Indian Journal of Health, Sexuality & Culture
Volume (7), Issue (2), December 2021
ISSN 2581-575X
https://www.iisb.org./

Review Article

Female sexual orgasm in the Indian context

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Date of Submission :
25 October 2021
Date of Acceptance :
24 December 2021

Abstract

Sexual satisfaction is a basic need of every individual. Positive sexual orgasms impact an individual's ability to perceive, identify and express emotions, gain self-confidence, and improve decision-making. Unfortunately, a large proportion of the Indian masses hardly know of the implications of sexual gratification, and for others, sexual activity is either about reproduction or male ejaculation. In our culture, sex is less talked of, let alone the sexual needs of a woman on whom many societal restrictions have already been imposed.

This article intends to revisit the evolution of female sexuality and female orgasm, focusing on its place in Indian society, the roots of Indian culture that places male supremacy on the forefront, and how they interplay with each other.

Keywords:
Female orgasm, Women, Indian, Sexuality

Introduction

Sexual satisfaction is a natural need of every individual, validated by human biology. However, its entitlement is not merely about finding sensual content and pleasure. A happy and fulfilling sexual life has positive implications over other aspects of one's life. Primarily, it acts as a strong catalyst that strengthens the bond between the two sexually involved persons. Subsequently, sexual satisfaction allows people to be positive, happy while ensuring their comprehensive wellness. Positive sexual orgasms even have consequences upon one's ability to perceive, identify and express emotions, gain self-confidence, and improve decision-making. However, while a large proportion of the masses hardly know of these implications of sexual gratification, for others, sexual activity is either about reproduction or male ejaculation. In India, where fundamental women rights and empowerment are yet not universally accessible and enjoyed, female orgasm is a

Corresponding author: Amit Khanna
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How to cite the article: Sharma, M., Khanna, A., (2021). Female sexual orgasm in the Indian context. Indian Journal of Health Sexuality and Culture 7 (2), 9–16.
DOI: https://doi.org/10.5281/zenodo.6058177

topic that does not feature even in the discussions of intellects. However, we probably fail to realize that female orgasm is also a fundamental subject, and we should incorporate it with basic female rights and entitlement. The negligence of society towards female orgasm stems not just from the history of prevalent patriarchy but also is evident as a concept less understood right from the Freudian era.

This article intends to revisit the evolution of female sexuality and female orgasm, focusing on the current place of female sexual orgasm in Indian society, the roots of Indian culture that places male supremacy on the forefront, and how they all interplay with one another. We would also discuss the role of psychiatrists considering the flawed statistics of female vs. male sexual dysfunction attributed to under-reporting by the female subjects.

Evolution of the concept of female sexuality

1. Psychoanalytic approach: Mature vs. Immature orgasm

While Freud's views of female pleasure and orgasm focused on the reproductive tract, he was also one of the earliest psychoanalysts to explore the concept of vaginal and clitoral orgasm. Labeling a woman who preferred pleasure through clitoral orgasm as 'frigid' added controversy to the already less understood complicated reflex called 'orgasm'. Freud labeled female sexuality as 'The Dark Continent' in 'Three Essays on The Theory of Sexuality' (Freud, 1905). He spoke about 'The Transformation of Puberty' and believed that a young adolescent girl who previously derived an 'unconscious' pleasure from clitoral stimulation (infantile orgasm) transfers her primary genital zone to the vagina (Sigmund, 1962). He rooted psychological issues like penis envy, conversion disorder, hostility, and neurosis in failure to undergo this 'normal' transformation. This was one of the earliest attempts to link female sexuality to heterosexuality while setting the limits of what he considered 'normal' back then.

In her book 'The Psychology of Women', Helene Deutch, a fellow of Freud, also roots the female sexual drive in the vagina (Deutsch 2010). She, unlike Freud, linked vaginal orgasm to a woman's innocence / naivety / feminine passivity. She said 'a silent vagina wants to be awoken to heterosexual desire by the penis' where she meant that a woman wants to be fought for and overpowered by a man (Deutsche, 2010). She

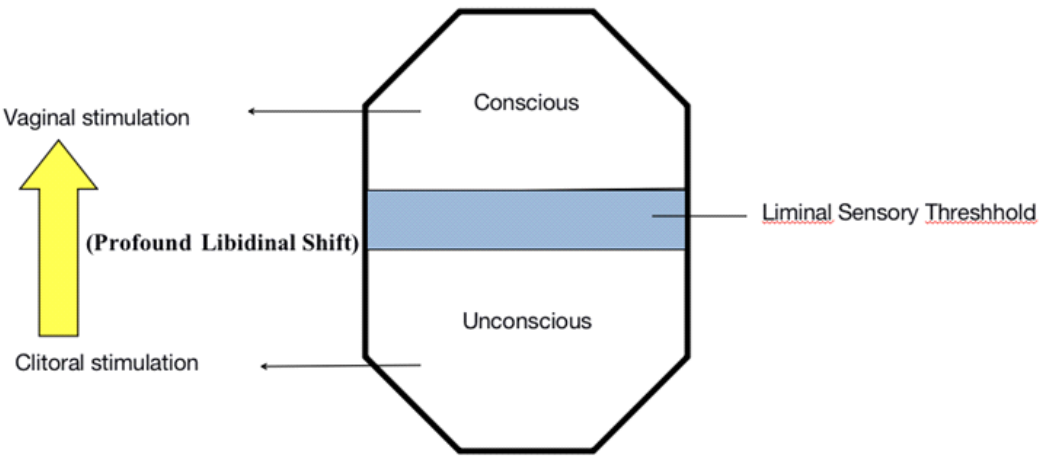

Fig. 1- FREUDIAN VIEWS ON SEXUAL IDENTITY OF A WOMAN

also viewed the sexual acts of violence as a catalyst for attaining sexual pleasure. The use of repression in her explanation of a woman's sexual needs was not well accepted by the feminist movement back then.

2. Feminist approach

Anne Koedt, an American radical feminist and author, called Sigmund Freud 'Father of vaginal orgasm' due to the latter's skewed views on mature vs. immature orgasm. She focused on delinking female sexual orgasm and female sexuality from gender identity and favored more towards the whole than the sum of its parts (Koedt, 2018).

3. Philosophical approach

An evolutionary concept by Elizabeth Lloyd, a science philosopher, and biologist, argued that female orgasm evolved as a byproduct (alongside) of male orgasm (Caton, 2006). However, the concept of 'Byproduct' was diminished by many other evolutionary biologists who believed in the adaptation theory of orgasm. In contrast, none of these two theories answered whether orgasm served a biological function or was an example of merely a pleasure principle.

4. Physiological approach

The questions raised by the psychoanalysts encouraged the sexologists to focus on the bodily responses than merely the repressed or the unconscious desires. Kinsey, Masters, and Johnson discouraged the Freudian definition of frigidity and emphasized bodily responses and sexual pleasure (Kinsey, 1998; Masters & Johnson, 1966). They all believed that these 'Freudian frigid women' required an accurate, adequate, and pleasurable sexual technique that can differ individually. Masters and Johnson dismissed the psychoanalytic distinction between the clitoris and vagina. Observing the changes in blood pressure, heart rate, tone of muscles, and skin color during sexual arousal, they observed that clitoral stimulation was the most pleasurable sexual technique that provided consistent sexual orgasm. They were the first to comment on a woman's ability to experience multiple orgasms (unlike men), thus discovering that female orgasm existed independent of men (Masters & Johnson, 1980).

Definition and typology of female orgasm

Many authors, ethologists, physiologists, psychologists, and sociologists have attempted to define orgasm in their ways. Its typological aspects were well explained by Levin (Levin, 1992). However, the poorly understood neuro-endocrine and cerebral mechanisms underlying female orgasm hinder the formulation of a comprehensive definition of orgasm that covers all its related perspectives. It is disappointing that none of the descriptions imbibes in it the aspect of sexual pleasure and remains confined to its biological or philosophical vectors.

Types of orgasms have been most talked in the context of women's orgasms (unlike men). The limitation remains that most of the types specified in the literature are self-reports or women's experiences. Kinsey's report gives a detailed account of female sexual orgasm and its types (Kinsey, 1998). The classes identified so far are:

- Vaginal: Stimulation of vagina leading to vaginal contractions.
- Clitoral: Clitoral stimulation leads to clitoral and, at times, vaginal contractions.
- Uterine: Associated with contraction of uterine muscles, apnoea, and gasping (Levin, 2002).
- Mixed or Blended: Involves both vaginal and uterine contractions

- Orgasm involving the anterior vaginal wall (Ingelman-Sundberg, 1997), called 'Grafenberg zone' induced orgasm (Syed, 1999).

Female sexual life in ancient India

From the exquisitely erotic sculptures of the caves of Khajuraho to the writings of the first-ever literature that depicted sexual intercourse as a form of art and science, Indian cultural history has played its role in determining sexual behaviors and their evolution. Despite the available Indian literature that highlighted the role of sexual pleasure ahead of its time, the less expressed hedonistic needs of Indians are limited by the pluralistic attitudes. While the erotic sculptures of the temples of Khajuraho depict sexual imagery mainly from the point of view of a heterosexual man, in line with the male supremacism prevalent in the Indian society, Vatsyayana in his epic, Kamasutra emphasized prioritizing a woman's pleasure and making sure that a woman's orgasm should be thought of before a man thinks of his own. He also highlighted the importance of eye-to-eye contact during sexual intercourse (Soma-sundaram, 1986).

In his book 'Sexual Life in Ancient India', Johann Jakob Meyer, a Spanish author, did not just give a detailed account of the place of women in Indian culture, but also explained how sexual pleasure, love, and wedlock were inseparably bound together for Indian women right from the mythological period (Meyer, 1971). He also wrote about the 'forbidden' desires of a woman and the societal regulations imposed on her with regards to sexual pleasures (not to be done in public, not during the daytime, not outside the vulva, and so on). Women who sought sexual pleasures outside these societal norms were punished and labeled as lewd or 'spoiled'. Such sky-high and lofty was the task of maintaining the 'dignity of women' back then.

Problem statement: The Indian framework

An unpublished PowerPoint resource (Mishra) cites various socio-cultural factors that limit the expression of sexual desires by both men and women. These encompass culture-bound syndromes like Ascetic syndrome that functions on the morality principle and promotes prolonged sexual abstinence. Such cultural beliefs are so deeply rooted that sex and orgasm are not talked of often in Indian families and are still considered a societal taboo.

The first clinical study on 'frigidity' in the Indian context was published in 1970s, where the author cited ignorance (lack of sexual knowledge), marital discord, easy fatiguability, and fear of pregnancy as the reasons for the inability to have the sexual pleasure (Agrawal, 1977). Another pilot study conducted among English-speaking adults assessed sexual functioning and attitudes of married and unmarried adults. Common sexual difficulties included decreased interest in sex (16.4%), arousal difficulties (21.3%) among both the sexes, while 28.6% of women reported orgasmic difficulties. Masturbation was considered wrong and an 'unclean practice' by 40 % of the female respondents (Kar & Koola, 2007). The knowledge of masturbatory practices was assessed among young college girls. It was found that while only 30% admitted to masturbating, approximately 80% of those who masturbated considered it as malpractice which could further cause weakness, disease, infertility, and marital disharmony (Sharma & Sharma, 1998).

In the West, around 76% of women interviewed reported sexual dysfunction (Frank et al., 1978). Low sexual desire was

reported by 27.5% of the women who also expressed associated distress on the Female Sexual Distress Scale (Rosen et al., 2009). In addition, 65% of these women expressed dissatisfaction with their sex life, with many of them reporting the failure to attain orgasm as one of the reasons for low satisfaction in sex life.

The higher prevalence of sexual dysfunction among females in these Western studies points towards the flawed statistical data in Indian studies that present a small number of females when it comes to sexual or orgasmic dysfunction. One of the attributable causes could be under-reporting due to social pressure and related fears.

These studies reflect the silenced desires and the guilt associated with expression of sexual needs by a woman amidst a cultural and traditional Indian society. Talking about one's sexual needs among married women is no less a tall task than among unmarried ones. The literature portrays the state of women in rural Indian society and how the control of female sexuality is shifted from the father to the husband post-marriage (Kumari, 1995). A cross-sectional study of 149 married women revealed that nearly 86.6% had unsatisfactory orgasms throughout their sexual lives, while 81.2% had an unsatisfactory sex life. The affected women never sought professional help and attributed the reasons to relationship issues, partner's illness, and cultural taboos (Singh et al., 2009).

Another study conducted in Kolkata highlighted the high gender differences in patients attending special sex clinics. Out of the 237 patients attending the clinic, only 2 (0.8%) were females (Pal et al., 2017). A study published from a tertiary care teaching hospital in North India showed that 52% of women reported low sexual desire, 31% struggled with lack of arousal, while 88% never really enjoyed sexual acts (Singh et al., 2020). All in all, while the history suggests a paradigm change in societal norms, gender roles, and change in the level of education among women, the expression of women's sexual needs by women themselves seems to have shown only a minor difference (Das & Rao, 2019).

Nosology of disorders of sexual orgasm

The definition of orgasmic disorder (other than those of organic etiology) does not differ much in ICD-10 and DSM-5. However, none of the classification manuals take into account the factors like socio-demographic and cultural differences, adequacy of sexual techniques used, frequency of sexual intercourse while classifying one's inability to experience orgasm under the umbrella of 'Orgasmic Dysfunction' (WHO, 1992) and 'Female Orgasmic Disorder' (APA, 2000). Another discussion that needs to be considered in future classifications is the limited definition of orgasm while the experience is largely individual for every woman (unlike men).

Unanswered question: Is orgasm the end-point of a sexual act?

After visiting the evolutionary science behind female orgasm and sexuality, many questions remain unanswered in association with the studies in the Indian context. A discussion on female sexual functioning remains a prohibited topic in most conservative and traditional families in Indian society. The level of uneasiness faced by Indian women in verbalizing their needs for sexual pleasure is a barrier. Gynecologists can play a substantial role in breaking this barrier as most females from the Indian community frequently visit gynecologists more often than 'sex clinics' or mental health clinics (Pal et al., 2017).

Another food for thought remains, 'does sex

ends at orgasm'? (Komusaruk et al., 2010). If yes, how do we explain the ability of a woman to have multiple orgasms? Also, how relevant is it to define female orgasm in the brackets of frequency and intensity of contractions of pelvic and perineal muscles? Women suffering from orgasmic dysfunction can have normal sexual arousal or desire but have difficulty attaining 'climax'. But who defines 'climax' after all, when different women experience sexual pleasure differently, other than the 'normative' vaginal way? (Kinsey, 1998; Lloyd, 2009).

Apart from the pathological (neurological, drug-induced) and contextual (age-associated) factors that may result in anorgasmia, the effect of the aforementioned negative cultural conditioning needs a renewed focus.

Another cultural concern that is particularly relevant in the Indian setting is the fear of abuse from the male partner if a woman expected to be submissive at large dares to desire more of a man or decides to 'talk' about the sexual intercourse following it. The 'male dominion' ingrained in most patriarchial minds might try to bully or overpower a woman who dares to demand more. This picture reflects not just the women who fail to explore or express their sexual needs or needs for intimacy but also portrays their choice to remain silent about their prolonged pleasure-deprived states.

Role of mental health professionals

Sexual health can have both positive and negative effects on one's mental state. Following are the possible roles of psychiatrists in thinning down the boundaries between a woman and her unexplored/unexpressed self:

1. Promotion of positive sexual attitudes of the society.
2. To help the couple focus on 'what an individual woman wants' than 'what women want' while leaving more room for joint flexibility'.
3. To include comprehensive talks on fantasy exploration during sex therapy.
4. Work on facilitating conversational skills. (Once you do it, talk about it so that you know what to do the next time).
5. Promote healthy masturbatory behaviors while working on the taboo and misconceptions related to female masturbation.
6. Therapy of the partner while helping him/her polish the sexual techniques, including the role of foreplay, clitoral stimulation, fondling of non-genital organs of women, the safe use of special sexual devices.
7. Couple sex group therapy and individual therapy.
8. Reinforcement training, sexual fantasy training (Rao & Nagaraj, 2015).
9. Encouraging roleplay as a means of exploring a woman's hidden desires and needs.
10. Conducting more methodological scientific research in the field of female sexual functioning and dysfunctions, as most of the research so far is carried out by sociologists, philosophers, feminists, authors, or media.
11. To work on bringing changes in the current classification system pertaining to sexual dysfunctions while considering the socio-cultural factors.
12. To raise awareness about female sexuality to address under-reporting and facilitate professional help-seeking behaviors among females experiencing sexual difficulties.

13. Special focus on sexual history during medical education, particularly history pertaining to masturbatory attitudes, beliefs and habits, sexual preferences, attitude/knowledge of sexuality and orgasm, individual preferences of methods to attain intimacy/orgasm, an account of marital, premarital, or extramarital relationships, knowledge of safe sexual practices.

Conclusion

The often performed yet less talked of act, 'sex' requires further push as far as female sexual expression and experiences are concerned. The sole focus on 'vaginal orgasm' that kept women sexually deprived for years requires a paradigm shift to ways other than vulva. The effects of unsatisfactory sexual life on women's mental health also require more methodological research to quantify the statistical data accurately. As psychiatrists, we can help women understand their sexual behaviors and needs, which needs to be done sensitively given the Indian context and the belief systems around female orgasm.

Acknowledgements : None

Conflict of interest : None

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