SEXUAL DISORDERS IN WOMEN: THEIR MEDICAL SIGNIFICANCE

BY

JOAN MALLESON, M.B., B.S.

*Clinical Assistant, Obstetric Department, University
College Hospital*

In this country, sexual disorders of the male have been fully described and classified by Walker, Strauss, and others; yet, curiously, great confusion exists about the equivalent disorders of women. This may be because the disabilities are mainly subjective and are therefore less readily manifest. In fact, however, most of them fall readily into quite simple categories.

There are cogent reasons for classifying the various feminine disabilities. Practitioners nowadays—appreciating that certain sorts of sexual frustration can cause symptoms of anxiety neurosis—are apt to confuse these types of disturbance with others which produce no symptoms whatever, and which cannot in any case be reasonably subjected to medical treatment. Thus certain disorders may be referred unnecessarily for advice on sexual technique or for a change of contraceptive method, whilst others, which may be causing obscure psychosomatic symptoms, tend to pass unrecognized.

I shall exclude here the rare cases of disorder due to endocrine or developmental abnormality. Although fatigue, deficiency of thyroid hormone or oestrogen, diabetes, and so on may produce a secondary frigidity, in the overwhelming majority of cases the disability is psychogenically determined.

Terminology

The word "frigidity" requires definition. It is generally used to describe cases in which there is an absence of the characteristic erotic sensation in either the vagina or clitoris, or in both. But psychiatrists sometimes apply the term in a more special way—namely, to any condition where the woman is unable for intrinsic reasons (that is, not because of incapacity of the husband) to attain orgasm, even if her erotic feeling is extremely urgent. This application of the word seems calculated to confuse patient and doctor, and I have known it to cause great offence, the woman feeling that such capacity as she has is being belittled. To my mind, "frigidity" should be reserved for a woman who lacks emotional or physical response to the sexual relationship under discussion. Thus, disinclination and lack of tumescence are symptoms of frigidity; yet a woman who experiences no erotic feeling whatever may suffer from neither. There is need for a term to describe the large group of women who can experience erotic sensation, in greater or lesser degree, but insufficiently to attain orgasm. Until such a term is coined they must be described as "lacking orgasmic capacity."

Theoretical "Norm"

Because confusion exists, it is necessary to be clear about what is normal in feminine sexual response.

As in the male, genital stimulation normally culminates in orgasm—automatic, rhythmic contractions of the genital muscle. If the eroticized area is clitoral, the outer muscles of the vulva only are involved; if the

vagina or cervix is sentient and is stimulated, the inner pelvic muscles will be involved as well. Although some women cannot distinguish between clitoral and vaginal orgasm, usually the functions are quite distinct. A woman who can get both types of orgasm nearly always values the vaginal one most; normally it evokes a deeper emotion and is more satisfying. But when inhibition is present—as it so very often is—it is generally the vagina which first experiences some suppression of feeling. Probably only one woman out of three is regularly capable of vaginal orgasm, whereas perhaps three out of four can get clitoral satisfaction. As some degree of disability is so very common, a practitioner should be cautious in making comments about sexual inadequacy, for harm can be done to a woman's self-esteem by unnecessary criticism. From the clinical standpoint, although a woman's failure to attain orgasm may cause disappointment to herself or to her husband, it is not likely to cause her strain or illness unless a high pitch of erotic tension has regularly been reached. But where this is the case, symptoms of anxiety neurosis are almost certain to be found, and the matter should be fully discussed.

Types of Functional Derangement

In women, disorders of the sexual function occur mainly as disturbances of feeling. The female generative tract is by far the most "hysterical" organ of the body, being subject throughout its length to anaesthesias, hyperaesthesias, paraesthesias, hypertonus and hypotonus, and hyper- and hypo-secretion. Of these, anaesthesia is much the commonest disturbance and, unfortunately, much less amenable to therapy than the other dysfunctions. It can affect either the vagina or the clitoris, or both. The distribution is comparable to the "glove and stocking" variety of hysterical anaesthesia: if the vagina only is involved it starts precisely at the introitus. Usually the repression of feeling interferes with the capacity for orgasm, but sometimes the orgasm is not totally lacking but is lessened in intensity. If anaesthesia is complete the woman will have no knowledge whatever of erotic sensation. Even in such cases the inhibition occasionally lessens in sleep, when the mental censorship is less active, and the woman may wake with erotic feeling or even with orgasm. Occurrences of this sort are by no means uncommon, and show without doubt that, although women may suffer permanently with anaesthesia, the capacity for feeling is still present, but is repressed. A chance reshuffle of the unconscious inhibiting forces, as so often occurs in dreams, can sometimes allow normal erotic feeling to be liberated. It may be only an occurrence of this sort which causes a woman to realize that her sexual feeling is usually inadequate.

Hyperaesthesia of the clitoris and vulva is a disability commonly associated with true frigidity; often the woman feels unable to accept a sexual relationship at all. Hyperaesthesia of the vagina is more curable, even though it always induces vaginismus.

Disorders of muscle tone are general gynaecological problems; the only condition which needs description here is vaginismus—a hypertonus of the muscles of vagina and pelvic floor which invariably causes dyspareunia.

When disabilities of this sort are persistent they must be classed as hysterical conversion symptoms. In common with tics, stammers, and so on, they have their roots in early childhood. It is said that on analysis such

symptoms prove to be manifestations of early wishes which were conscious once and perhaps in harmony then with the conscience, or which at that time solved some intolerable conflict. Occasionally the patient's attitude towards her symptom suggests its meaning. For instance, a woman with complete genital anaesthesia may be quite unaware of the vulva and vagina; her denial seems to imply, "There is no sexual organ at all—there can be no sexual feeling there." Hyperaesthesia of the vulva often suggests the attitude, "It is too fragile, too dangerous to be touched," and the hyperaesthesia of vaginismus, with its common accompaniment of anger, undoubtedly represents "I will not be penetrated. You shall not touch me. It cannot be done."

These sexual derangements are sometimes intermittent, and with experience and under favourable conditions they may resolve spontaneously. With the exception of vaginismus, they are not very accessible to effort by the patient or to advice by the doctor; and unless analytic treatment is necessary or feasible their presence may need to be accepted by all concerned. Most disabilities therefore should not be emphasized either to a woman or to her husband. These psychical patterns must surely be accepted as part of a woman's total personality: their presence need be neither more nor less open to criticism than that of any other personal characteristic.

The aetiological factors of anxiety hysteria and its conversion symptoms are obscure and fall into the domain of the psychiatrist rather than of the gynaecologist. Briefly, there seems much evidence that in early infancy erotic sensation of a type is universally experienced. This tension inevitably creates discomforts and guilts and therefore tends to undergo repression during early childhood. As development proceeds, the sexual responsiveness of every individual is liable to be affected by anxieties, conflicts, fixations, repressions, and inhibitions which can manifest themselves in an endless diversity of hysterical symptoms.

When functional sexual disorders are secondary to adult events they are much more likely to resolve. Thus transient anaesthesia, vaginismus, or frigidity can be based on resentment or on loss of affection. Sometimes a fear of pregnancy, or disappointment caused by failure to conceive, evokes a frigidity; and a certain knowledge that husband or wife is sterile may do likewise—an important point in these days of salpingography and seminal analyses.

Hysterical symptoms of this sort must not be confused with those of anxiety neurosis, which will be described later, and with which they are sometimes associated. Anxiety neurosis is of greater clinical moment, for it is associated with ill-health which can often be medically relieved. There the somatic symptoms may be multiple and are merely expressions of pent-up frustration, each individual responding to stress after his own autonomic fashion. The hysterical symptom, on the other hand, is usually single, often permanent, and represents a definite emotional idea. It is not influenced by medicine, although alcohol may sometimes go a little way to lessen its intensity.

Common Functional Disorders

Lack of space limits the description of sexual derangements to four only.

Vaginal Anaesthesia

This is by far the commonest sexual disorder in women and the one about which advice is most often sought.

It varies in degree and persistence. In most cases the woman is capable of a little sensation, generally not sufficient to give rise to vaginal orgasm; in others the anaesthesia is complete and permanent. Many women who suffer from this disability have no idea that there is anything amiss, nor have their husbands. Those who are capable of achieving clitoral orgasm, and whose husbands are competent to give it to them, may be entirely satisfied with their sexual relations. Others who have been criticized for their disability may feel in despair about it. It is difficult in many ways to prophesy the outcome of a vaginal anaesthesia. It is common in newly married women and may resolve; but in an experienced woman who has borne children yet has never known erotic vaginal feeling the chances that resolution may not occur are considerable. Such a woman will not usually suffer from frustration if her husband withdraws or is precipitate or impotent: on the other hand, it may not be fair to judge her ability for orgasm if the husband is invariably inadequate: a well-sustained coitus undoubtedly helps a woman to achieve her full capacities.

Fortunately, women handicapped in this way may be quite satisfactory as sexual partners; if they are emotionally receptive, tumescence occurs readily and they may enjoy their sexual intimacy. Indeed, it is said that many successful prostitutes are women who suffer from a total genital anaesthesia.

Inhibition of Orgasm

In another vaginal neurosis, much less common than anaesthesia but of greater medical significance, erotic sensation is experienced to the full, but the inhibition is so timed that it just prevents the attainment of any orgasm. Women with this disorder may suffer also from a sudden drying up of vaginal moisture; one described it "as though her throat went dry with fear." In some of these women desire tends to die down in spite of continued stimulation, but others are left quite unsatisfied and with a most exhausting frustration. To them, coitus usually brings sleeplessness and depression, followed by an aching back and pelvis the next day. These women invariably suffer from symptoms of anxiety neurosis and are sometimes positively ill in the early part of their marriages. They can present real problems in diagnosis, and it is important that their disability should be recognized for what it is. Commonly their situation has been made worse because neither they nor their husbands understand what is amiss. Such a woman nearly always complains to the physician that the fault must lie with her husband, or that she fears she has married the wrong man. But in fact her history can readily be sorted out from those who have a slight vaginal anaesthesia, or who lack orgasm on account of their husband's incompetence. These last, if there is no true inhibition, will almost certainly have achieved orgasm occasionally, either during their sexual intimacies or at other times in their lives.

Inhibition of orgasm is generally present from the beginning of marriage. Rarely, it develops in women who have previously appeared normal, or occasionally the condition is intermittent. Unfortunately, women with this disorder seem unable to cure themselves. In my experience the end-result (other than in those who have been relieved by psychotherapy) is that a secondary frigidity is imposed which is often accompanied by an extreme distaste for sexual relations. Such women suffer from psychosomatic illnesses, and their future in

marriage is not likely to be very happy. If the physician cannot, for practical reasons, recommend psychotherapy, he should do his best to explain that the handicap is intrinsic, is not dependent on the husband, and that the woman would almost certainly carry it with her even if she sought to change her sexual partner. It is unkind not to stress this point, for these women sometimes make fruitless experiments hoping for better results. Child-bearing early in marriage, though it does not cure the disability, often relieves the acute stress. This may be a sensible palliative to advise.

Vaginismus

Lack of space prevents a full description of hysterical vaginismus. In this disorder the spasm may be severe enough to prevent penetration entirely, or more often to cause discomfort, sometimes to the husband as well as to the wife. Women with extreme degrees of vaginismus often reach the divorce court for annulment of marriage. Minor degrees are very common. Sometimes, but by no means always, there is a lack of orgasmic ability: clitoral response is usually unimpaired, and occasionally the woman may have such urgent vaginal desire that her self-induced frustration causes her acute strain. In vaginismus the spasm is caused by an active unconscious fear, and the syndrome is protective. In about a third of cases a direct history of "conditioning" in infancy can be found; usually the trauma was due to the painful insertion of anal soap-sticks, sometimes to enemata or to catheterization. The earlier such traumata occur the more indelible the fear of "penetration" appears to be. Other cases have a history of some sexual affront, perhaps from an exhibitionist, in later childhood. Where no history can be found, analysis is said to reveal an attitude of fear which has been built up from childhood, often relating to stories about the pain of defloration or of childbirth, or to infantile memories of parental coitus. In passing, it might be said that nearly all cases are open to persuasion, and will learn to accept penetration provided this is received with the back, knees, and hips in the fullest flexion.*

Non-acceptance of Clitoral Orgasm

This can hardly be called a functional disorder, but clinically the condition is so important that it demands description. A large proportion of women who cannot get vaginal orgasm can get clitoral relief provided they permit their husbands to give them digital stimulation. There has been much textbook discussion on coital positions which permit clitoral stimulation, and doubtless in quadrupeds the clitoris is designed for stimulation in this way. In most women, however, coital movement is inadequate to produce a clitoral response. The amount of prejudice that invests this topic is hardly less than the amount of sexual suffering and ill-health which the taboo causes. The belief that clitoral touch is shameful springs largely from the austerities of Victorian nursery training. Being inculcated at such a tender age, the doctrine dies hard. This fear (usually rationalized as "dislike") often deprives women of their normal sexual release. The practitioner should specifically inquire whether the woman gets satisfaction from inside the passage during coitus or from preliminary clitoral stimulation. This will give a patient the chance to discuss her difficulties or those of her husband.

*I have described the treatment of vaginismus fully in the *British Medical Journal*, 1942, 2, 213.

Medical Results of these Disturbances

Anxiety Neurosis

It is common knowledge that sexual disorders can cause nervous ill-health. Some people have little tolerance of frustration and quickly become unwell.

Anxiety neurosis was first described as a condition which occurs when the libidinal excitation is greater than the libidinal discharge. The surplus libido then manifests itself as "free-floating anxiety." In the sexual sphere it is well recognized that *the greater the amount of stimulation the greater will be the strain of a missed climax*, and this is true whether the orgasm is prevented by intrinsic or by extrinsic factors. The psychosomatic symptoms which can then appear are legion: depression, irritability, and morbid anxiety are common emotional disorders; the physical ones are expressed by autonomic disturbances, and sometimes appear dramatically, like an illness. Thus a newly married woman experiencing frustration may suddenly lose weight, suffer from great fatigue, headaches, cardiac and gastric disorders, tremor, sweating, and so on. Between her tears she may assert that she is perfectly happy, which is usually true. If the condition has lasted for months or years the severity of the symptoms will have abated, but some chronic functional derangement can usually be detected.

Reflex Congestion

When pelvic organs repeatedly reach a state of tumescence but orgasm—and therefore decongestion—does not follow, symptoms of chronic pelvic congestion will develop. Congested ovaries are apt to be exceedingly tender and to cause reflex backache, dyspareunia, pain on defaecation, and general malaise. Menorrhagia, leucorrhoea, and frequency of micturition are commonly found too.

As a rule, some degree of protection develops in the form of a secondary frigidity. This prevents the repeated occurrence of tumescence, although it brings with it considerable neurotic ill-health. Classical cases of this sort are less often seen now that coitus interruptus has fallen into general disrepute.

Therapeutic Application

The causes of sexual frustration are conveniently classed as extrinsic and intrinsic. Only when the diagnosis is quite clear is sound advice likely to be given.

Extrinsic Causes

1. If a woman is capable of vaginal orgasm, but before she reaches it her husband either withdraws, is precipitate, or is impotent, she will ultimately suffer from severe frustration. Such interruptions do not usually disturb a woman who is frigid or who has vaginal anaesthesia. It is important to make this clinical distinction, for a woman of the latter type may be very well mated to a husband who brings these disabilities. Where withdrawal has been practised it is easy to arrange for a better contraceptive method; but where the husband's difficulties cannot be overcome the wife will have to adapt as best she can. She will be fortunate if she can get a clitoral orgasm to compensate her.

2. Great frustration can be caused when a woman who cannot get a vaginal orgasm deprives herself of the relief of a clitoral one. Sometimes a woman barely knows that she has the latent capacity to respond to clitoral

stimulation; or sometimes she desires it but doubts the propriety of her wishes. If the husband also has been restricted by his cultural training her sexual frustration may be complete. It is very easy for the clinician to overlook confusions of this sort, for some women deliberately evade admitting to a desire which they feel to be "all wrong" or "not natural." In such cases considerable persistence is needed to extract the true history. Even then, verbal reassurance may be inadequate; it may be best to recommend books, and in some cases advice on these subjects by clerical writers is particularly successful. A little sensible information on the matter can make a tremendous difference to some women.

Intrinsic Causes

1. Most serious of these is the condition already described, where there is only an inhibition of orgasm, not of erotic feeling. The treatment of choice is essentially psychotherapeutic; and a search for the inhibiting factors is sometimes successful. Where this is impossible the woman should be advised to cease trying to attain orgasm and to allow herself to be as little stimulated by coitus as possible; she can be given a quickly working sedative such as chloral to induce sleep immediately after coitus. In most anxiety states small doses of phenobarbitone, valerian, or bromide are useful too. Wherever possible, new interests and creative activities should be encouraged, so that the pent-up libido can find other channels of release. Even though child-bearing usually brings relief it may be unwise to advise it if the woman is already nervously ill. Women with this disorder may be better off as celibates, but this can hardly be advised if the marriage is to hold.

2. Occasionally a phase of frustration may occur in a woman whose vaginal anaesthesia is beginning to resolve, either spontaneously or with psychotherapeutic treatment. As her erotic desire gets nearly free enough to reach orgasm considerable nervous strain may be experienced. The condition is transitional, and should be explained to her.

3. Rarely, patients complain of unaccountable erotic desire; for instance, the wearing of a Hodge pessary may begin to cause orgasm, and so on. This is suggestive of incipient psychosis, and should there be other questionable symptoms an early psychiatric opinion is desirable.

4. "Holding back"—a deliberate suppression of orgasm—is practised by women who mistakenly believe that pregnancy can be avoided if an orgasm is not permitted. This pathetic hope is so widely held among uneducated women that sometimes a change of contraceptive method is advised for the husband yet inadvertently the wife is left practising this method as an additional precaution. The practice is invariably detrimental to health. Correct information should be given.

It is possible for women in categories other than these to experience sexual strain; but they do so less often, and do not usually require medical intervention. There are three invaluable rules in work on these subjects: to advise lubrication of the vagina with a water-soluble jelly (Prentif jelly, Lilly's lubricant, etc., but not petroleum jelly), to teach relaxation of the introitus by lying in flexion, and to advise the acceptance of clitoral orgasm if for any reason vaginal orgasm is unobtainable. But when frustration cannot be avoided, both partners

should be given an explanation, and be told that symptoms of strain are likely, in time, to become less intense. In a case of anxiety neurosis the physician should always supervise, because such patients are liable to go into a "nervous breakdown" without anyone being aware of what is happening.

Clinical Points

Disorders of this sort probably come the way of most practitioners, and clinical acumen usually suffices in giving help. Nevertheless, confusions about vaginal anaesthesia are very common, particularly in its relationship to contraceptive practices. Such women should not be urged to improve their contraceptive technique solely with a view to curing this sexual disability: disappointment is bound to ensue. The outline given above is therefore designed to fill in certain points which are not universally understood, and the classification offered is emphatically clinical, not academic. I should like to illustrate this by quoting a recent hospital case.

A multipara in the middle thirties had reached the orthopaedic department with the complaint of continuous low backache. Thence she was referred to the gynaecological out-patient department, where the pelvis also was found to be normal, but where it was discovered that her husband was practising withdrawal and that she was failing to get orgasm. At the contraceptive clinic, however, she averred no coital frustration at all, but finally admitted to clitoral tension, which she believed to be quite shameful. A fortnight after instruction she returned to report that clitoral orgasm was established and her backache had gone.

Unfortunately, out-patient departments are not very suitable for the discussion of these intimate matters. Since medical leisure and privacy are at a premium it is difficult to see how morbidity of this sort is usually to receive attention. There is also a real need for some mention of these matters in the medical curriculum.

Practitioners interested in this work develop a technique for getting salient information in the least possible time. Since most women know little about their sexual reactions and are disposed to admit even less, the practitioner must usually go more than half-way to help. Where, for instance, gynaecological symptoms suggest a pelvic congestion or where complaints of unaccountable anxiety are made, he can ask, "Is it possible that you are not getting your sexual satisfaction properly?" When questioning, particular allowances must be made for the fact that a patient with a sexual disability may be too inhibited to appreciate its existence; more often, perhaps, she is too confused to be able to speak of difficulties which she vaguely senses. It is not surprising that a woman who has never learned words in which to describe the sexual act, or has never even experienced normal coitus, fails in explaining, say, that her husband is too precipitate for her to get a vaginal response; or that she has clitoral desire only, vaginal feeling being unknown to her; or that she is too dry, or has too tight a vaginal spasm for her husband to effect penetration. Therefore, in questioning, the practitioner should make sure that at the same time he is offering the patient suitable terms in which to describe her difficulty. Even though his expressions may need to be worded very simply for an uneducated woman, questions of this sort—provided they are straightforward enough for a nervous patient to understand—will seldom, if ever, be resented.