WOMEN'S SEXUAL EXPERIENCE

Explorations of the *Dark Continent*

WOMEN IN CONTEXT: Development and Stresses

THE WOMAN PATIENT

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Edited by Martha Kirkpatrick

WOMEN'S SEXUAL EXPERIENCE

Explorations of the *Dark Continent*

Edited by

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"...after all, the sexual life of adult women is a dark continent of psychology."

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Preface

This book, like its companion volume, *Women's Sexual Development*, is a potpourri of ideas, not campaign literature to promote a particular point of view. The editor agrees with some of her authors and strongly disagrees with others. The "facts" are few, the questions many. The intent of both books is to evoke questions, delay convictions, invite controversy, and plead for opening minds. The examination and explanation of women's sexual experience has long been the province of men. The "is" and the "oughts" have been hopelessly confused by the investigators' (or exhorters') biases and limited experience, as well as by the use of the male sexual experience as the model for all human sexual experience. Women, at long last, are talking not only to each other, in personal journals and letters, but also in the more formal worlds of academic and scientific publications.

The papers in this book come from many sources. Some are academic; some are experiential, journalistic, or personal. Several emphasize the lack of adequate research and data but address an issue that is just appearing on the surface of contemporary controversy and concern. Many topics and sources of information are missing. Perhaps another book, at another time, will fill some of the glaring gaps (such as women's reactions to visual sexual stimuli, women's sexual fantasies, the question of adaptable and flexible sexual object choice in women, the role of holding and sensuality in female sexual satisfaction, the sexuality of breast feeding, and Latino women's sexual experience).

It is sometimes said, true or not, that the male's sexual fulfillment takes 2.6 minutes, and the female's takes nine months. Reaching for the even more delayed climactic moment of completing this volume, this editor has felt like an elephant gestating after mating with a whale. I hope timorously that the little Seussian offspring will flipper and gambol into its place in the strange kingdom of the study of human sexual life.

I am grateful for the support and tolerance of family and friends

during this prolonged gestation. Most especially, I appreciate the patience and good nature of my secretary and assistant, Elayne Mitchell, who has endured the endless penciling and revising of those pristine pages she thought were final. She has been a healer and a midwife.

MARTHA KIRKPATRICK

Los Angeles, California

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PART I

The General Condition

Chapter 1

Women's Sexual Response

HELEN S. KAPLAN AND ERICA SUCHER

WHAT IS NORMAL SEXUAL DESIRE?

Our concept of what constitutes the normal range of sexual desire is highly subjective, in contrast with our concept of normalcy with respect to genital functioning. Erections and orgasms can be observed objectively and therefore can be accurately described and defined, but our data regarding normalcy of libido in men and women are incomplete and largely anecdotal. However, there is a sense of the normal range of sexual interest, and while there is confusion in borderline situations, professional consensus does exist—at least in a general way—regarding the extreme and clearly pathological deviations from the norm. For example, most clinicians would agree that a married woman of 39 who never feels sexual desire, is attracted neither to her husband nor to anyone else, and never fantasizes or masturbates has an abnormally low libido. A history of significant change in libido also suggests that desire has become pathologically low and is not simply low normal (Kaplan, 1977).

The sexual response of males and females may be divided into three phases: desire, excitement, and orgasm. Desire is an appetite that has its locus in the brain (limbic brain and hypothalamus); excitement and orgasm involve autonomic reflexes of the genitals. Excitement in both males and females is the result of dilation of the blood vessels that invest the genital organs, while orgasm is produced by the contraction of certain genital muscles (Kaplan, 1974b, 1979).

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THE NORMAL SEXUAL EXPERIENCE

Normal sexual development can be described in only the most general terms because of the current incomplete state of our knowledge. But it seems that in the healthy individual some form of sexual appetite is present throughout life. As with any human trait, the intensity of the sex drive varies widely. At the extremes, it may be difficult to determine what is a pathological and what a normal variation. In other words, some normal persons apparently have such a low sex drive that they appear to be suffering from a pathological inhibition of sexual desire (Kaplan, 1977).

Sexual appetite changes in intensity with age and takes a gender-specific course of development. Infants seem to have the capacity for some erotic feelings, and these are evoked when their genitals are stimulated. When tiny clitorises and penes are stimulated in the course of bathing and dressing, infants express pleasure by smiling and cooing. If they are not stopped, children masturbate and later play sexual games that entail looking and touching. We tend to forget or to repress many of these early sexual fantasies and experiences, but some memory is normally retained. And if during a psychosexual evaluation the patient remembers *no* prepubescent erotic feelings, one can assume a certain amount of early sexual inhibition.

There is a substantial increase in sexual desire at puberty. It is correlated both with the maturation of the cerebral circuits that govern sexual expression and also with the increase in testosterone produced by the gonads at this time, which activates these circuits. After puberty, sexual development takes a different course in the two genders. In the male, sexual desire seems to peak at around 17 years and then slowly declines. The normal adolescent male is very interested in sex, is easily aroused, and in the absence of a partner masturbates from several times a week to several times a day while conjuring up erotic fantasies. If there is no sexual outlet, he experiences frustration. So predictable is this phenomenon that if the sexual history reveals no adolescent increase in sexual desire as reflected in masturbation and/or fantasy or actual intercourse, one may suspect a problem in psychosexual development. The intensity of the male sex drive diminishes gradually after adolescence. At middle age, he still desires sex but often can go without sexual outlet for longer and longer periods of time without experiencing frustration. His sexual desire can, however, be aroused under exciting circumstances all during his life.

Females also experience an intense increase in libido at puberty. However, in our culture, currently, it does not decline after adolescence but slowly increases and peaks around the age of 40. Female

sexual desire then also slowly declines. In general, female sexual desire is more variable than that of males. While women have a greater orgasmic potential, their sexuality is also more easily suppressed.

Clinically, it seems that female sexual desire is more easily inhibited than that of the male, especially during youth, when the sex drive in the male is so intense. In other words, inhibition of sexual desire can be produced in women of all ages and in aging men by relatively less intense factors. It takes relatively more substantial psychological pressure to produce an inhibition of sexual desire in a young male. Speculations about the relative contributions of biological or cultural determinants to these gender differences in sexual desire are legion and inconclusive at this time.

Thus, the normal person throughout his or her life both experiences spontaneous sexual desire and has the capacity to have desire evoked by an attractive partner. When the sex drive is high, the person experiences spontaneous desire and is aroused by a wide range of stimuli. As desire diminishes, the range of stimuli that evoke the sexual appetite narrows.

Both genders usually experience an increase in sexual appetite when in love, and both genders experience a decrease in sexual desire when they are under stress. Even when a couple have an excellent romantic bond, sexual desire normally fluctuates, but it never remains absent for long (Kaplan, 1974b, 1979).

NORMAL ASEXUALITY

The asexual state is certainly not universally abnormal. It has already been mentioned that some persons have a constitutionally determined sexual appetite that is on the low side of the normal distribution.

There are also many circumstances in which a person's sexual desire is inhibited on a nonpathological basis. It is not appropriate to find all potential sexual partners or situations attractive. Many persons do not really enjoy sex unless they have an intimate and sensitive relationship with the partner or unless the partner meets some special emotional and physical ideal. Such persons may choose to inhibit their sexual feelings until they can find a desirable partner to whom they can form a gratifying attachment. Celibacy on this basis is a constructive, mature, and dignified choice and should not be classified as pathological. The healthy celibacy in which desire is suppressed until a really satisfying partner becomes available should be differentiated from a neurotic rejection of suitable partners (Kaplan, 1977, 1979).

Thus, the capacity to inhibit as well as to express one's sexuality is a part of normal human functioning.

THE STAGES OF THE SEXUAL RESPONSE

We shall now describe in detail and compare the physiological sexual responses of men and women.

In order for the small, flaccid, urinary penis to be transformed into the erect, reproductive phallus, and in order for the dry, tight potential space of the vagina to be metamorphosed into the succulent, open reproductive receptacle, profound physiological reactions must occur. Masters and Johnson (1966) have described the sequence of events that prepares males and females for sexual union so beautifully and usefully that their descriptive scheme has become incorporated in the vocabulary of the field and now constitutes basic material in the curricula of training programs. Briefly, Masters and Johnson divided the male and female sexual response into four stages: excitement, plateau, orgasm, and resolution. The changes are comprised basically of genital vasocongestion and involuntary smooth as well as striated muscle responses.

In the female, during *excitement*, vasocongestion of labial, bulbar, and perivaginal blood vessels causes vaginal lubrication and swelling of the genitals. In addition, the vagina expands and balloons internally, and the uterus rises. This reaction reaches its extreme expression during *plateau*, when the intense local swelling has been termed the "orgasmic platform" by Masters and Johnson. *Orgasm* in the female does not include an emission phase; it consists of rapid involuntary contractions of the striated muscles surrounding the vagina. The pleasurable orgastic sensations are correlated with these involuntary contractions, as they are in the male. *Resolution* represents a drain of fluid from the genitals and the consequent return to the basal state.

In the male, *excitement* is characterized by erection. This becomes maximal during *plateau*, when erection reaches its limit; the testes, which are now enlarged and congested, rise into apposition with the perineal floor. *Orgasm* in the male consists first of *emission*, or the gathering of seminal fluid in the posterior urethra by the reflex contraction of the smooth muscle of the prostate, the seminal vesicles, and the vasa deferentia. This process is perceived by the man as the sensation of ejaculatory inevitability. It is followed a split second later by *ejaculation*. The latter response consists of rapid involuntary contractions of the striated muscles surrounding the base of the penis, as well as of the smooth muscles of the penile urethra. The pleasurable sensations of orgasm accompany this ejaculatory part of the response.

Resolution consists of an abatement of local vasocongestion and a return to the basal state.

THE TRIPHASIC NATURE OF THE SEXUAL RESPONSE

In both genders, the manifest appearance of the sexual response is a smooth sequence of events: desire leads to excitement and culminates in a climax. It would appear that it is an indivisible, unified event. However, a closer look reveals that the sexual response is actually a well-coordinated sequence of three discrete physiological responses: desire, lubrication-swelling, and orgasm in the female, and desire, erection, and ejaculation in the male (Kaplan, 1979).

There is much evidence for such a triphasic concept. First, in the male, the two genital components are innervated by different parts of the nervous system. Erection is mediated by the parasympathetic, as well as the sympathetic, divisions of the autonomic nervous system, while the emission phase of ejaculation is controlled by the sympathetic and somatic nerves (Kaplan, 1974b).

The erectile response is essentially due to hydraulic pressure against the limits of the tough penile fascia. This pressure occurs when there is dilation of the penile arterioles, a parasympathetically controlled reaction, together with a shutting down of valves (or polsters) in the penile vesicles, which prevents rapid drainage of blood. The polster reflex is probably initiated by sympathetic nerves.

Orgasm in the male consists of the two phases described above. Emission, or contraction of the internal male reproductive viscera, is governed by sympathetic nerves. Ejaculation, which consists mostly of involuntary clonic contraction of striated perineal musculature, is presumably innervated by somatic nerves that flow from a reflex center located in the sacral cord (Kaplan, 1974b).

Moreover, recent studies show discrete cerebral localization of desire, erection, and ejaculation (Kaplan, 1979). Definite loci in the primate brain, if stimulated electrically, produce ejaculation, even in the absence of erection. Electrical stimulation of different but closely related brain areas causes the animal to have an erection, but he does not ejaculate. Clinical observations also show that ejaculation and erection can be impaired separately. In retarded ejaculation, erection is not affected. The man is normally aroused and typically maintains his erection for long periods of time. However, his orgasmic reflex is inhibited, and he may have great difficulty ejaculating. Indeed, there is a rare syndrome that we have termed *partial retardation*, wherein the emission phase is intact, and only the pleasurable ejaculation part of

the male orgasmic response is inhibited. On the other hand, many men who suffer from erectile dysfunction and cannot attain or maintain an erection do ejaculate with a limp penis and feel normal orgasmic sensations if they are stimulated sufficiently.

The discreteness of the vasocongestive and orgasmic components of the sexual response has until recently been clinically recognized only for the male. However, an exactly analogous situation exists for the female. In the female, also, the arousal aspect of the sexual response consists of genital vasocongestion. Of course, the dilation of vessels and capillaries occurs diffusely in the perivaginal, labial, and pelvic areas, not in a discrete space, nor are there special caverns or valves in the female genitalia. However, the female genitals are richly supplied with blood vessels. The female genital vasocongestion does not produce an erection. It causes, instead, swelling and transudation. The latter appears on the vaginal wall in the form of vaginal lubrication. The swelling produces what has been described by Masters and Johnson as formation of the "orgastic platform." Thus, female genital lubrication and swelling are analogous to erection in the male.

The orgasmic reflex is also analogous in the two genders. Of course, there is no emission of ejaculate in the female. However, the female orgasm is triggered by similar stimuli and is expressed by motor discharge similar to that of the ejaculation phase of the male climax. In the male, orgasm is elicited by rhythmic stimulation of the skin of the glans and the shaft of the penis. Similarly, in the female, orgasm is brought about by sensory input provided by stimulation of the skin of the clitoris, which is embryologically derived from the same tissues that produce the penile shaft and glans. In the male, the motor expression of orgasm consists of rapid, rhythmic contractions of the muscles at the base of the penis: the bulbocavernosus, the ischiocavernosus, and some perineal floor muscles. These same muscles are involved in the orgasmic expression in women. These muscles contract against the thickened, engorged perivaginal tissues to produce the female orgasm.

The neurophysiology of the female sexual response has not yet been studied. However, by analogy, one can speculate that a similar discrete but related nervous-system organization of the two aspects of the sexual response exists in both genders. Clinically, also, one sees two separate dysfunctional syndromes in women that are produced by the discrete inhibition of the two components of the female sexual response. The more severe disorder is general sexual unresponsiveness, which is analogous to impotence, and the other is orgasmic dysfunction, which is in many respects similar to retarded ejaculation in males (Kaplan, 1974a).