Function of the Orgasm (Part II)*

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Reprinted from the *Journal of Orgonomy* Vol. 14 No. 1
The American College of Orgonomy

II. ORGASTIC POTENCY

We understand "orgastic potency" to be a person's capacity to attain gratification by discharging an amount of libido equivalent to the built-up sexual tension in the organism; further, the capacity to attain gratification should far outweigh one's susceptibility to genital disturbances, which occasionally trouble even the healthier organism. Orgastic potency is attained under certain conditions found only in persons with the capacity for pleasure and achievement. It is absent or inadequate in neurotic individuals.

Is it possible to describe orgastic potency as a specific function despite individual differences in sexual needs? One may object that we are describing as ideal type not even closely approximated in reality. We dispute that; actually, we are dealing with empirical facts. I am indebted to some of my colleagues for having given me a phenomenological description of their sexual experiences, which enabled me to list some criteria of orgastic potency; if these are lacking, we may diagnose orgastic impotence quite accurately according to type and severity, without having to rely on the most misleading statements made by patients.

Clinical observations support the depiction of a specific orgastic potency since, after we remove disturbances in potency, the patient's orgastic curve automatically approximates the curve of orgastic potency described by us. **1**

Let us begin with a discussion of the progress made by a patient during the course of analysis, a patient who, among other things, suffered from premature ejaculation and excessive masturbation.

Since age 8, he had masturbated one to three times daily without guilt or conscious fear that this would destroy him. As a rule, he would think about masturbating during the evening meal or at bedtime without feeling the least excited. He would commence reading in bed, then decide to masturbate after half an hour. At the beginning of masturbation, the penis was flaccid, but it became erect when manually stimulated. During the act, he would think about whom he would "dedicate" it to; it seemed like a mass which he must say for someone." Some fantasy then produced excitation, which increased steadily. His thoughts wandered to trivial matters concerning his business,

minor events of the day, etc. The excitation subsided whenever his thoughts wandered away, and returned as soon as he started to fantasize again. This occurred several times, and the whole procedure lasted about half an hour. Finally, he reached acme with strong physical tremors, and gratification returned him to the unexcited state he had been in just prior to masturbation. When asked to depict the course of the excitation graphically, he drew the curve in Figure 1.

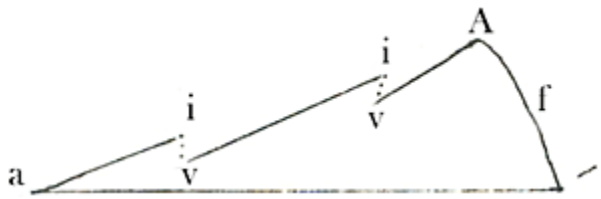

Fig 1 Course of masturbatory excitation.

a - absence of excitation
i - involuntary interruption of fantasy production
v - voluntary continuation of fantasy excitation
A - Acme
f - fall in excitation

Prior to his neurotic illness (erythrophobia), he had suffered from premature ejaculation, which had become much worse since that time. He was only relatively potent with a married woman who fulfilled some of his sexual needs. Forepleasure was greatly prolonged, and intercourse lasted about half a minute. There was greater satisfaction after coitus than after masturbation, especially when he and the woman reached orgasm together; in contrast to masturbation, he was left with a feeling of inner happiness. After intercourse with other women, he had felt only aversion and disgust. Curve 2 represents the course of orgasm with the beloved woman; curve 3 the excitation with premature ejaculation.

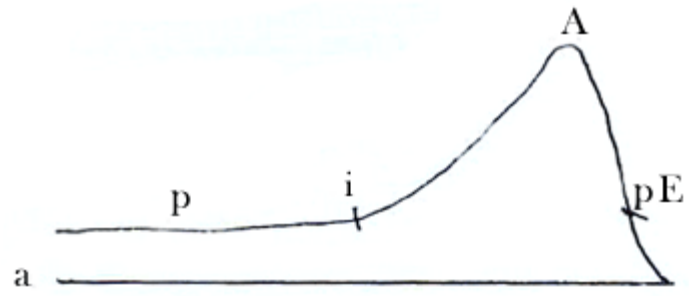

Fig 2 Coitus with faculative potency

a - absence of excitation
p - prolonged forepleasure
i - intromission
A - acme
pE - residual psychic excitation
Duration from time of penetration: about 1/2 minute

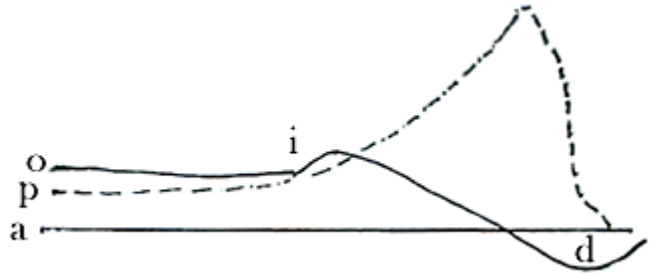

Fig 3 Premature ejaculation

---- comparative curve
o - overexcitement
p - prolonged forepleasure
i - intromission and flat acme
d - subsequent strong displeasure

At the time he started analysis, intercourse was characterized by a few censored homosexual fantasies and good erective potency when thrusting between the thighs or into the buttocks. He explained his behavior on the grounds that he did not want to get

the women pregnant. However, his dreams revealed intense fear of penetrating the vagina. So great was his fear, that I managed to persuade him that his explanation was nothing more than rationalization. He had wanted to prove me wrong, and, during his next attempt at intercourse, his penis "exploded" even before he had assumed his position. Analysis of the dreams that followed this fiasco showed his fear of a dangerous "some-thing" that he imagined in the vagina. Later, he himself interpreted his premature ejaculation as an expression of a fear of "remaining too long in the lion's den."

As his fear and some important but hitherto unconscious motives became conscious, he followed through with more satisfactory intercourse. He said that he had never experienced such gratification. He spent much less time than before on forepleasure, since his fear of coitus had lessened. He reported that coitus itself had lasted about three times longer (approximately one-and-a-half to two minutes) than with the beloved woman before his illness. Excitation was slow at first but then increased more rapidly; for the first time, he had not fantasized during the act and afterwards had felt pleasantly tired throughout his whole body without feeling terribly weary "in his head alone" as he did after masturbation or intercourse with premature ejaculation. The course of excitation is represented by the curve in Figure 4.

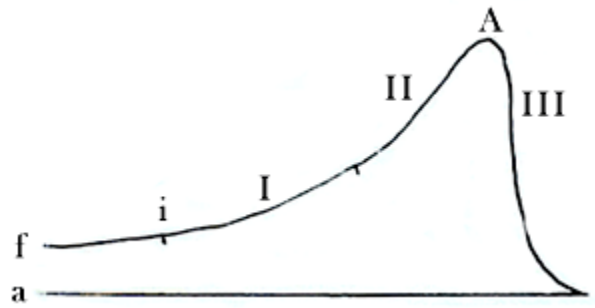

Fig 4 Course of excitation after analysis of the fear

a - absence of excitation
f - forepleasure (shorter)
i - intromission
I - more gradual increase in excitation
II - steeper rise of acme (A)
III - steeper fall and more gradual decline in excitation
Duration: about 2 minutes

Several months after terminating analysis, he told me, among other things, that he felt completely potent and satisfied: The sex act lasted about five minutes, he did not fantasize, and he did not feel "empty" afterwards.

When comparing the graphs, we note that the ascending part of the second curve is shorter than the fourth curve. The great trust the patient had in the beloved woman, plus certain sexual demands, enabled him to be erectively potent and to experience a relatively strong gratification; but the fear of coitus resulted in prolonged forepleasure and a considerable shortening of the friction time. The latter increased three-fold after he recognized his fear of coitus. With premature ejaculation, there was hardly any friction time; the orgasm was flat and attenuated; the few pleasurable sensations were accompanied by intense feelings of displeasure, unlike the intercourse he had when relatively free of anxiety.

In coitus free of fantasy and unmarred by anxiety or displeasure, the intensity of orgastic pleasure is directly proportional to the amount of sexual tension concentrated in the genital: The greater the amount of excitation and the steeper its drop, the greater the sexual pleasure.

The following phenomenological description of an orgastically satisfying sex act covers only the course of some typical phases and modes of behavior.

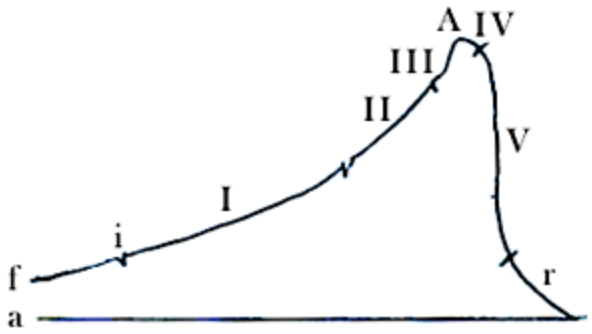

Fig 5 Typical phases of the sex act with orgastic potency in both sexes.

f - forepleasure
i - intromission
I - phase of voluntary control of rise in excitation: prolongation still harmless
II - (6a-d) phase of involuntary muscle contractions and automatic rise in excitation
III - (7) sudden and steep climb toward acme
IV - (8) orgasm
V - (9-10) steep drop in excitation
r - relaxation
Duration: about 5 to 20 minutes

A description of coital physiology is not necessary here because of the many excellent expositions found in the literature. Nor are we considering foreplay, which varies according to individual needs and shows no uniformity. In Chapter 4, we shall discuss excitatory processes in the vasovegetative system, with a view to grasping them phenomenologically.

1. Phase of Voluntary Control of the Rise in Excitation 2

1. Erection is not painful but pleasurable, and the genital is not overexcited. The female genital becomes hyperemic and moist through copious secretion of the genital glands. During penetration, the clitoris may be the excitation focus, but, in the orgastically potent woman, the excitation is immediately transferred to the vaginal mucosa with contest. An important criterion of orgastic potency in the male is the psychomotor urge to penetrate. Erections can also occur without this urge, from sensory stimuli alone, as happens with many erectively potent narcissistic characters.

2. The man is gentle in his aggression. Pathological deviations from this behavior are: harshness and pushiness stemming from sadistic impulses, as in many compulsion neurotics with erective potency, and the inactivity of the passive feminine character. In the "masturbatory coitus" with an unloved object, gentleness is absent. The woman is more passive than the man without being totally inactive. (There may be extreme inactivity, as, for example, that due to masochistic fantasies of being raped.)

3. The pleasure level, which during foreplay has stayed about the same, shows a sudden sharp rise in male and female alike, coinciding with the act of penetration. The man's sensation of "being sucked in" corresponds to the woman's sensation that she is "sucking the penis in."

4. In the man, the urge to penetrate very deeply increases without, however, taking the sadistic form of wanting to "pierce through" the woman, as is the case in compulsive characters. Through mutual, spontaneous, and effortless friction movements, the excitation is concentrated on the surface and glans of the penis, as well as on the dorsal portion of the vaginal mucosa. The typical sensation, which presages and accompanies ejaculation, is still completely absent (in contradistinction to cases of premature ejaculation). The body is still less excited than the genital. Consciousness is completely focused on the perception of pleasure; the ego participates in this activity, endeavoring to exhaust all pleasure potential and attain the peak of tension before orgasm occurs. Needless to say,

this is not done with deliberate intent, but rather, it happens quite automatically and differently for each individual, according to his previous experience, by a change in position, or the manner of friction and rhythm, etc. According to the consensus of potent men and women, the pleasure is all the greater, the slower and more gentle the friction movements are, and the better they synchronize with each other. This entails a strong capacity to identify with one's partner. Pathological counterparts are the urge toward harsh friction movements, as indulged in by sadistic compulsives with some degree of penile anesthesta and the inability to ejaculate, or the nervous haste of those suffering from premature ejaculation. Orgastically potent individuals never talk or laugh during the sex act-with the exception of words of tenderness. Both talking and laughing reflect severe disturbance in the capacity for surrender, which presupposes an undivided absorption in the sensations of pleasure.

5. In this phase, interruption of the friction movements is in itself pleasurable, due to the particular sensations of pleasure which appear when the partners lie quietly; this occurs without mental effort. It prolongs the sex act, since, during rest, the excitation drops off a little, without, however, completely subsiding, as it does in pathological cases. By the same token, interruption of the sex act through penile retraction is not unpleasant, as long as it follows a resting phase. With continued friction, the excitation keeps mounting higher than the level attained prior to the interruption, and begins to spread more and more to the whole body, while the excitation of the genital remains more or less at the same level. Finally, in the wake of another, usually sudden, rise in genital excitation, the second phase unfolds:

II. Phase of Involuntary Muscle Contractions

6. In this phase, voluntary control of the course of excitation is no longer possible. It shows the following features:

a. The increase in excitation can no longer be controlled; rather, it takes hold of the whole personality, producing tachycardia and deep expirations.

b. Bodily excitation again becomes more and more focused in the genital, without abating in the body; a sensation develops that may best be described as a streaming of excitation toward the genital.

c. This excitation mainly involves reflex contractions of the entire musculature of the genital and pelvic floor. These contractions flow in waves, the crests

coinciding with full penetration of the penis, the troughs with retraction of the penis. However, as soon as the retraction goes beyond a certain limit spasmodic contractions occur, which hasten ejaculation. In the woman, there is a corresponding contraction of the smooth musculature of the vagina (sucking movement of the vagina, according to H. Deutsch).

d. In this stage, interruption of the sex act is absolutely unpleasurable for both man and woman, because the muscular contractions leading to orgasm as well as to ejaculation fire off spasmodically instead of rhythmically. This results in intensely unpleasant sensations and, occasionally, in pain in the pelvic floor and small of the back; in addition, following spasm, ejaculation occurs earlier than in the case of an undisturbed rhythm.

The voluntary prolongation of the first phase of the sex act (1 to 5 in the diagram) to a moderate degree is harmless and rather serves to intensify pleasure. On the other hand, interrupting or deliberately altering the course of excitation in the second phase is harmful, because here the process already takes place in reflex form and the nervous system itself becomes irritated. This will be discussed further in the clinical section (e.g., neurasthenia, damage due to coitus interruptus).

1. With increase in the charge and frequency of the involuntary muscular contractions, the excitation rises rapidly and steeply to acme (III to A on the curve); normally, acme coincides with the first ejaculatory muscular contraction.

2. A more or less intense clouding of consciousness now takes place; the friction movements become spontaneously more powerful, after subsiding momentarily at the point of acme; the urge to "penetrate completely" **3** becomes stronger with each ejaculatory muscle contraction. In the woman, the muscle contractions take the same course as in the man; the only psychological difference is that, during and immediately after acme, the healthy woman wants to "receive completely." (Further similarities and differences in the behavior of the sexes will be discussed elsewhere). At the moment of acme, the breath is held; it is then released by heavy breathing; in the woman, it is usually released by screaming.

3. The orgastic excitation takes hold of the whole body and results in lively contractions of the entire body musculature. Self-observations of healthy individuals of both sexes, as well as the analysis of certain orgastic disturbances, show that what we call the release of tension and experience as a motor discharge (descending portion of the orgasm curve) is predominantly the result of

a flowing back of the excitation (from the genital) to the body. Furthermore, this reversal is experienced as a sudden decrease in tension.

The acme thus represents the turning point of the excitation flow: Up to the point of acme, the direction is toward the genital, but, at the point of acme, it reverses direction and flows back toward the entire body (Ferenczi). The complete flow-back of the excitation toward the whole body is what constitutes gratification. Gratification means two things: reversal of the flow of excitation in the body, and unburdening of the genital apparatus.

4. Before the zero point is reached, the excitation tapers off to a gentle curve and is immediately replaced by a pleasant bodily and psychic relaxation; usually, there is also a strong desire for sleep. The sensual relations have subsided; what continues is a feel of utter satiety, and a tender attitude toward the partner, inspired by feelings of gratitude.

By contrast, the orgastically impotent individual experiences a leaden exhaustion, disgust, revulsion, or indifference, and, occasionally, hatred toward the female. In the case of satyriasis and nymphomania, sexual excitation does not subside. The frequent occurrence of insomnia in women is an important indication of lack of gratification. However, we should not necessarily assume the existence of satisfaction if the patient reports falling asleep immediately after the sex act.

Looking back over the two main phases of the sex act, we see that the first phase is characterized mainly by the sensory, the second by the motor, experience of pleasure.

It is widely believed that the delayed orgasm in the female has a physiological basis; attempts have even been made to explain this fact biologically. Thus, the delay in female orgasm was supposed to have the biological purpose of inducing a second ejaculation in the male as a way of insuring fertilization (Urbach). To be sure, it is often harder for the woman to reach orgasm than for the man. However, one must omit those cases in which a (relative) delay in female orgasm occurs due to premature ejaculation of the partner. Furbringer, following Lowenfeld's standard of ten minutes, believes that a normal sex act lasts between five and fifteen minutes. This corresponds to our estimate. It cannot be called pathological if a man ejaculates between one to three minutes, though we cannot classify him as potent either, since we are finding that this so-called "premature ejaculation characteristic of certain healthy men" (Furbringer) is also based on psychic inhibition. This brings to mind our patient who before analysis attained relatively satisfying orgasm after half a minute and more than doubled the friction time after he became aware of his fear of coitus. The chapter entitled "The Social

Significance of Genital Strivings" will deal further with premature ejaculation and the reasons for not calling it pathological.

Aside from this, there are enough factors that can produce delayed orgasm in otherwise healthy women and concern the woman alone: the double standard in sexual morality, which makes the woman much more sex-negative than the man; and the desire to be a man who, without totally preventing gratification, can still sabotage the smooth course of the excitation. If these inhibitions are removed, the course of sexual excitation in the woman is in no way different from that in the man. **4**

In both sexes, the orgasm is more intense if the peaks of genital excitation coincide. This occurs frequently in those able to concentrate their tender, as well as their sensual, feelings on one partner who can respond in kind; it is the rule when the relationship is undisturbed by either internal or external factors. In such cases, at least conscious fantasies are completely absent; the ego is totally absorbed in the perception of pleasure. The capacity for the total absorption of personality and affect in the genital experience - despite possible conflicts - is our phenomeno-logical definition of orgastic potency.

Whether unconscious fantasies are also absent is difficult to say. Certain indications make this probable. Fantasies that must be barred from awareness can only be disturbing. Among the fantasies that may accompany the sex act, one has to distinguish fantasies that are in harmony with the actual sexual experience from those that gainsay it. If the real object is able to attract all the libidinal interest at least for the time being, unconscious fantasy activity becomes unnecessary; the latter, by its very nature, runs counter to the actual experience because one fantasizes only what one cannot have in reality. There is such a thing as genuine transference from an original object to the substitute object. The real object can replace the fantasy object, if he or she corresponds to the fantasy object in the basic traits. The situation is different, however, when the transference of libido occurs without this correspondence, only on the basis of a neurotic searching for the original object, and without the capacity for genuine transference. In that case, no illusion can eradicate a vague feeling of insincerity in the relationship. Whereas, in the case of genuine transference, there reaction of disillusionment after the sex act, it is inevitable here. In this case, we can assume that the unconscious fantasies did not deign to depart, but served the purpose of maintaining the illusion. In the former case, the original object-now replaced by the real object-has lost its interest and, with it, its power to give rise to fantasies. In the case of genuine transference, there is no overestimation of the real object; those characteristics that are at variance with the original object are correctly evaluated and well tolerated.

Conversely, in the case of false (neurotic) transference, there is excessive idealization, and illusions predominate. The negative qualities are not perceived (they are repressed), and fantasy activity is not allowed to cease, lest the illusion be lost.

The harder the fantasies have to work to equate the real object with the ideal, the more the sexual experience loses in intensity and sex--economic value. Whether and to what extent incompatibilities, which can occur in any long-standing relationship, diminish the intensity of the sexual experience, depends entirely on their nature. The likelihood for a pathological disturbance is directly proportional to the intensity of the fixation upon the original object, the inability to form a genuine transference, and the amount of energy expended to overcome aversion toward the real object. This leads us to neurotic disturbances of orgastic potency.

***** Translated by Barbara G. Koopman, M.D.. Ph.D. and Irmgard Bertelsen, B.S., from Die Funktion des Orgasmus, which was published by the International Psychoanalytischer Verlag in Leipzig, Vienna, and Zurich in 1927. This is not to be confused with The Function of the Orgasm (Volume I of The Discovery of the Orgone) published in 1942 by the Orgone Institute Press in New York.

Footnotes

1. For the sake of clarity, the orgastic disturbances are depicted graphically

2. The test from here to the conclusion of Part II is the only portion of the 1927 work incorporated into the later The Function of the Orgasm published in 1942.

3. This urge, which we can identify phenomenologically, is an expression of man's "craving to return to the womb" (Ferenczi's term). In his opinion, this urge is consummated psychically, at least by the male, through penetration by the sperm.

4. We may speculate whether the female child possesses a psychic anlage which corresponds to her later vaginal attitude toward the male. Such questions belong in the chapter on genital theory.