Lindenwood University
Digital Commons@Lindenwood University

Theses | Theses & Dissertations

9-1976

Group Treatment of Anorgasmia

Mona LaVine

Follow this and additional works at: https://digitalcommons.lindenwood.edu/theses

 Part of the Medicine and Health Sciences Commons

GROUP TREATMENT OF ANORGASMIA

A Culminating Project

Presented to

Lindenwood College

In Partial Fulfillment of

The Degree of Master of Arts

In Marriage, Family and Child Counseling

by

Mona LaVine

September 1976

LINDENWOOD
- COLLEGE -
LIBRARY

Thesis
L394g
1976

TABLE OF CONTENTS

2573

INTRODUCTION

In the past year at Lindenwood College I have acquired knowledge and gained skills in my field of endeavor; Marriage, Family, and Child Counseling. In addition to the educational goals achieved and recorded in my narrative transcript, I feel I have grown personally. This outcome is a result of the experiences I have encountered in this past year of learning through Lindenwood.

Much of my knowledge was acquired through reading, attending workshops, the cluster group and supervision. Also through clinical experience with individuals, couples and groups. My personal growth was achieved from the above experiences, the interaction with other Lindenwood students and faculty but mainly through the many group experiences I was involved with on a weekly basis.

One of the most meaningful groups in terms of academic and personal development has been the experience with my cluster group. In this, a structure was developed which provided confrontation and growth within an atmosphere of warmth and safety. I was able to apply what I learned in my cluster group to my clients and to my personal world. Through this and other experiences I realized the importance of group interaction.

The following is my research and practicum in my field of endeavor; Marriage, Family and Child Counseling. The specific focus of my project is the group treatment of anorgasmia. First examined is group theory, then the practicum discourse of a group and a case history of one of the women in the group.

Background to Project: The 1953 Kinsey Report reported the fact that only 45% of married women in the U. S. achieved orgasm with intercourse 90% of the time. Because of the pejorative connotation that something is "wrong" with the person who has never achieved orgasm, the word "anorgasmic" has been changed to "pre-orgasmic" implying that until now the client has not had an orgasm, and conveying optimism that the situation will change for the better in the future.

In the early 1970's research by Dr. Lonnie Barbach at U. C. Medical School at San Francisco and Dr. Joseph LoPiccolo at U. of Oregon indicated that small group treatment was more effective than individual therapy in terms of overcoming resistance, as well as in efficiency of time and money.

Studies have shown that women who have never experienced orgasm are out of touch with their own bodies. It has been found that the easiest way for women to learn about their own bodies and their sexual responses is through masturbation. Therefore, the method used with pre-orgasmic women involves a step-by-step desensitization (encouraging orgasm through masturbation) and then transferring this success to partners.

There are three basic factors which seem to account for the success of the treatment of pre-orgasmic women. These are: (1) Group Process; (2) Leadship skills and qualities; and (3) Desensitization techniques, all of which will be examined in detail.

GROUP PROCESS

The format of a small group of women meeting to discuss the intimate details of their sex lives is the most important aspect of the program. In research by Berzon (1963) the main curative factor of the brief eight session therapy resides in the interaction between group members. This research points out that the interpersonal feedback among group members is more important than the therapists' influence, as it enables clients to restructure their self image due, in part, to realizing the commonality of the problem.

The woman entering a pre-orgasmic group feels less isolated, and less like a "freak" when she discovers that others have similar problems. It is quite a relief to find that she is not psychologically maladjusted, but now part of a group of women united against a society which subtly encouraged her not to be in touch with her own sexuality. An important product of the group is that they learn to relate to one another, empathizing with each other and most importantly, accepting one another. According to Yalom (1970): "It is not only the discovery of others' problems similar to our own and the ensuing disconfirmation of our wretched uniqueness that is important: It is the effective sharing of one's inner world and then the acceptance by others that seems of paramount importance."

A sense of cohesiveness and trust develops almost immediately when members of a group realize that they have sexual problems and sexual history in common. Cohesiveness can be defined as "the resultant of all the forces acting on all the members to remain in the group"

(Cartwright and Zander, (1962)) or more simply defined by Bates and Johnson (1972) as "the attractiveness of the group for its members." According to Yalom (1970), this group cohesiveness is a necessary precondition for effective therapy, although he does not consider it a curative factor in itself.

We all live in social systems. Human beings are social animals. Much of their self-esteem is derived from the approval they receive from others and they will act in a way to attain approval. This is Cooley's (1968) theory of the "Looking Glass Self", meaning, that as an individual develops, she learns to regard and value herself according to how she has perceived others to have regarded and valued her. Therefore, in order for the group and its members to have an influence on each other, the group must have a sense of solidarity, of "we-ness."

Dickoff and Lakin (1963) conclude that not only is group cohesiveness essential for the perpetuation of the group, but it is, in itself, of therapeutic value. Clients who make the most progress as the result of their brief group therapy, attend more regularly, feel more accepted by the other members, participate more, and are more open in sharing and in identifying with others. The group then develops a sense of trust, openness and acceptance, as the result of this sharing.

As they share their secrets and strivings, the women receive validation from group members and group leaders. They discover that many women have the same feelings, and that they are not the "oddity" they have so furtively believed. Although a woman may feel separated from the rest of the group because of age or race, she will still identify with

the group because all have the same problem in common. Findings of the Yalom-Rand Project suggest that certain homogenity enhances the sense of group cohesiveness.

Both in group and at home the women become supportive of each other. They phone one another and exchange information about books; go together to buy books or vibrators; relate to each other by name; and help or compliment each other in terms of openness.

In the group, the women support each other by giving "strokes" (a term from Transactional Analysis meaning to "compliment"). According to Yalom (1970), "members of cohesive groups are more accepting of each other, more supportive, more inclined to form meaningful relationships with each other." This support-system is an important prerequisite for the changes to be made by the women in the group. The results of Dickoff and Lakin's Study (1963) show that clients experience social support as the chief therapeutic mode. In the pre-orgasmic group the support comes from knowing that other women are attempting to cope with the same fears and attitudes. Members meet socially and this support system continues long after the group ends.

Often, one woman can provide the therapeutic experience for the rest of the group. Each woman need not repeat the same issue in as much as the women learn from one another -- from mistakes, as well as from successes. One woman may discuss her feelings about sex in depth, while others merely listen or share peripherally. The result is the same as if each woman were the discloser.

Instilling hope, guidance, and feelings of universality are of considerable importance in the early part of therapy according to Yalom

(1970). He states that "faith in the process or evidence that it will be helpful accounts for the fact that clients who are experiencing considerable discomfort continue to remain in the group."

Increased awareness of sexual feelings tends to be immediate, due to the early homework assignments consisting of the Kegel exercises* and examination of body and genitals. Since the group is time-limited, results are expected quickly. Apparently all of these factors help to maintain the client's interest and participation.

Resistance is a natural part of the growth process. However, the various aspects of group process cut through the individual's resistance to the masturbation homework, and help women to experience orgasm more readily than when a client is seen individually or as one-half of a couple.

Peer-pressure and group-reinforcement are invaluable. If a woman feels like an integral member of the group, she is likely to take suggestions seriously and follow directions conscientiously. When this does not occur, the group norm appears to put pressure on her that she might resist if it came from a therapist in an individual session. However, this pressure is more difficult to resist when it comes from women who are seen as being like herself. A woman could easily convince herself that a sexually functional therapist would not be able to understand her, but it is more difficult for her to resist the attitudes and actions of the other pre-orgasmic women. This factor of group pressure is probably most important in the early stages of therapy, when a woman who has

---

* Page 16.

never masturbated and therefore has some resistance against the act, finds ways to avoid doing homework. Often, she "can't find time" to do her homework or something interrupts, such as the telephone or the children. Some women report that even when they do the homework, their feeling is one of frustration, while others, during masturbation, concentrate on what they don't feel (according to their expectations) rather than on what they do feel. At this point, a competent group leader can easily point out how all the women seem to be having a difficult time doing the homework. Generally one brave soul will admit to feeling embarrassed, ashamed or guilty, which leads others to look behind their own avoidance. Also as soon as someone has a positive response to any assignment, this acts as an incentive to others, as well as a re-inforcement. Women soon learn that they get out of the group only as much as they're willing to put in, since they can see that the women who are doing the homework are enthusiastic and are progressing.

As the group proceeds, the effect of one member reporting orgasm seems to give permission to the others, and often her success triggers others to overcome their fears. One by one, each woman has her first orgasm, and receives a tremendous amount of positive re-inforcement from the other group members and the leaders.

Frequently, cooperation and positive competition reinforce the processes that increase self-esteem. Cooperation may be reviewed in terms of group cohesiveness, sharing and acceptance. Given group cohesiveness and group norms which dictate that success is a desirable attribute, self-esteem is a general outcome.

Competition is a difficult issue for women. Although men are conditioned to compete, our culture has encouraged cooperation for women, even at the expense of succeeding. This may partially explain why individual members of a group are sometimes apologetic when they are first to have an orgasm, Barbach, (1975). The fear of jealousy or negative reactions of other group members can create some blocks to achieving the longed-for goal. Conversely, no woman wanted to be the only one not to have an orgasm.

Because the goal is more specific, pre-orgasmic groups tend to have more successes than general therapy groups. The goal of a tangible orgasm and the perception that they are indeed moving closer to that imminent goal is particularly reinforcing.

Time-limited groups create the impetus for women to do their work "here and now." The women have a sense of dealing with the problem now or never.

As the members become more aware of the closing date, they are more diligent about realizing their goals. Reports of orgasm increase during the last few sessions.

Another advantage to a time-limited group is that it is a closed group, a situation which is not possible with most outpatient therapy groups. The fact that the group is closed to new members after commencement affords a certain stability and enhances the possibilities for group cohesiveness. Research at University of San Francisco Medical School determined that 6-8 members is ideal. This supports Yalom's (1970) findings that approximately seven members is ideal with an acceptable range from between five to ten members. Yalom indicates that groups of less than five often cease to operate as a group.

All these factors; group norms, cooperation, competition, cohesiveness, etc. result in the group's taking on a personality and life of its own. Some groups focus mainly on psychological problems and do little or no homework. Other groups may be willing to do homework but resist discussion of feelings. Or a group may be social and seek each other out, maintaining close contact outside the group as well as within.

The fact that the group is composed of all women should not be overlooked as an important factor in promoting group cohesiveness, group support and changes which occur in addition to that of experiencing orgasm. Culturally, women have learned to adapt to others, seeking their approval and love, in an attempt to gain security. Along these lines, if a woman is loved, someone, (usually a man), will take care of her. Historically, men have wielded the power and made the decisions in this society. Women nurture their men and accept the idea that their status in society is determined by their fathers or husbands. The absence of males in the group leaves the women no alternatives but to use their own power, make decisions, and regard other women as authorities. This respect for other women enhances their own self-respect.

The women have in common a symptom, being pre-orgasmic, which binds them together. They also have a history and a set of many experiences and role expectations in common. This increases their ability to understand and support one another as they make changes. They learn that they can control and direct their lives in a way that they have never considered possible. This coincides with the findings of Bardwick

(1971); "In a group without men, women have more freedom to examine themselves in terms of their role expectation and their relationship to other women."

In summarizing, it is evident that group process is one of the crucial aspects accounting for the success of the pre-orgasmic women's groups. The optimism, homework exercises and initial sharing create group cohesiveness. The women realize that they are not alone in their problem and that they can share their negative and shameful feelings about their sexuality and still be accepted.

This acceptance and support by the other members of the group enable the women to confront their fears and begin the process of change. Group pressure facilitates dealing with each woman's resistance to masturbation and achieving orgasm. Positive competition also facilitates progress as long as group norms of success are established. In addition, orientation to a common goal and limiting the number of sessions also help to overcome resistance and to keep enthusiasm high.

The fact that the group is all-female enhances feelings of universality and mutual support, and awakens the women to the strengths that lie within themselves as individuals, as well as to their ability to control many circumstances of their own lives.

LEADERSHIP SKILLS AND QUALITIES

It is obvious that leaders contribute to the success of groups. However, determining which particular qualities and leadership-skills are essential, is complicated by the fact that the client-counselor

relationship within the group context differs considerably from the same relationship in individual therapy. "In the group, other group members, and the group as a whole, take on therapist qualities and have an impact which extends above and beyond that actually provided by the designated group leaders", Yalom (1970).

At the beginning of the group, the leader is an authority and a role model. She is responsible for the administrative functions of convening the group on time, stopping it on time, giving out information on sexuality, correcting misinformation and myths, keeping the discussion focussed on appropriate topics, making sure all group members are included and giving out appropriate homework assignments. These are her obvious tasks. While carrying these out, she is also determining a number of group norms. She is a model in many ways for the group members. By being open, honest and direct in her attitude and her approach to discussion, she promotes the same in others. By sharing information about herself and her sexual history she encourages a similar sharing among group members. Since the leader is seen as comfortable with her own sexuality and uninhibited in her discussion, she encourages clients to behave in a similar way themselves.

The group leader creates an atmosphere of acceptance by being supportive of each client's unique, individual differences. Warm and empathetic, she enables each woman to feel secure enough to explore herself sexually without expectation of any right or wrong outcome. As the authority, specially in the initial sessions, and by requiring specific and concrete answers to questions, she can exact information necessary to help each woman achieve orgasm.

The clinical ability of the leader to percieve differences in a member's defenses and modes of resistance and react accordingly are crucial. However, it is difficult to delineate because this ability is so specific to the individual being treated.

According to Yalom (1970): "The therapist has two roles or basic modes of presentation in the group: "She can be a technical expert and/or she can be a role-setting model. The leader's role as a technical expert, her ability to be an authority at the beginning, to impart information and to instill hope is very important to the establishment of group cohesiveness."

"Leader transparency is a disputed subject," Bates and Johnson (1972). The psychoanalytic approach is based on the assumption that the resolution of the patient-therapist transference is the primary curative factor in therapy. However, group therapy is significantly different from individual therapy. According to Yalom (1970) "the therapist who uses her own person increases the therapeutic power of the group because of her ability to determine group norm behavior." She becomes a model for open, honest, direct and uninhibited communication. She also acts as a person with whom the individuals in the group can "reality-test" their feelings. This is essential in brief-term group treatment.

The permission-giving role of the leader in this situation is a positive and important one. It helps the women to change old messages they received as they were growing up and at the same time, to develop self-esteem. The women become aware of roles they have been taught to play and external standards they had to conform to in our society.

The supportive aspects of the therapist's role is essential. The research findings of Truax and Carkhuff (1967), Sager and Kaplan, (1972) and Lieberman (1972) concur that the effective therapist is one who develops a warm, accepting, understanding and empathetic relationship with her patients. This accomplishes two important functions: a) the acceptance by a respected person heightens self-esteem, and b) the support and positive reinforcement help the women to make the difficult, although necessary, changes in order to become orgasmic. According to Yalom (1970) "The leader may, by offering a model of non-judgemental acceptance and appreciation of others' strengths as well as their problem areas, help to shape a group which is health-oriented."

"Initially, these attributes of permission-giving and support are necessary, but as the group develops, the role of the leader must change accordingly" (Yalom, 1970). Gradually the leader must become less intrusive, thereby allowing the women to develop more independently. The responsibility for the woman's sexuality and orgasm must return back to the appropriate owner, the client herself.

One of the main difficulties the leader has to cope with is the resistance of the client, who, having always felt powerless, expresses her strength by thwarting the percieved authority, in this case the leader. It is crucial for a counselor to recognize this common resistance and abdicate from the percieved power struggle in any way that will work for the individual client. This can be done by pointing out the power struggle if the client is capable of responding to this interpretation. In all cases of resistance the leader must support the woman in her struggle and yet, maintain no investment in the client's achievement of orgasm.

This aspect of the leadership role which enables a client to break away from the authority figure in a healthy way may be one of the primary factors which result in the outcome of women beginning to take control of their lives. Additional clinical skills that a leader should possess would be the ability to understand the conflicts of the client, their fantasy life, and to interpret behavior.

The use of group members and the dynamic group process can be most helpful in getting the group to be aware of their fantasies, feelings and resistance. The leader must also be able to confront in a non-threatening way, as confrontation often leads to change. The leaders help build self-esteem by their acceptance of the client and by encouraging the women to respect themselves.

The primary function of interpretation is to focus group discussion, to direct the group from the non-relevant "then and there" to "here and now" material (Yalom, 1970). Getting to the feelings, the fantasies, the resistance, the process between group members can be crucial to overcoming the orgasmic dysfunction.

Through direct confrontation of the shameful and guilty feelings that surround sex the woman is slowly released from these feelings. The ability to share these feelings with a group of peers and still be accepted reduces feelings of "aloneness."

The leader works with each woman, individually within the group setting. This helps the client develop her own sense of importance. The group devotes specific time just to her rights, her feelings and her unique response. The women are directed to take an hour a day at home, exclusively for their own needs.

In summation, certain attributes and skills appear to play a major part in the reversal of the dysfunction of an orgasmia and the interpersonal changes in the woman. These are the administrative and focussing skills of the leader which make her a technical authority: her role as a model, to set group norms, to be supportive, permission giving and confrontative. Also to be caring and accepting while allowing women to develop their independence and at the same time being aware of individual, interpersonal and group process. In this way she can make appropriate interpretations and explanations and still keep group members cognizant of the goal.

DESENSITIZATION TECHNIQUES

The Desensitization approach is based on the behaviorists' (Wolpe 1961) method of overcoming a symptom - in this case, anorgasmia, - through a process of graduated steps, in which the first steps are easily accomplished and produce little anxiety and where the later steps are more anxiety-producing. The comparative ease of the initial work, and the success that follows, motivates the group member to take greater risks.

The first important step is having the woman set aside an hour each day, at home, which she is to spend with herself. The initial homework assignments are not explicitly sexual in content, but represent groundwork for the forthcoming assignments. However, the message being given is one of the most important aspects of the program. Women are being told, frequently for the first time, that they, as individuals, in

and of themselves, are important. They are not important because of what they do, but because they are women and as such, deserve pleasure. Developing the feeling that she is worthwhile, and has the right to spend an hour a day on herself helps to heighten her self-esteem.

The Kegel exercises, developed by Dr. Arnold Kegel (1952) are practiced to strengthen the pubocuccygeal muscle, which in part, surrounds the vaginal opening. (The original purpose of these exercises was to assist women in the control of urinary-incontinence. However, it was discovered accidently that in the course of practicing these exercises, sexual pleasure in intercourse was enhanced. The strengthening and tightening of the vaginal opening appears to increase sensitivity. As a result they have now become a part of the routine practice for sex therapy).

Noticeable effects in many cases are not experienced for four to six weeks; therefore clients need to be encouraged to persist. As they strengthen their muscles, women become aware of their sensations in the genital area which in turn introduces them to the feeling of some control over their orgasmic situation.

During the first session, each woman is told to examine her nude body from all positions and angles while in front of a full-length mirror, and to touch herself all over, to become more attuned and familiar with her body. This exercise is not explicitly sexual, although it serves as a precondition for the exercises which follow. She experiences her nudity in a permission-giving and accepting way. This is the first step in touching herself, and it gives her an awareness of her narcissistic feelings. It also allows her to feel better about herself and her body,

not because she matches up with some ideal the media has put forth as a sexually attractive woman, but because in her uniqueness, she is sexually appealing. In addition, this exercise is designed to reduce self-consciousness in a sexual situation. If a woman can feel more confident about her own attractiveness, it is expected that she will be more confident and less inhibited in expressing herself sexually with a partner.

Chapter 3 on sexuality in Our Bodies Ourselves, Boston Women's Health Collective, (1971), is a homework assignment to be read mostly for the purpose of allowing the women to read about the sexual experiences of other women who have difficulty in reaching orgasm. This reading also supplies additional aid and comfort through the knowledge that they are not alone. Again, this is a low-anxiety producing assignment.

The information provided in the second group session on the genital anatomy, stresses the importance of the clitoral area and describes the physiological response cycle*, serves two functions: First, it corrects misinformation and myths. Second, it provides technical information to demystify the sexual-response cycle, thereby helping to allay fears and anxiety. Furthermore, the presentation points up individual differences and variability in areas of sexual sensitivity.

The act of viewing the photograph of a woman's genitals prior to exploring their own is part of the desensitization sequence. Body differences in the genital area are validated so that women are less

---

* Page 57.

afraid of what they may discover when exploring their own genitals in the privacy of their homes.

The women examine their genitals visually and tactually. After reporting back on this assignment, the next process is masturbation, which will eventually lead to orgasm.

This is a valuable learning technique. Kinsey (1952) found that any premarital activity which allowed a woman to reach orgasm, resulted in the woman's ability to respond orgasmically with marital sex three times as often as did women who had no orgasmic experience prior to marriage.

Masturbation is also the surest method of orgasmic attainment - 94% to 96% of Kinsey's (1953) sample who masturbated could reach orgasm and were able to do so 95% of the time. Kinsey's data and the findings of Master and Johnson (1966) assert that "orgasms produced by masturbation occur more dependably, more rapidly, and with greater intensity than those achieved through stimulation in intercourse." In addition the instantaneous feedback afforded by self-stimulation and the absence of outside distraction, often resulting from interaction with a partner, make masturbation an ideal way to achieve a first orgasm.

In addition, masturbation affords the woman control over her sexual excitation. Each woman is told that if she becomes uncomfortable with the intensity of the feelings she is experiencing, she can reduce or stop the stimulation. This control is essential. First of all, it enables the woman to progress via small steps, increasing the intensity at her own pace. Secondly, this experience gives the woman a feeling of control over other aspects of her life which stretch beyond the area of sexuality.

Masturbation becomes its own reward. The feelings the process produces are reinforcing in and of themselves. The perception of sexual feelings resulting from the masturbation produces high hopes of achieving orgasm and helps to create optimism and a more cohesive group.

The women are told to masturbate but not to orgasm. This is a paradoxical injunction (Haley, 1963) and produces two types of positive outcome. The woman who obeys the injunction has control over her stimulation and is able to experience sexual feelings without the threat that if she feels something she will have to continue on until orgasm. If she had this expectation she might be unable to allow herself to feel sexually aroused at all. On the other hand, when a woman ignores the injunction, and has an orgasm, she has successfully achieved her goal.

From this point the homework is individualized and each woman progresses at her own speed. The various styles of resistance are dealt with as the need arises.

Frequently, women are encouraged to use a technique called "teasing" in which the woman stimulates herself to a certain level, reduces the stimulation for a few moments and then reinstates it until a slightly higher level of arousal is attained, when she again reduces the stimulation.

Attention is paid to the psychological, as well as physiological aspects of sexual response. In addition to manual — or vibrator — (stimulation used in masturbation), the women are encouraged to experiment with pornography. My Secret Garden is suggested, and fantasy and focussing techniques are encouraged which enables them to concentrate on the sexual sensations. Kinsey (1953), Kaplan (1974) and Katcha-

dourian (1975) all refer to distractions, fatigue and preoccupation as being the most pervasive barriers to the enjoyment of a satisfactory sexual experience. Through this assistance in learning to focus their attention on sexual thoughts and feelings, the woman gradually learn to concentrate all their energy on the process of self stimulation and to experience orgasm as part of this process. The permission given to indulge in fantasy and pornography may be partially responsible for the increased acceptance of erotic materials.

After a woman can experience orgasm reliably with self stimulation, the homework progresses to include a partner if one is available. Women without partners can retain the pertinent information regarding how the progression is to be used once a partner is found. In addition to partner exercises the women are encouraged to broaden their masturbation techniques so that the positions and types of stimulation used in masturbation are closer to those used during partner interaction.

Different partner-assignments will be expounded upon in the following section.

Summarizing, the behavior modification technique of desensitization used in the group in addition to the homework progression is the third essential element in the pre-orgasmic treatment program. Showing the woman a picture of a female's genitals before they are assigned to view their own helps to demystify the process and alleviate anxiety. The homework progression which begins with mere body touching before genital touching, continuing on to masturbation and then orgasm, allows the woman to take small steps as she approaches the goal and to experience a number of reinforcing successes along the process until finally

she can experience orgasm with her partner. The orgasm need not necessarily occur through stimulation by the penis alone for the outcome to be considered successful.

PRACTICUM DISCOURSE

During the year at Lindenwood College I co-led a group of pre-orgasmic women with my Faculty Sponsor, Eleanor Katzman, M.F.C. Basically, it followed the methodology of Drs. Barbach and LoPiccolo. In as much as each group takes on a coloration of its own, the following is a description of the group and its treatment methods as led by us at the Southern California Counseling Center.

The group consisted of eight women from various socio-economic and ethnic backgrounds, ranging in age from 22 to 58. We met for two hours a week for a total of eight weeks. During the meetings, the women delved directly into their negative feelings about sex and masturbation, as well as their early sexual traumas. The impact of subtle messages given to the women by their families and society were explored — messages such as "sex is something a good wife puts up with" Bardwick (1971). Women were actively assisted in realizing that they have a right to sexual pleasure and that their body and their sexuality are positive attributes.

Myths from the past*, such as "sex is dirty" were dispelled, and literature, including a chart of the physiological sexual response cycle and diagrams of both male and female genitals were distributed to group members. Sexuality in advertising** was also discussed. Exercises to practiced at home were assigned each session.

---

* Page 45.

** Page 44.

These exercises followed a modified version of the 9 step masturbation program developed by Dr. LoPiccolo at the University of Oregon in 1972. This program differed in that Dr. LoPiccolo did not treat the women in a group, however, the desensitization techniques were very similar.

The LoPiccolo program is based on the therapeutic value of masturbation as a method for reaching orgasm, especially for those women who have never experienced a climax, from any source of physical stimulation. As mentioned earlier, Kinsey, et al (1953) reported that in 95% or more of masturbating attempts, the average woman reached orgasm --- a figure which far exceeds the probability of reaching orgasm through coitus (approximately .73 for average married women).

Not only is masturbation the most probable way of producing an orgasm, it also produces the most intense orgasm (Masters and Johnson, 1966). It has been suggested that an intense orgasm leads to increased vascularity in the vagina, labia and clitoris (Bardwick, 1971). In turn, evidence seems to indicate that this increase vascularity enhances the potential for future orgasms. This notion is also supported by the findings of Kegel (1952).

Although masturbation has been noted in the past to facilitate orgasmic potential, it apparently had not been a systematic part of a therapy program prior to LoPiccolo who developed the masturbation program on which the Barpbach program was based. The main difference in the two approaches is that the former program is an adjunct to a

behavioral treatment involving both the husband and wife with a male-female co-therapy team, while the latter has been adapted to pre-orgasmic women meeting in groups facilitated by two female co-therapists.

Members were required to set aside an hour each day at home, in order to practice their assignments. It was emphasized that no woman had to go any further than she could comfortably handle, but was to write down her feelings whenever she was anxious or blocked. Assignments progressed as the women's sexual responsivity increased. For the first few sessions, all the women received identical assignments, but as the women's "response-ability" increased, exercises were assigned according to the specific needs of each woman.

In the first session we began by sharing our own sex histories, in order to encourage others to do the same, so that we could discover where each person was. The women discussed messages from the past, about sex, such as: "Don't touch down there." Negative feelings such as disgust, dirtiness and guilt were shared. As leaders, we were very supportive and conveyed through our responses that "nothing shocked us."

The need for each woman to take responsibility for herself was stressed and we emphasized that no one was going to "give" them an orgasm. We discussed some of the myths about orgasm and provided important factual sex information. For example, many women were relieved to hear that Kinsey (1952) had reported that "over 50% of the women in the U.S. do not achieve orgasm with intercourse."

The homework assignment for the first session emphasized the need for time and privacy: "You must be willing to take an hour a day for yourself. Somehow there is always time for a husband, the children, etc. but you are entitled to some time for yourself and the homework is the single most important part of the program." Chapter 3 on "Sexuality" from Our Bodies Ourselves was assigned. We asked the women to make a "space" for themselves during this hour: "Decorate the space as sensually as possible using, candles, music, incense, etc." The women were asked to start with a sensual bath (for relaxation, not cleanliness). The following is an example of directions given: "Soak your body. When you wash with soap don't use a washcloth, use your hand to feel your own skin. See if you can be aware of what your hand is feeling, see if you can sense what your body is feeling. Be aware of how you feel."

Next they were to stand in front of a full length mirror and look at themselves from all angles: "Examine yourself slowly, look at your forehead, look at your eyes, look at your nose. Very slowly examine the rest of your body. The idea is to become friends with your body." We asked the women to be aware of how they felt before they did this and afterwards. We also explained the Kegel exercises and requested that they do them 10 at a time, three times a day.

In the second session the women shared their reactions to the homework assignments. We explored any resistances to the assignments. We also discussed their partner's reaction to their being in this kind of group. Contrary to the traditional Masters and Johnson (1970) sex-therapy treatment, sexual intercourse was never prohibited. Instead, we used Haley's concept of "paradoxical injunction" and told them "Have inter-

course if you want, but Don't have an orgasm. Tell your partner that orgasms are forbidden temporarily." This helped to take the performance pressure off.

We distributed and discussed pictures and diagrams of male and female genitalia and of the four phases of the sexual response cycle: excitation, plateau, orgasm and resolution.

For homework, the women were asked to continue to set aside an hour a day for a bath, but in addition they were to look at their own genitals, slowly and carefully, with the aid of a hand mirror, using as a guide a color photography of female genitalia in the Yes Book; Getting in Touch Ayres, (1972).

In the third session the women shared the reactions to the homework assignments from the previous week. Marie said, "I never knew how I looked down there!" We again explored any resistances to the assignment. The question was asked, "If you have been faking an orgasm all along, how do you tell your partners that you have been faking?" We also asked who the orgasm was for and emphasized that the program won't work unless the women were there for themselves and not to please their husbands or the leaders. "Own it and work on it."

For homework, the women were asked to read Liberating Masturbation, Dodson (1971). They were asked to examine and identify their own genitals using the pictures in the book as a guide. They were to explore their genitals tactually as well as visually.

At the beginning of the fourth session we introduced three techniques of Radical Therapy, learned in our cluster group. These were the concepts of: "What's your space?" (to discover in advance whether any

outside occurrences would keep a woman from participating fully). "Are there any held resentments?" (to permit each person to share, and thereby unload any negative feelings which might interfere with relationships in the group); and "Strokes" (the concept of ending each meeting on a positive and caring note). This proved to enhance group cohesiveness.

After beginning with the Radical Therapy structure we asked about the previous week's homework assignment. The women talked about how they felt when they touched their genitals. As leaders, we continually validated each woman wherever she was. We discussed resistances to the homework, guilt and shame, and looked at "meta-messages" such as unvoiced "shouldn'ts." We also explained their "rights to pleasure," i.e., "It's not bad to feel good!"

We distributed more written information about sex,* discussed the use of lubricants and the physical reaction to the body as one goes through the four phases of the sexual response cycle.

For homework, the women were asked to masturbate in any way that they wished to, but still "no orgasm." They discussed how they felt about having to do this assignment, and how they were going to tell their partner about the fact that they were masturbating. We also explored individual resistance to the assignment.

We started the fifth session with the Radical Therapy structure and a review of the homework assignment of masturbation. We shared ways in which to masturbate. Women who talked about their own successes and failures helped break through the resistance of others who hadn't

---

*Page 46.

done the assignment. We discussed myths of masturbation such as fear of insanity or nymphomania and examined the question, "What's going to happen to you when you have an orgasm?" Those with particular fear were asked to make a list of what they were afraid of. Then we talked about the use of vibrators.

As of this session most of the homework was tailored to the individual's pace and specific difficulties. In general, the women were encouraged to increase the intensity and duration of the masturbation, but again the focus was on "pleasure" rather than "orgasm." The use of fantasy was discussed, and as one of the group homework assignments, members were asked to read a book of women's sexual fantasies: My Secret Garden.

Those clients who were afraid of losing control if they had an orgasm and those who "almost" had an orgasm were given the assignment of "teasing." They were told to reach a plateau while masturbating and then stop, then start again. "Keep stopping and starting, but be aware of your feelings each time." Those women who felt nothing were asked to look for small feelings, and to "tease" a little more.

In the sixth session after homework assignments were reviewed and resistances explored the leaders discussed being assertive. We discussed saying no! ... as well as asking for what they want. We did an exercise in touching each others' hands and faces. ("May I touch your face?" "Yes, you may." At this point, either person could stop the action by merely saying "Thank you.") We practiced assertion training with those who wanted to learn to be more assertive. These exercises

stressed the necessity of specific and direct sexual communication if the woman really wanted to become orgasmic in the relationship.

In the seventh session, after Radical Therapy structure, review of homework assignments, and exploration of resistance, we confronted those members who seemed not to be fully participating. (At one point my co-leader said to one woman, "Sheila, I feel that you're trying to fight me by deliberately, doing nothing!" Sheila flushed, and burst into tears, after which she admitted she had been playing the "rebellious child." From then on her progress was remarkable.) In similar ways we tried to provoke the reluctant members to be angry with us. Their anger felt scary to them but in every case, it seemed to release them.

In this session the leaders also demonstrated deep breathing exercises, and used some bioenergetic techniques, maximizing the tension in the body and then relaxing.

By this time several of the women were able to achieve orgasm through masturbation. The focus shifted to enable each woman to experience orgasm through stimulation by her partner. As the first step, we asked her to masturbate with her partner observing her. This desensitized her to visually displaying arousal and orgasm in his presence, and also functioned as an excellent learning experience for her partner.

Resistance to this assignment was intense and was explored individually: "Well, if you can't masturbate with him in bed with you, can you do it in the same room? ... with his back turned? ... or outside the door?" No matter where the woman was in her unwillingness to respond, we gave her "permission" to be there, and supported her, always asking for just the tiniest of "baby-steps."

For those who were ready (had experienced orgasms through masturbation and masturbated in front of their partners) the next assignment was to engage in intercourse with her partner with additional stimulation of her genitals. This additional stimulation could be by herself and/or by her partner, either manually or with a vibrator. Where the partner would be providing the additional stimulation, we recommended the "female astride" position, lateral or rear entry into the vagina for this activity. (These positions allow the male easy access to the female's genitals during intromission.)

Again the instructions were to focus on pleasure and not try for orgasm. (This instruction takes the pressure off, often in itself, results in increased sexual sensations because the woman no longer has to "produce" if she feels aroused. This paradoxical injunction acts to keep the woman's anxiety at a minimum while interacting with her partner.)

In the last session we began as we had in previous sessions. While sharing their "space" some of the women expressed sadness at the ending of the group. We spent a great deal of time on feelings about termination. We reviewed with each person where they were when they entered the group and where they were now. There were lots of hugs and smiles as we parted, and the mood was best expressed by one of the older women, Estelle, who said to the others, "God, you women are so lucky that you're learning all this now, while you're still young enough and have all the years to use it all! and I think you're all so brave, and so beautiful! I only wish that when I was your age, I could have been where you are now!"

CASE HISTORY

The following is a case history of one of the clients in the pre-orgasmic womens group.

Physical Description

Marie is a 27 year old Japanese-American, single, elementary school teacher. She is petite in stature, weighing approximately 90 pounds and is about 5 feet tall. Her appearance is always neat and there is a clean aspect about her. Her long, black, shiny hair has a slight wave.

She comes from a working class family. Her mother is a waitress and her step-father is a cook in a Japanese restaurant. She and her sister are college educated.

Marie usually sits with her arms folded across her chest, which seems like a protective gesture. In general she has a quiet manner but her speech is quick, sometimes she chatters. Her face is animated when she laughs and she giggles a lot.

Marie feels she relates better to children than to adults and she likes her job as a teacher, very much. However, she does not relate to her peers at work and doesn't like to attend teacher meetings.

Personal History

Marie came to Southern California Counseling Center six months prior to her joining the pre-orgasmic women's group. I was her counselor. Her presenting problem was that she couldn't control her tears and cried

at inappropriate times. During the course of counseling it became evident that the tears were tears of resentment and anger. Marie felt obligated to never refuse anyone a favor and she felt constantly imposed upon. As she learned to be assertive, the tears stopped. During the course of the counseling, Marie would talk from time to time about her concern about her lack of sexual experience and she alluded to the few experiences she had as painful. I suggested she join the sex therapy group and she was enthused, if somewhat apprehensive.

Marie comes from a conservative Japanese home. Her father died when she was an infant and her mother subsequently remarried twice. Her memory is of a lonely, unhappy childhood in which her mother worked, leaving Marie alone to baby sit with her two younger sisters.

At 27, Marie was living at home with her mother, step-father, two sisters (24 and 14 years), and her grandmother, who only spoke Japanese. The three sisters shared one bedroom and Marie shared a double bed with her youngest sister.

Marie's mother never showed any emotions and no one ever hugged or touched each other in her family, which is typical of the Japanese culture. Marie tries hard to earn her mother's affection by being helpful in any way that she can. She remembers, as a child, her first step-father beating up her mother in terrible fights. Anger is upsetting to Marie.

She has a very close relationship with her sister who, like Marie, is a school teacher. She shares all her experiences and feelings with her sister. Her sister is the only person she is totally open with. Marie's friends are just acquaintances.

Presenting Problem

Marie had very few experiences with sexual intercourse and found penetration painful. During the six months of counseling it became obvious that she had a very inadequate background in terms of sex education, knowledge and experience. The subject was never discussed at home with her parents.

Although she had little sexual experience, she did not express feelings of inferiority or embarrassment in terms of her peers. Her social life was entirely within the Japanese culture and it was not considered unusual for the Japanese women in their late twenties to be virgins. For many months Marie had a platonic relationship with a young man who seemed satisfied with this arrangement.

Marie wanted to join the sex therapy group and at the same time she expressed ambivalence about sharing her feelings about sex with a group of strangers. Part of her ambivalence was because Japanese people are taught not to share the private lives with strangers.

Treatment

During the first group session, Marie (usually so shy that I anticipated complete silence from her) shared that her mother had never talked to her about sex. She also admitted that her only sexual experiences had been frightening and painful, that sex to her was something unpleasant which a woman had to "put up with" if she wanted to be in a relationship.

At the next session she said she didn't really want to do the homework but that she had done it and "it wasn't so bad."

Marie was rather quiet through the eight sessions. She once shared with me during our individual session, "I'm quiet, but I take it all in." This statement sums up Marie's involvement in the group. Her ability to be non-defensive and to absorb helped her to make many changes as the group progressed.

In the following session, Marie told the group that she had decided to get her own apratment, as she needed more privacy. This was a big step for Marie, she had never lived alone. She worried about being lonely but seemed to take it as another challenge. She made an excellent adjustment.

Marie had difficulty with the assignment of touching her genitals but overcame her resistance and tried it.

After having read the assigned homework, My Secret Garden, Marie came in smiling. She was so relieved to know that other women had sexual fantasies: "I thought there was something terrible about me, that I had these kind of fantasies, even when I was a young girl!"

Each session found Marie opening up a little more. She shared with the group that she had finally been able to tell her "platonic boyfriend" to stop calling. She was now seeing someone new.

After the fourth session, Marie cut her hair short. Everyone in the group responded with compliments, telling her how pretty she looked. One woman summed it up by saying, "You're like a flower that's opening up and blossoming." Marie shyly smiled and simply said thank you.

Marie had a lot of resistance to the homework assignment of masturbating. Each week she would come in with another excuse as to why she hadn't tried it. We explored the resistance each time. By the

eighth session, she shared that she was masturbating but hadn't had an orgasm.

Although Marie had not achieved orgasm by the last session, her own personal growth in terms of knowledge and ease with talking about sex was evident in her statement of the last session: She thanked everyone in the group for their support and their sharing. She said that she had learned a great deal and that now she wanted to integrate it all.

Marie terminated her individual counseling a month after the group ended. She felt really good about herself and the insights and changes she had gained from both the group and individual counseling.

Although Marie was still pre-orgasmic, the tremendous growth that had occurred during the group therapy indicated that she would continue to absorb and integrate the insights that she had gained and the prognosis for a fulfilling sex life in the future was apparent.

CONCLUSION

Sociologically, our experiment reinforced the conclusions of Barbach and others that women are taught from birth that there are certain activities approved for men but not quite acceptable for women, and among these is sex. The messages which women receive from society are confusing. "Sex is dirty," but to be "saved for the one you love," and is something "nice girls don't enjoy," but "the price you pay for marriage." Because of the many confusing stated and unstated communications, women have grown up with distorted and frightening views on sex which invite sexual dysfunctions. The result is that sex therapy has become popular.

In addition, conservatives oppose the idea of sex education in the schools; parents have neither the terminology nor the know-how to discuss it with their off-spring, and men have a "machismo" ideal to live up to....so hardly anyone in our society has adequate factual information.

Added to this is the fact that male chauvinism still is the prevailing theme in man-woman relationships. Accordingly, many men still believe (and countless more, without thinking about it, act as though) sex is an activity for men, which requires a female partner, although neither her enjoyment nor her consent is particularly necessary.

Since women have been actually conditioned to accept the idea that men know "all about sex" and that women should'nt know (or if they do, they must never let a man know, lest the "delicate male ego" be threatened) a "conspiracy of silence" takes place: Women are sexually unsatisfied and resentful, feeling "if only he loved me, he'd know what I want, without my telling him." At the same time, men are resentful that their partners are so dis-interested in sex, and they feel, "if she loved me, she'd want sex more often."

In the eight sessions of the pre-orgasmic women's group we attempted to therapize and educate women (and through them, their partners) to mollify these negative influences of an ignorant society's attitude towards sex. Through the methods studied in the field of Marriage, Family and Child Counseling, we applied techniques learned, to the pre-orgasmic group.

These techniques included fantasy using meditation, visualization and focussing. To help release anger, we used the Gestalt method of

talking to the imaginary person in an empty chair. Also used was the method of client-centered therapy involving active listening.

Many of the women benefited from the assertion training and learned to be able to ask their partner for what they wanted.

The Neo-Reichian techniques of body language were integrated into the sex therapy group as well as Lowen's bio-energetics.

The goal of the project was to help women become positive sexual individuals, to become more aware of their options and power, and to grow in confidence. Also, to help them to enjoy marriage, if that's what they want, or to enjoy single life (or any other life style) without being dependent on men (for sexual release or for "response-ability").

In assessing the effectiveness of this particular pre-orgasmic women's group, we note that six of the eight women gained the ability to achieve orgasm. The other two, who had originally felt that "self-stimulation" was taboo, were now masturbating although not yet to orgasm. Four of the women were orgasmic with clitoral manipulation by their partners but had not as yet transferred this to intercourse. The other two women reported happily that they had achieved orgasm through intercourse with their partners. We hope to do a follow-up study in six months.

Follow-up research done at the University of Oregon indicated similar results. In all eight cases, the women had gained the ability to achieve orgasm, and the follow-up (up to six months) indicated no relapse but rather, further gains in the enjoyment of sexual relations.

Although the research in this area is not sizeable, it is clear that this program offers considerable promise in the treatment of orgasmic dysfunction.

And since a stable society seems to require fulfilling relationships based on mutual understanding and commitment, the reversal of sexual dysfunctions may be considered a significant step in creating a society in which neither men nor women will be assigned roles as a result of gender, race or ethnicity.

APPENDIX

2573

INTRODUCTION TO PRINCIPLES OF SEX COUNSELING

Workshop attended:

University of Calif. Medical School,

San Francisco

Human Sexuality Program

The basis for sex counseling is defined in the following general way: Someone who is dissatisfied with his sexual relating. More specifically, it can be defined as a problem in the disruption of sexual arousal, erection, orgasm, ejaculation, insertion or sexual pleasure. Other concerns are the subjective discomfort or dissatisfaction with ones own or one's mate's sexual functioning, feelings, expectations or attitudes. Problems and concerns stated by an individual reflect that individual's perception that something is "wrong" in his or her sex life with reference to some set of culturally-based expectations. If an individual reports a problem in his or her sex life, at that moment, the problem is genuine even though it may vanish in minutes as a result of information or reassurance.

There are many facets to the treatment of sexual dysfunctions. One of these is the education of the clients in terms of sex information. As part of the educational process the therapist imparts "permission-giving" information relative to the client's dysfunction, i.e., "Did you know that masturbation is a common practice amongst married men?" Another important part of sex education is an indepth discussion and diagrams of female and male pelvic anatomy and of the sexual response cycle. This discussion takes place with both husband and wife present. The therapist

encourages the clients to become familiar with the names of the parts of the anatomy as preparation for future homework assignment.

In the discussion of the sexual response cycle, similarities as well as differences were pointed out between the male and female reactions to each stage of the cycle. In the male excitement phase the erection of the penis is the first sign of arousal. Erection is caused by engorgement of the penis with blood and is parallel to the lubrication of the vagina in women. The engorgement or vasococongestion is the result of more blood flowing into the organ than flows out. During this phase the scrotum becomes tense, congested and thick. The testes rise higher in the scrotum. Often nipples erect and swell in men. The first sign of arousal in the female excitement phase is the moistening of the vagina with lubrication fluid. As the walls of the vagina lubricate, the tissue engorges and the uterus pulls up from the bladder. The cervix pulls up from the back of the uterus. Sex is a total body response. Blood vessels change all over the body. Breasts swell, and nipples become erect. Sometimes there is a sex blush, or the skin can become blotchy.

In the male plateau phase the same blush develops in the male as in the female, but it is less frequent in the male. The testes increase in diameter about fifty percent over their unstimulated size and are pulled up even higher into the scrotum. The breathing rate increases. The tension of both voluntary and involuntary muscle heightens. There is no specific, defined moment in time which separates the excitement from the plateau phase. The most dramatic change in women during the plateau phase is the appearance of the orgasmic "platform." As a result of the swelling, caused by the engorgement of tissues, the diameter of the outer one third

of the vagina narrows and is reduced by as much as fifty percent. It thus actually grips the penis. The uterus enlarges and elevates during this phase. There is a ballooning of the inner two thirds of the vagina. The clitoris is engorged with blood and seems to retract under the hood.

In the male orgasmic phase breathing becomes faster, and heart rate and blood pressure rise just as they do in the female. There is an increasing tension all over the body. Male orgasm is a two stage process. First, semen is emitted into the base of the uretha. At this point the male knows he is going to ejaculate. This is known as the "moment of inevitability." During the second stage, a series of rhythmic contractions of the urethal bulb and of the penis itself projects the semen outward under great pressure. The rhythmic contractions are timed, as in the female, at intervals of four fifths of a second. The ejaculation of semen during orgasm is a complex process. The onset of the female orgasmic phase occurs simultaneously with an initial spasm of the orgasmic platform, i.e., the outer third of the vaginal barrel and the engorged tissues surrounding it. There occurs a series of rhythmic contractions which are muscular contractions. The uterus also contracts rhythmically. Each contraction begins at the upper end of the uterus and moves like a wave toward the cervical end.

There are many similarities in the female and male resolution phase. In both male and female, orgasm initiates the release of muscular tensions through the body and initiates the release of blood from the engorged blood vessels. The sex flush in both disappears and the nipples return to normal. The pulse rate, blood pressure, and breathing rate gradually return to normal in both male and female. In the male, the

return of the penis to its unstimulated state occurs. In most men the scrotal wall quickly reverts to its uncongested state, and the testes return to their unstimulated state. In the woman, the clitoris which has been retracted and is invisible during the plateau and orgasmic phases, returns to its normal position. As the cervix descends to its unstimulated position, the inner two thirds of the vagina becomes less distended and returns to its usual size in three or four minutes.

The above knowledge was imparted through lecture, slides and movies. We also did certain homework assignments in order to experience what a client might feel in following the same instructions. One of the assignments was a body awareness exercise that went as follows: "Set aside a time and space that is comfortable. Make sure you will not be interrupted by the telephone or other kinds of interruptions. Be aware of the process in putting aside this time and space for yourself. Take a bath or shower. When soaping yourself, be aware of how different parts of your body feel. Try to be aware in many different ways, i.e., What does your hand feel like? How does the skin on your fingers differ from the skin on your palm? What does your body feel like? Where does it feel most sensitive? Are there any parts which "go dead?" Be aware of when your mind goes "out" of the experience to automatic pilot. Try to be open to any new experience you have."

Another body awareness homework assignment was the following: "Undressed in front of a mirror, verbalize to yourself how you feel about your body. Go slowly and talk out loud about each part of your body, i.e., hair, eyes, nose, shoulders, etc. Try it in different positions. Note how you feel. If you have a hand mirror, look at your genitals."

The following session the therapist asks for feedback from clients on their homework assignment.

Much attention was paid to sensate focussing, a body awareness exercise used by Masters and Johnson. It is the deliberate focussing of attention on "no-demand" touching. By doing these graduated exercises with certain areas "off-limits," one experiences the pressure taken off sexual "performance" and can enjoy the feelings of touching and being touched. Through these exercises the client learns to relax and appreciate receiving as well as giving. Both partners learn to appreciate their own body, as well as that of their partner, and to know which parts they enjoy touching and which parts are sensitive to touch. A variation of this was the "candy experience" sensate focus exercise as follows: Each person was given a piece of hard candy. "Close your eyes and savor the candy. Person on your left describes in detail to the other person what the experience is like, the other person just listens. Keep the candy in your mouth and then reverse the process. What was the experience like for you?" One can take a given sensory experience and embellish it with one's own meanings.

Sex in advertising was another subject which was discussed, especially the more or less subtle ways in which sex is used in advertising. For example, American Airlines ads, show a 747 with a comment "Slip into something comfortable." Western Champagne flights, urge passengers to "Get it! On the Way to New York!" Ultra Ban shows several deoderant sticks in comparison to theirs which is shaped like a penis and is described as "Delicious and long lasting."

Gender Identity was another topic discussed, i.e., how we learn to be feminine and masculine in our culture. It was stressed that messages and myths are established by three years of age. It is interesting to note that our culture has two different ways for male and female to cross their legs, look at their fingernails and even carry their schoolbooks. Some of the other messages come from our differentiation in dress: Little boys wear blue, little girls, pink. Girls get the message that its wrong to feel sexual; their reputation will be tarnished. They are also told that how they dress, how smart they are (not too smart), how not to be too independent are all important if they are to attract the "right man." Another message girls receive is that: "Women don't care about sex until the right man comes along," and the paradox that; "Sex is dirty"---"Save it for the one you love." Boys, on the other hand, learn that men are supposed to take care of women. "Men are strong, develop their minds, don't have tender feelings." Also, men are supposed to learn the "right" technique (how and where to touch) in order to "satisfy" the women. If they don't they are "inadequate."

Two methods of taking a history were presented. The first was a Brief Sex History which included the following five points: Onset, Client's Perception, Other Help, Self Help, and Client's Goals. Questions to ask about the Onset includes: "About when did this start?" Has it been sort of the same since it started? Can you get erections in the morning?" If it is an erection problem check to see if the person has had a physical recently. Important information can be gotten from the Client's Perception of the Problem. "If you had a fantasy, what do you think caused it?" Other Help such as medical; gynecologist, internest may have been seen

by the client. It is sometimes valuable to find out what the client was told by his doctor. Other professional help, such as therapy should be explored. Ask if they are satisfied with the way the doctor responded. Ask if they are on any medication. It is important to explore Self Help methods: home cures such as reading books, trying to RELAX, etc. Also check out the Client's Goals and make a specific contract. "If you get the sex thing together, would you really like to live with each other?"

Another method of taking a history begins with a conjoint interview. Clients are given a questionnaire. The therapist needs to be cautious of being inundated with data. (H. S. Kaplan, Masters and Johnson and Hartman and Fithian have complete outlines of history). In the beginning you just need a brief outline. Find out what the family was like and what was the family model for feelings. Be aware to what extent the client discloses in front of the others in the conjoint interview. Some things only come out in the individual interview when the client is alone with his/her therapist. It is important to make clear that anything said in the individual interview is information for the conjoint therapy unless it is "red flagged." If you feel a secret is detrimental to the progress of the therapy, you need to share this with the client and examine alternatives. Client can "red flag" a secret but therapist clarifies that the client must be willing to discuss what they have red flagged with the therapist. Whenever possible turn a secret back to the client, i.e., "How can I be an effective as a therapist if you give me secret information. Unless that information is out on the table I can't see the therapy working." Some questions that may have value are: "If you were pleasing yourself and not the other person, what would you like your sex life to be

like? What do you see is the future of the relationship? What will you do if nothing changes? How would you like your life to be different if this problem is solved." Another value of the history taking interview is that the presenting cause may be a "red herring".

In our society sex means so much because it is related to the concept of inadequacy and therefore, to self image. For this reason lots of people try to outguess each other in sex. Simply learning to talk with each other is most helpful...to ask the partner what she or he is feeling. For example, many women will report (but not tell their partner) that orgasm with direct clitoral stimulation feels better than orgasm with intercourse. Orgasm with intercourse is described as "rounder," with clitoral stimulation it is more "defined." Expecting to have satisfaction from vaginal intercourse alone is like asking a man to have satisfaction from scrotal stimulation alone. Many women would like permission to touch the clitoris or have their partner touch it during intercourse. However, Masters and Johnson state that 91% of the time the clitoris can't be touched in the plateau stage as it retracts under the clitoral hood.

Much of the above information is conveyed to the clients at the "round table." In this session the lives of the couple are reflected back as if they were seeing the lives in a mirror. Communication is stressed in terms of learning to give "I" messages. Then the therapists proceed with the following treatment based on the individual problem.

Basically there are six sexual dysfunctions. Within the six dysfunctions, three of which are female and three that are male, there are primary and secondary dysfunctions. If a client has never experienced

intercourse (male) or never experienced orgasm (female) this is considered primary; if a client has had some experience in this area then the dysfunction is considered secondary.

The following paragraphs will discuss the sexual dysfunctions, their causes and the treatment used at University of California, San Francisco Medical School, Human Sexuality Program. The three most common male problems will be reported first, followed by the three female problems.

The inability to achieve or hold an erection is referred to as erectile failure. Causes of primary impotence may include one or more of the following: 1. seductive mother 2. religious restrictions 3. homosexual ambivalence 4. traumatic initial failure. Causes of secondary impotence include: 1. alcohol 2. overbearing parents 3. religious restrictions 4. homosexuality 5. long or serious illness. The treatment for both primary and secondary erective failure is the same.

Histories are taken on all clients and their mates. In the case of impotency, history taking should stress the timetable of symptom onset: Has there always been difficulty, or is the loss of erective power of recent origin? If recent in origin, what specific events inside or outside the marriage have been associated with the onset of symptoms? Are there any mastabatory difficulties? Is there a homosexual background of significance? Further questioning should define the male's attitude toward his partner. Is there rejection not only in the marriage partner, but also of other women? Are the female partner's sexual demands in excess of his levels of sexual interest or ability to comply? Is there a sexual disinterest that may have resulted from the partner's physical or personal

traits, such as excessive body odor or chronic alcoholism? The therapists should take special care to give the male confidence in himself and in the therapists as authorities who can help. Therapists must get the cooperation of the wife. There is a great advantage in training the wife to be an active member of the therapeutic team.

In early stages of treatment the co-therapists direct the couple not to participate in any sexual activity without specific instructions. This serves to take the pressure to perform off the male partner. Re-education includes discussion about religious taboos, homosexuality, drinking or whatever is the relevant treatment to the particular individuals. It is especially important for the impotent male to understand the effect of his negative attitudes toward sex on his ability to function. Sensate focussing exercises emphasizing touching without intercourse helps in the removal of performance fears and helps him to stop mentally watching himself during sexual activity. It also serves to remove his wife's fears. After several occasions of demand-free spontaneous erections, so that both know it can happen over and over again they move to intercourse with the specific directions of the therapist. (Masters and Johnson)

Premature ejaculation is defined as ejaculation before the man or his partner is ready for ejaculation to occur. This dysfunction frequently precedes secondary impotence. The causes of this dysfunction are: 1. alcohol 2. a dominating parent 3. religious restrictions. 4. homosexuality. The man with this problem develops a sense of inadequacy that deepens as he tries more and more desparately all the usual techniques to delay ejaculation. Holding back or blocking all the sexually stimulating signals from his wife eventually leads to erective failure.

In treatment, therapists need to take special care to give them confidence in themselves and in the therapists authorities to help. A sexually frustrated woman will sometimes obtain revenge by belittling him in different ways. If this exists, the wife must be urged emphatically to cooperate. At the initial interview the couple is instructed not to participate in any sexual activity without specific directions. This serves to take the pressure off the male. Treatment begins with the woman using the frenular squeeze technique. The male is manually stimulated by his partner for short periods of time. The shaft of the penis should be well lubricated to reduce cutaneous sensation. In general, this technique is not applied at the last moment before ejaculatory inevitability but is utilized about half a dozen times during each session of touching, at the discretion of the female partner. Each application consists of firm pressure applied for about four seconds. Occasionally the male will ejaculate so the couple should be encouraged to return to the technique repetitively until the male's obviously improved control leads to the next therapeutic technique. This will be the female superior mounting, which can later be converted to a non-demanding lateral resting position.

Retarded Ejaculation is the inability to ejaculate into the vagina. Sometimes the male can thrust for up to an hour without ejaculating. The source on the conflict and/or the content of the emotional state seems to be non-specific. Factors that can contribute are: 1. religious restrictions 2. fear of impregnating 3. parental disapproval of teenage masturbation or wet dreams.

Treatment approach to the man who cannot ejaculate begins with the sensate focus exercises. The wife is instructed to stimulate her husband in whatever ways he finds most exciting. The idea is for her to cause ejaculation so that he will identify this pleasure with her rather than regarding her as a threat. Her efforts should not be rushed, it may be necessary to repeat the technique for several days before it is successful. Therapist must convince the wife that she must "get to give" as she may feel resentful of his orgasms. After the masturbation technique has succeeded, and ejaculation can be accomplished easily, the next step is to have the female insert the penis after having manually aroused her mate to a point near ejaculation. The wife should be in the female superior position. She is instructed, once the penis is inserted, to move demandingly until ejaculation occurs. If he doesn't ejaculate after a period of time she is instructed to slip the penis out and go back to the manual stimulation. After she brings the man close to ejaculation again, she reinserts his penis and tries once more. Masters and Johnson have had a high success rate with this method.

Among female problems anorgasmia or pre-orgasmic dysfunction is one of the most common complaints. There are so many possible causes that it is difficult to list them all. The following are some of the causes and the dysfunction may include several. 1. negative messages of parents 2. troubled by inappropriate advance from family member 3. hopes some man will come along and teach her 4. may have experienced rape 5. mother seemed out of control. The treatment at University of California, San Francisco Medical School is conducted in small groups of 6 to 8 pre-orgasmic women. This treatment is presented

in the main part of this paper.

Dyspareunia is dysfunction defined as pain during intercourse. It is caused by: 1. failure to lubricate, 2. yeast infection (monila), 3. trichomonas, 4. herpes and 5. douches. Clients with infections are referred to their physcians for treatment. Clients who douche should be informed that douching does no more than remove the normal acid and make the vagina more susceptible to bacteria and fungus growth. Failure to lubricate actually indicates failure to be sexually aroused. Fears, resentments, anger and other feelings can cause lubrication dysfunction. The diagnosis of psychosomatic pain can only be made by carefully eliminating all other possible causes. Lubricants are a helpful aid in the treatment of dyspareunia.

If it is painful for a woman when the penis is inserted it helps to bear down as this relaxes the muscles. The angle at which the penis elevates is less and less as males get older. There is also less variation in the length of erect penises than among flaccid ones. This means that "size incompatability" is actually an arousal problem. Contrary to popular belief, men have multiple orgasms as well as women. However, there is not any one way to describe sexual experiences, as everyone is different.

Vaginismus is also painful because of the involuntary tightening or spasm in the outer third of the vagina. The causes are: 1. overly strict religious background, 2. physical assault (rape), 3. painful intercourse caused by physical problems such as tears in the uterus or growth of the lining of the uterus in other areas of the pelvis. The client is referred to a physician for gynocologial examination. The couple

is educated through illustrations so that they become familiar with her vagina. The couple are given vaginal dilators in graduated sizes to be used in their own bedroom. At first the husband inserts the dilator with the wife's hand guiding his. As her confidence grows and the spasm lessens, larger dilators are used by the husband under the wife's directions. Although it is relatively easy to deal with the physical aspects the emotional aspects must be treated also.

This reviews the six main sexual problems in male and female dysfunctions. The course at University of California Medical School, San Francisco provided a unique experience. It was not only an informational course but somehow a hundred people shared their intimate selves on an emotional level. It was a profound experience for all of us.

EXAMPLE OF HOMEWORK

MASTURBATION

Masturbation is self-stimulation for sexual pleasure. All parts of the body may be stimulated, but usually the genitals are the focus. Masturbation usually leads to orgasm.

Masturbation Myths

1. Masturbation causes insanity, headaches, epilepsy, acne, blindness, nosebleeds, masturbator's heart, tenderness of the breasts, warts, nymphomania, undesirable odor, uninhibited sexuality, and hair on the palms.
2. Excessive masturbation is harmful.
3. It is an abnormal, unnatural act.
4. It is immature.
5. It is practiced mostly by simple-minded people.
6. It is a substitute for intercourse.
7. It is antisocial.
8. People may learn to prefer masturbation to intercourse.

Masturbation Truths

1. There is no evidence that masturbation impairs physical or mental health.
2. Masturbation is a natural function. People in most cultures and many species of animals masturbate.
3. Many people masturbate throughout their lives. Many sexually active people with available partners masturbate as an additional gratification.

4. Intercourse and masturbation can be viewed as complementary sexual experiences, not as mutually exclusive.

5. Masturbation is a good way to learn about your own sexual responses so you can communicate them to a partner.

6. Masturbation is a good way to create your own orgasm.

Masturbation is a natural sexual function. It is good psychologically and healthy physiologically.

The desire to masturbate occurs at different times for different people and the frequency varies enormously from person to person. Again, we are all different and unique. Some people fantasize while masturbating, others don't. Some people come quietly while masturbating, others make lots of sounds, and still others thrash about. These aspects vary greatly. There is no "right" or "best" way to masturbate or to have an orgasm.

It is natural for children to masturbate. Children masturbate out of curiosity and for pleasure. Guilt is a result of being told by OTHERS that it is wrong. The better informed and more comfortable we are about our own sexuality, the more we can be at ease with ourselves and others.

At Home Exercise — Whole-Body Masturbation

This exercise will incorporate different parts of the body into masturbation.

While you are spending your hour stimulating yourself, think of other parts of your body that might feel good to touch. Some examples:

Breasts

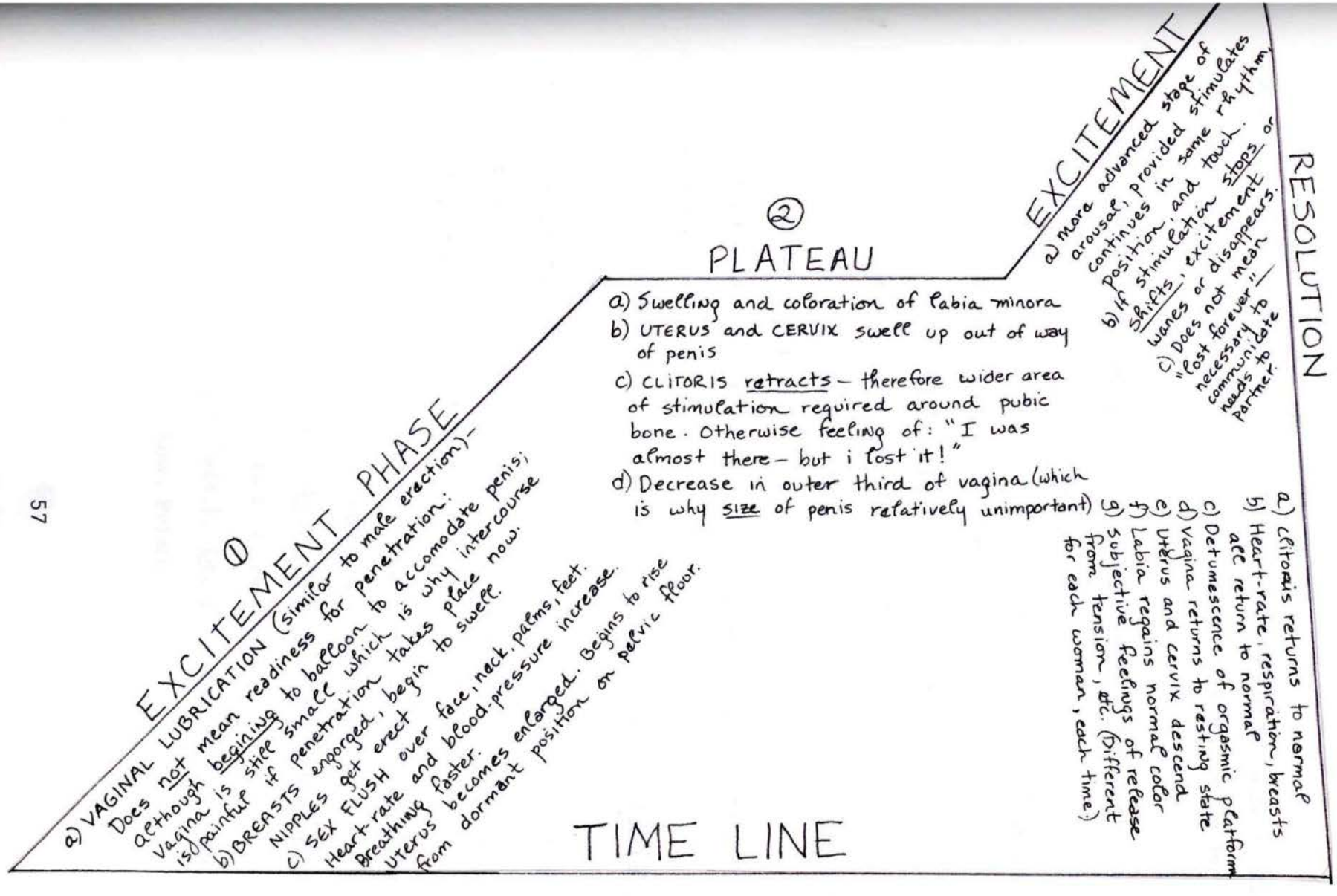
Face

Inside of arms

Inside of legs

Stomach, neck, shoulders, thighs, feet, chest.

Use both hands, one on your genitals and the other somewhere else, at the same time. Close your eyes and try to get in touch with stroking both places simultaneously. As you do this breathe slowly and evenly. Imagine the breath flowing along a path between the two places you are touching and stroking. See if this helps expand your sexual experience.



* sensations of ORGASM include: a) intense sexual awareness from clitoris to pelvis
b) suffusion of warmth
c) vaginal contractions
d) pelvic throbbing
e) suspended animation

(different for each woman, each time)

BIBLIOGRAPHY

Ayres, Toni, Rubenstein, Maggi, Smith, Carolyn, The Yes Book of Sex: Getting in Touch. San Francisco: Multi Media Resource Center, 1972.

Bandura, Albert, Principles of Behavior Modification. New York: Holt, Rinehart and Winston, Inc., 1969.

Barbach, Lonnie, "Group Treatment of Pre-Orgasmic Women," Journal of Sex and Marital Therapy, v. 1, no. 2, 1975

Barbach, Lonnie, For Yourself: The Fulfillment of Femal Sexuality. New York: Doubleday & Co., Inc., 1975.

Bardwick, Judith, Psychology of Women: A Study of Bio-Cultural Conflict. New York: Harper & Row, 1971.

Bates, Marilyn and Johnson, Clarence, Group Leadership. Denver: Love Publishing Co., 1972.

Belliveau, Fred and Richter, Lin, Understanding Human Sexual Inadequacy. Boston: Little, Brown & Co., 1970.

Berzon, Betty, "The Therapeutic Event in Group Psychotherapy: A Study of Subjective Reports of Group Members," Journal of Individual Psychology, v. 19, pp 204-12, 1963.

The Boston Women's Health Collective, Our Bodies Ourselves: A Book By and For Women. New York: Simon and Schuster, 1971.

Brecher, Ruth and Edward, (eds.) An Analysis of Human Sexual Response. New York: Signet, New American Library, 1966.

Cartwright, D. and Zander, A. (eds.), Group Dynamics: Research and Theory. Evanston, Ill.: Row, Peterson, 1962.

Corisini, R. and Rosenberg, B., "Mechanisms of Group Psychotherapy: Processes and Dynamics," Journal of Abnormal Sociological Psychology, v. 51, pp 406-411, 1955.

Dickoff, H. and Lakin, M., "Patients' View of Group Psychotherapy: Retrospections and Interpretations," International Journal of Group Psychotherapy, v. 3, pp 61-73, 1963.

Dodson, Betty, Liberating Masturbation, New York: Bodysex Designs, 1974.

Fisher, Seymor, The Female Orgasm. New York: Harper & Row, 1973.

Frank, J. and Ascher, E., "The Corrective Emotional Experience in Group Therapy," American Journal of Psychiatry, v. 108, pp 126-31, 1951.

Frankfort, Ellen, Vaginal Politics. New York: Bantam Books, 1973.

Friday, Nancy, My Secret Garden: Women's Sexual Fantasies. New York: Pocket Books, 1973.

Gornick, V. and Moran, B., (eds.), Women in Sexist Society: Studies in Power and Powerlessness. New York: Signet Books, 1971.

Greenberg, J. and Archambault, F., "Masturbation, Self-Esteem and Other Variables," Journal of Sex Research, v. 9, no. 1, pp 41-51, 1973.

Haley, Jay, Strategies of Psychotherapy. New York: Grune & Stratton, 1963.

Hartman, William and Fithian, Marilyn, Treatment of Sexual Dysfunction. Long Beach: Center for Marital and Sexual Studies, 1972.

Kaplan, Helen Singer, The New Sex Therapy. New York: Brunner/Mazel, 1974.

Katchadourian, Herant, and Lunde, Donald, Fundamentals of Human Sexuality. New York: Holt Rinehart & Winston, 1975.

Kegel, A. H., "Sexual Functions of the Pubococcygeus Muscle," Western Journal of Surgery, v. 60, no. 10, 1952.

Kinsey, A. C., Pomery, W. B., Martin, C. E., and Gebhard, P. H., Sexual Behavior in the Human Female. New York: Pocket Book, 1953.

Kronhausen, Phyllis and Eberhard, The Sexually Responsive Woman. New York: Ballantine Books, Inc., 1964.

Lieberman, M. A., Toward Self-Understanding: Group Techniques in Self-Confrontation, Springfield, Ill.: Charles C. Thomas, 1965.

LoPiccolo, Joseph and Lobitz, W. C., "New Methods in the Behavioral Treatment of Sexual Syxfunction," Journal of Behavior Therapy and Experimental Psychiatry, v. 3, pp 265-76, 1972.

Lowry, Thomas and Thea (eds.), The Clitoris, St. Louis: Warren H. Green Publishers, 1976.

Masters, William H. and Johnson, Virginia, Human Sexual Inadequacy. Boston: Little, Brown & Co., 1970.

Masters, William H. and Johnson, Virginia, Human Sexual Response. Boston: Little, Brown & Co., 1966.

O'Connor, John and Stern, Leonore O., "Results of Treatment in Functional Sexual Disorders," New York Journal of Medicine, v. 72, no. 15, pp 127-34, 1972.

Roseberg, Jack, Total Orgasm. New York: Random House, 1973.

Sager, Clifford J. and Kaplan, Helen Singer, (eds.), Progress in Group and Family Therapy. New York: Brunner/Mazel, Inc., 1972.

Sherfey, Mary J., The Nature and Evolution of Female Sexuality. New York: Vintage Books, Random House, 1966.

Stock, D. and Thelen, H., Emotional Dynamics and Group Culture. New York: New York University Press, 1958.

Sullivan, Harry Stack, The Interpersonal Theory of Psychiatry. New York: W. W. Norton, 1953.

Truax, C. and Carkhuff, R., Toward Effective Counseling and Psychotherapy. Chicago: Aldine Press, 1967.

Wolpe, J., Behavior Modification Techniques. Oxford: Pergamon, 1961.

Yalom, Irvin D., The Theory and Practice of Group Psychotherapy. New York: Basic Books, Inc., 1970.

Yalom, Irvin D., The Theory and Practice of Group Psychotherapy. New York: Basic Books, Inc., 1970.

Yalom, I. D., and Rand, K. H., "Compatability and Cohesiveness in Group Therapy," Archives of General Psychiatry, v. 13, pp 267-276, 1966.

BIBLIOGRAPHY - NARRATIVE TRANSCRIPT

Assagiali, Robert, The Act of Will. Baltimore: The Viking Press, 1976.

Bach, G. and Golding, Henry, Creative Aggression. New York: Doubleday & Co., 1974.

Baker, Ellsworth, Man in the Trap. New York: Avon Books, 1967.

Barbach, Lonnie G., For Yourself: The Fulfillment of Female Sexuality. New York: Doubleday & Co., 1975.

Bates, M. and Johnson, Clarence, Group Leadership. Denver: Love Publishing Co., 1972.

Bernstein, Anne C., "How Children Learn about Sex and Birth," Psychology Today, v. 9, no. 8, pp 31-35, January, 1976.

Boston Women's Health Book Collective, Our Bodies, Ourselves. New York: Simon and Schuster, 1971.

Butterfield, Oliver M., Sexual Harmony in Marriage. New York: Emerson Books, Inc., 1974.

Brecher, Edward and Ruth, An Analysis of Human Sexual Response. New York: The New American Library, 1966.

Clellan, S. F. and Beach, F., Patterns of Sexual Behavior. New York: Harper and Rowe, 1966.

Coleman, James, Abnormal Psychology and Modern Life. 4th ed., Chicago: Scott Foresman, 1964.

Ellis, Humanistic Psychotherapy: The Rational-Emotive Approach. New York: Harper and Rowe, 1968.

Erickson, G. and Hogan, Terrance, (eds.), Family Therapy: An Introduction to Theory and Technique. Monterey, Calif.: Brooks Cole Publishing Co., 1972.

English, F., "T. A.: A Populist Movement," Psychology Today, v. 6, no. 11, pp 45-50, April, 1973.

Farraday, A., Dream Power. New York: Coward, McCann & Geoghean, Inc., 1972.

Ferber, A., Mendelsoh, M., and Napier, A., (eds.), The Book of Family Thearpy, New York: Science House, 1972.

Gunther, Bernard, Sense Relaxation, Palo Alto, Ca.: Collier, 1972.

Hite, S., Sexual Honesty. New York: Warner Communication Co., 1974.

James, M., and Jongeward, Dorothy, Born to Win. Calif.: Addison-Wesely Publishing Co., 1971.

Jaffe, D., T. M. New York: Delecorte Press, 1975.

Kaplan, Helen S., "The Classification of the Female Sexual Dysfunctions" Journal of Sex and Marital Therapy, v. 1, no. 2, Winter 1974.

Kaplan, Helen S., The Illustrated Manual of Sex Therapy. New York: Quadrangle, The Times Book Co., 1975.

Kaplan, Helen S., The New Sex Therapy. New York: Quadrangle, The Times Book Co., 1974.

Kronhausen, Everhard and Phyllis, Sexually Responsive Woman. New York: Ballantine, 1972.

Lowen, Alexander, Betrayal of the Body. New York: McMillan & Co., 1967.

Lum, Kenneth, "Towards Multicentered Marital Therapy," Psychotherapy, Research & Practice, v. 10, no. 3, pp 208-211 (Fall 1973).

Ornstein, Robert E., The Psychology of Consciousness. San Francisco: W. H. Freeman & Co., 1972.

Riley, L. E. and Spreitzer, Elmer, "A Model for the Analysis of Lifetime Marriage Patterns," Journal of Marriage and the Family, v. 36, no. 1, pp 64-70, February 1974.

Rush, A., Getting Clear. New York: Random House, 1973.

Sager, C. F. and Kaplan, Helen S. (eds.), Progress in Group and Family Therapy. New York: Brunner/Mazel, 1972.

Satir, Virginia, Conjoint Family Therapy. Palo Alto, Calif.: Science and Behavior Books, Inc., 1967.

Smith, M., When I Say No I Feel Guilty. New York: The Dial Press, 1975.

Yalom, Irvin D., The Theory and Practice of Group Psychotherapy, 1970.

Wolpe, J. and Slater, Andrew (eds.), The Conditioning Therapies. New York: Holt, Reinhardt & Winston, 1964.

BIBLIOGRAPHY - NARRATIVE TRANSCRIPT

Agel, J. (ed.), The Radical Therapist. New York: Ballantine Books, 1971.

Alberti, R. and Emmons, Michael, Your Perfect Right. San Luis Obispo, Calif.: 1970.

Dreyfus, Ed, "Private Practice: A Therapeutic Collective," The Center for the Healing Arts, no. 5, December 1975.

Ellis, Albert, Sex Without Guilt. California: Wilshire Book Co., 1973.

Erickson, E., Childhood and Society. California: New York: W. W. Norton & Co., 1963.

Fagan and Shepherd, (eds.), Gestalt Therapy Now, Palo Alto, Calif.: Behavior & Science Books, 1969.

Fisher, S., The Female Orgasm, New York: Basic Books, 1973.

Ford, D. and Urban, Hugh, Systems of Psychotherapy: A Comparative Study. New York: Wiley & Sons, 1963.

Fromm, Eric, The Art of Loving. New York: Reinhart, 1958.

Ginott, Hain, Between Parent and Child. New York: MacMillan Co., 1965.

Glasser, William, Reality Therapy. New York: Harper & Row, 1965.

Gordon, Thomas, Parent Effectiveness Training. New York: Peter H. Wyden, 1970.

Haley, Jay, Uncommon Therapy. New York: Ballantine Books, 1973.

Herrigan, Jackie and Jeff, Loving Free. New York: Ballantine Books, 1973.

Hartman, William and Fithian, Marilyn, Treatment of Sexual Dysfunction. Calif.: Center for Marital and Sexual Studies, 1972.

Jackson, Don, (ed.), Therapy, Communication and Change, Calif.: Behavior and Science Books, 1973.

Katchadourian, H. and Lunde, D., Fundamentals of Human Sexuality. San Francisco: Rinehardt & Winston, 1972.

Kempler, Walter, Principals of Gestalt Family Therapy, Norway: A. S. Joh Nordahls Trykkeri, 1973.

Kogan, Benjamin, Human Sexual Expression. New York: Harcourt Brace Jovanich, 1973.

Laing, R. D., Politics of the Family. New York: Vintage Books, 1972.

LoPiccolo, J. and Lobitz, Charles, "New Methods in the Behavioral Treatment of Sexual Dysfunction," Journal of Behavior Therapy, v. 3 (4), pp 265-271, Dec. 1972.

Lederer, W. J. and Jackson, Don, The Mirages of Marriage. W. W. Norton, 1968.

Lowen, Alexander, Love and Orgasm. New York: The New American Library, Inc., 1965.

Masters, W. H. and Johnson, Virginia, The Pleasure Bond. Little, Brown & Co., 1970.

Maslow, Abraham, Toward a Psychology of Being. New York: Van Nostrand Reinhold Co., 1962.

Montagu, Ashley, Touching. New York: Perenial Library, 1971.

Movis, P., "The Relative Effects of Family and Peer Group in the Sexual Socialization Process," Journal of Marriage and the Family, v. 36, no. 1, February 1974.

Osgood, C. E., and Tannenbaum, P. H., "The Principle of Congruity in the Prediction of Attitude Change." Psychological Review, 62: pp 42-55, June 1967.

Perls, F., Gestalt Therapy Verbatim. Calif.: Real People Press, 1969.

Prochaskas, J. O. and Marzilli, Robert, "Modification of the Masters and Johnson Approach to Sexual Problems," Psychology, Theory and Practice, v. 10, no. 4, pp 294-296, Winter 1973.

Scanzion, J., Sexual Bargaining. New Jersey: Prentice Hall, 1960.

Smith, Muriel, When I Say No I Feel Guilty. New York: Dial Press, 1975.

Thompson, George, Child Psychology, Basong: Houghton Mifflin, 1962.

Watzlawick, P., Beavin, J. H., and Jackson, D. D., Pragmatics of Human Communication. New York: Norton & Co., 1967.

Wolpe, Joseph, The Practice of Behavior Therapy. New York: Pergamon Press, 1969.