the American colonies by the 1750s (Snow 1912: ch. 1; Sandzen 1904: 63). The devices were expensive and thus were purchased mainly by physicians, but there was no obstacle in custom or law to their purchase by any person who could afford them.

Hydraulic massage technologies were available at spas that began operating in Pennsylvania in the 1760s and in Virginia in the 1770s (Fishwick 1978:17). A steam-powered vibrator was invented in 1869; the electromechanical vibrator, immediate predecessor of the devices now at issue, was invented in 1883 (Legget 1874: v.2: 912; Mortimer-GraWil 1883; Snow 1912: ch.1). The vibrator became available in the United States as a consumer appliance in 1899, becoming the first personal-care electrical appliance (Hutches 1899:64; Lifshey 1973:28 1). No Federal law has ever prohibited or restricted the sale of vibrators, and no state did so before 1973. Thus Alabama’s statute § 13A-12-200 2(a)(1) (Supp. 1998) and similar measures in other states represent a departure from a tradition that had been established more than two hundred years before its passage.

4. The Federal Food and Drug Administration was empowered to regulate medical devices in 1938, and it acted vigorously in subsequent decades to remove products from the market that were dangerous or fraudulent, especially after the Medical Device Amendments of 1976 (US Congress 1982:5; FDA May 1999:3).

Vibrators were and are included in its oversight. Ordinary massage vibrators were made Class I devices in 1996, exempting them from pre-market notification requirements, although manufacturers must still register with the FDA (FDA CDRH Nov. 2000). Before 1996, manufacturers were required to fill out a form that asserted the device’s compliance with standards of performance (that is, that they operated as advertised), of electrical and radiation safety, and of branding and labeling (FDA 1995). The FDA has acted against misrepresentation in the advertising and labeling of vibrators, as in cases where they were promoted as effective therapies for polio and arthritis, but not against the devices themselves unless they were an electrical or radiation hazard (Lent 1904:225; US Food and Drug Administration 1963:11–23). The FDA explicitly recognizes massage of the human genitalia as a legitimate therapeutic use of vibrators, including vibrating dildos for Kegel’s exercise. Genital vibrators and vibrating dildos are Class II products for which manufacturers must complete a performance standards report on FDA form 3500A (FDA 1995; FDA 1998). The devices are listed in the FDA’s classification scheme with other technologies that do not require medical supervision or intervention for proper use, including condoms, breast pumps, and tampons.

opposite: Electric massage vibrator, manufactured by Drake Electric Works.
1922 Photo Ryo Manabe.
Non-powered dildos are not regulated at all, and never have been, presumably because there are no electrical, fraud, or other consumer hazards associated with them. The FDA’s documentation of its policies on these devices and its record of interventions clearly indicate that its only concerns are consumer safety and protection from fraud. There is no indication of any FDA interest in regulating public morality or in restricting consumer access to vibrators or vibrating dildos through the mediation of prescriptions and/or medical supervision of their use.

5. Massage of the genitalia to orgasm has been used as a treatment for female sexual problems since the time of Hippocrates (5th–4th century BC) (Veith 1965:13). The disorder which would now be called anorgasmia, or be identified as some other form of sexual dysfunction, was for more than two thousand years called “hysteria,” until Freud and his followers introduced a reinterpretation of this disorder in the early 20th century (Freud 1962; Slavney 1990). In the traditional medical canon, hysteria and its sister disorders, including chlorosis, originated in the uterus (hyster in Greek) and were caused by sexual deprivation (Laycock 1840: 140–142; Laqueur 1990: 44–51, 96–189). Symptoms were extremely vague, and included feelings of heaviness in the abdomen, headaches, sleeplessness, anxiety, irritability, sexual fantasy, and vaginal lubrication (Haller 1971: 474; Haller and Haller 1973: 471–479). Single women who suffered from this ailment were urged to marry vigorous husbands, and the married sent home with instructions to make love frequently and in such a way as to produce sexual release for the woman (Avicenna 1507 3.20:1.44; Paré 1634: 945). Sometimes horseback riding and bouncing in a swing were recommended (Soranus 1966:140–170; Veith 1965:118). If these measures failed, or if the woman was single and expected to remain so, the recommended treatment was massage of the genitalia, usually with a lubricant, until the “hysterical paroxysm[,]” considered analogous to the breaking of a fever, was produced (Forester 1653: 277–340). This result, which some physicians recognized as an orgasm, was not a cure but a temporary palliative; hysteria was considered chronic and usually incurable, requiring regular treatment either by a physician or midwife, or by visits to spas that provided hydriatic massage services (Highmore 1660:76–78; Veith 1965:13–115; Tripler 1883:46–47 and 350–351). Some physicians, particularly Catholic doctors after the Reformation, questioned the propriety of physicians’ manipulations of the female genitalia, but most doctors appear to have regarded it as a necessary and not particularly enjoyable professional necessity (Eccles 1982:79). Many, from antiquity well into the 20th century, encouraged their patients to receive hydriatic massage with heated mineral waters (Nichols 1946:244–248). Treatments at spas in Europe and America had the reputation of encouraging concep-

6. A number of physicians regarded in 18th-century America as significant authorities in Western medicine described hysteria and recommended massage of the genitalia as a treatment. These included Herman Boerhaave (1668–1738), who influenced the Revolutionary War physician Benjamin Rush (1746–1813) through his student William Cullen (1712–1790), who practiced medicine and taught at the University of Edinburgh, where many American physicians of the late colonial period were educated (Boerhaave...
Three great medical luminaries of the 17th century, William Harvey (1578–1657), best known for his discovery of the circulation of the blood, Bernard de Mandeville (1670–1733), and Thomas Sydenham, mentioned above, called the "English Hippocrates," all regarded hysteria as both widespread and potentially serious if untreated by the traditional methods of marriage, massage, exercise, and self-directed treatment at spas (Harvey 1653:501–502; Harvey 1847:542–545; Mandeville 1981; Sydenham 1846 v.256–95). In the previous century, the great French surgeon Ambroise Paré (1517–1590) had written at great length about the necessity of releasing copious quantities of vaginal fluid by manual massage from a woman, with "a certain tickling pleasure," when she "hath been used to the company of a man, but the absence whereof she was before wont to be pained" (Paré 1634: 634, 942). Abraham Zacuto (1575–1642) and Lazare Riviére (1589–1655) made similar recommendations and greatly influenced the medical thought and practice of the 17th and 18th centuries, including that of colonial American physicians (Zacuto 1637:252–266, 277–283; Riviére 1672). Cullen and his student Rush were also influenced by Albrecht von Haller’s (1708–1777) views on sexual release as an important factor in women’s health (Haller 1757:760). Haller’s work on female sexuality was still being cited in the 20th century by such important writers as Havelock Ellis (Ellis 1940:60–63). Two European contemporaries and colleagues of Rush’s were in the 18th century well-known for their research on the question of female sexual satisfaction as a factor in health: Franz Josef Gall (1758–1828), and Philippe Pinel (1745–1826), the latter a veteran of the French Revolution, famous for striking the fotters from the inmates of the Salpêtrière in Paris (Gall 1810–1819: v.3:86–129; Pinel 1962: 122–287). All of these authorities drew on their ancient mentor Galen of Pergamon (c. 129–200 AD), who described the clinically induced “hysterical paroxysm” with its vaginal contractions and release of the fluid of the Bartholin glands in graphic detail (Galen 6:11, 39).

7. At the time that the Constitution was written, the theories described above were the dominant paradigm in Western gynecology. Benjamin Rush, who was a close friend to and correspondent with John Adams, a fellow member of the American Philosophical Society with Benjamin Franklin and Thomas Jefferson, and the founder of the first hospital built in the new United States, was in Philadelphia ensuring that his new institut...
According to Adams, some women went to spas simply from “wantonness” (Levin 1987:237). Despite complaints from Protestant clergy echoing those of ancient Rome about the gambling, drinking, and general atmosphere of immorality that were thought to prevail at spas and watering places, the respectable and elite, including Thomas Jefferson and George and Martha Washington, continued to visit them (Fishwick 1978:41 and 170; Bridenbaugh 1946:160–161; Juvenal 1958:63–90).

Alabama’s hot springs were developed as resorts before the mid-19th century (Sulzby 1960:59). Before 1823, when the Cedar Hotel opened at Alabama’s Valthermoso Springs (Morgan County), most affluent valetudinarian Alabamians seeking physical therapy for hysteria and other disorders traveled north to Virginia (now West Virginia), where the hot springs over which Greenbrier now stands were already in use as a resort by 1780 (Greenbrier 2000). The “pelvic douche” was offered at nearly all of these establishments; orgasm would occur in most women after about four minutes of such treatment (Fishwick 1978:69; Halpert 1973:526). By the middle of the 19th century, hundreds of such spas had appeared in all parts of the country (Pond 1978:64–73; Roark 1974:28–38; Stone 1875:161–171; Thorne 1970/71:321–359; Woodlief 1954:159–164; Irwin 1892:85–134; McMillan 1985:36–49.)

There was no state or federal regulation of these spas nor of their methods of treatment, until a few states and municipalities in the early 20th century took action, not to protect the morality of spa-goers, but to preserve the purity of the water that attracted this exceptionally lucrative form of health tourism (Sigenst 1942:141; Ant and McClennan 1943:695–699; Fishwick 1978:205).

8. Given the scarcity of physicians, few 18th-century Americans outside the three largest cities could have had much contact with the medical establishment, but many apparently kept up with the then-accepted canon of good practices for sexual health through the medium of print. An English work of the late 17th century, called Aristotle’s Master Piece, went through 27 American editions between 1766 and 1830, and was the most popular medical work in late-18th-century America. This book presented a somewhat confused précis of Galen’s theories along with later centuries’ recommendations for keeping the juices of women flowing properly to insure marital happiness, frequent conception, and normal birth (Beall 1963:207–222). The Master Piece was only the first of what was to become a long American tradition of marital-aid books, in which sex toys, including dildos for stimulating the female genitalia, appeared by 1858 (Root 1858). The dildo was, of course, already a very old device, having been well-known to the ancient Greeks and Ptolemaic Egyptians (Liddell and Scott 1968:1216; Aristophanes, Lys. 109; Dierichs 1993:100–101, Herodas 3rd century BC, 6 G).

9. George Taylor, M.D., inventor of the steam-powered vibrator called the Manipulator (1869), explicitly designed and marketed the device for massage of the pelvic and abdominal areas, including the female genitalia (Taylor 1885:187–190). Like its predecessors, this device was expensive, and thus was purchased mainly by spas. In the years between the invention of the electromechanical vibrator (1883) and the end of the 19th century, more than a hundred models of vibrator appeared on the market, of which most were purchased by physicians and spas (Good Health Publishing 1909; Gorman 1905 and c 1912; Liedbeck 1891). The Fordyce Bathhouse at Hot Springs, Arkansas, for example, had vibrators in its massage room as early as 1909 (Petraglio 1987:410–411; de la Peña 1999:753).

In 1899, however, a battery-powered model was introduced into the consumer market, which was soon followed by other devices marketed to consumers that used line electricity, which resemble modern vibrators.
Some had dildo-shaped attachments, or “vibratodes,” as they were then called. Some of the advertising for early vibrators overtly suggested sexual uses, such as that of Lindstrom Smith, which described the action of its vibrators as “thrilling” and “penetrating,” promising that “the pleasures of youth will thro’ within you” (Lindstrom Smith 1908:15, 1910:27, 1913:75, 1915:45, 1916:154). These devices were marketed in household magazines and mail order catalogs until the late 1920s and early 1930s, when they began to appear in stag films and other pornographic materials, such as cabinet cards, examples of which are held in the collections of the Kinsey Institute (American Vibrator Co. 1906:42; Blake 1968:33–34 and 46; Maddocks 1916:126; Monarch Vibrator Company 1916:159; Sears, Roebuck and Co. 1918:8–9; Star Electrical Co. 1922; Swedish Vibrator Co. 1913:60). At the same period, physicians dropped the vibrator from their therapeutic armamentarium (Maine 1998:20). Vibrators remained legal throughout this period, and were malleable matter under the Comstock laws of 1873–1914. Although Anthony Comstock himself may have seized and destroyed some dildoes in his notoriously warrantless raids on retailers and manufacturers of rubber contraceptive devices, the evidence from primary sources, including cases, indicates clearly that enforcement of the Comstock laws was directed against contraceptives, abortion, and sexually oriented writings and pictures. There are no references to cases involving dildos and vibrators in either the annotations to the US Code for 18 USC 1461 or in Federal Cases (Broun 1927:92; Comstock 1967:137; Beisel 1997:158–159; Sanger 1915; D’Emilio and Freedman 1988:156–167; and Federal Cases 1896 v.24 case 14,751:1033–1107).


10. Although vibrators and dildos changed neither their purpose nor their functionality in the late 1960s and early 1970s, some models did undergo a modification in shape and appearance made possible by advances in plastics technology (Kelly 1974:808; Rainbird 1973). This development, and the vibrator’s new association with feminism, seem to have triggered a minor wave of repressive legislation. The anatomical shape of some of the new-model vibrating dildos seems to have created the illusion that it is possible to distinguish a device “useful primarily for the stimulation of the human genital organs” from other massage devices. That such a distinction cannot be made is clear on the foregoing historical evidence. One of the most popular masturbatory devices in today’s market for vibrators is the Hitachi Magic Wand, which is marketed for “standard health care use,” and thus could be legally sold in Alabama, as George Taylor’s 1869 device could not (Kushner 1999). Laws like Alabama’s that target the appearance, packaging or marketing of these devices, rather than their functionality, thus do not prevent or mitigate the supposed “evil” of “commerce of sexual stimulation and auto-eroticism, for its own sake” (Brief of Alabama Attorney General, 2 l). Their effect is merely to benefit one set of retailers (drug stores, health food stores, and discount houses such as Walmart, GNC and Target) at the expense of another (marital aids vendors).

Despite the apparent absurdity and tardy appearance of these legislative measures, Massachusetts retains on its books a law against the sale of “an instrument or other article intended to be used for self-abuse” (General Laws § 272-2 l), passed in 1879. The fossil character of this statute is evident both in its antiquated language and in its clauses prohibiting the sale of contraceptives, which were nullified by the Supreme Court’s decision in Griswold vs. Connecticut (1965). South Dakota included in 1968 vague warnings in its anti-obscenity act SD Code § 22-24-27 regarding unspecified “equipment, machines or materials” that might appeal “to the prurient.” The following year Kansas drafted legislation now comprising KS § 21-430 l, which in its present (amended) form prohibits the sale of “a dildo or artificial vagina, designed or marketed as useful primarily for the stimulation of human genital organs, except such devices disseminated or promoted for the purpose of medical or psychological therapy.” This Kansas statute did not withstand challenge in 1990, nor did Colorado’s Rev. Stat. § 18-7-1-101, 102, passed in 1981 and overturned in 1985. Georgia passed § 16-12-80 (c) on this question in 1975. The Texas statute § 43.2 l, passed in 1977 and upheld in 1985 and 1994, prohibits the sale of “a device designed and marketed as useful primarily for stimulation of the human genital organs,” making it an offense to possess “six or more obscene devices or [sic] identical or similar obscene articles” because such possession indicates intent to sell. In the same year, Nebraska legislated against any “article, or device having the appearance of either male or female genitals” (Nebraska Code § 28-808), clearly reacting to the appearance rather than the function of sexual devices. In 1983, two more states weighed in, Indiana with a statute (IC § 35-49-1-3) as vague as South Dakota’s and probably copied from it, and Mississippi with what was already becoming the standard wording for this new type of legislation, prohibiting the sale of any “device designed or marketed as
useful primarily for the stimulation of the human genital organs” (Mississippi Code § 97-29-105). Louisiana passed LA Code § 14.106.1 in 1985, struck down as “arbitrary and capricious” in 2000, prohibiting the sale of “an artificial penis or artificial vagina, which is designed or marketed as useful primarily for the stimulation of human genital organs” [State v. Brennan 772 SO 2nd 64 (LA 2000)].

In these legislative novelties, appearance, packaging, and marketing rather than functionality seem to be the decisive factor in whether or not a device is “obscene.” Other than these, all of the states plus Guam currently define obscenity in some way that includes only media of communication such as books, pictures, and films, which vibrators and dildos clearly are not.

11. On the historical record, if devices “designed or marketed as useful primarily for the stimulation of the human genital organs” represent an evil and/or a moral threat to the citizens of Alabama, the state has been remarkably dilatory in making this discovery, having waited for something more than two and a half millennia from the invention of the dildo and more than a century from the invention of the electromechanical vibrator to legislate against them. Apparent uncomprehended about the availability of vibrators to consumers beginning in 1899, and even about their use in the production of orgasm in women, for which there was ample evidence by 1930, the state did not act against these devices until a small percentage of them took on anatomical forms, and until they began to be associated with a new interest in orgasmic mutuality in heterosexual relationships. Significantly, Viagra, which enhances sexual experience for men but not necessarily for women, is legal by prescription in all states, including those with laws against vibrators and dildos. As an historian and as a citizen, I fail to see what legitimate purpose is served by institutionalizing an hypocrisy in which the sale of a standard and traditional therapeutic device is rendered unlawful by sexual references in appearance, packaging, or marketing. Alabamians had been exercising their right to include massage devices in personal and/or medical decisions regarding their sexual health for more than two centuries before the passage of the Alabama Anti-Obscenity Enforcement Act. I see no reason why they should not continue to do so.

12. I state under penalty that, to the best of my knowledge, the foregoing is true and correct.

Executed on April 30, 2001

Rachel P. Maines, Ph.D.
HEADACHE: Apply vibrator on 32, 8, 9, 10, and 11.
INDIGESTION: Apply vibrator on 34, 8, and 9.
CONSTIPATION: Apply vibrator on 7 across to 6.
NERVOUSNESS: Apply vibrator on 26 across 6 to 30 across to 30. 7 across to 6, 19 to 32, 16, 19, and 37.
INSOMNIA: Apply vibrator every night on 16. 7 across to 6, 12 to 15, then across and 9 down to 23.
NEURALGIA: Apply vibrator on 14 in front of left ear, also on 9.
RHEUMATISM: Apply vibrator pain is, then out 6, 9, 12, and 32.
WEAK LUNGS: Apply on lung, three times a day, two minutes each morning. Breathe deeply while doing.
OBESITY: Apply on 7 across 6 and 12.
SALLOW COMPLEXION: Apply on 7, across 6.
FALLING HAIR: Vibrator should be used for five minutes a day. Always rinse by pouring water back over head, and comb to 0 leaving 1/4 inch. To stimulate growth, blow from mouth.