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### The Measure of 'Sexual Dysfunction': A Plea for Theoretical Limitlessness

By Lisa Downing

[T]here are those [. . .] who say that sexuality is too mysterious and complex ever to be analyzed or comprehended. I disagree with them [. . .] To accept this attitude would be to negate the tremendous advances that genetics, neurobiology, evolution, and psychology have made in our understanding of the human mind. To give up on understanding sex is to surrender to ignorance, to despair of our own potential for thought and knowledge (Hamer and Copeland 14).

By asserting, in line with the tradition of enlightenment philosophy that has characterised Western epistemology since the eighteenth century, that knowledge *per se* is ethically beneficial, Hamer and Copeland, researchers into the elusive 'gay gene,' propound the belief that the greater the wealth of accrued scientific knowledge of sexuality, the more liberated and edified humanity will consequently be. This enlightenment logic extends to their (14) metaphorical language: 'A topic that impinges on the very existence of our species ought to be studied under the brightest light available,' they opine.

The project of scientifically studying sexuality, while undoubtedly bringing social benefits (in the spheres, for example, of genito-urinary health, the prevention of disease, and contraception, for those who want them), is nonetheless never an objective or ideologically neutral business. Despite the growing awareness in the medical, psychiatric and psychological disciplines of the importance of variable subjective, social and historical factors that may impinge upon diagnosis, the philosophy and methodology of scientific investigation still presuppose the existence of data that can be measured according to inflexible yardsticks of normality. And they still operate within a system in which normality is broadly equated with desirability. In the field of sexuality, this involves making judgements about the status of sexual subjects who fall outside of the prescribed norms of sexual 'health.' In an essay on 'Female Sexual Dysfunction,' for example, a New Zealand-based gynaecologist writes: 'physicians should respect a patient's choice to decline treatment, because studies show that sexual activity is not correlated with [. . .] satisfaction or intimacy in all patients' (Phillips 2000). Yet, despite this disclaimer which testifies to the individual's right to choose to deviate from the statistically observed norms of sexual behaviour, the article also quotes the recommendation that, when faced with female sexual abnormality, 'physicians must assume a proactive role in the diagnosis and treatment of these disorders.' Moreover, the article employs a language of value judgment in which the move towards the norms of sexual function is framed as 'improvement' and 'satisfaction.'

There is a significant discrepancy, then, between the expressed respect for the hypothetical patient's choice to retain her difference on the one hand, and the approbation that is accorded to the approximation of the described, desirable norm on the other. The two terms—normal and

different—do not carry equal weight here. This illustrates the falsehood, then, of the belief implied by Hamer and Copeland in the present paper's epigraph, that the neutral 'truth' about sexuality may be universally accessible and illuminating, and may mean the same thing to all subjects at all times. It is naïve to assume that a sexual subject designated by medical knowledge as other to the norm could have the same relationship to such knowledge as the one doing the diagnosing, either affectively or in terms of the power they may symbolically wield in the face of that diagnosis.

Recent developments in the theoretical humanities, largely influenced by Michel Foucault's *History of Sexuality*, originally published in 1976 and translated into English in 1978, but also indebted to the sociological perspective on homosexuality first given by Mary McIntosh (1981), have begun to question the validity and ethical basis of understanding human sexuality through a medical lens. [1] Such questioning operates at a meta-level to medical knowledge and admits of the cultural and historical specificities that cause certain mental, physical and sexual 'disorders' to come to prominence at certain moments in human history, and the kinds of relationships of power that presuppose them. For a scholar in the theoretical humanities, the body is not (just) a physiological entity, a fact of nature. [2] Rather, it is a site on and around which political and ideological meanings cluster, brought to bear by a complex constellation of social forces and networks of power.

Since the days of its inception in nineteenth-century Europe, sexual science has taken as its task the classification of sexual behaviour and the measurement of deviance as a means of establishing (epistemologically and instrumentally) the 'norm' of sexuality (Bullough, 1976; Hekma, 1991). Modern day sexology differs relatively little from its nineteenth-century origins. Where nineteenth-century physicians measured the skulls of degenerates to find the source of their perverse desires, recent attempts have been made by scientists to unearth neurological explanations for paraphilia and to isolate the 'gay gene.' [3] Female desire and orgasm have been incorporated into the field of study as important elements of human sexuality, but the didactic exhortation to experience desire and orgasm *in the right way* has replaced professional silence on the subject of female pleasure. [4] Moreover, the power wielded by the medical profession to influence which types of desire are considered acceptable or unacceptable is illustrated by the legal weight that continues to be attributed to some psychiatric diagnoses of sexual disorder, for example paedophilia.

One ramification of this systematic insistence on the existence of sexual normality—and the resulting assumption that what falls outside it is unhealthy—is that certain forms of sexual behaviour have been labelled as mental disorders. Despite the discipline's origins in Northern Europe, sexual science has been most predominantly located in North America during the late-twentieth century. The catalogue of 'Sexual Disorders' listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (hereafter *DSM-IV*), is a globally influential diagnostic tool. (The Mental Disorders section of the British *ICD-10* resembles closely the *DSM-IV*, and the *DSM-IV* is widely referred to in Europe). An examination of the rhetoric of the *DSM-IV* can thus reveal much about the ideological assumptions underpinning contemporary psychiatric attitudes towards sexuality, even though I would not wish to overstate the cultural universality of the manual, nor oversimplify the translation between the written text and the contingent realities of different branches of clinical practice.

The *DSM-IV*'s Sexual Disorders fall into three categories: Sexual Dysfunctions (incorporating desire disorders, aversion disorder, arousal disorder (male and female), orgasmic disorder, sexual pain disorders, and sexual dysfunction not otherwise specified), Paraphilias (exhibitionism, fetishism, frotteurism, paedophilia, sexual masochism, sexual sadism, voyeurism and paraphilia not otherwise specified) and Gender Identity Disorders (diagnosed by 'a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is of the other sex' (American Psychiatric Association 532) and 'evidence of a persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex' (533).

The logic of the *DSM-IV* is very simple: the sexual dysfunctions represent the primary level at which it is perceived that sexuality might 'go wrong.' They entail either the 'failure' of the genitalia to perform the necessary functions (hardness, wetness etc.) that allow the act of sexual intercourse to take place pleasurably, or else a psychological unwillingness to engage in sexual intercourse in the first place. In a fundamental sense, then, the consistent inability, lack of will or lack of desire for intercourse is considered sufficient evidence to constitute a mental disorder.

The 'paraphilias' are characterised by a marked preference for practices other than sexual intercourse, or for 'unusual' practices in which sexual intercourse is only a secondary factor in creating arousal and/or achieving orgasm. The *DSM-IV* states that one necessary diagnostic criterion for establishing the mental disorder of paraphilia is that 'the behavior, sexual urges or fantasies [must] cause clinically significant distress or impairment in social, occupational, or other important areas of functioning' (523). This may at first appear to suggest that the authors of the *DSM-IV* can account for the possibility of a 'happy pervert' who, by refusing to suffer from his or her difference, escapes the ranks of the mentally ill. However, a closer examination reveals that this would be an optimistic misreading. The second clause relating to 'impairment in social [. . .] functioning' ensures that the 'happy paraphile' still requires treatment. For, as we have seen, according to the *DSM-IV*, the ability to engage in and enjoy 'functional' sexual intercourse is a primary and necessary prerequisite of mental health and of social well-being. Moreover, the reason why the paraphiliac may experience 'dystonia' at the thought of the act or stimulus that brings him/her pleasure is not explored. It is assumed by the *DSM-IV* that *the content of the paraphilia itself* must be the factor causing the individual distress, rather than the overwhelming pressure to conform to an ideologically normative standard. The prospect of being diagnosed a paraphiliac and hence mentally disordered would, one might assume, be enough to provoke considerable dystonia in anyone.

Similarly, Gender Identity Disorder makes sense only in a culture in which the meanings ascribed to sexual difference are reducible to a strict scripting of expected binary gendered characteristics onto strictly delineated male and female subjects. The assumption that individuals must ascribe to this rigid sexual and gendered two-way division of labour is the straitjacket which produces this diagnostic category. Of course, it could be no other way so long as the primary logic according to which sexuality is called to signify remains a mutually-desired heterosexual genital act.

For a scholar working in those branches of the theoretical humanities influenced by the insights of gender studies and queer theory, the logic by which the *DSM-IV* ties together the sexual disorders it names into a series of binaristic, commonsense either/ors (functional/dysfunctional; normophilic/paraphilic; male/female; masculine/feminine) begs deconstruction. The idea that one might be able to measure and correct, objectively and scientifically, either sexuality itself or its dysfunctions is problematic. The assumption of 'natural' sex and sexuality and the refusal to attribute the source of norms to local and contingent cultural factors bespeak a denial of the relative status of historical processes.

My task in the rest of this article, then, is to explore some of the ethical difficulties implicit in the project of diagnosing dysfunction, using the insights of contemporary critical theory. At the same time, it is not my aim to dismiss the usefulness of the diagnostic function *per se* or to undermine the value of all types of medical intervention in sexual life. Rather, I hope to demonstrate theoretically how diagnosis may never be a neutral matter for the sexual subject, and therefore to suggest that psychiatry and sexology could benefit from a more detailed dialogue with the relativising discourses of the theoretical humanities. The scope of this essay is such that my contribution is necessarily introductory and theoretically exploratory, rather than conclusive. My intention is that it may stand as a document for debate on the possible futures of interdisciplinary ethical research between scholars in the humanities and the sciences, as they meet on the hotly contested territory that is human sexuality.

### **Acts and Identities: Relative Meanings**

The extent to which sexual normalcy and deviance are constructed according to socially determined prejudices and presuppositions, rather than given inevitably by an unchanging and natural sexual standard, may be illustrated by an examination of the history of the nomenclature of these 'conditions' within the various revisions of the *DSM*.

In the 1970s, a debate took place in psychiatric circles regarding the most appropriate descriptive label to attribute to sexual conditions constituting mental illnesses, with specific reference to the status of homosexuality. Irving Bieber proposed introducing the term 'dysfunction' to replace the then current label 'sexual deviation.' He thought this would be particularly appropriate to the case of homosexuality, as the homosexual, by definition, 'cannot function heterosexually' (Stoller et al. 1210). Richard Green agreed with the proposed term 'dysfunction' but rejected the idea that homosexuality per se met this description. For him, the dysfunctional homosexual would be one who 'finds it difficult to maintain desired object relationships, who compulsively uses sexuality to ward off anxiety or depression, or whose sexuality typically leads to depression or anxiety' (Stoller et al. 1214).

The removal of homosexuality from the ranks of the sexual disorders (including so-called 'ego-dystonic homosexuality,' which appeared in the 1982 *DSM-III*) came with the third edition revised of the *DSM* in 1987. This outcome reflected the effectiveness of political action in the social body over a period of more than ten years, commencing with the Stonewall riots of 1969, and marked a partial triumph for emergent gay identity politics. However, the assumption persisted, visible in Green's formulation of the necessity of 'maintaining object relationships,' that a homosexual whose sexual lifestyle does not ape that of a monogamous (or at least 'serially monogamous') heterosexual may still merit the label of dysfunctionality. In his discussion of this debate in *Sexual Investigations*, Alan Soble asserts forcefully that 'accounts of healthy human sexuality become a masquerade for partisan and contentious views about what sexual behaviours are proper and right, obligatory and permissible, attractive and repulsive, harmful or contrary to society's interests' (173). Soble effectively points out that medical and, in some cases legal, diagnoses are attributed to certain sexual behaviours, not because they might cause harm to the practitioner or others, but because they upset a conservative social ideal.

The understanding that the classification of deviance is culturally contingent—dependent upon a fluctuating moral climate—leads necessarily to a questioning of the status of those forms of sexuality that retain their pathological labels in *DSM-IV*. Just as 'homosexuality' has slowly been recuperated as a sexual and political identity rather than a marker of disease, so certain practices which continue to be labelled paraphilic conditions, if recast in the language and logic of different political agendas, become the lynchpin of alternative communities and subcultural groups. As Gayle Rubin puts it with an undisguised note of triumph, 'Sexualities keep marching out of the Diagnostic and Statistical Manual and onto the Pages of Social History' (287).

Those paraphiles 'suffering' from *DSM-IV* nos. 302.83 and 302.48—the sexual masochists and sadists—are, viewed in another light, the exemplary subjects of Foucault's longed-for revolution. Taking the gay subcultures of 1980s San Francisco as his inspiration, Foucault argued that it is by engaging in activities and desiring dynamics which avoid aping heterosexuality and socially-sanctioned coupledness that dissident pleasure may be liberated from normative discourse. With its conscious and playful mimicking of power structures, sado-masochism was seen by Foucault as a particularly rich source of subversion. The gay sado-masochistic ghettos were held up as paradigmatic alternative communities because they escaped regulatory cultural mechanisms by organising themselves around principles of pleasure and playfulness. Such sexual communities do not contribute to the social order, but parallel and parody it, refusing the utilitarian applications to which sexual desire is habitually put (Foucault 1989).

Other so-called 'paraphilic' practitioners may have access to underground communities, in either this world or the virtual online one, but may nonetheless lack public political narratives. One example of sexual subjects in this position is those whose practice is described in the *DSM-IV* as

'hypoxiphilia,' a sub-category of Sexual Masochism. 'Hypoxyphilia' (also known as erotic asphyxiation or asphyxiophilia), is defined as a practice which 'involves sexual arousal by oxygen deprivation obtained by means of chest compression, noose, ligature, plastic bag, mask or chemical' (American Psychiatric Association 529). The sexologist John Money, who has written widely on this phenomenon, describes asphyxiophilia as 'a sexual peculiarity in which sexueroptic arousal and facilitation or attainment of orgasm are responsive to and dependent upon self-strangulation and asphyxiation up to, but not including, loss of consciousness' (Money, Wainwright and Hingsburger 15–16).

In a recent article I co-authored with Dany Nobus (Downing and Nobus, forthcoming 2004), we explored the role of visual self-representation in the scene of autoerotic asphyxiation. Practitioners repeatedly represent themselves (in drawings, photos, videos) as bound, asphyxiated bodies, apparently (wishfully) dead. If the practitioner of autoerotic asphyxiation should actually die during his or her practice, is this a success or a failure of the act? Does death by asphyxiation here represent functionality or dysfunctionality (within the terms of the fantasy and behaviour in question)? Of course, the question cannot be answered simply or straightforwardly, since 'dysfunction' is a term that makes sense only when applied to sanctioned sexuality (that which, as well as working to the satisfaction of the participants, can also be said to 'function' socially, to have a use value). The term 'dysfunction' belongs to the language of 'good mental health' and the penetrative, phallic economy, the end point of which is defined as orgasm. The underlying logic of sexual mental health is that life, rather than death, must be the aim of a sexual act. Accounts of asphyxiophilia, such as John Money's, cited above, repeatedly stress that the aim of the practice is orgasm, while visual and written autobiographical accounts focus instead upon the wishful condition of deadness, beyond the contingency of orgasmic release. This is an extreme example, but paradigmatic in its lesson that sexuality may not be reduced to commonsense outcomes and obvious deductions. Where these deductions are made by professionals, one must examine closely the motivations subtending them. What the case of asphyxiation for pleasure shows is precisely that the notion of dysfunction ceases to make sense as soon as one respects the legitimacy of the internal codes and aims of a given sexual fantasy or practice that is not reducible to the law of genitality.

Even radical political defences of alternative gender performances and sexual behaviours, however, seem to draw the limit at those types of sexuality that are physically dangerous and ontologically risky in their approach to, or fetishisation of, death. Theorists of gay and queer desire, including Leo Bersani (1988; 1996) and Jonathan Dollimore (1998), have rigorously argued for a rejection of the cultural fantasy that links homosexual practices to mortality. Dollimore (312–327) goes so far as to posit that gay eroticism may be one of the few models of desire that can exclude the lack-driven model that haunts the history of discourses of desire. These strategies are perfectly understandable in the light of the campaign of panic against homosexuality seen at the time of the AIDS outbreak in the 1980s.

However, the risks involved in imagining a limitless definition of the sexual field, outside of diagnostic categories, may involve, to use Hegel's term, a willingness to 'tarry with the negative.' [5] The association of sexuality with 'health' and 'life' is one of the trump cards of sexual science, the means by which the delimitation and control of pleasures may be made justifiable and even attractive. Foucault's work has shown that the bodies and pleasures of subjects in the social system are submitted to 'bio-politics,' that is, to a state in which 'political power [has] assigned itself the task of administering life' (Foucault 1998: 139). The pervasive lure of the rhetoric of bio-politics may lead even radical thinkers to delimit those practices and identities that are 'good' (life-dealing) from those perceived as negative and destructive. A willingness to consider the most extreme sexual desires not as pathologies but as the radical literalisation of the dynamics of loss, risk and pleasurable boundary destruction may be the next theoretical step in thinking beyond positivistic and 'commonsense' definitions of sexual behaviour. [6]

The very notion of dysfunction, then, as it is used in diagnostic manuals such as *DSM-IV*, fails to

allow for the specificities and variables of the internal rules of different sexual modalities. It is a term that implies an absolute rather than a nuanced or relative understanding. The whole criterion of dysfunction fails if applied to practices which are not dependent on a particular sort of genital response or on the successful execution of an act designed to lead to orgasm. The paraphilias *have* to follow the dysfunctions in the *DSM-IV*'s list of sexual disorders, since to depathologise the variety of practices they describe would constitute an admission of the nonsense of the metaphor of 'functioning' in relation to sexuality. In the pleasures encoded as paraphilias, there exists a plurality of sexual acts and logics which exceed and show up the limits of the notion of function or dysfunction, working or not working.

Is it fair to state, then, that the only instance of sexuality against which notions of 'functional' and 'dysfunctional' can adequately be tested is the privileged act of reproductive genitality, heterosexual intercourse? Even in this, I would advise caution, for who is to say that in certain cases, according to certain desires and fantasies, by certain practitioners of heterosexual intercourse, at certain times, orgasm (that proof positive of functionality) may be eschewed—even deemed irrelevant—in the face of other kinds of pleasure occasioned by coitus (psychological connection; multifaceted dermal contact; the excitement produced by accompanying role play)? The only act, then, it seems, that is capable of standing up to the functional/ dysfunctional test is the socially-prescribed, *ideal* act of heterosexual intercourse. This is a discursive fiction to which real agents may aspire, but which takes place in the collective cultural imaginary only, fuelled by the emotive fictions of sexological texts and statistics reflecting a desired 'normality.'

### **Conclusion: Ontology Trouble**

Sigmund Freud was among the first to broaden the definition of the 'sexual,' to include family bonds and friendships. For Freud, all affective attachments between individuals fell within the realm of Eros (whence the accusation often levelled at him of pan-sexualism). As I have explained, the notion of sexual dysfunction assumes that we (always) know what is (always-already) at stake in the sexual project. What Freud began, contemporary queer theorists (although working with a quite different political agenda) have carried on. So it is that far from the notion of sexual 'performance' central to hetero-masculinist, penetration-focused discourse, queer theory after Judith Butler has come to describe sexuality and gender as operating according to codes of 'performativity.'

Performativity implies firstly that the gender and sexual roles we adopt are a series of imitations for which there is no original. They are repetitions in the world that accrue and—crucially for Butler—can transform their meaning. They are not natural or inevitable elements linked to biological or genetic facts about a person's sex and sexuality. For Butler, 'there are no direct expressive or causal links between sex, gender, gender presentation, sexual practice, fantasy and sexuality. None of these terms captures or determines the rest' (1993a: 315). Such theories of sexuality deliberately highlight elements of play, fluidity and interchangeability at work in sexual behaviour and sexual orientation, problematising the notion that gender can ever simply 'go wrong' ('be dysfunctional') or 'go right' ('follow its 'natural' course'). Butler's theories may provide us with a language with which to question the *DSM-IV*'s diagnosis of Gender Identity Disorder, by upending the notion that a boy child will 'naturally' behave according to codes of masculinity, and a girl child according to codes of femininity. That any deviation from this rule is tantamount to a mental disorder is a medical fiction which disavows both the cultural relativity of the meanings of 'gender' on the one hand, and the existence of physiologically intersexed children, on the other.

Judith Butler's work on gender has questioned precisely the ontological certainty which sexual identity has been accorded in the modern period—the notion that *one knows what is meant* by a given 'sexuality,' that one 'is' a lesbian, a gay man, a straight woman, and so on. While marching under the sign of 'lesbian' for political purposes, Butler (1993b: 308) nonetheless wishes that the meaning of the sign 'lesbian' should remain radically indeterminate. Her reservation is a valid one

for any reader of Foucault. Naming equals knowing; that which is known, catalogued, categorised is made familiar, recuperated as an object of discourse.

The sexologist John Money is responsible for ascribing names to scores of types of paraphilia. Money also tested and pioneered the use of an anti-androgen drug under the name Depo-Provera, which he continues to prescribe at the Sexual Disorders Clinic, Johns Hopkins University for 'sex offenders' suffering from the very conditions *he himself* has created as diagnostic categories. [7] Thus, the condition and the 'cure' are products of the self-same authority. This is among the most literal examples one could find of the relationship Foucault thematises between assuming a knowledge of sexuality and exerting control over bodies and pleasures. This is not to imply that Money's treatments may never bring relief to individuals perceiving their sexual conditions as a source of anxiety, but rather to illustrate how the circuits of meaning running between knowledge and authority, diagnosis and self-perception function in the clinical system. [8]

The attempt to think bodies and sexualities outside of existing authoritative epistemologies by which they are habitually understood—and thereby controlled—has led to some ambitious and abstract theoretical formulations. Gilles Deleuze and Félix Guattari, perhaps more influentially than any other modern critical thinkers, have constructed imaginative strategies for de-biologising desire. They replace the organic bodies of psychoanalysis and sexology with metaphors of 'desiring-machines,' and substitute 'being' with 'becoming' in a refusal of the traditions of ontology. The idea of an always forward-flung movement towards an undeterminable mode of experiencing replaces measurable sexual 'fixity' in the rhetoric of these thinkers, in a rejection of what they perceive as the complacency and the dangers of knowing. [9]

However, it is also important to inject a note of caution regarding the theoretical fashion for fluidity. While polemically valid and rhetorically empowering, this strategy entails its own problems. The notion that one's sexuality is politically viable only if it is characterised by variety and a conscious enjoyment of performativity risks excluding those who practice only one act, who enjoy the ritualistic and repetitious pleasures of fixity. Fixity has suffered a bad press. From the first of Freud's Three Essays on the Theory of Sexuality, which states that 'if [. . .] a perversion has the characteristic of exclusiveness and fixation—then we shall usually be justified in regarding it as a pathological symptom' (1953–1974, Vol. VII: 161) to the *DSM-IV*, which asserts that 'fantasies, behaviours, or objects are paraphiliac only when they [. . .] are obligatory' (American Psychiatric Association 525), the notion that variety makes sexual behaviour and identity acceptable is consistent in psychiatric discourse. Worryingly, however, it is also implicitly a tenet of queer theory (even if psychiatry requires that the 'variety' include heterosexual penetration, while queer theory does not).

For example, Moe Meyer defines queer as an 'ontological challenge' to concepts of sexual subjectivity that are 'unique, abiding and continuous,' favouring instead sexualities that are 'performative, improvisational, discontinuous' (2–3). This rhetorical privileging of discontinuity suggests that, for Meyer, those who self-define as fixated are in thrall to a 'bourgeois' and reactionary ideology of selfhood. Similarly, in Tim Dean's ambitious work which attempts to marry Lacanian theory and queer theory, he contends that '*the process of normalization itself is what's pathological*, since normalization 'fixes' desire and generates the exclusiveness of sexual orientation as its symptom' (237). Thus, even this bold attempt to write against the psychoanalytic orthodoxy (by pathologising the imperative to reach hetero-genitality rather than pathologising perversion) ends up taking the concept of fixity or 'exclusiveness,' rather than the symbolic imperative of compulsive heterosexuality, as the target of its attack.

Instead of constructing its own type of exemplary, appropriately plural subject, it is important that queer theory should focus on *semantic* slippage and *discursive* fluidity, without insisting that these qualities extend also to behaviour and identifications. Progressive theories of sexuality must avoid aping the authority discourses in their assertion that fixity is somehow pathological or inferior to plurality, and work to legitimise both plurality and singularity, not in a dialectical

configuration, but as infinitely equal and different.

Similarly, one must be aware that to deconstruct the naturalised binary logic underpinning the diagnosis of Gender Identity Disorder risks shading into a denial of the already fragile rights of individuals to seek medical assistance in changing their physical sex. A more desirable ethical agenda would surely be one in which these requests could be accommodated in a non-pathological context, with the aim not of replicating the 'natural' and 'functioning' binary constellation of 'man' and 'woman,' but of respecting the inviolability of a given subject's identifications, desires and fantasies, which cannot be possessed or reduced to presumptions regarding the unchanging and universal meaning of sexual difference.

And so, this caveat in place, I would repeat that we—humanities scholars and scientists alike—must be careful about 'being.' Asking or stating what one 'is' (gay/ straight/ bisexual/ a man or woman/ a sadomasochist/ intersexed) is a seeking after a truth, the very 'is' which has sought to define types of sexuality—in order to sort the socially sanctioned from the socially prohibited—since at least the late-nineteenth century. The task of theory is to destabilise common sense understandings of being that naturalise as inevitable historically and culturally contingent phenomena that are always underpinned by ideology. We must make sure that any 'is' that we pronounce is properly inflected with the voice of demystification—the voice that seeks not to ask 'what is the truth of your sexuality: is it working correctly or not?' but instead: 'what is it that people really mean when they talk of sexual dysfunction?' [. . .] 'What is it that motivates professionals to label behaviour functional or otherwise?' [. . .] 'And why this utilitarian language anyway?' [. . .] 'Why *would* sexuality function or not function?' [. . .] 'What function is it being called upon to serve?' [. . .] 'For whom does its functioning serve a function?'

**Lisa Downing** is Lecturer in French at Queen Mary, University of London. She is the author of a recent book, *Desiring the Dead: Necrophilia and Nineteenth-Century French Literature* (Oxford: European Humanities Research Centre, University of Oxford, 2003) and numerous articles and book chapters on theories of sexuality; modern critical theory; and literary and cinema studies. Her overarching research interest is in the intersection of sexuality and death in artistic, psychoanalytic and scientific production. E-mail: l.m.downing@qmul.ac.uk

## Notes

[1] Here McIntosh argues for a social constructionist perspective on homosexuality, drawing on comparative anthropological accounts and considering homosexuality primarily as a 'social category rather than a medical or psychiatric one' (43). [\[return\]](#)

[2] Within debates in the theoretical humanities, there is a divergence of opinion on the status of the physiological body. The most extreme position is represented by deconstructive gender theorist Judith Butler, for whom the physical body is a construct of ideology rather than an ontologically pre-existent entity (1993a). [\[return\]](#)

[3] The Italian criminologist Cesare Lombroso (1835–1909) inaugurated the method of measuring cranial and facial features in order to establish physiological determinants of moral and sexual degeneracy. For a thorough account of the work of Lombroso and the other Degeneration theorists, see Pick (1989). For twentieth-century correlatives of these deterministic arguments, see for example Milton Diamond's (1977) work on the effects of prenatal hormone levels on neural pathways and the neural endocrine axis in determining future sexual behaviour. On the controversial 'gay gene,' see Hamer et al. (1993) and Risch, Squires-Wheeler and Keats (1993). [\[return\]](#)

[4] The controversy surrounding the existence/supposed superiority of the vaginal over the clitoral orgasm has been a subject of particular interest for sex researchers. Havelock Ellis was one of the first sexologists to discuss the importance of female orgasm, followed by Kinsey in the 1950s (Ellis, 1942: 1–353, esp. 236; Kinsey et al. 1953). Masters and Johnson (1966) revisited this ground during the 1960s in *Human Sexual Response*. All of these sexologists privileged the importance of the clitoris over the vagina for female sexual pleasure, focussing on the role of masturbation and the possibility of female orgasmic multiplicity. The alleged discovery of the 'G-Spot,' with the publication by Alice Ladas, Beverly Whipple and John Perry (1982) of *The G-Spot and Other Recent Discoveries About Human Sexuality*, shifted the focus back to the vaginal orgasm, placing emphasis once again on heterosexual intercourse as the most important and authentic sexual act for a woman. For more information on these debates, see Irvine (1990: 60, 161–169 and 225–226). [\[return\]](#)

[5] In the preface of *Phenomenology of Spirit*, Hegel writes: '[T]he life of the Spirit is not the life that shrinks from death and keeps itself untouched by devastation [. . .] It wins its truth only when, in utter dismemberment, it finds itself. [. . .] This tarrying with the negative is the magical power which converts it into being' (in Zizek, 1993: epigraph). [\[return\]](#)

[6] An issue of potential relevance to my discussion of the abolition of 'limits' in conceiving of the sexual is the question of the ethics of consent, and in particular, the status of non-consensual sexuality with regard to dysfunction. As I could not fully do justice to this very broad question in a paper of this length, I am deliberately excluding it from the article's remit, but would draw readers' attention to my (2004) article which discusses 'liberal' sexological responses to the extreme test case of consensual murder pacts. [\[return\]](#)

[7] For an account of Money's involvement with the drug, see Tsang (1995). The drug has a controversial status in the context of other debates too: in Britain it is available as a female contraceptive injection and is also used to regulate the sexuality of women in mental health care establishments. [\[return\]](#)

[8] In *Money*, Wainwright and Hingsburger (1991), the asphyxiophilic autobiographer, Nelson Cooper, repeatedly expresses his relief at finally having a name with which to speak of his condition and a drug which curbs his desire. To acknowledge this fact in the microcosm is not to undermine the necessity to keep asking the larger question why and according to the operations of what ideologies a subject should be comforted by the processes of classification and medicalisation. [\[return\]](#)

[9] See Deleuze and Guattari (1984; 1987). See also, however, Joseph Bristow's (128–136) summary of the criticisms leveled at these thinkers' theory, notably the persistence of phallic imagery in their 'plugging in' metaphors and the high level of abstraction that makes it hard to apply their theory to material political ends or clinical reform. [\[return\]](#)

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