**‘You can’t dismiss that as being less happy, you see it is different’. Sexual counselling in 1950s England**

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In a 1950s sexual counselling session carried out with a married woman who could not achieve orgasm, Dr Joan Malleson exclaimed: ‘That is a shame when you are so happy!’. This conception of the lack of sexual pleasure within a happy marriage as problematic took root in the interwar years and became increasingly prominent in marriage counselling and sexual therapy in postwar Britain.[[1]](#footnote-1) Dr Joan Malleson, a birth control activist and committed family planning doctor, was one of the first doctors to try to help couples overcome their sexual problems. This was a novel experiment. While there existed a profusion of self-help sexual manuals from the interwar years, sexual counselling, as such, only became formally institutionalised in the 1950s and 1960s.[[2]](#footnote-2) This article uses audio recordings of sexual counselling sessions that Malleson carried out in the early 1950s, which are held at the Wellcome Library in London, as a case study to explore the ways Malleson and the patients mobilised emotions for respectively managing sexual problems and expressing what they understood as constituting a ‘good sexuality’ in postwar Britain. These audio recordings contain 13 cases of sexual disorders; one was the case of a menopausal woman and is not considered, since the session dealt mainly with symptoms of the menopause and no clear connections were made with sexual life. There were eight cases of vaginismus, two cases of frigidity and three cases of inhibition of orgasm. These tapes lasted between six minutes and one hour and provide fascinating insights into the doctor-patient relationship and the sexual and emotional difficulties experienced by ordinary Britons. Cries, sights, silences and more rarely laughter, as well as the verbal articulation of anxieties, fears and disappointments, testify to the wide range of emotions that patients and sometimes Malleson displayed during sexual therapy. Emotions and feelings are something that people experience, and they manifest through verbal or bodily expressions. Emotions ‘have both biological and cultural components’.[[3]](#footnote-3) While this article uses the articulation of emotions to access a broader understanding of intimacy, it does not attempt to offer a history of anxieties, fears or disappointments as such, or of the way these notions have shifted over time. Rather, it considers these emotions within the framework of sexual therapy, where the only means for patients to share their sexual problems was to put into words what they felt and found problematic in their sexual and marital life. Therefore, sexual counselling sessions allowed the patients’ articulation of their sexual self and emotional subjectivities to be placed in relation to their sexual difficulties. The history of Joan Malleson’s sexual therapy in London and the way by which Dr Malleson and patients played out emotions, I argue, might offer a fascinating glimpse into an emotionology of sexual difficulties. This term, invented by Peter Stearns, refers to the emotional codes and standards that shape subjective life.[[4]](#footnote-4)

This research builds on the work of historians who have analysed the history of sexuality and marital intimacy in Britain. They have underlined the advent of the companionate marriage model that became ideologically dominant in the mid-twentieth century.[[5]](#footnote-5) Central to this model was the idea of a harmonious and enjoyable sexual life. In particular, the landmark work of Clare Langhamer has shown that ‘sex and love became tightly bound together within the widely promoted notions of modern marriage’.[[6]](#footnote-6) In addition, she sheds light on the way that experts’ advice in popular magazines contributed to putting love at the centre of relationships in postwar Britain. The idea that love and affection became central to intimacy in the interwar years is also shared by Szreter and Fisher in their oral history study of sexuality.[[7]](#footnote-7) Therefore, studies using emotions as a ‘category of analysis’ reveal that love and sex became closely intertwined.[[8]](#footnote-8) However, the sexual difficulties that ordinary Britons encountered remain unfortunately overlooked, with few exceptions.[[9]](#footnote-9)

By focusing on sexual counselling, this article offers a means of evaluating the way that ordinary individuals responded to the cultural diffusion of new norms produced by experts. This article first provides a brief introduction into Joan Malleson’s life and recordings. It then moves on to analyse the role of emotions in sexual therapy. The article contains two interrelated arguments. First, it argues that Malleson used a psychological framework to inform her clinical work. She resorted to an emotion-based therapy that linked sexual difficulties with unconscious, repressed feelings rooted in past events. In so doing, Malleson actively helped to produce a new form of sexual subjectivity where individuals were encouraged to express their feelings and emotions, breaking with the traditional culture of emotional control and restraint that characterized British society up until the fifties.[[10]](#footnote-10) However, her contribution to sexual therapy was not constrained within the framework of psychology alone, as she suggested practical exercises to her patients for easing sexual intercourse.

Second, I argue that not only Malleson but also her patients relied on emotions. The performance of mainly negative emotions reveals what they perceived as the ‘normal’ and sexual ‘ideal’. I show how the expert-produced marital sexual ideal created new expectations on the part of the patients and the emotional impact this ideal had on them when they struggled to comply with it. Patients used a language of emotions that was inflected through a psychological model that tied how they felt together with their physical, mental and sexual health. Sexual therapy sessions reflected the seemingly changing nature of the self towards a more emotionally aware and open one that adopted both the language of emotions and that of popular psychology to articulate his or her sexual difficulties. In her sexual therapy sessions, Malleson explicitly encouraged this emotional language. As such, this article gives support to the notion that Britons increasingly ‘viewed both themselves and their world in psychological terms’ from the interwar years onwards, and that the 1950s should be understood as a period of transition and continuity between two emotional regimes – that of emotional restraint and that of the relaxation of emotional control.[[11]](#footnote-11)

**Dr Joan Malleson and sexual counselling**

Joan Malleson was a birth control advocate and one of the first female doctors to provide contraceptive and sexual health advice to her patients. Born in 1899 in Leicestershire, Joan Graeme Malleson first undertook medical training at University College London, but soon moved to the Charing Cross Hospital due to the hostility against female students she faced at the first institution. She graduated as M.B., B.S. in 1926, at which point she was already the mother of two sons with the actor, Miles Malleson, whom she had married in 1923. When they were first married, the couple made a contract that their marriage would be open.[[12]](#footnote-12) Among her friends were many progressive intellectuals such as the philosopher, Bertrand Russell, and the author, feminist and socialist campaigner, Dora Russell. Malleson was also a close friend of the sexual reformer, Havelock Ellis, who seems to have exercised a great influence on her career.[[13]](#footnote-13) She struggled with her open marriage, and eventually asked for a divorce. She was later a clinical assistant at the West End Hospital for Nervous Diseases before becoming the medical officer in charge of the Birth Control Clinic in Ealing Borough Council. In 1934, she helped set up the Islington branch of the National Birth Control Association, which later became the Family Planning Association.[[14]](#footnote-14) She advised married women on contraception and trained her fellow colleagues on the subject. She also published a medical birth control manual. In 1938, Malleson became head of the clinic for marital difficulties at the North Kensington Women’s Welfare Centre. She started providing sexual counselling to patients experiencing sexual disorders. This new orientation of her work was a response to her patients’ needs. Indeed, while she provided contraceptive advice, she realised that the sexual difficulties her patients faced were not limited to birth control but also extended to sexual marital relations. In 1950, Malleson was appointed to the contraceptive clinic at the University College Hospital, where she later established a dyspaneuria clinic. She died in 1956.[[15]](#footnote-15)

In her clinic at the University College Hospital, at the North Kensington Marriage Welfare Centre and in her private practice she counselled patients, women and couples on their sexual difficulties. She recorded 14 sessions without her patients’ knowledge.[[16]](#footnote-16) Some sessions were edited, and Malleson summed up the main difficulties of the case at the beginning of each tape.It is not clear at which location the sessions were recorded.[[17]](#footnote-17) As historical sources, these tapes provide a rare opportunity to access the patients’ experiences and voices. As such, they constitute incredible material for analysing the relationship and dynamic between the doctor and the patients. Nevertheless, these sources pose some ethical concerns. First, the fact that they were recorded without the patients’ knowledge is ethically problematic. One might wonder why Malleson did not tell her patients that she was recording them. Was she afraid that they might refuse to be recorded? It is worth mentioning that contemporary ethical guidelines did not prohibit the recordings of patients’ sessions. Another explanation is that she did not want them to feel uncomfortable in a situation that was already unusual and emotionally intense. By keeping the act of recording secret, Malleson might have wanted to secure the spontaneity of the patient’s words, avoiding any disturbances caused by them knowing that their words would be recorded on tape.[[18]](#footnote-18) A second element that is ethically problematic is the fact that these sessions contain highly intimate information and painful experiences that the patients might have not wanted to share with a broader audience. Despite these elements, I have decided to use these recordings and quote some extensive sections while being careful not to provide personal information, in order to maintain anonymity. While I do support the patients’ right to privacy and confidentiality, I nevertheless think that these sources, if handled with care and respect, are essential for a better understanding of the complexities of ordinary sexual difficulties.My decision is based on the fact that this material is very rare and provides a fantastic opportunity to access patients’ experiences and the running of a sexual therapy session, elements that are usually missing from the historical narrative of sex and intimacy. To avoid any ethical issues, the recordings have been anonymised and any personal information that might lead to the identification of individuals has been removed.

Another element that needs to be underlined is the fact that while patients’ words were central in sexual counselling sessions, the doctor was nevertheless in charge of the session, which might have influenced the way patients expressed their feelings and difficulties since they could have wanted to appear in a favourable light. Finally, these tapes constitute a micro-history and as such are not representative of the whole experience of ordinary people, first and foremost because individuals who sought help were not ordinary. Indeed, the taboo surrounding sexuality was still very powerful in the 1950s and being brave enough to seek help was therefore quite exceptional.[[19]](#footnote-19) Second, the records only contain 14 sessions and therefore any general extrapolation might be misleading. These records nevertheless constitute precious sources that help us better understand the way that emotions were performed and the extent to which ideals about what constituted a ‘good sexuality’, as spread by sex-help manuals and interwar sex reformers, created anxieties.

All the patients were married individuals apart from one patient, a young unmarried woman. The patients’ age ranged from 22 to 38, though age was not mentioned in every case. The majority of the patients obviously came from a social class that would allow them to pay for consultations. In addition, they had the social capital to feel it was legitimate to seek help. The main reasons for consulting Malleson fall into three categories: difficulty or inability to have sexual intercourse through penis-vagina penetration due to vaginismus, inhibition of orgasm and frigidity. All the patients were women, but three husbands came along and spoke with Malleson. It is difficult to make any generalization from this sample, but one can hypothesize that the fact that it was mostly women who came for consultations showed either that women were experiencing more difficulties than men or that women were more likely to recognize their difficulties and hence seek help or that men were uncomfortable discussing their sexual difficulties with a female doctor. It is possible that women outnumbered men because reproduction and sexuality were increasingly being medicalized and women were the main target of this medicalization. Another explanation could be that women, due to better access to education and increasing financial autonomy, were gaining confidence and felt it was legitimate to express their dissatisfaction and to claim equal rights in sexual pleasure. All these factors might have contributed to positioning women as the main ‘clients’ or ‘patients’ of this early form of sexual therapy.

**Therapeutics and emotions**

Malleson’s sexual therapy was original, as she developed her own style that was a mix between what she found useful, based on her clinical experience, and more formal sexual therapy informed by sexual, marriage and birth control manuals and academic scholarship.[[20]](#footnote-20) As a result, she used a psychosexual framework, which linked sexual disorders in adulthood to the sexual development of the child, alongside practical physiological exercises designed to reduce sexual difficulties.

Malleson was not alone in this endeavour; she was part of a burgeoning movement that sought to help couples achieve satisfaction – both emotionally and sexually – in their marital life. By the beginning of the Second World War, family planning centres, as well as marriage guidance centres, tailored their services towards the ‘sexual health’ of the married woman by broadening the scope of their work to counselling on marriage difficulties, sexual problems and infertility in an attempt to preserve the stability of the family.[[21]](#footnote-21) Joan Malleson and the birth control activist, doctor and successful sexual advice author Dr Helena Wright played a pivotal role in the new orientation of the FPA work.[[22]](#footnote-22) Wright also counselled patients on their sexual problems in her private practice, and I have written about the distinctive approaches employed by Wright and Malleson elsewhere. This new direction for FPA and Marriage Guidance Council work occurred at a time when the rising incidence of divorce was creating anxieties and marriage reformers were trying to campaign for harmonious sexual relationships as a way of saving marriages.[[23]](#footnote-23)

After the Second World War marriage was thought to be ‘an ideal community in miniature’, and the state started financing bodies that were directly aimed at preserving the stability of the marriage institution.[[24]](#footnote-24) In 1948, the Family Welfare Association created the Family Discussion Bureau (FDB), an organization specializing in marriage problems. Its caseworkers underwent psychotherapy training at the Tavistock Clinic.[[25]](#footnote-25) Their work focused mainly on marriage difficulties and spousal relationships. The Catholic version of the Marriage Guidance Council, the Catholic Marriage Advisory Council was created in 1946 and offered private counselling sessions for couples.[[26]](#footnote-26) Hence, while sexuality became recognised as an important and essential part of the marital relationship, the means to address difficulties arising from this new ideal were in embryonic form. The work of Joan Malleson was therefore part of a broader attempt at maintaining the marital relationship and offers an interesting case study for better understanding how this therapy worked in practice.

Malleson was not formally trained in psychology, but she had an intense interest in it founded in academic scholarship, which informed her own practice.[[27]](#footnote-27) The incorporation of psychology into marriage guidance counselling, as funded by the welfare state in postwar Britain, has been an object of recent interest.[[28]](#footnote-28) Teri Chettiar has shed light on the fact that sexual satisfaction was perceived as the main reason for family stability by interwar therapists and marriage counsellors, but after the Second World War, while sexual satisfaction was still important, it was more directly connected to mutual emotional wellbeing within marriage. This section supports this argument, since Malleson considered emotional and sexual satisfaction as core to a happy marriage. She adopted a psychological framework that valued the expression of emotions, since she would encourage patients to express their feelings by asking specific questions that would stimulate the dialogue.

As she explained in the foreword of her 1948 sex manual *Any Wife and Any Husband*, she developed her therapy out of her own experience by listening and learning from her patients. This manual offered a reading list that informs us of Malleson’s academic influence: she recommended marriage manuals and psychosexual academic work such as Helena Wright’s *Sex Factor in Marriage*, Dr Philip Bloom’s *Modern Contraception*, psychoanalyst Edward Glover’s *The Psychopathology of Prostitution*, sex reformer Kenneth Walker’s *Sexual Disorders in the Male* and Dr Kinsey’s *Sexual Behaviour in the Human Male.* Inspired by these authors*,* Malleson was convinced that emotions were not only key symptoms but also causes for sexual disorders; as she put it: ‘I shall expect to show that most sexual disorders have a “nervous” – that is, emotional – origin’.[[29]](#footnote-29) Hence, emotions were from the beginning connected to her therapeutic practices. She made clear that her work was inspired by a sexual psychological framework. She explained that many sexual difficulties in ordinary people resulted from their ignorance on the matter: ‘[O]nly during this century has sexual psychology been seriously studied,’ she explained. However, the knowledge produced on this subject came from psychiatrists, whose work tended to be considered with suspicion by people, since ‘none of us cares to be dubbed [a] “neurotic” person’. But she added that of all human functions, ‘sex is the most prone to neurotic disturbance, and the origins of all grave sexual troubles must be sought in the unconscious level of mind’. She was certain that the study of the sexual neuroses ‘would bring immense benefit’ but she was aware that such type of knowledge ‘penetrated slowly’. She adopted the ‘modern psychiatric teaching’ that stated that ‘the emotional behaviour of an adult was largely determined by the patterns of feelings laid down in infancy and childhood’. Malleson’s psychological understanding of sexual difficulties was also made clear in the article she published in the *Family Planning Journal* shortly before her death. She reminded the readers that people differed in their emotional behaviours because of varying childhood experiences, or what she called ‘conditioning’.[[30]](#footnote-30) This psychosexual framework clearly influenced her work; she used an emotion-based therapy that relied on unconscious feelings to try to cure sexual disorders.

During the session, she would try to gain as much information about the patient’s life as she could, regularly pushing the patients to reflect on any destabilizing events that might have occurred during childhood. In particular, she was keen to know whether patients experienced sexual feelings when they were children, adhering to the idea of children’s psychosexual development. To a female patient who could not achieve vaginal orgasm, she would say: ‘did you have any vaginal feeling as a child?’.[[31]](#footnote-31) In several cases, she tried to find out whether the patient experienced sexual pleasure when growing up: ‘Now, er, what was your experience of sexual feeling before your marriage, as a child? Could you get a climax from playing? Rubbing? Most children can, you know. Or can't you remember it?’.[[32]](#footnote-32)

To another female patient she asked:

* Can you give yourself a little pleasure if you rub, could you as a child?
* Mmm?
* Get some response? Did you not find out how to do that as a child?
* Mmm.
* Oh most children do. That was very backward, wasn't it?
* Mm. Well we were never told anything.
* Well you don't have to be told that you find out for yourself’. [[33]](#footnote-33)

This excerpt shows that Malleson could sometimes being judgmental with her patients when she wanted them to understand an idea, testifying to the power-relationship that remained in sexual therapy session. In addition, the patient reaffirmed her sexual ignorance, maybe as an attempt to actively demonstrate her respectability, as shown by Fisher and Szreter and Fisher in their oral history study.[[34]](#footnote-34)

For vaginismus and inhibition of orgasm, she thought that identifying the fears and causes of anxiety would act as a revelatory moment where the patient would understand her problems, which would eventually cure her. In summing up a case of inhibition of orgasm, she referred to her patient’s difficulties with holding her urine when she was a child, connecting early experience with current difficulties: ‘Going of course on the record, it has become evident that one of her reason for her inhibition was perhaps that her urinary feelings as a child was probably rather mixed up with her sexual sensation. That's not a very uncommon finding in work of this sort. A woman doesn't very often offer you the information that you ask for and you find that they are...’.[[35]](#footnote-35)

Malleson would also clearly ask about specific emotions such as disappointment, with the hope of triggering a longer description of this feeling and thus easing the diagnosis. Indeed, she believed that bodily feelings were closely connected to emotions. In so doing, she herself encouraged the departure from the culture of rigid emotional control and restraint that characterised British society up until after the Second World War.[[36]](#footnote-36) She would also question the patient about the partner’s feelings. To a young spouse who had vaginismus, she said: ‘Is your husband bearing up or is he suffering?’, suggesting that sexual problems affected the relationship.[[37]](#footnote-37) Apart from asking specific questions to try and make sense of the patient’s difficulties, Malleson would also present the patient with her own interpretation of her or his emotions, relying again on the psychosexual framework of the impact of children’s familial environment and relationship on their adult sexuality. For instance, she would associate the difficulties with maintaining an erection experienced by a patient’s husband to the relationship he developed with his mother: ‘You say he has a weepy mother. Well he probably has had a difficult mother even when he was three and four so at an age when he was sensitive and learning his relationships to women. Do you see? And he may feel guilty, subconsciously, about sexual things and he'll need you to release him of that subconscious guilt. Which means be cheerful, take the lead’.

With a young female patient who had vaginismus, she would clearly refer to fear as the main reason behind this difficulty. In her view, fears found their roots in childhood memory, or what she called ‘feeling memory’: ‘I had the impression that this wasn’t only just the fear of being touched, but, to be fair, it was more likely to be a fear of some sort of memory from childhood that had frightened you, your body might have a “feeling memory”, you might not have a memory in words but your body might have a feeling memory. The sexual activity provides early fears, very early fears also, and it was my impression that this feeling triggered early childhood fears’.[[38]](#footnote-38) After having asked her questions about her infancy and whether she had slept in the same bed as her parents, convinced that the patient had seen something she feared, she suggested to her that she should ‘think along these lines’

She mostly adopted a positive, encouraging and mostly empathetic attitude, trying to reassure her patients, explaining to them that their emotions were not exceptional but widespread. To the newly married woman who had vaginismus, she asked: ‘Have you been frightened of him coming in or are you aware of being frightened? A lot of girls are’.[[39]](#footnote-39) She also pushed the patients to see the glass as half-full instead of half-empty. She took great concern to explain, carefully and repeatedly, how important the clitoris was for female sexual pleasure, and sought to break the Freudian vision, spread by many sexual manuals, that vaginal orgasm was the target and the only form of sexual pleasure that women should pursue.[[40]](#footnote-40) The following excerpt is representative of the way she approached the issue, reassuring the patient that her experience was common and encouraging her to value the clitoral orgasm:

* When you do start, where is the part that you have the most feeling? Is it inside the passage or outside the passage?
* Well outside, I think
* Well that's very common in women who have difficulties, you know
* Mm

And you want to make the very best of what you've got, you see

* Hm um
* How is...if he stokes you gently and carefully for a while, can you not wake that part up?
* Erm. Well yes, I think so
* And have you ever had a climax from that…
* Yes.
* Ooh! But that isn't so bad! Don't you call that pleasure?
* Oh yes, I do, but erm...well...hmm...it’s not really the same thing, it’s not...
* (…) You can't dismiss that as being less happy. It's still different.[[41]](#footnote-41)

This long excerpt reveals many key issues at play during sexual counselling: the fact that Malleson tried to identify the source of sexual pleasure for the woman and helped her to make the most of it; the fact that she underlined the clitoris as a locus for sexual pleasure and happiness; and finally the fact that the patient, while having greater feeling in her clitoris, nevertheless thought she should have it within the vagina and wanted to achieve orgasm through penetrative sex.

Once Malleson had identified the emotions and sexual difficulties and the reasons behind them, she provided pragmatic advice on the best way to handle these sexual difficulties and gave the men examples of behaviours they should adopt. For instance, with a young married couple where the wife had inhibition of orgasm that Malleson attributed to the lack of preliminary touching on the husband’s part, she advised the husband about prolonged courtship and ways to arouse his wife sexually through compliments and caresses to the erogenous zones of the woman’s body. She also taught the women with vaginismus the body posture they should adopt during intercourse. Finally, she undertook a thorough physical examination to ascertain whether the patient might have additional physical difficulties that might explain her or his sexual troubles. If she found any, she would carefully provide information on their nature and what the patient should do to remedy the problem.

Even though she had no training in psychology, Malleson used psychological tools and resorted to an emotion-based therapy where negative feelings deeply rooted in childhood experiences were thought to be responsible for sexual difficulties to help and at times cure her patients. She believed that by shedding light on these emotions, the patient would overcome their barriers and be able to achieve a satisfying sex life.

**Patients’ emotional description of sexual difficulties**

The individuals who consulted Joan Malleson were mostly sent by their own doctors or psychologists, since they showed some signs of anxiety or distress from their sexual life. They were seeking help to face and overcome their sexual difficulties, testifying to their desire and hope to improve their situation. They told Malleson what their sexual life was and what they wanted it to be, and the frustrations and difficulties they faced. The factors that brought them to Malleson’s medical consultations reflected the new stabilization of the norm of a mutually enjoyable marital sexuality. Since the interwar years, a new emphasis was put on harmonious sexuality as central to the marital relationship in order to safeguard the marriage institution.[[42]](#footnote-42) This new norm of the mutuality of sexual pleasure within marriage was spread through advice manuals written by sex reformers, sexologists and doctors, and dedicated to married couples who were flourishing in the interwar years. Famous books among them included Marie Stopes’ *Married Love* and *Wise Parenthood*, Helena Wright’s *Sex Factor in Marriage* and Edward Griffith’s *Modern Marriage and Birth Control*, to name but a few. As several studies have shown, this literature, informed by a Freudian vision of sexuality, prescribed differentiated gendered roles in the sexual act. The husband was depicted as an active agent, who not only awoke his wife to the joy of the sexual act but had to make sure that he pleased her, while the wife, passive, should enjoy a vaginal orgasm. Hera Cook has shown that the content of sexual manuals did not change much from the 1930s to the 1960s; several manuals were simply reedited and the emphasis on mutual sexual pleasure through penetrative sex remained the same, while differentiated gendered roles within the sexual and marital relationship were actually becoming more ‘traditional’.[[43]](#footnote-43)

Patients displayed and referred to emotions in order to describe the symptoms and the reasons why they were consulting Malleson, revealing, therefore, what an ideal sexuality constituted for them. Patients mainly used anxiety as an entry into their sexual difficulties. The word anxiety, as explained by historian Joanna Bourke, had become increasingly popular over the twentieth century and replaced the older notion of fear. Indeed, fear referred to a state of objective and immediate threat, while anxiety was a ‘more generalised state’ where the threat was anticipated, yet subjective and mostly unidentified.[[44]](#footnote-44) In Bourke’s view, the popularity of the word ‘anxiety’ was closely connected to the advent and success of psychoanalysis. This term was widely used by Malleson and her patients.

In four cases, patients were sent by their psychiatrists because of their state of anxiety, which translated into depressive state, fear of intercourse and feelings of hopelessness. Among them was a young woman who went to Malleson for help with her condition. She had vaginismus, which Malleson scientifically described as ‘vaginal spasm varying from a constriction at the beginning of coitus (so slight that it may merely discomfort the woman herself) up to the extreme case in which the spasm causes acute pain to the woman and entirely prohibits any penetration by the husband’.[[45]](#footnote-45) which prevented the newly married couple from having sexual intercourse. The patient came for two consultations. The recordings contained the patient’s second meeting with Malleson after she had been lent a dilator to try to stretch the passage to allow penetration. She explained that she had made slight progress, since she ‘feels more relaxed, she feels much better and feels less pain’, however, as she explained, ‘I still feel in my mind that I need to relax, it is not physical, it is in my mind and cannot find a way to do that’. [[46]](#footnote-46)

Another patient had even greater psychological and emotional troubles, made clear by the fact that the recording was her fourth session with Malleson. She was sent by her surgeon for severe vaginismus. According to Malleson’s description: ‘[she] dislikes sexuality, fears men and childbearing. With the utmost courage she had managed to consummate but she still has acute anxiety’.[[47]](#footnote-47) Replying to a question about her feelings, the patient said, ‘It isn’t really any better on my side’. She explained that she had got used to having sexual intercourse, as it was not ‘as unpleasant at it had been’, but she got no pleasure from it and argued that ‘it is the case, I am afraid, that I just need to put up with it (sight)’. Fear was ruining her sexual life and she was desperately trying to hide it from her husband. Malleson explained that the patient’s mental health had not improved, nor her sexuality; finally, the patient lost her appetite and ability to sleep and Malleson referred her to a psychiatrist.

Besides putting into words what they felt, several female patients cried during the consultation, which exemplifies the extent to which sexual difficulties affected them. The account and summary given by Malleson at the beginning of one session illustrates this element: ‘The wife suffers from vaginismus as well as an acute anxiety neurosis, in the part of the interview she has been crying and crying’.[[48]](#footnote-48) Another patient, a 28-year-old married woman, burst into tears during the session. She was referred to Malleson by the Elizabeth Garret Anderson Hospital because she was having difficulties with her sexual life and suffered from anxiety neurosis. She was a complex case since she did not explain that she was still a virgin and answered the questions asked by Malleson as if the marriage had been consummated. On the recorded tape, Malleson annotated, ‘It appeared to be a history of vaginal anaesthesia until I examined her and was surprised to find an intact hymen. She was very much inclined to deny her difficulties’.[[49]](#footnote-49) This misleading talk might plausibly reflect the patient’s ignorance about the sexual act or to the fact that she was ashamed. She seems to have been incapable of recognizing whether her husband had penetrated. She described her gut problems many times during the consultation, emphasizing her anxiety. She also cried while answering questions about the extent to which her husband was aware of her troubles:

- Does your husband know about it?

- He does know sometimes, I can hide it better than others.

- Yes, and sometimes you are upset and want to cry, and he knows of course, is he

worried about it or does he just think it will come right soon?

- I think he thinks it will come right soon.

- I expect it will.

- How far have you got?

- Sorry (she cries)

This case was difficult to handle and Malleson lent her a dilator without success. During the second meeting, the patient claimed that she felt better, even though there was still no penetration. The session ended abruptly with Malleson’s explanation that this case ‘was total confusion’, and there is no more information on this patient.

Crying also occurred during attempts at having intercourse, according to several female patients, a situation which upset the partner. Crying reflected, as a female patient put it, ‘a sense of hopelessness (sight)’ that pervaded her sexual life, driving her to wonder ‘if it is all worth it’.[[50]](#footnote-50) Such a feeling of hopelessness is testimony to the extent to which sexual difficulties loomed large in the wellbeing and stability of her relationship.

The difficulties and hence the emotional strain felt by the patients resulted from their inability to conform to what they perceived or thought was the right sexual response and behaviours. First, patients wanted penetrative sex. Several female patients complained about the fact they were not able to have sexual intercourse through penetration and this situation upset them. For instance, a 22-year-old newly married woman went to see Malleson because she couldn’t ‘get any satisfaction at all’.[[51]](#footnote-51) She faced difficulties with penetration due to vaginismus. According to the discussion she had with Malleson, she became aroused and had sexual desires. However, the first attempt at having intercourse failed: ‘It didn’t work and I got so upset, so upset. I’d say the last couple of months we were just getting a rest’. Her distress regarding her inability to allow penetration shows that she expected sexual intercourse to be penetrative and easy. Importantly, her emotional worry reached such a point that she preferred to abstain for a period of time rather than making another attempt to have intercourse. Her emotional distress was obviously impacting on her relationship.

Second, patients wanted the female partner to reach sexual satisfaction. A newly married mid-thirties woman visited Malleson, on her doctor recommendation, because she had feelings of depression and had no sexual satisfaction. She contended that her husband was not particularly competent but that he was ‘trying very hard’. She didn’t want to tell him about her lack of enjoyment as she feared hurting his feelings: ‘He is very sensitive and I fear…and he has said once or twice to me: ‘Are you sure I am satisfying you, are you sure?’. And of course I said: ‘you are’. And he is very sensitive. I thought it might hurt him if he thought it wasn’t for him’. Interestingly, this conversation showed that her husband was anxious to satisfy her but that for her, preserving his emotions was a motive significant enough for hiding her sexual frustrations. This example illustrates that navigating between different emotions induced by gendered expectations, lack of sexual satisfaction and willingness to preserve the partner’s feelings and self-confidence, i.e. what could be today referred to as emotional labour, increased the level of difficulty and anxiety felt by the female patient. [[52]](#footnote-52)

However, the type of sexual satisfaction patients wanted to attain was very specific; they aimed to reach mutual orgasm, including a vaginal orgasm for the woman. For instance, a young bride consulted Malleson for advice on her sexual life since she didn’t ‘really feel anything’ and was ‘glad when it’s over’.[[53]](#footnote-53) She attributed this lack of feeling to the fact that her husband seemed to think only about his own pleasure: ‘But it’s all sort of intense, he is the sort who starts straight away, do you know what I mean? Whereas this time we just joke around and laughed and normally when we are getting intimate he just seems to be concerned with coming to the climax himself, he doesn’t sort of do anything to me’. Interestingly, the wife could reach a clitoral climax when he caressed her, but she explained that she ‘always thought that you have it together’. It is worth noting that mutual orgasm was expected by this patient, following here the norms spread by sexual manuals, as well as some form of male consideration towards her own sexual fulfilment. Indeed, the patient implied that her husband should place mutual sexual pleasure above any consideration of personal sexual pleasure. The husband, aware of his wife’s difficulties and keen to improve their sexual life, consulted Malleson as well. When asked if he had enjoyed sexual intercourse he replied ‘Yes, I mean it is what I thought it would be’. This case indicates that there existed competing feelings between the partners, absence of feelings from the wife and sexual satisfaction from the husband, and that the wife no longer wanted to experience sexuality only passively but was actively seeking help to improve her sexual life. In this case, the husband did come along too, showing his willingness to take her emotions and feelings into account. This new claim to equal pleasure have been made possible by previous forms of sexual campaigning undertaken by birth control activists and sexual reformers who not only fought for access to birth control – using the wellbeing of the mother and the family as a reason for increased access to contraception, thus separating sexuality and reproduction – and therefore empowered women, but also popularized the idea of mutual sexual pleasure through sexual manuals making it the ideal form of sexual intercourse. [[54]](#footnote-54)

Another example is that of a wife who had been married for four years and could not achieve vaginal orgasm. She first went to her doctor since the couple ‘was distressed’ about it; the doctor in turn sent her to Malleson. During the counselling session, she invoked her feelings of disappointment, showing she cared about having an enjoyable sex life: ‘I feel that I am capable of having it (…) And then he said : ‘Shall we try twice and see if anything happens?’ It is even more disappointing in a way and he decided that if he massaged me with his hands something would come, but it still didn’t give me any full satisfaction’.[[55]](#footnote-55) The excerpt is interesting for two reasons. First, the husband helped work out a solution to soothe his wife’s feelings, trying to please her with external caressing. Second, the wife wanted a vaginal orgasm, having internalized the new standard of vaginal orgasmic pleasure. Interestingly, as she argued later in the consultation, she was able to have clitoral orgasms, but devalued them as she sought to reach what she perceived as being the normal way of performing sexuality. When told by Malleson that one-third of women would never experience a vaginal orgasm, she replied, ‘How unfair!’, expressing her disappointment and sense of injustice with the situation. [[56]](#footnote-56)

Anxieties related to the woman’s inability to achieve orgasm was also the reason why a non-married patient went to Malleson. She explained that she had had sexual intercourse with three different men without reaching climax. Until she met her new partner, she did not mind this. However, the new partner was anxious to please her, and from then onwards she ‘worr[ied] about it’ and wanted to be able to reach orgasm.[[57]](#footnote-57) This session had a different dynamic from the other sessions. Indeed, the young unmarried woman asked very specific questions and showed strong agency in raising issues about which she wanted to gain knowledge, showing a new form of female independence. For instance, she pressed for clarification on whether her behaviour was common: ‘Do you think it is only a matter of time or something?’. After having three incidences of intercourse without orgasm, she wondered ‘is that normal’, explaining that she did not ‘know what the normal thing [was]’. She got some enjoyable feelings when her partner stroked her ‘outside’ but ‘couldn’t achieve orgasm’ and she ‘got very frustrated’, clearly expressing her own disappointment with the situation. Her behaviour contrasted with that of other patients who let Malleson lead and guide the session. In this case, the directness of the patient indicates a new sense of autonomy and self-awareness as well as a sense of insecurity about her own sexual reaction, which was perceived by Malleson when summarising the session as follows: ‘Discussion by unmarried woman who comes to complain she doesn’t get orgasm, her dissipation (?) is interesting in many ways. It shows many of the current fallacies and anxieties’. Malleson later explained what she meant by fallacy: the pressure to reach orgasm. She explained, ‘It’s a difficulty of your generation. Because twenty years ago, thirty years ago, hardly any women knew that anyone could get orgasm. And it wasn't talked about. Now its talked about, everyone thinks it should be a standard measurement and wonders if there's something wrong with them if they're not exactly like someone else they've heard about, you see’.[[58]](#footnote-58) Moreover, the patient was very anxious to understand the difference between a vaginal and clitoral orgasm, requesting clarity and explanation of the plausibly distinct feelings and sensations for each type of orgasm: ‘One is more like a receptive feeling and the other one aggressive?’ she asked, trying to make sense of what she felt. She wondered whether she was ‘undersexed’, testifying to the new pressure of being sexually active and having an enjoyable sexual life. Here, again, her new partner expressed worry about the lack of pleasure on the woman’s part, which underlines the new importance given to female pleasure.

‘Being upset’ was not constrained to the female patients, as some of them described their husband’s reaction after a premature ejaculation or loss of erection with words such as: ‘Well, he knew by instinct what to do, but that was a very fast experience and he felt very badly and very upset about it. And two or three times recently he had been able to penetrate and failed halfway through and he has been upset again, of course’.[[59]](#footnote-59) Male sexual performance also posed problems and created concerns. Similarly, men were upset about not being able to please their wife. In one case of inhibition of vaginal orgasm, the patient mentioned the fact that her husband was upset about her lack of pleasure: ‘It has upset him quite a bit but he is patient and very understanding’.[[60]](#footnote-60) Individuals therefore resorted to feelings to describe their conditions and that of their partner.

In one case, the lack of emotion and interest in the sexual act posed problems. A childless couple who had been married for ten years were referred by a psychiatrist for marriage guidance for help with their sexual difficulties. The wife did not have sexual pleasure at all and the husband wanted to help her achieve orgasm, once again showing how mutual sexual pleasure was becoming a norm. The wife was 38 years old and described by the psychiatrist as ‘an extraordinary crude creature who resents any sign of affection at all from the part of the husband and never had any interest in intercourse’.[[61]](#footnote-61) The patient explained that she wouldn’t have bothered to see a doctor if her husband had not insisted and arranged it. While she had never felt anything during intercourse, her husband ‘always gets his satisfaction’, she added.

The husband, suspecting that something ‘was wrong’ with their sexual life, encouraged her to tell him the truth. ‘But I knew I hurt him if I tell him, but he says, come on, what is wrong?’ She told him her lack of interest and this ‘put him off’. She explained that she wished to know what she was missing, because she heard colleagues speaking about having an orgasm. This case is interesting in that the wife displayed ambivalent emotional behaviour reflecting the contradictory feelings she held; while she acknowledged that she might be missing something in her sexual life, she was also quite clear that she was happy the way things were. She did not want to speak about this issue any longer with her husband, who was willing to find a solution. The situation was very upsetting for the husband, who wanted to make her happy, and explained that ‘I realize that we couldn’t possibly stay together if I would deprive her, if she couldn’t find a feeling for me, well, I was preventing her from finding a happiness somewhere else, you see’. Her lack of sexual pleasure therefore seems to have been a bigger problem for her husband than for her, the latter being under the impression that he was failing her. In this session, the husband seemed to have been equally if not more interested in his wife’s pleasure than his own.

The idea that sexual troubles might reflect the failure of one partner or spouse was quite common, as for sexuality to be seen as successful it required specific behaviours or elements such as reaching orgasm together, or at least reaching orgasm. Penetration was perceived as essential for ‘successful’ intercourse, as well as desire for it and feelings of pleasure. For instance, the remarried patient with feelings of depression was very anxious about not showing her husband that she did not enjoy sex, not only because she wanted to preserve his feelings, but also because ‘You see, I feel I am failing him a great deal (…) I thought my lack of sexual feelings for him on my part rather than his was a thing inside me’. This excerpt illustrated how love and sex were intertwined within the patient’s mind. Similarly, the unmarried patient asked Malleson: ‘Do you think I failed, am I undersexed?’ These cases shed light on the new pressure represented by the normative vision of heterosexuality as penetrative and orgasmic. Both male and female spouses seemed to have internalized this injunction and were seeking help to comply with it.

Some patients also adopted the rhetoric used by Malleson in her books and counselling session, though very often they were encouraged to do so by Malleson herself. For instance, a wife in her mid-thirties who was not experiencing sexual pleasure in her current married life, but had been sexually satisfied in her first marriage, explained :‘I am feeling an extreme fatigue all the time’ or ‘I feel so frigid’.[[62]](#footnote-62) Interestingly, this woman used the scientific terminology of frigidity to describe her lack of sexual satisfaction, showing how she adopted the sexual language used in sexual manuals and used by Malleson herself early on in the interview when she told the patient that ‘a woman who’s gone frigid makes, sort of, secondary difficulties’. Another example is a very short case of vaginismus that featured the husband alone. The couple had been married for one year but had not been able to consummate the marriage. They read many sexual manuals, including *Any Wife, Any Husband*, and consequently decided to consult Malleson. Malleson saw the wife first and then the husband. He described his wife as a ‘nervous person’ and explained that they were afraid that she was ‘undersexed or cold’, showing how sexuality had become important to their relationship and using Malleson’s own vocabulary.[[63]](#footnote-63)

Besides the adoption of the rhetoric used by Malleson, patients resorted to a form of psychological framework for finding reasons behind their sexual difficulties and engaged in self-analysis. A young patient that had vaginismus tried to find a reason for her physical reaction and went into detail about her own emotions and connected it to the fears of the unknown: ‘It is my mind, physically I feel I am all right but it is my mind. I am like that with lots of things. Everything that are unknown to me, I fear them… All sorts of things’. The process of self-analysis lent credence to the increasing role played by emotions and psychological framework in individual sex lives, since the newly married wife was trying to find the causes for her own difficulties, doing her best to resolve them. This strategy proved fruitful, since Malleson added that not long after the session, the patient called her, explaining that she ‘consummated quite unexpectedly and easily and she was very happy indeed’. Importantly, happiness and more generally positive emotions were connected with the ‘successful’ performance of sexual intercourse.

Similarly, the wife, who was described as being emotionally very cold, argued that her lack of feelings was due to the way she was raised, where hiding one’s own feelings was the norm: ‘I come from a large family, but we weren’t an affectionate family. And my husband is the opposite, very affectionate’. Interestingly, this patient tied her emotional restraint to the influence of her family, using a psychological model of social environment.

All in all, these patients valued a new form of communication that drew on sexual norms and ideals, where emotional openness became instrumental in the expression of their sexual difficulties. The difficulties they expressed suggest that for these patients, the emotional and sexual world of the 1950s was in many ways an uncertain or even sad one.

**Conclusion**

The history of sexual counselling, and more specifically the dynamic between the doctor and the patient and the ways that this relationship relied on emotions, are very difficult to access. Using recordings of sexual counselling sessions, this article has analysed the way that emotions were mobilised in the treatment of sexual disorders. Malleson used emotions as a tool to trigger descriptions of sexual difficulties. She explicitly asked her patients to describe what they felt. Her therapy mixed a psychological framework that connected emotions and sexual difficulties to the patient’s childhood experiences and practical exercises. This sexual therapy of Malleson’s own devising reflected the transitional nature of the period, during which psychology was progressively adopted by marriage guidance counsellors and family planning clinics as a useful tool to help individuals overcome their sexual and marital difficulties, and emotions were increasingly tied to sexual fulfilment. Malleson was therefore part of a broader movement of attempts to help couples overcome their sexual difficulties. This movement no longer imparted sexual advice to ordinary individuals through sexual manuals alone but increasingly developed practical means of addressing sexual difficulties using knowledge from psychology. In this sense, Malleson is a good example of continuity between the pre-war and postwar period and shows that these forms of therapy remained experimental in the early 1950s.

The patients’ quest for sexual fulfilment and mutual sexual pleasure did not appear in a vacuum but was the result of the circulation of new cultural sexual expectations. While mutual sexual pleasure became a new injunction in interwar marriage and sex manuals, this research shows that after the Second World War, ordinary Britons were increasingly internalising this new norm and were looking for help in complying with it. The sources provide a glimpse into the anxieties felt by presumably middle-class couples when they ‘failed’ to comply with these new ideals. I used emotions as a lens through which to gauge normative ideas and ideals about heterosexuality. What patients aimed for was to be able to achieve an orgasmic penetrative sex life.

If anything, this article shows that new norms in sexuality, however useful they might have been for encouraging female sexual pleasure, nevertheless had a downside in that they put new pressure on married couples and therefore created new anxieties relating to performance at a time when the marriage institution was under strain due to the new focus on love as the cornerstone of a happy marriage. Individuals suffered emotional hardship when they were unable to attain what they thought should be the ideal sexuality. Sex for these patients was disappointing and frustrating. However, they did not passively endure their distress but actively sought help to overcome their sexual disorders, believing that they could take action for their own sexual fulfilment. Patients relied on emotions to express their sexual dissatisfaction and used a language infused with psychological rhetoric to make sense of their difficulties. These sessions offer a valuable way of seeing how ordinary Britons saw themselves as sexual beings and how the emotional needs of their partner were central to their understanding of a fulfilling relationship. Patients opened up to Malleson and articulated their sexual desires and fears, testifying to a new form of sexual subjectivity and emotional openness that collided with the previous regime of emotional restraint.

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