

THE AVERAGE SEX LIFE OF AMERICAN WOMEN

RELATION BETWEEN EXPERIENCES AND GENITAL
FINDINGS: I. INTRODUCTION TO STUDIES *

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It is probably well within bounds to affirm that our present beliefs concerning normal sex life and average experience and practice have the status of surmises standing on foundations no more secure than general impressions and scattering personal histories. It is time we began building on collected case records running through lifetimes in series counted in tens of thousands. In view of the pervicacious gonad urge in human beings, it is not a little curious that science develops its sole timidity around about the pivotal point of the physiology of sex. Perhaps this avoidance—not of the bizarre and the extreme, the abnormal and the diseased, but of the normal usages and medial standards of mankind—perhaps this shyness is begotten by the certainty that such study cannot be freed from the warp of personal experience, the bias of individual prejudice, and, above all, from the implication of prurience. And yet a certain measure of opprobrium would not be too great a price to pay in order to rid ourselves of many phallic fallacies. Our vigorous protests against the sensual detail of pornographic pseudoscience loses force unless we ourselves issue succinct statistics and physiologic summaries of what we find to be average and believe to be normal, and unless we offer in place of the prolix mush of much sex literature the few pages necessary for a standard of instruction covering sex education. Considering the incorrigible marriage habit of the race, it is not unreasonable to demand of preventive medicine a place for a little section on conjugal hygiene that might do its part to invest with dignity certain processes of love and begetting.

As to gynecology, it seems to have been too much busied with the operative work that constitutes nearly one fourth of major surgery to give proper time to certain fundamentals. We have trained students and interns with an outlook on laparotomy and pathology rather than on physiology, life-adjustments, and pelvic social problems. So far, the subdivisions of the incipient science of preventive gynecology have been better obstetrics, cancer research and control, and venereal disease restriction.

* Read before the Section on Obstetrics, Gynecology and Abdominal Surgery at the Seventy-Sixth Annual Session of the American Medical Association, Atlantic City, N. J., May, 1925.

A plan has been suggested for a council to coordinate the work of the following organizations:

AGENCIES CONCERNED IN SEX PROBLEMS

1. Committee for Research on Sex Problems (under National Research Council); assists a number of special researches, chiefly on animals, and conducts a medical psychopathologic office study.

2. Bureau of Social Hygiene; surveys and assistance in sex problems; endowment over a million dollars.

3. American Social Hygiene Association, propaganda, sex education, combating prostitution and venereal disease, \$200,000 a year.

4. Committee of Fourteen, New York (of Fifteen, Chicago; of Twenty, Utica); investigation of sex vice conditions and watch on legislation; about \$15,000 a year in New York City. New York Society for the Suppression of Vice: to enforce obscenity laws; about \$15,000.

5 and 6. Department of Eugenics and Eugenics Record Office, Cold Spring Harbor (under Carnegie Institution of Washington); studies in heredity.

7. Committee in Eugenics and Dysgenics of Birth Regulation (under Eugenics Committee of United States); sociological studies; newly organized.

8. Committee on Maternal Health (medical); study by clinics and research in contraception, sterility and sterilization; \$21,000 in its second year, 1925.

9. American Birth Control League; publicity; amendment to state laws; clinic; some \$60,000 to \$80,000.

10. Voluntary Parenthood League; amendment to federal law; about \$20,000.

11. Committee on Maternal Welfare (representing American Association of Obstetricians, Gynecologists and Abdominal Surgeons; American Gynecological Society, and American Pediatric Society); prenatal and postnatal care; death rates; puerperal fever; small funds.

Churches and Christian associations, social agencies and public health organizations; schools and colleges; courts and legal societies; medical institutions and societies; biologic laboratories.

THE NEXT STEPS

The Committee on Maternal Health found that, as soon as it had surveyed the field and persuaded seven clinics to work out contraception studies—indications, methods and results, and related sterility and sterilization—steps must be taken to develop essential data not available. Among these missing facts may be mentioned age at marriage and at childbirth, by single years, for American women; duration of their reproductive life, with fecundity and fertility; the findings that make, or point to, the diagnosis of sex experiences; exact genital measurements; the anatomy of the sex act and the bearings of it on health; together with the correlation of pelvic disorders and diseases with sex practices of all kinds—the whole based no longer on opinion, but on trustworthy medical records. This paper is an introduction to the series, covering several thousand histories.

As an important preliminary I propose the first summary of an epoch making and elaborate study published by Katherine B. Davis, Ph.D.,¹ for the Bureau of Social Hygiene.

AUTO-EROTIC PRACTICES

From the anonymous answers received from a questionnaire sent to American college women living in city, town and country, 1,183 reports were summarized. The average age was 37, the largest group, 30. Two

1. Davis, Katherine B.: Study of Certain Auto-Erotic Practices, *Ment. Hyg.* 8: 668-723 (July) 1924; 9: 28-59 (Jan.) 1925; A Study of the Sex Life of the Normal Married Woman: I, The Use of Contraceptives, *J. Soc. Hyg.* 8: 2 (April) 1922; II, The Happiness of Married Life, *ibid.* 9: 1-25 (Jan.) 1923; III, The Happiness of Married Life, *ibid.* 9: 129-146 (March) 1923.

thirds of these unmarried women report the practice of masturbation. One third of the total number continue the practice. More than a third of those that started stopped within a year. Among the total auto-erotics, half carried on from ten to twenty years, while of those that continue, a third have kept on from twenty to thirty years. The practice commenced for the most part between the ages of 5 and 11 (42 per cent.), that is, well in advance of puberty, while before reaching 16 nearly 60 per cent. of those practicing had begun. The mode or peak of the beginnings is at the eighth year (Fig. 1). Herein lies a notable contrast between male and female, since three fourths of the males start between 12 and 17. As for orgasm, though the term was not always understood, it seems to be late in developing, since its appearance is listed, in 62 per cent. of those reporting, as beginning at or after the eighteenth year. The two chief reasons given were, first, to secure pleasure (with no great difficulty in stopping) and, second, the desire for relief from tension, or else an uncontrollable impulse for release, with unsuccessful efforts

RELATION WITH OTHER SEX PRACTICES

The relations with other sex practices are given in percentages, with the figures for the married group in brackets. All sex experiences denied, either auto-erotic or homosexual or heterosexual, 30 per cent. (51); sex intercourse only, 1.3 (2); homosexual physical relation alone, 4.5 (8); masturbation only, 42 (27); both masturbation and homosexual experiences, 12 (6.5); masturbation and sexual intercourse, 7 (3.6); all three, 2.6 (1.3); total who had had sexual intercourse, 11 (7); total who had had homosexual relation, 19 (16). Total masturbation at any time, 65 (38). Finally, it is to be noted that about one third of those who have masturbated have had other sex experiences.

As this large group represents a type of intelligent womanhood known to be busied in productive occupations, and reasonably assumed to be trained in self control, and as its admissions are probably minimal for the group or for less trained women, it seems to me a fair inference that auto-erotic practice is rather average experience among women and that moderate usage

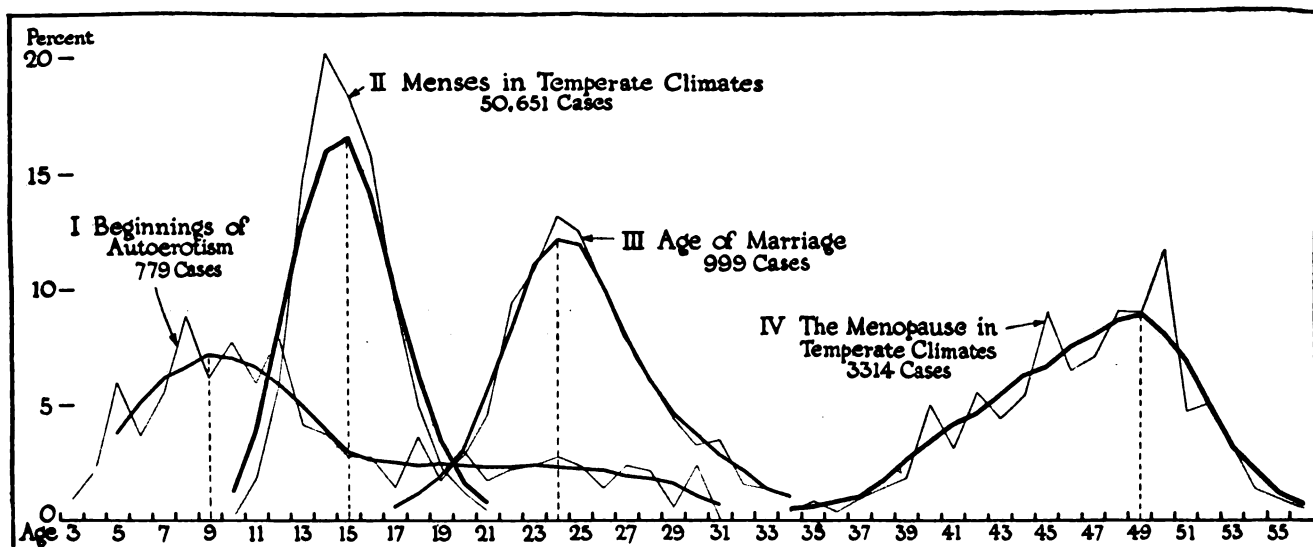


Fig. 1.—Main periods of sex life of women of the temperate climates: Information concerning auto-eroticism and marriage was obtained from educated Americans; on the beginning and ending of menstrual life, from a number of countries, from which our women differ by starting somewhat earlier and finishing later, as shown in other charts. The curves have been smoothed on a four year center, excepting the marriages. The striking features are the early age at which masturbation must be watched for, and the wide span of both puberty and the menopause. In both, late start and late finish assume large proportions. The menopause is much nearer 50 than 45. The peaks at round numbers, such as 45 and 50, show the untrustfulness of any memory other than recent.

to break off. The two classes were nearly alike in their membership. Suggestive reading is listed as a rather minor excitant, and very little blame is laid on "spooning" or dancing.

In the matter of frequency, one third report once or twice a month; with a fourth it is less often; with a fifth, once a week; but the duration of the practice at this rate or oftener is not given.

A correlation between masturbation and health at the time of reporting, in a list that covers the third that never experimented, the third that discontinued, and the third that continue, shows a "real difference" in the way of better health among those keeping on with the practice. Moreover, there is no appreciable difference in health between those who began early and those who started after 18. Effects called "good" and "negative," when grouped together, give 61 per cent. Not one in ten asked advice about the habit. Cessation was brought about as follows: One third, for fear of results; one third, because of feelings of shame or wrong-doing; and one fifth outgrew the habit.

may be called a normal sex experience. Two important bearings of these new data on sex education lie in the need of beginning of instruction before five years of age, and the ability to remove much unnecessary mental castigation.

MARRIAGE

Dr. Davis' married group of 1,000 averages 38 years old, with 70 per cent. college graduates. The median age at marriage was 25.7, and the number of marriages reported as happy, 87 per cent. Half the number report pleasurable sex relations throughout their married lives, the average duration of marriage being twelve years. Two thirds started pleurably. One third showed alteration in feeling thereafter, the gains and the losses apparently very nearly balancing. The difference in pleasurable relations between those instructed before marriage and those not instructed was found to be significant, however meager the instruction. About one in twenty mention reception of information on birth control. A previous habit of masturbation did not have any effect on initial sex relations, and in the early years

of marriage pleasurable reactions were significantly higher, but responsiveness persisted longest in the group that never masturbated. To judge by known cases, a fourth continued the practice after marriage. Among the fourth to whom the sex relation was distasteful, apparently about equal responsibility belongs to states of mind, to frigidity, and to faults of the husband. Fear of pregnancy plays little part, and mention of previous masturbation as a cause is notable for its absence.

The degree of intensity of the sex impulses of the wife as compared with those of the husband gave 31 per cent. as "about equal," the wife's greater in 3.5 per cent., and the husband's greater in 62 per cent. The frequency of desire ran close to these ratios in husband and wife. In frequency of repetition of coitus, the average comes somewhere near twice a week, as nearly as I can make out from the tables. Intercourse con-

ning of sex consciousness, of puberty, of marriage, and of menopause, finding the pointers toward a good deal of material in Kisch.² Where sufficiently numerous, American data alone are used. Where there are few from this country, as in the matter of the menopause, 3,200 cases from other temperate climates have been charted and the 332 American cases compared with them before plotting the larger number as an average.

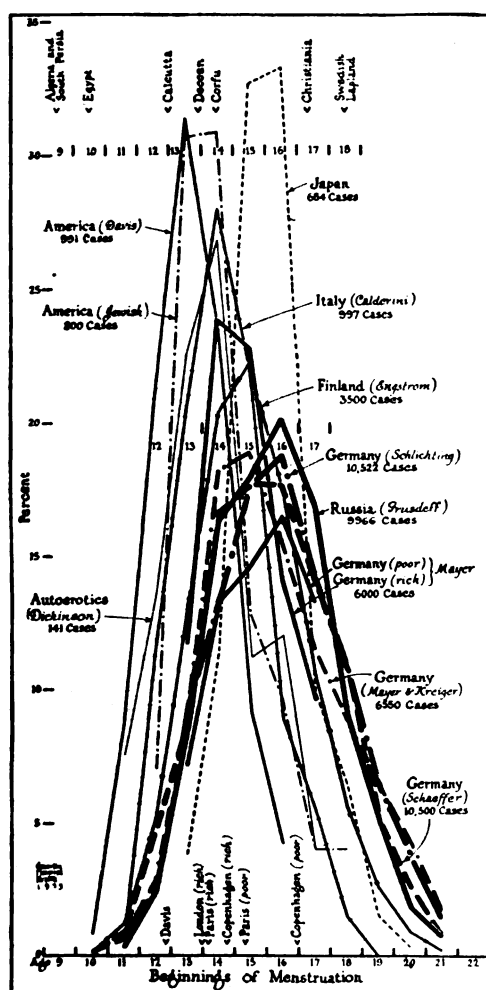


Fig. 2.—Data from which the general curve of Figure 1 is compiled. The records of 50,651 puberties are shown, to contrast various countries and climates and classes, the poor and the rich, the well nourished and the well educated. For each group reported, one should know details of the conditions of nourishment and nervous system and prosperity and, possibly, sensual stimulus, though the auto-erotic subjects here are no earlier than their American sisters. Finland, as a cold country, calls for explanation, with its early start. Darker lines indicate larger numbers.

tinued during entire pregnancy in 25 per cent., and from a few weeks to seven or eight months in 60 per cent.

CHARTS OF SEX LIFE

As an example of what is under way in the new plan of getting averages or standards, we have assembled on a graph (Fig. 1) the times of occurrence of the begin-

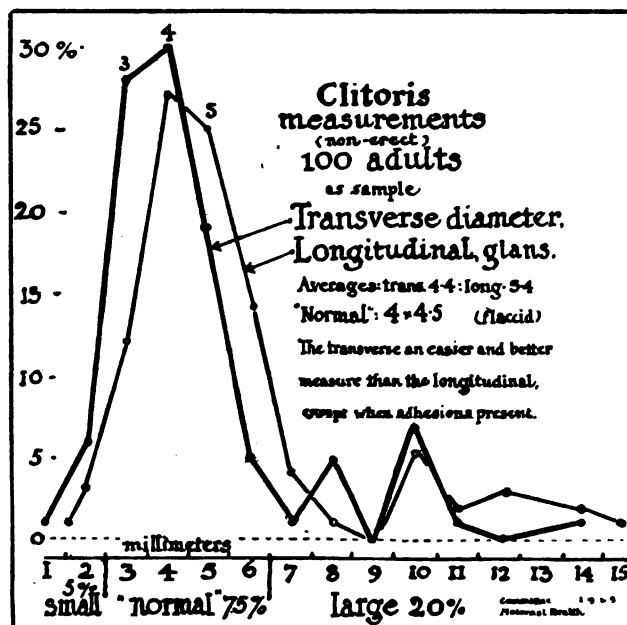


Fig. 3.—The utility of charting frequencies. Because the "average" is used in the anatomies in giving these diameters, other authors would class this largest group as "small" organs. Morris gives 8 mm., for instance, as average.

The verification of figures and curves and the smoothing of curves have been in expert hands. The marriage curve is drawn only from American college and club women because of the absence of data by single years for American women in general.³

We learn from this diagram that instruction concerning auto-eroticism must begin long before the time we had supposed. The curve rises rapidly from the fifth year and reaches its peak at the eighth. We learn further that to stress 13½ or 14, the average age for the menses to begin, is misleading when so large a proportion (among the 50,651) belong earlier, and a still larger group later. Even more markedly is this width of spacing true of the menopause. The skewness of this curve is striking. We have been teaching our patients to look forward to release at 45. Here we see that the greatest frequency is 49. These and other instances of the practical utility of applying modern statistical methods to our special work will be discussed more fully later.

MISLEADING PRESENT FIGURES

Only by charting can one acquire ideas of proportion. Thus, one discovers how misleading the term "average" may be. One learns to ask always, "What is the more frequent dimension or grouping?" This was shown when we started to inquire what constituted a normal or average clitoris. About the genitalia even anatomists are loose in their statements, the diameters running from 8 mm. (Morris) to 6.7 (Testut) and 5.6

2. Kisch, E. H.: *Das Geschlechtsleben des Weibes*, Berlin, Urban & Schwarzenberg, 1904.

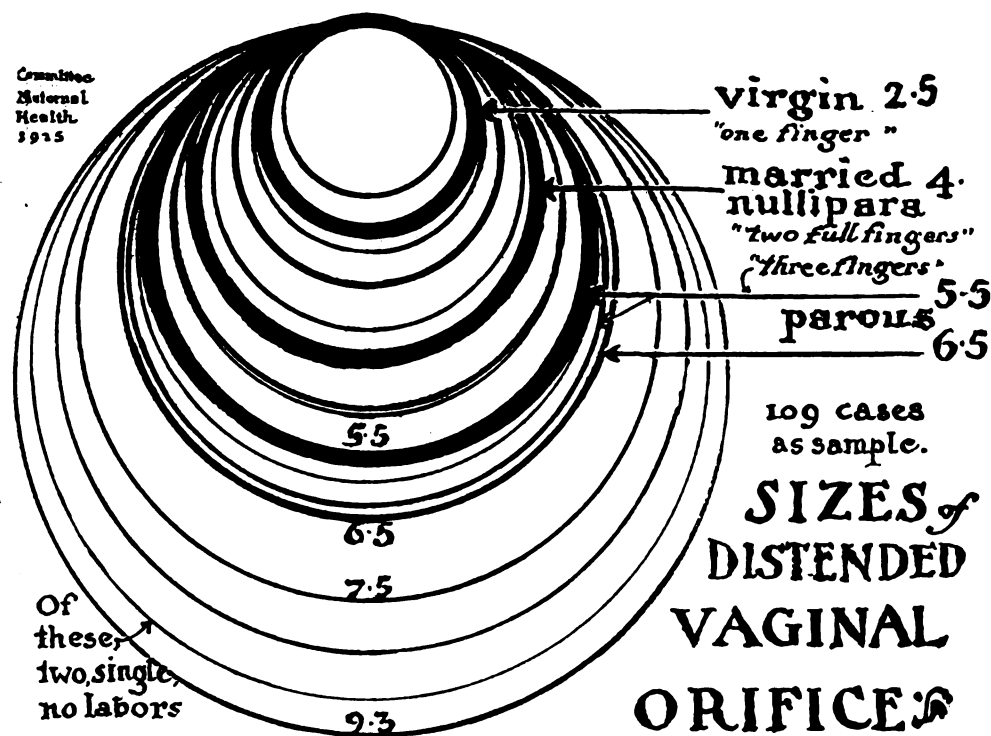
3. In our reprint and in the Transactions of the Section, separate graphs will show the multiple lines of the many sources from which this chart is made up.

(Waldeyer, Poirier, Jayle). This is because they had on a list a few scattering large examples. A graph of distribution of measurements shows strikingly that 4 mm. is the greatest frequency of both diameters of the glans, and exhibits the way the transverse measurements consistently group lower than the anterior-posterior. The genitalia have been the subject of no proper study of types and dimensions.

RELATIONSHIPS

We are studying the following propositions, among others, in subsequent sections.⁴

The dimensions and appearance of the hymen and of acquired hypertrophies about the vulva and vagina furnish much more diagnostic evidence of sex experience than is commonly apprehended.



Distribution indicated by relative thickness of the line
Operator, when repairing, narrows to two full finger size

Fig. 4.—Distribution of an unselected series of introitus distensibilities from office practice. To be of value, there should be three times as many in each series; but the trend is shown.

The untouched hymen admits no more than the average adult forefinger. Thus stretched, the edge is sharp to the touch, the sensitiveness well defined. Sharpness of edge disappears only from tearing or from a process of gradual stretching, and, if the distention is gradual and neither excessive nor too prolonged, will return.

Openings of the hymen larger than one finger are the result of one of the following agencies: douching, gynecologic treatment, coitus, delivery or vaginal friction.

Under graduated, oft-repeated stretchings, degrees of elasticity or distensibility may develop sufficient to allow the passage of a full sized head or of the adult hand without a nick of hymen or injury to other structures. Such fully dilatable, undamaged hymens, close or open, belong to the vigorous coital or manual massage groups. Either head-stretch or hand-stretch may produce the gaping vulva.

Well marked acquired hypertrophies about the vulva are auto-erotic evidence.⁵ These consist in largely developed labia minora and prepuce, laid in many-wrinkled, darkened folds, sometimes studded with outstanding sebaceous glands; in tabs of the meatus; in prominent veins; in active pelvic floor muscles; and, infrequently, in an enlarged clitoris.

Vaginal distensibilities and surface appearances, particularly in the nullipara, give clear evidences of marital or extramarital overindulgence, or actual or relative impotence or neglect.

THE VAGINAL ORIFICE

Measurements and classifications show the main groupings to be the conventional ones; namely, virgin, wife and mother. With these our histories develop standard diameters of 2.5, 4 and from 5.5 to 6.5, respectively. To the three groups (1) intact, unentered hymen, (2) married nullipara (or cohabiting imparous single woman), and (3) parous woman we add (4) the nulliparous orifice of very vigorous coitus; (5) the virgin orifice massaged to various dimensions—some among the largest—and (6) the parous orifice that seems to owe its immunity from damage to hymen or tear of pelvic floor to the oft-repeated stretch of one or both the foregoing experiences. For the crucial test of the intact hymen, that is, one free from entry by adult phallus or from finger frictions, it is shown that appearance—except for gross tears—counts less than sharpness of edge and sensitiveness taken in conjunction with diameter under distention. The measurements were made by using the finger or fingers as calibrator,

noting the depth of entry on the digits, or by the passage of graduated glass cylinders. The hymen edge was studied (for our drawings that were all made life size) by passing and then partly withdrawing a glass ball in order to spread the membrane out, or else by a cotton wad held in forceps. Vaginal profile diagrams were drawn full size by using the subpubic arch as the point of departure for measurement and direction, with the patient either in a knee chest posture with the sound, or in the dorsal posture. The fourth method was the glass test tube of average phallic diameter (3.3 cm.) to observe visually the vulvar and intra-vaginal mechanical factors. Thereby a vaginismus is observed through the bottom of the glass to be due to a tight hymen or spasm; or seen to be caused by impingement of the tip on an unusually deep or

4. Tables and illustrations are given in the reprints and in the Transactions of the Section.

5. Dickinson, R. L.: Hypertrophies of the Labia Minora and Their Significance, *Am. Gyn.*, September, 1902; Urethral Labia, or Urethral Hymen, Pathologic Structures, Due to Repeated Traction, *Am. Med.* 9: 347-349 (Jan.) 1904.

stretched and reddened fossa navicularis; or else with ample vaginal orifice, it is noted, through the anterior wall of the glass, that the meatus is, or when pushed on, becomes vaginal in outlook, and therefore in coitus is spread wide open and traumatized. Lastly, a raw cervix in the vaginal axis may be seen through this speculum to be the tender target.

BIRTH CONTROL

We have some definite figures concerning the prevalence of the practice and evidence of the standing of birth control among women of fine type. Among the first thousand answers to the Davis questionnaire, only seventy-eight expressed disapproval of any means to prevent conception. Approval "in principle" was expressed by 73 per cent., and these employed some form of contraceptive and averaged 1.9 children and 2.5 pregnancies each. Abstinence belonged to 8 per cent. Of the remainder it is not possible to say how many were sterile, but Dublin's⁶ 20 per cent. sterility for New York City, and the proportion of childless homes reported from Philadelphia would make it not unlikely that, save for the abstinent, those who used no preventives had no reason to do so. One infers also from the tables that economic and health reasons in nearly equal proportions influenced 70 per cent. of the users of contraceptives. To 37 per cent. of those instructed information was given by physicians.

Though it forms an important section under the title of our paper, the order of popularity of the various measures and the percentages of safety need not be taken up here, as they have been fully discussed in the first report of the Committee on Maternal Health,⁷ drawn from the figures of the London and New York birth control clinics and from the Davis group and covering about 4,700 cases in all. The unreliability of these returns calls for the real investigation of efficacy and harm or harmlessness which is now under way in university and other clinics. These studies, and the investigation of the indications and of the field of sterilization, and the researches on methods that would do away with the present mechanical schemes, should, in time, give the committee adequate definitions and a proper array of evidence of value.

CONCLUSION

As we began, we conclude. Organized study of certain neglected aspects of human sex physiology and practice are due and overdue. There is a part of this investigation that can be cared for only by the medical profession. Shall the American Medical Association have any representation in these activities?⁸

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ABSTRACT OF DISCUSSION

DR. JAMES F. COOPER, New York: I represent the American Birth Control League of New York. I was called to undertake clinical research work and to direct the activities of that

department. We have been conducting a clinic for the contraceptive treatment of married women, who under the laws of the state of New York are entitled to that advice. Four thousand cases have passed through that clinic and we have collected quite an amount of data in regard to the normal and abnormal sex life of women. Our experience deals with another class of people from that reported by Dr. Katherine Davis. She had the intelligent class, whereas ours are very largely drawn from the ordinary dispensary type of patient. The information we have received from them in regard to the normal sex habits coincide pretty much with the report made for this other group of women. I think what Dr. Dickinson has given might be considered as a cross section of the life of the average American woman in sex matters. The one big thing I want to emphasize at this meeting is what Dr. Dickinson brought out, namely, we have lay organizations undertaking the work which should be undertaken and sponsored by the medical profession. The request came to the organization for certain gynecologic information, and we found there was no reliable information to be given. On that account a research department was instituted to investigate the various contraceptive methods with the idea of learning their relative values and respective merits. This was a lay organization, but soon it became evident that the scientific side was necessary, so a small group of physicians was brought together to undertake that pioneer work, which has been going on for three years. I am the person Dr. Dickinson referred to as the member of the committee who wanted the medical profession to take up the work and to study the scientific problem of contraceptives and also the sex problems that are presented from time to time. When the time comes that our professional people will take up this subject adequately, our birth control clinic will have no need for further existence. Until then we are going on with the scientific work and publishing reports which can be secured by any physician on application to the organization; but the point I wish to make is that it is a matter for scientific study. Too many times, when I bring this matter before medical societies, it is looked on with disdain. With the terrible mortality we have in obstetrics and with the great morbidity, I feel we can never reduce to any extent the 20,000 maternal deaths each year until we are able to study our cases and find out the causes that contribute to this enormous mortality and until we study these cases and give to those who are rightly entitled to it the contraceptive information needed rather than turn them aside without giving proper information.

DR. ROBERT L. DICKINSON, New York: My advice is to start clinics for the study of these sex problems, contraception, sterility and sterilization, with emphasis on sterility, as it is an important factor. Quite recently a statistical study from the Metropolitan Life Insurance Company showed that one out of every five marriages in New York City is sterile. Regarding sterilization of the unfit, H. H. Laughlin of Cold Spring Harbor is the authority. No contraceptive information of any value can be obtained in Holland. We are trying to find out how France restricts its births. I hope this section will take an interest in those scientific investigations of sex that are basic. Our first paper today took up the latest discovery in the physiology of sex; our new study takes up the most neglected and interesting matter in obstetrics and gynecology.

6. Dublin, L. I.: Bull. Metropolitan Life Insurance Company, 1924. The Declining Birthrate: National Birthrate Commission, London, 1916, p. 35 (second report, 1920).

7. Contraception—Medical Review of the Situation, Am. J. Obst. & Gynec. 49:95 (Nov.) 1924.

8. At the meeting of the Section on Obstetrics, Gynecology and Abdominal Surgery, May 29, 1925, Dr. Dickinson offered a resolution, in the form of a motion, that the chairman of the section appoint a committee to consider the matter of cooperation with other responsible organizations on the study of sex problems. The motion was seconded by Dr. J. C. Litzberg, Minneapolis, and carried (THE JOURNAL, June 13, 1925, p. 1833). The author also offered the following resolution, which was seconded and carried: "Resolved, That this section hereby recommend the alteration of existing laws wherever necessary so that physicians may legally give contraceptive information to their patients in the regular course of their practice."