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The "problem" of frigidity: its inconsistent treatment and consistent role in marital advice from the 1920s to the 1960s

Frigidity loomed over the first half of the twentieth century as a threat to sexual satisfaction within marriage; in an age in which marital success was increasingly linked with "good sex", frigidity became a pejorative symbol of Victorian prudishness in the emergent sexological discourse. Paradoxically, it was common in popular marriage and often aspired to by the "civilized woman". Moreover, any totalizing definition of frigidity remained elusive. Frigidity was at once customary, a sign of neurotic pathology, and impossible to define satisfactorily. For decades, it played at the fringes of psychiatric literature – discussed only in medical diagnoses of neurotics – and then appeared in traditional marital manuals by the 1960s. This essay will attempt to tease out the multiplicity of causal threads that contributed to a radically different treatment of frigidity in marriage manuals from 1920 to 1960. Using Marie Stopes's *Married Love* (1918) and Romar and Lee's *A Family Relations Guide for the Canadian Woman* (1961), it suggests that while frigidity was explicitly excluded from the first and delicately included in the second, there is common cause behind both decisions. While the definition of frigidity was altered dramatically throughout the first half of the twentieth century, its *role* in marital advice was consistent. Frigidity was used as a tool for the institutionalization of sexological knowledge (Waters 56), one meant to prescribe normative heterosexual relations through its opposition. As such, its presentation in marital advice changed to better suit that purpose. In the broader sexological context, a paucity of research and radical discrepancies in accepted belief suggest far less interest in frigidity for its own sake.

From the term's earliest beginnings to its exhaustive formulations, a universally accepted definition of frigidity remained elusive. As a term defined by its *lack*, it is necessary to regard frigidity as inextricably linked to whatever stood as the popular conception of the "correct" female orgasm in an era when orgasm became the necessary marker of "good sex". For the twentieth-century woman in a post-psychoanalytic tradition, the failure to develop and ultimately enjoy vaginal orgasm was taken as a symptom of frigidity (McLaren 160). The vaginal orgasm represented a woman's passive and submissive acceptance of male sexual authority; it was deemed the only healthy female sexual response (Lewis 42). Correspondingly, over the course of the interwar period, the failure of vaginal orgasm became the conceptual lynchpin of frigidity (Angel 536). While the psychoanalytic tradition was influential,[1] psychiatric and medical communities continued to have different views on the specifics of frigidity. At one extreme, frigidity was characterized as a complete absence of sexual sensation, be it physical, sensual, or emotional; at the other, there was a rigid view that any sexual experience, except coitus concluding with orgasm, was symptomatic of frigidity (Schaefer 165). The definition changed not just over time, but between scientific fields as well. If there was any consistency to the definition of frigidity, it was as a term used to control and categorize, rather than describe. It stood as a tool for depicting normative sexual behaviour in its opposition to normality – an unspecific descriptor intended for use *against* itself.

While issues surrounding marital sexual satisfaction and frigidity were certainly widespread across class levels, it would be almost impossible to argue contact between most of the English speaking world and sexologists. As McLaren suggests in his *History of Sexuality*, even if the reading public was more enlightened in the 1920s, one should not exaggerate the impact of feminism, psychoanalysis, or sexology on the mass of the population (69). This claim holds weight throughout the first half of the twentieth century, for although there was research published on sexuality, it often did not make it into the consciousness of the dominant culture. What were distributed quite effectively, however, were marriage manuals, which exploded in popularity in the 1920s. Marie

[1] Kroger and Freed assert "what is called psychosomatic medicine today is the outgrowth of the efforts of psychoanalytically oriented physicians...the psychodynamic tenets of Freud have become well established diagnostic and therapeutic tools in all phases of clinical medicine" (Kroger, Freed 570).

Stopes's *Married Love* sold more copies than many popular novels and ushered in a genre that would remain fashionable for much of the century.

Marital guides were concerned with the improvement of marriage; the method for doing so had, by the 1920s, come to mean sexual education. More specifically, marital guides prescribed "correct" sexual practice. Over the next forty years, however, what was included in these manuals changed dramatically. Published in 1918, Stopes's project excludes frigidity, while the 1961 *Family Relations Guide for the Canadian Woman* includes it. Stopes's omission of frigidity is especially indicative because it is not accidental. Like so much of Victorian literature's deletion of sexuality, the exclusion is almost more telling than any inclusion would be. For the intellectual community of the 1920s, frigidity was a pathology to be understood and studied *as such* – it had no place in a happy marriage. Moreover, love in marriage had to be protected from it. By 1961, however, *Family Relations* devotes three full pages to a discussion of frigidity within marriage. Frigidity shifted from being viewed as a neurotic pathology to be categorized by obscure medical textbooks and began to be acknowledged in texts aimed at the general public.

To understand the many, and often seemingly contradictory, threads of twentieth century discourse on marriage, it is important to remember that these shifts are often reactionary. This is especially true of Stopes's *Married Love.* Her work, both as an author and with Margaret Sanger on the birth control movement, sought to change the public perception of sex and "sexology". Their opponent: Victorian prudishness in relation to sex within heterosexual marriage. Pioneering sexologist Havelock Ellis commented in 1910 that "by many, *sexual anaesthesia* is considered natural in women", citing medical authors who claimed frigidity rates of between 66 and 75 percent for "civilized women" (Maines 61).[2] In the nineteenth century, frigidity in women was not only commonplace, it was religiously and morally preferred. Sex was inextricable from its reproductive consequences and was controlled as such.

Stopes's opposition to the Victorian public's ignorance of "good sex" did not begin with dreams of sexual liberation, however: it was a project intended to revitalize marriage. By the inter- war period, heterosexual marriage had transitioned from a purely reproductive, economic union into a companionate relationship concerned with romantic compatibility. Many intellectuals expressed concern for marriage after the First World War. As a result, there was an explosion of new marriage manuals which emphasized the need for sexual pleasure and provided necessary advice on technique (Robb 99). Stopes's *Married Love* is arguably the first of this genre, and its subtitle, 'A New Contribution to the Solution of Sex Difficulties', suggested that marriage was in trouble and that good sex was the solution (Robb 99). Victorian purity became an enemy of good marriage; as the foundation for societal stability in the post-war backlash, marriage needed rescuing from this dangerous foe. What earlier generations had seen as woman's ideal purity was now labelled "repression" or "frigidity" (Robb 99). The marital advice literature of the early twentieth century emphasized the necessity of sexual fulfilment for a happy marriage – and, by extension, a healthy society (Angel 537). Yet, perhaps more significant than the war in creating this unexpectedly "sex-positive" culture (for the heterosexually monogamous, of course), was the increasingly popular use of contraception. For the first time in the history of sexuality, marriage was confronted with sex *separate* from reproduction. Before the widespread availability and active championing by some groups of birth control, "sexual pleasure in marriage was always overshadowed by fears of pregnancy" (Robb 90). For the marriage manual of the 1920s, sex was freed from reproductive control. The result: sexual norms had to be even more carefully policed. Stopes's marriage manual is

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[2] It should be noted, the problem of frigidity is a primarily intellectual concern centred around the upper and middle class, due to the expensive and personal nature of psychiatric treatments. There were never any efforts made by psychiatry or psychoanalysis to combat or treat frigidity on a large scale. Even by 1963, in "The Problem of Frigidity", Bergler comments: "mass treatment is out of the question. As a mass problem, the question of frigidity is, unfortunately, not to be solved" (375).

[3] Published in the late 1920s, the book was originally intended only for a professional

demonstrative of this trend; it was a tool for the improvement of normal, heterosexual and monogamous marriage, not a guide for dealing with abnormality.

Married Love ushered in a new era of marital advice literature that provided an educative function on correct sexual practices. The most famous is likey Theodoor vab der Velde's *Ideal Marriage,* a book concerned with the ABCs of sex – how it *should* be performed.[3] As discussed above, Stopes makes no attempt in *Married Love* to offer an explanation of frigidity; it does not belong in a discussion of a happy, 1920s marriage. She refers the "sexually anaesthetic" reader to the work of sexual pathologists like Forel, Ellis, Bloch, or Krafft-Ebing. Her usage of *sexual anaesthesia* suggests a familiarity with the sexological work on the subject, as does the pathologizing, almost taxonomical language used: she encourages the reader to discover what type of humanity they belong to (17). There is no need for such a reader to engage with her book, "for it is written about, and it is written for, ordinary men and women" (17). Once a normalized phenomenon, frigidity in the 1920s had become a danger to the romantic marriage; in a world where sex was no longer defined by reproduction, it had to be *correct*. As McLaren argues, any failure was presented as a threat to family stability and therefore to society. If pregnancy did not have to be feared, any lack of heterosexual ardour could be taken as a sign of frigidity (69). With the events of the early twentieth century, claims at a moral and religious backing for frigidity began to subside. It was now part of the taxonomy of pathological sexual dysfunction, and useful as a way of protecting and prescribing normal sexual behaviour.

Although the character of marriage may have remained static over the course of the next two decades, the heterogeneous field of sexology did not. It should be noted that while sexological works were certainly not best-sellers, Chris Waters claims that, by the 1930s, their ideas were being widely discussed, and shaped the academic sexology increasingly encountered at most levels of society (47). Sexologists' prescriptions of normal sex were passed down to the public through marital advice; as seen with Stopes, however, the public was shielded from the details of abnormal sex. Historically speaking, research into sexuality was defined by the interactions of sexologists, psychoanalysts, psychiatrists, medical doctors and researchers. While each field existed at the same time, since there were shifts in their prominence, the changing face of frigidity is most simply explained as following these paradigmatic shifts. From biological essentialism, to pathology, to behaviour that could be adjusted through counselling, even the reduction of frigidity to an artefact of male "unadroitness" (Stekel 123), the definition of frigidity changed depending on who was using the term. In the decades after Stopes, the field most inclined towards investigating frigidity was certainly psychiatry; as Angel points out, the salience of psychiatry in discussions of female sexual problems has its roots in the mutually entangled development of psychiatry, sexology, and criminology (536). Perhaps the most persistent – and paradoxical – trend throughout this dynamic period: while common, frigidity was associated with neurotic woman, and certainly something to be avoided. Throughout the first half of the twentieth century, the definition of frigidity was in crisis – shaped and reshaped by the popular paradigm of the day.

Beyond Freud's prescription of the vaginal orgasm, the most striking paradigm shift emerged with a hotly contested project of medical research: the publication of Kinsey's *Sexual Behaviour in the Human Male* in 1948 and then *Sexual Behaviour in the Human Female* in 1953. While psychiatry was still in its heyday, scholarship set out in a new direction: its declared aim was to study ordinary life and to examine society from the ground up (Cocks, Houlbrook 5). Rather than describe what ought to be normal behaviour in the top-down fashion of sexology, the Kinsey report looked into what was actually taking place in heterosexual marriage. As much as the "civilized woman" aspired to restraint, the Kinsey report provided statistical evidence showing discrepancies between the common assumptions of a moralistic public and the actual behaviour of people (Bowman 2). Moreover, its data suggested that medical professionals were out of touch with dominant sexual trends; rather than successful vaginal orgasm, sexual stimulation and climax were centred on the clitoris (Lewis 59). As a result, Kinsey argued what had been standard claims of over 50 percent frigidity in the work of Stekel, Kroger and Freed, and others, were unsubstantiated and exaggerated estimates (375). By employing empirical methods to demonstrate the shift in focus away from the vaginal to the clitoridean orgasm, Kinsey upset what had long been an accepted tenet of frigidity for many

audience, though it eventually became a public sensation.

sexologists. He went on to suggest, moreover, that the data confirmed that the persistent failure of the female to reach orgasm *in her marital coitus* may do considerable damage to a marriage (371). Amidst the panic around domestic and national security in the 1950s, any threat to heterosexual marriage was dangerous – Kinsey's claims caused an uproar.

By the mid-twentieth century, Edmund Bergler, W.S. Kroger and S.C. Freed stood as authorities on female sexual health, especially in sexual dysfunction: all three were staunch defenders of the primacy of the vaginal orgasm. They mirrored Wilhelm Stekel's earlier work on *anaesthesia vaginalis,* a condition he had described as "bordering closely on the realm of sexual pathology" (Stekel 117). As Bergler had articulated earlier in his hallmark essay "The Problem of Frigidity": "the formula, 'Orgasm is orgasm,' is wrong" (376). For Bergler, and Kroger and Freed, frigidity was defined by the "the incapacity of woman to have a vaginal orgasm during intercourse" (Maines 62) – in their eyes, Kinsey's efforts to validate the "clitoridean orgasm" would only serve to placate neurotics. They maintained the woman's passive acceptance of the penis was necessary – any failure at vaginal orgasm was caused by "a multiplicity of neurotic reasons" (Kroger, Freed 571). Despite maintaining statistics ranging from 75 to 90 percent frigidity in women, Bergler, Kroger and Freed continued to describe frigidity as a neurosis – and one with tragic consequences (Bergler 389). Enforcement of the vaginal orgasm, specifically passive penetration, was not mere medical prescription, however; it had real-world implications for the state of marriage, especially amidst the 1950s "conservative backlash".

Mirroring the post-war 1920s, the 1950s saw a shift in attitudes towards marital relations. Cold War anxieties and post-war tensions made the assertion of traditional gender roles within heterosexual marriage of paramount importance. The normal family unit, rooted in healthy heterosexual desires and behaviours, played an integral role in securing political, economic, and social stability (Lewis 68). Like the 1920s, contraception increasingly facilitated the separation of sex from reproduction – as did a preference for clitoral orgasm. Consequently, the medical profession tried to make motherhood the tangible expression of female psycho-sexual health, insisting that the only healthy sexual acts were those that contained the possibility for reproducing within the legal and moral sanctity of marriage (Lewis 68). As the basis of societal stability, the marriage model needed to be protected. The "traditional" role of the passive female so brilliantly contained in the vaginal orgasm helped safeguard gender roles: by maintaining it was the only correct orgasm, experts offered medical imperative to the post-war domestic ideology that valorized female domesticity and male bread-winning. In short, the vaginal orgasm became the key to ensuring domestic bliss and national security (Lewis 68). Female sexual dysfunction was dangerous not only for the family, but for society as a whole.

The Canadian Woman's Guide to Family Relations[4] emerged out of these deeply polarized attitudes toward frigidity. On the one hand, social anxieties dictated the importance of stable familial "relations" through successful vaginal orgasm; on the other, the picture of the heterosexual marriage painted by the Kinsey report in no way matched those prescriptions. Published in 1961, it appeared on the heels of the first FDA approved oral contraceptive, a marker that reaffirms the ever- broadening gap between sexuality and reproduction. The guide dismisses contraceptives on religious/moral grounds, but devotes a full chapter to the "Problem of Frigidity". It claims: frigidity in marriage is always a serious matter. It is crippling to both husband and wife...and to their marriage (66). Frigidity is presented, as always, in opposition to good marriage. In a clear link to earlier psychiatric efforts to taxonomize "different" types of frigidity,[5] *Family Relations* appeals to "some authorities who break the problem of frigidity into two categories, primary and secondary. In both, distinction is made between the completely frigid wife who never responds, and the relatively

[4] Like many other marriage guides, it was available via mail-order for private, family use, and advertised in marital advice magazine and journals.

[5] For examples, see: Bergler's 8 part "general typology" (378-379), Stekel's tripartite division of the "absolutely, relatively, and passionate-frigid woman" (98), and Williams's division of the population into: "perfectly adjusted, rarely have orgasm, and absolutely frigid" (572).

frigid wife who responds to some degree" (65). To elucidate on this distinction, it articulates three different stories:

> Three widely contrasting families, yet in their hearts and minds, a great similarity. Helen, meticulous and finicky, considered her husband gross and uncouth, hating to have him touch her...Annette, driven by ambition, had to excel in a man's world...Being 'just' a woman was not enough. Lorraine was terribly tired, but also terribly afraid. Whenever Norman wanted to kiss her, one of her headaches came on...Each of these women was a frigid wife. (64)

The usual conflicts between repression, psychiatric neurosis, and even early fears around pregnancy are all found here. Yet, over the course of the chapter, the emphasis is on the *emotional* causes of frigidity: it is portrayed as a difficulty to be overcome, rather than a neurotic pathology. Regardless, in all three cases, either medical or psychiatric treatment are strongly encouraged. Recalling Stopes's work, *Family Relations* rails against Victorian prudishness, citing "Victorian upbringing" as a common cause of primary frigidity (65). In what would become a trend towards the end of the 1960s, however, it also criticizes the extremity of this backlash against Victorianism. *Family Relations* comments: "the marriage manual which was aimed at breaking down Victorian attitudes of a generation or so ago may have some repercussions today...for such a book sets unrealistically high standards, regardless of individual differences" (66). As much as Stopes's project was intended to revitalize marriage, by the 1960s, it had begun to backfire.

While seemingly contradictory positions, the confluence of societal anxieties and Kinsey's data suggests a point of access for understanding this double perspective on anti-Victorianism and inadequacy. For the post-psychoanalytic woman, vaginal orgasm was not just encouraged, it was a necessary achievement – even a test of competence (Schaefer 174). Orgasm was not an experience, it was an indicator of success. The permission to have orgasm imposed a new burden, namely "the feeling of inadequacy if [the woman] fails to achieve it" (Schaefer 179). This inadequacy had been felt within the marriage, in the psychiatric chair, and in medical literature on the subject. With the emergence of Kinsey's data, however, it became publicly apparent that the vaginal orgasm could not produce sexual satisfaction. As Kinsey summarizes: "some hundreds of the women in our own study have consequently been much disturbed by their failure to accomplish this biological impossibility" (Kinsey 584). *Family Relations* sits in the uncomfortable convergence of these two opposing viewpoints. On the one hand, it forcibly prescribes heterosexual monogamous coitus amidst a society concerned with reproductive stability. On the other, it was published for an audience not only *struggling* to make that happen, but arguably *failing*. *Family Relations* occupies the delicate position of trying to "de-pathologize" frigidity by including it, while still maintaining it must be treated. This inclusive shift in marital advice emerged, in part, as a result of a broadening acknowledgement of frigidity in the public sphere, and marriage manuals' attempts to give heterosexual partners the correct information about it.

In the midst of the cultural and intellectual climate of the 1960s, including frigidity within marriage guides was a more effective way of controlling heterosexual marriage. While Kinsey's research may have been framed as "revolutionary scholarship", the way it was used in publicly-disseminated literature continued the top-down sexological tradition found in the 1920s. The inclusion may be explained by the fact that its absence had very publicly stopped working. The Kinsey report, rather than offer the public new information, had turned to the public to provide hard data for what people already knew. As Bowman argues, the attempt to study sex in terms of biological statistics reflected a recent stage of cultural development: Kinsey was no historical accident (1). What was significant, was that its popularity meant that the data could not be ignored. The medical community had been found to be out of touch with reality: actual bedroom practice did not match what they had previously prescribed. Consigning abnormal sexual practice, like frigidity, to pathological taxonomy had failed to control heterosexual practice effectively. In a culture of anxiety, this potential instability in marriage was a very real threat. As a result, rather than ignore it, marital literature embraced and included it – frigidity could no longer be relegated to obscure medical literature. Like the revolutionary practice of including graphic details of sexual activity in early marital manuals, however, this was not done out of newfound sexual liberalism. Frigidity, as a

symbol of the failure of sexual satisfaction so necessary to marriage, needed to be controlled. Paralleling Bergler and Kroger's insistence that there was no scientific difficulty with arguing that 80 to 90 percent of all women were "abnormal" in their dissatisfaction with vaginal penetration (Maines 62), the admittance of frigidity into marital manuals articulated it in contradictory terms: while removing its pathological connotation to some degree, the treatment also reinforced it. Frigidity was never normalized, despite being objectively common. McLaren reduces Kinsey's project to the claim "what is, is right" (165). It would seem fair to say that in the case of marital advice on frigidity, the verdict remained: what is, isn't right. Frigidity, though understood in different terms than the *sexual anaesthesia* of the 1920s, continued to perform the same role in marital advice manuals: it was cast in opposition to successful marital relations, used as a tool to propagate a specific model of heterosexual marriage – a fragile ideal, once again, under threat.

While frigidity was treated differently within the marital advice manuals *Married Love* and *The Canadian Woman's Guide to Family Relations*, it nonetheless played the same role, despite upheavals in the field. The definitions of frigidity changed depending on the current sexuality paradigm, but by the 1950s, two opposing camps had emerged: one championed the validity of the vaginal orgasm while the other defended the clitoridean orgasm. Frigidity was claimed by the first to affect upwards of 50 percent of women; for the second, less than 10 percent. Amidst wildly opposing viewpoints, societal anxieties, and the emergence of the broader public into the field of sexuality, frigidity continued on as it had: for most women, it was a source of tension in their marriage, a responsibility to an achievement they continually failed to meet. Marriage guides were not interested in what frigidity could say on its own; instead, they painted the contradictory picture of a common neurosis that had to be fixed. As a mechanism of the institutionalized prescriptions founded in sexological discourse, the role of frigidity remained the same in 1960 as it had been in 1920. Frigidity was used in marital advice as a tool for describing and encouraging "correct" heterosexual relations in a marriage model no longer defined by procreative sex.