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Sexual Unresponsiveness and Orgastic Dysfunction: An Empirical Comparison

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ABSTRACT: Testing a hypothesis made by Kaplan, the study investigates empirical differences between women diagnosed as "sexually unresponsive" (N = 50) vs. "orgastically dysfunctional" (N = 55). Treatment was carried out in the form of couples' therapy. The two groups show significant differences with regard to occupation (sexually unresponsive women are more frequently housewives), sexual behaviour (sexually unresponsive women have a more restricted sexual life), self-perception (sexually unresponsive women describe themselves as more timid, reserved and inhibited), and sexual attitude (sexually unresponsive women are more restrictive). Therapy success and one-year follow-up show no differences between the two groups.

INTRODUCTION

Kaplan[1] criticizes the concept of "orgastic dysfunction" introduced by Masters and Johnson[2] for being too imprecise. As in the case of the old and pejorative concept of "frigidity," it too groups two qualitatively distinct dysfunctions together, viz. sexual unresponsiveness and orgastic dysfunction, in the more restricted sense. Kaplan's suggestion for a conceptual separation of the two dysfunctions rests on physiological grounds: the character of sexual response is biphasic, excitement and orgasm are accompanied by different physiological reactions. With dysfunctions in the excitement phase (sexual unresponsiveness) subjects do not even perceive sexual responses. Defence may take the form of avoidance of sexually arousing situations and has the effects of an unconscious prohibition of any sensations.

On the other hand, the orgastically dysfunctional woman is sexually aroused, lubricates and experiences pleasure but does not reach orgasm.

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Defence is expressed here by "holding back" for fear of surrendering to the orgasm. Kaplan draws no distinction between the two groups' experiences of masturbation and orgasm during masturbation. However, she does divide orgastically dysfunctional women into "totally unorgastic" women, who do not even reach orgasm during masturbation, and "situationally unorgastic" women who have an orgasm when masturbating, but not during coitus.

The present study is intended to show whether the distinction derived from the symptom is reflected in

1. differences in sexual behaviour, self-perception, social data and sexual attitudes *before* therapy and
2. The varying success of therapy with the two groups, which Kaplan has suspected in a more recent study.[3]

The "low libido" syndrome that Kaplan distinguishes in this paper, and the distinction between total and situational orgastic dysfunction will not be brought into consideration here. We are exclusively concerned with the simple distinction between two clinical phenotypes: "sexual unresponsiveness" (which includes the low libido syndrome) and "real orgastic dysfunction" (excluding sexual unresponsiveness), independently of the extent to which the two groups can further be distinguished from one another.

METHOD

The subjects of the study were N = 105 women who took part in couples' therapy with their partners from 1973 to 1978 at our department in the context of a larger research project.[4] These women's sexual problems had at the time been classified under the general rubric "orgastically dysfunctional." It was, however, possible to make a division later into the two groups defined by Kaplan; the criterion applied was "frequency of feelings of pleasure without orgasm during petting or foreplay." If the women answered with "never" or "seldom (below 25% of the sexual contacts)," they were diagnosed as being "sexually unresponsive." If they indicated a frequency above 25%, they were diagnosed as "really orgastically dysfunctional." As a result the group of sexually unresponsive women numbered N = 55, the group of really orgastically dysfunctional women N = 50. The women were on average 28.2 years old, their partners 30.8 years old; 48% of them had one or more children, 73% were married and the others were living in permanent relationships. Most of the women had had their sexual problem for some time, 60% of them for more than 6 years. These data do not disclose any significant difference between the two groups.

TREATMENT

Treatment was carried out in the form of couples' therapy. The therapeutic concept is modelled on Masters and Johnson's[2] procedure, but it is modified in three important respects:

1. Indication was widened to include couples who experience conflict in their non-sexual life as well as partners with neurotic disturbances. It was merely necessary to ensure that the partners were willing to maintain their relationship and that no acute desire to break it off existed.
2. The psychodynamic treatment of partner conflict played a relatively large part in the therapy sessions. As a result, therapy lasted considerably longer than with Masters and Johnson.

3. The couples were treated in three different settings;
   1. two therapists, long-term (male and female therapist, two sessions a week, 35 sessions on average);
   2. one therapist, long-term (male or female therapist, two sessions a week, 35 sessions on average);
   3. two therapists, intensive (male and female therapist, daily sessions for three weeks, 16 sessions on average).

In the one-year follow-up study a comparison of the settings, which is detailed elsewhere,[5] showed no significant differences in the therapy result. Moreover, as the two diagnosis groups were more or less evenly distributed in the individual settings, the three treatment settings can be grouped together here.

ASSESSMENT

At the start of therapy the subjects' social data, data on sexual behaviour and on sexual functioning were recorded. The couples filled in a questionnaire on "Sexual behaviour in the last three months" and kept a "diary" for one week that encompassed questions on their sexual behaviour at the time and their sexual experience. In addition they filled in two personality inventories (the Giessen Test (GT) and the Freiburg Personality Inventory (FPI)), and a questionnaire on sexual attitudes which was compiled in our department. *At the close of therapy* therapists and patients assessed the success of therapy independently of one another. The criteria of therapy success will not be specified further here, but can be found in Arentewicz and Schmidt 1980. In the one-year follow-up study the success of therapy was assessed once again after a discussion.

RESULTS

1. Occupation and social class: Table 1 shows that in both groups the distribution of occupations varies significantly. Housewives tend more often to be sexually unresponsive, whereas female students are more often orgastically

TABLE 1: OCCUPATION

	Sexual unresponsiveness (N = 55)	Orgastic dysfunction (N = 50)	Sign.
Workers, white-collar workers	27	21	
Managerial occupations	9	6	.05
Housewives	15	9	
Students	4	14	

TABLE 2: SEXUAL BEHAVIOUR (1)

	Sexual unresponsiveness (N = 55)	Orgastic dysfunction (N = 50)	Sign.
Desired frequency of coitus/ week (T)			
never	25	2	
< 1 x /week	28	21	.001
≥ 1 x /week	2	27	
Actual frequency of coitus/ week (P)			
never	8	4	
≤ 1 x /month	16	6	
2-5 x /month	17	11	.01
> 5 x /month	13	27	
Frequency of lubrication during coitus			
≤ 25 %	28	4	
25 - 75 %	11	14	.001
> 75 %	15	32	
Occurrence of "oral-genital" (2) activities (p)			
none	21	16	
1,2	25	17	n.s.
3,4	8	14	
Frequency of masturbation			
≤ 1 x /month	42	35	
> 1 x /month	12	12	n.s.
Orgasm/masturbation (P)			
≤ 50 %	8	6	
> 50 %	19	15	n.s.

(1) The data were partly self-ratings by the patients (marked P), partly ratings by the therapists (T). Owing to refusals to answer the questionnaires, the number of self-ratings is slightly reduced (N = 54 for sexual unresponsiveness, N = 47 for orgastic dysfunctions).

(2) We inquired into the occurrence of four different oral-genital activities in the last three months (cunnilingus, fellatio; with/without orgasm).

dysfunctional. The level of occupations (employee vs. managerial) has no apparent influence on the designation of patients' symptoms.

2. *Sexual behaviour:* Sexually unresponsive women desire sexual intercourse less often and seldom do have intercourse in comparison to orgastically dysfunctional women. They are less open to oral-genital activities. Lubrication takes place less often during sexual intercourse. Orgastically dysfunctional women have an orgasm more frequently during petting or foreplay, i.e. as a rule on manual stimulation by the partner. There are no differences between the two groups both as regards frequency of masturbation and frequency of orgasm on masturbating (Table 2).

3. Self-perception: In the personality tests sexually unresponsive women describe themselves as being less attractive, they feel they are less readily accepted and feel they make less of an impression (GT 1) than orgastically dysfunctional women. They consider themselves to be more reserved, they show less feelings, are less easily approachable (GT 5), more timid in heterosexual contact, less sociable and less capable of devotion (GT 6) than orgastically dysfunctional women (Table 3). No significant differences were found between the two groups in any of the 12 FPI scales.

4. Attitude to sex: Sexually unresponsive women describe themselves and their attitudes to sex as being morally more restricted and more conservative (FAS 1). They distinguish more rigidly and stereotypically between male and female roles (FAS 2) (Table 3).

5. Therapy success; The therapists assessed the success of therapy at the symptom level as follows: 27% of the sexually unresponsive women were "markedly improved" or "cured," 37% were "improved;" 43% of the orgastically dysfunctional women were "markedly improved" or "cured" and 33% were "improved." This trend in favour of orgastically dysfunctional women cannot however be statistically corroborated. This can also be said of the patients' self-ratings. 63% of the sexually unresponsive and 69% of the orgastically dysfunctional women who had completed therapy said there was a definite improvement in their sexual difficulties (Table 4).

6. Stability of therapy success: The one-year follow-up study shows high stability. In both groups half of the patients who returned for the follow-up study was assessed with the same result as at the close of therapy (Table 5). The number of couples whose sexual problems had worsened roughly counterbalances the number of cured patients.

TABLE 3: PERSONALITY AND ATTITUDE SCORES BEFORE THERAPY

	Sexual unresponsiveness (N = 51)	Orgastic dysfunction (N = 47)	Sign.
GIESSEN - TEST	$\bar{x}$ / s	$\bar{x}$ / s	
1. Social Resonance	24.8 / 6.1	27.4 / 4.7	.05
2. Submissiveness	24.6 / 5.1	24.9 / 5.2	n.s.
3. Control	25.7 / 6.3	25.0 / 5.1	n.s.
4. Depression	29.4 / 5.3	28.1 / 5.2	n.s.
5. Reservedness	28.0 / 6.5	23.8 / 6.7	.01
6. Intimidation	23.3 / 6.0	20.0 / 4.8	.01
Sexual Attitude Scale	(N = 54)	(N = 45)	
1. Restrictivity	25.8 / 6.4	23.0 / 5.5	.05
2. Sex-role stereotypes	17.7 / 6.6	13.9 / 5.8	.005
3. Romanticism	23.5 / 5.4	21.9 / 4.8	n.s.

TABLE 4: THERAPY SUCCESS. ASSESSMENT BY THERAPISTS AND DIAGNOSED PATIENTS.

	Sexual unresponsiveness (N = 52)	Orgastic dysfunction (N = 49)	Sign.
Assessment by therapists			
Therapy discontinued	14 (27%)	11 (22%)	
no/slight improvement	5 (10%)	1 (2%)	
improved	19 (37%)	16 (33%)	n.s.
markedly improved / cured	14 (27%)	21 (43%)	
Self-assessment by patients (1)	(N = 30)	(N = 29)	
"sexual difficulties better /much better than before therapy"	19	20	
"sexual difficulties 'a little better' than before therapy"	8	9	n.s.
"sexual difficulties the same /worse than before therapy"	3	0	

(1) The self-ratings were only made by patients who had completed therapy. Drop-outs were not given questionnaires. 17 women did not return the questionnaire they had been given.

COMMENTS

In overall terms the results point to sexually unresponsive women having greater problems than orgastically dysfunctional women: sexual unresponsiveness is accompanied by further parallel impairments of the sexuality between partners. Sexual contact occurs less often, with less pleasure and less variation. There is a conspicuous lack of differences in masturbatory behaviour.

TABLE 5: STABILITY FO THERAPY SUCCESS (THERAPISTS' ASSESSMENT) (1)

	Sexual unresponsiveness (N = 29)	Orgastic dysfunction (N = 26)	Sign.
One-year follow-up study			
better than at the end of therapy	8	7	
no change	14	15	n.s.
worse than at the end of therapy	7	4	

(1) These figures only refer to patients completing therapy. Patients who discontinued therapy were invited to take part in the follow-up study, but appeared in such small numbers that they can be left out of consideration here.

Although the members of both groups masturbate relatively rarely, most of them reach orgasm on masturbating.

We had already pointed elsewhere[6] to the fact that women with sexual dysfunctions considered themselves to be more labile than a "normal" control group of women of the same age. The result can be differentiated further with the help of these data: sexually unresponsive women describe themselves as being more timid, reserved and inhibited than orgastically dysfunctional women in social relations. This difference can be understood in terms of the defence mechanism described by Kaplan[1] whereby women avoid proximity. It is thus a defence mechanism which arises at a very early stage in heterosexual advances, i.e. in the social approaches to sexuality and intimacy. Sexuality is avoided preventively, a tendency cognitively strengthened by a restricted and more conformable attitude to the role. The women's typical role of reticence and reserve forms an additional protection from the feared sexual encounter.

As the distribution of occupations (housewife vs. student) is uneven in both groups, it is uncertain whether the named difference can actually be attributed to the sexual dysfunction or whether it should be seen as a result of the different social and occupational situations of housewives and students. The small number of cases of sexually unresponsive students and orgastically dysfunctional housewives makes an answer impossible as to the extent to which the variance can be ascribed to the sexual dysfunction or, on the other hand, to the occupation. It should in any case be noted that the empirical differences between the two groups before therapy are easily reconcilable with Kaplan's hypothesis.

This does not, however, apply to therapy success. Therapy success is not significantly greater for orgastic dysfunctions than for sexual unresponsiveness. The one-year follow-up study showed no difference either. The therapy plan was however drawn up to be the same for both groups. This does not however exclude the possibility that different aspects were nevertheless emphasized and that more stress was laid on the sensate focus exercises in the sexually unresponsive group and on directed genital stimulation in the orgastically dysfunctional group. The presently available data cannot therefore corroborate Kaplan's hypothesis that orgastic dysfunctions are more easily cured than sexual unresponsiveness.

Kaplan's proposed classification is nonetheless useful in therapeutic work even if the resulting prognosis is not different. The diagnostic distinction between sexual unresponsiveness and orgastic dysfunctions is not merely a more precise description of the sexual syndrome; it is, in addition, an aid to a better understanding of the psychodynamics of dysfunctions and makes therapy planning considerably easier.

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