

## **Behavioral Assessment of Couples’ Communication in Female Orgasmic Disorder**

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*Communication problems are believed to play a central role in many sexual dysfunctions. The present study behaviorally assessed communication patterns within heterosexual couples in which the woman was experiencing female orgasmic disorder and within two groups of control couples. The sexually dysfunctional couples evidenced significantly poorer communication than controls, primarily but not exclusively when discussing sexual topics. Specifically, women with orgasmic disorder or their male partners demonstrated more blame and less receptivity. We discuss the etiologic and treatment implications of these findings.*

Effective communication has long been considered important to sexual adjustment (see, e.g., Ferioni & Taffe, 1997; LoPiccolo, 1978; McCabe, 1999; Wheelless & Parsons, 1995; Zimmer, 1983). For example, communication deficits and inhibitions are believed to play a role in the etiology or the maintenance of female orgasmic disorder, a common female sexual dysfunction characterized by difficulty reaching orgasm during sexual stimulation (Heiman & Grafton-Becker, 1989). However, the empirical literature offers minimal articulation of the specific nature of communication problems in sexually dysfunctional couples, including those with an anorgasmic female partner.

An examination of the necessary conditions for the development of effective sexual stimulation suggests some preliminary hypotheses for communication difficulties that might exist in female orgasmic disorder. Assuming she knows what she wants or needs sexually, a woman must then be able

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to express these wants and needs (a) clearly (Markman, Floyd, Stanley, & Storaasli, 1988) and in a (b) nonblaming (Halford, Hahlweg, & Dunne, 1990) manner, to a (c) nonblaming and (d) receptive partner (Halford et al., 1990).

Kelly, Strassberg, and Kircher (1990) looked for communication patterns that might distinguish anorgasmic from orgasmic women. They found that, compared with orgasmic women, anorgasmic women reported significantly less anticipated communication comfort regarding direct clitoral stimulation activities (i.e., cunnilingus, manual genital stimulation of the female), whereas they found no significant group differences regarding communication about intercourse. The authors hypothesized that specific difficulties with communication regarding these nonintercourse activities could play a particularly important role in the etiology and maintenance of female orgasmic disorder, given their relative effectiveness (compared with intercourse) as a means for women to achieve orgasm reliably (e.g., Griffitt & Hatfield, 1985).

More recently, Kelly, Strassberg, and Turner (2004) compared self-report data on communication (outside the lab) for couples with an anorgasmic woman partner with that of controls, including both a problem-free and a nonsexual problem-contrast group. They found that couples with an anorgasmic female partner self-reported more discomfort when communicating about issues of sexuality than did control couples. In particular, the anorgasmic women and their male partners both reported significantly more discomfort than did controls in discussing sexual activities associated with direct clitoral stimulation. The partners of the anorgasmic women also reported significantly more discomfort than did controls when the couple usually discussed intercourse. Furthermore, both the anorgasmic women and their partners appeared to view the woman as responsible for her sexual difficulties.

## THE PRESENT STUDY

Although informative self-reports of couples' experience of what typically occurs at home are subject to a variety of possible awareness and presentation biases. The present report describes the behavioral analysis of laboratory-assessed communication patterns exhibited by these same couples.

On the basis of the limited empirical research literature and the very basic sexual communication model described above, we hypothesized that communication within couples where the woman is experiencing an orgasmic disorder would be distinguishably more problematic than that within sexually functional control couples, at least where sexual topics were concerned. Specifically, we expected a behavioral analysis of communications between partners to reveal that couples with an anorgasmic female partner would be distinguishable from sexually functional couples by manifesting: (a) less clarity by the woman, (b) more blame by the woman or (c) her

partner, or (d) less receptivity by the male partner. We expected differences to be most evident or perhaps limited to discussions involving sexual topics, particularly those involving direct clitoral stimulation.

## METHOD

### Participants

Participants were 47 heterosexual couples recruited via campus and community newspapers, flyers, physician referrals, and contact with patient affiliate groups (e.g., Diabetes Association of America). Approximately 25% of initial respondents met the eligibility criteria, described below, and completed the study.

We recruited three groups of participants based on health and sexual functioning status, as follows: (a) couples in which each partner reported being free of physical health problems and in which the female partner reported the absence of orgasmic response in all types of sexual activity with her partner in at least 70% of sexual interactions (the anorgasmic [female orgasmic disorder] group,  $n = 14$ ); (b) couples in which both partners reported being free of problems in their physical health or their sexual functioning (problem-free control group,  $n = 16$ ); and (c) couples in which either partner reported a chronic physical health problem (e.g., diabetes) and in which both partners reported being free of sexual functioning difficulties (chronic illness control group,  $n = 17$ ). Males were considered free of sexual dysfunction if they reported sexual functioning sufficient for intercourse and orgasm (male) in at least 70% of sexual interactions with their partners (almost all were functional 100% of the time). Females were considered free of sexual dysfunction if they reported the ability to attain orgasm through some type of partner stimulation in at least 50% of sexual interactions.

The choice of how many and what types of control groups to use in a study of clinical populations is always a difficult one, impacted both by methodological and practical considerations. Our decision to include a group of “normal” couples was relatively easy. There were, however, several appropriate choices for a second control group. One would have been couples in which the man was experiencing difficulty reaching orgasm during partner stimulation (male orgasmic disorder). However, this is a relatively rare clinical condition and would have made recruitment of sufficient couples within a reasonable time frame virtually impossible. Couples in which the woman was experiencing some other type of sexual problem (e.g., vaginismus, inhibited sexual desire) would have also been a reasonable choice, allowing us to determine whether or not communication problems evidenced by couples with an anorgasmic female partner were specific to this dysfunction.

We chose a different alternative, that is, sexually functional couples experiencing a chronic medical problem. Research in chronic illness has suggested

that this problem is likely to have a major impact on a couple's relationship and provide challenges to their communication (see, e.g., Schmaling & Sher, 2000). The inclusion of the chronic illness group allowed for the exploration of whether communication differences, if found, between the female orgasmic dysfunction group and the problem free group were specific to couples with a sexual problem.

All participants were at least 18 years of age, involved in a relationship that they reported as "steady and sexually active" for at least 9 months, and reporting an average frequency of sexual activity of at least once per week. We found no significant group differences for age (males 20–69, median = 33, females 20–56, median = 30); duration of relationship (10–186 months, median = 48 months); frequency of sexual activity (4–33 times per month, median = 11); relationship adjustment (as measured by an adapted version of the Locke-Wallace Marital Adjustment Test [Locke & Wallace, 1959]; males median = 106, females median = 111). In 94% of couples participating, both partners were Caucasian. Couples were paid \$20.00 for participating.

## DISCUSSION EXERCISES

We assigned four brief discussion exercises to each couple, three of which were videotaped for observational analysis. A preliminary (untaped) discussion on the topic of "A Favorite Childhood Memory" was assigned first to assist couples in acclimating to the experimental setting and the presence of videotaping equipment. Following this, couples engaged in three 5-min discussions, each on a different assigned topic. Partners were asked to share with each other their feelings, ideas, and experiences related to (a) sexual intercourse, (b) a direct genital stimulation topic (either cunnilingus or manual genital stimulation of the female), and (c) being ill. The specific direct genital stimulation topic assigned to a couple was chosen based on which of the two (cunnilingus or manual genital stimulation of the female) the female partner listed as more uncomfortable to discuss on one of the previously completed questionnaires. Topics were assigned to couples in counterbalanced order. Instructions encouraged the couple to try to discuss the topic as they might do in their own homes and included a specific directive to communicate to each other particular likes and dislikes related to the topic.

## PROCEDURE

Each member of the couple was independently interviewed, first by telephone and then when arriving at our laboratory, to insure eligibility and group placement. Each participant also individually completed several self-report measures (see Kelly, Strassberg, & Turner, 2004). Participants were

informed that information shared in interviews and questionnaires would not be revealed to their partner.

After completing the self-report measures, participants were escorted to a small, comfortably furnished office. Discussion exercises were conducted and videotaped in this room. Two video cameras were mounted on opposite walls, approximately 2 feet above participants' heads. Each camera focused on one of the chairs. Participants were aware of the presence and location of the cameras.

Couples were left alone to complete the three 5-min discussions. Between each discussion exercise, a researcher returned and provided both partners with a discussion questionnaire assessing their reactions to the previous discussion exercise. After collecting questionnaires on the previous discussion, the researcher introduced the next discussion topic and again left the couple alone. This procedure was repeated for all three topics.

After the discussion exercises, couples were given an opportunity to ask questions and discuss their feelings about the research.

## OBSERVATIONAL MEASURES OF COMMUNICATION

### Communication Dimensions

We designed an original observational coding system for communication analysis to assess the three dimensions that we hypothesized to be important to the relationship of communication and female orgasmic disorder—Clarity, blame, and receptivity. We used the clarity dimension to rate process (e.g., fluidity, coherence) and content (e.g., specificity, complexity, detail) aspects of communication that we believe enhance the clearness of messages sent in a verbal interaction. We used the blame dimension to rate the degree of assignment of responsibility for problem areas and negative outcomes to one's partner used by each participant. We used the receptivity dimension to rate listening behaviors (e.g., attentiveness, eye contact) and verbal indicators of receptivity (e.g., acceptance/acknowledgment of one's partner's viewpoint, incorporation of partner's perspective into one's own communication).

### Coding Process

Different pairs of judges rated each partner in a couple on each of the three dimensions. On the basis of pilot testing, we chose a 1-min interval as the unit of measurement. This time period appeared long enough to allow for meaningful assessment yet not so long that participant behavior became too complicated for reliable measurement. Coders were blind to research hypotheses and couples' group classifications. Each partner of each couple was rated independently by both a male and female coder, and no couples were coded on more than one dimension by any individual coder.

After completing independent ratings, judges met to reconcile disagreements and establish a consensus judgment for each minute. The sum of these consensus judgments, across the 5-min discussion on a given topic, was entered into the data analysis.

### Reliability

We employed the Spearman-Brown formula (Anastasi, 1982) for estimating the reliability of averages as an estimate of the reliability of consensus. For clarity, Spearman-Brown estimates resulted in correlations of .71 to .85, with an average correlation of .81. For blame, reliability coefficients ranged from .80 to .90 with an average of .85. Reliability coefficients for receptivity ranged from .68 to .81, with an average correlation of .76.

## RESULTS

We analyzed results of the observational coding of communication via 3 (Group) by 2 (Sex—i.e., participant gender) repeated measures analyses of variance (ANOVAs). We used repeated measures designs because of the interactive nature of the discussion exercises. Clarity, blame, and receptivity dimensions were analyzed separately because differential hypotheses were proposed for each. Furthermore, because previous research (Kelly et al., 1990) suggested that communication differences may be topic-specific, we examined each discussion topic (intercourse, direct genital stimulation, and illness) separately for each of the three aspects of communication measured. Thus, on each communication dimension, three repeated measures ANOVAs are presented, one for each discussion topic.

Overall, there were a number of statistically significant differences among the couples regarding their behaviorally assessed communication patterns, involving the use of blame and the level of receptivity. In virtually every such case, the couples with a partner with female orgasmic disorder (the anorgasmic group) demonstrated the most problematic communication pattern. The results for each of the three communication features studied (clarity, blame, and receptivity) will now be presented.

### CLARITY

Results of repeated measures ANOVAs on clarity scores by Group and Sex for each discussion topic (see Table 1 for means) revealed no significant main effects or interactions. To test the specific hypothesis that anorgasmic women would be less clear than control-group women, we conducted

**TABLE 1.** Mean Clarity Ratings (and *SDs*) by Group and Discussion Topic

Topics	Group		
	Anorgasmic	Problem-free	Chronic illness
Intercourse	11.86 (2.06)	12.53 (1.77)	12.21 (1.80)
Direct genital stimulation	11.82 (1.55)	12.00 (1.50)	11.90 (1.81)
Illness	12.14 (1.56)	12.47 (1.77)	12.32 (1.63)

*Note.* Maximum possible score = 15, higher scores represent greater clarity.

planned contrasts of clarity scores for females on each topic, comparing the mean for women in the anorgasmic group with the combination of means for women in the problem-free and chronic illness control groups. These too failed to reach statistical significance.

## BLAME

The mean blame scores are presented in Table 2. As one can see, we obtained a number of significant effects.

### Intercourse

Only a significant main effect for Group,  $F(2,42) = 5.30$ ,  $p < .01$ , was found on the intercourse topic. A planned contrast analysis revealed participants in the anorgasmic group to be significantly ( $p < .01$ ) more blaming than the composite of couples in the problem-free and chronic illness control groups (see Table 2).

### Direct Genital Stimulation

Marginally significant effects for Group,  $F(2,42) = 2.84$ ,  $p < .07$ , and the Group by Sex interaction,  $F(2,42) = 2.63$ ,  $p < .09$ , were found for Blame on the direct genital stimulation topic. Given the expectation that the anorgasmic

**TABLE 2.** Mean Blame Ratings (and *SDs*) by Group and Discussion Topic

Topic	Group		
	Anorgasmic	Problem-free	Chronic illness
Intercourse	2.00 (1.76) <sub>a</sub>	1.22 (1.31) <sub>b</sub>	0.68 (1.08) <sub>b</sub>
Direct genital stimulation			
Females	1.21 (1.63)	1.31 (1.30)	0.65 (1.17)
Males	2.29 (1.64) <sub>a</sub>	1.00 (1.37) <sub>b</sub>	0.94 (1.25) <sub>b</sub>
Illness	2.36 (1.40)	1.91 (1.40)	1.68 (1.58)

*Note.* Maximum possible score = 5, higher scores indicate greater blame. Means with different subscripts in the same row are significantly ( $p < .05$ ) different.

group women might be particularly blaming, this marginally significant interaction was subjected to a planned contrast comparing couples in the anorgasmic group with the combination of those in problem-free and chronic illness control groups. This planned contrast was significant ( $p < .05$ ) and was followed up with separate one-way ANOVAs for males and females. There were significant differences in blaming among men,  $F(2,42) = 4.27$ ,  $p = .02$ , but not among women,  $F(2,42) = 1.14$ ,  $ns$ , when discussing direct genital stimulation. Neuman-Keuls analysis revealed that male partners of the anorgasmic women were significantly ( $p < .05$ ) more blaming than were their counterparts in the problem-free or chronic illness control groups (see Table 2).

### Illness

We found no significant Group, Sex, or Group x Sex effects for blaming behavior on this topic.

In summary, couples in the anorgasmic group were characterized by significantly more blaming than controls as follows: (a) both partners manifested greater blame than controls when discussing intercourse, and (b) males manifested greater blame than controls when discussing direct genital stimulation of the female.

## RECEPTIVITY

We found a number of significant differences between groups on the receptivity dimension. Table 3 presents the mean receptivity scores.

### Intercourse

The only significant effect involving the intercourse topic was the Group by Sex interaction,  $F(2, 42) = 6.59$ ,  $p < .01$ . Follow-up one-way ANOVAs

**TABLE 3.** Mean Receptivity Ratings (and *SDs*) by Group and Discussion Topic

Topic	Group		
	Anorgasmic	Problem-free	Chronic illness
Intercourse			
Females	8.36 (2.31) <sub>a</sub>	10.19 (1.05) <sub>b</sub>	10.06 (1.60) <sub>b</sub>
Males	9.93 (2.16)	9.81 (1.28)	9.98 (1.63)
Direct genital stimulation			
Females	8.57 (2.06)	9.88 (1.50)	9.65 (1.46)
Males	9.57 (1.22) <sub>ab</sub>	10.56 (1.21) <sub>a</sub>	8.94 (2.11) <sub>b</sub>
Illness			
Females	8.28 (2.09) <sub>a</sub>	10.44 (1.75) <sub>b</sub>	9.24 (2.14) <sub>ab</sub>
Males	9.14 (1.40)	9.56 (1.26)	8.35 (2.10)

*Note.* Maximum possible score = 15, higher scores represent greater receptivity. Means with different subscripts in the same row are significantly ( $p < .05$ ) different.

revealed no significant differences ( $F < 1$ ) in receptivity among men when discussing intercourse. In contrast, women in the anorgasmic group were significantly less receptive,  $F(2,42) = 5.34$ ,  $p < .05$ , than women in either problem-free or chronic illness control groups when discussing intercourse (see Table 3).

### Direct Genital Stimulation

Analysis of receptivity when discussing direct genital stimulation revealed a main effect for Group ( $p < .05$ ) and a marginally significant Group by Sex interaction ( $p < .08$ ). Again, considering the a priori gender-specific hypotheses regarding receptivity and this marginally significant interaction, we conducted separate one-way ANOVAs for males and females on this topic. A significant effect,  $F(2,42) = 4.29$ ,  $p = .02$ , for Group among males was found. Neuman-Keuls analysis revealed that men in the problem-free control group were significantly more receptive ( $p < .05$ ) than those in the chronic illness control group. The main effect for Group on receptivity among females on the direct genital stimulation topic approached, but did not reach, significance,  $F(2,42) = 2.56$ ,  $P = .09$ , with the women in the anorgasmic group having the lowest receptivity score (see Table 3).

### Illness

We found a significant Group by Sex interaction for receptivity on the illness topic. One-way analyses of receptivity for males and females on this topic revealed no significant differences in receptivity among men across groups,  $F(2,42) = 2.29$ ,  $p > .10$ . For women, however, a significant Group effect,  $F(2,42) = 4.38$ ,  $p < .02$ , was found. Neuman-Keuls analysis revealed that the women in the anorgasmic group were significantly less receptive ( $p < .05$ ) than women in the problem-free control group when discussing chronic illness (see Table 3).

To summarize, contrary to the research hypotheses, in no case were the male partners of women with orgasmic disorder significantly less receptive than men in either control group. Among women, however, those in the anorgasmic group were significantly less receptive than those in both control groups when discussing intercourse and less receptive than problem-free control group women when discussing illness. On the direct genital stimulation topic, women with orgasmic disorder had the lowest mean receptivity score, and we observed a trend toward significance. Thus, a pattern of low receptivity for women with orgasmic disorder across topics was evident.

## DISCUSSION QUESTIONNAIRE

Immediately following each exercise, we conducted one-way ANOVAs for men and women separately on the three variables assessed by the completed

questionnaire. Each item was rated on a 1–7 scale. Men and women in all groups rated their discussions as quite typical of how they usually discussed such matters ( $M = 5.53$ , average  $SD = 1.55$ ). No significant Group effects were found for men or women on this item ( $F_s = 0.62$  to  $1.76$ , all  $p_s > .15$ ).

A second questionnaire item asked how often individuals had previously discussed the same topic with their partner. The average across all participants on this item was as follows:  $M = 5.43$ , average  $SD = 1.63$  for the intercourse topic,  $M = 4.70$ , average  $SD = 1.72$  for the direct genital stimulation topic, and  $M = 4.03$ , average  $SD = 1.52$ , for the illness topic. Only one significant difference was found among groups on this frequency item: On the illness topic, as might be expected, women in the chronic illness group reported having discussed the topic more frequently ( $M = 4.65$ ) than did women in the anorgasmic ( $M = 3.28$ ) or problem-free groups ( $M = 3.38$ ),  $F(2, 42) = 3.74$ ,  $p < .05$ . The men in the chronic illness group also had the highest score on this measure, but the group differences failed to reach significance ( $p > .18$ ).

A third postdiscussion questionnaire item asked participants how comfortable they felt while having the previous discussion with their partner. In general, the male partners of the anorgasmic women reported the least comfort in all of the discussions. Men in the anorgasmic group reported (a) significantly less comfort ( $M = 4.64$ ) discussing intercourse than did men in the problem-free ( $M = 5.75$ ) or Chronic Illness ( $M = 5.65$ ) groups,  $F(2, 42) = 5.39$ ,  $p < .01$ ; (b) significantly less comfort than men in the chronic illness group ( $M_s = 4.86$  vs.  $6.12$ ) during discussions of a direct clitoral stimulation activity,  $F(2, 42) = 3.07$ ,  $p = .05$ ; and (c) significantly less comfort than men in the problem-free group ( $M_s = 4.93$  vs.  $6.50$ ) when discussing an illness,  $F(2, 42) = 6.16$ ,  $p < .01$ .

No other between-group comparisons reached statistical significance.

## DISCUSSION

Self-report data from this and other samples (Kelly, Strassberg, & Kircher, 1990; Kelly, Strassberg, & Turner, 2004), as well as the clinical and research work of others (Kilmann et al., 1984; LoPiccolo, 1978; MacNeil & Byers, 1997), suggested problematic communication patterns in couples with a female partner experiencing orgasmic disorder. The behavioral assessment of couples' communication in this study yielded results consistent with those findings. However, the pattern of differences revealed here was not quite what we had hypothesized. The specifics of the observed communication problems are described below.

As anticipated, couples with an anorgasmic female partner manifested more blame than those in the control groups when discussing sexual topics. Higher levels of blame were found to characterize: (a) both partners in the anorgasmic group when discussing intercourse and (b) males in the

anorgasmic group when discussing direct genital stimulation of the female. It is interesting to note that, when discussing direct genital stimulation, anorgasmic females did not demonstrate more blaming than orgasmic females even while they were receiving significantly more blame from their partners than were other women. Perhaps the anorgasmic women blamed themselves for any difficulties that they experienced in this domain (Kelly, Strassberg, & Turner, 2004). No differences in blaming were found between any of the groups when discussing illness, nor were any blaming differences found between problem-free and chronic illness control groups on any topic.

In addition to the blaming patterns seen in the anorgasmic group, these couples were characterized by comparatively poor receptivity when communicating on both sexual and nonsexual topics. However, contrary to our hypotheses, it was the women with orgasmic disorder and not their male partners who were relatively unreceptive. Specifically, these women were significantly less receptive than women from both control groups when discussing intercourse and significantly less receptive than chronic illness control group women when discussing illness. On the direct genital stimulation topic, we also found a nonsignificant trend ( $p = .09$ ) toward less receptivity by the women with orgasmic disorder. This relative lack of receptivity demonstrated by the anorgasmic women across topics could be, at least in part, a response to the blame, associated with their sexual dysfunction, that they experienced from their partners.

Contrary to our hypothesis, neither the women with orgasmic disorder nor their male partners were statistically distinguishable from their counterparts in either control group with respect to clarity. Couples in all three groups appeared to have no substantial difficulties expressing themselves clearly on either sexual or nonsexual topics, at least within the procedural constraints of this study. Therefore, it seems unlikely that the problems with blame and receptivity seen in couples in the anorgasmic group were a consequence of the women with orgasmic disorder or their partners being unable to communicate clearly with each other.

The postdiscussion questionnaires also yielded interesting findings. In particular, it was not the women with orgasmic disorder but their partners who reported significantly more discomfort than their control counterparts when discussing both sexual and nonsexual topics. Our previous work with this (Kelly, Strassberg, & Turner, 2004) and other samples of those with female orgasmic disorder (Kelly, Strassberg, & Kircher, 1990) indicated that these women anticipated more discomfort than did controls when discussing sexual topics with their partners. Perhaps the less-than-natural context in which our discussions took place limited the discomfort actually experienced by these women. Alternatively, these women may simply anticipate more discomfort in these discussions than they actually experience (perhaps because of the blame that they anticipate experiencing from their partners).

The findings of this study suggest that, contrary to the relatively simple unidirectional model originally proposed (e.g., she is unclear, he is unreceptive), the dysfunctional communication in couples with a partner experiencing female orgasmic disorder seems to be of a more-complex nature, involving both partners and including discussions of intercourse as much as discussions of direct genital stimulation. It would appear that in female orgasmic disorder, a thorough understanding of the interactive influences of blaming and lack of receptivity, by one or both partners in sexual communication, is worthy of further exploration. This should include an appreciation of the effects of these processes on each partner's comfort level with such discussions and on their motivation for continuing to engage in such a dialogue.

### IMPLICATIONS FOR TREATMENT

The results of this study and of our previous work (Kelly, Strassberg, & Kircher, 1990; Kelly, Strassberg, & Turner, 2004) are consistent with the belief that communication (or lack thereof) is an important element in couples' sexual adjustment (Cupach & Comstock, 1990; Ferioni & Taffe, 1997; McCabe, 1999; McCarthy, 1995; Rosen & Beck, 1988; Wheelless & Parsons, 1995). It seems clear that the treatment of female orgasmic disorder will be facilitated by attention to the relatively dysfunctional communication patterns revealed in both the self reports (Kelly, Strassberg, & Kircher, 1990; Kelly, Strassberg, & Turner, 2004) and behavioral evaluation of couples evidencing this problem. Such treatment would require, at least in part, a couples-approach to addressing this dysfunction (Bancroft, 1889; Heiman & Grafton-Becker, 1989).

The design of the present research does not permit the conclusion that disturbed communication results in sexual dysfunction. It is possible that the dysfunctional communication that we observed resulted from the sexual problem. Perhaps both process are involved (e.g., the dysfunction leading to blame, resulting in greater dysfunction). Alternatively, there may be no causal relationship between these process, and some other dynamic (e.g., sexual trauma) could produce both the sexual and communication problems. In any case, the existence and nature of the communication problems demonstrated by the anorgasmic couples suggest that these will need to be addressed in the treatment of this sexual dysfunction, if only because they could serve as a significant impediment to the successful resolution of the dysfunction.

### LIMITATIONS OF THE STUDY

The generalizability of our findings is limited by several factors. First, it is difficult to evaluate the extent to which our volunteer participants were representative of their respective populations (Strassberg & Lowe, 1995). Our findings also are qualified by the structured, laboratory nature of our

study. Although we attempted to maximize the ecological validity of our procedures, our success in this regard is unknown. The specific constructs of interest (i.e., clarity, blame, and receptivity) that we chose also limits our conclusions. Other features of communication could yield a different pattern of findings. Similarly, our reliance on a self-developed, previously untested, behavioral assessment system represents a limit. Although we were able to demonstrate adequate reliability for our rating system, there was no practical way to evaluate its validity beyond its face validity.

As with any study of this nature, our conclusions are limited by the specific target and control groups compared. The sexually nondysfunctional control groups that we chose, although appropriate, do not allow us to conclude that the differences observed between the couples with a partner with female orgasmic disorder and control couples represent communication deficiencies that are in any way unique to this sexual dysfunction. Additional research will be necessary to identify the extent to which the communication features seen in our anorgasmic group characterize couples with any other male and female sexual dysfunction.

Finally, because the present study attempted to evaluate a number of heretofore relatively unexplored issues, the communication analysis was, by design, somewhat elementary. The application of more complex methodological designs, such as sequential analysis, could offer further, or even different, insight into the interactive influences of communication dynamics operating in couples with an anorgasmic female.

## CONCLUSION

The results of this study demonstrate that there are behaviorally assessable differences in the communication pattern of couples experiencing female orgasmic disorder when compared with sexually functional couples. These distinguishably negative patterns were apparent even when compared with the communication of couples experiencing another serious problem area (i.e., chronic illness). Although couples with an anorgasmic female partner appeared capable of communicating clearly about sexual as well as nonsexual topics, the negative interactional dynamics of blame and lack of receptivity appeared to reliably distinguish their communication from that of control couples.

There were several methodological features that, in combination, distinguish this study from much of the previous published research in this area, specifically, (a) the inclusion of both partners in sexually functional and dysfunctional couples, (b) the employment of a direct observational analysis of actual communications, and (c) comparisons with two control groups, including couples with chronic but nonsexual medical problems. All three features allowed for a clearer delineation of some of the communication difficulties characteristic of the sexually dysfunctional couples.

Sexual problems can, and often do, become chronic sources of tension and discord for many couples. The more clearly we understand the communication problems that may characterize sexually dysfunctional couples, the more effectively we can target our treatment strategies. Hopefully, this study moves us a step closer in that direction.

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