The 'Coital Factor'

MEDICO-LEGAL APPROACHES TOWARDS SEXUAL INCAPACITY AND INFERTILE MARRIAGES IN MID-TWENTIETH-CENTURY NEW ZEALAND

FOR NEWLYWED COUPLES IN 1950s NEW ZEALAND, a satisfying sexual relationship and parenthood were considered to be two primary markers of 'modern marriage' and the prevalent assumption was that one would lead to the other. If a marriage failed to achieve these ends, then medical advice to solve the problems or legal advice to dissolve the marriage might be sought. In this article, primarily drawing upon medical journals and texts, particularly ones with a New Zealand focus, I first consider how New Zealand's medical profession – and particularly its emerging infertility specialists – responded to sex and 'sexual dysfunction' within infertile marriages.[1] Baby boom statistics show that the parenthood goal of 'modern marriages' was achieved by many, with couples having larger families than in previous generations. Such marital fertility may have been caused by increasing rates of marital coitus over this period, as historian Hera Cook has suggested in the English context.[2] For couples experiencing infertility (involuntary childlessness) during this period of seemingly abundant fertility, and particularly for those whose sex lives were the direct cause of their childlessness, the sense of marital failure must have been acute. For some, even broaching the subject of their troubled sex lives with a doctor was a deeply uncomfortable and challenging experience. But medical professionals too found these patients particularly challenging to treat and, within the confines of the clinic setting, many will have shared their patients' reticence on the subjects of sexual intimacy and their failure to conceive.

The medical literature about infertility – reflecting wider societal concerns about divorce – also periodically warned that unhappy sex lives and involuntary childlessness could result in divorce. Using two mid-twentieth-century divorce cases, in the second part of this article I turn to examine how infertility and sexual incapacity were represented in New Zealand's courtrooms around this time, including by expert medical witnesses. I argue that the reticence about sexual matters observed in doctors' offices was not apparent in the courtroom. Whereas doctors might have been ill-equipped and embarrassed to press couples for details of their sexual lives, to prove

non-consummation as a grounds for divorce, the most intimate details of a couple's relationship had to be held out for inspection in the courtroom. The 'coital factor', assumed to be a 'natural' outcome of marriage, proved, for a small group, to become a subject of medical and legal investigation.

Certain aspects of this topic have already been scrutinized by historians of sexuality and medicine, using a variety of approaches. Hera Cook, for instance, has carefully considered English attitudes towards sexuality in *The Long Sexual Revolution: English Women, Sex, and Contraception 1800–1975*, including the subject of sexual ignorance (which I also examine). Whereas Cook's major focus is on the intersections between sexuality and contraception, I focus on the intersections between sexuality and infertility, and in particular, medico-legal responses.[3] Historian Lesley Hall's scholarship on birth control advocate Marie Stopes (author of bestselling marriage manual *Married Love*) includes an analysis of Stopes's legal case in 1916 for the dissolution (annulment) of her first marriage on the grounds of her husband's sexual impotence.[4] Hall explores the 'reputation management' issues that Stopes faced when embarking upon these proceedings and also questions Stopes's well-established public account of her 'sexual ignorance'.[5] Likewise, Lucy Bland has analyzed marital relationships and sexual ignorance within the context of a fascinating high-profile 1920s English divorce but she does not consider the subject of infertility.[6] Within a study of first-wave feminists' responses towards sexuality, Barbara Brookes has examined several legal cases from early twentieth-century New Zealand relating to spousal refusal of sexual intercourse, and suggests that they indicate growing societal expectations that the state regulate standards of sexual behaviour through the courts.[7] Although a comprehensive history of infertility in New Zealand has not been published to date, historian Linda Bryder has examined infertility services at Auckland's National Women's Hospital from the 1950s to the 1980s.[8] Bryder's focus is upon three of the hospital's major infertility treatments over this period (fertility drugs, artificial insemination and in vitro fertilization), but she does not consider medical responses towards 'coital factor' infertility.

By the middle of the twentieth century, infertility (also still described as 'subfertility', 'sterility' and sometimes 'barrenness') was a growing topic of interest to New Zealand's medical profession and this, as I will show, led to their involvement in treating sexual incapacity cases. Leading United States infertility historians Margaret Marsh and Wanda Ronner have suggested that from the late eighteenth century, the inability to conceive was transformed from a social state into a medical condition, as infertile couples began seeking assistance from physicians for childlessness.[9] Medical developments in

gynaecology from the late nineteenth century, followed by the establishment of endocrinology as a specialty in the interwar decades of the twentieth century, had significantly advanced Western medical understandings of human reproduction by the 1950s and had led to some (limited) developments in the treatment of infertility.[10] In line with international interest and trends in infertility services, New Zealand's first dedicated infertility clinic was opened within National Women's Hospital in Auckland in 1946,[11] followed by a clinic based within Dunedin Public Hospital in 1955.[12] The topic of infertility began featuring in academic medical journals and texts available in New Zealand, and also as part of obstetrics and gynaecology education programmes and in popular women's magazines. Scottish-born doctor Eleanor Meares, who spent ten years of her medical career based in Christchurch, reflected on this development in a survey article on fertility published in the *New Zealand Medical Journal* (NZMJ) in 1950: 'A whole new field has been opened up in the investigation and treatment of sterility and impaired fertility in the last few years. The subject has now become a scientific study and although we have a long way to go yet towards a real understanding of the sex hormones, we know enough to be able to investigate cases in a scientific way.'[13] In the following year Wellington gynaecologist James Edmett Giesen also observed that infertility was 'one of the most common complaints which brings a patient to a gynaecologist', indicating that patients too were interested in seeking medical solutions for infertility.[14] Prominent infertility historian Naomi Pfeffer has suggested that, from the interwar period, more involuntarily childless women in England sought out medical attention for their condition both because it was becoming a socially acceptable course of action to take and also because of 'the promise held out by modern scientific medicine'.[15] I would suggest that this argument can be applied to the New Zealand context too, in the years following World War Two.

By the 1950s, infertility was being reframed as a medical condition that could equally afflict the male or female partner within a marriage – a pronounced shift from predominant earlier understandings of the subject, which had solely assigned the 'blame' for childless marriages upon the wife.[16] A 1962 infertility text, in promoting its modern approach to the subject, reflected upon past approaches as follows: 'History records the fate of numerous childless queens while the Bible refers in scornful sympathy to the barren female, yet little mention has been made of the barren male …. Today we realize that a subfertile marriage is just as frequently due to faults in the male as in the female.'[17] Although the exact figures shifted somewhat, infertility experts tended to estimate that about 10% of all marriages were infertile.[18] They estimated that 30% of all infertility cases were based upon

the 'male factor' (that is, the underlying infertility problem originated within the male's body), 30% were 'female factor' and in 40% of cases, a combination of both male and female infertility 'factors' was present.[19] But despite widespread medical recognition of infertility as a 'couple issue', notions of sole female responsibility for infertility continued to linger well into the 1950s and beyond. In his textbook *Gynaecology for Students*, for example, Professor Lance Townsend (from Melbourne University, Australia) defined infertility ('sterility') as 'inability on the part of a couple to conceive a child', but then said that a 'definition of sterility is usually made after a *woman* has been trying unsuccessfully to conceive for two years'.[20]

Despite the new scientific approaches towards the study of infertility that Meares described, investigating and diagnosing the specific underlying causes of a couple's infertility was sometimes a complicated and lengthy process, because (as one practitioner explained) 'many factors may be responsible, either separately or conjointly, in the male and female'.[21] The medical literature on infertility typically approached the topic by listing and describing the specific physiological 'factors' that could affect male and female fertility: these included, for example, uterine, tubal, ovarian and cervical factors in the female and testicular and endocrine factors in the male. The 'coital factor' – the focus of this article – was the factor common to both husbands and wives, as it related to the couple's physiological and psychological ability to engage in 'complete' heterosexual coitus.[22] In the absence of assisted conception practices (such as a third-party semen donor or medical assistance), the coital factor was an essential component of a couple's ability to conceive and accordingly it attracted medical scrutiny.

New Zealand-born obstetrician and gynaecologist Sir John Stallworthy was at the forefront of mid-century infertility practitioners who identified the importance of the 'coital factor' within infertile marriages.[23] In giving the Biennial Scholarship (Sterility) Lecture to the Royal College of Obstetricians and Gynaecologists in London in 1947, Stallworthy highlighted the large numbers of his Oxford Fertility Clinic patients who entered into marriage 'with little understanding of its physical implications and responsibilities' – in other words, lacking in knowledge about sex and conception. Such ignorance, he added, was 'not confined to any one class of patients' but found 'among artisans, teachers, the clergy, and even in the medical profession itself'. To illustrate his point, Stallworthy then described a study of 581 private and hospital infertility patients: in 5% of cases 'the marriage had never been consummated', and further, 'many of these patients were unaware that anything was amiss with the physical side of their married life'. These 'startling figures' about 'virgin wives', as Stallworthy and his contemporaries

described them, provided 'ample proof of the need for better pre-marital guidance on sexual matters and the need for readily available advice when this is necessary during marriage'. Infusing an element of population-building rhetoric into his lecture, Stallworthy then stated that he considered the 'loss of potential citizens to the nation from this ignorance' was 'culpable'.[24]

Drawing upon Stallworthy's work, medical practitioners in New Zealand also noted the problem of 'virgin wives' and unconsummated marriages specifically within their infertility practices around this time. Giesen, for example, wrote in the NZMJ in 1951: 'Complete and satisfactory coitus is obviously essential for conception and yet it is not uncommon to encounter an intact hymen in a patient complaining of sterility.'[25] In Dunedin in 1955, visiting professor Andrew M. Claye of Leeds noted 'the extraordinary mistakes in coital technique that patients can make, even medical patients'. Claye added that the 'most astonishing that I have come across occurred in a case where the husband, surprisingly enough, was a demonstrator in – anatomy'.[26] Likewise, Whanganui-based obstetrician and gynaecologist J.D. Baeyertz reflected in the *Australia New Zealand Journal of Obstetrics and Gynaecology* in 1967 that 'coital factor' infertility cases were 'of importance' but 'not always easy to detect'. Here, in his review of 307 infertility cases within his practice, Baeyertz identified that 'infrequency of coitus and history of a lack of seminal reflux' often provided useful clues that a couple was experiencing coital infertility, as did a clinical 'finding of vaginismus or an intact hymen'. Nearly 6% (18) of the infertility patients within Baeyertz's study had presented with 'coital factor' infertility. Of these 18 patients, he classified 14 as 'virgin wives' (presumably on the basis that their hymens were intact, as Baeyertz was applying Stallworthy's earlier research). Baeyertz observed that many of them had experienced long periods of infertility, up to 12 years.[27]

Outside of the academic literature, women's magazines in New Zealand also drew attention to the issue of non-consummated marriages and infertile marriages, even into the 1970s. A Family Planning consultant, for example, observed in a 1968 *Eve* magazine article: 'Even in these days of free-and-easy sex, it's astonishing how many "infertile" marriages simply turn out to be unconsummated.'[28] Likewise, *New Zealand Woman's Weekly* columnist Cherry Raymond observed in 1972 that there still existed 'isolated instances of **profound** ignorance, not only about contraception but, incredibly, about reproduction itself. There have been cases of adult people who literally don't know where babies come from!' Raymond outlined a case where a 'worried young couple' consulted a doctor because, 'though they had been married for two or three years, they had not had any children. The routine questions

customary in such cases gradually revealed to the doctor that they had never had sexual intercourse!'[29]

Experts of various kinds focused generally upon the so-called 'ignorance' of some childless couples about human reproductive processes and in these cases (and in the absence of any other known infertility factors), the attending doctor's primary role was to instruct the couple about such processes. Within this same medical category of 'coital factor' infertility, however, there also coexisted patients who experienced different types of sexual dysfunction (such as vaginismus, dyspareunia and impotence)[30] and who, being unable to have full coitus with their spouse, were accordingly unable to conceive. For these patients, the prescribed treatment often went beyond basic 'marital advice'. Baeyertz described, for example, how he treated his 'coital patients' with a combination of surgical procedures ('a simple midline episiotomy under general anaesthesia' or occasionally using local anaesthetic and cautery), hypnosis, 'advice in coital technique' and the use of glass vaginal dilators.[31] Some practitioners also attended their patients within the privacy of their own homes.[32] Tuatapere general practitioner Dr Elder, for example, when discussing how he treated married women who experienced dyspareunia (painful intercourse), said that after the initial appointment, he would then attend the patient at home, in her own bedroom, 'where she must face her problems herself.'[33]

For couples experiencing 'coital factor' infertility, seeking medical advice was something they sometimes actively delayed, or avoided altogether, due to reluctance to have their failed sex lives subject to scrutiny by a third party.[34] Baeyertz, for example, had noted that these particular patients experienced long periods of infertility (up to 12 years) and this is also reflected in the two divorce cases discussed later.[35] But patients' reluctance to discuss their sex lives was by no means confined to couples diagnosed with 'coital factor' infertility, and medical practitioners writing about infertility were aware of this tendency. Infertility experts frequently expressed particular sympathy for women in this respect, noting that in many cases wives had to attend initial medical consultations for infertility on their own before their husbands could be persuaded to attend. In particular, doctors recognized that husbands tended to show greater reluctance to seek infertility advice than their wives, for reasons (generally) related to deep-rooted perceptions that male potency and fertility were synonymous.[36] Bernadette Noble's observation in a *thursday* magazine article on infertility – which advocated that an infertile marriage must be approached as a 'joint account' – captures well the widespread and differing perceptions of male and female infertility over this period: 'It is sad, but true, that in most cases, the first move in obtaining help for infertility,

comes from the wife. A woman may be shaken by her inability to reproduce, but a man is likely to be devastated. And he is quite likely to refuse to admit that the failure of his wife to become pregnant, has anything to do with him. He may fail to realise that fertility has no bearing at all on his masculinity, or even his sexual prowess.'[37]

Medical writers recognized the importance of handling the initial first meeting with their infertility patients with care, particularly when broaching the subject of couples' sex lives. C. Lee Buxton and Anna L. Southam, two New York infertility specialists and the authors of a leading 1958 American text on infertility, observed that it was 'obvious that the marital and sexual habits of a couple may be of crucial importance so far as their fertility potential is concerned. Yet it is within this area that the patient and her husband are likely to be most reticent, and details of marital experiences are frequently difficult to obtain.'[38] Readers were advised that the doctor's – or rather 'interrogator's' – role here was therefore to be 'one-third physician, one-third father-confessor, and one-third detective'. In support of their argument about the need for careful history-taking, Buxton and Southam cited a case of a female patient who had made visits to their infertility clinic regularly for over a year 'before she finally revealed the fact that she never had sexual intercourse with her husband. This woman had of course been interviewed many times by various medical students, residents, and attending physicians, but owing to the casualness of the questioning and the patient's obvious embarrassment and reluctance to divulge this rather startling fact, a whole year had been wasted.'[39] Accordingly, Buxton and Southam counselled their readers that the doctor 'must not appear to be too curious or inquisitive, but he must so direct the questioning that he gradually, and if necessary over a period of several visits, obtains the information required' about the couple's sex life.[40]

Experts such as Buxton and Southam were seeking to establish infertility as a new subspecialty of obstetrics and gynaecology. Consequently, they confidently accepted and advocated that the doctor was the appropriate provider of advice about sex and conception in infertile marriages – a role which at least in part could involve psychotherapy. Stallworthy too, in his argument that couples needed premarital advice about sex, was also advocating that the medical profession was the appropriate source of advice. These responses reflect, as Claire Gooder has suggested, the understanding that those 'deemed knowledgeable in the area of sexual behaviour tended to be medical or religious people' and that the 'social standing of their profession bestowed a sense of objectivity and respectability to their engagement with this topic'.[41] But I have also encountered a persistent line of questioning

lurking within the medical literature on this subject, about whether doctors actually had the requisite training or skills to undertake this role. Professor Claye's 1955 address in Dunedin on 'The Problems of Dyspareunia' was notable for its insights into the medical profession's approach towards sexual dysfunction within marriage – and particularly the alleged deficiencies of that approach. Claye argued that this 'intimate subject was not always handled … with the frankness it deserves' – something for which 'both general practitioner and consultant are sometimes to blame'. Claye suggested that the general practitioner 'may have a distaste for talking about sex, he may be too shy to talk about it, or he may not be willing to spare the time to talk about it', and that as a result, the Marriage Guidance Council (in England) was required to make up for the medical profession's shortcomings.[42] Claye instead instructed his medical audience that they needed to provide information on 'anatomy and function' in a 'dispassionate way' which was 'detailed and clear'. Recognizing that patients had often had to 'screw their courage to the sticking place to come because of their own shyness', he stressed that the doctor's manner 'must not be shy'.[43]

Claye's address resonated with New Zealand and Australian practitioners. Christchurch Hospital obstetrician A.M. Hartnell, for example, said that it was the very first time in his career that he had heard the subject broached – but that he was 'delighted to hear this subject discussed' as it was one that had caused him 'considerable worry'. Hartnell suggested that in private practice in New Zealand it was rare to see couples presenting themselves for instruction in sexual relationships before or after marriage when difficulties had arisen, as they preferred to go to the Marriage Guidance Council instead.[44] He also observed that to deal with the issue of sexual dysfunction adequately one needed to be both a competent gynaecologist and an experienced psychoanalyst.[45]

Nearly 20 years later, Sydney gynaecologist Jules S. Black echoed Claye's concerns in an *Australia New Zealand Journal of Obstetrics and Gynaecology* article 'Sex and the Gynaecologist', arguing that one of the 'grossest deficiencies in our medical courses' was in the area of sex, as 'it can be confidently stated that many currently-practising doctors have had no training in sex and sexuality and the therapy of its problems'. Within the medical curriculum, the only time that sexuality was discussed was 'in a very aberrant form in psychiatry'. Whereas doctors such as Stallworthy had earlier labelled so-called 'virgin wives' and their spouses as 'ignorant' in the area of sex education, Black suggested that when doctors were confronted with a sexual problem, they sometimes decided not to handle it, 'either through ignorance or inability'. As the 'professed specialists in the female sexual

organs', Black said, the profession should 'follow cases through and not close the doors on sex and sexuality'.[46]

Analyzing New Zealand doctors' approaches towards contraception over this same period, historians Barbara Brookes, Claire Gooder and Nancy de Castro have suggested that the medical profession's reluctance to get involved in contraceptive advice could be reflective of 'its controversial nature, a male-centred embarrassment and ignorance in dealing with female patients, or an unwillingness to engage in the tricky business of fitting diaphragms'.[47] Similarly, Naomi Pfeffer, writing of a particular infertility test known as the 'post-coital test' – which evaluates the receptivity of a woman's cervix to her husband's sperm, by removing secretions around her cervix for examination after the couple has had sexual intercourse – notes the test's 'conceptual and technical complications which etiquette and embarrassment discouraged doctors from tackling too assiduously'.[48] Within the context of sexual dysfunction and infertility, many doctors would have experienced a similar reluctance – though the particular context of helping couples to become parents (as opposed to avoiding parenthood by using contraception) may have helped alleviate some of their reticence in part.

What is particularly striking within New Zealand's medical literature in this area is a widespread reticence about the treatment of male sexual dysfunction, beyond brief acknowledgment of its existence in 'coital factor' infertility. The treatment described for female sexual dysfunction within infertile marriages was consistently far more detailed and directive within the infertility literature than for male sexual dysfunction. Claye published a full article in the NZMJ on the subject of dyspareunia (experienced by women), for example, but no equivalent article on impotence appeared in this journal over this same period. The husband did sometimes shoulder some 'blame' for his wife's sexual difficulties: one practitioner, for example, suggested that a wife's dyspareunia could be due to the husband's 'ignorance or inexperience' or the fact that he 'was too timid and lacked the necessary drive, or was too clumsy or gauche'.[49] But male sexual difficulties such as impotence received very little attention as a subject distinct from female sexual difficulties. C.H. Belton's 1961 article 'The Sex Factor in Marriage and Its Significance in Neurosis and Divorce' reflects well both the influence of psychology upon medicine and contemporary concerns about female 'sex adjustment' within marriage: the case studies Belton described are all women.[50] Likewise, within marriage guides published over this period, the 'frigid woman' was the subject of greater attention. For example, *The Digest of Hygiene for Mother and Daughter*, published in Sydney in 1957 – while directed at female readers – included a full section

on 'Causes of frigidity in women' but did not mention the possibility of husbands experiencing sexual difficulties.[51]

This trend is also reflected in the New Zealand medical profession's reticence on the subject of artificial insemination, using the husband's or a donor's sperm, across the 1950s and 1960s. Artificial insemination using donor sperm was an infertility treatment which was particularly suitable where the husband experienced impotence (as well as other forms of male factor infertility), but was also suitable where the wife experienced dyspareunia or vaginismus. Artificial insemination was a well-established (if controversial) procedure by the middle of the twentieth century in countries such as the United States and Great Britain, and from the 1940s, New Zealand's newspapers regularly reported on overseas controversies arising through the use of this technique.[52] Within New Zealand, however, on the very rare occasions where medical practitioners broached the subject in journals, they did so carefully and without reference to any specific cases of their own.[53] Melbourne doctor Arthur M. Hill's 1970 article 'Experiences with Artificial Insemination' was highly critical of the 'paucity of Australian reports' on artificial insemination, and this is equally true of the New Zealand context. Hill speculated that gynaecologists' reluctance to publish their views or findings could be due to 'timidity, inexperience, distaste, fear of legal implications, religious or other reasons'.[54] Professor Dennis Bonham started the first hospital-based artificial insemination service at National Women's Hospital in Auckland in 1972 but – unlike other areas of his practice – he did not publish research in this area and the service was not publicized until the 1980s.[55]

Sexual problems, infertility and divorce

Within the medical discourse on coital factor infertility, doctors periodically warned that sexual difficulties and childlessness within marriage could result in divorce. Stallworthy, for example, had suggested that premarital advice could 'save many a marriage from disaster'; likewise, Claye, while acknowledging that sexual relations were not the 'be-all and end-all of marriage', suggested that serious sexual difficulty was 'often an important factor leading to divorce'.[56] Doctor Howard Balin warned that 'sterility ranks high among the causes of deep unhappiness in marriage because a childless union lacks the strong cementing force that leads parents to subordinate all selfish desires for the common good of the family'.[57] Such concerns were also shared and publicized in non-medical quarters. Readers of *A Digest of Hygiene for Mother and Daughter* were told that 'frigidity' – 'the inability of a woman to enjoy sexual intercourse' – was 'the cause of more wrecked

marriages than any other factor'.[58] These concerns formed part of a wider public discourse about the divorce rate in New Zealand, which was considered to be 'something approaching a social disaster' in the years following World War Two.[59]

These commentators were overstating the connection between coital factor infertility and divorce. The 'nullity cases' published within New Zealand's law reports – proceedings brought where a spouse tried to end a marriage specifically on the basis that it was unconsummated – do, however, provide a useful way of examining how both the judiciary and the medical profession dealt with the issue of sexuality in the courtroom context.[60] Although both intra- and extramarital sexuality did feature within other types of divorce proceedings,[61] nullity cases – which are not the same as divorce cases where a *lack* of sexual intercourse was alleged – sometimes featured medico-legal discourse on infertile marriages and the relationship between parenthood and 'normal marriages'. I want to focus upon two particular nullity cases from 1950s New Zealand, in which both infertility and sexual dysfunction feature. These cases both provide a level of detail and insight into troubled 'coital factor' marriages that few other archival sources from this period do and also indicate differing judicial approaches on the basis of the claimant spouse's gender.

In 1948 the House of Lords had decided in *Baxter v Baxter* that the procreation of children was not an essential feature of marriage. In doing so, it overruled a century of earlier case law, including the leading nineteenth-century case, *D v A*, where the presiding judge Dr Lushington had pronounced that the two principal features of marriage were as follows: 'in order to constitute the marriage bond between young persons, there must be the power present or to come of sexual intercourse …. Without that power, neither of the two principal ends of matrimony can be attained, namely a lawful indulgence of the passions to prevent licentiousness, and the procreation of children, according to the evident design of Divine Providence.'[62] Although the court in *Baxter* decided that procreation was not an essential feature of marriage, sexual intercourse – the 'lawful indulgence of the passions', in the words of Dr Lushington – was still legally recognized to be a principal feature of marriage. As Justice Salmond had observed in a New Zealand case from 1920, sexual relations were 'the essential element' which distinguished marriage 'from all other kinds of lawful cohabitation'.[63]

As a consequence, a husband or wife in New Zealand continued to be able to apply to the courts for a marriage to be nullified where the marriage had not been consummated.[64] To be granted the decree of nullity, the applicant needed to prove that the marriage had not been consummated due to the

incapacity (or wilful refusal) of the other spouse. In practice, the courts had decided that 'incapacity' usually equated to either absolute male impotence or female physical incapacity for intercourse (due to dyspareunia, for example). And although infertility was in itself not a specific ground for divorce, as the two 1950s 'nullity cases' show, the New Zealand courts continued to apply weight to the couples' infertility history and parenthood status in deciding whether to nullify the marriages, regardless of the House of Lords ruling in 1948 to the contrary.

In *B v B*, the husband applied in 1951 for his marriage to be nullified on the basis of non-consummation, after 24 years of marriage and after they had adopted a child in 1939. Over that 24 years, the couple had tried many times to have sexual intercourse – and those repeated attempts were (as required in nullity cases) the major focus of the hearings in the Supreme Court and Court of Appeal in 1952. As Justice Gresson stated, Mrs B, 'though not unwilling, and apparently welcoming the attempts he [Mr B] made, became always so resistant, tearful, and even hysterical as to make penetration impossible and to compel the petitioner [Mr B] on each occasion to break off the attempt'.[65] Around the time they adopted their child, Mrs B had consulted a Dr Martin, who diagnosed her with vaginismus, which was described in court as 'a condition of muscular spasm of the inlet of the vagina due to psychological causes'.[66] Mrs B, under anaesthetic, then underwent an 'operation to dilate the entrance to the vagina'.[67] According to Mr B's account, despite further attempts at intercourse on the evening following the operation and the next two evenings, full sexual intercourse was never achieved. Mrs B, on the other hand, testified that on those three occasions immediately following the operation, 'complete' sexual intercourse was indeed achieved and she therefore maintained that the marriage had been consummated, disputing the basis of Mr B's application for a nullity decree.

By 1945, the parties were occupying separate bedrooms and by early 1947, Mrs B had moved out of the family home and initiated separation proceedings. She returned home a few months later and Mr B continued to initiate sexual advances towards her over the next four years on a monthly basis. The parties in court agreed that these sexual advances were 'not unwelcome' on Mrs B's part – although within Mrs B's testimony there was also a strong suggestion that she feared his temper.[68] Mrs B's solicitors then proposed another separation agreement – to which Mr B's solicitors responded with an application for a nullity decree instead on the basis of non-consummation.

Justice Gresson, presiding over the High Court hearing, dismissed Mr B's application for a nullity decree and so Mr B appealed to the Court of

Appeal. The courts were generally in agreement that the marriage had never been legally consummated, with Justice Gresson deciding: 'I do not hold it to have been established that there was ever at any time a complete penetration …. I therefore hold that [the] respondent was incapable of ordinary and natural intercourse.'[69] Despite this finding, Mr B's nullity appeal was also unsuccessful, as the Court of Appeal accepted Mrs B's defence that Mr B's actions in agreeing to adopt the child had served to affirm the validity and existence of the marriage.[70]

The second nullity case, *L v L*, was heard before Justice MacGregor in the Supreme Court at Christchurch in 1954. The applicant's nullity application was also specifically denied on the basis of the couple's adoption of children.[71] But in this case, the applicant was the wife, Mrs L, who alleged that the marriage had never been consummated due to her husband's sexual dysfunction – that is, 'the marriage had not been consummated owing to the impotence of the respondent and that such impotence was incurable by art or skill'. Mr and Mrs L had been married in 1945 and had continued to attempt sexual intercourse until 1949. In January 1946 the couple had adopted a child, followed by another one the following April. In her evidence, Mrs L said that the reason both children were adopted was 'to assist the husband in sexual matters, but that the presence of children had no beneficial effect' on him. Although this line of evidence was not discussed any further here, the inference here was that where sexual dysfunction was considered psychological in basis, the adoption of children could act as a 'cure' for a couple's infertility.[72]

The parties' evidence that the marriage had never been consummated was corroborated in court by a Dr F.O. Bennett, who had examined Mr L in 1953 and had 'prescribed a course of treatment in order to stimulate sexual activities'. No further detail was provided about that course of treatment but it was apparently unsuccessful, according to Mrs L's testimony (the application was undefended by Mr L). Justice MacGregor too decided that the marriage had never been consummated due to Mr L's sexual 'disability' – but, as in *B v* B, Mrs L's application for a nullity suit was denied on the basis that other features of the marriage (including their adoption of children) had equated to 'recognition of the existence and validity of the marriage'. He decided that it would be 'inequitable and contrary to public policy that the wife should be permitted to challenge the marriage'.

Both of these nullity cases provide some valuable medico-legal perspectives on the relative importance of sex (the 'coital factor') within infertile marriages. In both *B v B* and *L v L*, the various judges provided their opinions about what constituted a 'normal marriage'. Justice Northcroft (in *B*

v B) said it was difficult to approach the case 'without sympathy and concern for both parties': 'Through no fault of her own, indeed, despite her proper efforts to overcome the [sexual] disability, the wife [Mrs B] has been unable to take her full part in a normal marriage nor to have the children she hoped for.' Despite the law's specific focus on the physical act of consummation in proving nullity cases, the judges in both cases all demonstrated that they were prepared to consider wider features of the marriage than just the parties' sexual relationship. Justice Northcroft reasoned that '[Mrs B] has had the status of a wife and mother (of the adopted son), she has performed all the normal household and social functions of a wife and has been held out in the world as the wife of the petitioner [Mr B] for nearly twenty-five years. It would be a distinct hardship for her, at this stage, to be denied that status.' Justice Northcroft again acknowledged the fact of the couple's infertility when he discussed the husband's position in the marriage: 'the husband has been denied his normal privileges and has been denied the children for which he, no less than his wife, was entitled to hope …. It must be said that it would not be surprising for special emotional difficulties to develop between the parties to so abnormal a marriage.' Likewise, Justice Gresson too showed some sympathy towards the parties' respective positions, observing for example that when Mrs B first left her husband in 1947, it was because 'she could bear the life no longer. For just on twenty years she had submitted to her husband's attempts to effect a penetration; that her distress on these occasions was acute petitioner [Mrs B] admitted. It says much for her that she was so submissive and acquiescent for nearly twenty years over something which must before long have become both distasteful and humiliating.'

Justice MacGregor in the second case *L v L* had also agreed that the marriage had never been consummated and, as in the first case, demonstrated a willingness to consider the wider features of the marriage than just the parties' sex lives. But in this particular case, Justice MacGregor responded with considerably less sympathy for the parties' positions and notably that of Mrs L, who was here seeking to end the marriage on the basis of her husband's impotence. Whereas in *B v B*, the judges had responded sympathetically to the husband's failed attempts to have 'normal' marital intercourse with his wife, Justice MacGregor made no such sympathetic observations of this sort. Instead he gave great weight to the fact that 'the wife has, in addition to accepting the status of wife during the last year, taken material pecuniary and other benefits in her capacity as a wife'. He was not satisfied with the 'sincerity' of Mrs L during the proceedings, largely it seems because she chose 'to continue the family life for her own benefit and the benefit of the adopted children' for a year after she found out about her legal right to initiate

nullity suit proceedings. Mrs L's motives, in seeking to end the marriage on the basis of her husband's sexual difficulties, were here called into question in a way that Mr B's were not – a finding which points to the challenges female petitioners such as Mrs L faced when navigating 'a male-controlled divorce system in which all the judges were men'.[73]

Conclusion

According to Hayley Brown, nullity cases only ever comprised a relatively small subset of the overall number of divorces in New Zealand in the first half of the twentieth century – a finding that suggests that contemporary fears about sexual incompatibility, infertility and rising divorce rates were generally unsubstantiated.[74] For the historian of sexuality, however, these published legal sources offer a valuable and detailed insight into the sexual dynamics of certain New Zealand marriages. These sources complement the contemporary medical discourse on 'coital factor' infertility and have particular value as case studies in the absence of other available archival sources.[75] In the case of Mr and Mrs B, the couple endured 24 years of attempts to have sexual intercourse, only seeking medical assistance after 12 years of marriage. Justice MacGregor implied that Mr and Mrs L, in the second nullity case, only sought medical assistance for Mr L's impotence after the couple had been married for eight years. Mrs L's testimony, however, that the couple adopted a child within a year of their marriage 'in order to assist the husband with sexual matters' suggests that the couple were at least aware of contemporary medical thinking that adoption could act as a 'cure' for infertility that was psychosexual in origin. In both cases, the couples' underlying motivation in persisting with these unhappy sexual efforts was (at least in part) to conceive their own child.[76]

These nullity cases also demonstrate the prominent role of the medical witness where sex performance was at issue.[77] The judges in both cases drew heavily on the medical reports supplied by the doctors – while also not shying away from adding their own insights into the nature of the parties' sex lives (disputing, for example, Mrs B's claims that complete coitus had occurred). Such insights demonstrate, as Brookes has suggested, the central role of the state in regulating standards of sexual behaviour.[78] Indeed, University of Otago legal academic A.C. Holden observed in 1966 that the legal focus on consummation in nullity cases 'encouraged in the courts an almost unhealthy preoccupation with what might be termed the mechanics of sexual relations'.[79] The feelings of embarrassment and unease that doctors may have had when treating their 'coital factor' infertility patients were not reflected within the courtroom setting. Brown has examined the 'public arena' of the

divorce court setting 'where husbands and wives contested the relationship between marriage and sexuality' and suggests that the courts functioned like a 'public stage'. The public nature of this particular setting, one where both judges and doctors had a formal and prescribed role, could possibly account for doctors' unreserved responses to discussing their patients' sex lives during testimony.[80]

The nullity cases and the associated medical literature on 'coital factor' infertility provide an alternative perspective on 'normal marriages', sexual relationships and childlessness during New Zealand's Baby Boom.[81] Although many 'coital factor' infertility cases did not end as unhappily and publicly as the two nullity cases that I have discussed, they provide a counter-perspective to the infertility treatment 'success stories' that gained attention in the popular media and in medical journals from this time, with a particularly high-profile New Zealand example being the 1965 birth of the 'Lawson quintuplets' as a result of the mother's treatment by fertility drugs.[82] While couples experiencing sexual dysfunction certainly did seek medical assistance in order to pursue their goal of parenthood as well as to improve their sex lives, it is also equally likely that other couples would have avoided the embarrassment and discomfort of medical (and legal) intervention altogether.[83] Instead, I would speculate that these couples may have been able to 'overcome' their infertility via New Zealand's system of closed stranger adoption, the most popular non-medical solution to infertility in the 1950s and 1960s, or they may have remained childless.[84] Despite the popular emphasis on the importance of sex for a happy marriage, some couples will instead have accommodated themselves to a range of behaviours within their marriages rather than seek medical or legal involvement in one of the most intimate areas of their lives.

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NOTES

I am grateful to fellow workshop participants, and particularly to Barbara Brookes and Angela Wanhalla, for their assistance with this paper.

1 Where I use medical texts published in places other than New Zealand, these are all texts that are held in the University of Otago Medical Library and would have been available to medical students over the period under discussion in this article.

2 Hera Cook, *The Long Sexual Revolution: English Women, Sex, and Contraception 1800–1975*, Oxford, 2004, p.266.

3 Cook, p.5.

4 Lesley Hall, '"The Subject is Obscene: No Lady Would Dream of Alluding to It": Marie Stopes and her courtroom dramas', *Women's History Review*, 22, 2 (2013), p.253.

5 Concerned at her failure to become pregnant, Stopes discovered, by studying medical and legal texts in the British Museum Reading Room, that her marriage had not been consummated. Hall, p.255. Hall suggests that it is debatable whether Stopes really was sexually ignorant, as she wrote, for example, an unpublished treatise on marriage in 1910. Reginald Gates, Stopes's first husband, also later alleged that Stopes was sexually knowing and had insisted on using birth control from the start of their marriage (thus challenging her infertility claims). Angus McLaren also questions Stopes's 'sexual ignorance' in her nullity case in *Impotence: A Cultural History*, Chicago, 2007, pp.164–6. He suggests that Stopes, in her manuals, skilfully claimed the 'authority of a self-proclaimed victim of male impotence' in order to advocate marital sexuality (p.166).

6 The case was *Russell v Russell* and one of its more scandalous aspects was that the wife Christabel had conceived with an intact hymen. Lucy Bland, '"Hunnish Scenes" and a "Virgin Birth": A 1920s Case of Sexual and Bodily Ignorance', *History Workshop Journal*, 73 (2012), p.118. I am grateful to Hera Cook for drawing my attention to this article. Hayley Brown does not consider infertility within divorce cases, but her thesis provides valuable information about marriage, divorce and sexuality in New Zealand in the 1950s: Hayley Marina Brown, 'Loosening the Marriage Bond: Divorce in New Zealand, c.1890s–1950s', PhD thesis, Victoria University of Wellington, 2011.

7 Barbara Brookes, 'A Weakness for Strong Subjects: The Women's Movement and Sexuality', *New Zealand Journal of History* (NZJH), 27, 2 (1993), pp.140–56.

8 Linda Bryder, *The Rise and Fall of National Women's Hospital: A History*, Auckland, 2014, ch.6.

9 Margaret Marsh and Wanda Ronner, *The Empty Cradle: Infertility in America from Colonial Times to the Present*, Baltimore, 1996, p.2.

10 For a helpful discussion of these early to mid-twentieth-century medical developments in endocrinology and infertility, see Naomi Pfeffer, *The Stork and the Syringe: A Political History of Reproductive Medicine*, Cambridge, 1993, ch.3.

11 Bryder, p.107.

12 S. Coggin, 'Gynaecological Outpatients' Department of Dunedin Public Hospital', 5th year Preventive Medicine Dissertation, University of Otago, 1956, p.26.

13 Eleanor Meares, 'Human Fertility: Some Modern Aspects of Sub-fertility and Contraception', *New Zealand Medical Journal* (NZMJ), 49, 272 (1950), p.384.

14 J.E. Giesen, 'Practical Aspects in the Treatment of Sterility', NZMJ, 50, 278 (1951), p.330.

15 Pfeffer, pp.98–99. Similarly, Marsh and Ronner suggest that both the intense pronatalism of post-World War Two America and the 'nearly unquestioning public faith in the power of science and technology' propelled couples to seek out medical solutions for their childlessness. Marsh and Ronner, p.3.

16 For further discussion about the new concept of ‘infertile marriage’, see Pfeffer, p.61.

17 Margaret Moore White and V.B. Green-Armytage, *The Management of Impaired Fertility*, London, 1962, p.273.

18 For example, Lance Townsend, *Gynaecology for Students*, 2nd ed., Melbourne, 1961, p.98.

19 For an example of this approach, see Reynold H. Boyd, ‘The Investigation and Treatment of Infertility: A Review’, NZMJ, July 1962, p.348.

20 The italics are my own. Townsend, p.98. The third edition of this textbook, published in 1974, contained the same definition.

21 J.D. Baeyertz, ‘A Review of 307 Cases of Infertility’, *Australia New Zealand Journal of Obstetrics and Gynaecology* (ANZJOG), 7 (1967), p.204.

22 That is, ‘heterosexual penetrative penile-vaginal intercourse’, to use Cook’s definition, p.5.

23 Stallworthy spent the majority of his career based in Britain, but – demonstrating the ongoing and important flow of medical knowledge between New Zealand and Britain over this period – he remained influential in New Zealand medicine. He had some involvement, for example, in the formation of New Zealand’s first postgraduate school of Obstetrics and Gynaecology. See Bryder, ch.2 (including pp. 29–30). See also John Armstrong, ‘The “Common-Health” and Beyond: New Zealand Trainee Medical Specialists in International Medical Network, 1945–1975’, PhD thesis, University of Waikato, 2013.

24 John Stallworthy, ‘Facts and Fantasy in the Study of Female Infertility’, *The Journal of Obstetrics and Gynaecology of the British Empire*, 55 (1948), pp.171–80. Stallworthy provided further analysis of these ‘virgin wives’ in a paper on infertility published the following year, writing that ‘ignorance, incompetence, or fear, either alone or combined’ was responsible for many ‘infertile unions’. He also explained that non-consummated marriage was the contributing factor in approximately 5% of couples complaining of sterility, but that this figure did not account for cases ‘in which the chance of conception is reduced by such coital difficulties as vaginismus or severe dyspareunia’. Stallworthy did not mention male sexual dysfunction here. John Stallworthy, ‘An Evaluation of the Various Factors in Infertility’, *Post Graduate Medical Journal*, July 1949, p.327. Note that these studies of ‘virgin wives’ do not discuss exactly what couples *did* know about conception. For a fuller discussion of ‘virgin wives’ in the English context, see Cook, pp.159–61.

25 Giesen, p.331.

26 Andrew M. Claye, ‘The Problem of Dyspareunia’, NZMJ, 54, 301 (1955), p.297.

27 Baeyertz, p.214. These doctors (i.e. Stallworthy, Giesen and Baeyertz) make no comment as to whether the husbands were also virgins.

28 Anne Barrie, ‘Why can’t we have a child?’, *Eve*, April 1968, pp.38–39.

29 Cherry Raymond, ‘Contraception’, *New Zealand Woman’s Weekly*, 27 March 1972, p.13 (bold type in original). For a full analysis about how sex education (including premarital advice) was approached in New Zealand over this period, including its role in reinforcing sexual knowledge and morality, see Claire Gooder, ‘A History of Sex Education in New Zealand, 1939–1985’, PhD thesis, University of Auckland, 2010, especially Chapters 1 and 2. Chapter 6 of Cook’s *The Long Sexual Revolution* includes a helpful discussion about profound sexual ignorance in England around the mid-century decades – such ignorance could include ‘lack of knowledge of how babies were made, that the baby emerged into the world through the vagina, of reproductive processes such as menstruation, of the body of the opposite sex, and of the actual act of coitus’, p.169.

30 ‘Vaginismus’ is where the vaginal muscles clamp tightly. For discussion, see Cook, p.160. ‘Dyspareunia’ is recurrent genital pain that can occur before, during and after intercourse. ‘Impotence’ (erectile dysfunction) is characterized by the inability to develop or maintain an

erection during sexual activity. See McLaren for a full account of impotence in history.

31 Baeyertz, p.214.

32 This was not necessarily unusual in gynaecological practice. Marsh and Ronner describe, for example, how leading American gynaecologist J. Marion Sims was most 'candid about his visits to his patients' bedrooms'. There he frequently '"examined the condition of the uterus after coition, and often in four or five minutes after it, [and] I have also frequently removed the mucus of the cervical canal immediately after sexual intercourse", in order to discover whether active spermatozoa were present'. Such frankness was however considered scandalous. Marsh and Ronner, pp.72–73.

33 Claye, p.306.

34 Such reticence could quite possibly have accounted for the long periods of infertility experienced by the 'virgin wives' in Baeyertz's study, for example. I have found it difficult to access direct patient accounts of their 'coital factor' infertility over this period in New Zealand and so my conclusions here remain speculative.

35 Baeyertz, p.214.

36 For a full discussion of the historical relationship between male sexuality and fertility, see McLaren.

37 Bernadette Noble, 'Infertility – And a New Miracle in the Search for Motherhood', *thursday*, 20 February 1969, p.5.

38 C. Lee Buxton and Anna L. Southam, *Human Infertility*, New York, 1958, p.37.

39 Buxton and Southam, p.28.

40 Buxton and Southam, p.37. Like Stallworthy and others, Buxton and Southam said they considered that the 'amount of ignorance concerning the physiology of reproduction is incredible even among educated people', p.29.

41 Gooder, p.76.

42 Claye's address was given at the first New Zealand Congress in Obstetrics and Gynaecology in Dunedin. The discussion was reported in the NZMJ. Claye, p.297.

43 Claye, p.297. Claye also observed that 'Gynaecologists may perhaps be forgiven if, through seeing many patients for sterility or dyspareunia, they tend to get warped ideas on the incidence of normal sex relations', p.298.

44 The Marriage Guidance Council in New Zealand was established in 1948, in direct response to increasing numbers of divorces during and after World War Two. Councils in New Zealand were strongly influenced by their British counterparts. Brown, p.228.

45 Claye, p.305. Concerns about doctors' knowledge about sex were also being raised outside of the profession: Gooder states that doctors' ability to advise on sex matters was questioned by the Juvenile Delinquency Select Committee, established in 1955 to consider the recommendations of the Mazengarb Report, p.104.

46 Jules S. Black, 'Sex and the Gynaecologist', ANZJOG, 14 (1974), p.238.

47 Barbara Brookes, Claire Gooder and Nancy de Castro, '"Feminine as her Handbag, Modern as her Hairstyle": The Uptake of the Contraceptive Pill in New Zealand', NZJH, 47, 2 (2013), p.214.

48 Pfeffer, pp.127–31. The 'post-coital test' was also known as the PCT, Sims, Huhner or procreation test and was devised by American gynaecologist J. Marion Sims in the nineteenth century. Pfeffer notes that the test is 'very distasteful' and 'would be ranked near the top of any list of undignified procedures performed by doctors on patients', p.127. Also see note 33 above.

49 Claye, p.303.

50 C.H. Belton, 'The Sex Factor in Marriage and Its Significance in Neurosis and Divorce', NZMJ, 60, 345 (1961), pp.198–201. See also Belton's accompanying article, 'The Role of the Family Doctor in Sex Education', on pages 195–8 within this same issue.

51 M.A. Horn, ed., *The Digest of Hygiene for 'Mother and Daughter'*, Sydney, 1947,

pp.52–53.

52 See, for example, Gayle Davis, 'Test-Tubes and Turpitude: Medical Responses to the Infertile Patient in Mid-Twentieth-Century Scotland', in Janet Greenless and Linda Bryder, eds, *Western Maternity and Medicine, 1880–1990*, London, 2013, pp.113–27.

53 Professor Northey's NZMJ article on artificial insemination was the sole research published in a New Zealand journal on the subject in the 1950s and 1960s. Northey's analysis was confined to the legal issues arising from artificial insemination and does not cite any specific instances of the procedure being used in New Zealand. J.F. Northey, 'Artificial Insemination – A Legal View', NZMJ, 57, 322 (1958), pp.531–4.

54 Arthur M. Hill, 'Experiences with Artificial Insemination', ANZJOG, 10 (May 1970), p.112.

55 Bryder, p.111.

56 Claye, p.298.

57 S. Leon Israel, *Menstrual Disorders and Sterility*, 5th ed., New York, 1967, p.409. Howard Balin had revised Chapter 23.

58 Horn, p.52.

59 David H.J. Morgan, 'Marriage and Society: Understanding an Era of Change', in Jane Lewis et al., eds, *'Whom God Hath Joined Together': The Work of Marriage Guidance*, London and New York, 1992, p.22, as cited in Brown, p.213.

60 'Consummation' was legally approached as where 'substantial penetration of the female body by the male organ has taken place'. *Baxter v Baxter* [1947] 2 All E.R. 886. The legal history of consummation and its relationship with the sacrament of marriage in church history is discussed by A.C. Holden, 'Dissolution of a Voidable Marriage', *Otago Law Review*, 1 (1966), p.128.

61 Sim's *Divorce Law and Practice*, a leading New Zealand text on divorce, features a variety of instances of sexual practices being examined in divorces cases, including, for example, 'cruelty associated with marital intercourse or sexual irregularities' where a wife's 'unnatural sexual relations with another woman' or a husband's 'irregular sexual conduct with third parties' could constitute cruelty. W.J. Sim, *Sim's Divorce Law and Practice in New Zealand*, 8th ed., Wellington, 1971, p.37.

62 *D v A* (1845) 1 Rob. Eccl. 279; 163 E.R. 1039.

63 *A v B* [1920] G.L.R. 313, cited in Holden, p.129.

64 The law surrounding this area was changing around the time that these cases were heard (as a result of the Divorce and Matrimonial Causes Act 1953) and then a decade later in the Matrimonial Proceedings Act 1963 (section 18). My purpose here is not to provide a technical legal analysis of 'nullity' law but rather to use two 1950s cases as case studies. See *Sim's Divorce Law and Practice in New Zealand*, Part IV, for fuller information in this regard.

65 *B v B* NZLR [1954] 358 at 360.

66 *B v B* NZLR [1954] 358 at 363. The 'psychological causes' for Mrs B's condition, although referred to several times throughout the judgments, are never explored in any depth, apart from evidence given by Mrs B that Mr B's temper scared her.

67 *B v B* NZLR [1954] 358 at 360.

68 *B v B* NZLR [1954] 358 at 363.

69 *B v B* NZLR [1954] 358 at 363.

70 To apply the specific legal terminology, the doctrine of approbation was successfully argued. This meant that the court agreed with the wife's defence that the adoption of the child was accepted as part of a course of conduct constituting approbation of the marriage.

71 *L v L* NZLR (1954) 386.

72 For example, see Marsh and Ronner, pp.168–9, for discussion of 'adoption as cure' theory.

73 Brown, p.41. Hall too has suggested that 'studies of women, crime and the courtroom have emphasised the extent to which women were obliged to manifest a convincing version of reputable womanhood for success in their cases', p.257. On this occasion, Justice MacGregor was seemingly unconvinced by Mrs L's 'version of reputable womanhood'.

74 Brown, pp.218–19.

75 I have found it difficult to access any patient accounts of their 'coital factor' infertility experiences, in comparison to other types of infertility 'factors', and so the nullity cases – although written by the judges – provide useful accounts of these marriages. Brown discusses the limitations of using court records, pp.198–9.

76 Both of these cases (*B v B* and *L v L*) featured couples who experienced relatively long periods of infertility and who had adopted children. These cases – and the courts' approaches – can be contrasted with another nullity case heard in New Zealand in 1952, *F v F* (otherwise D) *NZLR* 613, where the marriage remained childless. Here the husband seeking a nullity grant had only been married two years and Justice Hutchison granted the application (brought on the basis of the wife's 'impotence arising from nervousness, hysteria, or unconquerable aversion'). Justice Hutchison rejected the wife's counterclaims regarding her husband's cruelty towards her and instead suggested that the husband's (admitted) assaults, including slapping and locking her in her room, were understandable behaviour on the basis of his sexual frustration (at 621).

77 Lucy Bland too has identified that the medical experts were important in her analysis of a 1920s divorce case *Russell v Russell* (where the issue of whether the couple had had 'full' penetration was a critical one – Mrs Russell's hymen had remained intact even after giving birth to a child). Bland, p.129.

78 Brookes, p.154.

79 A.C. Holden, p.129. To support his argument about judicial focus upon sexual relations, Holden described *D v A* as 'verdict by tapemeasure' due to judicial analysis of the size of the wife's vagina.

80 Brown, pp.195–6.

81 For a useful historical analysis of marriage in post-World War Two New Zealand and specifically of notions of 'marital failure' of a different sort (relating to interracial unions), see Angela Wanhalla, *Matters of the Heart: A History of Interracial Marriage in New Zealand*, ch.7. See also Brown, pp.213–33.

82 Indeed, the subject of 'coital factor infertility' itself has not featured in infertility histories in the way that 'ovulatory factor' and 'tubal factor' have done. For one such example of an 'infertility success story', see G.H. Liggins and H.K. Ibbertson, 'A Successful Quintuplet Pregnancy following Treatment with Human Pituitary Gonadotrophin', *Lancet*, 15 January 1966, p.114.

83 On the other hand, some couples may also have pursued medical assistance for sexual dysfunction in order to improve their sex lives rather than to conceive a child

84 Social workers responsible for arranging adoptions were reluctant to question couples about their motivations for adopting (e.g. their infertility experiences) due to the subject's close connection with sex, 'a highly embarrassing topic'. One former social worker, for example, recalled 'one case in which she became aware from a couple's evasive replies that they were childless because they had never had intercourse. When she refused to place a child with them, they went to another agency and obtained one.' Anne Else, *A Question of Adoption*: *Closed Stranger Adoption in New Zealand, 1944–1974*, Wellington, 1991, p.62.