Feminism and the Body

Feminism and the Body: Interdisciplinary Perspectives

Edited by

Catherine Kevin

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As this book goes to press, my baby has just turned one. He was born a year after the conference and his arrival took me away from the book on more than one occasion. I am grateful to the contributors and the publishers for their patience with me as I came to grips with the juggle. I also thank the contributors for the energy and enthusiasm they shared at the conference and gave to the project of the book. It is, after all, their collection. Each chapter has been anonymously peer-reviewed by experts in the authors' given fields and I know the contributors join me in expressing my appreciation for the rigour, generosity and insight their peers have brought to this task.

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INTRODUCTION

CATHERINE KEVIN

Recently, while contemplating the place this collection might have in public conversations about social justice, I glanced at the front page of a Sydney newspaper to see a local football star had been accused of rape. In the days that followed, much of the commentary on the events relevant to this story was disappointing. This was not the first high profile footballer to be accused of rape in recent times and here in Australia we have come to expect that for the most part the main-stream media outlets will publish apologist attempts to resuscitate the reputations of football players after news of such incidents breaks through closed club ranks and into the press. Despite the familiarity of this story and the media's response to it, it still had the power to disappoint. So long as a man's physical prowess on the football field produces a yearning for his immunity from sanctions against sexual violence a disturbing hierarchy of embodiment emerges. It seems that feminist and other critiques that politicise the discourses competing to inform our understandings of embodiment, of our bodies 'as lived', are as necessary as ever.

By definition, feminism is concerned with the historical, social and political meanings of sexual difference in the human body, and the spectrum of experiences those meanings produce. Contemporary feminist scholars of the body have a rich tradition of feminist thinking to draw from. When, in the eighteenth century, Olympe de Gouge protested against the exclusion of women from the French political sphere, she was arguing that biological sexual difference could not determine the participants in a democracy. Her contemporary, Mary Wollstonecraft argued in 1792 that in women 'dependence of body naturally produces dependence of mind' and women would be relieved of these forms of dependence by education. Nineteenth-century Woman Movement activists continued to make such arguments about corporeal difference while they worked for the safety and freedoms of the sexual and reproductive bodies of women. In their attempts to raise the age of consent; to curb male drinking in order to protect women from domestic violence, including rape; and in their challenge to marriage laws they sought legal reforms that

would recognise and mitigate the historical effects of female embodiment. In the twentieth century, while this work continued, women's groups campaigned for greater resources for the prevention of maternal deaths and the recognition of women's unpaid maternal labours. In this period, feminist activists also endeavored to increase women's knowledge of sex and their ability to control reproduction. The aims of this work were theorised in new ways by the Women's Liberation Movements and other incarnations of the 'Second Wave' from the 1960s. During the 1970s and 1980s Anglo-American, European and Anglo-Australian feminists confronted their limitations in respect to class and race. Part of this process was to identify a variety of ways in which the reproductive body had been exploited and controlled that were race and class specific. In the same period American feminists Andrea Dworkin and Catherine Mackinnon became key players in the Sex Wars, which debated the salience of various feminist perspectives on pornography and heterosexual penetrative sex. Sexuality and the sexualisation of women and children remained on feminist agendas as the last century drew to a close. At the beginning of the twenty-first century, gendered forms of violence persist, abortion remains a political issue, reproductive and cosmetic technologies and their concomitant ethical questions are proliferating, and the presence of women's bodies in public spaces and for public consumption produces a range of anxieties about women's well being and the common good. In grappling with these issues, feminist scholars continue a history of intellectual endeavor that has striven to identify the interplay between corporeal differences and relationships of power.

In January 2007 the scholars whose work is published in this book came together to discuss their research on embodiment. In the dank cold of an English Winter the rooms of London House were warmed by the spirit of open engagement that people brought with them from places as distant as Canada and Australia, and from disciplines as varied as English Literature and Medical Sociology. This collection reflects some of the variety of expertise and habitat from which feminist explorations of the body are currently being launched. It is both cross-disciplinary as a collection and showcases examples of research that draw on more than one scholarly discipline. The aim of the conference was to identify recurring themes for feminist scholars undertaking this work as well as to survey the reach of feminism's impact on current research.

As a collection, this book explores the critical use of terms such as choice, agency, and medical sovereignty, particularly in relation to sexual practices and to practices such as abortion, cosmetic surgery and contraception. It confronts and constructively critiques the persistence of

violence against women in its myriad forms and across cultural, historical and geographical divides. It works to resist essentialism and maintain a sense of the body's historicity, and as part of this process the authors variously locate, explore or – more commonly – dispute the distinctions between materiality and discursivity when interpreting the meanings of bodies.

The book is divided into sections that reflect some of the broad themes that describe more than one example of the scholarship presented. The first theme addressed is the discursive production of the reproductive body. Judith A. Allen charts the gradual twentieth-century movement towards 'the aestheticization of coitus', ultimately via the contraceptive pill's anovulant effects, and evaluates the political benefits and costs for women of the widespread success of this movement. Isabel Karpin and David Ellison bring to light the discursive possibilities of Mary Shelley's *Frankenstein* for describing legal developments that marginalise gestating women in the policing of emerging reproductive techniques. My own chapter is an account of four episodes in the history of the pregnant body in Australia and its relationship to interpretations of the national good, and Pam Lowe presents her sociological research into women's perspectives on and practices in relation to vasectomy. By historicising the management of fertility and pregnancy, by deconstructing political rhetoric deployed in debates about new reproductive possibilities and describing the reasons women take up some contraceptive techniques and not others, this section works towards dispelling many of the myths that continue to inform contemporary reproductive ethics – that which calls itself feminist and that which does not.

The second section tackles histories of racial and sexual violence. These histories reveal the bodies of minority women to be constructed by dominant discourses as sexually available, the effect of which has been the distinct vulnerability of these women to a sexual violence that has few opportunities for official recourse and therefore reinforces the status quo. Jelke Boesten's chapter draws on rape testimonies offered to the Peruvian *Truth and Reconciliation Committee* (1998-2000). She identifies gender and race hierarchies expressed by perpetrators in accounts of sexual violence towards Peruvian women in war. Through a close reading of these testimonies she reveals the ways in which these hierarchies reflected structures that persist during times of peace. Clare Corbould's examination of African American women playwrights in the 1920s and 1930s demonstrates the ways in which the theatre became an important site of resistance to institutionalised sexual violence against women. While exploring the intersection of lynching and rape in the oppression of

African American women, especially mothers, these plays also offered a 'gentle rebuke' to accounts of racialised violence that have marginalised rape in order to fix their focus on lynching.

In the third section, the first two essays explore representations of the body in Australian novels. Ian Henderson offers a close textual analysis of Miles Franklin's *My Brilliant Career* (1901). By identifying a profound instability in the corporeality and therefore the subjectivity of the novel's heroine he counters the tendency of many scholars to read the text as a 'stable archive of values and beliefs'. Catriona Elder describes the attempts of non-Indigenous authors of fiction to explore and resolve complex problems inherent in assimilation aims through their representations of sexual relationships involving Indigenous women. With a particular focus on Leonard Manne's *Venus Half Caste* (1963), she details the different ways in which Indigenous men and women have carried the burden of colonial practices. The final two essays in the third section are written from the field of Screen Studies and look to film for subversions of dominant discourses of female embodiment. In the case of Jane Campion's 'In the Cut', Lucy Bolton argues that the audience becomes disoriented when their expectations of the visible corporeality of a familiar Hollywood star are not met. Meg Ryan instead portrays a complex, fully embodied subjectivity, what the author describes as nudity, both 'clothed and unclothed'. Ruth McPhee highlights the ways in which Catherine Breillat's 'Anatomie de l'Enfer' challenges conventional representations of heterosexual sex that continue to reiterate a phallocentric denial of the leaky and in other ways boundary-less female body. In so doing, she reads the film as pushing beyond dominant visual discourses of sexuality to enable previously invisible meanings of the female body and sexuality to emerge.

The fourth section of the collection offers accounts of women engaging in practices and inhabiting spaces that are traditionally dominated by men. Nicholas Chare reads the absence of images of women's athletic bodies in the sports media as a silence that reinforces the myth of physical prowess as an exclusively male domain. Adam Eldridge examines the anxieties produced by women in the company of other women, drinking in public spaces, particularly after dark. More specifically, he looks at media and academic responses to the recent rise in popularity of the hen party as a pre-wedding ritual and proposes that these events can be understood as a challenge to historical and socio-political forces that have traditionally limited the possibilities of women's participation in public life after dark.

In the final section, the authors take stock of feminist analyses, or lack

thereof, of a culture in which women respond to the scrutiny their bodies are subjected to with various practices aimed at producing corporeal transformation. In the first essay, Rhian Parker examines cosmetic surgery and draws on interviews with women patients and cosmetic surgeons that reveal significant discrepancies between the perspectives of these two groups on the aims and outcomes of cosmetic procedures. This material enriches our understanding of women's experiences and works to undermine the victim/agent dichotomy that characterises many existing interpretations of the practice. The final essay in this collection is by Claire Carter. Here she is interested in conceptual tools provided by theorists of ageing that could plug the gaps in analytic frameworks developed by feminist theorists of the body. These gaps, the author argues, lead to the failure of feminist theories to accommodate the ageing body in any meaningful way.

This collection takes us into many geographical locations and into domains in which a variety of discursive effects come to life in the embodied subject. From the medical setting to the court room; from Peruvian villages to African American plays of the 1920s and 1930s; from explicitly feminist novels and films to the mainstream press and right into feminist scholarship that theorises the female body as it is made meaningful in its many and varied locations. In so doing, it restates and reinvigorates feminism's longstanding, necessary and emphatic engagement with the female body.

PART I

CHAPTER ONE

CULTURAL GENEALOGIES OF ANOVULATION: REVISITING ABORTION, THE PILL AND FEMINIST SEXUAL POLITICS

JUDITH A. ALLEN

Figure 1.1: Margaret Sanger in Federal Court, Brooklyn, 1917

Figure 1.2: Marie Carmichael Stopes in the 1910s [Royal Commemorative Stamp]

At the 1930 Zurich international birth control conference, a German gynaecologist, Dr. Hertha Riese leapt to her feet in alarm. She had just heard about experiments in hormonal prevention of animal ovulation. "I have always been opposed to hormonizing on principle," she declared. "I don't know whether we can introduce hormones into another body without affecting the personality. I would hesitate to have myself hormonized. I want to be myself, to remain who I am."[1] Her colleagues assured her that

anovulation could not be prescribed for women without compelling assurances against risks.[2] Moreover, Margaret Sanger clinic director, New York's Dr. Abraham Stone noted that men could use systemic contraception just as readily, since already hormones altered "the spermangenetic function of the testicle."[3]

Over the next half century, outcry about the Pill's radical pharmacological and physiological implications became muted. It was naturalised as the first medically-prescribed drug to otherwise healthy women and girls for a social rather than a therapeutic outcome. To prevent conception and allow unfettered coitus, the Pill potentially suppressed ovulation throughout the reproductive life, other than for planned pregnancies. Despite the 1930s assurances to Riese, no studies of long term use risks preceded the U.S. Searle Company release of "Enovid" in May 1960.[4] Since carcinogens often manifest tumors only after a decade or more, skeptics could scorn any causal claims, even though 1930s estrogen experiments implicated hormonal anovulation in "the growth of uterine and breast tumors in mice."[5] Even when a 1964 Oregon University study confirmed cancer in mice fed Enovid, critics dismissed this as irrelevant to humans. Similarly, vocal interests insisted that 1980s evidence of elevated cancer rates in Pill-takers warranted no alarm. Instead, hormonal intervention surged with mass marketing of Hormone Replacement Therapy. With promises of protection against everything from breast cancer to Alzheimer's disease, HRT promised to forestall discomforts of menopause, perhaps defeat the aging process itself. [6]

Heightened postwar medicalisation of sexuality and reproduction suppressed scrutiny of the historical conditions making anovulation apparently necessary by the mid-twentieth century. After half a century, pressing feminist questions confront the post-1960s birth control norm of anovulent women, or in Riese's terms, a culture making "hormonization" natural in women. Feminists had questioned the Pill, but within certain limits.

So linked was the Pill with the Sexual Revolution that feminist questions stressed women's liberation. Did the Pill set women free, separating sex from reproduction, at last giving them erotic equality with men? Those answering in the affirmative form one feminist position on the Pill. Alternatively, others addressed the costs for women of sexual libertarianism within unchanged planetary patriarchy, the Pill as well removing the right to refuse coitus on demand. Worse still, with its genesis, contraceptive responsibility became solely female.

While diametrically opposed, feminist positions converged on anovulation being hugely consequential. Yet the question "Was the Pill

good or bad for women?" implied a singular, negative portrayal of women's historical experiences of coitus, itself open to question and historical exploration. After five decades then, there is purchase in posing different feminist questions about anovulation.

To understand the rapid acceptance and enthusiastic promotion of anovulation, despite disquieting evidence of its impact on women's bodies, the pre-Pill earlier decades of the twentieth century birth control discourses and practices need situated cross-national analysis. Influential expert discourses proved crucial. Experts orchestrated less the quest to disconnect sexuality and reproduction – that was already happening – than to disconnect *visible* birth control from coital eroticism. Accurate genealogies of anovulation – that is, accounts of "descent from ancestors, by enumeration of the intermediate persons and factors" – have four issues requiring scrutiny to frame successor hormonal contraception.

To infer that the Pill was developed for Western population control is erroneous though understandable enough both from eugenic elements in its back-story and its avid export to "developing countries" since the 1960s. In fact, as the Pill's ancient ancestors, "traditional" methods – that is, withdrawal, abortion, condoms, and abstinence – secured massive declines in Euro-American birthrates and average family sizes thirty years before the Pill. Second, experts like Marie Stopes and Margaret Sanger – who are usually called birth control pioneers – are better seen as interwar birth control restrictivists. They condemned existing methods, shared by the sexes, as at odds with aesthetic, romantic, spiritual, and physiological purposes of coitus.

Instead, as a third factor in genealogies of anovulation, experts exempted men from birth control. They held woman-borne cervical caps and diaphragms to be superior on scientific, eugenic, and feminist grounds. Even when these devices failed due to resistance and distaste, mid-century experts still urged disconnecting any visible birth control — especially withdrawal and condoms – from an idealised form of coitus advocated as the cement of modern marriage.

The fourth factor in the Pill's ancestry is the relentless upswing in abortion rates in 1920-1960, which, in turn, fuelled renewed transnational decriminalisation movements, framing the sexual politics context for the first mass testing of Enovid. Abortion forms a missing link in genealogies of anovulation. Like many a skeleton in family closets, or "the elephant in the room," to borrow a tired metaphor, it is repressed in family history narratives. By its nature and illicit legal status, evidence of its precise place in the genesis of the Pill will be suggestive or circumstantial rather than comprehensive and quantitative. Arguably though, abortion was a

crucial category in the postwar birth control landscape, one that helped to generate momentum for the resources marshaled in support of the Pill.

I. A "Traditional" Decline

> [T]he biggest transformation in women's lives in the past century – perhaps the whole of history—is measurable. . . . It is the use of effective birth control. Present day commentators often regard the introduction of the Pill in the nineteen-sixties as the breakthrough in birth control . . . But the real breakthrough in the capacity to control births came much earlier, by the nineteen-thirties. . . . The introduction of the pill was important, not in making birth control possible but in making it more comfortable.
> —Pat Thane, "What difference did the vote make? Women in public and private life in Britain since 1918," *Historical Research* 76 (May 2003): 280-81.

After averages of five to seven live births in the 1870s censuses, completed family sizes reached two or so children in most places of Euro-American settlement by the 1930s censuses. Put differently, Western birthrates had halved some thirty years before the Pill.[7] Moreover, birthrates declined uniformly by 40-50% between 1910 and 1930. The Soviet statistician, A.B. Genss reported, for instance, that the English birthrate fell by 41% between 1910 and 1927, from 28.4 to 16.7 births per thousand women of reproductive age, while the German decline from 34.7 to 18.3 was 47%.[8] Historians and demographers briskly debate the chronology and methods used in this decline. In the British context, for instance, Kate Fisher stresses withdrawal; Barbara Brookes favors abortion, while Simon Szreter and Hera Cook each pose abstinence as decisive. Others see this transnational revolution in sexual culture as some combination of all three methods.[9] Then, during the First World War, the improved condom emerged as a fourth method.

While one issue is what was used, another is what was effective, acceptable, or preferred. Americans, for instance, were said to favor post-coital douches of various concoctions, denounced by their British counterparts as ineffective and unromantic.[10] There can be no certainty as to the effectiveness of different single methods or combinations, since little serious testing was done before the 1920s, when the declining birthrate was well underway. Successful use of particular birth control methods leaves no traces. Nothing is less visible to outsiders than a problem-free abortion, an effectively used condom, a withdrawal in time without pre-ejaculate, or abstinence. The outcome of reduced childrearing

is clear, but the precise path to it in any particular instance is more difficult to disaggregate.

The striking drop in childbearing in 1870-1930, mainly by man-borne methods, as well as female-borne abortion, bespeaks the conviction that sexuality and reproduction were separable, and should be separated. Western averages of two or three children instead of five, six, or seven, signals considerable determination by one or both sexual partners and a changed vision of adulthood for men and women. It may also suggest altered concepts of sexuality and erotic life. Of course the average family size of two or three conceals extremes and varying points along a continuum, options strongly shaped by class, race, ethnicity, and region. Some had none, or only one or two, often the anxious middle-class couples relying on abstinence, writing in despair to Marie Stopes. Alternatively, petit bourgeois and skilled working-class mothers of three or four might have husbands using withdrawal, but sometimes condoms; and at other times, rely on periodic abstinence. If "caught," these wives might seek abortion, or not, vowing surer checks thereafter. Others of the laboring and poor might have 10, 11, even 17, their tragic conditions told in classic 1910s and interwar studies, often presenting chilling accounts of husbandly exercise of conjugal rights, despite wives' reluctance. Fabian socialist reformer Eleanor Rathbone lamented "the primitive ideas of marital rights which still prevail among the worst sort of husband": coitus on demand part of the price wives "are expected to pay for being kept by them." Investigators found wholesale dread of husbands' return from work among overburdened mothers, and "Then the nights!"[11] Rathbone indignantly attacked the absolute power of breadwinners over their earnings, and wives' lack of any legal right to any portion, which bred coercive and insidious conjugal patterns, with incessant childbearing and overwork: "There is perhaps no relation in life as it is lived in a modern industrial community where the temptations to selfishness are greater and the checks on it fewer than the relation between a wage-earning husband and a wholly dependent wife." [12]

Not that it was all coercion and resentment between sexual partners among the poor. Sometimes women loved and pitied their husbands when unemployed, only seasonally employed, invalided from war injuries, or humiliated by a vicious class system. Such wives described sex as one of the few comforts they could offer them, even when they had no desire themselves in "union." Yet, with seven, eight, nine, or ten and more children or miscarriages in as many years, little or no medical help, or worse, incompetent deliveries with lacerations, prolapses, and other injuries, many working class women pursued abortion upon missing a

period.[13] If the poorest saw their choices as abortion or larger families, overall birthrates declined when fewer reached 10, 12, or 15 before seeking abortion. This pattern of reduction made 1930s median birthrates the lowest ever recorded.

II. Discrediting Traditional Birth Control

Despite the fact that existing methods secured this epic scale volitional birthrate decline, interwar experts declared them an obstacle to a new prescriptive ideal – "the aestheticization of coitus." Here, experts functioned less as birth control advocates than as birth control restrictors. Their clients, market, and readership existed because birth control was already established practice, which they sought to regulate via "scientific" and pseudo-scientific criteria, principally to discredit men's methods.

Withdrawal, the most commonly used method, was unreliable. Sperm might be present in pre-ejaculate lubricant, causing conception even when withdrawal preceded ejaculation. Moreover, even with self discipline, a man might fail to "get away in time." Spoken in train travel metaphors, such as "getting off at Clapham Junction," not "all the way to Waterloo," physiological objections loomed. Withdrawal might cause "a lack of full detumescence," incomplete emptying of the vesicles, prostate and posterior urethral congestion, perhaps leading to irritation, exhaustion, impotence or prostatitis. And the disturbing vigilance required could generate "psychoneurotic manifestations."[14]

If this toll on men was deplorable, withdrawal also psychically wrecked wives. Worrying whether husbands would, as promised, "get off at Clapham Junction," was hardly conducive to sensual abandon and orgasm.[15] If, as experts reported, most men ejaculated within two to five minutes, withdrawal shortened duration of "union," decreasing odds of women's orgasms.[16] Hence, Drs. Gladys M. Cox and Abraham Stone lamented that women's "desire for sex relations" diminished into "an actual aversion and resentment toward the coital act," or frigidity.[17]

Probably few couples would deploy abstinence throughout marriage, but experts called even periodic abstinence an absurd family planning strategy. In 1935, Dr. Helena Wright, British gynecologist could not have been plainer:

> Marriage is an institution which is essentially based on a physical sexual relationship and any method of family limitation which necessitates denial of that relation condemns itself as a failure and a fantastic attempt to evade the facts of human nature.[18]

Experts called abstinence appalling, and criticised religious authorities for denouncing as sinful all other methods. In 1923, Anna Martin, socialist advocate of working women, rebuked moralistic depictions of poor mothers as failing at both self-control and husband control. Starvation of her children would be a wife's reward for abstinence: "If she refuses 'to please him,' the man refuses to go to work the next day, or he spends the evening in the public house, or utters the most dreaded of all threats, that he will go elsewhere."[19] In overcrowded housing, men lacked outlets for their energies, while no sanctions faced men "imperious" in the satisfaction of their "natural instincts." Against this dismal picture, American feminist birth controller Jane Barr urged that any man who really loved his wife would not "force on her sexual adventures that she does not desire," but instead would "consent to control." Even when women did not secure abstinence, if they approached coitus passively with "undisguised apathy," hoping against conception, husbandly infidelity would soon ensue. Thus abstinence defeated the objects of marriage, while even by showing desire for it, wives ran huge economic risks.[20]

Moreover, experts charged that abstinence was both physically and psychically injurious. German endocrinologist, Dr. Walter Riese warned that conjugal continence would lead adult men's drift into impotence, and that abstinent wives would develop hirsuitism, gradually becoming masculine from hormonal under-stimulation, and depression. He dubbed abstinence the triumph of the "death impulse." Despite recent claims that abstinence was the most significant factor in reduced childbearing, because it was the method preferred by women, the prevalence and increasing incidence of abortion, as gauged by several indicators, suggests its greater importance in the actual outcome of smaller families. [21]

The increasingly used condom was another danger. Experts charged it with being expensive, with blunting male sensation, being odorous, and too physical or material a presence, destroying the spontaneity and romantic flow of love-making, thereby, obstructing the couple's intimacy. Marriage advisor G. Courtenay Beale warned that husbands were "as a rule somewhat reluctant to adopt this method, its presence exiling that perfect closeness of contact." Lella Florence, veteran birth control clinician dissented somewhat from these critics, disputing the high cost claims in finding it the cheapest of reliable options.[22]

A significant objection came from Drs. Marie Stopes, Helena Wright, Abraham Stone, Gladys M. Cox and Sir William Arbuthnot Lane in the hypothesis that women absorbed beneficial nutrients from seminal fluids. Stopes suggested that men reciprocally benefited from women's alkaline vaginal secretions, giving coitus a physiological imperative: the sexes

quite literally needed each other. Hence she rejected both homosexuality and masturbation as failing the sexes' mutual physiological needs. This belief in women's capacity to absorb had ancient origins. Early modern European cultures saw this absorption as the benefit women derived from coitus, by giving them, at least temporarily, the much prized element of "heat." With this premium on absorption as the rationale for sex, some historians believe that this explains the lack of legal sanctions against lesbian erotic practices, the absence of semen rendering them incomprehensible or inconsequential, in contrast with men's same sex erotic practices.[23]

While Stopes's peer birth-control clinicians admitted the need for scientific proof, even the possibility she was correct led them to reject birth-control methods obstructing full vaginal/penile contact, such as the condom. Stopes herself may have first encountered these claims about absorption in Munich, where she undertook her doctorate. Members of that city's science and medicine establishment asserted the absorptive properties of the vagina. In 1910, E. Heinrich Kisch warned withdrawal could send women insane by depriving them of nutrient products.[24] Meanwhile, Wright noted that the sheath "automatically prevents there being any contact between the semen itself and the vaginal walls . . . The woman is obviously deprived of the reception of her husband's semen." But men felt this deprivation even more keenly. They feel justifiably "that an essential part of sexual intimacy is spoilt." [25] Hence, men resented the condom and refused its use. Lest mutual absorption seem a crazy idea presumably rejected by scientific professionals, in fact, 1930s birth control advocates made a top priority of testing this theory, which cast existing methods as unacceptable physiologically and psychically unsound.

Researchers held that four questions needed resolution for viable birth control advice. Did women vaginally absorb beneficial nutrients, which, if true, narrowed acceptable contraception to Stopes's cap? Could the uterus aspirate semen during orgasm, which if true, rendered douching completely pointless? Did the male pre-coital secretion contain sperm, which if true, drastically reduced effectiveness of both withdrawal and the condom? Finally, how long could sperm survive in the vagina, which, if as long as new research was beginning to suggest, would cause prematurely removed caps and diaphragms to fail? [26]

III. Promoting Female Appliances

With this curious combination of scientism and idealism, interwar experts imposed an applied romanticism on their patients, clients, and readers. In their novel mix of marriage guidance and sexual therapy, female responsibility now was their cardinal birth control directive. Sperm was no longer demonised as the problem to be eliminated, but instead had free flowing erotic liberty, its receptive environment, the female genital tract as now the zone to be altered. Wives were to insert cervical caps or diaphragms before retiring. Then, should coitus be desired, nothing need break the romantic atmosphere. Appliances stayed in place overnight or longer, removed and cleaned discreetly later. Fitted for each woman, their use was the modern, scientific, hygienic, and responsible course of the enlightened wife, the invisible guarantors of coital spontaneity.

Profound limitations, however, challenged the efficacy of caps and diaphragms. First, experts disagreed about which appliance was best. Here Marie Stopes, Britain's youngest ever woman science Ph.D. starkly challenged her birth control peers. She contended that women's strong and involuntary erotic responses included cervical orgasm. The donut shaped cervical ring would elongate and descend into the upper vaginal area to lock onto the glans of the penis, "milking it" and aspirating semen into the uterus.

Her "coital interlocking" hypothesis, led Stopes to reject appliance methods covering the upper vaginal area and so interfering with these ecstatic erotic movements. Specifically, she targeted the vaginal diaphragm, designed by Dutch gynecologist, Dr. Johannes Rutgers, extolled by Margaret Sanger, and promoted by London-based clinician, Dr. Norman Haire and United States authority, Dr. LeMon Clark. Only a man unmindful of women's erotic needs, declared Stopes, could have designed such a device. It prevented the coital interlocking of the cervical spasm; and by covering the upper vaginal wall, obstructed absorption of nutrients, a key function of coitus.

Instead, the vagina in Stopes's ideal coitus was wholly unencumbered, the post-coital couple remaining fully co-joined for as long as possible, even falling asleep in carefully prescribed positions, extending the duration of mutual contact. Thus, she insisted that the narrow purpose of contraception was preventing cervical semen aspiration. This was best accomplished with the high-domed cervical cap of her own design.

Her interwar peers argued worriedly about her theories. Far from simply dismissing them, many urged more research, especially in the wake of Stopes's best-selling books and the promotion of her theories in

international medical journals. Eugenicists joined professional brethren in advocating more and better birth control research. If Stopes's theories were correct, ineffective methods had to be jettisoned in favor of sure ways to curb the proliferation of the unfit. Unlike Stopes, many eugenicists favored abortion as needed, as well as voluntary sterilisation. But they also provided funds for contraceptive effectiveness testing and for the development of new methods, eventually contributing to the Pill. For instance, animal testing of the theory of uterine aspiration of semen proved inconclusive. So, in 1929, the Birth Control Investigation Committee moved from rabbits, rats and dogs, to humans, testing volunteer couples in London. They supplied experimenters with barium emulsion to be expressed into the vagina before coitus, followed by post-coital X-ray of the woman's pelvis and uterus "to detect the presence of any barium in the cervical canal or uterine cavity." Soon, Dr. C.P. Blacker, eugenicist and chair of the investigation committee, despaired of the human experiments as inconclusive, citing insufficient volunteers as a pressing problem. Yet, another committee member, Dr. Gladys M. Cox was still seeking participants in 1933.[27] Moreover, Cox found plausible the hypotheses of cervical and uterine agency, as well as theories of orgasm-generated "insuck of semen into the uterus."[28] She also believed in vaginal absorption, noting that substances such as quinine, sodium salunglate, potassium codeine, and perchloride of mercury "are absorbed by the vaginal mucus membrane." Hence, she concluded that if Stopes, Lane, Carpenter, and others, were correct, then "there may be a physiological hunger for the male fluid in the female organism analogous to the instinctive hunger for salt, lime, and vitamins."[29] So long was the currency of this theory that an interwar Harley Street specialist copied a Chicago pharmacist's 1898 formula for a "male secretion treatment for wives whose husbands used condoms."[30]

Experts' case for female appliances over traditional methods also deployed highly aesthetic and romantic rhetoric, the superiority of female methods allegedly permitting a more sensual erotic life. Margaret Sanger called sex expression the consummation of love, its completion and consecration, an art, a sacred gift awakening men and women to the innate beauty of life.[31] With this purpose and meaning for coitus, no contraceptive could be acceptable unless it allowed the spontaneity which is "of the essence of the function's wholesome performance."[32] No method was viable if it could destroy the "poetry and romance" of the conjugal embrace.[33] Nothing should be aesthetically objectionable (which for many experts clinched the case against the condom and withdrawal), interfere with the flow of emotion, nor require genital manipulations of either

partner in its use. Female appliances were the most likely facilitator of the new ideal: the aestheticisation of coitus.

Yet by the Second World War, experts despaired – their despair critical to the genealogy of anovulation twenty years later. Female appliances proved unacceptable to users. Fisher explains most working class women's reluctance: they disliked them as messy "foreign bodies," feared they were unhygienic and that they might be "lost inside." Their use had women facilitating coitus, contravening gender norms making this men's call. Poor women more comfortably discussed abortion than contraception, the latter the same as discussing sexuality, the former a solution after the event.[34]

The need for fitting and instruction, as well as ongoing surveillance by clinicians further reduced odds of appliances replacing other means of working-class birth control. Wives, whose husbands expected medical costs to be covered from weekly housekeeping, were stretched to the limit just to provide the basics, while not "one man in twenty feels it incumbent on him to increase his housekeeping allowance because of a new mouth."[35] Even when desperate women sought help at birth control clinics, untreated damage from closely-spaced births left half of them unable to use appliances. Furthermore, hygienic use of appliances required ready access to hot water, as well as private storage space for them when not in use. Overcrowding without indoor water or privacy made this impossible. And with the ubiquitous female diet of tea, bread and dripping, with one outdoor toilet shared by many families, experts noted that the widespread prevalence of adult female constipation conflicted with diaphragm use.[36]

The reduction in childbearing, long preceding Stopes and Sanger, signaled that Western populations already were separating sexuality from reproduction. Despite their reputations as birth controllers, their actual effects were questionable. A faulty theory of ovulation, posing mid-month as a sterile "safe" period, prevailed until the 1930s.[37] With Stopes's prescriptions for mutual absorption, co-joined post-coital sleep, and only minimal contraception via the cervical cap, her followers had high odds of pregnancy. Stopes and Sanger's more telling significance was as theorists of a newly romanticised heterosexuality, anchored by aesthetic spontaneous coitus, in which birth control was invisible. Their privileging of this specific form of coitus facilitated anovulation as the birth control solution. Yet, this urge to separate visible birth control from erotic encounters emerged long before anovulent contraception was available to secure this separation. The hiatus here spotlights abortion in the actual outcome of reduced birthrates in the pre-Pill decades.

IV. The "Desolation" of Abortion, 1920-1960

> [I]t appears that the performance of illegal operations is widespread and the ill-effects upon the health of women produced by clandestine induction of abortion, whether performed by abortionists or self-induced, are grave. . . . The sale of abortifacients and the introduction of patients to abortionists have become part of an organized and lucrative traffic all over the country. —Joint Council of Midwifery, *Interim Report of the Committee of Enquiry into Non-Therapeutic Abortion*, April 1937, 11.

Interwar contraception advocacy thoroughly demonised abortion. If its advocates charged that abortion was the disease, contraception was the cure.[38] Abundant indicators signal the salience of abortion, its scale, its relative safety, its familiarity in sexual life, and its differential access by class, race, ethnicity, and region. Internationally, abortion's accelerating medicalisation made it a professional dirty secret, reanimating the "search for the perfect contraceptive" into a postwar cultural emergency. Abortion then, is crucial in genealogies of anovulation in women's reproductive lives.

Many circumstances concealed the scale of abortion in the pre-Pill decades. These included under-reportage, under-prosecution, and low conviction rates. Hence scholars wrongfully accord abortion a negligible place in reduced birthrates. Certainly officials at the time often liked to say so, British sources being particularly notable in this respect. Indeed, demographic and social historians often minimise the significance of abortion, also assuming most attempts were self-induced and typically failed, while instrumental or surgical methods performed by others almost certainly led to critical illness or death. Even when some historians admit that outcomes were not so dire, they infer that the sensational publicity inspired by, for example, the finding of women's corpses dumped to conceal post-abortion fatalities would have deterred the vast majority of women from having unwanted pregnancies terminated. More lethargically, some commentators hold that since illegality ensures no accurate count of abortions past, the practice cannot be factored into historical analysis of birth control and sexuality. Historian Angus McLaren attributes this minimising of abortion as resistance to the implication that women could determine birthrates.[39] Further, investigation of the true scale of abortion risked scrutiny of doctors – and medical authorities fought any encroachments upon the profession's prerogatives. Yet, evidence on abortion rates can be read more instructively. Given that traditional methods, including abortion, had reduced Western birthrates by nearly

50% by the 1930s, despite expert rejection– tacit recognition of increasing abortion may have been a turning point in the genesis of the Pill.[40]

Illegality always obstructs certainty in historical abortion estimates. Yet, contemporaries hypothesised, often extrapolating from hospital deaths or complications, or projected from sample populations' experience.[41] At a 1916 English birthrate enquiry, C.V. Drysdale, of the Malthusian League, having "no figures as to the frequency of abortion in this country," cited overseas estimates, venturing "that probably from one to three million abortions are practiced annually in the United States."[42] If one English cultural knee-jerk was exceptionalist, insisting that U.S. trends were irrelevant to unique local conditions, other testimony highlighted ease in the concealment and official denial of the English abortion trade. Some 1916 enquiry witnesses claimed that, unlike in America, only drug methods were used in England, usually unsuccessfully.[43] Others called abortion frequent, but its incidence was mainly confined to "the industrial population."[44] Against such parochialism, other testimony noted instrumental abortion practitioners traveling nationwide to meet demand.[45] If not public, abortion information was "carried on among the women themselves."[46]

Stopes called abortion "desolation," an indictment of social conditions, sentiments that Sanger echoed exactly.[47] Abortion requests to birth control clinics outnumbered those for preventative advice on a 6 to 1 ratio.[48] In the three months after she published a 1929 article in *John Bull*, Stopes reported 20,000 abortion requests. During a 1928 public debate between Stopes and Charles Pillay, a Catholic barrister opposed to birth control, Pillay accused her of exaggerating abortion rates to justify "the cold-blooded introduction of a chemical or mechanical contrivance into a sphere where spontaneity and joyous abandon should reign." Pillay insisted that abortion was a rare offence, the audience laughing with cries of "No, no, you don't know."[49]

Pillay was correct enough that few cases came before the English courts.[50] Yet he ignored implications of the few criminal cases exposed. Rev. Francis Bacon, a London vicar, was sentenced to eighteen months' prison for a mail order abortifacient business he ran for a decade, with thousands of client files in evidence against him.[51] Like most abortion arrests, Bacon's was only due to an abortion going wrong *and* coming to the attention of authorities. Usually, the accused had practiced for years, with a large clientele and without detection. The 2005 Mike Leigh film, *Vera Drake*, was set in 1950 and dramatised exactly this situation. The event causing arrests often involved unusual factors, for instance, if a practitioner undertook risky later term pregnancies for a higher fee. Odds