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A Speculum on the Eighties

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Une des revendications principales du mouvement de la femme a été celle du droit de contrôle sur nos propres corps. Au début des années 70, on aurait dit que l'article ci-dessous avait dépassé les bornes.

The very last conference we attended in the decade was held at the end of November, 1979, at McMaster University, Hamilton. The focus was Women and Health *and women of all ages attended. It was a joy to listen to honest information given by feminist doctors about our own bodies. We're publishing one of the papers here– a paper that in 1970 would have been 'going too far'!*

Today women are increasingly asserting their right to be full and informed partners in decisions about their health and health care. In order to do so, however, women must be knowledgeable about their bodies, their sexuality and their reproductive function and they must become comfortable in using this knowledge. This is easier said than done.

From the time we are born, we are socialized to accept a variety of beliefs about our bodies and many negative messages (verbal as well as non-verbal) about our sexuality.

From the moment of birth we are all sexual beings. It is known that very young infant males have erections and very young infant females lubricate. We know that young children explore every part of their bodies and receive pleasure from this exploration.

They very early on learn that there are 'good' parts and 'bad' parts of our body and when we touch these bad parts we

ourselves become 'bad.' It is even worse for young girls than for young boys because boys at least have permission to touch their genitals when they urinate and thus have the opportunity to become familiar with this important part of their body, and to become aware that contact with this part of the body feels good.

We know that children must receive physical stimulation from others and themselves in order to develop emotionally, and that in order for optimal emotional development to occur, childhood eroticism must be nurtured, preserved and encouraged. Nevertheless, our society responds by denying children a language with which to speak about their genitals and we deny them permission to carry on exploration of their bodies.

Early in childhood we learn to say 'lips' and 'ears' and 'nose' and our parents applaud us when we can point to these parts of our bodies, but we grow up with a variety of misnomers or no-nomers for our genitals. It is not uncommon for us to hear adult women describing symptomatology in their reproductive tract because they don't have the language to describe these parts of their body. Indeed, so ingrained is the guilt associated with touching intimate parts of our body that many of our patients express tremendous reluctance to do breast self-examination because of their discomfort with feeling their own breasts.

As we grow up and our genital area becomes covered with pubic hair, it is even more difficult for us to know this important area of our body. But this is only part of the problem. Besides being deprived of approval for wanting to know, speak of and enjoy every part of our body, we constantly receive negative messages about our genitals and their function. For instance, feminine deodorant spray advertisements exploit the misinformation that so many of us carry around—that our genitals are dirty and smelly. Menstrual periods are called 'the curse' and in many cultures menstruating women are considered taboo and untouchable.

The idea of actually looking at our genitals with a mirror is something that is considered to be extremely upsetting and if looking is forbidden then, indeed, touching and learning more about these sensitive and responsive parts of our reproductive tract is absolutely forbidden. Once we reach menopause we are depicted in the ads as dried out, prune-like shrews whose *husbands* are the victims of estrogen deficiency.

Not only are our genitals a source of embarrassment to us, but society as a whole paints a picture of the ideal attractive woman whom we must all try to emulate. Either our breasts are too small or too large, our waist too thick or too thin, our hips too fleshy or too bony, our hair too curly or too straight, our noses too pointy or too hooked and I could go on and on. The net effect of all this is that many of us feel that we somehow don't measure up as far as our bodies are concerned. The result is that we find it very difficult to stand nude in front of a mirror and actually study our bodies and begin to know more about our bodies, that is, to become thoroughly familiar with them.

When it comes to the actual receiving of health care, women become enmeshed in another set of myths. It has been repeatedly shown in a variety of studies that women are much more likely to be diagnosed as having emotional ailments than men. Indeed, until very recently, a prevalent attitude in the medical literature was that women are prone to psychogenic ailments due to their constitutional inferiority or to their emotional immaturity or to the effects of their 'raging' hormones changing throughout the monthly cycle. It has also been shown that twice as many women as men get mood modifying drugs prescribed for them. What we have learned is that this is not due to an inherent inadequacy of women, but rather to the attitudes of the physicians who treat them (and to the effects of a society which denies to many women the opportunity to fulfill themselves). In speaking of the physicians, I must stress that I do not feel that we can categorize all physicians into one group. In my own day-to-day work, we are very involved in training future family physicians to dismiss these myths and to treat women as equals. Nor do I feel that male physicians cannot provide equally sensitive health care to women.

However, a significant number of physicians in the past have adopted a 'fatherly' role towards their patients, whom they perceive as being child-like. In 1973 an editorial in the *New England Journal of Medicine* referred to an article by Lenanne and Lenanne that reported that painful periods, nausea in pregnancy and pain in labour were being treated in an irrational and ineffective way because these conditions affected only women. Scientific evidence that clearly implicated organic causes was disregarded in favour of an acceptance of a psychogenic origin. The writers felt that the cloudy thinking that characterized the relevant literature about these conditions may have been due to a form of sexual prejudice. Indeed, a textbook of gynecology by Parsons and Summers, published in 1962, stated that in dealing with marital counselling 'it is easy to become over sympathetic to the wife's recounting of her difficulties. . . . It is far better to take the side of the undeclared partner in order that the wife recognize her own deficits.' And a few pages later, the authors state, 'The agressive female on the other hand who wishes to overpower her husband and to dominate him even in the act of intercourse will attempt to pursue her own rhythm independent of her husband. There are some homosexual attributes here.'

Because of this combination of factors—the inherent lack of education about our own bodies, our own reproductive function and our own sexuality and the attitude of a significant number of members of the healing professions over the decade, women began to rebel and to acquire and disseminate the information about themselves and their bodies. The tremendous success of a book such as *Our Bodies, Ourselves,* the development of women self-care groups, health collectives and so on attest to the fact that women are now increasingly aware of the need to know themselves.

The search for improved knowledge has been particularly active in the field of human female sexuality. This is because our sexuality is such an intrinsic part of our total being and because in no other area are we so damaged by false and misleading myths. The *Hite Report* by Sherry Hite, published in 1976, was based on a questionnaire answered by over 3,000 women. The responses, plus extensive references to other texts on the subject, helped to give us an insight into women's sexuality. A number of important facts came out from the questionnaire which I would like to summarize, but first I would like to review the development of the male and female genitalia.

Embryologically we all begin as females. In the presence of a Y chromosome, which determines the development of a male, the clitoris enlarges to enclose the opening of the bladder or the urethra and becomes the penis. The large lips fuse in the middle to become the scrotum, and the gonads (the ovaries in women) migrate into the scrotum and are the testicles in males. Once we understand this it becomes obvious that the female clitoris is the equivalent of the male penis and therefore sexually sensitive in the same way as the male penis. The vagina itself is richly supplied with nerve endings in the outer

third and it is this part of the vagina that becomes engorged and swells during sexual arousal. The deeper parts of the vagina, however, are very poorly supplied with nerves and all of you know that you have had pap smears done and some manipulation of the cervix without very much pain. Yet, in spite of this embryologic comparison, very few little girls are raised to use the word clitoris. We tell them boys have a penis but girls have a vagina—a direct reference to the fact that women's sexuality is intimately related to reproduction rather than pleasure *per se.* We also begin to recognize how ludicrous was Freud's conclusion that clitoral orgasm was immature whereas vaginal orgasm was the sign of a mature female, yet this conclusion has plagued millions of women for years.

In working in the Human Sexuality Clinic at McMaster, I have found that the vast majority of couples who complain of sexual dysfunction are really suffering from lack of information and have labelled themselves or their partners as having some serious problems. It is for this reason that I would like to quote some of the many conclusions from Sherry Hite's report, conclusions which we have found to be only too valid in dealing with patients. Some of these conclusions are as follows: women can masturbate to orgasm within a few minutes; the ease with which they do so certainly contradicts the general stereotype about female sexuality that women are slow to become aroused and are able to reach orgasm irregularly. Most women said that they enjoyed masturbation physically but often not psychologically because of guilt feelings. Others couldn't even let themselves enjoy it physically. Some saw it as a learning experience, as pure pleasure, as a substitute for sex, or as a means of independence or self-reliance. There were a large number of variations in the actual physical means of stimulation and this was important because only by knowing her own body and the way in which it responds can a woman help her partner to become a better lover.

It has often been said and written that women do not need orgasm the same way men do. A typical comment in the report was: 'Whoever said that orgasm was not important for a woman was undoubtedly a man.' However, on the other side of the coin was the fact that women are under great pressure to conform by having orgasms, especially during intercourse. There is a social pressure that a woman who has orgasms is more of a 'real woman' and the man who 'gives her the orgasm' is more of a real man. Some women reacted against this pressure to perform. To some women orgasm during intercourse was not important. Although there was nothing wrong with not having orgasms and nothing wrong with them empathizing with and sharing another person's pleasure, there was something wrong when this became a pattern where the man was always having orgasms and the woman not. Orgasm, with or without intercourse, is the same basic orgasm and the best way to learn to achieve orgasm is through masturbation. It is important to recognize that only 30 per cent of women in this study were orgasmic regularly with intercourse alone and these figures are similar to figures quoted by Kinsey, Fisher and Kaplan, to go back to our development model. Expecting women to always climax with vaginal penetration would be the same as stimulating a man's penis to arouse him, but then expecting him to achieve orgasm by pressing on the part between his scrotum and his anus. Masters and Johnson have stated that social, cultural influences more often than not place a woman in a position in which she must adapt, subliminate, inhibit or even distort her natural capacity to function sexually in order to fulfill her genetically assigned role of breeding. For actually, intercourse itself is only one form of sexual pleasure and is essential only when reproduction is considered.

To try to limit physical relations between human beings solely to intercourse is artificial. Our culture seems to assume, since sexual feelings are provided by nature to ensure reproduction, that intercourse should be our basic form of sexuality, even though women's sexual feelings are often strongest when they are not fertile—for example, during pregnancy or after menopause. As a result, heterosexual intercourse is the only form of sexual pleasure really condoned by our society and this forces women to adapt their bodies to inadequate stimulation and leads to the suppression of all other forms of sexuality and pleasureable, intimate contacts. These cultural pressures force many women to view themselves with contempt and to cause recurring feelings of insecurity and anger if they cannot adhere to this norm. They are led to believe that if they don't have orgasm there is something wrong with them physically or more likely emotionally. Their partners too begin to believe that if the woman does not have orgasm through intercourse there is something wrong with him. Many women regularly fake orgasm to satisfy their partners or avoid their anger and rejection. Older women, instead of being asexual, frequently experience an increase in erotic appetite during menopausal years although this is not universal. Eight per cent of the women responding to Sherry Hite described themselves as homosexual; another eight per cent as bisexual. In addition, Nancy Friday's book, *My Secret Garden* contained descriptions of a number of women's sexual fantasies, thereby exploding the myth that women don't have or enjoy sexual fantasies. In short, confusion between reproductive activity and sexual pleasure plays havoc with many women's lives because sexuality and the capacity to experience sexual pleasure are lifelong.

Thus, in summarizing what women say about their sexuality, we must conclude that there is no reason why there should be one set pattern for expressing our sexuality. Sex can be intimate physical contact for pleasure to share with another person or to enjoy alone. Sex can be enjoyed to orgasm or not, expressed genitally or just as physical intimacy. It can be expressed by oneself, with a partner of the opposite sex or with a partner of the same sex, whatever seems right to the woman at the time. As long as it doesn't involve the exploitation of other people it can be enjoyed. Unfortunately, too many women have been left without even these basic facts about themselves and the result has been a tremendous amount of unnecessary suffering.

I would like to close with a plea for mutual responsibility between patients and the health care profession. We in the health care professions have an obligation to continue to learn more about our women patients and to continue to expose and explode the myths that have been so widespread and that have contributed to second-rate health care for women. We have an important role to play in helping our patients to learn more about themselves and their bodies. However, as patients, you too have an obligation to know more about your bodies and your feelings, for the more that you will be able to tell us about them, the more we in turn can be of help to you.

You can learn a great deal from one another, as well as from those members of the health care profession who are willing to learn and share their knowledge with you, so that you can become proud of and knowledgeable about your bodies. And finally, you can continue to insist that the health care team treat you with respect and dignity, as full and equal partners with the right to make *informed* decisions about your body.