
Race, Ethnicity and Sex Therapy:

**Sex Therapy Discourses on the nature of Race
and Ethnicity, and on their Implications for
Sexuality, Sexual Problems and Sex Therapy**

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Abstract

Contemporary sex therapy, as a social location within which interventions are made in the field of human sexuality, constitutes a terminal point through which discourses of race, ethnicity, gender and sexuality interface and become mediated. It is also a site in which the particular outcomes of this mediation can be expected to have a significant bearing upon clients who, as social and sexual subjects, carry diverse racialised and ethnicised identities. Though a substantial literature exists pertaining to classical sexology, relatively little is sociologically known about contemporary sex therapy within the UK, and nothing is known of the manner in which discourses of race and ethnicity operate within the field. This exploratory research examines the discourses produced by sex therapists (both in talk and text) regarding the nature and significance of race and ethnicity, and the substantive qualities, significance and effects attributed to these in shaping patterns of human sexuality, sexual dysfunction and sex therapy. The aim is to analyse and account for these discourses as the products of underlying cognitive models of race, ethnicity, gender and sexuality, as these have evolved within the particular social location of sex therapy (as a deposit of a broader racialised and ethnicised social consciousness), and formed the basis of an active utilisation by therapists in the pursuit of ‘preferred renditions’ of sex therapy practice. The thesis also aims to explore sex therapists’ accounts of the necessary and sufficient conditions for the achievement of effective, equitable and non-oppressive therapeutic intervention in a context of racial and ethnic diversity. The research supports a rendition of sex therapy as a complex constituency, struggling to make sense of the nature and significance of race and ethnicity as sources of difference, and as dimensions of the social subject. Liberal-humanistic, biological-essentialist and versions of ethnic essentialism compete and coalesce as the primary elements of sex therapists’ constructions of race and ethnicity as dimensions of the gendered sexual subject, informing their accounts of the necessary and sufficient conditions for the delivery of appropriate, sensitive and non-oppressive praxis.

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Foreword

The catalyst for this project was unwittingly provided by a colleague with whom I shared the responsibility of membership to the Programme Management Team of an MSc in Human Sexuality and Relationship Psychotherapy. In the context of a discussion regarding the demography of sex therapy in Britain, the therapist informed me that “sex therapy is a very white profession you know”. I had by this point already noted some of the particularities of the absent-presence of race and ethnicity within the sex therapy context, formally absent for the most part yet frequently present in underlying assumptions and orientations, and more occasionally in explicit enunciations concerning the ‘different’ sexual problems of some racial/ethnic minority groups. The experience of developing a module entitled ‘Society and Sexuality’, and then of incorporating this module into a broader curricula, offered an opportunity to work with sex therapists and gain a better understanding of their collective world-view, and how issues of race and ethnicity became interwoven with this.

I had also become interested in an emerging literature within which two particularly pertinent themes emerged. Firstly, that an understanding of race, ethnicity and racism depends upon an awareness of how these dynamically interact with other ‘axes of differentiation’ (in particular gender and sexuality) to create variable and complex social phenomena. Secondly, that race, ethnicity and racism need to be understood in the context of specific social localities, which in their particular configurations of formative variables: shape the practical manifestations of race, ethnicity and racism; provide the institutional mediums within which people acquire and mediate their racial and ethnic identities, and circumscribe subjects’ social experiences and opportunities in racial and ethnic terms. The social locality of sex therapy therefore offered a research opportunity to understand one particular set of racial and ethnic manifestations, as these dynamically interact with variables of gender and sexuality within a field of direct therapeutic intervention. It also seemed to be a social location about which little was currently known within the sociological literature.

But sex therapy immediately seemed to be more than ‘just another’ context within which to understand the operation of race and ethnicity. I was struck by the profound power inhering within the social institution of sex therapy. Through their participation in the orchestra that is public sexual health and sex education discourse, sex therapy informs the generalised criteria in terms of which people come to define themselves, or become defined, as having sexual ‘problems’. Through their therapeutic work with individuals and couples those same criteria become the strategic and conceptual foundation for sex therapy praxis, enabling clients to achieve some form of sexual solution, or at least resolution to their problems. A reading of Foucault’s ‘History of Sexuality Vol. 1’ consolidated my interest in understanding the political components of sex therapy praxis, and in particular the underlying normative assumptions informing this. Whilst utterly convinced by my colleagues’ commitment to the welfare of all of their clients, and to the delivery of non-oppressive therapy, I was intrigued by the ideas and strategies underpinning their approaches to the delivery of equitable and effective care in a context of racialised and ethnicised diversity. It was from these initial ideas that this project was born.

*For Jan, Chloe and Ben,
and in loving memory of Doris Sellers and Robert Peel*

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Chapter 1 – Introduction

1.1 Aims and Scope of the Research

Contemporary sex therapy is an heir to the legacy left by long-standing and powerful religious, medico-scientific and socio-political interventions in the field of human sexuality. The origins of sex therapy ultimately lie in the emergence of more secular, scientific forms of sexual expertise within an 18th century context in which the boundaries of such expertise had become the source of intense contestation. Of particular significance in accounting for the genesis and subsequent development of sex therapy has been the influence of sexual science, sexual medicine, marital therapy and counselling. In this proliferation of interests, the sexual scientific constituency, of which sex therapy is a part, has done as much to *create* the field of human sexuality as it has to intervene within it.

Historical and sociological research in the field of human sexuality has served to shatter essentialist accounts that have located a determinate sexual nature either within a transcendent realm of the supernatural or within the depths of our biological nature. In their place has been inserted a social constructionist approach that emphasises the mutability or plasticity of sexuality, its profound willingness to succumb to social, economic and political agency. Sexuality, in all its complex dimensions, is a terminal through which social relations become manifest. It is a phenomenon that in large part has been constructed through the projections imposed upon it by a plethora of interested parties, of which arguably the most significant has been those of sexual science and medicine. As an illusive object of public scrutiny, human sexuality has been imbued with a multiplicity of significances: for the sexual subject, for freedom and autonomy, for self-discovery, for our relationship to God, for the nature of intimate relationships, for the health of the developing child, for the nature of, and relationship between the sexes, for normalcy, for the state of the nation and of its people; and as a marker of our racial and ethnic natures. Sexuality has become conscripted into the service of a range of social, political and economic interests. The outcomes of these investments have been variable and at times contradictory, though it is clear that in the process sexuality has acquired an unprecedented centrality within our lives. Sexuality has become constructed as central to our sense of self, to our personal well-being and to the integrity of our intimate and inter-personal relationships. It occupies a central place within the social identity claims of numerous social groups and has become commodified in and of itself, in addition to the role it

plays as a means to marketing other commodities. Issues of sexuality have also come to occupy a prime place within the policy concerns and initiatives of numerous state agencies.

The interests, interventions and understandings emanating from sexual science and medicine have rarely evolved in isolation from the socio-economic, political and cultural conditions of the day. Quite the contrary, they have evolved in explicit and implicit articulation with these conditions, simultaneously informing, and being informed by them. From the outset, public and expert discourses regarding sexuality, and the social practices they have expressed and enabled, have been infused by, and co-constructed with, questions of gender, race, and ethnicity. It is evident from historical and sociological research that we have witnessed a racialisation and ethnicisation of sexuality, and a sexualisation of race and ethnicity. It is also evident that these associations have been variably mediated by expert opinion from the sexual and medical scientific constituencies.

However, a marked feature of this emergent body of research is the relative preponderance of accounts of ‘classical’ sexual and medical scientific discourses and a consequent absence of more contemporaneous analyses. This thesis seeks to make a contribution towards rectifying this imbalance, in making visible the dynamics of race and ethnicity as they operate within one particular location of contemporary ‘sexpertise’. More specifically, it seeks to explore the discourses produced by sex therapists (both in talk and text) regarding the nature and significance of race and ethnicity, and the substantive qualities, significance and effects attributed to them in shaping patterns of human sexuality, sexual dysfunction and sex therapy. The aim is to analyse and account for these discourses as the products of underlying cognitive models of race, ethnicity, gender and sexuality, as these become applied by sex therapists in the construction of ‘preferred renditions’ of the role of sex therapy within a context of racial and ethnic diversity. This in turn requires an understanding of: the formative influence of broader racialised, ethnicised and gendered forms of social consciousness; of the interaction between these, and discourses deriving at least in part from within sex therapy itself; and of the situational and instrumental utilisation and manipulation of these models in accounting for sexual relations, practices and problems within the discursive contexts of journal papers and in-depth interviews.

By understanding “how exactly...members or institutions of dominant white groups talk and write about ethnic or racial minorities” (Van Dijk 1993: p. 92) we are enabled to

understand some aspects of the “...underlying ethnic or racial prejudices, ideologies, or other social cognitions about minorities” (Van Dijk 1993: p. 92) operating within the institution of sex therapy. Race and ethnicity are social and political constructs, produced at the boundary of dynamics of attribution and identification. Understanding the attributions (and their inherent operations of power) produced in the name of race and ethnicity within sex therapy enables us to examine how social subjects may acquire (and mediate) their racial/ethnic identities and experience racially/ethnically informed delimitations on aspects of their social experiences and opportunities. Of particular importance here is an understanding of how ideas about race and ethnicity inform therapists’ accounts of the necessary and sufficient conditions for the delivery of sensitive, effective, equitable, and non-oppressive sex therapeutic services, with particular regard to a range of strategies associated with racial/ethnic diversity: ‘colour-blindness’, multiculturalism and anti-racism.

These aims translate into a number of central research questions:

- ***How do sex therapists perceive human sexuality and the nature of the sexual subject, and how are these perceptions imbued with accounts of the role of gender?*** Sex therapists’ orientations towards questions of race and ethnicity, as these relate to issues of sexuality and gender, are likely to be mediated by their underpinning ideas about sexuality and gender themselves. These underpinning ideas have the effect of providing a framework into which, or perhaps alongside which, ideas about the nature of race and ethnicity must be located. In turn, this produces situationally-specific forms of articulation, contradiction, assimilation, accommodation and resolution between these two realms of knowledge.
- ***How do sex therapists perceive race and ethnicity as modes of difference, and what substantive qualities, significance and effects do they attribute to them?*** Sex therapists are social subjects first and foremost. They bring with them to their professional socialisation and therapeutic practice, socially-worked versions of race and ethnicity that must in some sense be accommodated in relation to the conceptual and practical forms of knowledge validated by the constituency of sex therapy. In a context where these socially-worked versions are becoming more diverse and complex, an understanding of what particular cognitive models of race and ethnicity capture the hearts and minds of sex therapists as social subjects is important, and serves as the foundation for an appreciation of sex therapy as one institutional context within which social subjects (the clientele) acquire race and ethnicity.

- ***What role do sex therapists attribute to race and ethnicity in shaping male and female sexual identities, relationships, practices and problems?*** The nature of sex therapy practice locates sex therapists at the intersections of discourses and practices of sexuality, race and ethnicity. In their engagement with the sexual realm, therapists are confronted in varying ways by experiences that require the making of connections between sexual phenomena and the forms of diversity to which labels of race and ethnicity are commonly attached. As a means to making sense of these connections, therapists have access to broader societal accounts that have served to racialise and ethnicise sexuality, and situationally-specific renditions that derive from training, from personal clinical experience, from interaction with peers, from anecdotal accounts and from published sources.
- ***What do sex therapists consider to be the necessary and sufficient conditions of ‘good practice’ in meeting the needs of a clientele differentiated along lines of race and ethnicity, and how is current sex therapy evaluated in these terms?*** Within the health arena generally, we have witnessed the emergence of therapeutic models and strategies directly concerned with addressing, and ‘managing’ the challenges presented by racialised and ethnicised forms of diversity. These models have emerged as a self-conscious challenge to pre-existing approaches that were seen to either pathologise or ignore the needs of minority groups. An exploration of sex therapy’s specific therapeutic response to the challenge of diversity, and of professional calls for new strategies to address the ‘diversity agenda’ hence become central components of this project. Of particular interest is the manner in which sex therapy understands the nature of oppression and equality in respect of therapeutic work in a context of racial and ethnic diversity, and the strategies seen to be effective in the achievement of equitable, effective, sensitive and non-oppressive therapy.

As a study of the discourses produced within sex therapy, this project does not offer any substantive account of: (a) how these discourses inform *actual* therapeutic practices; (b) how such practices are perceived and received by the clientele or; (c) their ultimate effects upon therapeutic outcomes. It is hoped however that this exploratory research will inform work in respect of these areas in the future.

1.2 The Rationale

The rationale for this project has a number of dimensions. A post-WW2 moratorium on official and public expressions of racialised and racist discourses has contributed to a public-political discourse asserting the ‘death’ of race, or at least its withering away as a central component of the forms of social consciousness found within western societies (Malik 1996). I would challenge this notion, and argue that though race may have ‘gone underground’ in places, its conceptual primitives prevail and continue to inform the consciousness of social subjects in complex and variable ways. It expresses itself directly and indirectly through a multitude of discourses, and manifests itself through the practices of, and relations between, social groups. This feat is achieved largely in the absence of specific reference to race, typically through a surrogate language of ethnicity, culture and nation. As such,

whatever the scientific, technical or logical difficulties we (as commentators or academics) encounter in using the terms ‘race’, racism etc., it is our job to trace the way in which the notion is inscribed in people’s consciousness and lends meaning and direction to their everyday conduct (Cohen 1994: p.106)

Perhaps in part as a product of this ‘drying up’ of public and explicit invocations of race within a host of social and institutional contexts, we know much more about how race was inscribed into accounts of sexuality and sexual relations within the fields of sexual science and medicine in the past than we do the present. The sociological literature regarding the role of race and ethnicity within contemporary sexual science generally, and sex therapy particularly, is limited in the first instance and practically non-existent in the second. This empirical blind-spot is in need of some correction.

If we are to claim that the meanings and effects of race and ethnicity are at least in part situationally-specific, then this suggests that an understanding of race and ethnicity within contemporary Britain cannot be directly achieved through the search for a decisive and grand theoretical deliberation. Rather, it becomes a process in which more focussed and nuanced accounts take on a critical role in building a cumulative picture of a racialised and ethnicised

social order. This project serves to make a contribution to this picture in an area currently somewhat obscured from view.

Informing this project is a theoretical stance concerning the nature of knowledge production. I would argue that all knowledge is imbued with political dimensions; in its motivations, its concerns, and its effects. The ‘will to know’ is inherently a positioned and interested phenomenon. This research is informed by a commitment not just to understanding, but to developing modes of understanding that are politically progressive, by which I mean supportive of an agenda concerned with enhancing equality, social justice and empowerment within social relations. In this context, this translates to challenging the essentialist readings of race and ethnicity that have done so much to oppress their racialised and ethnicised ‘objects’. More specifically, it is concerned with the oppressive implications of the ways in which race and ethnicity have imbued our understandings of gender and sexuality, and how these may be constructed and authorised by expert opinion.

Sex therapy can be conceived as a mode of therapeutic practice within which power inheres. The power of sex therapy operates on two levels. Through their participation in public sexual health and sex education discourses, sex therapy informs the generalised criteria in terms of which people come to define themselves, or are defined, as having sexual ‘problems’. Secondly, through their therapeutic work with individuals and couples, those same criteria become the strategic and conceptual foundation for practically working with clients to achieve some form of sexual ‘solution’, or at least resolution. As such, the institution of sex therapy has a (sometimes profound) bearing upon how social subjects think, feel and behave in relation to questions regarding the nature of human sexuality, of sexual normalcy and difference, and of sexual problems.

In suggesting that there is a need to explore the manner in which sex therapy addresses issues of race and ethnicity, on the grounds of a concern for how these differences are understood and acted upon, we may derive some support from a well established and comprehensive body of evidence that indicates that despite ‘best efforts’, health and therapeutic services within Britain have failed to meet the needs of a population differentiated along lines of race and ethnicity, and as such have offered services of noticeably unequal therapeutic value (for example, see Gerrish et al 1996). This failure can, and has, taken many forms. Whilst this thesis does not deny the existence of real patterns of cultural difference between populations, and with this the danger of oppressive practices that have their origins

in a 'difference unrecognised', it is primarily concerned with the problem of 'difference overstated'. More specifically with the oppressive implications of the forms of 'othering' produced by reified notions of race and ethnicity as sources of pseudo-biological and cultural difference and dissonance.

At the heart of the problematic nature of institutional and professional responses to questions of race and ethnicity are some fundamental dilemmas about the manner in which we conceive the social subject, and the role we attribute to race, ethnicity and gender in this respect. Essentialist and naturalistic modes of collectivist thought associated with the ideologies and practices of racism and ethnic oppression have rightly become the targets of scrutiny and struggle. One response to this seems to have been the production of revised forms of invidious racialised/ethnicised thinking (as in the case of a culturalist 'new racism'). But for those in opposition to such discursive outcomes there remains a deep ambivalence about how best to counter their cause and effect. Liberal-humanistic discourses (which are encoded within influential discourses of 'client-centredness' in practice) promise to erase the possibility of racial and ethnic injustice through a simultaneous atomisation and universalisation of the social subject (hence offering the hope of removing the conceptual conditions of possibility for invidious forms of racialised and ethnicised thought) and through pursuing an agenda informed by a discourse of rights and autonomy.

But in turn, I would suggest, such discourses have commonly suffered from what I would describe as a kind of 'naïve negation', as epitomised by the strategy of colour-blindness. The problem with colour blindness, as with a strict liberalism more generally, is that its atomisation/universalisation of the social subject results in a failure to engage with the fundamental material and discursive *locatedness* of the subject within the 'realm of the social' in favour of an abstracted universal selfhood. Locatedness, and this expresses the 'social thesis' upon which this project is based, implies that social behaviour, consciousness and identity are inextricably located within a social context that serves to delimit experiences and opportunities. Any attempt to negate a recognition of the productively constructive power of 'the social' as both the cause and therefore *necessarily* the site of explanation and engagement in questions of difference, oppression, inequity and injustice, is fundamentally flawed. Though without unanimity, influential anti-racist and multiculturalist approaches have elaborated versions of this 'social thesis'. Service providers within the health, welfare and legal arenas have struggled, and continue to struggle, with the conflicts and contradictions produced by this simultaneity of liberal-humanistic discourses and a host of more collectivist modes of thinking about the racialised and ethnicised social subject.

In the current context, where the ‘diversity agenda’ is beginning to have a significant influence within many institutional and professional arenas, we need a better understanding of how the tensions produced by these competing discourses regarding difference and oppression are mediated and resolved. Such an understanding may in turn inform ideas and strategies as to how accounts of difference grounded upon the ‘social thesis’ may be productively utilised in the pursuit of anti-oppressive, equitable and just engagements with the recipients of professional and institutional services.

As the substantive nature of sex therapy is quite unfamiliar to most, it would be helpful at this point to offer a brief, and largely descriptive account of this complex institution.

1.3 The ‘New Sex Therapy’

Sex therapy has an opaque and convoluted history. There is no clear sex therapy constituency to be tracked through historical time. The principle watershed in the formation of sex therapy as we know it today lies in the emergence of what have been described as the ‘new sex therapies’. The term, ‘new sex therapy’, has been used to account for modes of therapeutic intervention in the field of sexual problems informed by the ideas of William Masters and Virginia Johnson, and Helen Singer Kaplan (Cooper 1988). For some, sex therapy begins with Masters and Johnson. “Ultimately, Masters and Johnson helped establish a whole new profession, the sex therapist” (Bullough 1994 p.96). What distinguishes sex therapy specifically, from sexology generally, is the priority it attaches to direct therapeutic intervention, with a view to promoting sexual functioning and health. The ‘new sex therapy’ did then mark a point of departure, but one underpinned and made possible by the historical raw materials provided by the legacy of the past. Masters and Johnson put into practice a body of knowledge which had been developing within sexual science over many decades, and to which they themselves had made significant contributions through a long period of clinical research in the field.

Their particular contribution to the sexological archive of knowledge was to understand with greater clinical precision the mechanics and processes of sexual activity

through laboratory study of patient populations and volunteers (Masters *et al* 1995). From the data generated within extensive clinical observations they claimed to have understood, and so de-mystified, *normal* sexual physiology. This was personified in their formulation of the four phase ‘sexual response cycle’ of excitement, plateau, orgasm and resolution.

“The natural follow-up to the physiological studies of the human sexual response was treatment for dysfunctional clients” (Bullough 1994 p.203). In 1959, Masters and Johnson initiated programmes for the treatment of sexual dysfunction in the United States. They established both a sex therapy team and a methodology for working with the marital couple. According to Masters *et al* (1995), a number of guiding principles underpinned the ‘Masters and Johnson’ approach: firstly, the importance of individualised care, respecting the values and objectives to which the dysfunctional couple subscribed as a means to avoiding the imposition of the therapist’s own agenda; secondly, the assumption of sex as a natural function “controlled largely by reflex responses of the body” (Masters *et al* 1995: p.595) and occasionally blocked by intervening factors; thirdly, the need for therapy to operate at different levels of practical intervention; fourthly, the need to avoid the attribution of blame or responsibility for the emergence of the sexual problem. Finally, it was informed by the principle that sexuality must be understood within the broader context of the relationship. On a more practical level, their approach was characterised by a number of key elements (Masters *et al* 1995). Masters and Johnson insisted on working with couples rather than individuals, as their underpinning model of sexuality was fundamentally relational in nature. Furthermore, in contrast to existing psychiatric modes of intervention, they also argued for the need for two therapists (male and female) as a means to achieving balance. Therapy programmes also tended to be intensive, requiring daily attendance.

Whilst not entirely discounting psychological dynamics, or the possibility of social dimensions to sexual problems, Masters and Johnson’s work served to systematise sex therapy on a physiological base (Bullough 1994). In so doing, their work challenged the psychiatric and psychoanalytic domination of the sex field which still existed through to the early 1970s. They generated a new form of database, or archive of sexual knowledge, that repositioned expertise away from psycho-analytics and towards sexology. This repositioning inevitably had implications for treatment, serving to open up professional and economic opportunities to a broad range of constituencies (social workers, counsellors, nurses) by opening up the sex field. The success claimed by Masters and Johnson in treating sexual dysfunctions led to an enhanced demand from the general public and an increase in the

numbers of professionals realising the possibilities presented by sex therapy for augmenting their client base (Bullough 1994).

The initial valorisation of Masters and Johnson's ideas was to be challenged however by an increasing body of experience attesting to the limitations of their techniques in addressing both the deep-seated psychological causes of some sexual problems and the contribution made to sexual dysfunction by underlying medical conditions. Although Masters and Johnson's work still exerts great influence in the field of sex therapy (Cooper 1988), it now 'competes' with other models and strategies. Kaplan's (1974, 1981) psycho-sexual approach has striven to connect Masters and Johnson's model with a psychoanalytic approach better able to address the potential psychic causes of problems associated with sexual desire itself. Behavioural therapies, influenced by the methods of Joseph Wolpe (1969, 1958) have been developed by contributors such as Heiman and LoPiccolo (1988) and Leiblum and Rosen (2000), and utilised in the treatment of sexual dysfunctions. Psychotherapeutic models such as Rational-Emotive Therapy (RET) have been developed to understand and treat the impact of irrational beliefs and unrealistic expectations on sexual functioning.

The sexual problems with which sex therapy is concerned may pertain to sexual dysfunctions (an umbrella term used to describe a number of sexual problems which inhibit 'normal' sexual relations), relationship difficulties and/or to the gender and sexual identity issues of individuals and couples. Sexual dysfunctions, which may be lifelong, acquired, situational or generalised, may take a range of forms. Sexual dysfunctions have commonly been categorised in terms of disorders of desire (for instance, inhibited or hypoactive), arousal, orgasm and sexual pain (dyspareunia) (see Phillips 2000). Within these broad categories can be located a host of specific sexual dysfunctions. Whilst there is no reliable national data pertaining to the prevalence and distribution of sexual dysfunctions within the UK, dysfunctions such as low sexual desire and vaginismus (involuntary and pain-inducing contractions of the vaginal muscles associated with penetrative intercourse) amongst women, and premature ejaculation and erectile insufficiency amongst men are reported as some of the principle causes of referral to sex therapy (Hems and Crowe 1999). Additionally, within the category of sexual dysfunction could be included the paraphilias: "recurrent intense sexual urges and sexually arousing fantasies involving either non-humans, or the suffering or humiliation of oneself or one's partner, and even children or consenting adults...[causing]...clinically significant distress or impairment in social, occupational, or

other important areas of functioning". (American Psychological Association, cited in PsychNet 2004).

As most modes of sexual expression are enacted within an implicit and explicit relationship context, the capacity for a range of relationship issues to impact upon sexual needs, practices and identities is extensive. Sex therapists, in working with individuals and couples will commonly address relationship issues, such as those associated with intimacy, communication, power, negotiation and conflict resolution. Gender and sexual identity issues cover a host of phenomena, most notably problems associated trans-genderism (male to female and female to male), transvestism, and a range of issues associated with heterosexuality, bisexuality, homosexuality and lesbianism.

For those concerned with the psychogenic determinants of sexual problems, one or more choices may be made from the delineation of models offered in Figure 1.1. For those who favour biogenic explanations (grounded in the anatomical and physiological dimensions of human sexuality) a distinct bio-medicalisation of the field has empowered a host of organic interventions, forever energised by technological advance (Kleinplatz 2003). Pharmacological companies have exploited the potential for profit in developing chemical 'solutions' to sexual problems (Riley 1998), in the process re-defining understandings of sexuality in the direction of a biological reductionism. The introduction of Viagra, and its impact upon therapeutic approaches to 'erectile dysfunction', serves as a luminous example of this process. The pharmaceutical industry has now become the principle source of research funding within the field (Riley 1998), and as such a principle driver of the research agenda and determinant of what we are to know of sex. There is an evident degree of contestation, and some have said polarisation (d'Ardenne 1998a), around the role of medicine as a medium through which to understand and treat sexual problems. The dynamic created by this 'medical axis' has become central to the institution of sex therapy.

Calls for more integrative approaches within sex therapy (Kleinplatz 2003, Riley 1998, d'Ardenne 1998) are indicative of the current diversity of theoretical, classificatory (Wylie 2000) and therapeutic frameworks, and of the ambivalence that still surrounds their respective efficacy and mutual inter-relations. In the light of this, Boddington and Lavender (1995) claim that "therapy with couples spans the spectrum of treatment models, the choice of which often remains idiosyncratic and dependant, not upon the wishes of the couple, but upon

the preferred orientation of the referrer or therapist” (p.69). Beyond the potential conceptual axis of biogenic and psychogenic approaches lies a plethora of frameworks (and goals) for psychotherapeutic work with individuals and couples experiencing sexual and/or sexually-related problems (Crowe 2000) (see Figure 1.1).

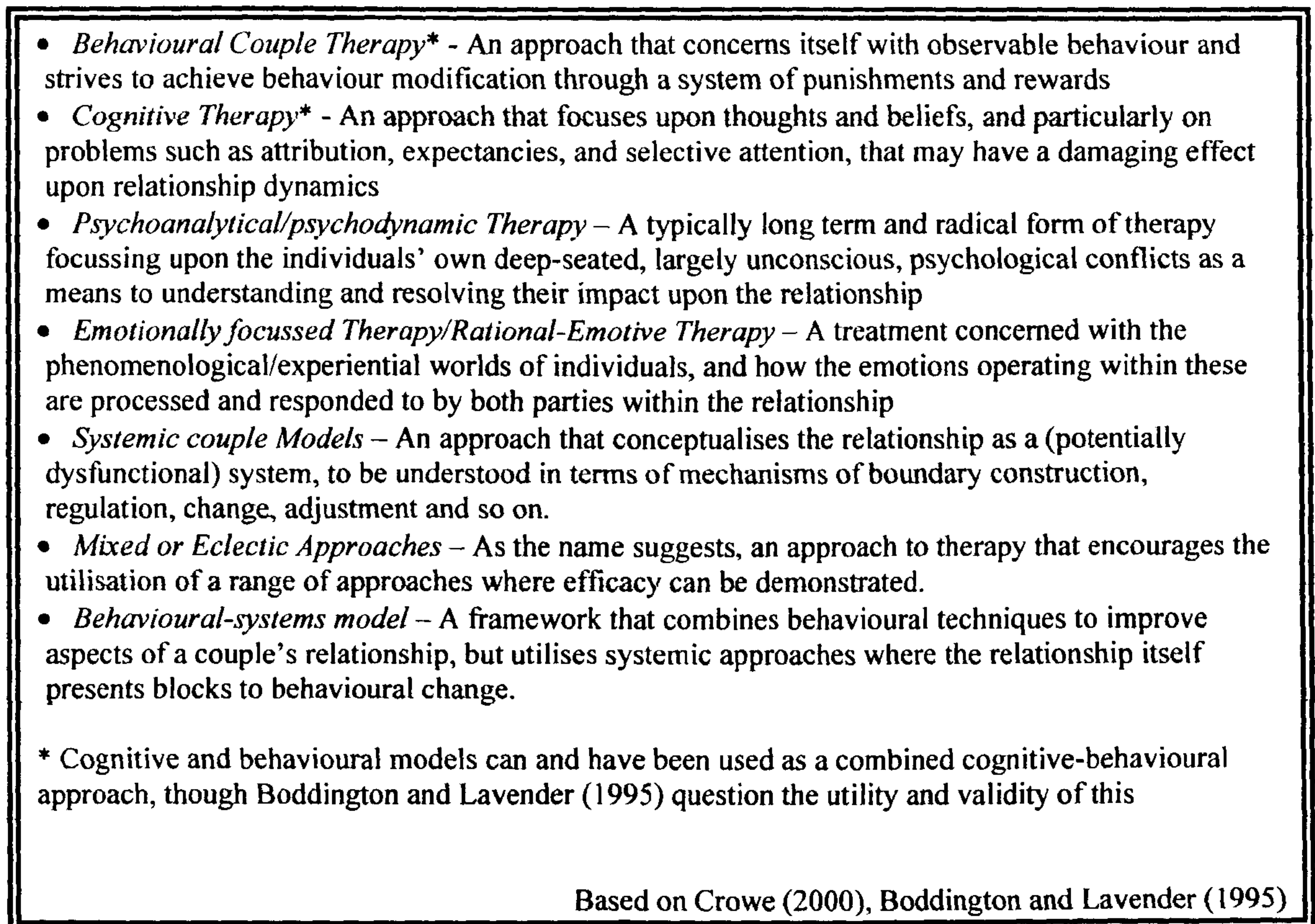


Figure 1.1 – Psychotherapeutic models pertaining to couples

Echoing the ‘sexual sociology’ of the post war period (Comfort 1950), there has been recognition within some circles of sex therapy, that an origin of, and solution to, many sexual ‘problems’ lies in socio-economic, cultural and political factors (d’Ardenne 1998b), with poverty, social exclusion, and limitations in sexual knowledge and education being seen as principle variables (Adler 1997). The impact of racial and ethnic diversity upon sexuality and sex therapy is also acknowledged, and perceived as a challenge for therapy (d’Ardenne 1998b). However, the importance and role accorded to such social and political analyses of sexuality within the institution of sex therapy is highly variable, and can be delimited by the underpinning ideological-therapeutic positions adopted by therapists in their practice. Sex therapy has been criticised for failing to effectively incorporate a social, economic or political analysis into its approaches to both sexuality and gender relations (Segal 1994). The sheer diversity and overall incoherence of sex therapy as a theoretical and therapeutic constituency

has led some to suggest that a profound fragmentation of sex therapy is pending (Kleinplatz 2003).

1.4 The ‘anatomy’ and ‘physiology’ of British sex therapy today

The work of Masters and Johnson and others in establishing new modes of sex therapy has led to an explosion in academic, therapeutic and organisational activity within the field of sex; a veritable gold-rush. Internationally we have witnessed a proliferation of organisational bodies concerned with the regulation and promotion of sex therapy, the scientific analysis of sex as an object of study, and the provision of sex education and sexual health materials. Human sexuality, sexual problems, and the modes of intervention within these realms have all become sites of complex, and at times conflictual struggles for professional legitimacy and cultural authority (Tiefer 1992).

‘New sex therapy’ was introduced into the UK via practitioners trained in the United States, and through a growing sexological and sex therapy literature (Cooper 1988). Of particular significance in consolidating British sex therapy was the establishment both of specialist sexual dysfunction clinics (Hems and Crowe 1999), and of sex therapy training by the National Marriage Guidance Council (now RELATE). The establishment of the British Association of Sexual and Marital Therapy (now the British Association of Sexual and Relationship Therapy - BASRT) in 1976, marked a significant development in the regulation and accreditation of sex therapy in Britain. Most practitioners who refer to themselves today as sex therapists have undertaken training programmes accredited by the BASRT, and/or Relate, and are accredited members of one or both of these organisations. Many therapists are in addition accredited members of other organisations, most notably the UKCP and a variety of medical bodies. But it is the BASRT, and its accredited members, that constitute the principle ‘centre of gravity’ of sex therapy in Britain, and as such serves as the focus of this project. As Tricia Barnes (2000) has stated, it is the “...unique and prestigious position [held by the BASRT] in the professional market place of human sexuality in this country” (p.4) that marks it out. Reflecting on her tenureship as Chair of Trustees of the BASRT, she states that “...another aim during my term as Chair [has been] to enhance the public profile of BASRT as *the* [my italics] responsible organisation and standard bearer of the profession...” (BASRT 2000: p. 4).

Through their 'Aims and Activities', Codes of Ethics and Practice, and Complaints Procedures, the BASRT has strived to systematise and homogenise aspects of sex therapy practice in the pursuit of establishing the foundations of a professional/therapeutic legitimacy and authority. The BASRT's aims and activities, as specified in Figure 1.2, embody the forms of social practice that lie at the heart of the professionalisation agenda. For some, the collective effects of sex therapy promise an enhancement of social harmony through the aggregative effect of improving the well-being of relationships:

It is to be hoped...that this slow but steady progress in improving our ability to help couples solve their sexual problems will eventually have a positive contribution to make, not only to the adjustment of the couples themselves, but perhaps indirectly towards the stability of society (Crow 2000 p.13).

But sex therapy's concern with individual and relationship problems is supplemented by a more proactive agenda of sexual health promotion, and strategic engagements with key institutions ranging from the media to the Department of Health to the pharmaceutical industry.

The BASRT has an accredited membership of 221, with 350 general and 63 student members (BASRT 2000) distributed unevenly throughout the country. A substantial number (though not the majority) enter sex therapy from a medical background, and on this basis tend to have an orientation towards a medical approach to their work, employing a range of interventions including bio-medical strategies of a pharmacological and even surgical nature. However, the majority of sex therapists derive from a broad range of non-medical occupational backgrounds, with counselling, psychotherapy and nursing featuring significantly amongst these.

A sizeable proportion of sex therapy today takes place within the public and voluntary sectors, where therapists effectively practice as public employees. The clients they see derive from a number of referral sources. A recent study of the Psychosexual Dysfunction Clinic at the Maudsley Hospital in South-East London (Hems and Crowe 1999) identified that 74.4% of patients were referred by GPs, 12% by psychology-orientated referrers, and 9% from other

medical sources. In this data distribution, the study reflected results from an earlier audit at Guy's Hospital, London (Hirst et al 1996). A large proportion of sex therapists however, combine (or entirely replace) public sector work with private practice, where clients may be referred by a GP, but more commonly self-refer. The motivations of therapists, in working across a number of sectoral contexts, may range from an ideological commitment to universalist principles of provision, to a purely strategic concern to ensure a viable income.

British Association of Sexual and Relationship Therapy	
Aims	
•	To promote the education and training of clinicians and therapists working in the fields of sexual and couple relationships, sexual dysfunction and sexual health
•	To set and maintain professional and ethical standards and codes of practice in sexual and relationship therapy
•	To promote research in the field of sexuality, its problems and its treatments
•	To raise public awareness of sexual and relationship therapy, of members' work and achievements and of professional and ethical standards
Activities	
•	Approves training courses
•	Accredits practitioners
•	Recognises supervisors
•	Advises (pharmaceutical industry, national training programmes for GPs and other clinicians)
•	Organises conferences
•	Publishes through its own quarterly refereed Journal
•	Public Relations
http://www.basrt.org.uk/content/about.htm	

Figure 1.2 – Aims and Activities of the British Association of Sexual and Relationship Therapy

The demographic characteristics of the clients with whom sex therapists work will depend greatly upon the geographical and sectoral location of the therapist. What data exists suggests that broad and systematic variations in class, gender, sexual orientation, age and racial/ethnic composition are all apparent in the composition of sex therapy's client group. Hems and Crowe (1999) found that the majority of their clients were male (73.7%), in relationships (74.5%), and lived locally. Over half (56.4%) were known to be in employment. Men tended to have a higher age profile than women, and the principle problems reported by

men were related to erectile dysfunction (in 73.5% of cases), and by women, low sexual interest/desire (in 40% of cases). Using place of birth as a measure of ethnicity, almost half (43.6%) reported being born in the UK or Ireland, while 15% were African or Caribbean, and 4.5% Asian. Interestingly, there were no significant associations between place of birth and gender. This demographic composition of sex therapy clientele within the public-sector is known to vary according to geographical location (Hems and Crowe 1999, Hirst et al 1996, Catalan et al 1990, Warner et al 1987). For those consulting a sex therapist in the private sector, a different class, gender and ethnic distribution can be expected, though no data for this are available.

Though the particular forms taken by sex therapy practice may vary, couples and/or individuals tend to receive focussed sessions, usually with one therapist (though sometimes with two), commonly lasting approximately one hour, and on a scheduled basis (weekly, fortnightly etc.). The total duration of the therapeutic work will vary according to a multitude of factors. Although numerous therapeutic strategies may be adopted, there is a tendency for the individual/couple to be given 'homework' to supplement the work done with the therapist/s, in the form of activities designed to positively address their sexual issues (Hems and Crowe 1999, Crowe 2000).

The initial diagnostic phase may be carried out by the sex therapist, particularly where a client/couple has self-referred. If an organic or psychiatric disease aetiology is suspected, a referral to a medical clinician will be a likely outcome, with the potential for a range of surgical and pharmacological interventions possible. If the client has been referred to the therapist by a medical clinician it is likely that the client has been deemed to have a problem of a non-organic/psychiatric disease nature, or a problem with a significant additional dimension. If the therapist deems the client/s difficulties to fall within their own area of therapeutic expertise, the client/s may be recommended any of a range of interventions (depending upon both the nature of the problem, and the theoretical, conceptual and clinical orientations of the therapist). These may include a schedule of cognitive, affective and/or behavioural activities, such as: 'stop-start' approaches to masturbation (perhaps in the case of premature ejaculation); mutual masturbation (perhaps in cases of intimacy barriers); use of erotic materials (in cases of inhibition); foreplay (in cases of low levels of arousal); avoidance and diversion (in cases of compulsive sexual behaviours) (see Charlton 1996 for an account of sex therapy treatment techniques pertaining to a range of sexual dysfunctions). Accordingly, Tiefer (1990) has highlighted the manner in which "the sex therapy literature seems to favour

the work language of skills, practice, scheduling, technique, and mastery even as it stresses the importance of a playful attitude” (p.307). Relationship and identity difficulties may be addressed via a range of interventions, typically those utilised widely within the psycho-dynamic, psycho-therapeutic, and couple therapy arenas, in accordance with a range of theoretical/conceptual approaches (see Figure 1.1).

1.5 The Structure of the thesis

Chapter 2 seeks to locate contemporary sex therapy within its historical context. It argues that human sexuality can be understood as in large part a social construction actively produced by the discursive and material investments made in it by social actors within particular social settings. It emphasises the role played by sexual science and medicine in this process of construction, and of the gendered dimensions of expert and popular renditions of human sexuality. An account of the emergence of sexual scientific expertise from the Enlightenment to the ‘new sex therapy’ is provided as a means to contextualising contemporary manifestations of sex therapy. The chapter goes on to locate this account within a broader theoretical context through exploration of the nature of race and ethnicity as the outcomes of the interconnected processes of racialisation and ethnicisation, and accounts for the ways in which these dynamic processes have enlisted sexuality and gender in their construction. Chapter 3 outlines the research methodology adopted within the project, justifying the adoption of qualitative methods of in-depth interviewing, and textual discourse analysis. It offers an account of the strengths and limitations of the methodologies used, and of the challenges experienced in undertaking this research. Chapter 4 initiates the substantial data analysis, through an account of the interview data concerning sex therapists’ understandings of male and female sexuality and the nature of the sexual subject. Such understandings form a foundational component of sex therapists’ approach to their work, and constitute a set of cognitive orientations onto which socially-worked versions of race and ethnicity must be grafted. Chapter 5 offers an account of sex therapists’ perceptions of race and ethnicity, using both the interview and textual data, and draws conclusions regarding the extent to which socially worked accounts of race and ethnicity are taken on board by sex therapists in their understandings of social and sexual subjects.

Chapter 6 elaborates on the roles attributed to race and ethnicity, within the textual data, as variables impacting upon sexual identities, relations, needs and problems, with a concern for how gender is incorporated into these discourses. Chapter 7 reproduces Chapter

6's focus, but with respect to the interview data. Chapter 8 explores the implicit and explicit frameworks encoded within the textual and interview data regarding how to 'manage' the forms of diversity attributed to race/ethnicity, with a particular concern for the influence of 'colour-blindness', multiculturalism and anti-racism. Chapter 9 focuses upon the practical therapeutic strategies discussed within the textual and interview data as the basis upon which effective, sensitive, equitable and non-oppressive therapy may be grounded, within a context of racial and ethnic diversity. Chapter 10 offers a concluding account of the project's key findings, and reflects upon their implications for future sociological analyses, and for sex therapy.

Chapter 2 – Sex Therapy, Sexuality, Race and Ethnicity: Interwoven Threads

Sex therapy can broadly be defined as a mode of therapeutic intervention concerned with enabling clients to achieve some form of resolution in respect of a ‘problematic’ dimension of their sexuality. But sex therapy, as a complex and ambiguous social institution, defies simple definition. In the boundaries of its constituency, in its theoretical and conceptual underpinnings, in its modes of therapeutic intervention, and in the objects of its concerns, sex therapy exhibits a distinctly indefinite and contestable quality. Moreover, sex therapy occupies an equally ambiguous relationship to the problems it seeks to address. Sexuality and sexual problems do not simply exist, they are at least in part the product of social construction, and the expertise to which sex therapy belongs is deeply implicated in their fabrication. Sex therapy then enjoys power not merely in the reactive ‘solutions’ it offers to sexual problems but in the positive role it plays in shaping the very terms upon which sexuality and sexual problems are understood. In this regard sex therapy constitutes one important institutional location in which subjects, as bearers of gendered, racialised and ethnicised social identities ‘acquire’ aspects of their sexuality and sexual problems.

The snap-shot of sex therapy provided in the previous chapter offers an initial orientation to sex therapy, but it does not come close to illuminating its complex and ongoing fabrication, or the multitudinous threads woven into its past and present forms. The unpicking of some of these threads, particularly those with a gender hue, has been the concern of an increasing number of historians and sociologists (most notably from a feminist vantage point). The threads of race and ethnicity however, and the forms taken by their inter-weaving with gender and sexuality within the tapestry of contemporary sex therapy, remain in the most part undisturbed.

There is no grand theory formulation appropriate to considering the relationship between gender, sexuality, race and ethnicity. Rather than displaying determinate forms of inter-relatedness, evidence suggests complex and deeply contextual forms of articulation, highlighting the importance of focused and detailed accounts (Solomos and Back 1996). Despite the complexity implied by the situational nature of the dynamics of racialisation and ethnicisation, and of their interactions with gender and sexuality, I will attempt to offer some illumination of their primary forms and articulations here. Given the essentially exploratory nature of this project, the scope of this theoretical contextualisation will necessarily need to be broad.

2.1 The social construction of sexuality

Sex therapy is concerned with people's sexual problems. But what does it *mean* to have a sexual problem? Precisely what is problematic about particular manifestations of sexuality? For whom are they problematic? If sexualities can be problematic, this would seem to pre-suppose the existence of non-problematic, 'normal' sexualities. But what in turn is a 'normal' sexuality, and upon what criteria have normal sexualities come to be defined?

Sexological, sex-therapeutic and medical discourses have commonly referred to sexuality as a matter of fact, as an essential and understandable object that resides to some degree outside the realm of the 'social', in relation to which they stand as mere observers, describers and where necessary interveners. But recent sociological and historical research has brought this distantiation of sexuality into question, emphasising the active social construction of sexuality, and of the forms of knowledge developed in its name. Social constructionism offers a direct challenge to the hegemony of essentialist accounts of human sexuality, particularly where these have taken scientific, bio-medical forms (Weeks 2000, Stein 1992). By demonstrating the ways in which sexuality has been constituted, to some degree or other, by social, political, cultural and economic dynamics, social constructionists have effectively deconstructed the boundaries between the sexual and social realms, and focussed our attention on the active role played by a host of constituencies, most notably those of a scientific, medical and therapeutic nature, in the construction of sexuality.

Social constructionist accounts of human sexuality take as their point of departure a critique of sexual essentialism (Tiefer 1992). Essentialism here refers to the notion that sexuality is a culture-independent, objective and intrinsic property of the individual/social group (Stein 1992)¹. Whilst not spelling the demise of theocracy, the Enlightenment marked a watershed in the emergence of essentialist bio-medical accounts of human sexuality (Porter and Hall 1995). The 18th century witnessed a more systematic application of scientific principles to the understanding of human sexuality, and a utilisation of scientific criteria for the legitimation of sexual norms. Nature became the subject of intense scientific enquiry, the purpose of which was to discover the universal laws underpinning the orderliness and symmetry attributed to the natural world (Nye 1999), and in so doing to valorise particular modes of sexual being and behaviour.

¹ According to Aristotelian doctrine, essentialism proposes a truth or force that inheres within objects, and to which our words about those objects refer (Zack 1997). Essentialism has characterised much of Western thinking about sexuality. Judeo-Christian doctrine located human sexuality essentially within a theologically-informed framework, invoking the authority of God in elaborating a hierarchy of sexual legitimacy.

In the late 19th century, in a scientific climate informed by the debates surrounding Darwin's work, an emerging sexology contributed significantly to the notion of human sexuality as expressing a biological essence. For Krafft-Ebbing, Bloch and Hirschfeld, the complexity and diversity of sexuality as experienced within society obscured an underlying and determining biological process. According to Weeks (1985), classical sexology served to 'naturalise' sexuality in such a way that foreclosed understandings of its historical genealogy. This naturalisation has constructed sex as the essence of our very being, theoretically and socially privileged heterosexuality, and submitted human sexuality to systems of classification of normality and abnormality (see Rose and Rose 1986). By grounding social relations in the realm of nature, social relations are rendered natural and hence inevitable, and in turn implacable to social intervention².

In contrast, social constructionism captures a range of theorisations that share in common the view that sexuality is inextricably connected to the realm of the 'social', and tends to take as foundational a number of broadly defined premises. Firstly, that sexuality is not a natural fact but instead a socially organised and 'fictional' unity of physiological, psychological and social potentialities. As such, we need to discard ideas representing sexuality as an autonomous realm answering to its own internal logic (Weeks 1985), and situate it firmly within history (see Foucault's 1976).

Secondly, that sexual forms (identities, practices, and even desires) are in a constant state of flux as they are informed by, and inform, our social lives. Sexualities are negotiated through struggle as an outcome of the circumscribed agency of social subjects, within a broader material and discursive context (Giddens 1992). Empirical research continues to evidence the transformations of sexual forms through history. Thirdly, it is argued that the importance of sexuality to the 'self', and to interpersonal relations, is also socially organised. The centralisation of sexuality to the self, as the very truth of the self, is a product of a complex interaction between emergent discursive categories, serving to hail particular sexualised social subjectivities into being (Foucault 1976), and the purposive use made of these categories by these social subjects (Weeks 1986).

² Interestingly, essentialism has also characterised the formulations of oppositional movements, most notably in some forms of feminism and Freudo-Marxism, where its repressive consequences have been challenged by a reversal of signification. An essential sexuality is seen as needing a form of liberation from the repression of a patriarchal/capitalist system.

Fourthly, sexuality resonates with, and betrays the influence of, the 'axes of differentiation' (gender, race, ethnicity, class) which do so much to shape the contours of our social geography. The processes of post-modernisation may have introduced hitherto unknown degrees of social flux and fragmentation, but empirically not to the point that we may be permitted to discard analyses of the powerful formative role played by these modes of social division in delimiting sexual behaviours, discourses, relationships and identities. An emerging sociological literature gives testimony to this fact. As a case in point, profound changes have taken place within gender relations and discourses, in part produced by the progressive augmentation of birth control, serving to reduce family size and separate sexuality from reproduction (Giddens 1992). We are in the midst of

...changes of great, and generalisable importance. These concern essentially an exploration of the potentialities of the 'pure relationship', a relationship of sexual and emotional equality, which is explosive in its connotations for pre-existing forms of gender-power (Giddens: 1992: p. 2).

Furthermore, sexuality has become central to a major transformation of intimate relations serving as a catalyst, test or signifier of intimacy within increasingly democratic interpersonal relations. For Giddens (1992), women's resistance and struggle within both the public and 'private' realms have been important in bringing about a revolution within intimate relations. Political parity, increased economic activity and the enhanced availability of contraception underpinned this process of revolution (Hawkes 1996). Unsurprisingly, sexuality has taken a central place within this struggle.

2.2 The role of sexual science

The precise role of sexual science (and the therapeutic interventions generated in its name) in constructing contemporary notions of sexuality is both complex and ambivalent. Sexual and medical science has generated a new language through which sexuality has been actively conceived, but at the same time re-articulated and consolidated already established discourses. It has produced new forms of knowledge that have made possible new operations of power and regulation, yet in many of its guises has been committed to radical humanistic notions of autonomy, and liberation from ignorance, myth and guilt. It has served to classify and fix sexual personages within prescriptive typologies, yet has been a resource for transgressive sexual identities (Weeks 2000, 1985). Though we may readily agree that

“sexology, or the ‘science of sexuality’, has developed to document, prescribe and provide advice upon the sexual government of the body” (Lupton 1994: p. 26), there continues to be much debate concerning its role in respect of contemporary sexualities.

For Foucault (1976), *scientia sexualis* has been the institution principally responsible for the construction of modern notions of sexuality. The body’s functions, sensations and pleasures do not stand out-with, or in an essentially antagonistic relationship to, the realm of the social. Rather, the discourses generated within *scientia sexualis*, and implanted within the social body, actually produced sexuality by grouping together biological functions, conducts, sensations and pleasures into the object *sex*. Sex became an object of importance, deliberation and intervention initially within ‘confessional’ religious practices, and later became the subject of more secular preoccupation during the Enlightenment. The latter marked a shift towards the valorisation of nature, and as a part of this process, the valorisation of human sexuality as an expression of this nature. The medical, scientific and political constitution of sexuality consolidated a process of sexual bifurcation (in the service of varying agendas) around the normal and the abnormal, the male and the female³, and as we shall go on to see, the binaries of race, reflecting medical science’s emergent cultural authority. In the process, it elaborated not only a whole new diagnostic sexual typology, but also new sexual personages such as ‘the homosexual’ and ‘the onanistic child’ (Foucault 1976).

But sexual scientific discourses were to some degree a response to historical developments.
Sexological claims

...locked into, and made theoretical sense of, a morass of popular beliefs about the proper spheres of men and women, and the demarcation of sexual normality...sexology was successful precisely to the degree that it made sense of inchoate feelings and beliefs - that its theories could be recognised as true by ‘common sense’ (Weeks 1985: p.88).

As such, sexology was grounded upon, and re-articulated in new forms, pre-existing discourses (Weeks 1985). The definitions of sexology were as much attempts at explanation as creation, and attempts at explanation redolent with the formative influences of its complex

³ Developments in sexual scientific knowledge, such as the 19th century shift towards sexual dimorphism and the discarding of a ‘one-sex model’, owed much to ideological shifts taking place beyond science, producing a need to emphasise sexual difference as a means to reasserting male power (Jordinova 1989, Laqueur, cited in Segal 1997).

social, cultural and political context.

Foucault's account of the role of sexual science as actually constituting sexuality through its particular 'will to know' is powerful, and certainly furnishes us with useful tools for understanding the operations of sexual science, medicine and therapy. It encourages us to take as a foundational principle the notion that sexual science has been profoundly influential in creating the object of sex as we know it. But a rounded understanding of the respective role played by sexual science in the construction of sexualities does require us to go beyond Foucault's particular concern with sexual scientific discourse, and address its situatedness within a socio-economic, political and cultural context. Rather than understanding the role of sexual science in a uni-directional sense as discursively determining the nature of contemporary sexualities, we should understand it as a complex terminal through which discourses and practices become mediated and re-directed. Sexual science (and the therapeutic forms it generates) is simultaneously author *and* recipient, both shaping and being shaped by the social formation of which it is a constituent part. This has important implications for understanding the circumstances of sex therapy in respect of the racialisation and ethnicisation of sexuality. In essence, sex therapy operates as a terminal point through which racialised/ethnicised constructs of sexuality flow and become directed. Sex therapy is neither author nor passive reader of these constructs, it is both.

Foucault's account, in assuming a degree of singularity to the constituency of *scientia sexualis*, fails to satisfactorily account for complexity, ambivalence and contestation. Sexology (and its therapeutic manifestations) and medicine have never been coterminous realms (Hawkes 1996). Much of sexology developed outside of, and in an uncertain relationship to medicine, with the latter consistently reluctant to sully its hands with sexual issues unless medical duty demanded. We should also be cautious in assuming too direct or immediate an impact of sexual scientific concepts of normality and deviance upon either medical or political thinking and policy. (Porter and Hall 1995). Turner (1987) is right to argue that "the doctor has replaced the priest as the custodian of social values..." and that a "...a panoply of ecclesiastical institutions of regulation have been transferred through the evolution of scientific medicine to a panoptic collection of localised agencies of surveillance and control" (p.38). But in respect of sexology, and the therapies which it inspired, acquiring legitimacy in the eyes of medicine has been, and continues to be, a struggle. This said, medicine still sets the hegemonic rules by which that legitimacy may be secured.

2.3 Key themes in the 'history' of sex therapy

Sex therapy is a distinctly late 20th century phenomenon, but with important formative historical precedents. Its provenance lies in the convoluted transformations of discourses and social practices orientated toward the provision of information, guidance and treatment on matters sexual. The Enlightenment marked a watershed in this history, insofar as it signalled a shift towards accounts of sexuality sufficiently secular in their nature as to facilitate the articulation of new forms of sexual expertise within which the sexual orthodoxies of Judeo-Christian theology could be mediated, and transformed (Segal 1997). For Porter and Hall (1995), the emergence of an 'Enlightenment sexuality' was the result. The systematic application of scientific principles to the understanding of human sexuality and the legitimising of sexual norms (Hawkes 1996, Porter and Hall 1995) was matched by a re-conceptualisation of sexuality as central to/defining of, our personage and the well-being of the self. This marked a point of departure for modern notions of the sexual subject that continue to underpin popular and scientific renditions of sexuality today. The Enlightenment also marked the emergence of a more 'democratic epistemology', expressing a commitment to a public dissemination of sexual information. The 18th century thus witnessed the proliferation of 'texts, tips and treatments' for the purpose of enabling the realisation of 'sexual health' (see Nye 1999).

Hawkes (1996) highlights two central features of a 'distinctive Enlightenment sexuality'. Firstly, in contrast to Judeo-Christian pathologisations, a scientifically authorised 'valorisation of nature' came to represent nature as a force of good. To live in accordance with the laws of 'human nature' was both idealised and made possible by a scientific endeavour to discover the universal laws underpinning the orderliness and symmetry attributed to the natural world (Nye 1999). Sexual desire, and pleasure, now expressed a natural mechanism central both to the order of nature, and to individual health and well-being (Porter and Hall 1995).

Secondly, a 'publicly evident celebration of sex and erotica' (Hawkes: p.36) emerged, underpinned by this emerging naturalism. The public profile of sexuality increased dramatically. Sexuality became the subject of both intellectual discussion and an elaboration of sexual aesthetics. An ethic of 'affective individualism' and an associated practice of companionate and intimate conjugality emerged from the mid 18th century within middle and upper classes (Stone 1977). An increased emphasis upon a form of decorative femininity as

an object and source of pleasure coincided with an enhanced recognition of women as having both a sexual libido and a rationality.

But the representation of Enlightenment sexuality as characterised by an un-fettered sexual hedonism is as partial in its account as it is ubiquitous in its influence. The promotion of pleasure had its limits, both in terms of those who were able or 'entitled' to indulge, and in terms of the absolute level of indulgence deemed to be healthy. According to Elias (cited in Nye 1999), the civilisation process has characteristically involved a transformation from external to internal constraints, and hence to an internalised sexual discipline.

Class divisions also shaped the elaboration of sexual practices and attitudes. A fear of working class sexuality, and its reproductive capacities, served to police the boundaries of the constituency for whom the valorisation of sexual pleasure and practice was deemed appropriate. "...Just as one didn't talk about atheism in front of the servants, so eroticism wasn't for them either" (Porter 1982: p.16). The limited nature of mass literacy amongst both peasantry and industrial working classes restricted their access to ideas and knowledge on sexuality. Women's sexual freedoms, whilst enhanced, were nevertheless circumscribed (Hawkes 1996). The terms and conditions of female sexual 'liberation' were largely determined by men. As Hawkes (1996) claims, "the recognition and celebration of women's sexuality followed a script driven by male sexual fantasy" (p.38). Enlightenment ideas about sexuality were masculinist in their language and underlying assumptions, manifested in the phallocentric nature of constructions of normal (and explicitly heterosexual) sexuality. Sexual double standards flourished as part of a broader mysoginist culture, a valorisation of the role of domestic motherhood, and a need to police female fidelity as a means to the limitation of instances of bastardy (Porter and Hall 1995). Underwriting such representations of women was an emerging science of anatomy and physiology which saw in nature a 'depth' within which powerful determinate influences were operating to shape the essential and divergent nature of male and female. In turn, the role attributed to science was to look deeply into, and intellectually master, this anatomical and physiological nature (Jordinova 1989, Schiebenger 1987). The medicalisation of sexual differences represented men and women as even more divergent in their nature than had Christianity.

With regard to the ethics of sexual practice, heterosexual coitus consolidated its ideological centrality. Masturbation, particularly youthful masturbation, was a source of substantial anxiety, as was 'homosexuality'. Homosexuality represented a contradiction to the Enlightenment valorisation of nature's capacity to reproduce. Non-reproductive modes of

sexual expression lost their equivalence and became constructed as, or relegated to, 'foreplay' (see Abelove 1992).

The relative explosion of 'expert' sexual literature during the 18th century both articulated and actively constructed these shifting meanings of sexuality. *Aristotle's Masterpiece* and Vennette's *Tableau de l'Amour Conjugal* were definitive of a 'sex advice' literature that reflected and informed public knowledge and attitudes towards sexuality. They served to codify sexuality in a fashion that was both descriptive and prescriptive. Far from offering a neutral account of a pre-formed sexual object, sexual literature actively produced that which it claimed to describe (Porter and Hall 1995). The mass nature of this literature, and its valorisation (albeit circumscribed) of conjugal sexual pleasure, ensured the disapproval of a medical establishment that viewed the actualities of sexual practices and interventions in the realm of 'sexual problems' as unsuitable for medical investigation or public deliberation. 'Quacks' colonised the vacuum created by medicine's reticence, claiming expertise and offering a wide range of 'treatments' and advice pertaining to a range of sexual problems. The boundaries of legitimate expertise in the field of sexuality had become deeply contested.

The 18th century then was marked by ambivalence and contradiction. On the one hand, a distinct valorisation of reproductive sexual pleasure is evident, associated with an enhanced public profile of a multitude of expressions and discourses of sexuality. On the other an elaboration of 'internal constraints' in the form of a sexual ethics and sensibility limited the hedonistic expression of sexual desire. Socio-economic, cultural and scientific developments impacted upon the prevalence and patterns of an 'Enlightenment sexuality' along lines of class, gender, 'race' and sexual orientation. Medical scientists came to see in nature both the depths of sexual antithesis and the normality of a phallocentric heterosexuality. Modes of sexpertise emerged within and without the boundaries of medical knowledge and practice, in the process broadening the base of sexual deliberation and contestation (Porter and Hall 1996).

In stark contrast to the assumptions of the 'repressive hypothesis' (Foucault 1976), the 19th century witnessed unprecedented discursive and material investments in the name of sex, consolidating and transforming its meanings in the process (Barret-Ducrocq 1989). Transformations in the relations of power placed sexuality centrally within new technologies of control over the individual and collective 'body', for the purpose of expropriating its capacity for health, wealth and productivity (Weeks 1985). This process of centralisation

rendered sexuality as a terminal through which a plethora of social, political and economic agendas could be enacted (Singer 1993, Weeks 1985).

The ‘great transformation’ of industrialisation brought with it emergent class conflicts within a context of substantial population growth, urbanisation, and the metamorphosis of social relations (Hawkes 1996). The capitalist logic driving these changes generated anxieties amongst the bourgeoisie about the need to limit the nature and extent of social flux. Sexuality and the body became a principle symbol of this state of uncertainty (Turner 1987), and a medium for the bourgeois class to re-establish principles of order, stability and discipline as a means to regulating and circumscribing both the aristocracy and the masses as competing drivers of change. The working class were understood in terms of a civilisation deficit. Domestic overcrowding signified for the middle classes the moral and sexual depravities that were assumed to be inherent to living in close physical proximity to others (Mason 1994). A ‘bestialisation’ of the working class was evident in public political discourses (Hawkes 1996), and served to enable the articulation of an antithetical bourgeois morality (Mort 1987). Sexuality became a principle disciplinary means through which the bourgeois class asserted, and valorised its own identity, as defining the nature of its physical and moral health (Nye 1999, Foucault 1976). Bourgeois evangelicalism offered a means to establishing new forms of moral authority (Porter and Hall 1995), and reflected the cultural hegemony achieved by the bourgeoisie through the medium of state institutions (Nye 1999).

Malthus’s ideas exerted a profound influence upon expert thinking on the sexuality of the masses throughout much of the 19th century. As Porter and Hall (1995) put it, “the long shadow of Malthus made dissemination of traditional sexual advice rather akin to toying with a loaded pistol” (p.127). Sexual restraint outside, and even within, marriage emerged as a defining ethic of the early 19th century. The Malthusian League (established in the 1870s) extolled the virtues of small families as part of a general anti-sexualism, though in the process contributed to a logic of fertility control that was deeply pathologised as immoral and criminal by sections of the press, the clergy and medicine alike throughout the 19th century (Maclaren 1994, Haste 1992, McLaren 1990). Malthusian ideas articulated with concerns about national and racial deterioration and the reproductive cost of sexual ignorance, as expressed by the influential Eugenics Society.

Through the 19th century, class-orientated discourses on sexuality coalesced with those of gender, in a context where fundamental shifts in the status of women were beginning to take shape (Turner 1987). Women were located centrally within discourses concerned with

the reproduction and moral well-being of the social body, largely through their role as mothers, and as the bearers and socialisers of children (Turner 1987). A continuity is evident through the 19th century with longer standing accounts of the health of women's bodies and minds as simultaneously underpinning, yet potentially threatening to moral and social stability (Turner 1987). Nineteenth century discourses pertaining to women's sexuality had moved significantly from 18th century accounts of female sexual capacity, and had become deeply ambivalent. Modes of sexual segregation were legitimated by renditions of women's natural sexual passivity and vulnerability, and by fears of their innate capacity to generate sexual energies (Segal 1997). Working class women became a particular source of anxiety as they occupied a position at the intersection of two avenues of discourse and intervention. The 'dark angel' of working class female sexuality (Hawkes 1996) haunted the hearts and minds of powerful interests within bourgeois society. Accounts of working class female sexuality resonated with notions of women as sources and transmitters of disease, and tended to foreground the active and dangerous elements of female sexuality found within broader and more contradictory representations.

Sexual science and medicine emerged in a form of dialogue with these material developments and their related discursive efflorescence. Sexology, whilst never quite coterminous with medicine, strived to follow the path of the latter's development (Hawkes 1996), establishing the conditions of its own possibility, and the legitimacy it craved, on the back of an emergent medical gaze (Weeks 1985). Throughout the 19th century medicine maintained a deep ambivalence about engaging with sexual knowledge, though as the century progressed a resigned acceptance of the need to assume control over the discursive and therapeutic field of sexuality came to prevail (Hall 1994). Though never with full consistency or unanimity, both medicine and sexual science were central to the development of new forms of disciplinary and regulatory power, producing new objects of knowledge and subjects of power (in particular the reproductive family, the hysterical female, the onanistic child, and the homosexual) (Foucault 1976). These emergent sexual subjects were understood within a discursive framework increasingly pre-occupied with the moral dimensions of health and disease (Hawkes 1996).

Within a 'social hygienist' discourse (Mort 1987), disease became both the dominant lens through which a range of sexual issues were represented, and the source of legitimation for a plethora of interventions (Nye 1999). The diagnostic category of hysteria, as it functioned through the 19th century within medical sexual discourse (Foucault 1976), was emblematic of the ways in which disease became a medium for the assertion of patriarchal

power (Turner 1987). Historically, medical ideology has invested heavily in the representation of women as inherently vulnerable and as in need of medical surveillance (Turner 1987). Through the 19th century, a profound biological reductionism within medicine consolidated notions of women as victims of a frailty deriving from their reproductive anatomy and physiology (Segal 1997).

Nature underwent a reconfiguring within much of academic and political discourse, becoming somewhat displaced as the underwriter of normality and health. Normality became more of an explicitly moral matter, with natural bodily forces requiring both control and direction in the interests of morality and psychological health (Hawkes 1996). The influential ideas of William Acton pathologised sex generally, and the sexual energies of the male particularly, promoting a mode of sexlessness, or at least sexual minimisation, for all (Porter and Hall 1995). Emerging from this articulation of medico-scientific and politico-moral discourses came a new mapping of legitimate sexualities, with an increased emphasis upon the potential dangers of sex generally, a marginalisation of non-procreative sex and a criminalisation of homosexuality (Hawkes 1996).

Within a context where public discussion of sex, even in the most clinical of idioms, was deeply problematic, medical movements in the direction of a greater interest in sexual issues were held with deep ambivalence within the profession as a whole (see McLaren 1994). The regard with which sexual texts were held by medicine depended almost entirely upon the medical 'credibility' of the author, but just as importantly, their commitment to discussing sexual questions in a manner, and through a medium, not accessible to the general public (Hall 1994).

Although the substantive language of 19th century representations of sexuality is redolent with pathologisation, and variations on the themes of moral and physical catastrophe, Foucault (1976) has forcefully argued that the Victorian era cannot be represented as repressive in any simple sense (Weeks 1985). The Victorians centralised questions of sexuality as *the* secret of selfhood, and the individual and social body. The body and its attributed sexual qualities, became the object of new forms of disciplinary power, and the 'surrogate medium' through which a range of social problems such as prostitution, sexual disease and imperial decline were articulated, and related anxieties addressed (Singer 1993, Weeks 1985).

The end of the century however marked the emergence of a new era of sexual science (Porter and Hall 1995), with the publication of Geddes and Thompson's *The Evolution of Sex* in 1889 and Krafft-Ebing's *Psychopathia Sexualis: With Special Reference to Antipathetic Sexual Instincts. A Medico-Forensic Study* in 1897. This new sexology was influenced by the naturalistic framework offered by Darwin's publications, and had gained enhanced respectability through its medical associations and orientations (Weeks 1985). Krafft-Ebing's method was formally committed to a scientific ethic of objectivity and detachment and, though partly moderated by an interest in the psychological dimensions of sexuality (Hauser 1994), expressed a broadly naturalistic, biological-reductionist approach. The purpose of sexology was to produce an enlightening truth able to dispel the unreason upon which he perceived much contemporary 'expert' thinking to be grounded⁴. In truth, this formal objectivity expressed a normative 'sub-text' (Hawkes 1996) inherent within his attempts to distinguish normal and abnormal sexualities around a valorisation of heterosexuality and male sexual performance (Segal 1997). Despite their formal commitment to a sexual enlightenment, the constructs of sexual theorists have regularly served to define and demarcate sexuality in ways that delineate human potentiality and reify human characteristics (Weeks 1985).

Krafft-Ebing's work epitomised the naturalisation of sexuality that has come to be the dominant ideological orientation of sexology for much of its formal history. This naturalisation has been expressed in more or less essentialist accounts of: the nature of sex itself as a form of instinct, in the privileging of a reproductive heterosexuality as a mode of sexual object choice dictated by the anatomy and physiology of the sexual organs, and in the classification of sexual variations (Weeks 1985). Sexology invoked a pan-sexualism within which a gendered 'hydraulic model' represented sexuality as the expression of powerful instinctual drives rooted principally in a male anatomy and physiology. These drives, through their sexual ambition, presented an inherent challenge to social and interpersonal order (Weeks 1985). The basis upon which classificatory sexual typologies were developed shifted towards a model of difference grounded less upon sexual acts or practices, and more upon a notion of sexual personages (Foucault 1976). These typologies expressed and reinforced new epistemologies of sexual thinking that were to become a resource for utilisation by a range of interests who saw in the sexual scientific discourses an authorisation for their respective agendas (Weeks 1985).

⁴ That the text was written explicitly for medical and legal audiences is indicative of the fact that he was attempting a top-down approach to realising enlightenment through engaging with expert opinion, and enabling a new political rationalism on sexual matters (Weeks 1985).

The turn of the 20th century was a watershed in the emergence of a second generation of sexology (Hawkes 1996) which simultaneously reinforced elements of established thinking and feeling on sexual questions, yet challenged extant contradictions, irrationalities and ignorance. The legacy of early sexology was therefore deeply ambivalent, challenging moral puritanism and promoting knowledge and education, yet re-articulating a masculinist heterosexual norm, and putting in place new regimes and knowledge and power.

The work of Krafft-Ebing, Havelock Ellis, and Edward Carpenter articulated a call for reform and enlightenment (Hawkes 1996, Weeks 1987, 1985). Sex research was invested with a capacity to salvage sexual pleasure as central to the human condition. Ellis, whose work remained influential until well after WW1, challenged aspects of the sexual polarisations of earlier works (and the intolerances they generated), and placed more emphasis upon the erotic rights of women within an enhanced egalitarian ethic (see Weeks 2000, Porter and Hall 1995). Ellis's work combined a biological determinism with regard to sex, with a cultural relativism in respect of morality (Weeks 1990), but ultimately walked a line between challenging and re-articulating extant accounts of human sexuality (Haste 1992). His account of 'sexual inversion' epitomises this duality. Similarly, though espousing a feminist ethic of egalitarianism, he normalised the coital imperative in a manner that re-articulated masculinist notions of penetrative sexuality (Haste 1992). This simultaneity of radicalism and conformity was a feature also of the work of other leading sexologists of the period, most notably Magnus Hirschfeld and Iwan Bloch.

Psychoanalysis emerged alongside sexology, but relocated the question of sexuality away from the realm of physiology and toward the interface between the psychic and social realms. The actualities of adult sexuality were here conceptualised as the outcome of the precarious and often incomplete repression (through socialisation) of a childhood polymorphous perversity, imposed in the interests of a reproductive heterosexuality necessitated by civilisation. Like sexology, psychoanalysis represented sexuality as the centre of individual subjectivity, but challenged the former's biological reductionism. Freudian notions of sexuality were to have radical implications in the longer term, in their challenge to the idea of a 'natural' heterosexuality, in their problematisation of sexual object choice and in their attention to the psychic/social interface in determining sexuality (Hawkes 1996, see Chodorow 1994). They marked a launching point for a proliferation of psychologically orientated accounts of sexuality that came to occupy a prime location in sex therapeutic accounts of sexual problems.

The second decade of the 20th century witnessed a shift in sex-related research toward a new laboratory-based anatomy and physiology concerned with understanding human sexuality through a reductionist methodology of microscopic analysis, which served to render human sexuality as a series of abstracted but intriguing laboratory questions (Porter and Hall 1995)⁵. Much of medicine remained deeply ambivalent about sexual knowledge and sexual science, and sexological work experienced consistent difficulties in securing publication and positive regard within medicine as a whole (see Hall 1994).

There were however some voices within medicine determined to contribute to the emerging scientific knowledge of sexuality, and to its communication to a broader public audience⁶. By the mid 19th century, what could be described as a British school of sexology had emerged “with both lay and medical representatives, the character of which has been pragmatic and empirical, lacking the theoretical constructs emanating from the continent, as one might expect, given the British empirical tradition” (Hall 1994: p.362-3)⁷.

As the century progressed, clinical experimentation, as a medium for generating sexual knowledge was supplemented by increased use of the ‘survey’ as a method for deriving knowledge from human experience (Porter and Hall 1995). The early 20th century witnessed a plethora of commissioned surveys of both ‘expert’ and lay opinion by a range of constituencies, exploring those aspects of social life that variably became the subject of political interest and anxiety. With some notable exceptions though⁸, sex surveys rarely tackled sex directly (Porter and Hall 1995), and principally concerned themselves with the condition of women and the poor. But underpinning these surveys was an assumption of progressive social improvement, and that reform could be enhanced by such investigative studies. The continued social and political anxieties associated with venereal disease, prostitution, child corruption, birth control, (and in some quarters ‘white slavery’ and foreign pimps) exercised a defining influence in Britain through to the end of WW2, and served as a driver for a diversity of reform agendas.

⁵ Marshall’s (1910) *The Physiology of Reproduction* is definitive of this work. A sexual conservatism prevailed within this constituency of scientists, with contributors such as Blair Bell and Walter Heape arguing a biologically determined sexual dimorphism in the characteristics and qualities of males and females.

⁶ Kenneth Walker, Joan Malleson and Helena Wright (influential in establishing the Family Planning Association), Norman Haire and Eustace Chesser stand out in this regard.

⁷ Furthermore, the late 19th and early 20th centuries had seen the emergence of interest groups, such as The Men and Women’s Club and the British Society for the Study of Sex Psychology, concerned with incorporating sexual questions into broader accounts of social relations, to various ends.

⁸ The Mass Observation Society’s survey on the efficacy of the Government anti-VD press campaign in 1942

Birth control emerged as a principle site of contestation. The British Sexology Society called for a more pro-active approach to birth control⁹ and to sex education but in so doing came into conflict with a significant proportion of medicine opposed to birth control and to contraceptive information (Hall 1994). It was left to the Family Planning Association (FPA), the Marie Stopes's Mothers Clinics, and the Marriage Guidance Council to offer support in these areas, though this relative autonomy did enabled developments in the field of psycho-sexual medicine (Porter and Hall 1995). Rationalist and moral/political discourses intertwined in the contestations around birth control. Eugenicist concerns about the size and 'quality' of the population, anxieties about the implications for female sexual behaviour of removing the threat of pregnancy, and moral conflations with abortion emerged as key themes in the debate. Moralist, feminist, medical and religious voices coalesced in an opposition to a comprehensive state-managed system of birth control. They variably feared that severing the link between sexual behaviour and reproduction may bring into question the institution of the family, and/or create the conditions for an un-fettered pursuit of sexual pleasure and exploitation (Hawkes 1996)¹⁰. However, morally-grounded anxieties about the implications of birth control for gender and sexual relations (in a context where women were challenging extant gender roles), were moderated by an emphasis upon the utility of family planning for the marital couple and for the nation (Hawkes 1996). The effective exclusion of the unmarried from birth control services (until the 1960's) enabled pro-family interests to be appeased and granted medical practitioners and service providers a necessary degree of 'respectability' in a contested terrain.

The early 20th century had witnessed the emergence of a new discourse of conjugal relations (Porter and Hall 1995), underpinned by a qualified commitment to the legitimacy, and importance of sexual pleasure to relationship happiness (Hawkes 1996, Bullough 1994, Evans 1993). Carpenter's critique of the extant institution of marriage as commonly grounded upon ignorance, a lack of companionship, and a restrictive regime of monogamy, exercised a significant influence in shaping this discourse, as it became articulated through the evolving genre of the post-war 'marriage manual'. Marie Stopes' *Married Love*, along with Theo van de Velde's *Ideal Love* became the defining texts within the field right through to the 1940's, enjoying unprecedented levels of sales (Bullough 1994, Haste 1992). They expressed a valorisation of non-reproductive sexuality, promoted birth control, and accounted for

⁹ In this manner, they paralleled the calls of the National Vigilance Association following WW1 for a comprehensive sex education programme as a bulwark against the perils of ignorance.

¹⁰ It was an emerging awareness, enhanced by the findings of the *Birkett Report* (1939), that women were taking the matter of birth control into their own hands, that produced the reluctant acceptance by both medicine and the state that the existing 'voluntary' system of provision needed to be replaced by a medically controlled, state-funded and planned system.

women's 'apparently' limited interest in sexual pleasure in terms of both an imposed ignorance and the limitations of their male lovers¹¹. The ideal to which relationships ought to aspire was to actualise 'good sex', defined by its moral and emotional legitimacy and erotic satisfaction (Porter and Hall 1995), and made manifest in the sexual skills acquired by the marital partners (Hawkes 1996). The texts served to foreground the limitations of medical knowledge and expertise in the area of sexuality, and were written from a somewhat marginal location out-with the power centre of medicine (Porter and Hall 1995).

Kinsey's (1953, 1948) work, as the pre-cursor to Masters and Johnson's initiation of a 'new sex therapy', emerged within a context in which sexuality was becoming the subject of unprecedented public deliberation and communication from a range of vantage points. But it was also a context in which reliable information on sexual issues was difficult to come by, and where sexual ignorance remained widespread (Porter and Hall 1995). Kinsey epitomised, perhaps more than any other, a commitment to the scientific method as the sole means to establishing truth. Kinsey's critique of the value-laden, normative nature of sexology's legacy was allied to an insistence on the democratisation of factually sound sexual knowledge (Hawkes 1996). He was critical of the essentialism that characterised earlier sexology, particularly in its tendencies towards the forms of typification that generated dimorphic notions of heterosexual and homosexual personages, and that demarcated acceptable forms of sexual expression. In its place, Kinsey's concern was with the development of an objective description of the full range of actual sexual behaviour. Within an ideological context of companionate marriage and of the importance of sex to the marital relationship, Kinsey stressed the capacity of both men and women for sexual arousal and satisfaction.

Kinsey's work articulated, through a scientific episteme, broad based changes in the nature and morality of sexual relations in Western societies. The uncoupling of sexuality from reproduction, and with it the direct association between sexuality and the reproductive, monogamous marital couple, was promising to transform sexual praxis (Hawkes 1996). Economic growth brought opportunities for greater financial independence for women, and empowered the implicit and explicit struggle for greater freedom and equality for women. The development of higher education opened up a space in which new identities and social/sexual practices could emerge. A 'negative utilitarianism' (Davies, cited in Hawkes 1996) inspired unprecedented state legislative activity, serving to 'liberalise' the social and political context within which sexuality was located. Within this climate of relative liberalisation, sexology

¹¹ Men, as the assumed initiators of sex, induced a frigidity in women through their unwillingness and inability to correspond their desires to the needs of their female partners, jeopardising the happiness of the relationship in the process (Porter and Hall 1995).

extolled the possibilities and virtues of female sexual pleasure (Hawkes 1996), to the point of virtual obligation.

A 'commodification of desire' challenged established modes of sexuality via an array of alternative and competing options. The 'reflexive subject' was hailed into sexual lifestyle choices. Critically, the body and sexuality have both become located centrally as objects of this reflexive agency. "...a rhetoric of personal happiness, individual choice and personal responsibility now figure as the organising principle of the sexual ethic" (Haste 1992: p.6). This has been associated with a veritable gold-rush of popular publications offering a facilitative guide to everything from the realisation of pure orgasmic sexual pleasure (for example, Chia et al, 2001), to the use of sex as a means to maintaining lifelong monogamy (for example, O'Connor 2003), to the pursuit of enjoyment as an 'ethical slut' (see Easton and Lutz 1997). For Giddens (1992), high modernity marks a shift in the balance of power within which the lay social subject, through the acquisition of knowledge in an increasingly democratised universe of information/experience, achieves greater authority in relation to the expert. But we must be cautious not to overstate the sovereignty of this agency. Choices are exercised within limits provided by particular sets of structural circumstance. The celebration of free choice can be an apparition that clouds the reality of new forms of hegemonic regulation. "The symbiotic relationship between discourses of self-expression and the maintenance of dominant ideologies" ensures that regulative power operates even at the moment of our most private of choices (Hawkes 1996). "Although overt state control has diminished, the social control of sexual behaviour and desire has taken on new forms, using different methods of coercion" (Haste 1992: p.6) Old fears about 'sex as pleasure' have indeed given way to a new celebration of sexuality, but at the expense of a new set of anxiety-making expectations authored by the sex experts, and encoding longer-standing gendered expectations. It has become necessary to choose sex (as it has become central to personal and relationship well-being), and to choose to be committed to ensuring that it remains interesting, inspiring and novel¹². Furthermore, coital sex remains implicitly and explicitly at the 'apex' of sexuality (Hawkes 1996), despite the relative problematisation of heterosexuality as a fixed and natural given underpinning a norm of monogamous heterosexuality. The outcome of these and other social transformations was to create a climate in which,

the focus on the dangers of unregulated expressions of sexual desire
was gradually superseded by the promotion of the advantages, both

¹² These expectations continue to fall particularly heavily upon women, in the process undermining their opportunities for autonomy (Hawkes 1996).

social and individual, of an informed sexual population monitored and shaped by the advice of experts – the scientists of sex and their successors, the sexual educators and therapists (Hawkes 1996).

2.4 Racialisation, ethnicisation, sexuality and sexual science

Having mapped the principle contours of the ‘new’ sex therapy’s formative ‘pre-history’, it remains to explore the nature of racialisation and ethnicisation. The disregard commonly given to the influence of race and ethnicity in shaping popular and academic ideas about the nature of human sexuality belies their profound impact. Race and ethnicity have operated as paradigmatic concepts through which the nature of human sexuality, and the diverse forms taken by it, have been implicitly and explicitly constructed within western societies.

Race and ethnicity are themselves social constructions, produced via *processes* of racialisation and ethnicisation. In emphasising racialisation and ethnicisation as *processes* we are concerned with understanding how sexuality has become enlisted in the service of constructing racial/ethnic boundaries and identities, and how in turn sexuality has become racialised and ethnicised.

2.4.1 Racialisation

Racialisation is a contested concept (Barot and Bird 2001). For the purpose of this project, “the concept of racialization signifies the extension of racial meaning to a previously racially unclassified relationship, social practice, or group” (Omi and Winant (1994, p.59). In other words, it refers to the attribution of social significance to imputed inherent characteristics (most commonly, ‘deep biology’, phenotypes, sexuality, intellectual capacity, cultural orientations and behaviour), whereby these characteristics become organised into ‘baskets of indicators’ of racial belonging and used to account for the nature of groups and their inter-relations. But racialisation involves more than the invocation of race. It is a “...socio-historical process by which racial categories are created, inhabited, transformed, and destroyed” (Omi and Winant 1994: p.55) in the service of a ‘racial order’ (Bashi 1998), shaping the lived experience and identities/psyches of those subjected to its imposition (see

Fanon 1967). The importance of the concept of racialisation rests in its emphasis upon *process*, and the scope it offers for analysing, whilst conceptually challenging, race.

Racialisation, as an essentially modern and European phenomenon, has been built upon historical antecedents. Multitudinous modes of ‘othering’ characterised the pre-modern European continent, with religiously based ‘virtual racisms’ (Fredrickson 2002) initially enabling the pathologisation and exclusion of sections of Europe’s own population (the Jews, peasantry etc) before being directed outward towards the Arab world, the Americas, Africa and the Indian sub-continent (Pierterse 1990, Miles 1989). But the proto-racism evident within the pre-modern Christian era laboured under the weight of its own scripture and doctrine (Fredrickson 2002). Principles of universalism, mongenism and environmentalism informed a notion of the *ultimate* commonality of all human beings, thus inhibiting the modes of othering that were to emerge with the hegemony of race.

Ironically, it was through the Enlightenment, and the espousal of a new form of humanistic universalism and egalitarianism, that the conditions for the emergence of race and therefore a fully fledged racism, emerged (Fenton 1999). It made possible the ‘sweeping aside’ of a whole range of particularisms, and their multitudinous forms of legitimation, that had in effect served to make the global dichotomies of the race concept a less likely development. It also laid the foundations of a naturalistic ontology, legitimated by the increasing status of science, that despite promising the eradication of unreason and superstition was to become fundamental to the emergence of an ultimately fictitious racial theory. The ‘modern’ concept of race has its origins in the 18th century (Fredrickson 2002) but it was not until later (typified in the work of exponents such of the Comte de Gobineau and Robert Knox) that a fully fledged biologically deterministic rendition of race was to emerge, and be utilised.

In an Enlightenment context in which the humanist principle of the equality of all men (as bearers of reason) became valorised, new ontological and epistemological foundations would be needed to achieve differentiation and exclusion. This was found in an emerging scientific racism in which the principles of polygenism and geographical determinism rendered particular populations, from their very origins, as ‘other’. Though taking many forms, and finding multiple points of theoretical/moral contestation and practical application, the scientific discourse of race was to exercise a profound effect upon the intellectual and

social consciousness of European nation-states, and jeopardise religiously grounded ontologies in the process¹³.

By the late 19th century, race had become the hegemonic concept of intellectual, social and political life. This hegemony was built upon the authority and veracity granted to scientific renditions of the world, and the manner in which such renditions could serve as a medium through which a host of social and political agendas could be pursued. Race became central to the consolidation strategies of European nation-states in their struggle for economic, political and cultural power at home and abroad (Solomos and Back 1996). In the hands of the social-Darwinistic Eugenics movement, and through techniques of categorisation and measurement, racial ideas became central to a project concerned with the improvement of the 'stock' of the nation (Burdett 1998). This in turn was seen to be fundamental to the fortunes of Britain as a national/racial constituency locked in a struggle for supremacy with others. Race and race prejudice also received some conceptual validation within the social sciences as expressing a natural primordial hostility towards those physically and culturally different (see Keith 1930).

Race became central to the colonial and imperial project, producing a racial 'norming of space' (Mills 1997). This racial norming had both epistemological and moral elements. It involved both a restriction of knowledge *per se* to European cognizers, and a construction of the 'dark continent' as morally inadequate. Taking European practices of settlement, industry and agriculture as a measure of legitimate human presence and value, the 'absence' of such practices in the 'darker' continents served as evidence of a lack of meaningful human presence and legitimated displacement and conquest.

Race became central to the management of population movements, and particularly immigration (Hickman 1998, Williams 1996). "Concern about the size and 'quality' of the population of the British Isles forms another thread running through national identity, nationality and immigration policy. Whenever population comes under scrutiny, immigration and 'race' are never very far behind" (Cesarani 1996 p. 68).

Race permeated popular consciousness via a multitude of cultural technologies (literature, cinema, newspapers, educational curricula), and became integral to the world-views of western societies in varying degrees of coherence and transparency. Though

¹³ It also found reinforcement in a resurgent neo-classical and racist aesthetics of beauty (Fedrickson 2002) that valorised whiteness as a 'somatic norm image' (Hoetenk, cited in Fredrickson 2002), and denigrated blackness (Young 1996).

racialised discourses were principally directed outward towards the African and Asian continents, they were also employed to make sense of the racialised minorities already resident within Britain, and of their relations with an implicitly racialised majority. Race was accessed and utilised to enable the pursuit of a host of oppressive and discriminatory practices in respect of employment, housing, education and leisure.

Racial thinking has always lacked unanimity, as its basic historicity rendered it subject to a multitude of influences. But collectively, its legacy has been to establish a range of ‘conceptual primitives’ in the intellectual and social consciousness of European societies, the principle elements of which are:

- An underpinning philosophical essentialism
- A biological or quasi-biological determinism/reductionism
- A delineation of inherent racial characteristics of a biological, ancestral, cultural/linguistic and sexual kind producing fixed cleavages of difference and dissonance
- Explicit and/or implicit notions of a racial hierarchy of inferiority/superiority
- A rendition of racial groups (and their individual representatives) as inevitably locked into a permanent state of conflict as a direct expression of their respective antithetical natures

By the mid 20th century, the race concept, in its doctrinal form, had come under decisive and terminal attack following a prolonged period of contestation (Barkan 1992). Scientific opinion had concluded that the biology invoked in the name of race was a fallacy. Moreover, the moral atrocities committed in the name of race, up to and during WW2, produced a political climate in which formal commitments to racism had become deeply jeopardising. But the ontology of race did not disappear. It would be more accurate to say that it metamorphasised, and not for the first time. The public prohibition on the vocabulary of race and racism in the post-war era presented a challenge to those, particularly within the political realm, who still had a will/need to articulate racialised and racist accounts of the social and political world (Brown 1999). A form of ‘metonymic elaboration’ took place (Solomos and Back 1996) through the medium of ‘new racisms’, directing energies towards a delineation of essential cultural, rather than explicitly biological, forms of otherness (Brown 1999).

The commonplace distinction between ‘old’ and ‘new’ racism has been overplayed though. Although we have seen a shift and diversification in the key signifiers of race, it remains the case that “racist discourse works through a conceptual articulation of social symbolism ultimately reducible to the non-social” (Brown 1999: p.31). What is novel about new racism is the manner in which it is able to articulate racism in the absence of its still central signifier (race).

The most notable development has been the proliferation of discourses that erase ‘race’, while in their place have arisen discourses of post-‘race’ signification, which form a flux around the signifying space, and which work through the articulation of its absent-presence (Brown 1999: p.32).

The culturalisation of race within new racism has produced a shift toward what could be described as ‘race-ethnic relations’ (see Solomos and Back 1996)¹⁴. The politics of the nation, and of citizenship, have become principle vehicles through which the new racisms have found expression. Race has become implicitly central to the formation of a national collective imagination (see Cashmore 2003, Anthias and Yuval-Davis 1992). Racialised ethno-nationalist discourses have constructed legitimate citizenship in terms of colour and descent, made manifest through markers of language, religion and culture (Singh 2001, Richardson 1998, Cesarani 1996, Silverman 1992, 1991). Racial/ethnic minorities thus become viewed as either inherently incapable of performing legitimised cultural practices, or capable merely of an inauthentic reproduction of such practices. Asylum seekers have become the principle focus of a form of ‘xeno-racism’ (Sivanandan cited in Fekete 2003), a non colour-coded racism directed towards Europe’s own displaced and dispossessed, and articulated as a ‘natural fear of strangers’. Practically, racisms vary in the *degree* to which differences are seen to be ‘permanent because inherent’. It can be sufficient in many contexts merely to establish that racial differences/inequalities are too intransigent for the circumstances (Fenton 1999).

Racialisation has become powerfully associated with dynamics of discrimination, disadvantage and criminalisation within western nations (see Fekete 2003, Goodey 2001). Correlations (real and imagined) between race, and opportunities/outcomes in education,

¹⁴ This application of a ‘race-ethnic’ relations model should not be taken as reproducing a deeply problematic operational conflation of race and ethnicity as concepts (see Bradby 2003). Rather that their conceptual inter-relatedness within popular discourses has reached a point whereby to analyse them in isolation may be to miss important dimensions of the question.

employment, housing and health have become central to British social and political life, attesting to the ‘realities’ of race. In relation to health, oppressive and discriminatory practices serving to disadvantage black and ethnic minority populations have been demonstrated in relation to psychiatric services (see Pilgrim and Rogers 1993), contraception (Williams 1996) and maternity care (Bowler 1993). Struggle and resistance, initiated by minority groups both in and against the name of race, have become an important part of the racialised contours of British society (Hall 1992). Particular formulations of the political concept of blackness within anti-racism have at times served to reproduce essentialist formulations of the racial subject (Body-Gendrot 1998).

Though lacking co-ordination and clarity, public-political policy and debate at many levels has variably but persistently placed race upon the perceptual map (Solomos and Back 1996). Institutional policy responses concerned with alleviating the oppression and discrimination experienced by racialised minorities, themselves institutionalise racialised categories in the service of alleviating their effects (Fenton 1999). Academic/intellectual utilisation of the race concept has at times been challenging and deconstructing, but has also been reproductive of reified common-sense readings of race (Malik 1996). The codes of practice, ethical frameworks and client-directed stratagems of professional groups have explicitly and implicitly encoded notions of race and ethnicity in their formulation and implementation. This ‘locatedness’ of race and racism produces plurality, and warrants analyses sensitive to the articulations between the dynamics of location and the broader forces at work.

Racialised social consciousness continues to hail people into racialised modes of subjectivity. Deposits of this social consciousness crystallise in the cognitions, affections and behaviours of individual subjects and become the building blocks via which racialised social identities are constructed¹⁵. Racial identities are structurally located within political, economic and social contexts and serve to fix the individual within the racialised contours of the nation. We acquire, and mediate, our racial identities within the contexts provided by a range of administrative apparatuses that communicate to us something about *who we are* in racial terms (Knowles 1999). Racial identities are the outcome of ‘work in progress’ (Knowles 1999), where the racialised subject is simultaneously both product and producer of their racialised lives.

¹⁵ In saying this, it is important to avoid the reductionist and deterministic assumption that racialised minorities and majorities are merely the products of racialialisation and racism (Modood 1992).

Critically, racialisation is a relational dynamic. Though race thinking has tended to be other-directed, racialised ‘representations of the other’ (Miles 1989) carry with them, because they encode, representations of ‘self’. Attributions directed at others become a principle means by which groups mark out their own identities and character. In some cases, as with ‘whiteness’, the representations of the racialised self are left largely implicit, and operate as an un-marked and vacuous norm against which the racial and ethno-cultural ‘otherness’ and particularity of minority groups is constructed (Dyer 1997). The relational nature of race extends to its dynamic interactive relationship with the axes of class, gender and sexuality. Both feminism and anti-racism have failed to appreciate the complexities produced by the intersections of race and gender, and most notably the specificities of the black female experience (see Frankenberg 1997 1993, Mohanty et al 1991, hooks 1987).

In short, “race can therefore be considered as one of the grand narratives of European modernity, not just as an analytical category but *in practice*. Crucially, this narrative has inflected other non-somatic categories of difference...” (Smaje 1997: p.309) in lending a culturally-coded ontology of ‘natural kinds’ to the dynamics of inter-group boundary formation and maintenance. In describing racialisation therefore, we are tracing the elaborations and transformations of race and racism in diverse historical contexts whilst maintaining some sense of their historical and logical connectedness (Solomos and Back 1996, Cohen 1994).

2.4.2 Ethnicisation

Ethnicity is a social construct, and as such has to be produced. For “...ethnicity to spring to life it is necessary that real or perceived differences of ancestry, culture, and language are mobilised in social transactions” (Fenton 1999: p.6). The active investments of social agents within particular historical circumstances (‘ethnicity making situations’) produces ethnicity as a *process*. Accordingly, Fenton (1999) highlights the common theme within theorisations of ethnicity when he states that “all commentators on the concept of ethnic group agree that it refers to the social elaboration of collective identities whereby individuals see themselves as one among others like themselves” (p.6). Ethnic boundaries and ethnic identities are not *determined* by the shifting facts of culture, language and ancestry, but by how perceived differences in these become signified and mobilised within particular social and political contexts (see Raj 2000). This signification we will refer to as ethnicisation, the process of *making* ethnicity. As a process of construction, ethnicity has had a somewhat different ‘centre of gravity’ to race (Fenton 1999). Unlike the vacuous fallacies produced by

the 'bad' science of race, ethnicity-building has some social grounding in the raw materials of language, culture, religion and ancestry, which are not 'simply' social constructions in the same sense.

But firm theoretical distinctions between race and ethnicity have become difficult, and perhaps misguided, to draw, as an outcome of their conceptual and empirical entanglement. It is now of dubious value to adopt an analytical stance informed by a determination to explore the nature and impact of these social categories separately (Fenton 1999, Smaje 1997). Racialisation, in the forms posited by the concept of new racism (and 'old racism' for that matter) has adopted the discursive vocabulary of culture, ethnicity and nation, in the process investing them with a racialised ontology. Similarly, in particular contexts, ethnicity has taken on deeply essentialist and pseudo-biological meanings. A 'race-ethnic' relations model (grounded upon a radical re-working of the ethnicity tradition) has become warranted both by these empirical convolutions, and by the evident theoretical failings of past disciplinary specialisations (Solomos and Back 1996).

The need for a 'race-ethnic' relations approach is indicative of the fact that despite theoretical moves to introduce an understanding of ethnicity as a highly variable and contingent process of social construction, in a multitude of social, cultural and political contexts a sense of self-evidency pervades accounts. From popular accounts, to media renditions, to institutionalised ethnic categories, to the assumptions upon which empirical research is grounded, a 'naïve empiricism' prevails via which ethnicity, and the cultural substance attributed to it, is conceptually reproduced and reified within a climate of taken-for-granted 'common sense' (see Smaje 1996, Ahmad 1993). This common-sense, or 'folk', model of ethnicity does however express a long-standing theoretical tradition in the conceptualisation of ethnicity, namely the 'cultural-area' model (Gil-White 1999). Underpinned by the work of both the British functionalists and the classical anthropology of Bronislov Malinowski, this model expresses a number of key assumptions about the nature of ethnic groups: that they are a self-conscious constituency; that others see them as such; that they have a common and distinctive culture and dialect; that they give preference to members of their ethnic group over others in most significant matters, and that they are biologically self-perpetuating (Gil-White 1999, Jenkins 1986). Within such an approach, 'ethnicity' as *process* essentially loses its meaning as ethnic identities, boundaries and even conflicts are seen to emerge organically from the 'cultural stuff' from which they are made.

Authorising such culturalist accounts of ethnicity tend to be assumptions about its 'primordial' nature. Ethnic identities are assumed to form organically from powerful and fundamental attachments to one's ethnic group as a receptacle of a shared culture, language and ancestry. These identities are assumed to form as stable, indelible and over-riding characteristics of the self through the process of socialisation (often conceived in pseudo-biological terms of 'inheritance'), and are assumed to be the basis of a super-ordinate mode of attachment with powerful affective components. Via the sense of trans-historicity, cultural fixity, intra-group homogeneity and inter-group difference typically invoked by such culturalist accounts of ethnicity, they are readily colonised by a racialised ontology.

Within popular culture, and within political and academic arenas, this cultural field approach (with its primordialist potential) has informed nationalist renditions of Britain and the British as a culturally bounded and white constituency. It has dramatically inflected debates about immigration, with accounts of the inherent 'otherness' of (particularly non-white) immigrants, and underpinned renditions of ethnic boundaries as inevitable points of conflict. It has also produced pre-occupations with the exotic differences of ethnic minorities, reducing minority populations to packages of cultural peculiarity (Stubbs 1993). In the context of health, it has produced a prevailing emphasis upon defining ethnic minorities in terms of specific diseases in relation of which they are held to be at a characteristically higher *relative risk* (Smaje 1995). It has also enabled various modes of victimisation as ethnic minority groups have been held culturally accountable for the social predicaments they experience (Bhopal 1992), epitomised in the *Stop Rickets Campaign* of the early 1980s (Sheldon and Parker 1992). Ethnic essentialist accounts have tended to displace understandings of the role of racism as direct and indirect cause of health inequalities (Karlsen and Nazroo 2002, Bradby 1995). In short, health research in the field has tended to focus upon an account of culturally determined 'islands of disease' (Ahmad 1993). The concept of ethnocentrism takes on a powerful meaning within a cultural field approach as it represents subjects as so rooted in their ethnicity that inter-ethnic empathy and sympathy becomes precluded.

The work of commentators such as Leach (1954) and Barth (1969) have radically challenged the notion that ethnic groups are the objective product of cultural characteristics, suggesting in its place a relational perspective that understands ethnic groups as the outcome of a *process* of labelling. Ethnic organisation produces the 'cultural stuff' of ethnicity rather than the other way round. Ethnic groupings, identities and boundaries are as a matter of empirical fact not the organic expression of a determinant and homogenous matrix of cultural

characteristics (Fenton 1999, Gil-White 1999). The ethnic categorisations and attributions imposed by ethnic *others* may in many cases be of more practical import in determining the 'nature' of the ethnic group than anything the ethnicised group might have to say about themselves. Ethnicity is therefore an outcome of processes of choice *and* constraint, of identification *and* attribution, and within given sets of power relations (Fenton 1999, Jenkins 1997, Solomos and Back 1996). Its relational nature also ensures that representations of the 'ethnic other' carry with them, and are often motivated by a need for, readings of the 'ethnic self'. As such, black and ethnic minority cultures in Britain must be understood within an explanatory framework that locates such cultural productions within a social, political and economic context of boundary construction (Billington 1991).

Such constructionist accounts of ethnicity point to the shifting and variable nature and salience of ethnic identities and mobilisations, highlighting the role of 'ethnicity making situations' (Fenton 1999) in the *process* of ethnic boundary formation. Ethnic mobilisation can be seen on the macro level of economic and political structure, the meso level of intermediate institutional structures, and on the micro level of inter-personal relations within everyday life (Fenton (1999). As ethnic categories have become encoded within institutional structures and processes, they have done much to (re)produce the boundaries, characteristics and needs of ethnic constituencies (Wieviorka 1998).

Instrumentalist perspectives on ethnicity have highlighted the manner in which ethnic identities are utilised in the pursuit of strategic aims (Banks 1996). The nature and intensity of ethnic identification in large part being determined by the instrumental value of such identification as perceived by the social subject. Particularistic identifications, and expressions of solidarity, are therefore not necessarily evidence of a depth of affective attachment with the group (the assumption of which is central to primordialist accounts of ethnicity), but may instead express a group's economic, political and social interests (Banks 1996). There are weaker and stronger versions of this instrumentalist account of ethnicity. The weaker form may accept the existence of socially grounded realities of culture, language and ancestry upon which ethnic identities are formed (even recognising the possibility of 'primordial' forms of attachment) but highlight the instrumental nature of how, and under what circumstances, these become mobilised in the pursuit of particular goals. The stronger version goes further in arguing that the very symbolic content of the group is a product of the uses to which the group identity is put.

The ‘situational’ nature of ethnicity has been highlighted, further bringing into question the assumption of ‘full-time ethnicity’ (Fenton 1999). Ethnic identities are here negotiated within particular situations, producing a diversity of forms and degrees of ethnic identification, logically to the potential point of zero (Fenton 1999). It is certainly the case that within ethnic groups sharp cultural differences can be detected (Fenton 1999), and levels of commitment to cultural symbols are highly variable. A social subject’s identity is constructed partly through the distance taken by the subject from their perceived group of belonging, and as such, there is no fixed dialogue between self and community (Kymlicka, cited in Body-Gendrot 1998). It is also the case that ethnic conflicts can increase simultaneously with a process of greater cultural homogenisation across groups. The salience of ethnic boundaries, and the extent to which these boundaries harden or soften within particular social contexts, is therefore not determined by the cultural characteristics of the people located within these boundaries (Jenkins 1997), but by their situational circumstances.

The ‘revival’ of ethnicity, and the prevalence of ethnic absolutism (Solomos and Back 1996), have been taken by many as an expression of the inherent nature of ethnic particularism and attachment (Fenton 1999). But there is another reading available. Fenton (1999) suggests that this revival may in fact be indicative not of an invigorated commitment to particularistic values but quite the opposite, an assertion of universalistic values of human dignity via a medium of respect for my difference.

The forms taken by these ‘revived’ ethnicities should also not be assumed to be mere extensions of the past. These are modern elaborations of ethnic boundaries and identities, in the process of active construction within a context of declining ethnic solidarities (in the sense of kinship and community solidarity) and an increased cultural homogeneity across groups (Fenton 1999). The diaspora experience has generated new and hybrid ethnicities, involving a dialogue between past and present (Gilroy 1997), and informed by both local and global dynamics. Robertson (cited in Anthias 2001) has referred to this as ‘glocalisation’. Invoking the *changing same* of black cultural experience, Gilroy (1994) describes “a determinedly non-traditional tradition, for this is not a tradition as close or simple repetition. Invariably conspicuous and unsystematically profane, diaspora challenges us to apprehend mutable itinerant culture. It suggests a complex, dynamic potency of living memory” (p.212), the implication of which is a constant process of boundary reconfiguration. Globalisation, though not inevitably, enhances the possibilities of hybridisation and formation of dual identities (see Saeed et al 1999). In the manner in which it enables juxtapositioning, interrogation, and the relativisation of ethno-cultural forms it provides a resource for cultural and identity

transformation (Barker 1998). The emergence and recognition of hybrid, syncretic cultures has been fettered and occluded by the reified nature of popular 'cultural field' accounts of ethnicity, by 'official' ethnic categorisations, and (see Saeed et al 1999, Wievorka 1998, Solomos and Back 1996), and by the efforts of powerful constituencies to produce cultural stasis. Though the post-modernist representation of the contemporary world may be the object of some contestation, the assertion that the human subject is complex, shifting and formed as a process across of range of possible identities is pertinent (see Cohen 1994). It also serves as part of the basis for challenging essentialist 'cultural-field' and primordialist renditions of ethnicity.

In the light of these insights then, "it is important to continue to be suspicious of reified notions of 'the community', 'homogenous ethnic identities', and fetishised traditionalism'" (Solomos and Back, p.138). Fixations with dusty ethnic motifs and detached symbols of exotic cultural difference continue to preclude understandings of the active manufacturing of new ethnicities. The dangers of a focus upon ethnicity, particularly in the traditional culturalist forms taken by this, lie in the representation of ethnic identities as unitary and constant, in a focus upon minorities and the associated representation of majorities as unproblematic, and of ethnic groups as trans-historical and atavistic (Solomos and Back 1996).

Multiculturalism, as a politics of ethno-cultural recognition and sensitivity, has strived to challenge the oppressive implications of ethnic 'difference-unrecognised'. But in some of its forms, it has undoubtedly contributed to the reification of ethnicity. The politics of diversity has no automatic claim to a progressive political mantle¹⁶. The particularisms claimed within identity politics, and reinforced within the policing of group boundaries, all too frequently result in: a displacement of a recognition of important forms of commonality across groups; a failure to acknowledge cross-cutting heterogeneities of class and gender; a displacement of a politics of redistribution and equality (Body-Gendrot 1998); a consolidation of processes of 'community king making'; and an empowerment of the claims of the majority against minorities.

¹⁶ She points out that in some cases, particularly with regard to what she calls the 'excluded of the exploited' (such as for instance Afro-Caribbean homosexuals), it has commonly been groups informed by an explicitly non-ethnic, universalist ethic that have offered support.

Such re-conceptualisations of ethnicity do not necessitate the negation of culture, or of the possibilities of correlations between ethnic and cultural boundaries¹⁷. But they do demand a radical de-construction of common-sense thinking about their inter-relations and a re-construction of an analysis that understands ethnicity and culture as produced in a manner that is complex, indeterminate, and fundamentally grounded within particular social, political and economic contexts.

2.4.3 Race, ethnicity and sexuality

Though there is no determinate relationship between the axes of differentiation of race, ethnicity, gender and sexuality, a recognition of their inter-woven, and co-constructed, natures is critically important. Research in this field is comparatively nascent but some key themes have emerged within the historical and sociological literature.

Research points to the importance of sexuality and gender as constituting some of the principle raw materials for the construction of racial and ethnic identities and boundaries (see Donovan 2003, McClintock 1995). Racial and ethnic groups have been imbued, and have imbued themselves, with particular forms of gendered sexual identity, behaviour and relations. Historical records show how central sexuality has been to the racialised ontologies through which the 'non-western other' has been constructed within a European context (see Gilman 1992). Throughout the middle ages, Islam, as the principle perceived threat to 'Europe', was constructed as aggressive, heretical, but above all as sexually licentious and indulgent in nature (Miles 1989). A sexually-infused exoticism pervaded accounts of the East, reaching a pinnacle within the Romanticism of the Victorian era (Netton 1990). The unbridled sexual desire previously attributed to Europe's own 'Wild Man' subsequently became personified in characterisations of the black African (Miles 1989) in terms of ignoble (and noble) savagery (see Kiernan 1990). In the 18th and 19th century colonial literature, the 'dark continent' was presented in implicit and explicit sexualised terms. Artistic renditions of black bodies encoded this sexualisation within iconic representations of the nature of black sexuality and of its relation to white bodies (Gilman 1992). In 18th and 19th century British society, anxieties regarding the alleged attraction felt by some white women (typically 'lower class') toward black men featured extensively in texts. Amongst the middle classes, a fashion for young male Moorish servants was underpinned by the sexualised signification of the

¹⁷ See Fenton and Sadiq-Sangster (1996) for an empirical account of the prevalence of particular modes of culturally grounded health belief amongst 'South Asian' women in Britain.

relations between civilised and virtuous adult white women and black adolescents (Pierterse 1992).

The 19th and early 20th century settlement of black male populations within Britain's maritime cities, such as Cardiff, Liverpool and Bristol, became the focus of popular/political anxieties and hostilities, manifested in forms of urban unrest. These were fundamentally grounded upon a racialised ontology of the black male as predatorily sexual, and as a source of simultaneous threat and desire for white women (Solomos and Back 1996). A fear of black sexual demands and of white female 'addiction' to those demands have been elaborated in conjunction with anxieties about consequences of sexual disease and prostitution (Solomos and Back 1996, Pierterse 1992). Renditions of the black male as hyper-sexual continue to this day within popular culture, via iconic representations such as Linford Christie's 'lunchbox', and accounts of 'black' areas of Britain's inner-cities as sexually promiscuous and a-moral. Similarly, African and Afro-Caribbean women have continued to be represented in sexually reductionist terms (hooks 1992). Such accounts, by locating black men and women in greater proximity to 'nature', impose a hierarchical schema whereby blackness comes to represent 'primitiveness' in juxtaposition to the civilisation encoded within whiteness. The black subject within the western context constituting an enduring and threatening 'bubble of wilderness' (Mills 1999).

However, the pathologisation of Britain's racial/ethnic others has not been achieved solely through attributions of sexual prowess and licentiousness. I would suggest that, notwithstanding the legacy of historical renditions of Asia as exotic and culturally sexualised (epitomised in western representations of Asian females as sensuous and well versed in the Kama Sutra (see Hall 2002)), the racism directed toward young male South Asian immigrants has been informed by a negation of their masculinity and sexuality. Constructions of the extended Asian family, and of the obligations and accountabilities such families have been seen to place upon their youth, have been utilised to produce a particular form of racism towards young Asian males that ethnically discredits them on the basis of their cultural 'emasculatation' and 'feminisation'.

One of the principle dynamics of the sexualisation of the non-white other, has been the role it has played in serving as a metaphor for repressed white sexualities. Across areas of psychology, criminology, anthropology and biology, reflected in areas of art and literature, blackness and its 'dark' territorial spaces became the objects of a multitude of anxious and

repressed 'western' projections. Such accounts of differential sexual 'natures', practices and moralities served dialectically to re-articulate idealised Christian sexual norms (Miles 1989). The intellectual, cultural and sexual pathologisation of the racial other became central to the renditions of European nation-states and their people as civilised because rational and virtuous. The binaries of civilised/uncivilised, cultural constraint/natural freedoms, have become eroticised as white western subjects project onto blacks the sexual desires simultaneously produced and repressed within such a racialised ontological universe. As Pierterse (1992) argues, "In this forcefield of attraction and repulsion, an ambivalence towards one's own sexuality is experienced and projected onto the outside world, which appears the more primitive and uninhibited the greater one's fears as to one's own sexuality. Under such pressure subliminal sexuality takes on larger, more extravagant forms. Subsequently, a connection can arise between the control and repression of one's own sexuality and the control and repression of 'Others'" (p.172).

Accounts of the national self and of the colonial other were developed within colonialist and imperialist propaganda through a racial frame utilising ideas of gender and sexuality. Via the image of Britannia, Britain became gendered as female, simultaneously representing the virtues and vulnerabilities of white femininity and sexuality abroad (Solomos and Back 1996).

In the hands of the Eugenics movement, racial ideas became central to a project concerned with improving the racial 'stock' of the nation (Burdett 1998), placing questions of sexuality and the family as central to the nation's health. Eugenics served to reinforce ideas about the role of women, of motherhood and of female sexuality, as women's primary function became the nurturing of the nation's racial health (Burdett 1998). The importance of sexuality lay not merely as a marker of the national/racial character of the British but also in its inherent potential for either reaffirming or undermining the racial boundaries of a nation locked in an inter-national Darwinian struggle for supremacy. Although its formal influence had declined by the 1940s, "eugenics was the intellectual and scientific pinhead of knowledge upon which a wide range of twentieth-century welfare discourses danced" (Williams 1996, p. 24).

Gender and sexuality have been important means by which nation-states have strived to enforce ethnicised and racialised boundaries (Fenton 1999, Nagel 1998, McClintock 1995, see Mosse 1985). One of the principle linkages between nation, ethnicity and gender has been the manner in which women have been invested with responsibility for the maintenance of ethnic identities and boundaries (Fenton 1999). According to Yuval-Davis (cited in Fenton

1999), women are "...the biological reproducers of ethnic collectivities, and the central participants in the ideological reproduction of the collectivity and as transmitters of its culture (p.57). The performance of culturally sanctioned gender roles and sexualities simultaneously becomes a measure of one's racial/ethnic authenticity, of the essential racial/ethnic character of the group, and of the boundaries that demarcate the racial/ethnic group from others (Weeks 1986). So not only are women frequently central to the reproduction of ethnic identities and boundaries as mediums for the reproduction of cultural, linguistic and ancestral symbols and as biological reproducers and home makers, they themselves become objects within a set of gender and sexual rules that may become central to definitions of a group's ethnic culture and value.

The delimitation of the citizenship of racialised non-white populations in Britain has partly been achieved through the medium of sexuality, by locating racialised/ethnicised minorities outside the boundaries of sexual legitimacy. The construction of a black male hyper-sexuality threatening the vulnerability of white feminine virtue; the pathologisation of the Afro-Caribbean family; the problematisation of the reproductive 'Asian' family; the popular and political anxieties pertaining to 'mixed-race' relationships and their children; the representation of HIV/Aids as a black African problem, have all served as examples of the centrality of sexuality to processes of racialisation and ethnicisation. The realm of sexual and familial relations has been an important terrain within which racial boundary guards have been in operation, demarcating the moral community of citizens from its moral aliens (Smith 1994).

Racial/ethnic 'purity' is fundamentally jeopardised by 'inter-racial' sexual relations. Within a eugenics frame, sexual relations between different races spelt disaster as they simultaneously 'polluted' and therefore undermined the superior race, and rendered the racial boundaries themselves permanently opaque. The 'one-drop rule', whereby one becomes black upon having 'one drop of black blood' simultaneously expressed the importance attached to the purity of whiteness, and the role played by whiteness as the norm from which blackness deviates. Likewise, the normative nature of whiteness and the white family is indicated by the fact that those of 'mixed' parentage have been named by their non-white component.

In Frankenberg's research (1993) white women having sexual relations with black men were seen as transgressors of a normative rule of same-race relations, where their proximity to black male sexuality reduced them to a personification of sexuality and rendered

them corrupted and perverted . White men's masculinity has also been racialised, as evidenced in their self-assignment as 'protectors' of white women from black men (Frankenberg 1993). Notions of masculinity and femininity betray the influence of racialisation and ethnicisation such that an 'authentic' racial or ethnic identity in part comes to rest upon a 'natural' adherence to prescribed gender and sexual relations (Frankenberg 1997, 1993). The inter-'racial' or 'inter-ethnic' couple represents an affront to a notion of family unity, grounded upon an idea of 'wholeness' and cultural homogeneity from which the 'mixed' relationship and 'mixed' person is a pathological deviation (Donovan 2003, Frankenberg 1993).

Political and economic inequalities between racialised/ethnicised populations have enabled and informed dynamics of sexualisation. Colonisation and slavery institutionalised such inequities with the effect that the economic and political power enjoyed by white men could be used to ensure sexual access to 'non-white women' who lacked the necessary and sufficient conditions for agency. The power relations characteristic of the Empire enabled the systematic sexual exploitation of women and children in Asia and Africa, extending to the official organisation of 'in-house' brothels specifically for the use of military personnel (see Berger 1988). The contemporaneous prevalence of sex tourism, and the human trafficking of impoverished women from the developing world, partly for the purpose of sexual exploitation, are cases in point of the enduring effect of economic and political inequalities on sexual relations. Within a racialised/ethnicised framework, these political and economic inequities themselves can and have become eroticised, such that the power imbalance itself becomes a source of desire (see O'Connell-Davidson 1998).

The historical and contemporaneous development of 'sexpertise' has to be understood within this broader context, though the extent of empirical research available to illuminate the question is extremely limited and has concerned itself primarily with 'classical' sexology. We do know that classical sexology appeared to have surprisingly little to say on the matter of race and sex. But the apparent absence of extensive and formal elaboration of the race principle within sexology and sex therapeutic texts should not be taken to indicate a real absence (Somerville 1998). The notion of biologically distinguishable racial groups, possessed of differing intellectual and cultural capacities, was a taken-for-granted truth so ubiquitous as to warrant no justification in sexology and medicine in the late 19th and early 20th centuries (Somerville 1998).

Classical sexology and medicine imbued the racialised social consciousness of the day and granted it scientific authorisation via a racialised reading of bodies and their sexualities, in turn providing a legitimisation for the pursuit of (eugenically infused) social and political agendas (Somerville 1998). It was with particular reference to the black female body, and most centrally her genitalia and buttocks, that the racial difference of Africans as a whole was based. The broader rendition of black Africans as excessively sexual gained a scientific authorisation from clinical studies claiming the ‘literal excess’ and peculiarity of the morphology of African female’s genitals and buttocks, as juxtaposed to a norm constituted by white female Europeans (Somerville 1998). From the early 19th century, Saartje Baartman (the Hottentot Venus) had symbolised the differential nature of black female anatomy and sexuality (Pierterse 1992) within a medical iconography which reproduced and informed an extant racialised aesthetics (Gilman 1992). Havelock Ellis, as the ‘founding father’ of sexology, articulated an absolute racialised aesthetics of beauty, which located black and white bodies at opposite ends of a hierarchical scale, and which he believed produced a natural barrier to inter-racial sexual attraction (Gilman 1992).

Sexologists, such as Edward Carpenter, discursively utilised, and as such consolidated, a racial ontology and epistemology in their accounts of difference in respect of sexual bodies. The idea of ‘intermediate’ bodies and of ‘sexual half-breeds’ drew directly upon a racial paradigm. “The beginnings of sexology, then, were related to, and perhaps even dependant on a pervasive climate of eugenicist and anti-miscegenation sentiment and legislation” (Somerville 1998: p. 68). With the shift towards a more psychological emphasis in the study of sexuality, race exerted an influence through the rendition of miscegenation as an abnormal sexual object choice (Somerville 1998).

A shift in scientific accounts of human sexuality took place in the early 20th century, in part influenced by the work of classical social anthropologists such as Malinowski and Mead. This work served to highlight the sheer diversity of cultural patterns, including those pertaining to sexuality. They also served to challenge a biological determinism with a similarly deterministic cultural alternative. The enormous influence exerted by these accounts contributed significantly to a shift in the terms of debate away from a doctrinal biologism and toward an ethno-cultural determinism. However, as Weeks (1986) points out, despite its emphasis upon relativism, the social anthropology of this period reproduced the longer-standing notion that non-western cultures were in some sense freer of constraint and closer to some natural and unfettered (sexual) condition.

But the trail of historical and sociological literature exploring sexology's and sex therapy's explicit and implicit engagement with race and ethnicity very quickly turns cold. We know very little about the ways in which race and ethnicity have become worked into sexual scientific and therapeutic readings of sexuality and sexual problems today, and it is toward making some contribution to a contemporaneous understanding of this question that this project is directed.

Chapter 3 – Methodology

3.1 The scope of the project

This project is concerned merely with one piece of a very large, and as yet, barely recognisable jigsaw puzzle. The completion of the puzzle would involve a comprehensive and definitive exploration of the roles played by race and ethnicity (in their discursive and material forms and effects) within sex therapy, which in turn would necessitate a multi-modal analysis of sex therapy's conceptual/theoretical underpinnings, its therapeutic strategies, the practical application of these within the therapeutic moment itself, the experiences of sex therapy's clientele, and the clinical outcomes of therapeutic interventions. Such an exploration is well beyond the scope of this project. This project will concern itself then, with merely one element of this field. Namely, the analysis of how sex therapists talk about race and ethnicity, and of the significance therapists attributes to them, as these pertain to questions of sexuality, sexual problems and sex therapy practice. It is concerned with describing and explaining the ways in which racialised and ethnicised discourses are both reproduced and produced within the field of sex therapy.

But even here there is a need to dramatically circumscribe the scope of the project. Sex therapy, as an object of enquiry, 'slips through the fingers' of our operational categories. Should we understand sex therapy in terms of its professional bodies, its theoretical/conceptual underpinnings, the modes of training undertaken by its practitioners, the nature of its preferred therapeutic practices, or the 'problems' of the clients to whom it attends? On the basis of its strategic role within the UK, as a source of accreditation for practicing sex therapists, and as a focal point for conceptual and practical deliberation in the fields of human sexuality and sex therapy, the scope of the research field has been set by the boundaries of the British Association of Sexual and Relationship Therapy.

This delimitation of the scope of the project also reflects the restrictions of time and resources imposed upon the researcher by the particular circumstances within which this project was undertaken, namely as the basis of an individual PhD, studied part-time and during a period of full-time employment. Effective methodologies are always a lesson in the 'art of the do-able', and in the final instance this often becomes a question of time and budgets (Arber 1993).

3.2 Ontological and epistemological assumptions

The underpinning ontological and epistemological position informing this project could best be described as *realist*. By realism I refer to the premise that, beyond language and individual consciousness, lies a social reality taking a multitude of material and ideological forms, and impacting upon social subjects. This reality becomes manifested through language and consciousness, but also via behavioural and affective phenomena. The discourses generated by individual subjects or by social institutions then become, at least to some degree, crystallisations of a set of material relations and a multivariate social consciousness to which they represent a form of instantiation. Discourses therefore reflect the context-specific and active use made of linguistic repertoires by social subjects *as* these are shaped by the discursive, relational and material context within which they are embedded and from which they derive their raw materials. Whilst one important function of research is to enable an understanding of how discourse is used by social subjects to actively produce morally-infused preferred renditions of the ‘truth of things’, and in particular, ‘narratives of competent or moral self-identity’ (Seale 1998, see Dingwall 1997, Gilbert and Mulkay 1984), these renditions can and should be explored for their embeddedness within a broader discursive, relational and material set of circumstances.

As such, the analytical status given to the data generated has been to see the data both as a topic in itself, but also as one resource through which a deeper and more situationally-transferable social consciousness may be explored. To this extent I concur entirely with Seale’s (1998) view that treating data as both a resource and as a topic is “...not mutually exclusive, in spite of the occasional extremist statement by researchers concerned to develop particular approaches” (p.215).

The purpose of sociological research is not merely to achieve descriptive renditions of social behaviour or individual consciousness, as these cannot themselves produce *explanation* (O’Connell-Davidson and Layder 1994, Gilbert 1993), but to locate these renditions within a theoretical context. The accumulated legacy of academically-credible theory, as developed in articulation with the production of empirical evidence (Seale 1998), is the closest we have to a means for establishing the quality, veracity and meaning of data. As the field of sex therapy, at least in respect of race and ethnicity, is a largely uncharted territory, this project must be essentially exploratory in nature. A ‘grounded’ and somewhat inductive approach to theory development is therefore warranted, enabling an understanding of how broader societal dynamics become produced and reproduced within *specific* social locations.

This project has been informed by a reading of knowledge-production, as inherently imbued with political interest. From the manner in which particular social phenomena become constructed as ‘problems’, to the impact of the knowledge once generated, socio-political and economic variables shape the contours of what we are to know of the social world. This ‘politics of knowledge’ also ensures that all theory development and utilisation necessarily carries with it positive and normative elements, encoding positionings in turn underpinned by explicit and/or implicit commitments to valorised criteria such as equality, autonomy and ‘truth’ (O’Brien 1993). It is critical then that researchers are reflexively aware of, and take positive responsibility for, the role played by the ‘politics of research’ in their work (Mason 1996, O’Connell-Davidson and Layder 1994).

In the light of these issues, a dual-mode research design was adopted in which in-depth semi-structured interviews have been supplemented by the textual analysis of journal papers (from the *Journal of Sexual and Marital Therapy*) as a means to generating the richness of data necessary to furnish answers to the research questions specified.

3.3 The Interviews

3.3.1 The interview format

The interview format adopted comprised one-off, in-depth, semi-structured interviews with 20 sex therapists. A series of open-ended questions were formulated and organised thematically to produce a question route in response to which the therapists were enabled to determine the breadth, depth and length of their answers. Interviews took place at a location and time of the respondents’ choosing and generally lasted between 1-1½ hours. Five interviews were carried out initially, and subjected to a process of ‘theoretical sampling’, enabling the generation of a greater quality and quantity of data, particularly concerning the nature of race and ethnicity themselves.

3.3.2 Rationale for choice of interview format

As the aim of the research was to illuminate the core themes pertaining to sex therapists’ accounts of race and ethnicity, as these were seen to relate to questions of sexuality, sexual problems and sex therapy, the project depended upon the generation of rich data, but with the additional capacity for comparability across the data set. Interviews, as “...a

resource for understanding how individuals make sense of their social world and act upon it” (May 2001: p. 142) seemed ideally suited to the generation of such data. Semi-structured interviews particularly have proved a useful tool for enabling the production of rich data, but with a degree of standardisation making comparison possible (May 2001). The richness derives from the manner in which respondents are able to elaborate their position with a reduced level of interviewer-imposed constraint, and in terms largely of their own choosing (May 2001). It is also a product of the capacity of the interviewer in this context to probe for clarification and/or further information as a means to maximising the opportunity to achieve a subjective understanding of the data (O’Connell-Davidson and Layder 1994), a facility I considered to be crucial¹.

Semi-structured interviews also seem well suited to exploratory research where there is a need to assume as little as possible about the field being studied. But if I am open to criticism from some for introducing a degree of direction and structure in adopting a semi-structured approach, then I would suggest that such an interview format reflects accurately the true nature of the interview as an interactive event.

The interview is a turn-taking system that requires that the interviewer proposes topics and that the respondent seeks to produce locally acceptable answers...an interview is not a conversation. It is a deliberately created opportunity to talk about something that the interviewer is interested in...(Dingwall 1997: p. 58-9)

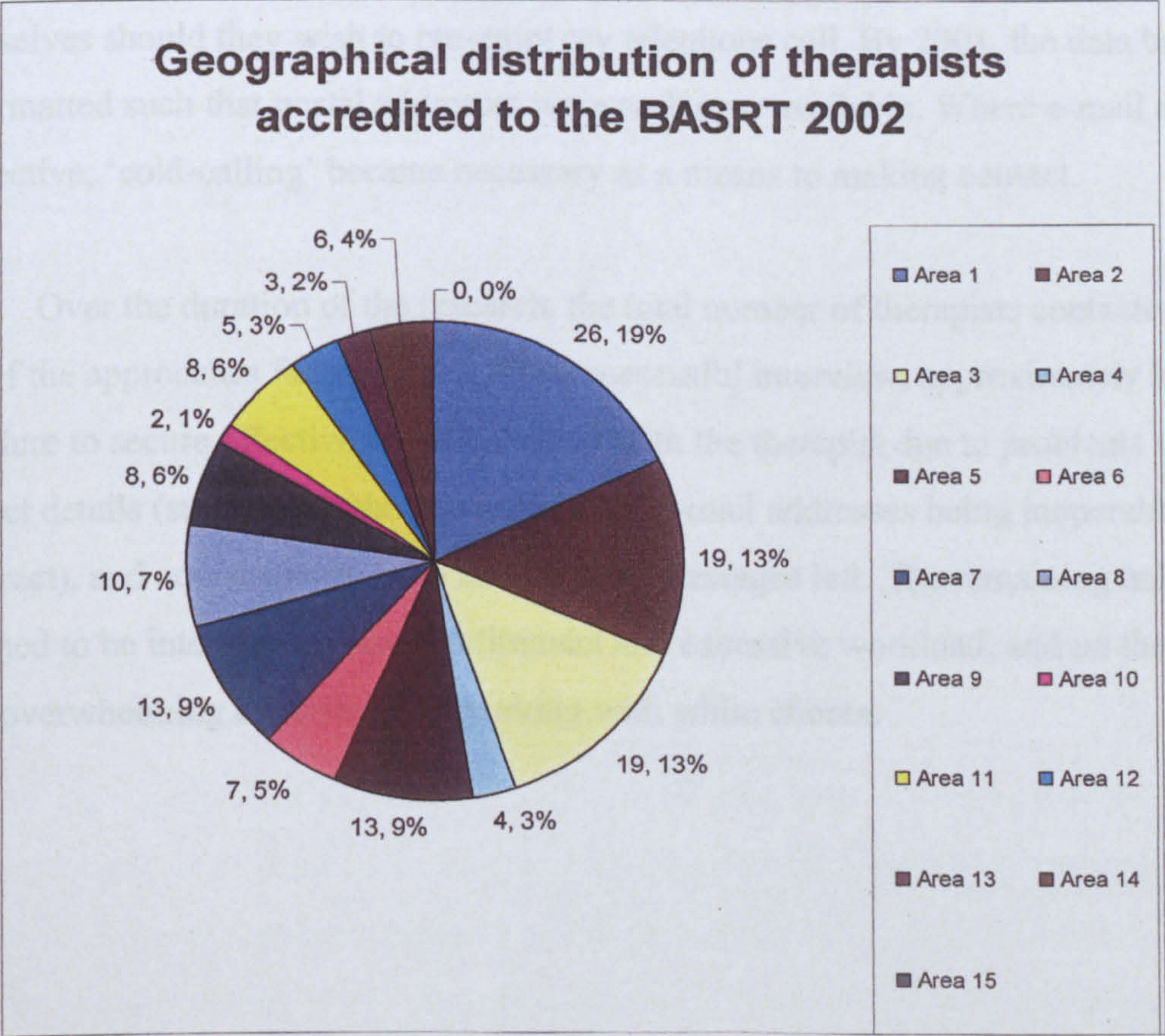
If a balance needs to be struck between the ‘subjectivity’ implied by the inter-subjective understanding characteristic the forms of interaction produced within in-depth interviews, and the ‘objectivity’ associated with a ‘detached’ analysis of the data so generated (May 2001), then the semi-structured interview would seem to offer some opportunity to achieve this via the richness/comparability couplet.

As such, in-depth interviews are one of the most effective means of identifying what “...cannot be seen or heard, such as the interviewee’s inner state – the reasoning behind their actions, and their feelings” (Seale 1998: p. 202).

¹ “There cannot be definitive rules about the use of open-ended questions, leading and loaded questions, disagreements with respondents and so on. Such choices depend on the understanding researchers have of the person they are with and the kind of relationship they have developed in the encounter” (Jones 1985: p. 48-9)

3.3.3 Sampling

A host of logistical issues dictated the particularities of the sampling process. The total size of the sex therapy population in the UK is unknown as there is no central, publicly accessible register to serve as a reliable sampling frame. A decision was made to limit the population to the accredited membership of the BASRT, as it constitutes the primary professional body for sex therapy in the UK. A list of accredited sex therapists was acquired through the association's own web-site, organised on the basis of geographical region. There is no guarantee that this list is comprehensive as some accredited members may not have wished for their details to appear in this context. However, as most therapists are commercially active, such inclusion would constitute a useful addition to other modes of public advertisement. A further decision was made to limit the sampling frame to those listed within Area 1 (London and Middlesex) on the basis of geographical proximity and number of therapists.



Area 1 - London and Middx
Area 2 - Kent, Surrey and Sussex
Area 3 - Berks, Hants and Wilts
Area 4 - Bucks, Glocs, Oxon
Area 5 - Beds, Essex, Herts
Area 6 - Cambs, Norfolk, Suffolk
Area 7 - Avon, Cornwall, Devon, Dorset, Somerset, Offshore Islands
Area 8 - Birminghman, Derby, Hereford, Leics, Lins, Northants, Notts, Shrops, Staffs, Warwks, Worcester
Area 9 - Humbs and Yorks
Area 10 - Cleveland, Cumbria, Durham, Tyne and Wear
Area 11 - Manchester, Cheshire, Lancs, Merseyside
Area 12 - Scotland
Area 13 - Wales
Area 14 - Ireland
Area 15 - IOM and Overseas

Figure 3.1 – Geographical Distribution of therapists accredited to the BASRT
(based on data derived from basrt.org.uk)

The bulk of the therapists were approached using a letter of introduction, followed by telephone and/or e-mail. The letter informed them that they would receive a telephone call within a week to establish their response. This approach enabled the respondents to offer a more informed consent, as they were able to spend time reflecting upon the request, and upon the proposed subject-matter of the interview. They were also able to initiate contact themselves should they wish to pre-empt my telephone call. By 2001, the data base had been re-formatted such that postal addresses were no longer available. Where e-mail details proved ineffective, 'cold-calling' became necessary as a means to making contact.

Over the duration of the research, the total number of therapists contacted amounted to 55. Of the approaches failing to result in a successful interview, approximately half were due to failure to secure effective communication with the therapist due to problems with the contact details (such as telephone numbers and e-mail addresses being inoperable or incorrect), and non-response from therapists to messages left. The remaining half verbally declined to be interviewed due to retirement and excessive workload, and on the grounds of their overwhelming experience of working with white clients.

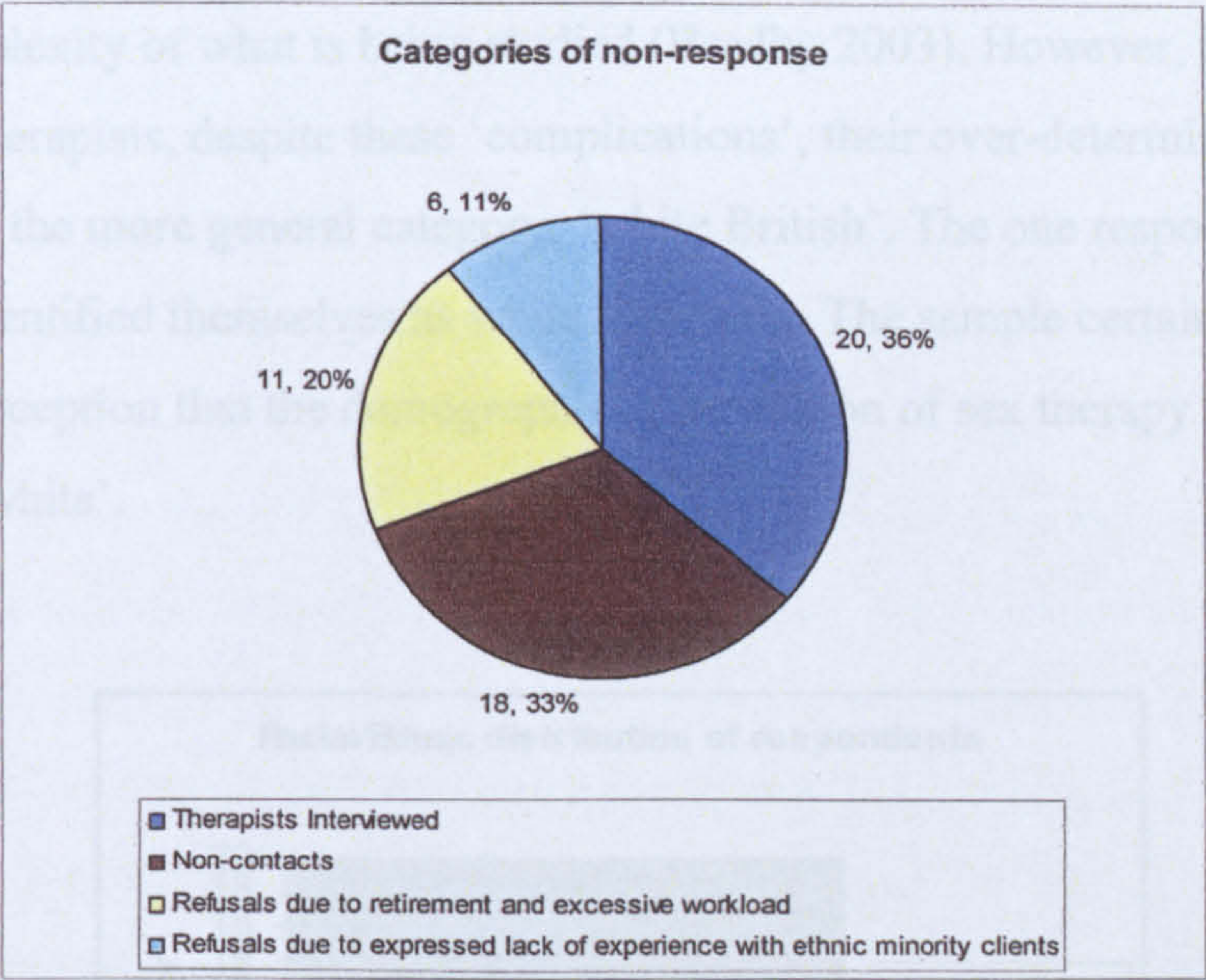


Figure 3.2 - Categories of non-response

3.3.4 Questions of representativeness

The sample achieved can make no claim to representativeness in terms of race/ethnicity, gender, class, sexual orientation, sectoral location, or therapeutic orientation, either for the Area 1 sample frame or for the broader sex therapy population. The formative effects of the multitudinous variables potentially impacting upon the self-selection of respondents, and the data consequently generated, cannot be measured. In terms of the principle axes of differentiation, the respondents indicated important aspects of their social identities through the medium of their responses to the substantive interview questions. This enabled respondents to define themselves in terms of their own choosing. The principle contours of the sample frame are indicated below.

Race/ethnicity:

The respondents were encouraged to define themselves in racial/ethnic terms, consistent with the use of the semi-structured interview as a device for enabling respondents to control many of the terms in which discourse is generated. Many of the therapists specified aspects of their identity which they felt made them being ‘more complex’ than just ‘white British’. East European parentage, Jewishness, birth outside the UK being examples of these. The eagerness with which respondents emphasised their complex identities, as transcending the reductionism of ‘white British’, may be indicative of many things. But it is certainly illustrative of the profound inadequacies of extant forms of racial/ethnic categorisation in

capturing the complexity of what is being studied (Bradby 2003). However, it was also clear that for the therapists, despite these ‘complications’, their over-determining identity was formed in terms of the more general category, ‘white British’. The one respondent in the ‘other’ category identified themselves as white European. The sample certainly reflected the therapists’ own perception that the demographic composition of sex therapy is overwhelmingly ‘white’.

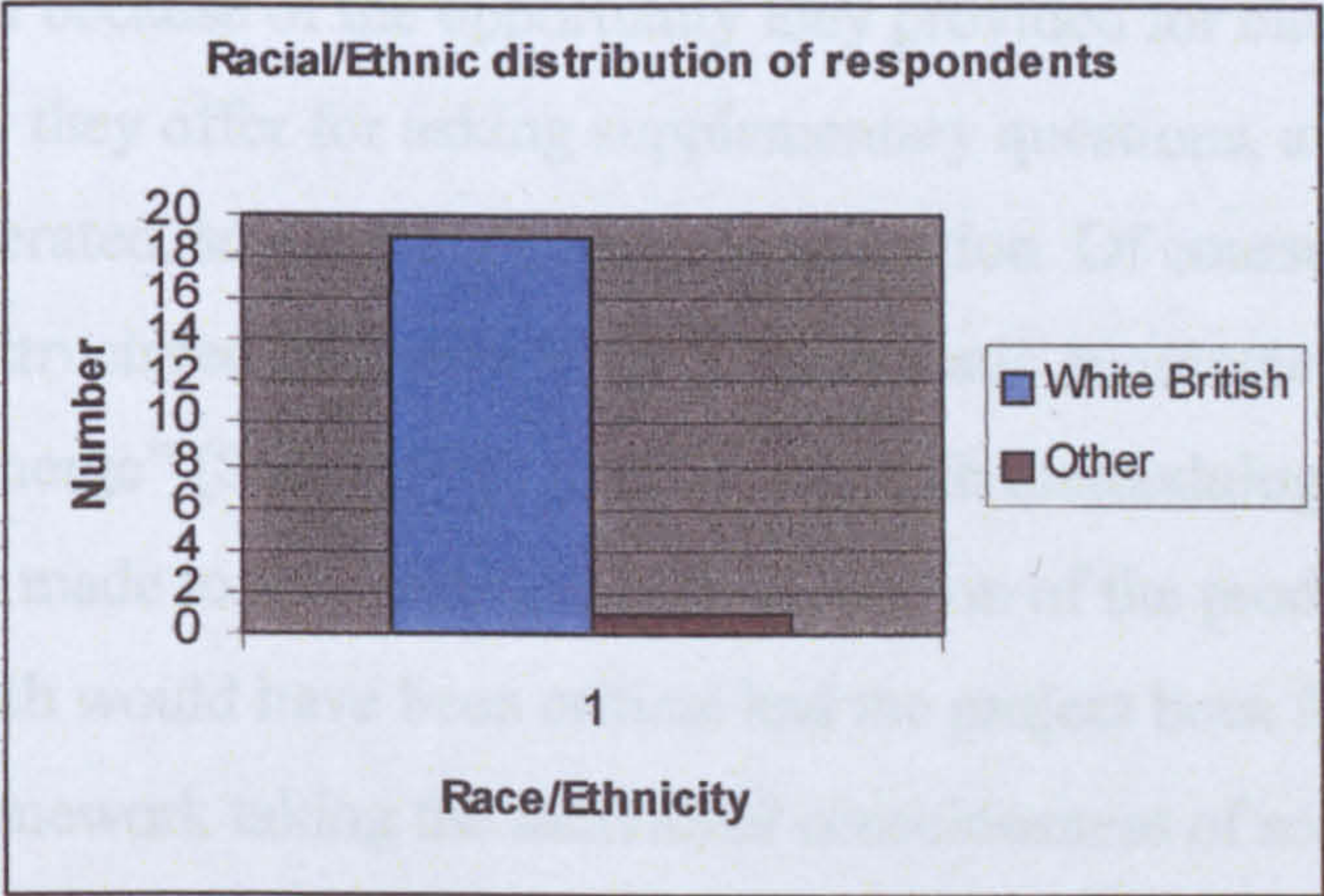


Figure 3.3 – Racial/Ethnic distribution of respondents

Gender:

Though reliable data is not available on the gender composition of sex therapy, the gender distribution within the respondents reflected the commonly expressed view amongst those interviewed that the sex therapy constituency was predominantly female.

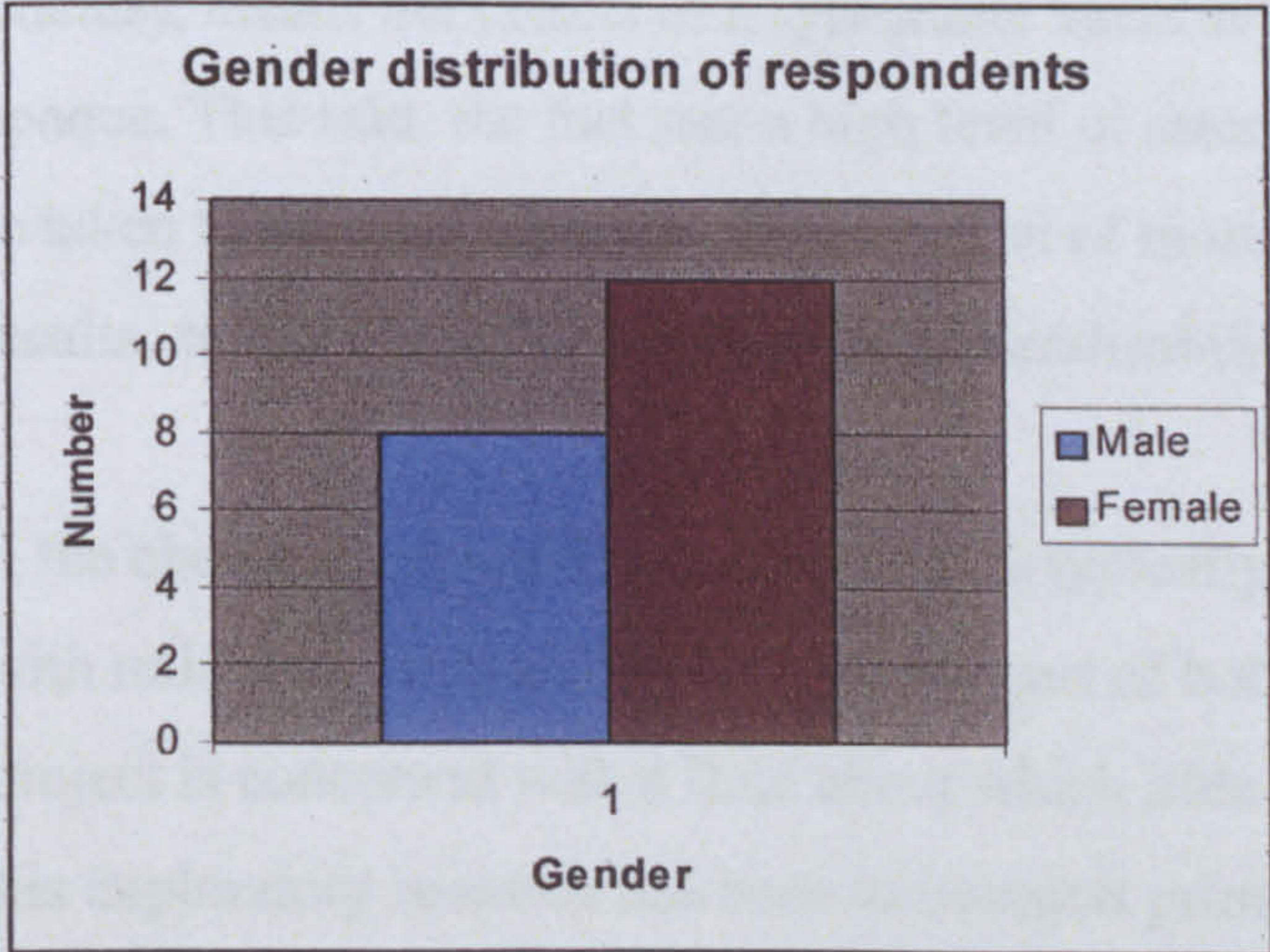


Figure 3.4 - Gender distribution of respondents

3.3.5 Validity, Generalisability and Reliability

“If your research is *valid*, this means to say that you are observing, identifying or ‘measuring’ what you say you are” (Mason 1996: p. 24). My object of observation and measurement were the discourses generated by sex therapists in talk and text, taken as indicators both of context-specific linguistic repertoires but also of an underlying consciousness (embodying a broader social consciousness). Semi-structured, in-depth interviews were selected because of the opportunity they provided for clarification of meaning both through the facility they offer for asking supplementary questions, and through the richness of the data generated, so enabling a level of validation. Of course, the relative ‘openness’ of the semi-structured interview is no “...automatic guarantee of the analytical status of the data that emerge” (Seale 1998: p. 209). For both methodological and logistical reasons, no attempt was made to secure respondent-validation of the products of my interpretive labour, which would have been critical had the project been firmly located within a phenomenological framework taking the individual consciousness of social subjects as constituting ‘reality’. Logistically, the opportunity to acquire respondent validation of the data analysis was also rarely available.

Generalisability is concerned with the extent to which wider claims can be made on the basis of the data set and conclusions generated (Mason 1996). In so far as the interviews conducted were not able to be based upon a systematic (random or stratified) approach to sampling, formal claims to generalisability are precluded. The inability to test the variables determining positive and negative self selection on the part of the therapists contacted (with the exception of those refusing an interview on the basis of their professed inexperience in working with minority clients), means the effects of a systematic variable upon the data generated may remain opaque. This said, the fact that a high level of saturation was achieved in the coded data may be taken to be suggestive that the inclusion of more respondents would have produced similar results, supporting some claim to the generalisability of the data.

As for reliability, the choice to use qualitative methods is typically associated with a much reduced concern with reliability in its strict sense, on the part of both research project and researcher. As this project is concerned with a field about which little is sociologically known, the concern of this exploratory research has been to interpret primary themes in the absence of already-existing research data, and therefore in the absence of any means to ‘standardise instruments’ (Mason 1996). The principle concern is exploratory, and seeks to establish a data set and related interpretations which may serve as a means to establishing a

range of more specific research questions in terms of which future work may be undertaken. It would be for this future work to be concerned with questions of reliability. As the project has been informed by a realist understanding of the interview data as a resource, rather than merely a topic, I would consider questions of reliability to be important in the longer term.

Using the interview as a resource, as a window to a reality that lies beyond the discursive event of the interview itself, is fraught with problems. As May (2001) points out, accounts provided by respondents may be inaccurate for one reason or another or accurate as a representation of the respondent's experience but not inclusive of a range of phenomena about which an interviewee is not conscious (including some of their own perceptions).

3.3.6 Gaining access

Initially, an attempt was made to secure acknowledgement and support from the Board of the BASRT. I calculated that this would; enable transparency as an ethically ideal basis for research, provide an opportunity for a mutually enlightening dialogue around aims and methods, open up access to important data-bases, and prove facilitative when approaching individual therapists in requesting interviews. I was aware that in cases of 'studying up', the 'defensive capabilities' of powerful groups (Hornsby-Smith 1993) can become a serious obstacle to the progress of a project, and calculated that this possibility was best addressed at the outset. The dialogue with the board proved both time-consuming and inconclusive, as members of the board expressed different positions on the prospective research. It was pointed out by a member of the board that as the web-site provided a data-set of accredited sex therapists, and as these therapists could be contacted without the need for the Board's consent, I was not in need of their approval. At this point I ceased the pursuit of formal acknowledgement and indicated to the prospective interviewees that the Board had been made aware of my project and had had the opportunity to comment on aims and methodologies.

3.3.7 Conducting the interview

The interviews took place in a place and time of the therapist's choosing. Typically this was at their place of work, or their home (for many, home and work were the same). As the therapists were in many cases self-employed, or if publicly employed, were offering time within their working day, this was a necessary condition for securing an interview. It also enabled the respondents to feel empowered as the interview was located within their space.

The interview followed a pre-determined question route, with respondents given as much time as they wished to respond. However, a dialogical approach was also adopted whereby mutually directed interactions were enabled to follow the initial questioning. The consequence of this degree of openness and flexibility was that although I strove to 'manage time' in order to get through the entire list of questions, this was not always possible. As such, each interview was characterised by its own particular balance of data.

Given the importance of accuracy in the recording of the data, and the centrality of an immersion within the data during the process of analysis, a decision was made to use a tape recorder in the interviews. The facility to tape record interviews enables both parties to engage in an interactive exercise in the absence of the ongoing references to an external agenda induced by the process of note-taking. May (2001) claims that both interviewee and interviewer may in fact forget that they are being taped, and this seemed to be the case in these interviews. The fact that I did not need to concern myself with recording information allowed for a more 'natural' dialogical approach to be adopted. All the respondents were informed in advance and signed a consent form to indicate that they agreed to being taped and that they understood how this data would be managed and disposed of during the research process. Upon conclusion, all the respondents were asked if they had any questions of myself or the project, and whether they would like a copy of the transcript.

3.3.8 Establishing the question route

A question route was selected as a necessary degree of structure to the interviews, though the questions were open-ended. The questions were designed to produce data appropriate to the realisation of the project's aims. The sequencing of the questions was determined in advance with a consideration for producing as 'natural', and as strategically effective a set of interactions as possible. By commencing with an opportunity for the therapist to share some biographical information regarding how they became a sex therapist, it was hoped that this would serve as an indication of my interest in/valorisation of them as a person and a therapist, and enable them to feel 'at home' in the subject matter of the interview. The subsequent questions regarding their understanding of sexuality and of the nature and role of sex therapy, it was hoped, would consolidate a sense of comfort derived from being on 'home territory', and confirm my interest in them and their views. It was also assumed that this would 'warm up' the respondents for what I anticipated may be more sensitive or problematic questions further in the interview. A degree of *theoretical sampling* took place (for a classical account of theoretical sampling, see Glaser and Strauss 1967).

Initially, on the basis of my reading of the ‘politics of race and ethnicity’ within the British context, and on a set of assumptions about the ‘threat’ that my project may pose to an elite constituency concerned to present an image of competence, I attributed a sensitivity to race and ethnicity that lead me to avoid direct questioning on these topics in their own right (see Elam and Fenton 2003). Rather, I looked to extract racialised and ethnicised meanings from the therapists’ substantive commentaries on areas in which such meanings would be inherent. After five interviews I felt that insufficient data was being generated in this important area and introduced some more focussed questions. The relative ease with which these questions were asked and responded to served as a case in point of how researchers may attribute a sensitivity to a topic that may not materialise in practice (Lee 1993).

3.3.9 Interviewing elites – the question of power

Power operates in complex ways within the context of the interview. A principle and formative dynamic lies in the social and political status of the respondent. The therapists, as the embodiments of a training programme granting a condition of scientific expertise, and as members of professional body, may justifiably be considered to belong to an ‘elite’. It is possible, however implicitly, that the respondents saw themselves within this context in these terms. Elite groups of this sort belong to what Silverman (1997) has described as the ‘interview society’, namely those whose concept of their personal and professional self includes an understanding of themselves as an object of the forms of narratives upon which interviews are based. As such, a capacity for reflexive dialogue was a central characteristic of the respondents.

As a sociologist with no training in the area of sex therapy, it is also possible that I was perceived as having an expertise, but one somewhat tangential to the matter at hand. It is also possible that as a sociologist I was attributed with particular qualities with which the discipline has come to be publicly associated, particularly with a ‘critical’ and ‘politically-informed’ approach to researching social problems, and with a disposition to explain specific social phenomena in terms of their locatedness within a broader social, political and cultural context. In interviewing elites, it is possible, in fact probable, that the typical balance of power between interviewee and interviewer is reversed.

3.3.10 *Dynamics of race, ethnicity and gender within the interview*

As a white, male interviewer, interacting with white male and female respondents, it is likely that dynamics associated with race, ethnicity and gender were operating within the interview setting. To the extent that the respondents defined the interview principally in terms of a consideration of racial/ethnic minorities, in most cases the interview became one of a discussion between two apparent representatives of a white British majority about Britain's racial/ethnic minorities. Two 'hosts' discussing their 'immigrants'. Within such a context a range of dynamics of transference and attribution are possible. It is probable that as a white interviewer, white respondents would feel enabled to express their perceptions in a context they defined as 'safe' due to the absence of exposure to a 'black gaze'. Research texts refer to the facilitative role played by 'blending-in', or matching, for characteristics such as race and ethnicity (May 2001), suggesting that my apparent white Britishness may have facilitated a less constrained account by the therapists. This apparent racial, ethnic and national correspondence between myself and most of the respondents may also have been an advantage in establishing 'rapport', as this routinely depends upon the ability of the respondent to feel 'safe' in 'trusting' the interviewer². It is of course the underlying assumption that whiteness marks some point of shared interest and orientation that underpins these dynamics of trust.

However, the realisation of rapport may have been complicated by the fact that I carried a sociological identity, and as a discipline, I would suggest, sociology is publicly associated with the politics of anti-racism and multiculturalism and deeply implicated with what has come to be described as 'political correctness'. I would suggest that in the eyes of many, sociology is perceived to be affiliated to the 'underdog' in such a way that respondents may see the sociologist, if not actually a member of an racial/ethnic minority, then as some form of representative of such populations.

² The 'politics of distrust', as Lee (1993) has described it, are commonly central to interviewing on sensitive topics. The fact that these interviews were one-off interviews carried out by a researcher unknown to the respondents and professionally unconnected to their area of practice, almost certainly will have impacted upon the 'politics of trust' in this case, though I have no way of knowing how. Though the one-off nature of interviews may present problems in establishing rapport and trust, the fact that the interviewee will not be meeting the interviewer again may be facilitative of disclosure. However, the anticipation on the part of the respondent, that the data may find its way into the public realm via publication may have limited disclosure. But this in turn would depend upon the therapist's relationship to the institution of sex therapy. For instance, if they positioned themselves as within, but critical of, aspects of sex therapy practice, it may be that the respondent perceives the interview as an opportunity to articulate this critique, particularly if an assumption is made that the interviewer may be receptive to such a critique.

Gender dynamics may also have been in operation. The majority of the respondents were female. Research has shown that ‘normal’ interactions between men and women are gendered in such a way that men tend to dominate conversational interaction (Fishman, cited in May 2001) via a host of mechanisms such as interruption and the invocation of certainty of knowledge and experience. The potential for such conversational oppression requires a reflexive examination on the part of the male interviewer (May 2001). Within the context of research, feminists have argued that an exploitative relationship is encoded within traditional interview decorum, as the injunction on interviewer participation in dialogical exchange and upon personal disclosure places them in a position of power over the interviewee (Seale 1998). Where the respondent is female and the interviewer male, patriarchal relations become reinforced. This more typical inequality may however have been tempered in this context by the fact that the female respondents have a greater access to power on the basis of their expert and elite status within the context of these interviews. This seems borne out by the fact that I was unable to detect any systematic gender effect within the context of the interviews.

3.3.11 *Analysing the data*

In qualitative methodologies, the work has only just begun with the collection of the data (May 2001). Analysis of rich data is both time-consuming and analytically challenging, requiring critical self-awareness and openness to change. There are no guarantees that the data will generate or support the conceptual aspirations of the researcher. As Silverman puts it, researchers often expect:

“...if only at a subconscious level, to ‘find’ educational, sociological, psychological concepts staring them in the face or leaping out from the data. It is a common enough misconception to expect to stumble across ‘authoritarianism’, ‘social control’, or whatever, and to be disappointed – even to feel betrayed” (cited in May 2001: p. 138).

In order to enable a comparative analysis of the interviews and texts, a comprehensive coding of the data was undertaken. The coded data was then analysed manually, with the primary concern being to uncover the key topics within the data. More specifically, a search for patterns of coherence, and incoherence, *across* interviews was undertaken as a means to uncover the key contours of consensus and contestation as manifestations of underpinning modes of social consciousness. This analysis was supplemented by an exploration of coherence and contradiction *within* interviews, as a means to understanding the utilisation of

linguistic repertoires by respondents in the production of coherence, and the problems of mediation this can produce.

3.4 The Textual Analysis

As a means to establishing some triangulation, the interviews were supplemented by a textual analysis of selected papers from the BASRT's own journal *Sexual and Marital/Relationship Therapy*. As this journal is received (and presumably read) by all accredited sex therapists, and is also a vehicle for publication, the journal constitutes an important part of the discursive universe of sex therapists in the UK. The journal, *Sexual and Marital Therapy*, was established in 1986 as the BASMT's vehicle for enabling a public deliberation of theoretical and empirical discussions regarding the nature of sexuality, sexual problems, relationships and sex/relationship therapeutic practice in their broadest senses. It has been since its inception, multi-disciplinary. The editors have frequently expressed their commitment to this: "the journal covers original research, single-case studies, discussion papers, book reviews and literature update. We wish to encourage this eclecticism, since the issues raised in human sexual relations pertain to so many clinical, training and educational settings" (d'Ardenne and Riley 1989).

3.4.1 Textual Analysis as a method

Textual analyses of discourses are fraught with methodological contestations and technical problems of method, and as such some specification of the approach adopted here is essential. "'Discourse' refers to a *system* of language which draws on a particular terminology and encodes specific forms of knowledge" (Tonkiss 1998: p.248). Papers published within academic and professional journals such as this encode hermeneutic rules regarding what can be said, and how it can be said. Discourse and textual analyses, in their various guises, are compatible with a multitude of theoretical and methodological orientations (van Dijk 1993), with hermeneutic, post-structuralist and post-modernist being perhaps most closely associated with such approaches. In this case, the textual analysis has been grafted onto a broadly realist set of assumptions. The nature of discourse is fluid and interpretive and does not lend itself well to hard and fast methodological rules (Tonkiss 1998). The approach adopted here is informed by the work of Teun van Dijk (1993).

Discourse analysis is here defined as:

...a systematic theoretical and descriptive account of (a) the structures and strategies, at various levels, of written and spoken discourse, seen both as a textual “object” and as a form of sociocultural practice and interaction, and (b) the relationships of these properties of text and talk with the relevant structures of their cognitive, social, cultural and historical “contexts”. In sum, discourse analysis studies “text in context” (van Dijk 1993: p.96).

Derived from the work of van Dijk (1993), the textual analysis undertaken here is directed toward an understanding of how sex therapists write about race, ethnicity and racial/ethnic groups, in respect of their implications for questions of sexuality and sex therapy. Furthermore, it is concerned with understanding what the structures and strategies woven into these texts tell us about therapists’ underlying social cognitions. The social, political, and cultural contexts and functions of sex therapy discourse on race and ethnicity are explored, and in particular, the role such discourse plays in the ‘local’ development, reinforcement, legitimation, and hence reproduction of a social ontology of racial and ethnic difference. As van Dijk has argued (1993), “...ethnic and racial inequality in all social, political, and cultural domains is multiply expressed, described, planned, legislated, regulated, executed, legitimated and opposed in myriad genres of discourse and communicative events” (p. 95).

According to van Dijk (1993) each occasion of talk and text is monitored by ‘models’, of which there are fundamentally two types: context models and social cognitions. These models are “...not built from scratch: Not only may they embody fragments of old models, they also feature particular instantiations of more general social beliefs (scripts, attitudes)” (p.99). Context models are built by participants, and account for particular communication contexts, including representations of self and other, the nature of the communication event’s goals, ongoing action and interaction, of the type of communication event itself. They govern the judgements made by participants concerning the implications of the communication context for what can and cannot be said, and the manner in which enunciations must be made. By considering these twin dimensions of discursive events, it becomes possible to understand the “...powerful and crucial *sociocognitive interface* of both personal mental models and socially shared mental representations” (p. 98). Van Dijk (1993) has primarily concerned himself with the study of ‘elite discourse’ about ethnic minorities, where forms of

“...consensus [are] largely pre-formulated and persuasively conveyed, top-down, by various (symbolic) elites, such as politicians, bureaucrats, scholars, journalists, writers, and columnists, as well corporate managers” (p. 102). I would suggest that the establishment of a consensus regarding the nature of race, ethnicity and the substantial qualities of racial and ethnic groups, as these pertain to questions of sexuality and sex therapy, has been the underlying motivation of the authors responsible for the selected texts within the journal. It is with an exploration of the nature of this consensus, and the powers inherent within it, that this project is concerned, more specifically with the discursive output of those who enjoy “...communicative control of knowledge, beliefs, and opinions” (p.101) within the context of the journal papers.

The ‘context models’ on the basis of which situationally-specific linguistic repertoires are performed in talk and text are to a large extent themselves part of a broader social consciousness regarding the nature of the situation in question (Van Dijk 1993). For instance, the ‘sensitivity’ of the interview focussing upon questions of race and ethnicity, is a sensitivity ultimately produced outside the parameters of the interview, and derives from the political contestations surrounding the field.

3.4.2 *The nature of discourse*

Van Dijk (1993) usefully draws a distinction between *surface* structure, and *deep* or *underlying* structure, where the latter’s general opacity stands in contrast to the former’s relative visibility (in the form of language, gesture, intonation). Deep structures are given expression through surface structures. In text, surface structures are more easily controlled than in verbal interaction. Syntactic structures (the structure of language) are an important indication of the cognitive orientations of the speaker/writer. Lexical style (the context-dependent use of words), also offers indication of underlying mental models, as in the use of terms such as freedom fighter or terrorist.

According to van Dijk (1993), in striving to understand the meaning of a particular discursive act, we can explore:

- the *perspective* from which an event is described (eg. from the perspective of the therapist)
- the *implications* (or implicit meaning) inferred by a particular discursive act. Because we occupy a shared universe of meaning, it enables us to convey and interpret meanings

which may not be formally expressed. As such, it may be possible to ‘see’ the presence of race even in its formal absence

- *presuppositions*, as specific forms of implication. These occur where claims are made as to the ‘normal’ nature of things, or to the inherent qualities of particular racial/ethnic groups.
- the *coherence* of discourse, in terms of the propositions presented.
- the *level of description* and *degree of completeness*
- *the global coherence and topics*, comprised of the constituent propositions as they contribute towards the ‘global’ coherence, or total meaning, of the speech act as a whole, and its major topics

Van Dijk’s (1993) analysis of elite discourse has been concerned primarily with how elite white majority groups talk about racial/ethnic minorities, and in particular with: how minorities may be effectively excluded from the communication context via limitations in the access to means of self representation; how minorities may be formally admitted but their right/opportunity to speak circumscribed; how minorities may be accounted for in ways that suggest the social superiority of dominant group; and how minorities may be “inferiorised, problematized, falsely accused, threatened, marginalized, derogated by discourses *about* them” (p. 118).

An important dimension of the textual form taken by the journal papers is the role played by ‘expert language’ (Tonkiss 1998). Expert language and its constituent terminologies, mark a ‘field of knowledge’ as belonging to a particular body of expertise. It also enables members to communicate effectively with one another in a manner that reaffirms their membership of a shared professional constituency. Finally, expert language bestows authority via its exclusiveness, and effectively serves to discredit accounts not framed in its terms (see Tonkiss 1998).

Understanding the context within which any discursive act takes place involves a consideration of a range of constituent components (van Dijk 1993):

- Access to the right to speak, for instance possessing the academic/professional qualifications/credentials to publish in journals and contribute to the substance of expert opinion
- The setting, medium and audience, in this case a professional/academic journal, comprised of papers, published for an audience of professionals and academics

interested in the field of sexuality and relationships (and their attendant problems), and therapy

- The genre, in this case the conventions governing the nature of academic and professional textual discourses within journals.
- Social action and social relations
- Participant positions and roles, such as those associated with the professional/expert identity

3.4.3 Sampling and analysing

A review of the papers within the journal, *Sexual and Marital/Relationship Therapy*, indicated a cluster of key terms through which issues associated with race and ethnicity were invoked (see Table 3.5). The strategy adopted in this study was to include all the papers that addressed these ‘key terms’ in their title, abstract or introduction.

The need to adopt such a comprehensive list is derived from the fact that ideas of race and ethnicity are commonly invoked using a wide variety of terminologies, which gives them an opacity of presence, at times only illuminated through the examination of the clusters of ideas surrounding them (see Tonkiss 1998). Since the first edition of the journal in 1986, a total of 432 substantive papers have been published, with 71 selected for analysis. This sample therefore constituted 14% of the total. With a typical edition comprising 9 papers, this means that an average of over one paper per edition addressed the field in some way.

- Race
 - Racial
 - Racist
 - Ethnicity
 - Ethnic
 - Ethno-
 - Culture
 - Cultural
 - Minority
 - Religion
 - Religious
 - Black
 - Asian
 - Non-Western
 - References to particular ‘non-western’ nations

Figure 3.5: Key words used as the basis for sampling papers from ‘*Sexual and Marital/Relationship Therapy*’

Following the same methods adopted for coding, handling and analysing the interview data, the textual data was sifted, compared and contrasted as a means to uncovering the key themes (see Tonkiss 1998). Patterns of coherence and incoherence were explored as a means to understanding underpinning modes of consciousness, and the work that was being done by the author to reconcile contrary orientations and/or to authorise preferred renditions and negate alternatives. Of great importance, particularly in the field of race and ethnicity, is the need to look for the silences, the gaps, the omissions (Tonkiss 1989). One function of definitive and authoritative accounts, is the role they play in silencing, or at least obscuring, alternative versions.

3.4.4 Representativeness

By the terms adopted within the sampling process, the data set achieved is completely representative, as it constitutes all the papers published formally pertaining to race and ethnicity throughout the history of the journal. However, it is not possible, without carrying out a sample of non-selected papers, to know whether these include some discussion of pertinent themes. But if no reference had been made to these themes in the title/abstract/introduction it was deemed unlikely that substantial discussion would be present. This said, given the 'absent-presence' commonly characterising race and ethnicity, it is inevitable that accounts not formally coded in these terms will have encoded important assumptions concerning them. Though this would undoubtedly have been a useful analysis, particularly in analysing the normative nature of hegemonic forms of 'whiteness', it was entirely beyond the logistical means of this project.

3.4.5 Validity, Generalisability, Reliability

As for validity, as an analysis of the discourses pertaining to race and ethnicity produced within the text of the journal, I am clearly analysing what I am claiming to analyse. However, I am making additional claims regarding the meaning of this data. Namely, that it says something about the underlying ideas of race and ethnicity within sex therapy, as these are mediated by the particular communication setting provided by academic/professional journals of this type. As to the extent to which we can see the data set as indicative of what sex therapists think, in other words its external validity (Tonkiss 1989), some qualification needs to be introduced. I am essentially engaged in an interpretive activity, and though I can assume some familiarity with the hermeneutic rules governing the modes of discourse

produced within academic/professional journals, this is no necessary guarantee of the validity of my interpretations (see O'Connell-Davidson and Layder 1994). A significant aid to the achievement of validity however, lies in the fact that the data itself is replete with references to, and interpretations of, itself, as authors comment upon one another's work.

A distinction can be drawn between papers having something 'substantial' to say on questions of race and ethnicity, and those papers that merely allude to the field, typically through a reference to 'culture' within the abstract. In the latter case, the inclusion of direct or indirect references to such forms of diversity may 'simply' be a manifestation of the 'rules' governing the presentation of professional textual discourses today than it does about the profile of the topic. More specifically the need to be *seen* to acknowledge the 'claims to recognition' of a number of social groups.

It is also important to stress that a significant proportion of the papers pertaining to race and ethnicity are not about sex therapy specifically, and are not written by sex therapists. Some of these are amongst the more sociologically and politically sophisticated papers (for examples, see Weiss et al 2000, Potts and Masho 1995, Stringer 1994, Clulow 1993). Once these are removed from the calculation (which they have not for the purpose of this analysis), the total number of papers written explicitly about sex therapy, by sex therapists, on substantial questions associated with 'race' and ethnicity becomes substantially reduced, implying a more limited interest than might at first appear. It is not known how these 'non-sex therapy' papers are read by the sex therapy constituency. As they pertain directly to questions of sexuality, they may appear pertinent to those therapists committed to a broader interpretation of their role, and of their requisite knowledge base. For others they may appear at best tangential.

However, though these papers may not all be written by sex therapists, and may not all directly pertain to sex therapy, their inclusion in the journal indicates that they satisfy the editorial board, and as such the BASRT, that the knowledge contained is theoretically and empirically pertinent to sex therapists. In this regard the editorial decisions can be taken as manifestations of the professionally approved knowledge base of sex therapy, even where these decisions are informed by a principle of eclecticism. Expert discourses of this type mark out fields of knowledge, confer membership and bestow authority (Tonkiss 1998). Furthermore, as the journal is received by all members of the BASRT, it constitutes a principle part of the theoretical, conceptual and empirical universe of practicing sex therapists, serving as a resource for the BASRT's membership. The substantive content of the

journal, because it is understood to be the outcome of a process of selection by sex therapy's own intelligentsia, sends a message to those with an interest in sex therapy, and particularly its own membership, about what constitutes professionally valorised sexual knowledge.

As for generalisability, the conclusions reached are a product of my analysis of all 71 papers. But how race and ethnicity feature, explicitly and implicitly, in those papers apparently not concerned with these questions, is beyond the scope of this paper. This limits the extent to which generalisations can be made. Furthermore, there exists an indeterminate but extensive sex therapy literature that exists beyond the context of the journal, and it is certain that if this broader literature was incorporated into the analysis it would throw a new, and at least potentially, different light on the matter.

The reliability of the textual data analysis cannot be demonstrated in this project, as no attempt has been made to test the methods or consequent interpretations of the data. There is no extant data in terms of which to evaluate my methods or interpretive conclusions. The textual data is complex and ambivalent and expresses a multitude of views, many of which have not been fully represented in my account. It is certain that distortions will have taken place via my signification and selection of particular elements of this data at the expense of others. But I do, however, find some reassurance in Parekh's (2002) concession to bias.

No exegesis of other writers is ever wholly faithful to all the nuances of their arguments, especially when one discusses large numbers of them...Indeed, a critic must sometimes swallow interpretive scruples in order to highlight and attack the basic limitations of his target's underlying assumptions and structure of thought. The legitimate ground for complaint arises when he makes no attempt to enter sympathetically into the latter's world of thought, tease out its insights and deeper concerns and anxieties, or engage in a dialogue with it (Parekh 2002: p. 145).

My aim has not been to "highlight and attack the basic limitations of my target". Rather, to open up for critical analysis the discourses produced by a constituency of therapists motivated to support and empower their clientele. If a challenging and critical tone is evident in my interpretation of the data, this should not be taken to indicate a failure on my part to

fully acknowledge the productive efforts and positive motivations of the therapists who have voluntarily given their time to support this project.

Part A

Constructing Meanings – Sexuality, Gender, Race and Ethnicity in Sex Therapy Discourse

Chapter 4 – Sexuality and Gender in Contemporary Sex Therapy

Sexuality, as an activity, as a way of relating, as a source of identity, as a determinant of legal status, and as an object of enquiry, has become a conduit for a multitude of discourses and social practices. These discourses have variably taken their energies from sources of tradition, religion, biology, psychology, political philosophy, the social sciences and a host of professional agendas. It is something of an irony that a phenomenon so readily perceived as natural, in fact betrays the influence of such a diversity of ‘synthetic’ inputs. In a contemporary context, where sexuality becomes ever more publicly problematised, this ‘construction of sexuality’ has never been more evident, at least for those with a will to see it. In fact, for many of those working with sexuality in a theoretical and/or professional capacity, it has become something of an article of faith that we recognise the multitudinous influences manifested within the field of human sexuality, as a means to demonstrating our wisdom and late-modernity. Contemporary sex therapy, in its collective theoretical and conceptual toolbox, and in its modes of therapeutic intervention, stands at the confluence of these diverse streams of sexual thought.

This chapter will show how these diverse streams become channelled within sex therapy in the production of preferred renditions of sexuality and sexual problems. It will account for the manner in which biological, psychological and social perspectives of sexuality become mediated and deliberated, as sex therapists strive to make sense of the contemporary condition of the gendered sexual subject, and its associated sexual difficulties. It is this process of mediation and deliberation that constitutes so much of the terrain upon which ideas of race and ethnicity are put to work in accounting for particular manifestations of sexuality and sexual problems and the challenges faced by sex therapy. In understanding sex therapists’ accounts of sexuality and gender we will be enabled to appreciate the situationally-specific dynamics that operate to produce complexity and contingency in the forms taken by race and ethnicity within the context of sex therapy.

4.1 Human sexuality – Ingredients without a recipe?

Within the interview, and following the initial questions concerned with the therapist’s entry into, and perceptions of, sex therapy, the therapists were invited to offer an account of their model or models of human sexuality. Taken as a whole, the data suggested a broad-based ambivalence regarding the very status of sexuality as an object warranting

conceptualisation. We might anticipate that the influence of accredited training, of the regulatory efforts of a professional body, and of the ongoing dialogue between therapists as peers (including supervisory work) may produce some degree of consensus regarding the status of sexuality as an object warranting formal conceptualisation, but this varied significantly.

For some, the need for a conceptualisation of sexuality at all was problematised. In such cases a professional discourse of client-centredness, expressing a commitment to the principle of client sovereignty in defining the nature of their own sexuality and sexual problems was foundational to the therapists' stance. Sex therapy was about "working with the construct of the individual, with those I'm working with..." [13], and seemed to require a resolution to adopt a formal conceptual passivity. In this respect the data gives credence to Vance's claim that "...though sex research is inevitably based on theoretical and conceptual models, researchers and therapists alike maintain that they have no theory, no basic assumptions, no axe to grind" (cited in Tiefer 1992). Even for those who were more willing to acknowledge and define their underpinning models of sexuality, this reticence was still in evidence as a moderating influence.

For many, being required to specify their understanding of human sexuality produced uncertainty and ambivalence. The following therapist, on being asked whether she subscribed to any particular model of human sexuality, responded by saying:

9: No, I'm not aware of it. It's certainly not just a mixture of physiological drives...I think it's a basic human nature but it's the basis of relationships, that sort of - I don't know. Sort of psychological, physical health, spiritual health, I mean it sort of works in all those...I don't know, I've never really thought about it.

This statement is notable in two respects. Firstly, there is a clear sense of confusion or ambivalence about the nature of human sexuality itself. Its biological basis seems unclear, as human sexuality is presented as simultaneously 'not *just* physiological' yet also a product of 'human nature'. Such 'holism' was common:

13: I get very angry, and express it openly many times, if people will go down one route, that [sexuality] is

biological, or is a social construct, or is psychological. It is all three and more

Secondly, that the conceptualisation of human sexuality appears, up to that point, not to have presented itself as a problem to the therapist. Thinking explicitly and conceptually about the nature of human sexuality appears to be experienced by the therapist as a novel problem. “I don’t know what I can say upon a model. Can I ramble for a minute?” [28] was a typical response to this question, and for some was a product of the novelty of the question, and for others reflected a more fundamental uncertainty.

For a small minority of therapists, there was an agreement with the assertion that all forms of intervention must be based upon some underlying model of human sexuality. “I agree with your first statement for starters...you can’t possibly intervene without having some notion of what sexuality is and then what healthy or unhealthy is” [28]. Within this stance, the expert role of the therapist brings with it the inevitability of a conceptual framework in terms of which sexuality is conceived. “You can’t not have at least an implicit model if you are operating as a putative expert...Even if you don’t know what it is, there is one” [16]. But the number of therapists who were willing and able to specify substantive conceptual frameworks were very limited. A reference to John Money’s integrative model of sexuality and another to the work of Wilhelm Reich were the exceptions.

This apparent conceptual inactivity on the part of the therapist was justified by the emphasis placed upon the sovereignty of the client’s own sexual constructs and formulations as practically defining sexuality. Whilst not exactly passive, the role of the therapist was widely defined here in terms of a determination *not* to conceptualise, as a means to ensuring sex therapy’s capacity to work therapeutically with all clients. In this context, it was an expressed imperative that any modelling of sexuality initiated by the therapist was to be a reflective expression of the client’s own constructs. Underpinning this formulation of the role of the therapist as enabler is a liberal-humanist discourse emphasising the agency and emancipation of the individual client. But as Atkin (2003) points out, humanist thinking also encodes a contradictory theme of prevention as a means to achieving human satisfaction. Prevention requires that subjects become the objects of knowledge and power in the service of an implicit or explicit (sexual) norm. This norm, as it is policed by professional/institutional constituencies, sets up a binary with modes of ‘deviance’, and may incorporate gendered, racialised and ethnicised underpinnings.

But the validation of this conceptual inactivity also came from another important source, namely ‘holism’. I have argued elsewhere (see Mulholland 1997) that within health and health care contexts, holistic models have exercised a profound influence. They have emerged as a ‘solution’ to the perceived limitations of one-dimensional, reductionist accounts of the human subject. Within a holistic model, the human subject becomes multi-dimensional, comprised of biological, psychological, social and spiritual dimensions. Holistic models provide a home for the multitude of conceptualisations of sexuality to which sex therapy is an heir. They practically enable therapists to house their particular orientations whilst seemingly accommodating the insights of others and in the absence of apparent conflict. It does this by providing its therapeutic chefs with all the ingredients necessary for success, whilst allowing each to invent their own recipe, and without the exposure of a formal and accountable taste-testing of their respective puddings.

42: I think where therapists have something to contribute...is that what we are doing is looking at bringing all those things [biological, psychological and social dimensions] you mentioned together and trying to see the person in that whole context.

The holistic approach is commonly juxtaposed to a bio-medical model, and constructed as the solution to its shortcomings. But in practice, I would argue that the model enables a ‘naïve eclecticism’ where aggregations of elements are produced whilst circumventing difficult but critically important problems of theorisation. The potential for an eclectic holism to enable the appearance of a consensus, necessary for the integration of sex therapy, is great, and must be appealing. As Lupton (1994) reminds us, “it is around the sexuality debate that the most intense battles between the proponents of naturalism and the relativism have centred” (p. 26).

4.2 Natural sexuality

Nature has, throughout the history of sex and gender discourses, operated as a fundamental though variable point of reference. A dualistic notion of sex (as nature) and society has been central to the formulations of a multitude of discourses (Judeo-Christian, scientific and political) within western societies, and constitutes a foundation of what Weeks’ (1987) has described as the ‘hegemonic’ model of sexuality. A prevailing feature of numerous influential academic accounts of human sexuality, even some of those found within the discourses of resistance (forms of feminism, Freudo-marxism, and ‘gay liberation’) has been

the notion that in ‘sex’ and ‘society’ we see distinct realms, forever locked into a problematic and often conflictual relationship. Characteristically, sexuality is seen as pre-existing society and as having been subsequently fettered by social imperatives.

The data is strongly indicative of the widespread assumption amongst many sex therapists of a sex/society dualistic model that sees nature as defining some form of biological essence in the sexual subject. Sex then, is “...how we are created, we’re created men and women with genitals and all these things, and we are defined as men and women” [31]. More specifically, “there is a general or universal sexual drive, sexual desire, sexual expression, but it is going to be expressed, or understood or used in different ways in different groups” [20]. Although empirical diversity is acknowledged here in the reference to different expressions and understandings of sex, the striking feature is the reduction of such diversity to a status of epi-phenomena, serving to divert attention from the true biological determinants of human sexuality.

20: [Is] every single person unique? Where is this uniqueness, what is it? Certainly we have individual differences, absolutely, but we are all human beings and the process is the same. We are also dealing with the biological/physiological process in sex...It's the expression of that...that we're dealing with. But the process is the same, sex doesn't take on a new thing because it's being done in Afghanistan...

Social variables are seen as external to sexuality, and may serve to negate, fetter and to distract. But there is no sense here of the productive role of societal discourses and practices as ‘manufacturing’ sexualities. “...There has to be some social construct and there has to be some psychological involvement but I think it’s a very powerful biological drive because it pops up by itself, it’s something that just happens as you grow” [34]. This is clearly illustrative of Weeks (1987) account of the influence of a ‘hydraulic model’ of sexuality as a gushing stream barely contained by social forces. It also seems clear that such forms of biological reductionism raise implications for the possibility of maintaining the individualistic framework so influential amongst sex therapists.

Reproducing a sex/society dualism, but within a critical neo-Marxist influenced analysis, one therapist accounted for sexuality as a bodily energy that in experiencing repression produces neurotic tension, depression and alienation. Natural sexuality, and the vagaries of desire associated with it, was seen as the victim of a repression rooted in the

“...narcissistic externalised commoditisation of oneself” [25] inherent within advanced capitalism, and the related drive for personal and psychic security. Another defined sex in a Freudian manner as an instinctual libidinal energy. In a climate where sex therapy is experiencing a progressive medicalisation in its modes of intervention, naturalistic accounts become empowered.

An inherent component of such dualistic thinking is an a-priori assumption of the historical continuity of sexuality. If sexuality has an essential nature, rooted in biology, then it follows that although social and psychological variables may impact upon human sexuality, they do not alter its fundamental nature or potentialities. Evidence of the influence of such thinking is found within the following assertion.

19: I think people still have the same problems today that they had then [in previous centuries]...I think they still want the same things. I don't think these things [sexual needs] change, I think they're fairly steady because people really don't change that much...Its [sexuality] been there since the beginning of time, of history...this is the basic thing which keeps everything going

Within such a naturalistic framework, a fundamental continuity transcends the transformations of society, negating the historical genealogy of sexuality (Foucault 1975). Although some social agency may be acknowledged, the significance given to it is circumscribed by an a-priori commitment to the natural foundations of an immutable human sexuality. “One cannot underestimate the power of that physiological drive” [34]. The ‘natural’ body evident in these accounts negates an understanding of the social structuring of the body and its sexuality, operating as an absent-presence, quietly authorising essentialist notions of human sexuality. At the heart of this is a long-standing legacy; “western science has defined not only sexual difference but the purpose and function of sexuality, primarily, in terms of reproductive biology” (Segal 1994).

Viagra, as one example of medicalisation, has enabled the reduction of sexuality to an individualised case of physiological dysfunction, through the nature of its particular ‘solution’ to the problem of ‘erectile dysfunction’. “I mean obviously viagra has made a difference because people have gone to their doctors for a quick cure...that makes a difference to our job” [3]. As Giddens (1992) points out, “once there is a new terminology for understanding sexuality, ideas, concepts and theories couched in these terms seep into social life itself, and

help re-order it” (p.28). Medicalisation has a power to shape the discursive and material climate within which people strive to make sense of their experiences, hailing people into medicalised modes of social/sexual subjectivity.

4.3 The sexual self

If naturalistic accounts represented one of the principle poles to which sex therapeutic discourses of sexuality were attracted, then the other would certainly have to be a humanistic-existential notion of the sovereign sexual subject, possessed of an autonomous self-hood. This tradition, within psycho-therapeutic thought, has close connections with a social and political liberalism in their respective accounts of the relationship between the social subject and society. Though sex therapy can and does operate on the basis of a multitude of substantive psychologically orientated approaches, this rendition of the nature of the sexual self was widely influential within the data, though typically lacking any thorough or explicit development.

The autonomous and sovereign sexual subject here becomes the author of its own sexuality, and it is with this respective role as author, that much of sex therapy is concerned, at least in its psycho-sexual therapeutic variants. This valorisation of a philosophical and psychological individualism receives much of its justification from the nature of sex therapy practice itself, as structured upon a framework of individual therapist working with individual client. This produced a determined but intermittent insistence on a methodological individualism, producing a distinct sense of unease with what therapists saw as “putting people into boxes” [1].

Therapists were heavily inclined to “object to lumping people together...[and were as a consequence]...careful to take someone who came to [them] as an individual...” [4]. The influence of counselling as a point of professional entry into sex therapy was important. “The way that I work I feel closer to the counselling model myself, to the humanistic or integrative therapy which I like in particular, more than the medical model...” [3]. This methodological individualism was powerfully authorised by the nature of sex therapy work as the therapist saw it, as “working very much with individuals” [9].

Sexuality has been discursively placed at the very epicentre of the self. As such, sexuality is experienced as being foundational to personal and inter-personal well-being, in turn producing an ‘internality’ to sexuality which serves to enhance its sense of naturalness

(Weeks 1987). This legacy of the ‘centralisation of sexuality’ was very much evident in the data. It is interesting to note that although most sex therapists saw sexuality as a “...crystallisation of the individual’s life issues and relationship issues in the broadest sense” [31], implying that sexuality serves as a terminal through which broader experiences become manifest, sex therapists were deeply reticent to consider the possibility that sex therapy’s interventions may be thought of as potentially implicated in setting the discursive and practical terms in which sexuality is popularly understood and evaluated. The negation of this possibility was central to the maintenance of a professional self-image of autonomy and a-political disinterestness.

The individualistic nature of many sex therapists’ accounts of the sexual subject militated against more sociologically informed accounts of sexuality. It is one thing to utilise a qualified methodological individualism as a pragmatically useful tool for illuminating that which is specific and unique in people’s lives, and another to extrapolate from such a position that the social subject can best be conceptualised in more general terms as an autonomous, sovereign and bounded unit, and the sole author of their sexual identities, norms, behaviours and problems. To the extent that such a position is adopted then an understanding of sexuality is directed away from accounts of its social construction within particular political, cultural and economic contexts. Sexual identities, norms and behaviours become a matter of subjective experience rather than of social consciousness.

4.4 The social dimensions of sexuality

The location of sex therapy is such that it sits at the intersection of a multitude of sexual discourses, including those underpinned by sociological and political accounts. The involvement of sex therapy in strategic engagements with a host of social and political institutions, and their proximity to politically conscious sexual communities has facilitated an awareness of sexuality as influenced by social, economic and political variables. But how do these recognitions of ‘the social’ articulate with the biological and psychological renditions of sexuality so popular amongst the therapists? The possibility of conceptual dissonance in the incorporation of accounts of social causation in respect of sexuality was practically averted again (for a community of therapists variably persuaded by the allure of philosophical individualism and naturalism) via a ‘holistic’ model of the person that enabled a simple aggregation of causal variables without the experience of a need for theoretical systematisation.

4.4.1 Structural constraints

The majority of therapists were willing and able to graft on to their notions of sexuality an acknowledgement of the influence of social variables. Perhaps the most limited sense in which the idea of social causation was evident in the data, was a recognition amongst most sex therapists that particular social structural circumstances could have an impact upon sexuality, particularly in terms of an impact upon levels of sexual desire and the opportunities for sexual activity. Social circumstances were here understood as external variables that become processed and internalised through cognitive and affective frameworks to subsequently impact upon the sexual subject's capacity to express their needs behaviourally.

16: social [influences] include animate and inanimate in this sense, that's environmental, so where you're doing it and who is in the room, what you are worried about, like your commitments in the real world which are children, money, work, the family, leisure, and so on....they get processed inside your head, according to the sort of cognitive and emotional rules, interacting with biographical expectations and other aspects of experience.

However, such accounts do not necessitate a recognition of the deep embeddedness of sexuality as a component of *social* relations (Padgug 1992). And to the extent that such socio-economic variables can be understood as being distributed on an individual basis, such recognitions do not necessarily lead directly to an engagement with the axes of differentiation of class, gender and race/ethnicity. Nor do they necessitate an appreciation of the constitutive role played by these axes in producing differential sexualities.

Social constructionist insights appeared to have had some influence though upon the therapists' conceptualisation of sexuality, though without jeopardising the sex/society dualism and individualism described above. Asked whether they thought that sexuality was 'socially constructed', the following therapist stated:

13: I don't think it's been constructed, it's been acknowledged, that I think is the difference...Sexuality played a very important role [in the past]. We didn't label it as sexuality but it emerged, it was visible and perhaps we articulated it more than documented it.

For this therapist, sexuality has a trans-historical importance and centrality in and of itself, as a direct expression of its essential nature. Sexuality is presented both as always-already significant, and as cajoled into the spotlight via the efforts of the enlightened. However, having reaffirmed the conceptual boundaries around an essential sexuality, so rendering it safe from a more radical social constructionist reading, the same therapist does go on to acknowledge that people's experiences of themselves as sexual beings are changing as a part of shifting patterns of gender relations, at least to the extent that women assert a right to sexuality, and for a longer duration of their lives.

13: Well, I think [sexual] things go on longer, women are not happy to have their babies, go into menopause and decline, they see themselves as still being sexual women with a right to sex and perhaps even more so because they're freer.

Clearly evident within this statement is a notion that people's expectations of sexuality have been changing, though not to the point that we could talk of a transformation in the nature of sexuality itself. The therapist acknowledges the importance of the transformations brought about by women's struggle for the enhancement of quality and equity in their emotional-intimate relationships with men (see Giddens 1992).

Some respondents attached real importance to the transformations taking place in people's experience of sexuality, and of the social origins of such changes. "I think there is a change in people's construing in this [sexual] area due to social forces" [16]. Social changes were directly associated with liberalisation, particularly in terms of the role of religion. The secularisation of society was seen as having removed one set of fetters on sexual expression and exploration, as having "taken off all the locks...." [9]. As such, therapists were acknowledging the twin components of liberalisation and secularisation at the heart of what Weeks (1987) has called the 'unfinished revolution'. Religion was universally associated with restrictive social constructs regarding sexuality, and was juxtaposed to the liberation in sexual constructs enabled by the secularisation process.

4.4.2 Sexuality, choice and the pleasure principle

For the therapists, asserting the centrality of sexuality to the self and to its relations with others coincided with a perception of sexuality as increasingly the subject of choice.

Sexuality had become a question of health and choice, as a component of a form of reflexive subjectivity.

9: There was less choice [in the past] and I'm sure less about pleasure, now we have choices about partners, about coming out, about contraception, the whole thing. I mean it's more about pleasure than procreation or anything like that so yes it's completely different in terms of our lifestyle and promoting our healthy lifestyle.

A discourse of health and well-being was the central medium through which sex therapists talked about the importance of sexuality both to the self and relationship. "I see sex therapy as helping individuals and couples achieve a well-being in their sexual experiences" [5].

The position adopted within these narratives is reflective of Giddens (1992) account of the reflexive self.

The self today is for everyone a reflexive project – a more or less continuous interrogation of past, present and future. It is a project carried on amid a profusion of reflexive resources: therapy and self-help manuals of all kinds, television programmes and magazine articles (p.30).

This sense of reflexivity, as an active characteristic of the social subject within the contemporary era, underpins the methodological individualism evident within a range of academic and professional contexts, and as we have seen, sex therapy is no exception to this. It does however, sit uneasily with the strains of naturalism evident in the therapists' accounts. Claiming that sexuality has become incorporated into new 'western' culturally informed modes of reflexivity, directly concerned with the 'quality of life', the following therapist states;

9: ...we can really work on our quality of life as opposed to our quantity of life. It's about qualitative issues in our lives in the same way that we spend all this time doing up our houses to make it nicer as opposed to just having a house that you live in....as opposed to just having sex, you have this best sex as you can.

As Giddens (1992) states, “‘sexuality’ today has been discovered, opened up and made accessible to the development of varying lifestyles. It is something each of us ‘has’, or cultivates, no longer a natural condition which an individual accepts as a pre-ordained state of affairs” (p.15). At the heart of this lifestyle sexuality is choice. According to Hawkes (1996) choice has become the dominant motif of late capitalism. Within this capitalist context, and made possible by the uncoupling of sex from reproduction, the freely choosing sexual subject consumes sexual commodities as a means to reflexively constructing their sexual identity. From the comment of the following therapist this would seem to have implications even for the manner in which people understand the nature of relationships.

34: It’s consumer society stuff, you know, get yourself a partner and if that doesn’t work, well you can always change...and go and get another one.

For the therapists though, this enablement of choice was primarily seen as creating the conditions of possibility for subjects to express their authentic selfhood. An alternative view is that such sexual consumption choices are a mechanism of control. “The choices that are for some the indicators of freedom are in fact a more subtle form of regulation through the myth of individual autonomy inherent in consumer choice” (Hawkes 1996: p. 115). Furthermore, that institutions such as sex therapy may be at the heart of determining the nature of the normative ideals in the service of which we make our choices.

Some sex therapists were aware of the potentially oppressive implications of personal choice. “Not only are you meant to have, you know, orgasms in one way, you’re meant to have them half a dozen times, and you know, you can’t not have them” [28]. The imperative to have sex under the ‘tyranny of the orgasm’ creates a context where some people “might not actually want to have intercourse but they present with a problem that they are not having intercourse” [31]. A few claimed that contemporary representations of sexuality project normative idealisations of sexual relationships and behaviour that in turn creates dissonance for individuals in their sexual lives. The expectations that normative idealisations of sexuality set up can themselves be the source of some people’s problems: “...it’s the whole message you get about what sex should be or what you should look like, and what sort of sex you should have. Its unreal...[its] a pressure” [9]. There was little apparent recognition that sex therapy itself, exemplified by Masters and Johnson themselves, had done more than most to lay the foundations for a ‘tyranny of the orgasm’ (see Segal 1994).

This passage illustrates the ambivalence of choice. We cannot choose but to choose, and those choices are made within a social, economic and political context that imposes a normatively hierarchical framework upon the options available. The potential importance of dissonance for the sexual subject is of course dramatically enhanced by the significance contemporaneously attached to sexuality. Sex has been imbued with enormous import (Weeks 1987), as an outcome of the vast causal powers attributed to it (Giddens 1992). The likely outcome being that people experience sexual issues far more profoundly than they might, and in excess of that which might be beneficial. Another therapist offers a more explicit concern regarding the implications of the contemporary social and cultural order for relationships and sexuality.

16:...I think there is trouble ahead, and this is a prediction, from the emphasis on self-expression exclusively which is evident not just in Thatcherite politics, you know 'society doesn't exist' and all that nonsense, but in the way films seem to depict, with approval, people doing things that demean or upset or injure other people. So more people will grow up with values about 'all I have to do is do my thing', and that will produce a lot of difficulties about how to have satisfactory close relationships.

The therapist here offers an account of the dangers of a form of egoistic individualism characteristic of the contemporary social and political context, in which the vacuum created by the authoritative collapse of established moral codes is filled by the demands of the pleasure-seeking individual. In this sense, the therapist seems to be articulating a broader social ambivalence.

Moral panics in the late 1980s and early 1990s surrounding homosexuality, promiscuity and pornography have centred around the view of sexuality released from close intimate bonds as destructive, deviant and violent, calling for restrictions to be enforced upon sexual expression (Lupton 1994: p. 29).

The therapist's account resonates with Weeks' (1987) concern regarding the challenges faced by sexual subjects today in establishing a new sexual ethics in the absence of religious or medical truths. Although new possibilities and sexual spaces have been created, it still remains necessary to construct a sexual ethics that whilst enabling a moral and sexual

pluralism, offers some limits to an anything-goes individualistic sexual relativism, epitomised by Foucault's account of the 'Californian cult of the self'.

Whilst there was little evidence of a radical social constructionism within the data, which conceptualises sexuality as constituted through social and power relations, some therapists asserted the formative power of socialisation in shaping people's sexuality with the effect of producing more unanimity than would be the case if sexuality were an individually determined phenomenon. An example of the productive influence of socio-political factors on sexual norms is offered by the following therapist, in their reflections on the importance of a reproductive heterosexuality to the Jewish community.

5: ...We do as a race tend to get bumped off fairly frequently...and so procreation is very very important, particularly having a son. I don't think that it is a particularly strong influence within our contemporaries but certainly the previous generation...my parents generation. It makes sense, that's why you stayed at home and had baby after baby after baby...

Other therapists acknowledged the importance of the legal parameters of sexuality both in terms of formal controls, "...we are governed by laws, British laws" [5], but also as a powerful medium for shaping belief, "...any law that's ever passed...these influence people's attitudes to themselves and to others in that society" [13]. The law is also acknowledged as a medium through which sexual relations have been altered as the outcome of changes in the legal status of men and women. "...Allowing women to have more power in the sense of being able to vote, to construct, make law, that sort of power. This actually influences male sexuality" [13]. Therapists also pointed to the media as a powerful source of ideas, in one case stressing the manner in which people become 'puppets' and 'identity slaves'.

The overwhelming majority of sex therapists were able to recognise social influences, but most operated on the basis of a concept of sexuality that delimited the influences that social structures, processes and discourses could exert on sexuality by the assumption of a unified (extra-social) sexual self, subjectively experiencing the largely determining influences of nature. Social constructionism was evident principally in the form of a recognition of 'external' socio-economic fetters upon the capacity of the individual or relationship to experience an unencumbered sexuality. There was also evidence of a recognition of the influence of culture in providing social mores that inform the subject's notions of sexuality,

particularly in the liberalisation of sexual morality. However, a more radical social constructionism that asserts the very object of sexuality itself as a constructed ‘fictional unity’ was almost entirely absent, as was an understanding of sexuality as comprised of, and rooted in, *social* relations.

As we will go on to see in later chapters, one particularly important effect of the absence of a substantial recognition of the importance of the body as a site (and in some part a product) of social signification is the difficulty it creates for sex therapists in appreciating the nature and extent of gendered and racialised/ethnicised discourses upon the construction of the sexual body. It also relocates such forms of differentiation, and the oppressions associated with them, to a natural realm, so imbuing them with qualities of inevitability and immutability.

4.5 The permitting society

One thing about which most sex therapists seemed to agree was that the contemporary British social climate could collectively be characterised as essentially open and permissive with regard to sexual norms, behaviours and identities. This was despite their own more contextualised references to examples of differentiation in the degree of acceptance, tolerance and legitimacy. It was commonplace for therapists to refer to a social climate change.

19: So the climate generally has changed, it is generally much more conducive to them expressing. Now, what the whole reason is for that...it's not one single factor....It could be a part of human or social development in the world that we live in. It's not as free in other countries, we know that, but it could relate here to the political situation.

This climate has been beneficial to all sexual orientations.

20: ...it is a fact that all sexual orientations are much more openly discussed and, on the whole, accepted these days. I'm not sure there's been such a huge change or swing [in sexuality itself], but it's much more open.

Within such a climate, social subjects have been able to realise their true sexual natures as the social and personal costs associated with doing so have declined. This

permissiveness extends to the right, opportunity and productivity of sexual reflexivity. Sex has become an object of enquiry and exploration, and sex therapy offers the enablement of this. “So the only way I think it's going is generally that society is more open about sex and therefore seeking more sex therapy, and also society is more open about just therapy generally, looking at themselves” [9].

There were examples in the data of some qualification to these renditions of permissiveness. Secularisation, for instance, better describes a process (and a partial one) than an event.

13: We only need a member of a certain religious group to stand up and have an anti-feeling....about family planning, premarital births, homosexuality. A religious preacher will have an influence on the population or congregation

The complexity of the contemporary era is reflected in some small manner by this reference to the ongoing influence of religion. Liberal-pluralist traditions of sexual thinking exist along side libertarian and authoritarian versions in a complex and shifting balance (Weeks 1987). Moral panics around sexual practices, moralities and identities have by no means been consigned to the history books. There was some recognition that the ‘revolution’ in sexual mores and practices was incomplete. For the following therapist, change has occurred but

35: possibly not as much as people think in the way that it is portrayed in the media, that there's this huge laissez-faire, women can do whatever they want, sexually have much more power in the bedroom. I think that's probably not as true as people imagine it to be

Although specific references were made to the existence of differential levels of acceptance, tolerance and commitment to diversity, these comments were rarely incorporated into an overall analysis, with the exception of the minority of therapists who adopted an explicitly neo-Marxist or feminist orientated approach. Drawing upon renditions of the historical past as a means to formulating ideas about the present (Weeks 1987), sex therapists broadly represented contemporary society as liberated from the repressive orders of previous generations. This rendition of the nature of social and sexual change is redolent with the influence of what Foucault (1975) came to refer to as the ‘repressive hypothesis’. This

hypothesis frames sex therapists' engagements with social division and differentiation. It means that although such divisions (and the 'who' restrictions and 'what' restrictions associated with them) may be acknowledged, they are not seen as foundational to the social order, or the manner in which we imagine the communities in which subjects are located. The widespread acceptance of what could be described as a 'perpetual progress' model of historical change also results in a failure to see the potential fragilities of progressive social change and the possibilities for advancements to be reversed within social contexts of reaction and fear (Giddens 1992). In this vein, Hawkes (1996) argues that the liberalisation witnessed in recent decades may be better conceptualised as a shift in the modes of regulation rather than their absolute removal. "From the Foucauldian perspective, then, the obsession of researchers working within science, medicine and the social sciences in documenting the sexual body over the past century...serves to cast an ever-wider net of disciplinary control over citizens" (Lupton 1994: p. 27). Furthermore, Davies (cited in Hawkes 1996) claims that many of the legislative and policy changes witnessed in the post-war era resulting in the liberalisation of sexuality have in fact been motivated by a form of negative utilitarianism. Sexuality in some senses remains a source of anxiety and fear, kept in check not so much externally by restrictive legislation, but rather internally by modes of self-management and policing in the name of health.

4.6 Sexuality and gender

To think about sexuality is to think about gender (Weeks 1987). Concepts of gender and sexuality have become interwoven through a multitude of religious, scientific and political discourses that serve as repertoires upon which social subjects may variably draw in making sense of their social world (O'Connell-Davidson 1998). A central characteristic of both Judeo-Christian and scientific ontologies has been an explicit gender dimorphism, a committed investment in the representation of absolute difference as the defining quality of the relations between men and women (Hawkes, 1996, Weeks 1987). In this respect religious essentialisms were partly replaced by naturalistic accounts grounded upon a biological reductionism that saw in the depth of men's and women's bodies, an antithesis (Jordinova 1989). In both religious essentialist and post Enlightenment biological reductionist accounts, sexuality, or more specifically heterosexuality, has been given a pivotal role in determining the nature of men and women and their inter-relations. Gender has become framed largely in terms of heterosexuality, where the differential biologies of men and women render them forever locked into a conflict that only finds resolution and synthesis in heterosexual desire and relations. Gender has also come to occupy a central though contested position within the

psychological and psycho-therapeutic traditions with biological and strands of psycho-analytical thought have consolidated notions of gender dimorphism.

The bifurcation of men and women has been characterised by a general differentiation of male and female natures and sexualities (Woodward 1997). In broad terms women have been constructed as naturally less sexual than men, though regulation has frequently been seen as necessary to ensure that women 'choose' this true nature of sexual passivity. To this end, distinctions between the 'madonna' and the 'whore' have served to police women's sexuality, corralling women into their 'natural' boundaries. However, although less sexual by nature, women have also been constructed as a threat to the moral integrity of men (Hawkes 1996), on the basis of a power that is seen to inhere in their capacity to engender sexual desire (O'Connell-Davidson 1998). The influence of religious and right-wing political discourses prevails, underwriting explicit opposition to a host of social developments, such as abortion, sex education, divorce and single parenthood, that threaten to jeopardise preferred versions of gender relations (Weeks 2000)

But such essentialist accounts of the nature of men and women, and of their respective sexualities have also been the subject of profound contestation. Strands of feminist and social scientific thought have challenged the realities constructed in the name of religion, science and political conservatism have brought into question gender certainties, foregrounding the social, political and economic underpinnings of extant gender relations (Lupton 1994). The challenges mounted to the hegemony of heterosexuality from sexual minorities have brought into question the normalisation of heterosexuality and imposed a radical relativity upon ideas of sexual legitimacy. Broad-based recognitions of the sheer extent of sexual diversity have become embedded within the social consciousness of many, as part of a progressive liberalisation of sexual values and behaviours (Weeks 2000). Significant transformations in discourses and experiences of gender have been realised as part of a dramatic shift in the balance of power between men and women. But in turn, this revolution in gender has been partial and contingent. Public debates around the changing structure of the family and of the social and inter-personal implications of female autonomy (epitomised by accounts of the 'single mother'), reflect deep social and political ambivalence about the future of gender and sexuality (Woodward 1997).

Relinquishing power in intimate and social relations has also proved difficult for men. Furthermore, strands of academic, religious and political thought continue to (re)produce renditions of gendered sexualities in polarised terms. Bio-scientific accounts of sexual

dimorphism continue to enjoy a high public profile via a media that continues to valorise scientific authorisations of gender difference. Sex therapy sits at the interface of these multitudinous discursive legacies and social developments, though as with psychotherapy generally, this may not yet have resulted in an enduring and comprehensive engagement with the implications of gender for practice (Rose 2002).

Unsurprisingly, the respondents' accounts were informed by a recognition of profound change in gender roles and identities.

20: ...there's been a huge change in a lot of men and women's roles...I've come across far more men who are being house parents and women at work and some of this is having a great impact on the sexuality of both partners...It does affect their expectations but it also brings about a change where men are concerned, sometimes there is the taking away of the very male dominant rule in some instances.

Accounts of gender were characterized by recognitions of the importance of power. The dominance previously enjoyed by men has been challenged by the powers acquired by women. The implications for sexuality of broader changes in gender roles and identities, was widely acknowledged by the therapists. This in part reflected a conceptual coupling of sexuality and gender within the data.

28: I think sexuality is fundamental to the individual, to the development of the personality. I think it's about who we are, I think it's about gender. Its about sexual function, it's about femininity, masculinity, it's about our notion of ourselves in the world...

These transformations were seen to be concentrated in the younger generations, but with parallels across the age groups.

13: ...women are not happy to have their babies, go into menopause and decline, they see themselves as still being sexual women with a right to sex and perhaps even more so because they're freer and certainly as an educated group they are very aware of the influence of HRT, menopausal drugs such as that which will promote their sexuality,

Changes in gender role and gender identity raise questions for the realm of emotion, as emotions have been so central to defining the respective natures of men and women.

3: ...I think that guys are more in touch with their tender side...they are more allowed to express the tender side of themselves, which is great for the kids and the relationship. Guys are expected to do much more at home in the way of hands-on fathering and enjoy it.

Here we have an explicit rendition of men and implicit rendition of women as having a 'side' to them that has previously been repressed due to its monopolization by the 'opposite' sex. The man has the opportunity to express 'feminine' qualities because the liberated woman is expressing her 'masculine' qualities.

But whilst these changes were acknowledged, the overwhelming bulk of the data was redolent with accounts of the partial nature, and/or problematic implications of, these transformations. Though there was a generalized representation of contemporary British society as being characterized by choice, reflexivity and permission, with the focus firmly upon gender, doubts were widely expressed about the extent of the underlying changes in understandings of sexuality and relationships. For some, gender continuity outweighed change.

19: I think I have found whatever the ethnic group, again their [men and women's] problems aren't that much different. Mostly, the women still want more attention, they want more sensitive men, and mostly the men don't know what they're talking about....no matter where they're from.

Western societies remain deeply ambivalent about a range of sex and gender issues in a manner that reflects past anxieties:

42:...we have a society that basically has problems with women and sex, has problems talking about sex, has problems with men and feelings, has problems with homophobia, but that's true of a large part of Western Europe...

Policy developments concerned with informing and advising the general public on matters of sexuality have not produced the transformations envisaged:

42: ...sex education is about sexual functioning and it misses out both sexual pleasure and, I guess relationships, responsible use of sexuality...So that when people get a bit older, it's been my experience and that of others I've talked to, that they see women, quite young women, who have issues around expressing themselves sexually, sexual pleasures, young men who aren't sure how to, and they haven't really thought about female orgasm...

Partly this was accounted for in terms of the lack of real knowledge of the basic physiology of sex, "how many young men of your acquaintance are aware of how a woman's orgasm works" [42]. For many therapists, the democratisation of knowledge has not produced the requisite cognitive, affective and behavioural changes necessary to enable men and women to fully exploit the possibilities made available to them in the present social context. Profound sexual uncertainties and concomitant anxieties were seen to prevail.

28: ...Men are less certain than they once were about their ability to please their partner or to be sexually functioning with their partner and so it either translates into avoidance or premature ejaculation, or occasionally into sort of reversal into something quite old, quite macho...

Beyond the question of understanding were concerns about the negative implications of changes in women's transformed employment status. "I mean, when you have two very, very busy careers and children. It's very difficult to juggle with all of that, and to still feel sexual at half-past eleven at night and when what you really feel is knackered" [42]. Furthermore, the cultural valorisation of female sexual autonomy and expression would not appear to be complete. For some therapists, a legacy of female sexuality as dangerous remained as a feature of British culture. "And it's that thing that seems to me, that is about sex being dangerous and, in that context, women being dangerous. And to have it controlled" [28]. Many therapists expressed the view that a democratisation of sexual relations, and the empowerment of women's control over their sexuality, may well have been impeded by particular bio-medical developments, most notably Viagra.

28: ...now what's happening I think is that we're back to a place in the sex world where I think people's view of sex has become again more

phallogocentric than it used to be. I think it always was, and I think we'd moved away from that a little bit, and now we're back to it.

For others, the forms currently taken in respect of the promotion of female sexuality has itself oppressive implications. One therapist suggested that a commodification of sexuality had, for women, resulted in a loss of their bodies as a site of dignity and honour.

25: Men's honour had to do with courage and women's had to do with virginity and prudence and all that. And that's an important thing to have woven into your body. In some ways it dampened down sexuality but it also gave a kind of dignity to the body...and I think that many people don't have dignity [today].

The sense of 'loss' expressed by the (male) therapist seems to be giving voice to a discourse on femininity of some long-standing, that serves to pathologise women who through choice or compulsion become reduced to sexual objects. Such women, as epitomised by the 'othering' of prostitutes, have routinely been the object of censure (O'Connell-Davidson 1998).

25: ...where is the self that has this body, because if you're using your body in that way, you are in the position that was traditionally given to prostitutes, you know, as people who sold themselves, who are wage slaves but here they are, kind of identity slaves

Women's bodies, through these particular modes of sexualisation have become dissociated.

25: ...it's like wearing the old regimental jacket or something, the old school tie, having your tits out as a girl. It's something like that, you know, it's something you flaunt, so your body has become a public, it's become a sign. You have a sort of semiotic sense of it, you know, your body becomes a currency that you use in the world.

Women have initiated a revolution in emotional and intimate relations, but this in some senses has left men behind, despite the latter's inevitably close proximity to the cause and effect of this transformation (Giddens 1992). For the respondents, the 'new man' would seem to be, if

not exactly scarce, beset by the endurance of traditional masculine identities and their own sense of ambivalence and dissonance regarding the implications of these changes. This is illustrated in the following passage:

28: ...one of the things I am struggling with at the moment is the number of women I'm working with who are in relationships where they feel the burden of keeping the relationship together...there's a real swing, I think, away from what used to be called 'the new man'.
[Women are] trying to drag these men along who don't want to do it actually, they just want to be left alone

The losses associated with the transformations in masculinity induced by more autonomous forms of femininity would seem to be at the forefront of therapists' minds.

20: ...a huge lot of it is going to link in with men's fear of women and women taking over, engulfing I suppose, control...It doesn't always work that way of course...there can be a greater balance and interaction, so it can be a healthy thing as well. It depends how far it goes and it depends how far it actually suits those people.

There would appear to be a threshold, or healthy limit to the changes that are taking place in gender relations. Although the therapist acknowledges complexity here, they identify the potential threat such changes may pose to male power in relationships, and to men's self esteem.

13: The classic one is the man who becomes unemployed, and his wife has quite a powerful job and is not willing to give this job up. He stays at home washing the kitchen floor and collecting the kids. He doesn't think it's a man's role and his self-esteem suffers, and the relationship suffers, and his sexuality function starts to suffer.

Clearly evident is the assertion that male sexuality in heterosexual relationships is grounded upon a broader gender role, in turn given expression through the enactment of particular tasks which via their traditional ownership by men serve to bestow an identity and experience of empowerment. The 'role reversal' associated with male involvement in

domestic labour thus becomes an experience of emasculation which jeopardizes the foundation of male sexuality. The therapist went on to say:

13: I have no evidence to support that they may have less sexual drive because of that...why would they really...just because they are doing women's work...

It is interesting to note in the above statement that in discussing the changing nature of gender identities, discussions regarding men getting in touch with their tender side invokes a statement regarding the male sex drive. The therapist offers the view that they “have no evidence to support that they [men] have less sex drive because of that...why would they...just because they are doing women's...”. The therapist's selection of the issue of male sex drive in this context suggests an anticipation of problems for the male sex drive brought about by a change in the nature of men's traditional mode of relatedness to the world, a mode characterized by distantiation, emotional restraint and a valorization of the separation of sex from emotion (O'Connell-Davidson 1998). A picture is presented here of a loss of control experienced by men, produced by the greater autonomy of women. “...Men quite often feel impotent because they feel that they have lost some of their power...” [1]. This perception reflects, and may well be informed by, accounts of the effects upon men of changes in gender role found within a sociological literature. Hawkes (1996) argues that the uncoupling of sex from reproduction has induced a new level of female sexual autonomy that has generated fears and anxieties, reflected in forms of opposition or resistance to women's contraceptive rights (Haste 1992). For men who experience challenges to their readings of masculinity from the redistributions in power in social, interpersonal and sexual relations, this can become manifested in sexual or pseudo-sexual terms.

A gender dimorphism was routinely asserted, and survived recognitions of the social changes that otherwise were seen as producing complexity to the point of social atomisation. Cognitive, affective and behavioural characteristics were accepted as marking the differential sexualities of men and women, despite the transformation of gender roles witnessed over the last century. Social constructionist and feminist influences were evident in the data, and enabled the therapists to account for the unstable and contingent nature of much that goes by the name of gender, including its sexual components. But what was most notable was the overwhelming presence of anxieties about the implications of the forms of gender equalisation witnessed through the late 20th century. It was not clear what was driving these anxieties. The data were suggestive of a number of factors. A feminist orientated standpoint

sensitive to the ongoing patriarchal nature of social and interpersonal relations, and the threat posed to male power by women's equality. A professional therapeutic standpoint grounded upon the imperative to maintain a consciousness of all problematic dimensions of sexual and interpersonal relations in order to be able to work therapeutically with these problems. And finally, though rarely fully explicit, a sense that in gender relations we are dealing with differences of such depth and endurance, that there may be 'natural' limits to socially driven changes, beyond which we may *expect* to find problems.

4.7 Conclusion

The aim of this chapter has been to map the principle contours of therapists' understandings of the nature of human sexuality and gender as a means to understanding the 'local terrain' within which ideas of race and ethnicity must operate within sex therapy. As sex therapy stands at the confluence of a multiplicity of discursive streams pertaining to the nature of human sexuality, it was important to establish an understanding of how these respective streams influence, and circumscribe, current thinking within sex therapy.

Biological and medical scientific discourses have been profoundly influential in the construction of sexual thought, and the role attributed by the therapists to biology in shaping human sexuality, whilst not crudely reductionist, was reflective of this influence. A certain sex/society dualism (Weeks 1985) was in evidence whereby important and inherent features of human sexuality were understood as located behind the wall of nature, though enabled to escape intermittently into the realm of the social. As one therapists put it, "One cannot underestimate the power of that physiological drive" [34]. But if naturalistic accounts represented one of the principle poles to which sex therapeutic discourses of sexuality were attracted, then the other would certainly have to be a humanistic-existential notion of the sovereign sexual subject, possessed of an autonomous self-hood. A 'centralisation' of sexuality to the self was very much evident in the data. This valorisation of a philosophical and psychological individualism receives much of its justification from the nature of sex therapy practice itself, as structured upon a framework of individual therapist working with individual client.

But the involvement of sex therapy in strategic engagements with a host of social and political institutions, and their proximity to politically conscious sexual communities has also facilitated an awareness of sexuality as influenced by social, economic and political variables. Therapists recognised the 'external' influence of particular social structural circumstances

upon a subject's sexuality, for instance via the effects of stress, and the legal parameters delimiting sexuality. More substantial social constructionist insights appeared to have had some influence upon the therapists' conceptualisation of sexuality in terms of the formative power of socialisation and recognitions of the changing meanings attached to sexuality. Sexuality, given its attributed centrality to the self, and a permissive social climate, was accounted for as increasingly a subject of reflexive choice-making, and by some a component of an emerging pleasure-seeking egoistic individualism. But the influence of both naturalistic and humanistic-existentialist accounts of the sexual subject seemed to militate against more comprehensive sociologically and politically informed account of sexuality.

A gender dimorphism was routinely asserted, and survived recognitions of the social changes that otherwise were seen as producing complexity to the point of social atomisation. Cognitive, affective and behavioural characteristics were accepted as marking the differential sexualities of men and women, despite the transformation of gender roles witnessed over the last century. Social constructionist and feminist influences were evident in the data, and enabled the therapists to account for the unstable and contingent nature of much that goes by the name of gender, including its sexual components. But it was also notable that there were some anxieties about the implications of the forms of gender equalisation witnessed through the late 20th century.

But what was most notable from the data was the influence of a form of pragmatic eclecticism in respect of accounts of human sexuality. Under the guise of a 'holistic approach' it becomes possible to simply aggregate the multitudinous variables impacting upon sexuality into some unsystematised whole. A need to comparatively evaluate the relative significance of these variables, and as such the need for critical and systematic thought, is negated, producing a new, though more multi-dimensional 'taken for grantedness'. It also enables an apparent theoretical consensus within sex therapy, in permitting each practitioner to pick and choose their own particular recipe of inclusion, resulting in an apparent unanimity that actually disguises a very real plurality.

The effect of this theoretical/conceptual eclecticism, and therefore indeterminacy, is to provide a landscape of such accommodativeness and fluidity as to provide largely unencumbered opportunities for multitudinous renditions of race and ethnicity to flourish within sex therapy. It is also to enable a host of un-theorised connections to be made between sexuality, gender, race and ethnicity. It is within such a landscape that extant common-sense readings of race and ethnicity are likely to find many paths of opportunity.

Chapter 5 – ‘Race’ and Ethnicity in Contemporary Sex Therapy

Sexual scientific and therapeutic discourses regarding the nature of human sexuality, the sexual subject and sexual problems have not evolved within a condition of ‘splendid isolation’. Rather they have developed (at times explicitly but primarily implicitly) in articulation with ‘socially-worked’ discourses and broader social relations concerned with questions of race and ethnicity, resulting in a dialogical process of co-construction (see McClintock 1995). Surprisingly however, the threads of race and ethnicity, as a constituent part of the tapestry of the contemporary sexual scientific and therapeutic constituency, have rarely been illuminated, and certainly not unpicked. Because race and ethnicity manifest themselves in different ways, as they become mediated by the dynamics specific to particular social locations, it becomes necessary to explore the particular characteristics of race and ethnicity’s purchase upon the hearts and minds of sexual scientists and therapists.

Contemporary sex therapy, as a social location within which interventions are made in the field of human sexuality, and within a social context of racial and ethnic diversity, constitutes a key site of mediation with respect to ideas of race, ethnicity, gender and sexuality. It is also a site in which the particular outcomes of this mediation can be expected to have a significant bearing upon social and sexual subjects carrying diverse racial and ethnic identities. Of particular significance here, given the power inhering within the ‘therapeutic alliances’ formed in the practice of sex therapy, is the potential role played by racialised and ethnicised readings of the sexual subject in constituting sex therapy as an institutional location within which clients ‘acquire’ aspects of their racial/ethnic sexual identity (see Knowles 1999).

The central aim of this chapter is to offer an account of the discourses of race and ethnicity produced within the *text* of the BASRT’s journal and the *talk* of the interviews with practising sex therapists. Particular attention has been given to detailing the qualities, significance and effects attributed by sex therapists to race and ethnicity as dimensions of the social subject and of social relations generally. Teasing out the underpinning cognitive models with which race and ethnicity are understood by sex therapists will make it possible to appreciate their mediation with ideas of with gender and sexuality, and of the social location of sex therapy itself.

5.1 Categorical difficulties

A distinctive characteristic of the textual data was the use made of multiple terminologies, an apparently eclectic utilisation of a range of concepts clustering to mark out the contours of the race and ethnicity field. These included ethnicity, ethnic, race, racial, minority, culture, cultural, religion, western, non-western. Though deeply ambiguous discursive patterns emerged from this eclectic vocabulary, there was little to indicate an appreciation of the deeply problematic nature of racial/ethnic terminologies.

The same cannot be said of the interview data. The difficulties experienced by the therapists in utilising a racial/ethnic vocabulary seemed to have two origins. Firstly, the vocabularies of race, and to some extent ethnicity, have become deeply sensitised as part of a post-war prohibition on public and political enunciations of explicitly racialised discourses, in the light of the ethical and humanitarian horrors initiated in the name of race before and during the second world war (Brown 1999, Malik 1996). Anti-racist and multi-culturalist initiatives have further problematised racial and ethnic vocabularies as a means to challenging the conceptual underpinnings they express. Racialised and ethnicised minority groups have also used their hard-fought, though incomplete, citizenship to bring into question taken-for-granted hegemonic discourses. The outcome of this has been a certain degree of ambivalence and contestation around just 'what can be said' in public space. This ambivalence was expressed by many therapists through their accounts of 'political correctness'.

31: we've [sex therapists] just become very pc conscious...I think it's a very difficult issue and we all feel tripped up by it. I am very aware that it's something that I could feel tripped up by; I have to be very careful about.

The notion of 'tripping up' implies a set of rules governing the legitimacy of language and practice within sex therapy with regards to issues of race and ethnicity, and points to the real possibility of therapists breaking these rules. This possibility produces anxieties. "I think here there is a fear of being politically incorrect" [19]. Within the meso-level of professional bodies and public institutions, the 'political correctness' stakes are often perceived to be high. Anti-oppressive discourses have arguably achieved a greater purchase within these sectors and as such offer bench marks for 'good practice'. To be seen to have failed in relation to these bench marks is deeply jeopardising for professional collective personas. Such anxieties

around the linguistic aspects of ‘political correctness’ were themselves a product of a more generalised perception of sensitivity.

41: I’m not sure there’s a lot of talking goes on, I think people find that still far too dangerous, far too scary and I guess something that we really haven’t talked about here, you know, the power issues related to the subjects that you’re talking about are huge.

It was evident that for some therapists, the emergence of ‘political correctness’ in this area had produced forms of un-freedom, and on this basis was challenged as unjustified and counter-productive. As one therapist argued:

16: ...there are a lot of slogans in this field [race/ethnic relations]....these groups [those who articulate the interests of racialised/ethnicised minorities] derive much from special pleading always, they have an excessive influence in my opinion.

Whether ‘political correctness’ has *actually* produced discursive un-freedoms may be questioned however. Since the 1950s an elaborate and coded language for articulating racial and ethnic essentialisms (using signifiers of diversity and culture) has emerged (Brown 1999, Malik 1996). Furthermore, the freedoms associated with the expression of oppressive racialised discourses produces a corresponding un-freedom for those who become subjected to them.

Secondly, the vocabulary available to social subjects may in its application be rendered inadequate by the complexities and transformations of the realities they serve to describe. Categories of race, ethnicity, nation and culture are all subject to change via structural circumstances and human agency, in the process acquiring new qualities and inter-connections, and disrupting established patterns of naming (Fenton 1999, Rattansi and Westwood 1994). One might anticipate therefore that social subjects (and in this case sex therapists) may well develop a sense of uncertainty and confusion in the act of naming and making sense of such a complex and shifting reality. This was certainly evident within the data. Therapists commonly managed this uncertainty by explicitly referring to, and finding safety in, the categories produced within official documentation such as the census. But this was only half the story. This conceptual and linguistic uncertainty was actually offset by an

underpinning confidence expressed by many therapists in their understanding of the social reality that lay beneath these problems of naming:

31: they [race and ethnicity] are both the same thing, originally, and I think what has happened is that race has become non-pc and associated with negatives. If you look in the English dictionary I'm sure you'll find that the definitions are very similar.... Is Jewishness a race thing or is it a cultural thing? I think you'd have to be an academic nitpicker to try and find the differences there....But you know it's okay to talk about people's cultural differences but it's not okay to talk about people's races.

The therapist suggests that beneath the changing fortunes of ethnicity and race as concepts for making sense of particular forms of difference lurks a common empirical reality. In their use of the term 'nitpicking', the respondent implies that an attempt to reflect upon the differences that may exist between a racial or cultural rendition of Jewishness is of little conceptual value.

There was also a near universal tendency to articulate ideas about race and ethnicity through the unreflective use of what may be described as a 'pick and mix' vocabulary. In referring to the diversity of their professional peer group, the respondent says:

1: The [supervision] group that I belonged to, the leader was Dutch, we've got an Afro-Caribbean woman, a Nigerian, there is me who is mixed race, and two Jewish women. So we bring quite a diverse culture to it ourselves....

This passage is clearly illustrative of the categorical ambiguities and connotations characteristic of the field as a whole (see Ifekwunigwe 1997, Stubbs 1993). The categories 'Dutch' and 'Nigerian' refer to a nationality but may also carry implicit assumptions about the whiteness of the former and the blackness of the latter. 'Afro-Caribbean' has a legacy within racial thought and will certainly carry an assumption of blackness. In terms of their own status as the child of two parents the term race is invoked to make sense of their own 'mixed' provenance. The reference to Jewishness is to a religious category, but one with complex and uncertain ethnic and/or racial associations. This account lends support to the claim that 'official' discourses and vocabularies commonly reproduce broader 'common-sense' formulations of race

and ethnicity in all their contradictions and ambivalences (Malik 1998), and without a consciousness of this.

It was typical for respondents to utilise more than one term (such as race, ethnic, culture, and religion) in any given enunciation. In some instances this seemed informed by a desire to invoke a significant difference. In other instances it operated as a 'belt and braces' approach adopted as a strategy for dealing with terminological and categorical uncertainties. However, there was a clear sense in which this apparently indiscriminate use of terminology reflected a naturalisation, or taken-for-grantedness, of the social realities of race and ethnicity that lay beneath the uncertainties of the language.

My interpretation is that for most therapists the deep ambiguities associated with how to articulate issues of race and ethnicity; "I think people get very tied up with it and so do I" [28], were perceived as problems of *articulation* rather than problems with what Brown has referred to as 'conceptual primitives' (Brown 1999). I would suggest that for sex therapists, outside of the somewhat exceptional and demanding context of the interview, 'any word might do' in describing the social realities of race and ethnicity. A 'taken for grantedness' (reflected in a naïve empiricism) prevailed that enabled an assumption on the part of the therapists that whatever word they might use, the real meaning was implicit because shared and understood.

Unsurprisingly, specifically ethnic vocabulary seemed less problematic for the therapists. Although conceptually a flawed distinction, Fenton (1999) does point out that race and ethnicity have been distinguished in terms of a malign-benign binary, whereby race's malignant quality is contrasted to ethnicity's generally benign associations and implications. Although this malign/benign binary is empirically unsustainable (and may well become publicly recognised as such in the light of recent atrocities carried out in the name of ethnicity) the malign/benign dichotomy seemed to be in operation within this context. Within such discursive scenarios, the terminology of ethnicity could be used without risk and whilst enabling the invocation of the therapists' preferred conceptual primitives.

5.2 Race

Race was referred to explicitly in twelve papers. As such, a direct 'call to consciousness' on issues of race was infrequent. In the very first edition of *Sexual and Marital Therapy*, Patricia d'Ardenne (1986), a key commentator on issues of ethnicity and

culture in sex therapy, contributed a seminal paper entitled “Sexual Dysfunction in a Transcultural Setting: Assessment, Treatment and Research”. Given its strategic position in the history of the journal, this paper served as something of an agenda-setter in marking out the terms in which issues of race and ethnicity were to be invoked, conceived and applied within the journal. Race makes an appearance at this early stage of the journal’s history in a reference to the importance of the “politics of race and sex” for therapists and their practice. Written in a mid ‘80s context, in which anti-racist politics had become the subject of high profile political contestations, such a phrase would undoubtedly have resonated with the readership, invoking contemporaneous issues associated with the family, sexuality, crime, unemployment, local authority services and the police. But the ‘politics of race and sex’ are not defined or described, and in the extensive list of key research questions, upon which the paper concludes, no further reference is made to the need to understand the meaning or implications of these politics. At no point in the history of the journal has the term race received even a definition, and certainly no theoretical elaboration.

None of the papers referring to race placed the term within inverted commas, a common practice for those who in particular kinds of communication settings (with unknown audiences, where the dictates of brevity prevent a fuller account of the concept), wish to indicate their recognition that the concept has a problematic and reified status. The commonplace critique (at least within sociological and political contexts) of the fallacious biological assumptions powerfully associated with the legacy of racial thinking is completely absent. It is noteworthy though that the term ‘caucasian’, a phrase redolent with racialised biological meaning (Bradby 1995), does make an explicit appearance in the data (see Vearnals and Campbell 2001, Gupta 1999).

However, this conceptual vacuity carries a ‘productive’ message. In a context in which social consciousness is racialised, this absence of conceptual specification practically reifies the existing presence of race. It expresses and reinforces a taken-for-grantedness about race within the journal, implicitly propping up an extant racialised common sense. If we assume that the journal has a respected status amongst its readership as a receptacle of valorised scientific knowledge (and the interview data supports this view), consistent conceptual superficiality in papers concerned with race and ethnicity may powerfully confirm the sufficiency of the readers’ extant common-sense understanding of race as a legitimate explanatory concept (see Miles 1989). This conceptual vacuity is particularly problematic in health contexts such as this as “...the debate about genetics and environment as contributors to the characteristics of research subjects is not resolved...[such that some writers in, and

readers of, the journal]...may be prepared to argue that there is some connection between the genetic inheritance of an ethnic minority and their patterns of ill health" (My words in brackets) (Bradby 1995: p.408; also see Atkin 2003).

Race routinely makes an appearance as one unelaborated dimension of difference, listed alongside others, most typically including some combination of class, gender, ethnicity, culture and religion (see Mackay 2001, Bhugra and De Silva 2000, Bhugra 2000, d'Ardenne 1996, Hirst et al 1996, Lenderyou 1994, Massey 1994). I would argue that in such contexts, the meaning of race is implied residually. It appears to refer to that which remains when other variables, readily associated with societal determination, have been accounted for. In this sense I would suggest, the reader is invited via the concept of race to think beyond the social and the psychological, to a sub-social, quasi-biological realm, in which races are taken to exist in some unspecified form, and exercise some influence over the nature of the human sexual subject. References to a "multiracial world", and to "racial differences in sexual attitudes" (d'Ardenne 1996: p.294) can therefore operate as the triggers for a naturalistic discourse.

Race appears in reference to the plurality of British society (see Hirst et al 1996, Lenderyou 1994, Massey 1994), and particularly in contexts where issues of conflict are raised within a rubric of 'race relations', equality and opportunity (see Compton 1989). It is possible that references to race within such contexts may suggest a more politicised notion of race on the part of the author, and to the reader. But there is no real support for this view from the data. Given that the assumption of conflict as defining the relationship between racial groups (as a direct manifestation of an assumed antithetical racial essence) has been central to much classical and contemporary racialised thought, unless this assumption is explicitly countered, consistent references to race in the context of conflict and inequality may well reflect and project quite traditional racist positions. To the extent that race is alluded to in a manner that directs our consciousness to a sub-social realm that fixes our natures and identities, to a diversity of 'natural kinds' (see Brown 1999), the text is more imbued with this latter reading.

Considering the public-political injunction on explicit racial discourse (Brown 1999, Malik 1996), one might expect to have to work hard to uncover racial ideas within the context of the interviews, and in some cases it was clear that therapists were averse to both its expression and to its ontological implications. But in a surprisingly large number of cases the

proximity of race to the surface of the therapist's consciousness produced something more clearly visible than anticipated.

It was clear that in race, therapists were articulating ideas that were far from fully 'worked through', and certainly not consciously or reflexively rendered into a readily available position. "Race, I take to be...eeerrmm...it's something I haven't thought about before. I'm trying to think of the best way to describe it" [41]. For most therapists, race was about physiology, it was about the biological sub-stratum of life. It was evident to one therapist both in terms of the racial blood of inheritance, and in the modern discoveries of genetics. In accounting for the race of the black British population, a therapist referred to "the blood of the black minority, they've inherited the genes" [34]. Tapping into an ethnographic perspective the same therapist offered an account of a human population subdivided by a typology of races

34: Jews are from a different race from gentiles and black Africans are a different race from Jews, and Arabs are very close to the Jews in their racial similarities and then you have, you know, then you go further east and then you go to the Far East. There are a number of races in the world.

Expressing the spacial mapping that has consistently been a feature of race (Mills 1999), another linked their typology to the continental geography of the world. "I guess in my mind it [race] links to the sort of five continents of where people come from and how they've developed on a biological basis" [41]. Race stood for an over-arching or underpinning biological category, subdivided by ethnic differences associated with historical experience and cultures, the latter reflected in phenomena such as signs and symbols. Another therapist associated race with 'inbred' qualities. It was recognized by most therapists that colour signification was a widespread phenomenon, and some recognized that it shaped the social and sexual relations people had with one another. These accounts seem redolent with a prevailing notion that race resides essentially in the *body* of the person (see Brown 1999). Accounts of this process of signification varied from naturalistic accounts to more critical readings. The following passages display both:

25: I am personally opposed to large-scale immigration of people of different racial origin, using racial in its ordinary sense, because I believe that people's capacity to integrate differences is very small and

I think that human beings are so overwhelmed at this time that they can't do it

and

25: I think race has clearly come to be a political term and ethnicity is a political term so I see them as names which individuals can make use of to try to shift their power relationships in society.

The 'problem' of immigration is framed here in explicit racial terms. The implication of the first sentence would seem to be that the immigration of people who are not racially different is not opposed by the therapist precisely because it is racial difference that constitutes the problem. 'Using race in its ordinary sense', in this context, would seem to suggest that there is a common-sense and universally familiar reality to race, belying the fact that racial consciousness does not develop directly from phenotypical differences between people and populations. Such differences, of which there are an infinity, have to be organised *into* racial categories (Gilroy 1998). The taken-for-granted differences that are race within the above passage are seen as inherently problematic because of the assumption that such 'natural' differences challenge our equally inherent limitations in coming to terms with such 'evident' difference. Difference, and especially racial difference, equals dissonance. The above passage does seem to provide evidence of an assertion made by Lola Young (1996).

Although, according to some commentators, the new racism does not use biological differences as a basis for separatism, I would argue those crude scientific discourses frequently lurk just below the surface, albeit with a shift in emphasis to an instinctual notion of difference. This instinctiveness – allegedly possessed by all 'races' – maintains that it is 'natural' for different racial groupings to want to keep cultural cohesion through homogeneity and any attempt to resist that is the result of misguided intellectualisation (p. 173).

Interestingly, despite the naturalism of this account, the same therapist is alert to the role played by both race and ethnicity as resources utilised within social and political relations.

This visible coinciding of a naturalistic and constructionist framework does seem to illustrate the power of the 'conceptual primitives' of racial thought to endure even alongside

more sociologically or politically informed insights. There was clear evidence that for at least some of the therapists, race referred to a sub-social reality of ‘natural kinds’. Though overtly racialised discourse could not be described as the norm within the data, it was also notable that at no point did any therapist offer an explicit critique of the race concept in the fashion that might be anticipated within a context where sociological and psychological approaches have challenged its conceptual legitimacy, and where such accounts are readily available to, and have been accessed by, professional groups within the health field.

Furthermore, I would suggest that the ontologies of race implicitly imbued and informed accounts in the absence of its specification. Where the ‘conceptual primitives’ of race prevail, and I would suggest that they do within sex therapy as elsewhere, a need emerges to express these primitives through changed signifiers and vocabularies. In the context of the re-articulation of race through a public-political discourse of ‘new racism’ (for a classical account, see CCCS 1986, Barker 1981), ethnicity has become an important surrogate medium through which race has found new modes of expression. Gilroy’s (1998) assertion that we are seeing the end of race, that the “call of racial being has been weakened” (p.844) as we have become “more sceptical than ever about the status of visible differences in relation to the unseen” (p.843), would not seem to be borne out by this data.

5.3 Ethnicity

Race and ethnicity have become deeply implicated concepts. Race has been ‘metonymically elaborated’ in cultural terms (Solomos and Back 1996), and readings of ethnicity have in some variants displayed primordialist and naturalistic qualities. Ethnicity occupies a conceptual middle ground, functionally connecting ideas about differences of a natural kind (race), with more socially acquired differences of a cultural kind. In one direction serving to adhere cultural variables to race, and in the other serving to lend a sense of inherence to the cultural characteristics of ethnic (typically minority) groups. In its mode of usage and in the context it provides for discussions of particular modes of ‘deep’, and at times apparently inherent culture, ethnicity serves as *the* key coupling device for connecting ideas about culture with ideas of pseudo-biological underpinnings.

The profile of ethnicity within the data was far higher than that of race, but this is not reflected in a substantially greater level of conceptual and theoretical clarity. As with race (and reflecting their profile within much of the health research and literature (Bradby 2003)), neither ethnicity or culture have been defined or theoretically elaborated in any explicit manner throughout the history of the journal. Once again, this is interesting given both the

problematisation of these categories within the public-political realm, and the expressed commitment within the BASRT to utilising a broad knowledge base (presumably including social scientific approaches) in the service of understanding and therapeutically intervening within the realm of sexuality and sexual dysfunction. One way of understanding this conceptual vacuity is in terms of its functionality. It is precisely this conceptual indeterminacy that renders ethnicity so effective in shuttling social subjects to their respective conceptual positions. It enables our individual and collective perceptions of real and imputed differences and commonalities to be organised in ways that facilitate the accommodation of often incommensurate orientations, and with a minimum of dissonance. But it also reflects the taken-for-grantedness that is produced by the ethnicisation of social consciousness. This conceptual taken-for-grantedness elides the profound conceptual and operational challenges posed by attempts to understand the relationship between ethnicity, sexuality and health (see Aspinall 2001).

The overwhelming impression within the textual data is of a concept of ethnicity understood in somewhat primordialist and culturalist terms. Primordialist orientations are evident in the emphasis placed upon the deep ancestral history of ethno-cultural groups, and the power attributed to ethno-cultural belief-systems over the consciousness and behaviour of the social subject. Within such an approach, ethnic identities are assumed to form organically from powerful and fundamental attachments to one's ethnic group, understood as a receptacle of a shared culture, language and ancestry. These identities are assumed to form as stable, indelible and over-riding characteristics of the self, and are assumed to be the basis of a super-ordinate mode of attachment, with powerful affective components, through a process that implies a synthesis of inheritance and socialisation. As such, the ethnicity with which an individual positively identifies, and in terms of which they are potentially identified by others, becomes something that lies beyond the realm of choice (see Banks 1996). To the extent that this is the case, the recognition that for "...ethnicity to spring to life it is necessary that real or perceived differences of ancestry, culture and language are mobilised in social transactions" (Fenton 1999: p.6), is negated.

For instance, in the context of a discussion about premature ejaculation amongst Asian men, Gupta (1999) states that "*Atharva-ved*, one of the ancient Indian religious books, mentions that a hundred drops of blood are required to make one drop of semen. Its loss is *inevitably* [my italics] seen as a loss of strength, the possible psychological reason behind these symptoms" (p.72). There was a distinct preference within the papers for authorising accounts of the present through direct reference to the past (see Khandaker et al 2002, De

Silva 1999, Sungur 1999, Gupta 1994, Gupta 1999, Sharma et al 1996, Rockman 1994, Rockman 1993). The trans-historical influence of religion and religious identity in respect of 'Asian' populations was reified through its taken-for-grantedness, with little recognition of the constructed and mobilised nature of religious affiliations (see Raj 2000). Such accounts failed to give voice to the fact that ethnic attachments, even those appearing primordialist in their strength, may in fact be motivated by instrumental concerns where an individual sees their interests and destiny to be inextricably connected to their membership of a particular group (Fenton 1999). Both past and present manifestations of ethnicity rarely offered an account of the social, political and economic circumstances that sociological research has demonstrated exercises a profound influence upon the dynamics of ethnic group formation, boundary maintenance and dissolution (Jenkins 1997). The ethnicity of 'Asians' both within and without Britain cannot be divorced from the dynamics generated by the legacy of colonialism and imperialism, and the political and economic characteristics of contemporary globalised relations¹. It is at the social, political and economic point of interface between groups, and the resultant 'generative symbolism of the boundary' (Smaje 1997), that ethnicity is made.

Instead, ethnicity tended to be conceived in culturally essentialist terms, such that ethnic identities were seen as emanating more or less directly from substantive cultural homogeneities. Claims as to the direct correspondence between ethnicity and substantive cultural characteristics have been the subject of extensive sociological critique, with the result that radically revised approaches to ethnicity now predominate (Joly 2001). Within these accounts, ethnic identities are variably understood as historically contingent, as actively constructed at the boundaries of interaction between groupings, as shaped by instrumental criteria, as situationally located, as cut across by, and standing in a complex and uncertain relationship to, dynamics associated with gender, nation, class and sexual orientation (see Jenkins 1997). These are elements to an analysis of ethnicity that are in short supply within the texts. Widely prevalent are highly generalised and essentially conceived representations of the ethnicity of ethnic minority groups as characterised by culturally specific qualities distinguishing them from others, most notably via the influence of religion (for example, see Basoglu et al 1986). As a case in point, Khandaker et al 2001, in a discussion of anticonceptive problems in Bangladesh state, "...that the high number and intensity of somatic, emotional psychosexual side effects after any kind of contraception engages the physicians for their early recognition, treatment and adequate counselling on genital physiology, religious rules and psychological attitudes" (p.365).

The papers in which ethnicity is directly or obliquely addressed focus almost exclusively upon the ethnic 'other', and in so doing confirm a sense that ethnicity is a quality exclusively possessed by ethnic minorities. This powerful association is reflected in the linguistic tendency to refer to ethnic minority groups simply as ethnic groups. In some cases, attention is paid to British-based ethnic minority groups, in others to ethno-national populations overseas. Accounts of 'Asians', Jews, Turks and the Chinese feature strongly. Where the focus is upon reference to British-based ethnic minority populations, it is commonly and somewhat anachronistically within a host-immigrant framework, stressing both the recency of arrival and the currency of a first generation styled culture-clash. This is reflected in, and enhanced by, data utilising 'country of birth' as indicators of racial/ethnic identities (for example, see Hems and Crowe 1999). There have been no accounts of the transformations, fragmentations, hybridisations of ethnicities, or of the cultural forms created within the social flux of contemporary British society. These points are exemplified in the following statement:

Britain is at the same time an increasingly multicultural society, and there are many differences in the attitudes to marriage between, for example, the traditional British concept, the Afro-Caribbean model, the views of Asian families and the views of West African families. In addition, the children of these immigrant families, who have been brought up and educated in Britain, may find themselves at odds with their parents, especially over marriage and the arrangements which the family makes for it. The couple therapist needs to be aware of these potential clashes of culture and to be able to facilitate discussion and resolution of the related conflicts (Crowe 2000: p.9)

The overall effect within the texts is to foreground the ethno-cultural 'otherness' of non-white ethnic minorities who continue to be driven by trans-historical and trans-local attachments to the foreign culture of 'home'. It is also to reaffirm a sense, in the sustained focus upon the 'other', that "white people have seen the black Other as an object of, and for, investigation" (Young 1996: p. 187).

Naturalistic and culturalist readings of ethnicity, whilst predominant, were not entirely without more sophisticated analyses. Some papers offer accounts clearly informed by a

¹ For example, see Turner (2003) for account of the globalised social and economic drivers of Islamism

recognition of a broader social and political literature on sexual questions, and make some application of this to issues of ethnicised diversity (for example, see Bhugra 2000, Pacey 1999). But collectively the accounts are fragmentary, and do not indicate a substantial appreciation of the social and political dynamics associated with race and ethnicity, and would be unlikely to contribute significantly to a cumulative critical reflexivity about such matters within the readership.

The brevity imposed by the format of a scientific academic journal may in some instances account for the lack of conceptual explication and exploration of race and ethnicity, but cannot account for the collective phenomenon. Furthermore, textual contexts such as this enable greater control over the surface elements of one's discourse due to the absence of a dialogic element (Van Dijk 1993). The absence of critically reflective and conceptually informed accounts of race and ethnicity are either a product of the relative absence of such papers being presented to the editorial board, or a sense of sufficiency in extant accounts within the sex therapy constituency, or both.

As within the journal, the interview data was indicative of a general conceptual preference for ethnicity over race, but with a similar tendency for ethnicity to be understood in a primordialist and culturalist terms, infused with an almost sub-social quasi-racial quality:

31: Ethnicity is what everybody uses when they want to try and establish what people's cultural backgrounds are. It's like the origin of something. I think that's what the genuine definition is, yes, like 'what is your family tree, where do you come from, what are your origins?' Not so much the country, but what's the genus, if you like. But the culture is really much more than that, because somebody might have been exposed to a wide range of cultures and have influence of different cultures. But I think ethnicity is associated more with race than culture.

The initial reference to ethnicity as culture is quickly modified to enable a distinction between the 'depth' and continuity of ethnicity and the superficiality and fluidity of culture. This concept of depth, of ancestry, ontologically places ethnicity on a quasi-biological plane, invoking race without its specification. The concept of 'genus' reflects an essentialist ontology of origin that places ethnicity outside and above history, a central characteristic of the race concept.

31: I do believe very strongly in the forces of ancestry and the belief systems that get handed down the generations, and it's very powerful, it really is powerful. Now the way that the individual copes with that, responds to that is of great interest to me....how then I assess the person responding to that...I don't know until he or she tells me.

Ethnicity seems to be understood as constituted by powerful forces of ancestry and deep belief, to be distinguished from culture generally, which is granted a more contingent and fluid nature. This formulation is clearly indicative of a primordialist model of ethnicity, though it is unclear whether the therapist is alluding to an 'objectivist' or 'subjectivist' interpretation of this (see Gil-White 1999). It suggests a degree of fixity that negates accounts foregrounding the constructed, contingent and dynamic nature of ethnicity. The evident 'visibility' of ethnicity to the therapists is testimony to the fact that mappings of ethnicity correspond to the colour boundaries of race, as skin colour was central to many accounts of ethnicity. It was evident that for some ethnicity *was* race plus culture.

41: Ethnicity I would see as different in terms of within the race, there are people who have developed differently, belong to different cultures, different sub-groups, had different experiences in terms of the way they've been brought up

It was commonplace for the vocabulary of ethnicity to be discursively substituted by culture, in a manner seeming to indicate either that: the former derived its reality from the latter; or that although there may be something 'deeper' to ethnicity, its specifically cultural aspects were far more easily specified and had a more self-evident reality. Perceptions of ethnic groups as internally culturally homogenous, and of ethnic relations as marked by enduring cultural difference/dissonance, were prevalent within the data. "Ethnicity to me means a group of people with cultural similarities or samenesses, it could be any group of people" [13]. In short, when culture is considered in the context of ethnicity, the qualities attributed to it acquire a sense of fixity and stasis, in contrast to the efflorescence and flux attributed to contemporary cultural forms in respect of other identities, such as those of gay men and heterosexual women.

There was a general taken-for-grantedness about ethnic boundaries, made possible by the assumption on the part of these therapists that their ethnic categories were a more or less organic expression of the empirical realities of the ethnic groupings to which they

corresponded. But there were occasions of recognition that the categories of the attributor may not correspond to the self identifications of the attributed.

16: If you divide ethnicity in restrictive terms to do with skin colour then of course you could say they [West Indians] are all the same, but that's misleading because in most respects they would define themselves differently. I had a...psychiatric nurse working with me and we had a West Indian patient come in and I said, 'This looks like one of yours, you'd better see him,' or words to that effect. He came back and said,... 'This man comes from Jamaica, I am a Bajan'. I was embarrassed and had to tell him that I didn't know what that was. He was born in Barbados and said, 'Barbadans don't like Jamaicans any more than...

For the therapist this is clearly a tale about the importance of recognising the internal heterogeneity cutting across (and hidden by) the categories generated and reproduced within an ethnicised social context. The relative invisibility of the 'ethnic' diversity of West Indians is an illustration of the power of racialised/ethnicised discourses to homogenise and essentialise the 'other' as part of a project of racial/ethnic hierachisation (Bashi 1998). It comes as a point of surprise and embarrassment for the therapist to realise that West Indians may not embrace the racialised identity given to them within white western discourses.

The primary ethnicised boundary within the data was one that separated an apparently culturally homogenous 'West' with a seemingly antithetical or incommensurate non-West. This clearly articulates a 'west and the rest' model, constructing a boundary that is less geographical and more culturally essentialist in its underpinnings. For the therapists, becoming Western was to achieve inclusion via a process of cultural transition, a process seemingly available to all, irrespective of colour.

A 'modernisation thesis' informed therapists' accounts of the West and Westernisation. Modernity, in the more mundane sense of 'living in the modern world' practically becomes the exclusive product and property of the West (see Goldberg 1993). This in turn creates a problem for the therapists in accounting for other ways of 'being in the world'. Non-western others are constructed therefore in one of two ways. They either exist in a timeless perpetual absence of modernity, or they become westernised. The notion

of development in the non-western world (and amongst their ‘ethnic representatives’ in Britain) as possessing its own relatively autonomous dynamics and as not reducible to either the re-production of tradition or to the performance of ‘Westernity’ was entirely absent within the data. Religion, as an over-determining perpetual influence in the lives of ‘non-western’ populations, was given great importance by the therapists:

9: Well, religion does [have an influence]. Often with the white population it doesn't, not with the people I see. Whereas, when I see other cultural groups, I always ask specifically about religion because it does often impinge quite a lot.

Sociological evidence indicates both that ethnicity is commonly conceived as a substantive quality that only others have (Frankenberg 1997), and that ethnicity is commonly conceived *as* religion, particularly in application to ‘Asian’ others (Raj 2000). In contrast to the religious vacuity of the British, ethnic ‘others’ are notable for their organic relationship to religion.

I would argue that the accounts offered within the data do suggest a capacity for ethnicity to house some or all of the conceptual primitives of race without its direct specification. Philosophical essentialism, a quasi-biological reductionism, a macro collectivist perspective, an assumed absence of agency, a sense of historical stasis, an assumption of inherence in ethnic characteristics, and a notion of fundamental tensions and conflicts associated with the most elemental ways in which racial/ethnic groups interact are all enabled by the ethnicity concept. In this sense, race can operate as an absent-presence within ethnicity discourse (see Brown 1999).

5.4 Race and ethnicity as sources of identity

Issues of identity, particularly with regard to race, ethnicity and sexuality, have become increasingly important. “Some academics agree that the construction, reproduction and reshaping of identity is the crucial preoccupation of our era” (Cohen 1994, p.204). Identity has become central to the formation of political constituencies and has come to serve as the basis of myriad political, social and cultural claims. Identity construction is a relational process, involving the circumscribed agency of identity-seeking social subjects as they engage with the socially-worked identities within which they find themselves located (Knowles 1999). Identity is concerned with the “...interplay between our subjective experience of the

world and the cultural and historical settings in which that fragile subjectivity is formed” (Gilroy 1997 p.301). Sex therapy, in its direct engagement with issues of identity, serves as an institutional location within which racial and ethnic identities are implicitly and explicitly ‘worked upon’ at the interface between client and therapist.

But for the therapists, thinking about identity produced tensions and ambivalences. Questions of identity brought to the fore the dissonances produced by incommensurate impulses towards a discourse pertaining to the power of race and ethnicity as sources of identity, and a preferred discursive terrain provided by a tradition of liberal-humanistic thought within which the sovereign universal subject is given centre stage.

In the uncertainties and ambiguities characterising therapists’ accounts of identities, it would seem that most therapists maintained a notion of dialogue between the ethnic subject and the imperatives of ethno-cultural identity. According to one therapist:

2: ...it depends on the priority the individual would give either to their own needs or the value system...an individual might say ‘Oh I recognise the society’s values about sexual differences...but I will give more prevalence to my own needs’.

A variety of outcomes to this dialogue are imagined, and were seen to be a product both of the qualities of the individual social subject and the legitimacy granted by particular ethno-cultural groups to an ethic of individuality:

2: ...an Asian man may not be too worried about his homophobic family whereas another Asian may be very affected by it, may be very devastated by it, whereas others may be able to separate themselves from the homophobia...I am very aware that some ethnic groups do not value at all, or wouldn’t promote much individuality...

The co-existence of accounts of race and ethnicity as over-determining sources of identity, with a notion of the instrumental identity-choosing subject, is reflected in the following passage:

25: When the tribal call goes out, who rallies to it? You know, when the Indian cricket team comes to England, you know, the Indian immigrants in Britain are cheering on the Indian team. ...people define themselves in different situations according to all sorts of things, usually on the basis of personal gain. These sociologists probably are very alienated themselves and are seeking to justify their own lack of embeddedness in any social context by maliciously undermining the fact that that's [ethnic group belonging] where most people get their identity from.

Ethnic identification is explicitly accounted for here through a discourse of tribal attachment, suggesting a trans-local and perhaps primordial power to ethnicity in determining identity. Yet simultaneously, there is a recognition of the instrumental use (in its weaker sense) made of such attachments by social subjects in the interests of personal gain.

Empirical research in the field of identity suggests the need for a transformation in sociological analyses that in the past assumed a unity, stability and coherence to social and personal identities (see Atkin, Ahmad and Jones 2002). According to Cohen (1994), contemporary sociological analysis of identity construction have come to foreground four principle themes (Cohen 1994): the fragmentation of identity; the prevalence of territorial claims as a means to assuaging this aforementioned fragmentation; the multiplicity of social identities characterising the contemporary social actor; and the situational nature of identity construction whereby social actors negotiate identities and manipulate identifications according to the social context, albeit within certain limits (Atkin, Ahmad and Jones 2002).

If such empirical transformations are in fact taking place, the data as a whole suggests that sex therapists have some consciousness of this. Whilst it was accepted that these concepts may have some macro sociological significance, they were seen as homogenizing people and as failing to take account of the diversities that operate at the micro levels of people's lived experience.

28: I think they [race and ethnicity] do say something. I think there are particular ways in which individuals view themselves and wish to be viewed...I think when people look at another person, they see two things; they see the colour of their skins and they see their gender...and

I think that absolutely, partly defines how they are then responded to...I think I am convinced that they are important variables, quite on the scale of importance I don't know...so I think it is very, very important...

Recognising the complexities of the modern social subject the following therapist states: "...we're all full of contradictions; we all are, even if we have lived in one place all our lives...the contradictions coming from the different cultures" [31]. There is a recognition here of the contemporary social subject as occupying a position at a terminal of multiple and contradictory cultures, even where there has been a continuity of place. On the level of the individual then, exposure to a multiplicity of influences generates a degree of complexity that defies assumption and generalisation:

31: It's very helpful, for example, to know what the different religions stand for or what their beliefs are but you may get a person who first, for a start, had a family background with that particular religion or might have three or four different religions within their family of origin and therefore will have conflicting beliefs which have drunk from all of those religions and/or he may have rejected some....it's very much a question of asking the questions and being open to non-standard answers. It's being open to what the individual's experience is.

For the sex therapists interviewed, ethnic and racial categories themselves had undergone little re-configuring. What had changed was the enhanced freedom differentially granted to individuals to detach themselves from these (statically conceived) identities as a means to realising their true selfhood. But as we shall see, this was a transition seen to be fraught with difficulties, given the primordially conceived hold granted to ethnicity over non-western populations. I would suggest that accounts of the 'difficulties' of acculturation experienced by ethnic minorities within the UK have been informed by a racialised ontology such that ethnic minorities become constructed as 'fighting against their natures' in striving to make cultural transition. Certainly, within the forms of cultural racism found within the UK, a permanent 'inauthenticity' is granted to ethnic minorities.

A minor theme within the data was the outright conceptual rejection of race and ethnicity as sources of systematic differentiation, in the name of a commitment to a more individualistically/universally conceived rendition of the subject. One respondent stated that

“I have found whatever the ethnic group, again their problems aren’t that much different”

[19]. Developing their position further, the therapist claimed:

19: They go into overkill and big issues are made out of someone because they're black. Do they do something the rest of us don't do, are they different from us, have they got different needs, feelings, desires and so on? Do they go through a different process? Of course they don't. What's different is the colour of their skin. If they're Arab, what's different is, well, they're a little darker, but their cultural environment, they've got a different family situation, but it's not so different from our own, it's also a matter of degree. A black skin is a matter of degree. You and I are very white, it shades away

The social reality of racialised colour signification and the processes of ethnicised boundary construction are denied, enabling the therapist to challenge the legitimacy of anti-racist/multi-cultural initiatives, describing them as ‘overkill’. A strong orientation towards an atomising philosophical individualism was a norm amongst most therapists, and for some produced evident cognitive dissonance in considerations of the macro and meso dynamics upon which race and ethnicity have been forged. “I am not very good at seeing things as a sort of, you know, total...people are all individuals and I just see individuals...” [13]. Such orientations made it difficult for the respondents to appreciate the manner in which racial/ethnic identities become forged and mediated within structural conditions marked by the systematic influence of racism and socio-economic inequalities (see Karlsen and Nazroo 2002).

Taken collectively, the data indicated an unstable and ambivalent rendition of race and ethnicity as sources of differentiation. Therapists struggled to synthesise their incommensurate orientations towards a racialised/ethnicised ontology and a professionally valorised philosophical/methodological individualism.

5.5 The ‘Isms’ – racism and ethnocentrism

The distribution and operation of power is central to the nature of inter-group relations, and in all its conceptual forms, the concept of racism has been concerned with understanding the modes of oppression experienced by racialised/ethnicised groups at the hands of more powerful others (Stone 1998). The nature of sex therapists’ accounts of power and racism are

therefore critically important as indicators of how they understand their positioning as sex therapists vis-à-vis their clients, and most importantly how they see power operating within this context. According to Stone (1998), accounts of 'race' and ethnicity must locate power (and therefore racism) centrally within their analyses if they are to transcend a mere partial and hollow rendition of difference.

Within the context of the journal, the concept of racism rarely appears. It is referred to superficially by some (see Bhugra and De Silva 2000, d'Ardenne 1996, d'Ardenne 1986) but as such is not defined in any coherent fashion, or discussed at any length. Its relationship to other more preferred concepts such as prejudice or ethnocentrism is unclear. What is clear however is that concepts of racism invoke questions of power, inequality and oppression, and generally imply culpability amongst powerful groups for the burdens experienced by the less powerful victims of racism (Stone 1998). It is interesting that in the only paper offering any substantive discussion of racism (see Bhugra and De Silva 2000) institutional racism receives a mere mention. The brief discussion of racism takes place within a section concerned with the *Pitfalls* into which therapists may fall. Two pitfalls are specified in respect of racism. Firstly, inappropriate *over-identification* of issues as the products of racism, and secondly, the temptations of a 'missionary racism' comprised of attempts made by therapists to 'save' the victims of racism 'from their plight'. The papers taken as a whole therefore do not support the view that sex therapy is concerned with the question of racism, and as such do not communicate a notion to the reader that they need be either. In the first edition, d'Ardenne (1986) asserted that the "...politics of race and sex cannot be dismissed as uncomfortable distractions to our thinking; they are an intrinsic part of it and need to be fully acknowledged as we struggle for a clearer understanding of all the issues involved" (p. 23). Unfortunately, seventeen years on, at least in respect of the textual discourse of the journal, a distraction they remain. I would suggest that this absence is contributed to by a generalised a-politicism, characterising the positions adopted by many health care professions with regard questions of power (Mulholland 1995).

The concept of racism was notable for its absence within the interview data, rarely being invoked by the therapists. Where it was mentioned, it was generally conceived as a psychological dynamic, commonly re-defined as prejudice. As such, the social, political and economic dynamics woven into racism remained largely unacknowledged, in favour of an approach that tended to strip away the political dimensions of inter-group relations and relocate them into a non-political inter-personal realm. For one therapist, racism was an expression of the fear of difference:

31: I think racism is a form of fear, a fear of difference. We're much more comfortable with similarity and therefore the more similar we feel the other person is, the more comfortable we are...

Here we can see an assumption of 'self-evident' differences between racial/ethnic subjects, which in particular packages constitute the triggers of 'racial fear'. Implicit within the therapist's account is an assumption of an inherent human desire, and perhaps need, for sameness. There is little evidence here of any recognition of the social construction of differences as a *product* of racialised or ethnicised discourses. The differences are merely taken as matters of fact. In this sense we see a 'naturalisation' both of the signs and symptoms of racial/ethnic difference and of the group dynamics subsequently generated. Under the label of prejudice we see a further example of the naturalisation of racism.

25: ...all over the world you see prejudice is part of human function. And under a liberal, bourgeois democracy to imagine that somehow you can transform what is, I would take as an evolutionary stance, fear of the other, fear of the stranger, fear of difference...I actually don't think we can cope with too much difference...I think people are asked to put up with a lot of psychological disturbance, I think people just can't cope.

A critique of 'liberal bourgeois democracies', as societies underpinned by an assumption of social subjects as mutable, is here grounded upon an assertion of powerful and determining forces ultimately lying within a non-social realm. The need for sameness seems inherent, as do the racial/ethnic differences that challenge this. In referring to evolution, these collective dynamics become accounted for as epi-phenomenal to biological processes.

In accounting for the relations between racialised/ethnicised groups, and for the potential of power and oppression to feature in those relations, therapists tended to utilise the term 'ethnocentrism'. Ethnocentrism as a concept does imply power, particularly in the form it has taken within professional health-related settings where it has been mobilised to foreground the oppressive implications of 'difference unrecognised'. But at the same time, it also serves to confirm 'otherness' and as such is quite compatible with essentialist readings of ethnicity. Many papers within the journal, and most therapists interviewed demonstrated an

awareness of the dangers of ethnocentrism as an obstacle to mutual recognition and understanding. Throughout both sources, the predominant concern was with the possibilities of racial and ethnic oppression as a product of ‘difference unrecognised’. In contrast, the potential for oppressive and exclusionary implications to derive from a process of ‘othering’, via a ‘difference overstated’, was rarely articulated within the data. This is a point to which we will return in some detail in later chapters.

Foregrounding and valorising difference has no ‘a-priori’ claim to ‘progressiveness’, as discourses of differentiation can have both ‘transformatory’ and ‘reactionary’ effects with regard to power and opportunity (Phoenix 1998 Bhatt 1994). Therapists’ orientation towards the concept of ethnocentrism (rather than racism) can be interpreted as an indication of the prevalence of assumptions about substantive ethno-cultural differences as the central determinant of the relations and dissonances between racial and ethnic groups. Such a formulation can also serve to displace the role of racialisation and racism.

5.6 Britain and the British – lacking substance?

Where a taken for granted common-sense prevails, or alternatively where a politicised climate produces a generalised experience of uncertainty and sensitivity, explicit and self-conscious public enunciations on the nature of race and ethnicity may become something of an exception. To the extent that this is the case, it becomes necessary to look for racialised and ethnicised discourses in the way that these underpin and inform analyses of more concrete and applied social ‘problems’. One principle medium through which ideas of race, ethnicity and racism continue to be articulated is in the characterisation of Britain and the British (Joly 2001). Race, ethnicity and nation are concepts that have become deeply implicated with one another (Cohen 1994). Globalisation, immigration, asylum, regional devolution, the fragmentation of established identities and life-styles, and the ‘new racism’ are some of the developments that have brought the question of Britishness to the formal consciousness of many, and have served to establish Britishness as a medium through which issues of race and ethnicity are deliberated (Solomos and Back 1996). But at the same time, there is a distinct yet contradictory sense that the white populations of the west have never been fully written into the racial and ethnic narratives that they have so determinedly authored.

The ‘universal’ qualities attributed to these western populations as a part of the ‘racial contract’ (see Mills 1999) are in one sense qualities of emptiness. Scientificity, secularity, and liberality are qualities that erase the kinds of racial/ethnic substantiveness and particularity

given to the ethnic 'other' (see Dyer 1997). In short, not only are 'we' different, but we are different in a different sort of way. 'They' are racial and ethnic in a way that 'we' are not.

Making sense of the nature of Britain and the British is central to sex therapy, as like many other professional bodies operating within the field of health care, sex therapy is explicitly committed to an ethic of service provision, informed by a principle of client centredness. This translates to an obligation to provide for the real and diverse needs (as these are perceived by sex therapy) of their clientele in a responsive and non-discriminatory manner, and carries with it a requirement to 'imagine' the nature of the national 'community' that is Britain today.

The 'British' do not formally feature as a conceptual category within the journal. However, ethnocentrism, as a concept describing the barriers to the understanding of others presented by our locatedness within particular ethno-cultural parameters, has had a significant influence within the journal. The concept of ethnocentrism does therefore impose a certain reflexivity, implying an 'us' to parallel 'them'. It invites the subject to reflect upon the substantive qualities of the category 'us'. Within the textual discourse, the preferred category for naming 'us' was 'the west' or 'western' or 'westerners'. The predominance of a 'west and the rest' model was clearly in evidence (for example, see Crowe 2000). Our westernness is what makes it difficult for 'us' to understand those who are non-western. However, the nature of westernness was rarely specified (see Daines 1988 as a notable exception), beyond allusions to the role of science, secularism, and liberal attitudes toward sex, and is generally implied negatively via the more confident assertions concerning the substantive nature of non-westerners (for example, see Li and Yan 1990). Accounts can shift with ease from references to 'western culture' as a singular phenomenon to western cultures in plural, when the purpose is to draw comparisons between European national/cultural groups (for example, see Johnston 1993). Accounts can also shift between notions of westernism and eurocentrism, with the principal effect that the United States slips into and out of the boundary demarcating 'us' from 'them'.

As such, the concept of ethnocentricity rarely, and never in these texts, produces the kinds of analyses of 'us' that are routine in accounts of 'them' (for example, see De Silva 1999). 'Ours' is a vacuous universal rationality that renders us as atomised individuals for whom the forms of generalised ethno-cultural attributions so readily practised with respect of ethnic others seem singularly inappropriate in application to the west's 'own' people. The question of who can be western, is also ambivalent. It is clear that through a trans-cultural

process, ethnic minorities can become westernised, but a sense of inherent difference seems to be underpinning. We see this in the prevalence of a host-immigrant framework, in the account of transculturalism as a stressful, unidirectional and perhaps never quite complete journey, and in the preponderance of papers concerned with the influence of deep historical legacies on the ethnicities of social subjects today (see d'Ardenne 1986). Accounts of this transcultural journey however, routinely lacked a sociologically and politically informed account of how racialised ethno-nationalist discourses have constructed legitimate citizenship in terms of colour and descent, (made manifest through markers of language, religion and culture (Singh 2001)) such that non-white immigrants become inherently non-Western 'others', as 'matter out of place'. Becoming Western within a racialised context may for some be simply unattainable as cultural transition does not guarantee full inclusion where a prior racial boundary asserts one's 'otherness'. Furthermore, the conceptualisation of the change process seemed to be located within a framework emphasising a singular axis of cultural change, negating an appreciation of the complex and contingent processes of inter-generational cultural production and reproduction (Atkin, Ahmad and Jones 2002).

A very similar pattern emerged within the interviews. Though the British were more evident as a discursive category, elaborations and specifications of the British as an ethno-national constituency were rare. Viewing Britishness' from the outside, one non-British European respondent claimed:

2: I can see some traits that are very specific to Britishness. As a society there is liberalism...but I still see Britain as being very much influenced by Victorian values which actually conflict, which impact upon liberalism. There is some sort of discrepancy between a liberal country and promoting individuality and freedom and also sometimes rigid values on sexuality...

Sometimes emphasising Englishness rather than Britishness, a substantive and defining ethno-cultural characteristic was offered by many therapists, namely emotional self-control/management: "...at a very general level in this culture, in England, we are very prone to emphasise people controlling their feelings...[4]. An emotional stoicism characterises the British as a white ethno-cultural group, a "stiff upper lip type of whiteness" [9]. Where there was a notion of the British as an ethno-cultural group, it was occasionally evident in accounts of a common historical legacy: "many of the British 20th Century sexual neuroses are directly

attributable to Victorian dottiness in this field. I still see people who in my mother's generation would have been said to have masturbatory insanity, occasionally" [16].

But even at this point of ethno-cultural attribution, a perceived atomisation of British society promised the end of Britishness via a form of egoistic individualism:

16: ...I think there's trouble ahead, and this is a prediction, from the emphasis on self-expression exclusively which is evident in Thatcherite politics, you know 'society doesn't exist' and all that nonsense...So more people will grow up with values about 'all I have to do is do my thing'

Primarily, the white 'British majority' served as a rarely specified norm from which the difference and particularity of others was identified through juxtaposition (Dyer 1997). A respondent articulated this sense of the normativity of whiteness: "I think there's an inherent racism because I think it [the importance given to race and ethnicity] is attributed to anything that's not white...a sense of 'this is what the majority is, ie. normal, and this is what differs from that'" [28]. A more consistent conceptualisation and operationalisation of ethnicity, that includes the exploration of the 'parallel ethnic peculiarities' of 'whites' is greatly needed (see Aspinall 2001, Bradby 1995).

The therapists were virtually unanimous in their view that Britain could best be understood in terms of the concept of multiculturalism.

31: In this country we are genuinely multi-cultural, particularly here in London, and this is one of the very fascinating aspects of working in this particular area, is that the area is full of all the different cultures. I work with a very wide range of people.

London is presented as representative of the 'multi-cultural' state of Britain as a whole, only more so. What regional differences exist here are in degree rather than in kind. The view that Britain was in the past essentially marked by an ethnic homogeneity brought to an end principally by post-war migration was a consistent theme within the data, and informed therapists' sense of the 'novelty' of contemporary challenges.

For many, this diversity and complexity was valorised and offered opportunities for enrichment and growth. But multiculturalism was simultaneously seen as problematic. The multi-cultural scenario was a product of a failure to secure a fuller integration, with minorities feeling overwhelmed and embattled due to their limited size and power. The majority status of the white British population inadvertently producing insensitivity towards minorities: "...the majority is always more powerful. I guess maybe we're not as sensitive to the minority groups' difficulties" [31]. For some, multiculturalism raised serious and problematic implications for stability and inter-ethnic relations:

25: ...there will be a lot of tension in the future if we open the eastern border to people from Poland, the Ukraine and so on. That will be extremely hard. And then you say to unemployed people down at Millwall, 'you know you should be more open hearted, you know, Britain's got a long history of inviting people in'. People don't think that way, they think 'my job, my future'.

In this account, the inherent otherness of eastern European immigrants is enhanced by the struggle for scarce resources. Racial and ethnic signifiers are reified, and hostilities naturalised in this account of national identity and personal vested interest. The *constructed* nature of these phenomena become lost. This sense of division and inter-group hostility extends to everyday social interaction; "there is almost no interaction...I think there are very complex power plays between groups. It doesn't, as far as I can see, lead to any kind of cohesive social bonding" [25]. A multicultural cornucopia may be "...the ideal view, the reality is more likely that we're probably made uncomfortable in a number of ways by losing our majority status" [3], and the cultural power this enables. These more critical renditions did seem to produce a need in some therapists to defend the tolerance of the nation in incorporating diversity; "one thing I do like about this country actually, is that I think by and large we're very humanitarian, in our funny ways, in our prejudiced ways. I think we are fundamentally a humanitarian, kindly lot" [31]. 'Our' compassion would seem to have been tested by the loss of our comfortable dominance. Such an account both negates "Britain's long history of systematically inferiorising black people" (Young 1996: p. 85), and enables a relocation of the problem to the presence of black people. As to who 'we' are, although it is not specified, it may be deduced that in 'our' juxtaposition to minorities 'we' represent the 'original' British: white, Christian and culturally bounded. The representation of the 'British' as well-disposed, yet pushed to the limits of their tolerance, has been a central component of 'new racist' accounts of black immigration to Britain (see Cashmore 2003, Brown).

5.7 Conclusion

I had anticipated that the particular location occupied by sex therapists, at the intersection of professional and academic discourses pertaining to the questions of race and ethnicity, may have produced a substantial mediation of broader, ‘socially-worked’ forms of racialised and ethnicised consciousness. In fact, what emerged were a set of dominant themes quite familiar to those with a knowledge of the accumulated sociological literature pertaining to ‘race and ethnic relations’ within the UK.

From the data generated here, the principle problem faced by sex therapists (and this is in no way unique to this constituency) would seem to be the dissonances and challenges created by contradictory ideological impulses towards an atomising liberal individualism on the one hand, and more collectivist modes of thinking encoding racialised, ethnicised and gendered constructs on the other. The data would seem to suggest that these contradictory impulses (both of which find voices of valorisation in the cacophony of accounts of professional ‘best practice’) are far from worked through.

A striking feature, both within the journal and the interview data, was an underlying taken-for-grantedness, and so reification, of race and ethnicity. Within the journal data, race and ethnicity received no conceptual elaboration whatever, whereas as a result of the opportunity available within the interview to directly ask therapists for their understandings, a greater conceptual reflexivity was clearly evident. But even here, beyond the recognitions of the uncertainties and sensitivities associated with articulating the vocabularies clustering around the themes of race and ethnicity, there was a clear sense that ultimately, these were self-evident phenomena, such that whatever words we might use ‘we all really knew what we were talking about’.

The vocabulary of race was more evident than anticipated within both data sources. I would suggest that the idea of race, as denoting a ‘difference of natural kinds’, prevails within sections of sex therapy as a deposit of an enduring racialised social consciousness. Whilst this was more explicitly present within the interview data, in both contexts the primary role of a racialised ontology was to implicitly authorise accounts of difference without a direct invocation of the race concept.

Ethnicity has however emerged as the dominant concept for understanding and constructing diversity. Ethnicity, though never defined in the journal data, and with difficulty in the interviews, was understood in largely primordialist and culturalist terms, with the primary theme in both sources being the substantive ethno-cultural attributions pertaining to ethnic 'others'. Though a 'west and the rest' model operated within both data sources, a condition of ethno-cultural vacuity seemed to characterise 'westerners'. This was partly because the ethnicities of the west were rarely the object of explicit elaboration and because when they were, they were understood largely in terms of a cultural absence produced by the influence of rationality. Relations between racial/ethnic groups were seen as problematic, as an outcome of three principle dynamics; the conflicts generated by the contradictory constituent elements of respective ethno-cultural groups; the problem of racial/ethnic prejudice as an expression of an inherent fear of difference; and ethnocentrism, understood in terms of the oppressive implications of 'difference-unrecognised'. In this context, accounts of racial and ethnic conflicts did invoke some need to substantiate the ethno-cultural nature of the 'British' in a manner paralleling that directed toward the ethnic other. But it was clear that this was far more problematic and partial a process, as the pull of an atomising liberal individualism was overwhelmingly more powerful in application to reflections on the white western subject than the non-white, non-western 'other'.

In the light of these data, demonstrating the conceptual mobilisation and attribution of race and ethnicity, I am reminded of Fenton's (1999) reference to 'ethnicity-making situations'. As a 'meso-level' social institution within which racialised/ethnicised mobilisations take place (though not without ambivalence), sex therapy could usefully be conceived in this sense.

Having explored sex therapists' constructions of sexuality, gender, race and ethnicity, it remains to show how these threads become woven into accounts of sexual praxis, problems and sex therapy.

Part B

The Racialisation and Ethnicisation of Sexual Praxis and Problems

Chapter 6 – Sexual Praxis and Problems - Textual Themes of Race and Ethnicity

Sex therapists, in striving to make sense of the sexualities and sexual problems of their clients, stand at the confluence of a range of theoretical and conceptual orientations. The turbulent waters generated by the competing, and often conflicting claims of these traditions require navigation by sex therapists, and this undoubtedly constitutes a challenge. Principle amongst these challenges are the tensions produced by approaches grounded upon a liberal and typically humanistic rendition of the sovereign sexual subject, and explanatory frameworks informed by a more collectivist account. In the context of sex therapy, the latter may well take a biological form, or may be grounded upon some form of ‘social’ thesis within which the sexual subject is understood as at least in part the constructed object of multiple social, political, cultural and economic investments. Within the realm of the ‘social thesis’ are included a host of accounts of the sexual subject variably informed by competing renditions of the natures and roles of gender, race, ethnicity and class.

Having established the principle contours of racialised and ethnicised thought within the sampled sex therapy constituency, this chapter will be concerned with exploring the significance attributed to race and ethnicity in shaping human sexuality and sexual problems, within the context of the journal. Of particular importance is the question of how therapists utilise, and critically reflect upon, extant empirical evidence and theoretical debate in support of preferred renditions of the racial/ethnic sexual subject. The effect of the racialisation and ethnicisation of social consciousness has been the production of a particular ‘will to racialise/ethnicise’. This ‘will’ is typically associated with a range of characteristics and effects, amongst the important of which have been: a reification of race and/or ethnicity as categories, a rendition of racial and ethnic categories and identities as the organic product of real contours of biological and/or cultural difference, a deterministically conceived relationship between the forces of racial/ethnic attachment and the subject, a conceptual prioritisation of ‘ethnic’ variables and a consequent displacement of the explanatory importance of other social, political and economic factors, a differential will to racialise/ethnicise ‘others’ as beset by their race/ethnicity, whilst leaving the racial/ethnic self out-with these parameters in a condition of substanceless rationality and individuality. This chapter then, will explore the principle contours of the journal data with respect to how this ‘will to racialise/ethnicise’ is played out in application to questions of sexual praxis and problems.

6.1 Gender

6.1.1 *Gender, race and ethnicity*

Although sociological research has demonstrated the complex interactions and inter-dependencies of race, ethnicity and gender, it remains the case that when these axes of differentiation become the subject of conscious reflection (in popular, political and academic contexts), they routinely do so in some degree of formal conceptual separation from one another (Brittan and Maynard 1984). This despite the often explicitly and implicitly gendered nature of accounts of race and ethnicity, and the racialised/ethnicised assumptions encoded within popular and academic renditions of gender. There are of course many dimensions to this explicit segregation/implicit infusion. In large part it reflects the fact that the social and political constituencies involved in addressing race/ethnicity and gender respectively have been different, as have their political and social priorities (Young 1996, Hill-Collins 1991). It also reflects the academic and political legacy of granting conceptual primacy to one mode of oppression over other 'secondary' modes (Young 1996, Brittan and Maynard 1984). The social contexts within which issues of gender and race/ethnicity have been addressed have also been different. But sex therapists, by virtue of the very nature of their work, must engage with the intersections of race/ethnicity and gender simultaneously. It is to their accounts of the nature of this intersection that we will now turn.

D'Ardenne's (1986) seminal paper emphasises the importance for sex therapists of an understanding of the 'politics of race and sex' as central to therapeutic practice¹. But what of their relationship? D'Ardenne's own paper is illustrative of the shifting presence of gender. Having cited Christopher's (1984) account of the internal heterogeneity of ethnic groups in terms of both gender and class as a cautionary note to those who may erase such differences through their use of ethnic labels, d'Ardenne then fails to make any further reference to gender in her agenda-setting list of key research questions concerning the racial and ethnic dimensions of sexuality, sexual problems and sex therapy².

Though explicit theoretical deliberations on the relationships between gender, race and ethnicity were rare within the data, some principle orientations emerged, ranging along a scale

¹ Sex is taken in this case to refer to both gender politics and sexual politics

² In a later paper (d'Ardenne 1996), gender returns in a consideration of the relatively advantageous position of ethnic minority men (in contradistinction to ethnic minority women) in respect to accessing and utilising services.

constituted by the degree to which either race/ethnicity or gender appeared to be given explanatory primacy. The principle orientation within the sampled journal papers was to locate gender within a race/ethnicity framework. The notion that gender identities and relations were 'culture-bound' was clearly in evidence within the journal (see Compton 1989, De Silva and Dissanayake 1989, Rockman 1993). Within this framework, the cultural mores that were seen to constitute ethnic groups were understood as being concerned in large part with governing the nature of, and relations between, men and women. The substantive nature of these gender-orientated cultural mores was, in most cases, presented as readily evident.

'Non-western' and 'western' populations were differentiated respectively in terms of the degree of inequity and oppression experienced by their female populations. The racial and ethnic 'otherness' of non-western populations was expressed through their culturally-authorized female oppression and male dominance. Non-western ethnic and national groups, by far the most frequent subjects of commentary, were presented predominantly in terms of a sense of historical stasis with respect to gender identities and relations. This stasis was in turn understood as a product of the oppressive effects of an enduring influence of ethno-cultural tradition and religion. As an example, according to Gupta (1994), "many Indian practices, including sexual ones, are based on Vedic teachings handed down through the centuries both verbally and through various books and treatises" (p. 57). There was, as a part of this framework, a distinct reproduction of hegemonic 'western' representations of 'Asian' gender relations, emphasising homogeneity, and an absence of agency. This theoretical prioritisation of the causal power of ethno-cultural tradition served to produce an account in which: a recognition of flux and contingency were negated; a recognition of the roles of contemporary economic, social and political variables was occluded, and through juxtaposition, 'western' gender relations were constructed as equitable as a more or less direct product of the absence of ethno-cultural and religious fetters to progress.

But there were also papers concerned to address gender relations within particular racial, ethnic and national groups in a manner that brought material questions of power and wealth more clearly to the fore. Pradhan et al's (1995) account of 'safe motherhood' in the developing world, Pacey's (1999) account of the ethical dimensions of physical interventions in the sexual self and Weiss et al's (2000) account of HIV in developing countries shared a common rendition of women's oppression as having complex and gendered economic and political underpinnings not reducible to a one-dimensional account of ethno-cultural essence. Potts and Masho (1995) provide an illustration of the limitations and dangers of crude ethno-culturalist accounts of sexual behaviour, and of the importance of an understanding of

material and political variables, in their discussion of contraceptive choices within developing societies.

No demographer predicted these rapid changes [a decline in fertility rates within developing countries following the availability of contraception]... Those who put together large scale family planning programmes in poor countries in the 1960s and 1970s perceived lack of motivation to have smaller families as an almost insuperable barrier to fertility decline (Sinding 1993). In reality, the failure of international family planning in the last 30 years has not been lack of motivation but the failure of services to keep pace with the demand for smaller families (p. 137).

But in the main, these papers were not written by sex therapists and were not directly concerned with sex therapy as such.

At the other end of the spectrum, there were a few papers addressing gender in largely universalistic terms, as associated with generalised and transcendent experiences of female inequality, injustice and disempowerment in interpersonal and marital relations (see Rabin 1998). Though feminist-orientated papers, granting a conceptual primacy to gender as *the* predominant 'axis of differentiation', may have been a common feature within the journal more generally, they were notable for their absence within the sample concerned with questions of race and ethnicity.

6.1.2 Women in racial/ethnic groups

The bulk of the journal data was concerned with the sexualities and sexual problems of men and women in the Indian subcontinent, Far East, Africa and more occasionally South East Asia and South America. Accounts exploring the complex and shifting experiences of British-based racial and ethnic minority women were rare, and accounts of the white British population almost entirely absent, reflecting a broad and longstanding dynamic whereby white western populations have rarely been located within the racial/ethnic parameters that they have done so much to map out (Dyer 1997, Young 1996). As such, papers concerned with understanding the position of women within 'non-western' populations in a 'non-western' context, past and present, provided the principle resource for those wishing to use the journal as an aid to thinking through the nature and implications of race and ethnicity for sexuality,

sexual problems and sex therapy in the UK³. Despite the authors' acknowledgements of a paucity of data regarding the intimate lives of men and women in many developing countries today (Sungar 1999, Sharma and Sharma 1996), this seemed belied by the apparent conviction with which some accounts were offered of their current condition.

Compton (1989) has pointed out that within western societies, Islamic women are perceived as oppressed by their marital and sexual relations, and this perception was clearly evident within the data. Muslim women, and Asian women generally (the principle focus of attention within the literature, and serving as something of a representative case) were consistently associated with particular components of oppression: as obliged to ensure their virtue in the name of family honour (d'Ardenne 1998); to maintain their virginity before marriage (d'Ardenne 1998); as unable to "say no to sex with her husband unless she is unwell" (Gupta 1994 p.65)⁴; as subjected to an overwhelming pressure to conceive (Bhugra and De Silva 2000), as exposed to a male-dominated agenda to control their sexuality (Pradhan et al 1995), as occupying a position of passivity within traditional societies (Sungar 1999); and as governed by sexual double standard such that the subject of women's sexuality remains taboo (Lenderyou 1994).

A general orientation towards an anthropologically-inspired 'cultural-field' account of ethnic groups vied with, and generally over-determined, more complex and multi-dimensional approaches such that a sense of complexity, instability and change laboured under a motif of ethno-cultural stasis⁵. In this sense, the "...racialized stereotypical image of the emotionally and materially dependant, passive South Asian woman 'walking three steps behind' her 'lord and master'" (Hall 2002) was invoked within the data⁶.

³ It is possible in this context that the nature of sexuality and sexual problems of ethnic minorities in Britain may be 'read off' from accounts grounded in the experience overseas

⁴ Gupta's account was based upon "a discussion between the author and a religious leader living in England", who in this context served as a definitive judge of the sexual relations of Asian Muslims generally. The role occupied by the religious leader here is illustrative of an important point highlighted by Lloyd (1994). "If 'minorities' are viewed in the UK as homogenous groups defined solely by their religion, this enables religious leaders to 'edge themselves into positions of political as well as spiritual leadership, defining the community's agenda and power structure, and negotiating with the state for resources' (Bard 1992)" (p. 233). Though the context is different in this example the same dynamic is evident, whereby the ethnic constructs held by the discursively powerful create roles within the ethnic constituencies which accord with, and reify, those constructs.

⁵ See Mohanty (1988) for an account of western feminist accounts of the 'Third World Woman'.

⁶ A greater theoretical complexity was evident in places though. The role of globalised economic relations, impoverishment, and lack of access to information, education and support were seen as central to the oppression faced by many women within the developing world (see Pacey 1999, Potts and Masho 1995). These dynamics were also seen as fundamental to women's progress.

6.1.3 Men in racial/ ethnic groups

Societies in the Indian subcontinent, Far East, Africa and South America were defined largely in terms of their ethno-culturally authorised male-centredness and their patriarchy (see Ng 1988) within the journal data. South Asian masculinity received the greatest deliberation and again was discussed primarily in terms of the formative influence of a historically-enduring set of ethno-cultural mores. As for British ‘Asians’, a continuity of tradition was commonly assumed between the South Asian and British contexts, supporting the notion that formulations of race and ethnicity within sex therapy render the conjunctural and contingent nature of race and ethnicity less visible. D’Ardenne (1986) cites Ballard’s anecdotal and general observations that Asian men have far greater concerns about their sexual potency than British men because (a) their potency is part of a larger religiously-informed cosmology of health (b) Asian men expect to exercise a much greater degree of personal dominance over their wives and therefore have greater anxieties about their ability to fulfil that role. For De Silva (1999), masculinity, and its sexual components, are culture bound. Asian men are profoundly influenced in their thinking about health and sexuality by the legacy of the Ayurvedic tradition, with its emphasis upon reproductive penetrative heterosexuality, and its proscription of same sex attraction.

It was notable though that where primary empirical research had been carried out on aspects of sexuality in the Asian sub-continent, the findings often brought into question aspects of these broader renditions. For instance, Bhugra’s (1997) research into homosexuality in India found an emergent urban gay scene, with operant models of homosexuality akin to those found within western societies evident. Bhugra (1997) points to the similarities that exist in the culture and experiences of gay men in contemporary India to those documented in the West.

The absence of any equivalent analysis of ‘white’ men within the data, conceived in similar racial and ethnic terms, was notable.

6.2 Westernisation

Within both the journal and interview data, the concept of westernisation was as pervasive as it was taken-for-granted. The mode of its utilisation owed much to a ‘modernisation thesis’. Within such a reading, the particularities of the West’s version of modernity becomes the only possible version. As the West *is* modernity, there becomes no

way for ‘non-western’ peoples to escape the entrapment of their historical and cultural fetters except through the gateway illuminated by the West’s prior passage. But within the data, this was a journey perceived to be beset by difficulties. Despite acknowledgements that our understanding of the sexual attitudes and behaviours of young people in much of the developing world is limited (Mackay 2001, Sharma et al 1996), this did not inhibit accounts of the nature of contemporary gender and sexual relations within ‘non-western’ contexts as uniquely the products of an over-determining historical past. Reflecting a broader rendition within the ‘West’ of “oriental culture [as] trapped in a state of eternal stagnation” (Abbas 2001: 251), the data expressed a sense that developing societies are locked into a stasis from which they may only emerge via a mechanism of westernisation, as they lack their own internal dynamics for change.

Where change was acknowledged within the developing world it tended to be accounted for in terms of an externally driven westernisation process. For instance, young people in South Asian societies were represented as uncomfortably sandwiched between a glamorous West and the traditionalism of their own nation.

In conservative and orthodox societies like India, where the mere talk of sex is taboo, it is generally presumed that young people do not indulge in premarital sexual relations. (Bhatia and Malik 1991). But in recent years, with free access to various Western TV programmes (some containing a high ‘dose’ of sexually explicit information), Indian adolescents find themselves sandwiched between a glamorous Western influence, which arouses their curiosities and interests, and a stern conservatism at home, which strictly forbids such discussions. This further aggravates the confusion (Sharma et al 1996: p. 147).

Such accounts parallel popular renditions of young ‘Asians’ in Britain, as beset by the dissonance produced by a cultural conflict between their parents and British society. In this regard, such intergenerational cultural conflict becomes an experience exclusive to ethnic others, displacing any recognition both of the universality of such conflicts (Stopes-Roe and Cochrane 1990), and of the evidence of more complex processes of cultural syncretism. The influence of the modernisation thesis upon therapists’ accounts of change amongst ‘non-western’ peoples was to impose a conceptual binary: namely, a condition of cultural stasis produced by an overwhelming attachment to the past, or a uni-directional and conflict-ridden process of acculturation to the ‘ways of the west’. In the case of British Muslims, the sense of

dissonance pervading popular public accounts of immigration and acculturation have been heavily influenced by renditions of Muslims as a threat to Englishness (Abbas 2001). Furthermore, an appreciation of change as a fundamentally interactive and mutually constitutive process is negated in the extent to which the 'non-west' becomes de-centred and peripheralised to a point where its role becomes merely reactive, and within a narrow range of options⁷.

There was complexity in the data though, and evidence of a consideration of social, economic and political considerations that served to introduce qualification to the ethno-culturalist accounts of the 'non-western' world and its people. But the predominant motif was of an 'oriental' world permanently permeated by a sense of cultural otherness⁸. If it is the case that "...historical archetypes [of the Orient] are indelibly ingrained in the modern Western imagination and psyche" (Abbas 2001: p. 252), then the prevalence of such renditions of the 'non-west' within the data should not be too surprising.

6.3 'Mixed' relationships

In social contexts where importance is attached to the reproduction of racialised and ethnicised identities, and to the boundaries that sustain these identities, mixed relationships are routinely attributed with great significance. Emotional and sexual inter-personal relationships across the divides of race and ethnicity do more than any other form of social arrangement in challenging the forces that strive to police racial and ethnic boundaries, and the ontologies that underpin them. They bring into question, and threaten to permanently undermine, certitude and clarity in respect of those qualities that serve to demarcate a racial/ethnic 'us' from 'them' (see Frankenberg 1993) and therefore serve to test the limits of social tolerance for principles of diversity and hybridity. The pathologisation of such relationships expresses the racist nature of society (Frankenberg 1993). Likewise, for those committed to the deconstruction of racialised/ethnicised social orders, or to the extolment of a society in which diversity is accounted for in terms of enrichment and growth, 'mixed' relationships⁹ represent the epitome of progression. But mixed relationships remain contentious, and this extends to the very language with which we discuss the phenomenon (Ifekwunigwe 1997, Alibhai-Brown and Montague 1992);

⁷ As a case in point, the possibility that exposure to 'western' values may, and in fact has, produced a revitalisation of commitment to 'non-western' values, such as in the case of a revivalist Islam (Abbas 2001), was almost entirely unrecognised, as such a scenario falls outside the stasis/acculturation binary.

⁸ See Said (1978) for a classical account of 'Orient' as a Western construct.

⁹ I have chosen to use this term, despite the potential for reification of the categories of race and ethnicity that it invokes, because it was the term used most readily by the respondents.

All language related to the conjunction of sexual and racial difference is problematic: miscegenation, mulatto, half-caste, mixed race, interracial and so on all carry with them the stigma of racist discourses, suggesting as they do an acceptance of the precepts of separate, biologically determined racial groups (Young 1996: p. 87).

However, a confluence of social and political developments, synthesised within what could be described as the 'diversity agenda', have served to challenge the pathologisation of mixed-race and mixed-ethnicity relationships. The theory and practice of relationship work (of which sex therapy is but one dimension) has emerged as one context in which hegemonic ideologies around a range of relationship issues (heterosexuality, monogamy and marriage) have been brought into some doubt, though not in a climate of unanimity. It has become professionally problematic, and even perhaps jeopardising, to be seen to be pathologising non-normative forms of relationship. The language of diversity has formally and rhetorically displaced a logic of perversity in such fields (see Weeks 1986). Within a discourse of diversity all relationships become predicated upon difference, where an acceptance of this difference becomes a mark of professional competence.

Mixed relationships are therefore of importance within the context of this research as their existence requires sex therapists to reflect upon the nature and significance of the forms of difference associated with race and ethnicity, and of their implications for the dynamics of emotional and sexual relations between people. They invoke ideas about the degree of proximity permissible, desirable and beneficial between racial and ethnic groups.

Despite this importance, discussion of mixed relationships within the sampled papers was limited¹⁰. Two papers were concerned directly with the question (see Stringer 1994, Clulow 1993) and were written by non-therapists working with a sophisticated sociologically and politically informed framework. There was negligible commentary on mixed relationships beyond these papers. Clulow (1993) claims that mixed relationships are becoming more prevalent as a direct consequence of the implications of globalisation and mass migration, and with this an enhanced permeability of boundaries of nationality, ethnicity and religion. Population movements, in and of themselves, produce greater probabilities of mixed relationships, but are supplemented in this effect by other dynamics. Clulow (1993)

¹⁰ Bhugra and De Silva (2000) acknowledge the limited nature of the discussion within the literature on what they describe as 'mixed-race' or 'intercultural couples'

suggests that a 'fascination with foreignness', with exotic forms of unfamiliarity, and the pragmatic benefits that may come from 'marrying in' provide active drivers for such relationships.

The status of mixed relationships as 'problem relationships' was ambiguous. The more sociologically and politically informed nature of the papers dealing with mixed relationships was evident in the manner in which they accounted for the problems such relationships may experience. For Clulow (1993), the difficulties faced by these couples needed to be understood within a broader context whereby mixed relationships were seen as crossing collective as well as individual frontiers. Where communities feel their resources, identities and belief-systems to be at risk, such frontier crossing may be experienced as threatening, as is generally the case within Northern Ireland (Stringer 1994). Externally-driven problems may emerge regarding the social identities of children and the potential social isolation of individuals and couples. Power imbalances may prevail within the relationship as a reflection of the broader political climate (Stringer 1994). Problems around communication, deriving from differences of historical experience and culture (Stringer 1994) were acknowledged, as were difficulties in respect of decision-making, habits, beliefs and customs (Bhugra and De Silva 2000). Bhugra and De Silva (2000) also stressed the ethno-cultural differences that exist in respect of notions of the self and self-esteem. Against this potential for problems, was a recognition that mixed relationships may be characterised by particular strengths associated with: higher levels of commitment (Stringer 1994), enhanced levels of planning, negotiation and tolerance, and a potential for deconstructing community barriers.

In the context of the data as a whole, I take the limited analysis of 'mixed relationships' as indicative of a sex therapy discourse over-determined by a multi-culturalist rendition of diversity that has tended to focus its energies upon the delineation of the internal characters of racial/ethnic groups, rather than on the interactions and 'transgressions' taking place at the 'boundary'.

6.4 Sexual Praxis and sexual problems

A distinction between sexual praxis and sexual problems has been made here principally for the purpose of organisation. A recognition of the socially constructed nature of sexual normality, in terms of belief, value, behaviour and inter-relations makes any universal and definitive distinction difficult, and even fallacious. The analysis of the journal data produced a basic typology into which the pertinent papers could be organised. Firstly, those

addressing the sexuality and sexual problems of ethnic (typically 'Asian') minority groups within Britain. Secondly, papers concerned with accounting for the ethno-culturally grounded sexual mores, practices and problems of ethnic/national groups in non-European contexts, principally the Indian sub-continent and South East Asia. Finally, papers with a noticeably global focus, concerned with issues such as contraception, sexual health, and comparative sexual practices within the developing world.

6.4.1 Sexual Praxis

D'Ardenne's (1986) paper, whilst concerned principally with the question of sexual dysfunction within 'transcultural settings' and its implications for therapeutic practice, offers an initial rendition of the relationship between race, ethnicity and sexuality. Informed by the experience of working with Asian couples in East London, the paper produces some early but portentous themes regarding the nature of sexuality in a context of ethno-cultural diversity. Theoretical developments within the field of psychiatry are drawn upon to emphasise the foundational principle that health and illness are socially constructed, and therefore relative, concepts. Citing the work of Bancroft (1983), the importance of sexual beliefs and behaviours as a source of ethno-cultural relativity and dissonance was highlighted. A dichotomy between 'oriental' and 'occidental' attitudes to sexual intercourse within marriage was mentioned, along with the cultural importance attached to semen amongst Hindus and Muslims.

Understanding the ethno-cultural determination and relativity of sexual beliefs, values, behaviours and difficulties was the primary 'problem' to be addressed. Drawing upon what could be described as a 'cultural area' model of ethnicity (Gil-White 1999), d'Ardenne (1986) suggests a coterminous relationship between ethnic boundaries (in this case 'Asian') and substantive, particular and more or less common culturally determined sexual mores and behaviours. Sexuality is therefore placed centrally as an anticipated primary marker of ethno-cultural difference. The concept of 'culture-bound' syndromes, as sexual problems experienced by particular ethno-cultural groups as a manifestation of culturally grounded sexual mores and practices, powerfully reinforces the 'cultural field' rendition of ethnicity. Via the medium of the concept of 'trans-culturalism', ethno-cultural change is presented as an exceptional and traumatic event brought about by dislocations such as migration, and as generative of a range of potential (including sexual) problems. A norm of cultural continuity and reproduction is implicitly re-asserted at the very point that the stressful realities of cultural (and therefore potentially sexual) change are acknowledged.

Though a 'cultural field' approach, reflecting a more popular common-sense rendition of the nature of ethnicity and ethnic groups, is the major chord struck within the paper, the availability of both personal experience, and an academic literature brings with it recognitions of trans-cultural universalities (such as the prohibition placed upon sex during menstruation within the world religions), and of internal heterogeneities within ethnic groups along lines of gender and class (Christopher 1984, cited in d'Ardenne 1986). Furthermore, the socio-economic circumstances of the Asian population of East London were recognised as having a bearing upon their opportunities for normal expressions of sexuality. But these are minor chords and their particular location within the text as points of qualification do not challenge a 'cultural field' reading of ethnicity within the text.

6.4.2 Sexual Problems

Although the empirical base of the scientific knowledge pertaining to the nature and distribution of sexual problems within and between racial, ethnic and national groups is limited, an established (though occasionally contested) body of opinion has emerged on these matters within the journal. This body of opinion is characterised by three key elements. Firstly, that particular 'others', conceived in racial, ethnic and national terms, are characterised by the prevalence of particular types of sexual problem, marking them as substantially different. Secondly, that though these problems may have a somewhat complex aetiology, they are overwhelmingly the product of the substantial ethno-cultural character of these groups¹¹. Finally, that similar accounts of the racial, ethnic and national 'self' as associated with, or productive of, sexual problems, are far less forthcoming¹².

The presence of particular racial, ethnic or national groups within the journal is highly differentiated. There are accounts of gender, sexuality and sexual problems in the 'developing world', predominantly in reference to the Indian sub-continent, China and Africa (Pradhan et al 1995, Potts and Masho 1995, Pacey 1999). There are papers specifically concerned with Brazil (Barker 2000), Poland (Slosarz 2000), Israel (Rabin 1998, Levran et al 1988), Portugal (Nobre and Gouveia 2000) and Turkey (Sungar 1999) but these lack the frequency to produce a cumulative profile and are generally not framed in clearly racial or ethnic terms, with gender

¹¹ Sheldon and Parker (1993) have highlighted the tendency within health research in the field of race and ethnicity to present culture as the key determinant of health outcomes at the expense of a recognition of other variables.

¹² Except in the context of acknowledgements of the ethnocentric nature of the concepts upon which western medicine and therapy has been based, which whilst an important recognition can serve in some hands to further emphasise the otherness of 'non-western' populations.

occupying a more significant conceptual role. The 'British' are only alluded to in most cases, and tend to be subsumed under the category 'Western'. Westernness had two principle guises. Where the 'West' was attributed with substance, it was in terms of the repressive influence of the Judeo-Christian legacy. But more commonly, the 'West' was implicitly represented in antithesis to non-western contexts, taking a form of vacuous modernity. In contrast, accounts of 'Asians' proliferated, particularly with regard to those domiciled in the Asian sub-continent (for example Bhugra 2000, Sharma and Sharma 1998, Sharma et al 1996, Gupta 1994, De Silva and Dissanayake 1989) and South-East Asia (Li and Yan 1990, Ng 1988). Substantive studies of people of Asian origin within the western contexts in which sex therapy is predominantly located were notable for their limited presence.

One would expect to find some range of opinion on the aetiology of sexual problems, given both their evident complexity and the range of influential theoretical approaches within sexology and sex therapy. Occasional references were made in some papers to the uncertainty still pervading our understanding of the aetiology of a range of sexual problems (for example Money and Annecillo 1987), but taking the data as a whole this very much constituted a background theme. As there was a general perception that patterns of sexual problems can and do correspond to the boundaries of ethno-cultural groups (but principally where these ethno-cultural groups were 'other'), there was a resultant pervasive acceptance that a generalised causal explanation was required.

Bio-medical accounts had a limited presence within the journal in respect of the racial/ethnic geography of sexual problems, and where evident were used to emphasise the influence of universal physiological variables, and so to challenge accounts of particular sexual problems as the 'mere' products of ethno-culture (for example, Chowdhury 1996, Money and Annecillo 1987). In the manner of its usage, the role played by accounts of the role of physiology in this specific context implicitly countered a formal ontology of race through its emphasis upon universality. Economic variables were suggested in some papers, particularly those adopting a stronger social scientific framework, as making a significant contribution to the sexual problems of some people, particularly within developing societies (for example, Pacey 1999, Potts and Masho 1995). Material deprivation was seen as underpinning the disempowerment of many, particularly women, with pathological implications for their sexual relations, experiences and autonomy. In these papers, and others, gender was a notable theme. Though without any overall clarity, or prevailing theoretical orientation, gender and ethnicity were often simultaneously invoked in accounting for sexual

problems. Where gender and ethnicity coincided in such accounts, ethnicity tended to operate as the over-determining concept.

Informed by an implicit and explicit social anthropological framework, with occasional references to the value of sociology, the majority of papers located the sexual problems of ethnic 'others' within an ethno-culturalist framework. Sexual problems ranging from premature ejaculation, erectile dysfunction, masturbation anxieties and female genital mutilation were accounted for as the more or less direct causal product of ethno-culture. As De Silva (1999) claims, "it is clear that a culturally held set of beliefs can produce, through psychological mechanisms, real clinical problems" (p. 106). Though there has more recently been some challenge to the concept of 'culture-bound syndromes' (for example Bhugra 2000), the idea that culture-bound syndromes can be distinguished from what by implication must be culture-less, or at least culture-incidental syndromes, has exercised a significant influence within sex therapy.

The role of ethno-culture was conceived on three levels. Firstly, in terms of the causal significance of substantial, historically enduring beliefs, mores and patterns of living attributed to particular ethnic, racial and national constituencies in producing the conditions of possibility for a range of pathological sexual outcomes. This is typified by the account routinely offered of Dhatt syndrome. Secondly, ethno-culture is presented as also being responsible for sexual and sexually-significant problems in contexts of social change. In accounts of the sexual problems experienced by immigrants to Britain (and their descendants), references were made to the pathological effects of stressful cultural transitions (for example d'Ardenne 1986). Such accounts draw upon transcultural ideas in psychiatry (for example, see Littlewood and Lipsedge 1997), and are underpinned by a host-immigrant model of cultural divergence and dissonance. They are concerned with the effects of the conflict assumed to specifically characterise the passage between two polarised ethno-cultural traditions. Finally, and formally challenging assumptions that the culture-bound nature of ethnic others can be juxtaposed to a form of rational and scientifically informed ethno-cultural vacuity within the West, was an account of ethno-cultural difference as one particularly importance manifestation of a broader principle of cultural relativity in social life. Within this framework, the validity of diagnostic categories concerning sexual problems were challenged, and their culturally constructed nature exposed. All illness categories here become seen as inherently culture-bound, as a product of the socially constructed rules governing the boundaries between normality and deviance.

Ignorance and misinformation were also proffered as the source of some sexual problems, and were couched within discussions of the obstacles to sexual enlightenment within particular societies. Poverty (Potts and Masho 1995, Pradhan et al 1995), absence of education (Ng 1988), tradition, religion (Khandaker et al 2002), female disempowerment (Pacey 1999), superstition and myth (Ng 1988) were all evident in these accounts. There is a real, and I would suggest illuminating, tension here though. 'Ignorance' and 'misinformation' of course presume the existence of an essential truth that in the case of these references lies in the scientificity of sexology and medicine. In maintaining the notion of an essential truth, it is possible to explore and give importance to the influence of culture, but in terms of the extent to which it may enable or fetter the realisation of this truth. But science itself, as a way of knowing about the world, must lie outside and above the realm of culture within such an account. This is illustrated in De Silva and Dissanayake's (1989) claim that, in respect of India, "there is no mechanism for providing correct information about sexual functioning and countering the Ayurvedic notions" (p.203). However, a clear theme within many papers is the need to understand all concepts of health and illness as culturally relative, including those espoused by the scientific tradition within western societies. From this point of view there is no objective ground upon which one can stand, merely a multitude of different though equivalent vantage points. I would argue that the presence of accounts of misinformation, ignorance and the problem of superstition and myth imply an ambivalence about the status to be attached to the expertise that authorises sex therapy practice. I would also argue that the implication of adopting a true cultural relativism is to strip professional practice of its principle source of authority and legitimacy, namely the claims to objectivity, veracity and validity encoded within the scientific tradition. This could be a difficult asset for therapists to relinquish particularly because it may disempower them in their struggles against what they may well see as oppressive and illiberal sexual discourses and practices. It may also induce a more basic professional-existential uncertainty. In the absence of a rendition of sex therapy praxis as contributing to the general good on the basis of some general principles of truth, what then is sex therapy?

The twin icons of 'culture-bound' sexual dysfunction within sexology and sex therapy literature have been the Koro and Dhat syndromes. One could argue that the fortunes of an ethno-culturalist theoretical and conceptual edifice within sex therapy teeters on the foundations provided by phenomena such as Koro and Dhat. Given their undoubted significance as 'test-cases', their presence within the literature warrants particular attention.

6.4.2.1 Koro syndrome

Koro makes its first appearance as a brief reference within d'Ardenne's (1986) paper on sexual dysfunction and trans-culturalism. The work of Rack is noted in the account of Koro as a 'culture-bound' syndrome, particularly prevalent amongst the ethnic Chinese. It is defined as a "delusional fear that [the] penis will retract into the abdomen and thereby cause death" (p. 25). The disorder has not appeared in the western classificatory tradition as the symptomatology has been seen to be characterised of another ethno-cultural tradition.

Koro makes its next appearance in Money and Annecillo's paper (1987) concerning a case of Koro within the United States. Koro is defined here as "an acute phobic reaction in which the patient suddenly fears that his penis is shrinking, will disappear into his abdomen, and bring on death; it is observed in southern China and the Malay Archipelago" (Goldenson, cited in Money and Annecillo (1987)). So for the purposes of the definition, the necessary conditions for a case of Koro are three-fold: a fear that the penis is shrinking, a fear that it is retracting into the abdomen, and a fear that this will bring death. Money and Annecillo go on to give an account of a man in the United States who believes his penis is shrinking, but where there appears to be no evidence of the other elements. This is taken nevertheless to be a case of Koro, and given that it exists outside of the geographical environment where Koro has a collective cultural recognition, is taken to indicate the fallacy of Koro as a culture-bound syndrome. Money and Annecillo question the 'social contagion' premise upon which accounts of Koro have been based. They challenge the assumption that fear of penis shrinkage is specific to particular geographical-cultural contexts and suggest that though its aetiology is as yet unknown, it may merely be a secondary symptom (a body image pathology) produced by real primary anatomical and/or physiological symptoms associated with undiagnosed deteriorative conditions such as multiple sclerosis. Money and Annecillo's paper provides a reading of Koro which challenges the readiness of western sexology to attribute sexual problems to ethno-culture. In this sense, Money and Annecillo's paper is potentially iconoclastic.

A further challenge to the account of Koro as 'merely' a culture-bound, because culture-generated, condition has been offered by Cowdhury (1996). Chowdhury challenges the account of Koro as a psychogenic illness initiated by cultural myths. He points to the reported cases of Koro around the globe and on this basis suggests a different aetiology. Citing many references, he claims that fear of penis shrinkage is characteristic of those individuals who, for a variety of reasons, have a heightened concern with penis size. The penis has, according

to Chowdhury, an inevitable centrality given its role in the genito-urinary functions of semen ejaculation and urination. With this psychological orientation, the trigger for a Koro event, and this reinforces the point made by Money and Annecillo (1987), may well be real changes taking place in the morphology of the penis. Cold temperatures, fear, and the reflexive changes to the penis associated with sexual activity and urination/defecation all bring about a potential reduction in penis size, and as such a trigger for a Koro event. However, the underlying premise of culturally demarcated ethnic communities, the members of which by virtue of the over-determining effect of cultural beliefs are primed to experience characteristic forms of sexual problem, does remain intact within this paper, though within a more complex account.

D'Ardenne (1996) offers a brief review of the accumulated findings regarding Koro and gives voice to a range of questions that in sum bring an ethno-cultural reading of the condition into doubt. She reiterates Chowdhury's (1996) suggestion that there may be a real physiological base to Koro and that we should be hesitant to assume a simple cultural aetiology. She also points to the apparent ubiquity of the disorder throughout the world and makes reference to Kirmayer's (1992) warning that a focus upon ethno-culture as the explanation of sexual problems runs the risk of negating social and psychodynamic dimensions, which in the case of Koro may be associated with anxieties to do with castration, masturbation, penis size and performance. But despite this, Koro appears again in papers by Ng (1999) and De Silva (2000) in its traditional guise as a 'widely recognised' and 'well described' culture-bound disorder.

Accounts of Koro then have been ambivalent. Its contestation as a 'culture-bound' disorder within the journal has served to open up a space where a broader set of assumptions about the nature of ethnicity could be brought under scrutiny. But it is not clear that the challenge to Koro has served as a springboard for questioning renditions of culture-bound disorders as distinctively and definitively 'other'. The insights accessible through the critical dialogue concerning Koro may not have been taken forward to inform a broader critique. Perhaps the 'will to ethnicise' is too strong, and the examples of other conditions, such as Dhat, too appealing to result in a radical revision of thinking in these areas.

6.4.2.2 Dhat syndrome

Dhat syndrome is also discussed initially in d'Ardenne's (1986) paper concerning the "very particular range of sexual difficulty" (p.23) being experienced by an Asian community in London. Making reference to Bancroft's (1983) distinction between "oriental and occidental attitudes to intercourse within marriage", and the account of culture-bound syndromes offered by Rack (1982), d'Ardenne describes Dhat as a "fixed belief that the sperm is leaking from the body through the urine, and is causing general debility and weakness" (p. 26). The condition is common amongst Asian Hindus and Muslims, and is seen as a neurosis produced by a historically enduring ethno-cultural belief system within which semen is understood both as the source of male health and vitality, and as a scarce fluid generated at significant cost for the individual. Sexual activity generally, and masturbation particularly, subsequently have a hazardous potential for the male in a context where demonstrable potency is central to a 'cosmology' of healthy manhood.

De Silva and Dissanayake's paper (1989) locates Dhat formally within a broader culture-bound syndrome, 'Loss of Semen Syndrome'. Loss of Semen syndrome is presented as a product of anxieties about the loss of semen, in turn generated by the influence of the Ayurvedic medical tradition. Within this tradition semen is understood as produced via the distillation of blood. These ethno-cultural beliefs, combined with neurotic orientations of the individual, account for the condition. A sample of clients presenting to a psychiatric clinic in Sri Lanka with a range of immediate presenting problems were all found to share strong beliefs about the importance of semen to their health. In the majority of cases Ayurvedic medicine had featured either in the clients' accounts of the origins of their beliefs or in their attempts to have their condition cured. De Silva and Disanyake conclude that the Ayurvedic tradition is "...undoubtedly the main source of these beliefs" (p. 203). They argue that the influence of this tradition upon the cultural context within Sri Lanka is supplemented by the absence of formal sex education in schools, the ongoing promotional activity of Ayurvedic practitioners, and the legacy of British sexual prurience during the period of the Empire. Gupta's (1994) paper reiterates the notion that "as semen holds such an important role in the Indian psyche, it is not surprising that its loss through premature ejaculation, nocturnal emission, masturbation and 'excessive' sexual activity produces anxiety neurosis in Indian males" (p.63). Such anxieties are seen by Gupta to be a legacy of an ancient intellectual and religious tradition that has prevailed formally and informally despite the influence of external forces, such as the British. There is consensus that Dhat syndrome, or 'loss of semen syndrome' is prevalent amongst Indian males (Sharma et al 1996). D'Ardenne (1996) refers

to studies that suggest the influence, across Indian society, of Ayurvedic-based pre-occupations with the harmful nature of semen loss.

Gupta's (1999) paper shifts the focus to the UK, and appears to shift, or broaden the definition of Dhat syndrome to that of premature ejaculation. "Premature ejaculation (PE) is a common problem (Kinsey et al 1948), especially amongst Asian males, where it is well recognised as Dhat syndrome (Gupta 1994; Bhatias and Malik 1991; Bhugra and Cordle 1986, 1988)" (p.71). The paper does go on to offer a conventional account of Dhat syndrome, making reference to statements regarding the importance of semen in ancient religious texts, but its precise definitional meaning vis-à-vis premature ejaculation has become unclear. As a demonstration of prevalence amongst Asians in Britain, Gupta points out that it was "...the third commonest problem seen in men attending our Sexual Dysfunction clinics in Central Luton, which has an Asian population of up to 20%" (p. 71). Besides the fact that this does not demonstrate the higher prevalence of premature ejaculation amongst Asian men in Britain (and neither does Bhugra and Cordle's (1988) comparative study of Asian and non-Asian clients in Britain), it is notable that the meaning of Dhat has shifted toward premature ejaculation, and does not seem to require the presence of specific forms of belief. Though the terminology may have become conflated within this paper, the powerful association built between sexual dysfunction and the ethno-cultural characteristics of particular 'others' prevails. De Silva (1999), in a short but powerful commentary on the role of culture and its influence upon sex therapy, consolidates the established reading of Dhat as a culture-bound syndrome, and reinforces the perception that this is well described in the literature as an established and largely unmediated product of a religiously informed ethno-cultural tradition.

Dhat's final appearance comes in Bhugra's (2000) paper on *Disturbances in objects of desire: cross-cultural issues*. Though its presence is limited, the context in which it appears would seem highly significant. Bhugra's paper contains a sub-section entitled 'culture-bound syndromes' in which he cites Davis's (1996) work in arguing that:

...there is a danger inherent in the psychiatric fascination with these exotic syndromes, through which clinicians and researchers alike reduce considerations of cultural sensitivity and turn these sexual disorders into colourful high profile conditions, overlooking the extent to which all the sexual disorders of DSM-IV are culture-bound (p.75).

This seems to be acknowledging an aspect of this differential will to ethnicise, whereby we come to extract, reify and ascribe definitive importance to some particular (real or imagined) dimension of an ethnic other as a means to rendering them as peculiarly, particularly and exclusively a product of 'deep' culture. In contrast, the attributing self remains in a state of culture-transcendent universality. Davis (1996) is cited in suggesting the need for a more consistent and radical constructionist account of sexuality, informed by Foucauldian insights. The paper does also suggest that "there is some evidence that Dhat (or the loss of semen anxiety syndrome) symptoms do occur in different cultures, though the presentation for help is quite variable. "Quite often, these syndromes also cover underlying anxiety and mood disorders" (p. 75). This does seem to shift the debate as it suggests that beneath the emphasis upon distinctiveness and difference may lay forms of obscured commonality. But taken as a whole, the discursive role played by Dhatt syndrome within the journal, as a 'culture-bound' disorder, is as a reference point for those seeking to foreground an ethnic geography of sexuality and sexual problems. It has operated in such a way as to reify ethnicity itself, to consolidate a notion of the 'other' as uniquely ethnic (in juxtaposition to the 'western' subject) and to displace an analysis informed by a recognition of the socially, politically and economically-constructed nature of ethnic categories and identities.

6.4.2.3 Masturbation anxiety

The issue of masturbation has an ambiguous presence within the literature. Its principle profile within the journal data is as a source of religiously and culturally-grounded anxiety within the world's Asian population. On the basis of the established discourse regarding the importance attached to semen for the health and vitality of the Indian male, as authorised by the Ayurvedic tradition, masturbation is accounted for as a source of great anxiety (see Gupta 1994) for Asian men (women are rarely mentioned in this context, but for an exception see Sharma and Sharma 1998). This anxiety manifests itself on an individual level in the form of an anxiety disorder, with powerful guilt associations (Sharma and Sharma 1998), and on a collective level in the form of a taboo, with an attendant prohibition on masturbatory activity. References to the fact that within Asian (Hindu and Muslim) culture/s masturbation was 'forbidden', or 'not permitted', were commonplace, though the precise nature of what constitutes 'forbidden' was often unclear. Within this discursive context, masturbation anxieties, and a generalised masturbation moratorium were constructed as definitively, because ethno-culturally, Asian, with religious doctrine underpinning the position.

One could be excused for thinking, from a reading of the literature, that because masturbation is 'forbidden' in Asian cultures, then it does not occur, or that it occurs only with pathological psychic consequences. Sharma et al's (1996) sample of adolescent boys in Gujarat appeared to support this assumption. All the boys expressed "a feeling of guilt/shame associated with masturbation and believed it to be a very harmful and detrimental activity". (p. 148). But another reading is available. All the boys masturbated, nevertheless, and with a mean weekly frequency of 8.47, and a mean age at first masturbation of 12.13. This degree of masturbatory vigour could be said to reflect and sustain a certain normalisation of masturbation. It also begs the question as to the status of masturbation in western societies. It is not as though adolescent boys within western nations receive certificates for socially approved and valorised demonstrations of masturbatory enthusiasm, or that they masturbate within a psychic comfort zone underpinned by a fully developed insight into its normality and health.

Sharma and Sharma (1998) suggest that the scope for a more positive concept of sexual health exists within India and that with this being the case, masturbation may offer a suitable mode of sexual outlet to be supported by those working within the sexual field. This despite their acknowledgement that masturbation has been powerfully associated with guilt, and mythical assumptions about its status as a source of disease, infertility and marital disharmony. Their findings, that almost one third of their sample of college girls in Gujarat admitted to having masturbated,

...merits attention because it belies the general assumption that girls in puritanical and orthodox societies such as India, do not practise masturbation. It may also be regarded as a development of the weakening of social control mechanisms and the relative liberalization of social norms regarding sexual behaviour in modern Indian society (p. 68).

Interestingly, they found no significant correlation between masturbational status and religion, which they claim supports data from other studies in different contexts. "It appears that during the period of adolescence, peer influences, socio-economic factors and familial factors have a greater impact on the sexual orientation and behaviour of an individual compared with religious factors" (p. 69). This comment stands in stark contrast to the importance typically attached, in accounts of Asian populations, to the enduring influence of ancient religious scripture in informing contemporary belief and behaviour. It also usefully

grounds phenomena, typically reduced to the category of ethnicity, within a broader explanatory context.

But by Gupta's (1999) and de Silva's (1999) papers, masturbation prohibitions have returned to their traditional discursive role as defining characteristics of the religiously underpinned ethno-cultural particularity of Asians abroad and in Britain. But in Bhugra's (2000) account of the cross-cultural nature of paraphilias, the ethno-cultural significance of masturbation is left in doubt. Bhugra acknowledges the explanation of the apparently western nature of paraphilias as the product of the absence of sexual partners and of the "primacy of masturbatory behaviour" (p. 76).

Masturbation is one topic where western societies have some form of presence as ethno-cultural constituencies, attributed with substantial and particular cultural characteristics. Discussing the loss of semen syndrome in Sri Lanka, De Silva and Dissanayake (1989) claim that

the condemnation of self-relief and other forms of sexual outlet, except within the bounds of marriage – and that too with a sense of moderation – is at least partly a relic of the Victorian ethic that Sri Lanka undoubtedly imbibed under British rule (1815-1948). One is reminded of the beliefs about the harmful consequences of masturbation and other forms of semen loss that were powerfully disseminated in the UK, US and Europe in the 18th and 19th centuries, especially by influential authors such as Aston, Boerhaave, Graham, Kellogg and Tisset (p. 203).

6.5 Conclusion

Some key themes have emerged from these data. In application to questions of sexual praxis and problems, where some form of empirical evidence is warranted to substantiate the conceptual claims made, explicit references to race recede. In its place, the ethnicity concept emerges as the dominant point of reference. The mode of its conceptualisation is however redolent with some of the ontological echoes of race in a number of ways. The boundaries of the ethnic categories employed follow the contours of earlier racial equivalents, with the 'usual suspects' occupying centre stage as the objects of delineation and explanation (typically 'Asians', Arabs, and Africans). A largely deterministic, and one might say

primordial, power is granted to the historically-enduring ancestral legacy of ethno-culture over the behaviours, thoughts and attachments of the ethnic 'other'. A geography of ethnic difference is also constructed via which the relations between ethnic groups become conceived as deeply problematic, as an organic product of this difference. The status of the 'ethnic self' is characteristically ambivalent. At one moment, the 'western' ethnic subject is erased through their location out-with the ethnic parameters constructed, and their implicit allocation to a realm of substanceless rationality. At other times the ethnic self becomes problematised as itself located within an ethno-cultural tradition, reflected in the cultural assumptions encoded in such things as western medicine's diagnostic categories.

A pervasive 'will to ethnicise' was evident within the data, which granted an over-determining role to ethnicity, vis-à-vis variables such as gender. Gender relations and identities became a product, and marker, of ethnicity. A sense of the inherent ethnic 'otherness' of non-western, non-white populations was realised in part through the discursive construction of gender relations in these diverse populations as oppressive and inequitable, in implicit juxtaposition to those found within the West. Sexual praxis and its attendant problems were considered similarly central to, and definitive of, ('non-western') ethnic groups, and were presented as demonstrative of the conceptual and explanatory importance of the ethnicity category itself. The focus upon 'ethnicity as variable' can and has served to displace a focus upon the role of other causal variables such as racism and socio-economic disadvantage/inequality (see Karlsen and Nazroo 2002). 'Culture-bound syndromes' provided the central platform for an established body of opinion regarding the causal importance of ethnicity as a generator of differential sexualities, even where empirical evidence was acknowledged to be insufficient, and served to reinforce a rendition of 'non-western' ethnic others as 'islands of disease' (Ahmad 1993). As part of the reification of ethnicity, the will to ethnicise is rarely dependant upon the existence of a comprehensive and definitive body of empirical evidence to sustain it. This would seem to demonstrate a key point about the nature of ethnic, and for that matter racial, categories. Namely, that these are constructions, with associated social and political motivations, that selectively enlist empirical phenomena in their name. This stands in stark contrast to the common-sense reading, as embodied within much of the data, that racial and ethnic categories simply *are*, as the organic expression of the empirical differences they embody.

Having considered the manner in which race and ethnicity are utilised by a largely self-selecting constituency of expert commentators in accounting for differential sexualities

and sexual problems, we can now turn to an exploration of these themes within a more 'representative' sample of practicing UK sex therapists.

Chapter 7 - Sexual Praxis and Problems – Talking Themes of Race and Ethnicity

The forms of discourse generated within academic journals and research interviews differ as an expression of the fact that distinct discursive rules operate within these respective realms. This may be reflected in the commentator's perspective, in the presuppositions made, and in the degree of coherence and completeness of the discourses produced. Interviews, as a dialogical event, are less amenable to the forms of discursive control typically enjoyed by authors within academic journals. The fluidity of interviews (at least those of a semi-structured form) raises the opportunity to explore and probe meanings, and within a context of a greater discursive freedom. This chapter will explore the same themes as Chapter 6, but will be concerned with mapping out the principle points of commonality and difference in the respective discourses.

7.1 Gender, race and ethnicity

The interview data suggested that amongst practicing sex therapists, gender was granted a greater conceptual and explanatory significance, as an axis of differentiation, than appeared the case within the journal data. The sense of gender's over-determination by race/ethnicity was less apparent. In fact, in contexts where gender became the focus of discursive attention, a degree of resistance to the conceptual elevation of race/ethnicity was widely evident.

For one therapist, gender was the only mode of collectivist thinking they were willing to formally entertain.

19: Mostly, the women still want more attention, they want more sensitive men and mostly the men don't know what they're talking about, no matter where they're from. I don't think their race or ethnicity is important...

Here a universal gender-dimorphism of need is invoked to directly negate any particularity that may be associated with race and ethnicity. This notion of gender as constituting the most undeniable and enduring point of human and social differentiation was almost universal, and operated as something of a common-sense amongst the therapists. A naturalisation of gender differences combined and competed with politically-orientated

feminist readings, but with the common effect of rendering gender difference as the primary point of differentiation in human sexuality.

2: A man living in New York, or London or Ethiopia will share the same myth that a man should be in charge in a sexual relationship, the man should initiate sex and should be the pleaser of the female partner....so that kind of sexual needs for instance is very much trans-cultural

In fact, the potential for categories of race and ethnicity to homogenise, and hence render gender differences less visible, was the basis of some therapists' circumspection concerning the validity of engaging with race and ethnicity. There was a distinct sense that reflecting upon gender as an axis of differentiation was conceptually and politically preferable to, and certainly less jeopardising than, a similar confrontation with race and ethnicity. This was not a theme of any import within the journal data.

But the context of the interview required explicit reflection, and produced implicit enunciation, on the relationship between race, ethnicity and gender. The accounts confirmed an intertwining of ideas of gender, race and ethnicity. Even those therapists most resilient in their insistence that race and ethnicity were of no particular significance in the context of sexuality and relationships, were lured inexorably by their unacknowledged complicity in modes of ethnicised and racialised thinking. It was clear from the therapists' accounts that groups become racialised and ethnicised in part through the medium of gender, in particular through imputations of systematic differences between such groups in terms of the forms of gender relatedness and gender identity found within. Attention was drawn towards how gender might be differentially manifested within particular racial and ethnic groups. In the following passage we can see the oscillation taking place between a desire to accept only gender as the sole mode of systematic social differentiation, but simultaneously the enduring allure of ideas of racial and ethnic difference.

19: where it does come up...is with the Arabs I've worked with, where women who are regularly being beaten...it will emerge in therapy that his father beat his mother, his grandfather beat his grandmother, and so on and she gets beaten if she misbehaves or if he is in a bad temper...These women are now demanding more in terms of rights for themselves as women. They haven't got the structure yet in Saudi

Arabia to deal with it but they do help each other, they are starting self-help groups...and that is also going into the bedroom, if you like, into their sex lives in that they are beginning to make more demands that they might not have made before. But their problems are still the same, the problems aren't different.

The primary relationship between race, ethnicity and gender within the data was the manner in which racial and ethnic diversity were seen to determine the power and salience of gender difference. "I think each [ethnic] grouping, however you identify it, probably has a different way of relating gender-wise" [40]. Masculine and feminine gender roles were seen to be dramatically amplified to the point of absolute bifurcation within racial and ethnic minority groups, in juxtaposition to the mediation and dilution of such roles within white western populations. The characteristic bifurcation of gender attributed to particular ethnic others, most notably 'Asians' was seen as problematic.

40: I think the biggest problem I perceive that that group ['South Asians'] has, is in their relationships with gender in terms of the male/female, how they come together. I see that as being a real source of difficulty for this group, not in terms of any particular sexual dysfunction but on a very general basis how they relate.

The diminution of the ethno-cultural props of gender inequality (such as religion and tradition) attributed to Western societies were seen as responsible for the extant gulf between the 'West and the rest' in respect of gender roles and identities.

Both data sources featured accounts of non-western racial/ethnic 'others' as marked by the inequitable and patriarchal nature of their gender relations, and conceived of these as a product of a historically enduring, and religiously informed ethno-cultural tradition. In this sense both data sources were replete with accounts that seemed to encode forms of racialised and ethnicised social consciousness, utilising gender in its service. But in contrast to the journal data, it was also clear that for most of the therapists interviewed, gender marked a terrain within which they felt much more comfortable. It was not, as we have seen from Chapter 5, that race and ethnicity were not powerful influences upon sex therapists' thinking. Rather, I would suggest it reflects an over-determining attachment to gender issues within the sex therapy constituency, with gender variably understood in biological-naturalistic and/or in sociological and political terms. Furthermore, that in contexts such as sex therapy,

professional-academic identities have come to be constructed in large part upon a conceptual prioritization of questions of gender to the point of discursive normalisation¹. This certainly cannot be said for questions of race and ethnicity.

7.2 Women in racial/ethnic groups

The importance attached by therapists to what appear to be the universalities of gender do not, however, overly fetter accounts of the women and men of (non-white) 'non-western' populations in terms of 'otherness', akin to the renditions found within the journal. Primarily this took the form of accounts of the sexually oppressed (and repressed) nature of 'Asian' and Arabic women, but unlike the journal, it was also expressed through renditions of the sexually active and assertive nature of some African and Afro-Caribbean woman.

With regard the oppressed/repressed female other, the genitally mutilated Somali, and the powerless Asian female became the principle and representative motifs. "Somali women...are totally oppressed and they are not expected to have any needs at all, hence circumcision" [5]. Asian women, particularly those of Pakistani and Bangladeshi origin, were understood to be vigorously controlled by Asian men, both in ideological and physical terms, as authorised by 'Asian' cultural norms. Asian women were, according to most accounts, unable to discuss sexuality at all, at least in the context most pertinent to sex therapy, namely outside the home and with experts. "...It just wouldn't be possible for Bangladeshi women [in Britain], maybe, to go outside the family to discuss [sexual] issues such as that ..." [40]. These oppressive gender relationships were perceived as being culturally reproduced within the British context (see Hall 2002, Abbas 2001).

In respect of the racial and ethnic other, there was a perception amongst the therapists that women's position was firmly a product of the agendas and needs of the ethnic group, and in a manner not remotely matched by reflections on white British women. A penetrative and mechanistic reproductive sexuality was imposed upon women in particular ethnic groups as a means to physically reproducing both the group itself and its patriarchal nature. References to such ethnically based gender oppressions were made in reference to Jews, where "Jewish women are seen but not heard" [5]. "When it comes to women, there is still that ingrained traditionalism" [5] within Jewish communities.

¹ This seems to echo Brittan and Maynard's (1984) claim that in respect of accounting for oppression there has been a conceptual and political tendency for particular constituencies to attribute primacy to one causal variable, in this case gender, at the expense of a recognition of multiplicity.

It was also a feature of 'Asian' gender relations, epitomised by the 'arranged marriage'. This 'visibility' of 'Asians' with respect to problematic gender relations reflects broader renditions of South Asian women as emotionally and materially dependant, and passive, renditions which have worked their way into the operant assumptions made by social institutions in their dealings with Asian people (Hall 2002). The arranged marriage "is a problem, especially when one of the couple is brought up here and the other one's imported or whatever" [9]. 'Arranged marriages' amongst South Asians have, within many western societies, become the object of extensive deliberation and pathologisation. Within these deliberations, a conflation of 'arranged' and 'forced' marriage has become commonplace (Hall 2002, Brah 1996).

Such inequitable relationships resulted in a "reduced libido in [Asian] women" [9], and as such a negation of their sexual health. But, in line with the account of westernisation discussed earlier, the exposure of Asian minorities in Britain to characteristically Western cultural norms pertaining to gender was seen to result in a process of progressive and uni-directional acculturation². This has manifested itself in ways that indicate that "...women in the Asian community have changed their role, which has an effect on men" [13]. Whilst there was recognition of generational change in cultural forms and identities, and of some heterogeneity amongst south Asians, there was an evident reproduction of the category of 'South Asian wife'. There was little sense amongst the therapists that "...the 'South Asian wife' should be regarded as a spurious category steeped simultaneously in racist and sexist stereotypes" (Hall 2002).

But representations of a passive and sexually oppressed femininity amongst our ethnic others has only ever been half the story. Female sexuality, and particularly that of 'non-western' women (Pieterse 1990), has simultaneously been constructed as potentially voracious and corrupting (Young 1996). The legacy of western accounts of African, Asian and Oriental women is replete with attributions of sexual insatiability. These have emerged as part of a broader naturalisation of non-western women, in turn enabling the construction of western women as, by comparison, civilised by religious and secular modes of belief and control.

² The assumption of the uni-directional assimilation of Asians as the inevitable consequence of exposure to British society was universal. There was no recognition of the contextual social and political determinants of ethnic-religious identities and boundaries, beyond the oft-cited dynamic of assimilation. As such, there was no evidence within the data that the therapists understood the manner in which the politics of multiculturalism within Britain may have as its "unsuspected by-product...the increasing fixity and reification of religious identities" (Raj 2000: p. 550) as forms of strategic essentialism required within a societal context where having a distinct and unambiguous identity has been central.

Accounts of powerful and sexually demanding West African and West Indian women, in places underpinned by the matriarchal structure of family life, were evident: "...one of the patterns of some people from the West Indies is a sort of matriarchal structure where women bring each other up and men are called in when they are required" [16]. And:

25: ...the expectations of who should be pleasuring whom, particularly with West African women, seems very, very clear. You know, "if the man can't satisfy me what's the point of being married". And they tell everyone, and apparently you know in Ghana that's fairly normal. So there's a lot riding on the penis.

Jewish and Hindu communities were also, and contradictorily, presented as being more interested than many Christian communities in female pleasure:

34: I do believe that Jewish people are more interested in women's pleasure than a lot of white people, or Christian people, have been traditionally. I mean, obviously today things are changing, and I think certain aspects of the Hindu culture like to celebrate sexuality in a way which we would find quite surprising or would have done until recently.

Despite popular hegemonic accounts of Asian women as utterly repressed and passive, it has not precluded contradictory accounts of "...Asian females as sensuous, exotic and well versed in the *Kama Sutra*" (Hall 2002: p. 61). The apparent simultaneity of accounts of black and ethnic minority women as both repressed and yet sexually active and demanding is directly associated, through juxtaposition, with the equally ambivalent account of white British women as liberated yet oppressed, as outlined in Chapter 4.

There were occasional recognitions that the perceptions of black female sexuality within white populations may be a product of a historical legacy of sexualised imagery of black people; "there was something attractive and sexual about eastern cultures, you know, Moorish influences and things like that" [40]. But on balance, the predominant theme was of a sense of confidence in the veracity of accounts of the sexuality of the racial and ethnic 'other' (as these have emerged within the West) as an organic expression of empirical realities. To the extent that such differences are assumed to exist in and of themselves, these accounts seem to reproduce "...the way in which European history has constructed black

female sexuality and femininity, characterising women of African descent as ‘lacking’ those ‘feminine’ qualities which have been attributed to white European women” (Young 1996: p. 177-8). Whether sexually oppressed/repressed or sexually powerful, accounts of non-white, non-western women in both data sources echoed with the sounds of ‘otherness’.

7.3 Men in racial/ethnic groups

Accounts of the relatively oppressed state of women within many ‘non-western’ racial and ethnic groups were closely matched by renditions of the particularities of the masculinities found within these same groups. Asian, Arabic and Afro-Caribbean men were predominantly accounted for in terms of the oppressive relations they established with women, as these became authorized via religion and cultural tradition. They were the beneficiaries of a distinctly non-Western degree of inequality in the balance of power within inter-personal relations.

But this masculine empowerment carried different implications for different racial and ethnic groups. For Asian men particularly, it resulted in a weight of responsibility and expectancy under which Asian men were perceived to be struggling. Family-orientated obligations to provide and reproduce were seen as productive of performance anxieties on many levels. The therapists seemed unanimous in their view that Asian masculinity revolved almost exclusively around questions of reproductive fertility. For Asian men, a masculine sexuality was by definition penetrative, both because of the imperatives placed on reproduction as the purpose of sexuality, and because of the fear, deriving ultimately from deep-seated cultural beliefs, of semen wastage as a threat to health. Again, though there was an acknowledgement of heterogeneity, “I’m sure there must be some radical Asians out there” [41], the dominant image of ‘Asianness’ seemed quite consistent with the renditions produced within the media concerning Asian Muslims particularly. These images may have become increasingly contested for their Islamophobic quality (see Abbas 2001, Halliday 1999), but evidently not within the sex therapy discourse. This may well reflect the ‘monist abstraction’ that is Islam within hegemonic western accounts (Halliday 1999), and the effect these have in negating a recognition the diversity and complexity that is the Islamic constituency.

For African and Caribbean men, masculine empowerment translated into sexual promiscuity, and a valorization of sexual performance more generally, as a marker of Afro-Caribbean masculine authenticity. As a measure and symbol of such prowess, a cultural

commitment to an aggregation of offspring was perceived as defining Afro-Caribbean masculinity:

3: I can think of one particular instance where it was a white Greek girl with a black partner and she had a child by him, but his culture was to have a lot of women and a lot of babies so he had babies all over place and she found it very difficult to come to terms with that.

This was seen by some respondents as reflected in Afro-Caribbean men's elevated expectations of penile performance.

13: There certainly would seem to be, from clinical experience of my own and a colleague's, black men who want to be increasingly virile with age and to sustain their erection of youth to keep many partners, not just a wife, or the named person, but many other partners and still be able to perform a sexual function with them. Despite the influence of alcohol and drugs which often accompanies that culture.

Whilst in general terms, men as a whole were described in terms of a masculinity in which sexual assertiveness and performance were valorized as defining what it meant to be male, in the context of accounts of black men, white British men were perceived as less expectant and in some cases less 'able'. White, western, and particularly heterosexual men were accounted for as particularly encumbered by a contemporary form of 'emasculated' sexuality. Differences of sexual orientation complicated the picture, as gay men were seen as an exception in this case, but white men seemed to be positioned in a 'middle-ground' between the repressed 'Asian' other, and the unencumbered Afro-Caribbean male.

Generally these renditions of an ethnicised masculinity were seen as describing real phenomenon internally produced within the groups themselves as a component of their substantial ethno-cultural character. However, on occasion something of the interactively constructed nature of these representations was evident in the data. Societal representations of black male sexual prowess, particularly in respect of penis size and potency were seen as having an impact upon, and even being productive of, the masculine and sexual identities of black men. They 'buy into' these representations, simultaneously enabling an elevation of their masculinity in their relations with women and white men, and producing a form of masculine entrapment.

1: ...One of the men I was working with, like I was saying with the premature ejaculation thing, was a young Afro-Caribbean man, and he said. 'It is very difficult to come forward for help, I'm caught in my own myth, that all black people are good at sex, they all bonk all the time, none of them have a problem', and he said you know, 'it makes it a lot more difficult to come forward' and I think that this is what has been happening with some of these previous couples I have been...It is the myth that perhaps they buy into.

The burden upon black men, be they British or otherwise, was seen as substantial. Black men suffered performance anxieties as they struggled to maintain the requisite levels of performance for the sustenance needs of their masculinity. A more positive reading of black identities, as at least in part, instrumental and situational modes of resistance to racist representations was, unsurprisingly, absent³. This reproduction of powerful images of the hyper-sexual Afro-Caribbean male marks a significant addition to the accounts found within the journal. African and Afro-Caribbean men simply have no substantial presence within the journal, even to the extent of lacking any noticeable account of the racist myths surrounding black male sexuality. This relative silence within the journal may say something about the difference between what can be said in the context of an interview and what can be written.

7.4 'Mixed' relationships

The profile of mixed relationships within the interview data was significantly higher⁴ than in the journal. The therapists were ambivalent about how to conceptualise mixed race and mixed ethnicity relationships. A minority of respondents were determined to do their best to see such relationships as 'just another relationship', as no more characterised by mixture than any other in which differences of age or class may feature. "I suppose I just see it as a couple, as if one were very old, one very young. It's like, okay what are the problems?" [9]. Within such a logic, the existence of dynamics particular to mixed race and/or mixed ethnicity relationships are negated via a collapsing of all modes of difference to a level of direct equivalence, as just another set of problems to address. Others were more willing to accept

³ According to Young (1996), "to a significant extent, black identities in Britain have been adopted as modes of resistant self-identification and political affiliation in order to counter the hegemony of Eurocentrism and racist ideologies and practices relating to difference" (p.186)

⁴ This will certainly in part be a result of the fact that I was able to directly question the respondents on their perceptions of mixed relationships within the interview.

that mixed race/ethnicity relationships may experience dynamics not directly equivalent to other modes of mixture, but saw these as peripheral to more generic dynamics inherent in all relationships. I have argued that such negations of the formative and ‘productive’ role of race and ethnicity partly express an explicit ideological commitment (however implicitly compromised) to an atomising individualism (with a parallel rendition of relationships as similarly autonomous and internally driven units), and to the instrumental need for such a rendition as enabling a representation of sex therapy as operating in a client-centred manner. But for the most part, even despite such formal commitments, therapists were labouring under the weight of a racialised and ethnicised ontology, authorising a range of views that imbued the sexual subjects within mixed relationships with the inherence of their race and/or ethnicity, raising questions for the respondents about the nature and potentialities of such unions.

The respondents seemed unanimous in their view that ‘mixture’ and complexity were *the* defining qualities of contemporary Britain, as characterising us all. “Most people, even if it’s just Irish, have got some sort of mix in them” [1]. “There are different variations, and we are all such a mixture anyway. We are all a mixture of goodness knows what...” [3]. In this sense, the respondents accounts were not without references to the post-modernist rendition of the social world as characterised by flux, and as productive of hybridities. These accounts would seem to imply a perception that racial and ethnic identities and boundaries are collapsing under the prevalence of hybridisation (see Ifekwunigwe 1997), and perhaps that this process is beyond reclamation or problematisation. But this would be slightly misleading. The ‘goodness knows what’ to which the therapist refers is implicitly a white ‘goodness knows what’. The melange of provenance to which they refer is contained within a boundary that is coded white and western. It is not clear that such apparently universalistically conceived renditions of ‘mixture as normative’ do actually endure consideration of mixture involving boundary crossings associated with race and ethnicity, particularly those involving populations bifurcated along lines of ‘white’ and ‘black’. The sense of mixture across racialised and ethnicised boundaries as a ‘special case’ involving differences of a ‘grosser’ kind, remained:

28: ...we all work often with two people who come from different groups and whether they’re white middle-class people who have made all sorts of assumptions about each other, but they still come from their families of origin, they’ve still got their assumptions about what relationships are, about what sex is about, and what families are about.

So I think there's that layer but when you add the more, if you like, gross obvious differences, then it's another set of layers, potentially, of difference which may be attractive and may be wonderful but may be sources of conflict

Collapsing into a vacuous equivalence, all forms of difference, here coexist in a contradictory relationship with an enduring racialised and ethnicised ontology. The appeal of such a negation of the structured social and political dimensions of race and ethnicity lay in its fit within a highly valorised philosophical individualism and in its ability to enable a particular, and rather heroic, rendition of sex therapy as able to cope with anything, *even* that!

7.4.1 Prevalence

Mixed relationships were perceived by all therapists to be more prevalent than in the past, with the implication of a normalisation of such relationships. "...The more it happens, the less significant it gets because it becomes more normalised, more and more understood..." [28]. None of the therapists had any direct knowledge of the actual prevalence or patterns of mixed relationships, though some were willing to speculate: "there is a systematic difference I've been given to understand with respect to Afro-Caribbean/white British unions. A lot of black men connect to white women, not very many the other way round..." [16]. Estimations of the geography of mixed relationships appeared connected to the therapist's broader view on the nature of mixed relationships within a context of racial and ethnic diversity. In this sense, estimations of prevalence operated as a variant of a 'numbers game'. As a case in point, one therapist asserted that there were relatively few mixed race children in the UK, and posited this as evidence supporting a broader claim that within one particular (and for the respondent, representative) north London borough, there was "an absolute rule of no eye contact between racial groups", reflecting the very limited nature of "inter-racial relatedness" [25]. This estimation of a limited prevalence of mixed relationships was functionally useful to a therapist who had previously expressed concern about the problematic implications of the forms of diversity introduced by mass immigration. It served as a 'grass-roots' validation of his account of people's natural desire for sameness, and fear of strangers (see Sivanandan cited in Fekete 2003), and of his assumption that in race and ethnicity we are dealing with real and somewhat immutable modes of difference.

7.4.2 Accounting for 'mixed' relationships

Mixed relationships were accounted for by the therapists both in terms of material changes taking place within society, and the meanings attached to such relationships by the racial and ethnic participants. In terms of material variables, mass migration, the enablement of cheap travel, and the racial and ethnic composition of one's locality were all posited as factors. "Sometimes it's about availability, about where you come from, about who you met in the Youth Club..." [28]. But above and beyond these material underpinnings, most therapists also saw mixed relationships as accountable in terms of the particular motivations of the participants involved. Some therapists alluded to a chemistry of sexual attraction and fear aroused by racial and ethnic difference. "I think difference certainly is attractive, isn't it, just as it's frightening ..." [34]. And:

13: ...there's something exciting and interesting if your partner's from foreign parts, mysterious parts. But likewise it goes the other way round as well, when poor quality traits whatever they are, are attributed to that culture.

In the therapist's account we see an example of what could be described as a 'racialisation of space' (see Mills 1999). Invoking an ecological framework, binding group to place, generates an assumption that being *from* 'foreign, mysterious parts' is to simultaneously *have* foreign, mysterious parts. Racial and ethnic groups therefore come to embody the distance of their place within their bodies (in their anatomy, physiology, behaviour, cognition, affect and particularly their sexuality).

34: I have been told by young Indian men many, many times and I've read it in other places, whether it's myth or not, but dark races are attracted to white races, particularly men to women and some women say they are very attracted to black men.

Pertaining to the mixture of 'white' and 'black', which was the principle reference point within the data, the therapists saw a number of dynamics as operating. One therapist suggested that for black subjects, approximating towards whiteness can be the desired aim, either through personal proximity or through the reproduction of 'whiter' children. "Even among some particular Asian communities, the paler you are the better" [42]. Commentating on one client, who she described as half-Indian, half-European, the therapist reflected upon

the desire the woman expressed to consolidate her whiteness.

34: I did work a long time with a girl...who was half Indian and half European and she had fallen in love with a boy who was half Indian and half European and she was terrified of marrying him in case they had a brown baby, you know, because she had been brought up in a white culture and she looked more Italian than Indian.

In accounting for white women's apparent attraction to Afro-Caribbean men, another therapist claimed:

25: I think it's a kind of desire for difference and kind of excitement and, in some ways, a desire to get back to somebody who lives in their body. You know, somebody who is kind of in their body, because you'd think biologically women are looking for healthy kind of men, you know men who could father children in a particular kind of way, not that there are all that much cross-race production of children.

We can see the assertion of race as signifying real and natural difference, and of the gendered 'excitement' that this may create across the boundaries of race. An ontology and epistemology of 'natural kinds' prevails here in the account of race as defining the 'biophysical substructures of existence' (Brown 1999). At the heart of this biophysical realm of course is sexuality, where black men and white women are presented as having a fundamentally closer relationship to their physicality. The dynamics of attraction across racialised boundaries are also presented in terms of a socio-biological dynamic of selection. The respondent goes on to say:

25: ...in many cultures the men are entitled to be embodied and to show their sexuality in all sorts of ways and the women have to hide it, you know. And that used to be the case in Britain. Now women show their sexuality, I think much more than men. It's the gay community that lead fashion design and displaying the body and what to do with the body, and the heterosexual couple are falling behind, very uncertain about how to express embodied being in a sexual way. Whereas I think Afro-Caribbean men have shown that.

A greater complexity is introduced here. Embodiment would seem to be something that once characterised us all, but that British men (white British heterosexual men) have lost this in the process of their particular forms of cultural development. The sexual appeal of black men, is not limited however to white women, but also to homosexual white men. One therapist reflected upon their working experience with:

42: ...gay men whose expression of their sexualities has involved them, more or less exclusively, with either black men, in terms of African, Afro-Caribbean men, or Oriental Chinese/Japanese/Korean or Asian in terms Pakistan, India, where something about that mix has been sexually charged.

The therapist claimed that the motivation was not, with regards to black men, explicitly associated with the myth of Afro-Caribbean penis size, but “something more intangible” [42]. A number of therapists made specific reference to the relations between white men and ‘oriental’ women, and in particular women of South-East Asia. Such relations were accounted for in terms of the desire amongst white men for submissive and sexually receptive partners, qualities the white European men associated within oriental women. Those respondents who referred to black women and their motivations for establishing relations with white men, accounted for this in terms of the appeal for black women of white men’s association with qualities of respect for women, and relationship stability.

The attraction of establishing a mixed relationship was also seen by a number of therapists as informed by a motivation to produce particular effects on significant others. ‘Mixed’ relationships were understood here as ‘saying something’ to a broader constituency. They were seen as a ‘tool’ or ‘strategy’ for achieving inter-personal goals, as an expression of ‘rebellion’ and a statement of autonomy from a family with whom a person may have a difficult relationship.

7.4.3 *‘Mixed’ relationships as problem relationships?*

The dominant theme within the data was of the potential for problems within mixed relationships. Accounts of these problems can be organised around a distinction between ‘internal’ and ‘external’ variables. Internally, ‘mixed’ relationships were associated with imputed higher levels of cultural dissonance around issues of gender identity and relations, sexual morality and sexual praxis. Ethno-cultural differences could raise significant

difficulties in the ways in which partners related, particularly in the form of conflicts around communication techniques. “I think they definitely have different dynamics. I think the first one is language. In terms of communication styles, for a start, that can be very difficult” [41]. Difficulties arising out of ethno-culturally different expectations warrant better communication skills. Commenting on a client couple, one therapist stated that:

40: ...for me the communication skills for them, to stay together, had to be far superior and on a higher level to somebody who may have been from the same culture in order just to get on. Because very often a behaviour, the way of saying something, an assumption, made by one party would seriously undermine the relationship

For the respondents, it was not that there weren't problems of this form in all relationships, it was that ethnic forms of cultural dissonance added an extra degree and depth to these common difficulties. Of particular significance for the respondents was the role played by religiously-informed differences in gender and sexual mores. A notable example of this ethno-culturally conceived dissonance regarded the difficulties experienced by white women in dealing with the promiscuity of their Afro-Caribbean partners, who were accounted for as culturally committed to an ethic of phallic performance. These internal, culturally grounded conflicts were seen in themselves as problematic by most therapists, and as producing 'awful problems'.

42: The more the differences are, the more complex the mix can become. That doesn't mean that it's automatically either positive or problematic, it's what the individuals do with the mix, what other people round them do with the mix and how they get viewed and fit it and how that's managed by everyone involved.

Whilst cultural similarity may therefore cut down conflict within a relationship, some respondents felt that ethno-cultural difference may make a relationship stronger precisely because such relationships require a greater level of investment for them to work.

In terms of external factors, the principle problem anticipated by the respondents was concerned with the respective families of the partners. “The problems or the difficulties in the marriage are very often linked to their different parents...” [20]. In some cases this may be the only problem: “So they may have a really good working relationship but the rest of their

families are nagging away at them, ‘you shouldn’t be doing this or you shouldn’t be doing that’” [42]. Though it was generally assumed that opposition from families was a source of additional conflict, it was suggested that in some cases this opposition may provide the ‘glue’ that holds such relationships together.

28: ...two people come together from different groups and cling together in defiance, and when the defiance isn’t there, then the relationship falls apart. So it’s almost as if they’ve made their statement and while they’re making their statement, they can hang in there and fight the world... the glue goes

The power of families in relation to ‘mixed’ unions was seen to be far more significant than any opposition at the level of society. It was the sense of immediacy that the respondents associated with family and friendship networks that was deemed significant.

I would argue that the data supports the view that the limited significance attributed to the ‘role of society’ reflects the relative absence of a politically infused concepts of race, ethnicity and racism via which societal dynamics can be fully illuminated. A desire to detach relationships, and the individuals within them, from an account of the formative influence of ‘socially worked’ versions of racial and ethnic identities and boundaries (Knowles 1999) was prevalent. This said, such accounts were not entirely absent. It was clear that some therapists adopted a more sociologically and politically grounded approach, enabling a fuller engagement with the societal dynamics within which the relationship is embedded. There was evidence of a perception amongst these therapists that ‘mixed’ relationships were a threat to the established order of ethnic communities and boundaries. As one therapist states:

40:...based on a Bengali community, where a lot of people I work with are first generation...The idea of any of their children marrying out of the community group, inevitably means a breakdown of their family and exclusion, social exclusion of the people who are not marrying out, if you like...it probably does have quite a lot to do with safety...its about maintaining culture, history, its about passing down wealth, you know. Staying within the community, and that exists not just in first generation communities, because even in very liberal Jewish communities, there’s still the preference that you marry within so that it doesn’t water down the culture...I think there’s also the thought of

external threat, rules of appropriateness, that all link to ideas of shame, about not shaming the family, marrying in the right way

Underpinning the many dynamics alluded to here is a sense that if one is to understand the nature of mixed relationships within the UK today, it requires an account of the relationship's 'situatedness'.

7.4.4 *'There's 'mixed' and there's 'mixed''*

Not all 'mixed' relationships were seen as equivalent. Important distinctions could be drawn on a number of levels. 'One night stands' were less problematic because they promised the opportunity of a form of social invisibility. Degrees and type of racial and ethnic difference between the partners were also seen as a contributory factor, with ethno-cultural dissonances associated with gender relations and sexual values being most significant in this regard. The levels of acceptance and support from the partners' families were seen as particularly critical. This may be both idiosyncratic and patterned in nature, as some communities were seen as being less tolerant of 'mixed' relationships than others.

The racial and ethnic identities themselves were also seen as potentially important variables. For instance, one therapist suggested that it would be more socially acceptable for a white British man to have an 'oriental' female partner, rather than an Afro-Caribbean partner. "Well, it's still around. It was sort of more culturally accepted that he had a nice Chinese wife than him having a black woman" [13]. I would suggest that this greater acceptability reflects an enduring hierarchisation associated with the legacy of race, such that sexual and emotional relations between particular racial and ethnic groups are accorded differing degrees of social acceptability. Furthermore, that the racialised and ethnicised nature of gender discourses is such that the women from racial/ethnic groups have been constructed differently, and particularly with regard to sexuality. The attractiveness of 'oriental' wives for white men therefore lies in the way that such women are imagined by these men, as enabling a relationship of interpersonal and sexual inequity. An aspect of this is recognised by this respondent:

13: one which has been accepted for many years were white men who had nice Chinese wives under control, you know, submissive girls which were bought as wives but born abroad... and these were nice women who were submissive to their husbands needs.

7.4.5 *The price of 'mixed' relationships*

Whilst 'mixed' relationships were not presented in pathological terms by any therapists, and many were at pains to emphasise the potential of such unions to be successful even against the odds imposed by internal differences and external opposition, there was a sense that such relationships may carry a particular type of cost. This takes the form of universal rejection, where the relationship itself becomes effectively excluded from all communities. "I've heard people talk about how, you know, both sets of cultures have rejected them..." [28]. The centrality of white racism as a driver for hostility towards, and rejection of, mixed relationships, was displaced by a construction of minority groups as being 'just as bad', if not worse.

16: I saw one black girl who explained to me that she lost all ways round because she knew that most people thought she was black except that the proper black people knew she was a half-caste. She says they're [black people] more racist than any other group.

This does raise the important question, though not for the therapist, as to whether black hostility towards mixed relationships is a direct parallel of the views generated within a legacy of anti-black racism. For those without a political framework within which to understand the nature of such views within the black community as in part a mode of resistance and survival, they may well seem to be. The rendition provided above does seem to express a broader view found within the public realm that "...interracial marriages are fraught with problems and that mixed race children are crazy mixed-up kids who are rejected both by black AND white communities" (Wilson 1987, cited in Alhibhai-Brown and Montague 1992). Reflecting a broader discourse, mixed relationships were seen as having particular implications for children (see Frankenberg 1993), and more so where their mixture may be visible through their colour. One therapist offered an account of reproduction within 'mixed' relationships as involving a sort of lottery, and with potentially high stakes. "You never know, you never know what's going to come up do you? You never know if you suddenly have a child who looks very different and then you've got to help that child if he is different" [34].

There was a perception amongst some therapists that the 'price to be paid' was in fact the motivation for the relationship. The relationship becomes a means for rebelling or establishing autonomy, particularly for those who have "difficulty separating from their

families...[or]...who want to make a statement about their own identity as separate from their families” [28].

As I argued in the previous chapter, emotional and sexual inter-personal relationships across the boundaries of race and ethnicity have, and continue to be, highly significant for their capacity to bring into question racial and ethnic boundaries, and their associated ontological underpinnings. They serve as an acid test for the limits of social tolerance for principles of diversity and hybridity, pathologised and defended in unequal measure. The predicament faced by contemporary sex therapists here is that of considering the (social) ‘perversity’ of ‘mixed’ relationships from a vantage point in which the hierarchical logic of the perversity principle has been formally and rhetorically displaced by a professionally valorised ethic of diversity. But the diversity principle does not in itself erase the ontology of difference upon which race and ethnicity are grounded. In fact it can offer an additional authorisation.

Accounts of ‘mixed’ relationships within the interviews were deeply ambivalent, oscillating within and across accounts, between a desire to collapse all forms of mixture to a level of equivalence, and a sense that racial/ethnic differences do in fact constitute forms of mixture beyond that of a ‘normal’ relationship. In the former case, two particular discourses were important: a (humanistically-informed) liberal individualism that serves to disengage and atomise the subject (and in this context the relationship) as sovereign because ‘extra-social’, and a particular form of gender-orientated analysis that operates in such a way as to displace the causal significance of variables other than gender. But in most cases, and with varying degrees of consistency, the ‘special-case’ that is a ‘mixed-race’ or ‘mixed-ethnicity’ relationship prevailed, expressing the enduring authority of racialised/ethnicised forms of consciousness via a sense of wholeness and cultural homogeneity from which the ‘mixed’ relationship marked a deviation (see Donovan 2003, Frankenberg 1993).

7.5 Sexual Praxis

Within the interview data, substantial and authoritative accounts of the relationship between race, ethnicity and sexual praxis were surprisingly limited. Whilst the ontology of racial and ethnic difference permeated the data as a whole, and authorised a degree of general certitude in the validity of racial and ethnic labels as marking matters of real difference, this was not reflected in an accessible and substantiating body of evidence for the therapists. This

is particularly significant as the bulk of the therapists felt convinced that the differences attributed to race and ethnicity were of such importance and inherence that they warranted particular and different forms of provision in sex therapy practice. In this sense, a gap appeared to exist between a ‘special provisions for special needs’ reading of sex therapy practice in a context of racialised and ethnicised diversity, and therapists’ awareness levels of the actual evidence warranting such a stance. This could be accounted for as an effect of the reification implicit within common-sense accounts of racialised and ethnicised difference. When such accounts are subjected to a need for substantiation, empirical support is commonly found wanting. In this regard, the interview data confirmed the findings of the textual analysis.

The accounts offered of the racial and ethnic geography of sexual praxis re-articulated themes documented in the sociological literature, as this literature has elaborated the forms taken by ‘western’ accounts of ‘non-western’ sexualities (see McClintock 1995, Frankenberg 1993, 1997, Pierterse 1990, Young 1996, Gilman 1992). African and Caribbean sexualities, where discussed, were typified in terms of elevated levels of sexual activity and expectations amongst both men and women. Elevated that is, in juxtaposition to western, and implicitly white, norms; as one therapist put it, as “OTT from the point of view of the average person that I am dealing with...” [4]. But also elevated in terms of what may realistically be expected of human sexual functioning according to a more ‘objective’ measure authorised by a scientific account of the ageing human organism. One client was reported as expecting to

4: be able to have four or five or six or seven partners with whom he can practice with equal enthusiasm...he’s Caribbean...and I thought well yeah...[respondent laughs]...I suppose in that case he may well feel dissatisfied with the level of achievement he has got.

But accounts of the sexualities of African and Caribbean men and women were qualified by a perception of their ethno-culturally informed commitment to a range of ‘who’ and ‘what’ restrictions in respect of sexual practices and identities. A group of East African women were reported as expressing a culturally grounded ‘horror’ at the idea of oral sex, and Afro-Caribbeans generally were described as evidencing a deep-seated rejection of homosexuality to the point that “you’re really out [excluded] if you’re not heterosexual” [41], even to the point of invisibility, as not being “seen to exist” [42]. Within Africa itself, where same-sex relations existed, these were seen as sexual behaviours, rather than as sexual identities:

...dealing with same sex attraction and behaviour is difficult for a lot of people in different cultures but in certain African countries...the whole concept of a gay identity is just unknown, it doesn't happen. Same sex behaviour can happen but the concept of an identity doesn't happen [42].

The influence of religion, and particularly a legacy of missionary Christianity was seen as important: "they have been the product of a lot of missionary work over the years and I think that has constrained some of the Afro-Caribbeans and their behaviour..." [4].

Accounts of the 'Asian' (used extensively within the data to refer to people of South Asian origin) community oscillated between renditions of a gender dimorphic, but otherwise apparently homogenous Asian sexual praxis, and more specific accounts distinguishing between Asian groups on the basis of generation, religion and country of origin. 'Normal' sexuality within the Asian community was accounted for principally in terms of its 'absences'. Of the greatest significance were the roles attributed to arranged marriage as disempowering to women (see Hall 2002) and to an ideological opposition to sex education and sexual awareness in imposing a broad based sexual ignorance and inexperience upon Asian men and women.

5: I think that has a lot to do with arranged marriages as well. There is no opportunity to practice, they have arranged marriages at say 14 or 15. They meet the woman, they certainly haven't bonked anywhere beforehand. There is this arranged marriage and she is the one and that is it....

Cultural rules associated with "no sex before marriage" [2] were seen to have a negative bearing upon development in respect of sexual ideas and practices, and to be particularly acute amongst Asians. Though there were some accounts of variables associated with generation, class and levels of westernisation, sexual ignorance appeared to be perceived as somewhat endemic within, and definitive of, the sexual praxis of Asians in Britain, as elsewhere. Asian sexuality then was accounted for primarily in terms of a hegemonic reproductive agenda, reducing sex down to its potential for fecundity, though in the manner that Muslims tended to be become representative of Asians generally it was not always clear where the boundaries were seen to lie. The influence of Islamophobic discourses within important social institutions such as the media, and their invigoration of a 'collective

memory' of Christian-Muslim dissonance around events such as the Rushdie Affair and the Gulf War, have had the effect of over-determining representations of Asians generally in terms of fundamentalist Islamism (Abbas 2001, see Halliday 1999)⁵. In respect of accounts of 'Asians', it certainly seemed as though an 'ethnicity *as* religion' model negated opportunities to appreciate the 'ethnicisation *of* religion' as a socially and politically grounded process of construction and attribution (see Raj 2000).

In a context of a discussion about Bangladeshi clients, one therapist stated that their sexuality was:

41: ...linked to the idea of having children, and the possibility of having children, so it's a different motivation...For a large proportion of those [Bangladeshi] clients it's not about quality of life, it's about other motivations that fit more within a Muslim family.

Reflecting popular renditions of 'Asian' women in Britain (Abbas 2001), a passive and disempowered Asian femininity were seen to both express and exacerbate this phenomenon. Accounts of a culturally-based hostility towards masturbatory modes of sexual outlet were commonplace, as were the centrality of ideas of sexual respectability for Asians in Britain.

The Jewish population were discussed principally in juxtaposition to the British, though the Jews referred to in the interviews in fact seemed to be British. In this sense, we see an example of the ambivalence that still surrounds the meaning of Britishness in a context where racial and ethnic criteria inform notions of citizenship and nation (Cohen 1994). Accounts of the Jews were contradictory. At one point they were accounted for as having a greater concern with sexual pleasure than the 'British as Christians', and particularly with respect to women. But they were also accounted for in terms of their sexual conservatism and traditionalism. A particularly strong orientation to a reproductive, heterosexual and marital monogamy was offered as definitive of Jews, and particularly older Jews. Homosexuality was seen to be the subject of a powerful cultural prohibition, the hegemony of this rule being proved by the exception: "interestingly, there is a newspaper called the Jewish Chronicle,

⁵ Accounts of Asian Muslims in Britain as characterised by their oppressive gender relations have their academic presence also. See Macey (1999) for an account of Pakistani Muslim male violence redolent with the themes characterising Islamophobic accounts

comes out every Friday surprise surprise. And two weeks ago there was a tiny tiny little advertisement for gays and lesbians, but it was minute. I haven't seen one before" [5].

Accounts of Britain and the British (as white, Christian, and as repositories of western culture) were notable for their shifting and indeterminate quality. On the one hand, as described in Chapter 4, the data pertaining to the general accounts of sexuality within the British context highlighted themes of openness, freedom, increased expectations and enhanced investments in the quality and quantity of sexual experiences. However, within contexts where ideas about Britishness were invoked, rather than simply accounts of contemporary Britain, a different quality emerges within the data. The British emerge as an ethno-cultural national constituency, imbued with qualities that were somewhat at odds with the rendition of contemporary Britain itself. The active legacy of Christianity was seen as influencing our cultural attitudes, and "tying us in a knot" [34] regarding our sexual values and practices. Victorian values of sexual conservatism and emotional control/restraint were seen as prevailing, serving to circumscribe sexual praxis within particular limits.

2: I still see Britain as being very much influenced by Victorian values which actually conflict, which impact upon liberalism. There is some sort of discrepancy between a liberal country and promoting individuality and freedom and also sometimes rigid values on sexuality, sort of conflicting.

This sense of rigidity, of a culturally imposed set of restrictions upon legitimate modes of sexuality, was expressed by others, though at times identified as a definitive feature of western Europe as a whole. "We have a society that basically has problems with women and sex, has problems talking about sex, has problems with men and feelings, has problems with homophobia, but that's true of a large part of Western Europe" [42]. Attitudes towards same-sex practice were seen as becoming progressively more tolerant, and generally, accounts of gay men and lesbians were redolent with notions of freedom, expression and sexual positivity. "It's the gay community that leads fashion design and displaying the body and what to do with the body and the heterosexual couple are falling behind, very uncertain about how to express embodied being in a sexual way" [25]. The road to sexual enlightenment in relation to masturbation was seen as less well travelled. Whilst Britain and the West are the implicit counterpoints to sex therapists' accounts of the issues Asians have with the question of masturbation, the British were themselves considered to experience issues of guilt and shame with respect to masturbation.

The shifting nature of Britishness and more generally of westernness supports the view that first and foremost these are constructs without inherent meaning in and of themselves, but rather are constructed via the qualities projected onto them in the service of particular agendas (Brah 1996). Britishness and westernness can shift readily from accounts of liberalism to conservatism in respect of sexual values and practices, and in large part determined by that to which they are juxtaposed. In the context of accounts of Africans and Caribbeans, renditions of the British were notable for their reference to inhibitions and restrictions. In the context of accounts of 'Asians', the British were notable for their sexual liberalism.

7.6 Sexual problems

As with the data relating to sexual praxis, the substantive knowledge alluded to by the therapists in support of their renditions of the relationship between race, ethnicity and sexual problems was more limited than expected (and far more limited than within the journal). Particularly notable was the relative absence of data concerning the sexual problems experienced by African and Afro-Caribbean constituencies. There were few accounts of black men experiencing sexual problems in respect of relationships, identities or practices. Though some therapists perceived black men as more promiscuous, and saw this as producing problems for the women in their lives, the only problematic specifically referring to black men was with regard to the anxieties that may result from high performance expectations. "It is the myth that perhaps they buy into" [1]. No therapists felt able to specify any particular sexual problems experienced by this group beyond the sense of entrapment that may be felt by some black men in respect of maintaining their myth of sexual prowess. Paraphrasing one of their black clients, one therapist stated, "I'm caught in my own myth, that all black people are good at sex, they all bonk all the time, none of them have a problem" [1]. For this therapist the mythical nature of such racist legacies is clear. But the relative absence of references to sexual problems within this group, taken in a context where black men have been described within the data in terms of being 'in their bodies' and as sexually promiscuous and expectant, may in fact express this legacy. In other words, black men are granted a sexual health as an expression of this legacy of naturalistic racialised thinking.

The nearest thing to unanimity within the whole data set was the certainty with which the respondents specified the problems of premature ejaculation and highly dysfunctional masturbation anxieties amongst Asian men, and reduced libido amongst women. Regarding Asian men, masturbation was seen to be culturally 'forbidden', yet enacted as an expression

of natural sexual needs, but with consequent problems for self-esteem and related experiences of anxiety. “The classic one is the Muslim young man who may have a terrific issue about masturbation” [13]. The use of the word ‘classic’ in this context is apposite as masturbation anxiety and premature ejaculation have become motifs for Asian sexuality within the sex therapy literature. Masturbation practice and premature ejaculation were suggested as causally connected. “In those particular groups [Asians] it appears that having almost no information about function, sexual functioning, getting into masturbatory habits that are about just getting to orgasm really quickly, feeling very ashamed of that” [28], may produce problems of PE, particularly in the absence of sexual health information:

28: Ejaculating before you get anywhere near somebody...not having any information and having this group very, very worried, very wound up, very out of touch with what’s actually happening in terms of the body, so unable really to kind of be aware of their arousal, because they’re so outward looking.

These sexual problems were accounted for primarily in terms of the formative power of the ethno-cultural elements of Asian belief-systems, and were presented as rooted in a deep history. In the life history of Asian boys, the problems would seem to start early. “Well, first of all, they don’t learn masturbation so they never really touch themselves, it’s all suppressed so any sexuality comes out and it’s all very quick and fast” [19]. The lack of opportunities to ‘learn’ masturbation is presented as an outcome of a general shame pertaining to masturbation, and a consequent fear of discovery. In the context of accounting for the heightened level of masturbation anxieties amongst Asian males, this would seem to imply that non-Asian males get opportunities to learn about masturbation and do not feel any sense of shame, or experience any fear of discovery. This shame is likely to be experienced within a very isolated setting, as within the Asian population, “sexual expression is actually banned or prohibited before marriage” [2]. For those therapists who could specify the particularities of the Asian ethno-cultural legacy underpinning such anxieties, the role of Ayurvedic medicine was specified. The Ayurvedic tradition was associated with the representation of semen as the life force of male physiology, and as a practically scarce and finite resource. But in most cases, the specific cultural origin of such anxieties were only vaguely substantiated. A complex of learnt sexual behaviour, psychological anxiety, and underpinning belief system were understood as producing problems of premature ejaculation in heterosexual relations, where reproductive capacity was highly valorised.

Substantial elaboration around the ‘culture-bound’ disorders of ‘koro’ and ‘dhat’ was quite rare. I would describe their role as something of an absent-presence within the discourses generated by the therapists. As we saw in Chapter 6, the function of these conditions within the textual literature is to serve as the precarious empirical props for a broader theoretical and conceptual agenda. I would suggest that within the constituency of practicing sex therapists they operate primarily as vaguely conceived, but academically and professionally authorised, points of reference via which a racialised/ethnicised ontology of sexual difference is validated. I would suggest that the tendency, in respect of minorities, for ‘ethnic’ health research to focus upon relative risk from specific diseases, rather than exploring the absolute burden associated with general health patterns (Smaje 1995), has contributed to a common-sense assumption of ethnically differentiated disease geographies.

Gender was seen as an influential variable in the aetiology of premature ejaculation. Though not without reference to heterogeneity within the Asian population, the data were indicative a broad perception that Asian men experienced problematic relationships with their wives, and with women generally. One dimension of this was the notion that premature ejaculation was a product of Asian male fear of, and anger towards women. Fear derived from the association between sex with women, and semen loss, generating a corresponding anxiety about a female theft of the male life force. Anger derived from the power of, and domination by, women:

9: ...it's sort of anger against women, somehow. I think that was one of the theories. If you have a dominant woman, it sort of somehow defiles her by coming quickly... And sometimes the women of the couples I've seen, the woman's not interested at all, so she wants him to get it over and done with as quickly as possible so that's not going to promote a more enjoyable sex life for both of them... I do think that's a religious and cultural...cause of all the problems.

Here we see that the limited sexual libido attributed to Asian women colludes with the sexual issues of the Asian male to consolidate a climate in which premature ejaculation is the outcome. The signs of their symptoms were for one therapist etched into their appearance and manner. “...they tend to be thin, sweaty palms, highly anxious, very nervous, very highly successful, very frightened of failure...[28].

The British were far less voluntarily and easily detailed in respect of their sexual problems. Again reflecting the legacy of white western identity as normative yet unspecified, therapists seemed to have difficulty saying much about the nature of the sexual problems they experienced (see Ahmad 1992). Their sexuality generally being defined negatively in terms of what it was not: “it’s very rare to have a white man come in and say, “My penis is shrinking.” or “I think I’m losing my seed away” [13]. One therapist specified premature ejaculation as a characteristic of young white British men, but there were few other such references. Another therapist suggested that masturbation anxieties were a part of the British tradition and still produced dysfunctional outcomes today. More prevalent was the claim that British heterosexual men and women, but particularly men, experienced difficulties relating to partners because of the communication problems produced by being achievement and career orientated. A ‘head-focus’ left the emotional dimensions of sexual relationships under-developed and productive of barriers to intimacy.

The representation of Britain as a context of sexual freedom, where sexual choice has been enabled to the point that subjects can realise their sexual needs exercises a powerful purchase over sex therapists constructs. This permissiveness within the British context was seen as being productive of an improved sexual health, for those willing and able to utilise its opportunities for exploration and expression.

2: The more restrictive those values regarding sexual expression the more that it would predispose people to become dysfunctional sexually. So I can see a very strong relation between very strict rules about for instance the prohibition of sexual expression and development of anxiety subsequently... So a society which tends to be permissive or which tends to have far less strict rules about sexuality seems to me to be a much more healthy system because it doesn’t seem to promote as much anxiety and therefore sexual difficulties...

Implicitly, it was the white British population who were assumed to have both the will and the ability to exploit this potential for sexual health.

7.7 Conclusion

The interview data was replete with the contradictions, inconsistencies and tensions produced by the location of sex therapy at the confluence of a multitude of competing discourses regarding the nature of the sexual and social subject. Individualistic approaches of a variety of forms compete with naturalistic and sociological accounts to produce a cacophony of renditions. The overwhelming majority of the sex therapists seemed to feel most comfortable operating within a perceptual landscape delimited by the boundaries of the individuals or relationships with whom they worked. But the deformations to this landscape produced by the power of forces lying beyond the individual/relationship was something that most therapists were not in a position to deny. Of these deformations, gender was the most readily and willingly acknowledged. In contrast to the journal data, the conceptual prioritisation of gender as a, and in many cases *the* primary axis of differentiation, was evident. The nature of gender relations were granted a somewhat universal character, with profound differences of degree acknowledged along lines of race/ethnicity. But the will to racialise/ethnicise social and interpersonal relations prevailed, variably intruding upon the relative safety offered by discussions of sexuality and gender. As with the journal, ethnicity replaced race as the dominant conceptual term, though not to the same degree. Direct reference to race was more evident, as was a greater presence of a naturalistic ontology underpinning some accounts, most notably in the notion that racial/ethnic groups may enjoy different forms/levels of embodiment. But ethnicity, implicitly and explicitly conceptualised as constituted by a historically-enduring ‘cultural field’ (productive of powerful cognitive, affective and behavioural attachments) became the primary reference point for the accounts of sexual praxis and problems. Unlike the journal data, the ‘mixed relationship’ became an important vehicle through which to articulate ideas about the connections between race, ethnicity and sexuality within the context of relationships. The therapists struggled here with their variable (and contradictory) impulses. A commitment to a therapeutic discourse within which the individual and relationship are understood as sovereign, and as dancing (more or less exclusively) to the tune of dynamics internal to the self/relationship informed a desire to view mixed relationships as ‘just like any other’. But the centralisation and problematisation of such relationships within racialised/ethnicised social orders such as the UK is not easily negated. The therapists’ accounts gave voice to ‘socially-worked’ racialised/ethnicised renditions of mixed relationships as embodying difficult, and problematic modes of mixture. The sense that in race/ethnicity we are dealing with modes of difference of such inherence and degree that personal and social inter-relations are rendered difficult and productive of conflicts and tensions, prevailed.

Perhaps the most striking feature of the data though was the relatively limited presence of substantive information pertaining to the sexual praxis and problems experienced by racial/ethnic groups. Striking in the sense that the edifice that is the presence of a racial/ethnicity ontology within sex therapy, would appear in this context to be based upon a rather limited foundation. This would seem to suggest that the will to racialise/ethnicise is not an organic product of a substantial empirical base of evidence and experience. But rather that where the will exists, a narrow, indeterminate and fragmentary empirical base may be all that is necessary to sustain and nurture it.

A universal gender dimorphism was assumed to characterise the relationships between men and women as a whole, but with the degree of polarity significantly determined by race/ethnicity. Gender inequity was taken as a defining characteristic of black and ethnic minorities within the UK as a manifestation of deep ethno-cultural orientation towards the oppression of women, though with differing forms and effects depending upon the group in question. South Asians were accounted for primarily in terms of a sexual praxis over-determined by the imperative of reproduction. A sexual passivity was attributed to South Asian women, just as a heavy responsibility was seen to fall on Asian men as guarantors of progeny. A range of sexual and relationship problems were seen to flow from this, in the form of low sexual libido amongst women and premature ejaculation and masturbation anxieties on the part of men. In the case of African and Caribbean men and women, a sexual expectancy was implied, which for both men and women, translated into elevated expectations of sexual satisfaction and pleasure. Besides the recognition that the persona of sexual prowess may be a burden for black men, a general sexual health appeared to be attributed to the black heterosexual population. The sexual health of these respective racial/ethnic 'others' was understood primarily as an organic expression of their ethno-culturally determined orientations towards sexuality. This conceptual foregrounding of the causal significance of 'ethnicity as identity' in determining sexuality and sexual dysfunction stands in contrast to research that has suggested that ethnic inequalities in health may be better explained in terms of 'ethnicity as structure', namely in terms of processes of racialisation and class experience (see Karlsen and Nazroo 2002).

In stark contrast was the absence of any equivalence in accounts of the 'British' as an ethno-cultural constituency with concomitantly distinctive orientations towards sexuality, and consequent vulnerabilities to particular sexual problems. This seemed supportive of the fundamental claim that despite their central role in the racialisation and ethnicisation and

'others', the British themselves have somehow stood out-with the boundaries of racial/ethnic particularity an a zone of substanceless universality, as 'subjects without properties' (Dyer 1997).

In respect of what this data tells us about sex therapists' accounts of human sexuality, the stress placed upon ethnic diversity in sexual patterns may seem indicative of a social constructionist position. Social constructionism (particularly of the form taken within classical social anthropology) would seem to have had some influence within the sex therapy constituency in terms of enabling recognitions of the capacity for culture to impact on sexual forms. But I would suggest that the data as a whole indicates a more limited commitment to the constructionist position. Though a principle of relativity is evident, the data still seem underpinned by a rendition of sexuality as encoding a set of truths, made visible by science, and distorted and fettered by the influence of ethno-cultural myths, in relation to which ethnic others are particularly encumbered.

Having established the principle contours of sex therapists' accounts of the relationship between race, ethnicity, sexuality and sexual problems, I will now turn to addressing the key question raised by this. Namely, how do therapists map these contours onto their understandings of the therapeutic moment itself? What are the implications of racial and ethnic difference for sex therapy praxis?

Part C

‘Managing Difference’

Chapter 8 – ‘Managing Difference’: Competing frameworks

The ‘diversity agenda’, in one form or another, has swept through the health-therapeutic field. Political, professional and socio-cultural influences have enlivened both the sense that ‘difference’ constitutes our principle ‘problem’ in the contemporary world, and its ‘management’ our most pressing imperative¹. Racial and ethnic difference continues to stand as the definitive case of both the problem, and its potential management solution. Sex therapy must be understood within this context. Sex therapists, by virtue of their location, are posed with many of the same questions as others within the health-therapeutic field. Most pertinent in this context, how might sex therapy best manage the challenges posed by racial and ethnic difference? Of course, this question cannot be separated from the primary question of how these differences are perceived in the first place: “...the pervasiveness of racist myths and stereotypes in service provision [can] serve to disadvantage minority ethnic populations” (Atkin 2003: p.91).

We have seen that the sex therapists’ accounts of the relationship between race/ethnicity, sexuality and sexual dysfunction are marked by ambiguity and tension as a direct manifestation of the influence of a number of competing conceptual orientations pertaining to the nature of the (gendered) racial/ethnic sexual subject. The most immediately evident of these orientations, and unsurprisingly given its authorisation within a host of contemporary health-therapeutic discourses, is a mode of philosophical, methodological and therapeutic individualism. Beyond the universal qualities typically granted to the self/relationship within such a framework, lie a set of ‘idiosyncratic’ differences expressing the uniqueness of the individual/relationship’s lived psychic experience. Therapeutically, the question of how to ‘manage difference’ tends to be displaced, as it either becomes negated via the emphasis upon universality, or rendered obsolete by the infinity (and hence normality) of difference implied by individualism.

But the purchase held by a host of gendered, racialised and ethnicised frameworks is substantial within sex therapy, implicitly and explicitly authorising accounts of deep and enduring contours of racial/ethnic difference. Within the collective field produced by these

¹ The Government's Modernisation Agenda for Health and Social Services, in conjunction with the drivers provided by the Amendment to the Race Relations Act, the Disability Discrimination Act, and the Human Rights Act have provided a context in which the question of diversity has been foregrounded. As one example of a strategic, institutional response to this, the ‘Positively *Diverse* Network’ has been established as a “...key NHS initiative designed to support NHS Trusts and Health Authorities in valuing and managing diversity in the workforce” (<http://www.info.doh.gov.uk/doh>). It seeks to “provide practical guidance on how to address the diverse needs of the

frameworks lies a host of competing and often contradictory renditions. Pseudo-biological racism, multi-culturalism and anti-racism have arguably offered the principle points of coalescence, around which the nature of racial/ethnic difference has been constructed, and its management implications elucidated. It is to an exploration of these frameworks, as they inform sex therapists' accounts of therapeutic praxis within both the journal and interview data, that we will now turn.

8.1 Colour blindness in Practice

The ontological and epistemological underpinnings of liberal individualism have produced, within social contexts marked by the contours of racial/ethnic diversity, a response/strategy commonly known as 'colour-blindness'. This embodies a way of 'not seeing' race and ethnicity via the determined employment of a philosophical and methodological individualism (Frankenberg 1993)². The central premise of 'colour-blindness', as it has frequently been applied within health care settings, is that the effects of both systematic and structured inequalities, and oppressive discursive regimes, can be negated through their perceptual denial within the therapeutic encounter. Expressing a liberal humanist epistemology, it proposes to cut straight to the selfhood that is seen to lie beyond the extraneous differences asserted in the name of race and ethnicity, and other axes of differentiation. It is premised upon the liberal conviction that "...the universalism of individual rights is the best response to the possibility of discrimination which is inherent in the classification of people on a cultural basis – usually to some extent naturalised by reference to race" (Wieviorka 1998: p.894).

'Colour-blindness' has been particularly influential within caring and therapeutic contexts as the philosophical individualism upon which it typically rests similarly underpins the discursive repertoires that legitimise individualised, client-centred models of care. The commitment to a form of *a-politicism* within health professions also reinforces the colour-blind approach. Though "...political action and literacy...should not be thought to be the pollution of an otherwise pure discipline" (Seedhouse 1986: p. 92), within health and professional arenas, it remains commonly viewed as such.

local community by ensuring that the workforce understands, supports and reflects those needs" (<http://www.doh.gov.uk/positivelydiverse/faqs.htm>).

² Colour blindness has been adopted in some health care contexts as a strategy for eliminating the collectivist basis of discrimination (see Johnson 2001), but more historically has served as the basis of a negation of the particularities of need experienced by black subjects (Gerrish et al 1996).

Colour-blindness has been the subject of extensive critique, most significantly for its denial of, and therefore collusion in, inequitable power relations, and for its failure to acknowledge the racialised and ethnicised assumptions encoded in its allegedly universalistic claims. In this sense, colour-blindness has properly been criticised for the manner in which it enables implicit dynamics of race and ethnicity to operate as an ‘absent-presence’, formally and rhetorically absent, yet substantially present (see Williams 1996). It is for this reason that Frankenberg (1993) prefers to describe such orientations as ‘power-evasive’ rather than colour-blind.

The journal data, taken collectively, stand implicitly, and at times explicitly, opposed to the ‘colour-blindness’ agenda. In fact, the primary motif of this literature was of the systematic differences associated with race and ethnicity. However, and this is a central limitation of the research design, the papers sampled within the journal were selected principally because of their conceptual prioritisation of issues associated with race/ethnicity/culture. Little can be said about the remaining papers except that the authors of the articles sampled set up their claims for the importance of recognising the differences associated with race and ethnicity *against* a context of their more typical negation within the theoretical and therapeutic frameworks operant within sex therapy, and other branches of the health-therapeutic field.

Within the interviews, only a minority of therapists articulated an explicit ‘colour-blind’ approach. Where colour blindness was extolled, a commitment to a form of humanistic individualism was explicit. As one therapist put it, “I am not very good at seeing things as a sort of, you know, total, a total part of the population...people are all individuals and I just see individuals...” [3].

With regards to ‘blackness’, the same therapist states:

3: I am not sort of looking at a black face, I am looking at a person. I think to be aware of culturally what happens in...like the example of anal intercourse which is commonly used as a birth control method in some communities...to be aware, to know that those things are there. That’s a person, not a black face or body...

A recognition of blackness as a symbol of race, and a simultaneous negation of its significance, is evident here, and typical of colour-blind (or colour-evasive) orientations. The therapist wishes to circumvent whatever importance might normally be attributed to colour, and get to the essential individual subjectivity that lies beyond and beneath.

Colour is formally presented as being meaningless, and as unreliable as a marker of any significance. "A black skin is a matter of degree. You and I are very white, it shades away" [19]. The therapist here utilises the valuable insight that a binary of white and black is empirically flawed, but as the basis of a denial that colour is socially and politically significant. This conflation of 'ought' and 'is' characterises the colour-blind approach. By asserting that colour ought to be an essentially meaningless and unreliable marker of difference, the therapist seeks to deny the social fact that colour continues to operate as a highly meaningful marker of race, and of ethnicity. The colour-blind approach, with its characteristic pre-occupation with denying collectivist, aggregative modes of thought (Frankenberg 1993), offers one means of resolving the conflict between the conceptual imperative of therapeutic practice to work with the individual uniqueness of each client, and the realities of a broader social context structured by relations of dominance and inequality. The conflict is resolved by negating the realities of the broader social climate, or by bracketing them off as entirely external to the problem of therapeutic work.

Colour-blindness has the appearance of a radical deconstructionist approach at times because of its apparent negation of many of the reified claims commonly made in the name of race and ethnicity.

19...do they [non-white ethnic minorities] do something the rest of us don't do, are they different from us, have they got different needs, feelings, desires and so on? Do they go through a different process? Of course they don't. What's different is the colour of their skin. If they're Arab, what's different is, well, they're a little darker, but their cultural environment, they've got a different family situation, but it's not so different from our own

It also finds support from a post-modernist style reading of racial and ethnic identities as fragmenting under the agency of social subjects creating new ways of being, and new and

multitudinous modes of identification and attachment³. Within such a framework, the complexities of increasingly hybrid identities are seen to be producing new mappings of difference within society as a whole in such a way that the perceptual dichotomies associated with traditional racial and ethnic categories are losing their salience.

The following passage, extracted from a therapist who was consistent in their wish to negate the significance of systematic differences associated with race and ethnicity, offers us some insight into the motivation for this negation of difference.

19: I would add also that culture at this level is a cop-out. I think it's a cop out. I think cultural issues in a relationship at that level are also a cop-out...The danger comes in if you have a therapist who believes that culture is a major issue and a couple who believe that culture is a major issue, I think together they might not get very far...it enables him to avoid the real issue.....and this happens a lot in mixed marriages...[Culture] has nothing to do with sex.

It is the professional-doctrinal imperative of conceptualising clients as sovereign subjects, governed by the psychological/inter-personal dynamics operating within a non-social boundary, that here rewards a discourse of colour blindness. Social reality is made to fit therapeutic ideology in order that 'the problem' can be relocated to a realm within which the therapist feels able to work; what the therapist describes as the 'real issue'. The real issues lie beneath and beyond the chimera of race/ethnicity. For those therapists who extol the virtues of a colour-blind approach, in formulating approaches that concern themselves with the dynamics of race/ethnicity, the exponents of both ethno-cultural recognition and of a politics of race, propose an inappropriate strategy that serves to foreground dubious expressions of difference lying beyond the 'real' issues. Strategies and regimens need concern themselves then, only with the 'real' and immediate issues of a bounded intra and interpersonal realm. In turn these issues can best be addressed through the application a generic therapeutic arsenal, modified in each case in the service of that which is unique and idiosyncratic.

A commitment to colour-blindness may be a product of a genuine inability to see the racialised/ethnicised nature of social life, and the contortions this introduces to the conceptual lenses through which we make sense of the world. Though there is good reason to acknowledge

³ This would not be surprising if Turner (1994) is right in suggesting that post-modernism may well prove to be little more than a contemporary and radical variant of a much longer standing tradition of liberal thought.

that people may not be entirely cognizant of the racialised/ethnicised nature of their own gaze, it is highly unlikely though that social subjects could achieve such a state of social ignorance in a context where the racialisation and ethnicisation of social subjects has been so profound.

There is perhaps another dimension to this utilisation of a colour-blind approach as a negation of the social realities of power. Namely, as a defence against the claims made by minority groups upon public and professional services. This seems to be the case here: “They [the representatives of black minority interests] go into overkill and big issues are made out of someone because he is black” [19]. There seems to be a *seuil de tolerance* operating here regarding the claims made by black citizens, and an insinuation that black people derive an illegitimate access to resources on the basis of a ‘special status’ (see Silverman 1991). This theme seems to be evident in the comment of another therapist; “these groups [ethnic minority representatives] derive much from special pleading, they have an excessive influence in my opinion” [16]. The colour blind approach may then be seen as a strategy for managing the dissonance produced by the acknowledgement of difference, where inequalities of power are involved. Colour-blindness resolves this dissonance by negating the difference at the very moment that it is acknowledged. It may also provide a politically legitimate, functional alternative to open resistance to minority demands for a more equitable distribution of resources. This a-political ‘refusal of power’ has been foundational to the orientations of professional-therapeutic constituencies throughout the health care sector, and justified as the basis for providing equitable care.

Most respondents though, expressed a more or less explicit opposition to colour-blindness as part of a multi-culturalist approach through which critiques of colour-blindness have been well rehearsed.

28: I know one therapist who used to say ‘As far as I am concerned I’m colour- blind’, and everybody was completely shocked. She said. ‘I don’t care’. We all kind of argued with her a lot because we were saying it must make a difference to how you see them, it must make a difference to how they see you. You can’t ignore it, you have to acknowledge it, you have to kind of see through the fact that there’s this difference between you, that actually has made a huge difference to both of you in your lives.

The therapist critiques colour-blindness as an unfeasible strategy, ill-suited to understanding the manner in which racial and ethnic difference impact upon the lives of social subjects. Another therapist referred to such a strategy as a form of ‘pretence’ that leads to a situation where the therapeutic relationship is “working in the dark” [34]. “... You can’t not acknowledge its presence in the room and what it does when it gets out there” [13]. This said, there was a sense in which the individualistic orientations of most therapists created tensions with the collectivist underpinnings of their multiculturalism such that even those who bought into the critique of colour-blindness found themselves expressing implicit versions of its logic at points of the interview.

8.2 Multiculturalism in Practice

Within the British context, the primary source of resistance to the liberal individualism of the colour-blind approach has come from multiculturalism. Multiculturalism refers to “...an endeavour to conciliate the demands of cultural specificity and that of universalism in areas of language, religion and education, or access to public services, employment and housing” (Wieviorka 1998: p.895). I would suggest that the purchase achieved by multiculturalism within professional contexts is accountable in part by the fact that in some of its guises it reproduces a ‘common-sense’, and therefore deeply familiar, reading of Britain’s racial/ethnic geography. For those unconvinced by the individualistic assumptions underpinning colour-blindness, multiculturalism therefore offers a politically valorised location within which accounts of the racial/ethnic subject, and of the social world generally, echo with an ‘innate’ familiarity.

Multiculturalism, as it has developed within Britain, has predominantly been concerned with the empowerment of ethnic minority groups, understood as contemporary depositories of a re-producing ethno-cultural legacy. This empowerment has been seen to depend upon the opportunity given to ethnic minority groups to articulate their ethno-cultural specificities as a means to raising awareness amongst the majority and achieving a generalised valorisation of their culture. Multiculturalism, in its sociological and political philosophical sense, has authorised a host of responses throughout a range of institutions, but particularly concerned with instilling a climate of ‘recognition’⁴. The ‘politics of recognition’ have exercised a significant influence within the health field, though not without tensions as

⁴ Multiculturalism that has also done much to reify and fix ethno-culture and the group boundaries assumed to be its organic product. Anti-racism has challenged multiculturalism’s pre-occupation with culture as a causal explanation for the lived experiences of minority and majority populations. Liberal and more recently post-

the recognition agenda becomes grafted onto incommensurate orientations towards universalism and individualism.

Despite a complete absence of any theoretical elaboration of its meaning within the journal data, the concept of multiculturalism served as a near universal point of reference within the papers. This absence of conceptual specification reflects the aforementioned similar treatment of race and ethnicity, and is in line with a broader tendency within health research to leave such concepts undefined and poorly operationalised (Bradby 2003). The influence of multiculturalism, in all of the three forms outlined by Wieworka (1998), enjoyed an unstable hegemony within both journal and interview. Multiculturalism in its ‘sociological sense’, as depicting a form of ethno-cultural pluralism whereby discrete and distinct cultural populations co-habit a common territorial/national space, was undoubtedly the primary rendition of the British context within the journal data. Multiculturalism in its ‘political philosophy sense’, as an ideological stance characterised by a commitment to cultural pluralism as constituting the ‘good society’, was also implicitly and explicitly influential. And finally, multiculturalism in its ‘political science sense’, as referring to particular forms of institutional structure and procedure designed to attend to the cultural diversity perceived to be present within the national space, was the (vague and indeterminate) end to which many the journal papers were put. Of course, this formulation offers only a broad template. Within and across these levels of multiculturalism there exists an enormous amount of ‘wiggle room’. Strong communitarian and liberal variants of multiculturalism offer poles between which quite distinct accounts of equality and culture may operate (see Kelly 2002a). For instance, it can be difficult (and was within both data sources) to determine the boundaries between a position informed by a pragmatic and moral concession to meeting the challenges presented by a diversity that ‘like it or not, is here to stay’, and a position that considers such diversity positively as constituting the ‘good society’.

8.2.1 Cultural relativism

One of the principle indicators within the journal papers of a broadly multiculturalist account (in its sociological sense), was in the rendition of sex therapy as itself located within a matrix of culturally relative constructions of health and illness, (including the diagnostic categories with which sex therapy strives to make sense of sexual health and dysfunction). Given the prior assumption that ethnicity, and ethnic group boundaries, are themselves the

organic products of particular and substantial cultural commonalities, then it follows for many of the commentators that ethnic minorities are marked by particular and specific concepts of (sexual) health and illness, reflected in distinct ideas about aetiology, diagnosis, prognosis and treatment (see Ng 1988 and Daines 1988). As such:

the direction of thinking and research for professionals, particularly for those in 'non-Western' cultures, should be towards an analysis of the ethnocultural realities underlying sexual attitudes, beliefs, norms, culture-specific meanings of sexual psychopathology and illness behaviour and culturally determined dynamics of patient-therapist relationship (Basoglu et al 1986: p. 188).

Within this reading, illnesses betray their cultural situatedness and commonly do not transfer from one ethno-cultural context to another. The culture-bound syndromes outlined in the previous chapters do not therefore connect with the diagnostic categories produced within a different, and western, cultural context. In other words, they don't fit. This rendition of dissonance as a feature of the relationship between 'non-western' notions of illness, and 'western' diagnostic categories exercised a significant influence within the data, though without substantial elaboration.

Other than in the case of dhat syndrome, and to a lesser extent koro, there were few accounts willing or able to substantiate the claim of a 'poor fit' between non-western sexual problems and western diagnostic categories. Generally, the "...incongruity between Western middle class ideals of sex therapy and the normative culture of traditional settings" (Basoglu et al 1986) was asserted but rarely elaborated in any detail. The most enduring sense of an absence of fit between non-western and western orientations towards health and treatment was in the claim that non-western cultures lacked a concept of a 'talking cure'. The psychotherapeutic dimensions of sex therapy therefore being rarely valorised by non-western populations (particularly South Asians and Africans) as an expression of their ethno-culture. I would suggest that this enduring sense of the 'otherness' of 'non-western' illnesses is informed by an underlying commitment to an ontology of racial/ethnic difference, and to the 'otherness' this attributes to 'non-western' populations.

But this apparent commitment to a principle of cultural relativism, to a notion of health as a cultural artefact, is quite literally only half the story, and even for some of those who appear to extol such a view. And here we see something of the limits to sex therapy's

commitment to a principle of multi-culturalism (and the principle of cultural relativism that, for many, it encodes). For instance, in the context of discussing the ethno-culturally bound nature of the ‘loss of semen syndromes’, De Silva and Dissanayake (1989) reflect on the obstacles standing in the path of effective intervention. Due to “the lack of formal sex education in schools, or any other institution...there is no mechanism for providing *correct* [my italics] information about sexual functioning and countering the Ayurvedic notions” (p. 203). The idea that there is a body of *correct* information pertaining to sexual functioning implies a status of falsehood regarding the Ayurvedic tradition to which such information stands in antithesis. It also indicates that the commentator’s commitment to a principle of cultural relativism is implicitly limited by a prevailing commitment to particular, scientific, renditions of the nature of (sexual) health, illness and treatment.

The problem of female circumcision, or female genital mutilation as it is now legally defined in the UK, is discussed in a number of papers. It stands as an acid test of the limits of a commitment to a communitarianist principle of cultural relativism. Female genital mutilation is generally addressed within the journal in a manner that circumscribes the principle of cultural relativism in favour of a more universalistically conceived notion of rights. Although authors are keen to emphasise the need for sensitivity (McCaffrey 1995), and argue for pragmatic moral positions from therapists when dealing with the issue of FGM (Pacey 1999), there is clear evidence that a moral position is adopted whereby FGM is considered to be a torturous manifestation of oppressive forms of male power (Whitehorn 2002 et al), and as essentially unethical. There are recognitions of the role of FGM as a right of passage granting enhanced status for women, of the psychological and social harm that may be done to women who are refused FGM following social exclusion from their community, and of the significance that FGM may have for Somali and Sudanese communities in Britain as a marker of identity within a culturally hostile climate. But these are presented as reasons for sensitivity and caution, rather than as a defence for FGM as a culturally valorised practice. The papers concerned with FGM ultimately conclude with a universalistic ethical premise based upon a liberal humanistic reading of individual rights, most pertinently the primacy of the right to be free from a harm inflicted upon the person by others.

8.2.2 Multiculturalism, ethnocentrism and their limits

What is being determined here in these difficult manoeuvrings is the ethical and political basis of sex therapy practice in a context of racial and ethnic diversity. In this

determination, a rendition of sex therapy as inherently ethnocentric/Eurocentric has been influential (see d'Ardenne 1986). Ethno/Euro-centrism has been the subject of extensive contestation and debate within professional and academic texts (see Robinson 1998), and these debates have informed the nature of the curricula upon which educational and training programmes have been grounded, and practice evaluated. Ethnocentrism as a concept has been concerned with accounting for the barriers to cultural empathy and sympathy produced by the ethnic situatedness of the social subject. More specifically with the inevitable perceptual and moral distortions produced by the cultural lenses through which we interpret a 'foreign' ethnic landscape. Within the health arena, ethnocentrism has occupied pride of place as the principle account of oppression, via its focus upon the disadvantageous effects of 'difference unrecognised'.

In a context where sex therapy in the UK is faced by the 'novel' realities of racial/ethnic diversity, and where western models of sex therapy have been exported to other parts of the world, these western therapies may be ill-suited to meeting the needs of clients with a non-western ethno-cultural heritage. Commentating on the UK context, d'Ardenne (1986) claims that "traditional health care practice may no longer be flexible enough for a generation born outside this country and now experiencing all the changes and the associated stresses of such an adjustment" (p. 23). "...Our present approach may be poorly adapted to the needs of those whose values are derived elsewhere" (p. 26). A further example of this position is found in the work of Basoglu et al (1986), who claims that "...short-term behavioural sex therapy based on... Western middle-class ideals [is unlikely] to effectively counteract an entire cultural heritage" (p. 187). In the context of traditional Turkish culture, the 'western' values of open sexual communication, awareness and acceptance of partner's sexuality, intimacy, trust and autonomy would be "incomprehensible and unacceptable to a patient whose values and norms regarding life, sexuality and marriage assume entirely different cultural meanings" (p. 187)⁵. A cultural clash can therefore be anticipated in the relationship between the western therapeutic agenda and 'non-western' populations (see Li

⁵ The certitude with which accounts of the cognitive, affective and behavioural power of ethno-cultural heritage over ethnic subjects were provided within the journal produces a perception of culture as over-determining all other attachments and identifications. We should however be cautious in accepting this over-determination principle. In contrast to Basoglu's reference to the power of Turkish ethno-culture as an overwhelmingly powerful source of attachment, Watson (2000) points out that what is perhaps most notable about the Turkish population in Germany "...is the apparent lack of commitment of the new immigrants to their own historical origins. Current institutional arrangements, as long as they safeguard economic opportunity and freedom of worship and provide scope for individual self-improvement, are deemed sufficient guarantees for the pursuit of the good life" (p.36). To the extent that this is the case it would seem to offer some support to the position offered by Barry (2001), which Kelly (2002) describes in the following terms; "the primacy attached to culture obscures the fact that what minority groups really want are the rights and resources enjoyed by those in positions of dominance and power, rather than the protection of cultural hierarchies that benefit those who enjoy the position of cultural entrepreneurs" (p. 13).

and Yan 1990). Emphasising the cultural situatedness of western couple therapy, Daines (1988) outlines a host of value premises upon which therapeutic work with couples is commonly, though often only implicitly, grounded:

-
- Sex is a good thing
 - Communicating is better than not communicating
 - Time should be taken over lovemaking
 - Lovemaking can be satisfactory without penetration
 - It is unrealistic to expect one area of the relationship (such as sex) to be good if the other areas are not (as defined by the therapist's values)
 - Household and child-centred tasks are not just a woman's responsibility
 - Work, money and decision-making are not just the province of the man
 - It is better to know than not to know
 - Education is a good thing
 - Sharing is good
 - Compromise is necessary
 - It is valuable to be aware of feelings
 - Relationships need to be worked at – they do not just happen
 - Homosexuality is acceptable
 - Scientific and research findings must be accepted as valid if not questionable within their own terms of reference
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(Daines 1988: p. 156-61)

Though Daines (1988) does not directly map these values to racial/ethnic boundaries, these value variables feature in many papers as the stuff of ethno-cultural difference. In the case of Hassidic Jews, Rockman's (1993, 1995) papers highlight the need for therapeutic approaches to be transformed in preference for a deference to the ethno-religious rules sanctioned by religious authorities⁶, and in accordance with an ethic of cultural relativism⁷:

⁶ One effect of political multiculturalism has been the enablement of elites within black and ethnic minority communities who have derived a degree of power and economic prosperity from their strategic role within the multicultural system (Wieviorka 1998). Back et al (2001) point to the role of 'community king makers' whose mobilising role within particular minority communities, and the 'conservative' nature sometimes taken by these mobilisations, is enabled by a form of institutional patronage. The dynamic envisaged within this passage between religious authorities and the institution of sex therapy is suggestive of just such a relationship. To this extent, political multiculturalism may institutionalise and so consolidate traditional and externally attributed differences which would otherwise be transformed and re-created in new and novel forms. The progressive elements of change and invention can become paralysed by an institutionally-imposed stasis.

⁷ The question of cultural relativism has been a thorny one within the ongoing manoeuvrings of liberalism and multiculturalism. In one sense, a commitment to cultural relativism is the logical end-point of liberalism as the

It is essential that any therapist counselling [Hassidic Jews] does not try to disrupt this [marital] balance by interjecting his or her own opinion...solutions need to be found within the framework of the Jewish law and, if need be, with the guidance of religious leaders (Rockman 1993: p. 267).

But how systematic and consistent is the application of this principle of the ethnocentric nature of sex therapy, and of the ethical imperative to concede to the (assumed) different cultural rules of the client? Well, not consistent in the slightest. A deep ambivalence pervades the commentators' accounts. This is clearly reflected in Pacey's (sociologically and politically informed) discussion of Female Genital Mutilation.

Concepts of sexual attractiveness and the perfect body are rooted in the social, political and economic context of a person's life. How the individual responds to that context is a facet of their uniqueness. When making ethical decisions about physical treatments, clinicians have a duty to elicit and consider the patients' own views and cultural perspectives, while doing their utmost to communicate the benefits and risks of treatment (Pacey 1999: p. 273).

On one level, the pragmatic ethical response for sex therapists, in working with women who have experienced female genital mutilation, lies in deferring to the will of the client, as this expresses the centrality of their ethno-cultural heritage. But it is clear also, in the final sentence, that the therapist reserves the right to determine *the* nature of the benefits and risks. Similarly for Whitehorn et al (2002), professionals have a responsibility to carefully dispel myths.

latter is premised upon a notion that as there are no transcendent criteria upon which to determine the superiority of one cultural choice over another, then the good society is one that leaves the determination of the good life to the cultural choices of subjects (see Watson 2000). But as Gellnor (1995) has pointed out, the paradox is that liberalism is premised upon the acceptance of the transcendent values of tolerance of difference, individual equality and autonomy. Where a culture contravenes these values, the liberal preference has been to not grant such cultures equality, producing practical limitations in liberal commitments to cultural relativism. Likewise, cultural relativism and cultural equality would seem to be the primary principles underpinning political multiculturalism, even at the expense of principles of individual liberty, as a communitarianist understanding of the social subject has informed multiculturalist views of the subject's dependency upon their cultural community for the realisation of personhood. But even here, multiculturalism is such a broad church that a multitude of formulations have been possible in the trading that takes place between principles of relativism and universalism (see Parekh 2002).

Daines (1988) expresses the duality that can exist within therapy, whereby sovereignty seems to be formally granted to the client, yet informally retrieved in favour of a rendition authorised by a more universalistically grounded set of truths. He describes the relationship between the therapist and client as follows:

We are going to help you work towards the kind of relationship *you* want [BUT

- i. you have to be prepared to accept what we think is realistic
- ii. we are going to convey pretty forcibly to you what we think makes for a good relationship
- iii. we are going to make it difficult for you to move in a direction that we think is unreasonable] (p. 153)

This seems to suggest that “when a gap exists between the attitudes and expectations of health care professionals and patients, there is a tendency to try to bridge this gap by inducing patients to conform to the view of the health care professionals” (Atkin 2003: p.100). Daines (1988) concludes with an affirmation of what seems to be a form of compromise position. “Certainly we must avoid the situation where one passively goes along with patients’ assumptions and values or one where we expect them to passively accept ours” (p. 163). In a later paper, this refusal to accept fully the principle of cultural relativism is reaffirmed. “In our experience, however, cultural factors can also be used as a smoke screen for difficulties which the couples have within their relationship, and respect for these factors should be tempered by common sense” (Ridley and Crowe 1992: p. 128). Of course ‘common sense’ routinely operates as a miscellaneous category into which value-orientations are encoded, whilst masquerading as consensual truths.

But this ‘compromise’ position is uncertain as it lacks any elaboration within the data. It may also in practice be a side-stepping of the problem, at least to the extent that it results in a reduced likelihood that sex therapy as an institution will confront its ambivalences and inconsistencies with regard to the tensions between relativistic and universalistic readings of the social subject, as these inform their thinking about racial/ethnic minority groups.

Though there may be opportunities for achieving some form of accommodation of the multiculturalist and liberal interpretations of social subjects (see Kelly 2002b), it is fair to say that in most social situations, apparently antithetical agendas are produced by multiculturalism and liberalism. Within a fully-fledged multiculturalist stance the social

subject tends to be understood in terms of a communitarianist ‘social thesis’, such that personhood is seen to be constituted only via an immersion within the realm of ‘the social’. One’s identity as a person is acquired through belonging to social groups, most importantly cultural groups. “A culture exists when a group of people share a distinctive conception about how life ought to be lived, and embody that conception in shared practices that they engage in” (Miller 2002: p. 49). Cultural communities also provide the subject with moral resources through which to live a ‘good life’, realise choices and enact circumscribed autonomy. Culture therefore endows particular activities with meaning and value, but directly and indirectly imposes constraints. Rights and opportunities are relative to, and dependant upon, shared cultural understandings or practices. As culture constitutes the person, the implication of disregarding or inferiorising the culture of another is that the person themselves are disregarded and inferiorised. As such, to value all equally requires a full acceptance, and even valorisation, of the substantial cultural characteristics of others. This involves acceptance of cultural practices that, by a strict liberal reading, may be contrary to the principle of individual autonomy and respect. Whilst the effect of the ethnicity concept has been to empower just such a social thesis (but typically *only* in respect of ethnic minorities), and though therapists appear to be willing to walk a reasonable distance with a relativistic logic of this type, they seem unwilling to complete the journey. The liberal humanistic foundations of sex therapy praxis are an article of faith that few commentators appear willing to forego, and with the result of an uneasy and un-theorised grafting together of practically incompatible impulses, under the guise of pragmatism. A general liberal multiculturalism prevails.

8.2.3 *Talking Multiculturalism, cultural relativism and ethno-centrism*

The contestation between a multiculturalist emphasis upon ethno-cultural relativism and difference, and a liberal-humanistic framework emphasising the universal/individual nature both of the sexual subject, and of sex therapy’s therapeutic arsenal, was also played out within the interviews. The predominant theme was that “sex therapy only has meaning within the context, within the society in which it is being practised” [14]. It is ethno-culturally located to an extent that makes it non-transferable. “...There are many parallels for example when we take medical techniques and try to apply them to Africa for instance...we really get ourselves into big trouble. They are misapplied and misunderstood in these countries...[14]. This ethno-cultural locatedness is such that the diagnostic categories themselves become problematic. “If you take psychiatry for example, the idea of what constitutes a proper diagnosis for Schizophrenia [in France] is very different from this country” [4].

Amongst the therapists, there was almost complete consensus regarding the profound influence of the ethno-cultural assumptions upon which Masters and Johnson's work was grounded. The notion that this historical legacy could still exert an influence today was common:

16: I think those forms of intervention that owe anything at all to the Masters and Johnson's work are culture bound...it came out of whatever part of America it was, and it entails views about how families are constructed, what marriage is, what relationships are, which are not shared by a huge number of the world's people.

The foundations of sex therapy practice, and more specifically the models informing the therapeutic tools with which therapists operate, were seen as ethno-culturally western. Sex therapy is "Euro-centric or Euro-American centric" [13]. Therapeutic strategies to encourage female partners to become less sexually passive, or for clients to engage in healthy sexual activity beyond a marital context, or to utilise masturbation or 'stop-start' techniques, were all seen to be ethno-culturally underpinned. In their existing form they encode cognitive and moral assumptions that are deeply problematic in application to ethnic 'others' (see Robinson 1998). In some cases (and most commonly in reference to Afro-Caribbeans) because the ethnic 'other' transcended the sexual orthodoxies of a western tradition grounded upon monogamy and marriage, or, in the case of 'Asians', because they were fettered by cultural barriers to a liberated sexuality. That the ethno-cultural underpinnings of therapy present barriers can be seen articulated in the following passage:

16: I would say, in general terms, that all the cognitive therapies and probably all the verbal have to be re-framed in terms appropriate to the country in which they are being provided and I think this applies within social groups within Britain.

One therapist offered a reflective account of a therapeutic incident in which the 'western' values encoded within their practice became inadvertently imposed upon their 'non-western' client:

2: What springs to mind is some brief work I did with an African man who was living in this country, and he was struggling with homosexual feelings. My attitude was very much focussed on his needs and not

so much on society's values about homosexuality which were very bad in this case... So that is an example of me using my western values...everything is fine, homosexuality is OK....as this is less and less of a problem in Britain perhaps or in the western world but in Nigeria of course it is very different

At times, the professional's entrapment within their ethno-cultural situation was presented as rendering the barriers to inter-cultural understanding insurmountable. For therapy to be effective for 'non-western' ethnic minority clients it is therefore necessary for the therapist themselves to be similarly and authentically non-western in their cultural orientations.

9: Well, it's partly that the therapists are probably mostly westernised, middle class people and educated, whatever. But as well, I think that sex therapy has to move on at some point and try and work with that but I don't know how. Everyone keeps talking about getting therapists who are of different ethnic cultures, or whatever. I think they have but I still don't think it works. We've got an Indian lady working here but she's also westernised middle class so...in a sense it would have worked by going back more to the real ... get therapists who really understand the culture.

For others, the trap of ethnocentrism could be escaped, at least potentially, by the acquisition of cultural self-awareness. The importance of an individual and collective self-awareness as a mechanism for understanding and managing the assumptions and attributions produced by one's ethnic location was almost universally espoused by the therapists.

4: ...we need to be constantly asking ourselves the questions about the legitimacy of our viewpoint. The more that we are personally committed to a particular belief system or practice in terms of medicine or sex therapy the more difficult it is for us to take on that there might be a different or another way of thinking that might actually be more right than

This notion of the productive and progressive implications of a knowledge and delineation of the ethno-cultural substance of white British ethnicity (as this becomes encoded within British sex therapy) was widely acknowledged. But the role of such awareness as a

guarantor of therapeutic effectiveness was questioned.

13: I know lots of people who have been on loads of self-awareness courses and come off even worse than they went on with more built-in prejudices and fixed ideas about their own belief systems than before they went. Yes, the measurement of how self-awareness takes place is very hard. People have years of psychotherapy and still aren't aware of themselves in relation to others.

Respondents highlighted the importance of the professional role as one which demanded an acknowledgement of one's locatedness within a particular ethno-cultural situation. Furthermore, that a questioning approach to professional practice could effectively operate as a bulwark against the oppressive implications of difference unrecognised.

28: I'm sure that I do expect things, I'm sure that I make all sorts of assumptions and have all sorts of value systems but I try because of my profession. I try to put those to one side and ask about their experience and ask about what difference it makes, and acknowledge the fact that I'm white and that I'm female and I'm middle-class and I'm all of those things. But I'm sure that I probably make, I know I do, make assumptions.

As with the journal data, the emphasis placed upon the limitations imposed upon the professional constituency by its condition of ethno-cultural situatedness produced a degree of dissonance. Professional renditions of expertise have commonly grounded claims to expertise upon a scientificity that constructs expertise in terms of generic and transferable truths/skills (Turner 1987). An acknowledgement of the non-generic and non-transferable nature of these skills in a context of ethnic diversity is therefore potentially jeopardising for therapists and their sense of competence. In a context in which professional competence is implicitly and explicitly challenged by the claims made in the name of diversity, "...people become experts because they don't want to be anxious" [25]. As such, many therapists were hesitant to move too far from a position centred around the generic nature of their skills. Occasionally, this was the basis of a more comprehensive rejection of the ethnocentrism argument.

19: It is about the person as a therapist and I believe if they [ethnic minority clients] are getting what they have come for and what they

want and the therapist is delivering, I don't think it's going to be an issue. It may well be an issue if they don't get what they want, or if [the therapist] is either too young, too inexperienced, maybe too cavalier, or too insensitive...most of the studies that have been done about therapeutic outcomes point to the most important factor in any outcome is the therapist and how the therapist is dealing with what he/she is doing.

There is a sense here that the real determinants of effective therapy lie in the qualities of the person as an *individual*, and qualities that lie beyond whatever patterned diversities may be attributed to racial or ethnic identities, or the social and political context within which those diversities are organised. Even for those who were willing to consider ethnocentricity, it was further than they wanted to go to declare sex therapy and sex therapists as ethno-culturally situated to a point of ineffectiveness.

2: initially actually sex therapy was definitely a white middle class phenomenon and I think it is actually the case still, perhaps for psychotherapy or counselling in general. But I think that we are moving away from that model and when I read now Masters and Johnson who were the protagonists really in sex therapy, and the pioneers...they were very rigid in their approach...when I look at my practice now I feel very far away from that...

The potential for a threat to expertise is very much evident in readings of western medicine and health care as inescapably ethno-centric, and the loss of a sense of expertise can have deleterious consequences. As such, the majority of therapists occupied a position that co-opted diverse themes, as these enabled a preferred personal and professional rendition of themselves as competent in respect of an ethic of cultural recognition, whilst simultaneously maintaining a faith in the transferability of expertise:

20: ...I would be aware of this particular ethnic group...but my next awareness, and one that I would want to use much more, would be regardless of whether they were from a different ethnic group or not, would be the way of starting to be able to communicate with them anyway, because of the apprehension level of people who come, you have to be able to gently build up a working relationship, whatever. So what I am saying is that although visually of course I would be aware

of it, at another level I would be thinking, yes, there's going to be a slightly different cultural approach, but my main line of approach is going to be very similar.

Accounts of the nature of sex therapy were largely dependant upon the characteristics of the ethnic groups to whom it was juxtaposed. In a context in which discussion had been concerned with the nature of Afro-Caribbean men, one therapist stated that

25: ...there's nothing [in contemporary sex therapy] about a humanistic approach, life enhancement and pleasure. And that has major implications for different kinds of groups in the culture. Some groups are much more pleasure oriented than others. Some groups are, for good or ill, more oriented towards the immediacy of pleasure and are willing to tolerate the vagaries of desire, rather than struggle for security.

In contrast, accounts of sex therapy in the context of 'Asian' clients typically highlighted the valorisation of sexual pleasure and desire by the sex therapy constituency in juxtaposition to their apparent pathologisation by Asian subjects. This shifting signification by therapists is indicative of the fact that sex therapy, rather than having a fixed and stable identity, is at least in part actively and variably constructed in the service of situationally-specific 'preferred renditions'.

For the overwhelming bulk of therapists, the recognition of ethnocentrism within professional practice was a central part of their professional self-image. It attested to their competence, whilst simultaneously threatening the very basis upon which much professional competence has been grounded. The implications of a focus upon ethnocentrism are, however, uncertain. A politics grounded upon recognising 'my differences' has no a-priori claim to progressiveness (Phoenix 1998). It can lead to the production of additional reifications in the delineation of an ethnic 'self' to match those more routinely produced in attributions directed at the ethnic other. Now one could argue that this is a sort of progress, as it brings the racial and ethnic identities of the majority into focus, potentially bringing into view its own peculiarities and specificities. But the possible and likely outcome is a consolidation of processes of ethnicisation and racialisation, and the reification of racial/ethnic difference and dissonance.

8.3 Contra reification: the 'politics of race and ethnicity'

It has been argued, and with good reason, that anti-racism is experiencing something of a crisis (see Solomos and Back 1996, Lloyd 1994). This crisis is associated with the essentially negative form taken by anti-racism, negative in the sense it has primarily been a politics of negation. It is far easier to understand what anti-racists are against (as they specify the barriers to the achievement of the 'good' society) than what they are for (in terms of what exactly would constitute the 'good' society for them). For this reason, anti-racism should be understood as a loose and inclusive term to cover a host of (potentially inconsistent) assertions concerning the nature of race and ethnicity, and the necessary conditions for a progressive engagement with/response to, their influence within society. Broadly, anti-racism can be defined in terms of its focus "on transforming the unequal social relations between black and white people into egalitarian ones" (Dominelli (1992: p.3).

Despite the indeterminate nature of anti-racism, many of the assertions made in its name have been profoundly influential, academically, politically and socially. It has served as an important resource within a host of social institutions as a conceptual bulwark against oppressive social relations, and as the basis for the formulation of strategic responses to those relations (see Anthias and Yuval Davis 1992). Whilst acknowledging aspects of the critique of anti-racism (see Modood et al 1994) I would argue that nevertheless it has encoded critically important orientations towards the understanding and 'management' of racialised and ethnicised social relations. Most importantly, anti-racism has concerned itself centrally with questions of power, and with how power becomes institutionalisation within a host inequitable social relations. It has also concerned itself with the oppressive implications of racism as a form of 'othering'. In these two senses anti-racism stands as a challenge to aspects of a diversity agenda, which in both its multiculturalist and post-modernist forms has tended to peripheralise power (see Stone 1998), and to foreground difference.

Elaborating the central components of an anti-racist response to racialised and ethnicised social relations is a difficult and selective exercise, but most renditions would include a number of key elements. Most importantly would be a conceptual and political challenge to the reification of race and ethnicity (see Solomos and Back 1996). By emphasising racialisation and ethnicisation *as processes* the dynamics of social construction are foregrounded, and the pseudo-biology and cultural essentialism that commonly characterises popular-political and academic renditions of race and ethnicity are challenged. 'Common-sense', 'taken for granted' invocations of race and ethnicity as referring to a self-

evident realm of profound empirical biological/cultural diversity are contested and held accountable for their indeterminacy and vacuity. The 'will' to racialise and ethnicise social relations, as this has operated as a mechanism for 'othering' and for discrimination, is challenged. This 'will' to racialise/ethnicise is understood within a historical, social, political and economic context that is seen to provide its central conceptual and instrumental drivers. In this sense, race and ethnicity are understood as deeply embedded within, and a product of, particular historically-informed racist social relations (Anthias and Yuval-Davis 1992).

Race and ethnicity, in their common mode of usage, construct an empirically fallacious representation of racialised/ethnicised groups as internally homogenous, and as characterised by inherent difference and dissonance in their mutual inter-relations (see Bradby 2003). This tendency derives from the biologically and culturally essentialist attributions given to racialised/ethnicised groups, and the failure to recognise the causal importance of other axes of differentiation associated with class, gender, sexual orientation, age, nationality, region etc. For anti-racists, the conceptual shift towards ethnicity (and away from race), is rarely granted the unconditional positive regard given to it by those elaborating a cultural diversity perspective. Ethnicity has become a new medium through which a racialised ontology continues to be elaborated and implemented, and forms the principle basis of a new racism (Brown 1999). The long-standing pre-occupation, evident within popular and academic renditions of ethnicity, with the 'exotically' different, illustrates the enduring influence of the processes of othering so central to racism (Stubbs 1993). It also enables a dynamic of victimisation, where the disadvantageous circumstances within which racialised/ethnicised minorities are often located, become the exclusive effect of 'their' culture (see Smaje 1996).

Driven by a desire to undermine the underpinnings of racialisation and ethnicisations as processes, and the discriminations and inequalities associated with them, attention has focussed within anti-racism upon institutional strategies concerned with achieving power equalisation. Whilst anti-racism has taken many forms, some of which may have amounted to a negation of culture in its entirety, it is entirely possible for a fundamentally anti-racist approach to move beyond a politics of negation and positively embrace cultural differences, but in a manner that avoids their reification. The principle elements of a constructivist, 'anti-reification' approach to the 'cultural stuff' to which concepts of race and ethnicity have alluded have been discussed in Chapter 2 but could be summarised as follows: that ethnicity is the product of 'ethnicity-making situations (Fenton 1999); that ethnic identities are produced dynamically via interaction at the 'boundary' between groups; that dynamics of

self-ascription and external attribution are central to this interaction; that ethnic groups have no necessary relation to any particular cultural content; that culture, and the signification of substantive cultural forms as definitive of the ethnic group is itself a product of the dynamics of 'ethnic interaction', and reflects situational and instrumental drivers⁸; that ethnic groups are typically culturally heterogeneous and increasingly so in line with the flux, contingency and complexity increasingly characterising contemporary social life (see Saeed et al 1999), and in accordance with cross-cutting axes of differentiation such as gender and class.

An effective and dynamic anti-racism would need to address questions of cultural diversity, but from a framework grounded within the social and political insights offered by a constructivist approach to culture. But it would also need to complement such an approach with the more familiar 'social engineering' implied by a host of policy and procedural initiatives directly concerned with countering the oppressive implications of the racialisation and ethnicisation of institutional practices. These could include: the enablement of racialised/ethnicised minority group self representation, in this case in the form of user-group activity (Ahmad 1992); the achievement of racial/ethnic staff representativeness within the sex therapy constituency as a means both to enabling the experiences of othering, exclusion and oppression to be given greater voice within the institution, and as a means to achieving the forms of individual and collective reflexivity induced by subjection to a 'black gaze' (see hooks 1981); the implementation of effective data collection and monitoring of staff and client composition, client experience and therapeutic outcome (see London Health Observatory (2003)⁹; effective and monitored anti-discrimination policies; the countering of implicit and explicit modes of racist discourse within the institution; ensuring recognition of, and provision for, the commonalties of (client) need experienced across racial/ethnic boundaries.

Within the context of the data, these orientations have enjoyed a very limited profile. The nature of sex therapy's understanding of ethnicity, ethnic diversity and of the nature/role of culture within these is in many ways antithetical to the foundations of an anti-racist approach as I have described it. A recognition of the questions of power and oppression was

⁸ Raj (2000) points out that multiculturalism has produced an institutionalised and discursive need to express a fixed and unified ethno-religious identity, such that "...multiculturalism's unsuspected by-product is the increasing fixity and reification of religious identities. The requirement for a substantive identity results in ethnic identity being understood in comparison with (or opposed to) other ethnic groups" (p. 550).

⁹ Data collection and monitoring does of course raise the serious challenge of how to measure inequality of experience and outcome without reproducing and reinforcing the very categories responsible for the inequality in the first place (Bradby 2003)

evident. Occasionally, references were made to the fact that a broader set of societal power relations may become manifested within the therapeutic encounter. For instance, according to Bhugra and De Silva (2000), “the power relationship between the therapist and the two partners is in many ways a microcosm of the society they live in” (p. 185). But power and oppression were conceived overwhelmingly in terms of the implications of *difference* unrecognised. Within the journal, any anti-racist ‘politics of race and ethnicity’ has been over-determined by a multiculturalist ethic of cultural recognition. An understanding of oppression as a process of ‘othering’, and of the potential dangers of culturalist accounts of ethnic difference in creating the conditions of possibility for the operation of racisms, has to this extent become delimited. Accounting more fully for the therapeutic impact of the power relations associated with the social and political dynamics of race and ethnicity, as comprising some of the most important contours of the social landscape within which sex therapy is located, is a project yet to be undertaken within *Sexual and Marital/Relationship Therapy*.

A similar over-determination of anti-racism by a politics of individualism and/or multiculturalism was in evidence within the interview data. The fundamental assumptions made by an anti-racist approach to questions of race and ethnicity, and the forms of ‘social engineering’ it implies were a source of resistance for therapists. The therapists’ accounts of the role of policy as a vehicle for contributing towards the realisation of an anti-oppressive and therapeutic sex therapy constituency will serve as a case in point.

8.3.1 The Policy Context

“Recent UK policy documents emphasise the need for a more systematic approach to planning and providing culturally sensitive services, particularly since there is increasing awareness of how institutional racism denies minority ethnic communities adequate care and support” (Atkin 2003: p.103) In contrast, the overwhelming theme to emerge in the interview data was one of a pervasive antagonism towards policy in general as a tool for informing therapeutic relationships and impacting on outcomes. The BASRT’s own Code of Ethics and Code of Conduct inevitably emerged as a point of discussion. Codes of Ethics provide discursive assertions of the moral underpinnings of professional practice, whereas Codes of Practice offer more applied elaborations of the necessary and sufficient conditions for the realisation of these morally based assertions. The current state of the BASRT’s Code of Ethics and Practice was almost universally considered sufficient for the realisation of effective relationships and outcomes in a context of racialised and ethnicised modes of diversity.

2: The code of ethics, the code of practice of the BASRT, was very impressive on ethnicity and on different cultural values. So there is respect from the BASRT about people from ethnic backgrounds, but there is nothing too specific about it in particular. It is OK as it is perhaps....

The lack of specificity and substance regarding the needs of racial/ethnic minority groups was perceived as an ideal. There was a distinct sense that 'less is more' in the case of policy. The juxtaposition in the above passage of the code of ethics/conduct being simultaneously "impressive on ethnicity" whilst there being "nothing too specific about it in particular" serves as an illustration of this. Codes of ethics were generally far more highly regarded than other, more 'invasive', policy options:

16: Providing guidelines is one of the fashions of the age, the National Health Service Executive produces them by the bucket-load. You can go to GPs' surgeries and find them this high. I have an allergy to guidelines. I don't mind ethical principles, I think that's important, very, very important in the field of sexuality since people can persuade themselves that various forms of misbehaviour are justified, but I don't much care for clinical guidelines.

Moving towards a more substantive policy climate regarding questions of racial and ethnic diversity was opposed on a multitude of grounds. Firstly, for the potential failure of policy to provide clarity of guidance; "I think it could be positively dangerous actually. It's open to misinterpretation" [19]. The assumption here would seem to be that it may be better to have no framework than to have one that may be open to interpretation. Secondly, the very structure of sex therapy militates against effective policy implementation and enforcement. "I don't think that the BASRT can, has the ability, or should impose strict boundaries... There is nothing in our work that I can see that a professional body could impose, I mean really impose" [5]. Drawing a parallel with surgery the therapist goes on to say:

5: Even in a profession like surgery where there are fixed guidelines, by the time that he has reached consultancy status he is autonomous. Unless he actually kills a patient there is very little a governing body can do. In most cases, these are thrown out of court.

The problem of resourcing the necessary conditions of good practice that such policies was invoked as a central rationale for the opposition to substantive policy. Thirdly, anything that implied a restriction upon the autonomy of the professional to determine (formally with the client's participation) the nature of the 'therapeutic alliance' was opposed. "As soon as you start with procedures, the very basic ones become inhibiting to practice" [13].

For the therapists, the overwhelming problem with policy was the fact that it operates on an assumption of systematic difference between people, which in the context of therapeutic practice, challenged the individualistic discourse of client-centredness that is so central to the professional self-identity of sex therapy. "It's [policy] also removing the therapy from the essential raw material...absolutely counterproductive" [19]. The following passage is reflective of the position of most of the therapists

20: ...say you introduce policies and guidelines to working with people of different ethnic groups, wouldn't you also be needing to say whether you introduce policies and guidelines for people of different sexual orientation? And I wouldn't like that at all because it's separating people out into groups far too much. Because there is the general or universal sexual drive, sexual desire, sexual expression, but that is going to be expressed, or understood or used in different ways in those groups. To have understanding and knowledge of it is wonderful, to be able to use that, but not as policies, it's too rigid.

There is a sense here that once you develop policies concerned with the manner in which therapists work with the differences associated with race and ethnicity, then you will have to do this for everyone else and 'then where will you be?' Where you will be, is in a place where people become differentiated in a manner that belies the therapists' wish to return, albeit via a detour into multicultural notions of difference, to the sovereign individual as the unit of consideration. The therapist feels the need to acknowledge differences of culture requiring cognitive understanding but balks at the restrictions that she associates with a policy perceived as producing rigidity.

There was a widespread anxiety that in using policies/guidelines to affect the way that therapists work with clients you could be introducing a rigid system that typifies groups and

fails to recognize universals and individual difference. “I think it is coming back isn’t it again to labelling people rather than being individuals with personal problems which can be addressed and helped and, you know, it feels like racist almost” [3]. It is interesting (and ironic) that the only specific reference to racism, or substantial evidence of a recognition of ‘othering’ as racism’s primary dynamic, comes here in the context of a discussion of policies that have had as their formal intention the alleviation of the effects of racism. It was also notable that policy rarely seemed to be a topic upon which a great deal of reflection had taken place: “this interview...It’s been very therapeutic in a way in making me realize that I would like to take the time to look at a lot more of these issues more thoroughly because it would benefit my work” [2].

It was as though a process of professional and/or political socialization had prepared the therapists for an antagonistic relationship to policies pertaining to race/ethnicity. Discussion gravitated towards those areas of policy that the therapists imagined may restrict the manner in which they worked directly with clients. Unfortunately, and there is no reason to doubt that this pertains to sex therapy, the professional autonomy demanded by the therapists may enable “...the informal culture of the health services broadly...[in allowing]...considerable discretion to individual professionals whose racialised perspectives influence the nature of the service provision to minority ethnic people” (Atkin 2003: p.96).

Other policy areas, such as the monitoring of practitioners and their clients, and mechanisms for tackling discrimination, had a low profile. The lack of apparent importance put on the monitoring of sex therapy’s racial/ethnic composition stood despite the fact that therapists had acknowledged that little was known about the racial/ethnic composition of clients. I would argue that underpinning sex therapists’ hostility to policy was an a-political orientation that served to strip racialised and ethnicised modes of difference of their social, political and economic locatedness, and most importantly to negate the redistributive implications of a politics of race and ethnicity that locates responsibility for injustice within the power centres of social institutions. A collective focus upon the capacity for institutional racism within sex therapy was therefore negated. Opposition to policy seemed to be strongly motivated by a resistance to what an anti-racist agenda might render morally and practically incumbent on the profession.

8.4 Conclusion

We have seen that within sex therapy, tensions and ambivalences are generated by the influence of competing and contradictory frameworks for understanding the nature of difference, with direct implications for how sex therapists understand what it would mean to engage with, and 'manage', these differences in practice. A philosophical individualism (manifested via a spirit of colour-blindness and a strong orientation towards a discourse of client-centredness in practice) competes with multiculturalist renditions of ethno-cultural diversity as the principle orientations.

The notion that the effects of both systematic and structured inequalities, and oppressive discursive regimes, can be negated through their perceptual denial within the therapeutic encounter has been influential within the health and therapeutic sectors not only as a product of a strong orientation toward a philosophical individualism but also due to the influence of a discursive apoliticism that seeks to render the therapeutic encounter as taking place out-with the broader socio-political, economic and cultural context. Whilst this approach was not espoused within the journal papers (though may well be implicit within non-selected papers), it was an explicit orientation for some and an implicit orientation for many of the therapists interviewed. The fact that the negation of systematic, structured inequality and oppression cannot be ameliorated simply by its practical perceptual denial, is expressed in Frankenberg's (1993) interpretation of colour-blindness as really a form of 'power-evasiveness'.

But, in line with earlier accounts, an ill-defined and unsystematic multiculturalism was the predominant theme (and invoked in direct challenge to colour-blindness by many). The multicultural nature of Britain (in its sociological sense) was accepted outright by most, and was seen to have the effect of producing both relativity in, and dissonance between, understandings of health, illness and therapeutic regimens. From this point, sex therapy's assumptions constitute merely one cultural reading (of health, illness, medicine) amongst many, and may operate in contradistinction to those of particular minority client groups. The 'otherness' of ethnic minorities' health needs seemed to constitute the central problem for a sex therapy accounted for as ethnocentrically rooted in an antithetical tradition.

But multiculturalism does offer a great deal of 'wriggle-room' for its various, and in this case ambivalent, affiliates. The 'politics of recognition' that accompany multiculturalism (in its political philosophical sense) secure a highly variable form and level of commitment.

This was amply evident within both data sources as statements as to the need to recognise, understand, and address difference were ubiquitous but accompanied by (explicit and implicit) limitations to the principle. Even for those who had a strong orientation to the politics of cultural recognition, reflected in their emphasis upon sex therapy's ethnocentrism, the commentators and respondents needed to salvage a more generic and transcendent vantage point for sex therapy, by way of which its expertise could be reinstated at the moment of its threatened dissolution. As we will go on to see in the next chapter, the degree of devotion to multiculturalism (in its political science sense), as a commitment to substantive institutional structures and procedures designed to attend to the cultural diversity perceived to be present within the national space, was difficult to fully ascertain as a consequence both of its lack of elaboration and its apparent circumscription in many accounts. Individual, and to a degree collective, 'self-awareness', combined with a comprehensive knowledge of the 'other', to provide the necessary, and at times sufficient condition for the realisation of an effective implementation of transculturalism within sex therapy.

Anti-racism, as a principal contestant in this arena, enjoyed a minimalist profile. The centrality attached by anti-racism to questions of power, to the dynamics of 'othering', and to a constructivist attack on racialised and ethnicised reifications, were not well reflected within the data. Ingredients commonly seen as necessary elements of an anti-racist approach were evident here and there but in the absence of most other ingredients and certainly with the complete omission of a recipe. This was epitomised by the relative silence on matters of policy within the journal and the substantial resistance to policy within the interviews. The dangers of misinterpretation of policy, its unsuitability for an institution structured in the manner of sex therapy, the restrictions to therapeutic autonomy, and the racist nature of the categorisations necessarily encoded within policy, were all bases for resistance to policy initiatives concerned with addressing questions of racial/ethnic diversity, disadvantage and oppression.

We will finish our journey in the following chapter with an exploration of the terrain implied by Wieworka's (1998) concept of multiculturalism in the political science sense of the term. In this context, this would refer to sex therapists' accounts of the most immediate level of sex therapy's engagement with racial and ethnic diversity. We will be concerned here then, with what therapists feel should, can and could be done on the most practical of levels to engage with the 'problem of racial and ethnic diversity' in a progressive and therapeutic manner.

Chapter 9 – Race, Ethnicity and the Therapeutic Encounter

d'Ardenne's (1986) seminal paper in the *Journal of Sexual and Marital Therapy* constituted something of a call to arms for the BASRT to begin the process of substantially thinking through the implications of racial/ethnic diversity for the practice of therapy itself. But seventeen years on, how have these arms been taken up? What has sex therapy had to say about the most immediate implications of racial and ethnic diversity for the therapeutic encounter itself? What (re)formation of the institution of sex therapy has been proposed? What transformations of theory and practice, of working alliances, of therapeutic stratagems, of practical techniques, have been extolled, implemented, systematically evaluated and promoted? On the basis of the journal and interview data, it would seem that sex therapy has some distance yet to travel in respect of establishing a systematic body of reflexive opinion about what may constitute a productive and therapeutic engagement with the questions posed by racialised and ethnicised modes of diversity. The necessary and sufficient conditions for such an engagement would seem, at least for sex therapy at this point, to be both unclear, and the subject of deep ambivalence. As a consequence, the data in this area lacked comprehensiveness. It was comprised rather of zones of discursive production, loosely and implicitly threaded together by theoretical and conceptual underpinnings themselves deeply ambiguous in nature. This final chapter offers an account of these areas of discursive production.

9.1 The racial/ethnic composition of sex therapy's clientele

Although quite different levels and forms of importance have been attached to the demographic composition of client and professional constituencies, that this composition has a role in shaping the nature of the therapeutic dynamic is widely accepted. For some, effective and equitable provision requires at the very least that the nature of this composition is clearly understood, and moreover, that this understanding forms the basis of strategies for provision (see Hillier 1997).

Within the journal, the question posed by the differential demographic composition of the client and therapist populations was raised. "...It is increasingly common that couples seeking therapy and the therapists who see them come from different cultural backgrounds" (Bhugra and De Silva (2000: p.183). There was a sense that the questions raised by this ethno-cultural diversity had reached a critical mass whereby "recognising the importance of cultural diversity is no longer an optional extra for sex therapists. Nor is it something that needs to

come into play in exceptional cases. One's routine work demands that one takes this into serious account" (De Silva 1999: p.105). But such calls stand as a stark illumination of the fact that the actual geography of the racial/ethnic composition of sex therapy's clientele remains essentially unknown as there is no systematic data collection within the field¹.

Although some clinical environments, particularly sexual health clinics operating within the parameters of the NHS, may keep a record of the ethnic status of their clients, the BASRT does not require sex therapists to maintain any records of the ethnic/racial status of their clientele.

The absence of a systematic data set may well reflect the fragmented structure of sex therapy services in Britain, but may also reflect the 'political' problems associated with securing ethnic monitoring within a sex therapy constituency powerfully influenced by a liberal/individualistic model of the client and their treatment. Though liberalism, with its emphasis upon the sovereignty and autonomy of the individual, can and has been used to justify strategies such as racial/ethnic monitoring as a tool for enabling forms of distributive justice (Miller 2002), it remains the case that liberal principles have continued to provide one of the principle sources of social and political opposition to such collectivist interventions. It is quite clear, within the context of the journal, that concerns about the absence of hard data have yet to generate the level of politically informed and sustained debate around ethnic monitoring seen elsewhere. An implication of the absence of hard data has been a variant of a 'numbers game' (see Jones 1994). In those papers concerned with race and ethnicity, the prevalence of racial/ethnic diversity has been consistently emphasised as a means to legitimising some re-thinking of the nature of sex therapy practice.

Within the context of the interviews, the 'numbers game' was also in evidence as therapists utilised estimations of the ethnic composition of their clientele to position themselves both in relation to their peers ("I seem to see a bigger ethnic mix than a lot of people" [1]), and in terms of their assumptions regarding the typical ethnic composition of sex therapy's clientele. Reflecting the aforementioned conflation of ethnicity per se, with 'non-white' minority ethnic groups specifically, and notwithstanding the profound definitional problems associated with all categorical schema (Ahmad 1992, Bhopal 1993), therapists

¹ There have been some location-specific studies which have attempted to clarify the demography of specific client populations. For instance, Hirst et al's (1996) account of a four year study of an inner-city London psychosexual clinic reported people with a 'non-European' ethnicity as comprising 16.8% of the clientele, with the largest categories being Afro-Caribbeans and Black Africans. The relatively high proportion of black and ethnic minority clients within this sample reflected the racial/ethnic composition of the local population, and as such may tell us relatively little about the nature of the national picture.

appeared to have ‘totted up’ how many ethnic minority clients they had seen ‘in anticipation of a question on numbers’.

A minority of therapists estimated a 5% proportion of their clientele as belonging to an ethnic minority, a figure that was described as ‘very low’ (though this figure actually corresponds closely to national data on the proportion of non-white racial/ethnic minorities in Britain). One therapist estimated a proportion of 10-15%, but still referred to this as ‘very few’. The majority estimated proportions ranging from 20%-50% (massively in excess of the national picture), referring to such levels as ‘quite a lot’, but not as an over-representation. Were these figures to be accurate it would suggest extensive sexual/relationship problems within minority populations and/or high levels of access and utilisation of services. Though such figures cannot be discounted, an over-estimation of the proportion of racial/ethnic minority clients could derive from the ‘hyper-visibility’ granted to some populations by the conceptual legacies of race and ethnicity. It could also be a case of ‘interviewer effect’, where the opportunity to report a significant number of ethnic minority clients may be interpreted by the therapists as indicating a positive and constructive therapeutic approach in a climate where health care generally has been the subject of criticism in its failure to meet the needs of a diversity of clients.

The overwhelmingly London-based location of the therapists undoubtedly had a bearing on the therapists’ perception of the composition of their clientele. Sex therapy in London was universally seen as engaging with a greater degree of diversity than elsewhere. This said, all therapists indicated that there were variations in the composition of clientele along ‘sectoral’ lines, with a higher proportion of ethnic minority clients using public sector services. The idea of ‘catchments’ was also widespread as an explanation for different ethnic/racial distributions of clientele. As within the journal, the lack of hard data was not generally perceived as problematic. In fact, and reflecting a liberal discursive legacy, to collect such data was frequently seen as jeopardising the autonomy, individuality and anonymity of the clients. The apparent absence of a substantial momentum for systematic data collection regarding client demography suggests some degree of consensus around the sufficiency of extant levels of knowledge and strategic response.

9.2 The racial/ethnic composition of sex therapy

The racial/ethnic composition of sex therapy in the UK is also unknown, leaving us with little to say regarding any relationship between reality and perception. Within the

sampled journal papers, sex therapy tended to be presented as ethnocentric and Eurocentric in part as a product of the racial/ethnic composition of the sex therapy constituency, which was taken to be predominantly white, western and middle class. Amongst the interviewees, there was a clear consensus that sex therapy was in its composition a white constituency. Many referred explicitly to the limited number of ethnic minority therapists in practice and in training, citing own experience of events such as conferences as evidence:

41: there was a show of hands about two years ago at the BASRT conference where the question was being asked, very similar to the one you've just asked now, so I asked, you know, how many therapists do we have from different ethnic communities and one person stood up.

The presence of ethnic minority practitioners was seen to be most evident in related areas of medical practice. "I've seen them [ethnic minority professionals] at medically-sponsored conferences in London, there are hundreds, mostly men and mostly Asian, who I'm told are there because the fields they find it easier to get into are urology, sexology, gynaecology, or psychiatry" [34].

Whether, and how, the presence of racial/ethnic minorities within sex therapy impacted upon the constituency as a whole seemed uncertain. An ethnic specialisation in the intellectual division of labour was alluded to by some therapists. As one therapist claimed, "...all of the articles are written by people who are Turkish or Asian, so perhaps it is how people from those minority groups contribute to the development of sex therapy" [2]. But the limited influence enjoyed by such minority groups within sex therapy was highlighted by some, with the effect that important questions concerning the nature of sex therapy practice in a context of racial/ethnic diversity "keep being brushed under the carpet...because maybe there's nobody, or groups, sort of saying, 'you've got to sort this out'" [9]. The presence of racial/ethnic minority groups within sex therapy is no guarantee that voices will be heard. In fact their presence, and their specialised expertise, may well enable a white sex therapy constituency to concern themselves with more 'mainstream' issues, safe in the knowledge that those most concerned or affected are 'dealing with it'. This reflects a broader dynamic, highlighted by Ahmad (1995), that "while the rhetoric of special needs and special provision remains strong its impact has been to marginalise the health needs of minority ethnic groups to 'special projects', without making more mainstream services more available" (p. 418)

The implication that this 'white hegemony' may be effectively countered only by a vigorously pursued strategy of increasing the racial/ethnic representativeness of the sex therapy constituency was not a strong conclusion within the journal or interviews². Rather, the emphasis was been placed upon the importance of training and awareness-raising for present and future therapists. A number of factors may be important in explaining this. The therapeutic value of achieving a greater racial/ethnic representativeness within sex therapy has been contested within the data. It has been questioned whether achieving racial/ethnic matching between therapist and client reliably produces better therapeutic outcomes, and that in some cases may be actively disadvantageous (see Bhugra and De Silva 2000). The limited influence of what could best be described as 'anti-racism' within sex therapy may also account for the narrow terms in which the question of sex therapy's composition has been conceived. Policy strategies such as quotas and 'affirmative action' have proved politically problematic in a British context where liberal principles of equality of opportunity have significantly delimited the scope within which such strategies have been considered³. A generalised faith in the sufficiency of extant staff to meet the needs of a diverse clientele may also be informed by the threat to expertise encoded within demands for greater racial/ethnic representativeness. They imply a de-centring and transformation of current centres of expertise, as the barriers to inter-cultural understanding could be taken to be such that only ethno-cultural minorities alone can be possessed of the requisite cultural knowledge to shape an effective therapeutic response to the needs of their communities.

9.3 Access and Utilisation

In the current social and political context, discourses associated with the diversity agenda and with social exclusion have reinvigorated debates concerning the provision of services (see Percy-Smith 2000). Professional and institutional bodies are under a renewed sense of scrutiny with regard to questions of access and utilisation, and this most fundamentally raises questions regarding the sufficiency of current levels of awareness as to the precise nature of patterns of service usage. Though liberal conceptualisations of equality, in terms of opportunity, have been most influential, egalitarian principles of equality of outcome have been sufficiently prevalent to contribute to a degree of suspicion where representative rates of access and utilisation cannot be demonstrated (see Kelly 2002a).

² D'Ardenne (1986) and Boddington (1995) do state the importance of recruiting more ethnic minority staff as a means to ensuring the closest possible cultural fit with clients, though there is no reference to the role that such personnel may have in acting as a bulwark against potential racism within the profession

³ For a comprehensive liberal critique of multiculturalism see Barry (2001)

But demands for equity and justice in the availability of services are not merely an externally driven phenomenon for professional groups. Such principles are encoded within the ethical frameworks and codes of practice in terms of which professional groups hold themselves accountable. I would therefore suggest that for professional bodies such as the BASRT, questions of access and utilisation carry with them a degree of jeopardy.

The proximity of questions of access and utilisation to matters of injustice and discrimination are reflected in d'Ardenne's (1996) statement:

It seems a reasonable moral assumption that all cultural and racial groups in society have an equal right to benefit from healthcare and health education. It might also be supposed that racism and cultural prejudice in general, and ignorance and ethnocentric practice in particular, still result in different access for different cultural groups, with different health outcomes (p. 289)

The focus here would seem to be on the institution of sex therapy. Ethnocentrism and cultural prejudice were accounted for as a potential problem, particularly with regard to how this may be implicitly communicated within the therapeutic encounter, and act as a barrier to trust and empowerment. The failure of sex therapy to meet the perceived cultural needs of the group emerged as the principle explanation for under-utilisation and elevated attrition rates (see Basoglu 1988). There were references within the papers to the elevated attrition rates amongst ethnic minority clients. Boddington (1995), in a study of a couple therapy clinic, found substantially higher drop-out rates for 'Non-White UK/Irish' (83%) than White UK/Irish (29%) clients. These data reflect other studies⁴, and have been accounted for in terms of the difficulties experienced in therapeutically engaging with clients across differences in cultural norms and language (Deyo and Inui 1980), and the difficulties for clients in trusting therapists from a different ethnic group (Watkins and Terrell 1988)⁵. According to Boddington (1995), research has shown that matching for ethnicity and language can reduce non-attendance and drop-out rates (Lin 1994, Flaskerud and Liu 1990). He concludes by highlighting the need for further research to understand the general factors

⁴ Bhugra and Cordle (1988) report in their case controlled study of sexual dysfunction in Asian and non-Asian couples, that Asian couples missed more appointments, did not inform the clinic of intended absence and dropped out more often than non-Asians

⁵ Boddington does point out that the collective data is not conclusive though. A study of Asian clients in family therapy (Stern et al 1990) and a study of black clients in substance abuse self-help groups (Humphreys et al 1991) found equivalent and higher attendance rates respectively.

which may explain low uptake of services by minority groups. But despite this call to institutional reflexivity, accounts of access and utilisation, framed within a discourse of racism and discrimination, were actually quite rare within the journal.

Of course, calls for sex therapy to overcome its barriers to developing a better understanding of the cultural needs of its minority clients still attests to the inherent ethno-cultural difference of such populations as the fundamental problem. This difference was seen to be reflected in the problems of access and utilisation produced by the particular help-seeking behaviours of minority groups, and particularly in terms of the cultural preferences that shaped this behaviour. A number of papers specified the preference of ethnic minority groups in the UK, and indigenous populations overseas, for 'traditional/folk' or 'self-help' alternatives as a first choice, as these approaches were both more familiar and trusted (see Li and Yan 1990, De Silva and Dissanayake 1989, Ng 1988, Sungar 1988). A lack of awareness of services, and an inadequate understanding of sexual health due to limitations in the field of sex education were also cited as factors (see Bhugra and De Silva 2000, Sungar 1988).

One variable, widely accepted as a significant obstacle to utilisation of sex therapy (particularly psycho-sexual therapy), were the treatment preferences of 'non-western' populations. D'Ardenne's (1986) work with Asian clients in the East End of London suggested a preference amongst Asian men for medical solutions to their problems, reflecting a broader tendency to somaticise their difficulties. Basoglu's (1986) account of sex therapy in Turkey emphasises the orientation, particularly within more traditional communities, towards mystical/magical interpretations of health and treatment. It also claimed that as a consequence of lower levels of 'psychological mindedness', lower rates of attrition were associated with greater use of medication, and with a more middle/urban class clientele.

Bhugra and Cordle's (1988) comparative study of 'Asian' and non-Asian clients of a sexual dysfunction clinic in Leicester, whilst based on a small sample, supported their conclusion that Asian clients had an 'underlying wish' for organic and medical explanations of their problems. Interestingly, this conclusion was drawn on the tentative basis that more Asian women than non-Asian women came to the clinic via an obstetric and gynaecology route (3 out of 10 Asian women, compared to zero out of 10 non-Asian women). But the conclusion seems to be challenged by a further statistic which draws no comment from the authors. Five out of the 21 Asian men in the sample came to the sexual dysfunction clinic via a psychiatrist, compared to 2 out of 21 for non-Asian men. It has been with particular reference to Asian men that the 'somaticisation/preference for organic treatment' thesis has

been grounded. “They [Asian men] are looking for a drug that will cure them” (Gupta 1994: p. 68).

This selective signification of the data seems to reflect a differential ‘will to ethnicise’ in the sense that data supportive of extant ethnicised models of difference become foregrounded whereas evidently contradictory data remains unacknowledged. For instance, the emphasis placed upon Asian men’s preference for medical approaches, as a characteristically ethnic trait, operates in the literature despite the commonplace accounts within the journal regarding the medicalisation both of sex therapy itself, and of popular understandings of health, illness and treatment. In this latter context, medicalised orientations to health are accounted for without any invocation of ethnicity.

De Silva and Dissanayeke’s (1989) study of men in Sri Lanka found extensive prior use of Ayurvedic practitioners amongst the sampled clients referred to a psychiatric clinic. The popularity of Ayurvedic approaches for such men was explained partly in terms of the advertising and self-promotion activities of Ayurvedic practitioners, but primarily in terms of the manner in which Ayurvedic ideas of health, illness and treatment gave expression to a broader ethno-cultural tradition. Ng’s (1988) account of sex therapy in Hong Kong also claims a preference amongst the Chinese for ‘traditional’ treatments and an orientation towards organic solutions, though emphasis is placed upon the prevalence of traditional treatment options, and low awareness levels of option of ‘western’-styled sex therapy as a significant influence on treatment patterns. These findings received some confirmation by Li and Yan (1990) in their study of patients with erectile disorder in China. The prevalence of non-scientific ‘magical’ understandings of health and illness, allied to a preference for physical modes of treatment, emerged as the predominant themes.

Gender was considered to be an important variable influencing access and utilisation of sex therapy amongst South Asian minorities in the UK, and amongst indigenous populations overseas (Indian sub-continent, China and Turkey being specified). Patterns of utilisation amongst South Asians in Britain show lower than average levels of female attendance (Bhugra and Cordle 1988). According to De Silva (1999), Asian men often do not want their wives to attend due to a sense of inappropriateness in their discussing sexuality and sexual problems in the company of women. D’Ardenne (1996) suggests that men from ethnic minorities: have been able to access services because they have been better educated and have had better language skills than their female partners; are more able to somaticise their health problems as a ticket to accessing health care; do not suffer the additional burden of sexism;

may be more able to use resources within their own communities, and experience less stigma than their female partners for doing so.

The fact that in all cases, the commentators were certain that therapy itself had a responsibility to understand and accommodate their client's ethno-cultural needs suggests a degree of commitment to a reading of cultural justice and equality sensitive to a recognition of 'cost'. For fair and equal treatment to be realised requires that the 'cost' of being different should not be borne by the client in the form of effective exclusion from services but rather by the service provider as an expression of a commitment to the equal validity of all ethno-cultural forms (for a discussion of 'costs', see Miller 2002). To this extent a broader interpretation of equality of opportunity seemed to prevail, broader than is than a narrow liberal concern with formal equality of access. The implication of this broader 'cost-sensitive' approach being a moral imperative upon service providers to offer therapeutic options that meet the needs of clients with a minimum of 'cultural cost' to the clients themselves. We have seen in the previous chapter, however, that in practice the commitment to such a 'cost-sensitive' conceptualisation of equality may be circumscribed in the name of a more universally-conceived formulation.

Unsurprisingly, the interview data pertaining to questions of access and utilisation were characterised by a generalised sense of speculative uncertainty. It was evident that the respondents were unsure of the nature and extent of access and utilisation of sex therapy services by racial/ethnic minority groups; "...they [Asians] are just not coming here. Are they going anywhere? Yes I am sure they are. I suspect they are going to teaching hospitals and to GPs..." [3]. Despite this readily acknowledged lack of hard data, and despite their own references to having what are in fact disproportionately high levels of racial/ethnic minority clients, there was a unanimity regarding the under-utilisation of sex therapy services by the Asian community, and archetypically, Asian women.

2: ...The Asian group for instance, they have difficulties to access the service. Particularly women...Asian men would be more ready to attend or Asian people would be more likely to attend as a couple...but Asian women on their own it would be very difficult for them to attend here...

Interestingly, most therapists seemed satisfied that access to sex therapy was formally open to all, that there was "an equal offering of the process" [20]. To this extent, a strict liberal

reading of equality as realised merely by the absence of formal, explicit discrimination seemed more influential here than in the journal. This despite a recognition, particularly from those working within the public sector, that awareness of services within particular ethnic minority communities may be undermined by the lack of materials produced in languages other than English⁶.

The predominant account of the under-utilisation of sex therapy by particular ethnic minority communities then was primarily concerned not with absolute barriers to access but with the ethno-cultural barriers to utilisation emanating from within the racial/ethnic minority community itself. "I imagine there are a lot more people with problems out there in ethnic minorities and they don't come forward...they are more reticent because of their culture. Well I suppose, I imagine anyway..." [9]. Assertion and uncertainty coalesce here. It is a quality of the 'common-sense' produced by culturalist and primordial versions of ethnicity that such uncertainty is mollified by the fit experienced between such speculations and the all too familiar ethnic and racial mappings of the social world.

In the context of a discussion regarding Asian clients, a therapist suggested that "All they need to do is feel they can go and ask for it but I don't think they will because of the family background and attitudes and expectations" [34]. The ethno-cultural attitudes and expectations, and the institutionalisation of such characteristics within both the family and religion were consistently invoked as the principle explanation for under-utilisation in terms of producing a concomitant failure 'to go and ask for it'. The perception that patterns of utilisation answered to the choice-making activities of sovereign ethnic subjects, and as such that the highly differentiated ethnic usage of services were a mere reflection of these informed choices, was widespread. This may well explain the general sense of comfort, seemingly felt by therapists, with the current state of awareness and provision. "I think people can arrange themselves, so the people I have seen are usually people who would benefit from it [psycho-sexual therapy]" [1].

Ethno-cultural differences in utilisation were accounted for on the basis of a number of substantive cultural variables. The status of sexuality as a taboo, particularly within Asian groups, was seen to render sex, sexual problems and sex therapy as indecent and shameful. This may affect utilisation, at least in certain sectors of sex therapy. "I think you get less Asians then because of the fear of involving their GP" [13]. Help-seeking behaviour was itself understood

⁶ The inadequacy of provision within the health sector for clients with a limited command of English has been widely documented (see Hillier 1997)

as ethno-culturally determined, and as responsible for differential patterns of usage. In juxtaposition to accounts of Asians, one therapist stated that: "I have a large proportion of Jewish clients but I think that is because Jewish people tend to be able to ask for help...It's part of the culture in some way. I can't quite define that for you..." [3]. Patterns of help-seeking were seen primarily as an emanation of the cultural stuff of ethnicity, more than as a product of experientially based perceptions of the exclusionary nature of medical and health services within Britain. This said, there was some recognition of the more political aspects of help-seeking. "Some people know how to use resources very well. Would know how to ask their GP to access a sex therapist. Other people wouldn't necessarily" [2]. An understanding of the machinery of help seeking is here acknowledged as unevenly distributed.

There was an awareness, and this certainly reflects the legacy of debates around the theme of ethnocentricity, that the ethnic composition of sex therapy personnel could produce a fear of not being understood amongst ethnic minority clients.

34: I think there must be cultural, you know...they are going to see a white woman and they're both Muslims, born in Pakistan or something like that. I can see that there would be a natural, instinctive feeling of 'will this person understand?'

For the therapist, the nature of ethnicity expresses boundaries of difference and dissonance that 'naturally' and 'instinctively' produce barriers to trust and empathy, presumably irrespective of the social and political context of ethnic boundary and identity formation. This naturalisation of ethnicity directs our gaze away from the social and political structuring of inter-ethnic relations and towards the generative power of the cultural specificities attributed to the minority group (Billington 1996). One particular dimension of this ethno-cultural dissonance between client and therapist is the ethnic minority client's unrealistic expectations of therapy, which can take the form of aspirations for magical solutions.

2: ...we have got perhaps more and more people from ethnic groups referred to us. Sometimes those people would have some unrealistic expectations of therapy. For instance, for me to tell them what to do or be able to inject a bit of magic in their treatment. Sometimes people who do not belong to this culture might have a distorted view of you, on therapy. But that is not specific to ethnic groups...

The solution to unrepresentative patterns of utilisation lies in large part with the willingness and/or ability of ethnic minority clients to achieve a liberation from the cultural fetters that generate these patterns in the first place. In formulating the question of utilisation in terms of the cultural characteristics of the client there is of course the danger here of setting up a victimisation dynamic where the client is essentially blamed for the circumstances in which they are found (Ahmad 1993). It also may detract attention away from questions regarding the organisation of, and racist assumptions within, service provision (Atkin 2003). Generational change was, however, seen to offer a long-term solution to the problem presented by such cultural 'fetters'.

34: I think the younger generation who've been born and bred here, you know on the phone you could hardly know that they had any ethnic difference, ...may not have that much of a problem in going to see [a sex therapist] just as they probably see a white doctor or dentist.

In contrasting past, present and future, there was unanimity in the assumption that things were getting better, as a direct reflection of the cultural assimilation of Britain's racial/ethnic minorities. "It's certainly not uncommon now for the Asian gentleman to attend with his wife, though maybe I'm taking a more westernised population" [13]. This westernisation is seen to be opening up spaces within the ethnic group for new forms of communication around sexuality, with the result that "...they are talking about sexual problems to one another" [1].

The collective journal and interview data pertaining to questions of access and utilisation defines the problem as a problem of *difference*. It is the gap produced essentially by the ethno-cultural otherness of minority clients that is at stake. The journal data seemed more informed by a tradition of trans-cultural theory in which the ethno-cultural particularities of western institutions are exposed, with an accompanying emphasis on the need to incorporate reflexivity, flexibility and sensitivity into the institution (see Littlewood and Dein 2000, Littlewood and Lipsedge 1997). But it rarely took long for the attention to shift to the cultural particularities of the client group. The interview data seemed more consistently focussed upon the client. It was the clients' cultural situatedness that presented the barrier to be overcome. Either way, an ontology of ethno-cultural difference and dissonance was the victor, serving to 'naturalise' differential levels of access and utilisation as the assumed direct or indirect result of sovereign ethno-cultural choices. What was absent in this focus upon the two sides of the dyad was a recognition of the productive and generative nature of the dynamic *between* them, and of the

social, political and economic drivers that this dynamic expresses, what Tuckwell (2001) has called a 'reflexive socio-political awareness'.

9.4 Transforming or tailoring practice?

Having got the clients through the therapeutic door, the problem of 'what to do' immediately arises for sex therapists. The discourse produced within the journal and interviews is suggestive of a host of possible, and particular, strategic responses. In some form of coalescence these responses may variably constitute, at one end of a continuum, a root and branch re-working of sex therapy praxis, and at the other, little more than a modest re-branding. The ambivalence evident within the data as a whole regarding what should constitute the proper theoretical and conceptual foundation for thinking about, and managing, racialised and ethnicised forms of diversity, was apparent through the indeterminacy of the discourse pertaining to therapeutic practice itself.

There have certainly been calls for sex therapy to become more flexible in its conceptual underpinnings and the use made of its therapeutic arsenal (for example, Wylie and Perrett 1999), and for the need to develop 'non-standard' interventions to meet ethno-culturally specific sexual mores and needs (for example, see De Silva and Dissanayake 1988). There are suggestions about how Masters and Johnson may be modified to produce effective results (for example, d'Ardenne 1986, Ng 1988), and how the 'systems approach' may represent the most effective conceptual and practical framework for working with the cultural dynamics characteristic of minority groups (see Bhugra and De Silva 2000).

Within the journal, d'Ardenne's (1986) seminal paper gets the ball rolling. She "...puts the case for an appropriate and workable code of practice that would make research, treatment and assessment of sexual disorders in ethnic minorities possible" (p. 24). To this end, she proposes some practical modifications to the work of Masters and Johnson which have proved useful for her work with Asian clients in London (See Figure 9.1).

With the prevalence, within the textual data, of trans-culturalist discourses, and of accounts of sex therapy as ethnocentrically locked into a western cultural tradition, one might anticipate calls for a thorough re-working of sex therapy if it is to be applicable to non-western ethno-cultural 'others'. But in fact, the principle emphasis lay not upon transformation but on the need ('merely') for the tailoring of practice, salvaging sex therapy from a more fundamental challenge. Some examples may be helpful.

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- Therapy conducted in English, with the male translating for the female, and an interpreter being used only where neither spoke English
 - Separate interviews provided only where both partners requested this
 - Family enlisted where possible to enable couple to find time and privacy to pursue homework
 - If necessary, the involvement of a senior family member in the initial assessment procedure
 - The use of diagrams and drawings
 - The 'selling' of the 'stop-start' technique as a therapeutic device for achieving ejaculatory control
 - The avoidance of the terminology of sickness/illness with a concomitant emphasis upon therapy as new learning
 - Repeated and authoritative instruction and expectation of precise execution of homework
 - For cultural and linguistic reasons, discussion was kept to a minimum, with an emphasis placed on outcome rather than experiential measures
-

Figure 9.1 – Psychotherapeutic models pertaining to couples (d'Ardenne 1986: p. 30)

D'Ardenne claims that "preliminary work on male sexual dysfunctions, notably premature ejaculation, carried out in the East End of London suggests that Asian couples may respond as well to this 'Western' [Masters and Johnson] approach as do those of the non-Asian population" (p. 28). The proposed modifications served principally to maximise the efficiency of established interventions within a context of the 'limitations' imposed by the couple's ethno-cultural circumstances. The conceptual and therapeutic underpinnings of sex therapy seem fundamentally unchanged. In fact, this tailoring of practice seems to involve a 'tailoring-down', or reduction, of therapeutic strategies and aspirations. There is no sense here of what an 'Asian' sex therapy may look like if the logic of cultural relativism and sovereignty were to be fully pursued. There is also a danger here of a 'self-fulfilling prophecy' operating where assumptions made by the therapist regarding the nature of South Asians become realised through their institutionalisation within a minimised sex therapy practice.

Ng's (1988) account of sex therapy in China identifies the limitations of contemporary knowledge of sexual problems and of the actual and potential role of a 'western' sex therapy. Ng points to the availability of, and preference for, traditional treatments and self help options in addressing sexual difficulties, and that some of these methods may have some efficacy. However, Ng proposes the adoption of only a slightly modified Masters and Johnson approach as an effective strategy in the Chinese context. This approach is presented as grounded upon scientific truths, in juxtapositions to the falsehoods that may characterise traditional Chinese beliefs. In discussing the early stages of the therapeutic process, Ng states that,

the first one or two sessions are usually devoted to imparting sexual knowledge, exploration and correction of mistaken beliefs and attitudes on sexual matters, with special focussing on those Chinese beliefs that are known to cause sexual dysfunctions or difficulties in sex therapy (Ng 1988: p. 247).

The ethno-cultural origin of sex therapy, and the East/West dichotomy that is commonly seen to characterise sex therapy's implementation within 'non-western' contexts does not in this paper amount to a need to implement more than a minor tailoring of therapeutic strategies. Li and Yan's (1990) account of sex therapy for erectile disorder in China indicates greater difficulties in the use of western sex therapy approaches than has been experienced in the West, a preference amongst the Chinese for traditional methods for addressing sexual problems, a prevalence of feelings of shame concerning sexual problems, a reticence towards women attending therapy, and a perception of masturbation and mutual pleasuring as harmful and 'wicked'. Nevertheless they report results not dissimilar to those reported in the West, and the paper seems to suggest the possibilities of effective implementation of a tailored 'western' sex therapy approach in non-western contexts, particularly in urban and more educated contexts.

Gupta (1994) elaborates the ethno-cultural, and principally religious, character of Indians both within the Indian sub-continent and the West. A host of religiously authorised cultural prohibitions renders some of western sex therapy's common strategies inapplicable, or at least unlikely to meet with a co-operative response. For instance, the improper nature of public displays of emotion within Indian culture renders suggestions that a couple explore non-sexual modes of intimacy out-with the sexual relationships inapplicable. Likewise, ideas regarding the value of semen renders masturbation techniques unlikely to secure ready compliance in the absence of substantial reassurance and explanation. Gupta (1994) anticipates a problem of western sex therapists condemning the practice of arranged marriage and appeals to them to work positively with couples to enable communication, negotiation and compromise, perhaps through using family elders in their work with Indian clients. Interestingly, Gupta (1994) suggests that in recent times the position of women in Indian society has become more subservient and suggests that the therapist points out to Indians that their own religious scripture promotes the view that sexual pleasure is legitimate and for the good of marital relations:

If resistance is encountered on religious or cultural grounds, it is worth reminding the couple that both the Hindu and Muslim religions not only give permission for sexual pleasure for each partner, they consider it obligatory in marriage. Examples can be drawn from their own religious texts (p.67)

The cultural stuff, in the name of which recognition and sensitivity is warranted, is in fact the outcome of a *process* of naming in which power inheres, rather than an evident fact merely requiring acknowledgement (Billington 1991). Where the therapist wishes to extol a value not currently subscribed to by a client, the therapist may search for this value within the clients' own cultural heritage to enhance the possibility of compliance with a preferred view. As such, 'cultural recognition' becomes a powerful resource for the therapist in the pursuit of an extant professional agenda of sexual pleasure as health, illustrating the instrumental nature of ethnic attributions (see Fenton 1999). Beyond the emphasis placed on an understanding of the cultural beliefs of Indians there is very little here by way of a radical re-thinking of sex therapy as a means to securing a fit with Indian clients. Again, a tailoring is in order, but nothing more it would seem.

McCaffery's (1995) account of the implications of female genital mutilation for clinicians in the UK stresses the importance of sensitivity to the needs of their female clients, but asserts the unethical nature of the practice and argues in favour of a policy of de-infibulation. McCaffrey (1995) also re-states the legal situation, by citing Kluge (1993), "if what the patient wants violates a certain fundamental ethical principle, then no matter how much the patient wants it, the physician does not have to agree to do it" (Kluge, cited in McCaffrey 1995: p. 198). "Continuous counselling, education and support of the families is necessary to break the cycle of female genital mutilation" (McCaffrey 1995: p. 199). In this case universalism prevails over relativism, and the value premises and practices of 'western' health care are left intact.

D'Ardenne (1996) notes a shift in the 1980s towards a recognition of the limitations of 'Western' sex therapy approaches in application to 'non-western' clients:

In the 1980s, therapists began to recognise the cultural as well as the methodological limitations of the Masters and Johnson approach to sexual dysfunction, and began to report on how individuals and couples from other cultures were presenting difficulties, and how

Western assessment and therapy might be adapted to address their needs (d'Ardenne 1996: p. 292).

A section entitled 'presentation and adaptation' has the role within d'Ardenne's text of demonstrating the different clinical presentations and needs of minority ethnic clients, and of the implications these have for an adapted sex therapy approach. In fact, the section seems to suggest the need for a tailoring of 'western' approaches at best, and in a manner that does not seem to support the more extensive theoretical underpinnings of her trans-cultural and multi-cultural perspective. Reference is made to Bhugra and Cordle's (1986) retrospective study, which demonstrates the different clinical presentation of South Asian men using sex therapy. However, this study in fact claimed that with no modification of approach, the success rates for South Asian men in therapy were the same as for non-South Asians. D'Ardenne also points to her own study of South Asians in East London (d'Ardenne 1986) and Li and Yan's (1990) work in China, both of which actually seem to point to the potential of 'western' sex therapy to work with 'non-western' clients.

De Silva (1999) discusses a range of 'non-western' cultural barriers to the implementation of some standard sex therapy approaches. Of particular note is the existence of culture-bound syndromes not widely recognised within sex therapy, but also of a range of cultural influences on the presentation of problems. Culturally determined ideas about the aetiology of sexual problems (particularly the tendency for South Asians to somaticise illness), reluctance to involve female partners in therapy, the influence of extended families, client resistance to female-centred therapeutic strategies, and an opposition to masturbation, all present obstacles.

None of these problems, however, should be seen as meaning that therapy for sexual problems, in clients from culturally different backgrounds, is bound to be unsuccessful. What they really show is that the therapist needs to be knowledgeable, sensitive, flexible and imaginative in his/her work with these clients. Cultural factors, obvious and not so obvious, need to be part of the assessment enquiry, and – equally – of the formulation that the therapist arrives at. They should also be very much in the forefront when therapy is planned, discussed and implemented. Cultural factors may sometimes narrow the range of options that a therapist can realistically consider for a client or a couple, they may also in some cases, widen it

(De Silva 1999: p.107).

Reflecting dominant discourses within the health arena generally, an ‘ethnic sensitivity’ model is very much in evidence here (Stubbs 1993, Culley 1996). But so are some other key themes evident within the data as a whole. The ethno-cultural characteristics described, despite best efforts, are nevertheless referred to as “problems”. In suggesting that therapy ‘across cultures’ is not “bound” to be unsuccessful, it seems to be simultaneously implied that therapy across cultural difference is typically unsuccessful. The “formulation that the *therapist* arrives at”, and which makes effective treatment possible, is a product of the therapist’s cultural knowledge and sensitivity. Interpretive sovereignty seems to still lie with the therapist.

Perhaps anticipating a reading of ‘culture as a problem’, De Silva (1999) concludes by stating that cultural factors may “widen” the range of options, but examples of these are not specified and the reader would understandably be at a loss to think how. If the principles of the above approach were to be introduced to the letter, it would seem to fall well short of a root and branch re-thinking of sex therapy based firmly upon a principle of the sovereignty of the client’s culture (as informed by the principle of cultural relativism and cultural recognition).

Bhugra and De Silva (2000) offer the most comprehensive elaboration within the journal of the implications of racial/ethnic difference for therapy. They define a key factor in the effectiveness of “sex therapy across cultures” as the establishment of a common goal between the client (in this case, couples) and the therapist, which in turn depends upon the culturally and experientially based expectations that the two parties bring to the therapeutic situation. They delineate a range of possible therapeutic scenarios based upon the cultural identity of the three participants (in terms of ‘majority’ and ‘minority’ cultures). They claim that within each of these scenarios arise dynamics which impact in three key areas: the ethnocentrism of all parties, the power imbalances within the triad, and the nature of the ‘therapeutic alliance’.

Concepts of self and self esteem, help-seeking behaviour, and attitudes towards treatment options are seen to be ethno-culturally dependant, and create the need for cognitive understanding on the part of the therapist.

“The therapist needs to have knowledge and sensitivity about these

aspects. This requires study of the culture/s of the couples one is dealing with, and training programmes for couple therapists need to include such study in their curriculum (see de Silva 1999). In addition, practising therapists have their own responsibility to acquire such knowledge as part of their ongoing professional education” (Bhugra and De Silva 2000: p.187)

Here we see a clear example of a ‘knowledge and sensitivity’ solution to the problem, a problem conceived in terms of the ignorance of ‘western’ approaches and their representatives, and potentially manifested in the individual prejudices of therapists (see Bowler 1993). It is unclear from this how far Bhugra and De Silva (2000) feel couple therapy needs to go to achieve a fit with the needs of their racial/ethnic minority clients. But in their subsequent extolling of the systems approach as most suited to dealing with couples for whom culture plays an important role (and this seems to be understood as the case primarily where one or more of the triad are from a ‘minority culture’), we get some indication that the agenda of the therapist remains predominant. “...Cultural factors, both within the couple and in relation to their interactions with their extended families and wider society and subculture, play an important role within the ‘system’ that one has to assess and try and modify” (p. 187). Not only are assumptions made here about the nature of ‘minority cultures’ in terms of extended families, but it is also clear that sovereignty ultimately lies with the therapist’s ethical/therapeutic judgements in cases of dissonance, hence the need to “try and modify” the system.

In the context of couples from ‘minority culture/s’ or ‘mixed cultural origins’ the influence of cultural norms is seen to be such that a range of assessment questions become particularly important (see Table 9.1). However, when the paper reaches the section on “therapy strategies” very little elaboration is offered. That “...the therapist is primarily an agent with both educative and psychological functions” tells us little about how these educational and psychological functions are to be implemented within a context of diversity, or of the underpinning frameworks involved. But Bhugra and De Silva (2000) do make reference to ‘indigenous therapies’ that may be usefully utilised in original, modified or combined form, but no information is provided on these, or on the theoretical/conceptual, political and practical implications of such a utilisation.

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- Normative age for marriage
 - Why that age?
 - Do men have to achieve certain things before marriage?
 - When are men/women considered eligible?
 - How much free will do they have?
 - History of arranged marriage?
 - Definition of arranged marriage
 - Whose responsibility?
 - Do these patterns continue with migration?
 - Other basis for mate selection
 - If so, how different?
 - How is it accepted by the culture?
 - Role of common interest, mutual attraction, love or lust
 - Expected duties of husband/wife
 - Gender roles
 - Self concepts
 - Division of responsibilities
 - Power, alteration of power equation
 - Role of families of origin
 - Conception of sexual relations
 - Do's and don'ts in interactions with outsiders
-

Figure 9.2 - “Assessment in couple therapy across cultures” (Bhugra and De Silva: p. 189)

Bhugra and De Silva (2000) conclude with a cursory⁷ discussion of the pitfalls awaiting therapists working within a context of racial/ethnic difference (See Figure 9.3).

Colour blindness:	Assumptions that minority culture client is the same as majority culture client
Colour consciousness:	All problems result from the minority status
Cultural transference:	Client’s feelings result from therapist’s race
Cultural counter-transference:	Therapist’s feelings towards client result for their race
Cultural ambivalence:	Therapist wishes to help but needs to control to maintain power
Over identification:	Minority therapist over-identifies everything in terms of racism and defines problems as racially based (same as colour consciousness)
Identification with oppressor:	Minority therapist denies his/her status by virtue of power and because it is painful

Figure 9.3 - “Some Common Pitfalls”

This is an intriguing list. ‘Colour blindness’, despite its specification of colour (and as such its invocation of race and racism) concerns itself with the problem of cultural

⁷ Cursory it may be, but it still exceeds the accounts offered by most regarding the competing agendas that govern the terms in which the question of diversity may be addressed within therapeutic contexts

‘difference-unrecognised’. It would seem that for the authors, colour delineates a reality of racial/ethnic cultural difference, and ought to be recognised not as a marker of the experience of racist modes of ‘othering’, but as an indicator of the *real* cultural otherness of particular racial/ethnic groups. In this form of usage, it would appear to share the same meaning as ethnocentrism. ‘Colour consciousness’ involves the opposite problem, where we attribute all problems to ‘minority status’, presumably at the expense of exploring other variables. Of course, colour consciousness may take the form of a politically and sociologically informed recognition of the role played by colour as a symbol of an ultimately fallacious but invidious racialised ontology. But this does not seem to be an option here. In this context, there is no way of determining from the above list what an appropriate response to the question of ‘colour’ should be. ‘Cultural transference’ again introduces race in an ambiguous manner, but one that seems to suggest that race and culture, or rather ethno-culture, are inextricably connected. In this account, a client’s attributions regarding the therapist’s racial/ethnic identity becomes a personal psychological pitfall to be avoided, a form of inter-personal error. To this extent, the broader social and political context through which racialised and ethnicised boundaries are constructed, and within which racial and ethnic subjects are produced through a dynamic of attribution and identification, recedes from recognition (see Solomos and Back 1996).

‘Cultural counter-transference’ involves the same process, merely in the reverse direction. ‘Cultural ambivalence’, as a form of terminology, is itself ambivalent. It seems to refer to situations where a therapist, motivationally, genuinely wishes to help, but is unable/unwilling to relinquish the power that derives from maintaining control over the terms and conditions of the therapeutic encounter. ‘Over-identification’ is claimed to be the same dynamic as colour consciousness, though where the therapist is from a ‘minority’. ‘Identification with oppressor’ would seem to indicate scenarios whereby minority therapists deny their racialised/ethnicised identity, and the meaning this may have for their clients, on the basis that they occupy a position of power as a therapist and because of the pain associated with such an acknowledgement of the minority experience. The ‘solution’ to these pitfalls lies in self-examination, curriculum development within training programmes, and regular supervision, the staples of a ‘cultural awareness’ paradigm (Rattansi 1992). But the conceptual and theoretical basis, and ultimately the aims, upon which this solution may be grounded are left unclear. If one were to attempt to deduce these negatively, in the sense of identifying the position that would in each case avoid the specified pitfalls, it remains impossible to determine what a proper orientation to working with racial and ethnic diversity would be.

The substantive data produced within the interviews on the central question of whether and how sex therapy practice could and should be modified was surprisingly limited. For some, ethno-cultural groups were generally perceived as embodying distinct matrices of need and problem. Ethno-cultural belief-systems produced particular renditions of sexuality and sexual relations such that culturally-grounded sexual needs were generated. The failure to meet these needs produced particular definitions of ‘problem’ to which sex therapy may offer some intervention. In this sense, sex therapy may differ between ethnic/racial groups in so far as it is concerned with some form of patterned difference of ‘problem’, in degree or in kind.

But the fact that there may be patterned differences in the problems that people experience does not necessarily imply a need to modify the conceptual and practical tools of sex therapy. There was substantial ambivalence around this question. For some, the implication of ethnic difference meant that both conceptual and practical tools could be rendered ineffective. “It’s a nonsense to try and apply Masters & Johnson to a Bengali couple. There are elements that you can work with and others that just are nonsense” [40]. The ‘nonsense’ nature of such an application derives from the perception that ethno-culturally grounded rules govern the nature of sexual normativity, and as such that western sex therapy and racial/ethnic minorities implicitly and explicitly subscribe to different sets of rules. This manifests itself most directly in the barriers presented by ethnic minority ‘rules’ for the use of ‘standard’ therapeutic techniques, such as masturbation. These ethno-cultural barriers prevent a standard sex therapy technology from operating:

34: ...you say, ‘okay, you’ve got erectile problems and now you need to do this, that and the other and she’s got to do this, that and the other and you need to practise so and so’. I mean you can go on until the cows come home in some cases if there’s something in the head saying, ‘I don’t think I should be doing this’, or ‘what happens if we have a baby, what religion is it going to be?’ They’re such huge blocks to sexual freedom.

A claim made by a number of therapists, connected to the perceived absence of a concept of talk ‘as cure’ amongst particular ethnic minorities, was that such minorities, particularly Asians were ethnically orientated to choose bio-medical forms of treatment over psycho-therapeutic approaches. This preference for medical treatments was attributed to Asians as Asians, despite the broader recognition amongst therapists that men had a preference for

such treatments, and that the general medicalisation of sexuality and sex therapy was producing a generalised orientation towards bio-medical approaches. The possibility that if there was a preference, it may be a reflection of a collective experience of services as not offering effective provision was less evident. Though it was assumed by some that strategies suited to meeting the needs of ethnic minorities, particularly Asians, were “very, very different from Western approaches to these things” [34], there was little substantive awareness of the forms that such approaches might take.

It was through discussion of a number of key therapeutic questions that therapists articulated their ideas concerning the most immediate implications of racial/ethnic diversity for practice; principally through the related matters of identity, knowledge, and language.

9.5 Identity, knowledge and language

9.5.1 Identity as a therapeutic tool?

An emerging topic of research and debate (Bradby 2001, Chevannes 2001, Robinson 1998) has been the implications of difference in the racial/ethnic identity of health professionals and their clients. It is perhaps unsurprising then that the therapists interviewed universally felt the need to offer commentary on the implications of the therapist’s identity for the therapeutic encounter, and for the nature of the ‘working alliance’. There is a sense in which the legacy of these debates, and their enlistment within an anti-racist and multi-culturalist politics of health, set the agenda for the manner in which they were to be discussed within the context of the interviews. The relatively high profile of policy debates concerned with enabling access for ethnic minority clients to ‘ethnically-matched’ practitioners (particularly GPs), and the aforementioned tendency to understand questions of ethnicity exclusively in terms of ‘ethnic minorities’, conspired to ensure that the agenda was defined in terms of the utility of ‘matching’ therapists with ethnic/racial minority clients.

There was a general assertion amongst the therapists, that whatever the theory of the matter, the logistics ensured that a systematic approach to ‘matching’ client and therapist for ethnic/racial identity was an impossibility, given the ethnic homogeneity of sex therapy. This despite the fact that many accounted for the need for matching on the basis of certain ‘rules of contact’ operating within the ethnic minorities themselves. “For instance, I know that Asian women would not go to a GP who was white British. Asian women would go to a GP who was an Asian GP” [2]. A minority of respondents claimed that where clients perceived therapists as

having a common ethnic identity to themselves, or to have an ethnic identity to which they could attribute similar collective values and social experiences, a degree of trust and identification was enabled. In this regard clients were reported as feeling understood, both empathetically and sympathetically, by the therapist.

Some of these therapists reported the positive value (though, they pointed out, against the better advice of the theory) of selective self-disclosure as a means to demonstrating to the client the point of commonality from which their capacity for empathy was derived. A shared ethnic identity was also seen as particularly valuable in the 'early stages' of the therapeutic process.

28: You're more likely to get people involved in a therapeutic process at the outset if they feel that you might have a one in ten chance of understanding where they are come from....I think as a way of getting people involved, then I think it's crucial...

However, this was a minority discourse. Far more common was a challenge to the assumption that ethnic/racial commonality was necessarily therapeutically positive. The fact that racial and ethnic matching could not guarantee therapeutic success was an important argument for the therapists in supporting a case for the irrelevance, and even counter-productivity, of matching. It was questioned whether racial/ethnic minority clients themselves were concerned to access a client of the same racial/ethnic identity.

16: One of my students did a project a few years ago about the business of client therapist preference...now we know in the world of family planning that a lot of people say, 'I'll see anybody except somebody from my own group', because they will criticise them...Anyway, this research worker asked a consecutive series of clients, 'if they were given the choice would they like to see a man or woman, white or black therapist'. The answer was quite straightforward, white/black didn't matter but they all said they preferred to see females.

Two principle rationales were offered to support the view that a 'matching agenda' was inappropriate for sex therapy. Firstly, that the generic skills of the therapist, and the 'will' of the client, are of determining importance within the therapeutic encounter (both of which are conceived as lying beyond and beneath race and ethnicity). Secondly, that the dynamics

that are generated between therapist and client are either unpredictable and/or contrary to typical assumption. It is interesting that although most therapists were explicitly opposed to a 'colour-blind' approach, arguing that you cannot but recognise the operation of dynamics of race and ethnicity within the therapeutic encounter, few were convinced of the need or value of addressing these dynamics through the medium of the therapist's ethnic/racial identity.

In respect of the first rationale, the effectiveness of the working alliance was seen to be based upon 'core conditions' that where satisfied, produced a therapeutic result irrespective of the presence of ethnic/racial difference. These core conditions were concerned with the generic skills of the therapist (particularly self-awareness, effective information gathering, and client centredness) and the 'will' of the client as an individual subject to participate within an 'open' therapeutic relationship. At the heart of this position was a challenge to the essentialist notion of 'experience' that assumes that the understanding of another can only be achieved through some direct unmediated and inevitably exclusive exposure to the other's lived experience (and which underpinned much of the therapists' thinking about ethnicity generally). This though seems to have been extended to a point where the complexity which characterises the realities of people's lives is seen to invalidate approaches concerned with addressing the axes of differentiation of race, ethnicity, gender and class. As such, the only effective tools become generic in nature.

In respect of the second rationale, many therapists claimed that if dynamics of an ethnic/racial nature were in operation, they were frequently contrary to typical expectation. The assumption of commonality implicit within the identifications and associations that may be established between a therapist and client of the same ethnic identity, may readily become obstacles as the complex realities of both parties defy effective prediction. The therapeutic value of matching was also challenged in the name of colleagues' experiences, who they felt had had difficulty withholding judgement on clients with whom they shared a common set of ethno-cultural characteristics on matters of sexual morality.

13: I supervise an Asian woman therapist and her comments about other Asian ladies are very interesting. They're not always empathic, in fact she's quite critical. Sometimes her own ethnicity is a barrier to approaching [the client] because she's aware that she's treading on something which culturally... Whereas perhaps I would have rushed forward, penetrated, if that's the right word

In such cases, though empathy may be enhanced, sympathy may be more problematic, and therapy inhibited by an anticipation/assumption of ethno-cultural sensitivities. A common assertion was that black clients may actually prefer white therapists because the assumed racial and ethnic difference enables clients to share sensitive information, safe in the knowledge that it isn't going to 'get back' to their community.

28: I think there are certainly occasions when I've worked with people who come to somebody like me because I'm just about as different as you can get from their own backgrounds. It's much more comfortable to talk to somebody who is seen as very, very different...I'm not going to bump into anyone they know...

One therapist reported that he had been informed by a black health worker that black people in London feel related either literally, or to a common network, and as such they prefer not to have a black health worker through whom discrediting information may enter their community. In the context of sex therapy, two therapists suggested that the legacy of colonialism had produced a powerful association between what could be described as 'western whiteness' and scientific expertise. This association, it was suggested, has been internalised by some ethnic minority clients resulting in a positive preference for white therapists.

28: ...there is this internalised racist thing, you know, 'those [white practitioners] are the people you go to if you need this kind of help'...They [black and ethnic minorities] wouldn't want to see a black doctor. Sometimes they don't think they're as well qualified as white doctors.

The data here would suggest that amongst the sex therapists interviewed, the foundational principle of anti-racism, to achieve a racially/ethnically 'representative' constituency of service providers, would not achieve much impetus from a concern about the implications of homogeneity for effective therapy. It is important to note that this is the case despite most therapists referring to, and to a degree lamenting, the limited number of ethnic minority people practising as sex therapists. The pre-occupation of anti-racism, to challenge the interpersonal *and* organisational and structural foundations of racist othering and exclusion (Stubbs 1993), was not evident within the constituency of therapists interviewed.

For at least one therapist, the homogeneity and whiteness of sex therapy was not a problem as minority groups knew what to expect of a British professional constituency.

19: Ethnic minorities coming here, when I say here I mean in this country, generally will expect to find, unless they are going to a particular place where it's like Black Sisters in Southall or something, they are going to expect to find a white therapist. They know when they come what to expect.

If non-white people make the choice to come here, to Britain as a 'white country', then they could hardly feel surprised if their therapist was white. But there also seems a sense here that the status of immigrancy (it is unclear here how recent this immigration would need to be to locate one within this general category) may discount any legitimacy to challenge the nature of the therapeutic alliance offered. The therapeutic contract seeming to be a variant of a 'when in Rome...' deal. To the extent that this is the case, one could usefully see such 'contractual' relations as practical tests of the limits of citizenship. Ethnicised notions of British citizenship do operate to construct concentric circles of legitimacy and belonging such that Britain's ethnic minorities become located at the outer reaches of citizenship, and so find themselves in positions of partial social, political and cultural exclusion in their relation to a host of social institutions⁸.

Gender was seen to be an important component of the matching question, with men preferring to see female therapists (and therefore choosing gender *difference*), and women also choosing female therapists (and therefore choosing gender *sameness*). In either case, it was the status of women as natural carers, that explained the preference; "I think there's a lot of expectation that women are the healers anyway. So I think there's that bit of women as the nurturers, the caretakers" [28]. However, when ethnicity is formally introduced by the therapists, the ascribed gender dynamics seem to change. In respect of acquiring legitimacy in the eyes of Asian clients, "being a doctor helps. Yes, that's a positive, but being a woman definitely is a negative" [9].

⁸ Citizenship discourses and practices have been described by Soysal (1994) as 'incorporation regimes', patterns of "...institutional practices and more or less explicit cultural norms that define the membership of individuals and/or groups in the society and differentially allocates entitlements, obligations and domination" (Shafir and Peled 1998: p. 412). Incorporation regimes have the effect of constructing concentric circles of legitimate belonging. The inner circles represent the zone of full legitimacy and entitlement to the entirety of citizenship rights, though they also mark that space which is most exclusive. Outer circles are more easily and more formally penetrated though are more peripheral to the condition of full citizenship.

For one respondent, securing the legitimacy warranted by therapists, as professionals, was generally difficult when working with Asian clients:

5: ...their behaviour, their attitude, I suppose it is more of an attitude problem. I mean, each to his own...but for me it comes down to money in that they see it as though they are paying for a service and they are damn well going to get what they are paying for. It's almost like being screwed, in both senses of the word, they are going to get every penny and they are going to make it known that they are going to get every penny

This was explained in terms of a migration of the ethno-culturally based perceptions of professions and professionals from the Asian sub-continent.

5: If they were back in their country, we are supplying a service and therefore we are very much subservient and that is still how we are being treated, we are service providers... they are buying the service, therefore they can treat us as they choose

9.5.2 *The 'knowledgeable doer'*

One of the principle legacies left by the multiculturalist agenda within the health arena has been a rendition of the effective therapist as a 'knowledgeable doer', armed with a comprehensive understanding of the specific cultural fields of a multitude of diverse ethnic groups. Multicultural knowledge of this kind becomes the necessary and sufficient condition for effective therapeutic work (Culley 1996, Mulholland 1995, Stubbs 1993).

Therapists seemed divided regarding the nature and role of 'ethnic knowledge'. Reflecting an important theme within the responses, one therapist claimed that, "knowledge can inform, knowledge can be helpful in certain situations but I don't think it's about rushing out and researching the entire history of sex in a particular ethnic group that's necessary" [19]. For this therapist, and others, this reticence seemed underpinned by a determination to foreground both the therapist's information gathering skills, and the utility of using the client as the principle source of knowledge. It also reflected the ambivalence felt by many therapists in straying too far away from the conceptual imperative of the sovereign individual subject.

But the major theme was one that combined a recognition of the importance of using the client as a resource, with an assumption that there exists a discrete body of ethno-cultural knowledge to be acquired about ethnic groups, and that it was the responsibility of the therapist to acquire it. These dual elements seemed to be combined with different emphases, depending upon the particular orientation of the therapist and its location within the interview context.

For most, the more comprehensive the knowledge of the ethno-cultural characteristics of the ethnic group to whom the client belonged, the more effective the therapeutic encounter promised to be. "I think the knowledge of the requirements of different groups is so important...to have understanding and knowledge of it is wonderful, to be able to use that" [20]. The field of knowledge to be acquired seems to be comprised of a landscape of reified cultural motifs, reified in the sense that in their representation they tend to be stripped of their social, political and economic situatedness, in essence their historicity. Cultural knowledge becomes a matter of acquiring an awareness of trans-historically conceived cultural fixities (see Solomos and Back 1996).

3: I am married to a Jewish American and I find that extremely helpful because I do understand in a sense where they are coming from culturally, I understand the kinds of rituals and the kinds of things that happen when they get married and you know and all those things. I don't shove it in their faces but I know where they are coming from...

Ritual and custom, particularly those connected with religion, constitute that which is to be known, and that which may enable the therapist. The cultural 'ground rules' that govern and characterise gender and sexual relations within particular ethnic groups constitute another area of knowledge. "I think you have to try and understand what the other person's ground rules might be" [16]. The implications of ignorance on the part of the therapists, about the 'ways' of other ethnic groups was variably considered, depending upon the sufficiency granted to the therapists' information gathering skills. For most therapists a balance needed to be struck.

28: I won't say 'I don't know'. I won't say 'Look I don't know an awful lot about your religion or how you interpret your religion. Will

you tell me what's okay with you and what isn't'. I might say, 'Well, as I understand it, in the Hindu religion you're allowed to do x, y, z'. Or I won't mention it and then when they go away, I'll do a quick bit of reading, come back thinking that I know. So I think a sense of being able to...stay with not knowing stuff and genuinely enquiring after the other person's experience, is actually a necessary set of skills and attributes and obviously a way of being able to say that to somebody saying, 'Look I'm not really sure about this. You may think that I should but I don't and so help me along here'.

The suggestion that a therapist will not openly declare complete ignorance, and may well 'go away and do a bit of quick reading' does seem to express the jeopardy posed by such ignorance to a professional status grounded upon cognitive expertise (Turner 1987). But the potentially jeopardising nature of ignorance is salvaged by a central and highly valorised component of the effective therapist's tools, namely the importance of withholding assumptions as a bulwark against typification and transference. There is within this reading a virtue to be found in the absence of substantive forms of knowledge concerning the lived experiences of ethnic minority groups. Also, that whilst it may be jeopardising for the therapist, and challenging for a client for whom the therapist's expertise is a central assumption, the effective therapist will be able to openly admit to their knowledge deficits. Valorising the acknowledgement of such deficits as a marker of professional competence, a further respondent pointed out that, "in this field you can make no assumptions about anything and one keeps being reminded that one's own assumptions don't apply necessarily so with that you need some sort of insatiable, enthusiastic curiosity..." [16]. There was a recognition that the expectation of 'cultural expertise' may come both from the therapist, and from the clients.

28: They come in, especially newer therapists, come in with a sense of 'I should know' and 'I should know about what your group does sexually and I should know about what your marriage rituals are and I should know about what your religion says about x, y, z....for masturbation...

In this case, the drive to know would seem to be a product of anxieties generated by the collective weight of expectation that comes with occupying the position of sexpert, particularly for these at the beginning of their career. But there were limits to how far an

insatiable curiosity could substitute the need for ethno-cultural familiarity. For some, unfamiliar ethno-cultural scenarios produced a competence crisis underpinned by the necessity of an expertise grounded upon a knowledge of ethno-cultures:

9: I just feel helpless, or hopeless. You just think it's not worth it, which isn't very nice but I don't know what to do...that's why, in a sense, you want some experts who work within the culture...very much involved in their whole sexuality, being very knowledgeable of it.

Significantly, the effect of these experiences of 'knowledge deficit' seemed not to bring about a more questioning and constructivist reading of ethnicity itself, or to substantially challenge the reifications produced in its name. Rather, it was to deliver a greater sense of comfort in acknowledging the limitations of one's knowledge of the ethnic 'facts', as a more effective strategy for acquiring 'cultural safety' (for an account of 'cultural safety' as a concept see Polaschek 1998).

9.5.3 Language

The issue of language as a barrier to effective therapeutic communication has long been a point of debate within the health arena (Atkin 2003, Bradby 2001). Language constitutes an important resource in developing and maintaining shared identities and constructing boundaries (Atkin, Ahmad and Jones 2002), and is central to questions of equity and therapeutic effectiveness (Bradby 2002). Written and spoken language, as a medium for communication, is central to all modes of sex therapy, even in its most medical of idioms.

To the extent that issues of language were discussed directly by therapists, and they were by approximately one-third of the respondents, a number of dimensions of the 'language question' emerged. Firstly, it was recognised that sex therapy spoke almost exclusively through the English language. Information and promotion of services were in English, with the implication that non-English-speaking sections of ethnic minority populations would be disadvantaged in terms of their awareness of services. As one therapist working within a public sector clinic pointed out, "we haven't done, for instance, any promotion work for the service in different languages in targeting different groups which is something that perhaps we should do. All our information in this place is in English" [2]. In suggesting that 'we should do', the therapist seems to be acknowledging both a principle of equity, and of the injustice of current

inequitable provision. The common acknowledgement of the inadequacy of current provision in this respect was not however framed by any of the therapists within an account of institutional racism (see Atkin 2003).

Secondly, that the implications for therapy of the client's inability to speak English were acute. In the absence of a representative multi-lingual sex therapy constituency (and there is no foreseeable prospect of this being realised), the possibility of finding and providing a therapist who speaks the client's language was perceived as limited. "Maybe ideally, I would ring up the BASRT and say, 'I've got this Asian couple, they need to speak Urdu and can you find an Urdu-speaking sex therapist?', and the NHS would pay for it. It just wouldn't happen" [9]. Given that the data was indicative of a view that language barriers were seen to be somewhat definitive of working with ethnic minority clients, and that this was not seen to be a temporary state of affairs, it was notable that though language barriers were defined as problematic, there seemed to be a generalised capitulation to the problem. A discursive 'shrug of the shoulders'.

In the absence of therapy in the client's language, translation and interpretation present themselves as 'the next best thing'. However, respondents were universally sceptical about the viability and utility of such strategies in the context of therapeutic work with clients. "Translation. I have given up on that one myself. Translation in counselling doesn't really work. It is OK for a consultation, a one-off session to give advice with a very specific focus..." [2]. Interpretation and translation present enormous obstacles in terms of the distortion of meaning ("Sometimes I would ask a question and the way that the client responded I was aware that the question I had asked had been distorted" [2]), and for the potential de-centring of the client in favour of the person of the translator. "Working through an interpreter is impossible. I can't understand what they are saying and I can't know what the answers are..." [5]. Another therapist offers more insight into the problems involved.

1: It is difficult to be able to put across abstract concepts where the language is a problem. I think a lot of things get lost in translation. I think words get lost. There is no word in English for what she wants to say to me at times...

The relationship between language and power was explicitly acknowledged by some. As one therapist put it, "*Language is power*" [5]. The significance of language for power can be understood on many levels. Clearly, therapists' command of the language through which

therapy is provided places them in an a-symmetrical relationship of power with those clients who have limited fluency in English. But there are also language-related power issues that arise within the couple, and these tend to be gendered.

1: One of the areas where I do have problems is where the wife, and it usually is the wife..., doesn't speak any English and where the husband translates for her. And you know sometime she gives a long explanation, and the husband says, 'No'. And I'll say, 'Is that what she said, because it sounds to me like she said a *lot*...'. I think that power and control is one of the real big things with sexual problems...

In such cases, the oppressive gender relations perceived to be at the heart of such racial/ethnic minority couples requires intervention, an intervention that implies a commitment to a reading of human equality as transcending cultural equality (as these oppressive gender relations are perceived to be ethno-culturally patterned). "Sometimes I will separate a couple. If I can see that she is almost bursting to talk, then I will separate them" [5].

It is evident that different levels of language competence can become devices for the exercise of power in gender and sexual relations, as these relations are in the first or last instance underpinned by the need for communication. The complexities and subtleties of language were readily understood by the respondents. Therapists emphasised the importance of "listening very carefully to what is not said, particularly with regard to ethnic diversity, because it tends to be what is not said that is the most important" [5]. By this, the therapist was referring to the ability to read non-verbal communication from their clients, particularly important where there may exist normative obstacles to explicit articulations of sexuality. In some cases, so the therapist suggests, ethnic minority clients "haven't got 'decent' words to use"[5].

But the question of language is not merely a technical matter, and the therapists were well aware of this. The role given to language as a means to expressing, clarifying and resolving conflicts was understood as itself a product of ethno-culture. Western culture was expressive, as manifested in the legacy of the 'talking cure'. "...The [sex therapy] courses are all very much based on the westernised culture of talking, and you've got to look at what sort of sex therapy other cultures want?" [9]. A combination of social class location, and the transformatory effects of westernisation, were seen to provide the cultural and linguistic conditions of possibility for effective therapeutic relationships:

9: I think it's very much a sort of middle class phenomenon. So whether you're white or black doesn't matter so much but more that you're middle class and speak English in a sense...So if you are westernised, okay westernised, middle class, it works very well...

'Wanting to talk', was presented by some of the therapists as a quality uncharacteristic of Asian and African ethno-cultures. These accounts were commonly accompanied by proclamations of the powerlessness of sex therapy in the face of this culturally-derived resistance.

42: ...the whole concept of therapy is a Western European and American concept and I learned quickly working with HIV with African communities, that this [the talking cure] is simply a concept they didn't have...conceptually they didn't understand the need, it didn't exist as a concept...

Talking, as a means of addressing and resolving problems was a concept generally presented as having little purchase within Asian and African communities. There is in this respect a real danger that racist stereotypes regarding the cultural, linguistic, and attitudinal competencies of ethnic minority subjects may lead to the practical exclusion of minority clients from services (see Atkin 2003).

Whilst not minimising the therapeutic challenges presented by issues of language (Nazroo 1997), I would suggest that debates around equitable care within a context of ethnic diversity have can become unhelpfully reduced to the question of language. Unhelpfully in the sense that ethnic minorities *generally* and *enduringly* became associated with language deficits. The empirical reality is of course somewhat different, as until recently with the arrival of greater numbers of displaced people seeking asylum in the UK, the proportion of racial/ethnic minorities speaking little English has constituted a significantly declining population. This enduring sense of linguistic deficit amongst Britain's racial/ethnic minorities can and does serve as a prop to the dynamics of 'othering' upon which racism has been grounded, and informed the symbolic basis of denials of full citizenship to Britain's racial/ethnic minorities⁹.

⁹ The recent increase in the number of asylum-seekers in Britain may serve to reinvigorate a sense of, and concern about, language barriers. So may recent enunciations by political commentators such as David Blunkett

It also reproduces accounts of cleavages of linguistic dissonance that are empirically belied by the complexities, fluidities and situationally strategic use made of language within a British context where processes of hybridisation are producing emergent forms of linguistic exchange (see Bradby 2003). As a consequence, new, more, and infinitely finer forms of linguistic diversity are promised.

In toto, the terms in which the 'linguistic otherness' of racial/ethnic minority clients were constructed by sex therapists were in keeping with the ontology of racial/ethnic difference that pervades the discourses generated within the journal and interviews.

9.6 Conclusion

In a different but related context (nursing), Gerrish (2000) has discussed the prevalence and influence of an ideology of 'individualised care', which takes as its founding conceptual premise the absolute uniqueness of the sovereign individual. 'Individualised care' is taken by its exponents (and this constitutes a whole profession in the sense that a commitment to 'individualised care' has become a professional article of faith) as a necessary and sufficient foundation for therapeutic practice. This professional ideology is of course based implicitly, and occasionally explicitly, upon a political tradition of liberal individualism, and as such shares its primary contours. I would argue that, as with liberal individualism generally, 'individualised care' discourses experience difficulties recognising, accounting for, and engaging with, systematic social difference and/or inequality.

But discourses of race and ethnicity have also exercised a profound influence within the UK, and have served to reify and naturalise contours of systematic difference of a pseudo-biological and cultural kind, with the effect that social subjects become invested with systematic modalities of inherent disparity. As such, these two contrary ontologies coalesce in complex and contradictory ways (in conjunction with ontologies of gender) in forming the basis of professionals' engagements with their practice and their clientele. The tensions produced by this were evident throughout, and produced a pendulum swing back and forth.

A somewhat eclectic quality has characterised this field of data. Some central questions have emerged as topics for discursive production, most centrally the matters of sex therapy's demographic composition, problems associated with access and utilisation of

services by minority groups, the nature and extent of changes to a 'standard' sex therapy practice required by the 'fact' of diversity, and questions associated with therapist identity, cultural knowledge and language. Again, as before, the commentators within the journal were more consistently swayed by a multiculturalist rendition of sex therapy praxis than were the therapists interviewed, showing the influence of the 'transcultural tradition'. But what was particularly striking across both data sources, and across many of the questions considered, was the circumscribed nature of the practical therapeutic initiatives seen to be required by the 'fact of diversity'. The influence of a discourse of 'individualised care' was over-determining in the final instance. When it came to the most immediate questions of practice, whilst the differences attributed to race/ethnicity were seen as requiring 'special consideration', many aspects of extant sex therapy seemed to be salvaged. The capacity of sex therapy, via the utilisation of an expertise based upon core transferable skills and truths, to transcend or at least negate the influence of powerful social, cultural and political dynamics lying out-with the therapeutic encounter, seemed quietly re-asserted. A combination of core reflexive skills, a body of residual transferable knowledge, and cognizance of the substantive ethno-cultural qualities inhering within racial/ethnic minority clients were seen to offer the basis of effective therapeutic engagements.

I would suggest that it is the deep ambivalence that surrounds the very conceptualisation of the sexual subject that accounts for the nascent stage of sex therapy's engagement with the question of 'diversity' in practice. Multiculturalist renditions of the ethnic subject compete with individualistically-conceived renditions, with antithetical implications for praxis. What is most evident though, is that beyond fragments, a rendition of the sexual subject as constructed through racialised/ethnicised social, political and economic discourses and relations, has had only a limited influence within sex therapy. The corollary of this is that a systematic and reflexive 'thinking through' of the racialised/ethnicised interpersonal, organisational and structural dynamics that frame sex therapists' relationships with their clients is dramatically inhibited. At times even rejected. The terms in which the 'problem' is conceived remains narrow. They are marked by a distinct oscillation between reified renditions of ethno-cultural difference and dissonance, implying systematic modifications to therapeutic praxis, and their rejection in the name of a liberal individualism/universalism. In the latter case, all practice is modified to the needs of the 'client as individual', and as such, to the extent that they are granted any form of reality at all, race and ethnicity become reconceived as simply additions to client idiosyncrasy.

Chapter 10 – Conclusions

10.1 The research questions

How do sex therapists perceive human sexuality and the nature of the sexual subject, and how are these perceptions imbued with accounts of the role of gender?

Naturalistic, biologically reductionist renditions of sexuality contributed toward a view of sex as embodying an essential natural mechanism lying out-with the realm of the social; a sex/society dualism. But such accounts were universally grafted onto a view of sex as the very epicentre of the sovereign human subject, the latter understood largely in existential and individualistic terms. The paradigmatic influence of these renditions was such that incorporation of a social constructionist reading of human sexuality as ‘produced’ by social, cultural, political and economic dynamics was heavily circumscribed.

The manner in which these various orientations were accessed by the therapists was indicative of a holistic approach, but one in which the constituent parts were eclectically aggregated rather than systematically organised, avoiding the need for critical theoretical reflection. In fact a general reticence to theorise was evident, in part as a consequence of the effect of this ‘holism as eclecticism’, and in part as a product of a valorised reading of the role of the therapist as necessarily conceptually passive.

Sex therapy was presented within the data in generally apolitical terms as merely a tool for facilitation whereby clients could access and utilise scientifically validated knowledge in the pursuit of a reflexive sexual agency within a social context generally defined in permissive terms. Sexual pleasure was valorised as foundational to the healthy self and relationship. Though the notion of the liberated, reflexive and knowledgeable sexual subject was the dominant motif, this coincided with a recognition of prevailing limits to sexual freedom and the potentially problematic implications of a culture of choice. In the latter case, both the imperative to choose, and the idealised form taken by the representation of our sexual choices were seen as productive of sexual difficulties.

Women were seen to have been the primary beneficiaries of these liberations in sexuality. The influence of a politicised feminist-informed reading of gender relations was evident in the therapists’ valorisation of women’s entitlements to, and realisations of, sexual pleasure, and in their accounts of the fetters that may continue to impede women’s access to

this. This influence extended to a hegemonic reading of human (sexual) relations as gender-dimorphic, and universally so. A naturalistic, biological reading of gender as expressing differences of great depth and inherence consolidated the motif of gender dimorphism.

Accounts of sexuality were formally inclusive and universal in remit, but seemed implicitly coded in heterosexual terms. Though it was clear that a shift had taken place away from a discourse of perversity, to a discourse of diversity, there was a sense that heterosexuality continues to operate as a sexual norm, if not an apex.

The influence of 'holism as eclecticism' renders the question of sex profoundly accommodating to the complex and ambivalent discourses that comprise the field of race and ethnicity.

How do sex therapists perceive race and ethnicity as modes of difference, and what substantive qualities, significance and effects do they attribute to them?

Despite enunciations pertaining to the complexities and uncertainties of race and ethnicity within the data, a distinct taken-for-grantedness pervaded accounts, reflecting and reinforcing their reification as concepts and as empirical realities. The absence of conceptual rigour is of course that which makes many of the assertions produced in the name of race and ethnicity possible (see Bradby 2003). The vocabulary of a racialised ontology of embodiment, as a deposit of an enduring racialised social consciousness, was more evident than anticipated within both data sources, suggesting its continued discursive legitimacy within the 'boundaries of the sayable' (see Malik 1996). However, whilst more explicitly present within the interview data, in both contexts the primary role of a racialised ontology of 'natural kinds' was to implicitly authorise accounts of difference without a direct invocation of the race concept (see Brown 1999). Ethnicity emerged as the dominant concept, and though never defined in the journal data, and with difficulty in the interviews, was understood in largely primordialist and culturally essentialist terms (see Fenton 1999), with the primary theme in both sources being the mapping of ethno-cultural 'otherness'. Racial/ethnic categories and identities were understood as the organic product of real contours of biological and/or cultural difference. A deterministically conceived relationship between the forces of racial/ethnic attachment and the subject dominated accounts of racial/ethnic other. A conceptual prioritisation of ethnic variables and a consequent displacement of the explanatory importance of other social, political and economic factors was also evident.

A 'west and the rest' conceptual binary operated within both data sources, within which a condition of ethno-cultural vacuity was the primary attribution given to a western world 'normally' populated by 'subjects without properties' (see Dyer 1997). This said, the data were supportive of the view that ethnic and national identities are actively and contextually constructed through juxtaposition, such that accounts of the British shifted according to the particular 'non-British' populations to whom they were contrasted. Relations between racial/ethnic groups were seen as problematic, as an outcome of three principle dynamics; the conflicts generated by the contradictory constituent elements of respective ethno-cultural groups; the problem of racial/ethnic prejudice as an expression of an inherent fear of difference; and ethnocentrism, understood in terms of the oppressive implications of 'difference-unrecognised'. It was notable in this context that racism, as a concept that locates power centrally within an account of the oppressive relations between racialised/ethnicised groups was for the most part absent.

Of particular importance as dynamics informing the mediation of discourses of race and ethnicity within the sex therapy context were a range of (not entirely commensurate) professionally valorised conceptual orientations: a commitment to a liberal-humanistic individualism as this underpinned a reading of the importance of individualised therapeutic practice; a reading of sex therapeutic expertise as grounded upon scientificity and a transferability of skills, and an incorporation of a reading of professional practice as requiring cultural sensitivity in respect of ethno-cultural minorities. This produced a shifting and at times inconsistent rendition of race and ethnicity as the therapists struggled to make synthetic sense of contradictory impulses.

What role do sex therapists attribute to race and ethnicity in shaping male and female sexual identities, relationships, practices and problems?

The inter-connected and co-constructed nature of race, ethnicity, gender and sexuality was evident within the data. Gender relations and identities were perceived as deeply marked by the contours of race/ethnicity, as the racial/ethnic group was attributed with governing the roles of, and relations between, men and women. Through juxtaposition to the West, the 'otherness' of non-western racial/ethnic groups (within and out-with the UK) was demonstrated by the degree of ethno-culturally authorised polarity and inequity between the genders, though with differing forms and effects depending upon the group in question.

Sexual praxis and its attendant problems were considered similarly central to, and definitive of ethnic minority groups, and were presented as demonstrative of the conceptual and explanatory importance of the 'cultural field' to which the ethnicity category was seen to attest (see Gil-White 1999). In line with popular renditions of the 'Asian female' (see Hall 2002, Abbas 2001), a pervasive sexual passivity was attributed to South Asian women, just as a heavy responsibility was seen to fall on Asian men as guarantors of progeny, with a range of sexual and relationship problems flowing from this. In the case of African and Caribbean men and women, a sexual expectancy was implied, which for both men and women, translated into elevated expectations of sexual satisfaction and pleasure. Reflecting broader renditions of Africans and Caribbeans (see Frankenberg 1993) a general sexual health appeared to be attributed to the black heterosexual population. In stark contrast was the absence of any equivalence in accounts of the 'British' as an ethno-cultural constituency with concomitantly distinctive orientations towards sexuality, and consequent vulnerabilities to particular sexual problems.

The reified nature of race and ethnicity is such that they rarely depend upon the existence of a comprehensive and definitive body of empirical evidence for their survival. It was evident within both data sources, and acknowledged as such, that the empirical knowledge base of sexual praxis and problems within racialised/ethnicised populations was characterised by a paucity of available data. Despite this, a predominant discourse appears to have emerged, characterised by a number of elements. Firstly, that particular 'others', conceived in racial, ethnic and national terms, are characterised by the prevalence of particular types of sexual problem, marking them as different. Secondly, that though these problems may have a somewhat complex aetiology, they are overwhelmingly the product of the substantial ethno-cultural character of these groups. Finally, that similar accounts of the racial, ethnic and national 'self' as associated with, or productive of, sexual problems, are far less forthcoming (see Dyer 1997).

'Culture-bound syndromes', and particularly the 'twin icons' of the Koro and Dhat syndromes, have provided the central platform supporting a racialised/ethnicised ontology of human sexuality and dysfunction. Accounts of Koro have been ambivalent within the journal, where some contestation regarding its status as a 'culture-bound' disorder has served to open up a space where a broader set of assumptions about the nature of ethnicity could be brought under scrutiny. The discursive role played by Dhat syndrome within the journal, has been to confirm the category of 'culture-bound' disorder, and in so doing, to reinforce a reified racialised/ethnicised geography of sexuality and sexual problems. Within the context of the

interviews the role of Koro and Dhat was to serve as something of an absent-presence, operating primarily as vaguely conceived, but academically and professionally authorised, points of reference via which a racialised/ethnicised ontology of sexual difference was validated.

Within the interviews the 'mixed relationship' became an important vehicle through which to articulate ideas about the connections between race, ethnicity and sexuality within the context of relationships. The therapists' accounts reflected broader representations of mixed relationships as embodying difficult, and problematic modes of mixture (see Frankenberg 1993, Alibhai-Brown and Montague 1992). Implicit within the therapists' accounts was a modernisation thesis via which a condition of cultural stasis, produced by an overwhelming attachment to the past, was attributed to the non-western 'other', from which the only route of escape was a uni-directional and conflict-ridden process of acculturation to the 'ways of the west'. Via the medium of the concept of 'trans-culturalism', ethno-cultural change was presented as an exceptional and traumatic event brought about by dislocations such as migration, and as generative of a range of potential (including sexual) problems.

A multiculturalist rendition of cultural relativism, as productive of ethno-culturally differential sexualities and sexual problems was extolled, yet delimited in ways that were far from consistent or reflexively acknowledged. This orientation towards cultural relativism also competed with a more universalistically (because scientifically) informed reading of sexuality as encoding a set of truths distorted and fettered by the influence of ethno-cultural myths. The circumscription of a multiculturalist principle of cultural relativism 'in the final instance' may reflect its potential for jeopardising the claims to a scientifically grounded objectivity, veracity and validity in terms of which the authority and legitimacy of sex therapy has in part been based.

What do sex therapists consider to be the necessary and sufficient conditions of 'good practice' in meeting the needs of a clientele differentiated along lines of race and ethnicity, and how is current sex therapy evaluated in these terms?

Competing judgements regarding the implications of racial/ethnic diversity for an ethical sex therapy practice were in evidence, with a philosophical individualism and a liberal multiculturalism being the principle orientations. 'Colour-blindness', as an expression of a radical, and a-political, form of philosophical individualism, featured within the interviews but not the sampled journal data. But the predominant theme was an ill-defined and

unsystematic multiculturalism. Wieviorka's (1998) delineation of the three principle dimensions of multiculturalism proved useful in providing a structure for the analysis of the data. Multiculturalism in its sociological sense was almost universally, though often implicitly, espoused as appropriate to accounting for the nature of racial/ethnic groups, and their differential world-views and needs. From a standpoint where sex therapy's reading of the nature of sexual health, dysfunction, and therapeutic praxis becomes merely one ethno-culturally governed rendition amongst many, its relationship to ethno-cultural 'others' becomes deeply problematic. The primary problem becomes the danger of ethnocentrism, whereby a western sex therapy fails to understand and accommodate an ethno-cultural 'difference-unrecognised'.

The 'politics of recognition' accompanying multiculturalism in its political-philosophical and political science senses secured a highly variable form and level of commitment. As there was little overall consensus or clarity as to what it was to have ethnicity (as a source of need and identity), there was a general ambiguity as to what was seen to be ethically incumbent upon sex therapy in terms of recognition and provision. In this way, questions of service provision are connected directly to issues of citizenship and what could be described as a 'politics of deservingness' (see Atkin 2003, Anionwu and Atkin 2001).

Anti-racism enjoyed a limited profile within both data sources. As such, anti-racist, constructivist attacks on the reifications characterising much multiculturalism were likewise limited in their profile (see Solomos and Back 1996). As were proposals for the implementation of the forms of strategic initiatives typically associated with an anti-racist position. The interview data uncovered a substantial resistance towards the use of policy as a tool for achieving forms of power equalisation.

The ambivalence of these general orientations produced a somewhat eclectic, and surprisingly limited account of the necessary and sufficient therapeutic conditions for working effectively with racial/ethnic diversity. Where a specification of these conditions was provided, they appeared to imply a surprisingly limited modification of a 'standard sex therapy' approach, surprising that is in relation to the significance generally attributed to race and ethnicity as sources of sexual difference and dissonance. A 'knowledge and sensitivity' model predominated (see Culley 1996), combining core reflexive skills, a body of residual transferable knowledge, and cognizance of the substantive ethno-cultural qualities inhering within racial/ethnic minority clients as the basis of effective therapeutic engagements. Certainly within the interviews, the influence of a discourse of 'individualised care' was over-

determining in the final instance, and served to reinstate the expertise of the therapist as facilitator to the sovereign (individual) client's needs, and to introduce uncertainty around the value to be attached to 'ethnic knowledge'.

A number of discursive foci emerged around the theme of the therapeutic encounter. Notable was the apparent absence of a substantial discourse pressing for systematic racial/ethnic data collection and monitoring pertaining to client and practitioner demography, suggesting some degree of consensus around the sufficiency and appropriateness of extant provision. Ethno-culture provided the principle explanation of, and served to 'naturalise', differential levels of access and utilisation as the assumed direct or indirect result of sovereign ethno-cultural choices. In this sense, an account of the social and political dynamics shaping the relations *between* sex therapy and its racialised/ethnicised clients was fettered. The possibility and therapeutic value of achieving a greater racial/ethnic representativeness within sex therapy has been contested within the data. Beyond the importance of the therapist's skill, the will of the client, and idiosyncrasy of the therapeutic encounter, little can be predicted. This despite the universal recognition that sex therapy was an essentially white constituency, with an apparently inherent capacity for Euro-centrism. Gender was seen to be an important component of the practitioner-client dynamic, with 'western' men and women consistently preferring to see female therapists and particular ethnic minority men selecting male therapists as part of a general discrediting of women as experts.

The 'otherness' attributed to the racial/ethnic minority client seemed manifested in, and confirmed by accounts of the particular challenges presented by the problems of language. As sex therapy in the UK continues to speak almost exclusively through the English language, the implications for 'linguistic others' were seen to be acute. The limited prospect of provision in other languages and the therapeutic ineffectiveness of translation/interpretation seemed to guarantee a future of disengagement. Beyond the technical difficulties associated with language deficit was an additional burden associated with the absence, attributed to many racial/ethnic minority groups, of any notion of talking as therapeutic.

We are left with a sense that what is really at stake is a modification of western sex therapy within a climate of ethno-cultural constraint, informed primarily by a commitment to the importance of not 'giving offence'. As Stubbs (1993) has pointed out, 'ethnic sensitivity' has been grounded more upon models of 'benevolence' than structural change.

10.2 Directions for future research in the field?

From the outset, this project was defined in broad and exploratory terms. It has been concerned with mapping out the principle contours of an area about which little is sociologically known. As such, it has offered something of a skeletal sketch, to which a great deal of future fleshing-out will be required. A limitless number of research avenues could be deduced from the data, but some particularly pertinent and complementary areas for future development seem evident.

The representativeness of this project is limited by a host of restrictions to the research scope. In respect of the journal data, greater representativeness could be achieved by the inclusion of all papers from *Sexual and Relationship Therapy* (with the potential for enabling a deeper analysis of the manner in which race and ethnicity operate as an ‘absent-presence’ within sex therapy discourse), supplemented by an exploration of the many sex therapy texts and related journals. In respect of the interview data, a larger and more representative sample of all practitioners working within the field, and not merely those accredited to the BASRT, would enable a more confident set of conclusions.

The research design was informed by the need to collect a rich data set, as a precondition for unearthing and examining the underlying cognitive models held and utilised by sex therapists in respect of race and ethnicity, and their implications for questions of sexuality and sexual dysfunction. However, the use of semi-structured interviews, and the textual analysis of journal papers, has not produced a data-set capable of providing answers to some of the detailed questions generated within this project. With regard to the journal papers, there was of course no scope for seeking further elaboration pertaining to theoretical or conceptual claims or empirical reference points. Though in the longer term, the discourses contained within academic journals may well become the subject of a dialogue, via which claims are challenged, detailed and substantiated responses marshalled, and meanings clarified, this has not been possible within the context of this research. As for the interviews, whilst open questions enabled therapists to elaborate, and facilitated probing and requests for clarification/substantiation on my part, the limitations of a ‘one-off’ interview were in evidence. Had an opportunity been available to re-interview the therapists, or acquire respondent validation, it would have been possible to acquire a greater depth and precision of meaning from the discourses generated.

One area in which this became particularly evident was in relation to a different dimension of the question of 'scope'. The 'one-off' interview format undoubtedly made it difficult for therapists to make comprehensive and careful linkages between their accounts of specific scenarios and more 'global' considerations pertaining to the nature and significance of race and ethnicity as variables impacting upon human sexuality. In the other direction, the constraints of the interview format presented difficulties in subjecting apparently 'global' statements to a level of probing dialogue capable of testing and revealing their precise boundaries or conditions of application. This is revealed in the indeterminacy that characterises part of the data. An example of this can be found in the insufficiency of the data as a reliable indicator of the sheer diversity of 'therapeutic alliances' formed within sex therapy practice. Whilst it is clear that the respondents believed that the dynamics of sex therapy practice are affected greatly by the particularities of the client/s (in terms of whether they were working with: an individual and/or couple, a 'mixed' relationship, heterosexuality/bi-sexuality/homosexuality, variables associated with social class and age), it was not always possible to comprehensively identify from the data whether and in what ways these systematically shaped their understandings and accounts. This indeterminacy within the data is reflected in my analysis and write-up, particularly with regard to its inability to do justice to the sheer diversity of therapeutic alliances produced by the multitudinous sexual and inter-personal relationship variables with which sex therapists must engage. As such, there are occasions where the unit of analysis may shift from the individual client to the couple, and even occasions where the unit of analysis is unclear.

It has also not been possible to build into the research design a substantive test for validity, beyond that which becomes possible through the analysis of internal patterns and consistencies within the data. Of particular value in this regard would be further exploration of the impact of a host of dynamics potentially operating within the interview setting. Most significantly in this context, given that all participants within the research process were white, would be the development of a better understanding of how the 'whiteness' of both respondent and interviewer effects the production of data. Untangling the respective and connected impact of gender, sexual orientation, age, biography and professional-academic orientations upon the dynamics informing data generation within the interviews would also be useful.

If the meaning of a discourse ultimately lies in how it is read, then this project has been unable to get to the real meaning of the discourse found within the journal. As such, a fuller understanding of the impact of the journal's content upon sex therapists would require a

methodologically more sophisticated and focussed exploration of how readers select, signify, incorporate and utilise the knowledge contained therein.

As the terms of this project were limited to an exploration of sex therapeutic discourse within journal papers and interviews, a more comprehensive understanding of the role of racialisation and ethnicisation would require its supplementation by an uncovering of other dimensions of the problem, most importantly:

- a) how issues of race and ethnicity are discursively constructed within and through social interactions between sex therapists in contexts such as supervision
- b) how these discourses inform *actual* therapeutic practices
- c) how such practices are perceived and received by the clientele
- d) their ultimate effects upon therapeutic outcomes.

On a more theoretical and reflective note, this project has been informed by a commitment to exploring the interconnections and co-constructions of race, ethnicity, gender and sexuality, as these become manifest within one particular social location, sex therapy. Whilst multi-modal, situated research of this type offers great potential for exploring the complexities of the empirical world, it presents enormous challenges on a methodological and communicative level. The overwhelming outcome of this project for me has been the realisation of how great the need is for “...the development of new measurement tools and analytical approaches to investigate ethnic [and racial] identity through the life-course, its intersection with gender, class, and sexuality, the multidimensional nature of the concept, and its frequent resistance to easy categorisation” (my words in brackets) (Aspinall 2001: p.853). And all this with a sensitivity to the profound structuring effects of socially-worked, and typically essentialising discourses of race and ethnicity, and a host of socio-economic and political inequalities.

10.3 The implications for sex therapy?

As a sociologist, it is not possible for me to read these findings as they may be interpreted from a standpoint located within the sex therapy constituency itself. There will undoubtedly be many questions, reflections and even rebuttals made possible by such a stance, but which are unavailable to me at this point. However, a number of implications for sex therapy seem to flow from my analysis of the data, most of which revolve around a call for greater socio-political reflexivity within sex therapy theory and practice. Sex therapy has been criticised for failing to effectively incorporate a social, economic or political analysis

into its approaches to both sexuality and gender relations (Segal 1994). In the context of the data, this point could be extended to include questions of race and ethnicity:

The constructive power of sex therapy

The data are imbued with a sense that whilst sex therapists are not unaware of questions of power, their reading of sex therapy practice is over-determined by a model of practitioner-client relationships as essentially facilitative. Sex therapy here becomes defined in terms of its enablement of the sovereign client's wish to address their self-defined sexual difficulty. In this sense, a recognition of the power inhering within sex therapy to actively construct understandings of the nature of human sexuality becomes limited. Consequently, sex therapists have difficulties in recognising the manner in which their praxis may itself become a medium through which 'socially-worked', reified and potentially invidious racialised and ethnicised readings of sexual difference have been actively constructed and institutionalised. The dialogue clearly taking place within sex therapy around concepts such as ethnocentrism must be utilised to illuminate not only sex therapy's inherent situatedness within a particular socio-political and cultural context, but most importantly the power inhering within sex therapy to become an unwitting medium for racialised and ethnicised modes of 'othering' (even in the name of cultural recognition and sensitivity).

The need for conceptual clarity

Whilst in no way exceptional in this regard, sex therapy discourse seems to embody a great deal of uncertainty and ambivalence around the nature of race and ethnicity as modes of difference. This ambivalence is disguised however by the taken-for-granted, common-sense quality granted to them. Far greater conceptual rigour and transparency is warranted in sex therapy's engagement with questions of race and ethnicity, though the outcome of this may well be to bring into question much of what is assumed in the name of these concepts. A professional discourse of multiculturalism, as a framework for valuing, engaging with, and managing diversity, is clearly valorised by many within sex therapy. But it is clear that there is little by way of consensus as to what multiculturalism means within the context of sex therapy, and the achievement of any consensus is inhibited by the conceptual vacuity pervading accounts. Furthermore, there is a distinct tendency for renditions of multiculturalism within sex therapy to take a 'disintegrated' form (see Wierviorka 1998). This means to say that questions of economic participation and social inclusion become separated from the matter of cultural recognition with the result that culture becomes unhelpfully

located as the sole determinant of people's life chances and identities (Martiniello 1998).

A corollary of this imperative for greater conceptual rigour and transparency is the need for sex therapy to confront more fully the tensions produced by an understanding of the social/sexual subject as constructed through systematic forms of differentiation (such as race, ethnicity and gender) and universal modes of individualised therapeutic praxis informed by a liberal-humanistic notion of the sovereign self. In other words, what does it mean, in theory and in practice, to deliver individualised care in a context of systematic racial/ethnic differentiation?

Raising the profile of race and ethnicity as contested issues

Accrediting training programmes, post-registration educational provision, conferences and publications constitute important tools for public/professional dialogue around the themes of race and ethnicity, and of the nature of diversity and oppression. As an indication of a recognition within the BASRT of the productive potential of such tools, *Sexual and Marital Therapy* has committed one entire edition per year to a topic deemed to be worthy of focussed attention, such as gender, age and sexual orientation. An equivalent focus upon race and ethnicity would be apposite. It is also important that the BASRT (as an accrediting body) and RELATE (as a key educational provider of sex therapy training) strategically examine the nature of their curricula within pre- and post-accreditation educational provision with respect to race and ethnicity. Education provides invaluable opportunities for challenging racialised/ethnicised forms of common-sense via a critical, reflexive and socio-politically informed approach. "Understanding what constitutes good practices and ensuring that this understanding is widely disseminated becomes the basis of transforming thinking and practice" (Atkin 2003: p.104).

Policy as a tool

Whilst the structure of sex therapy undoubtedly constitutes a challenge to the implementation of a more comprehensive policy framework, the primary obstacle to the use of policy as a tool for pursuing justice, equality and effectiveness in a context of racial/ethnic diversity would seem to lie in the therapists' own conceptually-informed resistance. I would suggest however that any effective strategy for effectively engaging with the impact of race and ethnicity within sex therapy requires a substantial enhancement of the extant policy framework. Most immediately, a commitment to systematic data collection in the areas of client utilisation and sex therapy composition would seem an imperative if an unproductive

‘numbers game’ is to be avoided, and a reliable understanding of the current situation is to be acquired. An effective strategy for working towards the realisation of a more representative constituency of therapists is also critical.

The need for informed research

The data are replete with references (within both the journal and interviews) to the limitations of the current level of evidence and understanding of the sexualities and sexual difficulties of minority populations. There is a pressing need for conceptually rigorous and methodologically sophisticated research into issues of sexuality and sexual problems within racialised/ethnicised minority populations within the UK if we are to be able to ‘think clearly’ about the causes of (sexual and health) difference (see Bradby 1995). Such research would not only augment the extant evidence base but would also serve to highlight the complex, contingent and constructed nature of racial/ethnic categories, and their associated empirical correlations, in a manner that may serve as the basis of a challenge to the reifications and crude typifications currently hegemonic within sex therapy. Of central importance is an approach to researching race and ethnicity that is sensitive to points of commonality across racialised/ethnicised boundaries, and sources of differentiation within. This would require explicit and conceptually informed operationalisations of race and ethnicity as variables, utilised within methodological frameworks sensitive to the multiplicity of socio-political and economic causal factors impacting upon sexualities. It would also need to firmly locate ‘white’ majority ethnicities within a consistent conceptual framework.

10.4 The contribution to sociology

This project has strived to make a contribution to our sociological understanding of race and ethnicity. It has illuminated an area of social life that has hitherto remained somewhat obscured, and in so doing added a significant piece to the complex empirical jigsaw puzzle that is race and ethnicity within contemporary Britain. But a thesis must do more than this. A thesis must be reflexive in the contribution it makes towards our theoretical and conceptual understanding. Though this thesis has not set out to test a specific theoretical position, it is nevertheless located within a particular theoretical and conceptual place, and has strived to make a contribution to our understanding within this context. This thesis sits within a tradition marked out by the work of Solomos and Back (1996) in emphasising the importance of understanding race and ethnicity as overlapping and interwoven fields of social

and political construction, requiring an integrated and multi-disciplinary ‘race-ethnic relations’ approach for their exploration. As the data analysis within this project has demonstrated, in order to make race visible it is important to understand its ‘metonymic elaboration’ into concepts of ethnicity, culture and nationality, which enable the invocation of race (and its conceptual primitives) even in the absence of its explicit specification (Brown 1999).

In demonstrating the manner in which race and ethnicity have become inextricably connected within the discourses generated within sex therapy the project has contributed to our understanding of the ethnicisation of race and the racialisation of ethnicity, and of the situated nature of these processes. Solomos and Back (1996) highlight the importance of accounting for race-ethnic dynamics within specific social contexts as a means to appreciating the interplay that exists between broader social, political and cultural dynamics and those operating within (and at times unique to) particular social locations. This project, in demonstrating the interplay between what Knowles (1999) has described as ‘socially-worked’ versions, and accounts of race and ethnicity deriving from within sex therapy discourses themselves, has contributed to an understanding of this crucial interplay.

Knowles (1996) argues that racial identities should be seen as formed by the active work of social subjects (as work in progress), *but* also as a process inevitably situated within specific institutional-administrative contexts which serve to communicate to us something about who we are in racial terms. Whilst not able to explore the manner in which clients *actually* receive communication as to their racially and ethnically differentiated sexualities, the project has contributed to our understanding of the racialised and ethnicised conceptual orientations informing sex therapy discourse, and to how these may become encoded within therapeutic approaches and institutional practices to communicate to clients something of their racial/ethnic sexual identities. In this sense it has contributed to our understanding of the institutionalisation of racial and ethnic identities.

The project has also been profoundly influenced by the theoretical drive within sociology towards understanding the interaction between race-ethnicity, and other axes of differentiation, most notably gender and sexuality (Frankenberg 1997, Young 1996, Anthias and Yuval-Davis 1992). In demonstrating the manner in which race, ethnicity, gender and sexuality become co-constructed within sex therapy, and therefore acquire complex and shifting forms inter-dependency, the data analysis has contributed to our understanding of

how various axes of differentiation (in this case gender and sexuality) become actively enlisted in the service of (re)producing others (race-ethnicity).

In his discussion of 'representations of the other', Miles (1989) captured a fundamental theoretical and conceptual orientation informing most contemporary sociological work in the field of race and ethnicity, namely the relational nature of racial/ethnic discourse (see Dyer 1997, Solomos and Back 1996). Discursive constructions of the racial/ethnic 'other' are never merely outwardly directed. Rather, in the construction of boundaries of belonging they enable both ascription and identification (Jenkins 1997). 'Representations of the other' encode, and therefore (re)produce constructs of the racial/ethnic self. In some cases, they serve to enable little else. Situationally-specific analyses of the social and political construction of racial/ethnic otherness must be informed by an understanding of the manner in which the construction of the other is both cause *and* effect of the will to construct a racial/ethnic self. The project has been consistently informed by this theoretical stance and has served to illustrate the manner in which racialised and ethnicised representations of the other (in the form of the sexually dysfunctional 'minority' client) both enable and constrain particular readings of sex therapy and the therapist as racially and ethnically situated.

Finally, in a sociological and political context defined increasingly by a post-modernist informed 'diversity-agenda' in which the problem of oppression becomes reduced to a matter of 'difference unrecognised', this project may be taken to be informed by a longer standing tradition in sociological and political thought. More specifically, a concern with the oppressive implications of reified notions of difference, as these have characterised racist and culturally essentialist accounts of the racial/ethnic other (see Solomos and Back 1996, Miles 1989). In this regard, the data analysis has highlighted the very real possibility that the oppression experienced by 'minority clients' may have less to do with the failure of therapists to value or understand the differences of particular client groups, and more to do with the manner in which these differences become informed by enduring racialised/ethnicised reifications. Sociological approaches to race and ethnicity would do well to maintain this longer-standing theoretical scepticism in the face of a proliferation of identity claims made in the name of difference.

10.5 A final comment

It has not been my intention within this project to deny the existence, or indeed importance, of the cultural, linguistic or even ‘ancestral’ raw materials that have at times served as the basis of racial or ethnic mobilisations. Rather, it has been my intention to illuminate the manner in which these raw materials have been mobilised within sex therapy in the name of race and ethnicity. Furthermore, I have sought to challenge many of the claims made in the service of this ‘will to racialise/ethnicise’ as conceptually and empirically flawed, and productive of an invidious ontology of ‘othering’. There is a profound need for conceptual rigour and reflexivity within the health and therapeutic field as a necessary bulwark against the typifications and exclusions experienced by minority populations in the name of *their* difference. To the extent that we can usefully and productively invoke and utilise race and ethnicity in our mappings of the social world, it must be within an analytical framework underpinned by the recognition that these are problematic social and political constructs. The only valid approach is one committed to exploring racialisation and ethnicisation as *situated processes*; as unstable, yet interested dynamics of identification and attribution operating in complex relations with axes of gender, sexuality and class.

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Appendix 1

Interview questions

- Thank-you for your time
- Introduce self
- Reiterate focus of interview
- **The focus of my research** is looking at the relationship between sex therapy and a broader social context characterised by ethnic/racial diversity.
- **The method** - It is a qualitative piece of research based upon a series of interviews, where the interviewees' expressed responses constitute the data. These are then coded and analysed in relation to broader categories emerging from the interviewing as a whole. **It is for this reason that I would ask for the opportunity to use a tape-recorder.**
- Tape recorder
- Length of interview
- You can stop the interview at any time

SEX THERAPY AND YOU!

- I wonder if we might start on a more general note? I wonder if you could say something about **how you came to be a sex therapist?**
- How long have you been a sex therapist for?
- What were your expectations/perceptions upon entering the institution of sex therapy?
- What do you see to be the role of sex therapy?
 - the individual/relationship
 - society - **trigger**
- Do you see sex therapy in the late 20th century as something that is changing or moving in any particular direction?
- Do you see sex therapy as it stands at the moment as having an equal value/utility for all, irrespective of gender, sexual orientation, social class or race/ethnicity?

SEXUALITY

Given that the question of sexuality has underpinned much of our discussion, I wonder if we might spend a few minutes talking about sexuality?

- I suppose that all therapeutic interventions must be based upon some underlying model of human sexuality. **What is your model of sexuality?**
- **What importance do you attach to sexuality and why?**
- In your experience, would you say that you have seen any evidence of social factors having an influence on aspects of people's sexuality? Say for instance with respect to the changing role of men and women.

Do you see any parallels here with regard to issues of race or ethnicity?

- Do you see any important changes taking place in the way in which people perceive or experience their sexuality?

RACE, ETHNICITY AND SEX THERAPY

I wonder if we may turn to the question of race or ethnicity?

Please feel free to use the terms that you feel most comfortable with or which come most easily to mind. It is quite common for people to feel a level of uncertainty with some of the terminology in this area.

- Within the academic literature, and within popular and professional language you here references to race and ethnicity. You may not have a thought through response to this question, and that would be understandable, but what do you take these terms to mean?
 - Race
 - ethnicity
- Do you think they are useful as ways of understanding people?
- In what ways?
- How many minority ethnic clients would you estimate you have worked with?
- Do you feel that there are any important factors (cultural, economic, religious etc) that may shape the level of access or utilisation of sex therapy by different ethnic/racial groups?
- Do you see the fact of whiteness, a persons whiteness, as having a significance with respect to sexuality, perhaps in terms of what whiteness may represent or symbolise? Could you imagine the fact of whiteness having an effect on how one experiences/lives one's sexuality?
- Would you normally see the majority white population as an ethnic group as such?
- Would you say that the majority white population have sexual traits/dysfunctions that are for you a product of their ethnicity?
- Would you say that race/ethnicity play an important role with regard to sexuality or sexual dysfunction? Could you give any examples?

- It is very common today for relationships to be comprised of people who are seen to have a different ethnic/racial identity. This has been seen by some as very positive and by others as problematic. Do you feel that any specific issues are raised by such relationships?

THE PROFILE OF RACE/ETHNICITY IN SEX THERAPY

I am trying to estimate the profile that debates around ethnicity have within the community of sex therapy.

- How did race and ethnicity figure in your training?
- What about other possible measures:
 - their presence within the literature
 - the focus of conference papers
 - subject of discussion and consideration amongst peers.

I wonder if you could say something about your estimation of the profile of issues of ethnicity within the field of sex therapy.

RACE, ETHNICITY AND THE THERAPEUTIC ENCOUNTER

- I am also trying to gain a better understanding of the influence of race/ethnicity upon the therapeutic process.
 1. How might the therapists own racial/ethnic identity shape the way in which they understand sexuality, sexual norms/dysfunctions and sex therapy?
 2. Secondly, how might racial/ethnic identity be attributed to the therapist by the client and what challenges does this pose?
- Do you feel that there are any particular
 - attributes
 - skills
 required by the sex therapist in providing psycho-sexual therapy in a context of ethnic diversity?
- In the light of my research to this point I have heard expressed different views about the implications of racial/ethnic diversity for the approach adopted by the therapist.
 - Some have said that sexuality and sexual needs are universal and therefore one broad approach suits all
 - Others have said that everyone is a unique individual and that race/ethnicity are irrelevant
 - Others have said that ethnic/racial groups often have quite different attitudes towards sexuality and exhibit different sexual behaviours. These need to be understood by the therapist

Do you see your own approach expressed in these views?

- Do you think it is possible or desirable to introduce guidelines/procedures specifically designed to shape the way in which sex therapists provide therapy in a context characterised by racial/ethnic diversity?

Close the interview.

Thanks, reiterate confidentiality/anonymity

Do you have any questions?