the *situation is discussed* immediately. Once the individual has been *reassured, suggestions* are made for improvement of future performance" (p. 314, emphasis added).

Another example of the tutelage provided is given in the quotation from the thirty-four-year-old man described in Chapter 19 of their book. He and his wife had entered the program hoping to obtain sexual instruction and seemed to have received all they expected and more. Masters and Johnson appeared to be unaware of any incompatibility between the roles of research subject and student or patient. Again, this reveals their preexisting standards for sexual response and their interest in measuring in the laboratory only sexual patterning consisting of erections, orgasms, ejaculations, whole-body physical arousal, and so on, that is, that which they already defined as sexual response.

In addition to overt instruction and feedback, social psychology alerts us to the role of covert cues. Research has shown that volunteer subjects often are more sensitive to experimenters' covert cues than are nonvolunteers (Rosenthal and Rosnow, 1969). One could speculate that sex research volunteers characterized by a "desire for effective sexual performance" may well be especially attentive to covert as well as overt indications that they are performing as expected in the eyes of the white-coated researchers.

The Bias of "Effective" Sexual Stimulation

As mentioned near the beginning of this chapter, Masters and Johnson set out to answer the question, "What physical reactions develop as the human male and female respond to effective sexual stimulation?" (Masters and Johnson, 1966, p. 4). What is "effective" sexual stimulation? In fact, I think this is a key question in deconstructing the HSRC. Masters and Johnson stated, "It constantly should be borne in mind that the primary research interest has been concentrated quite literally upon what men and women do in response to effective sexual stimulation" (p. 20).

The *intended* emphasis in this sentence, I believe, is that the authors' "primary" interest was not in euphemism, and not in vague generality, but in the "literal" physical reactions people experience during sexual activity. I think the *actual* emphasis of the sentence, however, is that the authors were interested in only one type of sexual response, that which people experience in reaction to a particular type of stimulation. Such a perspective would be akin to vision researchers only being interested in optic system responses to lights of certain wavelengths, say, red and yellow, or movement physiologists only being interested in physical function during certain activities, such as running.

In each of the book's chapters devoted to the physical reactions of a particular organ or group of organs (e.g., clitoris, penis, uterus, respiratory system), Masters and Johnson began by stating their intention to look at the responses to "effective sexual stimulation." But where is that specific type of stimulation described? Although the phrase appears dozens of times in the text, it is not in the glossary or the index, and no definition or description can be found. The reader must discover that *"effective sexual stimulation" is that stimulation which facilitates a response that conforms to the HSRC.* This conclusion is inferred from observations such as the following, taken from the section on labia minora responses in the chapter on "female external genitalia": "Many women have progressed well into plateau-phase levels of sexual response, had the effective stimulative techniques withdrawn, and been unable to achieve orgasmic-phase tension release. . . . When an

obviously effective means of sexual stimulation is withdrawn and orgasmic-phase release is not achieved, the minor-labial coloration will fade rapidly" (Masters and Johnson, 1966, p. 41).

Effective stimulation is that stimulation which facilitates "progress" from one stage of the HSRC to the next, particularly that which facilitates orgasm. Any stimulation resulting in responses other than greater physiological excitation and orgasm is defined by exclusion as "ineffective" and is not of interest to these authors.

This emphasis on "effective stimulation" sets up a tautology comparable to that resulting from biased subject selection. The HSRC cannot be a scientific *discovery* if the acknowledged "primary research interest" was to study stimulation defined as that which facilitates the HSRC. Again, the HSRC, "with orgasm as the ultimate point in progression" (Masters and Johnson, 1966, p. 127), preordained the results.

Clinical Criticisms of the HSRC Model

The HSRC model has had a profound impact on clinical sexology through its role as the centerpiece of contemporary diagnostic nomenclature. In this section, I will first discuss how contemporary nomenclature came to rely on the HSRC model and then describe what I see as several deleterious consequences.

HSRC and the DSM Classification of Sexual Disorders

I have elsewhere detailed the development of sexual dysfunction nosology in the four sequential editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (Tiefer, 1992). Over a period of thirty-five years, the nosology evolved from not listing sexual dysfunctions at all (APA, 1952, or *DSM-I*) to listing them as symptoms of psychosomatic disorders (APA, 1968, or *DSM-II*), as a subcategory of psychosexual disorders (APA, 1980, or *DSM-III*), and as a subcategory of sexual disorders (APA, 1987, or *DSM-III-R*).

The relation of this nosology to the HSRC language can be seen in the introduction to the section on sexual dysfunctions (identical in both *DSM-III* and *DSM-III-R*):[2]

> The *essential feature* is inhibition in the appetitive or psychophysiological changes that characterize *the complete sexual response cycle.* The complete sexual response cycle can be divided into the following phases: 1. Appetitive. This consists of fantasies about sexual activity and a desire to have sexual activity. 2. Excitement. This consists of a subjective sense of sexual pleasure and accompanying physiological changes. . . . 3. Orgasm. This consists of a peaking of sexual pleasure, with release of sexual tension and rhythmic contraction of the perineal muscles and pelvic reproductive organs. . . . 4. Resolution. This consists of a sense of general relaxation, well-being, and muscular relaxation. (APA, 1987, pp. 290–291, emphasis added)

In fact, this cycle is not identical to Masters and Johnson's HSRC (although it, too, uses the universalizing language of "the" sexual response cycle). The first, or appetitive, phase was added when sexologists confronted clinical problems having to do with sexual disinterest. In their second book (1970), Masters and Johnson loosely used their HSRC physiological research to generate a list of sexual dysfunctions: premature ejaculation, ejaculatory incompetence, orgasmic dysfunction (women's), vaginismus, and dyspareunia (men's and women's). These were put forth as deviations from the HSRC that research had revealed as the norm. By the late 1970s, however, clinicians were describing a syndrome of sexual disinterest that did not fit into the accepted response cycle. Helen Singer Kaplan argued that a "separate phase [sexual desire] which had previously been neglected, must be added for conceptual completeness and clinical effectiveness" (Kaplan, 1979, p. xviii). *DSM-III* and *DSM-III-R* then merged the original HSRC with the norm of sexual desire to generate "the complete response cycle" presented above.

Clearly, the idea and much of the language of the nosology derived from Masters and Johnson's work, and in fact they are cited in the *DSM* footnotes as the primary source. Is it appropriate to use the HSRC to generate a clinical standard of normality? Is it appropriate to enshrine the HSRC as the standard of human

sexuality such that deviations from it become the essential feature of abnormality?

Let us briefly examine how sexual problems are linked to mental disorders in the *DSM* and how the HSRC was used in the sexuality section. The definition of mental disorder offered in *DSM-III* specifies:

> In *DSM-III* each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more areas of function (disability). In addition, there is an inference that there is a behavioral, psychological or biological dysfunction. (APA, 1980, p. 6)

In an article introducing the new classification scheme to the psychiatric profession, the APA task force explained their decisions. With regard to sexual dysfunctions, the task force members had concluded that "inability to experience *the normative sexual response cycle* [emphasis added] represented a *disability* in *the important area* of sexual functioning, whether or not the individual was distressed by the symptom" (Spitzer, Williams, and Skodol, 1980, pp. 153–154). That is, deviation from the now-normative sexual response cycle was to be considered a disorder even if the person had no complaints.

The diagnostic classification system clearly assumed that the HSRC was a universal bedrock of sexuality. Yet I have shown that it was a self-fulfilling result of Masters and Johnson's methodological decisions rather than a scientific discovery. It was the result of a priori assumptions rather than empirical research. Arguably, a clinical standard requires a greater demonstration of health impact and universal applicability than that offered by Masters and Johnson's research.

In fact, it is likely the case that the *DSM* authors adopted the HSRC model because it was useful and convenient. Professional and political factors that probably facilitated the adoption include professional needs within psychiatry to move away from a neurosis disorder model to a more concrete and empirical model, legitimacy needs within the new specialty of sex therapy, and the interests of feminists in progressive sexual standards for women (Tiefer, 1992b). Thus, the enshrinement of the HSRC and its upgraded versions as the centerpiece of sexual dysfunction nomenclature in *DSM-III* and *DSM-III-R* is not scientifically reliable and represents a triumph of politics and professionalism.

Sexuality as the Performances of Fragmented Body Parts

One deleterious clinical consequence of the utilization of the HSRC model as the sexual norm has been increased focus on segmented psychophysiological functioning. Just for example, consider the following disorder descriptions, which appear in *DSM-III-R:*

1. "partial or complete failure to attain or maintain the lubrication-swelling response of sexual excitement [Female Arousal Disorder]"
2. "involuntary spasm of the musculature of the outer third of the vagina that interferes with coitus [Vaginismus]"
3. "inability to reach orgasm in the vagina [Inhibited Male Orgasm]"

In the current nosology, the body as a whole is never mentioned but instead has become a fragmented collection of parts that pop in and out at different points in the performance sequence. This compartmentalization lends itself to mechanical imagery, to framing sexuality as the smooth operation and integration of complex machines, and to seeing problems of sexuality as "machines in disrepair" that need to be evaluated by high-technology part-healers (Soble, 1987). If there is a sexual problem, check each component systematically to detect the component out of commission. Overall satisfaction (which is mentioned nowhere in the nosology) is assumed to be a result of perfect parts-functioning. Recall that subjective distress is not even required for diagnosis, just objective indication of deviation from the HSRC.

This model promotes the idea that sexual disorder can be defined as deviation from "normal" as indicated by medical test results. A bit of thought, however, will show that identifying proper norms for these types of measurements is a tricky matter. How rigid is rigid? How quick is premature? How delayed is delayed? The

answers to these questions are more a product of expectations, cultural standards, and particular partner than they are of objective measurement. And yet a series of complex and often invasive genital measurements are already being routinely used in evaluations of erectile dysfunction (Krane, Goldstein, and DeTejada, 1989). Norms for many of the tests are more often provided by medical technology manufacturers than by scientific research, and measurements on nonpatient samples are often lacking. Despite calls for caution in use and interpretation, the use of sexuality measurement technology continues to escalate (Burris, Banks, and Sherins, 1989; Kirkeby, Andersen, and Poulson, 1989; Schiavi, 1988; Sharlip, 1989).

This example illustrates a general medical trend: While reliance on tests and technology for objective information is increasing, reliance on patients' individualized standards and subjective reports of illness is decreasing (Osherson and AmaraSingham, 1981). The end result may be, as Lionel Trilling (1950) worried in a review of the first Kinsey report, that "the sexuality that is measured is taken to be the definition of sexuality itself" (p. 223). Although it seems only common sense and good clinical practice to want to "rule out" medical causes prior to initiating a course of psychotherapeutic or couple treatment for sexual complaints, such "ruling out" has become a growth industry rather than an adjunct to psychological and couple-oriented history-taking. Moreover, there is a growing risk of iatrogenic disorders being induced during the extensive "ruling out" procedures.

The HSRC has contributed significantly to the idea of sexuality as proper parts-functioning. Masters and Johnson's original research can hardly be faulted for studying individual physiological components to answer the question, "What physical reactions develop as the human male and female respond to effective sexual stimulation?" But once the physiological aspects became solidified into a universal, normative sequence known as "the" HSRC, the stage was set for clinical preoccupation with parts-functioning. Despite Masters and Johnson's avowed interest in sexuality as communication, intimacy, self-expression, and mutual pleasuring, their clinical ideas were ultimately mechanical (Masters and Johnson, 1975).

Exclusive Genital (i.e., Reproductive) Focus for Sexuality

"Hypoactive sexual desire" is the only sexual dysfunction in the *DSM-III-R* defined without regard to the genital organs. "Sexual aversion," for example, is specifically identified as aversion *to the genitals.* The other sexual dysfunctions are defined in terms of *genital* pain, spasm, dryness, deflation, uncontrolled responses, delayed responses, too-brief responses, or absent responses. The *DSM* locates the boundary between normal and abnormal (or between healthy and unhealthy) sexual function exclusively on genital performances.

"Genitals" are those organs involved in acts of generation, or biological reproduction. Although the *DSM* does not explicitly endorse reproduction as the primary purpose of sexual activity, the genital focus of the sexual dysfunction nosology implies such a priority. The only sexual acts mentioned are coitus, [vaginal] penetration, sexual intercourse, and noncoital clitoral stimulation. Only one is not a heterosexual coital act. Masturbation is only mentioned as a "form of stimulation." Full *genital performance during heterosexual intercourse is the essence of sexual functioning,* which excludes and demotes nongenital possibilities for pleasure and expression. Involvement or noninvolvement of the nongenital body becomes incidental, of interest only as it impacts on genital responses identified in the nosology.

Actually, the HSRC is a whole-body response, and Masters and Johnson were as interested in the physiology of "extragenital" responses as genital ones. Yet the stages of the HSRC as reflected in heart rate or breast changes did not make it into the *DSM*s. As Masters and Johnson transformed their physiological cycle into a clinical cycle, they privileged a reproductive purpose for sexuality by focusing on the genitals. It would seem that once they turned their interest to sexual problems rather than sexual process, their focus shifted to *sexuality as outcome.*

There is no section on diagnosis in Masters and Johnson's second, clinical, book (1970), no definition of normal sexuality, and no hint of how the particular list of erectile, orgasmic, and other genitally focused disorders was derived. The authors merely described

their treatments of "the specific varieties of sexual dysfunction that serve as presenting complaints of patients referred" (Masters and Johnson, 1970, p. 91). But surely this explanation cannot be the whole story. Why did they exclude problems like "inability to relax, . . . attraction to partner other than mate, . . . partner chooses inconvenient time, . . . too little tenderness" or others of the sort later labeled "sexual difficulties" (Frank, Anderson, and Rubinstein, 1978)? Why did they exclude problems like "partner is only interested in orgasm, . . . partner can't kiss, . . . partner is too hasty, . . . partner has no sense of romance," or others of the sort identified in surveys of women (Hite, 1976)?

In fact, the list of disorders proposed by Masters and Johnson seems like a list devised by Freudians who, based on their developmental stage theory of sexuality, define genital sexuality as the sine qua non of sexual maturity. Despite the whole-body focus of the HSRC physiology research, the clinical interest of its authors in proper genital performance as the essence of normal sexuality indicates their adherence to an earlier tradition. The vast spectrum of sexual possibility is narrowed to genital, that is, to reproductive performance.

Symptom Reversal as the Measure of Sex Therapy Success

A final undesirable clinical consequence of the HSRC and its evolution in the *DSM* is the limitation it imposes on the evaluation of therapy success. Once sexual disturbances are defined as specific malperformances within "the" sexual response cycle, evaluation of treatment effectiveness narrows to symptom reversal.

But the use of symptom reversal as the major or only measure of success contrasts with sex therapy as actually taught and practiced (Hawton, 1985). Typical practice focuses on individual and relationship satisfaction and includes elements such as education, permission-giving, attitude change, anxiety reduction, improved communication, and intervention in destructive sex roles and life-styles (LoPiccolo, 1977). A recent extensive survey of 289 sex therapy providers in private practice reinforced the statement that "much of sex therapy actually was nonsexual in nature" and confirmed that therapy focuses on communication skills, individual issues, and the "nonsexual relationship" (Kilmann et al., 1986).

Follow-up studies measuring satisfaction with therapy and changes in sexual, psychological, and interpersonal issues show varying patterns of improvement, perhaps because therapists tend to heedlessly lump together cases with the "same" symptom. It is erroneous to assume that couples and their experience of sex therapy are at all homogeneous, despite their assignment to specific and discrete diagnostic categories based on the HSRC. Citing his own "painful experience" (Bancroft, 1989, p. 489) with unreplicable results of studies comparing different forms of treatment, John Bancroft suggested that there is significant prognostic variability among individuals and couples even within diagnostic categories. He concluded, "It may be that there is no alternative to defining various aspects of the sexual relationship, e.g., sexual response, communication, enjoyment, etc. and assessing each separately" (p. 497).

It might be thought that using symptom reversal as the measure of success is easier than evaluating multiple issues of relationship satisfaction, but this is not true, since *any* measure of human satisfaction needs to be subtle. That is, it is indeed easy to measure "success" with objective technologies that evaluate whether a prosthesis successfully inflates or an injection successfully produces erectile rigidity of a certain degree. When evaluating the human success of physical treatments, however, researchers invariably introduce complex subjective elements. The questions they select, the way they ask the questions, and their interpretations of the answers are all subjective (Tiefer, Pedersen, and Melman, 1988). In evaluating patients' satisfaction with penile implant treatment, asking the patients whether they would have prosthesis surgery again produces different results from evaluating postoperative satisfaction with sexual frequency, the internal feeling of the prosthesis during sex, anxieties about the indwelling prosthesis, changes in relationship quality, and so on.

The present diagnostic nomenclature, based on the genitally focused HSRC, results in evaluation of treatment success exclusively in terms of symptom reversal and ignores the complex sociopsychological context of sexual performance and experience. The neat

four-stage model, the seemingly clean clinical typology, all result in neat and clean evaluation research—which turns out to relate only partially to real people's experiences.

Feminist Criticisms of the HSRC Model

Paul Robinson (1976) and Janice Irvine (1990) have discussed at length how Masters and Johnson deliberately made choices throughout *Human Sexual Response* and *Human Sexual Inadequacy* to emphasize male-female sexual similarities. The most fundamental similarity, of course, was that men and women had identical HSRCs. The diagnostic nomenclature continues this emphasis by basing the whole idea of sexual dysfunction on the gender-neutral HSRC and by scrupulously assigning equal numbers and parallel dysfunctions to men and women. (Desire disorders are not specified as to gender; other dysfunctions include one arousal disorder for each gender, one inhibited orgasm disorder for each gender, premature ejaculation for men and vaginismus for women, and dyspareunia, which is defined as "recurrent or persistent genital pain in either a male or a female.")

Yet, is the HSRC really gender-neutral? Along with other feminists, I have argued that the HSRC model of sexuality, and its elaboration and application in clinical work, favors men's sexual interests over those of women (e.g., Tiefer, 1988). Some have argued that sex role socialization introduces fundamental gender differences and inequalities into adult sexual experience that cannot be set aside by a model that simply proclaims male and female sexuality as fundamentally the same (Stock, 1984). I have argued that the HSRC, with its alleged gender equity, disguises and trivializes *social* reality, that is, gender inequality (Tiefer, 1990a) and thus makes it all the harder for women to become sexually equal in fact.

Let's look briefly at some of these gender differences in the real world. First, to oversimplify many cultural variations on this theme, men and women are raised with different sets of sexual values—men toward varied experience and physical gratification, women toward intimacy and emotional communion (Gagnon, 1977; Gagnon, 1979; Gagnon and Simon, 1969; Simon and Gagnon, 1986). By focusing on the physical aspects of sexuality and ignoring the rest, the HSRC favors men's value training over women's. Second, men's greater experience with masturbation encourages them toward a genital focus in sexuality, whereas women learn to avoid acting on genital urges because of the threat of lost social respect. With its genital focus, the HSRC favors men's training over women's. As has been mentioned earlier, by requiring experience and comfort with masturbation to orgasm as a criterion for all participants, the selection of research subjects for *Human Sexual Response* looked gender-neutral but in fact led to an unrepresentative sampling of women participants.

Third, the whole issue of "effective sexual stimulation" needs to be addressed from a feminist perspective. As we have seen, the HSRC model was based on a particular kind of sexual activity, that with "effective sexual stimulation." Socioeconomic subordination, threats of pregnancy, fear of male violence, and society's double standard reduce women's power in heterosexual relationships and militate against women's sexual knowledge, sexual assertiveness, and sexual candor (Snitow, Stansell, and Thompson, 1983; Vance, 1984). Under such circumstances, it seems likely that "effective sexual stimulation" in the laboratory or at home favors what men prefer.

The HSRC assumes that men and women have and want the same kind of sexuality since physiological research suggests that in some ways, and under selected test conditions, we are built the same. Yet social realities dictate that we are not all the same sexually—not in our socially shaped wishes, in our sexual self-development, or in our interpersonal sexual meanings. Many different studies—from questionnaires distributed by feminist organizations to interviews of self-defined happily married couples, from popular magazine surveys to social psychologists' meta-analyses of relationship research—show that women rate affection and emotional communication as more important than orgasm in a sexual relationship (Hite, 1987; Frank, Anderson, and Rubinstein, 1978; Tavris and Sadd, 1977; Peplau and Gordon, 1985). Given this evidence, it denies women's voices entirely to continue to insist that sexuality is best represented by the universal "cycle of sexual response,

with orgasm as the ultimate point in progression" (Masters and Johnson, 1966, p. 127).

Masters and Johnson's comparisons of the sexual techniques used by heterosexual and homosexual couples can be seen to support the claim that "effective sexual stimulation" simply means what men prefer. Here are examples of the contrasts:

> The sexual behavior of the married couples was far more performance-oriented. . . . Preoccupation with orgasmic attainment was expressed time and again by heterosexual men and women during interrogation after each testing session. . . . [By contrast] the committed homosexual couples *took their time* in sexual interaction in the laboratory. . . . In committed heterosexual couples' interaction, the male's sexual approach to the female, . . . rarely more than 30 seconds to a minute, were spent holding close or caressing the total body area before the breasts and/or genitals were directly stimulated. This was considerably shorter than the corresponding time interval observed in homosexual couples. (Masters and Johnson, 1979, pp. 64–65, 66)

After describing various techniques of breast stimulation, the authors reported that heterosexual women enjoyed it much less than lesbians but that "all the [heterosexual] women thought that breast play was very important in their husband's arousal" (p. 67). The authors repeatedly emphasized that the differences between lesbian and heterosexual techniques were greater than between heterosexual and male homosexual techniques.[3]

The enshrinement of the HSRC in the *DSM* diagnostic nomenclature represented the ultimate in context-stripping, as far as women's sexuality is concerned. To speak merely of desire, arousal, and orgasm as constitutive of sexuality and ignore relationships and women's psychosocial development is to ignore women's experiences of exploitation, harassment, and abuse and to deny women's social limitations. To reduce sexuality to the biological specifically disadvantages women, feminists argue, because women as a class are disadvantaged by *social* sexual reality (Laws, 1990; Hubbard, 1990; Birke, 1986).

Finally, the biological reductionism of the HSRC and the *DSM* is subtly conveyed by their persistent use of the terms *males* and *females* rather than *men* and *women.* There are no men and no women in the latest edition of the diagnostic nomenclature, only males and females and vaginas and so forth. In *Human Sexual Response,* men and women appear in the text from time to time, but only males and females make it to the chapter headings, and a rough count of a few pages here and there in the text reveals a 7:1 use of the general animal kingdom terms over the specifically human ones. A feminist deconstruction of the HSRC and of contemporary perspectives on sexuality could do worse than begin by noticing and interpreting how the choice of vocabulary signals the intention to ignore culture.

CONCLUSION

I have argued in this chapter that the human sexual response cycle (HSRC) model of sexuality is flawed from scientific, clinical, and feminist points of view. Popularized primarily because clinicians and researchers needed norms that were both objective and universal, the model is actually neither objective nor universal. It imposes a false biological uniformity on sexuality that does not support the human uses and meanings of sexual potential. The most exciting work in sex therapy evolves toward systems analyses and interventions that combine psychophysiological sophistication with respect for individual and couple diversity (e.g., Verhulst and Heiman, 1988). Subjective dissatisfactions are seen more as relative dyssynchronies between individuals or between elements of culturally based sexual scripts than as malfunctions of some universal sexual essence.

Defining the essence of sexuality as a specific sequence of physiological changes promotes biological reductionism. Biological reductionism not only separates genital sexual performance from personalities, relationships, conduct, context, and values but also overvalues the former at the expense of the latter. As Abraham Maslow (1966) emphasized, studying parts may be easier than studying people, but what do you understand when you're through? Deconstructing and desacralizing the HSRC should help sex research unhook itself from the albatross of biological reductionism.

NOTES

1. Robinson suggests that Masters and Johnson's "scheme of four phases" is "irrelevant" and "merely creates the impression of scientific precision where none exists" (Robinson, 1976, p. 130). The reader is referred to his dissection of the model's stages.

2. The same introduction persists in the just-released *DSM-IV* (APA, 1994). See Chapter 10, note 1, for further information about *DSM-IV*.

3. Again, it must be emphasized that subject selection plays a large role, as acknowledged by Masters and Johnson: "Study subjects were selected because they were specifically facile in sexual response. . . . The carefully selected homosexual and heterosexual study subjects employed in the Institute's research programs must not be considered representative of a cross-section of sexually adult men and women in our culture" (Masters and Johnson, 1979, pp. 61–62).

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