TREATMENT OF PREORGASMIC WOMEN UTILIZING
GROUP THREAPY AND HOME-BASED TRAINING

THESIS

Presented to the Graduate Council of the
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Fulfillment of the Requirements

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MASTER OF SCIENCE

By

Carolyn Fillis Cole, B. P. A.
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There have been various approaches to the treatment of nonorgasmic women, including psychoanalysis, desensitization, relaxation, masturbation, and group therapy. The present study was conducted to examine the efficacy of group therapy combined with home-based training in the treatment of primary nonorgasmic women. A no-treatment control group was also employed.

Treatment consisted of two weekly 1½-hour group sessions for 5 weeks. Educative processes were employed, such as detailed information on physiology of female sexual response. Structured homework exercises were also utilized, such as masturbatory techniques, role-playing orgasm, strengthening vaginal muscles, and assertiveness training in sexual and nonsexual situations. Results indicated an 88% success rate in the treatment group and no change in the control group.
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TREATMENT OF PREORGASMIC WOMEN UTILIZING

GROUP THERAPY AND HOME-BASED TRAINING

Orgasmic dysfunctions in women have often been labeled with the global term frigidity. This term has been used to describe a general lack of sexual arousal regardless of cause, inability to maintain a certain level of arousal during sexual activity, or inability to reach orgasm although a high state of arousal may have been maintained (Fink, 1974; Fisher, 1973; Polatin, 1970). Orgasmic difficulty in the female has been divided into two categories: primary and situational (Masters & Johnson, 1970). Primary orgasmic dysfunction (currently referred to as the preorgasmic phenomenon) is present when a woman has never achieved an orgasm although she may have experienced erotic feelings. Situational orgasmic dysfunction occurs when a woman has experienced at least one orgasm during her lifetime (Kaplan, 1974). Hypothesized factors accounting for orgasmic dysfunctions are varied.

Some physiologic determinants of primary orgasmic dysfunctions that have been cited include weak vaginal muscles or inhibition of the voluntary reflex action of certain pelvic muscles. Kegel (1952), in his early studies on the sexual function of the pubococcygeus muscle, postulated that the inability to reach orgasm was mainly due to weak vaginal
muscles. Kaplan (1974) stated that an inhibition of the voluntary reflex action of the pubococygeus, perineal, and uterine muscles provided one basis for sexual inadequacy. A paucity of research leaves the etiology of nonphysiologically related orgasmic dysfunction somewhat unclear. Freud (1938) cited hostility and parental attachments as precursors to female sexual inadequacy. Wolpe (1967) stated that sexual dysfunction is an unadaptive anxiety-response pattern which may have originated from nonsexual negative stimuli such as antisexual religious upbringing. Sexual inhibition leading to orgasmic dysfunction may, according to Polatin (1970), result in fear-anxiety stemming from a traumatic experience, hostility-aggression resulting from a need to control all emotions, or conflict-guilt resulting from abnormal parental attachments. Lazarus (1971) believed that a woman's sexual problems stem mainly from psychological determinants such as a reaction to a traumatic event. Masters and Johnson (1970), Pettit (1970), and Kaplan (1974) agreed that lack of adequate communication between a woman and her sexual partner has prevented many women from obtaining sexual gratification. Bardwick (1971), Sherfey (1973), Barbach (1975), and Graber and Graber (1976) pointed out that many of women's sexual dysfunctions are a product of ignorance of what an orgasm feels like and how they may achieve it. There appears to be little agreement as to specific etiology of nonphysiologic causes of primary
orgasmic dysfunction. The cause of such a disorder may be multi-determined, based on individual symptomatology.

Traditional psychotherapy has been the most prevalent treatment, but has not resulted in a high success rate (Masters & Johnson, 1970; Obler, 1973). This mode of treatment is also very lengthy (Kaplan, 1974). A paucity of adequate research into the nature of orgasmic dysfunction existed until Masters and Johnson began their innovative work in sex research. Their work also led to the development of more empirically based approaches to treatment, most notably among behavior therapies. These therapies, such as systematic desensitization, relaxation, masturbation, and supportive group therapy, have focused on orgasmic inadequacy as a learned phenomenon.

Systematic desensitization as a treatment procedure has been used quite successfully with preorgasmic women. This treatment modality includes constructing a hierarchy of stimulus items ordered from least to most anxiety provoking. While deeply relaxed the subject imagines confrontation with one hierarchy item. When the item can be visualized without discomfort, the subject proceeds to the next item until all can be fantasized comfortably. Lazarus (1971) cited typical hierarchy items for sexually dysfunctional women: embracing, kissing, being fondled, mild petting, undressing, foreplay in the nude, awareness of husband's erection, moving into position for insertion,
intromission, changing positions during coitus. Lazarus (1963) treated a nonorgasmic woman utilizing systematic desensitization methods. The first two hierarchy items (21. Dancing with and embracing husband while both fully clothed; 20. Being kissed on cheeks and forehead) required over 20 presentations before criterion was met (a 30-second exposure without signaling discomfort). After 36 treatment sessions the subject was able to climax. Follow-up 1 year later indicated that she was still orgasmic. Brady (1966) injected a 1% solution of Brevital as an aid to relaxing subjects. Then systematic desensitization hierarchy items were presented to five nonorgasmic women. An average of 11 sessions resulted in orgasmic success for four subjects.

Madsen and Ullman (1967) modified the procedure of systematic desensitization by having the husband present during therapy and having him introduce some hierarchy items. After five treatment sessions the woman experienced her first orgasm. After 12 sessions she was consistently orgasmic. A 9-month follow-up indicated frequency and satisfaction with sexual activity continued at the same level of success. The authors hypothesized that the husband's presence facilitated generalization of treatment effects to environments outside the therapeutic situation. Wolpe (1967) reported successful treatment of a woman diagnosed as nonorgasmic employing systematic desensitization methods. After 20 treatment sessions she was able to
achieve orgasm in 50% of her sexual encounters. Kraft and Al-Issa (1967) relaxed their female subject by hypnosis. They then presented a 26-item hierarchy over 84 sessions, each lasting 1½ hours. They reported success in her achieving orgasm. In addition, she produced reduced neuroticism and anxiety scores on pre- and posttreatment administration of the Maudsley Personality Inventory and Taylor Manifest Anxiety Scale. Lazarus (1971) treated a preorgasmic woman by establishing an eight-item hierarchy focusing on "bodily criticism." She developed a poor body image after a barrage of adverse comments by her husband. After only three sessions, she was able to accept and enjoy sexual advances.

Ince (1973) employed systematic desensitization techniques in the treatment of situational orgasmic dysfunction in a female. After 4 weeks of treatment (one 30-minute session per weekday), she was able to achieve orgasm upon intercourse.

Obler (1973) compared systematic desensitization employing deep muscle relaxation, graphic aids, and assertive training with traditional group therapy. The first treatment group was trained in deep muscle relaxation and a hierarchy of anxiety-producing sexual items was established. Then slides and films of anxiety-producing sexual encounters were introduced. Finally, assertive training to promote confidence in relating socially to the opposite sex was employed. The second treatment group engaged in traditional
group therapy, focusing on sexual anxieties. After 4 weeks of treatment the success rate for women treated by systematic desensitization methods was 42%, as compared with 3% for those involved in group therapy. Caird and Wincze (1974) utilized video tapes of sexual activity to reduce anxiety experienced by a situationally orgasmic dysfunctional woman. After relaxation training the subject viewed films of predetermined sexually anxiety-provoking situations. When the subject signaled discomfort, the film was stopped and relaxation reintroduced. After 2 weeks of treatment in which she viewed 50 films, the subject was able to reach orgasm upon intercourse.

Another treatment modality employed with pre-orgasmic women is masturbation. Psychoanalytic theory assumes that women who orgasm by clitoral manipulation are neurotic and immature, and posits that orgasm during intercourse is elusive for all but very well-adjusted and mature women (Bardwick, 1971; Lorand, 1939; Sherfey, 1973). However, Kinsey (1953) noted that among women who masturbated to orgasm only 13 to 16% were totally unresponsive during intercourse, as compared with 31 to 37% unresponding women among those who did not masturbate to orgasm. In further defense of masturbation as a satisfactory and natural sexual release, Masters and Johnson (1970) and Weinberg (1976) noted that masturbation tends to promote the orgasmic response in females. They also found that women who had difficulty in
obtaining orgasm through sexual intercourse could readily reach orgasm through masturbation. Lobitz and LoPiccolo (1972) developed a nine-step masturbation program for women. They treated 13 primary and three situationally orgasmic dysfunctional women. After a predetermined length of 15 therapy sessions, a 100% success rate was reported. A 6-month follow-up contact revealed no relapses. Masturbatory training in the treatment of a preorgasmic female was employed by Reisinger (1974). Three treatment phases were used: masturbation with sexual fantasies; masturbation with fantasy while viewing erotic films; and a return to fantasy only. After 36 sessions, the subject was able to masturbate to orgasm regularly. A 6-month follow-up contact indicated the rate of orgasm remained stable. Kaplan (1974) treated a primary orgasmic dysfunctional female by masturbatory techniques involving fantasy and an electric vibrator. The subject set her own schedule of treatment sessions and after 4 weeks was able to achieve orgasm through masturbation. An additional year of "insight therapy" was employed before she was able to climax during intercourse.

Various other treatment procedures have been utilized with nonorgasmic women. Lazarus (1971) implemented aversion-relief therapy in the treatment of a sexually unresponsive woman. Electric current was administered to her hand until she focused her attention on pictures of nude men, whereupon shock was terminated. More erotic
pictures were introduced in subsequent sessions. After 12 treatment sessions, the subject was able to achieve coital orgasm. Lehman (1974) employed slides depicting a woman engaged in various self-stimulation behaviors. The subjects practiced the same behaviors. Once orgasm was achieved, their partners were phased into the situation until the subjects were able to climax upon penile-vaginal stimulation. Of the five women treated, two became orgasmic upon intercourse.

The preceding treatment modalities were conducted on a one-to-one, subject-to-therapist, basis. A seemingly more efficient treatment program involving group therapy with preorgasmic women was developed by Barbach (1975). Treatment employed modified techniques developed by Masters and Johnson (1970) and Lobitz and LoPiccolo (1972). Groups of five to seven women met with two female cotherapists for 1½ hours twice a week. Treatment lasted 5 weeks. Weekly homework assignments based on a nine-step masturbation program (Lobitz & LoPiccolo, 1972) were employed. Results indicated a 93% rate of consistent orgasmic activity.

The nature of the preorgasmic phenomenon in women has been the subject of much theory and varied treatment. Too often orgasmic dysfunction in the female had been labeled with the misnomer frigidity. Whereas frigidity implies a total lack of erotic feeling, orgasmic dysfunction may simply be an inhibition of the voluntary reflex action of
the pubococcygeus muscle. Psychotherapy had been the traditional treatment modality in the past but was usually unsuccessful. In treating the sexual response as a learned phenomenon, behavior therapies appeared to obtain a high rate of success. The most rapid treatment procedure cited was a combination of group therapy and homework assignments. The present study was undertaken to replicate the efficacy of supportive group therapy in conjunction with home-based training. Supportive group therapy refers to the setting in which the experimenter served an educative and encouraging role rather than a traditional psychotherapeutic one. Unlike previous studies, a systematic method of data collection was employed. A contingency schedule was also utilized to encourage attendance at all treatment sessions. The MMPI, sex history, and medical history inventories (Hartman & Fithian, 1972) were employed to describe the sample. The Rathus Assertiveness Schedule was administered to ascertain level of assertive behavior. In addition, the present study only included primary orgasmic dysfunctional women.

The experimenter hypothesized that women who have never achieved orgasm would become orgasmic through self-stimulation via supportive group therapy and home-based training within 10 treatment sessions.

Method

Subjects

Eighteen subjects were selected from volunteers responding to newspaper and poster advertisements. They were
interviewed and administered a MMPI, sex history, and medical history inventories. Those chosen were women who reported never having had an orgasm. The selected women did not report on the above questionnaire any major physiological or psychological hindrance.

Meeting times were chosen to maximize the number of participants in the experimental group. Five subjects were available for the first treatment group, so a second group was conducted to increase the number of experimental subjects. Four subjects were available for the second treatment group. Control subjects were those women who could not meet during selected treatment times. Five subjects were available for the first control group, and four subjects were available for the second control group.

**Apparatus**

A MMPI, Form R (Psychological Corporation, 1970), a sexual history inventory (Appendix A), medical history inventory (Appendix B), and the Rathus Assertiveness Schedule (Appendix C) were administered to prospective subjects. A plastic battery-operated vibrator (Montgomery Wards Model 53C 20604) was suggested to facilitate arousal in some cases.

**Procedure**

Two female doctoral students in counseling psychology conducted the first treatment group. Only one of these therapists, the experimenter, conducted the second treatment group. Control subjects received no treatment.
Treatment subjects signed a contract (Appendix D) agreeing to attend all 10 treatment sessions. Preselected valuables (books, jewelry, checks) were deposited with the experimenter. A predetermined valuable was returned for each consecutive treatment session attended. An informed consent form (Appendix E) was signed by all subjects. Treatment sessions were 2 hours in length, twice a week, for five consecutive weeks. Homework assignments were given each week. Subjects recorded the assignment completed each day and the level of sexual arousal attained (Appendix F). This enabled the experimenter to evaluate compliance with the treatment regime and progress toward increasing sensual arousal. Upon distributing the data sheets, the following instructions were given.

You are to complete the data sheets every day and bring them to the group sessions. On the sheets describe the practice done and the time of day. Be specific in describing the activity in which you engaged. Instead of "Touched body" record "Touched arms lightly; pinched nipples; stroked leg roughly; etc." Also record the amount of time spent with each activity. In addition, record the amount of arousal felt with each activity on a scale of 1-5; 1 representing no sensual feeling; 2 representing some sensual feelings; 3 representing mild sensual feelings;
4 representing moderate sensual feelings; and 5 representing extreme sensual feelings. If orgasm occurred, record the amount of time spent masturbating prior to each orgasm.

Each treatment session followed a prescribed format with some leeway to allow for dealing with individual homework assignment difficulties. The format of the sessions was a modification of a program developed by Kerr (1976). The procedure was as follows.

Session 1. Each woman presented her sexual history to the group. This enabled the group to be more aware of and sensitive toward their and others' difficulties. A public contract with the group was made, stating that each woman would attend every meeting or phone if she could not make it, be honest in reporting progress or lack of it, and devote 1 hour daily toward homework assignments.

As many women are uninformed as to the anatomy of their genitalia, the therapists displayed an illustration of female genitalia and labeled the parts. Also, the women were instructed not to have an orgasm for at least the first four sessions, although they might have sexual encounters with a partner. This request was intended to alleviate pressure for them to attain climax.

Homework--Session 1. Subjects were to engage in the homework assignments (broken up into segments, if preferred) for 1 hour daily.
The women were instructed to perform the Kegel exercises three times per day. They were also to take a warm bath and pay attention to tactile sensations when bathing. After drying off, the women were to explore themselves visually and tactilely in front of a mirror, paying attention to their body image and sensations. As the exercise was for body awareness and not arousal, the genitals were not to be a focal point.

Session 2. Each woman reported on her homework and what her sensations were. If she did not complete her homework, she was queried on treatment obstacles. During this session the therapists dispelled myths concerning female orgasms and presented available current information as to the nature of orgasm. This session also introduced detailed information on anatomy and physiology of female sexuality. Information on hygiene and birth control was also presented.

Homework--Session 2. Again, the women were to take a long bath, focusing on tactile and visual sensations and do the Kegel exercises. This time more time was to be spent in exploring the genital area. Identification of the genitalia was to be done in front of a mirror.

As most women who have difficulty climaxing also have difficulty in asserting themselves (Lobitz & LoPiccolo, 1972), exercises in assertiveness were assigned. The women were instructed to engage in saying Yes and No to
three events outside the sexual area which the women would otherwise refuse or agree to. For example, if a woman's partner wished her to fix a meal when she did not want to, instead of acquiescing she would allow herself to say no. After these exercises the women were to say Yes and No to three things within the sexual area. For example, telling their partners to stroke them in a new way would constitute a Yes. These exercises enabled the women to practice control in asking for what they wanted and refusing what they did not want.

**Session 3.** Homework assignments were discussed.

**Homework--Session 3.** After bathing, the women were to stroke and stimulate themselves into a low state of arousal. Then they were to stimulate their genitals for 15-20 minutes, but not try to climax. If they should reach orgasm they were to enjoy it, but they were not to pressure themselves. The women were to pay attention to which strokes they liked best and try some different ones.

**Session 4.** During discussion of the homework each woman described her feelings (or lack) of arousal when stroking different parts of her body. Problems with masturbation were also discussed. The women were encouraged in the use of fantasy during sexual encounters. This was another way of demonstrating a certain amount of control over the situation. During this session the therapists discussed different masturbatory techniques, explaining
that some authors report the average length of time from no arousal to orgasm is about 45 minutes.

Homework--Session 4. The women were instructed to masturbate to an increased intensity of arousal. They were to stimulate themselves, then stop abruptly, wait a few minutes, and start again. (This technique is similar to the Masters and Johnson successful treatment method for impotence.) The women were given "permission" to have an orgasm, but the emphasis was still on pleasure and arousal, not orgasm.

Session 5. Each woman reported on her homework assignment. She summarized what touches, rhythms, and techniques she used. If she appeared to reach the plateau stage and stopped short of orgasm, her reasons for doing this were explored.

Homework--Session 5. The women who did not experience orgasm during the fourth week were encouraged to increase the intensity and duration of their masturbatory exercises. They were reassured that 30 minutes was not an unusual length of time before any feelings of arousal occurred. The women were also encouraged to use erotic fantasy (Friday, 1975) and erotic reading (Nin, 1977) or visual material (e.g., *Playgirl*) to enhance arousal. The women who did reach orgasm were instructed to keep doing their exercises and explore different techniques of masturbation.
Session 6. The homework assignments were reviewed. Any specific problem areas were carefully explored.

Homework--Session 6. The women who had not reached orgasm by this session were encouraged in the use of a vibrator. They were advised to purchase a battery-operated model (Montgomery Wards Model 53C 20604) to insure maximum flexibility of movement.

LoPiccolo and Lobitz (1972) hypothesized that women who are nonorgasmic at this stage are usually embarrassed or frightened of having an orgasm. These feelings may be tied in with fear of loss of control. Therefore, these women were instructed to desensitize themselves to the act of orgasm by role-playing the experience when alone at home.

Women who had experienced orgasm by this session were instructed to masturbate to orgasm with an object inserted at the entrance of their vagina. This consisted of their partner's finger, penis, a dildo, or any other nonabrasive object. Achieving orgasm in this way enabled women to become desensitized to vaginal containment.

Session 7. Homework was reviewed and problem areas were discussed. The behaviors of women who had not climaxed by this session were carefully reviewed as to any ways in which they may have sabotaged treatment: for example, not doing their 1-hour daily homework or maintaining a fear of orgasm.
Homework—Session 7. Women who had not climaxed were encouraged in further use of the vibrator and erotic visual aids such as Playgirl magazine. They were also encouraged to make noises during sex play to facilitate overcoming embarrassment.

Women who were orgasmic were instructed to masturbate to orgasm in the presence of their partners. This not only enabled the partner to learn which strokes the woman preferred, but also served to desensitize her to displaying arousal and orgasm in front of her partner. Women without partners were encouraged to explore different masturbating techniques.

Session 8. Homework was reviewed and any specific problem areas discussed. Women who were not orgasmic were requested to demonstrate their masturbating technique. This was done on their closed fist. They were to be specific in labeling their genitalia and method of stroking (Kerr, 1977). Such a demonstration enabled the therapists to judge the aspects of the women's technique of self-stimulation.

Homework—Session 8. Suggestions were offered to enhance the nonorgasmic women's masturbatory techniques. In addition, they were encouraged to prolong the use of the vibrator. Partner involvement was introduced for the four women who had available partners and were orgasmic. Each woman was to have her partner stroke and caress her in any
way she liked. Then her partner was to masturbate the woman until she was ready to stop. There was no demand for orgasm. For nonorgasmic women continued masturbation in their preferred way, in addition to practicing assertive behavior outside of the sexual area, was encouraged.

**Session 9.** Work with the partner was discussed. Non-cooperative partners or a woman's reluctance to ask for what she wanted were reviewed. Any specific area that the two orgasmic women without partners wanted to work on, such as more assertive training, was discussed. Further exploration of sexual arousal techniques was employed with the four nonorgasmic subjects.

**Homework--Session 9.** For the seven women with partners intercourse was suggested. For maximum access to her genitalia by her partner, the women were instructed to assume the female superior or lateral coital positions (Kaplan, 1974). The women were given "permission" to have orgasms, but the focal point was still on arousal and pleasure. For women without partners varying techniques of self-pleasuring were encouraged.

**Session 10.** This session was used for review and closure. The therapists elicited statements concerning self-concept and contrasted these with earlier reports. Any increases in positive self-statements were noted, and group members reported any heightened positive attitudes about their sexuality and self-esteem. The four women who
wanted to orgasm with their partners were encouraged to enter a couple therapy focusing on orgasm during intercourse.

Following completion of the first treatment group, data from control subjects concerning frequency of sexual activity and incidence of orgasm were collected via a telephone interview by the experimenter. The same procedure was employed, following completion of the second treatment group.

Results

Characteristics of the Sample

Experimental subjects ranged in age from 19 to 48 years (\( \bar{X} = 25.1, \ SD = 9.17 \)). Control subjects ranged in age from 19 to 36 years (\( \bar{X} = 23.89, \ SD = 6.41 \)). Marital status of subjects indicated that six members of the experimental group and seven members of the control group were single; two members of the experimental and control groups were married and one member of the experimental group was divorced. The experimental group ranged in total education from 13 to 16 years (\( \bar{X} = 14.89, \ SD = 1.17 \)). The control group ranged in total education from 14 to 20 years (\( \bar{X} = 15.44, \ SD = 1.88 \)). Six members of both the experimental and control groups were currently enrolled in school. Reports of religious affiliation indicated that six members of the experimental and control groups were Protestant; two members of the experimental and three of the control group were Catholic; one member of the experimental group was "other;" no subjects reported being Jewish.
The subjects' T-scale scores on the MMPI fell within a normal range (see Table 1). A t-test exhibited no significant difference between groups on any of the 13 scales.

Table 1

Pretreatment MMPI Scores for Treatment and Control Subjects

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Scores on the Rathus Assertiveness Schedule indicated that the experimental group was slightly nonassertive ($\bar{X} = 1.67; \text{SD} = 25.66$) and the control group was slightly assertive ($\bar{X} = 2.0; \text{SD} = 17.33$). A $t$-test of significance indicated no significant differences between groups ($t = -0.36; p < .73$).

Prior to implementation of treatment there were no significant differences between treatment and control groups in frequency of masturbatory and coital behavior per week or incidence of orgasm. The frequency of masturbation per week for treatment subjects was $\bar{X} = .11, \text{SD} = .33$; for control subjects $\bar{X} = .44, \text{SD} = .73$ ($t = -1.25; p < .24$). Frequency of intercourse per week for experimental subjects was $\bar{X} = 2.50, \text{SD} = 1.58$; for control subjects frequency of intercourse per week was $\bar{X} = 2.50, \text{SD} = 1.58$ ($t = .1, p < 1.0$). Orgasmic activity during masturbation or intercourse did not differ among groups prior to treatment, as no subjects in either group had ever experienced orgasm ($\bar{X} = 0.0, \text{SD} = 0.0$).
Treatment Effects

A $x^2$ test was employed to ascertain differences in frequency of masturbation and intercourse between groups after treatment. Frequency of weekly masturbatory behavior increased significantly among experimental subjects ($\bar{X} = 6.78, \text{SD} = .27$) as opposed to control subjects ($\bar{X} = .44, \text{SD} = .73$); ($x^2 = 15, p < .0006$). No significant differences in weekly coital behavior were found among experimental ($\bar{X} = 4.17, \text{SD} = 2.0$) and control groups ($\bar{X} = 2.39, \text{SD} = 1.58$); ($x^2 = 3.06, p < .21$). A $2 \times 2$ Fisher's Exact Probability test of significance was employed to ascertain differences in incidence of orgasm between groups. Significant differences in presence of orgasm with masturbation were found between experimental ($\bar{X} = 6.45, \text{SD} = 3.81$) and control groups ($\bar{X} = 0.0, \text{SD} = 0.0$); ($p < .0002$). One experimental subject reported posttreatment coital orgasm ($\bar{X} = 1.0, \text{SD} = 1.58$); ($p < .10$).

Discussion

The results of the study support the assumption that supportive group therapy and home-based training is an efficient and effective means of enabling women to achieve orgasm. Although the results are encouraging, they should be viewed with caution. The groups were not formed by usual random assignment; rather, time factors (day and time of meetings) played a major role in appointment of subjects to groups. However, no significant differences were found
between groups on the pretreatment measures of the MMPI, Rathus Assertiveness Schedule, incidence of sexual activity, and incidence of orgasm. Perhaps employing time of day for group assignment is essentially equivalent to random assignment. Self-report was the sole method of establishing frequency of sexual activity and incidence of orgasm. The number of variables introduced impeded identification of the most effective ones. Experimenter bias toward successful completion of criteria also may have affected results.

The day and time of meeting for the experimental groups were chosen by the experimenter to allow for maximum number of participants; therefore, only those who could meet on the preferred days were selected. The first group, led by the experimenter and another female, met on Monday and Wednesday evenings from 7:00 until 9:00. The second group, led only by the experimenter, met on Monday and Thursday evenings from 6:30 to 8:30. There appeared to be no significant effect for one vs. two group leaders.

Eight subjects in the experimental group reported increased sexual activity and presence of orgasm by the end of treatment. One subject reported having had orgasmed during intercourse. These results were declared during treatment sessions. Measurement of sexual activity and orgasm by monitoring physiological changes during sexual activity in a laboratory setting would have been a desirable addition to the self-report measure.
One difficulty in combining many variables during treatment is in ascertaining the efficacy of each separate variable. In Session 1 the women were instructed in the procedure of exercising the pubococcygeal muscle developed by Kegel. Kegel himself reported that many of his patients reported orgasmic success after employing this exercise. Research into the nature and effect of such exercise could be beneficial. During Session 1 the subjects were instructed not to have orgasm. Whereas this injunction was intended to relieve pressure to achieve, a paradoxical effect could have taken place wherein subjects strove to overcome the prohibition (Haley, 1976). Studies involving paradoxical intention in the realm of sexual behavior may provide useful information. Also, in this session the subjects were encouraged to engage in body awareness exercises. Becoming familiar with their bodies may have had a profound effect on subsequent sexual behavior. Further investigation into this area seems warranted.

Two additional procedures were introduced during Session 2. Detailed information on the anatomy and physiology of female sexuality, hygiene, and birth control was presented. This may have relieved many fears the subjects may have had about sex, thereby allowing them to adopt a more relaxed attitude about sexuality. Research into the area of dissemination of information on sexual behavior may produce useful results. The subjects were also urged to engage in assertive
exercises in sexual and nonsexual situations. Practicing these behaviors may have enabled the subjects to become more comfortable with their sexuality. Investigation into the efficacy of such training may be beneficial.

During Sessions 4 and 5 use of erotic material (fantasy, visual, and reading) was suggested. All subjects reported never engaging in fantasy during sexual activity; therefore, being encouraged to do so may have alleviated some inhibitions. Studying the effect of erotic fantasy with anorgasmic women may provide interesting results.

Use of a vibrator and role-playing orgasm were introduced during Session 6. Two subjects who had not climaxed by this session reported having done so with their initial use of the vibrator. (By Session 10 they were able to have orgasm manually.) The efficacy of employing a vibrator in the treatment of inorgasmic women seems to be a valuable area of study. Role-playing orgasm may have desensitized women to various aspects of sexual activity. Further investigation into this variable seems warranted. During this session the subjects who were orgasmic were instructed to have orgasm with an object in their vagina. This activity may have had a generalizing effect to orgasm during intra-vaginal containment. Research involving generalization may prove beneficial.

Subjects who were orgasmic by Session 7 were encouraged to masturbate to orgasm in front of their partner and
then have their partner masturbate them. This procedure may have had a generalizing effect to having orgasm with their partner. Exploration of this effect could be beneficial.

During Session 9 subjects who were orgasmic were urged to assume the female superior or lateral coital positions in order to provide maximum access to her genitalia and breasts by her partner. Such positions may have increased partner participation and prolonged foreplay, thereby prolonging arousal for the woman. The effect this may have had on orgasmic activity seems to be a useful area of study.

Demand characteristics of the experiment may have influenced subjects to report success in order to please both the experimenter and peers. The experimenter was consistently optimistic that all subjects would achieve orgasm. Peer pressure may have also influenced results. In the first group, one subject reported attainment of orgasm by the third session. The other members voiced their congratulations and reported some despondency over "lagging behind." In the second group, two subjects reported hesitating to announce having reached criteria in order to "protect" the others from "public failure."

The results of this study indicate that 88% of the treatment group reported having become orgasmic, whereas no control subject reported such activity. Many variables were introduced during the course of this study. Further research as to which procedural components (or combination)
are the most effective may prove beneficial in employment of efficient and effective treatment of orgasmic difficulties among women.
## Appendix A

**Sexual History Inventory**

### I. Sex Education

When did you first learn about:  

<table>
<thead>
<tr>
<th>Topic</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnancy</td>
<td></td>
</tr>
<tr>
<td>2. Intercourse</td>
<td></td>
</tr>
<tr>
<td>3. Fertilization</td>
<td></td>
</tr>
<tr>
<td>4. Menstruation</td>
<td></td>
</tr>
<tr>
<td>5. Venereal Disease</td>
<td></td>
</tr>
<tr>
<td>6. Contraception</td>
<td></td>
</tr>
<tr>
<td>7. Abortion</td>
<td></td>
</tr>
<tr>
<td>8. Male Erection</td>
<td></td>
</tr>
<tr>
<td>9. First sexual experimentation:</td>
<td></td>
</tr>
<tr>
<td>a. Age</td>
<td></td>
</tr>
<tr>
<td>b. Alone; with others</td>
<td></td>
</tr>
<tr>
<td>c. Activity (doctor, house)</td>
<td></td>
</tr>
<tr>
<td>d. Caught (fear of being caught)</td>
<td></td>
</tr>
<tr>
<td>e. Reactions</td>
<td></td>
</tr>
</tbody>
</table>

10. Parents' contribution to sex education: __________

11. Friends' contribution: ______________________

12. Experience with graphic depictions of sexual activity: ______________________
13. Formal sex education (which grades): ____________

14. Reading: ____________________________________________________________________________
______________________________________________________________________________________

15. Have you ever seen anyone engaged in sexual intercourse? _____ Reaction: __________________________

II. Masturbation

1. Age when first masturbated: _____

2. Reaction: ____________________________________________________________________________

3. Orgasm? ______

4. Why stop? ____________________________________________________________________________

5. Frequency when preteenager; teenager: ____________

6. Frequency now: _________________________________________________________________________

7. Current reactions: _______________________________________________________________________

_____________________________________________________________________________________

8. Fantasize during masturbation? ______

   a. Dominant theme: ______________________________________________________________________

III. Dating

1. Age at first date: _____

2. Frequency of dates before:
   a. kiss: __________
   b. petting: __________
   c. petting to orgasm: __________

3. Age at first intercourse experience: ____________
   a. Reactions: __________________________________________________________________________
   b. Frequency: __________________________________________________________________________

4. No. of pregnancies/Reaction: ______________________________________________________________________
5. No. of abortions/Reaction:______________________________

6. Current partner? _____
a. How attracted?______________________________
b. Why now attracted?______________________________

7. Intercourse with current partner:
a. Frequency per week:______________________________
b. Satisfaction with frequency:______________________________
c. Foreplay--amount:______________________________
d. Satisfaction with foreplay:______________________________

8. Who initiates sex play?______________________________

9. Can you express your sexual desires freely? _____
a. Tell partner what you like/dislike comfortably?_____ b. Does your partner accept this?____

IV. Contraception
1. What methods used?______________________________

2. What method currently using?______________________________

3. Does (has) using contraceptives hamper(ed) sexual activity? _____

V. Orgasm
1. Ever had? _____
a. Frequency:______________________________

2. Situations:______________________________
VI. Siblings
1. Sex, ages:

2. Their attitudes on sexual behavior:

3. Affectionate when young? 

4. Affectionate now? 

VII. Parents' Attitudes
1. Parents' attitudes toward sexual behavior:

2. Describe parents' sex life:

3. Parents affectionate toward one another in public? 

4. Parents affectionate toward children when young? 
   How? 

VIII. Expectations
1. Describe presenting problem:

2. Describe expectations of treatment:

IX. Other Information
1. Please provide other information that might be helpful (such as emotionally or sexually traumatic events):
## Appendix B

### Female Sexological-Medical Form

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>I.D. No.</td>
<td>Age</td>
</tr>
<tr>
<td>Occupation</td>
<td>Education</td>
</tr>
<tr>
<td>Religious Background</td>
<td>Marital Status</td>
</tr>
<tr>
<td>Years Married</td>
<td>No. of Children</td>
</tr>
<tr>
<td>How long since last pregnancy?</td>
<td></td>
</tr>
<tr>
<td>Any surgery which might effect vaginal muscular functioning?</td>
<td>Explain.</td>
</tr>
<tr>
<td>Is sexual intercourse ever painful?</td>
<td>always__ usually__ sometimes__ seldom__ never__</td>
</tr>
<tr>
<td>How important to you is clitoral stimulation for sexual satisfaction?</td>
<td>very__ somewhat__ not at all__ don't know__</td>
</tr>
<tr>
<td>Have you ever had vaginal warts or infections?</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>Do you feel this hampers sexual interest in any way? If so, how?</td>
<td></td>
</tr>
<tr>
<td>Do you use any kind of contraception? If so, what kind?</td>
<td></td>
</tr>
<tr>
<td>Do you feel the contraception hampers sexual satisfaction in any way?</td>
<td></td>
</tr>
<tr>
<td>If so, how?</td>
<td></td>
</tr>
</tbody>
</table>
When was the last time you had any sexual contact with a partner?

How frequently do you masturbate?

Is masturbation sexually satisfying for you?

Do you think it is important to achieve orgasm for sexual satisfaction? Why or why not?

Have you ever attained orgasm? If so, under what circumstances?

List any medication you are currently taking:

Date of last physical exam: ______________________

Any complications? If so, describe:
Appendix C
Rathus Assertiveness Schedule

Directions:
Indicate how characteristic or descriptive each of the following statements is of you by using the code given below.

+3 very characteristic of me, extremely descriptive.
+2 rather characteristic of me, quite descriptive.
+1 somewhat characteristic of me, slightly descriptive.
-1 somewhat uncharacteristic of me, slightly nondescriptive.
-2 rather uncharacteristic of me, quite nondescriptive.
-3 very uncharacteristic of me, extremely nondescriptive.

___ 1. Most people seem to be more aggressive and assertive than I am.

___ 2. I have hesitated to make or accept dates because of "shyness."

___ 3. When the food served at a restaurant is not done to my satisfaction, I complain about it to the waiter or waitress.

___ 4. I am careful to avoid hurting other people's feelings even when I feel that I have been injured.

___ 5. If a salesman has gone to considerable trouble to show me merchandise which is not quite suitable, I have a difficult time in saying "No."
6. When I am asked to do something, I insist upon knowing why.

7. There are times when I look for a good, vigorous argument.

8. I strive to get ahead as well as most people in my position.

9. To be honest, people often take advantage of me.

10. I enjoy starting conversations with new acquaintances and strangers.

11. I often don't know what to say to attractive persons of the opposite sex.

12. I will hesitate to make phone calls to business establishments and institutions.

13. I would rather apply for a job or for admission to a college by writing letters than by going through with personal interviews.

14. I find it embarrassing to return merchandise.

15. If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance.

16. I have avoided asking questions for fear of sounding stupid.

17. During an argument I am sometimes afraid that I will get so upset that I will shake all over.

18. If a famed and respected lecturer makes a statement which I think is incorrect, I will have the audience hear my point of view as well.
19. I avoid arguing over prices with clerks and salesmen.

20. When I have done something important or worthwhile, I manage to let others know about it.

21. I am open and frank about my feelings.

22. If someone has been spreading false and bad stories about me, I see him/her as soon as possible to "have a talk about it."

23. I often have a hard time saying "No."

24. I tend to bottle up my emotions rather than make a scene.

25. I complain about poor service in a restaurant and elsewhere.

26. When I am given a compliment, I sometimes just don't know what to say.

27. If a couple near me in a theatre or at a lecture were conversing rather loudly, I would ask them to be quiet or to take their conversation elsewhere.

28. Anyone attempting to push ahead of me in a line is in for a good battle.

29. I am quick to express an opinion.

30. There are times when I just can't say anything.
Appendix D
Treatment Contract

This agreement is made this ___ day of __________, 19___, between Carolyn Cole (Therapist), a student at North Texas State University, Denton, Texas, and ________ (Participant).

In consideration of the mutual promises and covenants set forth herein, Therapist agrees to sell to Participant, and Participant agrees to purchase from Therapist the behavior change services offered by Therapist, that consist of, to wit: attending each session in its entirety for the designated 10 sessions.

The program consists of the following essential phases:
1. Participant agrees that this behavior is to be partitioned in terms of units so that each violation is defined as: not attending each session in its entirety. Contractee must be present in each of 10 sessions by 5 minutes after the designated session starting time.
2. Participant agrees that consequences for each unit defined in #1 will be levied in the following manner: Loss of one of the items listed in #3; one violation per session.
3. Participant agrees to use the following items for consequences referred to in #2:
   1. _____________________________ 3. _____________________________
   2. _____________________________ 4. _____________________________
4. Participant agrees on the use of the following methods to observe and monitor the behaviors and/or behavioral outcomes under #1: Attendance at meeting with the use of 1st Denton County National Bank for standard time (387-0212).

5. Participant agrees to forfeit one item in #3 in the event that Participant fails to attend a monitoring session and/or is more than 5 minutes late without giving the Therapist at least 24 hours notice of the absence or tardiness. Meeting dates and time will be: Tuesday and Thursday evenings, 8-9:30 p.m.

6. Participant agrees to use the following method of rotating items under #3 in the event that objects other than money are used as consequences: Therapist shall hold 3 items at all times. Upon passing requirements for the session, contractee shall give Therapist 4th item and receive 1st in the series. At next session, upon passing session requirements, contractee shall give Therapist 5th item in series and receive 2nd. Sequence of exchange to continue throughout duration of contract.

7. Participant agrees that in the event that the Therapist does not rotate items listed under #3 in the manner specified in #6, the following consequences will ensue: loss of one item per day until designated item is brought in.
8. In the event that the Participant forfeits any monies because of breach of contract as specified in #1, 2, 5, and 7, Participant agrees to replace this lost money, to be held by Therapist, to be used as future consequences, at or before the first monitoring session after the loss occurred or will forfeit an additional $5.00 of existing monies at that monitoring session and each monitoring session thereafter until all monies lost are replaced.

9. Participant agrees to the following additional circumstances: Participant further agrees that, at the discretion of the Therapist, the Participant will subject him or herself within 48 hours after the Therapist's notice to a lie detection test given by a licensed polygraphist, or the Participant agrees to forfeit automatically all consequences at stake. The Participant further agrees to be responsible for the payment in full of services rendered by the licensed polygraphist in the event that the polygraphist rules that there has been no breach of contract.

Participant understands that all program phases are important and that his or her cooperation in attending all the scheduled sessions and completely following all the instructions will be a significant factor in determining the success of his or her efforts to control the above behavioral trait.

SIGNED_________________________ Participant __________________________ Date

Approved and accepted by Carolyn Cole.
Appendix E

Informed Consent Form

I, ________________________, hereby give consent to Dr. Howard Hughes and Carolyn Cole to perform or supervise the following investigational procedure or treatment: Behavioral treatment of sexual dysfunction. I understand that this investigation does not involve either medical diagnosis or medical treatment and that it is suggested that I consult a physician and receive a medical opinion concerning my present symptoms.

I have (seen, heard) a clear explanation and understand the nature and purpose of the procedure or treatment; possible appropriate alternative procedures that would be advantageous to me (him, her); and the attendant discomforts or risks involved and the possibility of complications which might arise. I have (seen, heard) a clear explanation and understand the benefits to be expected. I understand that the procedure or treatment to be performed is investigational and that I may withdraw my consent for my (his, her) status. With my understanding of this, having received this information and satisfactory answers to the questions I have asked, I voluntarily consent to the procedure or treatment designated in the paragraph above.

Date

SIGNED: _________________________ SIGNED: _________________________
Witness Subject or
SIGNED: ____________________________  SIGNED: ____________________________
Witness  
Person Responsible

Relationship

Instructions to persons authorized to sign:
If the subject is not competent, the person responsible shall be the legally appointed guardian or legally authorized representative. If the subject is a minor under 18 years of age, the person responsible is the mother or father or legally appointed guardian. If the subject is unable to write his name, the following is legally acceptable: John H. (his X mark) Doe and two (2) witnesses.
Appendix F
Data Sheet

In describing activity done be specific. Instead of "Touched body," record "Touched arms lightly, pinched nipples, stroked legs roughly, etc." Record amount of time spent with each activity as well as rate of arousal (1 = no sensual feelings; 2 = some sensual feelings; 3 = mild sensual feelings; 4 = moderate sensual feelings; 5 = extreme sensual feelings).

Name:___________________ Date:_________ Time:____ a.m. p.m.

Description of activity:

Amount of time:_________________________ Arousal:_________

Description of activity:

Amount of time:_________________________ Arousal:_________
References


