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RETROSPECTIVE STUDY OF PARTICIPANTS IN
PREORGASMIC WOMEN'S GROUPS:
LOOKING FOR LIFE CHANGES

by
Barbara Geiger

A practicum submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SOCIAL WORK

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1977

TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:

The practicum advisor approves the practicum of
Barbara J. Geiger presented May 16, 1977.

Betty Leonard, Practicum Advisor

May 16, 1977

TABLE OF CONTENTS

	PAGE
LIST OF TABLES	v
 CHAPTER	
I. INTRODUCTION.	1
II. METHODOLOGY	4
Instrument.	4
Data Collection	5
Population: Demographic Description .	7
III. HISTORICAL OVERVIEW: TREATMENT OF WOMEN'S PRIMARY ORGASMIC DYSFUNCTION. . .	13
Pre-Masters and Johnson	13
Masters and Johnson	20
Post Masters and Johnson.	30
IV. RESULTS	48
Sexual Changes.	48
Changes in Nonsexual Relationships. .	54
Activity Changes.	58
Body Image Changes.	58
Assertiveness Changes	59
General Affectual Changes	61
V. DISCUSSION.	63
Sexual Changes.	63

CHAPTER	PAGE
Changes in Nonsexual Relationships .	66
Changes in Body Image.	67
Changes in Assertiveness	68
General Affectual Behavior	69
VI. CONCLUSION.	70
REFERENCES	72
APPENDICES	74
A. Interview Schedule: Topographical Outline	74
B. Interview Schedule With Gross Rating Scale	76
C. Contents of Agency Letters.	81
D. Consent Form.	84
E. Cover Sheet	85

LIST OF TABLES

TABLE	PAGE
I. Responses to Initial Letter by Agency . .	8
II. Selection Process of Interviewees From Letters Returned.	9
III. Age Distribution by Agency.	9
IV. Highest Education Level Completed	10
V. Annual Income Distribution.	10
VI. Sexual Relationship Status Upon Entering Treatment	12
VII. Sexual Activity Resulting in Orgasm After Treatment	50

CHAPTER I

INTRODUCTION

It is the purpose of this research practicum to explore the self-reported changes of women who have participated in Preorgasmic Women's Groups. These groups are a type of treatment program for the problem of primary orgasmic dysfunction¹, and for women who want to learn to experience orgasm through manual masturbation.

A Preorgasmic Group relates to a combination of physiological and psychological components of orgasm. It is distinguished from other therapy techniques in that the program involves only women in a group situation and uses a combination of techniques. It combines group discussion, education of female anatomy and sexual function, and a behavior modification program done as homework, which is an adaptation of the nine-step desensitization program designed by Lobitz and LoPiccolo (Lobitz and LoPiccolo, 1972).

Preorgasmic Women's Groups were developed out of the

¹Primary Orgasmic Dysfunction: a term describing the condition of a woman who has never experienced orgasm. Secondary orgasmic dysfunction is a term describing women who have experienced orgasm outside sexual activity with a partner.

University of California at Berkeley in 1972 by Lonnie Barbach and Nancy Carlsen. Since then they have been offered as sexual therapy in many cities across the nation by female therapists trained by either Ms Barbach, Ms Carlsen, or one of their past trainees. These groups are becoming very popular as they result in a high success rate, are more economical than individual or couple therapies, and are acceptable for women without partners, women who do not wish to involve their partners, or homosexual women.

This treatment program has been offered in Seattle for over a year. Three local women have been trained by Barbach or Carlsen, they in turn have trained other therapists and so on. At the present time, this therapeutic approach is being offered by SISTER (Seattle Institute for Sexual Therapy, Education and Research), the Adult Development Program (Department of Psychiatry, University of Washington), Freemont Women's Clinic, University of Washington Student Health Center and various private practitioners.

The researcher became involved in this approach during her summer block placement (1976) at the Adult Development Program, where she received leader training in return for teaching at least one group this winter. During this training period, it became evident that, with the exception of Barbach's initial research, there was no research available on the subject (Wallace and Barbach, 1974). The coordinator of the program at the Adult Development Program did collect

some data, however, much of the material was gathered in an unsystematic way. After reviewing this material, Barbach's book For Yourself: The Fulfillment of Female Sexuality, and her research on the group outcomes, the researcher began to pinpoint important areas of women's lives, some considerably removed from sexual behavior, that may change through a woman's participation in these groups. It soon became obvious that much more than the sexual aspect of a woman's life (which is important in itself) could possibly be altered through this treatment program.

Many hours were spent with the group leaders from both SISTER and the Adult Development Program designing this practicum and sharing its progress. The women from these organizations supported the need for such research to be used by leaders as a feedback tool as well as for academic purposes. The researcher's intent was to explore the areas of possible change from the group member's subjective reporting, as opposed to a pre post, more objectively styled data gathering system. The objective was to hear from the women, in their own words, explaining the effects their participation in the Preorgasmic Groups had, or did not have, on their lives.

CHAPTER II

METHODOLOGY

I. RESEARCH DESIGN

This study is exploratory and descriptive in nature. The purpose is to develop, clarify and modify concepts concerning the effects of Preorgasmic Groups (hereafter referred to as PO Groups) by; 1) gathering descriptive data from subjects, 2) researching the literature and, 3) conceptualizing the interrelationships among these properties. Hopefully, the outcome will be several theoretical generalizations that might be considered potential research material.

The general topic areas to be explored in this study are; sexual changes, changes in nonsexual relationships, activity changes, body image changes, assertiveness changes and general affectual changes. Each of these areas, where pertinent, has been subdivided into information concerning behavioral changes and information about affectual changes.

II. INSTRUMENT

Tape recorded, hour long interviews were employed to collect information. The purpose was not only to gather some clear objectively defined data from each woman, but also to get a more subjective and descriptive glimpse of her

experiences as a result of the group.

An interview schedule was developed in the form of a topographical outline (refer to Appendix A). This was done to insure that all subjects were given the opportunity to comment on the same areas. However, the actual interviews did not necessarily follow in the sequence of the schedule.

Effort was put into using open-ended questions to allow the subject a broad response range. Each woman was given the opportunity to comment on any area that had not been explored before the end of the interview. Subjects were also encouraged to ask for clarification of questions, etc. Inquiries from the women regarding therapeutic advice were dealt with by asking them to please wait until the end of the interview, when the researcher would be willing to suggest referrals.

Rating scales were devised and made a part of the interview schedule to allow for greater ease in the later analysis of the information (Appendix B). Response categories were gross in nature. More detailed and anecdotal information was to be derived from transcriptions of the tapes.

A cover sheet requesting demographic information was given to the subject to fill out after the interview.

III. DATA COLLECTION

Of major concern to participating agencies was maintaining the confidentiality of their clients and in no

way coercing them into participation. The system of obtaining subjects was carefully planned and the ADP (as a part of the University of Washington system) required that the entire research plan be approved by the University's Human Subjects Committee.

Letters from each agency requesting past clients to become involved in the research were drawn up by the researcher, but addressed and mailed out by the agencies to protect the women's confidentiality (Appendix C). Interested women were asked to return the completed second page. Self-addressed envelopes were provided.

Two and a half weeks were allowed for returns, whereupon appointments for interviews were initiated by telephone. During this initial phone contact, each woman was assigned a code so that from then on, her tape, transcript and interview notes were labeled by the code. The women's names and codes appeared together in only one master notebook, which is kept confidential.

Interviews were scheduled between November and January. Women were given several options in regard to the location of the interview; the agency, their home or the researcher's home. They were asked to choose the most convenient site for them. The women chose the locations as a fairly equal rate. Care was taken to accommodate each woman's schedule, however, scheduling problems did arise, preventing several interviews.

Before each interview about ten minutes were allowed for social conversation to put the interviewee at ease. At this time, I explained my student status, relayed some information about my background in the field of sexuality and gave her an opportunity to ask me questions about my work experience and/or the study. Any previous interviewee's responses were not revealed at this time. The consent form (Appendix D) was then given to her and further explanation offered. The women were told that in exchange for their time, they would be supplied with the study results and/or time with me to discuss such results, upon request.

IV. POPULATION: DEMOGRAPHIC DESCRIPTION

When the impetus for this research began, there were three major agencies offering PO Groups: The Adult Development Program (ADP), Fremont Women's Clinic and SISTER. All three agencies were personally contacted by the researcher to inquire about their interest in participating in this research project. Both the ADP and SISTER responded enthusiastically. Fremont Women's Clinic decided not to include itself in the study.

The following six tables are demographic summaries of the population of women in this study. The information for Tables I through V was gathered from the cover sheet of the interview schedule that each woman filled out (Appendix E). The data for Table VI was obtained through the

interviews.

Table I illustrates the number and percentage of responses received by the researcher, to the initial letter of request for participation in the study. This information is separated by agency affiliation as well. The ADP women returned 31% of the initial letters sent to them, and SISTER women returned 32% of the letters. As a total, 31.5% of the women who were sent letters requesting their participation in the study responded. This 31.5% consisted of 24 women.

TABLE I
RESPONSES TO INITIAL LETTER BY AGENCY

Agency	Letters Sent		Letters Returned	
	#	%	#	%
ADP	51		16	31
SISTER	25		8	32
Total	76	100	24	31.5

Of the 24 women who responded (Table II), five (5) had scheduling problems with the interviews, and one (1) woman was a no show. This self selection process resulted in a total of 18 women, or 23.6% of the possible population, being included in this study. Eleven (11) women were ADP clients and seven (7) were from SISTER. This represents 21.5% and 25% of the possible populations respectively.

TABLE II
SELECTION PROCESS OF INTERVIEWEES FROM LETTERS RETURNED

Agency	letters returned		schedule problems		no show		actually interviewed	
	#	%	#	%	#	%	#	%
ADP	16	31	5	31.2	0	0	11	21.5
SISTER	8	32	0	0	1	12.5	7	25
Total	24	31.5	5	20.8	1	4.1	18	23.6

The mean age of these subjects was 30.3, with a standard deviation of 6.63. The ages ranged from 23 to 52 years, with the mean age of those from both agencies almost identical to the total mean age (Table III).

TABLE III
AGE DISTRIBUTION BY AGENCY

Agency	Range	Mean	Standard Deviation
ADP	23-52	30.45	4.49
SISTER	23-37	30.14	7.92
Total	23-52	30.33	6.63

The largest percentage of the subjects had completed four years of college. Some had finished a two year program and a significant number had completed graduate school (Table IV).

TABLE IV
HIGHEST EDUCATIONAL LEVEL COMPLETED

Educational Level	#	%
Elementary School	0	0
High School	1	5.6
2 Year College	4	22.2
4 Year College	7	38.9
Graduate School	6	33.3
Vocational School	0	0

When asked to check the category that best described their incomes, the most common category checked was "\$10,000-15,000", with the second most common category being "\$5,000-10,000", followed by "below \$5,000". Fewer women fell in the "\$15,000-25,000" category (Table V).

TABLE V
ANNUAL INCOME DISTRIBUTION

Annual Income	#	%
Below \$5,000/year	4	22.2
\$5,000-10,000/year	6	33.3
\$10,000-15,000/year	7	38.3
\$15,000-25,000/year	2	11.1
Above \$25,000/year	0	0

Table VI describes the sexual relationship status of the women upon entering treatment. Subjects are divided up by their agency affiliation. Most of the women did

define themselves as having a steady partner, although some of these same women said that they were involved with a variety of other sexual partners as well. Three (3) women only had casual partners and two (2) women had none. Two (2) women were married and three (3) were living with their steady partner. Fifteen (15) of the women were exclusively involved with male partners and one (1) woman was exclusively involved with female partners. Two (2) of the women were involved with both male and female partners.

TABLE VI
SEXUAL RELATIONSHIP STATUS UPON ENTERING TREATMENT

Subject	Steady Partner living with				Casual Partners		No Partner
	married	male	female		male	female	
ADP							
1	x						
2		x					
3			x				
4	x				x		
5	x						
6	x						
7					x		
8		x					
9	x						
10	x						
11	x						
SISTER							
1			x		x	x	
2				x			
3							x
4	x				x		
5					x	x	
6					x		
7							x

CHAPTER III

HISTORICAL OVERVIEW: TREATMENT OF WOMEN'S PRIMARY ORGASMIC DYSFUNCTION

I. PRE-MASTERS AND JOHNSON

Freudian Masters and Johnson have proven what women have known about their bodies for years, that the clitoris is more sensitive than the vagina. In fact, if one judges the sensitivity of an organ by the number of nerve endings per area, then the clitoris is more sensitive than the penis (shulman, 1971). Yet, as Ruth Herschberger pointed out in her book Adam's Rib (Herschberger, 1948), society refuses to acknowledge it:

It was quite a feat of nature to grant the small clitoris the same number of nerves as the penis. It was an even more incredible feat that society should actually have convinced the possessors of this organ that it was sexually inferior to the penis.

Freud makes it clear that women are not whole human beings due to their lack of a penis; that women long all their lives for a penis and struggle to reconcile themselves to this lack (Lydon, 1970). The concept of penis superiority is usually credited to Freud. However, many critics emphasize that Freud was, and is, a reflection of a culture that is male dominated. One wonders what might have been defined as the major male and female sex organs, the standard

sexual position, the psychic "tasks of development" as Freud called them, and masculinity and femininity themselves, had women, instead of men composed not only the medical profession, but the dominant caste in society (Shulman, 1971).

It is the vagina that Freud claims as the "mature" erotic organ. Freud (Freud, 1946) explains this concept:

In the phallic phase of the girl, the clitoris is the dominant erotogenic zone. But it is not destined to remain so; with the change to femininity, the clitoris must give up to the vagina its sensitivity, and with it, its importance, wholly or in part. This is one of the two tasks which have to be performed in the course of the woman's development; the more fortunate man has only to continue at the time of his sexual maturity what he has already practiced during the period of early sexual expansion.

A woman who fails to transfer her sexual sensitivity from the clitoris to the vagina at puberty is regressive, infantile, neurotic, hysteric and frigid according to Freud. He describes the vaginal orgasm as mature, beautiful and good, while the clitoral orgasm is seen as infantile, perverse and bad. By Freud's definition a woman is frigid if she does not have "vaginal orgasms" even though she may have frequent clitoral orgasms.

Within this framework the absense of "vaginal orgasm" was seen as a neurotic symptom, and the treatment prescribed was psychoanalysis. When women in psychoanalysis described the grasping sensations felt vaginally (that we now know correspond to the numerous muscular contractions triggered

by clitoral, not vaginal stimulation) their analysts interpreted this as their "inability to let go" (Lorand, 1939). So what was a normal and real orgasm for a woman in psychotherapy under the Freudian model was viewed as an immature clitoral orgasm and a sign of neurosis.

After many years of treating such women with little success, defined by the analysts as obtainment of "vaginal orgasm", they began to realize something wasn't fitting together. However, their explanation led them only further away from solutions (Lorand, 1939):

Many therapists concluded that they must be content if they can help the patient adjust herself to incomplete sexual gratification and to sublimate the sexual desire by converting the penis envy (which some analysts regard as the central problem) into the wish for a child.

Medical Influences Psychoanalysis has proved to be of little success in helping women with sexual complaints. In fact, it may well have hindered the general public by supporting the myth of the vaginal orgasm and the concept of penis superiority. However, it did seem to lessen the more barbaric treatments doctors had been using in the area of sexuality. Clitorecictomy (removal of the clitoris and its surrounding areas) was a trend in Europe during the late 1800's (it existed in other than western cultures as well) done to inhibit masturbation and prevent unfaithfulness of young women. The theory behind the operation was that if the clitoris and its surrounding areas were

removed, this area would then not interfere with the vagina's sensitivities (Barbach, 1975). Dr. Issac Brown Baker, who performed this operation often reasoned that it prevented sexual excitement which he claimed could cause insanities, hysteria, epilepsy, etc. (Lydon, 1970). Such practices began before Freud and did continue somewhat after. One presently prominent sex therapist reports having treated a woman who only thirty years ago had the hood of her clitoris removed at the age of four (Barbach, 1975).

However, as the treatment of psychotherapy began to be accepted, therapists started to experiment and branch out from the strict Freudian model of psychotherapy in treating women's sexual problems. In the 1940's, Viktor Frankl, an existential psychotherapist, employed his "de-reflection" technique to sexual problems. He had a woman refocus her attention during sexual activity toward her partner. Frankl felt that by this shift of attention toward the "proper object" that an orgasm would be established spontaneously. He did report some degree of success with this method (Frankl, 1946). One formulation for this method's success with some women is that it served to remove what we now call performance anxiety and so left the woman sufficiently relaxed so as not to block the orgasmic reflex.

The American Journal of Psychiatry reports an innovative approach tried by Drs. Stone and Levine, in the 1950's, for the treatment of women who complained of dissatisfaction with

their sexual adjustment to marriage. The treatment consisted of working in groups of male partners alone, female partners alone and then couples together. They combined presentation of information, support group and group discussions. The information presented included the concept of vaginal stimulation alone triggering orgasm, women possessing a minimal sex drive in comparison to men, and women lacking the full sexual response necessary for satisfaction (Stone and Levine, 1950). In other words, they relayed incorrect physiological information concerning stimulation, and did not encourage women to consider it their right and capability to achieve orgasm as often as they choose to. Emphasis was on orgasm through intercourse being preferable to other orgasms (Stone and Levine, 1950). As discussed in other sections of this paper, this concept disregards the fact that "an orgasm is an orgasm" (Masters and Johnson, 1966). What is outstanding in Stone and Levine's method is that it did at least address itself to the sexual response and did not overtly relay the concept that sexual problems were a sign of deeper neurosis.

At about this same time Kinsey began to do his research (which will be discussed shortly), but it is not until after Masters and Johnson that the more prominent view in this area moved from the neurosis concept to one that views sexual problems as a learned phenomenon that can or cannot be accompanied by other life problems. However, even as recently as 1969 a famed physician wrote, "The only effective treatment

for total orgasmic impairment is psychotherapy, because the condition is a psychiatric one. The sexual difficulty is simply a manifestation of a deeper emotional dysfunction" (Reuben, 1969).

Kinsey's Influences Kinsey began his studies on sexual behavior of the human male and female in the 1940's, and by 1953 published Sexual Behavior in the Human Female. His book was a descriptive study on the sexual activities of women as well as a physiological explanation. By bringing women's sexuality (and men's sexuality, for that matter) into the scientific realm, he opened the door for studying the subject in more objective ways. Kinsey was one of the first to view a person's sexuality as a learned behavior. Both of these factors set the stage for treating sexual problems as a main complaint rather than looking for an underlying personality disturbance.

He should also be credited for revealing many facts about female sexual behavior that led to new understandings of women's sexual complaints. Kinsey made public major findings in the area of women's orgasmic responses that especially influenced treatments. He began to dispel the myth of the "vaginal orgasm" by emphasizing his findings that the vagina, especially the inner two thirds, is insensitive and that the most sensitive erotic organ is the clitoris, followed by the labia minora. Kinsey states that "this insensitivity of the vagina has been recognized by gynecol-

ogists who regularly probe and do surface operations in this area without anesthetic" (Kinsey, 1953). He comments on the vain efforts of psychoanalysts, clinical psychologists and marriage counselors to teach their patients transfer of "clitoral responses" to "vaginal responses," as they have been attempting a "biologic impossibility" (Kinsey, 1953).

Kinsey's research revealed that the average woman reached orgasm 95% (or more) of the time through masturbation, and the average married woman reached orgasm only 73% of the time during coitus. It was also discovered that most females are able to masturbate to orgasm in coitus, and that women who had never masturbated to orgasm before marriage had more difficulty reaching orgasm in the first years of marital coitus. Another finding was that many women are capable of multiple orgasm (Kinsey, 1953). All this began to point to the major physical element of orgasm, clitoral stimulation, as well as the important role that masturbation can play in sexuality.

Approximately ten years after Kinsey, Masters and Johnson clarified and intensified research in this area and directly applied it to treatment (this will be reviewed later.) In the mean time, physicians and marital counselors of the post Kinsey era adopted his discoveries and we entered the "Marriage Manual Craze" (Lydon, 1970). Marriage manuals were directed exclusively toward married

couples. The major goal of the manual approach was to insure that wives were not robbed of their ability to experience orgasm. This relates directly to Kinsey's statement that all females, if sufficiently aroused physically are probably capable of responding to the point of orgasm (Kinsey, 1953).

However, even with Kinsey's negative stand on "vaginal orgasm", therapists refused to give up the concept and pushed the idea of simultaneous orgasms as well. But, oddly enough, they did grasp the importance of clitoral stimulation and focused much instruction on foreplay to insure some clitoral stimulation.

If viewed as part of a long process, this modality of treatment was positive. However, it also had many negative repercussions. As Susan Lydon (Lydon, 1970) describes it:

Under the guise of frankness and sexual liberation, they dictated prudery and restraint. Sex was made so mechanized, detached, and intellectual that it was robbed of its sensuality . . . the marriage manual put new pressure on women. The swing was from repression to preoccupation with the orgasm. Men took the marriage manuals to mean that their sexuality would be enhanced by bringing women to orgasm . . . they put pressure on women to perform.

II. MASTERS AND JOHNSON

Findings Dr. William Masters and Virginia Johnson, who began their research shortly after Kinsey in 1954, have

probably influenced today's sex therapists more than anyone else. Their method of studying human physical response to sexual stimulation in a laboratory setting generated data that is extremely difficult for any skeptic to refute. Whereas Kinsey used more of a sociological approach and depended on subjects' reports, Masters and Johnson used scientific observational methods. Their studies total a fifteen year investigation of the human sexual response and an eleven year study of human sexual inadequacy:

All sex therapy and educational programs in the United States today have their base in the work of William Masters and Virginia Johnson--if not in their treatment model, then at least in their research findings regarding the physiology of the human sexual response cycle (McIntyre and London, 1976).

In 1966, Masters and Johnson published Human Sexual Response in which they compiled the results of observation and interviews with 487 women concerning female orgasm. Briefly, their conclusions were:

- 1) The dichotomy of vaginal and clitoral orgasm is entirely false. Anatomically, all orgasms are centered in the clitoris, whether they result from direct manual stimulation applied to the clitoris, indirect pressure resulting from the thrusting of a penis during intercourse, or generalized sexual stimulation of other erogenous zones.
- 2) Women are naturally multi-orgasmic; that is, if a woman is immediately stimulated following orgasm, she is likely to experience several orgasms in rapid succession.
- 3) While women's orgasms do not vary in kind, they vary in intensity. The most intense orgasms experienced by research subjects were by masturbation, followed in intensity by manual stimulation by partner; the least intense orgasms were

experienced by women during intercourse.

4) The female orgasm is as real and identifiable a physiological entity as the male's; it follows the same pattern of erection and detumescence of the clitoris, which may be seen as the female equivalent of the penis.

5) There is an infinite variety of female sexual response as regards intensity and duration of orgasm (Masters and Johnson, 1966).

Treatment Program- General Overview The treatment they developed is based on the concept that "sociocultural deprivation and ignorance of sexual physiology, rather than psychiatric or medical illness, constitutes the etiologic background for most sexual dysfunction" (Masters and Johnson, 1970). They also operate under the assumption that ". . . there is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy. . ." (Masters and Johnson, 1970), thus, they define the marital unit as the patient. (When no partner was available, Masters and Johnson made use of cooperative and skillful surrogate partners.)

Masters and Johnson's treatment program is always delivered through a dual-sex therapy team. A major reason for this is the belief that no man will ever fully understand a woman's sexual function or dysfunction, and the converse applies to any woman. Following this line of thought, the therapists are instructed to act as interpreters and "friends in court" to the client of their like sex (Masters and Johnson, 1970). Masters and Johnson also feel that the dual-sex team approach serves to ". . . lessen

the need for enactment of social ritual designed to gain attention of the opposite sex therapist, 'an unnecessary diversion, which often produces biased material in its efforts to impress" (Masters and Johnson, 1970). In addition, they claim that the team method cuts down on possible transference, which they feel has no place in this type of therapy as it would distract from positive exchange between husband and wife (Masters and Johnson, 1970).

The initial portion of their program is consistent although the presenting sexual complaints may vary. Therefore, I will discuss this first, non-specific phase of the treatment and then explore specific treatment procedures used for women's orgasmic complaints. Masters and Johnson's program is always time limited to two weeks and one member of the therapy team is an M.D. The client couple is required to come to the clinic for two weeks and live in a near by motel facility. Only married couples were accepted and the cost ranges somewhere over \$2,000. The full sexual history and medical history, along with a physical examination is a standing part of the treatment. It also should be noted that intercourse is prohibited in this initial portion of the program and is incorporated at various times, and in different ways, depending on the sexual problem. The couple has sessions with the therapists as well as specifically assigned exercises to do in their private quarters.

All therapeutic procedures focus on the unit as the patient. Education is seen as the basis for success and the dual-sex team presents information by following a sex-linked guideline. Team members describe in detail the psychosocial backgrounds of performance fears and "spectator" roles. Alleviating these fears, education concerning male and female sexual response and improving communication between partners are the most significant features of the program.

Alleviating performance fears is a major thrust in the therapy. Masters and Johnson believe that the:

fear of inadequacy is the known deterrent to effective sexual functioning simply because it so completely distracts the fearful individual from his or her natural responsivity by blocking reception of sexual stimuli, either created by, or reflected from the sexual partner (Masters and Johnson, 1970).

To facilitate the marital unit in ridding themselves of these performance fears the team avoids all specific suggestions of goal-oriented sexual activity.

Another major focus in this therapy is to improve on the couple's effectiveness in communication. Masters and Johnson state that "usually, the failure of communication in the bedroom extends rapidly to every other phase of the marriage" (Masters and Johnson, 1970). When the dual-sex team works with the unit together, then "along with the opportunity to educate concomitantly exists the opportunity to encourage discussion between the marital

partners wherein they can share and understand each others needs" (Masters and Johnson, 1970). The event of both partners and both therapists meeting together is called the "roundtable". Its underlying premise is that:

. . .objective, controlled, knowledgeable communication between therapists and sexual partners can develop a nonjudgemental evaluation of the sexually dysfunctional individual's prejudices, anxieties, and inadequacies to the educational advantage of both marital partners (Masters and Johnson, 1970).

In combining the goals of eliminating performance anxiety and enhancing communication, Masters and Johnson developed a technique called Sensate Focus. This technique has been incorporated into almost all sexual therapies today. The principle of this exercise is that:

subjective appreciation of sexual responsivity derives return from positive pleasure in sensory experiences that in turn derive their individual meaning and value from the patient's psychosocial sexual background (Masters and Johnson, 1970).

It is based on the cultural tendency that communication intended to give comfort or solace, convey reassurance, show devotion, describe love or physical need, is first expressed by touch. Olfactory, visual or auditory communication generally serve as a reinforcement of the experience (Masters and Johnson, 1970). The couple is instructed to find a mutually agreeable time in the privacy of their room. Both partners are to be undressed. The partner the therapists have assigned to the "giving"

role first traces, massages or fondles the "getting" partner with the instruction of giving sensate pleasure to him/herself, and discovering the receiving partner's individual levels of sensate focus. The person being touched is told to focus on the sensations and let the "giver" know if anything is unpleasant or uncomfortable. During sensate focus, the genitals (breasts, vulva and penis) are not to be touched. The focus of this exercise is not sexual arousal, but a nondemanding exploration of physical sensations. After a given period of time, partners reverse roles. This technique, as well as their global approach to reducing performance fears and anxiety, draw from behavioral principles. Some earlier behaviorists who did work in this area are Wolpin (1969) and Lazarus (1963).

Treatment Program- Specific to Primary Orgasmic Dysfunction

When helping couples with this particular problem, Masters and Johnson feel that it:

requires the basic understanding by patients and cotherapists that the peak of sex-tension increment resulting in orgasmic release cannot be willed or forced. Instead, orgasmic experience evolves as a direct result of individually valued erotic stimuli accrued by the woman to the level necessary for psychophysiological release (Masters and Johnson, 1970).

This perspective is conveyed to the unit during "round-table" discussions. The therapists suggest that the couple develop a nondemanding, erotically stimulating

climate in which to do their home exercises. Specific suggestions of ways to put aside tension provoking behavioral interaction are given to the unit and the woman is encouraged to discover and share knowledge of what she finds stimulating. The woman is given much permission to self-focus. Intercourse is refrained from until other specific instructions are given.

An exercise called Sensate Pleasure is incorporated into their home assignments. The basic idea is identical to that of sensate focus, except that the emphasis is on the female in the "getting" role and genital play is the focal point. Masters and Johnson suggest what they call a nondemand position for female stimulation. The woman is instructed to place her hands lightly over her partners so as to guide his hand to the areas of her genitals that she finds most pleasurable. She is also encouraged to guide the tempo and type of touching. Attention is focused on her wants. The man is reinforced by the therapists for being accommodating, warm, understanding, etc. The focus however is not orgasm, and both the husband and wife are instructed not to set specific goals or demands on each other. "The husband's light, teasing, nondemanding approach to touch and manipulation allows the female partner full freedom to express her interests, her demands, her sexual tensions" (Masters and Johnson, 1970).

This exercise is continued until high levels of sexual tension in the woman are reached, whereupon, coitus in the female-superior position is introduced. Once mounted, the wife is instructed to hold herself quite still and simply to absorb the awareness of penile containment. When, and only when, the woman feels the desire she can institute a brief period of controlled, slowly exploring, pelvic thrusting. The cotherapists "encourage the wife to think of the encompassed penis as hers to play with, to feel and to enjoy, until the urge for more severe pelvic thrusting involuntarily emerges into her levels of conscious demand" (Masters and Johnson, 1970). Gradually the couple begin to explore the position that Masters and Johnson claim to be the most enjoyable for both sexes, the lateral. The message from the cotherapists is always one of non-demand and is not orgasm directed.

Although it is not clearly stated in their book, Human Sexual Inadequacy, Masters and Johnson appear to set the goal of orgasm through intercourse as the measure of success for women complaining of primary orgasmic dysfunction. This becomes most interesting when one begins to remember Kinsey's findings, as well as Masters' and Johnson's findings about masturbation; specifically the frequency and intensity of orgasms it produces. More recent therapies (to be explored later in this paper) do

take these findings into consideration and have changed their major goal and/or emphasis. However, Masters and Johnson are responsible for developing concepts and specific treatments for sexual dysfunction that are successful and have the credit of opening the whole field of sexual therapy as a recognized, respected and successful form of therapy. Their reported success rate for treating primary orgasmic dysfunction as of 1970 is 88.4%. This was by far the most successful treatment at that time and was reasonably short term, (two week intensive therapy). One major drawback was that the population that was considered for treatment was limited to heterosexual, married couples who could afford both the cost and the time away from work.

Probably the most important concepts that Masters and Johnson have contributed toward the treatment of women's orgasmic difficulties are: 1) that all orgasms are centered in the clitoris, 2) that women are naturally multi-orgasmic, 3) masturbation produces the most intense orgasms, followed by direct clitoral stimulation by partner, and then by intercourse, 4) that the clitoris is equivalent in tissue structure and responsivity to the penis, 5) that there is an infinite variety in female sexual response, 6) the importance of a nondemand orientation in treating sexual problems, 7) the use of an educational model, and 8) focusing on communication as

well. All these contributions underlie the vast majority of post Masters and Johnson sex therapies, although they are often utilized in different manners. The therapeutic approach of conjoint therapy with a dual-sex therapy team is also an important contribution of Masters and Johnson, and a large number, if not the majority, of sex therapists today use it. However, most recently therapists have been reporting much success with varied approaches from this that allow them to reach a broader range of clients.

III. POST MASTERS AND JOHNSON

The treatment model designed by Masters and Johnson put together aspects of several psychological perspectives; educational, communication and behavioral. It did not include any intrapsychic dimensions. Many sex therapists use their model almost exclusively for orgasmic dysfunctions, and for other sexual dysfunctions, as it has been proven highly effective. However, some therapists have experimented and changed this model of treatment to such an extent that its roots in Masters' and Johnson's program are almost unrecognizable. The innovations tend to occur within the psychological perspective that the therapist favors. It is interesting that all of these approaches report good results, although not all have supported these statistically. The most common thread in

all of these therapies is the acceptance of Masters' and Johnson's physiological findings and the nondemand orientation.

Hartman and Fithian Hartman and Fithian's actual therapy program resembles Masters and Johnson's in that it uses the dual-sex therapy team, treats the heterosexual couple together, is a two week intensive program, uses the round-table, incorporates specific nondemand techniques developed by Masters and Johnson, and includes a lengthy history taking and physical exam. The remainder of the program diverges from Masters and Johnson and is considered highly controversial as it contains aspects of nudity and pleasuring techniques in the office, in the presence of the therapists.

It is well known in educational and behavioral psychology that one of the most effective ways in which we all learn is through modeling, mimicking or demonstration. It is on this theoretical premise that Hartman and Fithian base their foundations. Many of the pleasuring techniques are modeled by the therapists in the office. "Doing it in the office rather than away establishes a warm, intimate framework that allows the intervention of the therapists to teach them how to touch each other" (McIntyre and London, 1976). Whenever exercises are done in the office, the therapists stay long enough to facilitate

the exercise being done correctly and then leave the clients alone for a period of time. In addition to using the therapists to model specific behaviors, wide use is made of visual materials.

One of the most controversial aspects of their approach is the sexological examination. This is an exercise where:

each client is examined by the therapists to check for sexual response. The female partner is checked for nipple erection, sensation or awareness in the vagina, lubrication and is taught to do vaginal exercises. The male partner is also examined for sensitivity and taught the squeeze technique. The partner comes in and participates at the end of the sexological examination (McIntyre and London, 1976).

The sexological examination has been changed to fit more conventional norms and is now used by many therapy approaches.

Joseph LoPiccolo Joseph LoPiccolo and his colleagues, then at the University of Oregon, developed a behavioral treatment program for a variety of sexual dysfunctions. The basic focus, very similar to Masters and Johnson's, was on "anxiety reduction, sexual skill training and improving communication between sexual partners" (McGovern et. al. . , 1975). A major effort was made to develop a treatment program for orgasmic dysfunctions. Treatment procedures for both primary and secondary dysfunction are based on a systematic masturbation program.

LoPiccolo took serious note of Kinsey's report on

Sexual Behavior in the Human Female (1953) which revealed that the average woman reaches orgasm in 95% or more of her masturbatory attempts and only 75% during coitus. He also incorporated Masters and Johnson's 1966 findings, that masturbation produces a more intense orgasm than either intercourse or manipulation by a partner.

It has also been suggested by Bardwick (1971) that an intense orgasm leads to increased vascularity in the vagina, labia and clitoris. In turn there seems to be evidence that this increased vascularity will enhance the potential for future orgasms. Frequent orgasms will effect an increase in vascularity, which in turn will enhance the orgasmic potential. Nothing succeeds like success, and the increased number of orgasms will lead to the psychological anticipation of pleasure in sex. This notion is supported by the findings of Kegel (1952). He discovered that patients who strengthened their pubococcygens muscle through his exercises (Kegels) experienced an increased frequency in orgasm.

LoPiccolo absorbed all this information and concluded that masturbation would be the preferred treatment intervention for women with orgasmic dysfunction. He developed a nine-step desensitization program for masturbation and used it in conjunction with a basic behavioral program for husband and wife, modeled after Masters and Johnson's procedure for treating inorgasmic women. A

dual-sex therapy team is used in a time limited, sixteen session setting. Progressive homework exercises are assigned to be carried out between sessions. The first thing that the therapists deal with is the couples' attitudes towards masturbation. After these feelings are dealt with the nine-step at-home program is initiated. A skeleton of this program proceeds as follows:

Step 1. The woman examines her nude body, including her genitals in a mirror. She also begins Kegel exercises which tone the pelvic musculature and thus enhance orgasmic potential.

Step 2. The woman explores her genitals through touch and sight without expectations of arousal.

Step 3. The woman begins locating sensitive areas that produce pleasurable feelings.

Step 4. The woman concentrates on manually stimulating her sensitive areas and learns masturbation techniques from the female therapist.

Step 5. Intensity and duration of masturbation are increased; and pornography and fantasizing are suggested for additional stimulation.

Step 6. The woman uses a vibrator if orgasm has not occurred.

Step 7. Usually orgasm has been achieved and the woman is instructed to masturbate with her husband watching. He pays attention to her techniques of stimulation.

Step 8. The husband begins to do the things for his wife that he observed her doing for herself.

Step 9. When orgasm has been achieved in step 8, the couple engages in intercourse with the man continuing to stimulate his wife's genitals- until orgasm occurs (Lo-Piccolo and Lobitz, 1972).

Although the main focus of the at-home work is on the woman, it is felt that "when prescribing masturbation for an inorgasmic woman, it is crucial to enlist the cooperation and support of her husband" (LoPiccolo and Lobitz, 1972). That is, if the woman has to sneak off to masturbate and feels her husband disapproves, there is little chance that masturbation will be effective in producing orgasm. LoPiccolo's program makes the husband fully aware of what the wife is doing so that he can support her masturbation completely.

Initially, partners are seen by their same sex therapists. The male therapist directly trains the husband to support his wife's masturbation with the use of modeling and role play techniques. The husband is encouraged to masturbate and to share that with his wife.

LoPiccolo's treatment for primary orgasmic dysfunction is the first to use masturbation as its central vehicle for change. This program has been systematically studied using approximately seventy five couples, and has proved to be 100% successful (LoPiccolo and Lobitz, 1972). All the women involved were orgasmic through masturbation at the end of treatment and six months later. The majority of women treated became orgasmic through partner sexual activity consistently, although less reliably through intercourse. This is consistent with Kinsey's findings.

Jack Annon Jack Annon is linked strongly to the behavioral model in his treatment of orgasmic dysfunction and other sexual complaints. He does not always treat the couple together. In fact, he often gives information and suggestions to male clients who report their wives' as having sexual problems. Annon does not feel that the cotherapy team is necessary in all cases. His basic philosophy is that different clients will respond to different levels of treatment and various professions can deliver services at different levels. Therefore, various helping professionals are capable of delivering therapy to fit specific client needs. If a client's needs are beyond a professional's training then he/she should refer that client. His basic approach for sexual problems in general, described in The Behavioral Treatment of Sexual Problems (1974), is called PLISSIT, which represents what he calls the four levels of therapy: Permission, Limited Information, Specific Suggestions, and Intensive Therapy. Annon suggests a linear movement through these as a client may respond in a very short period of time to one of the first levels, and so there would be no need to involve the client further in therapy. The therapy is not time limited, but could probably be considered short term because of this factor, along with its behavioral approach.

When specifically treating women with orgasmic dysfunction, he often found the first two levels of

therapy to be enough, thus giving the woman permission to engage in a particular behavior without guilt, and giving her some specific information about orgasm and female sexual response. If the woman is in need of further help, he moves into Specific Suggestions. One of the first suggestions that Annon makes to these women is to explore what they expect an orgasm to feel like, what they want to feel like while making love, etc. Then he helps her to discriminate between what is myth and what is real. For the women having problems with arousal, Annon begins to reshape their arousal response slowly by suggesting that she involve herself in sensate focus, and any other activity which she considers romantic or arousing in any way. At the same time he asks her not to involve herself in any sexual activity that she finds offensive. Annon also starts the woman doing Kegels (Annon, 1974).

Once the woman is feeling arousal levels, but failing to reach orgasm, Dr. Annon swings strongly into a nondemand approach. He tells her how it is impossible to "will" an orgasm, but that it is possible to "allow" it to happen. An initial suggestion made to the woman is a "redirection of attention". This consists of informing the client that "there is always another occasion and that it might be most helpful if she focused her attention on positive bodily sensations rather than on thoughts of 'will it happen this time?'" (Annon, 1974).

His suggestions include sensate focus, relaxation exercises, and dating sessions which involve each partner alternately being responsible for setting and arranging a social "date" in conjunction with a sexual "session". Jack Annon believes that "for women who have never or rarely experienced orgasm, the shortest and most direct route to such an experience is through self-stimulation" (Annon, 1974). He incorporates masturbation at this level of treatment using a modification of Joseph LoPiccolo's nine-step desensitization approach.

Annon suggests to the woman to systematically fantasize genital intercourse with her partner at the point of orgasm. This is a technique unique to Annon's program (Annon, 1974). Once the client is orgasmic through masturbation, he incorporates partner exercises that are a direct modification of LoPiccolo's exercises for couples, that in turn, originated from Masters and Johnson.

Jack Annon works in Honolulu, Hawaii. Statistics on the results of this program are not available at this time. One of the most significant contributions of Dr. Annon's is his philosophy of levels of intervention. This orientation can serve to greatly broaden the client population that can afford treatment as different levels of therapy require a varied amount of clinical time, hence some people can receive help at lower costs. This is in

contrast to the vast majority of other orientations that prescribe a set program with no short cuts available.

Helen Singer Kaplan Helen Singer Kaplan, author of The New Sex Therapy, combines an intrapsychic orientation with behavioral approaches in the treatment of orgasmic dysfunction, as well as other sexual dysfunctions. Specifically when treating primary orgasmic dysfunction, but also in the treatment of other problems, Kaplan uses behavioral techniques to teach the woman how to stop interfering with the natural occurrence of orgasm. If these techniques do not seem to be working then she begins to explore the "intrapsychic and transactional conflicts that originally caused the holdback of orgasm" (Kaplan, 1974).

Kaplan does not use a specific sequence of behavioral tasks, as do Masters and Johnson, and Hartman and Fithian. Instead, she uses certain techniques (such as sensate focus) when they are specifically indicated. The program is not time limited and clients are seen one to two times a week. Termination occurs when good sexual functioning is established and there is good indication that it will continue.

The weekly sessions are a combination of psychotherapy and the prescription and discussion of specific sexual behaviors to be done at home. As these sexual tasks are carried out, conflict and underlying pathology are revealed

rapidly. The material which emerges is dealt with intensively in following sessions. In this way the two aspects of the program are combined.

Although there is an intrapsychic focus, only those issues that appear to be obstacles to sexual functioning are dealt with and other conflicts or neurosis are ignored.

Resistance which is mobilized in the course of treatment is dealt with. This may occur either in the symptomatic client or in the spouse of the client and intervention occurs in either case. Resistance is seen to reveal previously hidden underlying causes of the dysfunction. Techniques to treat the resistance may range from simple confrontation to analytic work with highly threatening, unconscious material. Each case is considered individually and psychoanalysis is used only when appropriate (McIntyre and London, 1976).

As discussed before, Kaplan prescribes different behavioral techniques depending on the presenting problems. She views these prescribed sexual experiences as helping to alter the previously destructive sexual system, facilitate the resolution of sexual conflict by avoiding previous kinds of sexual patterns, and evoking the emergence of unconscious dyadic and intrapsychic conflicts which are then made available for psychotherapeutic intervention.

The dual-sex, cotherapist team is not considered necessary in treatment. The participation of both partners is seen as a crucial ingredient to successful therapy. However, this program is flexible with respect to the

extent that both partners are required to participate in each session. When dealing with the problem of primary orgasmic dysfunction, treating a woman without a partner is often the case and is acceptable in this model, as the woman can take the first steps toward sexual responsiveness with masturbatory exercises.

Controlled studies using this method are still in process. To date the results are impressive, but these were with uncontrolled studies.

Kaplan's program is unique in that it combines behavioral approaches within an intrapsychic framework. It also provides more flexibility than any of the other programs reviewed.

Lonnie Garfield Barbach The approaches to the treatment of primary orgasmic dysfunction mentioned thus far have all been designed to treat couples. Although some offer some flexibility in this regard, the programs are designed with conjoint therapy as the optimal condition. The major difference in Lonnie Barbach's design is that it is a group treatment program explicitly set to have only women in attendance.

Ms Barbach worked as a therapist at the University of California Student Health Service in Berkeley, treating couples according to the basic Masters and Johnson technique. Gradually, she and other colleagues began to

realize that not only was the couple treatment too expensive for many women, (as it required the time and cost of two cotherapists for each woman,) but also, by its very nature, it was unavailable to many people who needed help. It restricted treatment to those women who had steady sexual partners, and to those women whose steady partners were willing and able to attend the counseling sessions. This meant that a large number of women who wanted and needed services were excluded--women whose partners were unable or unwilling to participate in formal treatment, families who could not afford costly couple treatment, women who did not have a steady partner with whom to attend couple treatment, women in homosexual relationships, or the many women who for various private reasons did not want to involve their partners, at first, in the problem (Barbach, 1975).

With the goal of providing help for more women, regardless of the nature of their intimate relationships, Lonnie Barbach and Nancy Carlsen, in 1972, developed a new kind of group treatment program for women which did not entail working directly with a partner. Although "a more satisfying sexual relationship with a partner remained a primary goal for most women" (Barbach, 1975). The program incorporated elements from the Masters and Johnson therapy techniques, and from other established sex therapy programs, including the masturbation program

developed by Drs. Lobitz and LoPiccolo. What is distinctive about this program is that only women attended the sessions in a group situation, and a number of therapeutic techniques were used. The groups are called "pre-orgasmic" women's groups. The founders saw pre-orgasmic as a more appropriate term than non-orgasmic since they fully expected that a woman who entered the group would be orgasmic before the group ended. The groups are designed to meet for ten sessions for one hour and a half each, for a period of five weeks. Two female cotherapists run the groups that consist of five to seven women.

Excluding partners is also felt to be an advantage for women who are afraid of losing consciousness with orgasm as they would have a greater sense of security if they were regulating the intensity of the stimulation themselves rather than fighting against a loss of control initiated by their partner. Also, partners can be a distracting element in a masturbation program, and the objective here is to eliminate as much external interference as possible. The women are encouraged to work as a group in order to capitalize on the supportive features provided by women's consciousness-raising groups.

During the group meetings, the women delve directly into the shameful feelings about sex and masturbation as well as early sexual traumas. The impact of subtle messages given to the women by their family and society are

explored. The women are actively assisted in realizing that they have a right to sexual pleasure and that their body and sexuality is a positive thing. A certain amount of dydactic information concerning anatomy and physiology is also delivered.

Exercises that are done at home, called "homeplay", are assigned at each session. The homeplay follows a modified version of Lobitz and LoPiccolo's nine-step masturbation program, described earlier in this paper. The women are required to practice the assignment for an hour each day at home. During the following group sessions, each woman explicitly relates her experiences with her assigned homeplay. The homeplay assignments progress as the woman's sexual responsivity progresses. For the first few sessions, all the women receive identical assignments. Later, homeplay is assigned according to the specific needs of the individual woman. In the latter half of the program, women are encouraged to specify their own assignments.

No restriction is ever placed on sexual intercourse and after a woman has become proficient in experiencing orgasm with masturbation, homeplay is suggested that includes her partner, if she has one. These exercises stress the necessity of specific and direct sexual communication if the woman is to become orgasmic in the relationship.

The first step of including the partner consists of having the woman masturbate to orgasm while her partner is observing her. After that, both nongenital and genital exploration is encouraged by teaching the woman to guide her partner's hands over her body in the manner she prefers. In the last step, the woman masturbates herself while her partner's penis is inside her "if she desires orgasm with intercourse" (Barbach, 1974).

Women who have not previously masturbated usually have intense prohibitions against it that are difficult to overcome. These prohibitions deter them from being able to perform the masturbation assignments. Prolonged procrastination is minimized by limiting the number of group sessions to ten and by directly confronting the resistance through traditional therapeutic approaches, paradoxical injunctions, diversion techniques and through peer group support.

According to Lonnie Barbach (1974) the five essential factors that account for the reversal of the orgasmic dysfunction are: a) the supportive nature of the group, b) its permission-giving aspects, c) the therapist's ability to confront and cut through the client's resistance, while d) insuring that the client and not the therapist assumes responsibility for the orgasm, and e) the use of masturbation as the main learning technique.

For many people, sex is equivalent to intercourse.

However, the indirect clitoral stimulation afforded through intercourse alone is often insufficient to enable many women to reach orgasm. Rather than stressing orgasm through intercourse as a goal for women, the leaders try to expand their repertoire of sexual activities by encouraging them to seek sexual satisfaction in whatever manner is mutually acceptable. Therefore, rather than attempting to fit a woman into a mold that may not fit her specific physiological requirements for orgasm, the leaders attempt to broaden the acceptable sexual practices to meet her unique needs or capabilities (Barbach, 1974).

Statistics have been compiled by the Human Sexuality Program at the University of California Medical Center since the first group met in November of 1972. Several hundred women have participated in this type of treatment at the Center. The statistics indicate that an average of 93% of the women who entered the program left five weeks later experiencing orgasm consistently, usually through self-stimulation.

Of course, the five-week program could not completely reverse a problem, especially if a woman had experienced it for years. The treatment is based on the premise that the woman will continue the exercises on her own. Generally, within three months after group sessions were over, more than half the women could experience orgasm with partners. After eight months, the percentage was even higher (Barbach, 1975).

Further investigations have been carried out through this

Center, exploring other areas of change in the participant's lives (Wallace and Barbach, 1974).

Studies support that these pre-orgasmic women's groups that use group sex counseling techniques with the female partner only, are an effective and feasible way to treat primary anorgasmy. This method of treatment is truly unique in both its approach and in the diverse population that it can reach. Due to the different population this modality will tend to attract, it is difficult to make an across-the-board comparison of effectiveness rates. However, the effectiveness rates gathered so far definitely fall within a highly significant range (93%). When considering the degree of efficiency in both time and cost of this group treatment, it is easy to see why these groups are becoming more and more popular as the demand is becoming more evident.

CHAPTER IV

RESULTS

I. SEXUAL CHANGES

Orgasmic Capacity Before and After Treatment . Of the eighteen women interviewed, six were reliably orgasmic, through means other than manual masturbation, before entering their groups. Five of these women were orgasmic with a vibrator and one through intercourse (female superior position). This factor was considered as a variable in evaluating some of the data in this section.

Ten out of the twelve women who entered their groups having never experienced orgasm reliably did become orgasmic through self stimulation; six by manual masturbation, and four with the use of a vibrator. A total of seven of these women also became reliably orgasmic in partner activity². Of the women in this group, five fell into the above category of also being orgasmic through manual masturbation, and two were orgasmic through masturbating with a vibrator. Two women who entered the group having experienced orgasm regularly were not sure if they

²Partner activity, for the purpose of the paper, refers to any of the following behaviors; partner manually stimulating genitals of the woman, using a vibrator to stimulate her, oral/genital sex, or intercourse.

were in fact having orgasms. (As will be discussed later, the researcher feels that at least one of these two women was actually orgasmic, based on a lengthy interview.)

Three out of the six women who entered their groups already orgasmic through means other than manual masturbation reached their goals of becoming reliably orgasmic with manual masturbation. Two of these women were orgasmic with a vibrator before the group and one was orgasmic through intercourse. All but one of these six women became orgasmic in partner activity.

With this sample of women, 88.8% left their group orgasmic. Of those women who were not orgasmic by any means before treatment, 83.3% reported being orgasmic at the time of the interview. Forty percent of the women in this sample who entered the group orgasmic with the vibrator became orgasmic by manual masturbation. However, two of these women decided during the group that they had become comfortable now with using their vibrators and were not interested in learning how to masturbate manually anymore. These two women were counted in the success rate (refer to the Discussion) due to their change in goal. The one woman who was orgasmic through intercourse prior to the group did reach her goal (100%).

Sixty six percent of the total sample of women became reliably orgasmic within partner related sexual activity at the time of the interview.

Of the sixteen women who were orgasmic when treatment ended, eleven were multiply orgasmic. Five of those sixteen women reported that sexual activity resulted in orgasm as often as they would like it to. The remaining eleven women looked forward to becoming orgasmic in more varied sexual activities, usually partner related (Table VII).

TABLE VII
SEXUAL ACTIVITY RESULTING IN ORGASM AFTER TREATMENT

	Self Stimulation		Partner Activity			
	manual	vibrator	manual genital stim.	vibrator genital stim.	oral/ genital	inter-course
Orgasmic Status Before Group	1		1			1
	2					
	3		3		3	
	4		4		4	
	5	5		5		
	6	6	6	6	6	
	7		7			
	8				8	
	9(?)					
	10(?)					
	11					
	12					
Orgasmic Through Inter-course	13	13				
	14	14		14		
		15		15		
		16		16		
		17		17		
	18	18	18	18		18

Change in Frequency and Variety of Sexual Activity When asked if the frequency of their sexual activity had changed since their participation in the group, twelve of the women said that it had increased and six replied that it had remained the same. Thirteen of the women also reported an increase in the variety of sexual activity that they now engaged in. For most of these women, masturbation was now a regular part of their sexual lives. However, they also reported an increase in the variety of sexual expression in their partner related activities.

The most prevalent reasons that the women gave for the changes in the frequency and variety of their sexual activity were the support and permission that the group gave to them to be sexual, identify their sexual preferences and pursue them, as well as new factual information.

Changes in Communication Within Their Sexual Relationship(s)

Fifteen of the eighteen women felt that communication within their sexual relationship(s) had become "more open" since their participation in the preorgasmic group. The common theme in the explanation given for this change was that their groups supported them in discovering what they wanted sexually and then asking for that, expressing feelings, and generally being more assertive in their relationships. This response is almost identical to the reason they gave for many other sexual changes. Three women felt

that there was not a significant change in this area.

Changes in Type of Sexual Relationship(s) A change of status in sexual relationship(s) since participation in their groups was reported by eight women. Four of the women moved from having a variety of sexual partners to one steady partner, two had their steady partners move in with them, one woman had her steady partner move out and one woman moved from a steady relationship to having a variety of partners. Of this group of eight women who reported a change in this area of their lives, four felt that the change was at least in part due to their group experience. Three of these women changed from a variety of partners to one steady partner, and one woman had her steady partner move in with her. Three of these four women had men as their sexual partners, and one woman had a woman as her steady, sexual partner.

All of the four women who felt that the group had influenced a change in the status of their relationships felt that the group experience and becoming orgasmic gave them confidence to become more intensely involved with one partner. The one woman who is in a lesbian relationship felt that group enabled her to feel better about her gay relationship. Another woman said, "the group gave me the self confidence to get into the relationship and stay with it; to work through alot of the fears I had in that

relationship, instead of just saying something about him and running the other way."

Changes in General Level of Sexual Enjoyment Fifteen of the eighteen women said that they experienced "more" sexual enjoyment now than before the group. Three said they had "no change" in their level of sexual enjoyment and none reported a change in a negative direction.

Changes in Sexual Inhibitions When asked if they felt that they had "more", "less" or about the "same amount of inhibitions" concerning sex now as compared to before the group, sixteen reported "less" and two reported "no change".

Changes in General Feelings Toward Sex A change toward feeling more "positive" about sex in general was reported by fourteen of the women. The remaining four said they experienced no change in this area.

Changes in Feelings Toward Sexual Partner Seven women said they felt "closer" to their sexual partners, five did not feel that there was a change for them, four reported feeling "less close" now towards their sexual partners and two did not respond to the inquiry.

Changes in Feeling About Being a Sexual Woman To this line of questioning, fourteen women said that they felt "better",

two reported no significant change and two women chose not to answer the question.

Feelings About the Above Affectual Changes That Are a Result of the Group Sixteen of the women felt "good" about these changes, one woman did not answer the question and another woman said that she felt "good" about the changes in her self image, but "badly" about the distance she now felt from her sexual partner.

II. CHANGES IN NONSEXUAL RELATIONSHIPS

Changes in Relationships with Other Women The majority of the women reported no change in the number of female friends they have now compared to before the group, and four observed only a slight increase. "No change" was again the prominent answer concerning the quality of their female friendships. However, twelve reported a definite "increase" in the amount of personal information that they now share with their women friends. Four saw no change and one felt that she shared less now. All of these women who said that they are sharing more personal information with their female friends since the group felt that this was related to their group experiences. Most of these women recognized a normalizing affect that enabled them to talk openly; seeing that their problem was not uncommon. As one woman put it,

Just being in a room with eight other women sharing their personal affairs does make you really open up. It showed me that I wasn't the only one with those problems and helped me to talk about it alot easier.

Another woman described having a feeling of "comradeship" when she saw that others had the same problems.

Prior to her preorgasmic group this same woman felt that "there was something wrong" with her. When another woman described how the group had encouraged her to share more personal information with her female friends, she said,

The group has been an experience where I felt strain and then found that when I expressed these feelings, the strain was gone and the closeness I had been wanting was there. What made the group such a good place for that to happen was our subject of sexuality and orgasms, which is basically something we all have fears about.

Changes in Relationships with Men Only three of the women reported any change in the number of male (nonsexual) friendships that they were engaged in since the group. Two saw an "increase" and one a "decrease". The woman who reported the decrease did not see the group as a factor in it. The other two women, who saw the group as a factor, reported both a positive change in the quality of these male relationships and also that they were sharing more personal information with these men.

Five women noted a positive shift in the quality of their male friendships; all of whom labeled the group as a variable in that change. The other thirteen women did not

see a change in this area.

Of the eighteen women, eight felt that they were now sharing "more" personal information within their male relationships (nonsexual) and all of them felt that the group experience related to this shift. The remaining ten women reported no change.

Those women who experienced an "increase" in male friendships, "better quality in those relationships, and/or "more" sharing of personal information to their male friends, felt that these changes were encouraged by the group experience, due to the enhancement of certain qualities through the group. These qualities included; "self acceptance", "openess", "being more relaxed", and "assertiveness". One woman said that being a member of the group helped her to stop looking for "magical things from men." Another woman said that the "freeness" to express her feelings carried over to her male friends.

Changes in Feelings Toward Women Friends as a Result of Group

Twelve women said that they did "feel differently" about their women friends now, as a result of the group. The over riding theme to their answers was that they now felt more similar to them, were better able to see problems that they had in common, and to empathize with them. A few women said that they were now more "appreciative" of their female friends. Three of the women reported feeling

more sexual towards other women now. All of these three women were involved only in sexual relationships with men at the time of the interview.

Changes in Feelings Toward Male Friends as a Result of Group

Seven women reported feeling differently now about their male friends. Most of these women saw their male friends as more equal now and they felt as if they understood their problems better. One woman responded, "I feel more compassion for them and alot less competitive, oddly enough." Another woman stated that she no longer saw men as having "control" over her. Still another feeling voiced by a woman was that she could now comfortably recognize her sexual feelings toward men friends.

Changes in Feeling Toward Family (of Origin) Members as a Result of Group

When inquiring about this area of possible change in feelings, seven of the women did report a change. All but one of these women felt "closer" toward certain family members. This one woman, who felt more "distant" from her immediate family as a result of the group said it was due to their disapproval of her attending the group. The other six women felt more of a closeness toward family members; one towards her mother, one towards her mother and sister, one towards her mother and father, two towards their sisters and one woman felt closer towards her father.

All of the women who felt an increased closeness

toward some family member as a result of the group experience said that it followed long talks with that member. These talks all included a sharing of sexual experiences as well as an explanation of the group. One woman reported that after their talk, her mother began to masturbate and experienced her first orgasm.

III. ACTIVITY CHANGES

Changes in Major Daily Activities as a Result of the Group

Only three women reported having gone through some major occupational and/or activity change as a result of the group. Two of these women went through an occupational change; one quit her job, one she felt she had outgrown, and the other woman found a new job. Both said that being in the group gave them the confidence to make life changes, to be independent. The third woman saw a change in her interests. She said, "the group helped me to get in touch with things I wanted to do, like writing and then to follow through on them."

Four other women reported such major changes, but saw no connection between these changes and their attendance in the group.

IV. BODY IMAGE CHANGES

Deliberate Change in Outward Appearance Since Beginning of

Group Nine women said that since the group, they had delib-

erately made some change in their outward appearance. For seven of these women, the changes involved wearing clothes that they "enjoyed", "always wanted to wear, but were afraid to" and clothes that made them feel more "womanly". One woman changed her hair style. Another woman lost fifteen unwanted pounds since the beginning of the group.

Change in Feelings About Body Now as Compared to Before Group

All but two women said that they feel "better" about their bodies now compared to before the group. Two women felt the "same" about their bodies. Descriptions given by the women who had more positive feelings about their bodies included "liking it more", "more accepting of my body", "being less self-conscious", and being "more comfortable." Some of these women said that they finally realized that that their genitals were "normal", and could function well. One woman said that she began to "take a new interest in taking good care" of her body, because she liked it now.

V. ASSERTIVENESS CHANGES

Changes in Ability to State Wants in Sexual and Nonsexual Relationships

Fifteen of the eighteen women reported that they have become "better able" to state their wants since the group began. However, two of them said that this change toward being more assertive occurred in their sexual

relationships, and not in their nonsexual relationships. Three women, of the eighteen, saw no self change in stating their wants.

Most of the women who saw a shift toward being more assertive felt that they were still in the process of fulfilling this goal. At least one woman saw that her ability to state her wants was very closely linked with her knowing what she wanted. She said, "before the group I had no idea of what to ask for. Now I know what pleases me, I know what to ask."

One of the women who said that she was stating her wants more specifically noted her counseling experience, and not the group, as the impetus for that change.

Change in the Amount of Time for Self-Indulgence Spending "more time" to self-indulge was reported by thirteen of the women. Five women said that they had no change in this area. Most of the subjects did not expand their conversation with the researcher in this area. However, one woman did say that before the group she "always had to be doing something, accomplishing something" and that now, she took more time out for herself.

Feelings About Changes Made (or Not Made) in Assertiveness

All of the eighteen women reported that they were "satisfied" with the changes they had, or had not, made in this area, although about half the women wanted to make more changes.

There was only one woman who made no changes in stating her wants or taking time for herself. Many of the other women made changes in one area and not in the other, but most made positive changes in both.

VI. GENERAL AFFECTUAL CHANGES

Changes in General Level of Happiness When asked if they had experienced any change in their general level of happiness, most of the women were reluctant to answer and, in fact, two decided not to answer. The complaints were of vagueness in the question and the innumerable amount of variables that shaped the response.

Ten women said they were now "more happy". One woman in particular pinpointed the group experience as the reason for her increased happiness. She felt that the group was the "most significant" thing that she had ever done.

Six women saw no change in their general happiness. One of these women did feel however, that it was probably a result of the group that helped her to "sustain through" what was for her a rough period of time.

Change in Feelings About Yourself as a Person Thirteen of the women interviewed reported that their feelings about themselves as a person had changed since their group experience. All of these women said they "felt better" about themselves and "more satisfied" with themselves. Most of

these women felt that they had a better understanding of themselves, especially as a sexual being.

Four of the women interviewed saw no change and one woman chose not to answer.

Change in General Level of Relaxation Twelve of the eighteen women felt that their general level of relaxation had changed. All reported that they were generally "more relaxed". Several of these women relayed being "more relaxed" during sexual encounters, but not necessarily otherwise. Most of the women who said they had increased their level of relaxation saw masturbation as a good release of tension that they now used.

Five of the eighteen women saw no change and one did not respond to the question.

CHAPTER V

DISCUSSION

I. SEXUAL CHANGES

This study was designed to be descriptive and exploratory in nature, and was not designed to obtain an accurate success rate. The success rate of this sample was calculated as 83.3%, which includes the two women who changed their goals, deciding to continue to masturbate with their vibrators. Although this rate is lower than Ms Barbach's, the reason appears to be a research design problem when the selection process and sample size are considered. The women in this study did not agree to participate prior to treatment, as they did in Barbach's, and so did not necessarily feel a commitment to be a part of it. Taking part in the research required at least an hour of the women's time. It must also be considered that SISTER tends to have a more transient population than the average. Many women from their groups had left no address and at least four of the initial letters were returned by the post office due to address change with no forwarding address.

It is also extremely likely that the two women who were unsure if they were experiencing orgasms with their

vibrators may in fact have been orgasmic. It is commonly known to sex therapists that have worked with women using vibrators, that a vibrator can trigger an orgasm so fast as to not be noticed by the woman.

Further investigation that encompasses a larger sample as well as a better subject selection system is needed for these agencies to get more accurate success rates. A simpler design that looked only for objective sexual changes would also help.

The women who entered their groups already orgasmic with a vibrator are an interesting group, as there is no previous research on this separate population. In fact, Barbach does not mention them apart from her general population at all. Although these women entered the group to learn to masturbate manually, two of them did change their goals during the group, deciding they were now comfortable with the vibrator. These women felt so at ease with their vibrators that they incorporated them into partner sex. However, it is difficult to really draw any conclusions about this, and whether their shift in goals came out of a fear of failing or of choice.

The sixty six percent success rate for the women transferring their orgasmic capabilities into partner activity appears to be a highly favorable statistic. Barbach got an 87% rate for transfer however, her's was a year follow up and none of the subjects in this study

had been in treatment as long as a year ago. The one group that was post eleven months was the first group to be run out of the ADP and did have a lower transfer rate than the 66%. These particular results may reflect the inexperience of the leaders. When looking at this area, it is important to remember that this treatment program was not designed to be able to completely reverse the problem in five weeks. It is based on the premise that a woman will continue the exercises on her own. The whole aspect of partner transfer is very difficult to measure due to the fact that the relationship status of a woman can serve as an obvious barrier.

There appears to be a significant increase in both the frequency and variety of sexual activity that the women engage in after the group. This corresponds to an increased level of sexual enjoyment, a decreased amount of sexual inhibitions, generally a more positive feeling towards sex, better feelings about being a sexual woman, as well as developing more open communication within their sexual relationship(s). These results are further support to Barbach's hypothesis that through the group, the women lessen their rigidity which in turn allows them to be more open experientially, more expressive and expansive sexually and hence positively contribute to their satisfaction with sex.

Eight women did go through a change in relationship(s)

with their sexual partner(s). This is a larger amount than Barbach had found in her study, however, a greater number of her subjects were married (fourteen out of seventeen). Only four of the women said that the group had some influence on this change and all of these four moved from a variety of partners to one partner, or to a more committed relationship with their present steady partner. Hence, it does appear that the group may function to encourage monogamous behavior. Why this happens or, if in fact it is significant or just a product of this sample can not be determined at this time. Further research to determine a more accurate frequency rate at which this occurs along with analysis comparing it to other variables is needed.

II. CHANGES IN NONSEXUAL RELATIONSHIPS

The most significant change reported in the subjects' relationships with other women is an increase in the amount of personal information shared with a friend. This probably resulted from the modeling and general structure of the group which reinforces sharing and finding commonalities between the members. Women who were interviewed repeatedly commented on the power of the group. As put by one woman:

One of the first things we were asked to do in the group was to share our sexual history, and that is a very powerful experience for me. . . despite our different backgrounds that brought us to our problem, there was a common underlying.

Another woman said, "I just felt that getting together and learning things was very powerful, that we really could learn alot from each other."

The leaders are trained to gradually give up control and reinforce members for giving suggestions to each other. The women are told that they are their own experts about their bodies. This group structure is probably what resulted in most of the women feeling "closer" toward their women friends and more "appreciative" of them. One woman found herself to be the only lesbian in the group and felt anxious at first, but soon found, to her "surprise" that the sharing felt "neat" and that she "always came out of the group energized."

It is interesting that almost half of the women also felt that they were now sharing more personal information with male friends as well. Most likely this was a generalization of the behavior learned in the group of sharing openly.

The same phenomenon appeared with family members. Some of the women felt closer towards certain family members as a result of sharing some of their sexual experiences with them. The majority of the family members were female, however.

III. CHANGES IN BODY IMAGE

Most of the women improved their body image and

some made long wanted changes. Many women commented about their acceptance of their genitals in particular. The first part of the masturbation program is specifically geared toward generating acceptance of the body. Obviously this is done very successfully.

IV. CHANGES IN ASSERTIVENESS

The researcher looked at two aspects of assertiveness: 1) the ability to take time out for oneself, and 2) the ability to state wants. These were chosen as they are most often areas that women traditionally are lacking in. Positive changes in both of these areas were very prevalent. These changes occurred in the sexual as well as the non-sexual aspects of their lives.

It appears logical that a PO Group might have this outcome. One of the first issues in the group is taking time out for yourself to do "homeplay" and to treat yourself well. Often this requires rearranging schedules and child care, which frequently calls for assertive behavior. Group problem solving and/or role-playing may be needed before a woman can follow through. As the group begins to masturbate at home, they are instructed to pay close attention to what feels good and to indulge in that. And finally, if discussion around partner activity comes up, the women are coached how to ask for what they want directly and specifically.

This process of defining yourself as someone who has the right to feel good, identifying what you want and then asking for it draws a close parallel to assertiveness training.

V. GENERAL AFFECTUAL CHANGES

The group did seem to have somewhat of a positive effect on the women's general level of happiness. However, this researcher does agree with the subjects' comments that this line of questioning is complicated. There is also the question of just how long this positive shift lasts as the group experience begins to fade in time and newly learned sexual and nonsexual behaviors assimilate more naturally into everyday living.

The positive change in self-esteem may be connected with the satisfaction that the women reported towards the changes that they had made as a result of the group.

Relaxation training is often included in the PO Groups. This along with greater self-esteem and confidence in their newly acquired sexual skills may both contribute to the reports of an increased level of relaxation. However, it is just as probable that having a sexual release, orgasm, alone may account for this.

CHAPTER VI

CONCLUSION

As an exploratory piece of research, this study brings up many fascinating hypotheses about Preorgasmic Women's Groups as a treatment for women with orgasmic dysfunction. This paper describes many changes, often outside the sexual realm, that are probable outcomes of these groups.

Not only did the dysfunction, or inability to have an orgasm, usually reverse itself, but the women also reported a greater enjoyment of sex generally and a greater diversity in their sexual activity. Issues about subgroups of women in these groups, such as women who enter the groups already orgasmic with a vibrator are raised. This paper points to the need for evaluation systems to be built into these programs and used as feedback.

One of the outcomes of this research has been that at least one of the agencies is developing an evaluation system as a part of their program to serve as a feedback tool. This will only involve sexual changes. Hopefully, better documentation of their success as well as information about subpopulations in these groups will result.

This study also brings up the hypothesis that per-

haps PO Groups successfully deal with more general therapy issues too. The changes reported by the women in their body images, assertiveness, and communication all support this. More research however, is needed to confirm this.

Another aspect of PO Groups that this study has helped to open to further investigation is the "power of the group". The participants in this study gave an overwhelming response to the importance of the group. Just how much that factor contributes to its success and what this may suggest for other areas of sexual therapy are both intriguing.

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APPENDIX A

INTERVIEW SCHEDULE: TOPOGRAPHICAL OUTLINE

Sexual Changes

Behavioral Changes

1. Changes in orgasmic behavior.
2. Sexual activities leading to orgasm.
3. Changes in frequency of sexual activities.
4. Changes in communication within sexual relationship(s).
5. Changes in type of sexual relationship(s).
6. Has further information on sexuality been sought?
7. Are any of the above changes due to participation in the group?

Affectual Changes

1. Present satisfaction with orgasmic behavior.
2. Change in level of sexual enjoyment due to group.
3. Change in amount of sexual inhibition due to group.
4. Change in feelings towards sex due to group.
5. Change in feelings toward sexual partner due to group.
6. Changes in feelings of self as sexual woman due to group.
7. How do you feel about any of these changes that resulted from the group?

Changes in Nonsexual Relationships

Behavioral Changes

1. Change in number of women friends.
2. Change in quality of relationship.
3. Are these changes related to participation in group?
4. Change in number of male friends.
5. Change in quality of relationship.
6. Are these changes related to participation in group?

Affectual Changes

1. Do you feel any differently about your women friends as a result of the group?
2. Do you feel any differently about your men friends as a result of the group?
3. Change in feelings toward any family member(s).

Activity Changes

Behavioral Changes

1. Have there been any major changes in daily activities, i.e. occupation, interests?
2. Relationship of these changes to participation in group.

Body Image Changes

Behavioral Changes

1. Deliberate change of outward appearance since group.

Affectual Changes

1. Change in feelings about body since group.

Assertiveness Changes

Behavioral Changes

1. Changes in ability to state wants in both sexual and nonsexual relationships.
2. Change in amount of time one makes for herself (any kind of self indulgence).

Affectual Changes

1. Feelings about any of the above changes.

General Affectual Changes

Affectual Changes

1. Change in general level of happiness.
2. Change in feelings about self as a person.
3. Change in general level of relaxation.

INTERVIEW SCHEDULE WITH GROSS RATING SCALES

Sexual Changes

Behavioral Changes

1. Orgasmic before attending group?
Yes____ No____ Situational____
2. Orgasmic now?
Yes____ No____ Situational____
3. Through what means are you orgasmic?
Masturbation (manual)____
Masturbation (vibrator)____
Masturbation (water)____
Direct clitoral stimulation by partner____
Self stimulation with partner present____
Oral-genital sex____
Intercourse____ Which positions?____
Other_____
4. Do you have more than one orgasm during any one sexual encounter? Yes____ No____
5. Does sexual activity result in orgasm as often as you would like it to? Yes____ No____
6. Has the frequency of sexual activity changed for you since the group? (Probe to get before/after counts if possible as well as specify particular sexual activity.)

Per/week	Before	After
Masturbation		
Self stimulation with partner present		
Direct stimulation by partner		
Oral-genital		
Intercourse		

7. If there has been some changes in sexual activity, do you feel that your participation in the group is associated with any of these changes? How? Yes____ No____ If yes, probe.
8. Has the variety of your sexual activity changed? More variety____ Same____ Less variety____ Specific changes_____
9. Has communication within your sexual relationship(s) changed? More open____ Same____ Less open____ Details:_____
10. What type of sexual relationship(s) are you involved in now? before?

	Before	Now
One steady partner		
living with		
married		
More than one steady partner		
Variety of partners		
None		
Other		
Male		
Female		

11. If there has been a change do you feel that it was in part or in whole due to the group that you attended? How?_____
12. Have you sought any further information in the area of sexuality? Yes____ No____ Where?_____

Affectual Changes

1. How would you compare your level of sexual enjoyment now to before your participation in the group? More____ Less____ Same____
2. Do you feel that you have more, less or about the same amount of inhibition concerning sex now? More____ Less____ Same____ Probe_____

3. Have your general feelings towards sex changed?
More positive____ Same____ Less positive____
4. In general, have your feelings towards your sexual partner changed? Feel closer____ Same____
Feel less close____
5. Do you feel any differently about being a sexual woman? Better____ Same____ Worse____
Details_____
6. How do you now feel about any changes in this area that you have made as a result of participating in the group? Good____ Neutral____ Badly____
Details_____

Changes in Nonsexual Relationships

Behavioral Changes

1. Has the number of female friends you have changed?
Increased____ Same____ Decreased____
2. Has the quality of any of your female friends changed? Better____ Same____ Worse____
3. Has the amount of personal information that you share with your female friends changed? More____
Same____ Less____
4. If you do feel that there has been some change in the area of female friendships do you feel that the group experience is related? Yes____ No____
Explain_____
5. Has the number of male friends you have changed?
Increased____ Same____ Decreased____
6. Has the quality of any of your male friends changed? Better____ Same____ Worse____
7. Has the amount of personal information that you share with your male friends changed?
More____ Same____ Less____

8. If you do feel that there has been some change in the area of male friendships for you, do you feel that the group experience is related to it?
Yes_____ No_____ Explain_____

Affectual Change

1. Do you feel any differently about your women friends now as a result of the group?
Yes_____ No_____ Explain_____
2. Do you feel any differently about your male friends now as a result of the group?
Yes_____ No_____ Explain_____
3. Have your feelings toward any particular family member changed as a result of the group?
Yes_____ No_____ Who_____

Activity Changes

Behavioral Changes

1. Have there been any major changes in your daily activities, i.e. occupation, interests?
Yes_____ No_____ Occupation change_____
Explain_____
2. If so, do you feel that they have any relationship to the group? Yes_____ No_____ Explain_____

Body Image Changes

Behavioral Changes

1. Have you deliberately changed any of your outward appearance since the beginning of the group?
Yes_____ No_____ Explain_____

Affectual Changes

1. Do you feel any differently about your body now compared to before your participation in the group?
Better_____ Same_____ Worse_____

Assertiveness Changes

Behavioral Changes

1. Have you changed in your ability to state your wants in both sexual and nonsexual relationships?
Better able____ Same____ Less able____
2. Has there been any change in the amount of time you allow yourself to self-indulge in?
More time____ Same____ Less time____

Affectual Changes

1. If there have been some changes in this area, how do you feel about them?
Satisfied____ Neutral____ Unsatisfied____

General Affectual Changes

Affectual Changes

1. Has your general level of happiness changed?
More happy____ Same____ Less happy____
2. Have your feelings about yourself as a person changed? Feel better____ Same____ Feel worse____
3. Has your general level of relaxation changed?
More relaxed____ Same____ Less relaxed____

APPENDIX C

CONTENTS OF AGENCY LETTERS

ADP

The Adult Development Program has been running Pre-Orgasmic Women's Groups for about a year now. We feel that it is important to know how the women involved in these groups feel about their past participation and whether any life changes have resulted.

Your input is very valuable and will assist us in improving our services so that other women can benefit from your feedback. Bobbi Geiger, a second year graduate student of Social Work who has been doing her clinical work with the ADP, and has worked in the area of female sexuality, will collect this kind of information.

Your participation would be extremely helpful. It would involve a tape recorded interview with Bobbi. The information you give will not be identified by your name. You will be given a more detailed consent form to sign before the interview.

If you are willing to help us with this project, please return the second page of this letter as soon as possible in the self addressed envelope provided. Bobbi will then phone you to set up a time for the interview.

If you have any questions feel free to call Bobbi at the ADP or at home. Her home phone is 525-9062. The best time to get her is Wednesday through Sunday.

SISTER

Several Seattle agencies have been running Pre-Orgasmic Women's Groups for about a year now. SISTER, as well as other agencies, feels that it is important to know how the women involved in these groups now feel about their past participation in their group, and if any life changes have resulted.

We feel strongly that your input is very valuable and will assist us in improving our services so that other women can benefit from your feedback. A woman named Bobbi Geiger, who is a second year graduate student of Social Work at Portland State University, and who has been involved in Women's Health Care and Sexuality Counseling in Portland, has initiated a research project in order to collect this kind of information. She has asked for our cooperation in this study and we have spent time with her discussing the manner in which this project would best be carried out. We feel confident that she will do a good job and will not violate any of the policies of our organization.

Your participation would be helpful and would involve a tape recorded anonymous interview with Bobbi. All information will be anonymous, no names will be used. You will be given a more detailed consent form to sign before the interview. We have protected your confidentiality by mailing this letter out ourselves. No names have been given to Bobbi.

If you are interested in participating, please return the second page of this letter, as soon as possible, in the self addressed envelope provided. Bobbi will then phone you to set up the date and time.

If you have any questions or hesitations feel free to call Bobbi at 525-9062. The best times to get her are Wednesday through Sunday. You can also call SISTER and speak with Marilyn.

ADP and SISTER

Yes, I am willing to participate in this study. I understand it will take about an hour of my time, sometime between the months of November and February, in a tape recorded interview that will be kept confidential.

☐ You can reach me at _____
phone no.

Best Hours _____

OK to leave a message Yes _____ No _____

Other Phone _____

Hours _____

☐ I do not have a phone, but I will call you soon.
Month my group ended _____

X _____
signature

Comments:

APPENDIX D

CONSENT FORM

This study is investigating how women involved in Pre-Orgasmic Women's Groups later feel about their participation, and whether any life changes have resulted. There has not been much information of this kind collected. This information may be very helpful in improving upon these types of services for women.

Your participation will consist of a tape recorded interview by Barbara Geiger and will take about an hour of your time. The questions will be personal and you may feel some slight discomfort because of this. For example, you will be asked questions about number of orgasms and types of sexual activity. However, you will be given an opportunity to ask questions and you may see the interview schedule beforehand. The interview tape and its transcript will not be identified by name.

I agree to allow this tape recorded interview, taken today, to be used in the following manner(s):

1. Direct citations may be used in the written report of any future publications under Ms Geiger's supervision. Yes ☐ No ☐
2. The tape may be listened to for educational purposes at ms Geiger's discretion. Yes ☐ No ☐
3. If transcribed, it may be included in part or in full, in written reports or any future publications under Ms Geiger's supervision. Yes ☐ No ☐
4. Copies of the transcript may be used for educational purposes at ms Geiger's discretion. Yes ☐ No ☐
5. Other specific limitations on the use of this material:

I voluntarily consent to participate in this study. I have had the opportunity to ask questions. I may withdraw from the study at any time without jeopardizing my future participation in the agency activities.

signature of investigator date signature of subject date

APPENDIX E

COVER SHEET

CODE _____
Date _____
Ending date of group _____
ADP _____ SISTER _____

1. Age _____
2. Educational level: Elementary school _____
High school _____
2yr. college _____
4yr. college _____
Graduate school _____
Vocational school _____
3. Income: below \$5,000 _____
\$5,000-10,000 _____
\$10,000-15,000 _____
\$15,000-25,000 _____
above \$25,000 _____
4. Race: Causasian _____ Black Am. _____ Native Am. _____
Mexican Am. _____ Asian Am. _____ Other _____
5. Present Religion:
6. Religion of Rearing: