

Women's sexuality in the 21st century



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These are exciting times. For the past few years we have witnessed a surge of interest in women's sexuality, not only in the medical community and in research but also in the general public and even in the government. It is about time!

In the past, findings concerning medical problems and pharmacologic agents were based on research conducted on men and then extrapolated to women. Between 1977 and 1993 the Food and Drug Administration banned drug testing on women of child-bearing age because of the concern that if a woman became pregnant during a clinical trial, her fetus would be at risk for possible side effects or complications from that drug. Most clinical studies during those years excluded women altogether. Therefore, most studies did not test drugs for possible side effects or drug interactions with oral contraceptives or with other drugs commonly used by women. Furthermore, drugs were seldom analyzed to see if their effects on women might be different from their effects on men. Bernadette Healy, MD, former director of the National Institute of Health, was quoted as saying that men were the normative standard for medical research and treatment. This meant that male hormones set the standard for all of us—men and women. Let us hope that the same approach will not be used now in classifying women's sexuality or sexual dysfunctions.

There has been a paucity of laboratory research conducted on women since Masters and Johnson published their ground-breaking findings in 1966. To date, the number of clinical studies on men far exceed those on women.

Between 1990 and 1999, there were almost two and a half times more studies conducted on male sexual dysfunction than on female sexual dysfunction (FSD).¹

Masters and Johnson classified their findings about sexual response into a linear response cycle consisting of excitement, plateau, orgasm, and resolution. Men and women were attributed similar physiologic characteristics. Yet, recent laboratory and clinical studies have demonstrated that women do not always fit into Masters and Johnson's monolithic model, and that women are capable of a variety of sexual responses. Two examples of physiologic research from my own laboratory include the rediscovery of a sensitive area palpated through the anterior vaginal wall, which Perry and I

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named the Gräfenberg or G spot, as well as the identification of female ejaculation.^{2,3} Women report that orgasm from stimulation of the Gräfenberg spot feels deeper inside their body. Physiologically, the sensory pathways

and the muscle response during orgasm from stimulation of the Gräfenberg spot are different from those in orgasm from clitoral stimulation.

Other studies have demonstrated that women's sexual responses vary greatly. Komisaruk and I have documented that stimulation around the Gräfenberg spot has a natural analgesic effect, which is activated during sexual stimulation and during labor. Such an effect has been demonstrated across species. We also conducted the first lab study of orgasm in women from imagery alone,⁴ without any physical touching. Another study investigated orgasm in women with complete spinal cord injury.⁵ Using PET scan and fMRI of the brain, we are currently trying to deter-

mine areas in a woman's brain where orgasm occurs and where pain is blocked.

Many contemporary experts have elaborated on how men and women view sexuality differently. Chalker states that, "Our concept of sex has become so male-defined that the single orgasm has become the gold standard for women's sexual response."⁶ John Bancroft has suggested that, "Women's sexuality is different in a variety of important ways, but we are still trapped in male conceptual boundaries."⁷ Leonore Tiefer warns against the mechanical view of women's sexuality as modeled on research of male erectile dysfunction.⁸ Anthropologist Helen Fisher believes that scientists mismeasure women's sexuality because they base it on a male model.⁹

Another problem today is the focus on sexual *dysfunction* in women rather than on sexual *function*. Although the interest of pharmaceutical companies in research concerned with dysfunction is understandable, it behooves us to understand sexual function in women before we classify a behavior as dysfunctional. Timothy Canavan and Kristine Marchalonis provide a complete description of FSD classification in this issue.

In 1999, a consensus panel of 19 interdisciplinary experts in female sexuality revised the existing definitions and classifications of FSD from a psychogenic and organic perspective to provide clinical end-points and outcomes;¹⁰ but much remains to be addressed. Despite the widely accepted triphasic model of desire, arousal, and orgasm dating back to Masters and Johnson and Kaplan, women can experience sexual arousal, orgasm, and satisfaction without sexual desire, and they can experience desire, arousal, and satisfaction without

orgasm. The significant question is, if a woman has sexual satisfaction and does not go through all the linear phases of the sexual response cycle, should she be considered as having a sexual dysfunction?¹¹

One of the most common concerns of women, lack of sexual desire, was addressed in this journal in February, and additional insight is provided in this issue by Andre Guay. Again, is lack of desire always a dysfunction?

Most clinicians dealing with women's sexual concerns will support the notion that women's sexual experiences are complex and cannot be reduced to having an orgasm or vaginal lubrication. Women's sexual experiences encompass self-esteem, body image, relationship factors, pleasure, satisfaction, and other variables. Women cannot be fit into a monolithic model of sexual response, and clinicians must be aware of this complexity and address the sexual concerns of their patients, keeping an open mind to the variety of ways that women experience sexual pleasure. ♣

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