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NATURE, CAUSES, CONSEQUENCES AND THERAPEUTIC APPROACHES TO FRIGIDITY AMONG WOMEN IN NIGERIA

By

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Abstract:

Frigidity is a non-medical sexual dysfunction and inhibition of sexual pleasure (orgasm). Its etymology can be organic or psychosocial. Some of the causes of frigidity among women in Nigeria were traced to socio-cultural such as religious factors, early marriages, environmental stress, sex myths, taboos, beliefs and traditional female circumcision. The study also listed some of the negative consequences of frigidity to include reduced/total loss of sexual enjoyment, stigma, ego despair, familiar separation (divorce) and in extreme cases, depression. In order to stem the tide of frigidity and its allied negative consequences in Nigeria, the researchers recommended among others two (2) multimodal counselling approaches- (Sensate Focus and the PLISSIT model), legislation against childhood marriages, obnoxious sex practice and the sustenance of the on-going global women, empowerment schemes.

Introduction

Instincts are innate behavioural dispositions manifested by human beings independent of prior learning or learning or experience. Freud's (1955) theory of instinct is replete with these natural tendencies such as the instinct f sucking, crying, babbling, crawling, walking, safety/avoidance of injury and of course that of mating (Sex).

As a form of instinct, sexual relationships (coitus) among matured adults are not taught in most cultures of the world, but are rather "caught" with the onset of puberty. Even, in most of the contact cultures where pubertal initiation rites are performed, the initiates (teenage boys and girls) are not thought the physiology of sex. It is a disdain to publicity talk about sex in such cultures. Also, in developed countries of the world where sex education are taught formally or informally, it thus seem that the focal point of such sex education programmes are the anatomy and hygiene of the reproductive system, sexually transmitted disease, the family (types, consummation, roles, planning, communication, and conflict resolution strategies). From the above, it does appear that in both culture, these is little or no emphasis placed on the exercise physiology of sex, its orgasmic bliss and the resulting complexities of failure to attain maximum sexual satisfaction.

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In two identified foreign but independent studies; Frank (1978) reported that most women do not have orgasm each time they engage in sexual intercourse and about 15% of women never had orgasm. Also, in a survey of 100 couples who had not sought therapy, Masters & Johnson (1970) reported that 60% of the women said they had difficulty reaching orgasm, while most of the couples described their marital sex life as only moderately satisfying. In another related study, Balch & Balch (2006) opined that nearly half of all women and one-third of men employed in their study suffer from frigidity at one time or another. Frigidity is no doubt one of the leading causes of familial problems such as extra-marital sex, separation, single parenting and divorce. Others include decreased over all sexual responsiveness, lowered self-esteem and in extreme cases, depression (Frank, 1978).

It is in the light of all the above that the researchers attempt a discussion of the nature, causes, typology, and consequences of frigidity on women in Nigeria. And based on the negative consequences of the sexual dysfunction, the paper offers some counseling therapies and recommendations that will reduce frigidity to enhance full sexual satisfaction of couples and consequently strengthen hitherto frail sexual-familial relationships.

The Concept of Frigidity

Frigidity is a non-medical sex problem that has not been technical defined in medical literature (Balch & Balch, 2005). Consequently, frigidity is vaguely discussed in such disciplines as psychology, psychiatry, sociology, medicine, counselling and sexology-all with different definitions, connotations and interpretations. For example, frigidity is technically viewed as functional impairment of female genitalia (Seward, 1946), in orgasmic syndrome (Sarason & Sarason, 1972), anorgasmia (Olson & Defrain, 1994) and as sexual arousal dysfunction (Balch & Balch, 2006).

Albeit, it is erroneous to view frigidity as a predominantly female sexual disorder, rather, it is only more prevalent with females than males. Equally, frigidity is not a condition where a woman is not regularly experiencing sexual satisfaction (orgasm), but an express condition where a woman is rarely if at all able to experience orgasm through any form of sexual stimulation such as cunnulings or masturbation (Balch & Balch, 2006).

Normally, the appurtenance and touch of a matured, loved male sex partner triggers a lot of primary and secondary sexual characteristics in the female which include the reciprocal desire for sex, erection of nipples, tactile movement of the labia and release of vaginal fluid. The vaginal fluids and tactile movement in females are further accentuated with fore-play and consequent penetration of the vagina by the penis thus causing the inner "lips" of the labia minor to come together above the vagina opening to form a "hood" otherwise referred to as the prepuse of the clitoris (Seward, 1946). The movement of the penis against the hitherto wet prepuse of the clitoris coupled with reciprocal tactile touch and communication (verbal & non-verbal) results is an involuntary rhythmic motion of the clitoris, which allows the woman to reach orgasm.

The sum total of these pleasurable rhythmic movements of the sex organs in cycles from it initiation to peak and decline is referred to as orgasm. According to Masters & Johnson (1965), the ability of both sex partners (especially the women) to initiate, sustain and attain orgasm is a drive for ascendancy from one realm of orgasm to another with no time lapse. While the later experience applies to only a few percentage of sexually sensitive women, quite a handful requires additional stimulation in order to fall back to plateau or excitement phase. In frigid women, however, such sexual pleasures and excitement are illusions, Masters & Johnson (1965) concluded.

Typology and Causes of Frigidity

Frigidity as a form of sexual dysfunction may be difficult to classify. This is as a result of its multiple aetiology (Masters & Johnson, 1965), as well as its myriads of interwoven manifestations (Balch & Balch, 2006). Although in most sex-related literature (Bahch & Balch, 2006; Olson & Defrain, 1994; Masters, (1992), it is common to find different classificatory schemes and typologies; an introspection of all reveals some form of consensus. In this study therefore, Masters et al (1992) two-way class-scheme of frigidity is preferred. This is because of its specificity of frigidities and its causes.

Masters el al (1992), classified frigidity into two; organic and psychosocial frigidity.

1. Organic Frigidity

According to Master et al (1992) organic frigidity in women result from psychological or biological conditions such as menopausal syndrome, reduced cessation of vaginal fluids, abnormal physical structures/obstructions in, on and around the woman's body or genitals, and such other medical conditions, medications and surgery, About 10-20% of frigidity and sexual dysfunctions in women are usually of organic origin (Masters et al 1992).

2. Psychosocial Frigidity

Psychosocial frigidity is a complex one resulting from multiple eatiology (Masters, el al 1992), which may be psychological, development, interpersonal, environmental, phenomenal and cultural. Some of the developmental causes of frigidity in women stems from poor parent-child relationships, single parenting, negative parental attitudes to sex, sexuality and sex related issues, traumatic childhood-adolescent sex experiences and gender identity conflicts (Masters et al 1992). On the other hand, some of the intra, interpersonal and relationship causes of psychosocial frigidity in women are fear of pregnancy, fear of sexual pain and displeasure, fear of poor sexual performance, poor sex education, poor communication, power struggle between sex partners, gender role conflict, lack of physical attractiveness, hostility, deceit and distrust (Masters, el al 1992). While unconducive place and time for sex, fatigue, boredom are a few of the phenomenal causes of psychosocial frigidity, traditional role patterns of women, sex myths, taboos, beliefs and practices are some of the cultural causes of psychosocial frigidity among women.

In Nigeria, comparative conjecture of the causes of frigidity among women will perhaps rank psychosocial causes higher than organic causes. Albeit, some of the general causes of frigidity among Nigerian women which stems from phenomenal, socio-cultural cum religious beliefs and practices are early marriages, complications from teenage pregnancy, traditional female circumcision and the resultant effects of Female Genital Mutilation (FGM) and Fistula. Others include female domestic burden, fatigue, boredom, male dominance, ego, chauvinism, spousal squabbles, spousal separation, long abstinence from sex, lack of education, poor foreplay techniques, sex myths/taboos – (No sex during menstruation and breast feeling) and gynecological related problems.

Although, the researchers, from the seeming dearth of local sex related literature are not equipped with the percentage of Nigerian women suffering from frigidity, it is quite obvious that quite a sizeable percentage are covertly affected with far reaching negative consequences and damaged to the family psyche.

Consequences of Frigidity

The negative consequences of frigidity on women, couples and families in Nigeria include the followings:

1. Permanent inability to enjoy sex.
2. View of sex with disdain and as a form of punishment.

3. Break down of hitherto close bonds and relationships.
4. spousal suspicion, envy and complex.
5. stigma and loss of self esteem.
6. involvement of the males/ spouse in extra-marital sex.
7. familiar separation and divorce and
8. in extreme cases, depression (Balch & Balch, 2006).

The above devastation consequences of frigidity on women, families and the marriage institution in Nigeria presuppose that a multi-disciplinary approach be instituted to turn around the fortune of frigid and non-frig women and consequently bring back on tract seemingly frail familial relationship at the bring of collapse as a result of this sexual dysfunction.

Therapeutic Approaches to Frigidity

The management of frigidity and of course all other forms of sexual dysfunction among women are not simply an easy task. This is because, a higher percentage of people suffering from such sexual dysfunctions do not easily admit or disclose it and may consequently go without help far a very long period of time (Olson & Defrain, 1994). Nevertheless, frigid women and other sexually dysfunction clients should not be timed or unnecessarily anxious about their sexual dysfunction, moreso, as there is an avalanche of professionally competent therapists in Nigeria-family planning providers, Nurses, Counsellors, Gynecologists, sex therapists and sex Educators who can assist in the effective management of such sexual dysfunctions.

Generally, in most identified cases of frigidity, as with other forms of sexual dysfunction, an eclectic or multi-modal approach may be more potent in combating the disorder safe in specific cases requiring symptomatic procedures. In the same vein, Balch & Balch (2006) also opined that medication or surgery are not necessarily a panacea for frigidity except when they are as a result of some underlying medical conditions.

In view of the above, the researchers have selected and discussed two (2) among the existing range of therapeutic approaches for the management of frigidity among women in Nigeria. These approaches are the Masters & Johnson's (1966) Sensate Focus and the PLISSIT modal as postulated by Annon (1974). The rationale behind the researchers' choice of these two (2) approaches abound in the fact that they are educational, systematic, (stage wise) can be self administered with evidence of their efficacy and applicability. For example, Sensate Focus (Masters & Johnson, 1966) is an amalgam of two efficient counseling techniques-systematic desensitization earlier developed by Wolpe (1958) and cognitive restructuring. In addition, both approaches – Sensate Focus and PLISSIT model are holistic and multi-modal approaches for the treatment of frigidity.

1. Sensate Focus Approach

Sensate Focus was developed by Masters & Johnson (1966) and founded upon the philosophical premise that sexually dysfunctional or frigid individuals have lost the ability to think and feel in sensual ways because of various stresses that inhibit their sex life. Such clients should therefore be re-acquainted with the pleasures of tactile contacts. The basic strategy of this approach is to diminish distractions such as anxieties, hatred, inconveniences and other related factors that hitherto inhibit the clients' sexual response and thereby enhance erotic factors.

As an amalgam of systematic desensitization and cognitive restructuring, Sensate Focus is an intensive daily therapeutic programme for both frigid and non-frigid sex partners/coupes spanning a minimum of two weeks with the following as focus;

(i) Instructions on the anatomy and physiology of the sexual organs;
(ii) Daily exercises on erotic stimulation procedures;
(iii) Communication strategies between coupes/sex partners;
(iv) Procedures for alleviating fears related to sex ;
(v) Methods of boosting self esteem of frigid couples/sex partners as well as;
(vi) Homework and assignments;

In counseling frigid women in Nigeria and prior to the above intensive programme is an interactive counseling session geared towards the identification and collection of base line date/information about the client and the problem. Such base line data/information as the clients' name, age, family background, medical history, causes and manifestations of frigidity as obtained under maximum psychological conditions of warmth, genuineness, unconditional positive regard and confidentiality as postulated by Rogers (1966). The specificity and eatiology so obtained will prompt either a referral to medical experts (Surgeon, Gynecologists) if the frigidity is organic in nature and if otherwise, the initiation of appropriate counseling strategy as Sensate Focus. In applying Sensate Focus, the therapist should remember to employ appropriate counseling techniques-systematic desensitization and manifestations (stressors) of the frigidity during the two (2?) weeks intensive programme.

Sensate Focus has been found to be effective with women suffering from a aide range of sexual dysfunctions such as frigidity and menopausal syndrome. Post treatment reports of sexual satisfaction and orgasm were also obtained from large varied sexually dysfunctional clientele and low failure rate for both heterosexual and homosexually dysfunction clients (masters & Johnson, 1966).

However, two criticism of this approach as observed by Zibergeld & Evans (1980) are that Master & Johnson's report on the efficacy of Sensate Focus neither specified the procedures of clients' selection, nor the indices for measuring the programmes success and failure. Nevertheless, Sensate Focus was applauded by Sarason & Sarason (1972) as superior to earlier techniques for the treatment of frigidity and other sexual dysfunctions.

2. The PLISSIT Model

The PLISSIT model is also a behavioral oriented approach and further modification of Sensate Focus. Developed by Annon (1974), PLISSIT model is an educational, interactive and stage-wise treatment of frigidity and other forms of sexual dysfunctions. PLISSIT model has four (4) basic stages with progression from simple to indepth client- therapist interactive session(s). The coinage of the model –PLISSIT, in its four stages is given thus;

P = Permission Giving SS = Specific Suggestions
LI = Limited Information IT – Intensive Therapy

As usual, the preliminary counseling session(s) is devoted to obtaining baseline date/information on the client's name, sex, age, family background, medical history as well as the causes and manifestations of the frigidity. This is done under maximum psychological testing and core conditions of warmth, report, genuineness and confidentiality? (Rogers, 1966). With this baseline information/data, the therapist can then proceed to apply PLISSIT model thus:

Stage 1: **Permission Giving**

The first stage is perhaps the simplest of the four levels of the PLISSIT model. At this stage, frigid and sexually dysfunctional clients are expected to request and be granted permission by an authority/respected individual (spouse, sex partner, guardian or parent) to

engage in specific sexual behaviours. Granting permits to engage in sexual behaviour presupposes that such acts are harmless, not myths but are socially approved behaviours among matured adults. Couples, sex partners as well as frigid individuals should therefore communicate effectively and have mutual consent to engage in sex in order to reduce all forms of anxieties related to frigidity.

Stage 2: **Limited Information**

At this stage, clients are expected to pick-up bits of information about sex and frigidity from friends, sex partners, sex literature, sexuality couse and other related media. Through such limited information, reading and discussion, frigid clients may find valid and usable information and will enable them to effectively manage their frigidity and thereby become more sexually responsive (Olson & Defrain, 1994).

Stage 3: **Specific Suggestions**

It the first two stages above do not resolve the client's frigidity, the counsellor and the client will then move to this third stage of specific suggestions and behavioural exercises. A review of the client's bio-statistics earlier taken will be of added advantage at this stage of the therapy. For example, if fears of pregnancy or pains during penetration are underlying causes of frigidity, specific suggestions will include the use of aids, lubricants and preventive measures (condoms, barriers, insertions, jellies) and for intrusion, the selection of safe place and conducive time for sex. Some other times, an avalanche of suggestions may be prioritized, trial tested as behavioural exercises/assignments with appropriate feedback.

Stage 4: **Intensive Therapy**

This further tenet in Annon's PLISSIT model is the most intensive requiring client-therapist(s) interactions that may span several counseling sessions. According to Annon (1974) only about 10% of sexually dysfunctional or frigid clients need or get to his tenet of the model. The category of clients needing intensive therapy include dysfunctions requiring medication, surgery as well as "closed:, non-disclosing and uncooperative dysfunctional sex partners.

Conclusions and Recommendations

An attempt was made in this paper to discuss the nature, causes, typology, manifestations and consequences of frigidity on women in Nigeria. Frigidity was opined as a non-medical sex problem in which a woman is seldom or unable to attain maximum sexual satisfaction- (orgasm) through any form of sexual stimulation. Two frigidity typologies identified in the study were organic and psychological frigidities. Some of the pertinent causes of frigidity among women in Nigeria as identified in the study are traditional beliefs, practices, sex myths, taboos, female stress, male ego, spousal squabbles, illiteracy, female circumcision and its related gynecological disorders – FGM and Fistula. Also identified as the consequences of frigidity are permanent inability to enjoy sex, stigma, strained familial relationships, separation, divorce and in extreme cases depression.

In order to ameliorate or exterminate the consequences of this form of sexual dysfunction and effectively rehabilitate frigid couples, women and families in Nigeria, the researchers proffered two (2) holistic and stage-wise counseling approaches with proven research efficacy-Sensate Focus (Masters & Johnson, 1966) and the PLISSIT model (Anon, 1974). However, and in addition to the two (2) counseling approaches to frigidity, the following recommendations are made:

1. Nigeria women should eat good and balanced diet rich in fats, oils and vitamin E. These food types are obtainable from meat, legumes, poultry, diary products (eggs,

milk) fruits and vegetables. These vital ingredients enhance tissue elasticity, tone, and potency/sterility;

2. Nigerians (both male and female) should always involve in regular physical fitness exercises to keep the body supple, tonic and its system highly functional;
3. There should always be effective communication between spouses/sex partners both before and during coitus, adequate foreplay, body explorations and touch without restrictions are vital ingredients for secretion and arousals and inhibition of frigidity;
4. There should be mutual consent for sex and its conduct in a safe place, time with "wait time" to ensure orgasm for both partners;
5. Couples/sex partners should avoid taking alcohol, coffee, cigarette, steroids and drugs prior to sex. As stimulants/energizers, these substances inhibit hormonal/seminal secretions, cause friction, delay orgasm and may in the long run imitate frigidity;
6. Also try to avoid stressful daily activities and spousal rifts especially prior to intercourse;
7. Discountenance with unproven traditional beliefs, and do not engage in unwholesome traditional sex practices/behaviours such as early marriages, traditional female circumcision etc. There is need also for legislation against such obnoxious traditional practices and stiff penalties for its contravention;

In conclusion, it is the belief of the researchers that the employment of these therapies and recommendations multi-sectorally will no doubt reduce frigidity among women in Nigeria as well as the seemingly frail familial relationships.

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