TAKE TWO ASPIRINS AND MASTURBATE

sex-therapy clinics may help your love life, but the question is, are they sincere?

article By LINDA WOLFE

IN LOS ANGELES, during a cross-country investigation of new sex-therapy techniques, I met an apostolic woman named Nancy who stopped off to see me at her therapist's suggestion. She was on her way home from work to masturbate according to the instructions her therapist had given her. After talking to me, she explained, she would buy herself a half bottle of Cabernet Sauvignon, a bunch of roses and a small thick steak. She would drink the wine, smell the flowers, broil the meat and masturbate to orgasm. A year ago, she never had orgasms; a year ago, she never masturbated; now she has and does both frequently as a result of the treatment she has been receiving at the Discovery Institute, one of a number of mushrooming sex-therapy establishments. "Be good to yourself" is director Sylvia Kars's message. "Be as good to yourself as you would be to a date you had for the evening. Don't just masturbate. Play your favorite music while you do it. Shower and perfume yourself first. Maybe even light a little incense."

The treatment is a far cry from the classical couple therapy devised at our national sex Lourdes in St. Louis, the Reproductive Biology Research Foundation, directed by Dr. William H. Masters and Virginia E. Johnson. And yet, for curing orgasmic dysfunction—the problem of the woman who can't come—it may work. So, too, may "just talking dirty," particularly for some of the male dysfunctions, according to Dr. Herbert E. Vandervoort, who heads the human-sexuality program at the University of California's School of Medicine in San Francisco. "I cured a guy of primary impotence in two visits," says Dr. Vandervoort. "He was a virgin and he'd been married six months. He came in and sat down and I asked, 'What's your problem?' He said, 'My problem is I can't get a penile erection and engage in the marital act.' I said, 'Your problem is you can't get a hard-on and fuck.'" Vandervoort says he talked dirty for two sessions—"I became the adolescent buddy the guy had never had"—and didn't see the patient until two years later, when the man appeared towing two baby sons.

Four years ago, we had no sex-therapy clinics. That was just before Masters and Johnson published their second book, *Human Sexual Inadequacy*, detailing their spectacular

two-week cures for such previously inaccessible sexual hang-ups as premature ejaculation, impotence and lack of orgasm. Today, sex-therapy clinics are erupting all across the nation: The Center for Intimacy and Sexuality, The Institute for Sensory Awareness, The Institute for the Advancement of Sensuality, Discovery Institute, Human Sexuality Foundation, The Center for Sex Therapy and Education, The Center for Marital and Sexual Studies, Midwest Association for the Study of Human Sexuality, Sexual Therapy Medical Clinic.

The names themselves are tongue twisters, names to enchant a tax examiner and deliver up nonprofit status. In California, institute seems to be the more favored title, although often a California sex-therapy institute is nothing more than a male or female therapist with towels, a jar of coconut oil or petroleum jelly and a telephone answering machine. In the Midwest, they fancy center or foundation and all the clinics have secretaries as well as phone numbers. On the East Coast, sex clinics are, like the very landscape, more structured, more peopled and tend to be located in densely staffed universities and medical centers.

Only a year ago, most sex therapists were M.D.s or psychologists. Today, some are former teachers, ministers and priests, nurses, even former office managers. Masters and Johnson, bent on research, are not presently training anyone to follow in their footsteps, so others have leaped in to fill the gap, often with little experience of their own. Typical of the new sex therapist is Dr. Sylvan Sacolick, an internist in New York who opened the city's first private sex clinic, the Park Avenue Professional Group's Sexual Therapy Associates. Dr. Sacolick disarmingly admits to having no particular training for the job. "But where should I train?" he asks. "Masters and Johnson aren't doing any more training. There's Hartman and Fithian out on the West Coast, who give you a big fancy diploma for a one-day, eight-hour attendance at a movie-and-lecture thing of theirs. But where did *they* train?" Sacolick has read The Book, *Human Sexual Inadequacy*, has hired a staff of people with master's degrees in a variety of subjects, has trained them and opened his doors: He will be treating four couples at a time for $750 each for two weeks.

You could also be fairly certain a year ago that if you went to a sex therapist for any sexual dysfunction, you would be given sexual exercises as homework, along with a large dose of marital psychotherapy administered in the office. Masters and Johnson had constantly stressed that sex was a communication and that it took four to tango: a male and a female cotherapist for every male and female in distress. They did not treat individuals alone, and they insisted that for their treatment to be effective, couples had to take time off from work and family duties for two weeks of intense sexual exploration.

Today, nearly all sex clinics superstitiously cross their brochures somewhere with the magic names Masters and Johnson, as if warding off who knows what devils. But while some practitioners actually practice à la Masters and Johnson, many others are marching to altogether different drums.

Many of the new sex clinics do not sit well in St. Louis, where Masters and Johnson have begun warning the public against "sex quacks" and "patient traps." Newcomers in the field have been just as vociferous in attacking the founding father and mother. Says the Reverend Ted McIlvenna at National Sex Forum in San Francisco, "Mostly a bunch of medical fascist pigs are running the sex programs. . . . What Masters and Johnson did was give permission to go ahead and work in the field of sex, and that's what makes them valuable, but then they wanted to own it."

McIlvenna's outfit has been grossing $40,000 a month for its treatment program, Sexual Attitude Restructuring. As much education as therapy, S.A.R. is prescribed not just for the sexually dysfunctional but also for those who want to enrich their presumably stressless sexual lives; 35,000 people have tried it.

It usually begins with a Fuckarama, a heavy porn collection projected onto several screens at one time. These are called desensitizing films and consist of old familiars: lots of good-looking people screwing or going down on each other in groups of two, three or four; girls with eye shadow fondling rubber dildos; semen on the belly or the breasts; a Linda Lovelace look-alike making it with a dog.

The porn films are followed by what the National Sex Forum people call resensitizing films. These are movies in which the same acts take place (no dogs) but in which some small effort is made to suggest that a relationship—other than sexual—exists between the participants. In *Vir Amat*, two handsome young men cook dinner together before making love; in *Holding*, two hearty California princesses amble through a forest of leaves before bedding down.

At one screening of a film about masturbation, a woman said she thought the star, Shirley, for whom the film was named, was probably lonely, since she fussed so over her masturbation. The group leader admonished the viewer: "Not Shirley. *Shirley's* not lonely. I can tell you. I've met her. Wait till you see the other film she's made. It's *Joy in Her Pleasure*, with her husband, Wilbur. With a guy like Wilbur, she couldn't possibly be lonely." (Shirley and Wilbur, incidentally, after making their film for the National Sex Forum, decided to become sex therapists themselves and now run The Center for Intimacy and Sexuality near San Francisco.)

Last summer I decided to attend a Sexual Attitude Restructuring to see what it was like. The one held at the Marriage Council of Philadelphia was just for patients; at the University of Minnesota, the session was restricted mainly to paraplegics; I chose one in Chicago that was called "New Perspectives on Human Sexuality," for "professionals engaged in medicine, the law, the ministry, education, psychology, social work," but also for "other persons interested in exploring a wide spectrum of human sexual attitudes." That sounded like me. An inquiry to the office of the Midwest Association for the Study of Human Sexuality explained the program: a weekend of National Sex Forum films, including a Fuckarama, group discussions and a set of "trust" exercises. The weekend was a bargain at $75 for two, including a pizza-and-wine supper and a cold-chicken box lunch.

What strikes me first as I enter the screening room in which the workshop will be held are the furnishings: heaps of garish, massive pillows strewn about the floor. Sex therapy is not for people with bad backs, since three out of every four clinics provide the same sort of colorful cushions—and no chairs.

Group leaders Dr. Lonny Myers, formerly an anesthesiologist, and the Reverend Don Shaw, an Episcopalian priest, have been having a hectic morning. They are dedicated movers and shakers in the sexual revolution, and besides running the Attitude Restructuring Workshop, they have a busy vasectomy clinic and an abortion service, inexpensive and very popular. That afternoon, while 20 of us are restructuring, 80 women get aborted in the next room. Myers and Shaw have decided to make a change in the usual programing this weekend. They are going to start out with *Shirley* instead of the Fuckarama. "We think we can get to people's real sexual feelings faster with a film on masturbation," Shaw will explain to me later. "Sometimes they just say 'So?' to the Fuckarama."

Watching *Shirley* takes 15 minutes. The National Sex Forum program notes on the film explain that Shirley's orgasm is "strong and joyous." It sure is. Later, in the discussion groups, a number of men will express surprise at how intense her reactions are. Shirley, like the woman I met in Los Angeles, prepares elaborately for her masturbation: She showers first, brushes her hair, examines herself in the mirror and eventually comes with a big square green vibrator in hand. Some of the men say they are turned off by the vibrator; others admit

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they can accept the penis-shaped kind but not this square one. Some of the women ask where to buy one. Everyone, male and female alike, agrees that masturbating is a Good Thing.

The next day, at a session devoted to reading the results of a questionnaire that asked what people feel guilty about, two respondents answer "Masturbating." I conclude that sexual attitudes restructure slowly.

It hardly matters. We have moved away from self-love, have seen two short humorous sex films and now are "trusting" others. This involves a laying on of hands, similar to that practiced in encounter groups: The workshop participants indicate whether or not they trust one another by standing, eyes closed, in a small circle and allowing themselves to be caught by fellow group members as they fall; then they are raised in the air by joint huffing-and-puffing group effort; they are then deposited on the floor and massaged—fully clothed. The point of the exercise is to demonstrate that the body feels good when rubbed all over, not just when it is rubbed genitally, although each participant chooses whether he or she wants an E or an R massage—"everything" or "restricted." No one chooses R.

From generalized massage we move to feet and hands. Feet have become the big nonsexual symbol for many of the new sex therapists, which may seem odd to foot fetishists. Two West Coast sex therapists, Dr. William Hartman and Mrs. Marilyn Fithian, have theorized that if a couple can pay loving attention to each other's feet, they are on the way to being sexual 100-percenters. They prescribe a foot caress, often lasting upwards of an hour. Two disciples of theirs, Dr. Jeremy and Mrs. Virginia More, have filmed a foot caress and use it in therapy: an endless balming and bathing, rinsing and rubbing, wiping and wetting, which seems to last longer than *Ivan the Terrible*, Parts I and II together. In New York, the blithe Dr. Sacolick has made his own version of the asexual caress film, something he calls *The Whitefish Caress*, which features a young woman who blissfully unwraps a package of smoked whitefish, smells it and fondles it at length. But then Sacolick is not your garden-variety sex therapist: He has a sense of humor.

With all this attention to feet, it's no surprise that the highlight of the evening turns out to be Reverend Shaw anointing someone's toes and nibbling them. After the workshop breaks up, a few stalwarts stay for a bit of extracurricular massage, performed in underwear—except for the reverend, who dispassionately appears as God created him. I am told I cannot remain, since my nonparticipatory presence might discomfort some of the partakers.

The next morning we launched into the Fuckarama, to the canned tune of "She's a hooker, she fucks and sucks any schmuck with twenty bucks," and other porn songs taped to accompany the movies. The hit of the day was a song to the tune of *Jimmy Crack Corn*—"Jimmy fucks Sue and Sue fucks Sam,/Mary balls Dave and then eats Dan. . . . They call it friendly intercourse,/It's therapy to stop divorce." As the song was played over and over, therapist Myers danced to the music, kicking up her heels, while an assistant therapist named Dave energetically punched the air with a clenched fist.

When evaluations were taken after the workshop, the consensus was that the weekend had really been "an experience." One young man said, "It's been the most significant experience of my lifetime." He had come in with his wife and, by Sunday, had abandoned her big pillow for that of Dave's wife, although he had to share it with a second man as well. His wife was OK, though; she had made room on her pillow for Dave.

Of course, frequent studies have shown that if people are given any sort of innocuous treatment by a healer, whether it is a medication or a placebo, a prayer or a magazine, a high percentage will always feel helped. But even allowing for the "yea-saying response," as psychologists call it, there does seem to be hefty appreciation of the National Sex Forum films. A study conducted two years ago by the Forum revealed that 93 percent of the viewers found them "helpful"—an overwhelmingly positive response. This has led to interest on the part of several universities, which now show films to students, and on the part of prestigious medical-book publishers, who want to enter the sex-therapy field. McIlvenna feels that "specialized knowledge of human sexuality is the right of every person" and that through the showing of sex films, sex therapy ceases being "magical" and becomes "democratized."

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It is no surprise that the film weekend I attended started out with masturbation instead of the more usual Fuckarama. This is the year of the masturbator. For centuries civilization's dirty little secret, masturbation has finally come out of the closet. Betty Dodson has written a paean to it. "Socially institutionalized dependent sex is depersonalizing," she says. "Masturbation can help return sex to its proper place—to the individual." Dr. Joseph LoPiccolo, formerly at the University of Oregon, now in Texas, has written a nine-step masturbation program. For, as it turns out, masturbation is not everyone's secret. There are droves of women who have never tried it. Many of these women are what is known in the trade as primary anorgasmic—they have not reached orgasm through coitus or masturbation—and nothing makes a woman orgasmic quicker than teaching her to masturbate.

At the University of California, Lonny Garfield, a graduate student, has devised her own unique program for anorgasmic women. She works with women alone, whether or not they have male partners, gathering them in groups of six to eight. Following the format devised by the women's movement for consciousness raising, Garfield's clitoris-raising groups discuss their feelings and experiences with masturbation, lending support to one another. Garfield and another female therapist participate, assigning the group daily homework exercises in self-examination and self-pleasuring. One day they look at themselves all over and examine their genitals with a mirror. Another day they commence stimulating themselves but stop short of orgasm. Later, orgasm is permissible and different methods of stimulation are experimented with. Garfield insists on an hour's worth of homework a day. Intercourse is not part of the program. Garfield says, "I am not coital orgasm–oriented. Intercourse without additional clitoral stimulation doesn't work for many women." She prefers to leave the ultimate choice of how they will pursue their orgasms entirely up to her clients.

There are, however, some therapists—female ones, interestingly—who still respect the feelings of the woman who can reach orgasm through masturbation but wants to have the sensation while having intercourse with a man. According to Dr. Helen Kaplan at Cornell–New York Hospital Medical Center, which has a large psychiatrically oriented sex-therapy clinic, "The problems of the woman who's never had an orgasm are incredibly simple to resolve; we make half of the women who come in to us orgasmic in no more than three sessions." It is the others who are more difficult to treat, which may be why so many new therapists concentrate on the easy problem. Dr. Kaplan herself thinks coital orgasm may be impossible for some women, but she is uncertain about it. Orgasm, she explains, is a reflex comparable to the knee jerk or gagging. What triggers a reflex is stimulation, the doctor's rubber hammer to the knee, a cotton swab to the throat. "Some people require greater stimulation than do others before their eyes will blink or their knees will jump or their throats will gag. And some small percentage of people are totally lacking in these reflexes, no matter what the stimulation."

On the other hand, Kaplan continues, it is really not difficult to teach women who have the orgasm reflex how to experience it during intercourse, even without direct clitoral stimulation. "We don't consider it the end point of treatment if a man has to manually stimulate the

woman during intercourse," Kaplan explains. "Actually, when they're at that stage, we call it the 'transitional period.' "

At the neighboring New York Medical College's sex clinic, therapist Dagmar Graham concurs. "We call it a 'bridge technique.' It's the bridge to where they have asked to go, and the patient's expectations, not the therapist's, should direct the therapy."

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If some sex therapists are training women to satisfy themselves and letting it go at that, others are trying a technique that at least sounded logical to me: using men to do it. In California, they are breaking the great male-surrogate barrier. A sexual-surrogates organization has recently been formed with an eye to setting occupational standards, ethics and fees. The organization has 16 charter members, three of whom are male. I was introduced to one, a former physicist named Danny Tompkins, by a female friend who said, as she brought us together in a Mexican restaurant, "Female surrogates, that's just another way of servicing men. They've always had that available to them in one form or another. But male surrogates! That's really progress." I felt the same way.

While Masters and Johnson had used partner surrogates to work with impotent men and premature ejaculators who had no female mates of their own, they had avoided providing such partners for women. Their rationale was that men could accept such casual partners but that sexually dysfunctional women needed "the security of an established man-woman relationship, real identification with the male partner and warmth and expression of mutual emotional responsivity." I have always disagreed, having known many women who have been happy about casual sex partners—and particularly happy when casual but good sex replaced no sex at all. I mentioned this to Tompkins, a pleasantly shy, slight and handsome man of about 35, who was, he explained, still in training with another male surrogate, who was charging him a modest $100 for three training sessions, plus $75 for a weekend internship.

"What exactly does a male surrogate do?" I asked.

"Well," he said, "you have to understand that being a male surrogate does not necessarily mean having to come up with an erection. You can go a long way without having an erection."

The woman who had introduced us said in astonishment, "You can?" in the same breath that I said in astonishment, "You can? But then what do you do?"

"Well, first of all, you spend a few hours talking to the woman," Tompkins explained. "You discuss things until you both feel comfortable. Then you go into the bedroom, and it's not unusual after you've been in the bedroom for, say, two or three sessions, that the woman gets turned on and wants to fuck."

"No kidding," I said.

"Yes," Tompkins said. "Well, then you have to weigh 'Do I want to have a good time and fuck or do I want to be in the business?' "

"I thought that was your business."

"No, that's not the name of the game," he said.

Later, he explained a case. "One woman—a married woman—was basically an aggressive type. That's not why she came to see me; she came because she had not experienced orgasm with her man's penis inside her. But anyway, I diagnosed immediately that she was basically an aggressive type."

"You mean because she wanted to have an orgasm with a penis inside her?" I asked.

"Well, ninety percent of these problems are, after all, right here," he said, pointing to his head. "You don't have to put your penis inside. The idea is to get the person's head turned around so she regards sex as a clean act so she can get turned on and doesn't come into it cold and just say, 'I want an orgasm.' "

"Lots of women who think sex is dirty have orgasms," I said.

"I don't personally agree with that."

Tompkins had surrogated four women so far but had not had intercourse with any of them. He had, however, made them orgasmic. The treatment was a matter of making the right physical connections. "With this particular problem," he explained, "the thing you do is have the woman stick her finger into the introital opening of her vagina——"

"The what?"

"The opening. And then you have her rub her clitoris at the same time, alternately taking her finger out and then putting it back in. It takes a lot of training, but you can do it without entering."

The other woman and I asked simultaneously, "What's wrong with entering?"

Tompkins tried to explain. "I guess it's just the human female condition. The woman doesn't always have a live penis available to her, and the fact is she can always feel her clitoris. She can do it in front of the television set."

It was certainly beginning to look as if, in a growing fringe of the new sex therapy, "warmth and expression," and even intercourse, were on their way out.

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Female surrogates do not avoid intercourse, at least not in the elaborate therapy program devised by Dr. Bernard Apfelbaum, a psychoanalyst who heads the Berkeley Sex Therapy Group. "We don't like the term surrogate therapy," Dr. Apfelbaum says. "It implies providing a stand-in for the wife, implies you can do the same things in individual therapy that you do with couples. We've found you can't. The surrogate cannot just be a substitute for a wife. It's a new kind of relationship."

Apfelbaum makes sure the "relationship" is progressing by meeting with the patient and his surrogate after every two-and-a-half-hour bedroom session. The three of them discuss the sexual obstacles and peaks that have been encountered.

Bearded and rabbinical-looking, Apfelbaum theorizes that men with sexual problems also have troubled personality profiles; they are "loners, men who do not see women as people they can turn to, who do not see sex as a response but as something they must produce to please women." He hopes to uncover these feelings and change some of them along with changing sexual performance. Consequently, the therapy he espouses is a "talking" cure. The patient is encouraged to keep expressing himself, no matter what else is happening.

Sandi Enders, the gentle, dark-haired, soft-spoken woman who is Apfelbaum's chief cotherapist and has worked with over 35 men, explained the process to me. "Take someone who's impotent. We're trying to build up a reliability factor, so we practice by my giving him an erection, then his losing it, then gaining it again, then losing it. But we're continuously talking. The feelings the men get into aren't usually aimed at me. They get into loneliness, depression, abandonment. Quite often in this stage, they will really start crying, and I'll hold them. What they're doing is really getting down to some of the things that are wrong with sex for them and that sex is bringing up in them at other times when they can't express it."

Enders has no difficulty in keeping the conversation going. "I've sat there and talked for forty-five minutes with a penis inside me." She reaches orgasm very easily: "I can turn on to everything; that may be my sexual problem." But she warns her patients, "That's not the end point to look for. The orgasm is mine." What she is aiming at is getting the man to react to everything, including her orgasms, and she describes working with one patient, a 28-year-old virgin, to help him respond appropriately. "I told him I was probably going to have an orgasm, and what it was going to sound like, because I thought otherwise he would freak out. I told him I was very noisy. Then he laughed all the time I was having my orgasm. He just laughed and laughed and laughed."

The Berkeley surrogate-therapy program differs in many respects from the one Masters and Johnson used in their early research. They felt that the female surrogate should have a generous amount of social contact with the patient, so her job usually started with dinner and an exchange of biographical and intellectual opinions. Apfelbaum considers this

unnecessary and, indeed, has structured the program so that patients have virtually no social relations with the surrogates. They do not go to dinner; the surrogate need not, unless she feels like it, share details of her life; and when she and a patient have finished the two-and-a-half-hour lovemaking session, they drive to Apfelbaum's office in separate cars, like a quarreling suburban pair. Still, many patients fall in love with Enders—or are afraid they will—and do not seem in this respect different from people who respond emotionally to good sex partners.

Apfelbaum's treatment has become much in demand, since he is one of the few therapists in the country currently using surrogates. Masters and Johnson abandoned their surrogate program a few years ago, after a lawsuit was brought against them by a suspicious husband. They feel that while they are certain that female-surrogate therapy is an effective treatment device, it is not worth the risk of "blackmail," not only for the therapists but for the vulnerable patients as well. Apfelbaum is not worried about this; he has recently added two more surrogates to his staff.

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It is women more than men who seem to be getting treatments that are not yet validated. I suppose this should come as no surprise, and yet it is disconcerting, after women's lib, after the scares over the pill, after the furor over surgeons' performing unnecessary hysterectomies. One group of sex therapists has begun recommending "clitoral-adhesion removal," a surgical procedure, albeit a minor one. Some women are said to have a condition in which the skin covering the clitoris is stuck to the glans of the clitoris. It is, according to Hartman and Fithian, true believers in clitoral-adhesions removal, the normal situation in infants. Natural freeing of these adhesions occurs in the first few months of life, they say, but not always, possibly because when mothers are sent home from the hospital with baby girls, they are instructed not to wash the clitoris, not to handle the female genitals at all. If the clitoris does have adhesions, the foreskin won't pull back, which might make a woman uncomfortable—and possibly nonorgasmic.

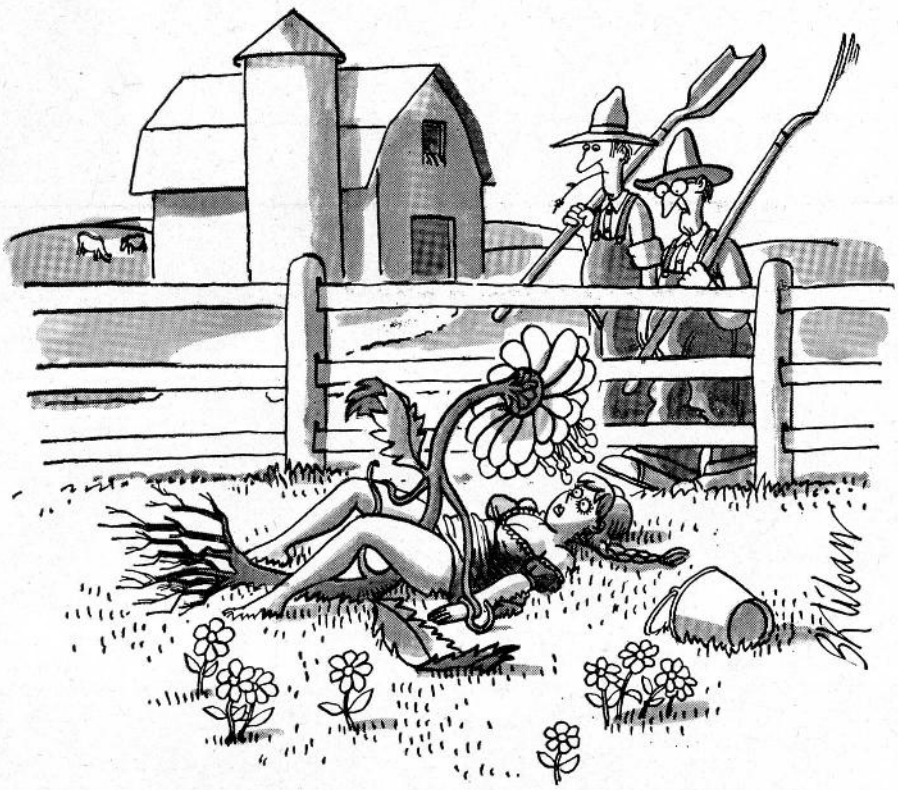
But how many women have this condition? Hartman and Fithian report that in a study they conducted of 83 nonorgasmic women, "approximately one third had clitoral adhesions." At another California sex clinic, the Sexual Therapy Medical Clinic, where clitoral-adhesion removal is regularly performed, Dr. Benjamin Graber reports that "Ninety percent of the women who come in here have foreskins that won't pull back." Yet at Long Island Jewish Hillside Medical Center, where over 100 female patients have been treated in a sex-therapy program that includes a gynecological examination, Dr. Leon Zussman, the gynecologist in charge, reports, "I have seen it once or twice." At Columbia Presbyterian Hospital, gynecologist Dr. Raymond Vande Wiele, who heads Columbia University's International Institute for the Study of Human Reproduction, reports that in his several decades of practice, "I haven't seen it." Since the believers in adhesions insist that the reason gynecologists don't see adhesions is that they don't ordinarily check the clitoris, I ask about this. Dr. Vande Wiele is not just a gynecologist but an endocrinologist, working on the physiological aspects of menstruation. "Oh, yes," he explains. "I always check the clitoris, since obviously the clitoris is the best sign for me of an increased secretion of androgens."

Those who seek and find the adhesions perform a minor surgical procedure to free the clitoris. "In several instances, women with clitoral adhesions have become orgasmic in the immediate subsequent coital opportunity," Hartman and Fithian report. This finding is, in the opinion of most sex therapists polled, an indication of the operation's placebo effect: The procedure doesn't really do anything one way or another, but the woman thinks it will because she's been told it will; consequently, sometimes it does.

In Marina del Rey, California, Dr. Graber and his nurse-wife, Georgia, are planning to study the problem. They are a young, attractive couple. "The incredible number of women who have clitoral-foreskin adhesions is overwhelming," they tell me. Unfortunately, however, they admit, "Many women who are orgasmic have this condition." Why do the surgery, then? I ask. The Grabers explain that the procedure may have no value whatsoever, but they want to study it. They say, "Bill Hartman said he talked to Bill Masters about it one time and Masters shrugged his shoulders and said, 'We just couldn't get to everything.' "

Later I ask Dr. Masters. He tells me, "It is true that there are adhesions in the minor labial prepuce; that is, the covering of the clitoris. Have they been demonstrated to be specifically and particularly important in the repression of female sexual responsivity? Under no circumstances anywhere any time has anything been published that is of statistical import." Masters feels strongly that the value of the procedure should be studied before being used for treatment and says, "If anyone has information that the removal of these adhesions will make dysfunctional women sexually functional, I'd be pleased to see the controlled information, the data, the statistics and the follow-up."

Dr. Albert Ellis, grand old man of sex therapy, who has seen more of it come and go than anyone else in America, having gotten into the work in 1939,



"I remember when crime was confined to the cities!"

is queasy. "It seems to me quite unethical," he says. "Some of these characters could be removing their patients' clitorises, too."

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At present, it is difficult to determine what works and what doesn't work in sex therapy, what is a valid technique and what is merely the equivalent of incantation. Everything—and nothing—may cure some people. At Columbia Presbyterian Hospital in New York last summer, Dr. John O'Connor, who heads the sex-therapy program, met with representatives of 13 of the most prestigious Eastern medical schools and universities to discuss their brands of sex therapy and research. One topic that fascinated all of them was how many "fast cures" they had accomplished.

"Seven to nine percent of our cases get cured in the first interview," Dr. O'Connor claimed.

A therapist from New York Medical College reported, "Three percent of ours get cured just being on the waiting list."

These figures are no surprise, since for many people, just admitting that they have a problem and making an effort to do something about it sets a change—and sometimes a cure—in motion. At the University of California, where Dr. Vandervoort and colleague Dr. Jay Mann are trying to evaluate all current methods of sex therapy in order to arrive at quicker and cheaper cures, they have found that in many cases, just giving troubled clients the counseling unit's *Yes* books (*You Can Last Longer* for premature ejaculators or *Getting in Touch—Self-sexuality for Women* for anorgasmic women) has effected sexual cures.

On the other hand, there are many people whose problems are more resistant. Masters' disasters were always scrupulously recorded and pondered: Some people seemed untreatable. Dr. Harold Lear, a urologist who has been running the sex-therapy unit at New York's Mt. Sinai Hospital, says, "You know and I know that you can't divorce sex from people's personalities or their relationships. Bad sex can be a symptom of ignorance or inexperience, but it can also be a symptom of a person's problems with intimacy. If the problem stems from the latter, then we have to work like dogs to make them pressure-free and guilt-free before their sex will change."

Dr. Sallie Schumacher at Long Island Jewish Hillside Medical Center finds the problem of sex-therapy failures even more complex. She has noticed that often when a patient's dysfunction is "cured," his or her sexual problem recurs some months later. This might be because the psychological difficulties in a couple's relationship have cropped up again or it might be because dysfunctional couples have a lower sex drive than do others. Dr. Schumacher, in conjunction with endocrinologist Dr. Charles Lloyd of the Hershey Medical College in Pennsylvania, is embarking on a lengthy study of the sex-hormone make-up of the 200 couples already seen at the hospital. While it's a long way off, Schumacher hopes that someday we'll know how to increase sex drive.

Some therapists do not buy these theories of individual differences and the complexity of sexual dysfunction and instead plunge patients, whatever the origin of their difficulties, into an athletic baptism of sink-or-swim sex: Couples are asked to do their sexual exercises either in front of the therapists or in the presence of groupmates or both.

The unconventional Hartman and Fithian recommend observing patients doing sexual caresses. In an account of their treatment written by Patrick M. McGrady, Jr., in *The Love Doctors*, they are shown at work as they witness a nude wife massaging her husband's body. While the husband found the experience very sensuous and remarked of the therapists, "I'm not really conscious of their presence," the wife said, "I'm *very* conscious of their presence." Later she complained, "I'm not turned on. I'm just embarrassed."

Jeremy and Virginia More, who run the Toluca Institute for Marital and Sexual Counseling in North Hollywood and were trained by Hartman and Fithian, have begun treating couples in weekend groups of 12 to 16. The couples work only with their own partners, starting out Friday night by learning to caress feet, advancing on Saturday to a facial caress and culminating Sunday afternoon with a body caress, done in the nude by all the couples present, simultaneously. It is timesaving for the therapists.

Curiously, the Mores are very conservative people who see themselves as catering to California's many "conservative," even "inhibited," couples. Indeed, many of their referrals come through local ministers and church leaders. Referring to a photograph that appeared in *Newsweek* of a nude sex-encounter group run by Dr. Martin Shepard in New York, More says, "If I were a conservative couple and I saw that orgy picture, I'd stay away." His own nude group, he explains, is quite different; it goes beyond the honor system: Everyone in a More group has his or her eyes closed, which presents no problem, "since part of sensate focus is keeping the eyes closed to avoid being distracted."

Therapists who observe their clients in sexual activity explain that they do so not because they are voyeurs but because they cannot be sure that couples given sexual homework will accomplish the assignments correctly, thus making observation necessary. They also assert that, in any event, our culture is too hung up on sexual privacy. This may be true, but it is a fact that not only American but Western culture in general practices sex in private. It would seem logical that the person with a sexual dysfunction—who is generally more vulnerable and therefore more private about sex than anyone else—might find himself feeling even more dysfunctional and possibly even depressed after being observed in performance. Unfortunately, the matter has not been adequately looked into before being offered to the public as a cure. Hartman and Fithian studiously avoid talking about their failures and, instead, set the tone of a large element of the new sex therapy by preferring not to give statistics—even success statistics. "We are loath to report statistical 'success rates,'" they write in their privately published book. "We are not interested in developing a numbers game where centers such as ours will enter into a kind of spurious competition based on numbers."

Because what used to be called scientific validation is increasingly thought of as a numbers game or spurious competition by some new sex therapists, the consumer of sex therapy has little to go on in deciding from whom to seek treatment. He has to beware, like any buyer. The field is infantile; so, too, are some of the practitioners. Every other sex therapist worth his or her petroleum jelly is currently writing or has just written a book, usually based on a handful of invariably "successful" cases and suffering excruciatingly from premature evaluation. While hundreds of new sex clinics have sprung up since Masters and Johnson published their work, not one has produced a treatment account that is even remotely comparable in honesty and accuracy to *Human Sexual Inadequacy*. In St. Louis, Masters and Johnson have begun to bemoan the fact that so many people are turning to the lucrative job of treating sexual problems, so few to the research drudgery that remains to be done. "We still know so little about sex" has become their litany, and sometimes they regret that the ship they launched is now sailing under less-experienced hands.

And yet, why sink it? Sex therapy is a brief treatment, inexpensive when compared with analysis, and all forms of it have helped some people. If this help has been less effective or less enduring or less dramatic than some of the new sex movers would have it, some people are getting help, and, on the horizon, at least a few of the new sex therapists are finally getting ready to explore the hows and whys.