Women Discover Orgasm

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Treatment of Orgasmic Dysfunction

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Treatment of Orgasmic Dysfunction

Despite the so-called sexual revolution, little progress has been made in the reduction of orgasmic dysfunction. Kinsey and his colleagues (1953:513) reported that approximately 10 percent of married American women and 30 percent of sexually active unmarried women never experienced orgasm. Only 40 percent of married women were orgasmic in 90-100 percent of their coital experiences (p. 403). Roughly the same figures were obtained twenty years later in a survey sponsored by the Playboy Foundation (Hunt, 1974) and even more recently by Hite (1976). The apparent stability of these figures for more than two decades testifies to the perseverance of antiquated ideas and the unavailability of effective treatment.

Psychoanalytically Oriented Therapy

In the past, if a woman sought help for anorgasmia, she was generally referred to a therapist who was psychoanalytically oriented. The therapist would treat the anorgasmia as a symptom of underlying problems or conflicts and would propose years of psychoanalysis as a solution (Lorand, 1939). After spending considerable time and money (Bergler, 1947), she might end treatment happier with some aspects of her life but often still not experiencing orgasm. In a study of 61 partially or totally "frigid" women treated four times a week for a minimum of two years, O'Connor and Stern (1972) found that 25 percent of the cases were cured and an additional 35 percent showed some improvement.

The relative ineffectiveness of early analytic treatment may have resulted from a number of factors, including the false distinction made by Freud and his followers between clitoral and vaginal orgasms. Also, by its very nature psychoanalytic therapy puts the woman in an inferior position vis-a-vis the therapist-authority. According to Chesler, "For most women the psychotherapeutic encounter is just one more instance of an unequal relationship, just one more opportunity to be rewarded for expressing distress and to be 'helped' by being (expertly) dominated [1972:373]." This situation makes it even more difficult for a woman to learn to assert herself and to recognize her own sexual needs. However, it must be kept in mind that no other form of therapy available before the 1960s was any more successful in

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reversing female orgasmic dysfunction.

Behavior Therapy

As I have noted, Kinsey laid the groundwork for the important assumption that orgasm is a learned response and that failure to achieve it may be the result of inadequate learning. The behavioral approach to treatment, with its foundation in learning theory, is based on this notion. It argues that some women have learned to feel intense anxiety during sex. Thus, therapy must help the woman unlearn the primary stimulus configuration and relearn a more appropriate configuration, (see Brady, 1966; Lazarus, 1963; Madsen and Ullman, 1967; Wolpe, 1969). This goal is generally accomplished through systematic desensitization and vicarious learning.

Vicarious learning is the process of learning through modeling or through the reports of another. Desensitization is a therapeutic process that involves relaxing the client and, once he or she is relaxed, gradually introducing the phobic stimulus. Self-relaxation is the technique generally used, but drugs such as Brevital, meprobamate, and chlorpromazine (Brady, 1966; Wolpe, 1961)—in fact any stimulus that competes with or is antithetical to the anxiety response can be used. For example, vaginismus, the involuntary, spasmodic contraction of the pelvic musculature prohibiting intercourse, is one reaction to anxiety during sex. To have the woman bear down in the pelvic area as if she were pushing out a tampon is a behavior antithetical to the muscular contractions that produce vaginismus. While she is bearing down, she cannot involuntarily contract.

The technique of desensitization consists first of determining a hierarchy of anxiety-producing behavioral situations. Next, the antithetical response (say, relaxation) is paired with each item in order, beginning with the one producing the least anxiety. Once this item can be presented without arousing anxiety, an item of slightly greater anxiety-producing potential is presented with the antithetical response. The hierarchy is gone through in small, discrete steps until the most anxiety-producing stimulus has been presented. The nine- step masturbation desensitization format developed by Lobitz and LoPiccolo (1972; described on pp. 19-20 of this chapter) is an example of such a program designed to dissipate anxiety related to sexual behavior. A desensitization program can be conducted either by using real-life situations (in vivo) or by having the client imagine the appropriate circumstances.

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For example, an exercise generally used early in conjoint sex therapy (see pp. 189-192) is sensate focus (a localized massage or body rub) because a nonsexual massage is generally less anxiety producing than an explicitly sexual exercise for a couple having sexual problems. If this step appears to be too anxiety producing, the partners may be asked to imagine that they are massaging, or being massaged, by each other before they actually do it.

The Masters and Johnson hierarchy of homework assignments is an example of in vivo desensitization. If the homework assignments are fulfilled only in fantasy, this would represent imaginal desensitization. Both methods can be successfully employed in the treatment of female orgasmic problems. Frequently, the client is encouraged to imagine a particular situation a number of times until she can do so without anxiety; then she attempts to complete the assignment in real life.

Behavioral therapists Lazarus (1963), Brady (1966), Madsen and Ullman (1967), and Wolpe (1969) have reported 86-100 percent success in the treatment of female orgasmic dysfunction. Unfortunately, since the numbers of cases reported were small and procedures varied considerably, rigorous evaluative research was difficult and generalization almost impossible. Lazarus (1963) considered his results (nine successes in a sample of 16) more encouraging than those of any other therapeutic approach at that time, particularly since all of his patients had received some form of treatment for orgasmic problems prior to consulting with him.

While behavior therapy may be effective in cases wherein the manipulation of the behavior is sufficient by itself, it sometimes ignores important intrapsychic conflicts. Also, behavior modification techniques used alone often fail to resolve the anorgasmic symptom in the woman who is experiencing hostility toward her husband.

Conjoint Sex Therapy

Although Masters and Johnson do not call themselves behavioral therapists, their treatment incorporates fundamental behavioral principles. The homework they prescribe is a basic desensitization program to extinguish performance anxiety, and their male-female team of therapists provides vicarious learning through modeling behavior for the clients—a couple—to imitate. Each member of the couple is

given a same-sex ally on the co-therapy team, and the therapists model communication behavior, which can be used by the clients to reinforce each other's positive changes. The dual-sex team also focuses on correcting irrational attitudes and beliefs in an educational and nonjudgmental manner. Conjoint therapy has the additional advantage of permitting the therapists to observe the couple's interactional and communication system directly and to intervene as necessary.

Masters and Johnson reported that of a sample of 193 women who had never experienced orgasm 16.6 percent totally failed to become orgasmic after two weeks of treatment; 22.8 percent of 149 women who were either anorgasmic with masturbation or with coitus, or infrequently or inconsistently orgasmic by these means, also totally failed to become orgasmic. The remainder of the women were successful to some degree (1970:314). Couples with serious marital or psychological difficulties in addition to the sexual problem were not accepted for treatment. Though this screening procedure probably increased positive results, this is offset by the fact that their goal of coital orgasm is now beginning to be viewed as not physiologically realistic for many women. As Kaplan noted, and as my research has corroborated: "The woman who does not reach orgasm on coitus, but is otherwise responsive . . . may represent a normal variant of female sexuality [1974:374]."

Though conjoint therapy provides important information regarding the couple's relationship, information not easily acquired by seeing only one member, there are obvious limitations with the Masters and Johnson approach. It precludes the treatment of women without regular sexual partners and of women whose partners are unwilling to participate in treatment. Also, because two therapists are required, this form of treatment is very costly in terms of therapist time and monetary expense to the clients.

Masturbation Desensitization

Although Masters and Johnson do not rely on masturbation as a learning technique, others have adapted their methods to include masturbation as a way for a woman to experience her first orgasm before having her partner control the stimulation. Lobitz and LoPiccolo (1972) developed a nine-step masturbation desensitization program for women who had never experienced orgasm by any means. The women practice each step until they have successfully completed it before proceeding to the next

step.

Step l:	Nude bath examination; genital examination; Kegel exercises (Kegel, 1952).
Step 2:	Tactile as well as visual genital exploration with no expectation of arousal.
Step 3:	Tactile and visual genital exploration with the object of locating areas that produce pleasurable feelings when stimulated.
Step 4:	Manual masturbation of the areas identified as pleasurable.
Step 5:	Increased duration and intensity of the masturbation if no orgasm occurred in step 4.
Step 6:	Masturbation with a vibrator if no orgasm occurred as the result of step 5.
Step 7:	After orgasm has occurred through masturbation, the husband observes the wife masturbating.
Step 8:	The husband stimulates the wife in the manner she demonstrated in step 7.
Step 9:	Once orgasm occurs in step 8, the husband stimulates his wife's genitals manually or with a vibrator during intercourse.

Lobitz and LoPiccolo developed a coordinated program of working with the woman individually on masturbation while working with the couple conjointly on related sexual and communication issues. They reported 100 percent success in a sample of three women, the slowest of whom required three months to achieve orgasm through masturbation. This program appeared to have considerable potential; however, they did not make it available to unattached females, and it was as costly as more traditional sex therapy.

The Preorgasmic Group Process

A new approach to the treatment of the anorgasmic woman seemed to be needed—one that would be available to women regardless of their relationship status; one that was short-term, relatively inexpensive, and economical in regard to therapist time so that a large number of women could benefit; yet one that could be tailored to the unique needs of each woman. The preorgasmic[1h4]

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