

The Role of Urethra in Female Orgasm

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A rather high percentage of women do not reach the climax in sexual intercourse. The frigidity figures of different authors vary from 10-80 per cent and come closer to the statistics of older sexologists. Adler (Berlin) came to the conclusion that 80 per cent of women did not reach the sexual climax. Elkan guessed that 50 per cent suffered from frigidity, while Kinsey found it to be 75 per cent. Hardenberg's figures have a very wide range from 10 to 75 per cent.

Many of these statistics cannot be compared, since the various authors use different criteria. Edmund Bergler sees the condition of eupareunia only in vaginal orgasm and so his frigidity figures are naturally much higher than those based on any kind of sexual satisfaction. The restriction to the vaginal orgasm, however, does not give the true picture of female sexuality.

Lack of orgasm and frigidity are not identical. Frigid women can enjoy orgasm. The lesbian is frigid in her relations to a heterosexual partner, but is completely satisfied by homosexual loveplays. A deficient orgasm need not always be associated with frigidity. Numerous women have satisfactory enjoyment in normal heterosexual intercourse, even if they do not reach the orgasm. Genuine frigidity should be spoken of only if there is no response to any partner and in all situations. A woman with only clitoris orgasm is not frigid and sometimes is even more active sexually, because she is hunting for a male partner who would help her to achieve the fulfillment of her erotic dreams and desires.

Although female erotism has been discussed for many centuries or even thousands of years, the problems of female satisfaction are not yet solved. Even though female doctors (Helena Wright) participate in these discussions nowadays, "the eternal woman" is still under discussion. The solution of the problem would be better furthered, if the sexologists know exactly what they are talking about.

The criteria for sexual satisfaction have first to be fixed before we make comparisons. Numerous "frigid" women enjoy thoroughly all the different phases of "necking." Should we count out all variations of sex practices which result in complete orgasm though not vaginal orgasm?

Innumerable erotogenic spots are distributed all over the body, from where sexual satisfaction can be elicited; these are so many that we can almost say that there is no part of the female body which does not give sexual response, the partner has only to find the erotogenic zones.

It is not frigidity, if the wife does not reach orgasm in intercourse with her husband, but finds it in sexual relations with another partner. One of my patients, who married early a very much older, rich man and had two children, pestered me persistently with questions as to why she could not

experience an orgasm. I explained that physically there was nothing wrong with her. Bored by the repeated discussions with her, I finally asked her, if she had tried sex relations with another male partner. No, was the answer and reflectively she left my office. The next day in the middle of the night, I was awakened by a telephone call and a familiar voice who did not give her name asked: "Doctor are you there? You are right," and hung up the receiver with a bang! I never had to answer any further sexual questions from her.

In spite of abundant literature dealing with female orgasm, our knowledge of the mechanism and the localisation of the final climax is insufficient. Different organs and their stimulation work as a trigger and cause an increase of the sexual "potential" up to the level where the orgasm goes off. One could suppose that the clitoris alone is involved in causing excitation, since this organ is an erotic center even before puberty, though it is aided by other erotogenic zones.

Inflammations of the clitoris, especially below the prepuce, can make it so hypersensitive that it loses its ability to produce orgasm. Such changes occur by masturbation in elderly women after the menopause when the external genitals shrink and become affected by hypoestrogenism. The erotogenic power of the clitoris passes then mostly to the neighborhood of the genital organs, to the inside of the small labia or to the pubic region of the abdomen. The entrance to the rectum can also become an erotogenic center, not for anal intercourse, but for stimulation with the finger. In one of my patients vaginal orgasm was lost completely, but orgasm could be achieved with a finger in the anus and the penis in the vagina.

Sometimes the breasts help the clitoris in producing erotization. Kissing the nipples, touching them with the penis, or inserting the penis between the two breasts lead to an orgasm. Cunnilingus or even insertion of the penis in the external orifice of the ear are other illustrations of the variability of the erotogenic zones in females.

Some investigators of female sex behavior believe that most women cannot experience vaginal orgasm, because there are no nerves in the vaginal wall. In contrast to this statement by Kinsey, Hardenberg mentions that nerves have been demonstrated only inside the vagina in the anterior wall, proximate to the base of the clitoris. This I can confirm by my own experience of numerous women. An erotic zone always could be demonstrated on the anterior wall of the vagina along the course of the urethra. Even when there was a good response in the entire vagina, this particular area was more easily stimulated by the finger than the other areas of the vagina. Women tested this way always knew when the finger slipped from the urethra by the impairment of their sexual stimulation. During orgasm this area is pressed downwards against the finger like a small cystocele protruding into the vaginal canal. It looked as if the erotogenic part of the anterior vaginal wall tried to bring itself in closest contact with the finger. It could be found in all women, far more frequently than the spastic contractions of the levator muscles of the pelvic floor which are described as objective symptoms of the female orgasm by Levine. After the orgasm was achieved a complete relaxation of the anterior vaginal wall sets in.

Erotogenic zones in the female urethra are sometimes the cause of urethral onanism. I have seen two girls who had stimulated themselves with hair pins in their urethra. The blunt part of the old fashioned hair pin was introduced into the urethra and moved forwards and backwards. During the ecstasy of the orgasm the girls lost control of the pin which went into the bladder. Both girls felt ashamed and tried to hide the incident from their mothers until a huge bladder stone had developed around the pin as centre. One stone was removed by supra-pubic, and the other by vaginal, cystotomy. A third hair pin entered the bladder and before the bladder was inflamed, it was angled out via the urethra. Since the old hairpins are no more in use, pencils are used for urethral onanism. They are longer than the hairpins and do not glide into the bladder so easily, though they cause a painful urethritis. Urethral onanism may happen in men as well. I saw a patient with a rifle bullet which glided into his bladder. He had played with it while he was lonesome on duty on New Years Eve.

Analogous to the male urethra, the female urethra also seems to be surrounded by erectile tissues like the corpora cavernosa. In the course of sexual stimulation, the female urethra begins to enlarge and can be felt easily. It swells out greatly at the end of orgasm. The most stimulating part is located at the posterior urethra, where it arises from the neck of the bladder.

Sometimes patients of Birth Control clinics complain that their sexual feelings were impaired by the diaphragm pessary. In such cases the orgasmic capacity was restored by the use of the plastic cervical cap, which does not cover the erotogenic zone of the anterior vaginal wall. Such complaints occurred more frequently in Europe than here in the U. S. A., and was one of the reasons for giving preference to the cervical cap over the diaphragm pessary.

Frigidity after hysterectomy may happen, if the erotogenic zone of the anterior vaginal wall was removed at the time of the operation. The vaginal wall is preserved best by the abdominal subtotal hysterectomy, less by the total hysterectomy and least by vaginal hysterectomy when always large parts of the vagina are removed. That is the cause of vaginal frigidity after vaginal hysterectomy observed by LeMon Clark.

The uterus or the cervix uteri takes no part in producing orgasm, even though Havelock Ellis speaks of the sucking in of sperm by the cervix into the uterus.

The non-existence of the uterine suction power was proved by a simple experiment, in which a plastic cervical cap was filled with a contrast oil (radiopac) and fitted over the cervix. The cap was left in for the whole interval between two menstrual periods. These women had frequent sexual relations with satisfying orgasm. Repeated X-ray pictures taken during the time when the cap was covering the cervix, never showed any of the contrast medium inside the cervix or in the body of the uterus. The whole contrast medium was always in the cap.

The glands around the vaginal orifice, especially the large Bartholin glands, have a lubricating effect. Therefore they are located at the entrance of the vagina and produce their mucus at the beginning of the sexual relations and

not synchronously with the orgasm. Sometimes the mucus is produced so abundantly and makes the vulva slippery, that the female partner is inclined to compare it with the ejaculation of the male. Occasionally the production of fluids is so profuse that a large towel has to be spread under the woman to prevent the bed sheets getting soiled. This convulsory expulsion of fluids occurs always at the acme of the orgasm and simultaneously with it. If there is the opportunity to observe the orgasm of such women, one can see that large quantities of a clear transparent fluid are expelled not from the vulva, but out of the urethra in gushes. At first I thought that the bladder sphincter had become defective by the intensity of the orgasm. Involuntary expulsion of urine is reported in sex literature. In the cases observed by us, the fluid was examined and it had no urinary character. I am inclined to believe that "urine" reported to be expelled during female orgasm is not urine, but only secretions of the intraurethral glands correlated with the erotogenic zone along the urethra in the anterior vaginal wall. Moreover the profuse secretions coming out with the orgasm have no lubricating significance, otherwise they would be produced at the beginning of intercourse and not at the peak of orgasm.

The intensity of the orgasm is dependent on the area from which it is elicited. Mostly, cunnilingus leads to a more complete orgasm and (consequent) relaxation. The deeper the relaxation after intercourse the higher is the peak of the orgasm followed by depression and hence the students' joke: *Post coitum omne animal triste est*. The higher the climax the quicker is the reloading of the sexual potential.

Other somatic factors help to sexually stimulate the female partner. As was mentioned there is no spot in the female body, from which sexual desire could not be aroused. Some women have greater sexual desire at the ovulation time while others at the time of the menstrual period. It may be that during menstruation the sexual tension is higher, because the danger of unwanted pregnancy is lessened. The woman-on-top posture is more stimulating as the erotogenic parts come in contact better. The angle which is formed by the erected penis and the male abdomen has a great influence on the female orgasm.

These mere somatic causes are often overshadowed by psychic factors, even the commonest automatic reflexes produce sexual reactions.

It is possible to cause an orgasm merely by using some stimulating sentence. Such a reaction follows the laws of the unconditioned reflexes.

The erotogenic zone on the anterior wall of the vagina can be understood only from a comparison with the phylogenetic ancestry. In the most commonly adopted position, where "the lady does lay on her back," the penis does not reach the urethral part of the vaginal wall, unless the angle of the erected male organ is very steep or if the anterior vagina is directed towards the penis as by putting the legs of the female over the shoulders of her partner. The contact is very close, when the intercourse is performed more *hestiarum* or a *la vache* i.e. a *posteriori*. LeMon Clark is right when he

mentions that we were designed as quadrupeds.

Therefore, intercourse from the back of the woman is the most natural one. This can be performed either in the side-to-side posture with the male partner behind, or better still with the woman in Sims', knee-elbow or shoulder position, the husband standing in front of the bed. The female genitals have to be higher than the other parts of her body. The stimulating effect of this kind of intercourse must not be explained away as LeMon Clark does by the melodious movements of the testicles like a knocker on the clitoris, but is merely caused by the direct thrust of the penis towards the urethral erotic zone. Certain it is that this area in the anterior vaginal wall is a primary erotic zone, perhaps more important than the clitoris, which got its erotic supremacy only in the age of necking.

The erotising effect of coitus a posteriori is very great, as only in this position the most stimulating parts of both partners are brought in closest contact i.e., clitoris and anterior vaginal wall of the wife and the sensitive parts of the glans penis.

This short paper will, I hope, show that the anterior wall of the vagina along the urethra is the seat of a distinct erotogenic zone and has to be taken into account more in the treatment of female sexual deficiency.

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