Causes and Treatment of Orgasmic Dysfunction: A Behavioral Approach

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CAUSES AND TREATMENT OF ORGASMIC DYSFUNCTION:
A BEHAVIORAL APPROACH

by

Francisco Jose Noleto Neto

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The realization of this thesis was possible because of the contingencies established by Professor Paul Mountjoy, who provided many reinforcements and much feedback. My thanks go to him, as well as to the other members of my Committee, Professors Kass Lockhart and Roger Ulrich. I wish to express my appreciation to other members of the faculty of the Department of Psychology at Western Michigan University who have shaped my behavior toward that of a future Psychologist. Nevertheless, I am the one person who is responsible for any errors in the content of this thesis.

Francisco Jose Noleto Neto
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INTRODUCTION

The central idea of this thesis is that the human problems usually labeled "frigidity", "impotence", etc. may be treated successfully when they are regarded as patterns of behavior which result from specific stimulative circumstances. This approach to human sexual problems was a consequence of both the results of extensive research in the experimental analysis of behavior conducted in recent years and numerous clinical reports. The application of the principles of operant conditioning (which had been developed in the animal laboratory) to clinical practice caused a true revolution in the treatment of sexual dysfunctions.

The principal purpose in writing this thesis is to evaluate the most efficient therapeutic already used in the treatment of orgasmic dysfunction, with the end in view of utilizing them upon return to the author's native country. It is hoped that on that occasion the suggestions for modification of these procedures which have been presented will be tested. As a consequence of the point of view that the relationship between the sexual partners (that is, the behavioral consequences delivered by the sexual partners) contains the major causative factors of the involved individuals' present sexual repertoires, it was necessary to discuss both
masculine and feminine sexual problems. An attempt was made to show that the development of more efficient techniques to overcome orgasmic dysfunction paralleled the changes in approach toward the social relationship between the sexual partners which maintains and in some cases may cause this dysfunction.

We attempted to avoid terms such as "frigidity" because they imply some kind of physiological and personality characteristics. Also, with their incorporation in the layman's verbal behavior they have acquired many subjective connotations which are undesirable in scientifics work. We prefer such expressions as "primary orgasmic dysfunction" and "situational orgasmic dysfunction", which have been so defined by Masters and Johnson (1970), as to facilitate communication. By primary orgasmic dysfunction they meant a woman who never was able to achieve orgasm; by situational orgasmic dysfunction they meant a woman who was able to reach at least one occasion of orgasm relief, regardless of the type of stimulation used. The same psychological principles must be used in the behavioral analysis of both clinical classifications of orgasmic dysfunctions, although the problem in primary dysfunction cases may be regarded as one of acquisition while in situational cases it may be one of maintenance. Consequently, the therapeutic procedures (learning model) used in the
treatment of these two clinical classifications or orgasmic
dysfunction are similar, but should be tailored to suit
the individual case.

Few studies of the treatment of human sexual
dysfunctions were designed in such a way that there is
no doubt concerning the reliability of the data. Usually
the therapeutic programs were composed of several procedures
which make impossible any statement concerning crucial
variables.
PSYCHODYNAMIC APPROACH

The influence of the Freudian point of view concerning female sexual behavior is clearly seen in papers by those who accept a psychodynamic orientation. Our discussion about Freudian theory will be restricted to the points concerning the etiology of orgasmic dysfunction.

Freud

Moore (1964) and Pines (1968) presented an excellent summary of this theory, according to which the two sexes pass through the same course of early development. Both boys and girls, during these early phases, do not pay attention to the vagina. For the girl the clitoris functions as a penis, from which she obtains pleasure through manipulation. After the first perception of the penis, she acquires penis envy, which induces the break up of the loving relationship with her mother. Because the clitoris is too short she renounces its manipulation and shifts to her father with a wish for a child. These ties to her father may persist into adult life or be partially dissipated.

Accordingly, the woman's normal sexual development is complicated by two factors: 1) the necessity for a change in the sex of the love object, and 2) a shift of the main erotogenic zone from the clitoris to the vagina. Hence, orgasmic dysfunction is related to
difficulties in the transference of erotogenicity. The existence of oedipus fixation, unconscious guilt accompanying aggression toward both parents, rejection of the feminine role and penis envy are the major causative factors of these problems (Lorand, 1939). The therapy should consist of analysis of the earliest period of attachment to the mother, with the purpose of explaining that her fears and aggression stem from early frustration by the mother.

Conflicting Empirical Evidence

Horney (1933) presented evidence of early vaginal excitation, and then related orgasmic dysfunction to the repression of vaginal sensibility by the denial of the vagina, caused by anxiety. She pointed out three sources of anxiety: 1) the tremendous difference in size between the father and the little girl (especially between the genitals of father and child), 2) the little girl's observation of menstruation in adult relatives, and 3) pain originating in early attempts at vaginal masturbation.

Masters and Johnson (1966) presented convincing experimental evidence for criticism of the Freudian hypothesis of transference of erotogenicity. Direct observations of the vagina during auto-stimulation and coitus were photographically recorded. They concluded:
"From an anatomic point of view, there is absolutely no difference in the responses of the pelvic viscera to effective sexual stimulation, regardless of whether the stimulation occurs as a result of clitoral-body or mons area manipulation, natural or artificial coition... when any woman experiences orgasmic response to effective sexual stimulation, the vagina and clitoris react in consistent physiologic patterns. Thus, clitoral and vaginal orgasms are not separate biologic entities" pp. 66-67.

Alternatives to Freud

The following clinical observations are presented as further support for the rejection of Freudian theory.

Layman (1972) suggested that the oedipal relationship might continue into adulthood. The continuation of that oedipal relationship would result in the individual associating his marital partner to a family member. The sexual act with this partner is then perceived unconsciously as an incestuous one, which is avoided either by impotence or orgasmic dysfunction.

Levit (1971) also looked at the relationship between the sexual partners as the major causative factor of orgasmic dysfunction. According to him the crucial factor is the "turning off" of feelings due to repressed anger toward the partner, provoking self-directed guilt, ambivalence, and depression.

Other authors, for example, Kleegman (1959); Seward (1964); Ellis (1961), also reject the freudian theory.
Kleegman (1959) pointed out that only a small percentage of unorgasmic women that she had treated presented this symptom as part of a severe neurosis. She observed that these women had many fears. She gave as examples: a fear of the brutality in man, of pain and of pregnancy. Ellis (1961) recognized the importance of the relationship between the partners as a causative factor of orgasmic dysfunction. These authors, although not specifically using the principles of the theory of reinforcement, refer to orgasmic dysfunction as socially conditioned.

Kleegman (1959) advised:

"Counseling of husband and wife, teaching of anatomy and especially physiology of coitus, release from worry and from a sense of inadequacy and guilt, a permissive supportive attitude allowing her to grow up and away from the restrictive, possessive home relationship is the therapy" p. 244.

Brief History of Changing Approach

Dissatisfaction with the result of traditional psychodynamic approaches led Esyenck (1952) to publish a paper based on the results of psychiatric studies, insurance company, and hospital records, in which he pointed out that adults who have received psychodynamic treatment might not differ from those who did not receive such help, with two-thirds of both groups showing some degree of improvement. Esyenck's criticism was supported by Levitt (1963), who presented similar conclusions.
Although the problems associated with such research have been pointed out (Bandura, 1969), usually the two-thirds improved figure is widely accepted. These criticisms certainly have put in question the efficacy of the traditional approaches and have directed the attention of many professionals toward a new approach to human problems.

With the publication of the books Science and Human Behavior (Skinner, 1953) and Psychotherapy by Reciprocal Inhibition (Wolpe, 1958), the bases of this new approach were established. As mentioned by Rimm and Masters (1974), Skinner presented the theoretical support necessary for the possibility of explaining human behavior in terms of the principles of operant conditioning and Wolpe gave an explanation of human neurosis and several procedural treatments based on Pavlov's and Hull's principles of conditioning.

This change in approach caused a scientific revolution. The task of therapy became the prediction and control of behavior itself rather than its inner causes, of which it had been said, the behavioral manifestations were merely symptoms. Diverse clinical problems were then successfully and rapidly modified, such as anorexia, hysterical blindness, elective mutism, academic disorders, asthmatic attacks, insomnia, alcoholism, anger and sexual problems (Rimm and Masters, 1974).
Although before 1970 the successful treatment of many sexual disorders had been reported in the behavioral literature (Semans, 1956; Lazarus, 1963; Haslam, 1965; Wolpe and Lazarus, 1966; Brady, 1966; Kraft and Al-Issa, 1967, 1968; Madsen and Ullman, 1967; Cooper, 1969), it was only in 1970, with the publication of the book Human Sexual Inadequacy by Masters and Johnson, that the efficacy of the direct behavioral treatment of sexual problems was definitively demonstrated, and received international recognition, both professional and public.
BEHAVIORAL APPROACH

Punishment

We will use the term "punishment", as proposed by Michael (1975), to refer to environmental changes which as a consequence of a response, will decrease its frequency. We will use the term "punisher", to refer to the static post-change of such changes; and the term "conditioned punisher", to the static post-changes which acquired the function of punisher, through a history of conditioning.

One may represent punishment in the form of a state diagram (Snapper, Knapp, and Kushner, 1970) as follows. The use of state diagram helps to organize thinking of the therapist.

\[
\begin{array}{c}
\text{start} \\
1 \quad \rightarrow \quad 2 \\
S1 \rightarrow S2 \\
R \\
t = \text{time (1)}
\end{array}
\]

The circles, called states, show the environmental conditions in effect. The contingencies for the transition from one state to the other are represented by the arrows with the specific events written next to them.

As pointed out by Azrin and Holz (1966); Johnston (1972); and Michael (1975), this definition of punishment is to decrease response.
An important finding related in the experimental literature (Azrin and Holz, 1966) is the possibility that conditioned punishers may become effective in the punishment operation. As pointed out by Johnston (1972), a number of verbal and facial expressions, postures, and other behaviors, which have been present in past punishing contingencies, may have acquired the function of conditioned punishers. In our everyday life we frequently emit such behaviors without consideration of the consequences (to be summarized later).

In their frequently cited review of over five years of research in the field of punishment and with a series of ingenious experiments of their own, Azrin and Holz (1966), discussed a number of important variables which determine the effect of punishment: the intensity of the punisher, the schedule of its occurrence and the manner of its introduction (sudden or gradually); the time elapsed between the response and the occurrence of the punisher, the schedule of reinforcement that is maintaining the responses, the subject's degree of deprivation, number of responses available to the subject for obtaining the reinforcer, and the possibility of escape responses.

Azrin and Holz (1966) also discussed the effects of the punishment operation on behavior. The general conclusion was that punishment directly and immediately decreased the frequency of the response being punished.
Other effects are: a gradual recovery during mild punishment (with intense punishment the frequency of the response may reach an absolute level of zero), a contrast effect (an increase in the frequency of the response that has been punished following the termination of the punishing contingency), generalization and discrimination. Perhaps the most important contribution of their research was the demonstration that a punisher, like other stimuli, may acquire the function of conditioned reinforcer. This new information clarifies a number of earlier experiments in which results were incompatible with the conclusion that punishment directly decreased the frequency of the response that had been punished.

For the purpose of our discussion of punishment here, the crucial point is that the use of punishment by one person against another person, besides the decrease in the punished response, may produce undesirable by-products. These are a "state of anxiety" and disruption of the social relationships between those two persons. These by-products of punishment may be the most important causative factors of orgasmic disfunction. The former is incompatible with the physiological aspects of the sexual function (Masters and Johnson, 1970; Wolpe, 1973); the latter simply makes impossible the initiation of sexual intercourse between a couple since coitus must inevitably depend upon an interaction with another individual.
Azrin and Holz (1966), pointed out three sources of social disruption resulting from the use of punishment: 1) escape from the punishing contingency, 2) operant aggression (this type of aggression is reinforced by its consequences - destruction or immobilization of the source of punishment), and 3) elicited aggression (this type of aggression is not learned). The elicited aggression can be directed toward any individuals or objects in the immediate surroundings (Hutchinson, Renfrew and Young, 1971).

Anxiety

Anxiety and fear have been presented as the major causes of orgasmic dysfunction. But, as Schoenfeld (1950) pointed out, anxiety is sometimes used as a synonym for fear, fearful anticipation, emotion, etc. The expression "state of anxiety" facilitates communication, but does not give any more information than the objective description of antecedent and consequent events, and also diverts therapeutic efforts toward causes inside clients.

In the form of a state diagram the experimental procedure for initiating anxiety is:

\[ \text{start} \rightarrow \frac{1}{S_n} \rightarrow t \rightarrow \frac{2}{S_1} \rightarrow t \rightarrow \frac{3}{S_2} \]
where $S_n$ represents the background stimuli, $S_I$ is a previous neutral stimulus plus background conditions and $S^-$ is a punisher plus background stimuli.

Schoenfeld (1950) made use of the concepts of respondent and operant conditioning in discussing anxiety. According to him, as a result of the anxiety operation, in addition to changes in on-going operant responses, $S_I$ acquires control over autonomic responses to $S^-$ and also becomes a conditioned punisher. In the procedure of initiating anxiety, the behavior is not a prerequisite for the transition from one state to the next, so the eliciting function of $S_I$ is exercised without the reinforcing function. He related anxiety to escape training, using the function of $S_I$ as a conditioned punisher, assuming that the termination of $S_I$ could be the only possible reinforcer for the response made under the "anxiety drive" presumed to be set up by $S_I$.

The procedural definition of escape is:

$$
\text{start} \rightarrow 1 \xrightarrow{t} 2 \xrightarrow{\text{Res}}
$$

(3)

With a slight modification of this procedure, we can make it more similar to the anxiety paradigm (2), as follows:
With the introduction of a response contingency for the transition state 2 to state 1, and a temporal requirement for the transition from state 3 to state 1, we now have the procedural definition for discriminative avoidance, or classical avoidance as it is frequently called. Where Sn represents the background stimuli, S1 is a previous neutral stimulus plus background conditions and S- is a punisher plus background stimuli, and Res and Rav are the escape and the avoidance responses, respectively.

With the concept of the conditioned punisher relating anxiety to escape training, Schoenfeld (1950) related avoidance to escape behavior, presenting his solution to the difficult problem of identifying the reinforcer of avoidance conditioning:

"The avoidance response, by this formulation, is not really avoidance..."
at all, or at least is only incidentally so. Its function is not to avoid, and it is not primarily an escape response, reinforced by the termination of...(conditioned punishers), including proprioceptive and tactile ones, and possibly also reinforced by the production of proprioceptive...(conditioned reinforcers)"
p. 88

Sidman (1955) was able to train rats under a procedure without explicit exteroceptive stimuli:

He used a $t_2$ too brief to allow an escape response. The consequence of the avoidance response was to delay the next shock for the specification of $t_1$ - the "response shock interval". Whenever the rat failed to respond, it received a shock at that time, and at the termination of $t_3$ - the "shock-shock interval" - thereafter.

With these findings it became obvious that the problem of identifying the reinforcer of avoidance behavior is a very complex one. Herrnstein (1969), in his discussion of anxiety proposed the so-called "one factor theory". According to him, the reinforcer of
avoidance behavior is a reduction in the frequency of the punisher. He was able to train his animals under the "random-shock procedure", which does not have the temporal regularities of Sidman's. The procedure is the following:

Set State One

\[1 \rightarrow R \rightarrow 2 \rightarrow Sn \]

[Diagram showing transition states 1, 2, and 3 with labels Sn and t, and transitions z1 and z2]

Set State Two

\[2^* \rightarrow P1:Z1 \rightarrow Sn\]

Set State Three

\[2^* + P2:Z2 \rightarrow Sn\]

(7)

\[P1 > P2\]

P1 = postshock probability
P2 = postresponse probability
Z1 and Z2 = electric pulses

The consequence of the avoidance response was to reduce the shock probability.

Snapper (1975) was able to induce his animals to increase the frequency of shock, in a situation not too different from that of Herrnstein's. Powell and Morris (1969), also were able to get their animals working to increase the frequency of shock. Thus, we must be
more careful when talking about frequency reduction.

Snapper (1975) called attention to the difficulty of obtaining reliable response from subjects working under procedures like that of Sidman's. The easiest way to do so is to start with the following procedure. \(^1\):

\[ \text{R1} \rightarrow \text{S-} \rightarrow \text{R2} \rightarrow \text{Sn} \rightarrow \text{Sn} \rightarrow \text{R1} \]

On the other hand, we do not have any evidence at all to believe that the mechanisms underlying all these procedures are the same. Thus, it is not reasonable to assume that a single theory should explain them.

A more plausible explanation of avoidance behavior under procedures similar to that of Sidman's was presented by Anger (1963). He used the term "temporal stimuli" to refer to covert events which change in a consistent manner through time, following some discriminable stimuli. According to him, the functioning of temporal stimuli is similar to that of exteroceptive stimuli. Thus, temporal stimuli preceding any punisher acquire the function of a conditioned temporal punisher.

\(^1\)R1 and R2 may have different topographies.
Avoidance behavior is reinforced because it is followed by temporal stimuli less punishing than those immediately preceding the avoidance behavior.

It seems to us that the occasion for sexual intercourse, in the everyday situation, is usually signaled by some kind of exteroceptive stimuli. Also, in our culture, the bedtime is during the night. Consequently, darkness may acquire the function of $S^D$ for sexual intercourse. In other words, the individual may discriminate the time of probable occurrence of the sexual act. In cases in which punishment is associated with sexual stimuli, the individual may learn an avoidance behavior pattern, as explained by Schoenfeld (1950), and Anger (1963).
BEHAVIORAL CAUSES

There is evidence in the experimental literature that the delivery of a punisher may interfere with those complex behavioral processes which lead to copulation, even at the lower phylogenetic levels, where sexual behavior is under more hormonal control.

Barfield and Sachs (1968); Cagguila and Eibergen (1969) reported that the application of a painful shock at a regular interval, to the back or tail of male rats (only the males received the shocks) evoked more frequent sexual behavior than when no shocks were delivered. In both studies, the females had previous sexual experience.

It seems to us that a possible explanation could be as follows: Let us consider the sexual behavior as a chain. With the proximity of a male, a receptive female rat remains in a characteristic position (Bermant, 1967), which is a conditioned reinforcer for the approach response and at the same time a $S^D$ for the male to mount the female. Because only the male receives the shocks, they do not directly interfere with the female's sexual responses. The male's sexual responses in this situation have two sources of reinforcement: the sexual behavior itself ending with ejaculation and the termination of covert stimuli - conditioned temporal punisher - which preceded it. This discussion is consistent with the well established principle that an increase in the
frequency of a response is directly related to the amount of reinforcement.

Ulrich (1966) reported that the sexual behavior of rats was suppressed and the subjects began to fight frequently when shocks were delivered at a regular interval through the floor grid of the experimental chamber. In this situation the female also received the shocks. Thus, for both subjects, the temporal stimuli preceding the shock became a conditioned temporal punisher, including those leading to the female's first characteristic sexual response - which is no longer emitted, interrupting the chain at this point.

The nature of the fight is not clear. See, for example, Ulrich and Azrin (1962); Bolles (1970); Hutchinson et al. (1971); Roberts and Blase (1971); Powell, Francis, Francis and Schneiderman (1972); Crosby and Cahoon (1973); Ulrich, Dulaney, Kucera, and Colasacco (1972).

Beach, Conovitz, Steinberg and Goldstein (1956) conducted a study with high sexually active male rats as subjects. Two shock intensities were delivered contingent on attempts to copulate with a receptive female. They reported that the delivery of high intensity (380 volts) caused a decrease of the frequency of the males' mating behavior to a level of zero during two successive tests. With several animals this effect
endured from the third to the sixth test (two to four weeks) without the punishing contingency. Some subjects mating behavior dropped completely. There was a generalization effect to the environmental situation of the test attempts to escape from this situation. The delivery of low shock intensity (100 volts) increased the frequency of copulatory behavior without ejaculation. These results were predicated by our discussion of punishment.

There is no reason for not applying the above approach to human beings, whose sexual behavior is much less dependent upon hormonal levels. A satisfactory sexual relationship is a very complex chain, which must be initiated by some stimulus, for example, the sight of the other individual. Each of the successive responses of a person involved in this situation function as a conditioned reinforcer for the previous response of the other person and as a $S^D$ for the emission of his/her next response.

The reinforcing value of a conditioned reinforcer in a chain depends upon two principles:

1) "...a conditioned reinforcer is less effective than the reinforcer (primary or conditioned) used to establish it..."

2) "...the frequency of reinforcement occurring in its presence" (Kelleher, 1966, p. 192)

The approval of the sexual partner and orgasm are the reinforcers that maintain the entire chain (Wallin,
The idea that sexual problems are conditioned can be found in the literature of over eighty years ago (McGuire, Carlisle, and Young, 1965). If a punisher (or a conditioned punisher) is delivered at any point of the chain (or contingent on any isolated response), all the precedent responses will acquire the function of conditioned punishers (their values being a function of the intensity of the punisher delivered, how far they are from the punisher, the frequency of punishment occurring in their presence and their values as previous conditioned reinforcers). The chain may be interrupted at this point and the person will have the tendency to avoid the emission of the responses of the chain, up to that point (see description of punishment, above).

Wincze (1971) provided an example of punishment occurring early in a chain. He wrote:

"She was extremely tense over the thought of any sexual behavior and would not kiss her husband for fear that her actions would be interpreted by him as desiring sexual behavior"p. 286

Similarly, the present writer treated an unorgasmic woman who every might received friends to play cards, and had too much to drink, only to have an excuse of being tired and drunk, to avoid having sexual intercourse with her husband.
Lazarus (1963) provided an example of punishment generalization, occurring near the end of a chain:

'The thought of a flirtatious glance or an ephemeral embrace initially produced observable anxiety reactions in two of the patients. The "mildest" case along this dimension was a patient who could accept coitus in the "normal position" but whose husband's erotic gratification depended on varying the sexual positions. "Frankly, I think that my husband needs treatment. He behaves just like an animal."

This patient's aversion to postural variations during coitus apparently emanated from feelings of fear and disgust when, as a young girl on the farm, she had on occasion been forced to witness animals copulating.' p. 275.

Because of the principle of stimulus generalization and the possibility of using conditioned reinforcers effectively in the punishment operation, the list of potential punishers is unlimited. They might be, for example, pain from early attempts at vaginal masturbation, as suggested by Horney (1933), religious principles, smell due to lack of hygiene, criticism, painful coitus due to lesions in the vagina or lack of lubrication, history of pregnancy, etc.

Other causative factors of orgasmic dysfunction may be the weak reinforcing value of the sexual partner, the inability to perform the necessary responses for the completion of the chain, as in the cases of lack of sexual skill, vaginismus, premature ejaculation and
impotence.

When we consider all these factors, it is not surprising that the unorgasmic woman varies from those for whom sexual intercourse is highly punishing to those for whom sex is reinforcing, but they have some difficulty in reaching an orgasm (Lazarus, 1971).
In the sections below we will discuss some procedures, found in the literature, used in the treatment of orgasmic dysfunctions.

Standard Systematic Desensitization

This procedure is based on the assumption, suggested by the interpretation of experiments with cats as subjects, that:

"If a response inhibitory of anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety response, the bond between these stimuli and the anxiety response will be weakened" (Wolpe, 1961, p. 189).

Theoretically any response that can inhibit anxiety (defined by Wolpe, 1958, p. 34, as "...the autonomic response pattern or patterns that are characteristically part of the organism's response to noxious stimulation") can be used. However, relaxation is the most widely used, with some reference to sexual responses and assertion.

The treatment starts with a careful interview embracing the client's life, with special attention

1By noxious stimuli is meant those which the organism tends to avoid.
to aspects of the sexual relationship that provoke anxiety in the client, who is asked to describe these stimulus situations in detail and to grade them with respect to the degree of anxiety elicited. This list of stimuli to which the client is reported to react with anxiety is ordered from the least to the strongest anxiety eliciting stimulus - the so-called hierarchy.

Wolpe (1961) called attention to the difficulty that, in some cases, one may have in building up a hierarchy, because the stimuli which the client avoids, may be not the real source of anxiety. He gave as an example the case of an impotent man whose anxiety was elicited by the idea of trauma related especially to defloration and not by the sexual relationship itself. It is not a prerequisite that the client has exposed himself to the anxiety-evoking situation in order to include it in a hierarchy. The total number of items to be included in a hierarchy depend upon the severity of the case, but typically vary from five to twenty-five items (Rachman, 1959).

The following is a hierarchy obtained by Lazarus (1963). The most anxiety-evoking items are at the top of the list.

1) Having intercourse in the nude while sitting on husband's lap.

2) Changing positions during intercourse.
3) Having coitus in the nude in a dining room or living room.

4) Having intercourse in the nude on top of a bed.

5) Having intercourse in the nude under the bed covers.

6) Manual stimulation of the clitoris.

7) Husband's fingers being inserted into the vagina during pre-coital love play.

8) Caressing husband's genitals.

9) Oral stimulation of the breasts.

10) Naked breasts being caressed.

11) Breasts being caresses while fully clothed.

12) Embracing while semi-clothed, being aware of husband's erection and his desire for sex.

13) Contact of tongues while kissing.

14) Having buttocks and thighs caressed.

15) Shoulders and back being caressed.

16) Husband caresses hair and face.

17) Husband kisses neck and ears.

18) Sitting on husband's lap, both fully dressed.

19) Being kissed on lips.

20) Being kissed on cheeks and forehead.

21) Dancing with and embracing husband while both fully clothed. (p. 276)
Concomitant with hierarchy construction the client is taught muscle relaxation. Although there is some variation, the relaxation method is essentially that of Jacobson's (1938) progressive relaxation.

After the construction of the hierarchy the desensitization process commences, with the client, in deep relaxation, sitting in a comfortable armchair. Instructions are given for the client to close his/her eyes and to visualize as clearly as possible the items of the hierarchy, which will be described by the therapist. The client is encouraged to signal with an arranged movement of hand or finger (Lazarus (1971) has been using normal verbal communication) at any time when the mildest anxiety is felt. On these occasions, instructions to increase the muscle relaxation are given, and the item is presented again. Normally, each item is presented twice. The first presentation is often a neutral one, followed by presentation of the least anxiety evoking item of the hierarchy. If the client does not report anxiety, the therapist may present the next item and so on.

To clarify the procedure, an example reported by Wolpe (1951) is presented below:

"You will now imagine a number of scenes very clearly and calmly. The scenes may not at all disturb your state of relaxation. If by any chance, however, you feel disturbed, you will be able to indicate this
to me by raising your left index finger one inch or so. (Pause of about 10 seconds). First, I want you to imagine that you are standing at a busy street corner. You notice the traffic passing - cars, trucks, bicycles, and people. You see them all very clearly and you notice the sounds that accompany them. (Pause of about 15 seconds). Now, stop imagining that scene and again turn your attention to your muscles. (Pause of about 20 seconds). Now, imagine that it is a work day. It is 11 A.M. and you are lying in bed with an attack of influenza and a temperature of 103. (Pause of about 10 seconds). Stop imagining the scene and again relax. (Pause of 15 seconds). Now, imagine exactly the same situation again..." p. 194.

Modified systematic desensitization

With a client who cannot achieve deep relaxation, Wolpe (1961) advised the use of drugs to induce it. Brady (1966) reported a case of orgasmic dysfunction treated with the use of Brevital to induce profound relaxation.

Madsen and Ullmann (1967) advised the husband's active participation during the treatment, in the therapist's office as well as at home. Contrary to Lazarus' (1963) suggestion to the husband to avoid sex with his wife during the treatment period with the purpose to preclude resensitization, they advocate the partners' cooperation to perform those sexual responses for which the client is prepared.
Caird and Wincze (1974) were able to treat an unorgasmic woman, to whom the items of hierarchy, involving heterosexual behavior, were presented by her husband with the use of videotape cassettes. They pointed out that this technique appears to be more effective than standard systematic desensitization; besides it is not necessary for the therapist to be present. They advised its use with women who have difficulty visualizing verbally presented anxiety evoking stimuli, and in those cases where normal verbal communication is impossible, as in the cases of language barrier and deafness.

It seems to us that the so called "in vivo desensitization", when used in the treatment of sexual problems, is the same technique that Wolpe (1952) named the use of sexual responses. This technique will be discussed in the next chapter.

Results

Although orgasmic dysfunction is a very common problem (Dengrove, 1967; Masters and Johnson, 1970) and systematic desensitization is widely used, few papers reporting the use of this technique as an attempt to overcome orgasmic dysfunction have been published. Almost all of them report success; however, the number of clients, in most of the publications, is only one.
Lazarus (1963), using the standard procedure reported nine successes from a total of sixteen patients, with a mean of 28.7 sessions. A patient was recorded as a success, if he answered affirmatively each of the following questions:

"Do you look forward to sexual intercourse? 
Do you nearly always reach an orgasm? 
Do you ever initiate sexual activity?" P. 277

It is important to note that among the seven failures there were cases of homosexuality, to which this technique is not appropriate. Although beyond the scope of the present review, we would like to point out that in the cases of homosexuality, the treatment should consist of two steps: a) the break up of the reinforcing value of stimuli stemming from the partner of the same sex, at least during the treatment period (LoPiccolo and Watkins, 1972), and b) the build up of reinforcement from members of the opposite sex.

O'Leary and Wilson (1975) reported a study conducted in 1971 by Brady, in which relaxation was induced with the use of Brevital. Improvement was reported for 16 out of 24 cases as indicated by the following criteria:

"(a) That the patient enter freely into sexual intercourse with her husband; (b) that she experience no pain or negative emotional reactions during sexual activities; and, (c) that she enjoy intercourse
and experience orgasm at least some of the time" p. 300

Follow-up data collected between three months to three years later showed no regression or symptom substitution.

Obler (1973), in a well controlled study, reported a 42 per cent success rate, using a total of 13 subjects. He introduced some modification, consisting of a) instructions to the client to avoid any sexual behavior which evoked anxiety in a previous therapy session, until no anxiety occurs in a subsequent session; b) the duration of presentation of the hierarchy items was increased to 30-60 seconds; c) when the clients had difficulty imagining any item, films or slides related to the client's difficulties were presented; d) the Ss received assertive and confidence training at the 6th, 8th, and 12th sessions. Follow-up data collected 18 months later showed no regression.

Crucial Variables in Systematic Desensitization

A great amount of research has been conducted to isolate the effects of several variables in the application of systematic desensitization technique.

Relaxation

Bandura (1969); Rimm and Masters (1970); O'Leary and Wilson (1975) reviewed the experimental evidence concerning the importance of relaxation and concluded
that relaxation is not a necessary condition for the successful use of systematic desensitization, although its use in this technique can facilitate the extinction process of avoidance behavior.

**Graduated item presentation**

Krapfl, cited by Bandura (1969), reported that there were no significant differences in the extinction of snake avoidance behaviors of subjects divided in four groups, to which the hierarchy items were presented in ascending order by the therapist; or in ascending, descending and random order via tape recordings. Significant differences were found between these four groups and the two control groups.

In regard to the four treatment groups, that which received the randomized presentation of the hierarchy items, exhibited the weakest extinction effects, and that which received the descending presentation of the hierarchy items exhibited high levels of anxiety and avoidance behavior to the procedure at the beginning of the treatment. These differences disappeared during the course of treatment.

**Theoretical Account**

The evidence presented above, brings into question the Wolpian hypothesis that systematic desensitization is a counterconditioning process, based on the inhibitory response process. Other authors (Bandura, 1969;
proposed different theories, all of that kind that Skinner (1972) suggested be unnecessary:

"...any explanation of an observed fact which appeals to events taking place somewhere else, at some other level of observation, described in different terms, and measured, if at all, in different dimensions:

A more parsimonious interpretation of desensitization seems to be as follows:

When a hierarchy item is presented to a client by the therapist or otherwise, an environmental change occurs, which is a punishment to the response being emitted by the client at that time; for example, relaxation. Because in this situation the change is a mild punishment (the item is a conditioned punisher), a gradual recovery of the relaxation response will be expected to occur. (Shubot, cited by Bandura (1969), reported that the amount of anxiety evocation was a function of extinction of avoidance behavior). With the repetitive presentation of the hierarchy item in the absence of the punisher, it gradually will lose its value as a conditioned punisher, and consequently, its control over the relaxation response.

Recalling that in a chain the value of a conditioned punisher is a function, besides other variables, of how far they are from the punisher - a hierarchy may be seen
as a verbal description of a chain - it can be stated
that the presentation of a hierarchy in the descending
order (from most to least anxiety provoking) will have,
at the beginning, more control over the response.
Recovery, at this time, is less probable to occur; or,
depending on which response we are recording, the
process of extinction of the avoidance response is
slower than when the hierarchy is presented in the
ascending order.

Another effect of the presentation of a hierarchy,
in its descending or ascending order, is the extinction
of the $S^+$ function of the items for further punishment.

The most notable characteristic of avoidance
behavior is its resistance to extinction. Herrnstein
(1969) reported that resistance to extinction is an
inverse function of the frequency of the response
at the start of the extinction process. He suggested
that it is possible to interfere with this process by
manipulating discriminability.

The facilitation effect of relaxation consists
merely of its incompatibility with the topographies
of the operant escape responses to the situation, facili-
tating the discrimination that the punishing contingency
is no longer in effect. This discussion is consistent
with the experimental evidence presented previously.
Conclusion

We suggest the use of systematic desensitization with the hierarchy being presented in its ascending order, for the treatment of orgasmic dysfunction, as a preliminary procedure, when the avoidance response is being emitted at a high frequency to the first links of the chain. Because relaxation can facilitate sexual arousal, we also suggest its use in the desensitization process.

Systematic desensitization can only provide an occasion for the extinction of avoidance behavior. As pointed out by Lazarus (1971), there are other procedures that improve the client's skill to perform a satisfactory sexual act. Another difficulty with the use of this technique is the impossibility of the therapist to exert control over the client's imagination process.
 Assertive Training

Under the label of "assertive training" are included several procedures to teach clients how to improve their skills in giving feedback - both negative and positive - to persons who interact with them. In other words, the objective of these procedures is to teach clients how to deliver consequences effectively in an interpersonal relationship.

Wolpe, as we saw in the preceding chapter, stated that assertiveness inhibits anxiety in a way similar to relaxation. At an observational level what happens is a decrease in the frequency of punishment, and an increase of reinforcement in the clients' social life.

Goldstein (1971) used assertive training as a technique to treat orgasmic dysfunction. He also made use of systematic desensitization concomitantly. It was a successfully treated case of a woman complaining of secondary orgasmic dysfunction. No details of the assertive training procedure were presented.

Assertive training should be given to those individuals who avoid social contact due to lack of skill in interpersonal relationship. We will return to this issue in the discussion of impotence.
The Use of Sexual Responses

This procedure, first reported by Wolpe (1958) as especially designed to overcome impotence, is indicated in cases where the client's avoidance behavior is not enough to prevent sexual relationship (Rachman, 1961; Lazarus, 1971). Instructions are given to the client not to try coitus until he has a strong desire to do so. With the cooperation of the partner, the client is supposed to engage many times in sexual foreplay, up to the point where little anxiety is felt. After each attempt, the anxiety evoked by the situation is decreased, until a level is reached where coitus can be performed without problems.

Wolpe (1958) was able to treat an unorgasmic woman with interpersonal difficulty by a combination of systematic desensitization and the present technique. Wolpe and Lazarus (1966) reported the case of a primary unorgasmic woman, who experienced strong pain in coitus. Her husband ejaculated prematurely. The treatment consisted only of a predetermined love-making sequence.

The sexual responses technique, it is said (Rachman, 1961), has a similar theoretical basis to that of systematic desensitization. Our interpretation will be presented together with the discussion of Masters and Johnson's (1970) procedure.
Aversion-Relief Therapy

Thorpe, Schmidt, Brown and Castell (1964) developed a technique which was later modified by Clark (1965), which is usually applied to the treatment of sexual deviation (homosexualism and transvestism). This procedure is based on experimental evidence that the delivery of a punisher tends to produce escape responses from the situation (see session about punishment). Any stimuli setting the occasion for the reinforcement of those escape responses acquire the function of conditioned reinforcers.

Lazarus (1971), with an adapted version of Thorpe et al.'s aversion-relief therapy, reported success in the treatment of a primary unorgasmic woman, after failure using systematic desensitization. She had strong avoidance behavior toward male genitalia. He used the following procedure:

An apparatus was used to deliver shock to the client's hand. Immediately after the word "shock", said by the therapist, the apparatus was turned on, and the intensity of the shock was gradually increased. The client was supposed to tolerate the pain elicited by the shock as much as possible. At this point, visual responses directed at photographs of nude men immediately terminated the shock. Intermittent shocks were delivered contingent to escape responses from the pictures. For the end of
the treatment the procedure was modified. Now, after the word "shock", if the client did not look at the photographs before eight seconds had lapsed, a train of shocks were delivered.

The treatment had a duration of twelve sessions. Several months later the client reported that the treatment was still effective.

The problem with the use of this type of technique is the possibility of the client to avoid the therapeutic situation itself, as reported by Thorpe et. al. (1964).

Masturbatory Training

McGuire, Carlisle and Young (1965) proposed that the fantasies and scenes recalled during masturbation are reinforced by orgasm. Their hypothesis received experimental support from studies conducted by Rachman (1966); Rachman and Hodgson (1968); Herman, Barlow and Agras (1974); Langevin and Martin (1975).

McGuire et al. (1965) reported successful results in overcoming several sexual deviations by instructing the clients to masturbate using any available means, but to concentrate on "normal sexual intercourse" during the five seconds preceding orgasm.

Marquis (1970) suggested what one may call reverse chaining, that is, the client is instructed to gradually increase the time preceding orgasm, during which he is expected to concentrate on normal sexual intercourse.

Reisinger (1974), in a very controlled study with
a young primary unorgasmic woman, reported that mastur-
bation with pornographic films was more effective than
masturbation with fantasy alone as a procedure for the
treatment of the subject's problem.

Although no prevision was made for generalization
to real life situations, the subject reported increased
frequency of orgasm in normal heterosexual intercourse.
A six months follow-up indicated the treatment had been
effective.

Masturbatory training does not have the same problem
that is associated with aversion-relief therapy. However,
as in systematic desensitization, the success of the
treatment, as described by the authors cited above,
depended almost exclusively on the client's imaginative
process, which is of difficult access to his partner or
to the therapist.

LoPiccolo and Lobitz (1972) designed an interesting
procedure involving masturbatory training. The procedure
was composed of several steps, and required the husband's
graduated participation in the process, which ended
with coitus. (See Chapter 8, below) The entire treatment
had a duration of fifteen therapeutic sessions. They
reported that all of the eight primary unorgasmic women
treated by this method were able to achieve orgasm;
two only through clitorial manipulation by their husband;
another two, through coitus and concomitant manipulation
of the clitoris; and the last four, through coitus (these four did not require direct manual manipulation of the clitoris). The frequency of orgasm-relief for these women varied from 25 per cent to nearly 100 per cent. Follow-up data collected up to six months later revealed no treatment reversal and further improvement in the reinforcer value of the sexual relationship.
THE MASTERS AND JOHNSON PROCEDURE

Outline of Program

Because Masters and Johnson (1970) did not present themselves as behavioral therapists, their procedure will be discussed separately. It is predicated on the basic assumption that the therapeutic emphasis should be directed at the relationship between the sexual partners. Another premise is that the treatment process should be conducted by a dual-sex team. The clients must dedicate two-weeks entirely to the therapeutic procedure, which follows a rather fixed schedule. The daily sequence is:

First day

Each therapist conducts an interview with the client of his/her sex. The interview embraces the client's entire life.

Second day

Based on the material collected during the first day, the clients are again interviewed. This second interview is conducted by the therapist of the opposite sex.

Third day

During this day, both clients pass through a careful physical examination. At this point of the
treatment the sexual partners are instructed to avoid sexual contact and discussion about the content of the first and second interviews. After the physical examination, the therapists and clients conduct a round-table discussion. The main objective of this session is to explain to the clients the probable causes of their present sexual dysfunction based on the results of the laboratory evaluation and the information obtained during the first two interviews.

Masters and Johnson assume that there is a cultural tendency for individuals to communicate affection, dedication, love, etc. mainly by touch (olfaction, vision and audition have a secondary role in the process). Hence a physical exercise for development of the perception of the feelings elicited by touch - the sensate focus exercise - is prescribed. The therapists designate one of the partners to initiate massage on the nude body of the other partner, who gives directions regarding which specific areas (except the genitals) and intensity is most pleasing. Clear instructions are given to the couple to avoid any goal, for example, ejaculation to the man and orgasm to the woman. Giving pleasure is the principal role of the partner who is giving the massage; but he also is instructed to concentrate on his own feelings in doing so:

"...to experience and appreciate the sensuous dimensions of hard and soft,
smooth and rough, warm and cool, qualities of texture, and finally, the somewhat indescribable aura of physical receptivity expressed by the partner being pleasured" (Masters and Johnson, 1970, p. 73).

There is no time limit. The client may please his partner as long as they desire. Then, the roles are reversed, with the partner who was receiving now giving the massage, following the same procedure. Depending on the results of the first roundtable discussion, the sensate exercise may be initiated in the next day.

**Fourth through fourteenth day**

Part of this session is devoted to discussion of what happened in the sensate focus exercise performed on the previous day. Instruction is given to repeat the same procedure, with the partner who is receiving pleasure in a more active role, indicating the exact intensity and speed of the movement and specific areas of the body (including genital area and woman's breast—but with clear limitation of coitus) by means of physical communication, with his/her hand on that of the client who is giving the massage. In this session, as during the entire treatment, a great deal of time is spent in the educational process of providing the clients with information about the sexual function.

The purpose of these exercises is to elicit sexual arousal spontaneously, which is the basis for future development of natural and effective sexual function.
After satisfactory completion of the sensate focus exercise, specific instructions are given, according to the sexual dysfunction being treated. In the case of orgasmic dysfunction, the next step is genital manipulation.

While the partner is in the nondemand position, the man begins the sensate exercise, following essentially the same procedure as the previous sessions, that is, the stimulation must be directed by the woman. An important point is that each exercise is practiced until there is full appreciation by both partners, so that the introduction of a new exercise functions as a new link of a chain.

After excitation is reached through genital manipulation, the next link to be added is intromission. This is accomplished in the female-superior coital position. The man's role is to remain quiet, but to maintain an erection. Instruction is given to the woman to make no movement at first; just to try to be aware of the sensation elicited by the penis. After a while, a brief period of slow and exploratory pelvic movement is advised. Subsequent to the development of vaginal sensation in this situation, the man is required to initiate slow pelvic movement.

After these steps have become well stabilized (that is, the man has better control over his erection,
and the woman enjoys the sensations elicited by the pelvic movements with the penis in her vagina) the couple is requested to change to the lateral coital position. In order to accomplish this change with a continuous movement, some practice may be required. The lateral coital position provides the opportunity for the woman to enjoy all aspects of the sexual act, either slow or rapid pelvic movement, in several directions.

It should be noted that the man's cooperation is crucial to the success of this procedure. A way suggested to reinforce his cooperation is manipulation to ejaculation at least with the same frequency that he stated as ideal during the first two interviews, and some operation to induce sexual deprivitation conducted at least every fourth day; on these occasions, the couple is declared on vacation from physical sexual expression.

Results

Masters and Johnson (1970) stated clearly that their sample is not representative of the general population. Indeed, it may be considered as representative only of the upper-class in both socioeconomic and educational aspects. Their results, expressed in terms of failure rates, are presented in Table 1. Data from follow-up during a five-year period are also presented in the same table.
Table 1
Overall Results of the Masters and Johnson Procedure

<table>
<thead>
<tr>
<th>Orgasmic Dysfunction</th>
<th>N</th>
<th>F</th>
<th>IFR</th>
<th>TR</th>
<th>OFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Orgasmic Dysfunction</td>
<td>193</td>
<td>32</td>
<td>16.6</td>
<td>2</td>
<td>17.6</td>
</tr>
<tr>
<td>Situational Orgasmic Dysfunction</td>
<td>149</td>
<td>34</td>
<td>22.8</td>
<td>3</td>
<td>24.8</td>
</tr>
<tr>
<td>Total</td>
<td>342</td>
<td>66</td>
<td>19.3</td>
<td>5</td>
<td>20.8</td>
</tr>
</tbody>
</table>

N=Units referred for treatment.  
F=Immediate treatment failure.  
IFR=Initial failure rate.  
TR=Overall rate.  
OFR=Treatment reversal.

Adapted from Masters and Johnson, Human Sexual Inadequacy, 1970, p. 367

Crucial Variables

This treatment program contains several procedures. There are no results as yet of systematic research conducted for the purpose of isolating the effect of specific independent variables.

Harris and Wagner (1973) reported a "striking success rate" (unfortunately no data are presented) using a procedure almost identical to that of Masters and Johnson. Two important differences between these procedures must be noted: a) the sample of the former is much more representative of lower socio-economic
class; b) the clients stay in their homes. The therapeu-
tic sessions are conducted two or three times weekly-
the entire treatment ranges from three to ten weeks.

Masters and Johnson (1970) called attention to
the importance of the social deprivation (vacation
from everyday life - business, children, secretary,
and friends). As a consequence the partner's value
as a conditioned reinforcer increases causing an
increase in the probability that the sexual partners
will develop a better relationship, which contributes
to easier discrimination and understanding of the basic
assumption that the focus of the therapy is the commun-
ication between the partners. They presented as evidence
the fact that clients referred to them from outside
the St. Louis area require only two weeks of treatment,
as compared to the three weeks necessary for those who
live inside the St. Louis area.

As pointed out by Murphy and Mikulas (1974),
another important variable must be noted. It is well
known that any stimulus that precedes immediately
the delivery of a consequence, acquires the same
function as that consequence, that is, the stimulus
becomes a conditioned reinforcer or a conditioned
punisher (Kelleher and Gollub, 1962). Thus, sexual
dysfunctions might be also under the control of environ-
mental aspects, as for example, the shape, color and
illumination of the bedroom. To those who have to move to St. Louis, the environmental stimuli which might have acquired the function of conditioned punishers are not present in the new contingencies of the therapeutic procedure. Under these conditions it is easier to modify the partner's avoidance behavior toward sexual intercourse.

The success in the reversal of orgasmic dysfunction reported by other authors (Lazarus, 1963; Madsen and Ullman, 1967; Brady, 1966; Wolpe, 1973; and Caird and Wincze, 1974) brings into question the importance of the dual-sex team. As pointed out by Skinner (1953), there is a high probability of reinforcement for imitative behavior. (Bandura, Grusse and Menlove, 1967; Bandura, 1969; Bandura, Blanchard and Ritter, 1969, have referred to this process as vicarious learning). The dual-sex team's behavior may facilitate the discrimination that punishment no longer follows talk about sexual problems. Their behavior also may serve as an example of the topography of the responses appropriate for the new situation. (See chapter six of Skinner, 1969).

It has been said (Murphy and Mikulas, 1974) that the Masters and Johnson (1970) procedure is composed of an educational process and a behavioral one. These authors pointed out that too much time has been spent in educating the clients, as contrasted to a direct
attack at more important variables such as the behavioral assignments. Lobitz and LoPiccolo (1972) have reported 100 per cent success in the treatment of primary orgasmic dysfunction, and 53.3 per cent in cases of situational orgasmic dysfunction. But they called attention to the fact that they had success with the last three cases of situational orgasmic dysfunction, after they made some modification in their procedure. They emphasize the behavioral assignments.

Theoretical Account

Masters and Johnson (1970) regard the sexual function as the result of an interaction between the physiologic and psychologic systems. Since their therapy is directed toward this interaction it is expected to result in the natural development of the sexual function. A difficulty with this approach, as pointed out by Murphy and Mikulas (1974), is that the Masters and Johnson (1970) procedure in some cases is not appropriate to elicit the natural sexual responses. Perhaps this is the weakest point in their procedure.

Murphy and Milulas (1974) suggested, besides other points, the following alterations in order to increase its efficiency. The therapeutic intervention should extend into the client's bedroom, for example, the environmental situation could be changed by rearranging its decoration and illumination. More attention should be directed toward shaping of the client's sexual
repertoire. Techniques more appropriate to specific cases should be utilized.

The Masters and Johnson (1970) procedure is a sophisticated form of Wolpe's (1958) sexual responses technique. The rationale underlying the use of this technique, according to the Wolpian point of view, is that sexual arousal is an inhibitory response to anxiety, which is elicited by aspects of sexual intercourse. With the gradual exposure to stimuli of a sexual nature, an in vivo desensitization process is initiated. When discussing the systematic desensitization technique we presented evidence that brought into question its interpretation in terms of a counterconditioning process, and suggested a more parsimonious interpretation, namely the extinction of the function of conditioned punisher and $S^D$ for further punishment of the links of the sexual chain. The same interpretation may be made of the sexual response technique. But, beyond the simple extinction process, the client has the opportunity to obtain reinforcers delivered by his/her partner, when performing the first responses of the chain, thus, having the chance to improve his skill as a lover, although in an uncontrolled fashion. The major contribution of Masters and Johnson to the treatment of sexual dysfunction was exactly the controlled process of shaping the client's sexual repertoire, by means of sensate exercises and the use of special coital positions.
SOME SUGGESTIONS

Experiments conducted with animals as subjects (Kelleher, 1966) suggest that the most efficient process to build up a chain, is the use of a backward chaining technique. That is, one should start with the last link, the closest possible to the delivery of the reinforcers, and add every new link in such a way that it precedes the last links added, but add new link only when the last new link is already well incorporated in the individual's behavioral repertoire. Accordingly, a more effective treatment program should first of all provide the client with the capacity to reach orgasm as frequently as possible. Some authors have advocated the use of masturbation to achieve this objective (LoPiccolo and Lobitz, 1972; Lobitz and LoPiccolo, 1972; Kaplan, 1974).

Masturbatory Program

LoPiccolo and Lobitz (1972) designed a special program to train their patients in the masturbatory process. It is as follows:

Step 1

After showering, the client is requested to scrutinize her nude body, paying attention to its beauty. Also, with the help of a hand mirror, she studies the anatomy
of her genital organs, following a diagram provided by the therapists. In order to increase her capacity to achieve orgasm the client is instructed to contract and relax her pelvic muscles for three sessions composed of ten repetitions per session.

Step 2

The next step in the shaping process is tactual and visual exploration, without any specified finality.

Step 3

Next the client is to locate the pleasurable genital areas.

Step 4

A discussion between the client and therapists about some aspects of masturbatory techniques, such as variation in the intensity and speed of strokes, and the use of lubricants. As part of this step, the client is instructed to stimulate manually those previous located pleasurable areas.

Step 5

If the client does not reach orgasm, she is requested to increase the intensity of the stimulation and to persist in the masturbatory process to the point of fatigue. The use of pornographic stimuli - pictures and literature - and erotic fantasies are also suggested.
Each step of the program is usually practiced for a week.

**Step 6**

If orgasm has not yet occurred, the client is asked to add the help of a lubricated vibrator. LoPiccolo and Lobitz (1972) reported that in their most resistant case, 45 minutes of daily stimulation with the vibrator was necessary for three weeks. Also they suggested the use of assertive training techniques for those clients to whom some specific aspects of the orgasm itself were identified as punishment. These clients were instructed to simulate an orgasm in their home.

**Building up a Sexual Chain**

According to Masters and Johnson (1970) the most common way to express feelings is by tactual communication. The present writer sees no reason to include the visual genital exploration in the masturbatory program. This activity might be punishment to several clients, as information provided by LoPiccolo and Lobitz (1972) suggests. We propose that the use of the backward chaining technique in the execution of their program would increase its efficacy.

After a woman is achieving orgasm frequently, a therapeutic procedure should be designed especially to teach every couple, using the backward chaining technique, how to build up an interaction between them.
which will end with orgasm through coitus or otherwise. The details of the procedure must be described according to each case. It seems to us that little attention, if any, has been directed to the importance of each sexual partner learning how to use his sexual responses as a reinforcer to induce the other partner to emit those responses which are reinforcers to himself. The entire treatment program should include other procedures designed especially to induce the clients to execute the therapeutic procedure, as suggested already by Lobitz and LoPiccolo (1972).
BEHAVIORAL TREATMENT OF VAGINISMUS

Vaginismus is an involuntary spasmodic contraction of the musculature investing the vaginal entrance and its vicinity, in response to pelvic tactual exploration. It is not a very common female sexual dysfunction. Masters and Johnson (1970) reported only twenty-nine cases during an eleven year period, from a total of 342 women treated. This sexual dysfunction has a high correlation with impotence of the male (presumably causal in both directions). Masters and Johnson presented this fact as further support of their assumption that the relationship between the sexual partners should be the principal objective of the therapeutic intervention.

This phenomenon may be considered as a strong avoidance behavior caused by punishment of high intensity. In the more difficult cases, as measured by the intensity of the contractions of the vaginal musculature, penile intromission is impossible.

Cooper (1969), and Masters and Johnson (1970), advocated the husband's presence during the treatment process. The first author used dilators of graduated diameters. With the patient in deep relaxation, the therapist at first, and afterwards the patient, introduces the dilators into the vagina, starting with the smallest diameter. He instructed the husband to behave more
aggressively and to extinguish the wife's complaints of pain. Masters and Johnson demonstrate to both partners the phenomenon of vaginismus and prescribe as home assignment the use of dilators of graduated sizes. The vaginal insertion of the graduated dilator is to be executed by the husband, with the wife's help, at first by physical direction and then, by verbal instruction. After the woman is able to tolerate the dilator of the biggest diameter, they advise its retention in the vagina for several hours. They also advise vaginal dilatation before coitus during the first six weeks following treatment. In order to overcome the psychological aspects of this sexual dysfunction, they provide the clients with information about its etiology and its prognosis.

Lazarus (1971), and Wolpe (1973), advised the use of dilators, concomitant with systematic desensitization.

All these authors cited above reported 100 per cent success, using penile intromission as criteria.
BEHAVIORAL TREATMENT OF PREMATURE EJACULATION

This male sexual dysfunction is characterized by the extreme rapidity of orgasm. The premature ejaculator reaches orgasm almost immediately after penile intromission. Masters and Johnson (1970) proposed a failure to satisfy his sexual partner, through coitus, in at least 50 percent of the coital opportunities as a criterion to consider one a premature ejaculator. They found that the ejaculatory process is composed of two stages: a) the ejaculatory inevitability stage - the prostate gland, and probably the seminal vesicles, start an irreversible contractional process a few seconds (from 2 to 4) prior to the emission of the seminal fluid; b) the involuntary emission of the seminal fluid, through the urethral meatus.

Semans (1956) described a simple technique to treat premature ejaculation. The sexual partners are instructed to engage in mutual masturbation. When the man reaches a level of sexual excitement in which he can identify the eminent start of the ejaculatory inevitability stage, he should tell his partner and move his hand away from his penis. After the urge to ejaculate disappears, the same procedure is repeated again. At the end of the session, the man should manipulate his partner to orgasm. When he is able to control ejaculation in this situation,
the couple is instructed to use a lubricant. After ejaculatory control is achieved with the use of a lubricant, ejaculatory control with vaginal intromission is expected. He reported eight cases successfully treated with this procedure. An average of three and a third hours interviewing the couple was spent in each case. Follow-up data collected from five weeks to fifteen months later revealed no relapse.

Wolpe and Lazarus (1966) improved the efficacy of the Seman's technique, by introducing a shaping process toward coitus.

Masters and Johnson (1970) developed a more sophisticated technique, by instructing the woman to apply strong pressure (for 3 to 4 seconds) at the coronal sulcus of the penis, as soon as the urge to ejaculate is identified - the called squeeze technique. The shaping process toward coitus is accomplished through the female-superior coital position, which facilitates the immediate application of the squeeze technique. At first, the couple stay in this position, without pelvic movements. Any time the man feels imminence to ejaculate, he should inform his partner, who is expected to apply the squeeze technique. The same procedure is repeated until the man acquires sufficient ejaculatory control to maintain his erection while making slow pelvic movements. After the man achieves better control over his ejaculatory process,
his partner is instructed to initiate pelvic movements, initially in a controlled fashion.

Masters and Johnson (1970) reported 97.3 per cent success rate with a total of 186 patients treated with the use of their procedure. They called attention to the fact that secondary impotence may appear, perhaps as a consequence of too frequent sexual intercourse after the couple learned how to perform a more satisfactory sexual intercourse.

Lazarus (1971) cited a urologist who has the opinion that prostatitis may be caused by the use of the squeeze technique.

Dengrove (1967) advised coitus frequently as a means to overcome premature ejaculation. He also advised the use of systematic desensitization for those cases in which avoidance behavior toward sexual intercourse is being emitted at a high frequency. Kraft and Al-Issa (1968) reported some cases successfully treated by this technique, using methohexitone sodium (Brietal, Brevital), as a method to induce relaxation.

Wolpe (1973) considered premature ejaculation as a manifestation of impotence. The response pattern of the sympathetic division of the nervous system (anxiety, according to him) elicited by a punisher, exercises an inhibitory effect over the parasympathetic function, thus impeding erection and facilitating ejaculation, which
is a sympathetic function.

For a complete account of premature ejaculation we still must explain the environmental situations which effect the nervous system. Information about its functioning is not enough for the practical control of this dysfunction. This argument is also valid for any behavior (Skinner, 1953).

Masters and Johnson (1970) suggested that premature ejaculation is a conditioned pattern of behavior. The conditioning process takes place during the first sexual experiences, in those contingencies where a very rapid sequence of sexual responses are reinforced. A man whose sexual initiation occurred with a prostitute, might become a premature ejaculator. Her principal reinforcer in this situation is the money paid by the customer. Usually, the amount of this reinforcer is a direct function of the number of men with whom she has sexual intercourse. Consequently, a rapid way to achieve orgasm is reinforced. The prostitute's rapid pelvic thrust is reinforced because the time spent with each customer is decreased, allowing her to attend to more customers; the customer is, of course, reinforced with orgasm. Another situation that may contribute to the establishment of premature ejaculation are those in which a rapid way to achieve orgasm decrease the probability of punishment, as when the sexual intercourse is occurring.
in places not safe enough from the public sight - in cars, drive-in movies, etc.

Changes in the sexual behavior of women who have frequent intercourse with premature ejaculating men is further evidence to support the idea that sexual behavior is under the same laws as any behavior. In this situation the women do not have the opportunity to develop skill in the sexual relationship; possible extinction process takes place, that is, they are no longer reinforced by orgasm through coitus. These women may become unorgasmic, the sexual stimuli stemming from the male partner may acquire the function of conditioned punishers. This may generalize to men in general, creating the opportunity for the development of homosexualism, for example.

That Masters and Johnson's interpretation is correct as reflected by the high success rate with techniques that directly interfere with this rapid pattern of ejaculation. Seman's (1956) procedure is a simple extinction process. The use of lubricant is an attempt to achieve generalization to the vaginal condition. The Masters and Johnson's (1970) squeeze technique is a simple method of delaying ejaculation Wolpe and Lazarus (1966), and Masters and Johnson (1970), have discussed the necessity of development new behavioral patterns.

We suggest that more attention should be dedicated to the shaping process of a long chain of sexual behavior.
As in the treatment of orgasmic dysfunction, every effort should be made to teach the sexual partners how to build up a satisfactory interaction between them.
The term "impotence" usually refers to the male's inability to produce or maintain an erection. Masters and Johnson (1970) proposed the expressions "primary impotence" and "secondary impotence". A male should be described as primarily impotent if he never was able to produce or maintain an erection of quality enough to achieve orgasm through coitus. If a male was able to reach orgasm through coitus, but fails in doing so in 25 per cent of his coital opportunities, he should be defined as secondarily impotent. These expressions are useful for communication purposes.

The etiology and treatment of impotence is basically similar to that of orgasmic dysfunction, which has been discussed previously.

Of course, there is a great difference between the male reproductive organs and the female's. Also, according to Masters and Johnson (1966) there is a difference between the male sexual response cycle and that of the female. The major difference between the human male and female's physiological-reaction pattern to sexual stimuli is the female's capacity to achieve immediately another orgasm, if she is stimulated effectively. In other words, the human female is insatiable physiologically. Due to the characteristics of the male's reproductive anatomy
(Shuttleworth, 1959), he might be more frequently exposed to sexual conditioning in his past history. For example, the baby boy has more opportunities to experience sexual stimulations stemming from his clothes. It is also the case that our society has been much more tolerant, even to the point of reinforcing the male's sexual behavior, as compared to that of the female. In spite of these differences the sexual behaviors of both male and female are assumed to be a function of the same conditioning laws.

The Wolpian interpretation of impotence was discussed together with premature ejaculation. Those who accept this orientation (Wolpe and Lazarus, 1966; Dengrove, 1967; Wolpe, 1973) have suggested the use of sexual response technique, a kind of in vivo desensitization, which was previously described. They have emphasized the necessity of a cooperative sexual partner as a prerequisite to treatment success with this technique.

The results of treatment of impotence with sexual responses reported by Wolpe and Lazarus (1966), are presented in Table 2. As we stated previously, these authors considered premature ejaculation as a manifestation of impotence. Thus, the data in Table 2 refer to both premature ejaculation and impotence.
Table 2

CASES OF IMPOTENCE TREATED BY USE OF SEXUAL RESPONSES

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Entirely satisfactory functional results (recovered or much improved)</th>
<th>Limited but significant functional improvement</th>
<th>Failures</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>21 (67.7%)</td>
<td>6 (19.4%)</td>
<td>4 (12.9%)</td>
</tr>
</tbody>
</table>

Mean age: 36.3 years
Mean time span: 11.5 weeks
Median time span: 8.0 weeks
Median time span for recovered and much-improved cases: 6.0 weeks

Adapted from Wolpe and Lazarus, *Behavior Therapy Techniques*, 1966, p. 115

Lazarus (1971) pointed out that many impotent men are unable to express their true feelings to women. In these cases, their sexual dysfunctions are frequently part of a nonassertive behavioral repertoire. These individuals have difficulties in maintaining a long-term social-sexual relationship, even though their specific sexual dysfunctions have already been treated (Herman and Prewett, 1974). Lazarus (1971) advocated the behavior rehearsal technique as a procedure to treat impotent clients who lack social skill. This procedure demands that the therapist play the role of individuals who maintain frequent social interactions with the
client who is instructed to react assertively. With the use of role reversal technique (Lazarus, 1966), sometimes the client plays himself, while the therapist is playing, for example, the wife's role. In other occasions, the therapist plays the client's role, while the client is playing his sexual partner's. These techniques provide the therapist with the opportunities to shape the client's social behavior and enable the client to learn by imitation.

It seems to us that a more efficient procedure, since the client has a cooperative sexual partner (a contingency established by Masters and Johnson (1970) to initiate the treatment) is one based on a token economy. Each partner is requested to make up a list, describing objectively the behavior which he/she wishes that his/her partner emit with high frequency. The couple is instructed in how to shape the social interactions between them, using the delivery of tokens to each other (Stuart, 1969).

Masters and Johnson (1970) suggested three principal goals in the treatment of impotence: a) extinction of the male's fears concerning sexual performance, that is, extinction of the male's avoidance behavior toward coitus; b) to change his behavior toward a more active one, that is, extinction of his role as a spectator; and c) remission of his sexual partner's fears related to her partner's sexual performance.

According to them, these goals are accomplished,
first of all, by convincing the couple that penile erection is a natural physiological process, that is, nobody can supplant or improve its occurrence. In other words, erection is a respondent behavior, inalterable by environmental contingencies. The next step in the treatment process is the reestablishment of communication between the couple, through dissemination of complete information about sexual function. The marital-unit is then instructed in the sensate-focus exercise and they are requested to perform mutual masturbation, with each individual indicating, by physical communication, the exact topography of his/her partner's responses which he/she wishes. After full erection is achieved and maintained, they are instructed in the use of the teasing technique - manipulation to full erection, followed by a brief period of extinction of the manipulation on the penis, manipulation again to full erection, and so on. The next step is penile insertion, controlled by the female, accomplished through the female-superior coital position. The penis should be manipulated during the intromission process. This procedure is repeated until erection can be maintained with security (this procedure is called the coital teasing technique). After this the female should initiate slow pelvic thrusting, in a nondemanding fashion, concentrating on the sensations elicited by the penis in the vagina, while the male stays quiet. Then the roles are reversed,
that is, the female stays quiet, while the male should initiate slow pelvic thrusting, paying attention to the sensations stemming from his penis in the vagina. The last step in the treatment program is simultaneous pelvic thrusting, with both partners concentrating on the sensations in their genital organs, without concern for satisfying each other.

The results reported by Masters and Johnson (1970) with the use of this procedure are presented in Table 3. Follow-up data collected during a five year period are also presented in the same table.

Table 3
Overall Results of the Masters and Johnson (1970) procedure

<table>
<thead>
<tr>
<th>Orgasmic Dysfunction</th>
<th>N</th>
<th>F (%)</th>
<th>IFR</th>
<th>TR</th>
<th>OFR (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Impotence</td>
<td>32</td>
<td>13</td>
<td>40.6</td>
<td>0</td>
<td>40.6</td>
</tr>
<tr>
<td>Secondary Impotence</td>
<td>213</td>
<td>56</td>
<td>26.3</td>
<td>10</td>
<td>30.9</td>
</tr>
<tr>
<td>Total</td>
<td>245</td>
<td>69</td>
<td>28.1</td>
<td>10</td>
<td>32.2</td>
</tr>
</tbody>
</table>

Adapted from Masters and Johnson, Human Sexual Inadequacy, 1970, p. 367

When the results of treatment of impotence are presented according to its basic etiology, one can see that religious orthodoxy and homosexual influence are
responsible for, respectively, 53.1% and 33.3% of the immediate failure rate of a total of 245 units treated (Masters and Johnson, 1970). These data reflect the weakest point of their procedure: the assumption that the respondent behavior of penile erection cannot be supplanted or improved by environmental contingencies. That this assumption is false is suggested by study conducted by Rachman and Hodgson, 1968; Laws and Rubin, 1959; Henson and Rubin, 1971; Barlow and Agras, 1973; Herman, Barlow and Agras, 1974; Herman and Prewett, 1974; Freeman, 1975. These authors used human beings as subjects.

Silberberg and Adler (1974) were able to change the rat's stereotypic pattern of copulatory sequence using a schedule of reinforcement.

As stated previously, in the case of homosexual etiology the building of reinforcing stimuli which stem from the opposite sex is necessary. (See, for example, Barlow and Agras, 1973; Freeman, 1975).

Religious orthodoxy is the most common causative factor of human sexual inadequacy (Masters and Johnson, 1970). Skinner (1953), in discussing the religious control over behavior, pointed out that:

"The agency punishes sinful behavior in such a way that it automatically generates an aversive condition which the individual describes as a 'sense of sin'. The agency then provides escape from this aversive condition through expiation and is thus able to supply
As stated before, the most notable characteristic of avoidance behavior is its resistance to extinction. This avoidance behavior is also reinforced by the promise of the heaven.

Another deficiency in the Masters and Johnson (1970) procedure is its relative rigidity (however, one must keep in mind that they had also research purposes). Nevertheless, the literature of the experimental analysis of behavior demonstrates the necessity of considering the topography of the responses in the client's repertoire when specifying the procedure which will be used to shape a final behavior. Masters and Johnson do not appear to appreciate this principle of behavioral specificity.
CONCLUSION

Sexual behavior is under the control of the same behavioral variables as any other behavior; it can be understood, controlled, and predicted by the application of the principles of operant conditioning. Sexual intercourse may be adequately understood when it is considered as a complex behavioral process in which each of the successive responses of an individual function as conditioned reinforcers for the previous response of the other individual and as discriminative stimuli for the emission of the next response. The female's sexual behavior is similar to that of the male, even admitting that there are differences in the sexual organs of the male and in his physiological-reaction pattern to sexual stimuli, as compared to those of the female.

Orgasmic dysfunction may be regarded primarily as the result of past punishment of sexual responses. The difference between primary orgasmic dysfunction and situational orgasmic dysfunction may be that primary dysfunction reflects a failure of acquisition and situational dysfunction involves a failure of maintenance of sexual behavior. The therapeutic procedures used in the treatment of primary orgasmic dysfunction should emphasize the problems related to the development of sexual skill while those used in the treatment of situational orgasmic
dysfunction should stress the extinction of avoidance behavior toward sexual intercourse.

All attempts to overcome sexual dysfunction, independent of theoretical orientation, place emphasis on the necessity to remove the punishing contingencies that may be in effect, and to provide means for the clients to discriminate that those contingencies are no longer in effect.

The analysis of sexual behavior according to the principles of operant conditioning has directed the attention of many professionals toward the consequences delivered by the sexual partners. These consequences are the major causative factors of the involved individual's present state of sexual dysfunction. The change in approach away from an illness model and toward the social relationship between the sexual partners as the principle maintaining factor of their sexual dysfunctions has made possible the development of more efficient techniques to treat such problems.

This analysis has resulted in a theoretical discussion according to the learning model, and some suggestions to increase the efficacy of the most efficient therapeutic procedures used in the treatment of orgasmic dysfunction, vaginismus, premature ejaculation, and impotence.
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