Women's Understandings of Sexuality, Sex and Sexual Problems: an Interview Study

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Abstract

Background
There are a paucity of studies that address women's own understandings of sexuality and sexual problems. Much of the research and theory which underpin current diagnostic criteria for sexual problems is based upon a set of sexual norms which are predicated upon male experience. Moreover, these dominant understandings, entrenched in a perspective that favours the material body, fail to take account of contextual factors of women's experiences.

Objectives
Within a diverse sample of women: to examine understandings of sexuality and sexual problems; explore the importance of sexual activity using their own definitions; and identify the influence of wider socio-cultural factors upon understandings of sexuality and sexual problems.

Methods
In-depth semi-structured interviews were conducted with thirteen women recruited from the general public and ten women recruited from a psychosexual clinic aged 23-72 years.

Data analysis
Data were analysed thematically using the conventions of template analysis within a material-discursive framework.

Findings
The findings of this study suggest that women's understandings of sexuality, sex and sexual problems should be understood as bodily 'experienced' *and* socially and psychologically mediated. Participants also appear to be influenced by the relational context of their experience and draw upon a patriarchal explanatory framework to make sense of their own sexual functioning and satisfaction.

Conclusions
This study poses a challenge to the recent drive to medicalise women's sexual problems via the Female Sexual Dysfunction (FSD) label. The findings dispute current diagnostic criteria for sexual problems which presuppose a highly individualized framework and take very little account of contextual factors. Consequently, this study concludes that such criteria need to consider biological, social, psychological as well as patriarchal and historical factors in determining the meaning and importance of sexuality, sex and sexual problems to women.

Acknowledgements

I would like to give a considerable thank you to those women who agreed to take part in this study. Without their participation, this thesis would not have been made possible. I am privileged to have had the opportunity to meet with them and listen to some of their innermost stories and feelings with someone whom, to all intents and purposes, was a comparative stranger.

I would also like to take this opportunity to express my sincere gratitude to Ms Julie-Anne Dooley from Pfizer Pharmaceuticals Inc. for providing an unrestricted educational grant enabling this thesis to achieve fruition. To Dr Merryn Gott and Professor Paula Nicolson as my supervisors for their advice, guidance, time and unwavering patience. I would also like to thank Dr Sharron Hinchliff for agreeing to act as a third supervisor and for lending an ear when times were difficult.

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Preface

Towards the end of the third year of a four year undergraduate bachelor degree programme in mental health nursing, I have extraordinarily vivid memories of sitting in a seminar room in the medical school of a large teaching hospital with all the other nursing students from my cohort to discuss ideas for our dissertation. Having branched off to pursue our individual specialist programmes in either care of the adult, care of the child or mental health nursing the previous year, we all met up again before the Summer holidays to share our ideas and present a brief outline of our proposed dissertation topic. The only guidance we had been given prior to that meeting was to decide on a topic applicable to the context of nursing which would maintain our interest for the duration of the study.

One by one, all of the students were asked to suggest a title for their study, a brief outline of the methods they intended to use and its relevance to nursing practice. Each title was subsequently written down on a large white board for students and staff alike to comment upon the feasibility (or otherwise) of the study within the given time period required to complete the study. When it came to the turn of the mental health branch students to provide their summary titles and the rationale for their study, we were met with what can only be described as a mixture of bewilderment and amusement from the other students and some of the staff. Our research proposals were in complete contrast to those suggested by students pursuing branches of nursing in the care of the adult and care of the child and ranged from topics that explored lunar cycles of madness, media

representations of mental illness and the effects of different types of music on peoples' mental state.

The study that I had decided upon was provisionally entitled *'Cottaging: culture, conflict and community. The attractions and anxieties of men who have sex with other men in public toilets'* (Bellamy, 1997). Despite the heady mixture of amusement and derision this topic elicited from fellow students and members of staff alike, I was able to support its relevance to nursing practice on the basis that an improved knowledge of this behaviour was fundamental to understanding and promoting the sexual health needs of a group of men who engaged in this clandestine, and at times, potentially dangerous activity. On the basis of the reaction that the title received, I decided that from the day of the study's inception to the day that it was submitted, it would remain unaltered. In brief, the study was qualitative and used a technique known as 'snowballing' to recruit participants to take part in a semi-structured interview. It was a study that I considered to be innovative and it was nominated for, and went on to win a prize for 'Outstanding Contribution to the Bachelor of Nursing Degree Programme'.

My interest in the concept of sexuality continued throughout my first post as a staff grade nurse on a 15 bedded assessment unit for older people with mental health difficulties. Indeed, something that struck me almost immediately on taking up this post was the very small space on the admission form that was reserved for the nurses' subjective observations of the patient's 'sexuality'. With hindsight, the observations which were documented for this component of the assessment varied noticeably between nurses. On

numerous occasions, it would be left empty, implying that the nurse responsible for completing that part of the assessment perceived a patient to be completely devoid of 'sexuality'. Some of the other nurses on the unit would customarily take an individuals' appearance to be indicative of their sexuality i.e. 'wears make up', 'goes to the hairdresser once a week' or 'makes the most of their appearance'. Other entries such as 'lives with husband and has two children' were more commonplace and were seen to imply the patients' sexual orientation. The broad spectrum of entries found in patients' nursing notes, or their omission, appeared suggestive to me of the multiple meanings that sexuality conferred and the difficulties nurses were experiencing in trying to isolate a distinct meaning of the concept.

In addition, my attention was drawn to the ways in which the two psychiatrists with in-patient beds on the unit made use of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association (APA, 2000). It has often been referred to as the psychiatrists 'bible' and was originally developed as a tool to provide uniformity between mental health practitioners in terms of the diagnoses applied to their patients. I became aware that whilst one consultant was resolutely entrenched within a medical model and used the DSM to routinely direct her practice, the other psychiatrist appeared more receptive of likely social, environmental and cultural factors in the aetiology and outcomes of mental health difficulties affecting her patients. This fed into an interest I had regarding the ways in which sexuality is classified by the manual.

Indeed, as a gay man, having been introduced to this manual at an early stage in my nurse training, it has always been something that I have been especially wary of. Had it not been for the removal of homosexuality as a psychiatric anomaly from the DSM in 1973, I too would still be considered both mentally and sexually dysfunctional. I also became increasingly aware that the ways in which sexuality, and specifically sexual 'dysfunctions'[1] as they are referred to in this manual, were categorised did not reflect the ways in which people lived their lives and that little was known of the 'patient' perspective. On the basis of those experiences, and with a keen interest in academic inquiry, I applied for a PhD studentship which explored the topic of women's sexuality and sexual problems. I chose to focus upon the views of women for the reason that their views tend to be subordinated to those of men's.

This research is opportune given the resurgence of interest in recent years in women's sexual problems and the growing trend towards the medicalisation of sexuality (Tiefer, 1996; Hart and Wellings, 2002). This has occurred partly as a result of the development of new pharmacological treatments for erectile problems (and attempts to develop comparable drugs for women), but it also reflects the increasing importance attached to sex in society generally and the ways in which sex is promoted within the medical and nursing literature, often unproblematically in ways that acclaim its potential health benefits (Davey Smith et al, 1997). Hart and Wellings (2002) argue that celibacy is now viewed as the new sexual deviancy and identify that the decision not to engage in an active sex life is considered as 'dysfunctional'.

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[1] Given the negative undertones associated with the term 'dysfunction' it is important for me to acknowledge at this point that it is not my perspective. Instead, I favour the term 'women's sexual problems'.

These issues have gathered, and then lost momentum, very quickly in recent years as has been evidenced by an online debate in the *British Medical Journal* (BMJ) initiated by Moynihan (2003) in an article that discussed the medicalisation of women's sexual concerns and, in particular, the emergent diagnostic label of 'female sexual dysfunction' (FSD). One such response, written by Nicolson (2003) asserted that asking women their personal views of what constitutes 'normal' and healthy 'sex' for women would enable us to move away from a set of noticeably Victorian and patriarchal ideas that continue to inform research and pervade popular opinion. It was this argument that helped me decide how to approach the topic as a researcher. As Nicolson (2003: p.39) states:

'It is vitally important for women's voices to be clearly heard...What is required now for the debate about FSD to be in any sense meaningful is for research to be conducted with a cross section of ordinary women of different ages, social classes and backgrounds asking them about their experiences, desires and beliefs about normal sexuality and sexual satisfaction. We need to disentangle beliefs about normality that women...hold and measure themselves against from what women see as pleasurable. It is only when we have better data that we will be able to make claims about sexual normality and what constitutes FSD'.

With this context in mind, the aims of the study presented in this thesis are as follows:

1. To examine the meaning of sex, sexuality and sexual problems to women;

2. To explore the importance of (self-defined) sexual activity to women;

3. To identify the influence of wider socio-cultural factors upon women's understandings of sex, sexuality and sexual problems.

The thesis is presented in seven chapters. Chapter 1 begins with a review of the literature which focuses upon historical understandings of female sexuality and sexual problems. It includes an examination of the work of those theorists considered to be influential in establishing how these matters have come to be understood within contemporary Western society (Robinson, 1989). The second part of this chapter pays attention to the way in which women's sexual problems have been classified and it includes a review (and critique) of those studies which report prevalence data relating to women's sexual problems. The remainder of this chapter discusses the small number of studies which examine women's views of sex and sexual problems.

Chapter 2 articulates the theoretical framework used to guide this study and Chapter 3 identifies the methods used for data collection. This chapter provides a step-by-step account of conducting the study revealing the need for reflexivity in the research process. Chapters 4, 5 and 6 present the empirical findings from the study including participants' views of sexuality and sex, the importance of sex and their views of sexual problems respectively. Chapter 7, the discussion, makes connections between the literature and participants' own accounts as well as drawing together the findings and conclusions of this study and my ideas for further research.

Chapter 1

A) Understandings of Sexuality, Sex and Sexual Problems: A Review of the Literature Relating to Women

This chapter is divided into two parts. The first part traces the development of knowledge claims in relation to women's sexuality by focusing upon the work of key theorists responsible for creating those sexual 'norms' which inform both 'scientific' and taken for granted understandings of female sexuality within contemporary society. This discussion provides the context for the second half of this chapter which examines how women's sexual problems have been defined and classified according to these 'norms', as well as exploring the, albeit limited, literature which captures women's own understandings of sexuality and sexual problems.

The questions that guide this literature review include:

1) What is understood by the term sexuality within contemporary society?;

2) How have these understandings of sexuality been arrived at?;

3) What do we mean when we talk about sexual problems? and finally;

4) To what extent do contemporary diagnostic criteria reflect women's own understandings of sexual problems.

Throughout this review, particular attention will be paid to examining taken for granted understandings related to sexuality and sexual problems. Tracing the development of these understandings, I focus initially on the theorists Sigmund Freud, Havelock Ellis,

Alfred Kinsey, William Masters and Virginia Johnson. According to Robinson (1989), these are the theorists who have been responsible for the development of the study of sex as a modern science. As a result, much of what is deemed as knowledge about women's sexuality today can be traced back to their work (Ibid.). Indeed, self proclaimed as being devoted to establishing scientific proof of what is normal and natural in terms of sexual identity and behaviour (Abbott et al 2005), these theorists have been influential in both establishing and promoting how sex, sexuality and sexual problems are understood within contemporary Western society.

Sexology, the scientific study of sex, provided a radical social movement which freed sexuality away from its close association with religious and moral doctrine (Ibid.). Focusing instead on the 'scientific' study of sexuality, religious moralism and authoritarian codes were deemed to be dissolved in the light of this new scientific reason. However, whilst sexology lent scientific credibility to this movement, feminist critics have argued that patriarchal definitions of 'normal' sexuality (Ibid.) remain clearly identifiable.

The second half of this chapter examines those studies that relate specifically to the classification of women's sexual problems and the concomitant debate about the value of this taxonomy- both in professional terms and in relation to the implications that this has for those women who are diagnosed with a sexual problem. Studies that have explored women's own understandings of sexuality, sex and sexual problems are discussed towards the end of the chapter and they form the springboard for the remainder of the

thesis. In the main, these have been conducted by feminist theorists who have challenged existing knowledge in relation to sex and sexual problems. As a result, they focus upon aspects of sexual life which are positioned predominantly within personal, relational and cultural areas, rather than being couched primarily in physiological terms.

Operational Definitions and Concepts: Sexuality and Sex

The starting point of this thesis is to explore what the term sexuality means and how it has come to be so defined. Tiefer (1991) maintains that one of *the* most difficult aspects pertaining to the investigation of human sexuality is the task of defining the subject in a tangible way. The following quote highlights the ambiguous and multi-faceted nature of the concept:

> *'Sexuality will be defined here as a broadly based term that indicates any combination of sexual behaviour, sensual activity, emotional intimacy, or sense of sexual identity. Any individual's wish to engage in any these activities may also be considered an aspect of sexuality. Sexuality may involve sexual activity with the explicit goal of achieving pleasure of climax (e.g. kissing, foreplay, intercourse), sensual activity with or without the explicit goal of achieving sexual pleasure (e.g. wearing body lotion to feel attractive or feminine), or the experience of emotional intimacy within the context of a romantic relationship. Thus sexuality incorporates a vast number of issues including body image, masturbation, love, libido, intercourse, homophobia, relationship satisfaction, marital satisfaction, desires for sensual and sexual experience, and participation in high risk behaviours'.* (Hillman, 2000: pp. 5-6)

From an historical perspective, the complexities involved in defining the term sexuality have been brought to light by the work of Foucault. Foucault (1978) claimed that sexualities are constantly produced, changed and modified and that the nature of sexual discourse and experience change accordingly. He also maintained that sexuality was a relatively new concept which did not appear until the beginning of the nineteenth century, effectively problematising the very category of sexuality itself (Foucault, 1978: p. 105):

'Sexuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries to gradually uncover. It is the name that can be given to an historical construct'.

Consequently, he cautions that the term sexuality *'should neither be overestimated nor over interpreted'* (Ibid. p.3). Weeks' (1985; 1986) work on the history and sociology of sexuality has also been influential in this debate. Both Foucault and Weeks are concerned with tracing the historical trajectory of shifting meanings that have produced current understandings of sex and sexuality, and hence, with the social and political conditions that produce certain kinds of sexual subjects. This literature calls in to question the assumption that sexuality is a powerful and natural instinct or energy, driven by a *'biological mandate which presses against and must be constrained by the cultural matrix'* (Weeks, 1986: p. 24). Moreover, it focuses explicitly on meaning, and on social, cultural and historical contexts. Thus, this literature seeks to describe and explain subjective experience rather than to quantify and predict it.

Consequently, it can be argued that, from this perspective, the concept of 'sexuality' is '*a product of diverse influences and social interventions. It does not exist outside history but is a product of it*' (Weeks, 1986: p. 31). Weeks (Ibid: p.15) has also suggested that sexuality exists as *'a palpable social presence and that it is an historical construction which brings together a host of different biological and mental capacities- gender identity, bodily differences, reproductive capacities, needs, desires and fantasies which need not be linked together'*. In doing so, he argues against the 'essentialist' approach to sex which attempts to explain the properties of a complex whole by reference to a supposed inner truth or essence and the assumption that in all matters sexual, there must be a single uniform basic pattern ordained by nature itself. This has the effect of putting the emphasis firmly on society and on social relations rather than on anatomical and physiological processes. At the same time, Weeks (1986) does not deny the importance of biology given that the physiology of the body is the prerequisite for human sexuality.

Indeed, there are a whole host of meanings that are invoked by the term sexuality (Gott, 2005). These include the view that sexuality is both a 'natural' and powerful urge (Tiefer, 1995), beliefs about 'normal' and 'abnormal' sexualities (Strong, De Vault and Sayad, 1999), and seeing sexuality as an inherent personality characteristic which underpins maturity and mental health (Freud, 1977; Skene, 2004). Others have equated sexuality primarily with (hetero) sexual intercourse (Bancroft, 1983) which seems to be suggestive of a male bias given the known differences in the pleasure derived from intercourse between women and men (DeLamater, 1987; Hawkes, 1996; Guggino and

Ponzetti, 1997; Gavey et al 1999). Finally, the physical body is increasingly viewed as an external marker of sexuality- the 'body beautiful' setting a physical standard for women (Travis et al, 2000: p.239) amenable to inspection and *'social monitoring and control'*.

Reviewing this literature determined the starting point for this thesis, namely my belief that sexuality is difficult to define because it is socially constructed (Seidman, 2003) and therefore does not have one predetermined meaning. This approach offers new and diverse possibilities about thinking about sexuality and sexual problems. However, it also conflicts with the position adopted within the sexological literature where fixed and universal meanings of sexuality and sex are assumed, as explored below. The ways in which women themselves define sexuality has not been explored empirically in any detail.

A social constructionist view has been put forward by a number of commentators who build on the work of Foucault and Weeks to argue that the term sexuality is an historical, cultural, and social construction (Hawkes, 1996; Horrocks, 1997). Thus, sexuality is constituted differently depending on sociocultural context, and to be a sexual being does not mean the same thing in different cultures and epochs. As such, it has been argued that sexuality cannot be examined without considering questions of power (Foucault, 1985), identity, and views of the self (Giddens, 1992).

Simon and Gagnon (1984; 1986) also argue that cultural scripts regulate sexuality by restricting sexual activities to reproductive anatomy and processes, specifically sexual intercourse. Effectively, these cultural scripts inhibit an awareness of more diverse sexual experiences or a broader range of activities. For example, adopting an altogether biological perspective or script in relation to the term sexuality, has, according to some authors, the effect of trivializing the social and psychological aspects of sexuality (Tiefer, 1987). Biological research typically represents sexuality as an urge that is impossible to overcome and minimizes the importance of social factors influencing sexuality such as sexual socialization, economic and social inequalities and the social climate of violence against women (Tiefer, 1991). Of importance to the current study is that these cultural scripts have been identified as patriarchal in that they forward men's interests to the detriment of women's, both in terms of the specific sexual encounter and the wider social relationship between the genders (Nicolson, 2003).

The term 'sex' can, by the same token, be as difficult to characterize given that it signals different things to different people. According to Weeks (1986) it is something which is experienced very subjectively due to the strong range of emotions that it invokes. The more expert we become in talking about it, the greater the difficulties we have in trying to understand it. In line with Gott (2005), I would argue that the notion of a solitary definition of either sexuality or sex is highly tenuous. As a result, I return to the argument of Weeks (1986: p.15) as the starting point for this thesis, namely that sexuality and sex can best be understood as a social construction which *'brings together a whole host of biological and mental capacities'*. Not denying the position afforded to that of the

physical body, this thesis aims to explore those different capacities in women's own understandings of sex, sexuality and sexual problems. As such, the credibility of the fixed and universal meanings of sex and sexuality adopted within the clinical and sexological literature will be scrutinized.

Sexuality: Controversy, Confusion and Control

We live in a world of rival and often contradictory descriptions and definitions (Weeks, 1986). There are many influences that contribute to our sexual identities including family life, schooling, media representation, religion and moral and political influences (Weeks, 1986). As a result, sexuality can be seen to be socially regulated.

Prior to the influence of medicine, within Western societies sexuality was understood predominantly within the boundaries of Christian religion with church doctrine defining what was considered to be both 'normal' and 'natural' (Potts, 2002; Abbott et al, 2005). Moreover, theological writings in relation to sex were justified primarily, sometimes exclusively, in terms of the reproduction of the species. Men took on a sexually active position with an accompanying instinctual drive for sex whilst *'women were paradoxically positioned as either passive- the asexual pure Madonna or, if they were sexually dominant, seductive and dangerous, they were positioned as a whore or a bitch'* (Potts, 2002: p.21). These discourses continue to inform contemporary understandings of sexuality and femininity and, as a result, women are still required to negotiate these complex boundaries (Ibid.).

Replacing one form of 'Ideological State Apparatus' with another (Althusser, 1989), medicine succeeded religion and, according to Davidson and Layder (1994: p.224), sexual practices previously condemned as *'immoral and unnatural by religious thinkers* [were] *identified by medicine as ...mental disease'*. This displacement of religious authority by medical authority was partly triggered by the work of the theorists discussed below, although the continuing influence of Christian morality is evident throughout much of their work.

Taking as its starting point the belief that sexuality and sexual problems are socially constructed and rejecting the idea of one 'true' sexuality (Tiefer, 2004), this study begins by exploring how this 'construction' has occurred. As noted above, it has been argued that what is 'known' about women's sexuality today is due primarily to the work of a handful of sexual theorists writing from the mid 19th Century onwards. The following part of the literature review examines the major contributors to this debate, including Freud, Ellis, Kinsey and Masters and Johnson. The work of these individuals will be presented in chronological order, although it is not presupposed that one 'led on' from the other in terms of knowledge creation around female sexuality.

Principal Sexual Theorists

Sigmund Freud (1856-1939)

The father of psychoanalysis, Sigmund Freud, is best known for his tendency to trace nearly all psychological problems back to sexual issues. For Freud, the sexual drive was basic to all human life for women and men alike. Although only parts of his theory of

psychosexual development are still accepted by mainstream psychologists, Freud's theory of the Oedipal Complex has become a cultural icon nevertheless. Other now famous Freudian innovations include the therapy couch, the use of talk therapy to resolve psychological problems, and his theories about the unconscious- including the role of repression, denial, sublimation, and projection. Initially a Viennese medical doctor, Freud was trained in neurology, and he originally drew inspiration from the work of Charles Darwin which explained behavior in evolutionary terms. Freud did not focus exclusively upon sexuality. Rather, he developed a comprehensive theory of human behavior that highlighted sex as the central aspect of human development. As a result, Freud's most significant contribution to understandings of sexuality was his popularization of the importance of sex in human development.

The impact of historical context upon Freud's work cannot be underestimated, particularly in relation to female oppression. For example, girls raised in bourgeois families were subjected to an exceptionally restrictive morality. It was not considered appropriate for them to express sexual desire, even within the context of marriage. Whilst men's genitalia were the objects of pride and power, women's were cloaked in secrecy and shame (Freud and Breuer, 1909). Further, marriage for women in the Victorian era was not aimed at cultivating their independence. Wives were expected to obey their husbands at any cost, and, upon marriage, were expected to relinquish any civil powers they may have previously held. Even if her husband was abusive or unfaithful, it was unfeasible for a woman to divorce; if she did, her reputation would be irreparably damaged. Simone De Beauvoir elaborates on the 19th century prescription for femininity:

'Woman was declared made for the family, not for politics; for domestic cares and not for public functions... Femininity was a kind of 'prolonged infancy' that set women aside from the 'ideal of the race' and enfeebled her mind... in morality and love women might be superior, but man acted, while she remained in the home without economic or political rights' (De Beauvoir, 1952: p. 111).

In short, women's sexuality was very much seen as a tool for men, creating their children, maintaining their homes, and providing sexual release whenever necessary. In the introduction to her compilation of Freud's writings entitled *Freud on Women: A Reader* (1990), Elisabeth Young-Bruehl states that the general feminist critique launched against Freud is that he views femininity as failed masculinity: *'Females start out like males and then- disappointed in their mother-love, humiliated over their lack of a penis, self-deprived of their masturbatory pleasure- take a fall into femininity.'* (Ibid. p. 41). In addition, other commentators repudiate Freud's psychoanalytic theories on the grounds of their male dominance (Figes, 1970).

One of the most important contributions of Freud's work towards understandings of female sexuality was his clitoral-vaginal transfer theory (Freud, 1933). This theory maintained that the psychosexually mature woman with a suitable sexual partner should be able to orgasm from the stimulation provided by the penis in the vagina during sexual intercourse alone. Freud argued that any other form of sexual pleasure experienced by a woman detracted from her role to provide penetrative sexual intercourse to her partner.

Freud (1933) contended that clitoral orgasm was adolescent. It was only at the time of puberty, when women started having sex with men that they should transfer the centre of their orgasm to the vagina. It was assumed that the vagina was able to produce a parallel sensation, but was deemed more 'mature' than the clitoris itself. Consequently, his theory was focussed primarily on sexual intercourse as the only suitable form of sex for women. Laws and Schwartz (1977) summarise Freud's position by asserting that *'in the Freudian view, the 'true woman' experienced orgasm only through penile stimulation of the vagina; the woman who experienced orgasm through clitoral stimulation was 'immature' and possibly 'masculine'. Moreover, when a woman did not experience orgasm through penile penetration, sexually she was considered a 'failure''* (Ibid. pp. 14-15).

Freud's (1933) clitoral-vaginal transfer theory is supported by no empirical evidence and it has been widely contested by sex researchers who argue that orgasm obtained via direct digital (or oral) stimulation is physiologically identical regardless of the source of stimulation (Masters and Johnson, 1966). In a seminal essay, the feminist writer Koedt (1970) argues that Freud did not base his theory upon a study of women's anatomy but rather on patriarchal assumptions of women as an accessory to men, and her consequent social, psychological and physiological role. Furthermore, she asserts that there is no ignorance on the subject of female anatomy (see for example discussions of the works of Kinsey, Masters and Johnson later in this chapter), but there are social reasons why knowledge of the clitoris as the centre of female sexuality has failed to become popularised; we live in a male society that has not sought change in women's roles

(Ibid.). Despite the fact that these ideas are not scientifically upheld, it has been argued that they still inform women's self concepts today, particularly penile-vaginal intercourse as a marker of the meaning of sex (Nicolson, 1993).

Having asserted his position regarding the nature of women's sexuality, Freud then went on to 'discover' the problem of 'frigidity' in women requiring a psychiatric response. Caprio (1953; 1966), a contemporary who subscribed to these ideas summarises:

'...whenever a woman is incapable of achieving an orgasm via coitus, provided the husband is an adequate partner, and prefers clitoral stimulation to any other form of sexual activity, she can be regarded as suffering from frigidity and requires psychiatric assistance'. (Ibid. 1966: p. 64).

Nowhere is the attempt to define and control women's sexuality as evident as in this era's construction of female 'frigidity'. Freud's use of the term 'frigid' was adopted into popular usage and his theory had a profound influence on those working within the medical and mental health fields, and on wider society generally. Laws & Schwartz (1977) argue that:

'For generations after Freud, women found that both their husbands and their therapists were sure to reinforce the "rightness" of the Freudian social construction and the "wrongness" of their own subjective reality... Women who wanted to assert the truth of their own experience – that they did not experience orgasm from penile stimulation but

did experience orgasm through stimulation of the clitoris – had to contend with the devastating judgments of Freudian authorities that they were 'frigid''. (p. 15)

In practice, the term 'frigidity' became a psychological and medical diagnosis assigned to separate out women deemed sexually abnormal. Gerhard (2001) writes that the label of frigidity represented a marker of that which threatened patriarchy, *'...clitoral sexuality embodied women's refusal to accept their feminine roles. It represented the chaos of women...rejecting their passive and maternal destinies'* (Ibid. p. 41). 'Frigid' women were the Freudian era's version of the Victorian sexually dangerous woman and the concept still has considerable currency today. Sex 'experts' for example use Freudian theory to support their pronouncements that healthy women's erotic selves depend on men and the importance hitherto prescribed to sexual intercourse.

Freud's work provides us with an insight into 19th Century beliefs surrounding female sexuality. As such, his work forms an important contribution to this review. Whilst his views on women often provoked controversy during his own lifetime, they continue to evoke considerable debate today. His views in relation to the popularization of sex in terms of human development and the fundamental position afforded to heterosexual penetrative intercourse and subsequently orgasm are decisive features of his work which it is argued continue to underpin contemporary understandings of female sexuality.

Henry Havelock Ellis (1859-1939)

Trained as both a medical doctor and a sexual psychologist, Havelock Ellis has been credited by Bullough (1994: 76) as a rightful 'sex reformer' and his book *Sexual Inversion* serves as a good introduction to his attitude towards the topic of sex, particularly in relation to women. He was one of the first sexual theorists to actively focus his attention upon women and he challenged the prevailing orthodoxy of the day, urging women to reclaim their social, political, economic, and erotic rights. He supported a woman's right to make use of contraception, believing that motherhood was a choice and not an obligation. As a result, he claimed that women had the right to enjoy active participation in sexual intercourse without the fear of pregnancy (Ellis, 1937).

However, according to Siann (1994), despite arguing for women's sexual equality, Ellis endorsed the prevailing view that men were the active sexual agents and women should respond passively to any sexual advances. Women were the 'instrument' from which the man 'evoked' music (Ellis, 1894: pp. 525, 538-39, 542). His work was based upon a model of unequal power relations which derived from his belief that human, like animal courtship, was based upon conquest. He also believed that for women, pain and sexual pleasure were sometimes indistinguishable writing that *'the normal manifestation of a woman's sexual pleasure are exceedingly like pain'* (Ellis, 1913: p. 165). In this manner, despite promoting women's right to sexual satisfaction, Ellis endorsed a biological determinism with respect to sexuality, arguing that it was in the nature of all men to enjoy conquest and women to enjoy submission.

He also maintained that a woman's capacity for sexual enjoyment was equivalent to a man's but that her impulse for sex was more passive, more complex and less 'spontaneous'. One particular feature of his second volume entitled *Auto-Eroticism* which appeared in 1899 was his suggestion that masturbation (which he termed 'autoerotic phenomena') was considerably more frequent in women than in men. In one sense, this contention served to undermine the nineteenth century belief that women lacked sexual feelings and did not find sex important. However, he did not consider the act of masturbation to be unproblematic; he continued to believe that it could result in nervous disorders. His essential objection to this behaviour was on the grounds that it entailed a divorce between the physical and the psychological dimensions of sexual expression.

His writings were bound together by a number of unifying themes. These included the concepts of 'tumescence' and 'detumescence' (Ellis, 1905) that were used to describe the physiological changes that accompany orgasm. He developed these concepts to describe the entire process of sexual arousal and orgasm. In this wider sense, tumescence referred to the 'accumulation' of sexual energy during arousal and detumescence the 'discharge' of that energy at the moment of sexual climax (Ellis, 1913: Volume 1, Part 2, pp. 63; 65). For Ellis, the sexual process he depicted was comparable to any physical event in which energy was stored up and released and demonstrated a striking similarity to Freud's libido theory.

Ellis did not consider sexual arousal an equivalent event for both men and women. He frequently characterized the male's achievement of tumescence as simple, direct, and spontaneous. In many respects, his treatment of female sexuality marked an important break with received opinion, most obviously in his refutation of the notion that women lacked sexual emotions. His own investigations had persuaded him that sexual desire was no less intense in women than in men, and that women's capacity for sexual enjoyment was likewise comparable to that of men (Ellis, 1913: pp. 191-96).

Ellis (1913) wrote that the sexual instinct in women was 'elusive' while male sexuality was 'predominantly open and aggressive' (Ibid. p. 189). As such, his work shares a number of similarities with Freud and Breuer (1909) who contended that women's sexuality was cloaked in secrecy. He believed this 'elusiveness' stemmed from the 'sexual process' in women being more complex and he contended that women's sexuality made 'courtship' for women necessary and essential (Bullough, 1994: pp. 84-85). 'Courtship' here refers to Ellis' (1913) ideas about natural active masculinity and passive femininity which were regularly accepted, widely influential and 'taught as axiomatic' in later sex manuals (Jackson, 1987: p. 61). Ellis also advocated as natural the traditional gender roles between the sexes and stated that *'woman breeds and tends; man provides'* (Ellis, 1894: p. 440). Consequently, he believed that women were designed primarily with reproduction in mind, with female sexual pleasure serving evolutionary ends.

Ellis (1913) also claimed that sexual excitement in men was wholly contained in a single event: penile erection that he classified as 'spontaneous'. He perceived the

corresponding event for women to be clitoral erection and this made him by no means willing to accept the Freudian legacy that adult female sexuality was exclusively vaginal. By way of contrast, he argued that several non-genital areas in women, above all the breasts, contributed towards greater sexual excitement. This superior distribution of sexual sensitivity meant that for Ellis, arousal for women was viewed as being a more complex process than for men. This led him to the conclusion that, in many ways, women were 'greater' sexual beings than men but he still wrote, in a particularly regrettable turn of phase, that *'their brains are in their wombs'* (Ellis, 1910: p. 527).

In his opinion, female passivity was so basic to the organisation of human sexual life that it had given rise to a universal character trait among women: modesty. Modesty was an instinctual component of feminine psychology, '*an inevitable by-product of...the naturally defensive attitude of the female'* (Ellis, 1910: p. 40). By and large, his insistence on the innate sexual passivity and modesty of women reflected his thinking about their position in society. Likewise, he argued that the male's natural aggressiveness ought to be tempered by a considerate attention to the woman's sexual needs. Since he considered women to be slower in terms of their arousal, he advocated that sexual intercourse should be preceded by extensive foreplay, during which the man, whilst remaining the active agent, assumed a gentle, coaxing attitude towards his female partner. He found it difficult to reconcile this new emphasis on respect with the traditional stereotype of masculine aggressiveness. He simply stated that the proper balance of both attitudes was essential to '*the art of love*' (Ellis, 1905: p. 21).

He claimed that his sexual studies differed from those of earlier investigators on his insistence that he devoted more attention to ideas of 'normal' sexuality. However, he still felt obliged to examine the sexual deviations that loomed so large in the minds of his predecessors such as Richard von Krafft-Ebbing.

Ellis can be considered as one of the first sexual theorists to actively focus his attention upon women. Whilst Ellis advocated sexual equality, his views regarding women's passivity, the traditional gender roles between the sexes whereby women breed and men provides and the deep rooted belief that men were the active sexual agents and women should respond passively to any sexual advances can be located in contemporary sexual understandings. Whilst Potts (2002: p.24) has argued that *'it is necessary to locate Ellis's work historically'*, his writing marked an important break with sexual tradition. His attempts to study sexuality outside of a strictly moral context and to study 'normal' sexuality in addition to sexual deviations are all important contributions to the field. In a similar manner to Freud, Kinsey's beliefs about female sexuality, particularly the importance of orgasm, are ideas that are entrenched within a patriarchal framework. Indeed, the clear influence of prevailing contemporary understandings of appropriate gender roles are clearly evident in his work. Again, it has been argued that this framework not only remains influential in dictating what constitutes women's well being but also prescribes 'normal' sexual behaviour (Nicolson and Burr, 2003).

Alfred Charles Kinsey (1894-1956)

According to Gagnon and Parker (1995), Kinsey was a prominent figure who shifted the focus of sex research away from Europe to the United States. Trained in zoology and entomology at Harvard University, Kinsey began his scientific career by studying the gall wasp. Hired by Indiana State University in 1920, and asked to co-ordinate an undergraduate course on marriage, Kinsey discovered how little reliable scientific research was available on human sexuality.

By interviewing thousands of men and women across the U.S.A. from all segments of the population, Kinsey and his two colleagues Pomeroy and Martin performed one of the largest and most comprehensive studies of sexuality of all time which has had a lasting impact on sex research. Policy makers and planners, for example, used the Kinsey surveys to inform initial predictions of the spread of HIV and AIDS in the 1990's (Parker, 2001). To this day, such a large-scale random sample has never been repeated.

The investigations of Kinsey and his colleagues, Pomeroy and Martin, focused on a vast array of behaviors, habits, attitudes and expressions of sexuality over the course of the life span. Their results were published in two volumes. The first, *Sexual Behavior in the Human Male* (Kinsey, Pomeroy and Martin, 1948) was followed by *Sexual Behavior in the Human Female* (Kinsey, Pomeroy and Martin, 1953). These works have been extensively critiqued elsewhere (see for example Christenson 1971; Pomeroy, 1973; Robinson, 1989).

Kinsey advocated sexual tolerance and the identification of widespread deviations from accepted sexual standards that he reported confirmed his commitment toward sexual progressiveness. It proved conclusively for Kinsey and his colleagues that any attempt to legislate sexual behaviour was doomed to failure and that the only proper sexual policy was no policy at all (Kinsey et al, 1953). His preoccupation with individual variation and common deviance found its intellectual basis in taxonomy, the science of classification. In Kinsey's hands, taxonomy was intended as more a critical than a constructive tool and he was interested in undermining established categories of sexual wisdom rather than creating new ones.

Kinsey paid little attention to the emotional lives of his research participants and preferred to concentrate primarily on the physical aspects of sexuality (Robinson, 1989). Moreover, this was done in such as way as to make direct physical comparisons between the penis and the clitoris. As Kinsey et al (1953) state, *'the clitoris...is the phallus of the female'* (Ibid. p. 574) and they also hypothesize about the sexual response of a *'female who had a phallus as large as the average male'* (Ibid. p. 573). Like Freud before him, this is arguably a reflection of the phallocentric nature of his thought and the subsequent positioning of women's sexuality as secondary to men's.

Sexual Behaviour in the Human Female was published five years later and differed in a number of ways from the male edition. Rather than paying attention to orgasm in terms of numbers, Kinsey went on to explain that the basic problem for women was not an inability to orgasm, but that a substantial minority of women did not achieve orgasm

through penetrative sex (Kinsey et al, 1953). Furthermore, most of the women he studied who achieved orgasm only sometimes through penetrative sex did so more readily through masturbation. However, Brecher (1969) has noted that Kinsey did not state that masturbation was more enjoyable than penetrative sex or that it was preferable in any other way thereby implicitly reinforcing the importance of penetrative sexual intercourse in comparison to masturbation.

Whilst Havelock Ellis argued that women's sexuality was much less genitally focused than male sexuality, and that a larger portion of the female body participated in sexual arousal than was the case with men, Kinsey disagreed. He concurred that many non-genital areas of the body (above all the anus, mouth and breasts) shared in sexual response. However, he argued that none of these organs, not even the breasts, had been shown to be any more responsive in women than in men, (Kinsey et al, 1948; 1953). Kinsey suggested that men could be more genitally focused than women. What he seemed to imply was that the difference was psychological in origin since he had explicitly denied that any physical basis existed for assuming that the sexual response was more concentrated in one sex than in the other, (Kinsey et al, 1953). Despite his contention that arousal in the female was physically indistinguishable from arousal in the male, he still affirmed that *'the female is generally less responsive than the male'* (Ibid. p. 575).

In support of their claims that women were sexually 'less responsive', the researchers noted their participants' frequent inability to achieve orgasm in (hetero) sexual

intercourse. Nine percent of their female participants had never reached an orgasm and two per cent had never consciously experienced sexual arousal. Kinsey was convinced that women's lesser responsiveness did not originate in any physical distinction between the sexes. Neither did he believe that it resulted from an inherent modesty or natural morality supposedly characteristic of women. Rather, their findings led them to the conclusion that women's lower frequencies of orgasm reflected their lesser sensitivity to psychological influences and a considerable body of evidence was assembled to support this hypothesis.

Some of their data came from participant's descriptions of the role of observation and fantasy in the sexual lives of both men and women. Kinsey and his colleagues found that male participants were consistently more 'susceptible' to visual and imaginary stimulation than women. Kinsey went on to argue that his examination of the various 'factors' affecting sexual behaviour supported the hypothesis of the female's lesser psychological responsiveness. The conclusions he came to were blunt: male sexuality was predominantly mental and female sexuality physical. As Kinsey expressed it, female sexuality appeared to *'be less subject to conditioning'*, meaning by that, less subject to influences of a psychological nature, (Kinsey, 1953: pp. 649-650). This had the effect of reversing the popular belief that sex for women was somehow more an emotional than a physical reality, more bound up with deep psychological considerations, such as love, than with the bodily fact of physical stimulation. However, Kinsey and his colleagues gave little weight to social pressures which shape women's sexual psychology. As

Robinson (1989: p. 114) remarks, *'their* [female participant's] *relative insensitivity to visual and imaginary stimuli was itself a product of* [social] *conditioning'*.

One of Kinsey's most influential theories was his Heterosexual/ Homosexual Rating Scale. This has been widely used to depict an individuals' identity on the basis of their sexual preferences. It was devised on a scale from 0, meaning exclusively heterosexual, to 6, meaning exclusively homosexual. In the Kinsey Reports, an additional grade was added for asexuality. This rating scale was first published in *Sexual Behavior in the Human Male* (1948) by Kinsey and colleagues, and also featured prominently in the subsequent work *Sexual Behavior in the Human Female* (Ibid. 1953). It can be argued that the complexity of an individual's sexuality, which Kinsey had unveiled, was obscured by the act of reducing sexual identity to numerical categories. Nevertheless, it represents the first scientific work which identified that people do not fit neatly into the binary divide of heterosexual-homosexual, hightlighting that sexual thoughts and feelings towards the same and opposite sex can change throughout an individual's life, and thus that sexual orientation is not fixed.

Kinsey's research has had a lasting impact on the field of sexuality. Many have suggested that he revolutionized sexuality so much that it is hard to imagine what sexuality looked like prior to the 1950's. As Ericksen (1998: p. 41) states, *'...researchers have begun to recognize that the process of doing the research is also a form of social interaction. This process will have an impact not only on the findings but also on subsequent ideas about sexuality. That is, Kinsey not only studied sexuality, he helped create it'*. For example,

his work triggered a more positive societal attitude towards certain sexual behaviours, such as masturbation, as natural variations of human sexual behaviour (Bullough, 1994). However, by isolating the importance of orgasm as a subject of scientific scrutiny, Kinsey and his colleagues reinforced the importance placed on biological determinants of sexual behaviour at the expense of social and emotional factors.

William Masters (1915-2001)

Virginia Johnson (1925-)

Masters and Johnson co-authored two influential texts in the area of sexuality, *Human Sexual Response* and *Human Sexual Inadequacy*, published in 1966 and 1970. William Masters was a gynaecologist and Virginia Johnson was a psychologist hired as his research assistant. Together they set about to determine the 'normal' physiology of human sexual functioning (Morrow, 1994). These data were used to develop their theory of the Human Sexual Response Cycle (HSRC). The HRSC was introduced at the beginning of *Human Sexual Response* (Masters and Johnson, 1966) and served as the organising principle for their research to describe the sequence of physiological events they observed and measured during laboratory performed sexual activities including masturbation and sexual intercourse. This was based on empirical data from 382 female and 312 male participants aged from 18 to 89 years who were involved in a series of laboratory based experiments that ranged from masturbation to artificial intercourse with a transparent plastic probe that resembled a penis.

Their research provides the empirical base for the criteria that are used in the diagnosis and treatment of sexual problems. As well as recording some of the first physiological data from the human body during sexual excitation, they also framed their findings and conclusions in language that espoused sex as a healthy, important and natural activity that could be enjoyed as a source of pleasure and intimacy.

In both men and women, they argued that the sexual cycle could be divided into four distinct and sequential stages: excitement, plateau, orgasmic and the resolution phase, (Masters and Johnson, 1966). This model might be thought of as a refinement of Havelock Ellis's concepts of tumescence and detumescence (1906), with the excitement and plateau phases representing the subcategories of tumescence followed by orgasm and resolution as subcategories of detumescence. The HSRC was expanded some years later by the work of Kaplan (1979) to include 'desire' in the model.

Masters and Johnson (1966) posited that women and men responded sexually in a similar manner, which they reduced to physiological changes associated with vasocongestion, muscular tension and subsequently orgasm (Masters and Johnson, 1966). However, critics have suggested that the assumption of an innate sexual drive that proceeds sequentially from desire to arousal and orgasm promotes a very mechanical view of the body given the *'clinical preoccupation with parts-functioning'* (Tiefer, 2001 a: p.53). In addition, Potts (2002: p.29) has argued that the HRSC continues to rely upon the male sexual response as *'providing a norm or paradigm for sexual functioning, which can then be (super) imposed upon female experience'*.

The book *Human Sexual Response* devotes nearly three times as much attention to women as it does to men. The female version of every sexual experience is presented first, while the male's pattern is cast in the role of variation (as opposed to Kinsey who addressed himself to the male first and used the female volume for comparisons).

Analogous to Kinsey, Masters and Johnson's entire conceptual framework appears to have been devised to highlight one single phenomenon- the importance of orgasm and as such, their work is rooted first and foremost in biological terms (Potts, 2002). This is evidenced in their recruitment criteria, namely *'a requirement that there be a positive history of masturbatory and coital orgasmic experience before any subject* [could be] *accepted into the program'* (Masters and Johnson, 1966: p.311). According to Rosenthal (1966) this introduced a number of experimenter biases whereby certain sexual responses such as orgasm were communicated as successes and viewed as the 'gold standard' and those failing to orgasm, gain a rigid erection or ejaculate too quickly were communicated by the researchers as failures.

Despite their work being presented as 'scientific' their findings did not alter the profound conservatism of a number of their ideas and this manifests itself in three broad areas of sexual enquiry. It is most apparent in their treatment of sex and marriage. Whilst they had no aversion to premarital sex, they conceived of sexual life in terms of enduring heterosexual relationships. This was further reinforced by their interest in reproduction

and at times, they seem as much concerned with procreation as they do with pleasure (Robinson, 1989).

Whilst conducting their research, Masters and Johnson were unwilling to provide single female participants with a sexual partner for the two-week therapeutic program, although partners were provided for single men. In defense of this decision, they asserted that cultural heritage prepares men to accept such surrogates, while women require more 'meaningful' relationships (Masters and Johnson, 1970: pp. 155-156). Again, this is an example of the ways in which prevailing social attitudes influenced 'scientific' understandings of sexuality.

Their research must also be considered within the context of their commitment to traditional marriage in which the sexual needs of the individual are subordinated to those of the relationship. Their enthusiasm for marriage is reflected in direct statements on the subject and is particularly evident in *Human Sexual Inadequacy*. Their clinical procedures assume that the object of therapy is not a single unattached individual but a couple. It is couples, they argue, that develop sexual disorders, and thus marriages rather than husbands or wives, which 'must be treated' (Masters and Johnson, 1970: p. 3). One might argue that, from a therapeutic standpoint, the individual does not exist. A further indication of their commitment to marriage is their aversion to all sexual relationships that violate the monogamous, heterosexual standard. They express their aversion by ignoring such relationships. A marital bias is also evident in their remarks about

homosexuality and they discuss it as a factor in the aetiology of sexual inadequacy (Masters and Johnson, 1970).

The publication of their second book in 1970 has been considered a truly landmark text for sexuality research. This is evidenced by the fact that the medical profession- particularly psychiatry incorporated the HSRC model as the bedrock to define and categorise sexual 'function' and 'dysfunction'. According to Potts (2002: p.30) the work of Masters and Johnson was *'readily accepted due to its reduction of sexual response to physiological goals'*. Accordingly, Tiefer (1991: p.19) has argued that *'the enshrinement of the HSRC and its upgraded versions as the centrepiece of the sexual dysfunction nomenclature is not scientifically reliable and that what constitute sex and sexual problems are more a product of expectations, cultural standards and particular partners than they are of objective measurement'*.

There is the assumption of an innate sexual drive that proceeds sequentially from desire to arousal and orgasm which promotes a very mechanical view of the body (Tiefer et al 2000). Moreover, aspects rated as important by women such as affection and communication are largely ignored (Hite, 1987; Tavris & Sadd, 1977). Yet, as Tiefer (1995) has demonstrated, the adoption of the HSRC was the result of a priori assumptions rather than empirical research. Despite the criticisms outlined in this chapter, it is likely that the DSM authors adopted the HSRC for a number of reasons, not least because the model was both useful and convenient. Professional and political factors that most likely facilitated the adoption of this model included the need within psychiatry to move away

from a neurosis disorder model to a more concrete and empirical model (Tiefer, 1991). There were also legitimacy needs with the new speciality of sex therapy and the interests of feminists in progressive sexual standards for women (Ibid). Prior to this, Freudian approaches to the treatment of sexual distress had assumed dominance and were the preferred model of treatment (Potts, 2002). The genesis of therapeutic programmes for sexual problems also coincided with the so called 'sexual revolution' of the 1960's when political groups, including the feminist and lesbian, gay and bisexual movements began to challenge the assumptions made by orthodox sex researchers regarding what was considered to be normal/natural.

In an effort to bolster their professional reputation, scientific sex researchers sought to consolidate the legitimacy of their discipline by affiliating with the medical establishment (Potts, 2002). Masters and Johnson's (1966; 1970) physiological emphasis strengthened this and, despite resistance, the medico-psychiatric establishment largely embraced this new approach by replacing psychoanalytic with behavioural and physical treatments. Thus, the enshrinement of the HSRC and its upgraded version as the focus of the sexual dysfunction nomenclature in the DSM *'represents both a triumph of politics and professionalism'* (Tiefer, 1991: p. 22). Furthermore, it enabled the medical profession to not only take responsibility for all matters sexual, but also maintain their authority on these issues (Scotti et al, 2000).

The work of Masters and Johnson can be seen as highly influential with regard to contemporary understandings of sexuality, sex and sexual problems. Promoting the

importance of 'normal' sexual functioning, their work has had a lasting impact on sexuality research. Like a number of their predecessors outlined within this review, their conceptual framework highlights the importance of penetrative sexual intercourse and female orgasm. As such, their work is rooted first and foremost in biological terms and they disregard socio-cultural factors. Whilst they claim that they were opposed to the Victorian views of women primarily as an embellishment to men, their work reinforced the goal of marriage and the importance of monogamy, arguing that better sex would mean better marriages. However, they failed to critically examine issues of sexual identity and power relations and the context in which women live their lives. Nevertheless, these understandings remain embedded in the ways in which we categorize behaviours and experiences as sexually problematic.

Summary

At the beginning of this chapter, I argued that isolating definitive meanings for the terms 'sex' and 'sexuality' is a highly questionable project. Rather, sex and sexuality can be best understood as social constructs which *'bring together a whole host of biological and mental capacities'* (Weeks, 1986: p. 15). This position is in opposition to that adopted within the clinical sexological literature which dominates this field as will be explored and I have highlighted that, to date, little is known about how 'ordinary' women understand these terms. I went on to identify how understandings of sexual norms have become a benchmark against which sexual problems are defined, a discussion of which forms the second part of this literature review.

In order to understand the current discourses associated with women's sexuality, it is important to have an appreciation of the historical context which has led to present day practices and prejudices. Prior to the 'age of enlightenment' in the eighteenth century, sexuality was understood within the boundaries of theology, as a moral construct, where the teachings of the church served to define what was and what was not 'normal' sexual behaviour (Weeks, 1990). The most commonly accepted view was that sexuality was a biological, instinctive drive that was essentially male, directed at the passive, if seductive, female. Man was driven, woman received and her pleasure was usually seen as secondary to her partner within the context of a marital relationship and usually within the confines of the bedroom. As Jeffreys (1990: p. 5) has argued, *'...men's power over women was to be supported through the regulation of marital sex'.*

I argued that these norms of women's sexuality have been defined by different forms of 'Ideological State Apparatus' (Althusser, 1989), and identified a shift that occurred in this 'apparatus' from theology to medicine. This review has concentrated on the latter given that much of what has been written about from the late 19th Century onwards under the auspices of medicine has informed contemporary views and understandings of women's sexuality (Potts, 2002).

Nicolson (2003) argues that the work of the key sexual theorists outlined in the first part of this chapter have shaped contemporary understandings of 'normal' female sexuality. The aim of the first part of this review has been to identify which features of their work continue to hold currency to this day. Whilst their accounts are diverse, common threads

can be identified. In particular, all have written about female sexuality primarily in physical terms, with particular importance placed upon penetrative sexual intercourse and orgasm. These ideas were popularized by the writings of Sigmund Freud (1933). A reproductive imperative was also evident. For example, Havelock Ellis (1894: p.440) wrote that *'woman breeds and tends; man provides'*- little mention was made of experiencing sex primarily for pleasure and Ellis, in particular, framed women as the essentially passive recipients of active and sexually aggressive males.

Rather than any of these theorists paying attention to the emotional or contextual aspects of women's sexual lives, the majority of their work is couched primarily in biological terms. Direct comparisons were made between the sex organs as a means of positioning women's sexuality as secondary to men's. The inference from this body of work was that not being able to achieve orgasm via coitus is problematic for women.

I have also highlighted the ways in which those sexual theorists highlighted in the first part of this chapter have presented their work as scientific 'fact' by promoting what they deem to be normal and natural in terms of women's sexual identity and behaviour. However, notwithstanding methodological problems in research, evident is the extent to which historical contexts regarding appropriate gender roles for men and women have influenced the state of sexual 'science'. According to Lloyd (1993) writing on the origins of female orgasm advanced by male behavioral scientists, science is itself socially constructed.

Building upon this body of work, Masters and Johnson (1966; 1970) consolidated these 'sexual ideals', particularly in respect of the orgasmic imperative. Their conceptual framework, referred to as the Human Sexual Response Cycle, the pinnacle of which being the ability to achieve orgasm through coitus, forms the empirical bedrock of the diagnostic criteria for female sexual problems. Moreover, this model (Masters and Johnson, 1966) characterises sexuality as a universal response having observed and reported an orderly and invariant sequence of neuro-genital physical changes. To date, these ideas form the backbone of contemporary sexology and the basis for the classification of contemporary understandings of female sexual problems. Predicated on these sexual 'norms', these views also reveal the power of science to develop a classification system for sexual problems which are deeply embedded in a male, patriarchal view. As a result, contemporary understandings of sexuality have in no way been informed by women's experiences.

B) FSD: Classification, Controversy and Control

The second part of this chapter examines the history of the classification of women's sexual problems before presenting those studies that relate specifically to the categorisation of women's sexual problems. These studies are presented to exemplify the 'state of the science' regarding female sexuality and sexual problems and reflect many of the androcentric biases identified in the work discussed above. Finally, I move on to consider those small number of studies that examine women's views of sexual problems from the perspective of women themselves.

Classification: A Brief History

From a review of the literature in the first part of this chapter, it is apparent that ideas in relation to what constitutes sexual normalcy 'created' by those prominent sexual theorists at the turn of the 19th Century through to the middle of the 20th Century underpin classifications of 'female sexual dysfunction'. This section briefly considers current classification systems for sexual problems, their historical development and reasons for their current popularity.

The classification system of the German psychiatrist Kraepelin, first published in 1883, formed the basis of the descriptions of syndromes and diagnostic categories still used by health professionals today (Ussher, 1991). In the first instance, Kraepelin's contribution to classification was important in view of the fact of its organisation. Whilst his predecessors had grouped diseases together based on the similarity of their symptoms, Kraepelin used a medical model and grouped them together based on a pattern of symptoms. He realized that the same symptom could occur across disorders but that different disorders have different patterns of symptoms. This work forms the basis of the classification system used by psychiatrists today known as the Diagnostic and Statistical Manual (DSM).

The DSM-IV-TR (APA, 2000) currently categorizes female sexual dysfunctions under nine explicit types. These include: sexual aversion disorder; hypoactive sexual desire disorder; sexual arousal disorder; female orgasmic disorder; dyspareunia; vaginismus; sexual dysfunctions due to a medical condition; substance-induced sexual dysfunction;

sexual dysfunction not otherwise specified. For diagnosis of a sexual problem, each of the above must include a personal distress criterion. This was incorporated into the fourth edition of the manual and as such, is a more recent addition to the original criteria proposed.

One important issue about the HSRC is the way that it so perfectly filled a social and professional need for bodily, biological, universal, natural sexuality to this day (Tiefer, 1991). However, critics have alleged that there remains an androcentric bias present in all revisions of the DSM (Brown, 1994; Unger & Crawford, 1996). The developers of the DSM classification system, predominantly White males, define what behaviours are viewed as healthy (e.g. autonomy and individualism), and unhealthy (e.g. concern with relationships and dependency). For instance, this bias codifies stereotypical female gender role behavior (e.g. going to excessive lengths to obtain nurturance and support, having difficulty expressing disagreement with others) as dependent personality disorder (Unger and Crawford, 1996). In contrast, the same codification of traditional male gender role behaviour (e.g. reluctance to take into account others' needs when making decisions, views work as more important than relationships) is not present (Caplan, 1991; Kaplan, 1983a).

The term 'female sexual dysfunction' brings to mind a number of harmful implications for the sexual lives of women. Whilst the term itself is used repeatedly throughout this chapter, it is done so primarily on the grounds that it is the expression used within the DSM and by those authors whose papers inform the bulk of the remaining discussions in

this chapter. However, I would argue that the word 'dysfunction'- medical terminology for anything that does not function in the way that it 'should' suggests that there is a hypothetical norm of female sexual functioning. However, as discussions previously in this chapter indicate, such a norm has never been established.

The Appeal of Classification

In trying to understand why the DSM classification for FSD has been accepted so readily in the absence of any evidence from women themselves, it is important to try to understand some of the forces contributing to past and present popularity of classificatory principles. Consider the following excerpt taken from the latest edition of the DSM of the American Psychiatric Association (APA) used as the basis for the diagnosis and treatment of mental health and sexual problems in particular:

'...each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely and culturally sanctioned response to a particular event, for example, the loss of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual. Neither deviant behaviour (e.g. political, religious or sexual) nor conflicts that are primarily between individual and society are mental disorders unless the

deviance or conflict is a symptom of a dysfunction in the individual, as described above.'

(DSM-IV-TR, 2000: pp. xxi-xxii).

According to Blashfield (1998) and Scotti and Morris (2000) the practice of classification serves a number of fundamental purposes. It establishes a nomenclature for clinicians and scientists alike and provides descriptive information quickly. It claims to be predictive in that it offers information on the course, prognosis and treatment of an illness and aids in the retrieval of information due to its organisation. In addition, in countries where medical treatment is financed by the individual, it enables the clinician to receive payment for their services and serves as a step towards a theoretical understanding of psychiatric disorders.

Ussher (1991) also provides an account into the impetus behind the eagerness for classification, making the direct comparison between medicine and psychiatry. She contends that whilst medicine has become more sophisticated in its theoretical underpinnings, psychiatry has not fared so well. As such, and in an effort to maintain a similar status, psychiatry has *'adhered to those constructs deemed closest to the positivistic scientific method-to taxonomy, and to classification in order to accrue the status given to their colleagues specializing in physical medicine'* (Ibid. p. 99). However, Crowe (2004) argues that whilst the categories used to separate sexual problems are neither totally satisfactory nor mutually exclusive, *'it is probably inevitable that the categories we have should continue to be used'* (Ibid. p. 1). At the same time, he also notes that sexual problems are difficult to categorize as exclusively physical or

psychological phenomena and that they can be seen to cross the boundaries between the specialisms of gynaecology, urology, genitourinary medicine, endocrinology, physiology and psychiatry.

The Feminist Backlash against the Medicalisation of Women's Sexual Problems and the Emergence of a 'New View' Classification System

Sex researchers, predominantly feminist, alarmed by the biological basis of the current diagnostic criteria for women's sexual problems have sought to develop a model with a greater emphasis upon the political and humanistic aspects of sexuality. These theorists perceive the medicalisation of sexuality as largely inappropriate and potentially dangerous- the invasion of a highly individualised, evolution derived, biologically based, disease and malfunction model into what is better seen as a relational and socially constructed sector of life (Kaschak and Tiefer, 2001; Byers, 1999). The arguments, and evidence against the accepted medicalised perspective, have been documented in '*A New View of Women's Sexual Problems*' (Kashak and Tiefer, 2001). This provides an alternative classification system to the DSM.

Medicalisation is a major trend whereby medical 'standards' dictate huge chunks of everyday life (Tiefer, 1996). For example, sitting at opposite ends of the life course, the medicalisation of childbirth (Johanson et al, 2002) and death (Clark, 2002) are two events that have not escaped this movement. Indeed, the medicalisation of women's sexual problems is only the latest example of the ways in which female bodies have been subject to the medical 'gaze'.

The successful treatment of male impotence with Sildenafil Citrate (Viagra ™) has resulted in a competitive and commercial hunt for the female equivalent, solidifying genital functioning as the primary focus of sexual problems and attempting to transpose those pharmaceutical developments onto women with postmenopausal women a particular target (Basson et al, 2003). As a result, there has been a drive to turn women into what Tiefer (2003: p.2) terms *'sex problem consumer-patients'*. However, in spite of the enormous expense invested in recent years, there has been no agreement reached on a treatable sexual disorder for women which is comparable to erectile dysfunction. This was confirmed in 2004 when Pfizer Pharmaceuticals suspended their clinical trials of the female equivalent of Viagra and the Procter and Gamble testosterone patch 'Intrinsa' was rejected by the Federal Drug Administration (FDA) in the USA (although it has recently been approved in Europe).

This 'New View' differs from medical expert opinion in terms of how issues are problematised, diagnosed and classified in accordance with current clinical guidelines for FSD outlined in the current edition of the DSM-IV-TR (APA, 2000). It suggests that the central role attributed to both biology and the body ignores other aspects that women deem sexually problematic in their lives. 'A New View of Women's Sexual Problems' includes sexual problems across four broad areas. It defines a sexual problem as *'discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience'* (Tiefer, 2001 b: p.5). These broad areas include sexual problems according

to socio-cultural, political or economic factors; partner and relationship factors; psychological factors and medical factors.

Essentially, this view sees sexual problems as socially constructed as opposed to the DSM framework whose approach is primarily biomedically focused. However, whilst this view appears highly regarded in its endeavour to formulate a woman-centred framework for addressing sexual problems, it fails to provide the researcher with any robust empirical evidence upon which to base its classification system of sexual problems. In addition, it fails to acknowledge the role of the clinician in addressing sexual problems (Candib, 2001). It also assigns issues that relate to the body and sexual pain as clearly separate from social and cultural factors further reinforcing the divide between biomedical, social or psychological factors, rather than seeing these issues as interrelated.

In spite of this feminist backlash, contemporary 'female sexual dysfunction' criteria remains rooted in a tradition which, since the mid 19th Century, has adopted an almost exclusive physical perspective. The following part of this chapter examines the current state of contemporary sex research through an examination of studies of FSD and in so doing highlights how knowledge claims are made about women in spite of their voices remaining curiously absent from the debate. Nonetheless, including these studies is crucial to understandings of the current state of sexual 'science'. It is also interesting, and important, to trace how understandings of sex and sexuality have been 'created'.

Female Sexual Dysfunction and the 'Mainstream' Literature relating to Women's Sexual Problems

The study credited in paving the way towards the existence of Female Sexual Dysfunction was published by Laumann and colleagues in 1994. It was conducted in the United States and consisted of a probability sample of 1410 men and 1749 women between the ages of 18 and 59 years of age living in households throughout America who are thought to be representative of the general population in that age range- roughly 150 million. In their concluding comments of the paper, the authors state that this work acts as the first population-based assessment of sexual dysfunction since Kinsey et al (1948; 1953). In reality, the figure of 43% incorporated all forms of sexual problems and was based upon a 1999 re-analysis of one solitary question asked in a 1994 Chicago sociology study (Laumann et al, 1999). Participants were asked whether they had experienced any of seven sexual difficulties identified by the researchers 'for several months or longer' during the previous year, including a lack of desire for sex, anxiety about sexual performance and difficulties with lubrication. Any woman who reported 'yes' to any one of these questions was regarded as having a sexual dysfunction and the study concluded that sexual problems were far more prevalent in women (43%) than men (31%).

Immediately, concerns must be raised about any form of classification which categorizes nearly half of all women as sexually 'dysfunctional'. Indeed, it is important to recognise that although this approach may well have recruited those who had enduring sexual problems, it may also have included women who had short-lived problems that were no longer troubling them. In spite of this, the authors were quick to conclude from their data

that FSD was a 'significant public health concern' and their figure of 43% has been extensively quoted in the both the scientific and lay press in recent years (see for example Berman, Berman and Goldstein, 1999; Guay, 2001).

According to Moynihan (2003), this figure helped to establish the parameters of what was considered sexually 'normal' and what was considered sexually 'problematic'. He labeled the idea of FSD as a 'corporate sponsored creation' in which he highlighted the fact that a number of the authors of the Laumann study disclosed close connections with a number of pharmaceutical companies. 43% is unquestionably one of the uppermost estimates of FSD in recent years, but has gained widespread currency within scientific and popular understandings of female sexuality. However, the fact remains that the study in question failed to ascertain whether the women themselves thought they had a sexual problem. Thus it is immediately apparent how contemporary sexual 'science' places little importance upon the views and experiences of women themselves.

Other studies have similarly reported that a sizeable percentage of women experience sexual dysfunction. Bancroft, Loftus and Long (2003) for example, who defined a sexual problem in terms of the absence or impairment of sexual response using frequency counts for the previous month, determined that 44.3% of heterosexual women who took part in their study experienced a sexual problem according to these 'objective' criteria. However, in reality, only 24.4% of participants felt that they experienced such a problem and experienced distress as a result.

Three studies conducted in the U.K. have reported rates of FSD ranging from between 39-42% (Read, King and Watson, 1997; Dunn, Croft and Hackett, 1998; Nazareth, Boynton and King, 2003). Dunn, Croft and Hackett (1998) studied a sample of 979 English women using their own operationally defined criteria to assess the prevalence of sexual problems and identified that a total of 41% of their sample were identified 'with a problem'. However, there was no indication as to whether the women themselves regarded these 'operationally defined problems' as actual sexual problems. Another study conducted in the U.K. by Osborn, Hawton and Gath (1988) identified high levels of sexual problems in their sample of 436 women aged between 35-59 years of age. Once again, the researchers derived their own operationally defined criteria and found that 33% met these criteria for one or more of these problems. However, only 23% regarded themselves as having a sexual problem.

With regard to the factors that influence the prevalence of overall sexual dysfunction, there is agreement amongst those studies that have been conducted that a woman's relationship with her partner affects both her sexual satisfaction and the extent of her sexual dysfunction (Bancroft, Loftus and Long, 2003; Nazareth, Boyton and King, 2003). In addition, both physical issues (Ernst, Foldenyi and Angst, 1993; Fugl-Meyer and Sjogen Fugl-Meyer, 1999; Laumann et al, 1999; Nazareth et al 2003; Richters et al 2003) and psychiatric problems have been reported to be correlated with the prevalence of sexual dysfunction (Lindal and Stefansonn, 1993; Osborn, Hawton and Gath, 1988).

There has been disagreement about the relationship between age and sexual dysfunction, with sexual dysfunction increasing with age in eight studies (Bachmann et al, 1989; Fugl-Meyer and Sjogen Fugl-Meyer, 1999; Laumann et al, 1999; Nazareth et al, 2003; Osborn et al, 1988; Richters et al, 2003; Rosen et al, 1993; Ventegodt, 1998) but no relationship with age and sexual dysfunction reported in a further three studies (Frank et al, 1978; Goldmeier et al, 2000; Read, King and Watson, 1997). Whether the context of marriage affects the prevalence of female sexual dysfunction is tentative. In two studies, unmarried women were more likely to have sexual dysfunction (Laumann et al, 1999; Lindal and Stefansonn, 1993) but in a third published study, married women were more likely to experience a sexual dysfunction (Read et al, 1997).

As well as overall levels of sexual dysfunction reported in the literature, there are those studies which have focused on specific sexual dysfunctions (as reported in the DSM). The following section of this thesis briefly examines the reported prevalence of these sexual dysfunctions that include hypoactive sexual desire disorder, female sexual arousal disorder, female orgasmic disorder and dsypareunia. I then move on to examine the issues associated with objectifying women's sexual distress.

Hypoactive Sexual Desire Disorder

Hypoactive sexual desire disorder is defined as having no interest in initiating sex and little desire to seek stimulation. The lack of interest in sex must cause a marked distress or interpersonal difficulty, cannot be accounted for by another diagnosis, and should not be due exclusively to the affects of drug abuse or general medical conditions for example,

diabetes or kidney failure (DSM-IV-TR, 2000). Researchers investigating this dysfunction have used an abundance of different terms which have included desire disorder, inhibited sexual desire, low libido, lack of or decreased sexual interest, no desire for intercourse, altered sexual interest, and frequency of sexual thoughts and/or fantasies. These terms are in addition to the current DSM-IV-TR diagnostic criteria of hypoactive sexual desire disorder.

Hite (1976) found that 1% of just over 3,000 women who responded to her questionnaire indicated no interest in sex. No sexual desire was self-reported by 10% of young women of lower socio-economic status attending family planning services (Golden et al, 1977) and 12% of women selected from Copenhagen registries had no interest in sex (Garde and Lunde, 1980). Similarly, Rosen et al (1993) reported that 15.1% of middle-aged women attending a gynaecological clinic were never interested in vaginal intercourse and consequently fitted the criteria for hypoactive sexual desire disorder. Two additional studies were conducted in Australia amongst random samples of women and reported high rates of desire disorder ranging from 27% of 18-29 year olds in the first study (Najman et al, 2003) to over 50% in women 20 years of age and over in the second study (Richters et al, 2003). The results of these studies also indicate that sexual desire diminishes with age (Najman et al, 2003; Richters et al, 2003), although this association was not observed in a population-based study of Danes by Ventegodt (1998) in which disorders of desire increased from the ages of 30-40 years but then decreased in women aged 50 years and over.

Only four studies that provided information on sexual desire disorders specifically addressed demographic and social predictors (Kadhri et al 2002; Klusmann, 2002; Rainwater, 1968; Shokrollahi et al, 1999). Longer partnership duration (Klusmann, 2002), unhappiness with a partner (Shokrollahi et al, 1999), numerous children (Kadhri et al, 2002), and financial concerns (Kadhri et al, 2002; Rainwater, 1968) were all positively associated with a women's decreased sexual interest.

Female Sexual Arousal Disorder

Female sexual arousal disorder is defined as the inability to achieve and progress through the stages of 'normal' female arousal. Disturbance must cause marked interpersonal difficulties or distress and should not be accounted for by another disorder or by medications (DSM-IV-TR, 2000). Studies of female sexual arousal disorder have routinely used the criteria of adequate lubrication as a marker from which to measure arousal for sexual intercourse to take place- thereby drawing attention to the importance of penetrative sex in the current diagnostic criteria.

Based on the results from Rosen et al (1993) and Dunn et al (1998), both of which included arousal and lubrication, rates for lubrication difficulties were higher than those for arousal difficulties suggesting that lubrication difficulties should not be equated with sexual arousal dysfunction. One of the highest rates of lubrication difficulties- 76% - was reported in a study by Nusbaum and Gamble (2001). However, the question asked how frequently participants had concerns about lubrication problems. In essence, this question addressed women's concerns rather than the actual experience and occurrence of

the problem. In addition, prevalence rates of disorders relating to arousal were noticeably wide-ranging from between 3.6% (Nazareth et al, 2003) to a peak of 48% (Frank et al, 1978).

Other factors that have been reported to influence arousal disorders included age, sexual attitude and the interpersonal relationship between sexual partners. Both Najman et al (2003) and Nazareth et al (2003) found that arousal dysfunction increased with age, but Nazareth's (Ibid.) findings were derived from a study using a less robust design than that of Najman et al (Ibid.). Women who exhibit a 'conservative approach' to sex or those whose husbands were dissatisfied with their sexual relationship have been identified to be more liable to have arousal disorder (Shokrollahi et al, 1999). That women were positioned in this manner is arguably a manifestation of a value system that ranks women's concerns simply as a by-product of the anxieties of their male counterparts and does not ask women's views about this issue directly. Notwithstanding this debate, these findings also need to be interpreted with caution on the basis that the authors provide insufficient information in respect of their study design and participation rates.

Female Orgasmic Disorder

Female orgasmic disorder is defined as a delay or absence of orgasm after 'normal' arousal (DSM-IV-TR, 2000). There are data in relation to orgasm as far back as 1938 (Terman, 1938) and on anorgasmia from 1957 (Chesser, 1956). A study entitled *Psychological Factors in Marital Happiness* by Terman (1938) was arguably the first of many studies in relation to female sexual dysfunction that provided the reader with

information on orgasm. Since then, the number of studies conducted has multiplied. The publication of *The Hite report: A Nationwide Study on Female Sexuality* (Hite, 1976) marked the first publication in which data on sexual desire and sexual pain as well as orgasm were provided. The majority of publications since that time have typically provided information on sexual dysfunction overall, and /or sexual desire, arousal, orgasm and pain or some variation of these individual disorders.

Studies that have examined female orgasmic disorder have prevalence rates which have been typically reported as being below 20% (Ard, 1977; Atputharajah, 1987; Bachmann et al, 1989; Bancroft et al, 2003; Chesser, 1956; Fisher, 1973; Garde and Lunde 1980; Gebhard and Johnson, 1979; Golden et al, 1977; Hite, 1976; Mercer et al, 2003; Ventegodt, 1998). Women with medical conditions such as diabetes have also been found to be at greater risk of anorgasmia (Kadhri et al, 2002), as have those who seldom engage in penetrative sexual intercourse and hold more 'conservative' attitudes towards sex (Shokrollahi et al, 1999). Women of Latino origin have been found to be less likely to have orgasmic difficulties compared to either Black or non-Latino White women (Golden et al, 1977).

A further four studies reported rates associated with anorgasmia that ranged from 20-40% (Laumann et al, 1999; Read et al, 1997; Richters et al, 2003; Rosen et al, 1993). One further study reported the rate of anorgasmia to be as high as 50% in their sample despite the fact that the views of women themselves remained absent in their analyses (Goldmeier et al, 2000).

Birnbaum (2003) provides an account of the differences between women who seek help for female orgasmic disorder and those that do not, recommending that future studies explore the reasons why women seek therapy. She highlights the possibility that non-referred women may not perceive themselves as dysfunctional on the basis of having orgasm problems. The author notes that *'the findings may demonstrate a tendency of non-referred women with FOD to attach little importance to their sexual lives, or even to their dyadic relationships altogether, or to deny the dysfunction and implications for sexual life and dyadic relationship'* (Ibid. p. 67-68). However, whilst the study highlights the possibility that non-referred women may not identify as dysfunctional on the basis of difficulties associated with their ability to achieve orgasm, to claim that *'the importance of trying to reach non-referred women with FOD in order to treat them and alleviate their aversive experience of heterosexual intercourse'* suggests that the orgasmic imperative assumes unrivalled sexual importance. This is despite the author making no reference to the personal distress criterion outlined in the DSM as a marker of sexual difficulties. However, to pathologise an already nebulous concept and then repackage it as a dysfunction is, according to some academics quite inequitable (see for example Potts 2002).

The sexual significance afforded to being orgasmic further affirms the opinion of Godson (2004) who argues that it may be less of a problem for the women than for their partners, who interpret it as a negative reflection on their performance. Moreover, the same author also asserts that in terms of global satisfaction scales, *'women tend to view overall sexual*

satisfaction as being more important and tend to think less about sex and more about relationships' (Ibid. p.20). As a result, the extent to which a lack of orgasm can be considered sexually problematic to women themselves is debatable on the basis that all of these studies failed to determine the views of women in relation to whether or not their inability to achieve orgasm was personally problematic.

Dyspareunia

Dyspareunia refers to genital pain before, during, or after intercourse ((DSM-IV-TR, 2000). Studies that have examined the issue of dyspareunia, reveal noticeably wide-ranging prevalence rates from 0.9% to 75% (Bancroft et al, 2003; Danielsson et al, 2003; Diokno et al, 1990; Ernst et al, 1993; Fisher, 1973; Fugl-Meyer and Sjogen Fugl-Meyer, 1999; Garde and Lunde 1980; Kadhri et al, 2002; Lindal and Stefansson, 1993; Mercer et al 2003; Nazareth et al, 2003; Osborn et al 1988; Pepe et al, 1989; Rosen et al, 1993; Shokrollahi et al, 1999; Starr and Weiner, 1982; Ventegodt, 1998; Atputharajah, 1987; Ende et al, 1984; Geiss at al, 2003; Golden et al, 1977; Laumann et al, 1999; Najman et al, 2003; Pepe et al, 1989; Richters et al, 2003; Schein et al, 1988).

Such wide-ranging prevalence rates are likely to reflect differences in- for example, the period of observation in question and the duration of dyspareunia. Four studies that have reported on prevalence rates of dsypareunia recorded much higher rates than other studies previously conducted (Bachmann et al, 1989; Dunn et al, 1998; Hite, 1976; Nusbaum and Gamble, 2001). The most likely reason for these higher prevalence rates was the wording used that asked whether the women had *ever* experienced any type of pain that

accompanied sex. Laumann et al (1999) found that pain differed by age, with the highest likelihood of pain in the 18-29 age cohort (21%) dropping to 14% in the 30 to 49 age cohort and finally to 8% in those participants aged 50 years and over. The questions put forward required participants to think about pain experienced on intercourse and whether that pain lasted for several months or more over the previous 12 months. However, the way in which the question was asked raises doubts over authenticity of their results.

Studies that have focused upon dyspareunia have claimed that it is positively related to high blood pressure, depressive symptoms and sleep disorders (Kadhri et al, 2002) but negatively associated with age (Danielsson et al, 2003; Laumann et al, 1999; Najman et al, 2003; Richters et al., 2003; Ventegodt, 1998). Shokrollahi et al (1999) have also reported a link between dyspareunia and sexual dissatisfaction with a partner. In recent years, there have been calls by some researchers to abandon dyspareunia as a sexual dysfunction altogether. For example, in a recent paper, Binik (2005) contends that dyspareunia would be much better dealt with if it were treated from the point of view of a 'pain perspective' (Ibid. p. 19) rather than as a sexual dysfunction perspective. She also argues that the struggle by psychiatry to 'retain' this discrete dysfunction has done very little to benefit the health and well-being of women themselves.

A Critique of 'Mainstream' Literature relating to Women's Sexual Problems

The assumptions upon which the studies reported in the previous section are based are numerous:

1) They assume that the meanings of sexuality and sex are fixed and universal.

2) They assume that sex is an important part of women's lives and sexual problems therefore will have significant psychological implications.

3) They ignore the influence of socio-cultural influences upon experiences of sexuality and sexual problems.

4) They conceptualise sexual problems as individually experienced.

5) They afford primacy to biology and the physical body.

6) They equate 'sex' with (heterosexual) intercourse and orgasm.

The roots of these assumptions have been identified in the work of those theorists discussed earlier in this chapter credited with 'creating' sexuality and hence sexual problems. This brief overview of 'mainstream' sex research also highlights that the ways in which women themselves understand these issues has not been explored empirically in any detail. The following section of this chapter discusses those (small number) of studies that aim to capture the voices of women themselves.

Studies that Examine Women's Views of Sex, Sexuality and Sexual Problems

Throughout the course of this literature review, a paucity of studies examining women's views of sexuality, sex and sexual problems were identified. Those that adopt this perspective are typically qualitative and small-scale. The following section of this chapter reviews studies of this type. These studies share a fundamental premise- that sexual problems are not experienced in an exclusively physical way but the inability to engage in certain practices, such as penetrative sexual intercourse and orgasm are usually subject to wider cultural (patriarchal) expectations. As such, they challenge the

prevailing orthodoxies of sexology identified above. However, they have yet to influence either clinical or popular understandings of sexuality and sexual problems.

A study conducted by Cacchioni (2007) examined the views of women who identified as having a sexual problem and the strategies they subsequently adopted for dealing with the 'labour of love' which she refers to as *'the unacknowledged effort and the continuing monitoring which women are expected to devote to managing theirs and their partners' sexual desires and activities'* (Ibid. p. 301). Documenting women's experiences of dealing with perceived sexual difficulties in day to day life and within the context of the *'post-Viagra, socio-medical climate'* (Ibid. p.301), these findings suggest an interdependence of culture and economics as reasons why women engaged in therapy or not. These findings have to seen within the context of the male sexual drive discourse (Hollway, 1984) which suggests that men are always ready for sex and women are expected to engage in the long-term legacy of the labour of love more so than their male sexual partners. As a result, these data are largely supportive of the work of Dunscombe and Marsden (1996) who write about the 'sex work' that is enacted within relationships. They argue that not only are women expected to have to contend with their own sexual difficulties, but to do so in a manner in which their own needs and desires are secondary to men's.

A further study conducted by Kaler (2003) examined the extent to which sexual problems have an effect on a woman's sense of herself as 'authentically gendered'. Documenting the experiences of a sample of women diagnosed with vulvodynia- a chronic pain

syndrome affecting a woman's ability to have heterosexual penetrative sexual intercourse- she contended that participants described themselves as failures on the basis that they were unable to engage in this sexual practice. A fundamental point that Kaler articulates is how participants' ideas about who they are as women stem essentially from the materiality of their own bodies. Furthermore, analysis revealed the extent to which there was considerable interaction between the materiality of the body and the socio-cultural norms that determine what it means to be a woman. For example, this was evidenced by the ideas that women diagnosed with vulvodynia had about themselves such as being unable to fulfil their role as a lover to their sexual partner and the inability to conceive via penetrative sexual intercourse.

Nicolson and Burr (2003) writing about women's experiences of orgasm found that expectations and desires differed from those reported in the clinical literature. Their participants described how sexual fulfilment was realized on a number of levels and did not rest solely on the successful achievement of orgasm per se. Their analyses also reveal a number of inherent male biases in respect of the women's expectations generally. As they note in their conclusion *'...orgasms were not central to their* [women's] *own sexual fulfilment. Women viewed orgasms in relation to the satisfaction of male desire and female orgasm was essentially the action through which male sexual fulfilment was to be achieved'* (Ibid. p. 1744).

In a similar manner, Lavie and Willig (2005) explored women's experiences of inorgasmia and its consequences upon women's sense of themselves. Whilst they

discovered that the absence of orgasm was viewed as problematic for a woman's self image, it also had a direct bearing upon their sexual partner. As a result, the experiences of inorgasmia are not limited to physiological processes alone. In accordance with Smith (1996), Lavie and Willig (Ibid.) also suggest that their participants' experiences of inorgasmia occur at the point at which meaning meets matter- that is to say that the meaning attributed to inorgasmia is brought about through a combination of physiological, cultural and psychological factors. It is entirely plausible that participants felt they were missing out because of this positioning of female orgasm as the pinnacle of sexual intercourse- an assertion that has been endemic in the clinical literature since the mid 19th Century and one which has been documented in the first part of this literature review.

Potts et al (2003), writing primarily in relation to the impact of Viagra, have been keen to point out that more attention needs to be paid to women's perspectives and desires, and to the specific dynamics of any given relationship than has previously been the case. Whilst much has already been written about the benefits of sexuopharmaceuticals for men, very little has been documented about the possible drawbacks for women. Writing within the context of ageing, one of the ideas to emerge from this study is the idea that Viagra is not purely and simply men's business. In their conclusions, they claim that *'Viagra affects more than a man's erection. It affects the nature of the sexual relationship that he and his partner share; the frequency with which they have sex, the practices that are included in sex and, potentially, communication around sex'* (Ibid. p. 713). However, that women

are very rarely consulted about their views once again bears testament to the inherent privileging of male sexual difficulties.

In Shere Hite's (1976) nationwide US study of female sexuality she asked women about their experiences and thoughts in relation to numerous sexual behaviours. These included matters such as sexual intercourse, orgasms, clitoral stimulation, masturbation and lesbianism. *The Hite Report* (Ibid.) stated that women '*have been told* how to feel about sex, *but they have never been asked about how they felt about it'* [sex] (p. xi). Thus she asked her participants about how they felt, liked and thought about sex. Even though this study took into consideration women's thoughts and feelings, it still asked them particular questions about specific behaviours. Women had the opportunity to speak about questions that they were asked but probably remained silent about those topics that the questionnaire did not cover.

Summary

This chapter has explored the development of knowledge claims in relation to women's sexuality, sex and sexual problems. It has included an examination of those theorists who have been influential in developing contemporary knowledge and understanding of sexual matters. Those theorists documented throughout this review have written about female sexuality primarily in terms of physical aspects of sexuality. They are largely male and can be seen as promoting male interests- namely the importance of penetrative sexual intercourse and orgasm. Their work is important to consider because it provides

the evidence base for the diagnostic classification system of the DSM, a classification system that is not in any way determined by women's views and experiences.

Through an examination of studies of overall levels FSD and their various subtypes, I have also identified the pervasive influence of these knowledge claims about women in contemporary 'mainstream' research, despite their voices remaining absent from the debate. Whilst I have examined those studies which have addressed women's understandings of sex and sexual problems which provide an alternative lens through which to view these issues, it is notable that these remain in the minority. In this respect the aims of this thesis are as follows:

1. To examine the meaning of sex, sexuality and sexual problems to women;

2. To explore the importance of (self-defined) sexual activity to women;

3. To identify the influence of wider socio-cultural factors upon women's understandings of sex, sexuality and sexual problems.

Chapter 2

Theoretical Framework

This chapter presents the rationale for adopting a material-discursive framework within a feminist methodology to address the aims of this study. It provides a detailed account of the historical underpinnings of this framework and its epistemological tradition. Epistemology in this sense refers to a particular philosophy that deals with knowing and the methods that are adopted for obtaining that knowledge (Stanley and Wise, 1993). I have also identified and described some studies which have utilised a material-discursive framework to guide their research as illustrative examples.

I start by examining the essentialist and social constructionist perspectives in relation to sex, sexuality and sexual problems before considering the biopsychosocial model as a precursor to a material-discursive framework. I also highlight the ways in which the essentialist and constructionist perspectives can be combined in such a way as to transcend those criticisms which have been levelled at the biopsychosocial model on the basis that it has conceded too much to a traditional biomedical approach (Foss and Rothenburg, 1987). I then justify my reasons for adopting an overall feminist methodology to address the aims of this study.

'Essentialist' versus 'Constructionist' Accounts of Sexuality, Sex and Sexual Problems

The two principle approaches used in the investigation of sex and sexual problems that predominate contemporary thinking about these issues are 'essentialist' explanations on the one hand and 'constructionist' approaches on the other. According to Ussher (1997), those who endorse the essentialist/material position focus almost exclusively upon the material/physical body. Conversely those who adopt a social constructionist position, apply a greater emphasis upon the 'discursive turn' and on the role of language in the constitution of both the world and the person (Ibid.). There is no compelling evidence to indicate that either perspective can single-handedly account for academic, clinical or lay understandings of sex and sexual problems.

The Essentialist Perspective in Relation to Sex and Sexual Problems

The essentialist perspective considers sexual problems to occur as a result of a disturbance in the assumed universal physiological Human Sexual Response Cycle (HSRC) which forms the basis of the classification system used to diagnose sexual problems as described in the previous chapter. Feminist critics and practitioners believe the APA's diagnostic manual is obsolete since it assumes that women's sexual problems are comparable to men's on the basis of physiological similarities (Tiefer et al, 2000). Furthermore, the emphasis placed upon physiology leads to the neglect of social and psychological issues that Tiefer (2001 a.) proposes can often lie at the root of sexual problems. She also argues that the current model assumes that all women can be treated

as a homogenous group with little or no recognition of different values, approaches to sexuality and social or cultural backgrounds.

From an essentialist perspective, there is an overwhelming focus upon observable facts in an effort to uncover objective truths, which are seen as independent of our activities and understanding. According to Ussher (1997) those who advocate an essentialist perspective tend to only address physical aspects of experience which are almost exclusively related to biological processes. She quotes the example of the DSM which classifies sexual problems according to material aspects of embodiment as discussed in the first chapter of the thesis.

The Social Constructionist Perspective of Sex and Sexual Problems

Within constructionist thought, a social construct is a concept or practice which may appear to be natural and obvious to those who accept it. In reality, it is an invention or artifact of a particular culture or society. Social constructs are generally understood to be the by-products (often unintended or unconscious) of countless human choices rather than laws resulting from divine will or nature (Berger and Luckmann 1966).

In recent years, 'essentialist' theories of the 'nature' of sex and sexual problems appraised by theorists from a social constructionist paradigm have become the subject of increased scrutiny. Those researchers working within the constructionist paradigm tend to focus upon social, subjective and linguistic domains. The primary method of analysis of social construction is discourse analysis and those who adopt this perspective take the

view that language, and the way in which people use it, fulfils many functions (Potter and Wetherell, 1987). With respect to sexuality, sex and sexual problems, they have attempted to obtain a clearer understanding of the ways that women formulate and give meaning to these aspects of their lives. Before labelling sexual difficulties as 'dysfunctions', it is important to attempt to conceptualize these terms against a backdrop of meanings and explanations given by women themselves in attempting to describe their sexuality.

According to Segal (1994: p.73) the social constructionist perspective advances a view of *'our experiences of the body and its desires* [as being] *produced externally through the range of social discourses and institutions which describe and manipulate them'*. Accordingly, it is to be contrasted with the essentialist approach which ignores the active role of the individual in favour of external forces that can be objectively examined and analyzed. Those on the constructionist side focus upon social and linguistic domains, ideology, culture and power.

According to Tiefer (1995) the major obstacle to establishing a constructionist approach to sexuality research is that biomedical ways of thinking tend to dominant huge aspects of daily life. As highlighted in the previous chapter, the ideological support for medicalisation is located in essentialist, naturalist, biological thinking whereas the constructionist perspective is to define and locate sexuality in the personal, relational and cultural, rather than in physical terms. However, there is also a downside to the deconstruction of social constructionism. We can be left with the idea that nothing is real

and everything is just a social label and an invention of those in power- almost to the point where there is no such thing as a sexual problem for example. It can marginalize and invalidate women's real experiences of pain and the fundamental position of the physical body (see for example Stoppard, 1997; Ussher, 1997). Therefore the implications of adopting an extreme social constructionist or sociolinguistics approach must be carefully examined. That the physical dimension of health and illness remain absent from constructionist analyses is a peculiar omission given that women's bodies are often clearly implicated.

Essentialist and social constructionist approaches are more often than not presented as discrete theoretical orientations- the implication being that they are antagonistic and, as a result, incompatible with one another. With regard to the aims of this thesis, and the theoretical framework adopted, there is a need to reconcile these fundamentally disparate aspects of experience in an effort to move towards a more comprehensive level of representation- particularly with regard to sex and sexual problems and my belief that adopting such discrete orientations towards such complex questions is erroneous. As a precursor to the material-discursive framework the following section of this chapter focuses upon its forerunner, the biopsychosocial model in order to clarify how the latter has developed.

The Biopsychosocial Model: Predecessor to Material-Discursive Frameworks

First advocated by Engel (1977) the biopsychosocial model conceptualized biological, social, and psychological influences as separate and independent factors that interact

within a multifactorial framework. In advancing the biopsychosocial model, Engel (1977) was responding to two main strands in medical thinking that he believed were responsible for dehumanising care. Firstly, he criticised the dualistic nature of the biomedical model with its separation of body and mind. Engel rejected this view for encouraging physicians to maintain a strict separation between the body-as-machine and the personal circumstances and emotions of the person- akin to focusing on the disease and excluding the person who was suffering without building bridges between the two realms. His research in psychosomatics pointed towards a more integrative view, showing that fear, rage, neglect, and attachment had physiological and developmental effects on the individual. Secondly, Engel criticized the excessively materialistic and reductionist orientation of medical thinking.

Critics of the model have argued that it remains rooted in an essentially biomedical perspective and cannot, therefore, provide a suitable framework for truly multidisciplinary methods of research and healthcare. Ussher (1997), for example, claims that this particular model operates within a narrow positivist epistemology, concentrating on quantitative methodologies and simple causational relationships between bio-psycho-social variables. The theoretical accounts of experience produced by such models are thus constrained by the absence of socio-historical context or attention to the dynamics of subjective experience.

As will become evident, from a material-discursive perspective, people's experiences are understood as being inseparable from the sociocultural and political context in which

their lives are lived, so that research should focus on people's everyday experiences, rather than adopting procedures that strip away this context (Stoppard, 1997). An important aspect of this context is social interaction and language, or the discursive, which plays a crucial role in shaping people's experiences and how they are interpreted. At the same time, people's everyday lives are regulated by a material world that is defined and delimited by human embodiment and social structures, such as laws, institutions, and customs. Foucault (1979) for example has drawn our attention to those institutions which form part of the surveillance and control of the individual. Consequently, medicine as one of those institutions is just one way in which 'normal' and 'abnormal' sexualities have come to be defined and regulated.

A review of the literature published in the last ten years which has adopted a biopsychosocial framework to provide an understanding of women's sexual problems shows that studies are limited. Those articles that have been published have tended to adhere to more of a biomedical perspective at the expense of a truly biopsychosocial model (Basson et al, 2000; Basson et al, 2003; Walton et al, 2003). The reasons for this are perhaps twofold. Theoretically, those who are taught the 'scientific' method include certain strategies to eliminate all variables except the one of interest in order to gain 'valid' results. The problem with this approach however is that it is not the way the 'real world' works. For that reason, Sexton and Weeks (2003: p. 352) caution against adopting either an extreme biomedical or a psychosocial perspective and assert that adopting a truly integrative approach that embraces the richness and complexity of our sexual lives is what is really required:

'...an over reliance on either organic or psychosocial factors in the evaluation and treatment of sexual dysfunction is not likely to fulfil the needs of the patient with a sexual dysfunction, any more than it will with any other disease or disability.'

The Rationale for a Material-Discursive Theoretical Framework

'For women to separate their bodies from who they are in the larger context of their lives is like trying to separate two sides of a coin' (Todd, 1989).

For the purposes of this thesis, the 'material' refers to the female body. The 'discursive' refers to the socio-cultural conditions that shape women's everyday lives. Starting from a position that acknowledges the interwoven character of material and discursive aspects of human experience, a material-discursive epistemology has a different grounding to the biopsychosocial model. Here, linguistic meaning and sociocultural processes are understood as both originating from and being manifested in physical being and materiality (Ussher, 1997; Yardley, 1996; 1997). A particular advantage of adopting this approach is that women's voices become audible in the research process. In an effort to reconcile discursive and materialist perspectives on health and illness, Yardley (1996) advocates this approach, which she argues is suitable for studying the reciprocal interactions between the sociocultural and linguistic (discursive) and physical (material) aspects of health and illness. She refers to this as the 'Material-Discursive Approach' and draws her ideas from a wide variety of disciplines including sociology, linguistics, philosophy and anthropology.

A material-discursive epistemology is predicated on the assumption that the material and the discursive are in constant interaction and, in fundamental ways, inseparable. From a material-discursive perspective, the material and the discursive are conceptualized as interconnected and intertwined domains of life that also cut across the categories of biological, psychological, and social in mainstream models. Thus, research that attempts to study psychological and socio-cultural aspects of human existence which are detached from the material realm are viewed as misplaced. The emphasis on the primacy of material as opposed to discursive practices was in part a reaction against the reductionist materialism of the biomedical model, whereby social and psychological interpretations of biological events are assigned a secondary importance to the underlying 'reality' of disease. This also needs to be considered alongside other factors, the environment and technologies for example. However, an insistence on sociolinguistic aspects of health and illness simply inverts and reproduces rather than replaces the previous dualism of the biomedical model. As Yardley (1996) cautions:

'*Although purely sociolinguistic approaches provide a useful illustration that meaningful analyses of the functions of discourse need not contain any reference to material considerations, it is nevertheless vital to find forms of sociolinguistic analysis which can incorporate material being, or can at least be reconciled with materialist accounts'.*

(Ibid. p. 492)

The material-discursive framework begins from a position in which the human body is understood as a *'lived body'*, an organism that is *'simultaneously a physical and symbolic artefact'* (Lock, 1993: p.373) rather than a passive biological entity of biomedical determinism. Thus, the material-discursive approach enables the materiality of the body to be acknowledged, whilst avoiding dualist and reductionist assumptions about the body's role in human experience and action. It serves to unify the individual contributions offered by both viewpoints and, according to Yardley (1997), provides a useful way to explore their reciprocal influence upon one another. Put another way when referring to both the biological reductionist and social constructionist paradigms in relation to sexual behaviour, Skene (2004: p. 13) argues in straightforward terms that:

'I don't accept either of these views. I believe there is convincing evidence that human personality and behaviour, including sexual behaviour, develop from an interaction between biological and social factors: it's not biology or society that calls the shots, it's both'.

Understanding Women's Experiences

My decision to use a material-discursive framework stems from its use within the social sciences as a framework for understanding women's experiences of health and illness. In this thesis, the term 'discursive' is used in a very broad sense to refer to a range of approaches which recognize the socially and linguistically mediated nature of human experience (Yardley, 1997). The 'material' signals attention to the physical features of

human lives, including *'not only our bodies and corporeal activities, but also our environment, institutions, artifacts and technology'* (Ibid. p. 485).

Discursive approaches (comprising a wide variety of theoretical perspectives including social constructionism, post structuralism and post modernism, as well as methodologies such as hermeneutics and discourse analysis) have rapidly gained acceptance across a wide range of disciplines including the social sciences, humanities and recently within health psychology. These approaches are numerous and contrasting but they share a common feature; namely the idea that human activities and social practices have a profound influence upon the nature of reality- both subjectively experienced and scientifically observed (Yardley, 1997). Consequently, rather than striving for the illusory goal of objectivity (as claimed by science and linked to the diagnostic criteria outlined in the DSM in Chapter 1 of this thesis), it is considered far more productive to examine the way in which our reality is shaped by the purposes, conventions, aspirations and assumptions, which form an intrinsic part of human life.

However, there is a growing need which is particularly acute in the area of health and illness to consider how the sociolinguistic aspects of experience relate to our material existence. As soon as questions such as these are posed, it seems obvious that socio-cultural and material aspects of human experience are intimately linked and that while each can be studied separately, it is also useful, indeed important, to explore them in unison. For many discursive analysts though it is not enough simply to add a

sociolinguistic angle to a traditional biopsychosocial analysis (Yardley, 1997). It is for this very reason that a 'material-discursive' approach has been adopted in this thesis.

A material-discursive approach to understanding aspects of health and illness has been advocated by theorists eager to shape an integrated account of insights from *both* diverse theoretical perspectives which I have previously referred to as 'essentialist' and 'constructionist' perspectives. However, the extent to which both can be considered complementary has been the subject of controversy given that they derive from diametrically opposed theoretical perspectives (Gilles et al, 2004). Consequently, with a material-discursive theoretical framework, there remains a certain level of unease *'about the extent to which they retain dualistic categories of mind/body and treat materiality as simply 'given''* (Ibid. p. 100).

Illustrative Examples

A number of academics (for example Stoppard, 1997; Ussher, 1997; Yardley, 1997) have adopted a material-discursive framework to both highlight the shortcomings of essentialist and a social constructionist positions and bring them together to provide a more inclusive picture whereby neither aspect is privileged over and above the other. Stoppard's (1997) study examining women's experiences of depression brings both material and discursive aspects together to accommodate both the subjective and the material, embodied in a way that escapes the dualistic modes of thinking underpinning mainstream research. In Karp's (1992) view, neither a solitary biomedical explanation nor an explanation in terms of psychosocial factors alone are able to fully explain women's experiences of depression, but a combination of both these elements is needed.

Stoppard (2000) argues that what she refers to as the 'women's bodies approach', with its focus primarily on the biological body, is closely associated with medical-psychiatric perspectives on depression. Furthermore, she considers this as a variation of the dominant biomedical explanatory models governing practices in this field whilst pointing out at the same time that opposing feminist arguments *'may seem to deny the reality of experiences which for some women are both physically debilitating and psychologically dispiriting'* (p.102).

Another important feature of the material-discursive framework lies in its potential to provide rich accounts of women's experiences in relation to sex, sexuality and sexual problems in ways that are free from the constraints of a dominant biomedical perspective which are based upon 'traditional' research methodologies. Efforts to 'explain' these issues need to draw on and integrate knowledge that is multifaceted and interdisciplinary in order to address the material-embodied and subjective-discursive aims of the thesis. A perspective that can encompass both material and discursive aspects of lived experience, that can keep both aspects in view, at this juncture appears to have the most to offer in the search for more emancipatory understandings and explanations- particularly when issues such as sex, sexuality and sexual problems are the primary topic under investigation.

From a material-discursive point of view, understandings of sex, sexuality and sexual problems are best understood as experiences which arise in conjunction with a woman's embodied efforts to meet socially constructed standards defining the 'good' woman. Consequently, this thesis supports a critical realist as opposed to a relativist, position

whereby discursive constructions of reality are not free-floating, but are grounded in social and material structures, such as the physical body and institutions (Parker, 1992). According to Pilgrim and Rogers (1997), this approach also affirms physical reality whilst recognizing at the same time that its representations are characterized and mediated by language, culture and political interests. Thus, while critical realism retains empirical enquiry as legitimate, it rejects a naïve positivist view of the world. The remainder of this chapter looks at how a material-discursive framework fits within the overall feminist methodology of this thesis.

Acknowledging the body in this way is fundamental to this thesis because sex and sexual problems are embodied experiences. Whilst biomedical approaches recognise the body, they may emphasize it to the extent that psyche, environmental and cultural influences are neglected.

Feminist Research Methodology: How Does It Differ From Mainstream Research?

Methodology is a complex concept which encompasses the choice of method, the implications surrounding that choice and how those methods are used (Campbell and Bunting, 1991). The principles of feminist methodology include paying attention to the importance of gender as a central element of social life, challenging the norm of objectivity to incorporate subjectivity into research, avoiding the exploitation of women as subjects and objects of knowledge and empowering women through social research-goals that are usually informed by extensive reflexivity throughout the research process (Fonow and Cook, 2005). Feminist and other qualitative researchers often point to the

idea that there is much to be gained from sharing with rather than taking 'from' their participants. However, I also recognise that researchers should not take a 'hit and run' approach and that they should also be mindful of trying not to take advantage of their participants (Booth et al, 1994). The researcher does not attempt to exert power over their participants but is eager to gain knowledge and listen to their experiences (Oakley, 1982; Klein, 1983; Harding, 1987).

Feminist methodology is more concerned with these principles than with a 'cook book' approach to research. Klein (1983) sees this flexibility offered by a feminist approach as an advantage, setting it apart from the traditional research methodology with purpose and outcome being seen as more important than process. The rigour of feminist research is judged upon its credibility and how worthwhile it is (Webb, 1993; Koch and Harrington, 1998) rather than the adherence to a strict set of procedures.

At this point, it is important to clarify the distinction between method and methodology. King (1994: p. 19) observes that in the past in some feminist research *'there has been a discrepancy between the author's interpretations of method and methodology'*. Harding (1987) makes a clear distinction between these two terms defining method as the technique for gathering evidence and methodology as a theory or analysis of how research should proceed. Furthermore, she goes on to claim that it is not the method that makes feminist research different from what she terms 'malestream' research, but: (a) the alternative origin of the problems, which concern women rather than men; (b) the alternative hypotheses and evidence used; (c) the purpose of the inquiry, which is to

understand a woman's view of the world and assist in the emancipation of women; and (d) the nature of the relationship between the researcher and the so-called 'subjects' of her inquiry (Harding 1987). Likewise, Cook (1983) in her examination of feminist research concluded that no matter what the discipline, feminist research demonstrates four major assumptions that may be viewed as a critique of mainstream research. The first assumption is that there is a persistent lack of information about women's worlds. Secondly, there is a bias in the under representation of women researchers. Thirdly, there is a need to re-evaluate previously investigated phenomena to include women's experiences. Finally, the kinds of research questions that are asked have *'fundamental implications both for the results obtained and for practical action'* (Cook, 1983: p. 127).

Methods are the tools adopted for data collection. Stanley (1990: p.12) states that *'there is no one set of methods or techniques which should be classed as distinctly feminist'*. The critical issue at stake is how those methods are used with regard to the topic under investigation and she advocates feminist researchers using any research techniques that further feminist aims. The subsequent methods chapter in this thesis examines these issues in a practical way to demonstrate how semi-structured interviews were undertaken to address the research aims of this thesis.

Some researchers equate feminist research primarily with qualitative approaches and thus view their employment as an essential element of feminist methodology (Lather, 1998; Sigworth, 1995). However, it is not the distinction between qualitative and quantitative methods that define feminist research as Reinharz (1992) makes clear, but rather its

particular theory of knowledge, or epistemology. Further to this, Oakley (1998), has argued against the construction of a gendered paradigm which poses an association between qualitative work and feminism and quantitative work and work that is specifically masculine and/or positivistic.

An aspect which sets feminist research apart from other approaches to social inquiry is its ontological claim that the reality depicted by much of scientific and social scientific knowledge is incomplete and fundamentally distorted (Stanley and Wise, 1993). Most studies in relation to sex and sexual problems are dominated by an androcentric worldview. That is, they communicate the male experience and are based on male assumptions and perspectives. Women, their understandings, experiences and perspectives have often been excluded (Belenky et al, 1986). To date, there are only a small number of studies which have examined women's views of sex and sexual problems. Whilst these studies have been documented in the first chapter of this thesis, it is hoped that this study will help to redress that imbalance by incorporating women's own subjectivities using the feminist principles that I have outlined above.

Social science has been dominated by *'theories and concepts emerging solely from a male consciousness* [which] *may be irrelevant for the female experience and inadequate for explaining women's behaviour'* (Shakeshaft, 1987: p. 149). At the most basic level, then, feminist research attempts to incorporate the female perspective into social reality. In examining various feminist social research methodologies, Reinharz (1992) asserts that this focus on perspective is a central theme across the work of many feminist

researchers. She also argues that a feminist criticism of established research stems from a distrust of the male power and perspectives in research and society, not from a rejection of traditional methods of inquiry. As such, Reinharz (Ibid.) suggests that feminism is a perspective, not a method.

However, the common focus on perspective in feminism does *not* suggest that feminist researchers share the same point of view. What is *shared* is the basic tenet that *'females are worth examining as individuals and as people whose experience is interwoven with other women'* (Ibid. p. 241). What is distinctive is the range of epistemologies represented among feminist researchers. Indeed, there are multiple feminist perspectives on social research methods, due to the sometimes stark differences in the lives of women and feminist researchers, as individuals and as members of social groups.

According to England (1993) feminism and feminist research methods, unlike mainstream research, give potentially disadvantaged and silenced groups an opportunity to be heard. In the case of this particular study, it allows women to characterize what they view as sex, sexuality and sexual problems rather than deferring solely to a fixed definition specified by institutions of power, particularly medical authorities, which may have no direct relevance to women's views and experiences themselves. As a result, it can be argued that this work goes some way to address the argument of Nicolson (1993) that we must deconstruct readily imposed patriarchal hegemonic discourses in relation to women's sexuality, such as the importance placed upon penetrative sex and orgasm

which was a principal characteristic of the work those early sexual theorists outlined in Chapter 1.

Rather than talking about the many different feminist positions that exist, it is important to highlight the issue of whether or not there are distinct research methods that can be considered feminist. To do so, it is vital to address some of the consistencies between the different feminist positions and how they differ from mainstream research. In studying some of the issues surrounding feminist research, I have found a consistency among the assumptions made by feminist researchers in their approach to their research. Fundamentally, for research to be considered feminist in nature, it must address matters concerning the oppression of women.

Controversies and Contentions: Men 'Doing' Feminist Research

A controversial issue within research that is influenced by a feminist viewpoint relates to who it is that is conducting the research. There are contradictory views in respect of who can and cannot conduct 'feminist research'. Some men (and indeed women) are hostile to the idea of men doing feminist research at all (Adelson, 1980), whilst other men label themselves and their research as feminist. Indeed, in the very early stages of this study, this was an issue that I became intensely aware of.

The feminist community is deeply divided about men's roles as feminists. Psychologist Nancy Henley argues against anti-male feelings, writing that being pro-woman and anti-male supremacy does not necessarily mean being anti-man (Henley, 1977). Others such

as Mary Daly claim that men can support feminism but cannot be feminists because they lack women's experience:

'Male authors who are now claiming that they can write accurately 'about women' give away the level of their comprehension by the use of this expression. The new consciousness about women is not mere 'knowledge about' but an emotional-intellectual-volitional rebirth'. (Daly, 1973: p. 200).

Contemporary debates about whether men can be feminists have focussed more generally on marginal location as a key to being able to identify with women (Collins, 1991). In this case, men should be able to demonstrate an experience of marginality but still with the understanding that all experiences of marginality are not the same.

Conversely, men have pointed out the oppressive nature of being excluded by women. Terry Kandal, an American sociologist highlights his views about this exclusion in the following quotation:

'Feminist critical discourse has raised the epistemological question of whether one must be a woman in order to contribute to an authentic sociology of, or for women. Obviously having written this book, my answer is: not necessarily. Although a man cannot experience what it is like to be a woman, this does not preclude making a contribution to the sociology of women. William James' distinction between 'knowing' and 'knowing

about' is apropos. Oppression seems to me to have transgender aspects, which those who experienced it can communicate' (Kandal, 1988: p. xiv).

Men who conduct what they call feminist research are very much in the minority. An interesting perspective raised by Fine (1985) is the claim that men are not victimised when they study feminists or women. Rather, she contends that they are viewed as greater authorities than the people about whom they speak which is indicative of the patriarchal nature of our society. As she goes on to argue:

'Those who study injustices are often ascribed more objectivity, credibility and respect. When men discuss feminist scholarship, it is taken more seriously than when women do. When whites study the black family, the work may be viewed as less 'biased' than when black scholars pursue that same areas...but if a black social scientist studies white people, one might expect the resulting analyses to be considered the black perspective' (Ibid. p. 103).

In a text that is now something of a landmark within feminist interviewing, Oakley (1982: p. 57) claims that *'a feminist interviewing women is by definition both inside the culture and participating in that which she is observing.'* Being a woman means that the researcher can personally identify with those whom she interviews and vice versa so that

'...personal involvement is more than dangerous bias- it is the condition under which people come to know each other and to admit others into their lives' (Ibid. p. 58).

From this, Oakley argues that an interview bond is more likely to develop on the basis of minimal social distance i.e. when both the researcher and the participant share the same gender, ethnicity or some other aspect of their identity. She also argues that these factors allow for identification and empathy between the researcher and her participants. This idea of shared characteristics also features in the work of Finch (1984). She maintains that the reasons why women are more enthusiastic about talking to a woman researcher lie in the social experience of women and their expectation that the researcher as another woman, shares with them this social experience and can, therefore, easily understand them:

'Women are more used than men to accepting intrusions through questioning into the more private parts of their lives...Through their experience of motherhood they are subject to questioning from doctors, midwives and health visitors; and also from people such as housing visitors...who deal principally with women as the people with imputed responsibility for home and household. As subjects of research, therefore, women are less likely than men to find questions about their life unusual and therefore inadmissible' (Ibid. p. 74).

With regard to women sharing their experiences with a male researcher, Finch (1984) asserts that *'...however effective a male interviewer might be at getting women interviewees to talk, there is still necessarily an additional dimension when the interviewer is also a woman, because both parties share a subordinate structural position*

by virtue of their gender. This creates the possibility that a particular kind of identification will develop' (Ibid. p. 76).

This view is endorsed by other authors who maintain that, in order for a woman to be understood in a social research project, it may be necessary for her to be interviewed by another woman. Spender (1980) argues that woman-to-woman talk is different from talk in mixed sex groups. In furthering her argument for excluding men from feminist research, Kremer (1990) also warns that this can lead to another power differential where men speak to men about women.

These arguments would appear to suggest that, by virtue of being a man, I am precluded from having the necessary woman-to-woman rapport described by Oakley (1982) and Finch (1984), making an engaging and informative interview extremely implausible. However, there is also literature to suggest that this may not always be the case although these are the views expressed by female as opposed to male social science researchers. Puwar (1997) illustrates her own experiences and argues that whilst at times her position as a woman interviewing other women gave her certain credibility, she was frequently considered an outsider on the basis that she did not share the same occupational identity of her participants. Somewhat paradoxically and contrary to her expectations, she did not always establish a rapport with those who she thought were similar in terms of experiences of class, gender and racism as well as political persuasion. Consequently, even though she was, in Oakley's (1982) terms viewed an insider, having this status did not confer any automatic relationship with her participants.

Indeed, whilst shared characteristics can be a useful resource to facilitate closeness and rapport, this is entirely dependent upon both individuals wanting to associate with one another, and feel at ease with in one another's company during the interview situation. Puwar (1997) also found that rapport would often develop in more unpredicted ways. She gives the examples of shared characteristics such as where one has lived, where one has studied, the places where members of her family had lived, worked or studied as factors important for the creation of rapport in an interview situation. Even more fundamental than this were the participants' attitude towards the subject under investigation.

This point is further supported by Riessman (1987) who argues that gender similarities alone are insufficient grounds to lay claim to an automatic relationship with research participants and that similar cultural patterns take on a comparable, if not a greater importance towards the development of a relationship between participant and interviewer. Putting it succinctly, she claims that *'gender is not enough'* (Ibid. p. 172). In a related manner, Condor (1986: p. 97) discovered that despite her use of an open-ended questionnaire, she could not sympathise with *'traditional women who supported the existing roles of men and women'*. Although she tried to reach *'an understanding of women in their own terms'* she found that *'regarding individuals and social events from the perspective of feminism...may...encourage the very tendency to objectify our subjects which feminism opposes so forcefully'* (Ibid. p. 102-103). I consider her work to raise a much more fundamental question about whether the researcher can empathise with some

and not with others, thereby questioning the woman to woman rapport advocated so ardently by Oakley (1982). I believe the answer to these dilemmas reflects a more basic principle which is that every aspect of the participants' and the researchers' identity and interactions can impede or facilitate understanding of the issues under investigation.

What this literature demonstrates (some of which dates back to the 1970's but still remains pertinent today) is the idea that these issues are by no means straightforward. Whilst Gray et al (2007: p. 230) argue that *'it is much less likely that they [men] can produce research based in women's experience, simply because it not their experience'*, this is evidence to suggest these are issues which continue to permeate contemporary thinking.

I return to these issues in Chapter 3 where, under the sub-heading 'A Man Conducting Research with Women', I discuss my thoughts about whether or not female-male rapport was established in my own work and address the question of whether or not a man can do feminist informed research. In my opinion, a continued association of interviewing women as 'women's work' compounds established views about women as good listeners and ignores the hard emotional work which is now an acknowledged aspect of much of the research undertaken by researchers, both women and men alike. This could be likened to the argument that states that equating men with quantitative methods continues and confirms stereotypes about men's superior numerical abilities and their lack of emotional skill (Lee-Treweek and Linkogle, 2000; Ramsay, 1996; Warren, 1988).

Summary

The aim of this chapter has been to describe and critique the epistemological and methodological underpinnings of this thesis. I have outlined my argument for the suitability of a material-discursive framework to address the aims of this study and, driven by a feminist methodology, have examined some of the theoretical arguments that relate to men conducting research with women. Chapter 3 explores the practicalities of conducting the empirical research reported in this thesis and includes a reflexive account of a male researcher conducting social science research with women.

Chapter 3

Methods

Introduction

Having considered both the methodology and epistemology of the study in the previous chapter, this methods chapter describes the step by step process of conducting the study. This includes the overall study design and the ethical and recruitment procedures (including some of the difficulties encountered). Participants' demographic characteristics, the interview setting and guide and the practicalities of conducting the interviews are also described comprehensively. In addition to the traditional structure of a methods chapter, I include a reflective account of my experiences which comprise both my personal reflections as a man *and* a gay man researching women's understandings of sexuality, sex and sexual problems, in conjunction with participants' views of talking to a male researcher. Providing a reflexive account of the research process is important on the basis that it allows the reader to gain insight into this process from the perspectives of those who took part in the study and the researcher alike. The chapter concludes with a description of the way in which the data were analysed, including a step by step account of the conventions that were adhered to using template analysis.

Study Design

This study used semi-structured interviews to explore women's understandings of sexuality, sex and sexual problems. Participants were recruited from two separate sources: a) members of the general public from two cities in the UK who volunteered to

take part in the study; and b) women registered at, but not currently undergoing any form of treatment, at a psychosexual clinic (so as not to have an effect upon any treatment outcomes).

The same interview guide was administered to all participants (see Appendix 1). I used a semi-structured interview method to investigate this topic because of its suitability and the flexibility that it offered *'...for studying people's understandings of the meanings in their lived world, describing their experiences and self-understanding and clarifying and elaborating their own perspective on their lived world'* (Kvale, 1996: p. 105). The development of the interview guide used throughout the course of this study is also described.

Semi-structured interviews permit issues to be explored which are of a complex nature and which cannot be explored in a straightforward manner by quantitative measures. Due to their diversity of meanings, sex, sexuality and sexual problems cannot be presupposed to be homogenous in any respect and do not lend themselves to a 'tick in a box' scenario. By its very conversational nature, the semi-structured interview lends itself readily to being easily adaptable and allows trust to be established between the participants and the researcher, thus potentially eliciting deep and meaningful responses (Hinchliff, 2001). This method also provides a 'fit' between the overall feminist methodology and the need to re-evaluate previously investigated phenomena to include women's experiences.

Interviews gain descriptions of the participants' life-worlds, so inconsistencies naturally arise (Ibid.). Indeed, it is argued that a particular strength of qualitative research is to find an array of views on a topic or theme and to demonstrate these within a diverse and uncertain world (Kvale, 1996). Semi-structured interviews also allow the researcher to address issues as and when they emerge, giving freedom of speech to the participant and a more thorough understanding to the researcher. This flexible structure enables the participant to follow their chain of thought, give a detailed account of their experiences and the opportunity to talk around issues of importance to them. Furthermore, it allows interesting responses to be pursued, whilst extricating meanings behind actions.

Ethical Approval

Members of the General Public

Ethical approval to recruit members of the general public was submitted to Sheffield University Research Ethics Committee. The initial application was submitted for ethical review in November 2003 but rejected over a number of concerns expressed by members of the ethical review panel.

In that proposal, I had originally designed the study to invite participation from all female employees in the School of Health and Related Research (ScHARR) via an email distribution list. Further discussion groups would then be carried out with members of the general public. All of these groups would be conducted with the help of a female colleague with experience of talking to women about sex and sexual problems. The reviewers' comments revealed a number of concerns about using this method to discuss a

topic with women who might be known to one another in their working lives, seeing this as a potential impediment to their ability to disclose information:

'It is likely that many of the participants will know each other and the interviewers. This will mean that people from the same work environment will hear each others personal information, which could cause difficulties relating to work in the future and with the honesty and openness of the data being shared.'

(Remarks of an anonymous ethical reviewer)

With hindsight, these concerns were corroborated by comments received by participants concerned about discussing these matters in a group setting. The following participant identifies the group setting for discussing sex and sexual problems as making her 'ill at ease'. Referring to the merits of the individual interview over and above the focus group method, she explains:

'Fine. Fine. But only 1 to 1. I couldn't do it [talk about sex and sexual problems] in a group, well I could but I'd be stupid, you know, I would. Oh no I'd hate it in a group..... I would, you know if somebody said, 'well actually, oh I don't know, he doesn't want it' [sex].... That wouldn't worry me because I am so open and so outgoing. What I couldn't cope with is somebody saying you know, oh I don't know, we haven't had it for 5 years. 'Then why are you still with him?' I'd be saying'.

(59 years of age. Married. Heterosexual)

A further observation made by one of the reviewers related to my gender as a potential obstacle to conducting this type of research:

'My only reservation about this project is that it explores women's sexuality and yet the investigator is male (and presumably young). However this is no bar to doing the research, although I see a woman is to help with the interviews. Thus my only concern is getting a representative sample.'

(Remarks of an anonymous ethical reviewer)

To begin with, I found the latter comment untenable. After all, the aims of this study were exploratory and I was not making any claims about a representative sample. Nonetheless, having given considerable attention to the debate prompted by feminist researchers regarding shared gender being a prerequisite for empathy and understanding in the previous chapter of this thesis, such a response was scarcely a surprise. Having altered the original research method from discussion groups to individual interviews, ethical approval was subsequently granted and I was able to proceed with recruitment.

Psychosexual Clinic Participants

Ethical approval was submitted to the Rotherham Local Research Ethics Committee as a Notice of Substantial Amendment to a study already in progress (Gott and Hinchliff, 2003). Research Governance approval was then granted from the Sheffield Health and Social Research Consortium. Once these requirements had been satisfied, as a non NHS employee undertaking research within the Sheffield Care Trust (STC), occupational health and Criminal Records Bureau (CRB) checks were carried out in order that I met

the necessary criteria for an NHS honorary contract to be issued (See Appendix 2). Such contracts are now standard practice where access is required by non-Trust employees who are undertaking research involving hospital staff, patients, their organs, tissues or data. In principle, it ensures that all researchers are contractually bound to take proper account of the NHS duty of care, thus affording protection to both the participant and researcher alike.

In addition to obtaining ethical approval to interview an NHS patient group, there was a further stipulation that I was health-screened by hospital occupational health services. Aside from the detailed questionnaire I was required to complete, this also involved taking a blood sample which would be tested for Hepatitis B to prove my immunity (or otherwise) to the disease. I was somewhat perplexed by the justification for this given that on balance, I was conducting a qualitative interview based investigation and not a study performing any major invasive surgical procedures. Consequently, there were very few or no risk factors involved for contracting or communicating any form of disease! Appraising an excerpt from my field notes I made at the time, I documented my bemusement for taking my blood to which the nurse quickly replied 'Well what if some of the women are pregnant or they try to bite you?' In the end, I considered it futile to try to dispute his professional accountability and continued to fill in the health questionnaire he had given me to complete. At the time I recall thinking to myself that I hoped my interview technique was not that bad so as to give good reason for being bitten by study participants!

All of these procedural requirements proved very protracted and it took nearly five months from securing ethical approval to reaching the point where participants could be officially contacted. My reason for documenting this experience in such detail is to draw other researchers' attention to potential hold-ups that can occur when working with organizations with the power to control the access of the researcher to study participants and to plan in advance for likely difficulties.

Recruitment of Research Participants

General Public: Procedure and Problems

A variety of organisations in two UK cities frequented by women from the general public were initially targeted as potential recruitment sites. These included libraries, private sports clubs and public toilets. The aim of this approach was to seek agreement to display a poster advertisement which outlined the researchers' name, affiliation, and the purpose of the study (see Appendix 3). The posters were intended to generate women's interest, encourage potential participants to contact the researcher to discuss the possibility of being interviewed for the study and to seek further clarification of the aims and objectives of the study. However, I encountered a number of difficulties when recruiting participants from the general public via the use of this method and subsequently switched to an alternative method. The overriding concern of individual organisations initially contacted to help with the study rested upon their views as to the suitability (or otherwise) of the topic under investigation. These concerns appeared to be entirely those of gate-keepers with the power to control the researchers' access to the women themselves thereby restricting my access. Anxious that the subject matter was

too sensitive, many of the organisations who were contacted refused my requests to display study recruitment posters. This made it difficult to recruit participants from a non health related source.

With hindsight, having had the opportunity to listen to and reflect upon to the views of women themselves, the anxieties of gate-keepers were almost always at variance with the views of women themselves. Arguably, this may have denied many participants the opportunity of contributing to the research. The requests to display posters to recruit participants to the study were met with an unreservedly negative response by those in a position of authority with the ability to sanction my request. Of those organisations contacted, they were all unwilling to display these either because of a strict commercial policy or because they considered the material outlined on the posters too 'risqué':

'I have discussed the matter with the Councils' Principal Policy Officer [Gender] and I have concluded that it would not be appropriate for you to use public toilets as a method of recruitment to attract participation in the study'.

(Male Council Official)

'Children might see the posters and tell their parents. We have to be very careful at this [private sporting] club'.

(General Manager. Private Sporting Club)

As a result of these reactions, and what I perceived to be an attempt to restrict the views of women, based largely on the argument of the perceived sensitive nature of the subject, I altered the method of recruitment. Consequently, local newspapers in both cities were contacted. Whilst one of them failed to respond to my request to place an advert in their newspaper publicising the study, the other sensationalised the study and placed the advert in the middle of a two page article in relation to prostitution potentially limiting response rates (see Appendix 4 for local newspaper coverage):

'Women's views on sex sought. Sheffield women are being asked to 'tell all' about sex for a University research project'.

(The Sheffield Star)

Faced with a rather disappointing response from those organisations contacted at the outset of the study, I looked into the possibility of using a different form of media and contacted two local radio stations with what I thought would be a sizeable target audience of women listeners. Both of the organisations contacted agreed to host a live studio broadcast and these proved to be the principal method of recruitment. Despite both the radio broadcasts sensationalist approach to the study, their impact was generally positive. Women interested in participating contacted both radio stations almost immediately after each broadcast to request further information and leave their contact details. In those broadcasts, I had made reference to the fact that I was interested in the views of women of *all* ages.

Referring to one of those radio broadcasts one participant subsequently interviewed for the study told me:

'I thought it [the study] sounded like a fascinating subject, having been interested in female sexuality for years and I rang the programme right away...'

(50 years of age. Separated. Heterosexual)

The majority of those who responded did so as a result of the two live local radio broadcasts I had taken part in (8 participants). The remaining participants responded to the advertisement in a local newspaper (2) or were 'snowballed' by individuals who had already taken part in an interview with me and were able to give backing to the study through their own experiences of taking part (3).

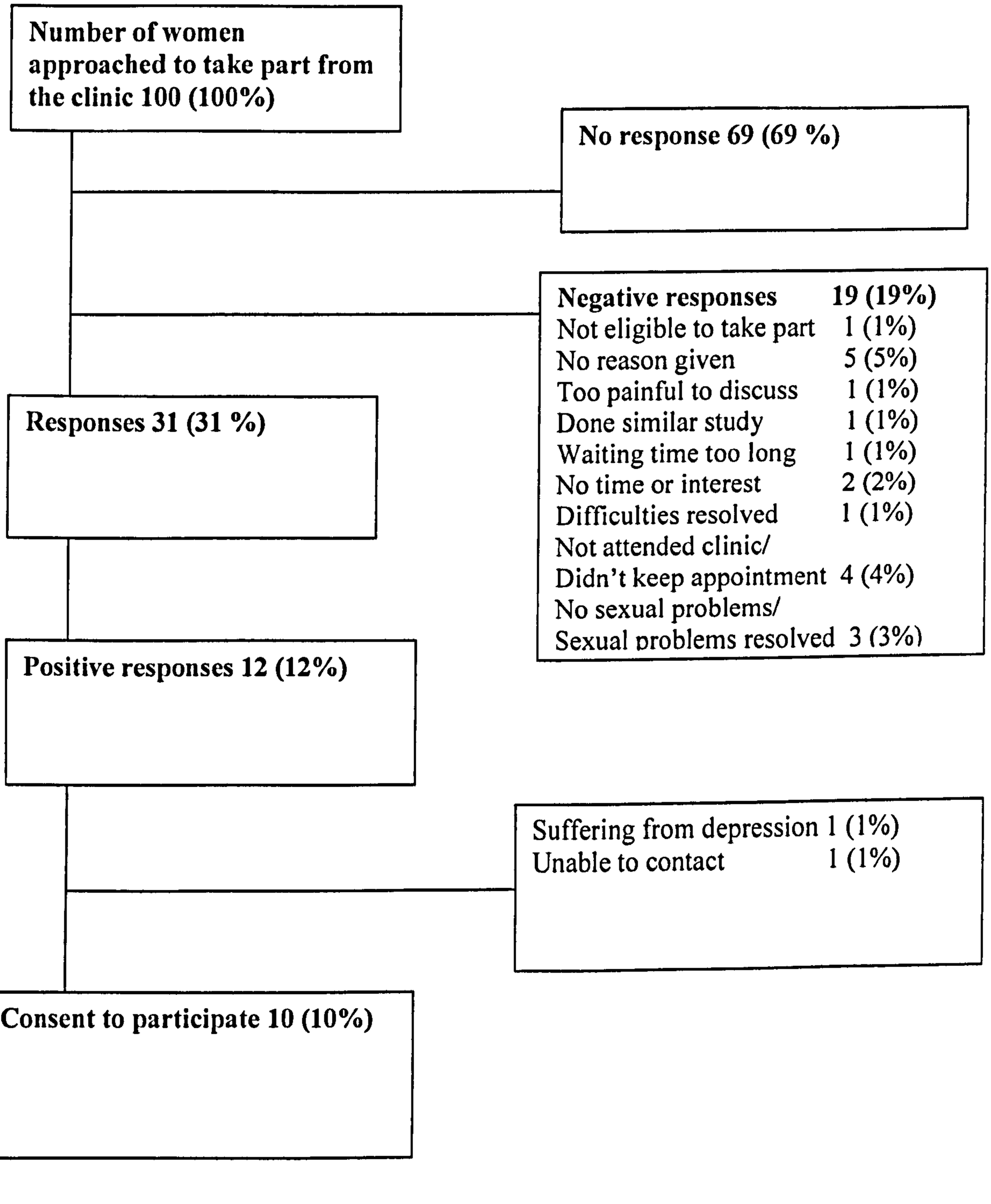
Snowball sampling has been defined very simply as a technique for locating research participants. In practice, one subject gives the researcher the name of another participant, who in turn provides the name of a third, and so on (Vogt, 1999).

Psychosexual Clinic: Procedure and Problems

With prior consent of the Clinical Director of the psychosexual clinic, a total of 100 letters were sent out to potential participants. A list was generated which contained the names of women who were registered at the clinic. Participants were cross-checked against a central database to ensure that a) they were not currently receiving treatment; b) they had not participated in a similar study and c) they were not transgender. The clinic

also screened the letters prior to sending them out to make sure that the above three criteria were safeguarded. An effort was made to recruit a diverse sample of women in terms of age, ethnicity and geographical locality. It was difficult to obtain a varied sample in terms of the women's presenting sexual difficulties as this information was unavailable until the interview stage. Using a freepost envelope and a reply slip, those women who were contacted were given an information sheet outlining the details of the study and asked to indicate a willingness to participate. They were also asked to complete the reply slip even if they had declined to take part in the study and to give the reason for their decision. If they replied indicating a willingness to participate in the study, they were contacted by the researcher. Figure 1 gives an account of the response rates and the reasons that were given by those not wanting to take part in the study:

Figure 1. Recruitment of participants from the psychosexual clinic



Sample Characteristics

A total of twenty-three participants were recruited to take part in the study. They ranged in age from 23-72 years (mean age 45 years). The thirteen women who were recruited from the general public ranged in age from 35-72 years (mean age 53 years). The majority of these participants were either married (6) or had a partner (2). The remaining participants were either divorced (1), separated (1), widowed (1) or currently single (2). Eleven participants were heterosexual, one was lesbian and one described her sexual orientation as 'confused'. Seven were in full-time employment, one worked part-time and three participants were retired. The remaining participant described herself as a full-time wife and mother. Eight participants had children. The majority of participants described their ethnic origin as white (8), three were Chinese and two were of mixed race.

The ten women recruited from the psychosexual clinic ranged in age from 23-49 years (mean age 35 years). Older women were generally unrepresented on the psychosexual clinic database (Wylie, personal communication, 2003). The majority of participants had a partner (5) or were married (4). One participant described herself as single. Nine participants were heterosexual and one described her sexual orientation as lesbian. Six were in full-time employment and the remaining participants described themselves as a full-time wife and mother (1), not working due to a disability (1), unemployed (1) and a full-time student (1). Five participants had children. The majority of participants recruited from the clinic described their ethnicity as white (9) and the remaining participant described herself as 'Slav' which I understood to be Yugoslavian.

Whilst I have highlighted the non-clinical and clinical samples of the study as separate in the above account, this has been chiefly to outline to the reader the diversity both within and across the two samples and the issues involved in their recruitment. For the purposes of analysis however, and for the sake of completeness, both datasets are presented concurrently in order to represent the entirety of participants' views and not to treat one group as distinct from the other. This is an approach that Davies et al (1999) advocate in their work relating to 'sexual desire discrepancies' in heterosexual couples and argue that focusing on clinical samples alone fails capture the *'knowledge of how sexual desire manifests itself in relationships and interacts with other important areas of relationship functioning in more normative ways'* (p.557). Moreover, presenting participants' views together is in recognition of the variability among those different theorists outlined in Chapter 1 of this study and the multidimensional ways in which sexuality, sex and sexual problems have been understood.

The Interview Setting

Offering participants a choice of venue for their interview was an aspect built into the study from the very beginning and was appreciated by those who participated for a variety of reasons. Of the twenty-three participants who took part, thirteen elected to be interviewed in their own home. The remaining ten participants expressed a preference to be interviewed on University premises where I had set aside a room to make sure that we would not be disturbed. Participants rated this choice as important. Those participants who elected for their interview being within their own environment argued that it made

them feel more at ease and consequently more likely to disclose information of a personal nature. This point of view is evidenced in the following interview extracts:

'...It [the interview] is helpful being in my home. Yes, I feel more comfortable sharing what I've shared with you because it's my territory. Also I don't want to get personal but things like the way you're dressed- the sweater and the jeans rather than the suit and the tie, you know do help to make people feel more at ease particularly given the subject matter'.

(50 years of age. Living with partner. Lesbian)

'I feel quite relaxed, because it [the interview] is my own home I suppose. I think that's quite important in itself as well isn't it- that you're in your own environment'.

(43 years of age. Living with partner.)

Conversely, for those who opted for their interview to take place on University premises, I endeavoured to make the situation as informal and relaxed as possible. Part of that process involved altering simple things like the layout of the interview room in an attempt to reduce the formality of the situation. As the following participant remarked:

'It's [interview setting] not a doctor's surgery. This is relaxed. It's quite informal as well. Sometimes you go into these places and the chairs are already laid out. I'm glad I'm not sat at one side of a desk and you're at the other, there's nothing between us. This is good. This is good Feng Shui, you've passed the Feng Shui test'.

(33 years of age. Living with partner. Lesbian)

I viewed the women who took part in the study as experts in their own lives and as such, I endeavoured to treat their accounts in that manner. To suggest that I am privy to any kind of superior knowledge because of my academic status is antithetical to the way in which I view myself and my involvement in the research. However, on occasions, participants did liken my position as a researcher to that of a doctor and counsellor. This is evidenced at an earlier point in this chapter whereby participants would readily position me as 'expert' on the topic under investigation. Consequently, as a researcher, one has to acknowledge that trying to equalise power relationships can be difficult (Oakley 1982, Devault 1990; Parnis et al 2005; Clarke 2006).

Prior to interview at the recruitment stage, I encouraged participants to ask as many questions about the study as possible before checking their agreement to record our conversation. This worked well and I was accepted in my role which would often move backwards and forwards from that of researcher to friend. Part of that process involved 'lowering my defences' and disclosing aspects about myself that would help to put participants at ease rather than being perceived merely as a neutral observer (Dickson-Swift et al, 2006). One factor that helped in this matter was my disclosure to participants that I identified as a gay man. This issue is examined in greater detail later point in this chapter. According to Watson et al (1991: p. 497) *'the abstract notion of remaining completely uninvolved is not altogether possible or desirable'*. I found that the relationships I shared with participants was based on empathy, trust and a positive regard

for their views on the topic under investigation coupled with my own willingness to divulge aspects about myself to help facilitate their own disclosure. Each interview was also pre-arranged for a time and date that would suit individual participants' requirements in terms of concerns such as work commitments and child care arrangements.

On the whole, participants were enthusiastic to share their views with me and hoped that their involvement might help other women. This motivation to improve the situation for others of their gender is familiar within feminist research (Oakley, 1982; Stanley, 1990; Webb, 1993). I thoroughly enjoyed meeting participants, and likewise, the women seemed to enjoy sharing their experiences, which often appeared to serve a kind of therapeutic function. This is evidenced in the following interview excerpt:

'Whenever I start to feel ... I don't know what the word is. Whenever I start to not worry about it but think about it again, like when the letter arrived and I thought God I remember that sodding [psychosexual clinic], you know, and then after that I think about it periodically because it's been brought back into my mind and its really about rationalizing the way that I feel and I always find that helpful. I think if we all did more of that it would be helpful. I feel very comfortable.'

(43 years of age. Married. Heterosexual)

I then began to speculate about the extent to which I may have possibly exploited these participants as a means of pursuing my enquiry, perhaps manipulating them with pseudo-friendship. They disclosed intimate and very personal details about their lives, which I

did not give in return, choosing only to disclose safe personal information. Reciprocity, the willingness to share experiences both ways between the participants and the researcher alike, is seen by many feminist researchers as an important design feature. However, participants would not have agreed to take part if they did not want to share their experiences with the researcher.

The Interview Guide

I based the interview guide (see Appendix 1) on a suggestion from Kvale (1996) who advocates an introduction to the areas of discussion and recommends that the first questions should be structured in such a way that they ease the participant into the interview. This argument supports Spencer et al (1988) who maintain that both participants *and* interviewers express a preference for questions that are ordered in such a way to begin with neutral questions followed by the more intimate and sensitive ones. The authors also argue that those initial questions provide participants with a 'contextual framework' into which their own life events can be situated. Given the potentially sensitive nature of the topic under investigation, adopting this approach worked very well within the context of the present study.

Upon reflection, a valuable and yet extremely simple technique implemented throughout the course of each interview was to pay close attention to the type of language participants used in relation to sex, sexuality and sexual problems and to then repeat their preferred choice of terminology in an effort to reduce the potential power balance. For example, if participants used terms like 'shag' to signify sexual intercourse, I would use

the same terminology in an effort to match their preferred expressions. Binson and Catania (1998) state that one approach towards establishing suitable verbal communication is to ask each participant to select the appropriate sexual terminology they would prefer the interviewer to use - a technique which has been shown to elicit higher reporting of sensitive behaviours (Ibid.). However, rather than taking what I would consider to be a rather mechanistic approach to interviewing, I would simply advocate an approach that reiterates their preferred terminology and attempts to minimize that divide. For example, one participant who used the word 'jump' to refer to sexual intercourse, I would simply mirror her preferred choice of language. Likewise, the term 'fuck', by other participants to refer to sexual intercourse would also be mirrored once I had established their exact meaning.

Each interview comprised five broad areas (See Appendix 1). The first part asked participants where they had heard about the study and their reasons for deciding to participate. This served as a useful 'icebreaker' and allowed participants to relax before we addressed some of the more potentially difficult aspects of the interview schedule. At the beginning of each interview, I made it clear that I was keen to pay attention to the women's general thoughts as well as my eagerness to hear of any personal stories that they felt able to disclose during our interview. Participants were then asked about what 'sex' and 'sexuality' meant to them and to explore the importance of sex. The interview guide continued by asking participants to consider the effect of age upon their views about sex and sexuality followed by a substantial section which examined their views of what they understood a sexual problem to be.

The penultimate part of the interview invited participants to consider who they thought was the best person to talk to about sex and sexual problems. Participants were then asked if there was anything further that they would like to add, in order for them to take up any issues that had arisen during the interview or any concerns regarding the research as such. Finally, participants were debriefed and asked to reflect upon talking about the issues covered in the interview with a man.

The first two interviews in the study were conducted as pilot interviews and both participants were asked to give feedback on the questions and the content of the interviews. As both pilots did not raise any need for changes in the interview schedule, the data gathered from these were incorporated into the main body of the analysis.

Conducting the Interviews

Prior to commencing any form of data collection, participants who had expressed an initial interest in the study were informed about the nature of the research. From those recruited from the general public, this was done in the form a telephone conversation and subsequently followed up with a brief letter and an information sheet containing further details of the study as discussed earlier. Those recruited from the psychosexual clinic were sent the information detailing the study from the outset and this was followed up with a telephone call. When I met with those still keen to participate, I used this opportunity to summarise the aims of the research and answer any queries they had. I

also took the time to recap upon the purpose of the investigation and the potential issues that might arise throughout the course of the interview.

Prior to their interview, each participant was given time to reconsider whether they still wished to be interviewed before signing a consent form. This was also countersigned by myself (see Appendix 5). Participants were informed that they were under no obligation to answer any questions which they felt uncomfortable with and that they could terminate the interview at any point. They were told that they could choose to end their participation in the research without giving any explanation. In the case of those participants recruited from the psychosexual clinic, they were informed that this would not impact upon the care that they received whilst still registered there. Permission to audio-tape the interviews was also sought.

After the data was captured on audio-tape assuring anonymity was vital. Participants' real names were not used but replaced with a simple code and the date and time of their interview. Interviews were then transcribed verbatim and for the purposes of anonymity, any identifying features which could link individuals with their interview transcript were carefully removed. Anticipating the potentially sensitive nature of the research material, I was keen to point out to participants early on that everything discussed throughout the course of the interview would remain confidential- the only other two people with comprehensive access to the material would be my PhD supervisors. Moreover, it was important to provide reassurance to participants that any identifying features mentioned throughout the course of their interview (such as place names, partner name and general

practitioner for example) would be replaced with a generic reference. Along with the biographical field notes, all the audiotapes were placed in a locked cabinet as a further safeguard. Participants were informed that at the end of the study that these would be destroyed.

After each interview was completed, I openly invited any questions participants had about the research or any general comments they wished to make and I was careful to explain how each of their transcripts would be used. I also gave participants the opportunity to have their transcripts as a token of their involvement in the research project once they had been 'cleaned up'. Only two participants- one recruited from members of the general public and one from the psychosexual clinic expressed interest in receiving a copy of their transcript. Other participants were quite happy to simply take part in the study in the hope that the findings would be of help to other women.

At the end of each interview, I thanked participants for their time and effort and once again outlined my contact details on the Information sheet (see Appendix 6). The sheet advised them to contact me if they thought I could be of any further assistance and that I would endeavour to respond to their queries appropriately. I also wrote to each participant thanking them for their valuable contribution to the study. However, none of the participants requested any further information, nor showed any distress as a result of their interview disclosure. Participants were happy to talk about their views in relation to the aims of the study and their eagerness to share their thoughts and experiences implied that no anxiety was caused.

As a gesture of my gratitude for their invaluable contribution to the study, each participant was given a voucher to spend at a well known high street outlet. Some authors have expressed concern about the possibility that offering a financial incentive for research participation can constitute coercion or undue influence which is capable of distorting the judgement of potential research participants (Grady, 2001). Grady (Ibid.) also argues that it can lead to a compromise in terms of the voluntary nature of informed consent. However, it is my belief that this small offering was primarily in recognition of the sacrifice participants' had given in terms of their time and effort to generate knowledge that was potentially of benefit to others, with potentially little or uncertain advantage to themselves (see also INVOLVE, 2006).

Detailed field notes were taken after the interview was recorded. An abridged version of these can be found in the appendices section of the thesis (see Appendix 7). However, in line with Coolican (1994) using an audio-cassette recorder allowed me to talk in a natural fashion without the need to take detailed notes during the interview itself: notes that I did make were used to jog my memory and to go back to any issues I thought were both important and interesting that required further exploration.

Shared Gender: A Necessary Prerequisite for Empathy?

Whilst I have discussed at length the case put forward by feminist researchers who see the same sex interviewer as a proviso for assisting empathy, it is my contention that this can be too constrained and the data presented here would also seem to suggest otherwise.

Whilst there can be little doubt that our gender differences impacted upon the research interview, for the majority of women who participated in this study, there were additional factors which participants considered more important in their interviews. The following participant maintains the viewpoint that irrespective of gender differences, there are other factors which take on greater importance including clear parameters around the interview and the idea that they considered the study to be a professional piece of work:

'OK, it was...I was anxious at first as I told you, but I think I would have been even if you'd been a woman because it's just like a new situation with somebody I don't know. But no, it's been fine. You made it very clear what it was we were going to talk about and I had some idea beforehand what we were going to talk about and I found the questions, you know, were fine, they were focused. So no, I haven't found it a problem.'

(39 years of age. Married. Heterosexual)

Whilst I had already been in telephone and written contact with each participant to arrange the interviews, when I met participants face to face, it was useful to reiterate the potential difficulties of discussing these issues to all intents and purposes with a relative stranger. This was done by adopting a straightforward approach to the topic, rather than treating it as taboo in an effort to avoid any embarrassment for the women taking part in the study. This was fundamental both for the confidence and the comfort levels of those involved. Part of this approach involved using my previous background qualifications as both a mental health nurse and a university researcher which I had highlighted in the information sheets sent to research participants. From the extracts presented below, both

of these roles appeared to delineate my position as bona fide and, as a result, little regard was paid to our gender differences as her opening remarks testify. At the same time however, I have to acknowledge that trying to equalise the relationship between myself and participants was a complex task and this is evidenced by the position of authority that participants can associate the researcher with:

'Fine. I don't have a problem at all. I think I would have had a problem if it was any man off the street but there are parameters to this interview, there is a structure to it and I suppose it's a bit like talking to a counsellor or talking to a doctor who has a definite role where you are prepared to share things and you were very clear about your role at the beginning and the structure the interview would take and the reassurances you gave me in terms of my anonymity and stuff like that so because of that I found the interview OK'.

(50 years of age. Lesbian. Living with partner)

'And I view you as a professional. I view you as somebody that I'm not going to pull which again I tend to look at men, whether, in the various contexts and in this context you are a professional and I'm talking about a subject that you want to know about. That's the playing field and that's how I'm viewing it'.

(50 years of age. Separated. Heterosexual)

Giving Voice to Research Participants: A Contentious Issue?

The idea that preferential treatment should be given to the voices of research participants is not without controversy. Indeed, within the feminist literature, there have been a number of debates regarding the negotiations of power differentials between researcher and participants which are said to be endemic to the research process. Mauthner and Doucet (1998) for example focus upon this issue and acknowledge that by virtue of the research process, giving voice is a combined construction between participant and researcher. Moreover, Fine (2002: p. 218) argues that even a *'giving voice approach'* involves *'carving out unacknowledged pieces of narrative evidence that we* [as researchers] *select, edit and deploy to border our arguments'*. As discussed in the previous chapter, a number of feminist academics in particular argue that emancipatory research can only be achieved by appealing to a sense of collective understanding through the dispensation of having a shared history (Oakley, 1982). Yet, in spite of our gender differences, I believe it to be misguided to assume that I can neither empathize with nor seek to empower participants. Rather, I would suggest that, despite our different gendered subjectivities, my participants and I were able to enter into a relationship, albeit short-lived, based on the common goal of looking at the issues of sex, sexuality and sexual problems, focussing primarily upon their beliefs and understandings.

A Man Conducting Research with Women

The feedback given by participants contradicted some of the assertions of feminist theorists who claim that men are unable to conduct research with women on the basis that they do not share the same gender (as discussed in Chapter Two). This point is

exemplified in the following quote where the participant discusses the idea that women are generally on the 'same wavelength' whilst excluding me from her point of view:

'...Erm. It's been ok. When I think about someone who is always studying this and looks at the issue from lots of different angles then it's ok. Generally it's easy for women to talk to other women about sex because women think more about this sort of thing whereas men don't. Men find it really difficult to talk about it because they don't think about it. They don't think about relationships. This is all about part of relationships and men don't ... I'm generalizing like mad, you know and present company accepted, but they generally don't think about it and women do. So women find it easier to talk to other women because they're on the same wavelength. But I haven't felt, you know because you're obviously researching this and you're deeply into it then it's been quite easy to talk about it.'

(38 years of age. Single. Heterosexual)

In a related manner, when asked whether her experience of being interviewed by a man was difficult to deal with she goes on to claim:

'I didn't even notice that. That [being a man] didn't come into it. I don't mean that I didn't notice that you were young [laughing]. No that hasn't been an issue, no, not at all. I've been ok with that'.

(72 years of age. Single. Heterosexual)

Likewise, other participants' claimed that their everyday life experiences, of talking to male doctors for example, equips them with the necessary confidence to discuss potentially sensitive matters with a male researcher. As the following participant retorts when I ask her about talking to a man about these matters:

'What have I just said to you about my doctor?... I relate better to men than I do women. I find women can be a lot more critical than men. So, a man will listen where I find women too ... I don't know. I can relate to both. I've always been able to talk to men'.

(67 years of age. Married. Heterosexual)

Kelly et al (1994) maintain that women may not always want to share their experiences with another woman and, even if they do, it may not always be of personal benefit. Indeed, overall from my experiences of interviewing women for this study, I can contend that being a female researcher does not necessarily confer the automatic and often taken for granted rapport that Oakley (1982) suggests. Participants in this study gave some very different thoughts and feelings towards being interviewed by a man. Whilst the dynamics of every individual interview can be undeniably different, it would seem that from a practical point of view, blanket assertions about the researchers' and participants' gender differences are an inappropriate supposition to make about whether an interview will be feasible.

Some participants for example reported feeling more relaxed in the absence of a shared understanding which worked well to facilitate participants' disclosure. This was a view

expressed by the following participant who felt that being interviewed by another woman might make her feel more uncomfortable and less able to share sensitive information for the fear of being 'judged':

'...I don't know whether I would find it [being interviewed by another woman] *more...I don't know. I don't know if I'd find it a bit weird talking to a woman about it, I don't know. I don't know whether she'd be sat there thinking oh I don't have those problems or stuff like that, I don't know whether. Yeah, I might have found it a bit like...I don't know because you find some women are 'I'm better than you' kind of people and probably feel like...I don't know, maybe a bit standoffish, a bit more reluctant to give out any information. Maybe she'd sit there and think, oh, I don't have those problems. I don't know. I just probably wouldn't feel as comfortable. Whereas some people would find it a lot more comfortable talking to a woman about it. I just...'*

(25 years of age. Single. Heterosexual)

Hermanowicz (2002) claims that interviewing is amongst *the* central method in social science research. He also notes that there are identifiable characteristics to an interview which distinguish the ordinary from those which can be considered as exceptional. One particular aspect of the interview situation he focuses upon, and which has relevance here is what he refers to as *'playing the innocent'* (Ibid. p. 486). This involves appealing to the participants' altruism and positioning them in the role of teacher or expert in their own lives-an issue which is customary in feminist research. To use the terminology of Hermanowicz (2002) as a man conducting research with women on sex, sexuality and

sexual problems, this was something I felt able to 'do' very easily. Speaking to a member of the opposite sex was sometimes seen by participants' as necessitating a greater explanation of the issues under investigation, often without any form of prompting. In this sense, our lack of shared gender was beneficial as suggested by a participant who stated that by the very virtue of possessing a shared female perspective on a topic increases the potential to overlook important information. She goes on to argue that there is a very real risk that this shared perspective works against the inclination to discuss particular issues in detail thereby omitting potentially rich interview material:

'Yeah, there's shared information already and there's too much of an urge to say to a woman 'You know what I mean'. If you'd been a woman I would have said I did all that childbirth thing, you know what I mean and they'd have just gone yeah and then no more would have been said. You elaborate. Because if I'd have said to a professional women sitting there you know how it is when you come in from work- yeah. I wouldn't have said anymore....wouldn't have talked about your life and that kind of thing because you just assume that they know what you're talking about so you don't bother to explain it. With men, I feel the need to explain it a bit more because they don't get it usually the first time'.

(43 years of age. Married. Heterosexual)

In addition to the perceived impact of being a man and conducting research with women, given a number of comments made throughout the course of our time spent together, I was also keen to explore the impact of my sexual orientation upon participants and its effect, if any, upon the interview interaction. Whilst I did not think that it was initially important to disclose my sexual orientation to participants, I quickly discovered its impact upon a number of participants who speculated about this aspect of my character and realised that talking about sex, sexuality and sexual problems only served to intensify such matters. In retrospect, I also wondered if I had introduced myself as a gay man at the outset of each and every interview, whether this would have elicited a different response, particularly from those who were initially reticent about talking to a man. Interestingly, several of those interviewed reported that they felt 'safer' in the knowledge that I was a gay man conducting the study. Consequently, their accounts reveal information that they claim they might not have otherwise disclosed, or felt comfortable to disclose, to a heterosexual man or, to my surprise, another woman. These concerns stemmed primarily from those women who identified as heterosexual and had expressed concerns over a perceived risk of sexual attraction. The following transcript excerpt exemplifies this point and highlights the complex nature of the dynamics operating in the research relationship:

'Oh I suppose I feel safe that you're a younger bloke, you're interested in women your age, you're not interested in older women. It [the interview] might have been very different if I was the same age as you or younger than you. It might not have been as easy.'

(49 years of age. Single. Heterosexual)

Those participants who identified as lesbian expressed no such anxieties relating to the issue of sexual tension. What this, and similar quotes from participants illustrate, are the multiplicity of factors operating within the research relationship. They also indicate that the researcher can become sexually objectified by participants. The following participant makes a similar point whilst putting her thoughts within the context of her occupation as a youth worker:

'Because it's like I know that in my working situations depending on who the worker is in any situation we're changing the dynamics of that space. It's like if I've got a girl's group, a women only group and then a man comes into that, if the guy's straight the dynamics are possibly a particular way but if the guy is gay then the dynamics are another way. So I think its things like that. Does any of that make sense?'

(52 years of age. Divorced. Heterosexual)

Those who commented upon my sexual orientation felt it played an important part in their ability to disclose personal information without the threat of sexual repercussions:

'When I first met you, and I might be wrong, but I got the impression that you might be nearer the gay end of the continuum [laughter]. I might be wrong about that. And that made me feel more at ease.... And I don't know why it is the thought that ... I guess it's

because I've had male friends who are gay and I always find it easy to talk to them. I don't know why that is. I think it's because it's more like talking to another woman than talking to a heterosexual man is because gay men tend to be able to be more open with their emotions and, in my experience anyway'.

(39 years of age. Single. Heterosexual)

In the following quote, this participant also points to the combination of my age and sexual orientation both as factors which allowed her to divulge more information that she might have done if I had been older and heterosexual:

'I would probably find it harder if you were older...older than me. Just because I would probably have been embarrassed. I suppose because you're younger I expect you to be...even though this is what you're doing, I suppose I just expect you to be...to know more. It's interesting actually; if I'd have thought that you were straight and older, I would probably have not chosen to be as open, definitely. Or, I might have got a different feeling'.

(52 years of age. Divorced. Heterosexual)

Rubin (1985) has argued that there is a purported natural relationship of trust between gay men and heterosexual women; an alliance that brings a level of comfort and equality that can sometimes be difficult for women (and gay men) in the heterosexual world to attain. In this study, gay male and heterosexual female quasi-equal status appeared to bring both the researcher and the participant together and allowed rapport to develop

more easily than if I had identified as a heterosexual man. As a result, this study supports Rubin's (1985) argument. Accordingly, Rubin (Ibid.) concluded that these friendships cross the gender divide and seem to afford the greatest equality and the least sexual tension.

Analysing the Interview Data Thematically

The final part of this chapter provides an overview of the method that was used to analyse the data obtained from the twenty-three verbatim interview transcripts. The process of analysis applied to the interview transcripts was that of a thematic analysis. It was chosen on the basis that it sits *'between the two poles of essentialism and constructionism which acknowledges the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while maintaining focus on the material and other limits of 'reality''* (Braun and Clarke, 2006: p.81).

Thematic analysis is best described as a search for themes that emerge as being important to the description of a particular phenomenon under investigation (Daly et al, 1997). Holloway and Todres (2003: p.347) identify *'thematizing meanings'* as one of the few shared generic skills across qualitative analysis. For that reason, Boyatzis (1998) has characterized it not as a specific method but as a tool to use across different methods. Ryan and Bernard (2000) have made a similar argument and have defined thematic analysis as a process performed within major analytic traditions (such as grounded theory for example). However, Braun and Clarke (2006) argue that it should be considered as a method in its own right. One of the fundamental benefits of thematic analysis is the

flexibility it offers and the ability to cross-cut particular theoretical and epistemological approaches. As a result, it is compatible with both essentialist and constructionist paradigms (Ibid.) which have been the two principle approaches used in the investigation of sex and sexual problems that predominate contemporary thinking. Given that theoretical freedom, it has been a valuable research tool to yield a rich, detailed, and yet complex, account of the data. In this sense, it fits well with the overall material-discursive framework adopted within this study.

The process itself involves the identification of themes through *'careful reading and re-reading of the data'* (Rice and Ezzy, 1999 p. 258). Whilst conducting the analysis for this thesis, I have found it practical to think in terms of degrees rather than absolutes when representing the voices of participants. This is in keeping with an argument by two feminist theorists, Mauthner and Doucet (1998) who advocate that there is no such thing as bona fide or authentic experiences or voices of participants. This claim is on the basis of what they consider to be *'the complex set of relationships between the respondents' experiences, voices and narratives, and the researchers' interpretation and representation of these experiences/voices/narratives'* (Ibid. p. 140). Moreover, it is important to recognise that as an academic researcher, my role also involves locating participants' responses and narratives within wider academic and theoretical debates. Akin to Alldred (1998) I also prefer to think in terms of 're-presentation' and 're/presentation' to indicate that my findings are actively produced and as such, they symbolize both the participants' and my own interest in the topic under investigation.

Analytical Procedure: Step by Step Account

All of the interviews were transcribed verbatim. Rather than differentiating between those recruited from members of the general public and women from the psychosexual clinic, transcripts were analysed collectively. Each transcript was then read repeatedly in tandem with the detailed field notes taken at the time of the interview which provided a clear framework to the interview itself and also served as a useful aide memoire. All of the transcripts were then subjected to a thorough cross-check with the original tape recording prior to being analysed thematically. Reading through each transcript allowed me to familiarise myself with the content of each interview whilst at the same time achieve an awareness of the whole (Giorgio, 1985).

The subsequent stage of the analysis was more concentrated. A decision was taken not to use any form of qualitative data package such as NUD*IST or NVivo. Instead, I favoured a more traditional, albeit labour intensive approach, using a pen and paper to identify categories both within and across the interviews. This method afforded a much closer degree of contact with the interview material itself.

The overall analytical approach adopted followed the conventions of template analysis which is a particular form of thematic analysis (King, 2004). Using template analysis each transcript was systematically coded into broad themes. Themes relevant to the aims of the study were then identified from the data. Each broad theme was then subjected to a more detailed analysis which led to the formation of more specific categories within each theme. This hierarchical coding allowed interview transcripts to be analysed at

different levels of specificity. Broad higher-order codes helped to provide a general overview of the direction of each interview, whilst detailed lower order codes enabled fine distinctions to be made both within and between interview transcripts. Whilst there is clearly a degree of overlap between some of the themes presented in the subsequent findings chapters, taken together, they provide a comprehensive overview of my interpretations of participants' views in relation to the aims of the study.

From an analytical point of view, this overlap is important because it corroborates an argument put forward by Dey (1993) who maintains that the themes generated must be meaningful with regards to the data but at the same time, they must also be meaningful in relation to other themes. Where appropriate, sections of the data were highlighted as being relevant to a particular theme and these were then used as example excerpts to corroborate the themes presented. Both size and content were taken as indicators of the mileage of a certain theme. Comparing and contrasting across entries, emergent themes that were found to be repeated were upgraded in status to recurrent themes that expressed some common and important elements of the experiences of those participants involved in the research. Despite the fact that I was looking for commonalities both within and across the interview data throughout the process of analysis, contradictions were noted. Where evident, these are highlighted in the findings chapters of this thesis.

Reflexivity

Akin to Willig (2005), I use the term personal reflexivity to reflect on the ways in which my own values, experiences, interests and beliefs have shaped the research as it

progressed. As such, this builds upon what was written in the previous chapter in respect of whether there is a distinct feminist method and whether men can conduct research which is considered to all intents and purposes as 'feminist'.

In order to address this issue, I have used participants' voices taken verbatim from their individual interview accounts. In doing so, I hope that this adds a welcome dimension to the thesis. By drawing on these voices, it is my hope that this addition will provide the reader with an insight not only into this debate, but also into the practicalities and the broader organizational obstacles of recruiting and conducting sex research with a diverse sample of women recruited from the general public and a psychosexual clinic. I envisage that the insight generated will be valuable to other researchers engaged with, or hoping to embark upon projects of a similar nature- regardless of whether they are a woman or a man.

Summary

This chapter has presented a practical and step by step account of the research process. It has provided the reader with more of a descriptive account of what I did in terms of obtaining a sample, the methods of research and the analysis of the research material. I have also detailed some of the difficulties that were encountered as a way of sharing these experiences with other researchers in the form of a personal reflection of the whole process.

Preface to the Findings

The findings of this study are presented in the following three chapters of the thesis. For the purpose of clarity, the abbreviations PI and PII that precede each of the excerpts indicate which participants were recruited from the general public (PI) and which from a psychosexual clinic (PII). The numbers that follow PI and PII indicate the unique number given to each participant's individual interview.

The quotations from participants' interviews have been taken out of the interview context but careful reflection upon their meaning during the analysis confers the essence of the themes identified. To substantiate the themes presented in the analysis, they are supported with verbatim interview excerpts. I have omitted the questions which precede their accounts in view of the fact that many of the explanations were not purely and simply the result of a straightforward question and answer scenario. Rather, their descriptions often emerged as part of an experience which was collectively described in relation to another aspect of their lives.

For the purposes of this study, participants were not asked to recount specific sexual acts that they engaged in. Whilst the majority highlighted penetrative sexual intercourse as their prevailing understanding of what sex meant several participants did discuss female masturbation. Interestingly, there were no discussions that related to either oral or anal sex. Of those instances which were recounted relating to masturbation- either

individually or in the presence of their sexual partner- this activity linked very closely with a sense of independence. As one participant stated in her interview:

PI: I3 *'I've learnt to pleasure myself as well which also helps. Which again goes back to me being a fairly independent woman'.*

Indeed, further research could be conducted to complement this study and focus specifically on female masturbation in an effort to highlight the connections between women's self-pleasure, sexual satisfaction and sense of themselves as autonomous individuals.

For the sake of completeness, both datasets are presented concurrently in order to represent the entirety of participants' views and not to treat one group as different from the other in any way. It is also a reflection of the view that women's definitions of sexual problems do not necessarily concur with the diagnostic criteria outlined in the DSM. Moreover, combining these datasets is in recognition of the argument put forward by Nicolson (2003) at an earlier point in this thesis which calls for a diversity of viewpoints in relation to these issues. I believe that adopting this strategy has also been important on the basis that it allowed me to interrogate both datasets more fully, thereby assisting with the process of analysis and enabled a much fuller investigation of the similarities and differences across both. Other advantages of combining the sample included a greater variability in responses, a larger sample size and the ability to detect subtle differences in

participants' responses. Consequently, it has helped to produce findings which are 'more than the sum of their parts'.

In comparing the accounts of participants recruited from the general public with those from the psychosexual clinic, some interesting differences were detected. The latter group were irrefutably more 'well versed' in respect of their sexuality and participants recounted many examples whereby they had challenged the views of the specialist practitioners whom they had been referred to, either by their sexual partner or a general practitioner, in respect of the root cause of their sexual difficulties. For example, based on hetero-normative standards, in the women's accounts there was a strong sense of men 'needing' penile vaginal sex and women having a strong sense obligation to meet this need in order to facilitate male wellbeing and self esteem in an effort to protect their partners' sense of masculinity. This was in spite of the fact that some participants experienced pain on sexual intercourse as a result of either an underlying physical problem or a partner's poor sexual technique. What these differences reveal is that women who had undergone therapy appeared to have thought about their sexuality more than those who had not. Whilst these views were grounded in participants' experiences, they were not fully held or explained by the available discourses in mainstream society which are based primarily upon a male model of sexuality as the following chapters reveal.

Chapter 4 examines the meaning of sex, sexuality and sexual problems to women.

Chapter 5 explores the importance of (self-defined) sexual activity to women and Chapter

6 identifies the influence of wider socio-cultural factors upon women's understandings of sex, sexuality and sexual problems.

Chapter 4

Women's Views of Sexuality and Sex

Sexuality: noun. (Plural- sexualities)

- **noun 1.** the capacity for sexual feelings. **2.** a person's sexual orientation or preference.

The Concise Oxford Dictionary 9th edition (1996)

The above definition implies that sexuality is a reasonably straightforward concept. However, in the findings presented in this chapter, participants describe the term 'sexuality' in diverse and often multifaceted ways indicating its complex nature. Notably, it was not a concept that all participants understood, unlike the term 'sex' which all participants recognised, even if they did not share a universal belief about what it meant. For this reason, the chapter begins by exploring participants' understandings of 'sexuality', before going on to examine the meanings they attached to 'sex'.

The analyses described in this chapter identified a number of common themes underpinning participant's understandings of sexuality. These included; sexuality as ambiguous; sexuality as sexual orientation; the female body as the ultimate marker of sexuality; sexuality as analogous to sexual activity; and finally sexuality as encompassing mind and body.

1. Sexuality as Ambiguous

A number of participants claimed that the term sexuality could only be understood on an individual by individual basis. That both ordinary women and academics alike are still trying to get to grips with one distinct and universally shared meaning supports the arguments which have previously been outlined that sexuality is a socially constructed phenomenon whereby a singular meaning does not exist. As the following short excerpts demonstrate:

P1: I2 *'But I do think that it's quite a difficult word for a lot of people to understand.'*

(52 years of age. Divorced. Heterosexual)

P1: I10 *'I don't know. I'd have to think about that one.'*

(47 years of age. Single. Heterosexual)

PII: I2 *'This word sexuality... It's just such a totally individual thing. I don't think there is ... I wouldn't attempt to define it.'*

(49 years of age. Single. Heterosexual)

PI: I7 *'I think it's hard to pin down. Yeah, cos I can decide whether or not I'm attracted to a person or a certain type of person but I couldn't say what it was what might ... if I think what's my sexuality I mean well obviously I would say I have an orientation towards women and I like this and I don't like that but sort of actually defining it I think I would find it quite hard.'*

(43 years of age. Living with partner. Lesbian)

2. Sexuality as Sexual Orientation

Other participants in this study equated sexuality with sexual orientation- in other words whether a person identified as heterosexual, homosexual or bisexual as the following excerpts highlight:

PII: I9 *'The first thing that comes into my mind if someone says the word sexuality would be their sexual preference...that would be the first thing that I think of but then I work in quite a PC environment don't I so I think the word sexuality normally refers to sexual preference. Are you homosexual or heterosexual, I think that's the first thing, but that's probably more to do with my job.'*

(43 years of age. Married. Heterosexual)

The above quotation also highlights the idea that from a professional perspective, the context of work also influences the way in which the term sexuality is understood. This is not to say that they therefore viewed sexuality as a straightforward concept. Their struggles to define it in this instance related to the tension between competing understandings of sexuality as an innate aspect of an individual (reflected by the term 'sexual being'), and the belief that sexuality as orientation could be preordained and exist on a continuum i.e. be in part socially constructed:

PI: I3 *'What I mean by it is obviously it can mean your orientation and then for me it means how I view myself as a sexual being.'*

(50 years of age. Divorced. Heterosexual)

PII: I3 *'I suppose generally sexuality is thought of as meaning whether you prefer to have, as a woman, to have a male or a female partner, but I also think there's every shade of ... if one end is white and the other end is black there's every shade in between, and if you have male partners that doesn't necessarily mean that you might not very occasionally feel attracted to a woman, so I think sexuality is whether you're attracted to women or men but it does have a big like a continuum to it. Because I know that when I was a teenager and I was first experiencing sexual feelings I was attracted to one or two other girls but as I've grown up I no longer have those feelings. So I can say I'm 95% heterosexual but I don't think, I think there's just a huge continuum and people are somewhere along that mark.'*

(49 years of age. Single. Heterosexual)

The following participant in particular stressed that an individual's sexuality is also subject to change. In her interview, she makes reference to the notion of a 'true sexuality' which has the potential to be realized in the fullness of time as an individual understands both themselves and their sexual desires better following key life experiences. Referring to sexuality primarily in terms of sexual orientation, she argues that her understanding of sexuality has changed:

PII: I3 *'I've known a lot of people who've experienced change in their sexuality or only come to their true sexuality later in life. So that's another reason that's the way I think about it because of my experiences with other people that I've known. I've maybe met them and they've been in a heterosexual relationship and then later on they've gone on and formed a gay relationship so in a way that's why I think of it that way because I've met and I know a lot of people from either end and people who've changed half way through my relationship with them [laughing]...'*

(39 years of age. Single. Heterosexual)

The above quotation indicates that sexuality (i.e. understood here as sexual orientation) can be dynamic through one's life course and may also be influenced by the desire to experience new/ other relationships. Again, sexual orientation was referred to as being on a continuum from heterosexual at one end of the spectrum to gay on the other.

Some participants viewed sexuality as so unequivocally linked to sexual orientation that they talked about it solely in terms of a lesbian and gay identity. As such, sexuality was disregarded as a universal phenomenon common to all women:

PII: I5 *'...when you said that earlier about talking about sexuality I thought 'oh god what am I going to say there?' I don't know because I suppose if you think about sexuality you think of people that are gay and their sexuality, I've not thought about it in my own terms of sexuality.'*

(37 years of age. Married. Heterosexual)

However, for other participants, such beliefs were a source of irritation and frustration. Whilst giving recognition to some of the inherent difficulties in attempting to define sexuality, these participants argued that it ought to be understood as a universally applicable concept, regardless of an individuals' sexual orientation:

PI: I7 *'One of the things that used to irritate me sometimes was it was like the misuse of sexuality because it was like sexuality is a lesbian and a gay thing, it isn't a thing that ... and it's a bit like ethnicity, people love to talk about ethnicity to do with black people. And even in my job at work, people who have been on social work training courses still have that thing around they don't see that white people have ethnicity and like unless you grasp the concept that everyone has ethnicity and sexuality then you're starting off at a wrong sort of assumption I think. And there is something about sexuality that is hard to define but I think that's part of its appeal.'*

(43 years of age. Living with partner. Lesbian)

3. The Female Body- The Ultimate Marker of Sexuality

A further theme identified during analysis was an acknowledgement of women's material bodies as a fundamental and visible marker of their sexuality. Perceiving the body as an external marker of one's sexuality included recognising a number of 'womanly ideals' alluded to by participants throughout the course of their interviews. These included characteristics such as big breasts and womanly 'curves' being seen as indicative of 'sexuality':

PI: I8 *'I enjoy making the most of my appearance, I enjoy feeling good, feeling feminine. I've got quite a decent cleavage so when I go out I tend to show that off, I don't mean over the top but I am quite curvy and to me that feels womanly and I just feel alive generally as a woman. Still do. I'm waiting for it, old age and whatever to descend on me and I'll sit in that chair forever more, but it hasn't. But my mind is alert all the time to every...everything: politics, sex, lust, feeling womanly. Yeah, I feel actually quite complete.'*

(59 years of age. Married. Heterosexual)

In the extract above, the participant makes reference to her physical appearance and, whilst we are given the impression that she feels 'complete', there is a pervading sense that she considers the ageing body and sexuality to be incompatible with one another. This incompatibility is echoed by another participant who claimed that for her, sexuality was inextricably linked to body image and, the older she became, the more it affected her sexuality. Once again, she identifies her physical body as the marker for her sexuality and argues:

PI: I6 'Well, as you get older you don't, you don't feel so attractive as you did when you were 18. Your body is not the same so for a woman it could cause a problem I suppose, you feel different inside...'

(66 years of age. Heterosexual. Widow)

Appearance of self to others was also a fundamental factor in the way that participants conceived of their sexuality. Regardless of age, the body assumed extraordinary significance within these accounts and appeared to be central to women's perceptions of themselves as individuals that 'have' sexuality. As the following participant goes on to argue:

PII: I1 *'Well my idea of sexuality is...it's hard to define...how I see myself as a sexual being. How I might appear to other people...'*

(39 years of age. Married. Heterosexual)

4. Sexuality as Analogous to Sexual Activity

For some participants sexuality was viewed simply as analogous to physical sexual activity and, in particular, heterosexual intercourse:

PI: I12 *'It [sexuality] means physical contact between two people, between a male and female... I think it's the physical part of a relationship.'*

(35 years of age. Married. Heterosexual)

PII: I5 *'Probably what I feel about sex or how sex is important to me. I don't know. Or how people perceive me in that light.'*

(37 years of age. Married. Heterosexual)

As a single act, these accounts identify sexual intercourse as a marker of a woman's sexuality that exhibits unprecedented status setting it apart from all other sexual acts. The resulting implication is that sexuality is typically experienced in the context of being with another person of the opposite sex whilst engaging in a specific sexual act. They also imply that sexuality is temporal and that women only 'have' sexuality if they are engaged in the defining act of penetrative sexual intercourse. This is an issue which is discussed in greater detail at a later point in this chapter when I describe how participants talked about the meaning of sex.

5. Sexuality: Encompassing Mind and Body

Other participants viewed the term sexuality in a much broader sense preferring to think of it in terms of being both physical *and* psychological, with neither aspect afforded greater priority than the other:

PI: I4 *'But erm, yes, it's [sexuality] affection but I suppose it need not be sexual but I think it would probably be better if it was both.'*

(72 years of age. Single. Heterosexual)

PI: I11 *'Sexuality meaning maybe two part; one part is from I think a wife stay together maybe while your husband go to work, give you hug, I love you, or something like that for one part. The other part might be the intercourse and you know you just feel maybe while you are young you enjoy that, and in two part I think I explain.'*

(38 years of age. Married. Heterosexual)

The excerpts above reveal the genuine difficulty that participants experienced in trying to put into words the essence of the meaning of sexuality in a way that acknowledged both the material and the discursive aspects of human existence.

Sex: noun, adjective & verb.

- **noun. 1.** either of the main divisions (male and female) into which living things are placed on the basis of their reproductive functions. **2.** the fact of belonging to one of these. **3.** males or females collectively. **4.** sexual instincts, desires, etc or their manifestation. **5.** colloq. sexual intercourse.
- **adjective. 1.** of or relating to sex (sex education). **2.** arising from a difference or consciousness of sex *(see antagonism; sex urge).*
- **verb.tr. 1.** determine the sex of. **2.** (as **sexed** adj.) **a** having a sexual appetite (highly sexed). **b** having sexual characteristics.

The Concise Oxford Dictionary 9th edition (1996)

The above definitions bring to light the multiple meanings afforded to the definition of 'sex'. Consequently, it is possible to argue that 'sex' has multiple intrinsic meanings (Vance, 1993). In reality, it describes an enormous range of activities. This is half of a dialectic: many things can be taken to be indicative of sex because sex has whatever meaning we experience moment by moment; and sex has an infinite range of meanings because the scope of activities that can properly be called sexual is so vast (Weeks,

1986). With those issues in mind, the second part of this chapter clarifies participants' understandings of the term 'sex'.

From the analysis, four broad themes were identified in relation to participants' views of what sex meant to them: sex as perfunctory; authenticating the coital and reproductive imperative; resisting the coital and reproductive imperative; and finally 'there's sex and there's *cont[sex]t*.

1. 'Sex' as Perfunctory

A theme to emerge from the data was that the term 'sex' itself was rather clinical and devoid of any particular warmth and sensitivity. As such, it lacked any real meaning to some participants. Those who expressed these beliefs argued that it failed to capture the very essence of one of *the* most physically and emotionally intimate activities that a woman was able to take pleasure from- thereby reducing sexual relationships to something more akin to perfunctory than pleasurable. As this participant argues:

PI: I2 *'If I just think [of] the word 'sex' what it conjures up is very little I suppose if you just mention that word to do with love and affection and stuff. It was always very difficult if you're with someone as well, I've found, what is it you call it that you've just had? You don't want to denigrate it so you say you make love but actually maybe you don't always do that. It's that really so if I just see the word 'sex' it's very dis-attached to other things. Well, the things like being in something that's loving and caring you know. The word 'sex' just seems very mechanical, I think or am I being semantic?'*

(52 years of age. Heterosexual. Divorced)

The excerpt above captures all of these ideas with the participant arguing that the word 'sex' communicates very little in terms of the context of a sexual relationship. She claims that the word 'sex' is primarily focussed on the body and, as such, excludes factors deemed to be fundamental components of sexuality and sexual relationships. The second excerpt, albeit more concise, raises a similar point and rather than using the word 'sex' the participant expresses a preference for the term 'making love' which she believes adds a certain emotional aspect to the experience which transcends the rather limited focus upon the physical body:

PI: I9 *'It's [sex], to me sex has always been a physical thing that you do with your husband that you enjoy but I don't find it enjoyable now. I'd rather have a kiss and a cuddle than to actually have sex. I don't like calling it sex; I like to say I'm making love with him.'*

(67 years of age. Heterosexual. Married)

2. Authenticating the Coital and Reproductive Imperatives

Whilst participants maintained that sex encompassed an extensive repertoire of reciprocal behaviours, such as kissing, caressing and spending quality time with someone whom they considered they could feel, and be intimate with, their authoritative definition of sex was nonetheless understood in terms of what has been referred to in this theme as authenticating the coital and reproductive imperatives. That is to say, the definitive

meaning of sex was penetrative sexual intercourse and occasionally, although not always, perceived to follow a woman's reproductive imperative. This is exemplified in the following quotations whereby participants equate a 'proper' sexual relationship first and foremost with penetrative sexual intercourse:

PII: I8 *'...I think you feel that if you can't even get the penetration right it's not sex.'*

(38 years of age. Heterosexual. Single)

PII: I2 *'It [sex] goes for everything doesn't it, from relationships between sexually attracted people; you know like how they converse and how they behave together to sexual intercourse.'*

(49 years of age. Heterosexual. Single)

Likewise, and in the face of her attempt to counter the restricted meaning of sex as penile-vaginal intercourse by claiming that 'there's lots of other stuff there', the following participant is rapidly co-opted back into the central, more authoritative version of sex. Consequently, she privileges a discourse of biology and concedes that the essence of sex is about penetration and subsequently reproduction:

PI: I3 *'...the ultimate act is basic reproduction, it's the urge to reproduce the human race, that's how I see it, but there's lots of other stuff there.'*

(50 years of age. Heterosexual. Married)

In addition to sex being synonymous with penetrative sexual intercourse, there was also importance placed upon the value of female orgasm as the *sine qua none* of penetrative sexual intercourse:

PI: I10 *'I know it's awful, it sounds selfish and all that but he wasn't for me anyway and I knew that right from the beginning. And even, I used to, we used to have this attempt at sex and it was really like poor because I wanted it all and he was really ... I mean he'd spend hours and hours at oral sex but I needed that penetration, I needed penetration and the whole thing and I just used to end up feeling more and more frustrated. ...the other person taking as much care to get me to orgasm or pleasure me as what I was prepared to put into them.'*

(47 years of age. Heterosexual. Single)

Taking a distinctively corporeal perspective, and in relatively broken English (she described her ethnic origin as Chinese), the following participant equates sex first and foremost with penetrative sexual intercourse before moving on to describe how the word also, for her, represents a biological classification of male and female, predominantly on the basis of reproductive functions:

PI: I13 *'Sex means for me I just think is intercourse. Is also for the body contact, or just for sex if the word 'sex' I think of in some forms- male or female, or say a boy or girl, woman or man. Especially for the sex maybe you say that's for intercourse. I think just this sex for me, that's fine, no special.'*

(55 years of age. Heterosexual. Married)

It was evident from participants' accounts that a woman's life circumstances directly influenced the meaning they attribute to sex. Imbued in these accounts is the idea that the coital imperative remained a defining feature of what sex meant but that this can be viewed as particularly challenging to the nature of the interpersonal relationship. In addition, difficulties associated with the ability to conceive were sufficient grounds for a shift in 'sex' to be viewed as an activity to be enjoyed to one which focused almost exclusively upon coitus and reproduction. That this subsequent change of focus had a detrimental effect upon the nature of the sexual relationship on the basis that 'romance' was usurped in favour of an exclusive and ritualistic focus on her own fecundity is also alluded to:

PII: I5 *'I mean it* [participant's view of sex] *started probably before the kids really, or probably the trying for the kids probably spoilt it. I think women become, very well, 'these are days I can have it' [sexual intercourse] and look down the calendar and 'we'll have it this day, that day and that day' and that probably took all the romance out it for starters, the spontaneity out of it and it just went on from there.'*

(37 years of age. Heterosexual. Married)

Further instances came to light whereby a woman's life circumstances impacted upon the meaning that she attributed to sex. For example, despite considering penetrative sexual intercourse as the 'crowning point' of the sexual relationship with her husband, and,

having struggled for numerous years in an attempt to acquire a diagnosis of vulvodynia[1], this participant is, in point of fact, denied active involvement in what she considers to be a fundamental activity because of the pain and distress it causes her to engage in sexual intercourse with her partner:

PII: I6 *'it's [sexual intercourse] just being in unity isn't it, to me it was just that special part and that's why we'd kept it as so special so that when we got married it was something that was special for us two. And that, you know we'd always had that belief, we'd always talked about it [sexual intercourse], erm but that's how we were and we just wanted that as something really special for us two and unfortunately that's not been the case so it's been really, really difficult.'*

(26 years of age. Heterosexual. Married)

It is clear that having this condition stopped her from 'feeling like a real woman' which, in her account, is defined on the basis of being able to engage in the defining bodily practice of penetrative sexual intercourse. Moreover, it also demonstrates the psychological impact of not being able to have sexual intercourse within the context of the loving relationship with her husband.

3. Resisting the Coital and Reproductive Imperatives

[1] Vulvodynia refers to chronic pain, usually manifested as burning, intense itching, aching or stabbing pains in the vulvar region, including the labia majora, labia minora, vestibule, clitoris, urethra and hymenal ring (Glazer et al, 2002). As a result, women who suffer this condition can experience severe pain upon penetrative sexual intercourse and even upon the insertion of a tampon.

Counter to the beliefs expressed above whereby participants routinely referred to the meaning of sex as 'authenticating the coital and reproductive imperative', other participants in the study were eager to contest penetrative sexual intercourse as the *sine qua none* of sex. An interesting finding was that, of those who opposed this viewpoint, the majority identified as either lesbian, were older, or had a partner who had experienced some form of erectile/performance related difficulties at some stage during their sexual relationship.

That particular groups of women actively repudiate the practice of penetrative sexual intercourse as a crucial component of sexual activity is exemplified in the following interview excerpt. Consequently, the activities that these participants identified as 'sex' often included a far greater repertoire of other sexually intimate actions:

PI: I1 *'That to me [love, feeling close, feeling good about oneself] is first and foremost about the sex thing and the reproduction bit is sort of secondary.'*

(50 years of age. Living with partner. Lesbian)

In a related manner, the following participant goes on to question the primacy afforded to penetrative sex as 'bona fide sex'. In the course of her interview, she questions this dominance and argues that such a narrow focus is at odds with her own view and considers it to be little more than a powerful form of social conditioning:

PII: I8 *'I'm not sure how much of that is just what you're kind of conditioned to think;*

that proper sex is this and if you're not doing it this way or you can't do it this way then you're a failure. I'm not sure how much of it is that kind of conditioning and how much is gut feeling actually. Well it's not what I actually believe. I don't believe that only penetrative sex is proper sex, I'm not trying to say that.'

(38 years of age. Heterosexual. Single)

However, at a later stage in her interview she contradicts her preliminary viewpoint when she asserts that *'...I think you feel that if you can't even get the penetration right it's not sex'*. Her different descriptions of sex reveal that attempting to isolate a single common meaning is not a straightforward enterprise.

4. There's Sex and There's Cont[sex]t

The final theme highlights the fact that the context in which sexual activity takes place is fundamental to the meaning that women attribute to sex. Participants described how they experienced sexual fulfillment on a number of levels- penetrative sex was one means to do so- but not necessary the 'gold standard'.

Most participants maintained that, for sex to be considered meaningful, it required a certain level of emotional intensity with the individual with whom they were sexually involved. Participants who had experienced a lack of emotional intensity in previous sexual relationships argued that, whilst this was in no way an impediment to their ability to have sex i.e. that they could easily divorce sex from love and affection and vice versa, they still felt that experiencing an emotional component added a definitive quality to the

act of sex. Moreover, participants described the ability to engage in sexual activity without feeling any emotional attachment to their sexual partner as akin to 'male' sexual behaviour. As such, their excerpts often revealed a sexual self-censorship associated with behaving in an appropriate way according to gender roles and stereotypes.

Those participants who made reference to the importance of a requisite emotional intensity frequently referred to the importance of 'love', 'affection' and 'feelings' as fundamental to a meaningful physical sexual relationship. Furthermore, participants maintained that these emotional underpinnings influenced and further enhanced a woman's physical sexual response. Several participants maintained that without these, they had little or no interest in the physical activity of sex whatsoever. The following excerpt highlights this viewpoint:

PII: I2 *'But for me personally I need to feel that somebody cares about me otherwise there's absolutely no interest, no physical interest [in sex].'*

(49 years of age. Heterosexual. Single)

The second excerpt makes reference to the importance of a personal 'chemistry' between both individuals as a marker of a satisfying physical sexual relationship which might also be interpreted as attraction as opposed to an emotional connection with another individual. Arguably, this is a contradiction across these accounts in the sense that women can only have sex when they are emotionally involved with someone:

PI: I10 *'I'm convinced now that if you don't basically get on with somebody and there isn't that chemistry or whatever it is that makes you click with somebody then sex isn't going to be right anyway. For women. I don't know about men.'*

(47 years of age. Heterosexual. Single)

In addition, we are also given the impression that 'real feelings', 'love' and 'being together' are indispensable components of a satisfying sexual relationship:

PI: I6 *'It's [sex] between two people who have feelings for each other, real feelings, not just a spur of the moment thing or something that happens because you've had a drink. It should be when two people care for each other; it should be a lasting thing.'*

(66 years of age. Heterosexual. Widow)

PI: I12 *'Yes, it's [sex] part of love or anything. If you love somebody then it's part of the relationship between you.'*

(35 years of age. Heterosexual. Married)

PII: I6 *'Well sex to me is about showing each other how much we love each other. Being together and knowing it's just us two and nobody else. Just us two being together and showing how much we love each other and having fun and being together and that's how we've always seen it [sex].'*

(26 years of age. Heterosexual. Married)

In all of the excerpts above, the context of the relationship is mentioned as a fundamental requirement of a successful sexual relationship and participants appear to draw upon a moral dialogue in relation to the meaning they ascribe to sex. In the following interview excerpt, whilst the participant adopts a similar perspective to that put forward by previous participants, she also alludes to the idea that her husband thinks about sex in a way which fulfills an instantaneous need, a need which does not necessarily correspond with her own perception of good quality sex:

PII: I5 *'...more making love, spending time with, being close to, but I don't know I think he sees it [sex] as more of a quick 10 minutes...'*

(37 years of age. Heterosexual. Married)

However, not all participants viewed sex in a manner that required a requisite level of emotional involvement and intensity. The following account reveals these complexities and contradictions as well as the idea that the meaning of sex is subject to change on the basis of temporality, spatiality and identity:

PII: I9 *'... to me, it [sex] means different things at different times really. Sometimes it means a quickie, sometimes it means a long drawn out lazy afternoon, sometimes it means a cuddle, sometimes a kiss, sometimes just a really quick shag. A whole load of things really. I don't really see it as one thing. I see it as lots of things at different times and at different times in my life as well I think.'*

(43 years of age. Heterosexual. Married)

Continuing her appraisal of the different meanings she attributes to sex, this participant then goes on to compare the sex she has with her husband to that with a man whom she met on holiday a number of years ago. In the excerpt that follows, she puts those two relationships side by side and maintains that the numerous roles her husband enacts such as lover, friend and father to their child directly influence the sexual dynamics of their relationship in a way which was not the case with her previous partner where it was more a case of 'instant attraction':

PII: I9 *'Well I think [husband] and I, my husband and I, are very close to one another, we're a very close unit [husband], myself and our daughter are a very close knit group. We do everything together, most things together. I still wander off periodically and do my own thing from time to time but we're a very tight knit group and [husband] and I are friends as well and I think sometimes that has impacted because I've felt sometimes I'm in bed with my best friend which is a bit of an odd way to think and I have to think oh no, hang on a minute I'm not, it's actually my husband. But I don't think that's a bad thing, I think it's a healthy thing but I think that it's a different sort of sex from the sex that you have say for example when I met this delicious Swedish man in [country] and I went to [country] to stay with him for the weekend and that was a different sort of sex to how it is now with [husband], but we have had that together in the past it's just that we don't so much now. Occasionally we do, we have our moments, but I don't...so I see sex as all different sorts of things really.'*

(43 years of age. Heterosexual. Married)

As her discussion comes to a close, we are given the impression that these additional responsibilities hamper her sexual expression to the extent that there is a sense of sexual boredom particularly when she makes reference to the idea that *'we have had that together in the past it's just that we don't so much now'.*

Participants explicitly referred to the interplay between the mind *and* the body when they talked about the meaning they ascribed to sex. Put simply, they asserted that sex was both a psychological and a physiological phenomenon, but in order for a physiological response to develop, a woman's mind had to be 'sexually connected'. Some participants also posited that not being able to think in a sexual way severely limited their body's sexual response. Once again, their responses were repeatedly framed in terms of the differences that they perceived as extant between men and women:

PI: I5 *'I can't have pleasurable sex unless my head is engaged as well as my body which means that if my husband has bought me a bunch of flowers and is being affectionate to me and thoughtful I'm much more likely to want sex. Because I'm feeling...he's not bribing me with a bunch of flowers but he's actually showing that he's thought about me earlier on in the day. If you talk about foreplay, foreplay to me is not just the physical foreplay that can happen, does happen but the mental foreplay – setting it up in advance. So you really are thinking...that's the most successful sex to me is when my partner, whether it's been these fella's in between or my present husband, have really thought of me in advance and have really, been affectionate, kind and thoughtful. That to me is just*

as important, if not more important, the mental foreplay as well as the physical foreplay. Whereas I don't think that is so important with men. I don't know, I'm guessing.'

(57 years of age. Heterosexual. Married)

In a similar manner to the last participant who claimed that her husband saw sex *'as more of a quick 10 minutes'*, this participant reported knowing women, including herself that *'can fuck for fuck's sake.'* Nonetheless, in her account, she maintains that 'women tend to be emotionally involved'. As a result, the following excerpt challenges stereotypes of male and female sexual behaviour which are typically positioned as binary opposites:

PI: I3 *'There's differences in their approach. Generally speaking, to me, you usually find, to me, that the men – their brains are down their trousers as it were, whereas women tend to be emotionally involved. Generally, and it doesn't work every time, because I've met men who really are emotionally involved and I've met women who can just fuck for fuck's sake, you know, which I have done on occasions. It doesn't work. My experiences have been more quantity than quality, there are only a handful of men that I've really enjoyed the sex and there's plenty more that have just been physical. It's just a physical activity.'*

(50 years of age. Heterosexual. Separated)

Furthermore, the following participant claims that she sees nothing whatsoever wrong in having sex purely from a desire to engage in physical sexual activity which, to all intents and purposes is free from any additional emotional attachment to a sexual partner:

PI: I1 *'I don't think you particularly have to love the person you're having a physical relationship or sex with, but I think it's important to feel comfortable with them you know as another human being. It is nice if you love that person but you don't have to because as I said before it can be quite nice.'*

(50 years of age. Living with partner. Lesbian)

In this sense comfort implies a lack of coercion. However, 'comfort' aside, other participants raised the contradictory viewpoint that sex, at various times throughout their lives was sometimes driven by an instantaneous need- a notion which has already been highlighted at an earlier point in this chapter and is alluded to in the following short interview excerpt:

PI: I2 *'I think the two [sex and affection] can be very different but the old generalization that lots of men can have sex without having to be emotionally involved and I think I definitely went through a time like that a bit when I was younger but just because I think the sex itself was important as well.'*

(52 years of age. Heterosexual. Divorced)

Thus, some participants needed an emotional connection to enjoy sex whereas others did not. This is a tension which pervades a number of accounts that have been reported throughout the course of this chapter.

Summary

From the different explanations offered by participants, the concept of sexuality embodies complex, contradictory, ambiguous and diverse meanings. Participants' accounts implied that there was no distinct or universally shared meaning of the term sexuality. There was no notion of one 'true' sexuality and the majority of participants who defined themselves as heterosexual argued that it was primarily a lesbian and gay phenomenon and as such, the term did not apply to them- often angering those who did identify as lesbian. At the same time, the material body was identified to be socially significant as a visible marker of 'sexuality'.

Similarly, other participants viewed the term in a physical sense but prefered to think of sexuality in terms of sexual intercourse. In comparison, there were those who viewed sexuality in a much broader sense as being both physical *and* psychological. Within these accounts, neither aspect was granted greater priority than the other.

With regard to participants' understandings of the term sex, it too was considered to have competing and contradictory meanings. The word itself was, at times deeply problematic for some participants to define. Consequently, they argued that from a semantic point of view, it failed to capture the essence of one of *the* most physically and emotionally intimate activities that a woman was able to take pleasure from- thereby reducing sexual activity to something rather more mechanical than pleasurable. In addition, participants argued that the most authoritative meaning of sex was penetrative sexual intercourse. Depending on their age, participants linked this to a woman's reproductive role. This

was in contrast to those participants who attempted to resist the coital and reproductive imperatives and instead argued for a more inclusive view which took into account a much greater repertoire of sexually intimate actions. However, even within these latter accounts, there were a number of ambiguities and contradictions. For example, displacing penetrative sexual intercourse from the realm of the inevitable was, in reality, not considered an option open to participants. The gold standard of penetrative sexual intercourse assumed unparalleled meaning and the inability to engage in this activity had implications for the way in which participants thought of themselves as 'real' women.

A majority of participants believed that whilst sex could easily be divorced from 'love' and 'affection', it meant more if there was an emotional connection between partners that heightened the sexual experience- put by one participant as a kind of 'mental foreplay'. Without this emotional connection, several participants argued that they could see little or no meaning in the physical act of sex purely from the point of view of physical gratification.

Chapter 5

Is Sex Important to Women?

This chapter explores the importance of sexual activity to women. Whilst there is an increased importance attached to sex in society generally and a promotion of the purported health benefits of sex within the medical and nursing literature (Davey Smith et al, 1997), there are a paucity of studies which examine how women prioritise sex (Gott and Hinchliff, 2003). As identified in Chapter 1, this is an important issue to explore because of the argument put forward by Laumann et al (1994) who claim that FSD represents a significant public health concern because of the importance that women attach to sex.

Within my participants' interview accounts, three themes were identified: age as a dynamic in determining the importance of sex; the perceived disparity in the importance of sex between women and men; and finally sex as important 'for all the wrong reasons' or 'not important at all'.

1. *Age as a Dynamic in Determining the Importance of Sex*

Those participants who referred to age as a dynamic in determining the importance of sex did so in relation to their experience of sex assuming different levels of importance at different periods of time throughout their lives. This theme shares a number of similarities with one identified in the previous chapter- 'there's sex and there's cont[s]ext'- whereby participants referred to the idea that the meaning they attribute to

'sex' is subject to change on the basis of time, place and person. Whilst participants' responses varied, there was a general assumption that sex is more important to younger women than older women. For example, the following participant asserts that lots of physical sexual activity was more important when she was younger which, at that time, she considered to be the 'norm'. Speaking now as a 52 year old woman, her thoughts quickly turn to an exploration of what it was she wanted, either sex or love and affection or a combination of all three:

PI: I2 *'Yes it [sex] is [important] and more so at different times of your life, very much so. I think, certainly for me it's very related to how I feel, certainly as I've got older it's no longer just a... maybe it's not quite as vital as it once was [laughing]. Yes, yes. Sexual activity, lots of it, has always seemed the norm for large periods of my life. You know, those times certainly when I was younger generally feeling that I was horny but then it's also as a woman I also know about the whole thing about sex and affection. You know, it's hard sometimes to distinguish what it actually was that I wanted.'*

(52 years of age. Divorced. Heterosexual)

The following excerpt is taken from an older participant who maintains that the meaning she now attaches to sex has changed from 'the wild, thrusting, sex that you had when you're young' to something far less physical. Older participants in particular, who once equated sex primarily with penetrative sexual intercourse, now claimed that that activity had now been displaced to a large extent by other activities such as kissing and hugging for example:

PI: I9 *'It's [sex], to me sex has always been a physical thing that you do with your husband that you enjoy but I don't find it enjoyable now. I'd rather have a kiss and a cuddle than to actually have sex... since the menopause we've both sort of wound down from the sexual ... I mean I don't say that we don't do it, we do, occasionally but it's not every night or twice a month or 3 times a month or whatever, once a week. We just do it when we want to. It could go 6 months and that's it. But erm, it's [sex] not the first priority in my life. Far from it. I would put it [sex] on the back of the list, sort of thing.'*

(67 years of age. Heterosexual. Married)

This participant's lack of interest in penetrative sex was contextualized within the relationship with her husband, who had experienced erectile dysfunction for a number of years due to taking prescribed medication for the management of his heart condition. There is a general reluctance expressed in her interview to resume the physical element of their relationship and, through her own admission, she now prefers 'a kiss and a cuddle than to engage in penetrative sex'.

In a similar manner, others maintained that whilst sex had been used as a mechanism to establish a connection between themselves and their partners at an early point in their relationship, its importance had gradually diminished and, as a result, had been replaced by other more important aspects of their life together. As one participant explained:

PI: I5 *'When I was younger it [sex] was more important. But, I think it is to do with this bonding thing...'*

(57 years of age. Married. Heterosexual)

She made clear in her interview that the combination of living together for a long period of time as husband and wife and growing older conferred additional responsibilities such as raising a family. Subsequently, sexual intercourse had been usurped by these additional responsibilities. As a result, physical sexual activity is assumed lower importance and 'care', 'concern' and 'affection' were now considered more important within the context of their relationship. In a joking manner, she also makes reference to what she believes are other more productive leisure pursuits such as digging the garden:

PI: I5 *'Yes, definitely. Less so when you get older I must admit and when, because, having been married a long time it becomes less important. When you're younger it [sex] is more important. I've been married 20 odd years and I think sex is partly to do with bonding, when you first meet somebody there's loads of it and it's partly to establish that bond but once you've been married a long time and had children together and you've bonded in different ways, particularly through the children, sex is less important although still important to continue that physical touching that you need. If I had to choose between the two [sex and her children] I would choose being with the children. And in fact, if I just think about my husband it's the affection rather than sex which is more important to me now. Just the care and concern of each other which is more important than sex. But it doesn't mean we don't have sex, we do because we still find*

that's, that's pleasurable but again if I had to choose between affection and sex I would choose affection...It's not a personal thing to your other half, it's just, in general I'd rather sooner go out in the garden, digging the garden rather than jumping around in bed, it's more productive [laughing].'

(57 years of age. Married. Heterosexual)

Similarly, getting older and living together within the context of a longstanding relationship and feeling 'comfortable' were also proffered as reasons why physical sexual activity assumed a lesser importance. This suggests a rather intriguing and yet at the same time, contradictory meaning of the notion of 'comfort' within the context of sexual activity. Having been given as a precondition for better sex in the previous chapter, (see 'there's sex and there's cont[sex]t') feeling comfortable with a partner was subsequently offered as a reason why for others, sex was no longer considered to be important. Confirmation of this contradiction is manifest in the next excerpt. Claiming that physical sexual activity was no longer important to her prior to the death of her husband, this participant talks in relation to the immeasurable and symbolic value of a kiss, a cuddle and holding hands as gestures which subsequently displaced the importance of physical sexual activity i.e. penile-vaginal intercourse for her. In turn, these function in a way that enabled her to not feel 'guilty' about the previous lack of physical sexual activity in their relationship prior to her husband's death:

P1:I6 *'When you're younger it's [sex] more intense and as you get older the feelings are still there but not the same ... your feelings change especially if you've got a long-term*

partner, you understand each other and it's different. Well you're more comfortable with each other, I don't know. I mean my husband died a long while ago and we still enjoyed a normal married life right up until the end, but it's not so intense as when you're teenagers but you can go to bed of a night and you can hold hands, you can kiss goodnight and it's still a nice feeling. It's the same but different. No you don't. And you don't feel guilty about it. You could just hold hands, have a cuddle, go to sleep and that was it that was fine. Yes, over the years, you sort of settle down into that. I mean you've got no hang ups about it. You don't feel guilty and that, you're comfortable with each other.'

(66 years of age. Widowed. Heterosexual)

The following participant, aged 67 years at the time of our interview, also makes reference to age as a dynamic in determining the importance attributed to sex. Classifying 'sex' first and foremost in terms of penetrative intercourse, she claims that whilst she does engage in this activity with her husband, albeit infrequently, the importance that this activity once assumed in their relationship has subsequently diminished. Rather than using this activity to authenticate the feelings she has towards her partner, she claims that 'a different kind of love' has evolved whereby sexual intercourse has become secondary to other less physically intimate actions which nonetheless is still indicative of a desire for sexual tenderness:

PI: I9 *'At my time of life now? Now? No. No. I've had my time. I think attitudes change when you go through the change [menopause] if you understand me. It isn't that*

we don't love one another; we wouldn't have been married all these years if we didn't, but a different kind of love comes in. You get more complacent. It's not the wild, thrusting, sex that you had when you're young. And err, I won't say the carpet's getting thin on the landing because as you get older you don't bother so much, you don't want it, you're just happy to be together rather than to keep, you know, have sex. Actually you take each other for granted and yet you don't. It's very hard to, it's very hard to explain that is. I think because you get to know each other so well and you've done all the fancy things in sex, you know, and you've tried different positions. It's a different kind of love, it's one where ... it's more compatible, you're closer. It's hard to describe. I feel comfortable. I feel very comfortable, with my...He's my best friend.'

(67 years of age. Married. Heterosexual)

Conversely, the idea that 'older' women do not believe sex to be an important and intrinsic part of their lives was not one that could be upheld. Speaking as a woman who had been married for 40 years, this participant stresses that sex has always been, and to this day, continues to remain important to her:

PI: I8 *'I enjoy it [sex]; it's part of life. I miss erm, I miss the urges that I used to have, I used to be a terrible flirt, and being desired. I do miss that because the only people who chat me up are old men looking, I think really, to look after them in old age and who wants an old man? I've got one of those. I do miss it yeah, I miss the urgency of sex. I would have sex purely for lust but I see nothing wrong in that you see. Yes because there's nobody around that I fancy for a start, they're all old men. Whereas an Argentine*

manager from football that I tried to freeze-frame [laughing], that's the only one – I like somebody that is a little bit different and there int anybody. The nearest I've got is the husband I've got and had 40 years. And our sex life, compared to most, is quite good.'

(59 years of age. Married. Heterosexual)

Another widespread characteristic of these accounts was the idea that 'sex' like 'sexuality', in its various guises has assumed varying levels of importance throughout women's lives. Reflecting upon the influence of the 'reproductive imperative' which links into the previous chapter, another participant claims that younger women are duty bound into thinking first and foremost about their fertility. This fluidity in terms of the importance and meaning of sex is omnipresent when reflecting on ideas in relation to the importance within the context of ageing:

PI: I1 *'When you're young, and I suppose this is all to do with reproduction isn't it, you have to tart yourself up to look like a little flower to get the bee so that you can reproduce and then as you get older you perhaps realize that your sexuality and also the things that attract you to somebody else, apart from a physical attraction, it's more than that. Again it's a cliché but it's more than what you see, it's more than the cover of the book and it can be things like the way somebody expresses themselves, how confident they are.'*

(50 years of age. Living with partner. Lesbian)

2. The Perceived Disparity in the Importance of Sex between Women and Men

A further theme to emerge during the analysis was the idea that participants believed men

exhibited a much greater propensity for sexual activity and that it was more important to them than to women. Moreover, men were considered to be less discerning- particularly in respect of the context in which sexual activity took place:

Participants claimed that these disparate expectations were sanctioned by societal mores and propagated by the popular media. Furthermore, they also argued that men had a greater proclivity towards sex in an effort to maintain their 'macho' image, whereas women were felt to prioritise quality of sex rather than quantity:

PII: I9 *'You've got the guys, the machos going oh yeah I'm there 5 nights a week mate, and this is how they talk in their work environment. You know, they're all in the showers after they've had a greasy day making all the food and they're 'oh my tackle's well used mate'. That's how they are but how do we know how many times a week people actually have sex? I don't think we do. I don't think we've got a clue. Because you'd have to get an honest response from the entire nation wouldn't you to come up with the norm.'*

(43 years of age. Married. Heterosexual)

Despite these assertions, a common thread pervading their accounts was that both women and men should have an equal right to enjoy sex but, at the same time, there was a pervasive conviction that cultural mores made it difficult for women to do so:

PI: I13 *'In some sense I think sex is you know, nature for the human being. For woman I think it is also important for her life, not just for you know, men. They say men enjoy*

sex. For woman they have a right to enjoy you know, sex. Because most, even movie and books they talk about things about the men, whatever, whatever and for woman how she is enjoying sex is less. So it's not equal and actually for human being is not just men, it's both sexes. So these things not just for men but also for woman.'

(55 years of age. Married. Heterosexual)

Likewise, rather than making the distinction between men and women in terms of the importance that is attached to sex, the following participant is swift to assert that sex is important for 'people' and she does not draw a distinction between the sexes:

PII: I8 *'Erm, I think it's important to people. I think it's an important part of being human actually and I think if...I think it's something that everyone has to deal with in some way in their lives. Even if you don't have sex in the whole of your life you have to make a decision not to. It's something that everybody has to face in some way or do something about in some way.'*

(38 years of age. Single. Heterosexual)

3. Sex as Important 'for all the Wrong Reasons' or 'Not Important at all'

A number of participants claimed that sex was either 'not important at all' or that it had become 'important for all of the wrong reasons'. Whilst participants' explanations were wide-ranging, the common characteristic they all shared was that sex had become problematic at a particular point in time in their lives. One participant claimed that sex had never been very important to her, and, despite having difficulties with her

spoken English (she identified her ethnic origin as Chinese), she implies that a general apathy towards sex combined with getting married later in life were factors contributing to her indifference towards sex:

PI: I13 *'Err, for me, I –how to say that err, the younger, I'm not very good about sex. I understand sex very late. My first marriage was also late and I'm not very interested about sex... Yes, so that's not for me, maybe some woman they're very interested about it [sex] whatever, yet I'm not very interested about that sex.'*

(55 years of age. Heterosexual. Married)

Another common feature identified by some participants was that sex had never really been an aspect of their lives that they had considered to be important. It was only when its lack of importance became problematic within the context of a relationship that it was considered to rank as high on participant's personal agendas. Once again, this theme shares a familiar position with another one highlighted in the subsequent chapter of this thesis-'measuring up to a male benchmark' whereby participants felt that women are expected to compromise their own values for the sake of their partners sexual pleasure. As this participant explains:

PII: I7 *'No. When I think about it* [sex] *no not really. Never really became an issue until like I say about a year ago, until my partner, my ex-partner, started making an issue out of it. Erm, but before I were...don't know. Quite used to how things were.'*

(25 years of age. Heterosexual. Single)

Moreover, participants' accounts revealed that sex (particularly penetrative sex) could be voluntarily traded in exchange for affection and emotional fulfillment. As a result, it was not the sex that was important but the feelings that this activity engendered. For that reason, sex became important for 'all of the wrong reasons'. Trading sex as a means of acquiring affection was identified by a number of participants who contended that, during a time in their lives when they were single, they had actively bartered for affection by using sex as a metaphorical currency.

The following participant reflects upon this idea of trading her body as a means for acquiring affection. Rather than being by herself in bed, she would proffer sexual intercourse to her partners at a time when all she wanted was to be able to feel unconditional love and non-sexual physical affection from another human being. She recounts this in the following excerpt:

PI: I5 *'...when I think back, you know, these series of lovers that I had were not really for love they were just wanting a human being really. So rather than being on my own in bed I would say ok well come to bed and I'll give you sex. I wanted sex too but it was more about loneliness I suppose, I enjoyed... which is a bit contradictory because I actually enjoyed being alone and living single but there were times when I needed to have, to have sex as well as affection. And I think that's why, to be honest, I slept around really because I just wanted to exchange this idea I suppose of having some physical contact with somebody. And then, because I'm actually a faithful person, I've never*

played around during marriages, with both marriages I've always been totally faithful because I believe in that, but in between when I was trying to find somebody else I suppose, in a way it was a trade off. Yes. Wanting some affection and in a way, taking it, you know, giving the one for the other. Looking back I didn't really get affection because it was just sex really [laughing] but anyway, trying to find affection.'

(57 years of age. Heterosexual. Married)

Rather than making a distinction between women or men in her interview, the following participant contends that in general, 'people' capitalize on, and trade their bodies, that is to say, 'they go for sex' as a way of achieving emotional satisfaction:

PII: I2 *'Well some people go for sex to get the emotional satisfaction. Sex is their route and people like that will say they have slept with people...Do you see what I mean that with some people the sex comes first as a means to emotional satisfaction, whether it's on a good level or a bad one, whether it's actually safe for them or not safe but the others want to feel cared for before there's any sexual involvement, before that thought comes to mind.'*

(49 years of age. Heterosexual. Single)

For one participant, sex had been traded in the more conventional sense. She recounted how she spent numerous years working as a prostitute, and as a result, routinely associates sex with financial gain. For her, this association has become so all-consuming it has become the crucial reason for requesting a referral to a local psychosexual clinic in

an effort to maintain the relationship with her current partner. This is evidenced by her claim that 'I need to stop thinking about sex as money and power'. In her interview, she talks about the meaning of sex exclusively in monetary terms devoid of any emotional attachment and as a means of manipulation against men.

Having left prostitution a number of years ago, and even in the context of living with a new partner, there was a real sense throughout her interview that she still struggles in terms of her ability to think about sex in a way that does not involve issues of power, manipulation, money and feelings of impassivity. As she claims:

PII: I10 *'OK. On a good day it's* [sex] *quite nice but on a normal day it's* [sex] *power and money and that's what it means to me. It's a weapon and it's a tool. That's what it means to me. It's a means of manipulation against men and that's where it has been in my head for a very long time. And erm, it's not that I can't see it changing, it's just that it's quite hard to change that mindset that I have... I can literally just do sex any time, any place, with absolutely no feelings about it at all, completely impassive, nothing positive or negative, and he's quite aware of that so I, but at the same time I can use it to get what I want and to manipulate and so on and so forth, and not even the full sexual act if you see what I mean, other little sexual tools that you develop around it with other people.'*

(23 years of age. Heterosexual. Single)

The subject of having children also featured heavily in other accounts in relation to the

importance attributed to sex. For example, on the basis of being told by medical practitioners that she was unable to conceive a child, the following participant reported that sex meant nothing to her whatsoever. Furthermore, it underpinned the primary meaning she attached to sex as being one which has been referred to previously in this thesis as 'authenticating the coital and reproductive imperative':

PI: I4 *'I knew from fairly, erm, teenage [years] that I wasn't going to have children. That wouldn't be the case today because things have moved on and very few women can say that they could not have children today because of medical advances. I thought that that being the case I didn't see that marriage was going to mean very much. And so, I mean eventually, as I told you just before the interview, I did get a very satisfying job which was working with children and I didn't have a, that sort of relationship until I was about 34. Erm, quite old really isn't it? I just didn't encourage that sort of ... I wasn't going to get in to that deep, I wasn't going to have to say to somebody well look this is the case and that isn't an option. Marriage isn't an option.'*

(72 years of age. Heterosexual. Single)

Summary

A total of three themes have been identified throughout the course of this chapter. These include; age as a dynamic in determining the importance of sex; the perceived disparity in importance between women and men; and sex as important 'for all the wrong reasons' or 'not important at all'. With regard to the first of these themes, replete within these accounts was the general assumption that sex was more important to younger than

older women. As a result of getting older, or being in a relationship for longer, physical sexual activity was argued to be surpassed for the more companionable attributes of 'care', 'concern' and 'affection'. Whilst a prevailing discourse of penetrative sexual intercourse permeated participants' accounts, these findings did not support the stereotype of an asexual old age.

Participants also argued that men exhibited a greater propensity for sexual activity and that it was more important to men than women. Men were also considered to be less discerning- particularly in respect of the context in which sexual activity took place. Participants also argued that women prioritized sex for its quality rather than the quantity. Despite these assertions, there was the conflicting argument that women should have an equivalent right to sex but cultural mores made this difficult for women. These disparate expectations were fuelled by societal mores and propagated by the popular media placing expectations upon women in respect of the 'proper' way to behave.

Finally, there were those participants who claimed that sex was important 'for all the wrong reasons' or 'not important at all'. Whilst participants' explanations were wide ranging, the common characteristic they all shared was that sex had been become problematic at a particular point in their lives. Those participants who argued that sex had become important for all of the wrong reasons had either traded sex as a means of acquiring affection or money and found it difficult to think about this activity in isolation from some sort of personal or emotional gain.

Chapter 6

Women's Views of Sexual Problems

The final chapter of the findings section of this thesis presents an analysis of participants' understandings of sexual problems. Five recurrent themes were identified from participants' interview accounts: sexual problems as physically and medically focussed; sexual problems as physically and psychologically complex; sexual problems as context dependent; sexually problematic media representations of women; and finally women's sexual problems-measuring up to a male benchmark.

I begin with a theme highlighted by participants on frequent occasions which regards their views of sexual problems as physically and medically focused. My decision to focus first upon the physical aspects of women's understandings of sexual problems is in no way indicative of a belief on my part that the body assumes greater importance than psychological and social influences. The aim is to highlight how sexual problems can arise at the intersection between women's bodies and their lives and to not confer greater importance upon one at the expense of the other.

1. Sexual Problems as Physically and Medically Focused

A key theme to emerge from the analysis was the privileged position assigned to the physical body in terms of how participants conceptualized a sexual problem. Those who focused on the body did so predominantly in relation to a dialogue which centered first

and foremost upon pain and privileged penetrative sexual intercourse as a marker of 'real sex':

PI: I1 *'It could be the actual mechanics of sex, people having a physical discomfort for example...Well I would guess if you have sex and it hurts like stink, you know, that's a real issue isn't it...Or you could have some physical problem and whenever you have sex it hurts you or you bleed.'*

(50 years of age. Living with partner. Lesbian)

Conversely, a sexual problem without an explicit physical basis was considered to lack legitimacy. Indeed, having to justify such difficulties in psychological rather than physical terms led the former to emerge as lacking in credibility and as a result, being akin to a 'good excuse'. Experiencing sexual difficulties that were physical in origin- which were amenable to surgical intervention for example- was considered to be far more plausible:

PII: I5 *'I thought I had physical problems or maybe I wanted to believe that I had physical problems because that would have been a really good excuse wouldn't it if the doctor had said 'well actually one of your tubes is blocked and that's causing the pain so you can have an operation and it's cured'. That would have been good. I quite like that one [laughing]... Well then I'd have something to blame other than me and then the problem was obviously then with me and in my head, whereas if there had been a medical*

reason then that's what I could blame. It's always good to have a scapegoat isn't it? [laughing] You blame being tired, you blame working hard, you blame the kids.'

(37 years of age. Married. Heterosexual)

The pivotal position afforded to the physical body compared to emotional or social factors as the root cause of sexual difficulties was a commonality identified in the data. The material body often assumed precedence within these accounts on the basis that it was more straightforward to explain, isolate and treat physical 'anomalies' than to deal with psychogenic ones. For example, those who had experienced sexual difficulties following a traumatic birth were eager to draw attention to the primacy of a physical cause for their sexual difficulties:

PII: I9 *'I think my problems began, well I know they began when I had my daughter, because I had a wonderful pregnancy but I had a dreadful labour that lasted 48 hours. After that I had two operations because there was a lot of damage to my bowel that they did with the forceps when they were pulling her out so I had to have that repaired, and then I had an episiotomy to get her out and that went wrong and they sewed it back in the wrong place. So after a considerable time, well maybe about 8 or 9 months I had to go back into hospital and have it all cut open again and moved because the scar tissue was completely in the wrong place. They'd [doctors] actually sewn the wrong part of my vagina to the other part of it so I had to have it all cut open and done again. So I had a considerable amount of pain and, for the first, I think...until two years ago, so five years after I'd given birth I couldn't even insert a tampax without it hurting, and I kept saying*

it was hurting and they were saying it was in my mind but it slowly began to heal and since it's healed it doesn't hurt and that's where the problem came in for me because I kept saying 'but it hurts, it's too painful, it hurts too much.' And all I was being told was it's in your mind, it doesn't hurt and I knew it did. And it did because now it doesn't and it hasn't done for a couple of years.'

(43 years of age. Heterosexual. Married)

Of those participants who attended the psychosexual clinic, instances came to light whereby having finally summoned the courage to reveal some of their most intimate sexual concerns to a clinician, they were simply told that it was 'all in your head'. This next excerpt describes the struggle one participant encountered with a genito-urinary registrar to substantiate her concerns in relation to the bodily pain she was experiencing before being referred for counselling at the psychosexual clinic for further investigation:

PII: I6 *'Especially with the sexual side, every doctor I went to see to begin with – 'there's nothing wrong with you'. How could I say that to my husband? I did not know how to, to begin with. What do I say? I just did not know. Sitting down, sobbing my heart out saying 'they say again there's nothing wrong, it's all in my head.' Which was why they sent me to [psychosexual clinic] for counselling. The amount of people who said 'you need counselling or anti-depressants' I've lost count of.'*

(26 years of age. Married. Heterosexual)

The impression we are given here is that psychological pain, indicated by the phase 'it's

all in your head' was viewed by some medical practitioners as being somehow less worthy of further investigation than a clearly identifiable physical sexual problem and is evidence of a preconceived notion of the superior value attached to the physical body. From the participants' personal point of view, we also get a sense of the relief generated by having these sexual difficulties eventually validated:

PII: I6 *'Yeah. I'd got this assessment and we must have been there a couple of hours and we went through everything. And at the end of it she said we can't talk through anymore of this, you need to be seen by a specialist because it sounds like you've got vulva-vestibulitis or vulvadynia she called it at the time, is that right and I was like 'what's that?' It was like someone had given me a name [laughing]. Wow. Yippee. And I came out with this huge smile on my face with tears running down my cheeks because somebody had actually listened, and somebody actually took note that there was actually a problem with me that was a problem between us.'*

(26 years of age. Married. Heterosexual)

2. Sexual Problems as Physically and Psychologically Complex

In addition to those participants who referred to sexual problems as primarily physical for the purposes of legitimacy, others referred to sexual problems as a combination of both physical and psychological aspects, often with one influencing the other. Recounting an experience of sexual assault, the following excerpt reveals how for this participant, her sexual problems were physically and psychologically interdependent:

PII: I2 *'I would say for me sexual problems have very much been problems caused by the whole gamut of problems associated with an assault and that would be for me. So a lot of those problems are nothing to do with sexual behaviour or sexual intercourse. So for me it would be that whole gamut of problems, that whole range of tricky issues as well as some of the purely physical issues which are probably emotionally attached to the same events, so there's ...The mind and the body are not separable, it's just one of those things.'*

(49 years of age. Single. Heterosexual)

In addition, the following two short excerpts also exemplify participants' beliefs that in the event of a sexual problem, the body is inextricably linked to the emotional and psychological:

PII: I2 *'I think with women the emotional and the physical are so closely tied together that it's almost impossible to pull them apart. They almost don't exist separately.'*

(49 years of age. Single. Heterosexual)

PII: I3 *'I think a sexual problem is any type of physical or mental problem that prevents you from enjoying the sex life which is available to you but you can't enjoy it because you have a physical or a mental problem.'*

(39 years of age. Single. Heterosexual)

Adopting either a sole physical or psychological point of view was considered to be erroneous by participants. Rather, they saw a fundamental need for sexual problems to be considered by health professionals in broader terms rather than being physical, social *or* psychological:

PII: I9 *'if somebody's got a deep rooted issue then it's not just going to be about sex it's going to be about other things too because you can't just have a problem with sex that's come from your past, you've got to have problems with other things like relationships or interactions or fears that you have that are slightly irrational. So you can treat it as a whole issue, not just a sexual problem isn't it? And I think if they tried to begin to treat women as a whole picture and not ... at the [psychosexual clinic] they treated you as ... they may as well have just said you with the sexual problem come in here and sit down and let us tell you what your problem is. I don't find that helpful. You need to look at the whole picture and stop perceiving it as a problem.'*

(43 years of age. Married. Heterosexual)

3. Sexual Problems as Context Dependent

A common feature manifest in many of the participants' accounts was that sexual problems do not occur in a vacuum. Rather, it was apparent in their accounts that in order for sexual problems to be understood, there is an unequivocal need to examine the context of the lived experience. This includes a need to consider the quality of an emotional and sexual relationship and the impact that the multiple roles of wives, working mothers *and* lovers can have upon a woman's ability (or not) to be and feel

sexual. As such, many of the issues raised here lie outside of the woman herself and may be considered as a byproduct of a patriarchal society- the wife as cook, cleaner, child minder, for example, as roles that she is duty bound to perform on a daily basis in addition to her sexual responsibilities:

PI: I11 *'Before you have no children, no problems but now you have children, have family. But this, like I talk my sister and she told me just before [it's] temporary, the problem, but after that, you move on, you feel the better and the better but I just feel that even now you have difficulty to bring up the children but you should still understand, still respect you know.'*

(38 years of age. Married. Heterosexual)

PII: I5 *'No...other than women do seem to, this is no disrespect to anybody, but women do seem to have so many more different aspects to deal with in life in terms of working mothers, there's a lot to take on isn't there so I do often see the man's role as they go to work and they come back and that's all that they can do. There's this awful thing isn't it about men can't multi-task and women do five things at once but I think women...I think women find it hard to switch off and everybody that knows me, I don't relax. If I sit down on the settee for more than 5 minutes I think 'gosh I shouldn't be here' and I have to get up and do something. But normally I don't sit down because I just know that there's just so much stuff to do so I just think that women perhaps take too much on board in terms of house, housekeeping, children and sorting you know. And I've got a good husband who does a lot so people that are married to someone or in a relationship*

with someone that does absolutely nothing then god knows how they cope.'

(37 years of age. Married. Heterosexual)

Participants' experiences were wide-ranging and revealed that their everyday lives and previous life experiences exerted a powerful effect in terms of what they regarded as sexual problems. For example, they indicated that their problems stemmed from being too tired for sex, that their partner did not want sex in the same way, at the same time, or in the excerpt below that they had simply fallen out of love with their partner. The following participant contends that her sexual difficulties originated from the fact that despite still loving her partner, she had grown tired of the relationship and other aspects in her life now assumed greater importance. She gives the example of a busy working life in her interview and appears more or less nonchalant in her attitude towards maintaining the sexual side of her relationship with her partner:

PI: I2 *'We still love our man/partner but for me everything else surrounding our life was the bit that was much more important. I got very lazy, I couldn't be bothered. There's the whole thing as well about you working and you're tired and life gets in the way and it's hard to feel quite as sort of spontaneous about it* [sex] *all.'*

(52 years of age. Divorced. Heterosexual)

The following participant draws upon the theory of Maslow's (1943) 'Hierarchy of Needs' to explain the importance that she places upon sex and the factors which have the potential to trigger sexual difficulties. The basic concept is that the higher needs in this

hierarchy only come into focus once all the needs that are lower down in the pyramid are entirely satisfied. Only after those basic needs have been met does a woman achieve her sexual potential- her inference being that sexual problems are a corollary of a woman's everyday life experiences. As she explains:

PI: I7 *'I think having a lot of stress, having loads of kids. If you're in poverty and you've got things to worry about all the time I think basically your life ... it's a bit like Maslovian isn't it in that you might want ... basically you've got to get shelter, you need food, you need warmth and if you haven't got any of those then you're not going to be that bothered about whether or not you self actualise, you're just gonna be too busy trying to get clothes and ... Yeah. I guess if people are really tired and it tends to be other things that make you that tired but for myself just tiredness, worry but other than that no.'*

(43 years of age. Living with partner. Lesbian)

Participants also reported that the quality of their personal relationship and more fundamentally, the ways in which they felt they were appreciated by a partner as an 'equal', were crucial to their self-esteem and their ability to feel and be sexual. Consequently, sexual problems were seen as very much embedded in the context in which women live their lives:

PII: I9 *'Well in my experience I think that low self-esteem is the biggest problem for women. That they are, it's how they perceive themselves and the relationships that*

they're in. I think there's a lot of unhealthy relationships out there where there are still sadly a lot of men that treat women really badly, especially the ones that they live with and they're married to and I can well understand...I've got a really low opinion of British men. If you stand in an airport queue and you look at them you can spot them a mile off. They're generally the ones who have totally gone to seed, they're overweight, they're badly dressed, they're unattractive and yet they make these demands on you: 'I want to have sex with you', and my answer would be 'well I don't want to have it with you. Why? Because look at you, you're awful'.'

(43 years of age. Married. Heterosexual)

From the summary point in her interview, this participant gives the impression that if a woman fails to succumb to a man's sexual demands, it is her who is routinely held to account for the lack of sexual desire rather than the man. This point can also be related to a later theme in this chapter where I contend that women are frequently required to compromise their own sexual standard and measure up to a male standard. The same participant then goes on to contend that a holistic approach needs to be adopted which recognizes the complexity of sexual problems in the everyday lives of women rather than defining them as being couched primarily in biomedical terms. She argues that a 'lives' approach is needed to fully appreciate those factors which thwart a woman's ability to be sexual. In the following excerpt, she contends that the reality of having a full-time career impedes her capacity to be sexual all the time. Conversely, she maintains that she could reduce her stress by not working but this would also impact on other aspects of her life.

As a result, there are a number of complexities and contradictions which pervade participants' understandings of sexual problems:

PII: I9 *'...I think we have to look at the whole picture of our lives, I think is what we've tried to do together. We've looked at the whole picture. I could give up work so that I wasn't tired or stressed and I could be here ready with my very attractive thong, because I've got a passion for nice underwear, waiting for [husband] to come home every night but if we look at the reality of that that wouldn't happen would it because I'd be bored, frustrated in my day because to be in the house all day would absolutely drive me insane, there isn't enough to do for me. So I'd be bored, frustrated and skint and we wouldn't be able to afford to do the extra nice things that we would like to do because that's really what I work for, so that would bring with it its own tensions and its own difficulties which would then impact. [Husband] would walk through that door, I'd say tell me about your day, I'd be desperate to hear any adult conversation...so that would impact on us so I think you need to look at the whole picture and that's what we've tried to do.'*

(43 years of age. Married. Heterosexual)

In the case of one particular participant (whose situation was described in greater detail in the previous chapter), the long-term effects of having worked as a prostitute limited her inability to think about sex in ways other than being related to male power and financial gain:

PII: I10 *'The other problem is that, because you're the only one who gets punished in the*

arrangement, the men who buy your services yes you may be offering or are you? They don't get anything. If you're raided in a brothel, and I've been in many raids, all the police come in and all they do is tell all the men to get themselves dressed and leave as quickly as humanly possible. They are not charged at all and they're told to go home. They're not held so that impacts.'

(23 years of age. Single. Heterosexual)

In addition, factors such as infidelity and sexual abuse were given as examples of the root causes of sexual problems. These were described in the context of the potential difficulties that a woman might experience in establishing trust with a new sexual partner. This is evidenced in the following excerpts:

PI: I4 *'I suppose if their men are playing away that's a big problem to them and they don't want to be, they can't bear the thought, well I wouldn't think so, of coming to you when they've been with somebody else. Well, I couldn't take that, I could not take that. I should have to have somebody utterly faithful.'*

(72 years of age. Single. Heterosexual)

PI: I1 *'I suppose things like physical abuse as children possibly, physical abuse within a relationship I would guess would have an effect on how people saw sex, and particularly this is the one thing I find I have no time for I suppose is sex and violence. I can't even look at a film if there is ... I can watch sex and I can violence, it's like sweet and sour, I can have the savoury and I can have the sweet but I can't have them together. I think*

that the sex and violence together I have absolutely no time for and I would guess that women in abusive relationships possibly abuse linked to sex, then those two together may cause some sort of sexual problems.'

(50 years of age. Living with partner. Lesbian)

4. Sexually Problematic Media Representations of Women

An additional issue which participants found to be sexually problematic concerned the idealized images of women's bodies and the idea promulgated in the popular media that women should make every effort to achieve the 'ideal' body type. This theme resonates with participants' understandings of the concept of sexuality being akin to the physical body and a number of the 'womanly ideals' that participants alluded to throughout the course of their interviews. Such portrayals of the sexualized woman disseminated by the popular visual media exerted a powerful influence upon women's everyday lives and served as potential source of anxiety. Living up to such expectations was considered by participants to be wholly unfeasible and served to strengthen 'ordinary' women's anxieties about their own bodies. The superlative representations of femininity which participants believed they were expected to live up to were revealed to various degrees with particular reference to mainstream magazines, television and films. Participants also expressed their concerns about the ways in which this physical imagery was used as a means to market an assortment of products by models that were much younger than those whom the products were aimed at.

Moreover, they also claimed that it was not uncommon to see very young models setting the standards of sexual attractiveness for older women and discussed the subsequent resistance this incited in them. The following participant draws our attention to this issue when speaking about the marketing campaigns by cosmetics producers and the deceptive strategies that manufacturers employ to sell their products:

PI: I1 *'You look in the magazines, you look on the telly, you go to the cinema and the only thing that is desirable is youth. It makes me laugh because I have a particular cosmetic and it's an established French firm and I would guess, it is quite expensive and I would guess that it's mainly people in the older age group that can afford it and yet the models that they use must be about 16. What 16 year old needs a £70/80 pot of night cream, it's ridiculous...'*

(50 years of age. Living with partner. Lesbian)

The analysis revealed that the ways in which women's bodies are portrayed by today's media are by no means innocuous. Participants spoke at length of women being represented primarily in terms of their body parts; legs, breasts or thighs, thus further reinforcing the message that they are objects intended primarily for male desire rather than complete human beings. Participants claimed such imagery implied that women should concern themselves primarily with attracting and sexually satisfying the needs of men. This is highlighted in the following interview excerpt, where the participant refers to Jordan, a renowed British glamour model and television personality known primarily for having breast enlargements:

PI: I6 *'...especially with the media. You've got it thrown at you all the while, how you should look. You know that you don't look like they do on the television but in your mind you think 'oh God I should look like that'...I just look at it and think 'God if I'd have the money I'd have the operations and look like they would' [laughing] but that's never going to happen but it is a bit of a come down at times, just a knock back....I mean if we all looked like Jordan we'd be well away.'*

(66 years of age. Widowed. Heterosexual)

That women feel pressured into living their lives by a standard which concedes to media imposed images were evident in their accounts. The daily pressures that women have to contend with include corporate sponsored campaigns which persistently reinforce the primary value of the feminine ideal-the big breasts, slim thighs and collagen enhanced lips for example. This imagery is capable of exerting a negative effect in terms how women view themselves and their own bodies as physically and sexually flawed. From the analysis conducted, it reveals that the media has a powerful influence upon women's levels of self-confidence and self-esteem:

PI: I5 *'Because of all this media about these wonderful looking women, you know and you think right, 'I'm not sexually attractive any more' and you're falling apart, falling down, drooping and all that [laughing] you think well...'*

(57 years of age. Married. Heterosexual)

5. Women's Sexual Problems: Measuring up to a Male Benchmark

The Primacy of the Penis

Despite one of the principal aims of this study being focused upon capturing women's views of what they believed to constitute *female* sexual problems, it was noteworthy that participants focused repeatedly upon their partner's erectile difficulties as a catalyst for their own problems:

PI: I3 *'Sexual problems in terms of how the act or whether the man can or what happens is the mechanics of it...If they can't perform they think they're total failures.'*

(50 years of age. Divorced. Heterosexual)

My main reason for introducing this sub-theme here relates to the fact that not being able to take part in the hetero-normative activity of 'real sex' due to erectile dysfunction was a matter which participants felt they must take responsibility for fear of their partner perceiving themselves as 'total failures'. As a result, participants had to manage a partner's emotional and physical anxieties associated with his erectile dysfunction as well as their subsequent inability to engage in penetrative sex. Accordingly, participants would assume the responsibility for these difficulties in an effort to placate the guilt and suffering experienced by their partners:

PI: I6 *'Well my husband, the last year or so of his life, he, well, we both knew it was problem but due to his long illness that he'd had he was impotent but that bothered him more than it bothered me. He used to feel guilty about it and I used to try and sort of*

try and get over to him that don't worry, it honestly did not matter to me but it bothered him. He couldn't understand it and he used to get frustrated about it...it was more of a problem for him. I think he thought that because he couldn't do it he wasn't a man sort of thing which was rubbish. I used to try and get through to him but it was hard on him, but that was his illness. He used to try and apologise for what he couldn't do and that were it. I'd say 'it's alright you're still here and we've got each other and we don't need that [sexual intercourse]' but in his mind it bothered him...'

(66 years of age. Widowed. Heterosexual)

Another interesting feature revealed in the following interview excerpt is that, despite identifying her sexual orientation as a lesbian, this participant describes sexual problems in primarily male genitally focused terms (despite not participating in the convention of heterosexual penetrative sex herself). She focuses primarily upon erectile difficulties before going on to consider wider issues which can be construed as women's sexual problems:

PI: I7 *'Something where either a person can't have sex or can't enjoy sex. Somebody can't have an erection or they are not able to think in a sexual way about somebody else because they are emotionally not able to do that for whatever reason. It could be because of past experiences or whatever which often inform a lot of sexual problems I think. I guess mainly around either not being able to partake of sex or intercourse or love in a physical love in a way that's meaningful. I guess that's a bit broad, but I guess it's a bit more than about whether or not you get an erection or you get moist or...But,*

whilst there are physical causes for a lot of sexual dysfunctions there's also a lot of emotional stuff around it isn't there. That's what I would see as a sexual problem'.

(43 years of age. Living with partner. Lesbian)

As well as having to take an active role in resolving their partner's erectile difficulties, participants often felt compelled to 'shoulder the blame' when a partner was unable to achieve an erection. The following participant criticizes her own body as the root cause of her partners' erectile difficulties and for thereby not getting the kind of sex she wanted:

PI: I10 *'Well the problem for me was not getting the sort of, the kind of sex that I wanted really. Then like I said not getting an erection was a problem because that at the time made me think it was me, and linking that into age I was convinced that it was, 'oh my God' this is what was going through my head, 'oh my God they've got to this point, I've taken my clothes off and they've thought oh my God her body is really horrible' and the erection has gone. Not that it was there in the first place I don't think because most of the time it was ... I can remember thinking that. I can remember thinking 'I must look all right with my clothes on' but then all of a sudden they've thought, you know, something happened between me and my fella and it meant that I didn't have an orgasm and he said [laughing] 'maybe your coming days are over' and I said 'oh my God don't say that', I said 'oh no', I said 'it's just a blip [laughing]. I just thought oh my god fancy him thinking that. I said 'why do you think my coming days are over?' so he said 'I don't know it's just a thought'. I said 'listen I'm not drying up*

yet' [laughing]. Do you know what I mean? I mean the thought of it going now after the menopause is like oh my God. Because I like it [sex] and it's something that ... I mean this is how I feel; it [sex] just makes me function better. You know when I wasn't having regular sex I couldn't sleep, I couldn't eat ... I'm not saying it was just the sex, I think it was all about being on my own.'

(47 years of age. Single. Heterosexual)

These data suggest that women carry some, or in some cases, *all* of the blame for a partners' erectile dysfunction. That participants expressed doubts about themselves as sexually attractive women on the basis of a partners' difficulties with maintaining an erection is indicative of an entrenched view of sexuality and sexual problems that promotes an (essentially male centred) biological reductionist approach.

Women's Sexual Problems: A Case of Blame?

Other participants referred to specific sexual problems such as vaginismus and anorgasmia which are categorized specifically as 'female sexual dysfunctions' in the DSM-IV-TR (APA, 2000). However, once again, an overriding element of measuring up to a male benchmark pervaded these interview accounts. Referring to her experiences of inorgasmia in the first of these excerpts, evidenced by the phase 'it's made the men in my life unhappy', the following participant demonstrates a propensity to show more concern with the sexual gratification of her partner rather than with her own sexual needs. Whilst she acknowledges that there is no 'hard and fast' rule, there is a pervading sense in her account that the inability to achieve orgasm is tied in with a sense of male sexual

prowess. For this participant, orgasm is not the pinnacle of sexual nirvana in the way that it is considered to be in the clinical literature:

PI: I2 *'... if you don't have orgasms very easily. That's often called, it used to be anyway a sexual problem but I think the thinking on that has changed now thank God. Well my thinking is that I don't think it should be a problem as long as you're enjoying it. They're not something that have been very easy for me but then I sometimes wonder if that's part of my not losing control. I'm not sure but it's never made me as unhappy... [laughs] It's made the men in my life unhappy [laughing] and I think it does make partners unhappy, certainly straight men because it's tied up with their own sexual performance and virility. But then there are men out there who understand enough that actually it's got necessarily nothing to do with them.'*

(52 years of age. Divorced. Heterosexual)

Highlighting her experiences of vaginismus, a 'sexual dysfunction' outlined in the current DSM, this participant asserts that her inability to engage in penetrative sexual intercourse was not directly attributable to her independently, but linked to her previous partner's abrupt sexual technique. Once again, it seems as though her sexual problems could be attributed to both parties and, as a result, the 'blame' cannot be isolated to either the woman or the man without paying due attention to the circumstances, historical precedents and the technique of the partner involved in the sexual encounter. In this particular case, applying such a diagnosis to the woman herself would be unwarranted without first taking account of these interconnected factors:

PII: I3 *'Well in my case I experienced vaginismus and that was a sexual problem for me because I was, I was in a position where I'd just met a new partner and I really wanted to be able to have successful sex with him. And we'd go to bed and I'd really want to have sex with him but I just couldn't and that's a sexual problem because it's preventing you from enjoying the sex life which is available to you and you'd really like but you just can't do it so... that's how I've come to my understanding of what a sexual problem is, in that it's something physical or mental that prevents you from enjoying a sex life that you could otherwise have... subsequently my new partner ... obviously the first time we attempted to have sex I just tried to be really open minded about it and thought 'we'll have a try, if it proves to be a problem we'll have to do something to sort it out' but I'll just give it a go first, I won't say anything about it, I'll just see how we go. And it hasn't been a problem with him at all which is really interesting because I've maybe had sex with ... well I'm 39 so but not that many people [laughing], really not that many people, but in my entire life only 2 people have I been able to easily have sex with and one of those was a relationship that only lasted a few weeks and the other one is my current partner who I've been seeing for about a year now. And, yeah, it's not a problem at all which is quite strange because it sort of makes me feel like it was never my problem in the first place in a way. It was just finding the right person.'*

(39 years of age. Single. Heterosexual)

Similarly, in the following excerpt, the participant assumes sole responsibility for her current partner's poor sexual technique which she describes as 'getting it in'. Her

account highlights the effort she has gone to to explore the root cause of her partner's sexual difficulties and the various strategies she has used in her attempt to resolve the problem of her partner's poor sexual technique:

PII: I8 *'Well he didn't have any problems with erections but he had real problems getting it in...yeah, well basically, we did other things, I mean we still had a pretty good sex life but I didn't like to pry into his past but I get the impression that he'd had this problem before. And I suspected it was just probably just a question of technique so I persuaded him to come with me to my doctor. And she was brilliant, she was very good. She took lots of notes and, and then she said 'well it could be a range of things but I can't really say because I'm just a GP' and she referred us to [psychosexual clinic]. As I said before we waited for a couple of months and didn't hear anything, phoned them up and found out that they had a waiting list of a year and that's when we went private. The sexual psychotherapist, I think they're called that, we saw, I think we saw a few times, two or three times and she was very good at talking through all the possible psychological reasons that could have been behind this which I thought was useful. I suspected it was a technical problem but there were all sorts of possible you know, reasons going through my head so that was quite useful to sort that out. In the end the answer was lubricant, and that was it, it was as simple as that. And practice. And now it's fine. So erm, yeah, it wasn't a big deal, it wasn't anything to worry about and it was fixable.'*

(38 years of age. Single. Heterosexual)

For some participants, infrequent or a total lack of sex was also considered to be analogous to a sexual problem. In the following interview excerpt, it became apparent that for this participant, not having regular sex was more of problem for her husband than herself. However, it was seen as entirely the responsibility of the woman to act as the driving force to make enquiries about treatment with psycho-sexual services in an attempt to appease her husbands' anxiety:

PII: I5 *'Just by not having regular sex really. I think it's seen as a relationship, you have sex regularly, and if that's not happening then there's a problem. It's how I saw it, quite clinical.'*

(37 years of age. Married. Heterosexual)

The excerpt below implies that the meaning women ascribe to sex is also dependent upon a male perspective which might not always automatically equate to their own view of sex and that this can lead to sexual problems. We are given the distinct impression that the participant's partners' view of sex was incongruent to her own resulting in a sexual 'stalemate'. Moreover, when this excerpt is critically examined, the participant's tendency to self-blame (noted by the phrase 'if he wants it [sexual intercourse] and I don't then it is me') is suggestive of a partner who pays little or no attention to her sexual requirements:

PII: I5 *'... if you're [husband] not getting sex [intercourse] because I'm you know not able to at the moment or can't get my head around it, but I said but neither am I getting a*

back massage or a whatever that I would class as being lovely. So I suppose we did talk a bit about it being you know, an effort could be made on both sides but I think it was just a bit of stale-mate really; I'm not having sex so you're not having that. It sounds really horrible but it wasn't. But I see that sex is sex and if he wants it and I don't then it is me. But certainly we talked about the before sex bit because I think and I'm sure that I'm not speaking for all women, but I think a lot of women prefer the bit that runs up to it. So all the foreplay and that sort of stuff. But, you know, he didn't do that bit [foreplay] so I didn't do the other bit [sexual intercourse] either but it wasn't like that but they were things that ... I mean we used to talk 'til we were blue in the face and we just talked around the whole situation and we'd have the same conversation four months down the line.'

(37 years of age. Heterosexual. Married)

Whatever the cause of a sexual problem, participants claimed that it was typically the woman who took action to try resolve any difficulties. Despite her own indifference to sex after 12 years of marriage, the following participant talked about being pressured into making a referral to the specialist psychosexual services with her now ex-husband for sensate focus therapy[1]. She stresses that she instigated the referral because the lack of sex made her partner unhappy and it was a final attempt to save their relationship. From this, she goes on to argue that what are conventionally referred to as 'women's sexual

[1] Sensate focus refers to a series of specific exercises for couples which encourage each partner to take turns paying increased attention to their own senses. These exercises were originally developed by Masters and Johnson (1970) to assist couples experiencing sexual problems. When used in the treatment setting, sensate focus is done in several stages over the course of therapy. Touching the breasts or genitals are strictly off limits until the latter stages of the therapy.

problems' are based upon a male norm of sexual interaction i.e. if it prevents men from having sex, then it is typically represented as the woman's problem:

PI: I2 *'But a lot of the other things that people call sexual problems are very often because its some bloke has decided it's a sexual problem. When I was in a long term relationship, I was with someone for 12 years, and I know I could have then had something that was defined as a sexual problem because I basically went off sex and I think sex in long term relationships for women, and I've spoken to other women friends, whether this is necessarily about ageing it's maybe more about long term relationships, and we've gone off sex.'*

(52 years of age. Divorced. Heterosexual)

Furthermore, women reported feeling pressured into taking control of a sexual problem even in cases where it was deemed more appropriate that the man should take more of an active role in managing the situation. This raises the suggestion that what has been traditionally referred to as either a man's sexual problem or a woman's sexual problem are, in essence, problems shared by both. This can be related back to an earlier part of this chapter where the case was made to reconsider such problems not as individual but as shared:

PI: I8 *'I've had a sexual problem because he's got a bent willy. Seriously. That is his problem but ultimately it's become my problem... He's never ill right, but his penis has gone ... well it's laughable if it wasn't quite so serious and he refuses to go to the doctor.*

'I haven't got a problem' [husband] but I have. I geared it all up for him to go and see the nurse at the doctors, everything but will he go? And unless it drops off I can't see him going. Yeah I have got one now but it's been steadily getting worse. We do still have sex but I don't find it satisfying. I tell him, all the time, and it's become a bit of a joke. 'We're stretching it a bit'. Actually that's what he's not doing is it, stretching it [laughing].'

(59 years of age. Married. Heterosexual)

Summary

This chapter has identified the complexities and the contradictions in participants' accounts of what constitutes sexual problems for women. On the one hand, their accounts revealed that, for the purposes of legitimacy, a sexual problem ought to possess a distinct physical basis. For a small minority, having to justify sexual difficulties in any other way, and particularly in psychological terms lacked credibility. Conversely, there were those who claimed that sexual problems resulted from a combination of physical, social and psychological factors, often with each exerting an equal influence.

Participants also claimed that there was the unequivocal need to consider the multiple roles carried out by women- the wife as cook, cleaner, child minder for example in addition to her role as bed partner. Male privilege, particularly the importance afforded to the penis and the centrality of penetrative sexual intercourse featured heavily in participants accounts of sexual problems.

Rather than focusing on issues in relation to their own bodies, participants had a tendency to focus upon men's bodies (and particularly the penis) as a benchmark for their own difficulties- the implication being that rather than thinking in terms of either a man's or a woman's problem, these should be interpreted as the couple having a sexual problem. In addition, there was also the added pressure that participants faced on a daily basis in terms of conforming to a sexual standard ordained by the popular media- usually in terms of body parts and not as entire individuals. A failure to achieve this standard gave rise to a lack of confidence with their own bodies and engendered feelings of anxiety and a negative effect on their levels of self esteem leading to sexual insecurities and problems.

Chapter 7

Situating Sexuality, Sex and Sexual Problems: A Discussion

This qualitative, exploratory study has, within a sample of women recruited from the general public and a psychosexual clinic: examined the meaning of sexuality, sex and sexual problems; explored the importance of (self defined) sexual activity; and examined the influence of wider socio-cultural factors upon understandings of sex, sexuality and sexual problems. These issues have been investigated by amassing in-depth interview data from 23 participants aged 23-72 years whose characteristics revealed diverse demographic backgrounds in terms of marital status, ethnic origin and sexual orientation. The impetus for the study was a need identified in the literature to ascertain women's personal views of what constitutes 'normal' and healthy 'sex' (Nicolson, 2003) given the pervasive influence of patriarchal ideas in informing research and popular opinion.

Tracing the development of knowledge claims in relation to sexuality, sex and sexual problems, this study has also sought to examine how these claims have determined contemporary diagnostic criteria for women's sexual problems which are predicated on penetrative sexual intercourse and orgasm. Whilst a 'New View' of women's sexual problems has been developed (Kashak and Tiefer, 2001) to provide an alternative classification system for women's sexual problems, a salient omission has been to attend to the views of women themselves. This study has sought to address that fundamental gap.

This chapter will also explore the suitability of adopting a material-discursive framework for investigating women's experiences of sexuality and sexual problems. Given that there still remains a level of unease *'about the extent to which the material and the discursive retain dualistic categories of mind/body and treat materiality as simply given'* (Gilles et al, 2004: p. 100), I have been particularly keen to explore how women's accounts 'fit' within this framework. Finally, the strengths and limitations of this study will be examined and the implications of this work for clinicians, policymakers and other researchers.

Understandings of Sexuality

'What is to be included? How much of the body is relevant? How much of the life span? Is sexuality an individual dimension or a dimension of a relationship? Which behaviours, thoughts and feelings qualify as sexual?' (Tiefer, 1995: p.20).

Supporting my conclusions for the socially constructed nature of sexuality and rejecting the notion of one 'true' sexuality, participants' understandings resonate with the complexities inherent in the literature reviewed throughout the course of this thesis. As a result, their understandings are at variance with the position adopted within the sexological literature where fixed and universal meanings of sexuality are readily assumed. Given its constructed nature, being able to isolate and give credence to a definitive meaning to the term is, for participants and academics alike, an arduous undertaking given that sexuality is subject to a number of diverse influences. This has important implications for sexology research and, in particular, highlights the need to

develop a critical awareness of the term within research exploring sexual issues. That the ideas that 'ordinary' women hold may be at odds with dominant understandings of sexuality within the sexological literature is important to bear in mind when critically evaluating previous research and in developing future research.

My findings are therefore in line with Weeks (1986), who argues that it is more fitting to talk of 'multiple' sexualities. Given such ambiguities, these findings also correspond with the work of Burr (1995) who maintains that sexuality is *'never fixed, always open to question, always contested, always competing'* (Ibid. p.39).

These complexities were evident in participants' accounts when they revealed how they imbued sexuality with numerous different meanings. Some participants defined sexuality as analogous to sexual orientation. Their accounts resonate with Rothblum (2000) and Gott (2005) who argue that sexuality is popularly understood as akin to categorical definitions of sexual orientation, such as heterosexual, bisexual or lesbian. However, this is not to say that this meaning is necessarily straightforward. In line with Burr (1995) sexual orientation as a marker of sexuality was never seen as fixed, but was conceptualized as existing a continuum from heterosexual at one end of the spectrum to lesbian and gay at the other.

Other participants equated sexuality primarily with (hetero) sexual intercourse which is supportive of the work of Bancroft (1983), as well as claims that this activity continues to represent the 'gold standard' of sexuality (Jackson, 1984; Gavey et al, 1999; Bogart et al,

2000). It is interesting to trace the work of the 'founding' theorists Sigmund Freud, Havelock Ellis, Alfred Kinsey, William Masters and Virginia Johnson in participants' accounts of sexuality and identify their legacy in understandings of sexuality couched primarily in physical terms and which promote the importance of penetrative sexual intercourse and orgasm. Indeed, this provides empirical support to the claim of Nicolson (1993) that, to this day, patriarchal knowledge created by a small number of predominantly male theorists continues to permeate contemporary understandings of female sexuality. Moreover, it is an indication of the privileged position afforded to the physical body within both academic and 'ordinary' women's understandings.

Likewise, participants accounts also revealed the extent to which the physical body was implicated in understandings of sexuality and, in particular, viewed as an external marker of their sexuality- the 'body beautiful' setting a physical standard for women (Travis et al, 2000: p.239) which is amenable to inspection and *'social monitoring and control'*. That the physical body assumes fundamental importance within participant's accounts resonates with the views put forward by Tiefer (1991). In a similar manner, media activist Kilbourne (2000) notes that women's bodies are often dismembered into legs, breasts or thighs, reinforcing the message that women are objects rather than whole human beings- offering a kind of pseudo-sexuality that makes it far more difficult to discover their own unique and authentic sense of themselves. Whilst participants' accounts in this study focused upon body 'parts' their views call into question the fixed and biologically determined nature of sexuality enabling us to think about its constructed

nature and the societal pressures that women are subjected to in an effort to meet those 'acceptable' norms. This finding is both unique and important.

Regardless of age, the body (and its parts) assumed extraordinary significance and, as a result, was central to participants' perceptions of sexuality. Whilst the female body was clearly implicated in participants' accounts of what they view as sexuality, the socially constructed nature of women's sexuality took precedence in certain accounts. Rather than focusing primarily upon the material body, the extent to which ideology, culture and power intersect with notions of the material body indicate the multidimensional, constructed nature of sexuality.

Understandings of Sex

In a manner comparable to the concept of sexuality, the term 'sex' was also open to an array of different and competing meanings. However, the dominant idea of heterosexual coitus was widespread in participants' accounts. As a result, these findings resonant with the work of Jackson (1984) on the basis that some participants found it difficult to think about sex in a manner which did not involve the defining bodily practice of heterosexual intercourse. Moreover, even when participants in this study sought to oppose the coital imperative, their views often acquiesced back to this prevailing benchmark. As a result, these findings resonate with the views of McPhillips et al (2001: p. 239) who assert, that 'it *is* hard to resist' even in the face of adversity.

This adversity was especially evident in those accounts that participants recalled in

relation to being unable to engage in this activity. Similarities between the views expressed by participants who experienced vulvodynia in this study and the work of Kaler (2003) can be identified. She argued that *'one's sense of self as authentically gendered- as a 'real woman'- is defined in significant measure by engaging in certain activities which are culturally defined as 'real sex''* (Ibid. p. 1). Kaler's conclusions supports the findings of this study, whereby participants talked about feeling 'less of a woman' for not being able, or having no desire, to engage in the defining practice of sexual intercourse and subsequently be a 'good wife'. These views also resonate with the work of Ussher and Ayling (2007) who argue that women's gendered subjectivities are defined by the ability to engage in heterosexual penetrative intercourse.

That sex was seen by participants as analogous to penetrative sex and for some, in solely reproductive terms are all ideas that can be traced back those theorists reviewed in Chapter 1 of this thesis. Ellis (1894: p. 440) for example, argued that *'woman breeds and tends; man provides'* thus solidifying the importance of the reproductive imperative. These views resonate with participants' experiences almost to the extent that the inability to conceive was considered antithetical to 'womanhood'. Again, these views are in line with Kaler, (2003).

That some participants took the decision to remain single *and* celibate on the basis of problems associated with their fertility is an endorsement of the centrality of 'motherhood' to constructions of femininity. As a result, these theorists have exerted a powerful and legitimizing influence upon the ways in which sex has come to be

understood within the context of women's natural, primary and often sole role of motherhood (Nicolson, 1993b). As a result, these ideas provide a powerful ideology and a system of socialization whose ideas, discourse and practices continue to pervade women's everyday lives.

The primacy afforded to penetrative sex as a benchmark of 'real sex' was one which also suffused the sexual experiences of those who identified as lesbian. This is interesting because lesbianism allows for the construction of alternative 'sexualities'. However, this adds to existing evidence of the persuasiveness of a hetero-normative discourse of penetrative sex as *the* sexual norm. It is intriguing that this imperative still figures markedly within such accounts. These findings resonate with the work of Ingraham (1996: p. 169) whereby 'heteronormativity' structures reality in such a way that *'heterosexuality circulates as taken for granted, naturally occurring, and unquestioned'*.

Accordingly, within traditional sexological discourse, women are positioned as the nurturers and carers of men and children dependent on 'achieving' a male partner. Women need to make themselves attractive to men by fitting in with male desires. Such power relations work to keep women subordinate to men and men not only dictate women's 'natures' and how they behave, but 'objectively' describe this behaviour in a way which fits in with the patriarchal paradigm. According to Nicolson (1993: p. 61) *'women either actively pursue passivity or self pathologise'*. In order to make sense of their own sexuality, women draw upon these discourses surrounding sexual behaviour and desire: active/passive heterosexuality; orgasm as the goal for sexual encounters; and

the dominance of penetrative sexual intercourse. A similar argument has been put forward by Ramazanoglu and Holland (1993) who argue that women's sexual desires are moulded to match those of men and that '*normal heterosexual practices and relationships are constructed in men's interests to control women's bodies and subordinate women'* (pp.240-241).

In addition, rather than defining sex primarily from the perspective of the material body, detached from the realities of their everyday lives, participants claimed that the context of any sexual encounter played a fundamental part. Moreover, sex was deemed to be a means of achieving both emotional *and* physical wellbeing without primacy being afforded to one aspect above the other. These findings draw attention not only to the position of the physical body but also to much wider social and psychological aspects and sexual expectations which resonate with the work of Kaschak and Tiefer (2001). The findings also support the work of Byers (1999) whose research provides strong empirical support for including the relational context in any discussion or definition of women's sexual functioning and/or sexual satisfaction, as well as sexual problems. Moreover, participant's views of sex and what it means to them repudiates primarily physical understandings of sex. Instead their views draw attention to a meaning of sex which transcends dualistic forms of thinking (e.g. the body-mind and nature-culture dichotomies). These ideas can be located in the work of Ogden (1997).

Likewise, participants' accounts also revealed the extent to which 'sex', for them, consisted of a much wider range of behaviours and did not automatically include

penetrative sex as a benchmark of 'real sex'. This has implications for the usage of the term in everyday life given that its meaning is subject to diverse understandings. That participants described sexual fulfilment on a number of levels which did not rest solely on sexual intercourse and the successful achievement of orgasm resonates with the work of Nicolson and Burr (2003) but is suggestive of a number of inherent male biases in respect of the women's sexual expectations generally As a result, the findings of this study concur with a study conducted by McPhillips et al (2001) whose work drew attention to the tensions and the fissures in participants' talk about what sex meant to them and revealed the 'alternatives' through which the supremacy of the coital imperative was challenged. These included a much wider repertoire of behaviours- 'care and concern', 'real feelings' and 'love' and resonated with the opinions expressed by participants who took part in this study.

These findings are also largely supportive of another exchange of ideas operating predominantly within heterosexual relations which have been previously referred to as the have/hold discourse put forward by Hollway (1984; 1989) which positions women as more interested in 'love', 'affection' and 'feelings' than sexual intercourse. Despite being written primarily from a heterosexual standpoint, these ideas do not exclude other relationships and were evident in the views of those women who identified as lesbian in this study.

Participants' talk in relation to sex was complex. It contained contradictions and multiple positions around sex and intercourse were adopted. Whilst many were able to access

positions which stood outside of the dominant position of sex as akin to penetrative sexual intercourse and challenge the coital imperative, some participants found it difficult to imagine sex without intercourse. These findings resonate with the work of McPhillips (2001) who identified that women's views would often succumb to this prevailing standard- even in the face of immense difficulties.

The Importance of Sex

Whilst 'sex' is frequently promoted within the medical and nursing literature as important and in relation to potential health benefits (Davey Smith et al, 1997), women's voices have, to a large extent, been absent from that debate. Moreover, as the imperative of sexual adequacy has grown over the 20th Century, being sexually 'normal' has come to be regarded as a matter of good physical and mental health. Hart and Wellings (2002) argue that celibacy is now viewed as the new sexual deviancy and the decision not to engage in an active sex life is considered 'dysfunctional'.

The findings of this study indicate varied opinions with regard to the importance that participants attached to sex. Their views pivoted around three prevailing themes- the perceived disparity in the importance of sex between women and men; and sex as important 'for all the wrong reasons' or 'not important at all'.

Rather than making blanket assumptions about sex being more important to men than women, there was evidence within participants accounts of a permissive discourse (Hollway, 1984; 1989) which is more often than not associated with libertarian ideals and

ethics in which sexual activity is afforded as more of a male privilege but which some participants also identified with. *'I've met women who can just fuck for fuck's sake, you know, which I have done on occasions'* is one such example.

Whilst participants generally expressed the idea that men were much less 'discerning'- particularly in respect of the person with whom sexual activity occurred, contradictions were evident. Whilst the male sexual drive discourse (Ibid.) serves a biological 'need', there is the supposition that women do not have the same drive for sex. This is not helped by the fact that women are required to negotiate complex boundaries- positioned as either passive- the asexual pure Madonna or, if they were sexually dominant, seductive and dangerous, as a whore or a bitch (Potts, 2002: p.21).

Some participants expressed sexual needs in ways that are classically associated with a male perspective and similarities can be found in the work of Lee (2006) published from a web 'blog'. This 'blog' demonstrated that we live in a culture which still finds a woman's carefree attitude towards sex almost alien.

These findings do not support the stereotype of an altogether asexual old age. This has been evidenced in Chapter 5 whereby participants claimed that sex still assumed importance in later life. In line with the findings of Gott and Hinchliff (2003: p.1627), the findings of this study also support their analyses that there are a *'diversity of views that older people hold about the value of sex in later life.'*

However, there are many complexities and contradictions with regard to ageing and the importance of sex. Whilst some participants' accounts corresponded with the work of Frank and Anderson (1980) in the sense that a preference for tenderness in the form of a 'kiss and cuddle' or 'a different kind of love' was expressed, other participants, who had been in similar long-term relationships, lamented about how they missed the physicality of the sexual relationships that they had experienced in previous years. These findings are similar to those of Rubin (1991) who reported that many of her participants in longer-term relationships *'mourn the passing of...passion'* (Ibid. p. 166 71) and occasionally get nostalgic flashbacks and wonder, *'Why can't we make this happen all the time'* (Ibid. p. 186).

Other participants simply claimed that sex had never been that important a consideration. As a result, these findings challenge the conclusion put forward by Laumann et al (1994) that FSD is a significant public health concern on the basis that all women find sex important.

Sexual Problems

In giving a voice to women and making comparisons with both the clinical and the small amount of feminist literature available, this study has shown the complexities inherent in thinking about sexuality and sex in ways which do not always endorse the essentialist/material position on the one hand or a social constructionist position on the other. Likewise, this study has also demonstrated that there is no compelling evidence to indicate that *either* perspective can single-handedly account for 'ordinary' women's

views of sexual problems. In a similar manner to the way in Weeks (1986) conceived of multiple sexualities, it is also pertinent to talk of 'multiple' sexual problems.

A review of papers published in the *Journal of Sexual and Relationship Therapy* over the last ten years revealed no significant shifts in sex and relationship therapy in the UK. Indeed, in relation to women's sexuality and sexual problems, a paucity of studies adopted a qualitative methodology, and those which highlighted cultural and feminist understandings were also in the minority. As a result, women's understandings of sexuality, sex and sexual problems have remained relatively unexplored within this journal and published studies remain entrenched within a medical framework. Consequently, this study provides a contrast to those published articles and adds to the small body of literature which offsets a highly medicalised approach.

The resolute determination of participants to separate out issues relating to the body from those relating to the mind in their understandings of sexual problems is indicative of the influence of the medical model and its central metaphor of the body as a machine which can be readily fixed (Tiefer, 1995). As a result, many participants viewed sexual problems as having a distinct physiological basis, as opposed to being socially or psychologically mediated. Those who focused on the body did so predominantly in relation to a dialogue which centred first and foremost upon pain and privileged penetrative sexual intercourse as a marker of 'real sex'. These views clearly resonate with the views of Masters and Johnson (1966; 1970) and can be seen as the culmination of the works of those previous theorists who have been influential in developing our

understandings of women's sexuality, sex and sexual problems. However, the danger here is that women's psychological 'pain' can run the risk of being invalidated.

Seeing the body as fundamental is arguably one of the central tenets of contemporary medicine. In a comparable manner, participants' attempts to separate physical from psychological aspects as the basis of sexual difficulties were evident to the extent that not having an identifiable physical aetiology was seen as less 'worthy'. These views are reflected in the efforts of clinicians to identify, separately organic and psychogenic components of diseases and complaints which have become the standard modus operandi with sexual complaints- the DSM IV (APA, 2000) instructs the clinician to first eliminate physiological/medical/substance abuse/medication before assessing any psychological or psychosocial issues and resonate with the views of Wylie (1995).

Whilst contemporary diagnostic criteria used to classify sexual problems take no account of a partner, responses that were elicited from participants in this study suggest this is an oversight. The fact that a woman is given a particular diagnosis of a sexual problem does not put pay to the idea that it may be as a direct result of her partners' sexual performance. Consequently, the views expressed refute the claims inherent in the DSM that sexual problems are highly individual, but they align themselves closely with the 'New View' of women's sexual problems outlined by Kaschak and Tiefer (2001) where partner and relationship factors are seen as central to the categorisation for sexual problems.

The latter point is particularly important given the argument put forward by a majority of participants who claimed that they were often left to accept responsibility, and on some occasions, the culpability for their partners' perceived lack of sexual competence. This was particularly the case in accounts where participants' experiences of 'dysfunctions' such as vaginismus were discussed. Their accounts revealed that rather than paying sole attention to the physical aspects of the phenomena, due care and attention needs to be paid to the circumstances and the technique of the partner involved in the sexual encounter. Consequently, a 'dysfunctional' label cannot be applied to the woman herself without first paying attention to the contextual factors- factors which fit more appropriately with the framework of sexual problems proposed by Kaschak and Tiefer (2001).

Similarly, and with particular reference to the 'dysfunction' of anorgasmia, participants revealed that not being able to achieve orgasm was not necessarily a source of anguish for women themselves but may cause their partner to experience anxiety with regards to their sexual prowess. Potts (2002) has traced the transformation that has occurred over time in respect of understandings of women's ability to achieve orgasm. She asserts that prior to the late 18th Century, female orgasms were deemed necessary for procreation. During the 19th Century, this changed and orgasm was deemed to be harmful and abnormal. Present day classification criteria however claim that a women's inability to achieve orgasm is harmful and abnormal and advise such women to seek therapy. Whilst the history surrounding female orgasm is multifaceted, the findings of this study resonate

with the views of Nicolson and Burr (2003) on the basis that the ability to achieve orgasm was not always central to women's ideas of sexual fulfillment but more about the satisfaction of male desire- female orgasm being the action through which male sexual fulfillment is achieved. As a result, making blanket assumptions about orgasm as the pinnacle of sex, and endorsing it as a 'dysfunction' could be argued to be a product of male privilege. Moreover, it can also be argued that the 'science' of sex is itself is socially constructed in ways that have been advanced primarily by male sexual scientists (Lloyd, 1993).

In a wider sense, these findings share a parallel with the theories of 'emotional work' of Hochschild (1983) and the 'sex work' of Dunscombe and Marsden (1996) who argue that there is much unacknowledged effort and continued monitoring which women are expected to devote to managing theirs and their partners' sexual desires and activities and to placate men's sexual anxieties. Not only are women expected to have to contend with their own sexual and emotional difficulties, but to do so in a manner in which their own needs and desires are usually secondary to men's.

These data also suggest that societally institutionalized gender inequalities of power ensure that most emotional (and by analogy sex) work will be performed by women for men (Hochschild, 1983; James, 1989; Dunscombe and Marsden, 1995). As a result, participants would often assume the responsibility (and on occasions the guilt) associated with these difficulties in an effort to actively manage their partner's anxiety and unhappiness. This also included taking the responsibility for managing a partners'

erectile difficulties. As a result, the findings of this study resonate with work conducted by Cacchioni (2007) whose study highlighted the often unacknowledged effort and the continued monitoring which women are expected to devote to managing not only their own, but also their partners' sexual desires and activities.

In opposition to an almost exclusive focus upon the material body and the highly individualising framework put forward by the DSM, sexual problems were deemed by participants to be multifaceted. These findings fit with the views of Stoppard (1997) whose work, despite being primarily in relation to depression, recognizes these complexities and is written within a material discursive framework. The interplay between the physical, social and the psychological was evident within their accounts with neither aspect being afforded greater importance than the other.

The findings of this study also resonate with the work of Reavey et al (2001), whose narrative study found that women's experiences as survivors of child sexual abuse were individually, socially and culturally mediated. For example, their conclusion that focusing *'too eagerly on the 'personal' without acknowledging how people make use of culturally available discourses to represent their psychological history and interpret their past and present subjectivity'* (Ibid. p. 327) has direct relevance to the study of women's views of sexual problems in the sense that context is crucial to a complete understanding rather than focusing on a set of physical symptoms alone.

Whilst contextual aspects are not taken into account by 'expert' medical opinion in

respect of sexual problems and the diagnostic criteria currently in use, my findings indicate that the context in which women live their lives and the kind of relationship they share with their partner should not be underestimated. Context has the potential to influence the way in which women think about these issues and the problems that can develop as a direct result. The work of Kaschak and Tiefer (2001) parallels participants' views in this study. Likewise, the corresponding claim has also been applied to men by Tiefer (2003: p.4) who has argued that *'endless ghastly sociobiologizing...may never lead physicians and researchers to the awareness that sexual life is contextualized for everyone'*. In other words, Tiefer (Ibid.) claims that sexual life is contextualized for both the sexes and whilst men tend to have the 'upper hand' in terms of context, they too cannot be reduced to sexual 'robots' (Ibid. p. 4).

The findings of this study also resonate with the discourse of reciprocity proposed by Braun et al (2003: p. 259) and suggests that achieving *'a relationship in which there is mutual action, influence, giving and taking...between two parties' is an anticipated norm of social life'*. Participants who perceived there to be little or no reciprocity within the context of their relationship claimed that this had a direct impact upon their ability to be and feel sexual. As one participant commented in the course of her interview, *'...the other person taking as much care to get me to orgasm or pleasure me as what I was prepared to put into them'*. That these issues can be seen as highly contextualized resonates with a study conducted by Tunariu and Reavey (2007) whose work revealed that sexual boredom resulting from complacency on behalf of a partner can exert a detrimental effect on the nature of the sexual relationship. Resonating with the

conclusions of these studies, the current study adds further evidence to the importance of recognizing the considerable impact of the interpersonal relationship context upon women's experiences of sexual problems.

As a result, participant's views also correspond with Weeks (1986), who has argued that whilst *'biological capacities clearly provide the potentiality out of which so much that is human is shaped, and set the limits of social activity (*Ibid. pp. 52-53*), the material body is transformed and given meaning only in social relationships'*. Consequently, the extent to which physical aspects are seen as altogether separate from social and the psychological aspects in much research, as well as the DSM, is erroneous. Efforts to 'explain' these issues need to draw on and integrate knowledge from all viewpoints in order to address the material-embodied and subjective-discursive.

In addition, contemporary diagnostic criteria fail to take account of the complexities of women's emotional and sexual relationships, the impact of their multiple roles as wives, working mothers and lovers and their effects on women's abilities (or not) to be and feel sexual. This was evidenced in participants' accounts when they discussed sexual problems that resulted from significant life changes, such as becoming parents. These findings resonate with previous research referring to the concept of 'habituation' or the impact of the distractions associated with family life and work (Frank and Anderson, 1980; Rubin, 1991; Weiss, 1990) upon a woman's ability to be and feel sexual.

Accordingly, credence should be given to a view of sexual problems which pertains to a broader framework of cultural and relational factors.

My study also identifies that another dynamic with the potential to create sexual difficulties in the lives of ordinary women are understandings of sexuality actively constructed by the popular media. Indeed, some of the omnipresent and highly sexualised media representations that were commented upon by participants were considered to be damaging and can lead to a sense of insecurity with respect to a woman's sense of self- both physically and psychologically. Accordingly, MacDonald (1997) has pointed out that older women, bigger women and those with wrinkles are rarely accorded sexual subjecthood and are subject to offensive and sometimes cruel representations. It is understandable from looking at everyday media representations that only some women are constructed as actively desiring sexual beings. Moreover, participants' accounts reveal the extent to which 'ordinary' women are increasingly trying to attain the perfect appearance, not necessarily for themselves but for their male sexual partners. They also support the writings of Kilbourne (2000) and, in particular, her observations that cultural stereotypes can be a source of distress for women who fail to achieve these ideals. However, that the downside of not achieving these socially constructed ideals can include women experiencing sexual inadequacy and potential sexual problems has not been reported previously.

These findings in relation to media expectations provide a fit with a material-discursive viewpoint in the sense that these issues can be understood as experiences which arise in

conjunction with a woman's embodied efforts to meet socially constructed standards defining the 'good' woman. As a result, they are grounded in social and material structures, such as the physical body and institutions such as the media (Parker, 1992). This again represents a novel finding in relation to women's sexual problems and how they draw upon cultural resources as a measure of their own sexual attraction.

Whilst the female body is clearly implicated in participants' accounts of what they view as being sexually problematic, it is this socially constructed nature of these images that can be far more detrimental. For that very reason, Nicolson (1993) has argued that it is insufficient to put forward a separate physical (or psychological/social) cause for a sexual difficulty and then treat it out of context of any other facet of a woman's experience. On that basis, it is fair to argue that neither the DSM-IV-TR classification system (APA, 2000) nor the 'New View' (Kaschak and Tiefer, 2001) captures the complexities involved in women's understandings of sexual problems.

A Material-Discursive Framework

Rather than developing a theory in relation to women's views of sex, sexuality and sexual problems, the overall aim of the study has been to provide an insight into the views of an age range of 'ordinary' women in an effort to critique some of the more dominant theoretical perspectives in this area- namely those construed to be deeply essentialist and biomedical on the one hand and those which are profoundly constructionist on the other.

According to Ussher (1997) those who have endorsed the essentialist/material position focus almost exclusively upon the body. Conversely those who adopt a social constructionist position have applied a much greater emphasis upon the 'discursive turn' and on the role of language in the constitution of both the world and the person (Ibid.). Consequently, both positions can be considered as polar opposites to one another and exhibit very little common ground. The implications of adopting either an absolute social constructionist or essentialist approach have already been carefully examined earlier in this thesis. The emphasis on the primacy of the sociolinguistic aspect in relation to the former was in part a reaction against the reductionist materialism of the biomedical model, whereby social and psychological interpretations of biological events are assigned a secondary importance to the underlying physical 'reality' of disease. This also needs to be considered in conjunction with other factors including the environment and technologies for example. However, an insistence on sociolinguistic aspects of health and illness simply inverts and reproduces rather than replaces the previous dualism of the biomedical model as cautioned by Yardley (1996). This division has been acknowledged in the work of Stoppard (1997). Her argument in relation to women's experiences of depression and the subsequent reconceptualisation of their bodies as being both culturally and naturally produced provides an encouraging alternative to either a purely biological, social or psychological explanations to understanding the role of the physical body in women's experiences.

Based upon the findings of this study, it is my view that neither perspective alone can entirely account for the array of factors that influenced participants' understandings of the

terms sexuality, sex and sexual problems. Indeed, evidence from participants accounts suggest that both the physical and psychological aspects of health and illness are clearly intertwined and do not work independently of each other; my findings are therefore supportive of the work of Ussher (1997). With the above arguments in mind, the use of a material-discursive framework has revealed the extent to which both perspectives can be viewed together, sometimes entirely and at other times, only partially.

Within participant's accounts there is a plethora of compelling evidence to suggest a combination of these viewpoints, albeit to various degrees, coalesce to inform women's understandings of the terms sexuality, sex and sexual problems. To examine only one level of experience, be it either the material or the discursive is, I would argue, to negate the importance of the other. Therefore, this study has helped to think about and forge the connection between the essentialist and social constructionist perspectives in order to move towards a more comprehensive level of understanding. For example, we can see how the material and the discursive elements combine when we look at particular themes in chapter six of this thesis which highlighted women's views of sexual problems. What they demonstrate is the way in which women's bodies are inseparable from the sociocultural and political context in which their lives are lived.

As a result, a particular strength of this research is how it helps to focus our understanding on women's everyday experiences, rather than adopting procedures that strip away this context. Another strength of adopting a material discursive framework is that it allows women's voices to become audible in the research process. However,

whilst this framework was valuable in terms of making sense of large amounts of qualitative data and participants' accounts of the body and culture as they related to the aims of this study, the extent to which it fully encapsulated the views of *all* women is questionable.

Whilst this framework succeeds up to a certain point by highlighting the ways in which women account for their views of sex and sexual problems as a combination of the material *and* discursive, other participants focused largely upon physical factors associated with sexuality, sex and sexual problems. This is arguably a reflection of the way in which dominant understandings outlined in the first chapter of this thesis have become embedded in contemporary understandings and the supremacy of the physical body in matters of a sexual nature. This is arguably linked to having to legitimate sexual difficulties primarily on a physical basis within contemporary help-seeking models.

Writing as a Man

In writing about these issues, one of the key concerns as a man that I have been acutely aware of has been the extent to which the *'relationship between public, private and personal 'knowledges' and ways of being, all acknowledge that theoretical and practical dilemmas and challenges are involved when we* [as researchers] *are concerned with hearing, retaining and representing research participants' voices'* (Edwards and Ribbens, 1998: pp. 20).

On that basis, critics may be justified to argue that this is hitherto yet another piece of research written by a man about women. However, as I have discussed in detail in earlier chapters of this study by drawing out and reflecting upon pertinent examples from participants' transcripts, it is too restrictive to focus on gender differences alone as a barrier to understanding between researcher and participant. The logical extension of this argument would be to assert that discrepancies in age, sexual orientation, race and ethnicity would also serve as barriers to conducting all manner of research projects. I would maintain that being an 'insider' (Oakley, 1982) does not routinely lead to a bond being established with participants and that research relationships- however brief have to be worked at in an honest, supportive and open manner.

Strengths and Limitations of the Study

According to Tiefer (2003), the problems and apprehensions of contemporary sexual life have seen the creation of a variety of markets, not least of which is a medical market. In recent times, this has been evidenced by the quest to transpose the successful pharmaceutical developments of Sildenafil Citrate (Viagra ^{TM}) for men onto women and is an issue which continues to evolve. As a result, classifying women's sexual function and 'dysfunction' has become not only complicated, but contentious. Accordingly, the way in which sex has been defined by participants in this study has obvious implications for the way in which sexual problems are classified. Given that the DSM V is due for revised publication in 2011, one of the strengths of this study is that it could feed into these ongoing debates to provide a much greater insight into the views of women- particularly in respect of the physical, social and psychological factors that influence

understandings of sexual problems. Making explicit the socio-cultural context would only serve to strengthen classificatory approaches.

A further strength of this study has been the fact that the sample characteristics of participants were unusually diverse for a small sample. Despite this study including relatively small number of participants, the findings produced were rich because a) I talked in depth to the women involved and b) the data was analysed rigorously. As a result, the aim was essentially exploratory and it was not the intention to produce findings that could be generalised to the entire population of women.

Rather than treating participants drawn from the general public and the psychosexual clinic as distinct from one another, an additional strength was that they were treated as one in an effort to represent the entirety of women's views by combining a non-clinical with a clinical sample. It was also based on the fact that I do not consider the current DSM diagnostic criteria as a valid assessment tool because its evidence base represents the views of patriarchal sexologists, rather than 'ordinary' women. I was therefore unwilling to use it to make distinctions between potential participants. Participants were also drawn from a wide range of ethnic origins including those of African-Caribbean, Pakistani and Chinese origin and included those who were single, divorced, separated and widowed in addition to those who were in long-term relationships. It also represented the views of lesbians, heterosexual women and those who self-identified as 'confused'. Finally, participants ranged in age from 23-72 years. An age diverse sample was desired because women over 50 have been excluded from 'mainstream' sex research for

erroneous reasons related to the perceived sensitivities of engaging with older women in relation to this 'sensitive' area.

To the best of my knowledge, this study represents the first UK based empirical study exploring women's own views of sexuality, sex and sexual problems. It provides rich data on these issues and can be used to develop knowledge and feed into current debates on the medicalisation of women's sexual problems via the FSD label. This study challenges many of the underlying assumptions of how medicine views women's sexual problems, and in particular, the medical and individualised approaches of the current diagnostic criteria with its disregard for the context in which women live their lives.

Conducting a qualitative study of women's views of sexuality, sex and sexual problems as a male researcher can also be considered as both a strength and a weakness. The feminist debates of men not being able to conduct research with other women on the basis of a lack of shared empathy and the subsequent argument about having the inability to appeal to a sense of collective understanding filtered down to the ethical review stage of the study. However, when participants were questioned, they claimed that the opportunity to talk to a man was beneficial on the basis that they would not be 'judged' as they might be by talking to another female researcher. As a result, this finding challenges some prevailing feminist assumptions and adds to our knowledge at a methodological level- rather than making blanket assertions about what is and is not permissible.

A potential weakness of this study relates to the fact that no repeat interviews were conducted with participants. However, time constraints did not allow for any repeat interviews to be conducted. In addition, the fact that I did not conduct interviews with partners can be considered a weakness given the fact that I have previously argued that sexual problems should be considered within the context of the sexual relationship. On the other hand, the fact that men were not included in this study can also be considered as a strength given that women's views have often been neglected from this debate.

Whilst the reader is left to judge the credibility of this research for themselves, the rigour of this research should be assessed upon how it has addressed women's understandings of sexuality, sex and sexual problems (Webb, 1993; Koch and Harrington, 1998). Arguments in relation to the credibility of qualitative research have been well documented but the key feature in assessing the credibility of this research is the extent to which participants experiences of marginality have been brought to the fore (Standing, 1998).

Validity is also an issue that has been described in great deal by qualitative and quantitative researchers alike. Validity can be described as the extent to which the data is plausible, credible and trustworthy. There have different opinions on validity with some suggesting that the concept of validity is incompatible with qualitative research and should be abandoned while others argue efforts should be made to ensure validity so as to lend credibility to the results (Cresswell and Miller, 2000). In line with Maxwell (1992), I would argue that this study demonstrates both descriptive and interpretative validity. In

this sense, great efforts were made to report what was heard and to interpret what was going on in the mind of participants and the degree to which their views, thoughts, feelings, intentions and experiences were subsequently reported in this thesis.

A potential weakness of this study relates to the idea of the sample being biased towards a particular 'sort' of individual. In studies that have the potential to be considered sensitive, it is entirely feasible to hypothesize that those who take part in such studies are different to those who do not. However, the direction of the bias may not be so predictable. For example, it could be surmised that women who are more comfortable with the subject material are more likely to participate thereby sending estimates of sexual dysfunction down (see for example Catania et al, 1986). Participation bias has also been documented in a variety of sexual behaviour studies and is associated with the participants' characteristics (for example sex, age, social class) beliefs and sexual behaviour (Catania et al, 1990). Moreover, Clement (1990) argues that the more intrusive a study, the more likely researchers are to encounter participation bias that overestimates variability and frequency of sexual behaviour (since those with conservative or normative lifestyles are less likely to participate). As a result, this thesis does acknowledge that those who were highly motivated to respond, typically those who had strong opinions, are overrepresented.

Ideas for Future Research

Further research in this area which would complement this study would be to use the same methodology to explore how clinicians themselves appraise and make use of

current classification systems for sexual problems in their practice. There is also a need to conduct research with women in other countries for the purposes of cross-cultural comparisons as this would help build our knowledge base related to the socio-cultural context of how women define sexual problems. However, the very fact that sexuality, sex and sexual problems are subject to a plethora of different meanings has implications for future research in terms of how these concepts are defined and subsequently researched.

It would also be valuable to conduct a similar study and pay particular attention to the views of specific groups of women in terms of varying ethnic groups, sexual orientations and ages in order to make comparisons and detect similarities and differences between them. This would enable the knowledge base on women's sexual problems to be extended. Ideas for further research might also include a longitudinal study of women and their partners.

Conclusion

The ways in which sexuality, sex and sexual problems are understood and experienced by 'ordinary' women are complex, fluid and subject to a wide variety of influences. By problematising the very nature of what sexuality and sex has meant to participants, this study has fundamental implications for the way in which sexual problems are classified. This is particularly the case with the FSD criteria whereby women's views in relation to sexual problems digress considerably from current medical thinking. In light of this

study, current diagnostic frameworks for women's sexual problems fail to capture many of these complexities.

As a result, this research should encourage clinicians to consider the applicability of current classification systems and how they relate to the lives of 'ordinary' women whilst at the same time being mindful of social and interpersonal determinants that affect a woman's ability to be and feel sexual. Developing a more sophisticated framework that encompasses these issues is likely to be an onerous undertaking given that sexual problems are not easily determined nor are they understood as an individual, universal experience which is common throughout different social, cultural and historical contexts. This study has highlighted that these issues are as diverse as the women who experience them. It has given rise to a much greater insight than has previously been the case with the clinical literature and that a 'one size fits all' classification system for women's sexual problems fails to capture many of the complexities and nuances evident in 'ordinary' women's accounts.

References

Abbott, P., Wallace, C. and Tyler, M. (2005). *An Introduction to Sociology: Feminist Perspectives.* 3rd Edition. London, Routledge.

Adelson, J. (1980). Androgyny Advocates Pose a Threat to Scientific Objectivity. *Behaviour Today*, 11 (11): pp. 1-3.

Alldred, P. (1998). Ethnography and Discourse Analysis. In Ribbens, J. and Edwards, J. (Eds). *Feminist Dilemmas in Qualitative Research.* London, Sage Publications.

Allen, R. E. (1996) (Ed.) *Concise Oxford Dictionary of Current English.* 9th Edition. Oxford, Clarendon Press.

Althusser, L. (1989). *Lenin and Philosophy and other Essays.* London, New Left Books.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition. Text Revision. Washington, DC, American Psychiatric Association.

Ard, B. (1977). Sex in lasting marriage: A longitudinal study. *The Journal of Sex Research*, 13, pp. 274-285.

Atputharajah, V. (1987). Some aspects of sexual knowledge and sexual behaviour of local women. Results of a survey- XII. Sexual problems and concerns. *Singapore Medical Journal*, 28, pp. 509-512.

Bachmann, G. A., Leiblum, S. R. and Grill, J. (1989). Brief sexual inquiry in gynaecologic practice. *Obstetrics and Gynaecology*, 73, pp. 425-427.

Bancroft, J. (1983). *Human Sexuality and its problems.* London, Churchill Livingstone.

Bancroft, J., Loftus, J. and Long, J. S. (2003). Distress about sex: a national survey of women in heterosexual relationships. *Archives of Sexual Behaviour*; 32: pp. 193-208.

Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., et al. (2000). Report of the international consensus development conference on female sexual dysfunction: definitions and classifications. *Urology*, 163: pp. 888-893.

Basson, R., Leiblum, S., Brotto, L., Derogatis, L., Fourcroy, J., Fugl-Meyer, K. et al (2003). Definitions of women's sexual dysfunction reconsidered: Advocating expansion and revision. *Journal of Psychosomatic Obstetrics and Gynaecology*, 24, pp. 221-229.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). *Womens' ways of knowing: The development of self, voice and mind.* New York, Basic Books.

Bellamy, G. (1997). *Cottaging: Community, Conflict and Culture. The Attractions and Anxieties of Men who have Sex with other Men.* Unpublished undergraduate thesis. The University of Nottingham.

Berger, P. L. and Luckmann, T. (1966). *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. New York, Anchor Books.

Berman, J. R., Berman, L. and Goldstein, I. (1999). Female Sexual Dysfunction: Incidence, pathophysiology, evaluation and treatment options. *Urology*; 54, pp. 385-391.

Binik, Y. M. (2005). Should Dyspareunia Be Retained as a Sexual Dysfunction in DSM-V? A Painful Classification Decision. *Archives of Sexual Behaviour*; 34(1), pp. 11-21.

Binson, D. and Catania, J.A. (1998). Respondents' understanding of the words used in sexual behavior questions. *Public Opinion Quarterly*, *62*(2), pp. 190-208.

Birnbaum, G. E. (2003). The meaning of heterosexual intercourse amongst women with female orgasmic disorder. *Archives of Sexual Behaviour;* 32(1), pp. 61-71.

Blashfield, R. K. (1998). Diagnostic models and systems. In Bellack, A.S., Herson, M. and Reynolds, C. R. (Eds.), *Clinical Psychology: Assessment*, Volume 4, (pp. 57-79). New York, Elsevier Science.

Bogart, L. M., Cecil, H., Wagstaff, D. A., Pinkerton, S. D., & Abramson, P. R. (2000). Is it 'sex'?: College students' interpretations of sexual behavior terminology. *The Journal of Sex Research*, 37, pp. 108-116.

Booth, T. and Booth, W. (1994). The use of depth interviewing with vulnerable subjects. *Social Science and Medicine*; 39, 3, pp. 415-424.

Boyatzis, R. E. (1998). *Transforming qualitative information: thematic analysis and code development.* London, Sage Publications.

Braun, V., Gavey, N. and McPhillips, K. (2003). The 'Fair Deal'? Unpacking Accounts of Reciprocity in Heterosex. *Sexualities*, Volume 6, No. 2, pp. 237-261.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3: pp. 77-101.

Brecher, E. (1969). *The Sex Researchers.* Boston, Little, Brown and Company.

Brown, L. S. (1994). *Subversive dialogues.* New York, Basic Books.

Bullough, V. L. (1994). *Science in the Bedroom: A History of Sex Research.* New York, Basic Books.

Burr, V. (1995). *An introduction to social constructionism.* London, Routledge.

Byers, E. S. (1999). The interpersonal exchange model of sexual satisfaction: Implications for sex therapy with couples. *Canadian Journal of Counselling*, 33: pp. 95-111.

Cacchioni, T. (2007). Heterosexuality and 'the Labour of Love': A Contribution to Recent Debates on Female Sexual Dysfunction. *Sexualities*, Volume 10 (3): pp. 299-320.

Campbell, J. C. and Bunting, S. (1991). Voices and paradigms: perspectives on critical and feminist theory in nursing. *Advances in Nursing Science*, 13 (3): pp. 1-15.

Candib, L. (2001). A New View of Women's Sexual Problems- A Family Physician's Response. In Kaschak, E., & Tiefer, L. (Eds.). *A New View of Women's Sexual Problems*. Brimington, New York, Haworth Press.

Caplan, P. (1991). Delusional dominating personality disorder (PDPD). *Feminism and Psychology*, 1, pp. 171-174.

Caprio, F. S. (1953). *The Sexually Adequate Female*. Citadel Press, New York.

Caprio, F. S. (1966). *The Sexually Adequate Female with Case Histories*. Greenwich, Conneticut, Fawcett Gold Medal Publishing.

Catania, J. M., McDermott, J. A., and Pollack, L. M. (1986). Questionnaire response bias and face to face interview sample bias in sexuality research. *Journal of Sex Research*, 22 (1): pp. 52-72.

Catania, J. M., Gibson, D. R., Marin, B., et al (1990). Response bias in assessing sexual behaviours relevant to HIV transmission. *Evaluation and program Planning;* 13, pp.19-29.

Chesser, E. (1956). *The sexual, marital and family relationships of the English woman.* London, Hutchinsons Medical Publications.

Christenson, C. (1971). *Kinsey: A Biography*. Bloomington, Indiana University Press.

Clark, D. (2002). Between hope and acceptance: the medicalisation of dying. *British Medical Journal*; 324: pp. 905-907.

Clarke, A. (2006). Qualitative Interviewing: encountering ethical issues and challenges. *Nurse Researcher*, 13(4): pp. 19-29.

Clement, U. (1990). Surveys of heterosexual behaviour. *Annual Review of Sex Research*, 1, pp. 45-74.

Collins, P. (1991). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment.* New York, Routledge.

Condor, S. (1986). Sex Role Beliefs and Traditional Women: Feminist and Inter-group Perspectives. In Wilkinson, S, (Ed.). *Feminist Social Psychology.* Philadelphia, Open University Press.

Cook, J. A. (1983). An interdisciplinary look at feminist methodology: Ideas and practice in sociology, history and anthropology. *Humboldt Journal of Social Relations*, 2: pp. 127-151.

Coolican, H. (1994). *Research Methods and Statistics in Psychology* (2nd Edition). London, Hodder and Stoughton.

Cresswell, J. W. and Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice,* 39 (3) pp. 124-131.

Crowe, M. (2004). Sexual problems: Introduction, description and classification. *Psychiatry.* Volume 3, Issue 2: pp.1-3.

Daly, M. (1973). *Beyond God the Father.* Boston, Beacon Press.

Daly, J., Kellehear, A. and Gliksman, M. (1997). *The public health researcher: A methodological approach.* Melbourne, Australia, Oxford University Press.

Danielsson, I., Sjoberg, I., Stenlund, H. and Wikman, M. (2003). Prevalence and incidence of prolonged and severe dyspareunia in women: Results from a population study. *Scandinavian Journal of Public Health*, 31, pp. 113-118.

Davey Smith, G., Stephen Frankel, S. & Yarnell, J. (1997). Sex and death: are they related? Findings from the Caerphilly cohort study. *British Medical Journal*; 315: pp. 1641-1644.

Davidson, J. and Layder, D. (1994). *Methods, Sex and Madness.* London, Routledge.

Davies, S., Katz, J. & Jackson, J.L. (1999). Sexual desire discrepancies: effects on sexual and relationship satisfaction in heterosexual dating couples. *Archives of Sexual Behavior*, 28(6): 553-567.

DeBeauvoir, S. (1952). *The Second Sex.* New York, Vintage Books.

DeLamater, J. (1987). Gender differences in sexual scenarios. In Kelley, K. (Ed.). *Females, males and sexuality: Theories and research.* New York, State University of New York Press.

Devault, M. L. (1990). Talking and listening from women's standpoint: feminist strategies for interviewing and analysis. *Social Problems*, 37, 1, pp. 96-116.

Dey, I. (1993). *Qualitative Data Analysis. A user-friendly guide for social scientists.* London, Routledge.

Dickson-Swift, V., James, E. and Kippen, S. (2006). Blurring Boundaries in Qualitative Health research on Sensitive Topics. *Qualitative Health Research*, Volume 16, Number 6, pp. 853-871.

Diokno, A. C., Brown, M. B., Herzog, A. R. (1990). Sexual function in the elderly. *Archives of Internal Medicine*, 150, pp. 197-200.

Dunn, K. M., Croft, P. R. and Hackett, G. I. (1998). Sexual problems: a study of the prevalence and need for health care in the general population. *Family Practice*; 15, pp. 519-524.

Dunscombe, J. and Marsden, D. (1995). Workaholics and Whingeing Women: Theorising Intimacy and Emotional Work- the last Frontier of Gender Inequality. *Sociological Review*, 43 (1), pp. 150-169.

Dunscombe, J. and Marsden, D. (1996). Whose Orgasm is it Anyway? Sex Work in Long-Term Couple Relationships. In Weeks, J. and Holland, J. (Eds.). *Sexual Cultures.* Basingstoke, Macmillan.

Edwards, R. and J. Ribbens (1998). Living on the Edges: Public Lives, Personal Experience. In Edwards, R. and Ribbens, J. (Eds.). *Feminist Dilemmas in Qualitative Research.* London, Sage.

Ellis, H. H. (1894). *Man and Woman.* London, Contemporary Science Series.

Ellis, H. H. (1899). Sexual Inversion. In *Studies in the Psychology of Sex.* Volume I, Part IV. London, The University Press.

Ellis, H. H. (1905). Sexual Selection in Man. *In Studies in the Psychology of Sex,* Volume 1, Part III. London, The University Press.

Ellis, H. H. (1906). The Mechanism of Detumescence. In *Studies in the Psychology of Sex* Volume 2, Part I. London, The University Press.

Ellis, H. H. (1910). Autoeroticism. In *Studies in the Psychology of Sex, Volume 1, Part I.* London, The University Press.

Ellis, H. H. (1913). Analysis of the Sexual Impulse. In *Studies in the Psychology of Sex, Volume 1, Part II.* London, The University Press.

Ellis, H. H. (1937). *On Life and Sex: Essays of Love and Virtue*. New York, Garden City Publishing Company.

Ende, J., Rockwell, S., and Glasgow, M. (1984). The sexual history in general medicine practice. *Archives of Internal Medicine*, 144, pp. 558-561.

Engel, G. (1977). The need for a new medical model: a challenge for biomedicine, *Science* 196 : pp. 129–136.

England, P. (1993). The Separative Self: Androcentric Bias in Neoclassical Assumptions. In Ferber, M. and Nelson, J. (Eds). *Beyond Economic Man*. Chicago, University of Chicago Press.

Ericksen, J.A. (1998). With enough cases, why do you need statistics? Revisiting Kinsey's Methodology. *Journal of Sex Research*, 35 (2): pp. 22-44.

Ernst, C., Foldenyi, M. and Angst, J. (1993). The Zurich Study: XXI. Sexual dysfunctions and disturbances in young adults. Data of a longitudinal epidemiological study. *European Archives of Psychiatry and Clinical Neuroscience*. Volume 243, pp. 179-188.

Figes, E. (1970). *Patriarchal Attitudes: Women in Society*. London, Panther.

Finch, J. (1984). 'It's Great To Have Someone To Talk To: The Ethics and Politics of Interviewing Women'. In Bell, C. and Roberts, H. (Eds) *Social Researching: Politics, Problems, Practice*. London, Routledge and Kegan Paul.

Fine, M. (1985). 'Contextualising the Study of Social Injustice'. In Saks, M and Saxe, L. (Eds.). *Advances in Applied Social Psychology*. New Jersey, Hillsdale.

Fine, M. (2002). *Disruptive voices: the possibilities for feminist research.* Michigan, University of Michigan Press.

Fisher, S. (1973). *The Female Orgasm.* New York, Basic Books.

Fonow, M. and Cook, J. (2005). Feminist methodology: new applications in the academy and public policy. *Journal of Women in Culture and Society, 30*(4), pp. 2211-2236.

Foss, L. and Rothenberg, K. (1987). *The Second Medical Revolution: From Biomedicine to Infomedicine*. Boston, New Science Library.

Foucault, M. (1978). *The History of Sexuality: The Will to Knowledge*: Volume 1. New York, Random House.

Foucault, M. (1979). *Discipline and Punish: The Birth of the Prison.* New York, Vintage Books.

Foucault, M. (1985). *The History of Sexuality: The Use of Pleasure*: Volume 2. New York, Random House.

Frank, E., Anderson, C. and Rubinstein, D. (1978). Frequency of sexual dysfunction in 'normal' couples. *The New England Journal of Medicine*, 299, pp. 111-115.

Frank, E. and Anderson, C. (1980). The Sexual Stages of Marriage. *Family Circle.* February, p. 64.

Freud, S., and Breuer, J. (1909). *Studies on Hysteria.* New York, Basic Books.

Freud, S. (1933). *New introductory lectures on psychoanalysis*. Lecture 33: Femininity. Standard Edition, Volume. 22. pp. 136-157.

Freud, S. (1977). *On Sexuality.* London, Penguin Books.

Fugl-Meyer, A. R. and Sjogen Fugl-Meyer, K. (1999). Sexual disabilities, problems and satisfaction in 18-74 year old Swedes. *Scandinavian Journal of Sexology.* 2, pp. 79-105.

Gagnon, J. H. and Parker, R. G. (1995). *Conceiving sexuality: Approaches to sex research in a postmodern world.* New York, Rutledge Hill Press.

Garde, K. and Lunde, I. (1980). Female sexual behaviour. A study in a random sample of 40 year old women. *Maturitas*, 2, pp. 241-246.

Gavey, N., McPhillips, K. and Braun, V. (1999). Interruptus Coitus: Heterosexuals Accounting for Intercourse. *Sexualities,* 2(1): pp. 35–68.

Gebhard, P. and Johnson, A. (1979). *The Kinsey data: Marginal tabulations of the 1963-1983 interviews conducted by the Institute of Sex Research.* Philadelphia, W. B. Saunders.

Geiss,, I. M., Umek, W. H., Dungl, A., Sam, C., Riss, P. and Hanzal, E. (2003). Prevalence of female sexual dysfunction in gynecologic and urogynecologic patients according to the international consensus classification. *Urology*, 62, pp. 514-518.

Gerhard, J. (2001). *Desiring revolution: second-wave feminism and the rewriting of American sexual thought, 1920 to 1982.* New York, Columbia University Press.

Giddens, A. (1992) *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*. Cambridge, Polity.

Gilles, V., Harden, A., Johnson, K., Reavey, P., Strange, V. and Willig, C. (2004). Women's collection constructions of embodied practices through memory work: Cartesian dualism in memories of sweating and pain. *British Journal of Social Psychology*, 43: pp. 99-112.

Giorgio, A. (1985). Sketch of a psychological phenomenological method. In Giorgio, A. (Ed). *Phenomenology and Psychological Research.* Pittsburgh, Duquesne University Press.

Glazer, H and Rodke, G. (2002). *The vulvodynia survival guide: How to overcome painful vaginal symptoms and enjoy an active lifestyle.* Oakland, CA, New Harbinger Publications, Inc.

Godson, S. (2004). Sex on the brain: The scientist who championed the G-spot is now delving deep in our minds to measure sexual response. *The Times*, 15 May.

Golden, J., Golden, M., Price, S. and Heinrich, A. (1977). The sexual problems of family planning clinic patients as viewed by the patients and the staff. *Family Planning Perspectives*, 9, pp. 25-29.

Goldmeier, D., Judd, A. and Schroeder, K. (2000). Prevalence of sexual dysfunction in new heterosexual attenders at a central London genitourinary medicine clinic in 1998. *Sexually Transmitted Infections*, 76, pp. 208-209.

Gott, M. and Hinchliff, S. (2003). How important is sex in later life? The views of older people. *Social Science and Medicine*, 56 (8): pp. 1617-1628.

Gott, M. (2005). *Sexuality, Sexual Health and Ageing.* Buckingham, Open University Press.

Grady, C. (2001). Money for Research Participation: Does it Jeopardize Informed Consent? *American Journal of Bioethics*, Volume 1, Number 2: pp. 40-44.

Gray, P. S., Williamson, J. B., Karp, D. A. and Dalphin, J. R. (2007). *The Research Imagination. An Introduction to Qualitative and Quantitative Methods.* New York, Cambridge University Press.

Guay, A. T. (2001). Advances in the management of androgen deficiency in women. *Medical Aspects of Human Sexuality.* May, pp.32-38.

Guggino, J. and Ponzetti, J. (1997). Gender differences in affective reactions to first coitus. *Journal of Adolescence*, 20, pp. 189-200.

Harding, S. (1987) Is there a feminist method? In Harding, S. (Ed.). *Feminism and Methodology: Social Science Issues*. Bloomington, Indiana, Indiana University Press.

Hart, G. and Wellings, K. (2002) Sexual behaviour and its medicalisation: in sickness and in health. *British Medical Journal,* 324, pp. 896–900

Hawkes, G. (1996*). A Sociology of Sex and Sexuality*. Buckingham, Open University Press.

Henley, N. (1977). *Body Politics: Power, Sex and Nonverbal Communication.* New Jersey, Englewood Cliffs.

Hermanowicz, J. C. (2002). The Great Interview: 25 Strategies for Studying People in Bed. *Qualitative Sociology*, Volume 25, Number 4: pp. 479-499.

Hillman, J. (2000). *Clinical Perspectives on Elderly Sexuality.* Dordrecht, Kluwer Academic Publishers Group.

Hinchliff, S. (2001). *Phenomenology and the Dance Culture: Women's Perceptions of Ecstasy use, Clubbing and the Body.* Unpublished PhD Thesis. Sheffield Hallam University.

Hite, S. (1976). *The Hite Report: a nationwide study of female sexuality.* New York, Dell.

Hite, S. (1987). *The Hite Report: a nationwide study of female sexuality.* New York, Dell.

Hochschild, A. R. (1983). *The Managed Heart.* London, University of California Press.

Holloway, I. and Todres, L. (2003). The status of method: flexibility, consistency and coherence. *Qualitative Research* 3, pp. 345-357.

Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, R. (Ed.) *Changing the Subject: Psychology, Social Regulation and Subjectivity.* London, Methuen.

Hollway, W. (1989). *Subjectivity and method in psychology: Gender, meaning and science.* London, Sage Publications.

Horrocks, R. (1997). *An introduction to the study of sexuality.* London, Palgrave Press.

Ingraham, C. (1996). The Heterosexual Imaginary. In Seidman, S. (Ed.). *Queer Theory/ Sociology.* Oxford, Blackwell.

INVOLVE (2006). *A guide to reimbursing and paying members of the public who are actively involved in research.* Eastleigh, Department of Health.

Jackson, M. (1984). Sex research and the construction of sexuality: A tool of male supremacy. *Women's Studies International Forum*, 7 (1) pp. 43-51.

Jackson, M. (1987). Facts of life or the eroticization of women's oppression? Sexology and the social construction of heterosexuality. In Caplan, P. (Ed). *The cultural construction of sexuality.* London, Tavistock.

James, N. (1989). Emotional Labour: Skill and Work in the Social Regulation of Feelings. *Sociological Review*, 37, pp. 15-42.

Jeffreys, S. (1990). *Anti-Climax.* London, The Women's Press.

Johanson, R., Newburn, M., and MacFarlane, A. (2002). Has the medicalisation of childbirth gone too far? *British Medical Journal*; 324, pp. 892-895.

Kadhri, N., McHichi Alami, K. H. and McHakra Tahiri, S. (2002). Sexual dysfunction in women: Population based epidemiological study. *Archives of Women's Mental Health*, 5, pp. 59-63.

Kaler, A. (2003). Unreal women: gender, identity and the lived experiences of vulvar pain. *Feminist Review*, 82: pp. 50-57.

Kandal, T. (1988). *The Woman Question in Classical Sociological Theory.* Miami, Florida International University Press.

Kaplan, H. S. (1979). *Disorders of Sexual Desire.* New York, Brunner and Mazel.

Kaplan, M. (1983a). The issue of sex bias in DSM III. *American Psychologist,* 38, pp. 802-803.

Karp, D. A. (1992). Illness Ambiguity and the Search for Meaning. A Case Study of a Self Help Group for Affective Disorders. *Journal of Contemporary Ethnography* 21, pp. 139-170.

Kaschak, E., Tiefer, L. (2001). *A New View of Women's Sexual Problems.* Brimington, New York, Haworth Press.

Kelly, L., Burton, S. and Regan, L. (1994). 'Researching Women's Lives or Studying Women's Oppression?: Reflections on what Constitutes Feminist Research'. In Maynard, M. and Purvis, J. (Eds). *Researching Women's Lives from a Feminist Perspective.* London, Taylor and Francis.

Kilbourne, J. (2000). *Can't Buy My Love: How Advertising Changes the Way We Think and Feel.* New York, Simon & Schuster.

King, K. E. (1994). Method and methodology in feminist research: what is the difference? *Journal of Advanced Nursing*, 20, pp. 19-22.

King, N. (2004). Using templates in the thematic analysis of text. In Cassell, C. and Symon, G. (Eds.) *Essential Guide to Qualitative Methods in Organizational Research.* London, Sage Publications.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E. (1948). *Sexual Behavior in the Human Male.* Philadelphia and London, W.B. Saunders.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E. (1953). *Sexual Behavior in the Human Female.* Philadelphia and London, W.B. Saunders.

Klein, R. D. (1983). How to do what we want to do? Thoughts about feminist methodology. In Bowles, G. and Klein, R. D. (Eds) *Theories of Women's Studies.* New York, Routledge.

Klusmann, D. (2002). Sexual motivation and the duration of partnership. *Archives of Sexual Behaviour*, 31, pp. 275-287.

Koch, T. and Harrington, A. (1998). Reconceptualising rigour: the case for reflexivity. *Journal of Advanced Nursing* 28, pp. 882-890.

Koedt, A. (1970). The Myth of the Vaginal Orgasm. In Tanner, L. (Ed.). *Voices From Women's Liberation.* New Jersey, New American Library.

Kremer, B. (1990). Learning to say no: keeping feminist research for ourselves. *Women's Studies International Forum* 13, pp. 463-467.

Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing.* California, Sage Publications.

Lather, P. (1998). Feminist perspectives on empowering research methodologies. *Women's Studies International Forum* 11 (6) pp. 569-581.

Laumann, E. O., Gagnon, J. H., Michael, R. T. and Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States.* Chicago, University of Chicago Press.

Laumann, E. O., Paik, A. and Rosen, R. (1999). Sexual Dysfunction in the United States Prevalence and Predictors. *Journal of the American Medical Association;* 281: 6: pp. 537-544.

Lavie, M. and Willig, C. (2005). 'I Don't Feel Like Melting Butter: An Interpretative Phenomenological Analysis of the Experience of Orgasm. *Psychology and Health* Volume 20, Number 1: pp. 115-128.

Laws, J.L. and Schwartz, P. (1977). *Sexual scripts: The social construction of female sexuality.* Washington, DC, University Press of America.

Lee, A. (2006). *Girl with a One-track Mind: Confessions of the Seductress Next Door.* London, Ebury Press

Lee-Treweek, G., and Linkogle, S. (Eds.). (2000). *Danger in the Field: Risk and Ethics in Social Research.* London, Routledge.

Lindal, E. and Stefansson, J.G. (1993). The lifetime prevalence of psychosexual dysfunction among 55 to 57 year olds in Iceland. *Social Psychiatry and Psychiatric Epidemiology*, 28, pp. 91-95.

Lloyd, E.A. (1993). Pre-theoretical Assumptions in Evolutionary Explanations of Female Sexuality. *Philosophical Studies*, Volume 69, Numbers 2-3, pp. 139-153.

Lock, M. (1993). *Encounters with Aging. Mythologies of Menopause in Japan and North America.* Berkeley, CA, University of California Press.

MacDonald, M. (1997). *Representing Women: Myths of Femininity in the Popular Media.* London, Edward Arnold.

McPhillips, K., Braun, V. and Gavey, N. (2001). Defining (hetero) sex: How imperative is the 'coital imperative'? *Women's Studies International Forum, 24*, pp. 229-240.

Maslow, A. (1943). A theory of human motivation. *Psychological Review, 50*, pp. 370-396.

Masters, W. H. and Johnson, V. E. (1966). *Human Sexual Response*. Little, Brown and Co. Boston.

Masters, W. H. and Johnson, V. E. (1970). *Human Sexual Inadequacy*. Little, Brown and Co. Boston.

Mauthner, N. and Doucet, A. (1998). Reflections on a Voice-centred Relational Method. Analysing Maternal and Domestic Voices. In Ribbens, J. and Edwards, R. (Eds). *Feminist Dilemmas in Qualitative Research* (pp. 119-146). London, Sage Publications.

Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review*, 62(3), pp. 279-300.

Mercer, C. H., Fenton, K. A., Johnson, A. M., Wellings, K., Macdowall, W., McManus, S., Nanchahal, K. and Erens, B. (2003). Sexual function problems and help seeking behaviour in Britain: National probability sample survey. *British Medical Journal* (Clinical Research Edition), 327, pp. 426-427.

Morrow, R. (1994). The sexological construction of sexual dysfunction. *Australian and New Zealand Journal of Sociology*; 30 (1), pp.20-35.

Moynihan, R. (2003). The making of a disease: female sexual dysfunction. *British Medical Journal*; 326: pp. 45-47.

Najman, J. M., Dunne, M. P., Boyle, F. M., Cook, M. D. and Purdie, D. M. (2003). Sexual dysfunction in the Australian population. *Australian Family Physician*, 32, pp. 951-955.

Nazareth, I., Boynton, P. and King, M. (2003). Problems with sexual function and people attending London general practitioners: cross-sectional study. *British Medical Journal* 327(7412): pp. 423-429.

Nicolson, P. (1993). Public values and private beliefs: Why do women refer themselves for sex therapy. In Ussher, J. M. and Baker, C. D. (Eds). *Psychological Perspectives on Sexual Problems* (pp. 56-78). London, Routledge.

Nicolson, P. (1993b). Motherhood and Women's Live's. In Richardson, D. and Robinson, V. (Eds.). *Introducing Women's Studies*. London, Macmillan.

Nicolson, P. (2003). Feminism and the debate about FSD: do women really know what they want? *Sexualities, Evolution and Gender* (5) April 2003 pp.37-39.

Nicolson, P. and Burr, J. (2003). What is 'normal' about women's (hetero) sexual desire and orgasm? A report of an in-depth interview study. *Social Science and Medicine* 57, pp. 1735-1745.

Nusbaum, M. R. and Gamble, G. (2001). The prevalence and importance of sexual concerns among female military beneficiaries. *Military Medicine*, 166, pp. 208-210.

Oakley, A. (1982). 'Interviewing Women: A Contradiction in Terms'. In Roberts, H. (Ed.). *Doing Feminist Research*. London, Routledge.

Oakley, A. (1998). Gender, Methodology and People's Ways of Knowing: Some Problems with Feminism and the Paradigm Debate in Social Science. *Sociology*, 32 (4): pp. 707-732.

Ogden, J. (1997). The rhetoric and reality of psychosocial theories of health. *Journal of Health Psychology*, 2, pp. 21-29.

Osborn, M., Hawton, K. and Gath, D. (1988). Sexual dysfunction among middle aged women in the community. *British Medical Journal*, 296: pp. 959-962.

Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology.* London, Routledge.

Parker, R. (2001). Sexuality, culture and power in HIV/AIDS research. *Annual Review of Anthropology*, Volume 30, pp. 163-179.

Parnis, D., Mont, J. and Gombay, B. (2005). Cooperation or co-optation? Assessing the methodological barriers involved in conducting qualitative research through medical institutional settings. *Qualitative Health Research*, 15, 5, pp. 686-697.

Pepe, F., Panella, M., Pepe, G., D'Agnosta, S. and Pepe, P. (1989). Frequency of sexual dysfunctions among Roman Catholic women. *Family Practice,* 6, pp. 16-18.

Pilgrim, D. and Rogers (1997). 'Mental health, critical realism and lay knowledge'. In Ussher, J. M. (Ed.). *Body Talk. The Material Discursive Regulation of Sexuality, Madness and Reproduction.* London, Routledge

Potter, J. and Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour.* London, Sage.

Pomeroy, W. B. (1973). *Dr. Kinsey and the Institute for Sex Research.* New York, Signet Press.

Potts, A. (2002). *The Science/Fiction of Sex. Feminist deconstruction and the vocabularies of heterosex*. London, Routledge.

Potts, A., Gavey, N., Grace, V. M. and Vares, T. (2003). The downside of Viagra: women's experiences and concerns. *Sociology of Health and Illness*, Volume 25, Number 7, pp. 697-719.

Puwar, N. (1997). Reflections on Interviewing Women MP's. Sociological Research Online. Volume 2, Number 1 http://www.socresonline.org.uk/socresonline/2/1/4.html. Accessed 1/10/2005.

Rainwater, L. (1968). Some aspects of lower class sexual behaviour. *Medical Aspects of Human Sexuality*, 2, pp. 15-25.

Ramazanoglu, C. and Holland, J. (1993). Women's Sexuality and Men's Appropriation of Desire. In Ramazanoglu, C. (Ed.). *Up Against Foucault: Explorations of Some Tensions Between Foucault and Feminism*. London, Routledge.

Ramsay, K. (1996). 'Emotional Labour and Organisational Research: How I Learned not to Laugh or Cry in the Field'. In Lyon, S.E. and Busfield, J. (Eds.). *Methodological Imaginations*. London, Macmillan Press.

Read, S., King, M. and Watson, J. (1997). Sexual dysfunction in primary medical care: prevalence, characteristics and detection by the general practitioner. *Journal of Public Health Medicine*, 19(4) pp. 387-391.

Reavey, P. and Warner, S. (2001). Curing women: child sexual abuse, therapy and the construction of femininity. The International Journal of Critical Health Psychology, 3, pp. 49-71.

Reinharz, S. (1992). *Feminist Methods in Social Research*. New York, Oxford University Press.

Reissman, C. (1987). When Gender is Not Enough: Women Interviewing Women. *Gender and Society*. 2 (1): pp. 172-207.

Rice, P. and Ezzy, D. (1999). *Qualitative research methods: A health focus*. Melbourne, Australia, Oxford University Press.

Richters, J., Grulich, A. E., de Visser, R. O., Smith, A. M., and Rissel, C. E. (2003). Sex in Australia: Sexual Difficulties in a representative sample of adults. Australian and New Zealand *Journal of Public Health*, 27, pp. 164-170.

Robinson, P. (1989). *The Modernisation of Sex: Havelock Ellis, Alfred Kinsey, William Masters and Virginia Johnson.* New York, Cornell University Press.

Rosen, R. C., Taylor, J. F., Leiblum, S. R. and Bachmann, G. A. (1993). Prevalence of sexual dysfunction in women: Results of a survey of 329 women in an outpatient gynaecological clinic. *Journal of Sex and Marital Therapy*, 19, pp. 171-188.

Rosenthal, R. (1966). *Experimenter Effects in Behavioural Research.* New York, Appleton-Century-Crofts.

Rothblum, E. D. (2000). Somewhere in Des Moines or San Antonio: Historical perspectives on lesbian, gay and bisexual mental health. In Perez, R., DeBord, K., and Bieschke, K. (Eds.). *Handbook of counselling and therapy with lesbians, gays and bisexuals.* Washington, DC, American Psychological Association.

Rubin, G. (1985). *Just Friends.* New York, Harper and Row.

Rubin, L. B. (1991). *Erotic Wars.* New York, Harper Row.

Ryan, G.W. and Bernard, H. R. (2000). Data management and analysis methods. In Denzin, N. K. and Lincoln, Y. S. (Eds). *Handbook of Qualitative Research.* London, Sage Publications.

Schein, M., Zyanski, S. J., Levine, S., Medalie, J. H., Dickman, R. L. and Alemagno, S. A. (1988). The frequency of sexul problems among family practice patients. *The Family Practice Research Journal*, 7, pp. 122-134.

Scotti, J. R., and Morris, T. L. (2000). Diagnosis and classification. In Hersen, M., and Ammerman, R.T. (Eds.), *Advanced Abnormal Child Psychology*, (pp.15-32). Mahwah, New Jersey, Erlbaum.

Seidman, S. (2003). *The Social Construction of Sexuality*. New York, W. W. Norton and Company.

Segal, L. (1994). *Straight Sex: The Politics of Pleasure*. London, Virago Press.

Sexton, T. and Weeks, G. (2003). *Handbook of Family Therapy. The Science and Practice of Working with Families and Couples.* New York and Hove, Brunner-Routledge.

Shakeshaft, C. (1987). *Women in Educational Administration.* Newbury Park, CA, Sage Publications.

Shokrollahi, P., Mirmohamadi, M., Mehrabi, F. and Babaei, G. (1999). Prevalence of sexual dysfunction in women seeking services at family planning centres in Tehran. *Journal of Sex and Marital Therapy*, 25, pp. 21-215.

Siann, G. (1994). *Gender, Sex and Sexuality. Contemporary Psychological Perspectives.* London, Routledge.

Sigworth, J. (1995). Feminist research: its relevance to nursing. *Journal of Advanced Nursing* 22: pp. 896-899.

Simon, W. and Gagnon, J.H. (1984). Sexual scripts. *Society*, 22, pp. 52–60.

Simon, W. and Gagnon, J.H. (1986). Sexual scripts: Permanence and change. *Archives of Sexual Behaviour*, (15) 3, pp. 97-120.

Skene, O. S. (2004). *The Sexual Spectrum. Exploring Human Diversity.* Vancouver, Raincoast Books.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, pp. 261-271.

Spencer, A., Faulkner, A. and Keegan, J. (1988). *Talking about Sex: Asking the Public About Sexual Behaviour and Attitudes.* Social and Community Planning and Research.

Spender, D. (1980). *Man Made Language.* London, Routledge and Kegan Paul.

Standing, K. (1998). Writing the Voices of the Less Powerful: Research on Lone Mothers. In Ribbens, J. and Edwards, J. (Eds). *Feminist Dilemmas in Qualitative Research.* London, Sage Publications.

Stanley, L. (1990). *Feminist Praxis.* London, Routledge.

Stanley, L. and Wise, S. (1993). *Breaking Out Again: Feminist Ontology and Epistemology.* 2nd Edition. London and New York, Routledge.

Starr, B. D. and Weiner, M. B. (1982). *The Starr-Weiner report on sex and sexuality in the mature years.* New York, McGraw-Hill.

Stoppard, J. M. (1997). *Women's lives, women's bodies and depression: Towards a reconciliation of material and discursive accounts.* New York, Routledge.

Stoppard, J. M. (2000) *Understanding Depression: Feminist Social Constructionist Approaches.* London, Routledge.

Strong, B., De Vault, C. and Sayad, W. B. (1999). Human Sexuality: Diversity in contemporary America (3rd Edition). Mountain View, CA, Mayfield Publishing.

Tavris, C. and Sadd, S. (1977). *The Redbook Report on Female Sexuality.* New York, Delacorte Press.

Terman, L. (1938). *Psychological Factors in Marital Happiness.* New York, McGraw-Hill.

Tiefer, L. (1987). Social constructionism and the study of human sexuality. In Shaver, P. and Hendrick, C. (Eds). *Sex and Gender.* Newbury Park, CA, Sage Publications.

Tiefer, L. (1991). Historical, scientific, clinical, and feminist criticisms of the 'Human Sexual Response Cycle' model. *Annual Review of Sex Research*, 2, pp. 1-23.

Tiefer, L. (1995). *Sex is Not a Natural Act and Other Essays.* Oxford, Oxford University Press.

Tiefer, L. (1996). The medicalization of sexuality: conceptual, normative, and professional issues. *Annual Review of Sex Research,* 7: pp. 252–282.

Tiefer, L., Alperstein, L., Ellison, C., Fishman, J. R., Hall, M., Handwerker, L., Hartley, H., Kashak, E., Kleinplatz, P. J., Loe, M., Mamo, L., Tavris, C. (2000). A New View of Women's Sexual Problems. *Electronic Journal of Human Sexuality*, 3: p. 15. www.ejhs.org. Date accessed 20/11/05.

Tiefer, L. (2001 a.). A New View of Women's Sexual Problems: Why New? Why Now? *The Journal of Sex Research*, 38: 2: 89-96.

Tiefer, L. (2001 b.). Arriving at a 'New View' of Women's Sexual Problems: Background, Theory & Activism. In Kaschak, E., & Tiefer, L. (Eds.). *A New View of Women's Sexual Problems.* Brimington, New York. Haworth Press.

Tiefer, L. (2003). The Pink Viagra Story: We have the drug but what's the disease? *Radical Philosophy.* September/October. Number 21, pp. 2-5.

Tiefer, L. (2004). *Sex is Not a Natural Act and Other Essays.* 2nd Edition. Boulder (Colorado), Westview Press.

Todd, A. D. (1989). *Intimate Adversaries: Cultural Conflict Between Doctors and Women Patients.* Philadephia, University of Pennsylvania Press.

Travis, C. B., Meginis, K. L. and Bardari, K. M. (2000). Beauty, sexuality and identity: the social control of women. In Brown Travis, C. and White, J. W. (Eds.). *Sexuality, Society and Feminism.* Washington, DC, American Psychological Association.

Tunariu, A. and Reavey, P. (2007). Common patterns of sense making: A discursive reading of quantitative and interpretative data on sexual boredom. *British Journal of Social Psychology.* Volume 46, No. 4, pp. 815-837.

Unger, R., and Crawford, M. (1996). *Women and gender: A feminist psychology* (2nd Edition.). New York, McGraw-Hill.

Ussher, J. M. (1991). *Women's madness: Misogyny or mental illness?* New York, Harvester.

Ussher, J. M. (1997). *Body Talk. The Material Discursive Regulation of Sexuality, Madness and Reproduction.* London, Routledge.

Ussher, J. M. and Ayling, K. (2007). If it hurts, am I still a woman? The subjective experience of vulvodynia in hetero-sexual women. *Archives of Sexual Behaviour,* Volume 37, Number 2: pp. 294-304.

Ventegodt, S. (1998). Sex and the quality of life in Denmark. *Archives of Sexual Behaviour*, 27, pp. 295-307.

Vogt, W. P. (1999) *Dictionary of Statistics and Methodology: A Nontechnical Guide for the Social Sciences*, London, Sage.

Walton, B. and Thornton, T. (2003). Female Sexual Dysfunction. *Current Women's Health Reports,* 3(4): pp. 319-326.

Warren, C. (1988). *Gender Issues in Field Research.* London, Sage.

Watson, L., Irwin, J. and Michalske, S. (1991). Researcher as Friend: methods of the Interviewer in a Longitudinal Study. *Qualitative Health Research,* Volume 1, Number 4: pp. 497-514.

Webb, C. (1993). Feminist research: definitions, methodology, methods and evaluation. *Journal of Advanced Nursing* 18, pp. 416-423.

Weeks, J. (1985). *Sexuality and its discontents. Meanings, myths and modern sexualities.* London, Routledge.

Weeks, J. (1986). *Sexuality.* Milton Keynes, The Open University.

Weiss, R. S. (1990). *Staying the Course.* New York, Fawcett Columbine.

Willig, C. (2005). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method.* Berkshire, Open University Press.

Wylie, M. S. (1995). DSM and the medical model. *Family Therapy Networker* pp.27-33, 65-68.

Yardley, L. (1996). Reconciling discursive and materialist perspectives on health and illness. *Theory and Psychology*, 6 (3): pp. 485-508.

Yardley, L. (1997). *Material Discourses of Health and Illness.* London, Routledge.

Young-Bruehl, E. (1990). *Freud On Women. A Reader.* London, The Hogarth Press.

Appendix 1

Interview Guide

Introduction

Introduce PhD aims and objectives

Check participants preferred names

Administer consent form prior to interview

General

How did you hear about this study?

Can I ask you what made you decide to take part in the research?

Definitions and importance

What does sex mean to you?

Do you think sex is important to women?

Sex and Ageing

Do you think a woman's view about sex changes as she gets older?

- probe thoughts and feelings about sex in later life

Do you think ageing has an effect on women's sexuality?

-probe what women think 'sexuality' is, body image, are there other ways of being sexual when older

Sexual problems

Could you try to explain to me what you think is meant by a sexual problem?

Do you think that there are differences between women and men?

What about older women? Do you expect to be sexual in your 70's, 80's and 90's?

Do you think that ageing causes sexual problems?

Are there any other things that you can think of that might cause a woman to experience sexual problems apart from the ones you have just mentioned to me?

Service provision

I'd like to move on now and talk to you about some of the issues we've talked about regarding sexual problems and where you think women might seek advice about these problems. In this guide, it gives the reader quite a comprehensive guide to sexual matters for women. It says in the guide that many women find it hard to talk about these issues because they are so personal. From your point of view:

Do you think sexual problems should be discussed with women?

What about with older women?

-probe thoughts about older women and sexual problems, are there any specific considerations

Who do you think might be the best person to talk to with regard to sexual problems?

Would you be able to talk through these issues with someone?

Debriefing

How have you felt about talking about these issues today?

- as a man
- as someone younger

How have you felt about talking to me with me regard to women's sexual problems?

Is there any way that the experience of taking part in this study could have been better for you?

Do you know of any other women who might be interested in taking part in the study?

Voucher and post interview information sheet

Sheffield City Council

Sheffield Care Trust NHS
Mental Health and Wellbeing

Appendix 2

HONORARY CONTRACT

1. Appointment

I have been asked to confirm the following unpaid appointment for:

Name:	Gary Terence Bellamy
Post Title:	Research Project Worker
Date of Commencement:	April 2005
Duration of Post:	4 months approximately
Hours of Work:	As and when required
Work Base:	City wide
Duties:	To undertake a qualitative study by interviewing female clients from Porterbrook Clinic to establish their views about what constitutes a sexual problem.

2. Registration

Should this be applicable you are required to maintain your registration with your professional body.

3. Notice Period

You are required to give one-month notice to terminate this contract. Should the Trust wish to terminate your honorary appointment, for reasons other than gross misconduct, you will be entitled to one months notice.

4. Professional Indemnity

You are normally covered by the NHS Indemnity against claims of clinical negligence. However, in certain circumstances you may not be covered by the indemnity. You are therefore advised to maintain membership of your professional organisation.

5. Confidentiality

The Trust requires its employees to maintain the confidentiality of information they may acquire in the course of, or arising from their employment. Any unauthorised disclosure will be treated as a serious breach of discipline.

6. Notification of actual or intended criminal proceedings

You must notify the Research Manager, Shaun Ryles if you are charged with, or convicted of a criminal offence.

7. Policies and Procedures

These have been adopted to ensure the safe operation of the Trust's services and the welfare and interests of users of the service and those who work for it. You should familiarise yourself with practises and procedures which have been adopted in your place of work.

8. Variation to Contract

Should any variation to this honorary appointment be necessary, this will be discussed and agreed with you prior to implementation. However, it may be necessary to make changes to the existing policies and practises, and to introduce new ones from time to time. You will be informed of these by the Research Manager, Shaun Ryles.

Signed (on behalf of the Trust)

Margaret Timms – Recruitment Officer

Date

(Please do not detach)

FORM OF ACCEPTANCE

I hear by accept the honorary (unpaid) appointment mentioned in the forgoing statement of Terms and Conditions and return one signed copy.

Signed: _____

Name: _____

Date: _____

Appendix 3

The University of Sheffield
A study to examine women's views about sexuality

I am a PhD student at the University of Sheffield conducting research on women's sexuality. I have a background in nursing and health research.

I would like to recruit women living in Sheffield/Nottingham as volunteers to take part in either a discussion group or an individual interview. I am only interested in your general attitudes and *not* your personal experiences.

The interviews will be treated confidentially and you won't be identified by name in any published research reports. Expenses will be reimbursed and we will offer you a £10 gift voucher for participating. If you are interested in taking part in this study please contact:

Gary Bellamy on:

0114 222 6255 or email sex-research@sheffield.ac.uk

Sponsored by an educational grant from Pfizer Pharmaceuticals

Appendix 4

WOMEN'S VIEWS ON SEX SOUGHT

■ SHEFFIELD women are being asked to tell all about sex for a university research project.

■ Gary Bellamy, a PhD student at Sheffield University, is seeking evidence on women's general sexual attitudes rather than their personal histories.

■ He is particularly keen to interview women aged 50 and over but any volunteer will be welcome. Group interviews will be conducted as well as face-to-face sessions.

■ Areas to be explored will include views on 'normal' sexuality, sexual satisfaction and how sexual problems develop.

■ Interviews will be confidential and no one will be mentioned by name in the report.

■ Gary can be contacted on 0114 222 6255 or at the email sex-research@sheffield.ac.uk

Appendix 5
The University of Sheffield

A STUDY TO EXAMINE WOMEN'S VIEWS ABOUT SEXUALITY AND SEXUAL PROBLEMS

CONSENT FORM

NAME OF RESEARCHER: GARY BELLAMY

To be completed by the person taking part in the study:

Have you read the information sheet about the study?	Yes / No
Have you been able to ask questions about this study?	Yes / No
Have you received answers to all your questions?	Yes / No
Have you received enough information about this study?	Yes / No

Who have you spoken to about this study?

(Name) .....

Do you understand that you are free to withdraw from this study?

At any time

Without giving a reason for withdrawing

Without affecting any future or current medical care you may have

	Yes / No
Do you agree to take part in this study?	Yes / No
Do you give your permission for the interview to be taped?	Yes / No

.....	.....	.....
Name of participant	Signature	Date
.....	.....	.....
Name of researcher	Signature	Date

Version 1 December 2003

Appendix 6
The University of Sheffield

A STUDY TO EXAMINE WOMEN'S VIEWS ABOUT SEXUALITY AND SEXUAL PROBLEMS

You are invited to participate in a study exploring women's views about women's sexuality and sexual problems. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

What is the purpose of the study?
This study will investigate how women define their sexuality and what they consider to be a sexual problem. The researchers are also interested in your views of what is 'normal' particularly within the context of ageing. The findings from this research will inform the second phase of the research and it will also feed into on-going debates about sexual problems.

Why have I been chosen?
We are asking a number of women recruited from the general public to take part in the study in the hope of building up a range of opinions on this subject.

Who is organising the study?
Gary Bellamy, a post-graduate research student at the University of Sheffield is carrying out the study. This work fits into a broader programme of research with other colleagues at the University. Gary qualified as a nurse in 1997 and has also worked as a health care researcher. Dr Sharron Hinchliff, an experienced researcher will also be involved in the study.

What will I be asked to do if I take part?
If you agree to participate in the study you will be offered the opportunity to take part in either an individual or a group-based interview with small number of other women. We anticipate that this will take no longer than 1 ½ hours to complete. We will arrange this interview at a time and place to suit you. To begin with we will ask you, or help you to complete a short, anonymous questionnaire about yourself. We will then ask you about what you feel sexual problems are. We would also like your opinions about what language should be used to discuss sexual problems and your thoughts on seeking advice about treatment and whom you think is the best person to seek that advice from. With your permission we will use a small tape recorder to tape what you say.

Do I have to take part?
No. Your participation is entirely voluntary. If you would prefer not to take part you do not have to give a reason.

What are the possible risks in taking part?

We are aware that for some people, talking about sex and sexual problems can be potentially embarrassing. However, we are interested in your general attitudes and not your personal experiences. The researchers are experienced in talking to people about sensitive issues. We will also be able to put you in contact with sources of information and support if you wish.

What if I change my mind about taking part in the study?

You are free to change your mind about participating in the study and information that you have provided will not be used.

What if I have any further questions about the study?

If you have any further questions or comments, please telephone Gary Bellamy on (0114) 222 6255 or e-mail: g.bellamy@sheffield.ac.uk

Version 1 December 2003

Appendix 7

Mini Biographies of the Participants Involved in the Research

Interviews 1-13. Participants recruited from members of the general public

Interview 1

A 50 year old, soon to be divorced, mixed race woman. Her mother was White British and her father was Caribbean. She had been married with two adopted children but had since left her husband about a year ago and moved in to live with another woman. She described her sexuality as 'confused'. She described her health as good but explained that she was currently recovering from cancer that had been diagnosed 2 ½ years ago. Her cancer was currently in remission.

Interview 2

A 52 year old divorcee who had separated from her husband *'many years ago'*. She had no children from the marriage. She described her ethnicity as 'mixed race'. Her father was originally from Bangladesh and her mother was White British. She described her sexual orientation as heterosexual. She described herself as a child of the sixties and welcomed the opportunity to discuss the subject matter.

Interview 3

A 50 year old woman who had been married twice in the process of what she described as a very acrimonious second divorce. She had been separated from her second husband since July 2003. She described her ethnicity as white and her sexual orientation as

heterosexual. Her 10-year-old daughter was conceived with her second husband. The custody arrangements in place were described as *'amicable'* and that she did not feel that her daughter had suffered as a result of the separation. She was very keen to take part in the study and that she had always been extremely interested in issues relating to sex and sexuality and was keen to make use of the opportunity to make her views known.

Interview 4

A 72 year old participant who described her ethnic origin as white and sexual orientation as heterosexual. She had never married on the basis that she was unable to conceive. She described her health status as good despite suffering from osteo-arthritis. She described only one notable relationship that she had had with a man whom she got to know when she was nursing her mother before she died but described it *'as in no way sexual'* and was based primarily on friendship.

Interview 5

A 57 year old woman who described her ethnic origin as White British and married to her second husband. The marriage to her first husband had dissolved many years ago. She told me that she had two children from her second marriage, a boy and a girl. Both were in their late teens and early twenties. Their 17-year-old son was still living with them and their daughter was away at University.

Interview 6

A 66 year old participant who described her ethnic origin as White British. Her husband had died 11 years ago and she had made the decision that she would never remarry or begin a relationship with another man saying that she wanted to remain 'faithful' to him. Their marriage had lasted 38 years and she had five sons. Her husband was Pakistani and their relationship and subsequent marriage had caused both her parents to *'want nothing more to do with her'*. She explained that one of her neighbours had also expressed an interest in the study and said it such a way as to make me aware that the neighbour knew of my impending visit that afternoon- arguably a way of ensuring her own safety.

Interview 7

A 43 year of old White British woman who described her sexual orientation as lesbian. Her partner had gone to see her mother in an effort to make herself *'scarce for the evening'* whilst we talked. She told me that she had known her current partner professionally for about 10 years and had started a relationship with her 18 months previously. She said that she loved her partner very much and wanted to spend the rest of her life growing old with her. At first, she appeared nervous about taking part in an interview but told me that she felt reassured once I had explained the checks that had put into place with regards to anonymity, confidentiality and the fact that she did not have to reveal any personal experiences that she was uncomfortable with.

Interview 8

I was greeted at the door very cautiously by this participant. Yet, at the same time, she stood there with a wry grin on her face. Her first word was *'Name!'* and then she burst

out laughing. We sat down together at the dinner table and were kept company by a large black cat that was sprawled the length of it. She was a very confident individual. She told me that she was 59 ¾ at the time of our interview but was not really looking forward to her 60th birthday. She described her ethnic origin as White British and had been baptized into the Church of England but had no strong religious beliefs.

She explained that she had spoken to her family and several friends about the fact that she was going to be taking part in a 'sex research' project and it had been met with some interesting comments. Two of those included '*Oh Mother, what are you going to do next'* and *'So, you've got a pervert coming to see you'*. We talked at length about lots of different issues both before and after the interview and, as I was leaving, she pointed out to me where several of her friends lived whom she thought might be interested in taking part in the study. She told me that she would talk to them in due course and give them one of the fliers that I had left with her.

Interview 9

The following participant had been recruited into the study via a friend who had also taken part in the study. She was 67 years of age and described her ethnicity as White British. She was married in 1957 and was due to celebrate 47 years of married life shortly. She had 3 children all of whom lived locally. Two babies that she had given birth to had died in infancy. We sat in her kitchen and she smoked numerous cigarettes. She told me that she was not prepared to give up for anybody. She gave a good interview and stated that she had enjoyed the experience of taking part in the research. After the

interview, we sat chatting in the living room. I was shown various different photographs of her family and she told me that she was very proud of them. She told me that she liked to surround herself with her family because it made her *'feel good'*.

Interview 10

A 47 year old woman recruited to the study via a live radio broadcast. She told me that she had heard my request for participants and felt it was something that she could take part in given her past experiences. She explained that had she heard the broadcast a year ago she would not have been able to participate given the fact that she had just finished a 24 year relationship with her partner and talking about these issues would have been too painful for her.

She was currently in a relationship with someone but seemed uncertain whether they were *'matched'* either intellectually or financially. She described her ethnic origin as Caucasian and her sexual orientation as heterosexual. She told me that she would struggle to talk generally about the issues and would only be able to talk from personal experience. When she was talking about issues related to her ex-partner, she sat folding a piece of paper very meticulously, often looking very nervous and, on occasions, tearful. At the same time, she appeared relaxed and friendly and appeared to enjoy the time that we spent together.

Interview 11

A 38 year old Chinese woman resident in the U.K. since 1997. She had been married for 14 years whom she met during the time she had spent working in Europe. I arrived at her door rather wet due to a torrential down pour and thunderstorm. Having taken off my shoes, she passed me a pair of slippers and a towel and we sat down talking for a while in her living room. It felt strangely comfortable.

Her daughter, who was 2 ½ years old, had been born with various physical problems. She talked at length about the difficulties she had been experiencing with her daughter and the feelings that this had engendered- particularly around the fact that she had not been able to work since her birth. There was a sense in which their daughter's health problems had put a tremendous strain on the marriage and her potential to earn a salary to gain some independence from her husband. I found her talk very difficult to follow at times and she found it difficult at times to express herself. She explained to me that not having a job and interacting with people on a daily basis made her feel quite lonely at times and she was keen to get back to work and pursue her work and her career but was unsure when this would be. Leaving the house, she waved at me though window as I got back into the car.

Interview 12

A 35-year-old married Chinese woman recruited into the study via a friend who had taken part in an interview a couple of weeks previously. She had moved to the U.K. from China to complete her postgraduate studies. She had been married for 10 years but did

not say whether she had any children from her marriage. She had had no relatives living in the U.K.

She proved incredibly difficult to engage in conversation with. For the first 20 minutes of our meeting, her ability to maintain any form of eye contact was very poor. This improved slightly throughout the interview but at times, I was left to wonder whether she was bored, embarrassed or simply a very private individual who thought that perhaps my questions were a little too intrusive. This proved to be one of the shortest interviews conducted and proved difficult to allow her to expand on the one-word answers that she gave throughout the time we spent together.

Interview 13

A 55 year old Chinese woman who had moved to the UK in 1996 from China. She was recruited via the previous participant. She had married her second husband in 1997 but did not tell me anything about her first husband. She had no children. She agreed for her interview to be taped and, given her ability to talk quite fast and the difficulties that I was experiencing with understanding her, she tried to talk a little slower. She was able to answer all the different topics that I raised with her but these were often answered on a very general level and she did not allude to any personal experiences at all throughout the time that we spent together. She did explain to me that sex had never really been that important to her throughout her life and didn't see this as a problem. Like all the other participants, I wrote her a brief letter thanking her for her time and assuring her that our interview would remain confidential.

Interviews 14-23. Participants recruited from a psychosexual clinic

Interview 1

A 39 year old woman due to celebrate her 40th birthday very shortly. She described her ethnic origin as Caucasian and came from a family of four other children. She had lived with her partner for over 20 years and had been married for 14 years. She described her physical health as good but her mental health as not so good. She had been treated in the past for depression but was not receiving any form of treatment at the moment. They had adopted a son who was now five years of age. She described him as being very important to both of them.

She had been referred to the psychosexual clinic via her GP when her *'problems came to head'* and to seek advice and guidance for a low libido which had got much worse. She was discharged from the psychosexual clinic in September 2004.

Interview 2

A 49 year old Caucasian woman. She had never been married and was the mother to five children. She had been separated from her long-term partner for the last 14 years but had recently become involved in a relationship with him again. She described her physical health as poor and this had impacted upon her ability to hold down a full time job. She had been referred to the psychosexual clinic and was currently waiting to receive an appointment.

Interview 3

Aged 39 years, the following participant was recruited to the study having received a letter sent out from the psychosexual clinic on my behalf. She had contacted me by telephone to ask if it would still be acceptable to still take part on the basis that she had never been seen by anybody at the clinic. Despite being referred there by her GP, she had subsequently cancelled her appointment because her sexual difficulties had resolved. She was a confident, expressive and outgoing individual which was reflected in the excellent interview that she gave. She was due to celebrate her 40th birthday very soon.

She described herself as single but had recently started a relationship with another man with who was very happy. She had no dependents. She described her ethnic origin as White, had no strong religious beliefs but was born and raised in the Church of England. She described her health status as good. She explained that what a good idea she thought it was for someone to be asking women their understandings of sex, sexuality and sexual problems thought that it was be a valuable study to participate in.

Interview 4

A 33 year old woman recruited to the study following the first mail shot sent out from the psychosexual clinic. She described her ethnic origin as White British and her sexual orientation as lesbian- she had been with her current partner for 11 years. She expressed no religious beliefs and described her physical health as fair. They had been referred to the psychosexual clinic following an appointment that she made to see her GP.

Neither she nor her partner found the counselling very effective and she was forthright in her criticisms of the counsellor whom she believed had no prior experience of dealing with sexual problems for same-sex couples. She was a very eloquent individual and enjoyed the opportunity to talk. She was comfortable and relaxed and the interview went extremely well.

Interview 5

A 37 year old woman keen to participate in the research having previously described it as an 'interesting' subject and heartened by the fact that someone was researching the views of women themselves. She had been married for the past 11 years and was the mother to two young children. She told me that she had suffered two miscarriages whilst trying to conceive her children. She described her health as good. She had sought advice for her sexual problem (low libido) from her GP who subsequently referred her to the psychosexual clinic. She declined the appointment having waited 18 months stating that her difficulties had since resolved. Reflecting upon the interview, she said that being interviewed by a man had not bothered her and she was glad of the opportunity to help with a piece of research that could potentially help other women.

Interview 6

A 26 year old woman who had been married for the last four years. She had been engaged to her current partner four years previously. She described her ethnicity as White. She was one of two children and expressed the longing for a family of her own

but this had been complicated by the problems that she has experienced with regards to her sexual health and the diagnosis of vulvodynia which had been recently confirmed.

Interview 7

A 25 year old woman who wanted to participate in the study on the basis that the subject was a 'very grey area' and hoped that her contribution would help other women. She described her ethnicity as White and her sexual orientation as straight. She was currently single- she had been engaged to the father of her three-year-old son but the engagement was broken off as a result of attending the psychosexual clinic. She expressed no religious beliefs and described her physical health as good. She described herself as something of a 'wild child' when she was growing up but had since settled down and her attention was very focused on her son.

She self referred to the GP after sexual relations broke down with her previous partner who was concerned by the fact that she did not want sex with him. She had since been discharged from the clinic.

Interview 8

A 38 year old Caucasian woman who telephoned wanting to take part in the study. She described her marital status as single and was currently in her second relationship with a man. She expressed no strong religious beliefs and described her health status as good. She has no children.

She was initially concerned about the confidentiality of the interview and I explained to her the efforts that had been put into place to protect the anonymity of research participants. Her decision to take part in the study was based on the fact that she considered the subject worthy of detailed investigation and wanted to help in any way that she could. She had been referred to the psychosexual clinic but, shocked that they were going to have to wait for almost a year to be seen, she took the initiative to contact a private sexual therapist in an effort to resolve the difficulties they were experiencing. These difficulties have since been resolved.

Interview 9

A 43 year old Caucasian woman born and raised in South Yorkshire. She had lived with her current partner for 10 years before getting married 3 years ago and they have a daughter. She described her ethnic origin as White British and expressed no religious beliefs. She was referred to the psychosexual clinic by her GP as a result of complications associated with the delivery of her daughter. The two therapists whom she saw at the clinic tried to convince her that the physical pain she was experiencing 'was in her head'. She saw them a total of three times and then discharged herself.

She was very eloquent and gave a very good interview. She told me that she had enjoyed being given the opportunity to take part in the study. I thanked her for her time and as I left, she kissed me on the cheek.

Interview 10

A 23 year old woman who responded to a letter sent out from the psychosexual clinic from the second mail shot. Concerned by the nature of the study, she had written on the reply slip that I could contact her by phone and leave a message for her but I was only to mention that I was calling from the University of Sheffield. Once we had spoken, she agreed to take part and expressed a preference to be interviewed on University premises.

She described her religion was Serbian orthodox although she had no strong religious beliefs, her ethnicity as Slav and her sexual orientation as heterosexual. Her physical health she described as good and her mental health she described as fair. She gave a very good interview and explained that she was still awaiting an appointment with the psychosexual clinic and had been for the last 18 months although she was unsure whether the clinic would be able to help her to resolve her difficulties.