Mehmet Atif Ergun
mehmetaergun at yahoo dot com

The Western Medicalization of Heterosexual White Women's Orgasm

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Introduction

According to Foucault (1990), throughout ages, power has regulated and controlled individuals' and groups' sexuality by using four common strategies. One of these strategies is the persistence of the statute. According to this statute, power constructs and defines binary codes such as licit vs. illicit, allowed vs. prohibited, and *normal* vs. *abnormal* sexual acts.

Foucault (1990) states that the end of the 18th century witnessed the emergence of new technologies of sexuality that rendered sexuality into a secular concern of the state. One of these technologies, *medicine* focused on the sexual physiology of women and constructed "nervous disorders" (Foucault, 1990, p. 117).

Through these new technologies of sexuality, the 18th century was marked by an overflow of discourses on sexuality. This overwhelming "interest" in sexuality as a taboo allowed power to exploit sexuality as *the* secret:

> "Rather than the uniform concern to hide sex, rather than a general prudishness of language, what distinguished these last three centuries is the variety, the wide dispersion of devices that were invested for speaking about it, for having it be spoken about, for inducing it to speak for itself (…). Rather than a massive censorship, (…) what was involved was a regulated and polymorphous incitement to discourse." (Foucault, 1990, p, 34)

While the Western medical institution engaged in diversifying and amplifying the medical discourses on human sexuality, it overlooked female sexuality, and ignored specifically the female orgasm. Medically or socially, the female orgasm has not been perceived as a component of the "real" (hetero)sexual intercourse in non-feminist spheres.

Race, Ethnicity, Class, Gender, and Sexual Orientation

The literature review has revealed no study examining how orgasm is experienced or medically treated across different races, ethnicities, sexual orientations, and economical classes. It seems that U.S. research does not discuss ethnicity because of the American cultural assumptions that ignore the possibility of "ethnicity" (which, in the U.S. Context, is replaced with "race"). Also, when the U.S. studies do not discuss race, it usually means that either all or majority of the subjects who participated in the research are white. Because there is no place for speculation when there is no study to elaborate on, this paper does not include discussions specifically related to the orgasm(s) of non-white and non-heterosexual women although causes of not experiencing orgasm might be related to race and sexual orientation.

In addition to the absence of research on race and sexual orientation, the literature review has revealed no studies discussing the effects of these variables on women's orgasm. Since I do not have any

information on the socio-economic status / class of subjects used in the studies I used, this paper will exclude the variable of class. The reader should be cautioned that there is a high probability that subjects used in these studies were middle or upper class women because working class women may not have time (because, for instance, they might be working hard to make ends meet) or opportunity (because, for instance, they might not have access to child care during the study) to participate in such studies.

In terms of gender, there are significant differences between men and women in experiencing orgasm or sexual dysfunction. Lips (2005) reports that 75% of men report *always* having orgasm during sexual intercourse as opposed to 29% of women. Lips (2005) also reports that although men and women do not differ in the kinds of sexual dysfunctions they experience, men are less likely to report having difficulties with orgasm. Instead, they tend to experience premature ejaculation.

A Brief Historical Review of the Western Medicalization of Heterosexual White Women's Orgasm

Women's orgasm was always an issue for the early Western medical institution. It seems that the mere existence of the female orgasm itself was not widely known by that time. Most often, the medical focus was on the sexual satisfaction of women instead of their orgasm. Women who were not satisfied by means of penetration alone were seen as sick or defective, and were offered treatments accordingly.

During the Antiquity and the Middle Ages, the main "female disorder" was "hysteria", a Greek word, which means "that which proceeds from the uterus" (Maines, 1999, p. 21). It was thought that hysteria, which manifested itself with common psychosexual symptoms (such as irritability, sleeplessness, anxiety, vaginal lubrication, lower abdominal pain etc.), was a consequence of the lack of sufficient sexual intercourse. The common prescription was genital massage and exercise. (Maines, 1999)

While the definition of hysteria did not change during the Renaissance, its cure became marriage. However, during the 18th and 19th centuries, the definition of hysteria as a disorder became confusing. It was not explaining the variations in empirical data obtained. Consequently, it became three separate disorders: greensickness (attributed to the sexual deprivation of virgin women with marriage offered as its cure), heurasthenia (attributed to the stresses of the modern life), and hysteria (attributed to general sexual

deprivation and disinterest in marital sexual intercourse). (Maines, 1999) The focus on women's sexual satisfaction disappeared during this period.

Later, Freud's exploration of hysteria shifted its definition from sexual deprivation to traumatic childhood sexual experiences, then to unresolved childhood sexual fantasies (Maines,1999). In the mean time, Freud focused on orgasm as an indicator of women's maturity. By constructing two separate types of orgasm, vaginal and clitoral, he was able to reinforce the male phallocentric model of sexuality that depended on penile penetration. According to Freud, maturing women's sexual experience was supposed to shift from clitoral orgasm (i.e. orgasm generated by the stimulation of the clitoris) to vaginal orgasm (i.e. orgasm generated by penile penetration alone). Until Masters and Johnson (1966, in Lips, 2005) claimed that orgasm was possible only by stimulating clitoris, this biary definition of the female orgasm remained the prominent definition of women's orgasm in the medical and social life. (Lips, 2005)

The common treatments of hysteria, before the emergence of the psychoanalytic theory, were hydrotherapy (baths with appliances for pumping water, therapeutic douches, etc.), manual massage (by a qualified professional), vibratory treatments (using mechanical vibrators and massagers), and electrotherapeutics (such as electrical vibrators with attachments, direct-current devices, electrets, and electrodes etc.). (Maines, 1999)

The Contemporary Western Medicalization of Heterosexual White Women's Orgasm

The Physiology of the Female Sexual Response

Lips (2005) identifies four stages of the female sexual physiological response. The first stage, "excitement" (p. 253), is defined as the vasocongestion of genital organs with increased blood flow causing fluids to seep through the membranes of vaginal walls. In this stage, the glands of clitoris swell and labia and the upper two thirds of vagina expands. Heart rate and blood pressure also increase.

During the second phase, "plateau" (p. 254), vasocongestion reaches a peak level while clitoris retracts, labia deepen in color, and the tissues around the outer third of the vagina swell to form the "orgasmic platform" (p. 254). The model defines "orgasm" (p. 255) as the third stage of the female (as well as male) sexual response. It is described as a series of involuntary rhythmic contractions of the orgasmic

platform, the uterus, and the surrounding muscles. Female ejaculation may also happen during this stage. The final stage is "resolution" (p. 256) where vasocongestion is reversed, the blood is released from the enlarged blood vessels, and the muscular tension is relaxed.

The Androcentric Model of Sexuality

As Fleck (1979, in Hubbard, 1990, p. 1) argues, "in science, just as in art and in life, only that which is true to culture is true to nature." As a result,

> "Women's biology has been described by physicians and scientists who, for historical reasons, have been mostly economically privileged, university-educated men with strong personal and political interests in describing women in ways that make it appear 'natural' for us to fulfill roles that are important for their well-being, personally and as a group." (Hubbard, 1990, p. 119)

From this perspective, it is not surprising to see that human sexuality in general, and women's sexuality in particular are constructed around male interests. It is apparent from this perspective that "human" sexuality is constructed to serve men's sexual demands and desires.

Lips' above depiction of female sexuality, although accepted by some feminist scholars, is thus problematic in its nature. The construction of the stages reflects the Western sexual "culture", or the dominant sexual act. Western heterosexual couples might be accustomed to this particular definition of sexuality. However, once the medicine accepts and institutionalizes the culture by constructing it into a medical fact, the dominant sexual act becomes a societal norm that cannot be rejected by any "sane" human being.

But what does Lips' stages describes us? How do these stages and the sexual act itself, as it is commonly accepted in the West, serve the interests of men?

The stages offered by Lips construct the physiology of the female sexuality in a certain way so that it serves one particular interest of men: pleasure. The words "excitement" and "plateau" imply an upcoming event that is the "goal" of the sexual practice. Moreover, the word "resolution" locates this goal: orgasm. Excitement and plateau are preparations for orgasm while resolution is just a medical term for the feelings of relaxation of a person who accomplishes the specific goal of the sexual act.

Reflecting on Lips' stages, one might argue that the "official" depiction of the sexual practice includes the orgasm of women. However, it should be noted that the addition of women's orgasm into the medical description of the sexual practice has been recently done. Moreover, such an addition has resulted actually in adding more psychological pressure on women who did not attain orgasm during the intercourse.

It should be noted that the female orgasm, medically or socially, has not been seen as a component of the "real" heterosexual intercourse. Before the 20th century, references to the female orgasm in medical articles were absent. The sexual intercourse was defined in terms of preparation for penetration, penetration,

and male orgasm. (Maines, 1999)

After 1966, the female orgasm became part of the "normal" sexual intercourse. However, its subsequent medicalization still reinforced the legitimacy of the androcentric model of human sexuality. Especially after the female orgasm was popularized (primarily by feminist scholars), women who did not attain orgasm during the preparation-penetration-male orgasm sexual sequence were medically labeled abnormal, frigid, anormasmic, or dysfunctional. (Maines, 1999)

The medical institution, and consequently the general society assumed that the way Western culture constructed sexuality was the norm and anyone who did not or could not feel ultimate pleasure during intercourse could not be "normal". Few scholars have questioned whether the male-defined sexual intercourse was satisfactory for women. The general assumption has been that "however *he* performed, it would be good enough [for her]" (Maines, 1999, p. 47, italics mine). In other words, the medicalization of the female orgasm, represented as pathology, has necessitated no alteration of abilities or attitudes by male sex partners. (Maines, 1999)

The "Disease"

The Categorization

The World Health Organization (WHO) defines the "female sexual disorders" as "the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish" (WHO ICD-10, in Basson et al, 2000, p. 888). The lack of experiencing orgasm, from this perspective, is named as "orgasmic dysfunction" (WHO ICD 10, F52.3, in Basson et al, 2000, p. 888).

The American Psychiatric Association's (APA) DSM-IV defines the "female sexual disorders" as disturbances in sexual desire and in the psycho-physiological changes that characterize the sexual response cycle and cause marked distress and interpersonal difficulty" (APA DSM-IV, in Bassom et al, 2000, p. 888). The specific name used for the lack of experiencing orgasm, from this perspective, is "female orgasmic disorder" (APA DSM-IV, 302.73, in Bassom et al, 2000, p. 888).

Both of the definitions mentioned above are based on the assumption that there exists a specific sexual cycle, defined above as the androcentric model of human sexuality. According to both perspectives, if a woman is not sexually satisfied, or if she does not experience orgasm during sexual intercourse, it's her fault. The sexual cycle is neither questioned nor criticized.

The Statistics

Relevant statistics demonstrate clearly that it is not women who should be blamed but the phallocentric definition of the sexual cycle and men who define it so. According to Heiman et al (1997),

only 29% of women always experience orgasm during sexual intercourse and only 41% are physically satisfied with their partners. In addition, 19% to 28% of women are diagnosed with "female orgasmic disorder".

Lips (2005) report that women are much more likely than men to report difficulty achieving orgasm while men are more likely to report problems with premature ejaculation. In other words, it seems that men have got more than what they asked for. Lips (2005) also reports that 30% of women never or only occasionally experience orgasm during intercourse. 75% of men report always experiencing orgasm (which is strikingly high when compared to 29% of women who report to expreience orgasm always during sexual intercourse, as reported in Heiman et al, 1997).

Nusbaum et al (2000) reports, in a sample of women who visit their gynecologists annually for routine care, that 83% of women expressed some difficulties with having orgasm, while 29% reported having severe problems with experiencing orgasm (N = 964). The study also reports that 67% of women's sexual needs were unmet and 60% were preorgasmic some time during their sexual life. Although the sample consisted mostly of married women (85%) with a mean age of 45.4 years (std = 16.79), the study mentions that the rate of reporting sexual problems increases for unmarried and / or younger women, which renders the percentages even more significant.

The statistics mentioned above seem significant. It seems that almost all of Western women have problems with orgasm at some point during their sexual life and two third of them do not experience orgasm consistently.

The statistics become even more alarming when Millett's (1970) claims about women's orgasm are taken into account. Looking at previous research, Millett (1970) claims that with optimal arousal, women are capable of having up to 3 to 5 manually-induced, or 20 to 50 mechanically-induced sequential orgasms in average without a refractory period. Millett (1970) adds that theoretically, a woman could go on having orgasms indefinitely if physical exhaustion did not intervene.

Millett (1970) concludes that

> "While patriarchy tends to convert women to a sexual object, she has not been encouraged to enjoy the sexuality which is agreed to be her fate. Instead, she is made to suffer for and be ashamed of her sexuality, which in general is not permitted to rise above the level of a nearly exclusively sexual existence." (p. 119)

The Reasons / Causes

It is widely accepted that availability and accuracy of any knowledge is strongly linked to who holds power in a given society. It seems that one of the major causes of "female orgasmic dysfunction" is

lack of knowledge of both the medical institution and the lay people about women's sexuality. There are still too many “mysteries” among medical professionals regarding orgasm and the clitoris, the sexual organ that initiates women’s orgasm.

Even as late as 1998, O’Connell’s article on the clitoris unveiled much truth that was previously unknown. According to O’Connell (1998, in http://www.the-clitoris.com/f_html/new_anat.htm), erectile structures in women are much larger than once thought. While the urethra is surrounded on three sides by erectile tissue, the body of the clitoris is 0.39 to 0.79 inches wide and 0.79 to 1.57 inches long. Contrary to the common beliefs, the clitoris is located outward from the pubic bone instead of lying down on it.

Because scientists’ knowledge even on the organ that initiates orgasm, the clitoris, is fairly limited, it is not surprising that lay people now much less about the clitoris than they know about the male genitals. According to Tuana (2004), the figures in textbooks that describe the inner structures of the vagina are new, unclear, and mostly promoted by feminist scholars. Tuana (2004) also mentions that most frequently, lay people’s knowledge on women’s sexuality is limited to the menstrual cycle and female reproductive organs. They tend to know neither the internal nor the external anatomy of the female genitals.

The most cited psychological reasons for “female orgasmic dysfunction” are emotional, physical, and sexual abuse, early psychological trauma, history of poor relationships, substance abuse, depression, anxiety or psychiatric disorders, and emotional responses to sexual “dysfunction” such as feelings of inadequacy, sadness, loss, frustration, anger, and so on (Ducharme).

Childbirth, and birth control pills are also associated with the “orgasmic dysfunction” in women (Ducharme). Hysterectomy is also seen as a cause for triggering the “disorder”. While 33% of all women in the US will have a hysterectomy by 60 years of age, hysterectomy is known to cause loss of ability to have internal orgasms due to the damage done to the clitoral and erectile nerves during the operation (Goldstein). It should be noted that the common operations that put clitoris in danger are not fully understood and further research is needed (http://www.abc.net.au/quantum/scripts98/9825/clitoris.html). Andersen (1995) cites antidepressants, MAO (monoamine oxidase) inhibitors, benzodiazepines, and neuroleptics as pharmacological agents that cause loss of orgasm in women.

It is clear from the literature review that the clitoris, the female orgasm, and “female orgasmic dysfunction” are not researched enough and understanding of these topics is poor and inadequate due to lack of sufficient clinical trials or experimental data (Basson et al, 2000).

The Treatments

Although there is not enough research that clearly validates the effects of pharmacological agents, there are a number of drugs being developed for women who have difficulties during sexual intercourse

(see Table 1). Even though most of these prescription drugs focus on the blood flow to women's genitals, making sexual intercourse more desirable for women may be a step forward for treating women's orgasm difficulties.

Table 1 – Prescription drugs for women who have difficulties during sexual intercourse (http://www.newshe.com/articles/article_retrieve.php?articleid=13):

Drug	**Manufacturer**	**Key Ingredient**	**Use/Potential Use**	**Status**
Androsorb (cream)	Novavax	Testosterone	Hormone-booster for hypogonadal men, but may heighten libido in postmenopausal women	Phase II clinical trials
Alista	Vivus	Prostaglandin E1	New product. Increased blood flow to genitalia	Phase II clinical trials
Femprox (cream)	NexMed, Inc.	Blood vessel dilator	Improves blood flow to genitals; enhances arousal.	Phase II clinical trials
Intrinsa (patch)	Proctor & GambleWatson Laboratories	Testosterone	In six-month study women reported increased sexual activity and pleasure	Phase II clinical trials
NM1-870 (pill)	NitroMed	African tree bark fortified with nitric oxide	Increases vaginal blood flow in postmenopausal women; may enhance arousal	Phase II clinical trials
Testosterone creams	Off-label prescriptions from compounding pharmacies	Testosterone	Male hormone replacement therapy	Not FDA approved for use in women
Vasofem (tablet)	Zonagen	Blood vessel dilator	Increases blood flow to clitoris	Phase II clinical trials

Other drugs that are being developed include dopamine agonists, melanocortin-stimulating hormones, nitric oxide delivery systems, prostaglandins, and so on. (Fourcroy, 2003). However, it is not

clear whether any of these potential drugs will be safe or effective (Fourcroy, 2003).

One of the newest non-pharmacologic developments in the treatment of women's sexual problems is EROS-CTD, a suction device for clitoris and the surrounding tissue in order to enhance blood flow, lubrication, and sensation. Although the device proved itself useful against sexual difficulties in a clinical trial sample of 25, it did not increase the rate of orgasm at all (Berman).

Other non-pharmacological treatments include directed masturbation[1], pelvic floor exercises (i.e. pubococcygeal muscle exercises), relaxation training, attention-control on orgasm training, desensitization[2], technique of sensate focus[3], communication training between partners, sexual skills training of the partner, body image exploration, and sexual awareness training (O'Donnohue, 1997; Heiman, 1997). Although not frequently cited in medical articles, vibrators are also convenient and easy to use and they tend to render medical intervention unnecessary. (Maines, 1999)

Alternative Discourses

The G-Spot

Many researchers argue that there was only one sensory pathway, the pudental nerve and the clitoris, that initiates orgasm in women (Whipple). However, other researchers argue that there is an alternative pathway to orgasm (and ejaculation) as well: the pelvic nerve and the "g-spot". This approach proposes that in some women, orgasm and ejaculation are related while in some, they are not. In other words, some women report that they ejaculate by clitoral stimulation, while others report ejaculation without clitoral stimulation. (Whipple)

Not all researchers who have conducted sexological examinations of the vagina have found the g-spot. (Whipple) Thus, discussions on the issue continue to this day.

The researchers who defend the position that the g-spot exists claim that it consists of both the female prostate (a small and elongated organ, embedded in the wall of urethra near the opening of the urethral canal) and a network of erectile tissue. The erectile tissue surrounds the prostate and extends beyond the g-spot to include the clitoris and other areas. When aroused and swollen, this tissue can be felt through the vaginal wall and it stimulates the pelvic nerve. (Sundahl, 2003)

The female ejaculate is created in and expelled from the female prostate into the urethral canal. It flows either out to the urethral opening, or into the bladder. According to chemical analyseson the

[1] This exercise consists of beginning with visual and tactile body exploration that moves toward increased genital stimulation with eventual optional use of vibrators. (Heiman, 1997)

[2] Often used when anxiety plays a significant role on not experiencing orgasm. (Heiman, 1997)

[3] The technique is defined as exchanging physical caresses that move from non-sexual to sexual over the course of the assigned "homework". (Heiman, 1997)

ejaculate, it is predominantly a prostatic fluid mixed with glucose and trace amounts of urine. It is clear, watery rather than slick, and usually unnoticeably creamy or white.

Although more research is needed to reach any conclusion about the g-spot, it is important to note that the proposition of the g-spot and female ejaculation provides women with other choices than the orgasm through male penetration only. It encourages women as well as their partners to explore their bodies and come up with new techniques for attending sexual satisfaction and climax.

International Perspectives on Orgasm: Turkey

The Turkish Popular Media

In this study, I reviewed two popular mainstream Turkish newspapers ("*Hurriyet*" and "*Milliyet*") to analyze the conception of orgasm and of "orgasmic dysfunction" in the Turkish media. My review consisted of searching the newspapers' news archives with the keyword "orgasm". The archives were going back to 1995 for both newspapers. The news articles are not attached to this paper simply because they are in Turkish. The research revealed that none of the newspapers published any articles regarding "orgasmic dysfunction" in women.

My search in *Hurriyet* yielded 140 articles that contained the word "orgasm". Most of the articles were responses to reader questions regarding sexuality and orgasm. Most of these articles related to women were either ridiculing women's orgasm or gave no particular importance to women's sexuality. Some other articles reported scientific findings of sexuality studies conducted in other countries. None of the articles mentioned any research done in Turkey.

My search in *Milliyet* (using Google instead of the newspaper's own archive-search machine, due to some technical difficulties) yielded 450 articles that contained the word "orgasm". Of these 450, I had the opportunity to scan about more than 130 articles. The articles in *Milliyet* tended to be more liberal and open-minded regarding women's sexuality and the female orgasm. Although none of the articles were about "orgasmic dysfunction" in women, the newspaper had an exclusive section about sexuality, where they published interviews and reported findings from both Turkish and foreign studies. A psychologist also answered readers' questions regarding sexuality and orgasm.

It seemed that orgasm is not regarded as a very important topic in Turkey, although it attracts some attention from the readers who are having sexual problems. The Turkish popular media does not seem to be particularly interested in women's orgasm or the difficulties they experience during their sexual lives.

Views of Two Turkish Feminist Women

In order to expand the scope of this study and gather a different perspective on the issue, I sent emails to two of my female Turkish feminist acquaintances[4]. B.[5] is currently residing in the US as a graduate student while A. is currently writing for a Turkish magazine.

A. stated that the major cause of women's problems with orgasm is related to the Turkish patriarchy and its construction of sexuality on the basis of male interests and demands. She also mentioned that ignorance (i.e. either not knowing or ignoring) plays an important role in the difficulties experienced by women. Men do not know or choose to ignore the importance of foreplay for women and both men and women are not familiar enough with women's bodies and sexualities. In her response, she commented that medicine is not focusing its attention on the causes of "orgasmic disorders", but rather it is investing in treating the symptoms of this condition. She concluded that "sex should be seen as a source of equal pleasure for both men and women".

B. stated that women's sexuality is prohibited in Turkey while men's sexuality is encouraged. She also reported that the medical institution blamed women for not having orgasm while the definition of sex (as penetration) was a male construct that might / would not meet the sexual desires and demands of women.

Conclusion

This paper attempted to investigate the contemporary western medicalization of orgasm. I first explored how several scholars and researchers defined the physiology of the female sexuality. Then I attempted to relate this definition to the androcentric model of sexuality that placed women as the object instead of the subject of the sexual pleasure.

After investigating how the medical institution (especially psychology) defined and constructed the "female orgasmic dysfunction", I tried to explore alternative ways of looking at the problem of not having orgasm. The review of the popular Turkish media revealed that although the media was not absolutely insensitive to women's sexuality, their depiction of female sexuality was problematic in that there was no particular focus in these news articles on the difficulties experienced by women during their sexual lives. The g-spot thesis was a positive step towards the further exploration of women's sexuality. This theory provided women with more choices other than penetration to have orgasm and it enabled women and their

[4] See appendices for translation of the email messages sent by A. and the original English text sent by B. The Turkish text was translated by Emek Ergun (B.A. from Bogazici University Translation Department, M.S. from Towson University Women's Studies Department) to provide a more objective reading and translation of the Turkish text.

[5] Names are not disclosed for privacy reasons.

partners to explore and discover the female body. The feminist views from Turkey clearly demonstrated the frustration and anger towards the patriarchal construction of sexuality as a source of male-only pleasure. Both women agreed that the medical institution failed to address the concerns of women and that it chose to treat the symptoms of the problem instead of its source.

Appendices

Appendix 1 - The Translated Response from A.

Question: What do you think about that many women do not have orgasms, specifically in Turkey, and that "female orgasm" has been turned into a medical "problem" that can be diagnosed and cured?

Response: "I believe that the fact that women do not have orgasms is a completely patriarchal problem. I can name two reasons for that. First, what men consider of sexual activity is not something that women can have pleasure from. Men perceive sex as a way to ejaculate. At this point, there is a social construction of sexuality: It is seen as a normal act that men ejaculate into every "opening" they get, sometimes even without questioning their sexual orientation. Under these conditions, series of sexual activities with men as the subjects are being experienced in which men see it unnecessary for women to have pleasure during sex and they either do not know or ignore the importance of "foreplay" for women. Second reason can be explained in terms of being woman. The fact that women are raised not to know their bodies and to see their sexuality as shameful leads them to think of sex as something essentially aimed to please the man. Even when women dream of different sexual activities in their fantasies, they cannot tell that to their lovers or husbands, because they have learned and also teach that it is shameful.

"Among these reasons, the factor of living in a Muslim society cannot be denied. But does not religion essentially serve to patriarchy? In fact, in Turkey, the issue of not having orgasms cannot even become an issue to be diagnosed and cured, because sexual intercourses experienced without "foreplay" and only for the desire of the man, cause women not to lubricate enough, which in turn causes the woman to have painful intercourse, not to have pleasure, and even to have the problem of vaginismus. Therefore, medicine should be dealing with the actual causes of this problem in its treatment, but instead of the actual causes it is interfering with the consequences (symptoms) of the problem. This prevents medicine from finding a solution to the problem of not having orgasms. The field of medicine, including psychology and psychiatry, should aim to free the relationships between men and women from the context of an oppressor-oppressed relationship.

"In short, women's orgasm should be evaluated in the same perspective as men's orgasm and ejaculation, which make them feel relieved both physiologically and psychologically and which is regarded as a natural process. Also, it is very important for men and women to see each other as individuals with the same needs. If we think that even some of the women are unaware of their clitorises and especially in the eastern part of Turkey, some people do not know anything about sexuality and believe that sexual intercourse is performed through belly button, we can say that for a satisfactory sexual life, sex should be freed from its position as a taboo in the society (including religion) and should not be seen as a platform for men to prove "strength" or power. Sex should be seen as a source of equal pleasure for both men and women."

Appendix 2 – The Original Response from B.

Question: What do you think about that many women do not have orgasms, specifically in Turkey, and that "female orgasm" has been turned into a medical "problem" that can be diagnosed and cured?

Response: "I believe that the issue of women's not achieving orgasms has two faces. First is that women do not have orgasms, because of the double standard of sexuality prevalent in patriarchal societies. While men's sexuality is encouraged, women's sexuality is prohibited. Women are raised to keep their legs together, but men are raised to "score." Sex is pleasurable only to men, not to women. While women are regarded as the givers, so they should be restricted in terms of sexuality ("stay virgin until marriage"), men are regarded as the takers, with high sexual drive and no control over this drive.

"The second face is that in our society, which is based on double standard, some women cannot have orgasms and medical science call them "dysfunctional." It actually surprises me that there are many women who can have orgasms! In addition, men create the medical science, and the common incorrect belief that women can have two types of orgasms (vaginal and clitoral) is an indicator of this male-creation of female sexuality. Studies on not having orgasm (medicine, psychology etc.) do not seek for answers why women do not have orgasms, but they blame women for not having something they are taught to stay away from. Women who do not have orgasms are regarded as patients, but women are not sick. It is our patriarchal societies and institutions that need to be cured!

"The whole problem is the general patriarchal structuring of our societies and that sex is defined in male terms. Sex is the penetration of penis into vagina and the goal is to enable men to ejaculate. Women are not seen to be pleased, but to get pleasure from. This reminds me of a sexist statement, which summarizes the male-definition of sexuality: "Woman is the unnecessary flesh around the vagina."

"In short, orgasm does not start in the clitoris, but in our heads! As long as our society continues to fill our heads with double standards to control our bodies and sexualities, the number of women who cannot have orgasms will never vanish and doctors and drug companies will earn millions of dollars for "curing" (but actually deceiving) women who do not have orgasms, and these women will believe that the problem is them, while it is this male-made world."

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