Archives of Sexual Behavior, Vol. 2, No. 2, 1972

The Role of Masturbation in the Treatment of Orgasmic Dysfunction

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It is proposed that a program of directed masturbation can be effective in treating primary orgasmic dysfunction. A brief review is made of the normality of masturbation and its effectiveness in producing orgasm in women. A nine-step program of masturbation, designed to lead to heterosexual coital orgasm, is described. Techniques for dealing with clients' negative emotions towards masturbation are discussed. Case material and treatment outcome statistics are presented to illustrate the effectiveness of this masturbation program.

INTRODUCTION

"No other form of sexual activity has been more frequently discussed, more roundly condemned, and more universally practiced than masturbation" (Dearborn, 1967). In contrast to this general condemnation of masturbation, we feel that masturbation is not only a normal, healthy activity but is an extremely effective aid in the treatment of primary orgasmic dysfunction in women. This paper will describe the role directed masturbation plays in therapy at the University of Oregon Psychology Clinic Sexual Research Program.

Greenbank (1961) studied the attitude toward masturbation of graduating medical students and the faculty in five Philadelphia area medical schools. His research indicated that "half of the students have a feeling that mental illness was frequently caused by masturbation. Even one faculty member in five still believes in this old, and now discredited idea." Because of the apparently still widespread misconceptions about masturbation, even among health professionals, a note on its normality is in order.

Among subhuman primates, masturbation occurs in many species even when ample opportunity to copulate with receptive partners exists (Ford and Beach, 1951). Although masturbation is more common in male than in female animals,

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it has been observed in female dogs, chinchillas, rats, porcupines, elephants, and dolphins, among other species (Ford and Beach, 1951; Kinsey *et al.*, 1953). The phylogenetic evidence, then, is that masturbation is a "natural" rather than an "unnatural" act and is seemingly an inherent part of our biological endowment.

Other cultures vary considerably in their attitudes toward masturbation (Ford and Beach, 1951). In some cultures, the Lesu in Melanesia, for example, masturbation is acceptable and is practiced casually in public. In other cultures, it is severely prohibited. Such prohibitions seem to have only the effect of causing people to masturbate in secret rather than actually reducing the occurrence of masturbation. For example, Apinaye boys and girls masturbate frequently, even though such activity is punished if detected, and despite the fact that at a ceremony conducted when they are half-grown, their genitals are examined and they are severely beaten if there is any "evidence" of masturbation (Ford and Beach, 1951).

Masturbation is culturally prohibited in American society, despite the total lack of any scientific evidence that it has any psychologically or physiologically harmful effects (Johnson, 1968; Dearborn, 1967). This prohibition seems to have arisen from religious doctrine rather than from any rational scientific basis (Johnson, 1968).

In spite of this cultural prohibition, masturbation is more common in our society than many parents, therapists, and clients realize. The Kinsey data (Kinsey *et al.*, 1948, 1953), now over 20 years old, indicate that 94% of men and 58% of women masturbate to orgasm at some point in their lives. Other more recent studies have obtained higher figures, up to virtually 100% of men and 85% of women (Dearborn, 1967). These incidence figures can be useful in reassuring clients (and therapists) about the "normality" of masturbation.

THEORETICAL BASIS FOR THE USE OF MASTURBATION IN TREATMENT

Although the high incidence of masturbation is useful information for encouraging its acceptance by clients, the ability of masturbation to produce orgasm has more therapeutic importance. Masturbation is especially therapeutic for the primary inorgasmic women, i.e., one who has never experienced an orgasm from any source of physical stimulation. For this problem, it seems most sensible to begin treatment with the technique most likely to produce an orgasm. Kinsey *et al.* (1953) reported that the average woman reached orgasm in 95% or more of her masturbatory attempts. This figure considerably exceeds the probability of reaching orgasm through coitus (about 0.73 for average married women).

Not only is masturbation the most probable way of producing an orgasm, it also produces the most intense orgasm. In a now famous study, subjects' subjective reports as well as recordings of their physiological responses (heart

rate and vaginal contractions) indicated that masturbation produced a more intense orgasm than either coitus or manipulation of the genitals by a partner (Masters and Johnson, 1966). It has been suggested that an intense orgasm leads to increased vascularity in the vagina, labia, and clitoris (Bardwick, 1971). In turn, there seems to be evidence that this increased vascularity will enhance the potential for future orgasms. "Frequent orgasms will effect an increase in vascularity, which in turn enhance the orgasmic potential. Nothing succeeds like success, and the increased number of orgasms will lead to the psychological anticipation of pleasure in sex" (Bardwick, 1971). This notion that increased vascularity enhances orgasmic potential is supported by the findings of Kegel (1952). He discovered that patients who strengthened the pubococcygens muscle through his prescribed exercises experienced an increase in their frequency of orgasm. Since exercising a muscle leads to increased vascularity, it is possible that the increased vascularity in the pubococcygens was responsible for the increased orgasmic frequency. An increase in pelvic vascularity has also been suggested to explain the effectiveness of androgen therapy in facilitating orgasm (Bardwick, 1971).

To summarize, since masturbation is the most probable method of producing an orgasm and since it produces the most intense orgasm, it logically seems to be the preferred treatment for enhancing orgasmic potential in inorgasmic women.

Although masturbation has been noted in the past to facilitate orgasmic potential, it apparently has not been a systematic part of a therapy program. Hastings (1963) reported that some of his patients increased their sexual responsiveness by increased masturbation. Similarly, sex authorities from Albert Ellis (1960) to "J" (1969) have recommended masturbation with an electric vibrator to facilitate an orgasm. We have developed such a systematic masturbation program for treating primary orgasmic dysfunction.

THE MASTURBATION PROGRAM

The masturbation program does not form the totality of our treatment program for inorgasmic women, but is an adjunct to a behavioral, time-limited (15 sessions) treatment program involving both the husband and wife. The general program involving both husband and wife and a male-female cotherapy team is modeled very directly after the procedure developed by Masters and Johnson (1970) for treating inorgasmic women. The masturbation component of our program is unique to our own work, however, and has been developed by us.

In prescribing a masturbation program, the therapist must obviously deal with both the woman's and her husband's attitudes toward masturbation. It is typical of our clients to have learned very negative attitudes toward masturbation. Several of our clients were directly instructed by their parents that

masturbation would have dire consequences ranging from acne to cancer to insanity and were severely punished for masturbating as adolescents. One of our clients was forced, as a child, to bathe wearing her underpants, so that she would never directly see or touch her own genitals. In such cases, it would be extremely naive to expect a simple order to "go home and masturbate" to have any therapeutic effect if these negative attitudes, fears, and simple errors of fact were not dealt with.

There are several techniques which can be used to help overcome the client's negative attitudes toward masturbation. One such technique is to ask the client to estimate what percentage of people masturbate, before and after marriage. Even well-educated clients typically grossly underestimate these figures (i.e., estimates of 20 to 30% premaritally and 5 to 10% postmaritally are common). The client can be given the correct information, with the therapist also correcting other misconceptions about the normality and universality of masturbation at this point.

However, a lecture by the therapist on the true facts about masturbation does not always deal with the client's irrational emotional reaction to masturbation. In cases where resistance to masturbation is not based so much on ignorance and misinformation as on emotional conditioning, therapist self-disclosure is often useful in changing the client's attitude. That is, given that the client has had time to develop some regard and respect for the therapist, the therapist's calmly and unashamedly discussing his or her own masturbation can be extremely effective in changing the client's negative attitude. The therapist, of course, must be truly unconflicted and comfortable about revealing this information for it to be effective.

When prescribing masturbation for an inorgasmic woman, it is crucial to enlist the cooperation and support of her husband. That is, if the woman has to sneak off to masturbate and feels her husband disapproves, there is little chance that masturbation will be effective in producing orgasm. The husband should be made fully aware of what his wife is doing, the reasons for it, and should be instructed by the therapists to fully support his wife's masturbation. In our treatment program, we typically split up initially. The female cotherapist discusses masturbation with the female client, while the male cotherapist does the same with the male client. In these individual sessions, the male therapist explains to the husband the rationale for a masturbation program for the wife and deals with any negative reactions the client has. The therapist then directly trains the husband to support his wife's masturbation. With modeling and role-play techniques, we train the husband to make convincingly supportive statements. Our male clients typically take to this procedure well, since they are highly motivated to help their wives become sexually responsive.

In this individual session, the male therapist also suggests to the husband

that he should masturbate or, if the husband does masturbate, that he tell his wife about it. We advocate this for two reasons. First, for the wife to feel truly guilt-free about her masturbation, she needs to know not only that her husband approves but that he masturbates as well. In addition, masturbation by the husband is useful in keeping him cooperative, in that the early phases of the Masters-Johnson (1970) treatment for inorgasmic women involve abstinence from intercourse. While the male cotherapist is following this procedure with the husband, the female therapist is similarly explaining the necessity of masturbation to the wife and dealing with any negative reactions she has.

Following these individual sessions, the therapy team rejoins, and the masturbation program is explained in detail to husband and wife.

This program usually consists of nine steps, with the client typically working on one step per week. These steps will be described, with case history data to exemplify the principles involved.

Step 1

In step 1, the client is told that she is "out of touch" with her own body, that indeed she has never really known her own body nor learned to appreciate the beauty of her sexual organs. Accordingly, she is given the assignment to increase her self-awareness. She is told to examine her nude body carefully and try to appreciate its beauty. The client is to use a hand mirror to examine her genitals closely, identifying the various areas with the aid of the diagrams in Hasting's book *Sexual Expression in Marriage* (1966). We recommend this genital exploration be done just after bathing, for reasons of cleanliness and to capitalize on the relaxing qualities of a warm bath. Many of our clients express amazement after following this step. Typical statements are "I never really knew what was down there" and "I was amazed at how little I knew about myself."

At this time, the client is also started on a program of Kegel's (1952) exercises for increasing the tone and vascularity of the pelvic musculature, which presumably will increase her orgasmic potential. We advocate having the client tense and relax her pelvic muscles ten times, repeating this exercise three times daily.

Step 2

Next the client is instructed to explore her genitals tactually as well as visually. She is instructed to explore through touch the various parts of her genitals. To avoid putting her under any performance anxiety to arouse herself sexually, the client is not given any expectation that she should be aroused at this point. In these first two steps, we merely want the client to become

desensitized to the sight and feel of her genitals and become used to the idea of masturbation. Interestingly enough, it is in these first two steps that we get most resistance from clients. Not uncommonly, the woman reports that she tried, but could not bring herself to look at or touch herself. Additional support from the therapists and the husband will usually overcome this problem. It is also useful for the therapists to tell the client that we expect her to feel some apprehension or aversion at this point but that these feelings usually disappear once she begins actually following the program.

Step 3

Next the client is instructed to continue visual and tactual exploration of her genitals, but with an emphasis on locating sensitive areas that produce feelings of pleasure. She is not to focus on any area in particular but to thoroughly explore the clitoral shaft and hood, the major and minor labia, the vaginal opening, and the whole perineum, especially that area immediately adjacent to the clitoris. In line with the findings of Kinsey *et al.* (1953) and Masters and Johnson (1966), we have yet to have a client locate the vagina as a strong source of sexual pleasure; most of our clients focus on the clitoral area as the most pleasurable.

Step 4

With the pleasure-producing areas located, the client is now told to concentrate on manual stimulation of these areas. The female cotherapist at this time discusses techniques of masturbation with the client. As most of our clients locate the clitoris as the most pleasurable area, this is usually a discussion of techniques of clitoral manipulation; topics covered include variations of stroking and pressure and the use of a sterile lubricant jelly to enhance pleasure and prevent soreness.

Step 5

If orgasm does not occur in step 4, the client is told to increase the intensity and duration of her masturbation. She is told to masturbate until "something happens" or until she becomes tired or sore. We think of 30 to 45 min as a reasonable upper limit for duration of masturbation and indeed have had clients achieve their first orgasm after as much as 45 min of continuous, intense masturbation. We also recommend the use of pornographic reading material or pictures to enhance arousal. In addition, we suggest the use of erotic fantasies to further increase arousal. Interestingly, the concept of fantasizing during masturbation does not seem to occur spontaneously to our female clients. This is

consistent with the data of Kinsey *et al.* (1953) that a much smaller proportion of women than men fantasize during masturbation.

Step 6

If orgasm is not reached in step 5, we instruct the client to purchase a vibrator of the type sold in pharmacies for facial massage. These can be purchased for as little as 5 dollars and, as the classified ads in any underground newspaper will attest, are extremely effective in producing sexual arousal. There are two general types of vibrators available: those that strap on the hand and cause the fingers to vibrate and those that are applied directly to the object to be massaged. Both types are effective, but individual preference varies. We have prepared a fact sheet for our clients which lists the various types of vibrators available in town, the price, and where they may be purchased. The client is instructed to masturbate, using the vibrator, lubricant jelly, and pornographic materials. In our most difficult case to date, 3 weeks of vibrator masturbation, with daily 45 min vibrator sessions, was required to produce orgasm.

We have found a technique of use in cases where orgasm does not occur after some time in step 6. A woman may simply be embarrassed or afraid to have an orgasm, fearing an undignified loss of control with muscular convulsions, inarticulate screaming, and involuntary defecation or urination. To desensitize them to their fears of loss of control, we have such clients role play the experience of orgasm in their own homes.

Step 7

Once a woman has achieved orgasm through masturbation, our focus shifts to enabling her to experience orgasm through stimulation by her husband. As the first step in this process, we instruct the woman to masturbate with her husband observing her. This desensitizes her to visibly displaying arousal and orgasm in his presence and also functions as an excellent learning experience for her husband. He learns just what techniques of genital stimulation are effective and pleasurable for his wife, from the only person who is truly expert in this subject. Some clients are initially reluctant to masturbate in front of their husbands, but the same techniques of therapist's verbal self-disclosure and coequal involvement of the husband that are used to overcome initial reluctance have also proven effective here.

Step 8

Step 8 simply involves having the husband do for his wife what she has been doing for herself. If she has been using a vibrator, he now uses it on her. If she has been manually manipulating her genitals, he now begins to do this for her.

Step 9

Once orgasm has occurred in step 8, we instruct the couple to engage in intercourse while the husband concurrently stimulates the wife's genitals, either manually or with a vibrator. We recommend the female superior sitting, lateral, or rear entry coital positions for this activity, as all these positions allow the male easy access to the female's genitals during intromission. Once orgasm has occurred at this step, the client should logically be considered "cured," since the clitoris and not the vagina is now known to be the major locus of sexuality and orgasm in the normal woman (Masters and Johnson, 1966; Kinsey *et al.*, 1953; Lydon, 1971; Weisstein, 1971; Ellis, 1962). Some clients, however, especially those who have been exposed to psychoanalytic theory and its specious distinction between "clitoral" and "vaginal" orgasm, express a wish to achieve orgasm without the necessity for concurrent manual stimulation during coitus. For such clients, we emphasize the importance of achieving adequate clitoral stimulation from some source (e.g., the husband's symphysis) during coitus and point out that this stimulation is most effectively achieved through direct manual manipulation.

In assessing the effectiveness of this program, two questions arise: how successful is the program in producing an orgasm for the totally inorgasmic woman, and how regularly does this woman become orgasmic in sexual activity with her husband?

We have completed treatment (15 therapy sessions) with eight women who had never previously experienced orgasm. In all eight cases, these women have gained the ability to achieve orgasm.

In regard to the second effectiveness question, two of these women are now orgasmic with clitoral manipulation by their husbands, but not yet during intercourse. The other six women have achieved orgasm through intercourse with their husbands and continue to experience orgasm in this way. Four of the six no longer require direct manual manipulation of the genitals during intercourse to reach orgasm. The regularity of coital orgasm varies—one client reports orgasm on about 25% of coital opportunities, one on about 50% of coital opportunities, and the other four on nearly every occasion. We are continuing to gather follow-up data on these clients, to assess the stability of change. So far, our follow-up (up to 6 months) indicates no relapses but rather further gains in the enjoyment of sexual relations.

It is also of interest to note that the crucial first orgasm may occur seemingly at almost any step in this program or indeed in response to nonmasturbatory stimulation following exposure to the program. Of our eight clients, one client first experienced orgasm at step 2, one client at step 3, two clients at step 4, and two clients at step 6. The other two clients did not experience first orgasm through masturbating, but in sexual activity with their husbands. One

woman experienced first orgasm in clitoral manipulation by the husband, which was temporally concurrent with step 4. The other client achieved first orgasm in intercourse with her husband, which followed several weeks on step 6. While it cannot be proven, it is our feeling that neither of these women would have achieved orgasm without having first experienced our masturbation program.

Although our sample is as yet small, we feel that this masturbation program offers considerable promise in the treatment of primary orgasmic dysfunction.

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