A Comparison of Systematic Desensitization and Directed Masturbation in the Treatment of Primary Orgasmic Dysfunction in Females

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Abstract

Thirty subjects seeking treatment for primary inorgasmia accompanied by sexual anxiety or aversion were assigned to one of three groups: systematic desensitization (SD), directed masturbation (DM), or waiting list control (WL). Following treatment, subjects were retested, and the WL group then received directed masturbation treatment. A third testing constituted a follow-up for the SD and DM groups and a posttreatment testing for the WL. Both treatments were equally effective in improving subjects' sexual self-acceptance and increasing sexual pleasure. Changes in anxiety were negligible; however, sexual arousal and orgasm for DM and WL subjects increased. The gains of the WL group not only replicated the findings of the DM group but also were of greater magnitude.

Despite advances in the treatment of sexual dysfunction, substantial numbers of women continue to experience general sexual dissatisfaction or specific difficulty with orgasm. The incidence of primary orgasmic dysfunction alone ranges from 7% to 15%. However, when women enter treatment, behavioral sex therapy models have resulted in significant improvements in functioning and changes in orgasmic status.

The two most widely used behavioral treatment choices for alleviating primary orgasmic dysfunction are systematic desensitization and directed masturbation. During the last 20 years, there have been numerous demonstrations of the efficacy of systematic desensitization for female sexual dysfunction. Reductions in sexual anxiety are consistently reported by women receiving systematic desensitization treatment; however, change in orgasmic status is variable. Roughly 75% of subjects experience orgasm during treatment or shortly afterward when seen individually, but lower estimates of changes are found for group treatment designs. A newer treatment for primary inorgasmia has been to use graduated masturbation exercises. Initially there was correlational support for this technique, and recent controlled investigations have confirmed its efficacy and examined such variables as session spacing, partner involvement, and group treatment formats.

The present investigation examined the relative efficacy of these treatments in alleviating primary inorgasmia. Subjects were screened, and groups were equated on relevant demographic variables which covary with outcome. Group treatment was offered to optimally utilize therapist time, but group size was kept small (five members per group) to ensure individualization. A broad-band assessment strategy was used to assess change in heterosexual anxiety and dissatisfaction, sexual self-acceptance, pleasure, and arousal. A waiting list control

group assessed change in these areas only from the expectation of future treatment. Directed masturbation treatment was subsequently provided to the control subjects, which provided an additional comparison with those subjects who did not wait for treatment. Thus, the investigation offered a comparison between the two treatment choices and a replication of the effects of directed masturbation treatment.

Method

Thirty primary nonorgasmic female subjects were selected from 70 applicants. The women ranged in age from 19 to 42 years and included high school graduates and those with advanced degrees. Two fifth- and sixth-year female psychology graduate students with extensive clinical experience served as therapists. Each therapist conducted both treatments.

One week prior to the start of treatment, subjects were pretested with the assessment battery, which included LoPiccolo and Steger's (1974) Sexual Interaction Inventory (SII), the Bentler (1968) Heterosexual Behavior Hierarchy (HBH), and the Hoon, Hoon, and Wincze (1976) Sexual Arousal Inventory (SAI). On the basis of these scores, subjects were rank ordered, randomly distributed from stratified blocks, and assigned to one of the three groups. The same procedure was used for subdividing the groups to create five-person treatment groups for each therapist.

All treatment groups met twice weekly for 11/2-hr, sessions for 5 weeks. Systematic desensitization (SD) treatment followed five stages: explanation of treatment rationale, progressive relaxation training, hierarchy construction, SD proper, and in vivo exercises. Directed masturbation (DM) treatment involved completion of a series of extratherapy sensuality and masturbatory activities including visual and tactual genital and whole body examination, focused genital exploration and touching, and continued masturbation supplemented with erotica. Following treatment termination, all subjects were retested, and DM treatment was then offered to the waiting list (WL) control group. One week following treatment termination for the WL women, all subjects were tested a third time, which constituted a 6-week follow-up for the SD and DM groups and a posttreatment assessment for the WL group.

Results

Analysis of variance (ANOVA) models were used to calculate the majority of the results. The levels of analysis included experimental condition (DM, SD, and WL) and time (pretreatment, posttreatment, and follow-up). One-way ANOVAs for pretest data indicated no differences between any group on any variable and for posttest data indicated no significant differences between subgroups as a function of therapists.

The SII female scales were each entered into 3×3 repeated measures ANOVAs. These analyses indicated significant change as a result of time on all scales except dissatisfaction. Noteworthy were the Experimental Condition $\times$ Time interactions, indicating differential changes between groups. First, there was a significant interaction for the SII self-acceptance scale, $F(4, 27) = 2.75$, $p < .04$. Multiple comparisons indicated that the DM group changed significantly ($p < .05$) at posttreatment; however, this gain was not maintained at follow-up. In contrast, the SD group changed significantly at posttreatment and also maintained the gains. As expected, there were no changes at posttreatment for the WL group but significant changes after treatment at follow-up. Second, the analysis for the SII pleasure scale also approached standard significance levels, $F(4, 27) = 2.28$, $p = .072$. The multiple comparisons indicated that changes for the DM group approached significance at posttreatment but not at follow-up. Again in contrast, the SD group changed significantly at posttreatment and maintained and slightly improved upon these

gains at follow-up. Again as expected, there were no changes for the WL group at posttreatment but significant changes at follow-up.

The HBH analyses indicated significant time changes for the masturbation items, $F(2, 27) = 9.85$, $p < .0002$, and change approaching standard significance levels for the heterosexual items, $F(2, 27) = 2.79$, $p = .07$. More important, however, is the significant Experimental Condition $\times$ Time interaction for the masturbation SBH score, $F(4, 27) = 4.28$, $p = .005$. Multiple comparisons indicated that the DM group reported being significantly less anxious about masturbation following treatment, and this change was maintained and slightly improved upon at follow-up. Neither the SD nor the WL groups reported being less anxious about masturbation at the time of post-testing. After the WL group received directed masturbation treatment, significant reductions in anxiety were reported.

The SAI analyses indicated a significant interaction, $F(4, 27) = 2.99$, $p < .03$. Multiple comparison analysis indicated that the DM group reported being significantly more sexually aroused to a variety of erotic experiences following treatment; however, these gains were not maintained at follow-up. The SD group reported no significant change in sexual arousal at posttreatment or follow-up. As expected, the WL group showed no change at posttreatment testing but significant increases in arousal at follow-up.

At the conclusion of treatment, the SD group had one orgasmic member, and the DM group had two. However, for these two women, orgasm was more regular, and for one woman, it occurred with a variety of types of stimulation. During the waiting period, one WL subject also became orgasmic. At the time of follow-up, two additional DM subjects had become orgasmic, and the abilities of the previous ones had improved. Following directed masturbation treatment for the WL group, six of the subjects, a number equaling the total number of women becoming orgasmic at earlier points in time, were orgasmic.

Discussion

The treatment comparison findings might be usefully viewed in the context of previous investigations. First, these data are unique in the demonstration of comparable effectiveness in increasing actual pleasure during heterosexual sexual activities. Second, the absence of change on the anxiety reduction measure was surprising. However, while all subjects were nonorgasmic, they represented a continuum of those identifying sexual anxiety as instrumental. Thus, a more stringent test would be to compare groups of subjects with different levels of sexual anxiety. Third, more generalized gains as reflected on the SAI were found with the directed masturbation treatment. Fourth, as the previous group treatment literature had indicated, directed masturbation was superior in enabling subjects to become orgasmic.

In comparing the outcome of the groups that both received directed masturbation treatment, the WL findings not only replicated those of the DM group but were also of greater magnitude. Although these data may simply reflect response variability, it may also be the case that waiting for some forms of therapy may enhance their subsequent effectiveness. If this is the case, it could be a general phenomenon or a circumstance unique to sex therapy. The latter case is suggested from the clinical finding of considerable stress, embarrassment, and thought that many clients experience when entering sex therapy. If clients then experience a delay between being accepted for treatment and receiving it, this may only heighten their motivation rather than dampen it. It is hoped that there will be continued investigation to separate the fact from the artifact of this new finding.

Acknowledgments

References

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