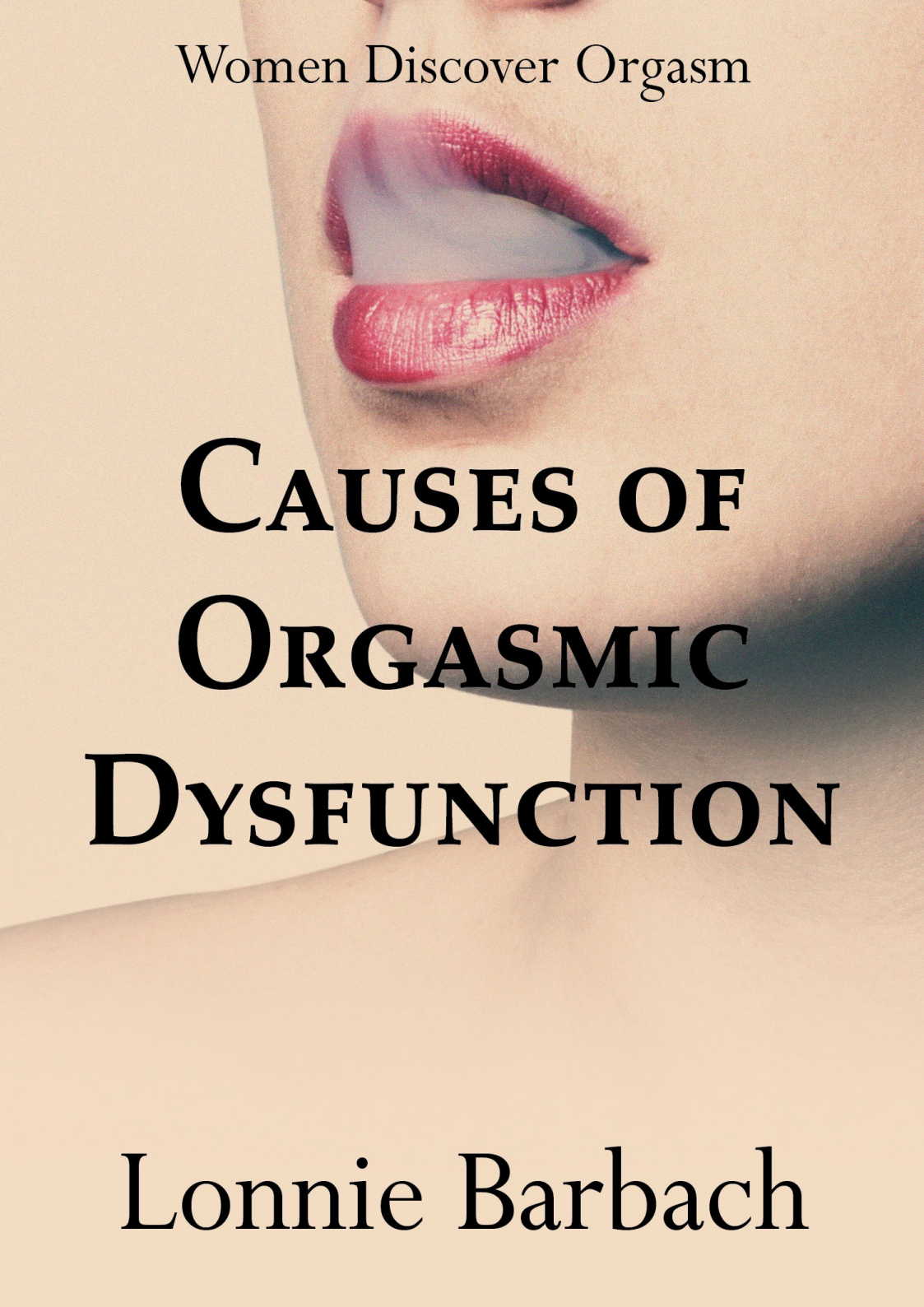
Women Discover Orgasm



Causes of Orgasmic Dysfunction

Lonnie Barbach

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Causes of Orgasmic Dysfunction

According to Masters and Johnson, orgasm is defined as: "a psychophysiologic experience occurring within, and made meaningful by a context of psychosocial influence. Physiologically, it is a brief episode of physical release from the vasocongestive and myotonic increment developed in response to sexual stimuli. Psychologically, it is subjective perception of a peak of physical reaction to sexual stimuli [1966: 127]." Since no two people are physiologically or psychologically alike, the experience of orgasm is unique to each person. Women vary not only in the type of stimulation they require for orgasm, but in the intensity of the experience, and the number of orgasms necessary for satisfaction; a wide range of factors, including diverse relationship and environmental influences, affect each orgasmic response. Women in my therapy groups have described orgasm as a "rush," a "mint-flavored heat wave," "like one heartbeat all over," a "misty cloud that envelops me." One woman said, "I feel this buildup, then there is this feeling after it that's different, that's distinct. I don't feel contractions, but I don't feel like going on anymore. And I feel relaxed."

Through the years, many competing theories have been offered as to the causes of anorgasmia in women. The factors cited range from simple lack of information and misinformation to negative sexual attitudes and pervasive psychological disturbance. Each theory adds bits of information to a complex puzzle. The current understanding seems to be that in most cases there is no one single cause of a woman's inability to experience orgasm, but, rather, a number of interacting factors are responsible.

Lack of Information and Negative Attitudes

A popular viewpoint that appears to explain those cases of orgasmic dysfunction that can be reversed with minimal intervention, attributes the absence of orgasm to either lack of information or negative sexual attitudes. The psychoanalytic writings of Caprio (1953), Fenichel (1945), Lorand (1966) and the work of Kaplan (1974) cite sexual ignorance, prudishness, misinformation about normal sex, and inadequate understanding of stimulation techniques as creating orgasmic dysfunction. The behaviorists (Lazarus, 1963; Wolpe, 1973) blame sexual problems on faulty attitudes and sexual

practices; Masters and Johnson (1966) add that negative attitudes on the part of one's parents and their failure to transmit information greatly contribute to anorgasmia.

Women who are not orgasmic commonly report that they learned nothing at all about sex from their parents or at school. Many have no idea of what is involved in having sex, do not know that women can and do masturbate or that women experience orgasm, or have a false expectation of what an orgasm is like. Generally, these women had done very little self-exploration. Possibly because, as Mead (1949) claimed, the female genitals are not readily visible and thus receive less touching than the male genitals, many little girls fail to discover the erotic sensations that can be aroused there. More likely however, this lack of interest is the result of trained inhibition. We have seen that when given even minimal information, many women with this history seem to be able to stimulate themselves to orgasm almost immediately.

Lack of information is just one contribution to female sexual problems. False notions that women are not supposed to enjoy sex still prevail; for example, until the early part of this century it was generally believed in our society that a "good woman" had little or no sex drive; she was virtuous and chaste (Bullough and Bullough, 1977). Sex was a wifely duty, nothing more, and any indication of sexual appetite was a clear sign of immorality. (This perspective is not wholly dead; a woman in one of my therapy groups reported that she had been told by her mother always to make it clear to her husband that intercourse caused her pain.)

Strict sexually disapproving religious environments have been found to affect sexual responsiveness adversely as well (Kinsey, et al., 1953; Masters and Johnson, 1970). Religious teachings may lead women to feel that they are bad or abnormal if they experience strong sexual urges. Feelings of shame and sometimes disgust toward the genitals and sexual functioning often result from exposure to religious orthodoxy. In these cases, the woman must first overcome the negative messages by receiving considerable support and permission from others. Once this task has been accomplished, she is generally able to achieve orgasm easily.

The Elusive Vaginal Orgasm

Without accurate anatomical and physiological information, many women expect that the one "right" way to be sexual is to have orgasms as the result of the penis's thrusting in and out of the vagina. If they have other experiences, and especially if these are enjoyable, they feel that they are abnormal. This very common misunderstanding arises in large part from Freud's distinction between vaginal and clitoral orgasms.

Freud presented a theory of psychosexual development that described sexuality as a life drive in both men and women, from birth onward. Although his work was the foundation and framework for contemporary psychotherapy, his view of female sexual inadequacy has had many harmful repercussions. Lacking accurate scientific data and writing from the perspective of a middle-class Viennese male, Freud developed the notion that there are two types of orgasm experienced by females—an immature (clitoral) orgasm and a mature (vaginal) orgasm. He argued that the development of healthy sexuality in women is complicated by the need to renounce the clitoris, originally the principal genital zone, in favor of a new zone, the vagina: "In the phallic phase of girls the clitoris is the leading erotogenic zone. But it is not, of course, going to remain so—with the change to femininity the clitoris should wholly or in part hand over its sensitivity, and at the same time its importance to the vagina [1965: 118]." Freud's work had a powerful impact upon Western society: with few facts to go on, many psychoanalysts (e.g., Fenichel, 1945; Horney, 1967) have continued to assert that even though a woman experiences orgasm with clitoral stimulation, failure to achieve a peak sexual response from the thrusting of the penis during intercourse indicates fixation at an earlier stage of psychosexual development and is symptomatic of an underlying conflict warranting psychiatric assistance.

These conceptions of female sexuality are rooted in the Victorian view that sexual activity is permissible only within rather narrowly defined limits: between married people and principally for the purpose of procreation. Sexual activity as a source of healthy pleasure and a way of expressing intimacy was not popularly encouraged, especially for women.

The modern scientific position, as expressed by Masters and Johnson, is that "from an anatomic point of view, there is absolutely no difference in the responses of the pelvic viscera to effective stimulation, regardless of whether the stimulation occurs as a result of clitoral-body or mons area

manipulation, natural or artificial coition, or for that matter, specific stimulation of any other erogenous area of the female body [1966: 66]." Yet the influence of Freud persists. Although Hite (1976) found that 70 percent of her sample of women required direct clitoral stimulation in order for orgasm to occur, most of them continued to feel abnormal if the so-called vaginal orgasm was not within their grasp. Sherfey amplified this psychocultural observation: "More and more women (and men) accept the equation: vaginal orgasms equal normalcy. Hence, there is an ever-growing incidence of guilt, fear, and resentment in otherwise healthy women who find themselves unable to achieve the elusive prize [1972:26]."

The repercussions of this viewpoint cannot be overemphasized.

> Not just the couples with sexual problems and most of the educated public, but almost all psychiatrists and physicians (excepting gynecologists and endocrinologists) are still committed to the belief in the existence of the vaginal orgasm as distinct from the infantile clitoral orgasm and consider the vaginal orgasm to be a vital sign of normal feminine development. . . . Could many of the sexual neuroses which seem to be almost endemic to women today be, in part, induced by doctors attempting to treat them [Sherfey, 1972: 27-28]?

Meanwhile, convincing women about the normalcy of clitoral stimulation requires considerable attitudinal change, a process that generally takes time to solidify.

Belief in a Standard Sexual Response

We all admit that each of us in unique in many ways—in the jobs we choose, the hobbies we enjoy, and the people we find attractive. Some women are great athletes, others have fine manual dexterity, some are musically inclined, and some have a sophisticated palate. Likewise, each woman's sexual responsiveness is unique. Kinsey noted that whereas "considerable variation occurs among males, the range of variation in almost every type of sexual activity seems to be far greater among females [1953: 146]." Masters and Johnson also cautioned: "It always should be borne in mind that there is wide individual variation in the duration and intensity of every specific physiologic response to sexual stimulation [1966: 7]." Accordingly, Lazarus (1963) found that a low threshold of distractibility can interfere with orgasmic responsiveness in some women; Masters and Johnson found a history of low sexual tension to be correlated with anorgasmia; and Kaplan (1974) and Hite (1976) found that lovemaking techniques that are not suited to the needs of the individual woman are frequently

responsible for the inability to climax.

Yet much of the public remains unconvinced by the documentation produced by these and other researchers and adheres to a fixed notion of sexual normality. In addition, since so little information is available about how others respond to sex, many myths continue to circulate, creating a variety of sexual problems. Thus, if a woman learns that multiple orgasm is possible, she feels somehow deficient if she has only one orgasm at a time. If she learns that some people make love for an hour, she thinks she must lack sexual energy if she prefers shorter episodes. If she finds anal sex painful, she wonders what is wrong with her. Some women become sexually aroused very quickly; others respond slowly. Some women require intense and direct clitoral stimulation to reach orgasm whereas others react to subtle pressure and indirect clitoral stimulation. Lack of acceptance of the physiological differences among women (as well as men) creates a personal sexual Olympics: there is no other human activity in which everyone expects to be a gold medal winner or regard herself as a total failure.

The physiological issues become more complex when a woman strives to adapt her unique physiological requirements to the anatomical and physiological uniqueness of her partner. He may like hard and rapid thrusting though she prefers a slower and more sensual movement; she may require a protruding pubic bone for sufficient clitoral stimulation during intercourse whereas his pubic bone recedes. If she has been taught to believe that there is only one right way to function sexually, she will try to fit herself into a mold she assumes is normal and thus will not attempt to develop lovemaking techniques that meet her own needs and enhance her sexual pleasure.

Orgasm Is Learned

The need to learn to be sexual, that is, to learn appropriate techniques for deriving sexual satisfaction, is a revolutionary concept, especially for women who grew up thinking that sex should be a totally spontaneous and natural activity. However, since nearly everything we do is learned, it should come as no surprise that Kinsey found that more highly educated women, who were more likely to be sophisticated and liberal and hence not to accept wholesale the views of parents or clergy, were also more likely to experience orgasm; that women who experienced premarital orgasm by any means were three times more likely to experience orgasm in marital sex than were those without such a history; and

that the ability to experience orgasm increased with the length of the marriage. Kinsey wrote, "It is doubtful if any type of therapy has ever been as effective as early experience in orgasm in reducing the incidence of unresponsiveness in marital coitus, and in increasing the frequency of response to orgasm in that coitus [1953: 385-386]."

Kinsey's data, therefore, laid the foundation for the important assumption that orgasm can be considered a learned response and that failure to achieve it is not necessarily a sign of neurosis but, rather, a possible result of faulty or inadequate learning. Furthermore, a learned response reflects certain cultural definitions. Mead pointed out that "there seems to be a reasonable basis for assuming that the human female's capacity for orgasm is to be viewed much more as a potentiality that may or may not be developed by a given culture [1949: 217]." Thus, women who have sexual problems because they define as normal only certain responses within the confines of certain limited activities are frequently demonstrating inadequate or inappropriate sexual learning.

Female Role Scripting

It is extremely difficult to change women's perceptions about normal female sexual functioning in a way that makes them more accepting of both the need for clitoral stimulation and their own physiological uniqueness. Their resistance appears to be based on the female role scripting in this culture, which teaches women, among other things, not to be assertive.

In our society, both men and women are taught that men are the authorities on sex. With no instruction, each man is somehow expected to understand each woman's unique sexuality. This, of course, is supposed to occur without any input from the woman herself, who, if she is decent and respectable, is expected to be innocent of sexual knowledge and experience. The man cannot ask his partner for information: not to be omniscient would make him appear less masculine. Likewise, the woman cannot tell her partner what would bring her pleasure because first, she is not supposed to know and second, because she fears she may hurt his ego by implying that he is inadequate or insufficiently knowledgeable. Some women subscribe to the romantic expectation that if a man "really" loves her he will know specifically what she would most enjoy at every point in love-making.

Submerged in the mystical vision of sex that arises out of this mutual lack of information, many women do not learn about themselves sexually and do not accept responsibility for their sexuality but, rather, expect the man to awaken them.

Nelson (1974) found that women fall into two categories regarding their sexual attitudes. They are either "romantics," whose attitudes reflect an idealistic, mystified vision of romantic love, or "realists," who show a rational understanding of conscious sexual cooperation. Realistic women were discriminating about their sexual activity and able to tell their partners what they liked and did not like; they were active in initiating sex; they concentrated primarily on themselves during lovemaking, and tended to direct lovemaking overtly in order to get what they wanted. Romantic women, by contrast, did not talk about sex, rarely initiated sex, focused selflessly on the partner in an attempt to please him, and amiably followed their lover's direction during lovemaking. It is interesting to note that Nelson's subjects' self-reports indicated that 77.3 percent of the romantic women were low-orgasmic whereas 70 percent of the realistic women were high-orgasmic. Nelson's research thus gives credence to the popular theory that the way women are trained to behave may in itself contribute to the lack of female orgasm.

The sex-role training of American girls establishes passivity and dependence as desirable female attributes. As they are prepared for their future roles as wives and mothers, girls are taught to provide the nurturance their husbands and children will require. They are trained to serve selflessly but are not adequately provided with the skill or the confidence to manage their own lives and achieve a sense of independence. Since they are taught to be dependent, they learn to approach life from a powerless position. They are trained, above all, to seek love. If they are attractive, charming, and not so intelligent as to threaten the man's self-esteem, they can get a man to take care of them for the rest of their lives. Their security lies in being loved. If they are loved, they will be cared for and will not be abandoned. Their position in life is therefore determined by how good their choice of a partner has been. They feel no sense of positive power to attain things for themselves. Their only power is to make requests of (or to manipulate) their husbands and, when they do not like what they get, to withhold.

A woman trained to be passive may relinquish control over her life to others—to a spouse, for example, or to the fates. When she does attempt control, it often takes the form of resistance, or negative control. Her behavior is a way of saying that even though she cannot attain what she wants, no one can

force her to do what she does not want to do. Such a woman may deprive herself of the experience of orgasm as a way of punishing her partner for her dissatisfaction with their relationship by making him feel inadequate sexually. This response is understandable in a society that views sex as an activity engaged in for the man's and not the woman's pleasure. Since women can use sex as a way to catch a man, they can withhold sex when they are angry. The case of Maria illustrates this point.

Maria: In my relationship with Greg I don't have orgasms all the time and I want to have them all the time.

Therapist: Do you ever have them with him?

Maria: Yeah, but I want to have them all the time. When I don't, I feel really left out and I feel real cheated and I feel anger, too. Greg said, "Why don't we keep a record every time you have an orgasm?" I felt that was not the right attitude either. He has an orgasm every time we have sex, so why shouldn't I? Why should I be deprived of having an orgasm every time?

Therapist: It's probably not possible every single time. Aren't there some times when you're exhausted and it's too much effort?

Maria: Yeah.

Therapist: That happens to me every once in a while, too. Sometimes I feel like having sex but I don't feel like putting in the effort to have an orgasm. But, meanwhile, what's the difference between the times when you do have an orgasm and the times when you don't?

Maria: I probably go into it thinking, "I'd better have an orgasm or I'm going to be mad."

Therapist: And then you do or you don't?

Maria: And then I don't.

Therapist: Okay, so you set it up. Anything else you notice about the times you don't have orgasms?

Maria: How can I say it? Like if I felt in the day that I was hassled with cleaning or cooking or something. He comes and he's reading. How dare he sit and read when I've been doing all these things! I feel that that is my way of getting even. And then the days when he helps me with the dishes or something everything's fine. It's all very simple.

Therapist: So when you're angry enough, instead of just being angry, you just don't have an orgasm. And then you can really be angry, right? A good, legitimate reason.

Maria: Yeah, except I'm hurting myself.

Therapist: In addition, he doesn't know what you're angry about.

Maria: That puts a lot of pressure on him. That's the other thing I was thinking about. When I don't have an orgasm he

feels that I don't love him. And then he gets more desperately into pleasing me.

Therapist: That's a great payoff in addition.

Maria: Yeah.

Fear of Losing Control

The lack of control that women feel over their lives can be pervasive. Kaplan (1974) noted that the fear of losing control over feelings and behavior is very common among women who are preorgasmic and that the resulting defense mechanisms of holding back and overcontrolling are crucial in the genesis of this disorder. At the intrapsychic level, a feeling of control is intimately related to the degree to which a woman experiences herself as separate and differentiated from others. Having well-defined ego boundaries affords a person a certain sense of control; she feels the power and security of being whole and autonomous. Since most women sense a loss of control at the point of climax, relinquishing conscious control when experiencing the orgasmic state can be extremely anxiety producing for a woman with little or no initial sense of control. These women often express the fear that they will dissolve or merge with the partner as sexual sensations become intense.

Fear of loss of control appears to be the fundamental problem of women who require more than simple permission and information in order to reach orgasm. These women need to experience sexual arousal gradually so that they can slowly become familiar with sexual intensity and thus feel more in control. If arousal mounts too rapidly, they can be overwhelmed by the strength of their sexual feelings and experience fears of exploding or even having epileptic fits. The compensatory overcontrol, which limits sexual expression, frequently also encompasses the expression of other feelings, such as anger and caring. Women who fit this pattern are often incapable of showing feelings to a limited degree. They experience the world and their options as either black or white, with no gradations between the extremes. They are thus unable to set limits and find themselves either immobilized and unable to approach something new, or overwhelmed because they jump in too quickly.

Maria: That's what I do, okay? I have a vibrator, and if I can't take it anymore, then I move the vibrator on other parts. And when it builds up again and it's great, then it comes to pain again. I'm getting better at it, so I can take more. I feel something coming. It's getting so intense. And I say, "Oh! Time out!"

Beverly: The pain is getting intense or the feeling?

Maria: The feeling, something, the orgasm. It's just when it's coming. My lover says that I always stop the orgasm when we're making love. Just before I'm coming, I'm just somewhere. I just start going into space and I'm afraid.

Josephine: I caught myself doing that, stopping myself.

Maria: Just after I was eighteen and I wasn't a virgin anymore, I asked this older woman, "How does it feel to have an orgasm?" And she said, "Oh, it's like an explosion. Your whole body explodes." And I think that must've made an impression on me 'cause I think something's going to happen to me. I'm going to explode. And I'm scared of that.

Pamela: I'm afraid I'll die if it happens. I'll lose such control and that'll be the end of it.

Abby: I'm scared of shaking and looking like I'm in an epileptic fit. That's what I'm scared of. I'm also scared of not being able to hold my urine at a certain point.

The process of learning to reach orgasm by approaching new sexual situations in carefully graduated steps helps such women to develop a sense of internal control thereby eliminating the need to overcontrol. To become orgasmic, a woman must test levels of sexual intensity slowly and over time until her security is built up by the knowledge that indeed she can control these feelings. She finds that she can stop the stimulation if she wants to or she can continue with it and gradually experience more and more intense feeling. Slowly, she can learn to trust her sense of control to the extent that she can allow the sensations to build to orgasm and still expect to survive the experience, first while alone, then with a partner. When that is achieved, she learns to assume control by asserting her needs and communicating her sexual likes and dislikes to her partner in order to insure that the sexual encounter will be satisfying.

A change in the woman's sense of control has been documented through testing before and after participation in a preorgasmic group, using the Rotter Internal-External Locus of Control Inventory (Rotter, 1966). Heinrich found a "significant difference in the direction of internal locus of control indicating an increase in the subjects' belief in their personal control of events [1976: 102]." She explained the finding thus: "The treatment for primary orgasmic dysfunction rests heavily on the notion that people should take responsibility for their own sexuality. The [research results] suggest that this notion may have generalized to other areas of life for those subjects in the study [p. 98]."This analysis of the role of control in anorgasmia is somewhat simplified, but I hope the point is clear: young girls are trained to be passive and to relinquish control over their lives. The sense of insufficient control leads to other problems: absence of differentiated ego boundaries, inability to express feelings, and lack of

orgasm. Consequently, if girls are trained to be more assertive and independent, one would expect that the incidence of anorgasmia would be greatly reduced in situations in which these dynamics come into play. This premise is substantiated by the findings of anthropologists Ford and Beach.

> The societies that severely restrict adolescent and preadolescent sex play, those that enjoin girls to be modest, retiring, and submissive, appear to produce adult women that are incapable or at least unwilling to be sexually aggressive. The feminine products of such cultural training are likely to remain relatively inactive even during marital intercourse. And, quite often, they do not experience clear- cut orgasm. In contrast, the societies which permit or encourage early sex play usually allow females a greater degree of freedom in seeking sexual contacts. Under such circumstances, the sexual performance of the mature woman seems to be characterized by a certain degree of aggression, to include definite and vigorous sexual activity, and to result regularly in complete and satisfactory orgasm [1951:266].

Other Psychological Factors

Psychoanalysts used to believe that a number of other situations resulted in anorgasmia. Most of these theories have been either dismissed or reinterpreted. The idea that "excessive" masturbation localizes the woman's sexual feelings in the clitoris for example, was dismissed when Masters and Johnson (1966) discovered that in masturbation women stimulate the clitoris rather than the vagina because of the already existing density of nerve endings in that area. The incestuous wishes resulting from an unresolved Electra complex—the little girl's desire for sexual union with her father and the implied wish for the death or disappearance of her mother in order to make this union possible—are believed by many psychoanalysts to produce severe conflict in the young girl, frequently manifested in anorgasmia and/or fear of injury to the genitals. Kaplan (1974) asserted that if the young female abandons herself totally to her sexual feelings, she fears being deserted or destroyed by her jealous mother, particularly if the daughter is very dependent. Thus, she reinterpreted the Electra complex to place less emphasis on an unresolved relationship with the father and more on issues of dependency and vulnerability if control is lost. Finally, Thompson (1971), Moulton (1973), and others have attributed penis envy—the belief that aggressive women are anorgasmic because they have an unconscious wish for a penis and feel cheated or deprived because they lack one—to the woman's craving for the societal status and freedom experienced by the possessor of a penis rather than to the wish for the male organ itself.

Although in some rare cases it may be true that deep-seated problems cause orgasmic dysfunction,

women who do not respond to short-term behaviorally oriented treatment and require intensive psychotherapy to experience orgasm have been few and far between. Fisher's research seems to indicate that for the most part lack of orgasm and psychological disturbance are not correlated: "There are so many things with which orgasm consistently is *not* linked. Particularly noteworthy is the fact that it does not seem related to maladjustment or psychological disturbance. . . . There does not appear to be a relationship between the 'mental health' of a woman and her ability to attain orgasm [1973:275]." Age, religious affiliation or religiosity, characteristics of the husband, or measures of femininity (e.g., use of cosmetics or adornments and attention to dress) were also found not to correlate with ability to achieve orgasm.

Both Fisher and I did find, however, that the inability to experience orgasm correlated with having grown up with a physically or emotionally absent father (Barbach, 1974; Fisher, 1973). Fisher interpreted these findings psychoanalytically to mean that the father's absence creates fears of love-object loss in the young girl. However, anorgasmia resulting from this situation can also be ascribed to the woman's abandoned mother unintentionally teaching her that men are unreliable and likely to desert her. In this situation, the mother, through her own insecurity, may transmit to her daughter the need to control her emotions and maintain separateness.

It appears that although a woman's overall mental health may not be called into question because of her lack of orgasm, many psychological concerns can be linked to the issue of orgasm. Fears of pregnancy, childbirth, and venereal disease, among others, may affect a woman's anxiety level and hence her responsiveness during sex; so may her concern about problems involving children, illness, or money, particularly when these worries are chronic. Deeper fears, however, frequently surface once the woman becomes actively aroused sexually. Some women feel overly vulnerable to their partners as sexual tension mounts. The fear of losing the partner becomes exaggerated as they anticipate the intense intimacy that might occur with orgasm. Other women fear they will not find the partner attractive, or that their partner will find them unappealing once they become orgasmic and hence will have to face the possibility of separation or divorce. Many women fear that by becoming orgasmic they will have to behave more maturely or that their lives or personalities will change dramatically. These anxieties tend to be associated dynamically with the fear of losing control. In order for orgasm to occur in these cases, it appears to be less important to resolve the underlying issue than to disconnect it from the experience of

orgasm. Work on these other issues can be resumed if they remain problematic after the simpler task of learning to become orgasmic has been achieved. (The question of psychological issues is explored further in Chapter 6.)