Sexual Dysfunction:
Assessment, Treatment, and Evaluation

by

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PART I

INTRODUCTION

The purpose of this practicum was to gain a basis of knowledge and experience in the assessment and treatment of sexual dysfunction. Specifically, this involved developing the theoretical background on the nature of the problems in sexual dysfunction as well as the intervention techniques for the treatment of the same, acquiring experience in the assessment, treatment, and evaluation of intervention, and, finally, deriving the benefits of qualified supervision and direction in undertaking this practicum.

The theoretical framework used in the assessment and treatment of sexual dsyfunction was based on the behavioral approach, following the orientation of the Director of Sexual Dysfunction Clinic. This approach provided a structured and systematic format for assessment and treatment, as a result of its emphasis on empiricism and operationalism throughout the therapeutic process (Jehu, 1979).

The clients were seen at the Sexual Dysfunction Clinic (Psychological Services Centre, University of Manitoba) following a professional referral or on the basis of their own initiative. Their problems were predominantly psychological in nature but sometimes involved organic (etiological) factors, as decribed in the Case Studies in Part IV.

A range of therapeutic interventions was used in the treatment process, reflecting the diversity of the sexual problems and the individual needs of the clients. The treatment program was comprised of office (in session) and homework (sexual assignments) components.

The evaluation of the individual treatment processes was based on a within-subject (AB) design. Specific methods of evaluation were verbal reports (interviews), selected questionnaires, and client records. The questionnaires and client self-reports were administered repeatedly throughout the assessment and treatment phases of therapy in order to monitor changes in sexual functioning during the therapeutic process.

This report describes the process through which the practicum was undertaken and completed. Part II contains a literature review of each of the sexual dysfunctions which were identified in assessing and treating the individual clients. Part III describes the assessment and evaluation procedures, as well as the intervention techniques which were used in treatment.

Part IV presents the eight case studies which provided the practical experience in assessment, treatment, and evaluation of the interventions involved in treating the individual sexual dysfunctions. Finally, Part V (Conclusion) summarizes the experience of the writer, in completing this process.

PART II

LITERATURE REVIEW

Introduction

Sexual dysfunctions are defined according to the subjective judgement of inadequacy, by an individual and his/her partner. Since there are no absolute standards of sexual behavior, an individual will make this judgement on the basis of historical and contemporary experiences. For example, the situation in which the behavior occurs, its frequency, and its duration are important in determining its definition as a problem. As well, the consequences of the behavior, including the reactions of the individual and his/her partner, are significant in this respect. The degree to which the problem may deviate from the perceived or absolute normative standards for sexual behavior also influences the individual's judgement. Finally, various characteristics (such as age, sex, and religious or moral background, for example) of the individual and his/her partner, who usually judge the behavior, are considered in influencing this judgement (Jehu, 1979).

For purposes of clarity and ease of management, the range of sexual dysfunctions have been classified according to interest, arousal or intromission, orgasm or ejaculation, and pleasure. It is noted that more than one problem may co-exist in the same individual simultaneously. The classification is not intended to suggest either causal factors or treatment approaches. As well, this classification is only in early stages of study; the system itself lacks reliability, and the definitions of the problems in each category are often incomplete (Jehu, 1979).

Table One Categories of Sexual Dysfunction

ASPECT	MALE	FEMALE
Interest	Inadequate sexual interest	Inadequate sexual interest
Arousal or Intromission	Erectile dysfunction	Vasocongestive dysfunction Vaginismus
Orgasm or Ejaculation	Premature ejaculation Retarded or absent ejaculation Retrograde ejaculation	Orgastic dysfunction
Pleasure	Inadequate sexual pleasure Dyspareunia	

(Jehu, 1979: 75)

For purposes of this practicum report, only selected sexual dysfunctions have been described in detail, corresponding with the problems presented in the Case Studies (Part IV). These include inadequate sexual interest, erectile dysfunction, vaginismus, retarded ejaculation, orgastic dysfunction, and dyspareunia. For more information on those dysfunctions which are not elaborated upon in this report, the reader may refer to Jehu (1979) for descriptions and further references.

ORGASTIC DYSFUNCTION

Introduction

Orgastic dysfunction is an involuntary impairment of the orgasm phase of the female sexual response cycle, so that a difficulty or failure is experienced in releasing the reflex contractions of the vaginal and pelvic musculature (Jehu, 1979). It is analagous to retarded or absent ejaculation in the male, according to Jehu (1979). Orgastic dysfunction may also occur as a psychological condition in which climax does occur and contractions are experienced but the corresponding erotic feelings are absent (orgasmic anasthesia) (Offit, 1977).

Orgastic dysfunction may be primary or secondary in nature. In the first case, the woman experiences a lack of orgastic attainment during her entire life span, regardless of the type of stimulation she has received from herself or her partner, and under all conditions except sleep or fantasy (Adkins, 1983; Kilmann, 1983; Anderson, 1983; Nairne and Hemsley, 1983). Secondary (or situational) inorgasmia, on the other hand, indicates that a woman has experienced at least one incidence of orgasm during her lifespan (by some means of stimulation from herself or her partner), but currently experiences a low orgasmic frequency or orgasm only in response to restricted forms of stimulation (Adkins, 1983; Kilmann, 1983; Nairne and Hemsley, 1983; Anderson, 1983).

The definition of orgastic dyfunction is very subjective and depends on the woman's reaction to the condition, as well as her judgement of inadequacy. This depends, for example, on the persistence and frequency of orgastic failure, the circumstances in which it occurs, the reaction of her partner, and her resultant feelings of frustration, inadequancy and/or shame (Jehu, 1979). In general, the identification of this condition as a problem depends primarily on the woman's overall degree of sexual satisfaction which may be independent of orgasm (Adkins, 1983). If the woman becomes dissatisfied with her orgastic ability, she can be said to be suffering from an orgastic dysfunction.

In terms of the incidence of this problem, inorgasmia is estimated to be the most prevalent form of (female) sexual dysfunction (Kilmann, 1983). It is estimated that from 5% to 25% (Adkins, 1983) of women experience orgastic difficulty at some time in their lives. As well, it is suggested that from 7% to 10% of women have primary inorgasmia (Adkins, 1983).

Causation

A range of causal factors have been identified in the etiology of inorgasmia, indicating the complexity and individuality of the problem (Adkins, 1983). Smith and Meyer (1978) suggest that inorgasmia may relate to inadequate sexual techniques, as well as to developmental, psychodynamic, learned, institutional, and socio cultural factors. For purposes of discussion, the causes will be categorized under physiological factors and psychological factors (previous learning experiences and comtemporary conditions).

a) Physiological Factors

Organic factors are rarely implicated in the etiology of inorgasmia (Anderson, 1983). Jehu (1979) notes that renal disorders such as diabetes mellitus may be direct causal factors in this case. As well, if dyspareunia (painful intercourse) is experienced, the woman's orgastic ability may become impaired (Jehu, 1979).

b) Psychological Factors

Previous learning experiences are identified in the etiology of inorgasmia and may be represented in a range of factors. First, a restrictive upbringing or overly rigid religious background may result in the woman feeling guilty and anxious about becoming sexually aroused. Traumatic experiences in early life and adverse family relationships are also identified in this sense (Jehu, 1979). In terms of the latter of these, a poor father-daughter relationship or one which has been disrupted by father's death or prolonged absence from home may result in

conflicts regarding love-object permanency. This may be manifested in the woman "turning off" in order to protect herself from the impact of the anticipated loss (Anderson, 1983, suggests that this theory has little support in the literature however).

Contemporary conditions are most pronounced when they interact with previous learning experiences, but are also important in directly causing inorgasmia. Under this category, psychological stresses are most frequently noted. These stresses include fears of having an orgasm because of injury, loss of control, becoming promiscuous or insatiable, or experiencing major life changes (Jehu, 1979). Fears of harm as a result of pregnancy or intimate relationships are also noted.

Performance anxiety is frequently experienced by women who are frustrated by this problem or whose partners may exert pressure on them to achieve orgasm. This may lead to cognitive monitoring or spectating, detachment and reduction in subjective arousal, or an involuntary inhibition of muscular contractions (Jehu, 1979; Adkins, 1983).

Partner discord or relationship conflicts have also been associated with orgastic dysfunction, especially secondary inorgasmia (Jehu, 1979; Kilmann, 1983). This may relate to power or control struggles in the relationship, fear of intimacy or greater commitment, and lack of attraction towards the partner, for example (Jehu, 1979; Kilmann, 1983).

Finally, the woman may be receiving insufficient or inappropriate stimulation to have an orgasm. This may relate to a lack of interaction regarding sexual response or poor communication between the woman and her partner in stating sexual preferences (Adkins, 1983; Kilmann, 1983; Jehu, 1979).

Several personality characteristics of inorgastic women have been identified in the literature. These include low self esteem, poor body image, compulsiveness (and need for control over body and sexual response), passive-aggressive behavior, and a lack of balance between assertiveness and receptivity required to both give and take in the sexual relationship (Offit, 1977; Smith and Meyer, 1978).

Treatment

Considering the complexity of causal factors in inorgasmia, an effective treatment program should be based on accurate diagnosis of the dysfunction provided by a systematic and thorough assessment of the problem (Smith and Meyer, 1978; Jehu, 1979).

Treatment for orgastic dysfunction has typically involved the application of one or a combination of treatment components in a program which tends to reflect both the theoretical orientation of the clinician and the individual needs of the client. These components include systematic desensitization, sensate focus, sex education, directed masturbation, and hypnotic techniques (Anderson, 1983; Fichten, 1983; Kilmann et al., 1983; Nairne and Hemsley, 1983; Jehu, 1979).

In reviewing major treatment programs developed to treat orgastic dysfunction, Masters and Johnson are best known for their treatment of primary inorgasmia in a program which aimed to alter etiological factors presumed to be causing or maintaining the problem (for example, sexual ignorance, conflicts, anxiety, ineffective sexual techniques, and communication difficulties) (Fichten, 1983). This program focused on the use of sensate focus with non-genital caressing, followed by genital caressing or masturbation in order to improve sexual skills and to learn what sensations are pleasurable to the woman (Fichten, 1983; Adkins, 1983). This process is graded to the extent that intercourse (with the female in the superior position) is gradually attempted in order to generalize orgasm to partner related activity (Adkins, 1983). Masters and Johnson also incorporated techniques such as sex education and a ban on intercourse (or other problematic sexual activities) in order to meet the specific needs of the woman and her partner (Fichten, 1983). While this program has claimed a relatively high success rate, the absence of control in treatment evaluation has resulted in difficulty assessing its effectiveness (Adkins, 1983).

LoPiccolo and Lobitz developed a behavioral, time-limited program designed for individuals or couples. This program follows the format

developed by Masters and Johnson (above) but incorporates a nine step series of assignments on directed masturbation training to increase the overall effectiveness of the program (Jehu, 1979; Adkins, 1983). This program, which is most effective for primary inorgasmia, involves relaxation training, self-pleasuring exercises (as homework assignments), sex education and counselling, desensitization (towards masturbation, for example), sensate focus, and other components according to the individual needs of the client (Jehu, 1979; Nairne and Hemsley, 1983). The focus on directed masturbation training in this program reflects the observation that orgasm is more likely achieved in masturbation (than coitus, for example). As well, it is proposed that achieving orgasm during masturbation should resolve the woman's doubts about her orgastic ability, alleviate her fears of injury or loss of control, and provide her with information on the nature of stimulation she needs to produce orgasms (Jehu, 1979; Adkins, 1983). While the program developed by LoPiccolo and Lobitz is difficult to evaluate because of its small sample size and lack of control groups, the authors have noted a very high success rate (100% in 8 women treated). As well, variations of this technique have been used by various clinicians (including self-help manuals) with apparent effectiveness (Jehu, 1979; Adkins, 1983).

Variations of the programs developed by Masters and Johnson and LoPiccolo and Lobitz have been used extensively in the treatment of inorgasmia. These have generally focused on directed masturbation and have included assertiveness training, sensate focus, systematic desensitization, and sex education for example, according to the individual needs of the client. Treatment has also been undertaken on an individual, couple, and group basis according to the orientation of the clinician and the suitability of the client (Adkins, 1983).

The treatment programs developed for orgastic dysfunction have been evaluated according to both overall effectiveness and effectiveness of the individual components of treatment (Jehu, 1979; Adkins, 1983). As indicated above, both Masters and Johnson and LoPiccolo and Lobitz have noted high rates of success with their treatment programs. This has been quite consistent in subsequent clinical experience, especially for

primary inorgasmia where it appears that fewer contemporary or situational variables (for example, partner discord) complicate the problem (Jehu, 1979, provides outcome data on the major treatment programs developed for both primary and secondary inorgasmia).

Specific components of treatment programs have been evaluated according to their effectiveness in treating primary and secondary inorgasmia. First, it is generally held that directed masturbation is most effective in treatment, whether in individual, couple, or group settings and whether it is used alone or in combination with other treatment modes (such as sensate focus or desensitization, for example) (Adkins, 1983; Fichten, 1983). Second, systematic desensitization has been most effective in therapy to reduce anxiety in primary or secondary inorgasmic women (Everaerd and Dekker, 1982; Kilmann et al., 1978; Fichten, 1983). Third, communication training is an important component in treating secondary inorgasmia where partner conflict is a contributing factor (Kilmann et al., 1978). Finally, sexual skills training (sensate focus used in conjunction with directed masturbation training) is generally most effective in treating primary inorgasmia (Kilmann et al., 1978).

Conclusion

Despite these observations on the effectiveness of treatment programs and individual components thereof, it is apparent that major studies reflect a considerable number of methodological deficiencies. For example, there has been a noted lack of specificity regarding subject characteristics, a failure to develop reliable measures of outcome, and an inconsistency in criteria indicating treatment success (Nairne and Hemsley, 1983; Jehu, 1979; Kilmann et al., 1978). As a result, it is difficult to identify treatment programs which are most effective for specific variations of inorgasmia (Kilmann et al., 1978). Further research with more systematic and controlled study of treatment modes is necessary in order to derive more conclusive statements regarding these observations.

VAGINISMUS

Introduction

Vaginismus involves the spastic and powerful contraction of the levator muscles at the entrance of the vagina and, frequently, of the adductor muscles of the thighs so that they cannot be separated (Fertel, 1977; Jehu, 1979; Batts, 1982; DeMoor, 1972). Likened to the blink of the eyelids when a threatening motion towards the eye is perceived (Jehu, 1979; Fertel, 1977), it appears to be conditioned reflex or response stimulated by imagined, anticipated, or real attempts at vaginal penetration (Fertel, 1977; Arentewicz and Schmidt, 1983). Once initiated, the muscular spasm may continue for a variable and extended period of time (Medical Aspects of Human Sexuality, 1979).

While these muscular spasms are often accompanied by a phobia of penetration, vaginismus is also distinguished from coital phobias without vaginal cramps (Arentewicz and Schmidt, 1983). In this case, the fear of intercourse is so great that a woman cannot even allow an attempt at intercourse to be made; she either refuses the attempts or responds with a panicky impulse to escape. In either situation, the spastic contraction of the vaginal muscles does not occur.

According to Trimmer (1982: 25), "vaginismus can present at any point on a continuum that may begin with a state of difficult or impossible penile or digital vaginal penetration, intensifying to its most florid presentation, as a condition in which visual examination of the external genitals is an impossibility". Complete vaginismus, as above, is the most serious form of the dysfunction and frequently results in the non-consummation of marriage (Jehu, 1979; Trimmer, 1982).

Situational vaginismus, on the other hand, describes vaginismus which only occurs under certain conditions of penetration. For instance, the muscular spasms may not occur with the insertion of a tampon, under the influence of alcohol, or during gynecological examination (Lamont, 1978).

Trimmer (1982) also distinguishes between non-consummation vaginismus (described above), coded vaginismus, and behavioral vaginismus. Coded vaginismus exists when sexual "neo-phytes" complain of vaginal tightness or dryness, or of being too small for penile penetration; this is rarely a serious problem and often requires sex education in order to correct inaccurate perceptions. Behavioral vaginismus, on the other hand, is a secondary sexual dysfunction which occurs as a learned response to religious orthodoxy, psycho-sexual duress, or other precipitating event(s). (These will be further received in the following section on Causation.)

Vaginismus has been noted as the source of physical and emotional problems to both the client and her partner. In the first case, vaginismus is a causative factor in dyspareunia when penetration is attempted (Lamont, 1978; Ellison, 1972; Kaplan, 1983). It also causes feelings of anxiety, humiliation, disappointment and inadequacy. For her partner, it contributes to frustration and disappointment as well as to the possibility of sexual dysfunctions (this is noted in the association between vaginismus and erectile problems). In some cases, marital breakdowns or, in the least, relationship conflict may occur (Jehu, 1979).

Vaginismus is considered to be quite rare among both normal and clinical populations; however, no concisive information is presently available to sustantiate this. Existing reports show a range of 9% to 11% in the incidence of vaginismus among females treated for sexual dysfunction (Jehu, 1979). However, it has been asserted that in fact the incidence of the problem may be much higher than estimates have indicated but, as long as the problem is not perceived to be serious enough to eliminate sexual pleasure, treatment is not sought (Leiblum et al., 1980; Ellison, 1972).

Causation

In their review of clinical experience with vaginismus, Leiblum et al. (1980) noted the lack of consistent themes in the etiology of vaginismus. They concluded that many factors play a role in the

development of vaginismus and no single etiological pattern emerges as definitive. Within this context, a range of organic and psychological factors, identified in the etiology of vaginismus, are presented below.

a) Physiological Factors

Physiological factors are responsible for only a minority of symptoms in women according to DeMoor (1972). Furthermore, this is most likely the case when vaginismus is global in nature (Kaplan, 1983; Kolodny, 1979). According to Ellison (1972), primary organic vaginismus may be the result of congenital malformations of the vagina or it may be due to introital damage or infection such as vulvitis, or deeper pelvic conditions including a retroverted uterus, pelvic tumors, or polyps. Secondary organic vaginismus, on the other hand, may be due to cervicitis or to pelvic infections, new growths, displaced organs, endometriosis, laceration of the broad ligaments following childbirth, or other post-partum conditions such as hemorrhoids. Kegel (in Fertel, 1977) suggests that vaginismus may also occur as a defense against pain directed at areas of the vagina where atrophic, weak, and tender pubococcygeal muscles are found. Kaplan (1983) notes that vaginismus may develop as a result of painful intercourse caused by any of the above factors, or as a result of impaired arousal or the resultant lack of normal lubrication and swelling.

b) Psychological Factors

According to Kaplan (1983), vaginismus is a conditioned response that results from the association of pain or fear with attempts (or even fantasies of) vaginal penetration. The original noxious stimulation may have been either physical pain or psychological distress (described above). Once the reflex is established, a negative contingency becomes associated with the act or fantasy of vaginal penetration and the woman continues to respond to the threat of penetration with muscular contraction and anxiety (also see Fertel, 1977; Jehu, 1979).

Considering this theory, numerous contributing factors have been identified in association with the negative stimulus or contingency.

These involve fear or anxiety concerning sexual activity, especially coitus, primarily because of ignorance and misinformation regarding sex and in particular sexual response (Ellison, 1972; Fertel, 1977). As well, painful first coitus (Medical Aspects of Human Sexuality, 1979), excessive religious orthodoxy (during upbringing) with resultant guilt, fear of punishment, and negative attitude towards sex (DeMoor, 1972; Fertel, 1977, Ellison, 1974; Jehu, 1979), earlier psychosexual trauma such as rape (Fertel, 1977; Jehu, 1979; DeMoor, 1972; Kolodny, 1979), and previous homosexual experience (DeMoor, 1972; Batts, 1982) are noted factors. Specific fears of contracting venereal disease or other infection, and of becoming pregnant are also noted amongst woman (Fertel, 1977; Kolodny, 1979).

According to psychoanalytical theory, vaginismus is a conversion symptom involved in the female "castration complex" and "penis envy" (Fertel, 1977). In this case, the woman wishes to destroy the man's potency or to castrate him by breaking off the penis and keeping it (DeMoor, 1972; Fertel, 1977).

The partner is important in both the etiology and maintenance of vaginismus (Leiblum et al., 1980). This may relate firstly to ignorance or misinformation by the partner regarding his belief that the woman's vagina is, in fact, too small to accomodate his penis and his resultant tendency to over-sympathize with her. Secondly, sexual dysfunction in the male may contribute to the development of vaginismus in his partner. For example, vaginismus is often linked to premature ejaculation in the woman's partner. She may be sexually stimulated but fails to reach orgasm or to achieve sexual satisfaction because of her partner's problem. Repeated anticipation and frustration combined with local pain following recurrent pelvic congestion commonly leads to the gradual but insidious onset of vaginismus (Ellison, 1972).

Treatment

A thorough assessment of the sexual problem should precede the formulation of a treatment approach for vaginismus. This should include determining the sexual history of the client (both from her own and her

partner's perspective), the nature of underlying emotional problems, and the symbolic meaning (if any) of the problem or the role that vaginismus plays in their relationship (Kaplan, 1983; Fertel, 1977). A pelvic examination to differentiate phobic avoidance of penetration from pathology or physical conditions that may obstruct or hinder vaginal entry is also recommended (Batts, 1982; Fertel, 1977; Kaplan, 1983). It is noted that the physical examination also represents an initial phase in treatment as the patient is introduced to the desensitization process frequently followed in therapy. She also receives accurate information on the nature of the muscular spasm which occurs when penetration is attempted, as an initial step in the educational component in therapy. (These are discussed in greater detail below).

Regardless of the etiological hypothesis of the clinician, treatment of vaginismus inevitably involves the gradual insertion of objects of increasing size into the vagina (for examples, fingers, tampons, or artificial dilators) under conditions of relaxation and patient control (Leiblum et al., 1980; Arentewicz and Schmidt, 1983). This is based on the notion of deconditioning and (in vivo or systematic) desensitization (Jehu, 1979; Ellison, 1972) as it is believed that vaginismus has been learned through a process of conditioning and, consequently, can also be unlearned through the appropriate procedures (DeMoor, 1972; Batts, 1982; Ellison, 1972).

With regards to desensitization, the vaginal dilation process is a gradual one, in which the client adjusts to each step in the process before progressing to a larger dilator, for example, and therefore is not traumatized or precipitated into avoidance or escape reactions (Jehu, 1979; Ellison, 1972). Alford (1979) describes this process as "tactile stimulus fading" or the use of a fading procedure to gradually introduce successive tactile approximations of intravaginal penile stimulation.

The most well known and widely followed approach to treating vaginismus was that developed by Masters and Johnson in treating 29 women in their eleven years of practice (Leiblum et al., 1980). This approach was based on the view of vaginismus as a psychosomatic condition in which

an involuntary reflex of the vaginal muscles occurs in reaction to the threat (real, imagined, or anticipated) of vaginal penetration. It combines elements of behavioral and cognitive therapy in treatment.

The physical component of the program initially involves a demonstration to the couple of the existence of an involuntary vaginal spasm, during a pelvic examination by a physician. The educational aspect of therapy is also introduced in this manner.

The use of graduated vaginal dilators, under the woman's control, is central to treatment and actually begins with the physician inserting a finger or speculum into her vagina during the pelvic examination. Intravaginal retention of the dilator, for up to several hours, is encouraged so that the woman becomes used to the sensation and learns that she is able to allow vaginal penetration. Coitus is attempted only after the woman successfully adjusts to each of the dilators (or to her partner's fingers) and feels no apprehension about this prospect (Fertel, 1977; Shahar and Jaffe, 1978; Leiblum et al., 1980). Graduated sensate focus exercises are also included in treatment in order to enhance sexual feelings and communication between the couple (Leiblum et al., 1980; Fertel, 1977; Shahar and Jaffe, 1978).

The psychological component of treatment initially focuses on the etiological factors related to the origins of the symptoms, as perceived by the woman and her partner. Presentation of accurate information regarding sexual anatomy and response is important throughout therapy.

Kaplan's approach to treating vaginismus has similarly become widely used by subsequent sex therapists. Like Masters and Johnson, Kaplan attempts of modify the immediate cause of the disorder by using graduated vaginal dilators and in vivo desensitization to deal with the phobic elements of the avoidance response (Fertel, 1977). Where deeper psychological problems present an obstacle to treatment, she also incorporates psychoanalysis, hypnosis, and systematic desensitization (to imagine the stimulus under conditions of relaxation). Kaplan holds that the client cannot be cured unless she inserts something into her vagina; she is

therefore encouraged to confront the unpleasant affect and situation and "stay with" her feelings in order to overcome the psychological components of the problem (Fertel, 1977).

Variations of these techniques have been used by other clinicians according to their theoretical notions of etiology. For example, Ellis (in Shahar and Jaffe, 1978) incorporated additional cognitive restructuring to deal with irrational, overgeneralized, and self-defeating attitudes and beliefs held by the client.

Psychodynamic oriented therapists have placed a greater emphasis on searching for the origins of the emotional conflicts and tensions, which are manifested in the noted physical response (Ellison, 1972; Kolodny, 1979). This is based on the notion that, because of its psychogenic roots, vaginismus resists physical therapeutic approaches (Medical Aspects of Human Sexuality, 1979).

In other cases, a ban on intercourse has been applied to reduce the pressure on the woman and to increase her control during sexual assignments (Trimmer, 1982; Fertel, 1977).

Kegel's exercises have also been used to develop more muscular control, by voluntarily contracting the vaginal muscles while the partner has his finger in the woman's vagina (and holding this, then relaxing the muscles). This corresponds with Kegel's theory that poorly toned and tender vaginal muscles contribute to vaginismus (Fertel, 1979; Kolodny, 1979).

Conclusion

The treatment of vaginismus has had highly successful results, regardless of the identified etiological factors or the specific treatment approaches used by clinicians (Arentewicz and Schmidt, 1983; Kaplan, 1983). Kaplan (1983) holds that most women with vaginismus are easily treated with brief, direct behavioral treatment. Progressive dilation is inherent in this approach.

Considering this prognosis, Ellison (1972) proposes that the motivation of the client and her partner towards preserving the relationship and having children, for example, is probably the most important factor in treatment. Further to this, Leiblum et al. (1980) state that the motivation of the woman and her relationship with the therapist are more important than any other single variable, including the nature and effectiveness of therapeutic techniques used to treat the sexual problem.

DYSPAREUNIA

Introduction

Dyspareunia is defined as recurrent and persistent genital pain in either the male or the female during coitus (DMS-III in Kaplan, 1983; Jehu, 1979; Musaph and Haspels, 1977). This definition is extended to include the pain associated with orgasm, sexual excitement, and non-coital activity (masturbation and manual or oral stimulation by partner) (Kaplan, 1983; Jehu, 1979).

According to Jehu (1979), the discomfort in males may occur only during erection, insertion, thrusting, or ejaculation, or throughout more than one of these processes. Furthermore, the pain is most commonly felt in the prepuce, glans penis, penile shaft, testicles, groin, pubic area, and thigh or lower back (Jehu, 1979; Wabrek and Wabrek, 1975). Women may experience pain at the entrance to the vagina, in the clitoris, the vaginal barrel, or the internal pelvic organs. This may occur during intromission, intercourse, and/or after intercourse has ended (Jehu, 1979; Musaph and Haspels, 1977).

Dyspareunia is either primary, manifested immediately during first intercourse, or secondary appearing after a period of normal (painless) sexual functioning (Musaph and Haspels, 1977).

While dyspareunia is believed to be a relatively common (perhaps the most common) cause of sexual difficulties, the actual incidence of the problem is presently unknown (Wabrek and Wabrek, 1975). It is believed that dyspareunia has not been perceived by women and men to be a problem of sufficient severity to consider therapy. Many women, for example, have been willing to endure pain or discomfort in the mistaken belief that pain is a self evident side effect of sex (Musaph and Haspels, 1977; Lazarus, 1980; Lehfeldt, 1977). However, this is changing as increased reporting of dyspareunia suggests that women are expecting more pleasure from sex. As well, recurrent and severe pain during coitus may result in repeated disappointment, sexual frustration and dissatisfaction, possible

loss of self-esteem, feelings of resentment or rejection towards a partner, or a loss of intimacy in the relationship (Lazarus, 1980; Lamont, 1980). This may subsequently lead the individual to seek treatment.

Causation

Dyspareunia may occur as a result of either physiological or psychological factors (Jehu, 1979). However, this distinction is frequently difficult to make (Wabrek and Wabrek, 1975).

a) Physiological Factors

Jehu (1979) states that while psychological factors are involved in some cases of dyspareunia, the cause is usually organic in nature.

In terms of organic etiology in (male) dyspareunia, Jehu (1979) distinguishes between painful erections which are typically related to pathologies in the external genitalia, and ejaculatory dyspareunia in which the internal sex organs are more commonly affected. In the former case, causal factors may include Peyronie's disease (curvature of the penis), penile trauma (scar tissue resulting from an injury), penile chordee (downward bending), inflammatory conditions and infections affecting the external genitalia (for example, gonorrhea, herpes, Reiter's syndrome), conditions of the female genitalia (for example, inadequate lubrication), and allergic reaction to contraceptive devices (Jehu, 1979; Lehfeldt, 1977; Wabrek and Wabrek, 1975; Kolodny, 1979). Ejaculatory dyspareunia, on the other hand, is almost always a result of acute prostatitis seminal vesiculitis (Jehu, 1979; Lehfeldt, 1977; Kolodny, 1979; Wabrek and Wabrek, 1975). As well, general illness may result in back pain during thrusting (with arthritis, for example), or in chest pain (in cardiac patients) (Jehu, 1979).

Similarly, women may experience pain in various pelvic locations relating to specific organs. In the first case, pain which occurs at the entrance of the vagina during foreplay or during penile penetration may result from a variety of factors. For example, this may relate to

vaginismus, an intact or rigid hymen, inflammations (for example of the Bartholin's gland or vulvitis) tender scar tissue (after sexual trauma, or episiotomy, for example), or inadequate lubrication (Jehu, 1979; Kolodny, 1979; Lamont, 1980; Wabrek and Wabrek, 1975; Kaplan, 1983). Painful inflammation of the clitoris may result from too vigorous clitoral stimulation, lesions or scar tissue on the shaft, or from accumulation of smegma under the hood of the clitoris (Jehu, 1979; Lehfeldt, 1977; Wabrek and Wabrek, 1975).

Second, burning, itching, or aching sensations in the vaginal barrel (mid-vaginal pain) both during and after intercourse is most often the result of insufficient lubrication. Vaginal wall atrophy, in which the lining of the vagina is thinned as a result of estrogen deficiency after menopause or use of low estrogen and contraceptives, is also a noted cause of dsypareunia. Additional causal factors in this case include vaginal infections and allergic sensitivity to fabrics, chemicals in contraceptives or soaps, lesions of the vaginal wall, and a congenital shortened vagina (Wabrek and Wabrek, 1975; Jehu, 1979; VanKeep, 1977; Kaplan, 1983; Kolodny, 1979).

Third, deep pelvic pain occurs during or shortly after deep penile penetration and thrusting and relates to the cervix, uterus, and pelvic structures. In this case, causal factors include endometrical tissue growth, cysts, tumours, fibroids, pelvic inflammatory disease, intense vasocongestion, fixed uterine retroversion, and scar tissue following hysterectomy (Jehu, 1979; Kaplan, 1983; Lehfeldt, 1977; Wabrek and Wabrek, 1975).

Finally, systemic diseases such as arthritis or angina pectoris may result in general or chest pain during sexual activity (Jehu, 1979).

b) Psychological Factors

The psychological factors involved in dyspareunia are frequently more difficult to determine and may relate to individual or interpersonal problems (Lamont, 1980).

First, individual or interpersonal problems are often a result of developmental factors in which the individual has been brought up in a (morally or religiously) restrictive environment in which sex was associated with guilt and shame, or in which misinformation resulted in anxiety, confusion, or ambivalence towards sex.

Traumatic events in the individual's past such as previously painful intercourse (as a result of earlier organic pathology, for example), violent defloration, clumsy lover, or rape may leave fears of sexual activity. This may occur if the individual continues to anticipate pain even when the traumatic event or organic pathology no longer exists. Feelings of guilt and anxiety concerning sexual activity may similarly impair arousal, leading to a disruption of vaginal lubrication and resultant pain during intercourse (Jehu, 1979; Lamont, 1980; Musaph, 1977). In regards to anxiety, research has established a link between hysteria and dyspareunia in women (Jehu, 1979; Kolodny, 1979).

In terms of relationship factors, anger or conflict between the individual and his/her partner as a result of poor communication, control issues, and sexual performance pressures, for example, are also related to the onset of dyspareunia. In this case, the conflicts create stresses which may disrupt arousal and reduce vaginal lubrication or cause muscular stresses (as in vaginismus) (Lamont, 1980; Jehu, 1979; Musaph, 1977).

In cases of both individual and relationship problems, or in otherwise problem-free contexts, situational events such as inadequate foreplay and fears of being overheard or interrupted, for example, may create stresses which lead to discomfort during intercourse (Lazarus, 1980).

Treatment

Treatment of dysparenunia should follow a detailed assessment which includes a gynecological or urological examination to distinguish physiological from psychological factors in the etiology of pain. In

this way, treatment can be more effectively directed towards the individual case (Lazarus, 1980; Kaplan, 1983; Wabrek and Wabrek, 1975; Lehfeldt, 1977; Musaph and Haspels, 1977).

In the past, treatment of dyspareunia has focused on physiological factors and little attention has been directed towards treatment of psychological dyspareunia (Lazarus, 1980). The range of medical interventions is wide, corresponding with the numerous causal factors relating to organic etiology. For purposes of this discussion, however, treatment of organic dyspareunia will be limited to hormonal or drug therapy to correct estrogen deficiencies in women suffering from atrophic vaginitis causing painful intercourse. In this case, estrogen may be administered orally or locally (ie. vaginal creams) to correct the deficiency (Jehu, 1979; VanKeep, 1977). It is noted that organically caused dyspareunia is generally responsive to therapy which is directed towards the organic pathology (Lehfeldt, 1977).

In terms of psychological treatment of dyspareunia, there is a paucity of information on which to base discussion. With this limitation, the following section identifies the predominant treatment modes outlined in the literature.

Lazarus (1980) recommends a broad spectrum treatment regime based on behavioral principles in order to deal with the complex factors involved in psychological dyspareunia. He suggests, for example, the use of systematic desensitization with assertiveness training, social skills training, marital therapy, and cognitive restructuring or disputing. To this list may be added information provision regarding human sexuality, sexual response, and dyspareunia specifically. This is intended to resolve problems which may relate to ignorance or misinformation and to reassure the client that she/he may be physically normal and that dyspareunia is a common sexual problem resulting from both physiological and psychological factors (Musaph, 1977).

Desensitization, as mentioned above, is used where specific fears inhibit sexual pleasure; in this case, then, the intent is to reduce the negative emotional reactions to sex. Systematic or in vivo

desensitization may be used, in which case the client either imagines the hierarchy of anxiety invoking activities, or proceeds through these in real life (Jehu, 1979; Lazarus, 1980).

Sensate focus or pleasuring, as developed by Masters and Johnson (1970), may also be used in this context. This consists of structured sexual interactions between the couple which are aimed at reducing anxiety and gradually achieving painless, pleasurable intercourse (Jehu, 1979; Lazarus, 1980).

Relaxation training is frequently used to reduce muscular tension which may impair or prevent sexual activity (Lazarus, 1980; Jehu, 1979). As well, cognitive restructuring is used to supplement more direct behavioral techniques. In this case, the intent is to deal with irrational or dysfunctional thoughts relating to deficient self-esteem, insecurity, and lack of autonomy, for example, which may affect the individual's sexuality (Lazarus, 1980).

Additional treatment modes which have been used in the treatment of dyspareunia include hypnotherapy, abreaction therapy, narcotherapy, and (classical or brief) psychoanalysis in accordance with the structure of the patient's personality and the appropriateness in the case (Musaph, 1977). According to Musaph (1977), psychoanalysis is considered to be time consuming and costly even to those who advocate this model.

Treatment may be undertaken on a individual, couple, or group basis. Active inclusion of the partner is considered to be most expedient in terms of successful treatment outcome, often as a result of the partner's role in the perpetuation of the problem (Musaph, 1977).

Conclusion

There is a significant lack of information regarding treatment of dyspareunia, both in terms of overall treatment outcome and the effectiveness of the individual techniques used by therapists. For example, while behavioral treatment is frequently advocated in treating

dysparuenia (Lazarus, 1980), there is presently no information on the outcome of treatment for dyspareunia when these techniques have been used (Jehu, 1979).

Factors such as a positive client-therapist relationship, the absence of serious relationship conflicts, flexibility in applying treatment modes, and including an active treatment component (ie. sexual assignments) are considered to be most important in contributing to successful outcome.

At the present time, however, statements concerning treatment effectiveness and outcome remain inconclusive. It is apparent that systematic, controlled research is needed in order to better understand dyspareunia and to develop more effective programs for its treatment.

INHIBITED SEXUAL DESIRE

Introduction

Inhibited sexual desire (or lack of desire) is defined as the persistent and pervasive inhibition of sexual desire (Kaplan, 1979; 1983). It may exist as either a low frequency of sexual activity, for example, less than once every two weeks, unless a higher frequency is a result of reluctant compliance with the partner's pressure for sexual activity. In other cases, it may be presented as a subjective lack of desire for sexual activity, in which case desire includes sexual dreams and fantasies, attention to erotic materials, awareness of wishes for sexual activity, and feelings of frustration if deprived of sex, for example (Schover and LoPiccolo, 1982).

Sexual aversion has also been categorized under inhibited sexual desire, at the extreme end of the continuum of sexual avoidance behavior (Schover and LoPiccolo, 1982). However, in contrast, Kaplan (1977; 1983) contends that sexual aversion is actually a phobic reaction to sex and that is is qualitatively different than inhibited sexual desire.* In either case, sexual aversion is represented as an active and generalized reaction of anxiety, fear or disgust to being touched in a sexual way, being seen nude, or even noticing feelings of arousal in one's self. In contrast to inhibited sexual desire, the individual with an aversive reaction towards sexual contact may actually want to respond sexually but feels incapable of overcoming the strong aversive feelings toward sexual activity (Murphy et al., 1979; Murphy and Sullivan, 1981).

Inhibited sexual desire may be primary or secondary in nature. In the first case, the condition is marked by a lifelong history of lack of sexual desire to the extent that she/he may not even masturbate.

*Despite this disagreement, the approaches to treatment do not appear to differ significantly, whether the explanation proposed by Kaplan or Schover and LoPiccolo is used.

Secondary inhibited sexual desire, which is a much more common problem and which is often of a shorter duration, exists where there is a loss of sex drive after a history of normal sexual activity (Schover and LoPiccolo, 1982; Kaplan, 1979; Jehu, 1979). Similary, lack of desire may be either global or situational. In the former, there is a complete lack of interest in sex in all situations with all partners, and towards masturbation, fantasy, and erotic wishes, for example. Situational lack of desire exists when the loss of sexual desire is more psychogenic and tends to be blocked in specific situations with specific partners (for example, usually with desirable partners who may represent a psychic danger, or in situations which may be considered "unsafe") (Kaplan, 1979; 1983; Jehu, 1979; Schover and LoPiccolo, 1982).

Considering the range in occurrence of lack of desire, the actual definition of the problem is a subjective one, made by concerned individuals when a disparate level of sexual desire exists between a couple or when an individual is concerned with an absence or low frequency of sexual desire and/or activity (Jehu, 1979; Reckess and Bryd, 1983). As well, the basis for judgement is made by the clinician who takes into account age, sex, health, intensity and frequency of sexual desire and stimulation, and the context of the person's life (Kaplan, 1979; Jacobs, 1981). This is particularly important if expectations of the individual or couple are unrealistic (LoPiccolo, 1980).

Lack of desire has traditionally been noted to be as more common among women. More recently, however, it seems to be more common among men, reflecting the notion that men should be more sexually aggressive (Jacobs, 1981). An overall increase in the reported incidence of lack of desire may be the result of a change in cultural values concerning sexuality, increased sexual permissiveness (Jacobs, 1981), or greater sophistication in assessment and typology (LoPiccolo, 1980).

The range of occurrence of lack of sexual desire has been estimated in normal and clinical populations. In the former, LoPiccolo (1980) estimates that, on average, 35% of women and 16% of men are actually turned off by sex. In clinical populations, this problem has been noted

among 27.8% to 69% of cases of sexual dysfunction. This appeared to be more common among women than men (Jehu, 1979; LoPiccolo, 1980; Schover and LoPiccolo, 1982), in contrast with the (previously noted) statement concerning the higher incidence among males in recent years (Jacobs, 1981; Horwith and Imperto-McGinley, 1983).

Causation

Lack of sexual desire is attributed to both physical and psychological factors. Physical factors are more often suspected when the problem is global, primary, or when it is linked to specific etiological factors in secondary lack of desire.

a) Physiological Factors

Physical illnesses which have a debilitating or disabling effect, such as systemic illnesses including renal disorders or cirrhosis, for example, are frequently noted in the etiology of lack of desire (Jehu, 1979; Renshaw, 1978; Horwith and Imperto-McGinley, 1983; Kaplan, 1983).

Hormonal balances may contribute to lack of desire when a significant dimunition of plasma testosterone (in men) or androgens (in women) is apparent (Renshaw, 1978; Horwith and Imperto-McGinely, 1983; Kaplan, 1979; 1983; LoPiccolo, 1980; Jayne, 1983).

The ingestion of certain drugs inciuding narcotics, aicohoi, psychotropic and antihypertensive medications, and oral contraceptives is also noted as possible etiological factors (Jehu, 1979; Jayne, 1983; Kaplan, 1979; Horwith and Imperto-McGinley, 1983; LoPiccolo, 1980; Renshaw, 1978).

Surgical interventions such as hysterectomy, mastectomy, prostatectomy, or ostomy may also reduce sexual desire in a more indirect manner (by reducing one's feelings of being sexually attractive, for example) (Jehu, 1979).

Additional physical factors such as pregnancy, aging, (following) heart attack, diabetes, cerebral diseases, and general fatigue have also been noted as causal factors in lack of sexual desire (Kaplan, 1979; Jehu, 1979; Renshaw, 1978; Horwith and Imperto-McGinley, 1983).

Depression is a very common cause of lack of sexual desire and has both physiological and psychological components. For example, depression directly affects vegetative symptoms such as sleeping, eating and overall libido (Kaplan, 1979; Renshaw, 1978; Kaplan, 1983; LoPiccolo, 1980). The cause may also be more indirect, as depression reduces the individual's capacity for intimacy, pleasure, motor activity, initiative, and assertiveness, for example (Jehu, 1979).

b) Psychological Factors

Psychological factors are more frequently noted in the etiology of inhibited sexual desire. First, Kaplan (1979) relates this condition to a "turn-off" mechanism, in which the individual involuntarily and unconsciously suppresses sexual desire by evoking negative images and allowing them to intrude when a sexual opportunity is apparent (Kaplan, 1979). In this case anger, fear, or distraction, for example, replace erotic feelings of desire and the sex circuits become blocked. LoPiccolo (1980) relates this "blocking" reaction to cognitive processes in that internal and external sources of sexual stimulation may be tuned out or mislabelled. According to LoPiccolo (1980), this reaction may be a result of earlier negative conditioning experiences. He notes Kinsey's observation that all people are born with an innate capacity for sexual response and that learning and conditioning are responsible for this dysfunctional behavior.

Probably the most frequently noted psychological factor in the etiology of inhibited sexual desire is stress or anxiety. This may be either conscious or unconscious, and sexual or non-sexual (Kaplan, 1983; Renshaw, 1978; Jehu, 1979). Kaplan (1979) categorizes these stresses as mild, mid-level, and deep anxieties. First, mild stresses include performance anxieties, guilt, anticipation of lack of sexual pleasure,

problems with an overly aggressive or over-anxious partner, and concern about contraception, for example. Mid-level stresses are more difficult to determine but may include fears of success and intimacy (usually with a highly valued and loved partner because of the overwhelming intensity of the interaction), and identity crisis in which past choices (including marital choice) are scrutinized (Ruben, 1978). Deep anxieties reflect more psychoanalytical interpretations including unconscious fears of injury or castration, unresolved oedipal conflicts, narcissistic personalities (with abnormal early emotional development and subsequent impaired ability to fall and stay in love), and suppressed homosexual tendencies (Klebanow, 1978; Nutter and Condron, 1983; Renshaw, 1978; Jehu, 1979, Kroop et al., 1978; LoPiccolo, 1980; Kaplan, 1979; Jacobs, 1981; Reckess and Byrd, 1983).

When lack of sexual desire reflects marital conflict or distress, it frequently occurs as a masking statement (Kroop, 1978) in which unexpressed feelings of anger or hositility between partners, boredom or tedium in sexual activity, struggle for control in the relationships, or poor communication are manifested indirectly in sexual dysfunction (Jayne, 1983; Reckless and Byrd, 1983; Kaplan, 1979; 1983; Bontelle, 1978; Jehu, 1979). In this regard, Kaplan (1979) suggests that it is not possible for normal persons to experience sexual desire for a partner with whom they are angry; sex and anger act as mutual inhibitors.

Lack of sexual desire may be secondary to other sexual problems experienced by the individual or couple. In this case, the individual may attempt to avoid sexual activity in order to avoid (physical) pain or embarrassment of problems such as dyspareunia, arousal phase dysfunctions such as erectile difficulties or impaired arousal, or orgasm phase dysfunctions such as premature or retarded ejaculation or inorgasmia (Kroop; 1978; Jayne, 1983; Sullivan, 1981; Bontelle, 1978).

Finally, sexual dissatisfaction and a resultant lack of desire may occur if an individual does not know his/her preferences for sexual stimulation or pleasure or does not communicate these to his/her partner (Kroop, 1978).

Treatment

Problems of sexual desire are more difficult to treat and have an overall poorer prognosis than do other sexual dysfunctions (Reckless and Bryd, 1983). This is a result of the wide variety of factors involved in the etiology and maintenance of the problem (LoPiccolo, 1980); as well, sexual anxieties which lead to lack of desire are more tenacious and profound than those that underlie problems of arousal and orgasm, for example (Schover & LoPiccolo, 1982). In addition, it is frequently more difficult to motivate a client with lack of desire as his/her reasons to seek therapy are frequently a response to the threat of partner separation or infidelity (Schover and LoPiccolo, 1982).

As a result of these factors, a detailed assessment is critical to treatment of lack of desire (LoPiccolo, 1980; Ruben, 1978; Bontelle, 1978). This should include assessing the actual and desired frequency of coitus, subjective measures of emotional response to sexual behavior, marital satisfaction, knowledge of sexuality, anxiety or aversion towards body parts and functions, and medical examination, for example (LoPiccolo, 1980; Horwith and Imperto-McGinley, 1983).

Based on assessment, a treatment program should be flexible, innovative, and directed specifically towards the needs of the client. LoPiccolo (1980) suggests that multimodal therapy is crucial to successful outcome in treating lack of sexual desire because of the complexity of the problem.

In terms of specific treatment modes, the administration of medication is the focus of treatment when a specific physiological cause can be identified. Medical therapy frequently takes the form of hormone treatment to increase testosterone levels in males or androgen levels in females (LoPiccolo, 1980; Kaplan, 1979; Horwith and Imperto-McGinley, 1983). In cases of sexual aversion, however, Kaplan (1979) notes that the problem indicates a phobic anxiety; she suggests drug therapy to reduce panic attacks and thereby facilitate psychotherapy.

Behavior therapy is widely used in the treatment of both primary and secondary lack of sexual desire. This is typically directed towards reducing anxiety and performance pressures, increasing activity levels and providing reinforcement for the same, improving social and interpersonal skills, increasing assertiveness, and improving the client's ability to deal with life stresses (LoPiccolo, 1980; Kaplan, 1979).

Kaplan (1979) uses several behavioral techniques in treating lack of desire. With a focus on reducing anxiety, she describes a program which includes sensate focus (graded from general pleasuring to non-demand coitus), systematic or in vivo desensitization (to reduce performance anxieties), muscle relaxation, assertiveness training, and thought stopping (to extinguish a certain pattern of thinking) (Kaplan, 1979; Murphy et al., 1979).

Schover and LoPiccolo (1982) also incorporate communication training, increasing (the couple's) positive exchanges or caring behaviors, and conflict resolution into their treatment program in response to relationship problems or low marital satisfaction levels noted among clients. When resistance to the straightforward behavioral approach becomes apparent, they supplement the program with Gestalt or psychodynamic interventions (also see LoPiccolo, 1980).

Additional behavioral techniques which may be used in treating lack of desire include flooding and classical conditioning. In the first case, the client is exposed to the problematic situation in a rapid and prolonged manner without the deliberate use of an alternative response. In classical conditioning, the client may view erotic pictures while fantasizing about his/her partner, for example, to increase feelings of sexual desire towards partner (Jehu, 1979).

In treating lack of sexual desire, behavior therapy is most frequently combined with counselling (Jehu, 1979). The provision of information to increase sexual knowledge and to enhance sexual techniques is commonly incorporated into the counselling aspect of therapy (LoPiccolo, 1980; Nutter and Condron, 1983; Kaplan, 1979). As well,

cognitive restructuring, to alter dysfunctional thoughts which may have precipitated and/or perpetuated the sexual problem, may be undertaken if this is considered to be appropriate (Reckless and Byrd, 1982; LoPiccolo, 1980; Jehu, 1979).

Further to this, a recent development in the treatment of inhibited sexual desire (as well as other forms of the treatment of sexual dysfunction) is the incorporation of "scripting" (or "rescripting") into more traditional forms of sex therapy. This may be implemented alone or in conjunction with other behavioral techniques outlined above. This is based on the theory that people acquire scripts of desirable and appropriate forms of sexual contact in childhood and adolescent learning experiences. Where these are dysfunctional in limiting a full range of sexual expression (as in inhibited desire), a process of modifying performative or cognitive scripts is undertaken (a detailed description of this process is provided in Gagnon et al., 1982).

When resistance by the client is encountered during behavioral therapy, or when behavioral therapy is completely unsuccessful, psychodynamic approaches are frequently attempted in treatment (Kaplan, 1979; Ruben, 1978; Reckless and Byrd, 1982). Often referred to as insight therapy, this involves helping the client to better understand the causes and maintenance of his/her problem (intra-psychic conflicts or hidden relationship problems, for example) as well as the fact that the sexual problem is potentially destructive to a valuable relationship (Kaplan, 1979). Kaplan (1979) suggests that the client may be confronted directly or that the therapist may join in the resistance by using paradoxical confrontation in dealing with resistance.

Conclusion

There exists a paucity of outcome data on the various treatment approaches to lack of sexual desire. As a result, it remains difficult to determine a treatment program which is responsive to the specific needs of a client (Kaplan, 1979; Jehu, 1979). However, several therapy issues which affect treatment outcome and maintenance are presented by

LoPiccolo (1980) and Kaplan (1979) on the basis of their clinical experience.

First, a close and trusting relationship between the therapist and the client (or couple) is essential in order for the client to gain the confidence to face the emotional risks of therapy. Second, a close and caring relationship between the couple is important in providing the client with the motivation to resume a more active and pleasurable sexual relationship. Third, ambivalence towards therapy and resistance to change, as a result of fears of intimacy, loss of control and deeper intra-psychic conflicts, for example, are detrimental to successful outcome. Finally, LoPiccolo (1980) suggests that the maintenance of therapeutic gains will depend to a large extent on the functional role which the problem has had in the relationship.

Considering, then, the complexity of etiological factors involved in inhibited sexual desire, treatment must be innovative, flexible and individually designed according to the client's needs. Despite this knowledge, past experience has indicated an overall poor prognosis in treatment. At the present, there is a need for additional research in order to develop more effective treatment programs to treat dysfunctions of sexual desire.

ERECTILE DYSFUNCTION

Introduction

Erectile dysfunction, or impotence (Rosen, 1983), involves an impairment of the erection phase of the male sexual response cycle so that vasocongestion of the penis does not occur in a normal manner. It is defined as a persistent inability to obtain and sustain a sufficiently firm erection to allow intromission and pelvic thrusting during intercourse (Jehu, 1979; Reynolds, 1977, 1981; Rosen, 1983; Schiavi, 1981).

Erectile dysfunction maybe primary (lifelong) or secondary (not lifelong) in nature. Primary erectile dysfunction exists when the male has never achieved an erection sufficient to function in a sexual context (intercourse in particular) (O'Connor, 1976; Jehu, 1979). This is a relatively rare and potentially serious condition which may have detrimental effects on self-esteem and interpersonal relationships (Rosen, 1983). Secondary erectile dysfunction has been defined as a persistent erectile failure on at least 25% of a man's attempts at intercourse. This is a much more common problem affecting as many as one-half of adult males at sometime in their lives (Rosen, 1983; O'Connor, 1976).

Erectile dysfunction may be acute or insidious in onset. In the first case, the problem may be linked to a discrete physical or psychological precipitant. Insidious onset, on the other hand, is represented by a gradual and progressive reduction in erectile capacity over a period of time (Jehu, 1979).

According to clinical reports, erectile difficulties are experienced by 10% to 31% of males seeking treatment for sexual dysfunction (Jehu, 1979; Ellis, 1980). While this problem is relatively rare for men under the age of 35 (1.3% are permanently impotent according to Kinsey's research in 1948), it is much more prevalent in older men, experienced by approximately 55% of males by the age of 75 (Jehu, 1979; Reynolds, 1981; Bancroft, 1983).

The number of men seeking treatment for erectile difficulties has increased in recent years (Rosen, 1983). However, rather than an overall increase in occurrence among the (male) population, this has been attributed to greater awareness and acceptance of the problem by individuals (Rosen, 1983).

Causation

Erectile dysfunction has been attributed to numerous causal factors and no single theory has been sufficient to explain all of the phenomena involved in the problem (Reynolds, 1981). Rather, a complex interplay of psychological and physiological factors are noted in the etiology of this problem (Wise, 1981; Schiavi, 1981).

a) Physiological Factors

Estimates by clinicians propose a range in the incidence of erectile dysfunction from organic causes, from 10% (Rosen, 1983) to 50% (Nolan, 1981) of the total number of men reporting this problem.

Erectile dysfunction has been linked to aging. This is most common among aging males who do not understand their need for more penile stimulation to gain erections or their need for increasing periods of time between erections. The problem may also result from anxiety or depression concerning these effects (Jehu, 1979; Bancroft, 1983).

Drug ingestion has also been linked to erectile dysfunction (Wagner, 1981). Included in this case, are antihypertensive drugs, antipsychotic drugs, antidepressants, fenfluramine (used in treating obesity), methyldopa, and disulfiram or antabuse (used in treating alcoholism) (Wagner, 1981). Alcohol has also been linked to erectile dysfunction as an estimated 28% of addicted alcoholics between the ages of 30 and 40 experienced this problem, according to one study (Wagner, 1981; Wise, 1981).

Surgical causes of erectile dysfunction include prostate surgery, ileostomy and colostomy. This may be a result of damage to vessels or

nerves during surgery, or depression and loss of self-esteem following surgery (Jehu, 1979).

Chronic renal failure (Wise, 1981; Jehu, 1979; Wagner, 1981), local genital disorders such as Peyronie's disease or testicular atrophy (Rosen, 1983; Bancroft, 1983; Wagner, 1981), vascular disorders such as arteriosclerosis (Schiavi, 1981; Wagner, 1981; Bancroft, 1983), and neurological disorders such as diabetes mellitus, Parkinson's disease, or following spinal cord injuries (Rosen, 1983; Schiavi, 1981; Wagner, 1981; Jehu, 1979, Bancroft, 1983) have been linked to erectile dysfunction.

While these physiological factors often imply a direct cause and effect relationship in the etiology of erectile dysfunction, a more indirect relationship may also be apparent. For example, the male may react to surgery or illness with depression or anxiety; in this case, the psychological condition may be the immediate cause of the problem. This is also apparent in men who may feel self-conscious or awkward as a result of a physical disability or disfigurement and who therefore experience erectile difficulties because of this reaction to their physical condition (Wise, 1981).

b) Psychological Factors

According to Kaplan (in Reynolds, 1981), erectile dysfunction may occur as a result of sexual or non-sexual stresses, in which the parasympathetic responses are inhibited by the sympathetic components of anxiety. According to this explanation, sources of (sexual) stress may include reactions of fear or distain towards the genitals or sexual responses (Jehu, 1979; Bancroft, 1983), performance concerns and spectating (Reynolds, 1981), transgressions of moral or religious standards (Jehu, 1979; Reynolds, 1981), lack of knowledge about sex (Reynolds, 1981; Zilbergeld, 1978), and a negative reaction from a sexual partner (Reynolds, 1981).

Non-sexual stresses have a similar affect on sexual response but are more indirect in terms of causation. First, general partner discord,

hostility, and poor communication are a significant factors in the etiology of erectile dysfunction (Bancroft, 1983; Jehu, 1979; Reynolds, 1981). Anxiety concerning historical factors such as trauma associated with early coital experience, homosexual orientation or experience, and incest are noted in the etiology of this problem (Jehu, 1979; Reynolds, 1981).

Depression can be a significant factor in the etiology of erectile difficulties. First, this may cause a gradual decrease in libido. Second, the male may react to intermittent impotence with feelings of depression and thus aggravate what may have once been a minor problem (Wise, 1981; Jehu, 1979).

Cognitive monitoring and cognitive avoidance (feeling no sexual response) are also linked to erectile difficulties, often as secondary responses to occasional erectile problems (Jehu, 1979). Once a cycle of cognitive monitoring has been established, for example, the problem is perpetuated because of this response.

According to traditional psychoanalytical theory, erectile difficulties occur as a result of sexual fear and guilt which stem back to unresolved oedipal conflicts (Reynolds, 1981; Wagner, 1981; Wise, 1981). In addition, this theory suggests that fear of vaginal dentata, fear of punishment from observing parental sexual activity, fear of pregnancy, and beliefs in the evilness of sex or the threats of sexual activity are also associated with erectile difficulties. In this case, erectile dysfunction is perceived as a neurotic defense against the emergence of conflicts (Wagner, 1981; Wise, 1981; Reynolds, 1977, 1981).

Because of the variety of causal factors in erectile dysfunction, no profile of the male with this problem has been established. On a general observation, however, it has been suggested that men who have general feelings of anxiety, depression, worthlessness, self-pity, hostility, and who exude impulsive, addictive, and neurotic behavior are likely to experience this problem (Wise, 1981; Ellis, 1980; Reynolds, 1977).

Treatment

In order to distinguish between psychogenic and organic causes of erectile dysfunction and plan treatment accordingly, a thorough assessment is important prior to commencing treatment. While a variety of medical and psychological tests are noted in the literature (Reynolds, 1981; Hehu, 1979; Rosen, 183; Wagner, 1981), the most effective test for physiological causation is the Nocturnal Penile Tumescence Monitoring which tests erections during rapid eye movement (R.E.M.) sleep (Rosen, 1983; Reynolds, 1981; Wagner, 1981). The differ- entiation between organic and psychogenic causation is significant in the treatment of the dysfunction, which will correspondingly focus on physiological or phychological intervention techniques, respectively.

Masters and Johnson have led in the treatment of erectile dysfunction with a program which focused on altering the dysfunctional behavior without emphasizing underlying personality change. Specifically, this involved changing (sexual) attitudes, improving communication, and changing sexual behaviors in a couple relationship through counselling and sexual (homework) assignments (Reynolds, 1977). The sexual assignments are based on systematic desensitization techniques which incorporate relaxation, sensate focus and, sexual intercourse. A ban is initially placed on intercourse in order to reduce performance demands and anxiety relating to the erectile problems (Reynolds, 1977; Bancroft, 1983; Jehu, 1979).

Cognitive restructuring, sex education (the provision of information) and fantasy training are also incorporated into this program during counselling sessions (Rosen, 1983; Zilbergeld (1978) provides "self-help" instructions which describe the stimulation component of this program).

Kaplan developed a treatment program which resembles that used by Masters and Johnson but which focused more on the sources of anxiety. In this case, sexual assignments which incorporate sensate focus to enhance pleasure while reducing anxiety are coupled with (individual and couple) counselling to explore sources of anxiety, guilt, performance pressures, and relationship problems (Reynolds, 1977).

Ellis (1980) developed Rational Emotive Therapy which incorporates behavioral, cognitive, and emotive therapeutic methods to respond to the range of causal factors in erectile dysfunction. For example, he includes behavioral techniques such as flooding, operant conditioning, sensate focus, desensitization, assertiveness training, and homework assignments. Cognitive aspects focus on cognitive restructuring, education, imagery training, and cognitive distraction through sensate focus, for example. The emotional aspects of the problem are dealt with by exploring and resolving guilt and fear in a supportive and accepting atomosphere.

In addition to the treatment components identified above, therapists have also incorporated additional techniques such as hypnosis and biofeedback, to supplement other measures used (Wagner, 1981; Rosen, 1983; Reynolds, 1977, 1981). Psychoanalytic techniques have also been used in treatment in order to delineate and resolve the irrational belief systems of clients (Reynolds, 1977). While this has been incorporated into both Kaplan's and Masters and Johnson's programs, it is generally held that psychoanalysis alone is of limited value in treatment (Ellis, 1980; Reynolds, 1977).

A range of medical interventions have been developed in treating erectile dysfunction which is caused by organic factors. For example, surgical interventions such as implanting a prosthesis (Wagner, 1981; Rosen, 1983), reconstructing an occluded artery (Rosen, 1983; Wagner, 1981), and suturing or repairing defective (drainage) facilities have recently become more widely used in treatment. Hormonal treatment involving androgen supplementation has been successful in cases where the erectile dysfunction has been caused by a hormone (usually testoterone) deficiency (Wagner, 1981; Schiavi, 1981; Rosen, 1983).

Conclusion

In conclusion, erectile dysfunction is attributed to numerous causal factors and has been treated according to a variety of approaches emphasizing behavorial, psychoanalytical, and physiological aspects of the

problem. While a lack of comparative data on treatment outcome has been noted in the literature, it appears that the approach developed by Masters and Johnson (for couples only) has been most successful with a 70% success rate in the treatment of impotence (Reynolds, 1977; Rosen, 1983).

It has also been asserted that success may depend more on client characteristics than on the specific treatment mode. Factors such as acute onset preceded by adequate sexual functioning, high motivation, absence of relationship problems, absence of additional psychopathological symptoms, and and heterosexual orientation are noted in contributing to successful outcome (Reynolds, 1977).

It is apparent that before more conclusive statements regarding treatment selection and efficiency can be made, additional clinical research which emphasizes controlled, systematic treatment and empirical evaluation is necessary.

RETARDED EJACULATION

Introduction

Retarded ejaculation* is defined as the persistent difficulty or inability to ejaculate despite the presence of adequate sexual desire, stimulation, and erection (Jehu, 1979; Munjack and Kanno, 1979). It is represented by a range of conditions, as difficulty or inability to ejaculate in one or a combination of the following situations: nocturnal emission, self-masturbation, partner masturbation, oral-genital sex, and sexual intercourse (Wabrek, 1976). Within this range, the most common occurrence of this problem is noted in intravaginal ejaculation; as a result, many authors have defined retarded ejaculation synonymously with this situation (Morse and Morse, 1981; Kolodny, 1979; Lieh-Mak, 1981; Schull and Sprenkle, 1980). At the other end of the spectrum, the most infrequent and most serious condition exists when the male is unable to ejaculate by any means (McCarthy, 1981; Jehu, 1979).

Corresponding with this range in occurrence, retarded ejaculation may be primary or secondary in nature. In the first case, the male has never been able to ejaculate in a specific situation (for example, intravaginally) or under any circumstances (Oziel, 1978; Jehu, 1979; Munjack and Kanno, 1979). Secondary retarded ejaculation typcially occurs after a period of normal sexual (ejaculatory) functioning (Oziel, 1978; Kolodny, 1979; Jehu, 1979). In this case, the onset is sudden or acute, and may be precipitated by a traumatic event (Jehu, 1979).

Retarded ejaculation has also been defined as a dysfunction of both the climax and desire or arousal phases of the sexual response cycle. In

*Retarded ejaculation is also referred to as ejaculatory imcompetence by Masters and Johnson (in Pryde and Newell, 1976), anejaculation (Wayneberg in Munjack and Kanno, 1979), anorgasmia (Schwale in Munjack and Kanno, 1979), primary inorgasmia (Brindley and Gillan, 1982), and ejaculatory inhibition (McCarthy, 1981).

the first case, Jehu (1979) states that retarded ejaculation is a dysfunction of the orgasm phase and is the male equivalent of (female) orgastic dysfunction. Apfelbaum (1980), on the other hand, maintains that retarded ejaculation occurs when the individual lacks the motivation and the libido to have orgasms with partners (as the males are most aroused by masturbation).

In regards to this controversy, Munjack and Kanno (1979) assert that ejaculation problems do not necessarily reflect orgastic difficulties as ejaculation and orgasm may occur independently of each other. For example, in the case of retrograde ejaculation or "dry run orgasm" (Jehu, 1979), the emission phase does occur but the semen is expelled in a retrograde manner into the bladder (Munjack and Kanno, 1979; Wabrek, 1976).

It is noted that retarded or absent ejaculation may occur independently of erectile problems. For example, men with retarded or absent ejaculation are usually able to maintain full erections during lengthy periods of coitus (Kolodny, 1979).

Retarded ejaculation is relatively rare among males who seek treatment for sexual dysfunction (Jehu, 1979; Lieh-Mak, 1981). For example, it is estimated that 3%-4%, of sexually dysfunctional males present with this problem (Jehu, 1979; Connor, 1976). Despite this rarity in clinical populations, McCarthy (1977) suggests that the incidence of intermittent or situational retarded ejaculation among normal males may be as high as 15%.

Causation

The causes of retarded ejaculation may reflect both physiological and psychological factors. While it is generally held that this condition is rarely attributable to organic factors (Jehu, 1979; Oziel, 1978), this possibility should be investigated in assessing the problem. Oziel (1978) states that organic causes typically affect other areas of sexual functioning and they are therefore more apparent as etiological factors.

a) Physiological Factors

Neurological disorders which affect the lower neurological apparatus causing damage to penile tactile perception, autonomic impulse flow, or the spinal reflex centres for ejaculation, are identified in the etiology of retarded ejaculation (Oziel, 1978; also see Jehu, 1979). Most frequently neurological disorders occur as a result of spinal cord injuries, surgery, genetic defects, the use of exogenous drugs, and degenerative diseases of the spinal cord (Parkinson's disease, diabetes mellitus, and multiple sclerosis, for example) (Jehu, 1979).

Systemic illnesses such as renal failure (Jehu, 1979), genito-urinary tuberculosis (Schull and Sprenkle, 1980), prostate and/or bladder surgery (Schull and Sprenkle, 1980), and congenital anotomic lesions of the genito-urinary system (Kolodny, 1979) are also noted in the etiology of retarded ejaculation.

Drug ingestion has a significant effect on ejaculatory functioning and sexual functioning in general. Munjack and Kanno (1979) identify the major groups of drugs which are believed to affect ejaculation by depressing the entire sexual cycle (include libido) or specifically affecting ejaculation. First, a series of narcotics, sedatives, tranquillizers, and hormones are identified in this regard (Munjack and Kanno, 1979; Kolodny, 1979; Jehu, 1979). In addition, antiadrenergic, antipsychotic, antidepressant, antianxiety, and anticholinergic drugs have been linked to this problem (Jehu, 1979; Munjack and Kanno, 1979).

Inadequate (physical and psychological) stimulation is also noted as a causal factor in retarded ejaculation. In this case, it is proposed that the male's ejaculatory threshold is very high and genito-congress and thrusting are not sufficient to cause ejaculation (Schull and Sprenkle, 1980).

Additional physiological causes which are identified in the literature include gonorrhea (Jehu, 1979; Schull and Sprenkle, 1980), general illness and fatigue (Schull and Sprenkle, 1980), and aging (Comfort, 1982).

b) Psychological Factors

According to behavioral theory, retarded ejaculation is considered to be an inhibited reflex. In this case, ejaculation becomes involuntarily inhibited by its association with some traumatic factor and the (ejaculatory) response cycle is blocked just as though the man is anticipating the negative reponse or punishment to occur (Dow, 1981; Jehu, 1979). Examples of contributing factors may include being caught during masturbation or coitus or being punished for some sexual experience (Jehu, 1979).

Anxiety, in general, is identified in the etiology of retarded ejaculation with a noted correlation of 94% between coital anxiety and male (potency) disorders in males tested for sexual dysfunction (Razani, 1972). While coital anxiety is the most common factor in this regard, other anxieties or fears may relate to very strict religious upbringing which equates sex with sin (Jehu, 1979; Kolodny, 1979), fear of impregnating a partner (McCarthy, 1981), passing on undesirable congenital traits to offspring (Wabrek, 1976; Jehu, 1979), and fears of becoming physically expressive because of concerns for masculinity (McCarthy, 1981). Non-sexual stresses are also linked to sexual functioning but the specific correlation is often unclear (Schull and Sprenkle, 1980).

Relationship conflicts or difficulties may also contribute to the etiology of retarded ejaculation. For example, problems relating to a lack of intimacy in the relationship, interpersonal hostility or resentment, ongoing power struggles, routinized sex, or loss of attraction towards partner are noted in this regard (McCarthy, 1981; Munjack and Kanno, 1979; Jehu, 1979; Schull and Sprenkle, 1980). The sexual orientation of the male is also of note in this case as arousal may be low in heterosexual relationships generally (Munjack and Kanno, 1979).

From a psychoanalytic perspective, retarded ejaculation is linked to the male's fear of castration (Munjack and Kanno, 1979; Apfelbaum, 1980; Ovesey, 1971), an unwillingness to "give in", anal retentiveness, oral sadomasochism, and fears of loss of self and death because of loss of semen (Schull and Sprenkle, 1980), for example.

In terms of personality, the range of characteristics associated with the retarded ejaculation is wide. For example, characteristics such as compulsiveness, obsessive paranoia, depression, emotional immaturity, shyness, passivity, lack of introspection, and lack of confidence in sexual performance (Munjack and Kanno, 1979; Jacobs, 1981). In his study of 10 males with retarded ejaculation, Jacobs (1981) concluded that a characteristic common to all of his clients was a poorly delineated identity as a person, with a underlying fear of fragmented self in intimate relationships.

Treatment

The most frequently employed and successful treatment program is based on the behavioral model and relies heavily on (systematic and in vivo) desensitization techniques (Dow, 1981; Jehu, 1979). In this case, the inhibited ejaculatory reflect is the focus of treatment and the program is based on successive approximation to the ultimate goal of ejaculating intravaginally (Dow, 1981; Jehu, 1979).

Masters and Johnson (1970) and Kaplan (1974) prescribe a graduated treatment program which starts with the client ejaculating through manual stimulation (masturbation), followed by manual or oral stimulation by his partner in closer and closer proximity to the vagina. The client is instructed to insert his penis into the woman's vagina at the point of ejaculatory inevitability so that he may experience intravaginal ejaculation. Penile insertion at lower and lower levels of arousal is gradually attempted (Razani, 1972; Oziel, 1978).

At each stage in this process, an attempt is made to gradually extinguish competing responses or distractions (such as performance pressures) by using sensate focus to facilitate sexual arousal and reduce anxiety (Jehu, 1979; Pryde and Woods, 1980; Dow, 1981; Kolodny, 1979).

Masters and Johnson also incorporated sex education into this program to facilitate sexual (re)learning (Jehu, 1979; Munjack and Kanno, 1979). Cognitive restructuring which focuses on anxiety and depression

is also recommended in treatment if these problems are apparent (Ellis, 1962; DiGiuseppe and Wessler, 1980; Behavior Therapy, 1982).

Despite the high rate of success achieved by Masters and Johnson in treating retarded ejaculation (83.4% or 14 out of 17 clients), (Jehu, 1979; Razani, 1972; Kolodny, 1979), this approach has been criticized by Apfelbaum who regards it as the most aggressive attack on a symptom in the field of sex therapy (Apfelbaum, 1980). In contrast to this high pressure and performance demand strategy, Apfelbaum suggests that treatment should be similar to that used to treat (female) coital inorgasmia. In this case he uses a non-demand strategy which eliminates performance anxiety; as well, he asserts the traditional prescription that the man must become subjectively aroused before ejaculation. He incorporates relabelling and cognitive reappraisal to change the male's self concept, from giving complusively in sex (without desire, arousal or pleasure) to understanding and venting his feelings towards sex and his partner, for example. In this process he learns to express his own needs during sex and to increase his sexual satisfaction and pleasure with a partner.

The use of mechanical stimulation, using an electrovibrator cup placed on the glans of the penis, was also attempted for treating retarded ejaculation with a notable success rate (Munjack and Kanno, 1979; Newell, 1976; Jehu, 1979).

"Electro-ejaculation" has also been used to treat men with absent ejaculation as a result of spinal cord injuries. This rather obscure treatment mode involves electrical stimulation (with electrodes) in the rectum to obtain semen while the patient is under an anesthetic; the intent is to obtain semen to impregnate a partner. While semen was obtained from all patients treated in this manner, it was rarely of a quality which could engender impregnation (Brindley, 1981).

Psychoanalytical treatment has been employed in treatment where the client displays major pathological characteristics. In this case, the intent is to deal with the underlying conflicts which have been manifested in the problem of retarded ejaculation (Munjack and Kanno, 1979).

Various other treatment components have been incorporated into treatment for retarded ejaculation, frequently in combination with the aforementioned treatment approaches. These include deep muscle relaxation training (Razani, 1972; Cooper, 1968a; Mann, 1976), bibliotherapy (Zilbergeld, 1978; McCarthy, 1981), role modelling (re: masculinity and sexuality) by the therapist (Jehu, 1979; McCarthy, 1981), guided imagery (Pryde and Woods, 1980; Jehu, 1979), communication training and heterosexual skills training (Kolodny, 1979; McCarthy, 1981).

Conclusion

In conclusion, there is still a lack of agreement in the literature regarding both the etiology and the most effective treatment approaches for retarded ejaculation. This may be a result of both the infrequency of this problem among men who seek therapy for sexual dysfunction, as well as because of the lack of systematic, controlled treatment programs. It appears, then, that before more conclusive statements can be made regarding either the etiology or treatment of retarded ejaculation, more research in this area is needed (Jehu, 1979; Munjack and Kanno, 1979).

PART III

ASSESSMENT

The purpose of the assessment was to "identify and specify the client's problems and the contemporary conditions that influence them, to ascertain the resources available for treatment, to select and specify its goals, and to plan a suitable program" for the client (Jehu, 1979: 75).

The assessment of the sexual problem was based on information gathered during interviews, as well as from the results of questionnaires and medical reports which supplement the client's (and partner's, where applicable) verbal reports. The structure for the assessment was primarily derived from a detailed assessment outline which covers the problem description as well as contemporary conditions and previous learning experiences which may have contributed to the present situation (Appendix One) (Jehu, 1979).

The assessment of resources for treatment focused on those situational, personal, and therapeutic resources apparent in each client's case, which may either facilitate or hinder treatment. This assessment similarly followed an outline which identifies the specific factors (strengths and weaknesses) in each of these contexts, to present a realistic assessment of the resources of treatment (Appendix Two) (Jehu, 1979).

After three to four assessment interviews conducted in this manner, the therapist had gained the information required to develop a formulation of the sexual problem. This specified in behavioral terms the dysfunctional behavior, the hypotheses on the contemporary conditions that initiated and maintain the behavior, and the resources for treatment (Jehu, 1979). This problem formulation also provided the therapist with the information on which to base the selection of therapeutic goals and the treatment plan, both of which are specific to the client's problem(s). All of this information is shared with the client and his/her partner in order to improve their understanding of the problem(s)

and to gain their cooperation in implementing the treatment plan (Appendix Three).

As noted above, a combination of methods of data collection was used to develop a thorough assessment of the problem(s) and resources for treatment. These are described below.

First, the interview was the primary source of information as the client and his/her partner verbally provided information concerning the range of subjects relating to the presenting problem. This process was directed by the therapist who adhered to the assessment outlines developed for this purpose.

A second means of collecting data was a series of written questionnaires, completed by the client and his/her partner during the assessment. (These are also completed by the client and his/her partner at the completion of therapy for evaluation purposes, as outlined in the section concerning the evaluation procedure.) The questionnaires used for this purpose include:

(1) Sexual History Form (Schover et al., 1980);
(2) Index of Sexual Satisfaction (Hudson et al., 1981);
(3) Sexual Arousal Inventory (Hoon et al., 1976);
(4) Erection Difficulty Questionnaire (Price et al., 1981);
(5) Dyadic Adjustment Scale (Spanier, 1976);
(6) Marriage and Sexual Relationship Questionnaire (Jemail and LoPiccolo, 1982);
(7) Culture-Free Self-Esteem Inventory (Battle, 1981);
(8) Beck Depression Inventory (Beck, 1978); and
(9) Belief Inventory (Unpublished) (Jehu, 1983).

Sexual History Form (S.H.F.) (Appendix Four)

The Sexual History Form is a 28 item self-administered questionnaire which seeks information on the client's sexual history. This includes information on aspects of sexual desire, arousal, and satisfaction as well as the frequency of sexual activity and the range of activities engaged in.

The measure is not scored but it is used as a source of background information and to compare changes in the client's sexual behavior before and after treatment. Each item on the questionnaire allows a range of responses (from 5 to 9 possible responses) to make it fairly sensitive to change (Schover et al., 1980).

As with most paper and pencil instruments, the Sexual History Form is subject to error and/or bias due to the possibility of the client misunderstanding certain questions and/or attempting to reduce or magnify the severity of a particular problem (social desirability) (Bloom and Fischer, 1982).

Index of Sexual Satisfaction (I.S.S.) (Appendix Five)

The Index of Sexual Satisfaction is a 25 item self-report scale which measures the client's (and partner's) dissatisfaction with his/her relationship with a partner. The items are structured as both positive and negative statements regarding various aspects of the sexual relationship. These are rated by the client on a 5-point scale which ranges from "rarely or none of the time" to "most or all of the time".

Internal consistency and test-retest reliability exceed 0.90. The instrument also possesses a high validity rating in terms of discriminant, factoral, and construct validity (Hudson et al., 1981).

Sexual Arousal Inventory (S.A.I.) (Appendix Six)

The Sexual Arousal Inventory is a 28 item self-report scale which was designed (for women) to measure the process of change in the cognitive dimensions of sexual arousal during sex therapy. The instrument is sensitive to the dimensions of arousal and allows a range of six responses from (-1) "adversely affects arousal"; "unthinkable, repulsive"; or "distracting", to (5) "always causes sexual arousal"; "extremely arousing".

The S.A.I. possesses high test-retest reliability and internal consistency, both exceeding 0.90. Concurrent and construct validity are also very high, to make the S.A.I. a useful and effective measurement tool (Hoon et al., 1976).

Erection Difficulty Questionnaire (Appendix Seven)

This is a 24 item self-report questionnaire designed to assess the male's erectile capacity as well as his emotional and attitudinal responses to the same. These items, which are specifically worded in relation to all aspects of the client's erectile capacity, are rated along a .5-point continuum ranging from either "always" to "never" or "completely true" to "completely false".

While there is no psychometric data on the scale, it is found to be sensitive to changes in the client's erectile capacity. For example, a significant correlation was found between pre and post-treatment changes on this scale and client self-reports relating to both frequency of erectile difficulties and overall improvement in erectile functioning (Price et al., 1981).

Dyadic Adjustment Scale (D.A.S.) (Appendix Eight)

This scale was developed to measure the quality of marriage and similar dyads. It assesses four basic components of dyadic adjustment including dyadic satisfaction, dyadic cohesion, affectional expression, and dyadic consensus. The D.A.S. includes 32 items and is rated according to scales which range from "always agree" to "always disagree" and "extremely unhappy" to "perfect", for example.

The scale is considered to be an effective measure of dyadic adjustment according to content, criterion-related, and construct validity. This was also proven for internal consistency which was measured at 0.96 with a mixed population of married and divorced persons, and 0.91 with recently separated persons (Spanier, 1976).

Marriage and Sexual Relationship Questionnaire (Appendix Nine)

This instrument consists of two separate questionnaires (for males and females) and is divided according to marital defensiveness and sexual defensiveness. The items in each of these categories are structured in the form of statements which are answered true or false by the respondents.

The scale was designed to measure defensiveness concerning both the marital and the sexual relationships. Defensiveness, in this case, is defined as the tendency to endorse socially desirable items which are unlikely to occur and deny socially undesirable items which characterize most honest responses (Jemail and LoPiccolo, 1982).

According to norms taken from a sample of 217 couples, the scale was found to be an effective measure of defensiveness regarding the marital and sexual relationships. It rates favourably in terms of construct validity. Reliability is also high with an internal consistency of 0.90 for the marital scale and 0.80 for the sexual scale (Jemail and LoPiccolo, 1982).

Culture-Free Self-Esteem Inventory (S.E.I.) (Appendix Ten)

This scale measures an individual's perception of self-worth. It is a 40 item self-report which measures general, social, and personal components of self-esteem. It also includes 8 lie items in order to assess the reliability of the individual's response. The responses are categorized under "yes" or "no", according to each item.

The scale was designed so that it would have content validity; concurrent validity ranges from 0.72 to 0.84. Test-retest reliability is favorable (Battle, 1981).

Beck Depression Inventory (B.D.I.) (Appendix Eleven)

This 21 item self-report inventory consists of a series of ordered statements related to a particular symptom of depression. It contains statements used to measure affect, cognition, overt behavior, somatic symptoms, and interpersonal behaviors. Each item is scaled from 0 to 3, indicating the severity of the symptom in ascending order.

The B.D.I. is rated favorably in terms of split-half and test-retest reliability and discriminant validity. It is considered to be sensitive to clinical change and is therefore widely used in research and clincial practise (Beck, 1978).

Belief Inventory (Appendix Twelve)

The belief inventory is an 18 item self-report scale which is administered to (female) victims of sexual abuse to measure the nature of their attitudes towards the experience of abuse, themselves, and other people. Each item is scored according to a 5-point scale, ranging from "absolutely untrue" to "absolutely true".

While there is no psychometric data on the inventory to date, the range in each response provides a sensitive measure of changes in attitude as a result of sexual therapy focusing on victimization (Jehu, 1983).

Sexual Activity Checklist (S.A.C.) (Appendix Thirteen)

A third means of collecting data was the Sexual Activity Checklist which is completed by the client on a daily basis throughout assessment and treatment. It is intended to monitor changes in sexual activity (especially arousal and orgastic ability) throughout the therapeutic process.

The female version of the S.A.C. contains 18 items which represent a range of individual and partner-related activities engaged in each day.

The respondent rates each item according to the degree of arousal (very low to very high) and whether or not orgasm was reached.

The male version of the S.A.C. is a 9 item scale which presents a range of individual and partner-related activities engaged in each day. It is completed by the respondent according to the fullness and duration of erections achieved during each activity. The responses are rated according to a 7-point scale, measuring the fullness of erection from completely hard (1) to completely soft (7), and duration of erection from completely satisfactory (1) to completely unsatisfactory (7). Both scales are highly sensitive to changes in the client's sexual activity and, more specifically, arousal level and orgastic ability (female) and fullness and duration of erection (male).

Archival Records

A fourth source of information used for assessment purposes was the archival records, containing information on the medical and psychological history of the client. These are frequently provided by the referral source on referral to the Sexual Dysfunction Clinic. Where they are absent, they may be requested or the client may be referred for medical examination, for example, if this has not been done but is considered to be appropriate to the presenting problem and details of the case (Bloom and Fischer, 1982).

Physiological Tests

Finally, physiological tests were ordered when an organic problem was suspected. The two major physiological tests are the penile plethysmography which measures erectile responses in males, and the vaginal plethysmography which measures (female) vasocongestion during sexual arousal. In the first case, the male is referred to a urologist who administers the test to the client in order to determine whether the erectile dysfunction relates to organic or psychogenic (or mixed) origin. In this test, the penile volume and circumference are measured during rapid eye movement (R.E.M.) sleep. Test results are subsequently

forwarded to the therapist for use in the assessment of the problem (Jehu, 1979).

The vaginal plethysmograph may be administered in a medical setting or by the woman herself and involves inserting a vaginal probe which measures the amount of light reflected on the walls of the vagina. This varies with the degree of vasocongestion during sexual arousal (Jehu, 1979).

TREATMENT OVERVIEW

Introduction

A range of behavioral interventions are implemented in the treatment of sexual dysfunction, as indicated in Table Two. These interventions are directed towards various elements of the sexual problem(s). For example, ignorance or misinformation, negative or ambivalent attitudes and beliefs, stress reactions to certain activities, and interpersonal or relationship conflicts are among the conditions which may contribute to the development or maintenance of a sexual problem.

In the following section, the interventions used in the treatment of clients represented in the Case Studies (following) will be described. Where a specific interventive technique was not considered to be relevant to treatment in any of the Case Studies, and was subsequently not implemented as part of treatment, it will not be described in this practicum report. Rather, the reader may refer to Jehu (1979) for elaboration on this component, as well as for additional references to further investigate the subject.

TABLE TWO

Types of Intervention for Sexual Dysfunctions

A. General Therapeutic Conditions

Therapeutic relationship
Causal explanation
Prognostic expectancy

B. Sexual Assignments

General pleasuring
Genital stimulation
Sexual intercourse

C. Specific Procedures

1. Provision of information

Verbal
Bibliographical
Audio-visual

2. Modification of attitudes and beliefs

Sanctioning
Self-disclosure
Role playing
Cognitive restructuring

Table Two (cont'd)

3. Reduction of stress

Relaxation training
Desensitization
Flooding
Guided imagery
Thought stopping
Modelling
Vaginal dilation

4. Sexual enhancement

Classical conditioning
Biofeedback
Hypnosis
Exposure to erotic material
Pelvic muscle exercises
Drugs/hormones
Prosthetic/mechanical aids

5. Relationship enhancement

Increasing positive exchanges
Communication training
Problem solving training
Assertiveness training
Heterosocial skills training

A. General Therapeutic Conditions

1. Therapeutic Relationship

A warm, empathetic, and sincere relationship between the therapist and the client is important in facilitating the treatment program. In this case, the development of the client's sense of trust in the therapist influences the openness, communication, receptiveness, and, ultimately, the positive change in the client (Jehu, 1979; Klassen, 1983; Jacobson & Margolin, 1979).

2. Causal Explanation

It is important that the client is provided with an acceptable and plausible explanation for a previously inexplicable problem. This is most beneficial in contributing to the client's sense of reassurance when the problem is described as a common and normal occurrence rather than strange or pathological, as temporary rather than permanent, and as a function of external rather than internal causes (Jehu, 1979).

3. Prognostic Expectancy

This involves the client's expectations for therapeutic outcome. It is held that a strong correlation exists between the client's expectations that she/he will receive effective help and subsequent symptom reduction in therapy (Jehu, 1979). It is noted that factors which produce a positive prognostic expectancy include the client's overall expectation of help, the relief of fear and uncertainty as precipitating factors are identified, and his/her confidence in the therapist and the treatment program (Klassen, 1983).

B. Sexual Assignments

Sexual assignments are an important component in sex therapy as a means to reduce stress reactions to sexual behavior, to promote effective sexual stimulation and responses, and to reveal impediments to adequate sexual functioning (Jehu, 1979).

In introducing sexual assignments into therapy, it is important that the therapist describe the procedure(s) and the rationale for their emphasis on therapy. A process of negotiation regarding the specific nature of the exercises will facilitate the development of exercises which are most suitable and acceptable to the client(s). In addition, the therapist should inform the client of the inevitable awkwardness which will accompany the acquisition of a new skill, the likelihood of setbacks or obstacles to improvement as the client proceeds with the exercises, and the need for close monitoring of the client(s) so that as obstacles do arise, the program may be modified appropriately (Jehu, 1979).

1. General Pleasuring

General pleasuring, or "sensate focus" (Masters and Johnson, 1970), is used in the treatment of a large proportion of clients. This may be introduced alone, or in combination with a ban on intercourse (or other stressful activities) during the duration of the exercises, in order to reduce stress and performance pressures (Jehu, 1979).

In general pleasuring, the couple takes turns exploring the sensual pleasures of touching and caressing each other's bodies so that they discover where and how they like to be touched. Initially, breasts and genitals are excluded; these may be incorporated into the exercises after 3-4 sessions, or when the client(s) feel comfortable with this. It is noted that genital pleasuring should be done in a teasing and tender manner rather than in a vigorous, rhythmic, and demanding one which is intended to bring the partner to orgasm (Jehu, 1979).

In proceeding with the exercises, it is important that one partner be nominated to lead each session; the couple should be assigned roles of "giver" and "receiver". As the "giver" discovers and implements various ways of touching and caressing which are pleasurable to the "receiver", the "receiver" needs only to concentrate on the tactile stimulation she/he is receiving. Arousal is not the object of the exercises, but may occur as a result of the pleasurable sensations experienced.

The couple is informed of the need for privacy in doing these exercises and of the importance of positive feelings towards each other (as opposed to anger, tension or fatigue, for example) in facilitating the exercises.

2. Genital Pleasuring

Genital pleasuring, or stimulation by self or partner, is used in programs which are directed towards inorgasmia (Heiman et al., 1976), premature ejaculation, retarded or absent ejaculation, and erectile dysfunction (Zilbergeld, 1978). In introducing genital pleasuring, the client's attitudes towards masturbation should initially be discussed. As well, the therapeutic rationale for including masturbation in treatment and accurate information about masturbating should be presented to the client.

Variations of genital pleasuring include (first) the 9-step series of masturbation assignments for totally inorgastic women (developed by LoPiccolo et al., 1976; also described in Jehu, 1979). Second, in the treatment of premature ejaculation, the stop-start technique (Kaplan, 1974, 1975) and squeeze technique (Masters and Johnson, 1970) are the focus of sexual assignments. Third, the treatment of erectile dysfunction also involves the stop-start and squeeze techniques (Kaplan, 1974, 1975; Masters and Johnson, 1970; also described in Jehu, 1979). Finally, in the treatment of retarded or absent ejaculation, Kaplan (1975) has used genital pleasuring in a program which involves successive approximation to the ultimate goal of intravaginal ejaculation (Jehu, 1979).

3. Penile-Vaginal Intercourse

Several forms of penile-vaginal intercourse are used in sexual assignments in the treatment of impaired arousal, inorgasmia, erectile dysfunction, retarded or absent ejaculation and premature ejaculation. Specific variations of penile-vaginal intercourse for each of these problems are described below. However, the exercises involving the

extension of the stop-start and squeeze techniques into penile-vaginal intercourse (for treating premature ejaculation) are not described as this problem was not represented in the case studies in this practicum (The reader may refer to Zilbergeld (1978) or Jehu (1979) for a description of this procedure).

(a) In undertaking non-demand coitus (for impaired arousal), the couple initially becomes aroused by general and genital pleasuring. The woman then adopts a female superior position and inserts her partner's penis into her vagina, starting with no movement, to minimal movement (by the woman), eventually to regular intercourse as the couple proceeds through each successive stage of the exercises (Jehu, 1979).

(b) Non-demand coitus is also used in the treatment of erectile dysfunction. In this case, the client initially obtains erections by general and genital pleasuring and inserts his erect penis into the woman's vagina where it is contained with limited movement of a non-demand kind. The penis is subsequently withdrawn and the process is repeated several times during the session. The "stuffing technique" is also used in the treatment of erectile difficulties. This involves stuffing the flacid penis into the woman's vagina (by either partner) with no or limited movement so that only sensations and feelings are enjoyed (Jehu, 1979).

(c) The bridge manoeuver is used in the treatment of orgastic dysfunction when the woman is orgasmic by direct clitoral stimulation but not by penile movement alone. Initially, the client and/or her parter stimulates her clitoris until she is near climax. At this point, direct clitoral stimulation is stopped and intercourse is started so that vigorous penile thrusting triggers the orgasm. This process may have to be repeated several times as the woman's level of arousal may drop as direct stimulation stops (Jehu, 1979).

(d) The (male) bridge manoeuver technique is used in the treatment of retarded or absent ejaculation. In this case, penile stimulation by either the client or his partner precedes vaginal penetration at the

point of ejaculatory inevitability so that the male is able to ejaculate intravaginally. As with the previous example, this process may be repeated if the erection is lost when direct stimulation stops (Jehu, 1979).

The combination of general pleasuring, genital pleasuring, and penile-vaginal intercourse is used in succession in several of the therapeutic programs described in the case studies in this practicum report. First, the program outlined in Becoming Orgasmic (Heiman et al., 1976) involves a variation of these procedures in treating women who are inorgasmic. Second, Male Sexuality (Zilbergeld, 1978) outlines graduated exercises which focus on these techniques to treat erectile problems, premature ejaculation, and retarded or absent ejaculation. In addition to these directed programs, a combination of these techniques may be used for desensitization purposes in cases where stress reactions to sexual activity is apparent (Jehu, 1979).

C. Specific Procedures

1. Provision of Information

Information regarding human sexuality, sexual response, dysfunctional behavior, and therapeutic techniques is provided to the client verbally, through bibliographical sources, and with audio-visual aids. In the case studies in this practicum report the bibliographical material supplied to the client included Becoming Orgasmic (Heiman, et al., 1976), Male Sexuality (Zilbergeld, 1978), Feeling Good (Burns, 1980), and Marital Therapy (Jacobson and Margolin, 1979). Audio-visual aids aimed at demonstrating sexual responses and techniques included "Program on the Diagnosis and Treatment of Erectile Problems" (LoPiccolo et al., 1980), and "Becoming Orgasmic" (Heiman et al., 1976).

2. Modification of Attitudes and Beliefs

"The mechanism of attitude change involved (in all these procedures) is often said to be the reduction of inconsistency between one attitude and another or between attitudes and overt behavior, and the task of the therapist is to provoke such inconsistency so that the client changes his attitude and/or his overt behavior in order to achieve greater consistency" (Jehu, 1979: 133).

(a) Sanctioning

The purpose of sanctioning is the provision, by the therapist, of permission and reassurance regarding sexuality as being something enjoyable and important rather than dirty, obscene, or perverted, for example. As well, this may serve to modify unrealistic or performance oriented attitudes towards sexuality and to reduce guilt and inhibitions regarding certain forms of sexual behavior (according to the wishes of the client) (Jehu, 1979).

(b) Self-Disclosure

At certain points in therapy, the therapist may disclose his/her own (sexual) attitudes and practices. This is typically done when such disclosure is considered to be appropriate and helpful in sanctioning a particular activity or desire, for example, and in changing the attitudes of the client(s); an atmosphere of mutual liking, respect, and trust is important to the effectiveness of this procedure (Klassen, 1983).

(c) Role Playing

In role playing, the client assumes the role of another person and presents the attitudes of that person (for example, of someone who finds sex pleasurable and normal). In this manner, she/he increases her/his understanding of an alternative viewpoint and may persuade her/himself of its validity.

(d) Cognitive Restructuring

Cognitive restructuring is based on the premise that a person's assumptions, expectations, or beliefs about a situation have a significant influence on her/his emotional or behavioral responses to the situation. If the thoughts about a situation are irrational or illogical, then they are likely to be conducive to feelings and actions that are inappropriate responses to the situation (although perhaps appropriate to the person's subjective interpretation or labelling of the situation) (Jehu, 1979).

Cognitive restructuring follows a process similar to that outlined below.

1. The therapist presents the rationale for the method to the client (generally, rather than specific to the client's problems).

2. The therapist and the client(s) review some commonly held irrational assumptions (of relevance to the client) to help the client recognize their untenability and to encourage him/her to present his/her own arguments against them.

3. The therapist focuses therapy sessions on client's own problem(s). These are reviewed with him/her in terms of the circumstances in which they occur, the rationality (or otherwise) of the thoughts, and the underlying beliefs which evoke them.

4. The client is taught to change his/her reaction to those situations which cause the disturbed thoughts and feelings by stopping to consider what she/he thinks about the situation that makes it disturbing for him/her, and trying to replace irrational thoughts with other more accurate and realistic thoughts regarding the same (Jehu, 1979; Burns, 1980).

3. Reduction of Stress

Specific interventions used to reduce stress are implemented in cases where attempts to do sexual assignments or activities are prevented or impaired by high levels of tension and anxiety. These are reviewed below.

(a) Relaxation Training

Relaxation training is based on the notion that muscular tension is related to anxiety and if an individual can learn to relax his/her muscles, then his/her anxiety is also alleviated and replaced by a calm feeling. Training involves systematically tensing and relaxing various

muscle groups and learning to discriminate the sensations associated with these states. The ultimate goal, then, becomes the reduction of muscular tension to enable the client to feel deeply relaxed (Jehu, 1979).

(b) Desensitization

Desensitization involves a process in which the client identifies events which evoke anxiety in a hierarchical manner from the least to the most disturbing. Following this, the objective becomes selecting a response which is an alternative to anxiety and training the client to perform it satisfactorily (for example, sexual arousal as an alternative to anxiety). In desensitization the therapist induces a state of relaxation in the patient. She/he then presents the (least) disturbing event to the client and when anxiety no longer exists, proceeds to the next disturbing event in the hierarchy until the range of events is completed in this manner.

Two variations of this technique which were used in therapy were systematic and in vivo desensitization. In the first case, the client imagines the hierarchy items and uses muscular relaxation as an alternative response to anxiety. In the latter case, the client proceeds through the hierarchy of events in real life rather than imagination (Jehu, 1979). In the case studies, anxiety was typically replaced by sexual arousal, in programs which progressed from general and genital pleasuring to non-demand coitus.

(c) Guided Imagery

Guided imagery is used in conjunction with cognitive restructuring and desensitization in therapy sessions. In these cases the client uses his/her imagination in combination with certain coping skills to reduce adverse emotional reactions, for example; negative or stress responses are replaced by more appropriate and rational responses (arousal or relaxation, for example) to the imagined situations using this technique.

(d) Modelling

Modelling involves the active demonstration by the therapist or audio-visual aids, for example, of alternative forms of behavior, new skills, or sexual techniques. The client's own situation provides the context for the demonstration so that learning is as direct as possible. Behavioral rehearsal may be attempted to actively involve the clients in the learning process (Klassen, 1983). In other cases where, for example, sexual skills are imparted through audio-visual aids, the clients are instructed to practice in the privacy of their own home(s).

(e) Vaginal Dilation

Vaginal dilation is a technique used for treating women with vaginismus. Vaginal dilators, in graded sizes, are used by the client and her partner so that the client is gradually able to tolerate vaginal penetration without muscular reaction. In the case study described in this practicum report, the client's fingers were inserted instead of artificial dilators. In this case, she started with her finger tip and proceeded with one finger, two fingers, and her partner's fingers, as she felt ready for each successive step.

4. Sexual Enhancement

(a) Exposure to Erotic Material

Looking at erotic pictures and reading erotic literature is incorporated into therapy as a means of evoking feelings of sexual arousal in the client, and to help him/her to get in the mood for sexual activity. This may also be helpful in reducing boredom if the relationship has become routinized, rigid, or narrow in terms of the range of sexual activities engaged in by the couple (Jehu, 1979; Zilbergeld, 1978; Heiman et al., 1976).

(b) Pelvic Muscle Exercises

Exercises are frequently assigned to the client as a means of improving pelvic muscular tone and thereby increasing vaginal sensations. This is based on the observed association between poor tone in the pubo-coccygeus and other pelvic muscles and a lack of sexual sensation in this area together with a limited capacity for arousal and orgasm (Kegel, 1952; Jehu, 1979). In theory, blood flow to the pelvic area is increased with improved muscular tone; this in turn has been related to an increase in feelings of genital pleasure (Descriptions of these exercises are available in Heiman et al., 1976; Jehu, 1979).

(c) Prosthetic/Mechanical Aids

Electro-vibrators are the most commonly used sexual aids and are frequently used to facilitate arousal and orgasm in clients, in whom these responses are impaired. Their use has been found to be useful in the treatment of sexual dysfunctions, where the client(s) is able to use it without revulsion or guilt (Jehu, 1979; Heiman et al., 1976).

5. Relationship Enhancement

Relationship enhancement becomes an important component of therapy in cases where sexual functioning is adversely affected by partner discord, maladaptive views of male-female roles, deficits in expressive and cooperative skills, and inability to communicate and/or to express desires to the partner (Klassen, 1983). The intent is to alleviate these conditions so that the couple can work cooperatively on their sexual assignments and generalize new skills to their daily interaction. It is noted that the individual techniques described below are largely based on the behavior exchange model outlined in Marital Therapy (Jacobson and Margolin, 1979).

(a) Increasing Positive Exchange

The couple is instructed to identify and accelerate those behaviors that would enhance their relationship and, conversely, to decrease the

undesirable behaviors which are detrimental to the same. It is proposed that relationship satisfaction will increase as significant relationship behaviors are increased (Jacobson and Margolin, 1979). While some couples have found this method to be successful in solving certain relationship problems, other strategies have been required to resolve more difficult problems.

(b) Communication training

Communication training is a systematic program of skill training involving instruction, feedback, and behavioral rehearsal (by the client) of the skills imparted by the therapist. In this case, the focus is on empathy and listening skills, validation, feeling talk, negative feeling expression, positive expressions, assertiveness, and problem solving (Jacobson and Margolin, 1979).

(c) Problem Solving

Using principles of reinforcement, the couple is taught behavioral management skills in order to become more proficient in bringing about desirable behavior changes in the relationship through direct negotiation (Jacobson and Margolin, 1979). The procedure used in therapy followed the problem solving manual in Marital Therapy (Jacobson and Margolin, 1979). This manual discusses the appropriate setting, the proper attitude for problem solving, the basic structure of the problem solving sessions, and the conditions under which they occur. This process is broken down into a definition phase and a solution phase, indicative of the nature of the exercises.

(d) Assertiveness Training

Assertiveness training is typically undertaken on an individual (or group) basis, in cases where the individual (or couple) have a difficult time standing up for their rights and need to be taught more effective ways of achieving the same. This process involves discussion of the individual's rights, modelling, role playing and behavioral rehearsal,

for example, in learning to apply and generalize this knowledge to daily interaction (Jacobson and Margolin, 1979; Klassen, 1983).

(e) Heterosocial Skills Training

Heterosocial skills training is undertaken as a means to develop social skills where the sexual problems may be secondary to the avoidance of heterosexual social situations, maladaptive views of male-female roles, and deficits in expression and cooperative skills (Jehu, 1979; Klassen, 1983). This may be undertaken prior to or concurrently with sex therapy, if obstacles to successful completion of therapeutic tasks are attributed to these factors.

EVALUATION

Introduction

The evaluation technique used to assess the effectiveness of the therapeutic intervention(s) was based on a within-subject design (Bloom and Fischer, 1982). It was intended to systematically monitor and evaluate the progress and outcome of treatment on a continuous basis throughout the assessment, intervention, and follow-up stages of therapy (Jehu, 1982).

Baseline data was collected prior to any intervention in order to predict how the functioning level would have continued without treatment. The length of the baseline covered 3 to 4 measurement points in order to establish the level, stability, and trend of the client's pre-intervention functioning.

A multi-modal evaluation program was selected for purposes of measuring change in the client's level of functioning before and after treatment (Bloom and Fischer, 1982). On this basis, the information for evaluation was provided by the client and his/her partner (where applicable) through verbal reports, paper-and-pencil instruments (questionnaires), and sexual activity checklists. The questionnaires were administered to the client and his/her partner once during the assessment and once at termination to provide an overall measure of change in functioning as a result of the therapeutic intervention. (These questionnaires are described in the previous section on the assessment procedure; samples of the questionnaires are provided in Appendices Four to Thirteen.

The Sexual Activity Checklists were completed by clients on a daily basis and served as the primary source of data for constructing the baseline (A) and for measuring ongoing change in the client's functioning throughout the intervention phase (B) of therapy.

Evaluating the Outcome of Therapy

1. Presentation of Outcome Data

The outcome data was recorded and presented in the form of a line graph, with the time intervals (from baseline to follow-up) indexed on the horizontal axis and the outcome data indexed on the vertical axis. The commencement of the intervention (B) phase is noted on the graph with a vertical line.

Additional information (the results of the questionnaires administered during assessment and at termination) was recorded in tables. This was used for comparative purposes to measure the changes in sexual behavior as well as the secondary benefits of therapy (for example, dyadic adjustment, self-esteem, and depression).

2. Interpretation of Outcome Data

The outcome data, as presented on the line graph, was interpreted by visual inspection or "eye-balling" (Bloom and Fischer, 1982). This was useful throughout therapy to monitor the effectiveness of the selected interventions by observing changes in sexual functioning, and at termination to indicate the overall effectiveness of the intervention in treating the sexual problem.

3. Criteria for Evaluating Outcome

The outcome of the intervention was evaluated by the client, his/her partner (where applicable), and the therapist in terms of clinically significant behavior change. Two methods used to determine clinical significance in each case were subjective evaluation and social comparison.

The subjective evaluation method was determined by the client and his/her partner in terms of their own sexual satisfaction after therapy, relating to the reduction or elimination of the sexually dysfunctional

behavior. The social comparison method of evaluation was determined primarily by the therapist on the basis of the client's level of sexual functioning following the therapeutic intervention. In this case, the outcome of therapy was compared to the norms within each population group (Frank et al., 1978; Jehu, 1979).

As well, many of the paper and pencil instruments used during therapy were accompanied with tables of summary scores which include cut-off points, for example, for normal and dysfunctional behavior and attitudes. The comparison of the client's responses with these measures provided further evidence of clinically significant change to reinforce the subjective evaluation by the client and his/her partner (Kazdin, 1980).

Summary

The evaluation technique used in the case studies contained within this practicum report was useful in providing feedback to the client on his/her progress, revealing the need for revising the treatment plan (where applicable), and demonstrating the effectiveness of the treatment program.

It is noted that in cases where the evaluation was not completed in the manner outlined above, the clients had dropped out of therapy prior to completion of treatment. In these cases a complete evaluation was not considered to be necessary or appropriate. The record of the client's progress at that time was usually sufficient to indicate the effectiveness of the therapeutic intervention.

PART IV

CASE 1

Andy: erectile dysfunction
premature ejaculation

ASSESSMENT REPORT

Andy was referred to the Sexual Dysfunction Clinic by his doctor at the Health Sciences Centre (Department of Rehabilitation Medicine). His presenting problems were intermittent secondary impotence and premature ejaculation. Andy was a polio victim (1953) which rendered him paralyzed in his upper extremities; he has limited respiratory function, no voluntary movement or reflexes in the upper portion of his body (including his arms), and minimal leg weakness. The strength and sensory modalities in the lower portion of his body are near normal.

Description of problem(s)

Andy usually has only partial erections (occasionally has full erections) which are lost prior to intromission during lovemaking with his partner. Corresponding with the loss of erections, Andy experiences premature ejaculation; he describes an abnormally small, and weak "trickle" of ejaculate at these times.

Andy's problem has occurred intermittently and varies according to several situational antecedents. In general, he has been experiencing the problem since becoming sexually involved with his current partner, Cheryl after a long period (13-14 years) of sexual inactivity.

Contemporary influences on problem(s)

Situational antecedents

Andy notes several stresses relating to his current partner and their sexual relationship. First, he is concerned that he will not be sexually attractive and will not be able to sexually satisfy his partner

because of his disability. This relationship is the first he has really cared about and therefore he is more anxious about her feelings and reactions towards him and especially towards his disability and physical limitations. Second, Andy and Cheryl have only recently become emotionally and sexually involved and are still not completely sure about the other's feelings and commitment. Third, Andy sees his disability as directly related to his sexual problems. The paralysis in the upper part of his body restricts his movement and makes sexual contact awkward. Because of his respiratory problems, Andy tires easily and lacks the energy for any activity, including sex. Thus when his energy level is higher, Andy's sexual problems are likely to be less prominent.

While the problem has been quite consistent since onset, Andy feels that it is becoming less serious as his relationship with Cheryl becomes more secure and he and Cheryl have begun to discuss it. He subsequently feels less pressure to perform sexually as this uncertainty is clarified.

Organismic variables

Andy was initially unsure about the extent of his physical disability and the possibility of an organic cause for his sexual problems. His lack of (accurate) information was of foremost concern in seeking therapy.

Andy experiences significant anxiety over his physical disability and his ability to be an attractive and satisfying lover. Since onset of the problem, he is also anxious about whether or not the problem will continue to occur. For example, when he does have a full erection during lovemaking, he immediately worries about whether it will last for intercourse. As a result of this problem, Andy's feelings of inadequency as a companion and sexual partner are intensified.

As note above, Andy suffered from polio in 1953 when he was in his late teens. He was completely paralyzed in the upper portion of his body and originally spent 1 1/2 years in an iron long, followed by a year of nights in the iron lung.

At the present time, Andy must spent 12-16 hours per day on a rocking bed (which facilities breathing). His physical examination prior to referral indicated that he has some strength in his upper extremities. He has nearly full strength in his neck muscles but is unable to move his shoulders; he has normal sensations in his arms despite their lack of voluntary movement.

Andy's lower extremity strength and sensory modalities are near normal. There is no evidence (from the medical examination) of diabetes or bowel or bladder dysfunction; his genitalia, rectal function and prostate are normal. Andy experiences some difficulty in movement (and balance) and tires easily after minimal exertion. He is not taking any medication at the present.

Situational consequences

Andy's partner, Cheryl, has been very understanding and patient in response to Andy's sexual problems. The couple has discussed the problem and is satisfied to let their sexual relationship develop slowly. They have subsequently not attempted (nor do they anticipate) intercourse when they are together; rather, their sexual contact is limited to less "stressful" activity (touching, pleasuring, etc.).

Personal and family backgrounds

Both partners

Andy is 49 years old; Cheryl is 27. Andy has never been married and he has spent most of his (adult) life in a hospital where he has received special care since stricken with polio. Cheryl has been separated (from her husband of seven years) for one year; she has two children aged 7 and 10. During Cheryl's marriage she had separated and reconciled with her husband several times; she considers the present separation to be permanent.

Both Cheryl and Andy have high school educations. Cheryl was previously employed (in a non-professional capacity) at the hospital

where Andy lives; that is where the couple met. Andy has spent a lot of his time investing money in various business ventures and he considers himself to be financially secure. He feels that he needs approximately two more years of this activity before he would feel satisfied that he could be financially independent enough to marry, leave the hospital, and/or support another person.

Andy is of Anglo-Saxon descent; neither he nor Cheryl hold strong religious beliefs. Neither Cheryl nor Andy have alot of friends (Cheryl is very shy and Andy has spent most of his life in institutions). They spend their leisure time (together) at Cheryl's house where Andy usually spends weekends and at least one evening per week. They had considered the possibility of Andy moving a (portable) rocking bed to Cheryl's so he could stay overnight or for an entire weekend but decided that this would be too difficult for the children to accept. Andy still needs the rocking bed in order to stay longer as he needs to rest on the bed if he tires, as his breathing becomes very difficult.

Andy grew up in Eriksdale, Manitoba (on a farm). His mother died in 1975; his father is 80 and still lives in Eriksdale. He has 3 older sisters and one younger brother; they have all been very supportive towards Andy since he became ill but they do not maintain very close contact.

Children

Cheryl's children are very close to her and have grown fond of Andy. They accept his presence and are open and inquisitive about his relationship with Cheryl, his physical disability, and his limitations. Andy is unsure of himself around the children and feels very inadequate because he cannot do any physical or strenuous activities with them.

Childhood and puberty

Andy had practically no knowledge or experience with sex before he became ill with polio. He had several casual girlfriends as a teenager but was not sexually involved with any of them. He masturbated regularly

since his early teens. Andy did have a girlfriend when he got polio; she continued to see him (hospital visits) for several months after he was hospitalized but the situation was too difficult for her to continue (or for him to expect the same).

Sexual experience before current partnership

As noted above, Andy began masturbating in his early teens and dated several girls throughout high school (with very limited sexual contact). Since he became ill and paralyzed he has not masturbated (paralysis in his arms and lack of interest in exploring alternatives).

Andy was involved with several (6-7) women prior to meeting Cheryl. He met most of these women in the hospital (none were patients) and usually saw them socially in their homes. He was sexually involved with all of these women but only had intercourse with three of them. He had no sexual problems during those times. However, Andy felt that he was inadequate as a sexual partner and that he was unable to satisfy his partners sexually. In all of these cases, he stopped seeing the women before any emotional attachment developed between them and himself.

Current partnership

Andy and Cheryl first met each other approximately 3 - 4 years ago; their relationship only developed beyond friendship in the last 6 months (and sexually in the last 3 - 4 months).

They usually see each other several times a week; Cheryl often visits Andy in the hospital. Approximately twice or three times a week, Andy visits Cheryl at her home and spends the evening with her family (children). He then stays late into the night but must return to the hospital as he tires and needs his rocking bed in order to resume breathing normally. As a result, their time together is always limited and complicated by other stresses (children, staff and other patients in the hospital, etc.).

Cheryl recently stopped taking birth control pills and the couple uses no contraceptive devices; both are concerned about this as neither wishes a pregnancy. The general relationship between Andy and Cheryl is very good, open, and mature. They realize the problems involved in Andy's disability and his anxiety over sex, as well as other factors such as Andy's insecurity over being able to contribute to a relationship, and Cheryl's children and their reactions to Andy (and vice versa), for example. They have decided to let the relationship develop slowly without pressures such as commitment, sexual involvement, expectations, and demands on each other. They communicate openly and quite honestly and have been able to resolve any problems which they have, as a couple, encountered.

Self concept

Andy is very insecure about his physical disability and his attractiveness as a person and as a sexual partner, specifically. Because of this, he has felt that he must compensate for the disability by working to become financially independent. In this way, he feels he could contribute to a relationship.

ASSESSMENT OF RESOURCES FOR TREATMENT

Situational resources

Cheryl and Andy appear to have a good relationship but they need more time to become closer and more secure with each other. Cheryl has no apparent sexual dysfunctions; she is concerned with Andy's problem and she is very willing to help him. This is important as Andy's disability makes it difficult for him to attempt many of the sexual assignments which may be recommended as part of treatment.

A major constraint to therapy is the couple's limited time together and lack of privacy even during these times (either at the hospital or in Cheryl's home). A second contraint involves Andy's breathing problem and tendency to tire easily. Thus, if he has had a strenuous day or week he may be too tired to attempt any sexual activity and, if he does, he may

encounter problems and be more insecure about sex the next time they are together.

Professional resources

The therapist is available for weekly 60 - 90 minute therapeutic sessions, as requested by the patient. The therapist has a good understanding of the details of this situation (re: sexual problem and physical disability) and has a good, open relationship with the clients.

PROBLEM FORMULATION

Dysfunctional behavior

Andy is (usually) unable to have full erections during sexual contact with his partner and when he does, he is unable to retain them in order to have sexual intercourse. Correspondingly he ejaculates prematurely, prior to attempting vaginal penetration.

Hypotheses

Andy suffers extreme anxiety and insecurity in terms of his (sexual) attractiveness and performance because of his physical disability. He is in a situation where he is not completely secure with his partner but he does care for her and wants to be an attractive, desirable, and satisfying sexual partner. He is therefore very anxious about her perceptions of his physical condition and his ability to meet her needs and expectations.

Andy is facing other stresses in this relationship; these will require time, some compromise, and adjustment. He must remain sensitive to his physical condition and needs for rest (usually in his rocking bed) and special care in order to function normally; he is often too tired to respond sexually.

Andy is unsure of Cheryl's commitment; that is, whether she will wish to (or be able to) accept and learn to live with his disability. He

wishes to "postpone" making any commitments until he is more financially secure in order to contribute more fully to the relationship.

Andy and Cheryl spend limited time together and when they do, he is always worried that either the children or hospital staff (depending on the location) will interrupt them.

Thus, Andy has several sources of stress that cause him anxiety during sex and directly affect his ability to respond sexually.

Selection of therapeutic goals

1. To have full erections which are maintained for sexual intercourse with partner.
   This goal is broad and encompasses the resolution of Andy's sexual problems: his inability to have (or maintain) a full erection for sexual intercourse.

2. To delay ejaculation (and climax) so that intercourse is of satisfactory duration to the couple.
   Andy ejaculates prior to intromission and usually does so without having a satisfactory orgasm.

3. To reduce the anxiety associated with sexual contact.
   This is a more secondary goal which involves understanding his sexual response and his physical disability, his relationship with Cheryl, and other practical arrangements which may cause anxiety.

Planning treatment

Therapist

One (female) therapist has been assigned to this case; she has a good (therapeutic) relationship with the patient and his partner. She is familiar with the physical disability and the other variables involved in this situation.

Therapy was initially intended to proceed on a weekly basis (one 60-90 minute visit per week) but the client and his partner have requested that they be able to contact therapist if and when they consider additional information or advice/assistance necessary.

Treatment program

1. Provision of information will initially be the focus of treatment in order to answer the client's questions regarding sexuality with a physical disability. Emphasis will be on the client's own disability.

2. Cognitive restructuring concentrating on the client's anxiety regarding sex, in relation to his self-esteem and body image.

3. The client will follow the program for treating erectile problems, as outlined in Male Sexuality (Zilbergeld, 1978). Audio-visual material (film series on diagnosing and treating erectile problems (Schover et al., 1980) will be used to supplement the bibliographical material.

4. Communication training will be provided to the couple in order to facilitate better communication between the client and his partner, particularly in regards to his sexual disability, expectations, and his performance anxieties.

TREATMENT SUMMARY

Therapy commenced with a focus on the provision of accurate information regarding sexuality, in particular in regards to the client's physical disability. This proved to be very useful for the client who was unsure as to the effect which his disability had on his sexual response. As he became increasingly aware of the effects of anxiety on his sexual response, the client decided that he would terminate therapy (after 5 sessions) until he and his partner were more comfortable with each other and secure in the relationship. Since neither he nor his

partner wanted to rush into a sexual relationship, they decided that they would give themselves more time to allow the relationship to develop slowly and thereby reduce Andy's stresses related to sexual performance. It was agreed that the couple would return to therapy if Andy's sexual problem persisted after they had achieved these relationship goals.

The client contacted the Sexual Dysfunction Clinic six months after terminating therapy. He felt that his relationship with Cheryl had strengthened and Andy felt much more secure with her. His sexual problem had decreased as their relationship had improved but a series of events (prior to reestablishing contact with the therapist) had resulted in a setback, with which neither knew how to deal.

At that time, it became apparent that the client had been putting high performance pressures on himself as he felt that his partner expected him to be a very good lover (as measured by frequency of sexual intercourse). When he was overtired as a result of family gatherings and a disrupted schedule, he experienced sexual problems. He subsequently overreacted to this situation and became so anxious about sex that he could no longer have full erections.

Therapy was initially concerned with the provision of information and reassurance in order to reduce the client's anxiety level. He and his partner were provided with communication training to enable them to discuss Andy's expectations and his concerns about Cheryl's expectations.

The couple proceeded with the exercises (sexual assignments) from Zilbergeld (1978) for treating erectile dysfunction. Because Andy has no movement in his hands, he was unable to proceed with the portions of the exercises involving self-stimulation and he needed Cheryl to participate in all stages of the exercises. She was agreeable and the couple slowly proceeded through these (from partner manual and oral stimulation, to non-demand coitus, to resume normal sexual activity).

OUTCOME

The exercises were very successful in resolving the client's erectile dysfunction; his problems involving premature ejaculation were resolved as was the erectile dysfunction and no direct treatment was required for this problem. The couple had become much closer and more open as a result of their need to communicate openly about the sexual problem as well as their (mutual) expectations and needs. They were also better able to understand Andy's physical limitations and, thereby, they became more patient with regards to Andy's vulnerability to erectile difficulties as a result of his physical disability. All of the therapeutic goals were accordingly achieved after an additional 8 therapeutic sessions (for a total of 14 sessions).

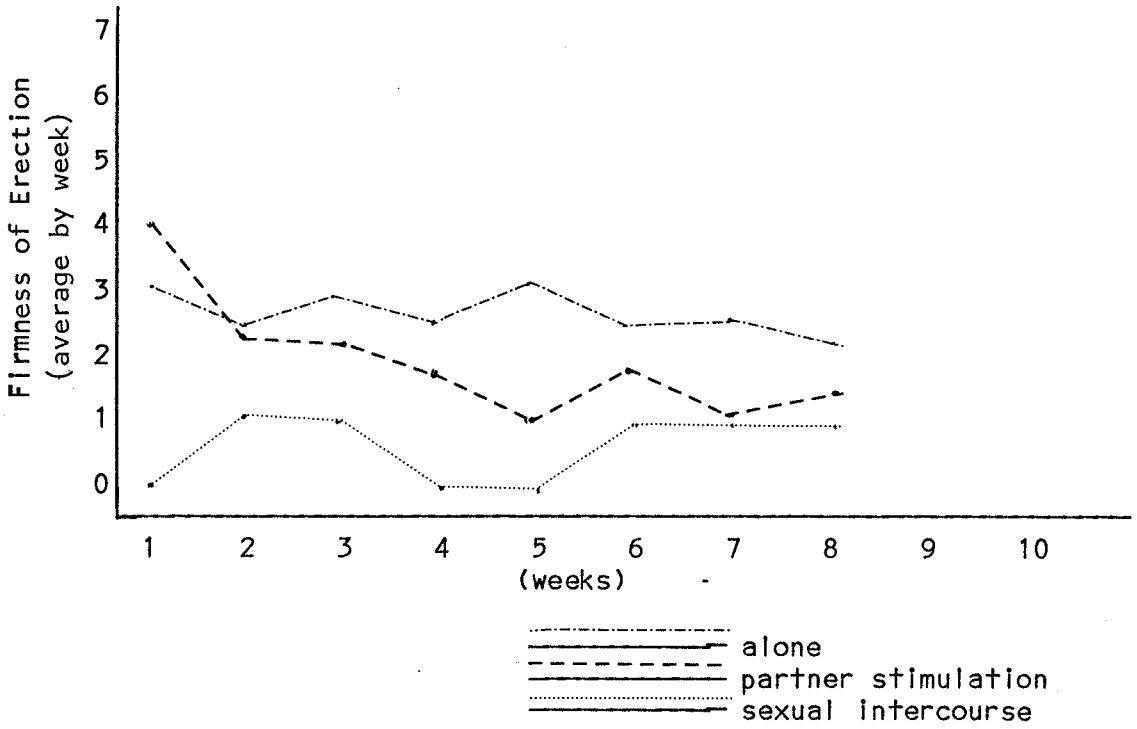
TABLE 3

INSTRUMENT	ASSESSMENT		TERMINATION	
	ANDY	CHERYL	ANDY	CHERYL
Index of Sexual Satisfaction	1	2	3	8
Self-Esteem				
Inventory	30 (97%)		29 (88%)	27 (78%)
Social	8 (100%)		7 (80%)	6 (44%)
General	16 (100%)		15 (97%)	15 (93%)
Personal	6 (73%)		7 (90%)	6 (82%)
(Lie items)	4		4	6
Marital Defensiveness	30	33	29	33
Sexual Defensiveness	11	14	14	14

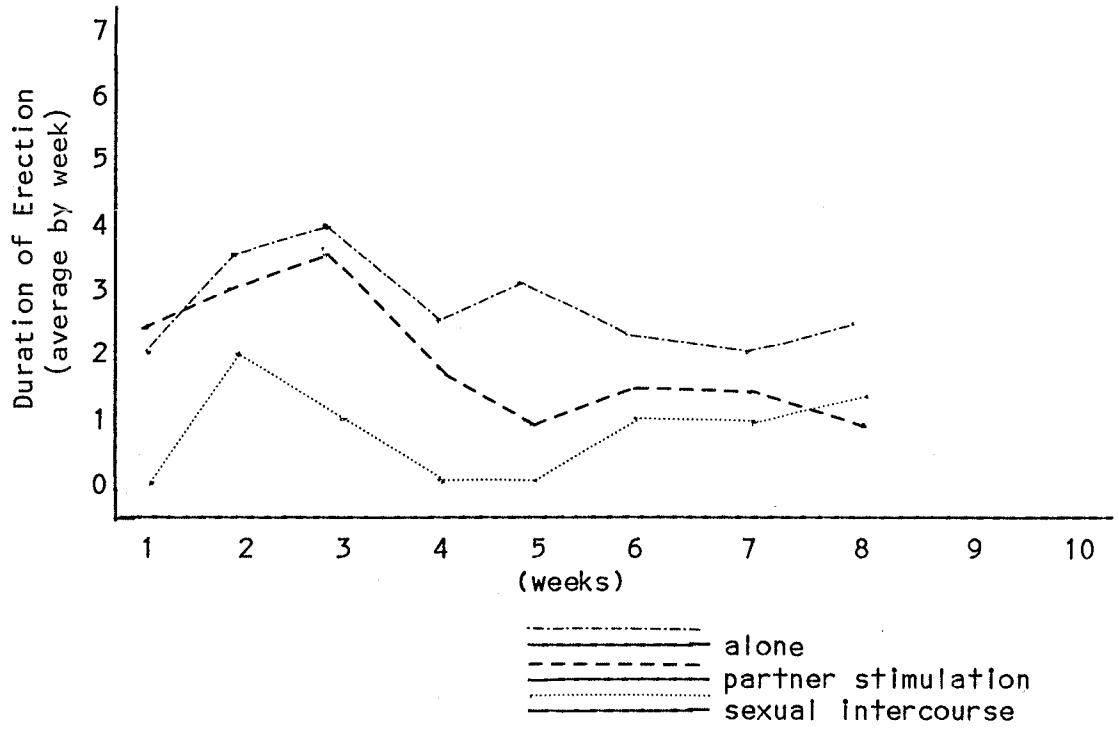
Interpretation: Appendix Fourteen

GRAPH 1 - ANDY

(a) Firmness



(b) Duration



CASE 2

Ann and Jim: Inhibited sexual desire
dyspareunia
(primary) inorgasmia

ASSESSMENT REPORT

Description of problem(s)

Ann has a lack of interest in sex. She avoids sexual contact as much as possible but does occasionally submit to her husband for his satisfaction alone.

Ann also experiences an impairment of physiological and psychological arousal and suffers (mild) superficial dyspareunia during penile entry due to a lack of vaginal lubrication.

Ann is also inorgasmic (primary); she considers this to be of lesser urgency than the previous problems. With few exceptions, Ann's problems occur during every sexual encounter. The two exceptions in the last year were during holidays in March 1983 (during a long weekend in Minneapolis) and one Saturday afternoon in early summer when they were in the middle of preparing dinner and they had been relaxed, drinking wine and feeling very good about each other. Ann can become aroused by reading erotic literature but switches off when lovemaking starts. Other times before the problem became so severe, Ann did become aroused without reading this literature but switched off when her husband began to make sexual advances. The problems are also global at the present time. They are secondary in nature (with the exception of primary inorgasmia).

Ann began to lose interest in sex in the fall of 1980 but the problem was very mild and it only occurred when she was very anxious or tired. It got progressively worse since this onset and in January 1981 she could barely tolerate any sexual contact; her problems with arousal and painful intercourse also intensified during this time. Since then it

has worsened to the point where the couple only engage in sexual activity approximately once a month. This usually occurs on Saturdays or Sundays and has been the case since their marriage 12 months ago.

Ann's problem also occurred in one previous relationship (of two years duration, immediately prior to her current partnership). In both cases, she was more sexually responsive during the initial stages of the relationship and did experience some sexual pleasure. However, her interest declined as the relationships became more stable and serious. For example, she began to lose interest in sex at the same time that she and John acknowledged their commitment to each other and, particularly, when they went on their first holiday together.

Contemporary influences on the problem(s)

Situational antecedents

Ann has always considered herself to be asexual and unattractive. She is very uncomfortable with seeing or touching naked bodies (including her own) and considers male and female genitalia to be very offensive. She has a great deal of trouble expressing herself physically in both sexual and non-sexual situations. She considers sex to be very biological and crude.

Ann has always engaged in sexual activity with very calculated motives (ie. to lose her virginity, to be a good lover to please her partner, etc.). Ann notes that the greatest pleasure in all of her sexual relationships has been the knowledge that her partners found her sexually attractive; this far exceeded the pleasure she experienced as a result of the sexual activity itself.

In the past, Ann's problems were worse when she and her partner were in her parents' home (as opposed to John's home or in his parents' home) because of her knowledge of their intolerance towards this. More recently, Ann has become very uncomfortable about even being in the bedroom with John when they have guests. She also dislikes holding

hands, kissing, and showing any physical expression in public. It seems that appearances are very important and the prospect that people will see this or suspect that they have a sexual relationship is embarrassing to her.

Organismic variables

Ann switches off any feelings of sexual arousal or interest she may have with thoughts that it will be too messy or too much trouble, that sex is somewhat too biological and crude, or that she has this problem so it is better not to start anything she cannot finish. Thus, she does not even allow herself to think about sex or fantasize (unless her fantasies involve other people).

Ann feels very anxious about sex at the present, especially since the onset and development of her sexual problems. She has always felt somewhat adverse to sexual activity because of her attitude towards naked bodies, sex generally, and her inability to express herself physically. She is always turned off by oral sex and she feels dirty and disgusted when she has performed oral sex on her partner, in particular.

Ann has always found that she becomes distracted during sex by various unrelated thoughts and frequently finds herself spectating when she and her partner are making love.

Situational consequences

Ann's partner has been very patient and understanding towards her in regards to this problem. However, he is becoming increasingly frustrated by the lack of sexual contact between them and especially by Ann's unresponsiveness even when they do make love.

Personal and family backgrounds

Ann is 27 years old; John is 29. They have been married for approximately 10 months; this is the first marriage for both of them. Ann and John are both practising law in Winnipeg.

Ann grew up in a very "respectable, waspish" family in which, she feels, appearances (both within the family and to outsiders) were very important. For example, she describes her mother reprimanding her brother for running around the house naked at the age of 11-12 which, according to Ann, was far too old to be seen naked. When Ann was engaged to John, and still living at home, her parents told her that she should not sleep over at his place (as she had done with her previous boyfriend) because they were paying for a large, sophisticated wedding and they wouldn't be disgraced by such behavior before the wedding.

John, on the other hand, grew up in a very intense "Slavic" family which was very emotional (fighting or making up, getting drunk together, etc). They were very physical and expressive in contrast to Ann's family.

Neither Ann nor John ascribe to strong religious beliefs. John appears to be quite tolerant of a range of behaviors and attitudes. Ann, on the other hand, is more rigid about what is right and she resembles her parents in her high standards for herself and others. Ann and John spend most of their leisure time together. They rarely entertain other couples or friends and spend their time watching television, reading, and they attempt to go jogging together daily. Both Ann and John are in very good health and physical condition.

Client's parents

Ann's parents are in their mid-fifties. Her father is a tax auditor; her mother teaches kindergarten. While neither ascribes to strong religious beliefs, they have very strong beliefs about morality and public behavior and have strongly influenced Ann in this regard.

Ann has always felt that her parents were uncomfortable with physical expressions of affection; they never hugged each other, held hands, or kissed in front of the children. Ann always felt that her parents probably only had sexual contact twice (as they had two children). They were very careful about proper behavior in front of Ann and her brother. Her father would always change in the bathroom; her mother changed in the bedroom, frequently with the door open but carefully hidden from view.

Partner's parents

John's parents live in Dryden, Ontario and work in blue collar jobs. They are very warm and expressive. John always knew that they had a good sexual relationship and accepted this as very normal. (This same factor surprised Ann who was not used to such behavior; she initially found it rather crude but is slightly more tolerant now).

Client's siblings

Ann has one brother, nicknamed "Josh", who is 2 years older than she. Ann never felt close to her brother and, in fact, never liked him at all. She felt that her brother was sloppy and overweight and that he was not very intelligent. She feels that Josh was always very physical and expressive; he was well liked by people and was much closer to his grandmother than his parents (as his grandmother looked after him for 2-3 years when he was a baby). Ann always felt somewhat jealous of Josh because she envied his ability to get along with people and to be so warm and expressive, in contrast to her coolness and unhappiness.

Partner's siblings

John has two brothers (aged 28 and 25) and a younger sister. They are quite close and supportive and have a close intense relationship. John's family, including all brothers and sister, live in Dryden.

Childhood and puberty

Ann had a very restricted upbringing in regards to her knowledge of sex, any exposure to the subject, or indication of a sexual relationship between her parents. Physical expression was very rare in her family, especially between her parents; she still finds it difficult to believe that her parents do have a sexual relationship.

Ann never spoke to her parents about sex but acquired her knowledge through reading, discussions with friends, and experimenting when she began dating in University.

Ann started dating when she was 18 and had several short term boyfriends; none of these relationships were very intense and, sexually, did not progress beyond petting until she was twenty.

Sexual experiences before current partnership

When she entered law school in 1977, Ann decided it was time to lose her virginity. She started to take birth control pills and met a man at the first school function. She did not particularly like this man, nor was she attracted to him, but she was pleased that he found her attractive; she pushed him to have sex soon after they started dating. They saw each other for about one month. Her second boyfriend, Alex, was more sexually attractive to Ann and she enjoyed sex with him. However, she knew that the relationship had no future and Alex left Winnipeg after about 6 months. (He was also Jewish and made it clear to her that there would be no future for the two of them).

Ann began to date Allan in the spring of 1978; they met at law school and although she was not attracted to him, was pleased with his interest and attraction to her. She felt the relationship was always one-sided because she had no commitment to it and she took advantage of Allan's feelings. She was initially interested in sex and being a good lover because she believed that this was important but she gradually started making excuses to avoid sex as her interest declined. She first had oral sex with Allan and found it quite repulsive; she would not let

him kiss her after he had performed it on her. As well, she found it quite disgusting to do it to him.

Ann stopped seeing Allan because she began to feel guilty about the relationship and Allan's feelings; she had also met John and was interested in going out with him.

Current partnership

Ann and John attended school together and started seeing each other socially in the fall of 1979. (Ann was still going out with Allan at the time.) They did not date initially but ran together several times a week; Ann was always very attracted to John. When he stopped dating his girlfriend, Ann and John started dating (March 1980) and Ann stopped seeing her boyfriend (Allan).

Ann and John initially had a very intense emotional and sexual relationship. John had plans to leave Winnipeg at the end of April so they decided that they should maximize their time together. They agreed that they would not continue the relationship after John left Winnipeg.

After John left, he and Ann wrote a few times but they both started dating other people. When John returned for a visit in July, however, they decided that they still cared about each other and would maintain the relationship on a long distance (weekend visiting) basis. This continued for approximately two years until John moved back to Winnipeg in 1982 (April). During this time, their relationship became more serious and they decided to get married in the fall of 1981. They were married in September 1982.

Sexually, their relationship started to get worse in the fall of 1980. Ann had always felt uncomfortable and tense if they made love in her parents' home for fear that they would get caught by her parents. This did not occur at John's parents' place, however, as she felt that it would be more acceptable if they were caught. However in late 1980 even this pattern changed and she began to resent John for wanting to rush in to the bedroom when he saw her, instead of talking about their week

apart. Soon after this time (in January 1981) John and Ann went to Hawaii for a holiday; she was totally unresponsive at that time. While her sexual motivation continued to fluctuate after this holiday, it got progressively worse during their engagement and marriage.

Despite the sexual problems experienced by the couple, they are very compatible. John is very understanding and patient and Ann is concerned with resolving her problems in order to enhance sex for John's pleasure. They spend all of their leisure time together and usually participate in social and recreational activities as a couple.

Perhaps the only source of tension in the relationship, besides the current sexual problem, has been Ann's feeling of discomfort and embarrassment with physical expression of feelings, particularly in public. While Ann feels that she is improving, she is still feeling that they look conspicuous and childish if they hold hands or kiss in public and she becomes irritated with John is he tries to do so.

Self concept

Ann has a very poor body image. She always felt she was ugly and she wore braces and thick glasses until she was in her mid-teens. She was very self-conscious about being flat-chested and had a silicone injection to increase her breast size in 1977. She is still embarrassed about her heavy thighs, rounded stomach and any slight weight gain; she exaggerates these features. She does not like John to see her naked, especially if she has gained any weight. Ann is also very concerned with dressing right and looking perfect. Ann is still not confident about her own attractiveness, especially sexually as she has always believed she was asexual and ugly.

Ann does not feel that she is popular with men or women as she displays a very cool, snobbish image. She feels that if people knew her better they would like her and she is very sad and frustrated by her inability to show her feelings.

Ann's self-esteem appears to be quite low as indicated through verbal reports (the results of the Self-Esteem Inventory were inconsistent with her verbal reports). She is never satisfied with herself, she is somewhat withdrawn, inexpressive, cool and condescending. She is unhappy with these qualities despite a superficial defensiveness and self-righteousness.

Attitudes towards treatment

Ann is moderately motivated towards treatment due to the problems which her sexual problems are starting to create in her marriage. She anticipates that the problem will not be resolved on its own and she cannot imagine their marriage lasting under present circumstances. It is noted, however, that both she and John approached therapy with the hope that a fast easy solution would be available.

Both Ann and John are busy with work but have the organizational capacity to accomodate therapeutic sessions and homework assignments if they so desire. They are quite optimistic about successfully resolving their sexual problems in the course of therapy.

PROBLEM FORMULATION

Dysfunctional behavior

Ann's problem involves a lack of interest in sex. She is generally indifferent to participating in sexual activity but occasionally does so for her husband. Both her psychological and physiological arousal are also impaired and she is unresponsive during sex. She experiences distracting thoughts during lovemaking and frequently finds herself "spectating" the activity, especially her own response and actions. She experiences some pain during penile pentration (superficial dyspareunia) due to the lack of lubrication normally accompanying arousal.

Ann can become aroused with erotic literature but switches off when lovemaking starts. She rarely fantasizes and when she does, she is never

part of her fantasies (rather an observer). She has never masturbated and she is inorgasmic (primary).

Ann's problem has developed over the last 1-1/2 to 2 years, approximately 6 months after she became sexually active with her husband. Since onset, it has become progressively worse to the point that their sexual relationship is practically nonexistent.

Hypotheses

Ann was raised in a sexually restrictive family, in which sexual activity was never mentioned or indicated (ie. between her parents) and in which physical expression was rarely apparent. As a result she is very self-conscious about expressing herself physically, in both affectionate and sexual situations. For example, she was initially uncomfortable with holding her husband's hand or kissing him in public; she is becoming less uncomfortable with this, however. In addition, she never makes sexual advances and is inhibited about touching herself or her husband during lovemaking.

Ann has a very poor body-image. She has always considered herself to be unattractive and while she presently does feel that she is attractive looking when dressed for work, for example, she does not feel sexually attractive and is very dissatisfied with her body, particularly its minor flaws. Following the nature of her background and her family situation Ann seems to have problems accepting and enjoying the sexual aspects of a serious or marital relationship. She has always been sexually responsive in temporary relationships and during the initial stages of her current relationship. However, when it appears that the relationship is more serious and stable, her interest in sex declines as though it is no longer right or acceptable in this context. This may be a result of the behavior displayed by her parents in her home and her subsequent feelings that her parents had no sexual relationship (she makes frequent references to this). In her own marriage, then, she has difficulty with a sexual relationship (as this is a similarly respectable and proper situation).

In addition to these factors, it appears that Ann is very vulnerable and recognizes this vulnerability. She has always felt a need for physical intimacy; even as a child, she wished that people would respond to her as they did to her brother. She finds it very important, though, that she stays in control of her feelings as she is apprehensive about people knowing when she has been hurt or offended, for example (she never drinks alcohol so that she can maintain control of her feelings). It seems, then, that physical intimacy especially in a sexual context is too threatening because of the emotions and need that it evokes in her. She has always attempted to control or deny these needs and she is afraid of letting herself go in situations in which they will be more exposed, such as (sexual) intimacy with a loved one.

Resources for treatment

(a) Situational resources

The situational resources in this case are highly favorable. Ann and John appear to have a very good relationship and John is very supportive of Ann, in seeking therapy. John has no apparent sexual dysfunctions. Ann and John are both highly paid professionals and possess the socio-economic resources to meet any requirements of therapy.

(b) Personal rsources

Ann and John are quite motivated, especially Ann who sees the problem as her own rather than one which relates to the relationship. They possess the organizational ability and intellectual capacity to meet the organizational and intellectual requirements of therapy. One possible problem or hindrance in therapy may be Ann's very rigid beliefs regarding sex, her ambivalent feelings towards physical expression and human bodies, and her own self-concept.

(c) Professional resources

The therapist has allocated 1 1/2 hours per week to therapeutic sessions. While this type of intimacy problem is still only moderately

understood (in the literature, for example), the therapist possesses the basic knowledge and skills to work with the clients in resolving these problems and has access to suitable resources, where required.

Therapeutic goals

The therapeutic goals have been selected with the specific intent of enabling Ann to examine and redefine her attitude and feelings towards physical intimacy and expression, and sexuality in order that she become more sexually expressive and responsive.

1. To explore and understand her attitudes towards sex, especially in terms of its contextual significance.

2. To redefine her attitude towards sex generally and especially in the context of her current partnership (long term and serious relationship).

3. To examine and redefine own body image in terms of general attractiveness and specifically, her sexuality.

4. To gradually increase her ability to express herself physically, especially regarding her comfort with her own and her husband's bodies.

5. To become sexually responsive to her husband, a well as more sexually-assertive to improve their sexual relationship in terms of Ann's participation and interest (concerns sexual interest and arousal).

6. To reconsider the possibility of becoming orgasmic as part of therapy.

Planning treatment

One female therapist will be involved in the treatment program. Treatment will be conducted at the Sexual Dysfunction Clinic (Psycholog-

ical Services Centre). Weekly sessions will be scheduled for therapy until the goals of therapy have been reached to the satisfaction of the clients and the therapist.

Treatment program

1. Cognitive restructuring will initially be undertaken to address the problems related to Ann's attitudes towards physical expression, her body image, and sexuality.

2. A desensitization process will be implemented to enable Ann to overcome her inhibitions regarding sexual expression. Selected portions of the sexual learning programs (especially Becoming Orgasmic) will be used to demonstrate the pleasuring or sensate focus exercises (individual and couple) which will serve as the basis for desensitization.

3. The program outline in Becoming Orgasmic will be used, at an appropriate time in therapy (following the implementation of the above techniques), as a means to treat Ann's inorgasmia. This will incorporate both written material and audio-visual aids.

4. Throughout treatment, an emphasis will be placed on providing (accurate) information regarding sexuality, sanctioning various sexual activities, and relaxation training where appropriate.

TREATMENT SUMMARY

Treatment commenced according to the outline developed in the assessment report. The initial therapy sessions focused on cognitive restructuring as Ann's attitudes towards her body, John's body, male and female genitalia, and sexuality in general were examined. This was very difficult for Ann who presents as a very rational, controlled, and liberal person and who carefully conceals her real fears and insecurities.

In therapy, Ann fluctuated between being very defensive to being very open and concerned with changing these attitudes. However, it became apparent after several weeks that Ann did not want to change her attitudes towards sexuality, even if these prevented her from resolving her sexual problems. Throughout this process, John took little interest in participating in therapy and did not take Ann's efforts very seriously.

After several weeks of therapy, sexual assignments were incorporated into the program at Ann's request. It was agreed that she would start the program for becoming orgasmic (in Heiman et al., 1976) and proceed with exploring her body and general pleasuring (herself), according to the directions in the book. Part A of the (Becoming Orgasmic) film series was shown to Ann to supplement the reading material.

Ann thought that the film was disgusting. She stated that she was bored doing the exercises from Becoming Orgasmic. She decided that she did not want to try the genital pleasuring as she did not want to masturbate; she was very adamant about this and alternatives were subsequently discussed.

At the suggestion of the therapist, Ann and John began the (couple) pleasuring exercises. This was considered to be more appropriate for the couple, considering Ann's reaction to masturbation and her problems with sexual activity specifically involving her husband. John was very receptive to this and both he and Ann were initially very optimistic. The excercises were explained in the session (using a portion of the LoPiccolo (1980) film to demonstrate this excercise); in the discussion following, Ann stated that she found the film disgusting and the procedure to be contrived and unappealing. She also stated her inhibitions about her body and touching John's body, but she did agree to attempt the exercises.

Ann and John completed the first assignment (general pleasuring) and they stated that they found it quite enjoyable. However, subsequent to that they repeatedly cancelled appointments as Ann decided that she did not want to devote the time required to do the assignments and she and

John agreed that they did not have enough time to do the assignments. It became apparent that they were not motivated enough to continue therapy and given the choice of continuing therapy or terminating, they chose the latter.

OUTCOME

Ann and John had approached therapy with the hope that they would receive an instant "cure" to their sexual problems. When this was not available, Ann was not prepared to change her attitudes towards sex or to participate in a process which challenged or upset her in any way. It did appear that she had begun to examine her attitudes but that she preferred to maintain these (at that time). While her reactions to sex are a source of stress to her and John, they are not sufficiently problematic or urgent to motivate her to change. As a result, therapy ended before the therapeutic goals were achieved. As well, it was not possible to administer questionnaires before the couple terminated therapy and no comparative data is available (see Table 4).

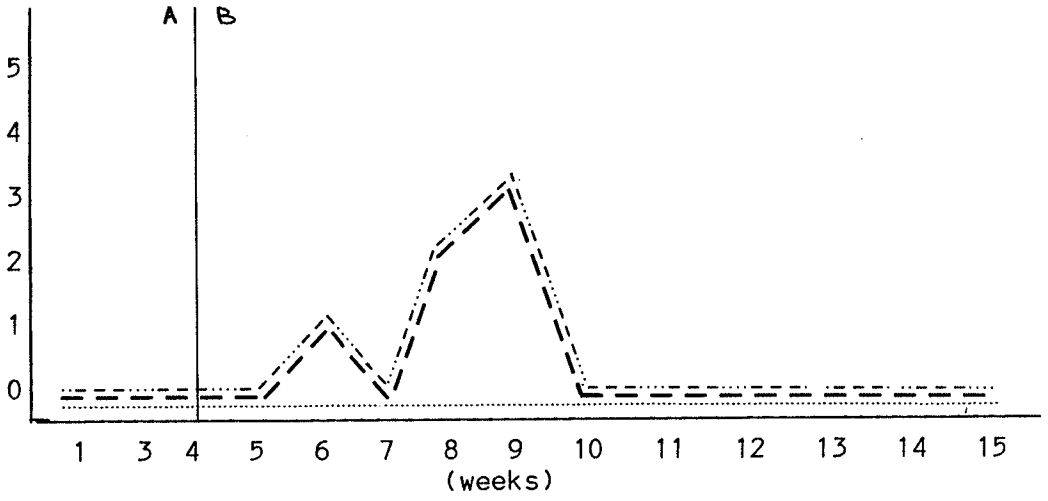
TABLE 4

INSTRUMENT	ASSESSMENT	
	ANN	JOHN
Index of Sexual Satisfaction	55	41
Sexual Arousal Inventory	1%	
Dyadic Adjustment Scale	110	107
Dyadic Consensus	46	46
Dyadic Satisfaction	41	40
Affectional Expression	5	5
Dyadic Cohesion	18	16
Marriage Attiudes Scale	15	
Sexual Attitudes Scale	3	
Self Esteem Inventory	22 (41%)	
General	12 (58%)	
Social	6 (44%)	
Personal	4 (54%)	

Interpretation: Appendix Fourteen

GRAPH 2 - ANN

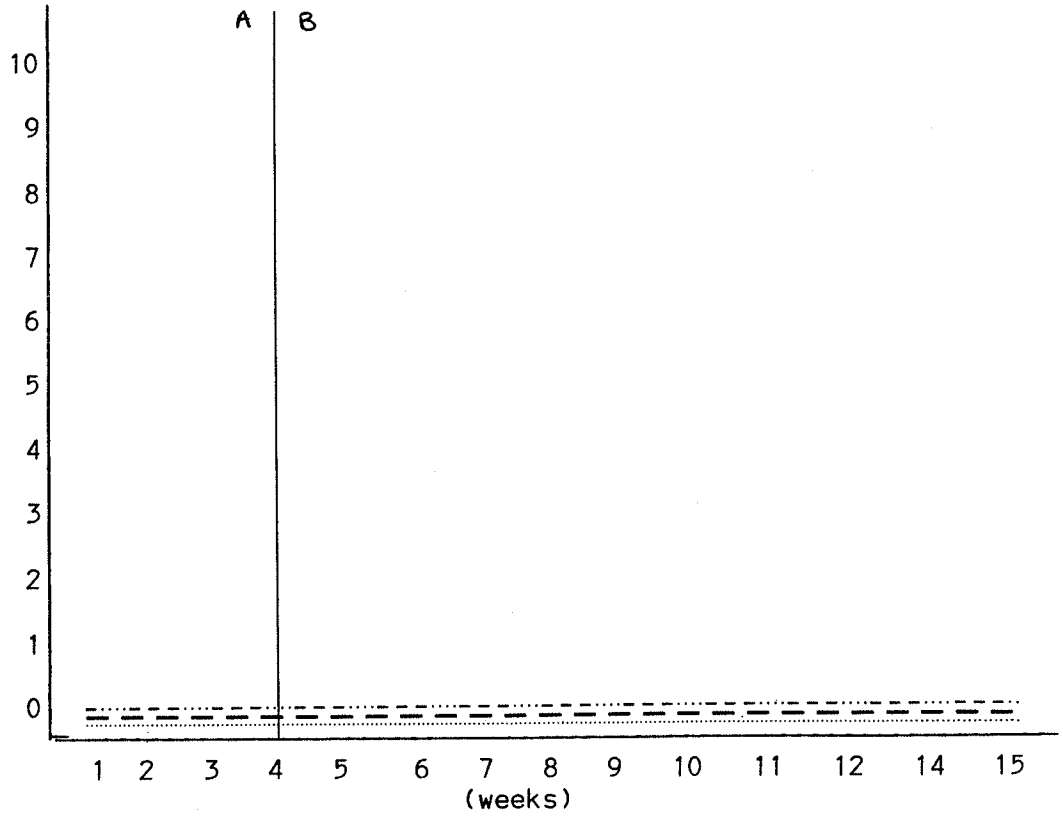
(a) Arousal



* 0 = No sexual activity

masturbation
genital stimulation
sexual intercourse

(b) Orgasms



masturbation
genital stimulation
sexual intercourse

CASE 3

Susan and Ian: inhibited sexual desire
vaginimus
dyspareunia

ASSESSMENT REPORT

Susan was referred to the Sexual Dysfunction Clinic in June (1983) by her gynecologist. The problem at that time was defined as a lack of libido for the previous 8-9 months. She was initially seen in August, 1983, at which time she decided to postpone therapy until later in the fall.

Description of problem(s)

Susan feels a lack of sexual motivation; she rarely feels sexual desire and she engages in sexual activity only to satisfy her boyfriend.

Susan also experiences impaired sexual arousal, both physiologically and psychologically. She frequently does not lubricate, making intromission painful. Susan also has vaginismus and dyspareunia; even when she does submit to her boyfriend, she tenses up to such an extent that he is unable to penetrate her vagina. When this is attempted, then, she loses any feelings of arousal she may have had and her interest in continuing to make love diminishes.

Susan experiences these problems every time she and her partner make love. However, she reacts particularly strongly when her partner has been out drinking to some excess. At these times, her arousal is nil and the entire experience is very unpleasant for her; intercourse is never possible at these times.

Susan's problems initially occurred in the spring of 1982. At this time, she was writing her Chartered Accountant's exams and was under significant stress. She was also developing a cyst on her Bartholin's

gland; this was very painful and made intercourse painful. However, she was not certain that her boyfriend really believed that her pain was real. In addition to these factors, Susan had temporarily stopped seeing her boyfriend (Ian) a few months earlier because of problems resulting from her declining interest in sex. When they reconciled their differences over this, Susan told Ian that she would attempt to resolve this. She always felt some degree of pressure from Ian to be more responsive (this feeling has gradually increased over the last year and a half).

Since onset of the problem, it has gradually intensified. Initially, she only felt a lack of interest in sex but she could usually convince herself to try to make love. Corresponding with this lack of interest, Susan's arousal level also became increasingly low and she felt that it became harder to feel excited about sex (or Ian) and lubricated less often when she did try to make love.

The vaginismus and dyspareunia developed after the first cyst was removed (June 1982) and became much more severe a year later when she had a second cyst (on her Bartholin's gland) removed. This was also very painful, both before and after surgery. Susan felt that Ian pushed her to resume sexual intercourse before she felt ready and she always feared that the stitches or the incision from the surgery would break open. She felt that she did experience pain at that time and she attempted to "brace" herself for it. These problems have gradually worsened to the point where they engage in sexual activity less than once per month; this is usually against Susan's wishes.

Contemporary influences on problem(s)

Situational antecedents

Susan and Ian do not appear to have a very stable or caring relationship. At the time of the initial interview, Susan confided that she was not certain whether this was a sexual problem, per se, or if it was a symptom of their relationship problems. At that time, she wished to take time to decide whether or not she even wished to remain in this

situation. As a result of this, Susan often finds it difficult to feel loving towards Ian.

Susan also resents Ian's sexual "style". She finds him very rough and aggressive and feels that this really turns her off. In particular, Susan feels that Ian is very rough and demanding when he has been drinking with his friends; he often comes home late, wakes her up, and attempts to make love when she is not responsive.

Organismic variables

Susan cognitively monitors her sexual responses; she is always aware of how aroused she feels, whether or not she is lubricating, and finally whether she will be able to have sexual intercourse (without tensing up). Because of this, Susan feels that she cannot be spontaneous (if she so wished) and cannot enjoy sex.

Susan feels alot of anger towards Ian because she thinks that he pressures her into sex and he does not respect her feelings. She also feels very defensive because Ian blames her for this problem and constantly reminds her that if their sexual relationship is not improved they will have to split up and she will have to move out of the house (as he owns it).

Organic states

Susan has had two cysts on her Bartholin's gland since June 1982. In both cases, the cysts grew quite large and were removed surgically. Susan experienced considerable pain with both of these cysts, both before and after surgery. She feels that she may experience some pain during sexual intercourse because of the scar tissue; this is not clear, however, as the pain may also relate to her vaginismus.

At the present time, Susan suspects that she may be developing a (third) cyst; she already anticipates the additional pain this will cause.

Situational consequences

Susan's partner is very frustrated and impatient with her. He considers this to be her problem and he does not wish to accept any responsibility for changing the situation. He has frequently threatened Susan that, if she cannot get this problem solved soon, he will have to ask her to move out so that he can find a more satisfactory partner and relationship.

As a result of these (sexual) problems, the frequency of sexual activity has declined to less than once per month. Ian continues to pressure Susan daily to make love but she has gradually reduced the number of times which she complies. Presently, Susan does attempt to respond to Ian's advances approximately once per week but, because of the difficulties she experiences these are usually unsuccessful attempts.

Personal and family backgrounds

Ian is 27 years old. He has never married and his current relationship with Susan represents his first serious relationship. He and Susan have lived together since May 1983 (nearly one year at the time of writing).

Ian is employed as a Chartered Accountant. Ian's ethnic background is German (he is a third generation Canadian, however). He does not ascribe to any particular religious or moral beliefs but is generally conservative in his attitudes towards (male-female) relationships, education, and professionalism.

Ian spends a significant portion of his leisure time with his friends; he is part of a closely knit group of men with whom he had previously worked when training as a Chartered Accountant. He spends most of his time participating in (or viewing) sports, and he often goes out drinking with his friends. Ian spends the balance of his leisure time with Susan; they generally go out alone or to small parties or

gatherings but they do not share any common interests (aside from their work).

Ian is in good health; he is in good physical condition as a result of his involvement in sports and he has never had any serious illnesses.

Susan is 27 years old. Like Ian, she has never been married; she has only been involved in one serious relationship before meeting Ian. Susan is also employed as a Chartered Accountant in Winnipeg.

Susan was born in England; her family came to Canada in 1966 and she has actually grown up in Canada. Susan does not ascribe to any strong religious beliefs; she is a non-practising Roman Catholic. She is very reserved and somewhat conservative in her attitudes with the exception of (male-female) relationships, education and professionalism concerning women (this has always been an area of contention between her and Ian).

Susan is very quiet and has few (female) friends, most of whom are also Accountants. In her leisure time, she prefers small gatherings with close friends, small dinners parties, and movies to larger social events. She spends alot of time at home and prefers intimate evenings with Ian to other activities.

Susan is in generally good health, with the exception of the cysts she recurrently develops on her Bartholin's gland. Susan uses birth control pills as a measure to prevent pregnancy; she had previously felt that this affected her libido and she stopped taking the pills temporarily.

Partner's parents

Ian's parents are both in their late 50's; they have a fairly solid marriage but their interaction tends to consist of Ian's mother nagging

and criticizing and his father ignoring her (this has been the case for most of their marriage). Ian's father works as a labourer with Manitoba Telephone System; his mother is a Loans Officer in a bank; neither completed high school.

Ian's parents have a very traditional marriage and hold conservative values, generally. They are both non-practising members of the United Church.

Ian is not extremely close to either of his parents; he prefers his father's company because of his mother's tendency to be critical (of Ian). Susan is not close to any members of Ian's family.

Client's parents

Susan's parents are both in their mid-fifties; they have been married for thirty years and, according to Susan, have a very close and loving relationship. They are not (physically) demonstrative but do speak to each other with caring tones. They have rarely had arguments (with raised voices, for example) in front of Susan.

Susan's parents moved to Winnipeg (from England) in 1966. Neither parent had completed high school or any training and both work as labourers. Susan's father is an electric fitter; her mother is a blue-collar worker in a factory.

While they are non-practising Roman Catholics, her parents hold very strong and conservative values. They have a very traditional marriage; for example, because her father is quiet and introverted, her mother rarely goes out. Neither parent supported Susan's decision to live with Ian when they were not married.

Client's siblings

Susan has one older sister who is less than one year older than she. This sister is married to a man whom Susan describes as quiet and lacking

in ambition; she dislikes this man and feels her sister made a mistake. She is employed as an ultrasound technician. Susan has a younger brother (aged 24). He is single and attends the University of Manitoba, studying zoology.

Susan gets along well with both her brother and sister; however, she is not particularly close to either of them. Since she dislikes her sister's husband, she sees little of her sister; her brother is very quiet and involved in his work. Their family does not appear to be very close, in general.

Partner's siblings

Ian is the second oldest of a family of seven. He has one older brother, three younger brothers and two younger sisters. Ian describes his family (siblings) as very competitive; he is not close to any of his siblings with the exception of his youngest sister whom he feels he can trust and rely on for help or support when he needs it. Since he moved away from home 2 years ago, he has seen his family approximately once per week.

Childhood and puberty

Susan was not aware of any family attitudes towards sex, either positive or negative. She did learn however that while sex was pleasurable and important it should be saved for marriage.

Susan was very naive when she began dating in her mid-teens. She had learned very little about sex from her parents or her friends, for example, and acquired her knowledge through experimentation with her partner(s).

Susan started dating at the age of seventeen. She was very careful about not getting carried away because she was afraid of pregnancy. Until she was twenty-one, her sexual contact with her partners was limited to necking and some petting.

Susan started menstruating when she was thirteen. She started masturbating when she was in her late teens but she stopped after becoming sexually involved with Ian. In some ways, she feels that this may be typical of her declining interest in sex.

Sexual experience before current relationship

Susan first became orgasmic when she was 22 or 23 years old, when she was in a very good relationship (sexually). She has since been orgasmic with direct clitoral stimulation (manually, orally) and during sexual intercourse.

Susan began dating when she was seventeen; she dated the same boy for two years until he went to University and she got a job and their lifestyles diverged. This relationship did not ever get serious and their sexual contact consisted of necking and occasional petting. Susan dated several men in the next year but she did not develop a relationship with any until she was twenty. In this relationship, they experimented more with sex and made two unsuccessful attempts at intercourse.

When Susan was 21, she began to date Martin. She dated him for three years until he left Winnipeg to live in Toronto and became involved with another woman who became pregnant and subsequently pressured him into marriage (according to Susan). Susan and Martin had a very good and satisfying sexual relationship and Susan felt that she was very interested in sex; she found it highly arousing and pleasurable. She first attempted intercourse, oral sex, and she became orgasmic in this relationship. She felt that Martin was very gentle and caring and she still constantly compares him with Ian, whom she feels lacks these important qualities.

Current partnership

Susan and Ian met in May, 1980 when they were working for the same (Chartered Accounting) firm. They occasionally worked together and started dating in May 1981. At first, they went out with groups of

people from the office. Susan felt that Ian treated her like "one of the boys" when they were with a group; when they were alone, however, he was very considerate, kind, and gentle. Susan felt that Ian was always playing a role when his friends were around; she feels that he still does this and that he is still very much influenced by his friends. She does not like the way Ian behaves when he is with them. She is also very angry with him when he goes out with them and drinks; she feels that Ian becomes very aggressive, demanding, and shows no respect for her. She always resists his sexual advances when he is like this and frequently refuses to speak to him for (at least) a day if he has been particularly pushy or aggressive.

Susan and Ian became sexually involved in November, 1981 (approximately seven months after they started dating). Initially, their sexual relationship was good; they both lived at home (for the first two months before Ian got his own apartment) so they were rarely able to spend alot of time alone. Ian was much more considerate then, according to Susan, and both she and Ian enjoyed sex.

Their sexual relationship started to deteriorate in the spring of 1982. They stopped seeing each other for approximately two weeks as Ian felt that he was not satisfied with their sexual relationship. They reconciled and Susan promised to try to be more responsive. This was the case for about a month until Susan started to develop a cyst and intercourse became painful. This got worse until she could not stand the pain and they stopped having sexual intercourse completely.

They resumed sexual activity after two months (one month after the operation on the cyst) but Susan felt that it was too early and that Ian pressured her too much. Their sexual relationship continued to deteriorate until Susan developed another cyst the following June. At that time, she also experienced alot of pain and they stopped having intercourse for two months (one month prior to surgery for removal of the cyst and one month after). Susan again felt that Ian rushed her too much and that he didn't believe that she was in such pain. After the second cyst, their sexual relationship became very unsatisfactory to both

partner, to Susan, because Ian was pressuring her so much and, to Ian, because Susan was so unresponsive sexually.

Ian and Susan seem to have an unstable relationship; both complain constantly about many of each other's characteristics. Ian seems to be very aggressive and dominating at times, and caring and considerate at other times. He is very annoyed and frustrated with Susan because of her sexual problems and he has informed her, on several occasions, that she will have to leave if things don't improve.

Susan is softspoken and protective of her feelings by acting cool and detached much of the time. She feels very badly because of her sexual problems and Ian's reaction to these. She cares about Ian; when he is spending time with her and shows his softer side they get along very well. When Ian has been drinking, when he is demanding (sexually), or when he tells her that she may have to move out, she becomes very angry. In order to hide her feelings she ignores Ian, withdraws, and tells him that she doesn't care anyways. Ian and Susan do not communicate openly and honestly; when they discuss something that they don't agree upon, they end up arguing and one or the other walks away. Subsequently, they do not resolve any of the problems between them and their relationship continues to swing from being fair to being on the verge of breakup.

Self image

Susan has a fairly high self-esteem in most respects (according to verbal reports and her score on the Self Esteem Inventory). She is very competent at her work; she is very intelligent and ambitious. She is relatively attractive but she does not take an interest in caring for herself besides looking tailored and efficient for work (Ian has often complained to her about taking better care of herself and trying to be more attractive and feminine.) In general, Susan is satisifed with her appearance and she does not concern herself with it.

Susan has few close friends and she does not make friends easily. She does not feel that she is popular with other people because of her

rigid, controlled manner. These are not of major concern to Susan; she accepts this situation as it is.

Attitudes towards treatment

Susan is not highly motivated in therapy. She initially wished an instant "cure" and she has not put very much effort into attending therapy sessions or into thinking about her sexual problems, especially in the context of her relationship with Ian. Usually Susan reacts to problems by reverting to her defenses and states that she is not sure that this is a sexual problem but seems to be a problem with the relationship. She inevitably swings back and decides that the relationship is important and that she will try to deal with the sexual problems. Ian, on the other hand, considers this to be Susan's sexual problem and takes no interest in participating in therapy. Despite these factors, Susan does anticipate that her sexual problems will be resolved. She has the organizational capacity to attend therapy sessions and she has the (intellectual) ability to understand and relate new information and skills to her situation.

PROBLEM FORMULATION

Dysfunctional behavior

Susan has a lack of sexual motivation; she rarely feels sexual desire and, in fact, dreads Ian's sexual advances. Susan experiences impaired sexual arousal, psychologically and physiologically. She frequently does not lubricate even when she attempts to make love with Ian and she does not feel excited by either Ian or sex.

Susan has vaginismus and dyspareunia. She tenses up when Ian attempts to penetrate her vagina and she feels considerable pain if he is able to penetrate at all. When Susan does become aroused, her feelings diminish as soon as Ian attempts to penetrate, because of her anticipation of pain.

Hypotheses

Several factors appear to be relevant in initiating and maintaining this behavior.

Ian and Susan's relationship seems to have considerable problems which have existed since they started to date and which have intensified since they began to live together. Susan is often very hurt by Ian's behavior and treatment of her which, to her, shows no caring or respect. She reacts very defensively to Ian's suggestions that she may have to move out if her sexual problems are not resolved. Ian is very strong-willed and inflexible. He does not consider the possibility that he may contribute to Susan's sexual problems.

Susan is also angry with Ian because she feels that he did not believe she was in such pain at the time of her cyst operation(s) and because he believes that she could "get better" if she wanted to as her pain is "not real" anyways.

Susan may have initially developed vaginismus and dyspareunia at the time she developed her first cyst; this would then have been aggravated by her second cyst (growth and removal). At that time, intercourse was very painful for her and Susan did tense up in anticipation of the pain. It is not certain at this point if any of the pain she presently experiences is a result of scar tissue but it does appear that it is caused by the vaginal tensing, moreso than any scar tissue. The combination, then, of this reaction to the pain from her cysts and the relationship with her partner seem to have caused and perpetuated the sexual problems.

Resources for treatment

Situational resources

The relationship between Ian and Susan is not particularly stable or supportive and may be a detriment in therapy. Ian does not wish to participate in therapy and his cooperation is questionable at the

present. The couple's socio-economic resources are adequate and Susan should have the time and economic resources to meet any requirements of therapy.

Personal resources

Susan's motivation is quite low at the present; it is anticipated that this would improve if she saw any improvements in her sexual behavior, or if Ian showed more interest in the program. Neither of these can be determined at the present.

Susan has the organizational capacity to meet the requirements of therapy. Susan does not possess any religious or moral beliefs which would impede therapy. The possibility that Susan is developing a (third) cyst on her Bartholin's gland could be a problem in therapy as it will only intensify Susan's pain and reaction to intercourse.

Professional resources

The therapist has allocated one to one and one-half hours per week for therapeutic sessions as well as additional time, as required, for research or consultation with supervisor. The therapist possesses the knowledge and skills to work with this client (and her partner); if required, additional resources are available at any time.

Therapeutic goals

The goals have been discussed by the client, her partner, and the therapist and relate directly to the problems identified above.

1. To increase Susan's level of sexual desire.

2. To reduce, and eventually eliminate, Susan's tension and muscular spasms (re: vaginismus) during intercourse.

3. To reduce or eliminate the pain which occurs when vaginal penetration is attempted.

4. To improve the relationship between Susan and Ian (communication, problem resolution).

5. To develop a more egalitarian and reciprocal sexual relationship.

Planning treatment

One (female) therapist will be working with the client and her partner. Treatment will be undertaken at the Sexual Dysfunction Clinic at the University of Manitoba. Weekly sessions of one to one and one-half hours are planned for treatment purposes, as noted above.

Treatment program

The treatment program will consist of the following components (in approximately the order in which they will be implemented).

1. Relationship enhancement

    1. Communication training
    2. Problem solving
    3. Increasing positive exchanges

    This is intended to improve the couple's relationship so that sexual problems which are secondary to their relationship problems will be reduced.

2. Progressive vaginal dilation will be undertaken by process of inserting Susan's (and later, Ian's) finger(s) into her vagina, under conditions of control by Susan. This will gradually be increased until she is able to allow penile penetration.

3. The client will be referred to a gynecologist at the commencement of treatment, to determine the extent to which painful intercourse is secondary to organic or psychogenic factors (or a combination thereof).

TREATMENT SUMMARY

Based on the treatment program outlined in the assessment report, Susan and Ian attended therapy sessions together and they attempted to begin communication training, as an initial stage in relationship enhancement. This was very difficult as they were constantly arguing and would not collaborate to the extent that they could make any progress with this. Ian showed very little interest in participating in therapy as he felt that this was Susan's problem and he refused to consider an alternative explanation.

Susan attended the next sessions alone as Ian didn't want to accompany her and she wished to discuss the future of the relationship alone. She was very unhappy in the relationship and felt that she could not resolve her sexual problems in the relationship because of Ian's aggressive and overbearing personality, but she didn't know if she wanted to leave him either.

Susan continued to fluctuate between leaving Ian and trying to work on their relationship problems for the remaining therapy sessions she attended. After 9 sessions, Susan realized that she could not change Ian and that she could not resolve her problems in the context of that relationship. However, she was not prepared to leave Ian.

The attempt to introduce vaginal dilation into therapy (as a homework assignment) was successful to the extent that Susan could insert a tampon or her (two) fingers into her vagina, without any muscular reaction or pain. However, she could not do this with Ian as she did not trust him to insert one finger (or two fingers) and feared a sexual confrontation. Subsequently, progressive vaginal dilation was (temporarily) stopped until Susan felt that she could trust Ian enough to allow him to do this.

Susan and Ian came to a point in therapy where they were not making any progress as this required that they collaborate to work on the communication and problem solving training, or to make a decision as to the future of their relationship. They were not able to make this choice

and began to miss (therapy) appointments until the therapist contacted them and suggested that they either terminate or return to work on making this decision. They decided to terminate at that point.

It is apparent that Susan did want to resolve her sexual problems and work on the relationship but that she and Ian were generally incompatible. Susan wished to change many of Ian's characteristics because she did not like his aggressiveness, detachment, and self-righteousness. Ian had no interest in changing, however. Thus, Susan preferred to tolerate the situation rather than to make some decisions which were frightening to her (such as leaving Ian).

OUTCOME

In this predicament, it became clear to Susan that neither she nor Ian could benefit from therapy at that point in time. As a result, therapy was terminated before any of the therapeutic goals were reached. It appears that the only benefit Susan derived from therapy was to force her to face the facts that she could not change Ian or improve the relationship without his cooperation, and that she must make some decisions as to her happiness and future in that relationship. Because therapy was terminated in this manner, questionnaires were not completed at termination and no comparative data is available (see Table 5).

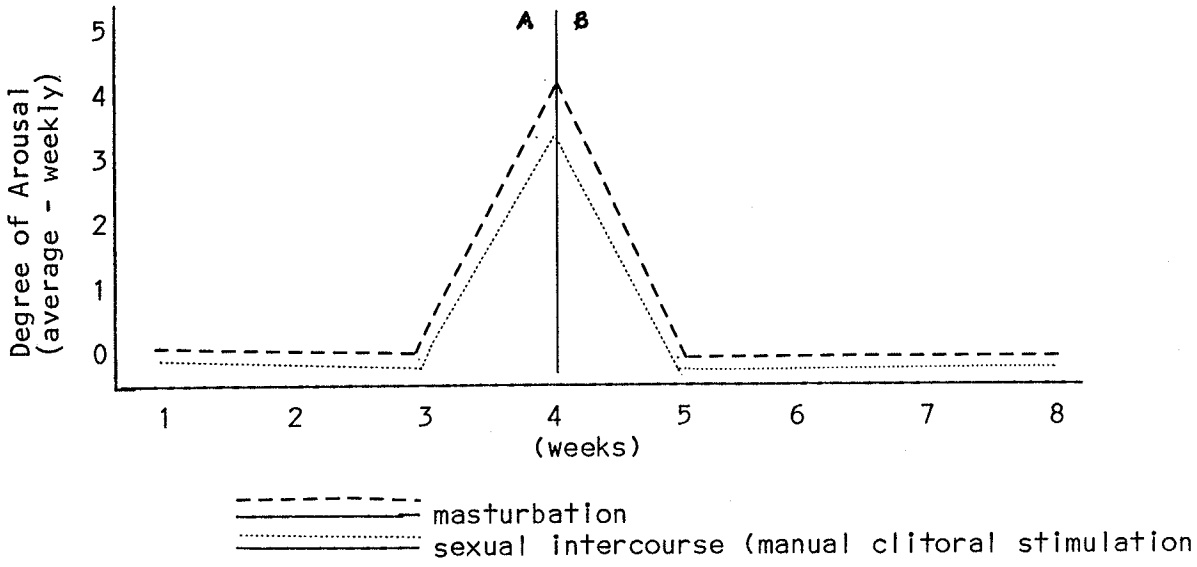
TABLE 5

INSTRUMENT	ASSESSMENT	
	SUSAN	IAN
Sexual Arousal Inventory	4-5% ile	
Index of Sexual Satisfaction	79	48
Self Esteem Inventory	28 (84%)	
General scale		
Social scale	14 (81%)	
Personal scale	7 (78%)	
Lie items	7 (95%)	
	8	
Marriage Attitudes Scale	2	7
Sexual Attitudes Scale	1	1
Dyadic Adjustment Scale	87	103
Dyadic Consensus	39	47
Dyadic Satisfaction	29	36
Affectional Expression	4	4
Dyadic Cohesion	15	16
Sexual History Form		
Frequency of Intercourse	once/month	less/once month
Frequency of Desire	once/week	once/day

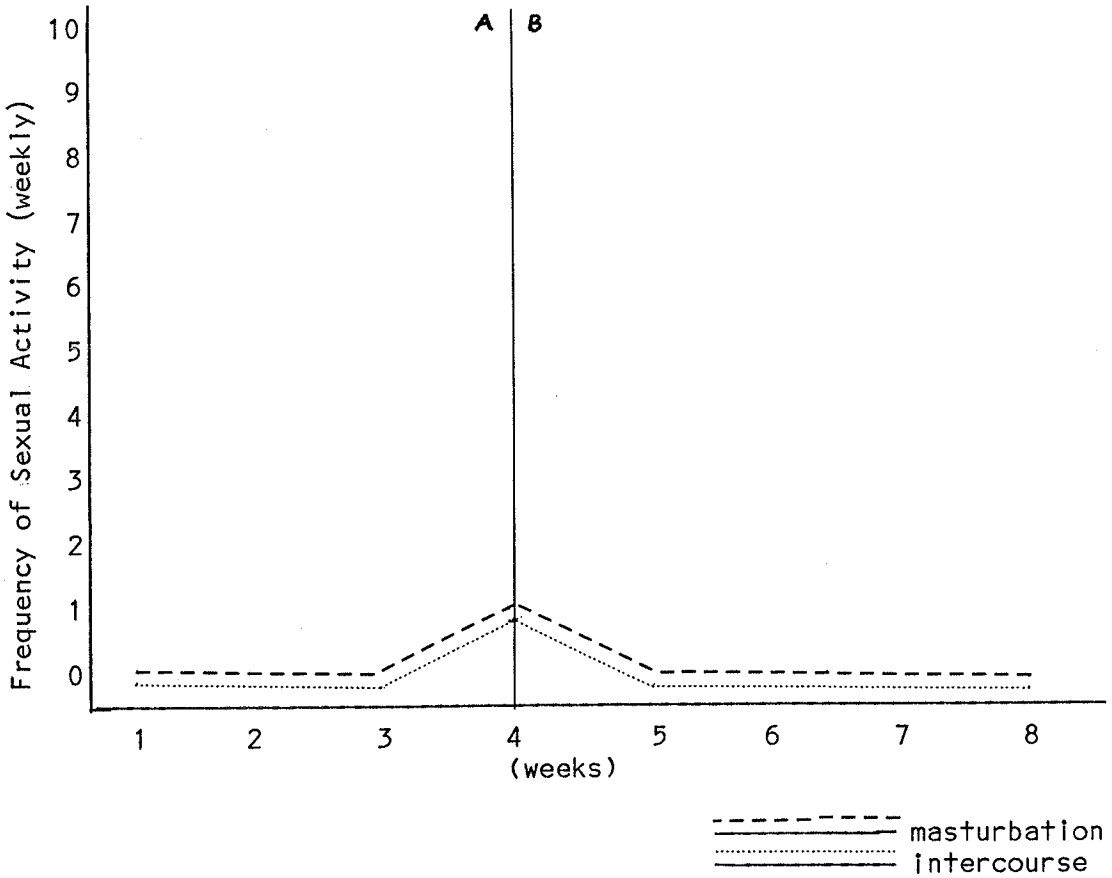
Interpretation: Appendix Fourteen

GRAPH 3 - SUSAN

(a) Arousal



(b) Orgasm



CASE 4

Lynn and Fred: inhibited sexual desire
(sexual aversion)

ASSESSMENT REPORT

Lynn was self-referred to the Sexual Dyfunction Clinic because of her problems with impaired psychological arousal and aversive reactions to sex. Her problems have worsened since referral, as she reacts aversively to any physical contact with her partner.

Description of problem(s)

Lynn reacts by becoming tense and withdrawing from her partner when he touches or caresses her in certain parts of her bod (nipples, neck, sides, genital area) during lovemaking. She is turned off, psychologically, when this occurs and she feels an urgency to stop further sexual contact. If her partner persists or attempts to persuade her to continue, her physical reaction and adverse psychological reaction increase and she becomes afraid, angry, and disgusted simultaneously.

Lynn has experienced these feelings in two previous relationships, in much the same manner as she does at the present. In all three cases, her negative reactions (psychological and physical) occur with increasing intensity and frequency as the relationship develops and emotional (intimacy) commitments are apparent. Thus, in a new or casual relationship Lynn does not experience any problems (as described above) and finds sexual activity very pleasurable. If the relationship does develop, she initially reacts (negatively) on infrequent occasions and to a minor extent so that she can continue the activity. Later, she is more sensitive (in more parts of her body); she reacts more frequently and more adversely until sexual activity becomes intolerable to her. While she had always intepreted these reactions to mean the relationship must be wrong for her and she subsequently ends it. She does not feel that this is the case at the present despite the fact that the problem is more serious than ever before.

Lynn feels that she would not react so aversively to caressing, kissing, etc. if she did not feel that it would lead to sexual intercourse (or activity). However, she finds it impossible to distinguish between an affectionate hug or kiss and one which suggests further sexual contact. She also states that she has more control over these feelings if she is the aggressor. For example, if Fred (her partner) makes a sexual advance and she refuses, he often persists until she becomes angry and somewhat disgusted with him (ie. "men are animals"). When he does give up, she often decides that she would like to make love and proceeds to approach him (he is always agreeable); in these cases she has minimal, if any, negative reactions towards sexual activity.

Contemporary influences on problem(s)

As mentioned above, Lynn is concerned with her problem because she knows that it is irrational and unfair and she does not usually communicate, to her partner, her feelings towards him and towards sexual activity, in general. She knows that her changing perception of Fred (as intimacy increases) is reflected in (her) thinking that what was once seen as gentle, kind, or patient behavior, for example, becomes weak, passive, and fearful in her mind. Her immediate reaction to sexual advances is panic as she anticipates this negative reaction. This causes her to remain constantly aware of her reactions (physical and psychological) towards her partner and his actions as lovemaking occurs.

Emotional reactions

Because of her awareness of her reactions towards her partner during sex Lynn feels very guilty and frustrated with herself and her partner. She feels guilty because she feels that he is personally offended and disappointed. She is frustrated with herself because she has no control over her reactions and frustrated with her partner because he often persists with lovemaking (or his advances) and he does not seem to understand the extent of her feelings. Lynn also feels tense and anxious if a sexual advance is made as she immediately wonders if "it will

happen again"; this anxiety continues throughout the initial stages of foreplay until intercourse starts (usually) after which she knows it will not happen. Recently, however, she began to feel this way during intercourse, as well, to increase her anxiety and frustration.

Situational consequences

Lynn's partner (Fred) has taken her negative reactions and frequent rejections very personally and he is not able to understand the reasons for their occurrence. This has put a major strain on their relationship, to the extent that Lynn has begun to think about plans for her life after they separate.

Because of Lynn's frequent rejections of Fred's advances, he has stopped attempting to initiate sex as often as he did previously. As a result, the frequency of their sexual activity has decreased significantly. As well, they feel that the quality of their sexual relationship has decreased as they are both tense and careful and Lynn is always watching and anticipating her response.

Personal and family backgrounds

Lynn is 27 years old; Fred is 35. They have been living together for two years and they knew each other for one year prior to that. Lynn is divorced and has been involved in one (previous) common-law relationship. Fred is in the process of a divorce and he has been separated from his wife for 4 years. He initially had trouble adjusting to the separation nd he returned to his wife and family (two children, aged 6 and 8) several times prior to meeting Lynn. At present, he is having problems with custody and support arrangements; much bitterness exists between Fred and his wife and he cannot assert himself to the extent that he could resolve these difficulties. The situation between Fred and his wife and family is a constant source of tension in his relationship with Lynn.

Lynn is presently a student at the Unversity of Winnipeg; prior to this year she had worked at various banks and credit unions (for 10 years) as a loans manager. Fred is a high school guidance counsellor.

Lynn does not ascribe to any particular religious beliefs; she was confirmed in the United Church but has not attended Church since that time. Fred is Jewish but he is non-practising, except for Passover. His children attend Hebrew school, as did he when he was a child. Lynn states that religious differences are not a problem between them but she will not convert to Judaism.

Lynn and Fred have a fairly active social life as they have a large network of friends and see them quite often. Lynn has many more friends than does Fred as she is very friendly and outgoing. Fred is somewhat withdrawn and he prefers to spend his time with Lynn (alone). Lynn sees this characteristic as a weakness in Fred and wishes that he would go out more frequently and be less attached to her, especially for social gratification.

Partner's parents

Fred's mother died in September, 1982 and his father still lives in Winnipeg; he does not seem to be very close to his family. He has one sister who lives in Edmonton; the family usually gets together at Passover (here or Edmonton) but otherwise rarely sees each other.

Client's parents

Lynn's parents are divorced. Her father still lives in Stonewall, Manitoba where she grew up. Her mother has remarried and lives in Toronto; she often travels as her present husband is an Engineer and has international contracts. Lynn has one brother who is 29 years old; he also lives in Stonewall with his family. Lynn does not seem to be very close to her family and sees them on holidays and special (family) occasions.

Lynn's father has always been a very private person. He is a warm and reliable person and very supportive of the children and his wife, but Lynn does not feel very close to him.

Lynn was much closer to her mother. Her mother has had a history of illness (since before Lynn was born); she spent alot of time in bed or in the hospital, as she had several operations (approximately 18) for back pain. While Lynn was growing up, then, she spent alot of time with her mother (sitting with her while she lay in bed and talking to her). Lynn always felt that her mother ws "super-human" as she lived with so much pain and still managed to do most of the housework and care for the children and her husband. As a result, Lynn always felt that she should be supporting her mother and helping her more and she felt guilty because she could not and, frequently, would not do this (ie. when a teenager, she preferred to go out rather than stay at home and help her mother).

When Lynn was 16 her mother left her father. Prior to this separation, her mother confided in Lynn about her marital problems and overall unhappiness. Since Lynn felt responsible for supporting her mother, she did not try to talk her out of leaving and did not really defend her father. As a result, when her mother did leave she felt she had betrayed her father and that she was partially responsible for their separation. Lynn's mother moved to Winnipeg after the separation and stayed there until she moved to Toronto and remarried several years ago.

Lynn has always felt that her mother is nearly perfect because of the way she has managed with her illness and made sacrifices for the family. While they are still quite close, Lynn does not feel that either of them have been completely honest with each other; when she does attempt to be honest there is much tension between them.

Childhood and puberty

Lynn describes a positive attitude towards sex in her family despite a lack of direct conversation or discussion about the subject. She reported that she always knew about sex (between her parents) and that it was normal and enjoyable in such a relationship. Lynn was able to discuss her own sexual problems, experiences, and uncertainties with her mother. She notes that she was able to confide in her mother after the first time she and her boyfriend attempted intercourse (age 16); her mother was very open and supportive.

Lynn's first boyfriend was her first sexual partner; they began to date when she was 16 years old and, soon after, were engaging in sexual intercourse. After their first unpleasant attempt at intercourse their sexual relationship was satisfactory, although never very exciting. She felt that they were like good friends who regarded sex as an obligation in a dating and (later) marital relationship.

Traumatic sexual experiences

Lynn decribes two sexual experiences which were more disturbing than traumatic; according to Lynn, neither incident was very serious and each was limited to one encounter.

First, when Lynn was twelve or thirteen she took confirmation classes from a Minister who took each of the "more mature" girls in the class to his office to explain his true desire to be a dentist and, following, to examine their teeth. He would also tell them that he always wanted to be a father (to have daughters), so "would they please call him father". He did not make a direct sexual advance. He was subsequently forced to leave the Church (and in fact the Ministry) after he was reported by the girls. Second, Lynn's Grade eight teacher would approach the girls in the class during their films and show them Playboy magazines, stroke their hair, and tell them what (his) daughters did with sanitary napkins. Lynn was embarrassed and she felt rather guilty about this because she did not tell her parents for over a month. The teacher was eventually reported and fired.

Sexual experience before current partnership

Lynn was sexually active when she was 16 years old, and she began to masturbating at approximately this same time. Despite an initially disappointing sexual relationship (her first boyfriend/husband was not very interested in sex), she has always been interested in sex, easily aroused, and orgasmic.

When she first started having sex (regularly) she was very easily aroused. Her boyfriend would stimulate her until she was just about going to have an orgasm, and then he would stop stimulating her and tell her to calm down. She describes this as very frustrating and probably the reason she lost interest in him as a sexual partner. She dated her (first) husband for 3 years prior to their marriage (that lasted one and one-half years).

Lynn began to feel almost repulsed by her husband's touches and sexual advances about three months after they were married. This got progressively worse until their separation, at which time sexual activity had stopped. She attributed her aversion to sex at that time to the failure of the marriage generally.

Lynn became involved with Vic three months after her separation. They dated for six months and lived together for one year. Vic was a very unhappy and "needy" person and Lynn felt that she always had to be the strong, positive partner. She began to lose interest in sex, and later, to find it aversive so that their sexual relationship actually terminated several months before they broke up. At Vic's request, she went to see a Psychiatrist but was not satisfied with his suggestion that they marry in order to resolve the problem. Instead, she and Vic broke up. She attributed her negative reaction to sex to their other relationship problems.

Her third partner, Ed, was her co-worker for one year prior to their dating (one and one-half years after she broke up with Vic). Ed was in the process of separating from his wife when Lynn and he started dating. She describes their relationship as a "cliff-hanger" as Ed was always coming and going; she was never sure of his feelings for her, nor of any commitment or future with him. They saw each other for one year, until he moved to Toronto. Lynn was very attracted to Ed and found their sexual relationship very exciting and highly satisfactory. She never experienced any sexual problems with Ed.

Lynn also had several casual sexual partners before she met Fred (these were usually between longer term relationships). She describes these as very exciting and sexually gratifying for both herself and her partner(s).

Current Partnership

Lynn and Fred have known each other for three and one-half years and have been living together for two years (at the time of writing). They became sexually involved approximately six to eight weeks after they started seeing each other (they did not actually "date" initially and their relationship had seemed more platonic to Lynn). Their sexual relationship was very positive and satisfying for the first six months; they had sexual intercourse very frequently (5-7 times per week), initiated approximately equally; they considered it to be an important part of their relationship.

Shortly after they began living together, the couple went for a one month holiday to Europe. Lynn felt that the holiday was a disaster because she could not stand to have Fred near her; he repulsed her sexually and she had to force herself to be near him. However, she was determined not to let this spoil Fred's holiday so she concealed it as much as possible. Their sex life improved when they returned home and it only began to get worse after they began to live together. Since that time it has become progressively worse and it has become a major problem in their relationship.

Lynn was using birth control pills as a contraceptive measure until approximately 8 months ago. She and Fred began to discuss marriage and children at that time and Fred had an operation to reverse his vasectomy (It is noted that their sexual relationship also worsened at approximately that time, despite its overall gradual deterioration.) Lynn is no longer sure that she wants children, due to the present uncertainty of their relationship.

In general, Lynn and Fred are quite happy and compatible. However, several problems, as noted earlier, do exist in their relationship. Lynn does not find Fred particularly attractive; she was initially attracted to him because she felt he was a warm and gentle person. She finds that (as with all previous partners) she has to be the strong, positive person who makes the decisions; she always supports and consoles Fred when he is unhappy. She feels that Fred is emotionally dependent and has tranferred this from his mother to his (previous) wife to her. She feels that she is losing respect for him and that he is often too weak and too demanding of her emotional energy. Fred, on the other hand, has always been (and still is) infatuated with Lynn and he sees no wrong in anything she does. She feels that this only puts more pressure on her to meet his expectations and not to hurt him. Lynn feels that she could survive the breakup of their relationship much more easily than could Fred and she realizes that this is a possibility at the present.

Self concept

Lynn is quite insecure and since her childhood she has been insecure, "guilt-ridden", and needy of affection. However, she knows she is not perceived by others in this manner as she is always the strong, sensible, and positive person. She has many friends and is considered to be a "good" friend for the above reasons. She is attractive, friendly and intelligent.

Attitude towards treatment

Lynn is a very motivated client as she feels that her problem could spoil this and any future relationships she may have. She is capable of meeting the time and organizational demands of therapy and is realistic in terms of its possible longevity. In terms of desired outcome, she is concerned with understanding and resolving her current sexual problems within or outside the context of this relationship.

PROBLEM FORMULATION

Dysfunctional behavior

Lynn's dysfunctional behavior involves impaired psychological and physiological arousal and aversive reactions (muscular tension, turning away, for example) during sexual activity. Initially, she reacted this way only from being touched in certain places during foreplay (ie. breasts, sides); she was frequently able to ignore or "wait out" the feelings and eventually respond. However, since onset, this problem has become progressively worse. Lynn reacts negatively to her partner's sexual advances (frequently refusing him) and feels this way on all occasions and throughout foreplay and intercourse. The frequency of their sexual activity has declined sharply and has become a source of conflict in their relationship. Lynn has had this (same) problem in two previous relationships. In both of these relationships, the problems gradually worsened until the relationships ended.

Hypotheses

Lynn's problem has occurred in three separate relationships, in similar manner(s), and with a similar onset and course. In each case, the relationship was quite serious and involved an emotional commitment to the other person. As they became more intimate and were living together or as marriage or children were discussed, the problem worsened. In each of the two previous relationships, she interpreted these problems as a sign that the relationship was over.

Lynn never felt this way during the initial stages of the relationships or in casual (sexual) encounters. The three relationships (above) have had other similarities. In each case, Lynn became involved with the men very soon after they met; she later grew disillusioned and discontented when she became aware of their weaknesses. In each case, the men were, in fact, experiencing personal problems or were in some way "needy" and Lynn assumed the strong, positive role in the relationship as, she felt, was mutually expected. In each case, Lynn provided

support, strength, and emotional energy to her partners; this was not usually reciprocated and Lynn saw the relationships as somewhat one-sided and emotionally draining.

It appears that Lynn has negative expectations of intimate relationships. These have been reinforced by her experiences in each case increasing intimacy has involved an increasingly unequal balance of support. Thus, when this becomes apparent in their relationship and when Lynn is making more decisions and providing more support to her partner, she reacts aversively to sexual activity. She begins to focus on her partner's weaknesses and resents him for the same.

It appears, then, that Lynn's sexual problem represents a reaction to intimacy in her relationships. She fears losing control in anticipation of being hurt, and she attempts to prevent this by becoming overly critical of her partner. She also becomes overcome with strong, fearful, and aversive reactions to physical intimacy, as sex begins to represent an expression of their feelings rather than only a source of sexual satisfaction.

Resources for treatment

Situational resources

The general relationship between Lynn and Fred is quite good. They are able to communicate quite openly and they are presently committed to the relationship and therefore motivated towards therapy to the extent that it may affect the future of their relationship. No sexual dysfunctions have been apparent in Fred, according to Lynn's report. The couple both have the time, organizational capacity, and intelligence to fully comprehend the information presented during therapy and to understand and complete the questionnaires and assignments during this process.

Personal resources

Lynn is highly motivated towards therapy at the present time as she sees the future of her (current) relationship largely dependent on the

resolution of her problem. She is intelligent and articulate. She holds no strong religious beliefs which may hinder her acceptance of therapeutic procedures or assignments. Lynn is in good health and has no apparent psychiatric syndromes.

Professional resources

Since initial contact, the therapist has spent approximately one and one-half hours per week with the client; this will continue throughout therapy. While information on this type of problem (intimacy) is still limited, the therapist understands the nature of this problem (as the client has described) and possesses the skills and resources to undertake therapy with the client. At present, therapist and client have a very good relationship.

Therapeutic goals

The therapeutic goals have been selected by the client and discussed with the therapist during assessment interviews. The goals are directed specifically at replacing the sexually dysfunctional behavior with more satisfactory (according to the client and her partner) behavior. The goals thus reflect realistic alternatives to the present problems.

1. To enable Lynn to respond to sexual advances (or initiate the same) without negative psychological reactions and/or aversive physical responses. This includes her responses to initial sexual contact, sexual foreplay, affectionate touching/caresssing, as well as verbal suggestions by her partner. In terms of initiating sex, Lynn would like to be able to do this more often without fearing aversive reactions.

2. To enable Lynn to resolve her fears and ambivalent expectations and perceptions of intimate relationships and to understand her sexual problem in the context of these feelings.

3. To enable Lynn to apply this knowledge to her present relationship, to enhance the reciprocity of the relationship and the balance between her and her partner in terms of providing support, love and encouragement on a mutual basis. It is noted that this goal implies a change in Fred's behavior as well as in Lynn's. In order to facilitate this change, Fred will also be involved in therapy (see Goal 4).

4. To improve the couple's communication and problem-solving skills.

Planning treatment

Therapist

A (female) therapist, with good understanding of this situation, will be involved in treatment. Access to additional resources, if required, is available. The client and the therapist have a good relationship. The client and her partner will be seen at the Sexual Dysfunction Clinic (Psychological Services Centre). Treatment will commence immediately and consist of weekly one and one-half hour therapeutic interviews, as established during assessment.

Treatment program

The treatment program consists of five basic components, reflecting the therapeutic goals and sequenced in approximately the following order.

1. Cognitive restructuring to examine and resolve Lynn's attitudes and feelings towards intimate relationships will be involved. The primary focus will be on Lynn's current relationship. Some attention will also be paid to improving Lynn's self-esteem.

2. Relationship enhancement to improve the couple's communication and problem solving skills.

3. Desensitization, through a gradual process of sensate focus or pleasuring, to directly confront Lynn's current sexual response.

4. The provision of information (verbal and bilbiographical) to the client, as required.

5. Various segments of the Heiman et al., (1976) program for becoming orgasmic will be used for therapeutic purposes (for example, to demonstrate and explain specific sexual skills, as noted in #3, above).

TREATMENT SUMMARY

Treatment commenced with cognitive restructuring following the program developed in the assessment. The therapist and client systematically examined the client's feelings and attitudes towards herself, her partner, intimate relationships, commitment, and sexuality as a component of intimate relationships. This proved to be very effective in enabling the client to understand her sexual problem in the context of an intimate relationship especially as it appeared to reflect her fears concerning commitment, trust, and loss of control.

Therapy sessions also incorporated the provision of information regarding sexual dysfunction of this nature, as it often relates to emotional and relationship factors. This was useful in reassuring the client and in providing an explanation of her behavior; this was also effective in supplementing the cognitive restructuring process and improving the client's prognostic expectancy.

Despite these improvements, the client continued to experience aversive reactions to sex however on a less frequent basis. She tended to fluctuate between showing a normal sexual resonse and being overcome with aversive reactions to sexual activity. Each time that contributing factors were identified and discussed, she became more reassured and confident of herself (in the relationship) and she was able to resume normal sexual behavior. This process continued for approximately 4

months, until it appeared that the client had resolved her fears concerning the relationship and no longer reacted to sexual activity.

While the client was involved in the cognitive restructuring process described above, she and her partner were also engaged in relationship enhancement excercises. This involved communication training and problem solving (Jacobson and Margolin, 1979) as Lynn endeavoured to express her feelings towards the relationship and, in particular, towards her partner. As well, they attempted to resolve the problems they were experiencing as a result of unclear expectations of each other, unmet needs, and faculty assumptions concerning each other's feelings. This process was very effective in increasing Lynn's trust and reassuring her of her partner's support and commitment.

Desensitization was also attempted simultaneously with the above processes when it became apparent that the client was emotionally capable of undertaking sexual assignments. Audio-visual aids (selected portions of the film "The Diagnosis on Treatment of Erectile Difficulties" which demonstrated sensate focus) were used to supplement verbal and bibliographical explanations of sensate focus. However, the client displayed a very strong negative reaction to the film and to the exercises and could not proceed with this process. As a result, this (desensitization) process was not pursued in therapy.

The client terminated therapy after seventeen therapeutic sessions (five months of treatment) as she and her partner felt that they were satisfied with the results of treatment. Lynn no longer reacted aversively to sexual activity and she felt that she had gained the understanding of herself and her problem in order to deal with occasional setbacks if these occurred.

The client reestablished contact with the therapist four months after termination. At that time, she was experiencing a serious setback and could neither understand nor deal with the recent onset of her aversive reactions to sexual activity. Therapy was resumed with a focus on the events which precipitated the reoccurrence of her problem. It

became apparent that she and her partner had been experiencing some relationship difficulties. They had been discussing the prospect of marriage prior to the onset of these difficulties and it appeared that Lynn was still afraid of this commitment. She began to withdraw again, causing her partner to react, and eventually, this led to serious arguments involving their future.

Lynn's fears were discussed and cognitive restructuring was again commenced with a focus on the same issues which were initially dealt with in treatment. The provision of information, roleplaying, and communication training were also incorporated into therapy to supplement this process. Lynn was seen for an additional 10 sessions (over a period of 5 months) before it was felt that she had resolved her sexual problem.

OUTCOME

Lynn gained a very good understanding of her sexual problem in relation to her fears of commitment and intimate relationships. Over the process of a year, she was able to develop a sense of trust in her partner which reinforced the knowledge she had acquired in therapy. She was very satisfied with her relationship and very happy with her partner's support and commitment to their relationship. She no longer reacted aversively to sexual activity and was confident that she had resolved this problem. This was also the opinion of the therapist, noting the verbal reports by the client and her partner. Questionnaires were not administered consistently throughout assessment and treatment; subsequently, the scores were not considered to be an accurate representation of outcome.

CASE 5

Arlene and Bill: primary inorgasmia

ASSESSMENT REPORT

Description of problem(s)

Arlene was referred to the Sexual Dysfunction Clinic by her gynecologist, whom she had seen regarding her inability to reach orgasm. With the exception of one sexual encounter approximately three years ago, Arlene had not ever been able to reach orgasm through any means of stimulation. Although she has never masturbated, her husband (her only sexual partner) has provided direct clitoral stimulation (manual and oral) and penile thrusting without additional direct stimulation.

Arlene's level of sexual desire fluctuates slightly but appears to be within a normal range. As well, her physiological and psychological arousal is satisfactory.

Arlene describes the problem as one in which her arousal increases to a very high level when she and her husband make love; she reacts by wanting the feeling to stop (rather than going with it) but is unsure of her reasons for this.

Contemporary influences on problem(s)

Since Arlene's problem may be considered primary and global in nature, it is not affected by any situational factors which would otherwise be considered. However, in these same terms, it would be useful to examine the situation during which Arlene once did have an orgasm. This occurred one night after she and Bill had come home from a party, at approximately 2-3 a.m. They had both had a few drinks but neither was drunk; she was not surprised that they had made love as this was quite common after socials occasions. Arlene considers her level of desire to have been much higher than usual at that time, as was her arousal, as she

had been very relaxed and aroused by the cues that she and Bill had been exchanging throughout the evening. During lovemaking, she does not recall direct clitoral stimulation and she had an orgasm during penile thrusting alone. Arlene felt that this encounter was very reciprocal, in terms of mutual interest and assertiveness.

Arlene feels that she does consciously monitor her level of arousal during lovemaking and feels that she may actually stop herself from becoming more aroused than she could become because of the anticipated frustration of not climaxing. As well, it seems that she is not sure of what to expect during orgasm and cannot let herself relax at this point.

Arlene's inability to reach orgasm and her noted reactions to high levels of sexual arousal have never been a problem to her. However, her husband does consider this to be a problem both in Arlene's ability to feel such sexual pleasure as she would otherwise, and in terms of his own feelings of satisfaction or achievement in being a good lover. Subsequently, much of Arlene's motivation for seeking sexual therapy arises out of her attempt to increase her husband's satisfaction.

Personal and family backgrounds

Arlene is 29 years old. This is her first marriage and, in fact, her first serious relationship and only sexual partner. She has been married for nearly 11 years (July 1973).

Arlene was educated as a teacher, but started having children soon after she completed University; she has never taught school and is a full-time homemaker.

Arlene was the only child of her mother's second marriage; three children from a previous marriage were much older than Arlene and she feels that she grew up as an only child. She lived with her mother, her father, and one older brother in Moose Jaw, Saskatchewan until she was nine when her father died and her mother moved to Winnipeg. She lived with her mother, alone, until she was married in 1973.

Arlene's parents were German and attended the Lutheran Church regularly. While she remembers little of her father, she recalls her mother as being quite closed in terms of her ability to talk about personal feelings. She was very strict with Arlene and only allowed her to date in groups of people or to be home before dark, before she started to go out with Bill. She considers this to have been different with Bill since he was older than she and had gained her mother's consent prior to asking her out.

Arlene grew up with very definite ideas about standards for behavior; she seldom went out and had few close friends. This is still the case, as most of the friends she and Bill have are actually friends of Bill's or were initially his friends.

Arlene is in good health. She is subject to high blood pressure, particularly when she is pregnant. She has two children and is currently pregnant with her third.

Bill is 35 years old. This is also his first marriage. Bill has a University education and teaches high school in Winnipeg. He is of Dutch background but was brought up with no sense of tradition or ethnic ties. His parents did not practise any religious beliefs; Bill did attend the Anglican Church and was confirmed in this faith when he as a teenager.

Bill was the second youngest child in a family of three boys and one girl. During his childhood, Bill's parents had recurrent problems concerning his mother's health (depressions and psychiatric care) and his father's drinking problem. His parents separated two years ago, after 43 years of marriage, and the family has subsequently become divided over the parents' problems. Bill was very hurt and upset over this situation. He rarely sees either of his parents or his siblings.

As indicated previously, Bill is slightly older than Arlene (by 6 years) and he has always taken a role as the leader in the relationship. Subsequently, most of their friendships and leisure activities are initiated by Bill and Arlene generally follows. Bill tends to treat Arlene as one of his students; they have a very unequal relationship.

Children

Arlene and Bill have two daughters, aged four and six; she is expecting a third child in March. Their older daughter has just started school (Grade one) this fall. They are both in good health.

Childhood and puberty

During Arlene's childhood, she received little information about sex. Her mother was very closed about personal subjects and she never discussed sex with Arlene. As well, Arlene was not aware of any physical intimacy between her parents. She felt that they had a practical marriage, as her mother met her dad through an advertisement in the newspaper for a housekeeper/companion and she married him shortly after commencing work for him.

Arlene learned most about sex from her husband. Prior to that time, she dated once or twice but never had any serious or sexual relationships. She had never talked to her friends about sex.

Traumatic sexual experience

Arlene describes two separate (sexual) experiences that were traumatic in nature.

The first of these occurred when she was living with her parents in Moose Jaw, Saskatchewan and was recurrently fondled by an older "travelling dentist" who stayed with their family one winter. Arlene was approximately 8 years old at the time. She describes waking up to find this man fondling her genitals. Each time, he would motion her to keep quiet and he would leave the room. Arlene felt very guilty about this and never told anyone except her husband. She hated the old man but she felt helpless because her parents didn't know. She could not tell them but she could not stop this man by herself. After several months he left their home and the problem ended.

The second incident occurred when Arlene was in her mid-teens (14-15 years old) and involved her brother-in-law who was much older than she (he was 35-40 years old at the time). In this case, her brother-in-law would frequently drop by for coffee on mornings when her mother was working. Arlene was always intimidated by him and was slightly afraid of him because of his suggestive remarks and glances. He also kissed her very "passionately" (she felt). She was both afraid and repulsed by this. She attempted to push him away but she did not want to be too disrespectful. These encounters did not go any further than this; the brother-in-law stopped coming after several months but for reasons of which Arlene is not aware. She felt very guilty and repulsed by this and has never told anyone about this incident. She feels that she was much less a victim in this case (than when she was a child) and therefore she still feels that she was in some way responsible or, conversely, that she could have stopped it sooner.

Puberty

Arlene began to develop (physically) at a very early age and she started menstruating when she was 11 years old. She was very mature looking as a teen and did not really fit in with the other people her age. Since she had been brought up largely in the company of older people, Arlene found it easier to relate to people who were older. She was very shy and uncomfortable around people her own age and, coupled with her physical appearance, had very few friends her own age.

Current partnership

Arlene and Bill were married in July, 1973. They met at a party at the home of Arlene's neighbours for whom she babysat. Arlene was in Grade 12 at that time. Bill did not realize that Arlene was as young as she was and he asked her out. She began to see him more regularly and Bill proposed in September. They were engaged in December, 1972. Arlene and Bill first slept together shortly after they became engaged. Arlene felt that Bill always pushed her as she did not want to sleep with him before they were married. She was very young, inexperienced, and

scared. Bill treated her like a child, in many ways, but Arlene always appreciated it because she did not feel capable of making her own decisions, motivating herself, or judging her own abilities or preferences. She felt that Bill rescued her from her mother's domination and took over this role.

Arlene has generally enjoyed sex but her desire and arousal have fluctuated according to her moods, her husband's moods, and the nature of the interaction between them. For example, Arlene felt that Bill had often talked her into making love when she really didn't want to. She also is both humiliated and angered when Bill forces her to make love when he is drunk because she feels that she is being used. She is too afraid to object, however, for fear that he will become violent.

The relationship between Arlene and Bill is, on the whole, quite good in the opinion of both. Their relationship is based on a pattern of interaction which always sees Bill in a dominant position. He believes that Arlene cannot make the simplest decision on her own and he takes much pride in the fact that he talks her into doing everything she does which is worthwhile. He talks to her and reprimands her as though she were one of his students. She is completely submissive around him. Arlene feels that Bill has a tendency to be violent (so far only verbally abusive) when he has been drinking and/or when he has had a particularly frustrating day at work. Arlene is afraid of Bill when he is moody and she does not want to provoke him even when he is in a good mood.

Self concept

Arlene has a very poor self-concept. She feels that she is quite plain looking and that her large breasts prevent her from ever looking sexy or attractive; she is very self-conscious about her physical appearance.

Arlene does not feel that she is attractive or popular. She finds that she can never think of the right things to say to people; she has trouble talking in groups and she is very shy. She has few good friends,

male or female, and she has made friends with Bill's friends. Arlene feels that she lacks motivation, ability, and intelligence; in general, she feels that her presence or absence would never be noted.

Attitudes towards treatment

Arlene is fairly motivated in therapy at the present time. She feels that when she starts something, it is very important for her to finish. As well, therapy for her problem is very important to Bill and she feels that by becoming orgasmic she will also contribute to his sexual satisfaction. Arlene does not work outside the home and therefore she has the time (and ability) to organize her activities to include therapy sessions and assignments. Arlene is seeking to become orgasmic through masturbation and with her partner. The observations of the therapist (regarding Arlene's self-esteem) have also been discussed with her and she is interested in working to enhance both her self-esteem and assertiveness.

PROBLEM FORMULATION

Dysfunctional behavior

Arlene is inorgasmic. She cannot reach orgasm through manual or oral stimulation or during sexual intercourse with her husband. She has never masturbated. Arlene has only had an orgasm once; this was very spontaneous and occurred during sexual intercourse without additional stimulation.

Hypotheses

Several causal factors may be identified in this case. First, Arlene has never masturbated and has not been concerned with receiving any direct stimulation from her husband. It appears, then, that this may be partly a matter of inappropriate or insufficient stimulation and lack of awareness of her own sexuality. However, Arlene also feels that she does react by "turning off" when she reaches high levels of arousal because she is afraid of the feelings she is experiencing and she cannot

seem to deal with the intense feelings of pleasure. This may relate to her feelings of worthlessness if she does not think that she should feel such pleasure. The effects of her molestation as a child and the seductive behavior of her brother-in-law as a teen are unclear at the present. Arlene denies feeling any guilt or negative feelings as a result of her childhood experience. She has shared this with her husband and feels that she was a victim of a bad situation. However, she does feel guilty about the incidents between herself and her brother-in-law when she was a teen and she does not wish to let Bill know about this. The effect of these incidents will be further examined in therapy and it is the opinion of the therapist that a stronger relationship between these events and Arlene's current lack of self-esteem or feelings of worthlessness may exist.

Resources for treatment

Situational resources

The relationship between Bill and Arlene is generally good with the exception of Bill's dominating behavior. They are generally compatible enough to participate (together) in therapy and in completing sexual assignments. The couple possesses the socio-economic resources to meet any requirements of therapy.

Personal resources

Arlene is quite motivated in therapy and has the personal resources to participate in therapy. A major concern is her low level of self-esteem which may relate (causally) to her sexual problem. As well, it appears that Arlene's motivation relates to her desire to please Bill, considering his concern for her to reach orgasm with him.

Professional Resources

The therapist has allocated time for weekly one to one and one-half hour therapy sessions, as well as any additional time required for

preparation for the same. The therapist is familiar with this situation and she has a good working relationship with both the client and her partner. She possesses the knowledge and skills, or has access to additional resources, to undertake therapy with the client.

Therapeutic goals

The goals have been discussed and selected by the client, her husband, and the therapist and they are directed towards resolving the presenting problem (inorgasmia) as well as Arlene's low self-esteem and lack of assertiveness.

1. To become orgasmic during masturbation and from oral and manual stimulation by her husband.

2. To improve Arlene's self-esteem.

3. To increase Arlene's assertiveness.

Planning treatment

One (female) therapist will be responsible for the treatment process. Treatment will be based on weekly meetings of one to one and one-half hours, to commence immediately. The setting is the Sexual Dysfunction Clinic in the Psychological Services Centre, University of Manitoba. The treatment program will be flexible, according to the needs of the client, but will proceed as follows:

1. Following the sexual learning program in Becoming Orgasmic, (Heiman et al., 1976) the client will begin with self-exploration, pleasuring (general), masturbation, and progress to activities involving both her and her husband (use of book and audio-visual material).

2. Cognitive Restructuring directed towards Arlene's low self-esteem. As well, some specific assignments will be included to reinforce the cognitive restructuring (ie. from David Burns, Feeling Good, 1980).

3. Assertiveness Training.

4. Relationship enhancement, especially problem solving training.

The overlap of these components is expected and will depend on the progress and/or additional needs of the client. Any additional problems relating to the client's molestation as a child (and teen) will be incorporated into the treatment plan if they become apparent.

TREATMENT SUMMARY

Therapy initially focused on cognitive restructuring with the objective of improving Arlene's low self-esteem, and specifically her feelings of intellectual inferiority, social awkwardness, guilt and general worthlessness. Her feelings about the molestation she experienced as a child were also discussed at some length. Exercises from Mood Therapy (David Burns, 1980) were provided to Arlene to enable her to systematically identify and modify the thoughts and feelings which resulted in her poor self-concept. Arlene was very receptive to this information and progressed significantly in this regard.

Following this procedure, Arlene started on assertiveness training in order to gain the skills which she needed to assert herself in social situations, as well as with her husband in order to start changing the balance of power in their marriage.

Bill attended the subsequent therapy sessions as the focus of treatment became their marital relationship. Exercises involving communication training and problem solving (Jacobson and Margolin, 1979) were discussed and homework assignments which required practical application of these skills into their daily interaction were successfully completed by the couple. They reported that Arlene felt more competent and effective in her role as wife and mother, and as a person generally. Bill was also more satisfied with the relationship as Arlene was happier and he felt less pressure to be responsible for making most decisions in the relationship.

Arlene also started on the program for becoming orgasmic (Heiman et al., 1976) while she was involved in the above process. Her progress was quite slow as she became uncomfortable with genital pleasuring. She felt that masturbation was wrong and she felt guilty about doing the exercises which required this. However, she did discuss this and cognitive restructuring was engaged in so that Arlene was able to resolve this to the extent that she could proceed with the exercises involving genital stimulation. She reported that she did become aroused by stimulating herself but did not reach orgasm.

Arlene subsequently realized that she had never been as interested in her ability to have orgasms as had Bill, but that she was largely going through this process to increase his sexual satisfaction. She was also feeling that, due to her pregnancy, she did not feel very sexual and that becoming orgasmic was not a concern for her at that time. She subsequently decided that she would terminate therapy until she felt that it was a higher priority for her. She felt very good about this decision because it proved to her that she had the right to decide what she wanted in the (sexual) relationship and that she was able to communicate this to Bill. She felt that her self-esteem and assertiveness had increased significantly as a result of therapy and she was able to make this decision for herself.

OUTCOME

As a result of these decisions, Arlene and Bill did terminate therapy without achieving the primary goal of the same. However, Arlene did achieve the other (two) goals of therapy and she was very satisifed with these results. This was also apparent in the results of the questionnaires administered at termination, in particular the Self-Esteem Inventory (see Table 5). She does enjoy sex without having orgasms and until she does wish to work on this, she was satisfied to terminate with these gains.

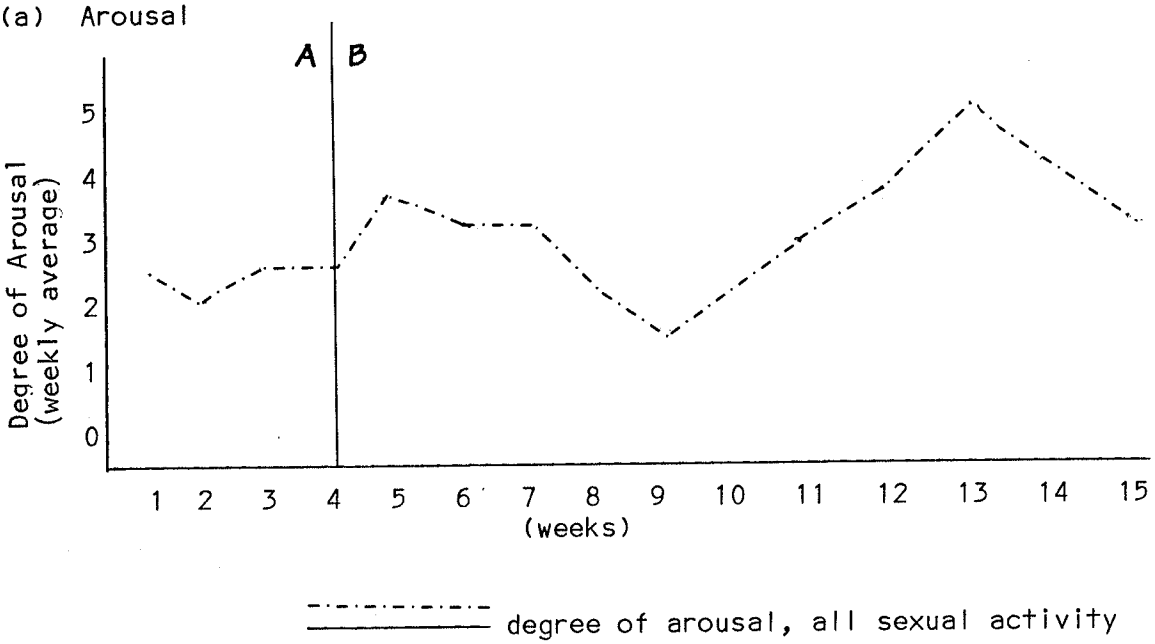
TABLE 5

INSTRUMENT	ASSESSMENT SCORES		TERMINATION SCORES	
	ARLENE	BILL	ARLENE	BILL
Index of Sexual Satisfaction	28	22	21	18
Sexual Arousal Inventory	66 (20%)		40%	
Dyadic Adjustment Scale	107	105	110	114
Dyadic Consensus	45	50	44	51
Dyadic Satisfaction	39	36	43	40
Affectional Expression	9	9	8	9
Dyadic Cohesion	14	10	15	14
Marriage Attitudes Scale	14	10	12	9
Sexual Attitudes Scale	5	1	6	3
Self Esteem Inventory	9 (4%)		16 (11%)	
General	4 (4%)		6 (7%)	
Social	5 (22%)		5 (22%)	
Personal	0		1 (14%)	

Interpretation: Appendix Fourteen

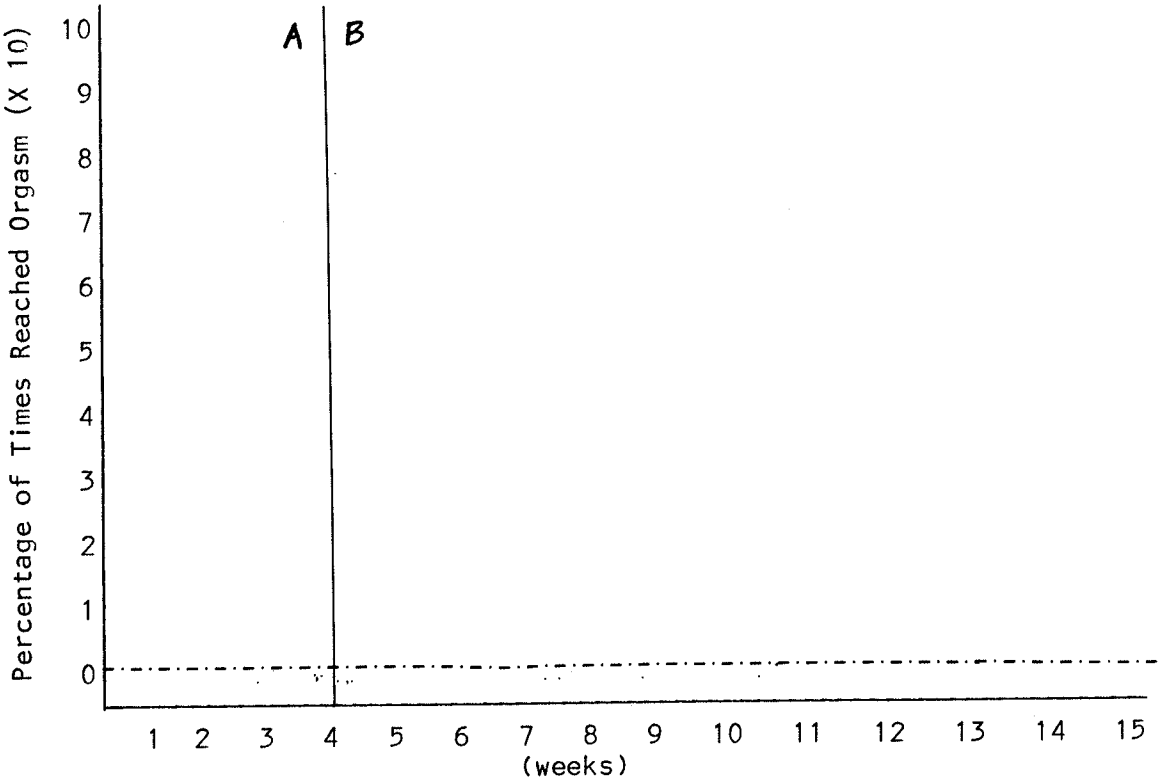
GRAPH 4 (ARLENE)

(a) Arousal



degree of arousal, all sexual activity

(b) Orgasms



orgasms reached, all sexual activity

CASE 6

Paul: erectile dysfunction
retarded ejaculation

ASSESSMENT REPORT

Description of problem(s)

Paul was referred to the Sexual Dysfunction Clinic by his physician whom he had seen for depression during the spring of 1983. At that time, Paul had also been very upset about erectile and ejaculation problems which he had experienced for several years.

Paul has difficulty getting full erections when he is with a sexual partner and, to a lesser extent, when he masturbates. His erections are usually insufficiently hard to penetrate his partner's vagina. Paul does not ejaculate when he is with a partner. In most cases, he loses his (partial) erections during foreplay and subsequently he does not ejaculate (he often has erections prior to engaging in sexual activity but these do not last when he is with his partner). When he maintains erections during sexual activity, Paul is frequently unable to ejaculate in his partner's presence.

Paul's problem have been apparent since he first became sexually active ten years ago, when he was in his early 20's. Since that time, he has only gone through one brief period during his marriage (1974-1975) when the problems did not exist. The problems have generally been consistent in nature, varying little with sexual partners. However, they are currently less serious due to the fact that his current relationship is much more trusting and secure than have been previous ones. With the exception of his marriage, he has never been able to penetrate his partner's vagina during lovemaking.

Contemporary influences on problem(s)

Situational antecedents

Paul has always been very self-conscious about his body and his sexuality. Since his first sexual experience, Paul has been very worried about whether he would be able to perform sexually and whether he would be able to have full erections and have sexual intercourse with his partner. Paul's problem is less serious with his current partner, with whom he feels less anxious and self-conscious than he did in previous relationships. As well, when his marriage was good Paul was able to respond satisfactorily and they had a relatively good sexual relationship. This stopped soon after they started having other problems.

Paul is only able to have full erections during masturbation when he is lying on his stomach; this is also the only time he is able to ejaculate. This has always been the case and, according to Paul, reflects learning more than any other specific cause.

Organismic variables

Paul always (cognitively) monitors his sexual response during lovemaking with a partner. He is always conscious of whether or not he wil get an erection, whether it will be possible for them to have sexual intercourse, how his partner will react to his problem, etc. This has always been the case since his first sexual experience due to his feelings of awkwardness and self-consciousness.

Paul has reacted to his problem with feelings of embarrassment, humiliation and depression. He also has become very anxious about his problem and lovemaking, in general, because of his expectations that he will be a failure and that his partner may be critical of his problem.

Situational consequences

Paul's partner is very understanding and supportive and she has already helped him to feel more relaxed and less self-conscious. Since

Paul has become sexually involved with her, he occasionally has been able to have erections which are sufficiently firm to penetrate for intercourse.

Personal and family backgrounds

Paul is 31 years old. He is divorced and had been married for approximately one year when he was 22 years old. He is currently involved with a woman (Ruth) whom he met in February 1983. They are very serious about each other and Paul feels that this relationship holds more promise than did his marriage.

Paul is a University student; he is in his second year of Arts at the University of Winnipeg. He has had a varied employment history having worked as a construction worker, a labourer, and a Union organizer. He is a communist and attempts to direct his studies and jobs towards this end (for example, through his work with labour unions).

Paul is of a German-Mennonite ethnic background; however, his parents left the Mennonite community when Paul was very young and the influence of religion in his background was minor. Paul acquired his strong beliefs on the importance of human equality, the work ethic, and standards of right and wrong from his parents because although they left the Church, they were still very moralistic. This has been a significant influence in his interests in politics, labour unions, and sexual equality.

Paul spends alot of his leisure time alone or with Ruth. He has a few friends but many are involved in politics and union affairs and Paul has withdrawn from this since returning to University. He enjoys quiet activities such as listening to music, going out for dinner, movies, and concerts. Paul is generally in good health.

Ruth recently moved to Winnipeg from British Columbia in early 1983. She has a Bachelor's degree in Psychology and is employed with

the provincial government. Ruth is 30 years old; she is the eldest of three siblings, aged 26 (brother) and 19 (sister). Her parents still live in British Columbia; Paul has never met them and knows little about the family.

Client's parents

Paul's family lived on a farm outside of Winkler when he was growing up. His father was a mink rancher but has since sold the farm. Paul's mother and father work in Winnipeg now; his father is a labourer and his mother is a waitress. They are 60 and 50 years old, respectively.

Paul is not close to either of his parents. He considers them to be rather cool, not expressing alot of emotion (or physical expression of feelings); he felt that he could never really depend on his parents for warmth and comfort when he was hurt or when he had problems. Despite this fact, he recognizes that they do care about him (and his siblings) and they show this by helping them with material support when it is needed.

Paul feels that his father has trouble expressing his feelings, positive and negative, towards his mother as well as towards the children. His parents were never particularly expressive or affectionate towards each other. He feels that this reserved behavior is a result of their strict Mennonite background.

Client's siblings

Paul has a younger brother (aged 29) and sister (aged 25); he is close to both of them but feels that he gets along better with his sister who is more expressive and supportive than his brother. Paul finds his brother to be friendly and outgoing but somewhat distant and they do not understand each other well. Both his brother and sister have relationships with their parents which are similar to that described by Paul.

Childhood and puberty

Sex was not ever discussed in Paul's home; however, no negative attitudes were ever expressed either. Paul subsequently acquired all of his knowledge about sex through conversations with more "experienced" friends and through sexual experiences with more knowledgable partners when he was in his late teens and early twenties.

Paul's parents never supported the idea of him dating when he was home and, in fact, interfered and prevented him from going out with a girl in whom he was interested in high school.

Paul was always very shy and awkward around women; he avoided going out with girls until he was in his late teens (particularly after the above experience). His first sexual experiences were somewhat traumatic because of these feelings of self-consciousness. From his initial sexual encounter, Paul had erectile problems and his anxiety over this has compounded his feelings of awkwardness around women.

Sexual experience before current partnership

Paul does not recall the age at which he first had nocturnal emissions. He began to masturbate when he was in his early teens. Since he began to masturbate, Paul has laid on his stomach while he masturbates. This is currently the only means by which he can get erections and ejaculate.

Paul frequently has sexual fantasies involving the women with whom he is involved at any particular time. These are usually positive, in his opinion, and simply involve the two of them making love (Paul has normal erections and ejaculation in these fantasies).

Paul's first involvement with a woman occurred when he was 19 years old. He was on a tour to Russia with several other people (Communist group) and he was "seduced" by a woman who was also on the tour. Paul spent about 3 weeks with her, during which time they repeatedly attempted

to make love but were unable to have sexual intercourse because of Paul's inability to gain an erection. Paul was very upset and felt clumsy, self-conscious and very nervous about the problem because he had always felt shy and clumsy around women and this just reinforced his feelings. However, the woman was very patient and sympathetic and she did try to talk to Paul about the problem; he did have difficulty talking about it at that time.

Paul dated very few women after this until he met his wife, Joyce, about one year later. He and Joyce met in Toronto at a Convention of the Communist Party. She was from Vancouver and they saw each other occasionally and wrote and telephoned each other regularly. They were married within a year. Paul experienced erectile problems the first time he and his wife made love; after a few nights this problem was resolved and for the next year their sex life was satisfactory. This changed when Paul began to have increased pressure at work and problems with the union; he was unable to feel relaxed even when he was at home. At the same time, he and Joyce began to have marital problems. She was no longer happy in Winnipeg, or with Paul's heavy commitment (time and emotion) to the party and the union. She began to have affairs with other men and she became very critical of Paul and, particularly, his sexual behaviors. She constantly criticized him when they made love, especially when he started having erectile problems. Paul felt very hurt but still tried to resolve their problems, seeking professional help. He finally gave up when she initiated the separation. Paul felt like a failure over these problems and the way his marriage broke down. He felt very responsible for all of their problems.

Paul took a long time to get over this situation. Since he felt like such a failure, he took this fear into each new relationship. As well, each time he had erectile problems, these further reinforced his negative feelings towards himself and his sexuality.

Current partnership

Paul met Ruth in February, 1983 and started dating her in March. They were seriously involved, sexually and emotionally, by April and seem

to have a solid and satisfying relationship. Although Paul's problems have been reduced in this relationship, he still has erectile and ejaculation problems. Ruth has been very patient and understanding and Paul's anxiety has been reduced in this sexual relationship. He has been able to have erections which are firm enough to penetrate for intercourse. However, he loses these erections after penetration and he does not ejaculate.

Paul and Ruth spend most of their weekends and several evenings during the week together. They are very close and compatible and, although they never discuss marriage or even living together, they see their relationship continuing to improve and strengthen.

Self concept

Paul has a poor body image. He feels that he is too skinny, that he is unattractive and that he is awkward in movement and dress. He has always been very shy and uncomfortable around women. He feels that he is socially inept and prefers small gatherings to large groups.

Paul's self-esteem is low but this has improved as a result of counselling (for depression) last year. Despite the positive experience he had with counselling, Paul feels that he has to continue to apply what he learned before he will be satisfied with himself. Paul's self-esteem has also been affected by his sexual problems. He feels like a failure because he has not been successful as a sexual partner.

Attitudes towards treatment

Paul is motivated in therapy at the present. He is currently in a very supportive relationship and he feels that a good sexual relationship would further enhance this. Paul is very optimistic about resolving his sexual problems; he hopes to be able to have erections which are sufficiently hard to have sexual intercourse with his partner, as well as to maintain his erections and ejaculate when they are making love.

PROBLEM FORMULATION

Dysfunctional behavior

Paul is unable to get full erections during sexual activity with his partner. He often gets erections prior to engaging in foreplay but loses these when foreplay commences. When he is able to maintain an erection of sufficient hardness to penetrate during intercourse, he often loses it while inside his partner's vagina. He is not able to ejaculate in the presence of his partner. Paul is only able to get satisfactory erections and ejaculate when he masturabates while lying on his stomach. With the exception of his current parter, he has always been alone when he masturbated in this manner. Paul's problem has been apparent since his first sexual encounter; the only exception to this occurred when he was married approximately eight years ago.

Hypotheses

Paul has always been very awkward and self-conscious around women. He was very anxious the first time he was sexually involved with a woman; he felt like a failure and even more self-conscious and uncomfortable when he had erectile problems at that time. He felt this way with all of his sexual partners after this time, except during his marriage when he was feeling secure in the relationship. When his erectile problems reoccurred during a period of high job stress and marital discord, his wife was very critical of him and his problem. This reinforced his negative feelings towards himself and he has had sexual problems in all subsequent relationships. It seems that Paul's anxiety and self-conscious feelings have caused and perpetuated his sexual problems. Recurrent failures have reinforced these feelings and it is only in his current relationship, in which he feels quite comfortable, that his problem is less severe.

Resources for treatment

Situational resources

Paul and his partner appear to have a good relationship. Paul feels comfortable and secure in the relationship and he has already experienced a reduction in the severity of his problem. Paul possesses the socio-economic resources to participate satisfactorily in therapy; he has sufficient time to attend therapeutic sessions and complete homework assignments.

Personal resources

Paul is presently motivated in therapy as he feels that his sexual problem could be detrimental to the future of his current relationship. Paul is able to organize his time sufficiently to meet the requirements of therapy. His religious and moral beliefs will not affect his responses to new information or assignments during therapy. Paul is healthy and displays no psychiatric syndromes.

Professional Resources

The therapist has allocated time for therapeutic interviews as well as for any additional research or consultation (with supervisor), as necessary. The therapist has the background knowledge on this client's problems and current situation and she possesses the skills to undertake therapy at the present time. The therapist and client have a good working relationship.

Selection of therapeutic goals

The therapeutic goals which have been selected are directed towards alleviating Paul's sexual problems. These have been discussed at length between the therapist, client, and his partner.

1. To reduce Paul's anxiety over sexual activity with a partner.

2. To enable Paul to have full erections when he is with his partner, in order that vaginal penetration is possible.

3. To enable Paul to maintain his erections in order to have sexual intercourse with his partner.

4. To enable Paul to ejaculate during sexual activity with a partner, especially in order to ejaculate during sexual intercourse.

5. To increase the range of techniques used by Paul to masturbate to full erection and ejaculation.

Planning treatment

One (female) therapist will be responsible for therapy in this case. The setting for treatment will be at the Sexual Dysfunction Clinic at the Psychological Services Centre, University of Manitoba, and on the basis of weekly one to one and one-half hour sessions.

Treatment program

Treatment will commence immediately, according to a schedule outlined below.

1. Following the treatment program for erectile problems in Male Sexuality (Zilbergeld, 1978), the client and his partner will gradually go through a process involving sensate focus, penile stimulation, and non-demand coitus.

2. Relaxation training will be incorporated into the treatment program concurrently with the Zilbergeld program for erectile problems.

3. If appropriate at any stage in therapy, exercises aimed at improving the client's self-esteem will also be incorporated into therapy.

4. Throughout therapy, information regarding sexuality will be provided to the client and his partner through verbal, bibliographical, and audio-visual means. The basis for this will be Male Sexuality (Zilbergeld, 1978) and the "Program on the Diagnosis and Treatment of Erectile Problems" (LoPiccolo et al., 1980).

TREATMENT SUMMARY

Treatment commenced with the provision of information to the client and his partner regarding male sexuality and the psychological factors (for example, stresses) which affect sexual response. This included verbal explanations (and discussions) and the assignment of reading material regarding the same (Zilbergeld, 1978). This information substantiated the hypotheses which the client and his partner had already developed concerning the sexual problem.

With this reassurance, the client proceeded with the exercises for treating erectile dysfunction (in Zilbergeld, 1978). This incorporated relaxation training as well as the outlined procedures including sensate focus, general pleasuring, genital pleasuring, non-demand coitus and eventually the resumption of normal sexual activity. The client progressed through these processes slowly, but with success as each stage was introduced and completed. In addition to the explanations provided by the therapist and in Male Sexuality (Zilbergeld, 1978), the film on the diagnosis and treatment of erectile difficulties was also shown to the client and his partner to demonstrate the sexual assignments.

The client was also instructed to refrain from masturbating in his routine or habitual manner and attempt various other positions and types of stimulation. This was intended to change behaviors acquired through previous learning and to increase the range of stimulation which he needed to have erections while masturbating.

As the client gained more confidence in his sexual responses and was able to have (full) erections which were sufficient to engage in sexual intercourse, his anxiety level decreased significantly. As well, his

self-esteem and his relationship with his partner had strengthened as a result of engaging in the therapeutic process. The couple was able to communicate more effectively and Paul felt more confident in the relationship and more comfortable with Ruth, generally. This, in itself, improved his overall self-esteem and reduced his performance anxiety to the extent that his problems involving retarded ejaculation were also reduced.

In order that the client completely resolve his problem with retarded ejaculation, the couple engaged in a graduated program based on the "male bridge manoeuvre" (Kaplan, 1975) which gradually shaped the client's ejaculatory response towards the goal of ejaculating intra-vaginally during sexual intercourse (Jehu, 1979). The couple progressed through this program and the client was able to ejaculate without earlier noted problems.

OUTCOME

Therapy was successful in achieving the therapeutic goals originally developed by the client and the therapist during the assessment. Over a total of fifteen sessions (over five months), Paul resolved his sexual problems to the satisfaction of both himself and his partner. His confidence (overall and specifically in regards to sexuality) had also increased as a result of the successful completion of treatment. These gains were also observed by the therapist, noting the verbal reports of the client and his partner as well as the questionnaire results which, to some extent, substantiated the couple's and the therapist's observations (Table 7).

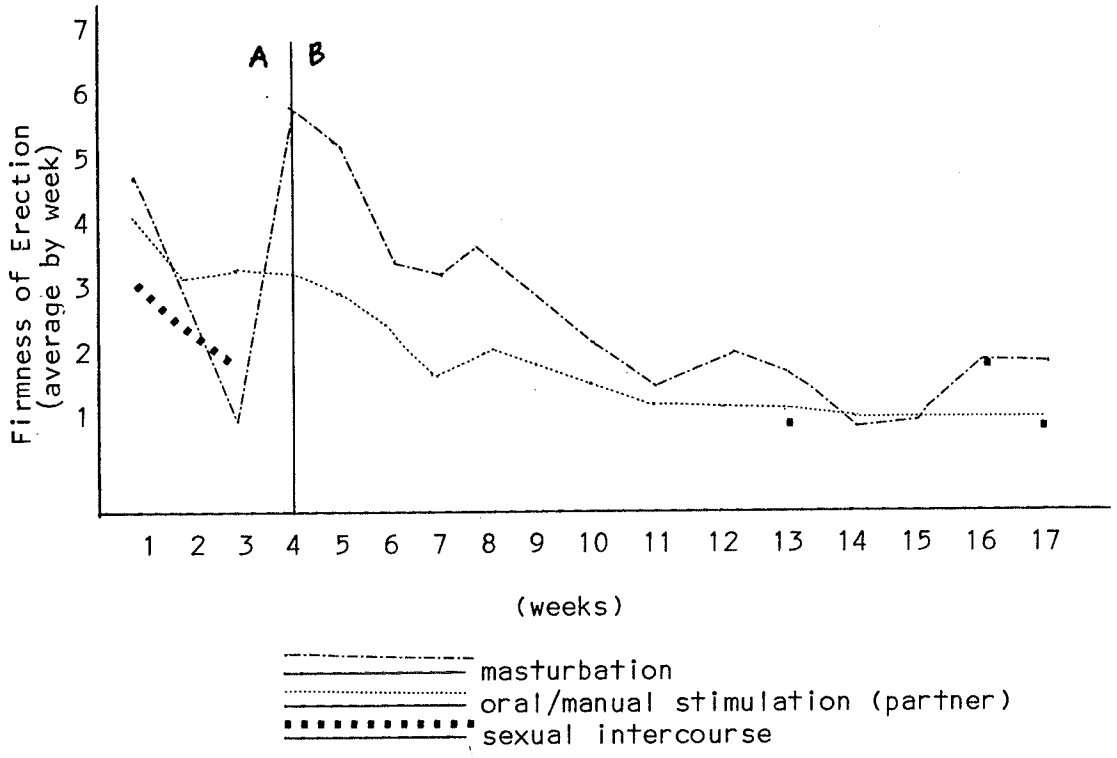
TABLE 7

INSTRUMENT	ASSESSMENT		TERMINATION	
	PAUL	RUTH	PAUL	RUTH
Index of Sexual Satisfaction	13	27	23	32
Self Esteem Inventory	14 (5%)		18 (10%)	
General Scale	8 (13%)		9 (18%)	
Social Scale	6 (51%)		7 (80%)	
Personal Scale	0		2 (23%)	
Lie Items	7		5	
Marital Attitudes Scale	24	11	21	16
Sexual Attitudes Scale	7	9	10	3
Beck Depression Inventory	14		11	
Dyadic Adjusment Scale	94	87	105	75
Dyadic Consensus	43	37	46	29
Dyadic Satisfaction	29	32	35	29
Affectual Expression	5	6	6	6
Dyadic Cohesion	17	12	18	11

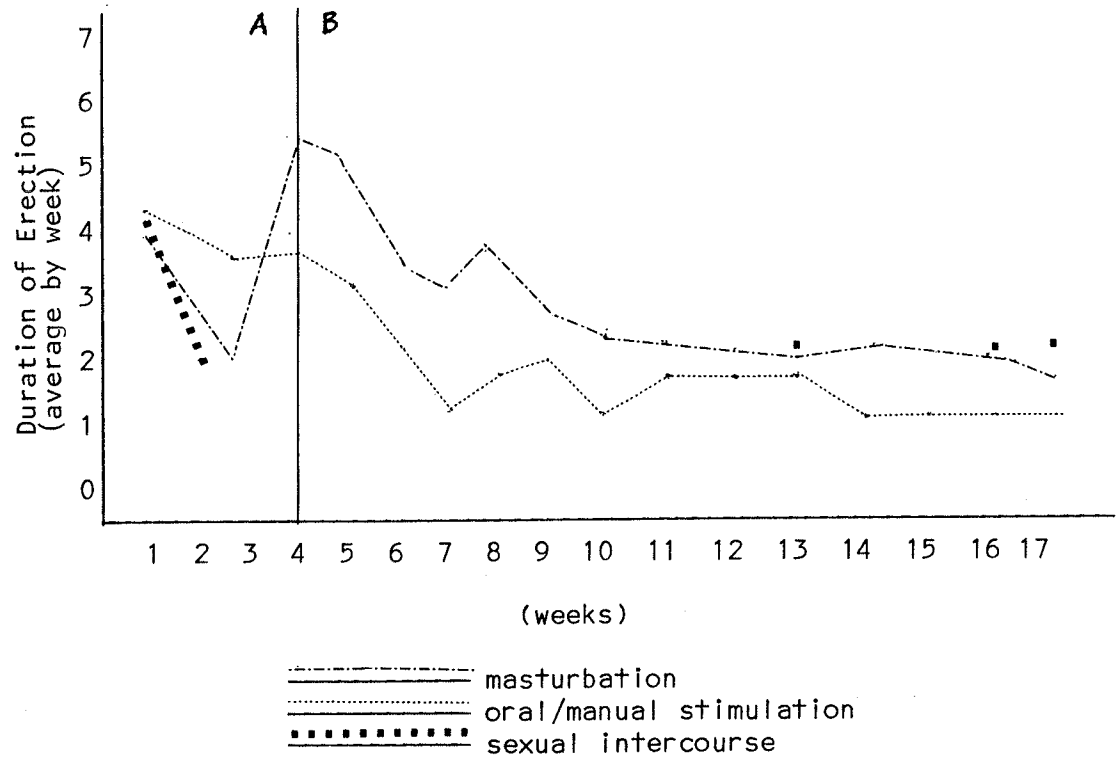
Interpretation: Appendix Fourteen

GRAPH 5 - PAUL

(a) Firmness



(b) Duration



CASE 7

Louise: secondary inorgasmia

ASSESSMENT REPORT

Description of problem(s)

Louise was self-referred to the Sexual Dysfunction Clinic. She has never been able to reach orgasm by manual or oral stimulation from a partner or during sexual intercourse. She is only able to reach orgasm in the presence of a partner when she uses a vibrator as a means of stimulation. During masturbation, Louise is nearly always (90% of the time) able to reach orgasm by manual stimulation or with the use of her vibrator.

Louise's level of sexual arousal is normal, according to the mean scores on the Sexual Arousal Inventory (see Table 8). In fact, her score of 89 was approximately 8 points above the mean. While her desire flucuates with the nature of the relationship, it is relatively high (would like to have sexual inter- course more than one per day and feels desire once a day).

Louise has had this problem since she became sexually active, at the age of 17. However, she was completely inorgasmic until she was 19 when she purchased a vibrator and became orgasmic by using it. Louise no longer uses a vibrator and feels that she can only have orgasms with very intense stimulation, in a certain manner which only she knows and which she has never taught a partner to her satisfaction. Thus, she also feels that her partners have not be able to provide the appropriate stimulation to enable her to reach orgasm.

Contemporary influences on problem(s)

Organismic variables

Louise is aware that she cognitively monitors her sexual response with her partner, especially when she becomes highly aroused. When she

is very highly aroused, she stops her partner from stimulating her before she reaches orgasm. She believes that she does so because she perceives that they are not interested in stimulating her adequately (usually in terms of time) to reach orgasm. Alternatively, she feels that they have been very selfish in terms of their sexual satisfaction and she has had to give so much more than have they. Subsequently, she decides that she will not have an orgasm because she will not give more ("they don't deserve it"). She also recalls why they don't deserve it, by remembering all of the selfish things they had done in their relationship. Louise reacts to her problem with frustration and anger, as her sexual need/desires are not satisfied. She subsequently uses this to further blame her partner for being too selfish (sexually) to satisfy her sexually. While this reinforces her beliefs about their selfishness, it also makes her angry at them and she becomes more careful of not giving so much the next time they make love.

Situational consequences

In the past, Louise's partners have been less aware of this situation and they have never considered it to be a problem. She felt that as long as they were sexually satisfied, they were quite happy in the sexual relationship. She had never identified or directed her anger to the extent that she does presently.

In her present relationship, her partner (Dan) is very much aware of Louise's concern for reaching orgasm. He feels that she is overreacting to the situation in that he does attempt to satisfy her sexually. He has become very defensive over this, as she addresses him almost accusingly when she asks for anything or suggests something new or different during sex.

Personal and family background

Client

Louise is 26 years old. She is single and has never married. She is an artist and works at a local art gallery to supplement her income

from art. She has a Bachelor of Fine Arts from the University of Manitoba.

Louise is of French and Metis background. Her family was Roman Catholic, but they did not strictly adhere to the religion; she does not practise it at all presently. She is quite liberal in her attitudes and beliefs and considers herself to be a feminist.

Louise spends alot of her leisure time at the studio, drawing and painting. Since Dan is away during the week (working) they spend their weekends toegether, alone or visiting a few close friends. Louise also sees her sisters and a few close female friends when Dan is not in town or when he is out with his friends. They have tended to drink excessively in the past as she also did in previous relationships but she drinks much less now; she does not consider this to be a problem at the present time.

Louise had one abortion when she was 25 years old. She became pregnant just before breaking up with her previous boyfriend, Michael, and went through the entire experience alone. She is still bitter over this but considers it to be quite typical of male behavior.

Client's parents

Louise's parents were divorced three years ago. She feels that they had an unhappy marriage; her parents argued alot and her father was emotionally abusive towards her mother. She feels that her father was very selfish and was only good to her mother when he wanted to gain favour with her for some reason. Her mother, on the other hand, was warm and self-sacrificing in relation to both her husband and her children. Despite their poor relationship, Louise's parents stayed together for 25 years. When her mother started working full-time, after years of being a housewife and volunteer on the local school board, her father reacted by demanding that she quit or he would leave. She did not quit and he left.

Louise's father is still in Dauphin where he lives with his girlfriend and child (from the relationship). He rarely sees his family

and Louise feels that he has been very selfish with both his time and support. She is very angry with her father; she hates the type of person that he is, and hates the way he treated her mother and the children. Since divorcing her father, Louise's mother has gone to University and she is currently employed with a rural school division. Louise is very close to her mother and proud of her strength, ambition, and intelligence.

Client's siblings

Louise has eight brothers and sisters. She is the fourth eldest with an older brother and two older sisters, four younger sisters and one younger brother. When her parents separated, all of the children moved to Winnipeg with her mother; at the present, approximately half of them are in Winnipeg. Louise sees her brothers and sisters who are close to her in age. They have been able to confide in each other and Louise notes that all of them have had similar problems in their marriages or relationships (re: strong, dominating partners, sexual problems).

Childhood and puberty

Louise states that sex was never openly discussed at home but that everyone was aware of a sexual relationship between her parents. While her parents were not affectionate as a rule, they often made sexual overtures towards each other (especially her father). Louise also heard her parents making love on several occasions and she was quite repulsed by it. She always felt that her father was very selfish and overbearing in their sexual relationship. He knew that her mother used no birth control but she did not wish so many pregnancies; he frequently made very aggressive sexual advances when her mother was tired, busy, or angry with him and did not feel like being sexually intimate with him.

Louise learned about sex from personal experience as a teenager and from her older sisters who often shared their stories with her. She had ambivalent feelings about sex because of her feelings of disgust with her parents, especially her father, but she was not apprehensive (initially)

about experimenting as a teenager. She began to engage in sexual activities (intercourse) at seventeen and started masturbating when she was nineteen.

Traumatic sexual experiences

Louise recalls one sexual encounter which was, to her, traumatic. This involved her first sexual partner, when she was sixteen years old. She had liked a (male) classmate for a year when he asked her out on a date. On the date, he tried to rape her. They were outside a house where they had gone to a party. The experience was traumatic because he tried to force her to have sexual intercourse. However, he could not penetrate because her vagina was too dry and tight to allow penile penetration. The experience was especially distressing because several people from the party saw them. Louise was also upset because this same fellow spread very vicious rumours about her being a "slut". She was very hurt, angry, and bitter about the double standards for men and women and the way in which she was humiliated because of this.

Sexual experience before current relationship

Following the traumatic sexual encounter when she was 16 (above), Louise did not go out with anyone for a year. However, when she was 17 she met Al; they went out together for 2 years. When she first dated Al she would not have sex for about 6 months; she was still feeling badly about the previous experience and did not trust Al to be discreet about their relationship. However, after that 6 month period they did have a very active sexual relationship. Louise enjoyed sex and, although she was always inorgasmic, she found it to be very pleasurable. They dated for about 1 1/2 years, until Al started taking out another girl. Louise was very hurt and shocked because she hadn't suspected this and Al had violated her trust.

Louise started to date Ron when she was 21 (two years after Al and she stopped dating). He lived in Dauphin and they saw each other every second or third weekend for the first year of their three year relation-

ship (he moved to Winnipeg after the first year). Louise wanted to marry Ron but he would never commit himself to the relationship; she always felt that she was at a disadvantage in this relationship. She felt that, like her previous partners, Ron was very selfish and dominant in the relationship. Even in their sexual relationship, Louise felt that she gave so much more than did Ron. He had a problem with premature ejaculation and she helped him to resolve this; she never got the same attention or caring from him. Louise stopped seeing Ron because she felt that she had loved him but that this was never reciprocated and she finally got tired of always being in this situation.

Louise met Michael a year later, when she was in Regina on holidays. They spent one night together before she returned to Winnipeg. She saw Michael a year later when she was back in Regina and they had a 10 day affair; after the 5th day she found out that he was living with another woman. She was quite upset about this but saw him for the duration of her holiday. Soon after she returned to Winnipeg, Michael moved here and they lived together for less than a year. She was very much attracted to Michael and felt that their sexual relationship was good; however, they had a very shakey and, on the whole, unhappy relationship. She became pregnant and went through the pregnancy and abortion alone. She was very angry and hurt because she felt that she had been cheated in the relationship.

In all of these relationships, Louise enjoyed sex and although her arousal was generally high she never had orgasms. She always felt that her partners were more interested in their own sexual pleasure than in hers and that she never had the time or attention she needed to fully enjoy sex. She felt that they were loving and tender only when they wanted sex; she always felt somewhat used because of this situation.

Current partnership

Louise met Dan shortly after her first breakup with Michael. They started dating approximately 6 weeks after they met; Louise was attracted to him because he was a "challenge". He was not initially interested in

her so she had to do the pursuing. She found him to be somewhat cool and aloof; he also reminded her of Michael because of his voice and mannerisms (she also notes his resemblance to her father).

Louise and Dan lived together briefly (March to June, 1983) soon after they were dating regularly. This was very unsuccessful and they separated because of frequent arguements. They continued to see each other and their relationship has improved but it is still unstable. Louise feels that Dan is more conscious of her emotional and sexual needs and that he is more considerate of her, generally. However, the problems they experience are, according to Louise, a result of Dan's tendency to be self-centred. She feels that he is very selfish in their sexual relationship because she is always trying to satisfy him but every time she asks him to do anything for her, he gets very defensive and withdraws.

Louise does not trust Dan to be faithful or to stay in the relationship and she finds that she is always concentrating on his weak points and actions, so that she will not be caught in a situation where she is at a disadvantage, emotionally. She is looking for any signs of his loss of interest in her and/or the relationship and she feels that by concentrating on his weak points, she will not be as hurt as she would be otherwise.

Louise feels that she is really being unreasonable because Dan has been very consistent and, overall, loving and supportive; she feels that she is spoiling their relationship because of her lack of trust. She finds that Dan often becomes very frustrated because he "can't win" or do anything right. He has told her many times that she overreacts to his behavior (sexually) and that she is always attacking him over minor and meaningless situations or actions.

Louise feels that, despite these constraints, their relationship is improving as Dan is proving himself to be unlike previous lovers. She reports that, on the whole, their sexual relationship is quite good.

Self concept

Louise has a fairly positive body image but feels slightly self-conscious of her appearance in most situations. She feels awkward in her style of dressing and feels that she never looks "quite right" in that something doesn't fit or match.

Louise feels that she is quite comfortable in most social situations. She has several close female friends but few male friends; she feels that she is quite popular, socially.

In general, Louise has a relatively low self-esteem. This is reflected in her scores on the Self Esteem Inventory. Louise is aware of her low self-esteem and feels that this may contribute to both her choice of partners and her inability to trust them and to believe that they really care about her.

Attitudes towards treatment

Louise is highly motivated in therapy at the present time. She feels that she has repeated the same patterns in each of her relationships and that she must resolve her problems before she can expect to have a positive relationship with anyone. She feels that her inability to have orgasms with a partner is symptomatic of a larger problem which she neither understands nor knows how to resolve.

Louise has the organizational capacity and intellectual ability to fully participate in therapy and meet any requirements (assignments). Louise would like to become orgasmic with her partner. She would also like to resolve some of the ambivalent and, she feels, self-defeating attitudes towards men and relationships. She would like also to increase her self-esteem and assertiveness.

PROBLEM FORMULATION

Dysfunctional behavior

Louise is unable to reach orgasm through manual or oral stimulation (or during intercourse) when she is with a partner. She has only reached orgasms with partners when she has used a vibrator but she is not satisfied with this (and has, in fact, thrown away her vibrator). Louise's problem extend to all partners past and present, in all situations.

HJypotheses

It appears that Louise's problem relates to several causal factors. She has very ambivalent feelings towards men and, in particular, all of the men with whom she has been involved. She perceives all of her past and current partners to be selfish in their relationships, both generally and sexually. She feels that she has been taken advantage of in each situation, and she has never trusted any of her partners. She also is repeatedly in situations in which she is attempting to control the relationship. She has recurrently been hurt by her partners after unhappy and unsatisfactory relationships.

Louise feels that her inability to have orgasms with her partners is a reaction to this situation. She has decided that her partners are not truly interested in her and therefore they aren't really considerate or caring enough to be concerned with her satisfaction or pleasure. She therefore does not even let them try. Louise also admits to making conscious decisions, when making love with her partner, not be orgasmic when she is highly aroused. She has felt that she gives and gives so much of herself without getting the same in return and that she will not give them the satisfaction of bringing her to orgasm. She does not want to lose control in front of a partner either as control in this context, to her, reflects the nature of their relationships which are always a sort of power struggle in which she is constantly trying to gain or maintain control.

Louise's problems seem to stem back to her childhood where she saw her father's ability to control the whole family and, in particular, her mother. He was always selfish and manipulative and it seems that she learned to expect this of men. This was subsequently perceived and reinforced in her relationship with men.

Louise has a low self-esteem and she is always attracted to men who are a challenge or who are initially not interested in her, who are generally not considerate or responsible and who, inevitably, meet her negative expectations.

Louise also admits to needing a very specific and intensive type of stimulation n order to have orgasms. None of her partners have been able to provide this and she has never attempted (or wanted) to teach them this technique.

Resources for treatment

Situational resources

The nature of the relationship between Louise and Dan is not ideal. First, he is away during the week as he works out of town; they only spend the weekends together and both have other commitments during the weekends which further reduce the time they spend together. Second, Louise and Dan are often arguing over the problems described previously. Third, since Dan works out of town he is not available to directly participate in therapy.

Personal resources

Louise is quite motivated in therapy at the present time. She is very intelligent and grasps new concepts and ideas fully and easily. She has already put alot of thought into her problems and she is very receptive to new ideas and information.

As indicated previously, Louise holds many ambivalent and negative feelings towards men and, in particular, towards the the men with whom she has been involved. These attitudes will undoubtedly impede her ability to reach her goals in therapy and, in fact, will be the focus of part of the treatment program.

Professional resources

The therapist is allocating time for a weekly therapy session of one to one and one-half hours for this client. She has the background knowledge of this client's problem, the relevant literature on this type of problem, and the therapeutic skills to benefit the client. The client and the therapist have a good relationship.

Selection of therapeutic goals

The therapeutic goals have been selected in response to both the sexual problem (inorgasmia with partner present) as well as to the nature of the background or causal factors which are perceived, by therapist and client, to perpetuate the situation. The goals have thus been selected first, to deal with the attitudes and feelings Louise has towards herself, men, and intimate relationships.

1. To increase the client's self-esteem.

2. To resolve the client's negative and ambivalent feelings towards men, her relationship(s), the sexual component of her relationship(s), and, in particular, her current relationship.

3. To learn to relax and to respond to more varied (sexual stimulation) techniques to increase the client's capacity for orgasm alone or with a partner.

Planning Treatment

One (female) therapist will be involved in this treatment program. She possesses the therapeutic skills which are required to undertake this

program and provide a thorough and directed treatment plan. The therapist and client will meet on a weekly basis (for one to one and one-half hours) at the Sexual Dysfunction Clinic, Psychological Services Centre.

Treatment program

Treatment will commence immediately, and be structured as follows:

1. Cognitive restructuring

   - directed towards: - client's self-esteem
     - basic attitudes, perceptions, and expectations (as above).

   This will eventually be directed towards Louise's current relationship, in order to enable her to assess more objectively the quality of her relationship and help her to reach some decision on her future in this situation.

2. Relaxation training

   - To be applied during masturbation and when client is with her partner.

3. The Becoming Orgasmic program (Heiman et al., 1975) will be used to increase the client's range of sexual pleasure and in order to increase her capacity for orgasm through more varied means. This will be generalized to her sexual relationship with her current partner.

The three major components of treatment will overlap, to a large extent, as they are perceived to be related and mutually reinforcing.

TREATMENT SUMMARY

According to the treatment program developed during the assessment, therapy commenced with cognitive restructuring as the client systematically examined her feelings and attitudes concerning intimate relationships and her partner(s) in particular. This proved to be successful in enabling her to resolve some of her negative expectations and perceptions of relationships and to more objectively assess her current situation.

Simultaneously with the above process, the client commenced the program for becoming orgasmic (as outlined in Becoming Orgasmic, Heiman et al., 1976) with relaxation, self-exploration, general pleasuring, and genital pleasuring. These progressed satisfactorily until the participation of her partner was required. At this point, progress was disrupted as the client did not feel comfortable sharing her experience with her partner. It became apparent that therapy should (temporarily) focus on the relationship in order to facilitate the (above) process.

Relationship enhancement was directed towards communication training and problem solving, in order to resolve the interpersonal difficulties experienced by the couple. These processes were undertaken with ambivalence by both partners as firstly, the client's partner considered her problems to be the source of the difficulties and secondly, because the client was not sure of her own commitment to the relationship. As a result, more problems related to mutual commitment and control in the relationship were exposed during this process.

The client subsequently requested that she continue therapy on her own in order to determine whether or not she wished to remain in the relationship. She also requested that therapy be directed towards improving her self-esteem and assertiveness, as these were perceived to be factors contributing to her problems. As the client's self-esteem increased, she became increasingly concerned with her own happiness and needs in the relationship. She became increasingly dissatisfied with her relationship and her partner's lack of support and concern for her

difficulties at that time. She subsequently decided to terminate this relationship as she felt that her needs were not being met and would not be met as her partner refused to participate in the therapeutic process and support her personal growth and change. Treatment was also terminated as the client's problems were specifically related to her relationship.

OUTCOME

The goals of therapy, as outlined in the assessment report, were only partially achieved as a result of treatment. The client felt that her self-esteem and assertiveness were improved to the extent that she was able to terminate an unsatisfactory relationship when this was acknowledged. She was better able to identify her own needs and expectations of an intimate relationship and she felt more confident in her ability to find a relationship which would be more reciprocal in terms of trust, caring, and support.

The client's sexual problems, per se, were only partially resolved as a result of this outcome. She was able to reach orgasm (during masturbation) by less intense and specific stimulation and subsequently she felt more confident of her own sexuality. It is uncertain, at the present time, whether or not she will continue to experience similar sexual problems (inorgasmia) in future relationships. It is anticipated that this may be less problematic if the client is able to establish a relationship which better meets her needs and in which issues of trust and control are less apparent.

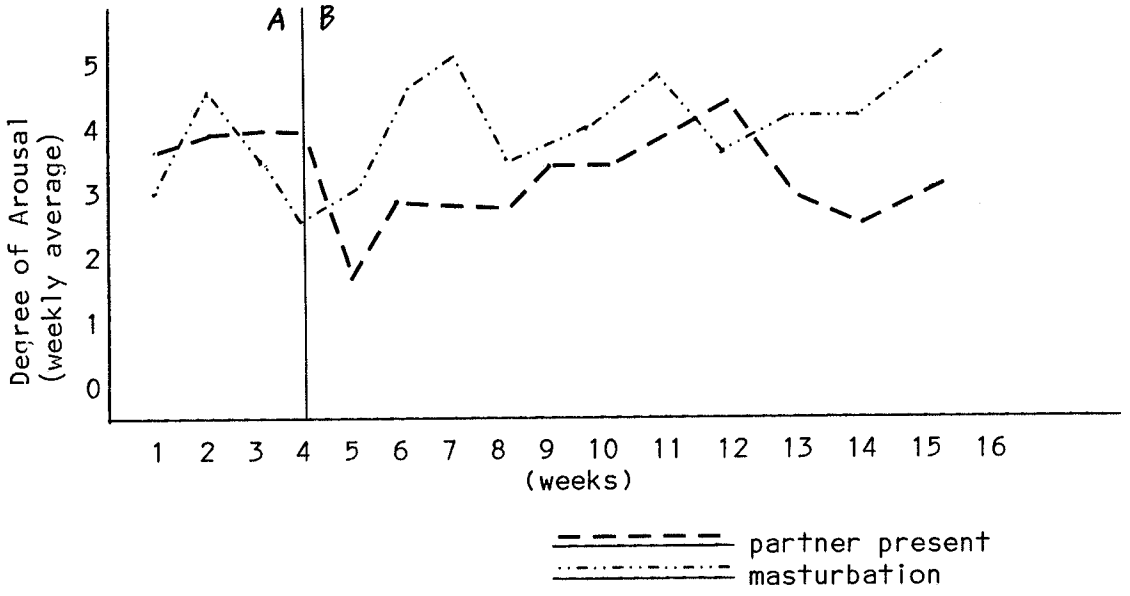
TABLE 8

INSTRUMENT	LOUISE	
	T^1	T^2
Index of Sexual Satisfaction	26	29
Sexual Arousal Inventory	89 (55-56%)	108 (90%)
Self Esteem Inventory	13 (6%)	19 (26%)
General	5 (5%)	9 (24%)
Personal	1 (14%)	3 (39%)
Social	7 (78%)	7 (78%)
Lie Items	6	8

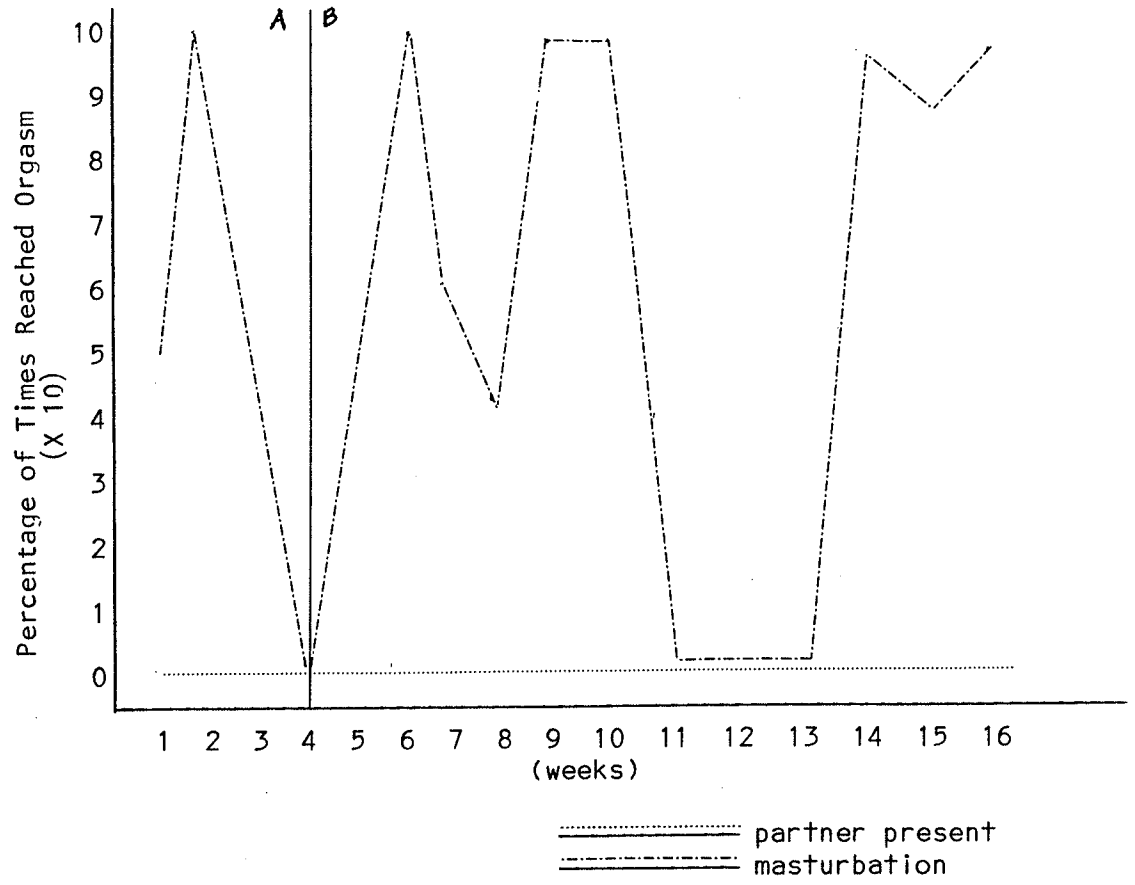
Interpretation: Appendix Forteen

GRAPH 6 - LOUISE

(a) Arousal



(b) Orgasms



CASE 8

Beth and Sam: inhibited sexual desire

ASSESSMENT REPORT

Description of problem(s)

Beth was referred to the Sexual Dysfunction Clinic by her gynecologist for therapy concerning her lack of sexual desire. She and her husband, Sam, had not engaged in sexual activity for three years as a result of Beth's problem. They noted increasing marital stress because of this problem.

Beth's loss of desire initially occurred just prior to her second mastectomy in June 1980. Since that time there has been no sexual contact between the couple. Any sexual advances by Sam were automatically ignored by Beth until he gradually gave up trying to reestablish their sexual relationship. While Beth still feels no motivation to change the present situation, Sam's concern for this led the couple to seek therapy. Beth's concern for the marriage itself has motivated her to cooperate in this respect.

Contemporary influences on problem(s)

Situational antecedents

At the time of Beth's second mastectomy, she felt that she received no support from Sam. Because of their poor communication, they were unable to express their feelings about the mastectomy at that time. Sam felt that the decision to have the second mastectomy (which was recommended as a preventative measure in light of the high probability of cancer in her second breast) should be Beth's and he felt that he should not influence her decision. Beth interpreted this reaction as a lack of understanding an concern and decided that if Sam would not share in the decision or provide the support she needed, she would do it on her own.

At that point, she shut Sam out of this part of her life. She subsequently refused to talk to him about the surgery and has not even allowed him to see the operative site (although he has never pressured her in this regard). Beth's loss of interest in sex reflects the stress in their relationship as a result of this experience.

Situational consequences

The couple had never acknowledged the absence of a sexual relationship until several months ago when Beth asked Sam if he would be satisifed with leaving the relationship as it was (without a sexual component to it). At that time, Sam realized how serious the situation was and he felt that they should do something to resolve it. Both he and Beth are concerned with the deterioration of their relationship and see the sexual problem as very closely related to this. Beth feels quite guilty about her role in the situation but resents Sam for his contribution to it (in its initial cause). Sam feels that Beth has been unfair in reacting to his inability to share her feelings regarding the mastectomy. Both are presently very defensive and resentful towards each other and Sam is also very insecure about Beth's commitment to their marriage at the present.

Personal and family backgrounds

Both partners

Beth is 46; Sam is 52 years old. They have been married for 25 years; their current problems are the first they have experienced since marriage. They feel that they had a relatively happy marriage prior to the onset of these problems. Beth has a Grade 12 education. She is a clerical worker for a small company. She has worked for this company for approximately 18 years; she worked at home on a part-time basis for 8 years when she managed the company. She continued to work there after Sam left for his present job and she has been working full-time for the last 10 years.

Sam completed training at a Technical College for working in a management capacity. He is currently the manager of a very large local business. He is very satisifed with his job despite its heavy demands and high stress level.

Beth and Sam are Jewish and practise their religion liberally (observing major holidays). They are generally conservative in terms of their beliefs, however.

Neither Sam nor Beth are Canadian by birth. Beth was born in England where she lived until moving to Montreal with her family at the age of 14. Sam lived in Germany until his parents were placed in a concentration camp in 1939. At that time he was sent to England where he lived in a boy's hostel for the next 10 years. He moved to Toronto in 1952 where he stayed with distant relatives for 6 months before moving to Montreal.

Sam and Beth do not share in their leisure activities, wit the exception of occasional weekend visits to friends' cottages and various social functions involving professional contacts, family, and friends. Beth and Sam agree that when they do go out together, they spend very little time together as it is quite common for the men and women to separate into groups at most functions. They are both active in private fund raising groups in the city.

Sam is in good health. Beth is presently also in good health but has a history of illness surrounding her experience with breast cancer. Beth first was confronted with this in September, 1977 when she was diagnosed has having breast cancer. She had modified radical surgery to remove the cancerous tissue. She has recovered all the movement in her arm from this operation. In June, 1980 Beth had her remaining breast removed, on the advice of her physician who anticipated that she may develop cancer in her other breast. She had reconstructive surgery in November,1980 following the loss of her second breast. She is not worried about future possibilities of developing cancer.

Beth does not feel that she has reached menopause yet, due to the absence of any notable physical changes (menstrual cycle). It does appear, however, that Beth is experiencing a mid-life crisis as she is frequently depressed, concerned with "being her own person", discovering her strengths and talents, and critically assessing her past.

Parents

Both of Sam's parents died in a concentration camp in Germany during the second world war. He has few memories of his parents. Beth's father died in 1962; her mother still lives in Montreal and has not remarried. Beth is still quite close to her mother.

Siblings

Sam has two sisters and one brother living in the United States. He sees very little of his family, but has some contact with one sister. Due to the loss of their parents at such an early age, Sam was separated from his siblings and he grew up alone. Beth is the youngest of three children. She is still close to her sister but rarely sees her brother; both still live in Montreal.

Children

Beth and Sam have three children - Darrel (22 years old), Kevin (20); and Rachel (16). Kevin and Rachel still live at home; all three children are very close to their parents, particularly to Beth. She feels that all of the children have been quite dependent on her and she encourages Darrel's attempt to become more independent. Beth is very close to Rachel who, she feels, depends too much on her for everything from selecting her clothing to making decisions about which schools she will attend. Darrel and Kevin both attend University; Rachel is in Grade 11. Beth feels that all of the children are aware that they (she and Sam) are having marital problems; only Darrel has actually asked them about this though.

Childhood and puberty

Beth grew up in a very conservative family, in which sex was never discussed. She acquired most of her information/knowledge about sex from her older sister who dated and married at an early age. Beth feels she was quite innocent when she married; Sam was her first sexual partner as previous relationships had always been quite superficial and never sexually intimate.

Sam grew up in a boy's (refugee) hostel and had little contact with girls until he was in his late teens. Most of his knowledge about sex was acquired through talking with the other boys at the hostel and he felt that most of this was inaccurate and reflected more fantasy than reality.

Sexual experience before current relationship

Beth had two steady boyfriends before she met Sam. She was proposed to by one of these boyfriends but turned him down when she realized that she couldn't decide whether or not she should marry him. She was engaged to her other boyfriend but broke off the engagement after only a short period of time. She was not very serious about either of these men and she was not deeply affected by the relationships.

Sam had one serious relationship before he moved to Canada. He dated a woman in England for several months before he joined the army, after which she met another man. Sam was very disturbed initially but realized that she had not been as serious as he and he soon got over her. Neither Sam nor Beth had alot of sexual experience prior to their marriage.

Current relationship

Beth and Sam met in Montreal in the 1950's. They dated briefly for several weeks but saw little of each other for the next two years. In

1957 they started dating again (September) and were engaged in December. They were married in June, 1958.

Sam was always attracted to Beth because she was very attractive, friendly, and warm; she thought that Sam was very nice, quiet, and mature. They lived in Montreal for six years following their marriage. They had two children when they moved to Winnipeg in 1964 and they felt that they had a good, stable marriage. Their only problems concerned domestic matters and both feel that their marriage has been quite equal in terms of financial matters and decision making. Beth considers the fact that she worked for Sam when they moved to Winnipeg to have been the source of strain in their relationship. She began to resent him for bringing work home for her to do when she had so much work with the three children, as well as household responsibilities. This was resolved when she started working half-days at the office.

Beth and Sam both agree that they never communicated well and rarely talked about their feelings, especially when any problems were apparent. Sam considers himself to be quite emotional (for example, he cries in sad movies) but he has difficulty expressing his emotions. He feels that Beth is not as emotionally expressive as he. She feels that she is not able to talk about her feelings to Sam because he does not understand. Beth feels that she "mothers" Sam and has had to support him during their move to Winnipeg and when she had her first mastectomy. She feels that he would have been emotionally unable to cope without her support. She has always felt that he depended on her for everything from buying his clothes, to dishing out his meals, to intervening with the children.

Beth and Sam were quite happy with these arrangements until the time of her second mastectomy. Even though Beth feels that Sam could not handle (emotionally) the first mastectomy, she was able to cope well enough with the situation to deal with it on her own. However, she felt that the second mastectomy was much more difficult because it involved a specific decision (the first one was more urgent and left little time for thinking). Beth needed Sam much more at the time of the second mastectomy but because of their inability to communicate their feelings

and their lack of understanding of the other's emotional needs, this event split them apart significantly. It left some resentment which has continued to wear away at their relationship.

Both Beth and Sam consider these events to have destroyed the intimacy in their relationship and consider their present interaction to consist of exchanges of news rather than real conversation. Beth resents Sam's dependence on her and she now refuses to buy his clothes or make decisions for him. She has become much more independent and finds she needs less emotional and intellectual fulfillment from the relationship, especially with her commitment and involvement in the Cancer Association. Sam has seen Beth's independence and personal development as a threat to their marriage. He feels that she has shut him out of this part of her life. He is defensive about her tendency to think and talk for him and he feels that she condescends to him when they talk (which makes him more defensive and withdrawn). He is insecure about her commitment to the marriage. In terms of their sexual relationship, he is slightly frustrated and still finds Beth very attractive and sexually appealing. Neither Beth nor Sam indicated any sexual experience outside their marriage.

Self concept

Beth seems to have accepted her mastectomies and considers the loss of her breasts to be sad but a relatively minor cost for her life. Her body image has improved since she had reconstructive surgery on her breasts. She is very attractive and she is aware of this fact. Sam was shaken by Beth's first mastectomy but was not particularly shocked or offended by the sight of Beth's surgical incision. He has never seen the second operative site, nor has he seen the reconstructed breasts. He still considers Beth to be very attractive.

Beth is much more self-confident, assertive, and thoughtful than is Sam. He is insecure about their marriage, quite introverted, and he has difificulty expressing himself. He seems to avoid dealing with feelings especially those which are unpleasant. He tends to cope with problematic

situations by blocking them out. For example, he does not seem to be aware of the intensity of Beth's feelings concerning her mastectomy; he forgets significant events, and the feelings he had about significant events.

Attitudes toward treatment

Sam and Beth are both motivated in treatment. They wish to prevent further deterioration of their marriage which they consider will be inevitable if their sexual problem is not resolved. They are beginning to understand that the sexual problem reflects deeper problems in their relationship, and see marital therapy as a very important component of sexual therapy.

The couple is quite optimistic about therapy in terms of resolving these problems; they possess the resources and organizational capacities to meet the requirements of therapy as long as they remain committed to it.

PROBLEM FORMULATION

Dysfunctional behavior

Beth's problem is a lack of interest in sex. She feels no sexual desire and is satisfied with the absence of a sexual component to her marriage. The couple has had no sexual contact over three years.

Hypotheses

It seems that Beth's lack of interest in sex developed at the time of her second mastectomy when she decided that she could not count on Sam for sharing her trauma over surgery and she would therefore shut him out of this part of her life. At that time, she sought other sources of help to get through the experience and the intimacy of their marriage soon declined. Beth has never allowed Sam to see her breasts since the second operation, and she has never since been physically intimate with him.

Beth and Sam were never able to communicate where deep or problematic feelings were involved. This had never been a problem until Beth had her mastectomies, when her emotional needs were greatest. Since they lacked the skills required to share their feelings, they were unable to meet each other's emotional needs and they grew further apart as a result of the experience.

Since the operation, they have allowed resentment, guilt, and anger towards each other continue to grow as they become more and more distant.

It is not clear whether Sam has ever really come to terms with the mastectomies as he has never been closely involved with the experiences nor has he seen the operative site (after the second operation). He states that this never bothered him, however. At the same time, Beth may have more discomfort with her mastectomies than she indicates as she has rot allowed Sam to see her naked since the second operation. As well, she does not consider her (reconstructed) breasts to be attractive, sexual, or even part of her body.

Resources for treatment

Situational resources

The general relationship between the partners is not ideal at the present and would impede sexual therapy without prior marital therapy. As a result, marital therapy will be an initial priority in the treatment process. The couple does have the socio-economic resources to meet the requirements of therapy including attending weekly treatment sessions, as well as completing (homework) assignments when required.

Personal resources

At present, both partners are motivated in therapy because of the fear of the breakdown of their marriage and also because of their positive expectations in treatment.

Personal resources, (including organizational capacity, educational and socio-economic levels, religious and moral beliefs, organic conditions, absence of psychiatric syndromes and sexual variations) are positive. However, both Beth and Sam are very traditional in their attitudes regarding sex and may resist certain therapeutic techniques if these challenge their attitudes. Another possible hindrance to the therapeutic process, especially the portion focusing on marital therapy, may be Sam's problems with understanding and expressing deep emotions. In addition, the resentment and insecurity that each feels may complicate this situation. Despite these problems, it does appear that they are sufficiently motivated to overcome these impediments.

Professional resources

The therapist has allocated the time required for weekly one to one and one-half hour therapeutic sessions, as well as any additional time for consultation and additional sessions if required. The therapist understands the problems which exist in the relationship and has a good relationship with the clients.

Selection of therapeutic goals

The goals have been defined according to the specific needs of the clients. This reflects the requirement for marital therapy prior to undertaking therapy focusing specifically on the couple's sexual problems. The goals are:

1. To learn effective communication techniques, in order to express feelings of positive and negative emotions.

2. To learn effective problem-solving skills in order to deal with recurrent problems (marital, sexual, and domestic) in a positive and constructive manner.

3. To ensure that the couple has resolved their feelings regarding Beth's mastectomies and the problems which have subsequently developed as a result of this experience.

4. To increase the intimacy in the couple's relationship, especially through the development of communication techniques to facilitate this.

5. To increase Beth's interest in sex so that the couple resumes a satisfactory sexual relationship.

Planning treatment

Therapist

One female therapist will be involved in this treatment process. The therapist possesses the knowledge and resources in order to undertake therapy with this couple at the present time. Treatment will be undertaken on a weekly basis (of one hour to ninety minute sessions) at the Sexual Dysfunction Clinic, Psychological Services Centre, at the University of Manitoba.

Treatment program

The treatment program will proceed according to the following outline. It is anticipated that some modification and overlap between treatment components will occur as therapy progresses.

1. Relationship enhancement

   Communication and problem solving training will be provided in order that the couple resolves the basic problems which have contributed to their sexual problems and which continue to perpetuate the same.

2. Information will be provided to the clients to clarify basic issues concerning breast cancer and treatment (especially regarding the implications for the patient's intimate relationships), mid-life crisis, sexuality, and others as required.

3. Examination (by both Beth and Sam) of Beth's breasts in order to facilitate greater physical intimacy.

4. Sensate focus (general pleasuring) as a means to facilitate greater physical contact and increase the couple's enjoyment of the same (this is particularly important to Beth).

TREATMENT SUMMARY

Treatment commenced with relationship enhancement as the primary objective, as it was agreed that the couple's relationship problems would impede mutual collaboration in sex therapy. Extensive time was spent on communication training and problem solving (Jacobson and Margolin, 1979). The couple had considerable difficulty with both of these procedures as they had never communicated openly and they had developed patterns of communication and problem solving which reflected mutual defensiveness, domination by Beth, and resentful compliance by Sam. As well, Beth was very controlled and protective of her feelings and Sam had a great deal of difficulty in both acknowledging and expressing his feelings. To complicate this situation, they were both resistant to change and therapy progressed very slowly as they fluctuated between trying to resolve their problems and withdrawing and blaming each other for their problems.

Despite these recurrent setbacks, the couple persisted in therapy and were eventually able to break down some of their defenses and incorporate these skills into their daily interaction. They were better able to understand their problems in the context of their previous communication and problem solving patterns, their (individual) reactions to Beth's mastectomies, and their (individual) contributions to their current problems. When these issues were resolved through a problem-solving process, the couple felt that they were prepared to undertake sex therapy.

The couple was initially instructed to go through a process which involved examining Beth's breasts in a manner which would gradually desensitize both partners to the fear and uncertainty regarding this. However, it became apparent that Beth was not ready to proceed with this aspect of therapy and requested more time to express her feelings of dissatisfaction towards her marriage, her traditional role as a wife and

mother, and Sam's reaction to her increasing independence. When Beth felt satisfied with this "verting" of her feelings, the couple resumed sex therapy.

A process of sensate focus was described to the couple as a means to gradually resume physical contact and intimacy. They were assigned an exercise involving general pleasuring in which both partners would be partially clothed. They agreed to undertake this assignment after discussing their reservations concerning the same. It was agreed that they would only attempt this to an extent that was comfortable to both of them (for example, wearing pyjamas or underclothes or being partially covered by a towel or bedsheet).

It was subsequently reported that Beth was unable to complete this assignment. She reported that she had never been a "touching or physical" person, nor did she wish to become so. Instead, she decided that she would force herself to have intercourse with Sam and thus avoid this process. She noted that she was not concerned with her own sexual satisfaction but that she felt that she could go through with intercourse in order to satisfy Sam.

OUTCOME

The goals of therapy were only partially achieved in improving the couple's marital relationship. This was perceived by Beth and Sam, both of whom were more satisfied with their marriage as a result of treatment. As well, it was apparent to the therapist that the couple was not prepared to change their relationship quickly or significantly. While they realized that they could not continue to relate as they had prior to the onset of their difficulties, they both wished to resume this style of interacting as much as possible within the context of their present situation. Thus, while their relationship goals were only partially reached, the couple's overall marital satisfaction increased.

In terms of resolving the sexual problems (Beth's lack of interest and the resumption of sexual activity), the goals of therapy were similarly only partially reached. Beth's interest did not increase but the couple did resume sexual intercourse, however forced and unsatisfying to Beth. It is not certain, at the time of writing, how long this situation will continue.

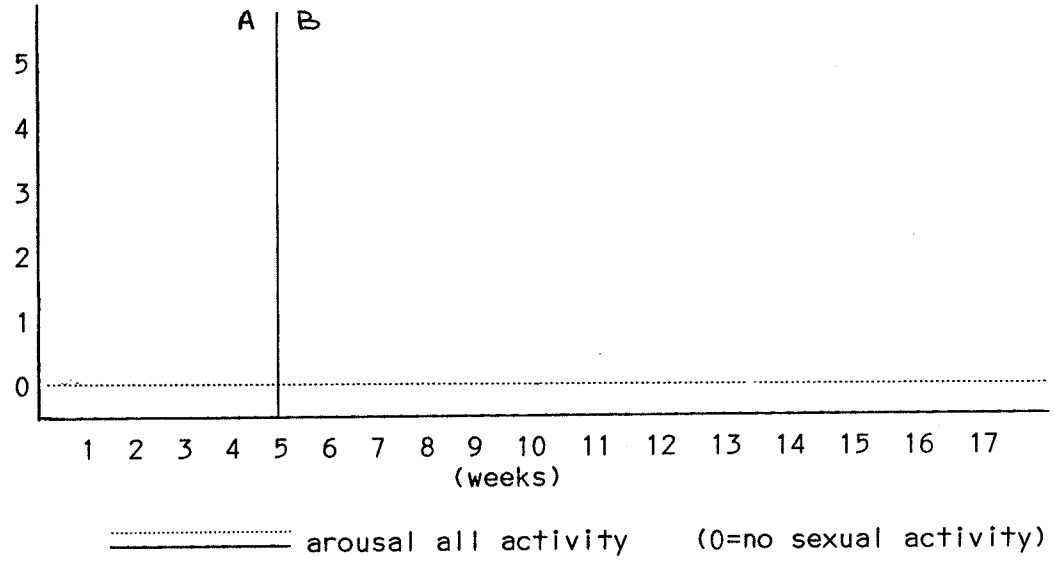
TABLE 9

INSTRUMENT	ASSESSMENT		TERMINATION	
	BETH	SAM	BETH	SAM
Index of Sexual Satisfaction	32	40	30	29
Sexual Arousal Inventory	-2 (0%)		4 (1%)	
Dyadic Adjustment Scale	83	100	93	101
Dyadic Consensus	43	49	48	47
Dyadic Satisfaction	28	40	34	38
Affectional Expression	7	3	7	6
Dyadic Cohesion	5	8	4	10
Marriage Attitudes Scale	8	15	6	17
Sexual Attitudes Scale	3	5	4	3
Self Esteem Inventory	25 (64%)	27 (75%)	28 (84%)	26 (68%)
General	14 (81%)	15 (97%)	13 (70%)	12 (54%)
Social	7 (78%)	7 (80%)	7 (78%)	6 (44%)
Personal	4 (54%)	5 (61%)	5 (67%)	5 (61%)

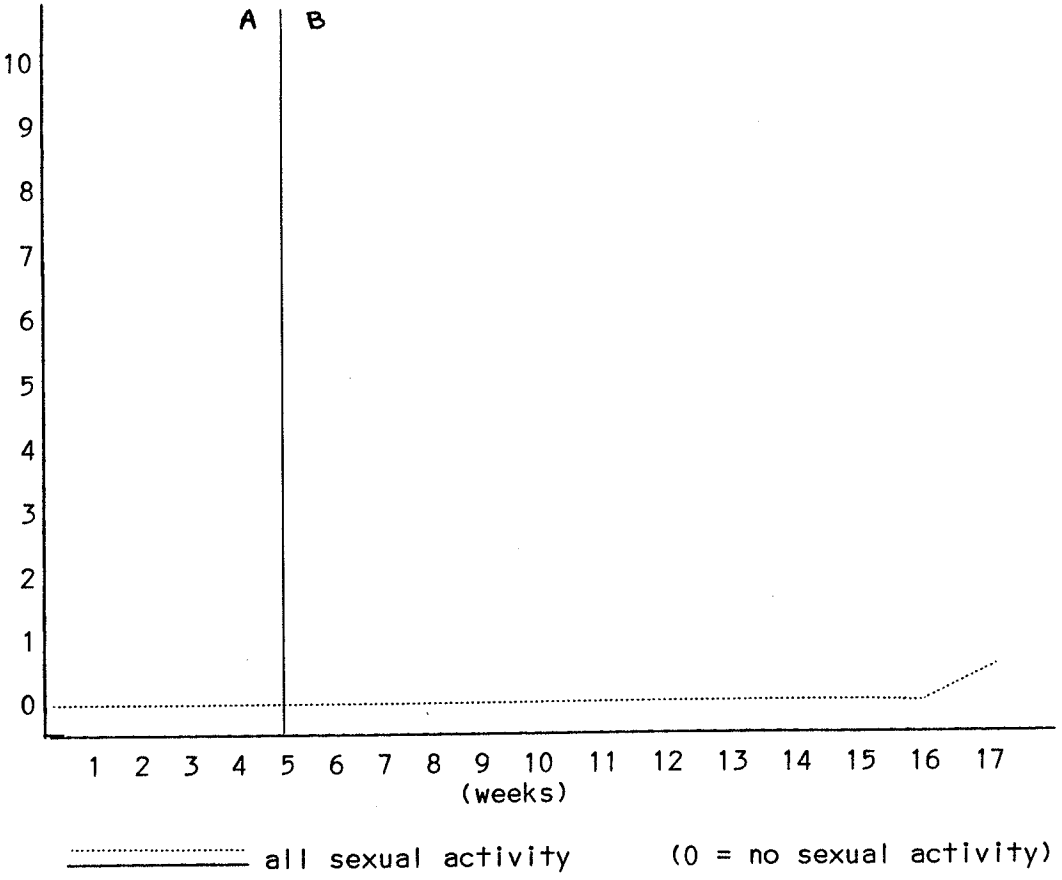
Interpretation: Appendix Fourteen

GRAPH 7 - BETH

(a) Arousal



(b) Frequency of sexual activity



PART V

CONCLUSION

This practicum was undertaken with the intent of developing the theoretical background and practical experience in the assessment and treatment of sexual dysfunction. Through a process which was based on a systematic and disciplined approach to psychological treatment, the writer was successful in achieving these objectives.

Over a period of approximately seven months, eight clients were treated for various sexual dysfunctions. With few exceptions, as noted in the case studies, the clients were able to reach their (treatment) goals to the satisfaction of themselves and the writer. In retrospect, it is apparent that the therapeutic interventions used in the treatment of these clients were supplemented by the clients' own motivation in confronting and changing basic attitudes and behaviors regarding their sexuality.

Thus, what was initially perceived by the writer to be a difficult and personally challenging process became a very positive and rewarding experience as she gained a greater knowledge of human behavior, individual strength and motivation, as well as an understanding of the therapeutic process in general. These results are attributed to determination and hard work by both the clients and the writer, in the context of effective guidance and support, without which this outcome may not have been achieved.

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APPENDICES

APPENDIX ONE

Checklist of Topics For Assessment Interviews With Sexually Dysfunctional Clients and Partners*

It is intended that therapists will select and sequence items from this checklist to suit individual clients and their partners, rather than using it in a rigid or chronological fashion.

DESCRIPTION OF PROBLEM(S)

1. Nature
2. Frequency
3. Timing
4. Surrounding circumstances (see also 8, 9, and 10 below)
5. Duration
6. Onset
7. Course

CONTEMPORARY INFLUENCES ON PROBLEM(S)

8. Situational antecedents

    e.g. (a) sexual stresses

    (b) deficient or inappropriate stimulation

    (c) relationship with partner

    (d) timing and setting of encounter

    (e) concomitant non-sexual stresses

9. Organismic variables

    (a) thought processes

    e.g. (i) cognitive avoidance

    (ii) cognitive monitoring

    (iii) deficient or false information

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*Reproduced from Jehu, D. Sexual Dysfunction: Behavioural approaches to causation, assessment and treatment. Wiley, London, (In press).

(b) emotional reactions

e.g. (i) anxiety

(ii) guilt

(iii) depression

(iv) anger

(c) organic states

e.g. (i) aging

(ii) illness

(iii) surgery

(iv) drugs

10. Situational consequences

e.g. (a) partner's reactions

(b) absence of sexual relationships, due to avoidance reactions

PERSONAL AND FAMILY BACKGROUNDS

11. Both partners

(a) age

(b) sex

(c) marital status and history

(d) occupation

(e) education

(f) ethnic background

(g) religion and moral beliefs

(h) leisure activities

(i) friendship pattern

(j) health (including inter alia venereal disease, infertility, pregnancies, abortions, menstruation, menopause, use of alcohol or illicit drugs, and psychiatric disorders).

12. Partner's parents

    (a) year of birth

    (b) year and cause of death

    (c) marital status and history

    (d) occupation

    (e) education

    (f) ethnic background

    (g) religion and moral beliefs

    (h) health

    (i) relationship between parents

    (j) relationships between each partner and (i) own parents
        (ii) parents-in-law

13. Partner's siblings

    (a) age

    (b) sex

    (c) marital status and history

    (d) occupation

    (e) education

    (f) health

    (g) relationship with parents

    (h) relationship with each partner

14. Children

    (a) age

    (b) sex

    (c) education

    (d) occupation

    (e) health

    (f) relationship with each partner

CHILDHOOD AND PUBERTY

15. Family attitudes towards sex
16. Learning about sex
17. Sexual activities
18. Traumatic sexual experiences
19. Puberty
    (a) menstruation or first emissions
    (b) secondary sexual characteristics

SEXUAL EXPERIENCE BEFORE CURRENT PARTNERSHIP

20. Nocturnal emissions or orgasms
21. Masturbation
22. Sexual fantasies and dreams
23. Erotic literature, pictures and films
24. Dating and previous partnerships
25. Petting
26. Intercourse
27. Frequency of orgasm from all outlets
28. Traumatic sexual experiences

CURRENT PARTNERSHIP

29. Date of marriage or cohabitation
30. Engagement
31. Sexual experience with current partner before marriage or cohabitation
32. Honeymoon
33. Sexual relationship during marriage or cohabitation
34. Contraceptive methods and wishes concerning conception

35. General relationship between partners

SEXUAL EXPERIENCE OUTSIDE CURRENT PARTNERSHIP

36. Nocturnal emissions or orgasms
37. Masturbation
38. Sexual fantasies and dreams
39. Erotic literature, pictures and films
40. Sexual partners
41. Petting
42. Intercourse
43. Traumatic sexual experiences

SEXUAL EXPERIENCE SINCE LAST PARTNERSHIP ENDED

(e.g. by death, separation or divorce)

44. Nocturnal emissions or orgasms
45. Masturbation
46. Sexual fantasies and dreams
47. Erotic literature, pictures or films
48. Sexual partners
49. Petting
50. Intercourse
51. Traumatic sexual experiences

SEXUAL VARIATION

52. Homosexuality
53. Bestiality
54. Paedophilia

55. Voyeurism

56. Exhibitionism

57. Fetishism

58. Transvestism

59. Transsexualism

60. Sadomasochism

61. Sexual assault and rape

62. Incestuous behaviour

SELF CONCEPT

63. Body image

64. Gender identity

65. Popularity and attractiveness

66. Self-esteem

ATTITUDES TOWARDS TREATMENT

67. Motivation

68. Organizational capacity

69. Prognostic expectancy

70. Desired outcome

APPENDIX TWO

ASSESSMENT OF RESOURCES FOR TREATMENT

Situational resources

1. General relationship between partners
2. Availability of a regular partner
3. Sexual dysfunction in both partners
4. Socio-economic resources

Personal resources

1. Motivation
2. Organizational capacity
3. Educational and socio-economic levels
4. Religious and moral beliefs
5. Organic conditions
6. Psychiatric syndromes
7. Sexual variations

Professional resources

1. Therapist time
2. Therapist knowledge, attitudes and skills
3. Therapeutic procedures

APPENDIX THREE

FORMULATING PROBLEMS, SELECTING GOALS AND PLANNING TREATMENT

Problem formulation

1. Specification of dysfunctional behaviour
2. Hypotheses concerning the contemporary conditions that initiate and maintain this behaviour
3. Appraisal of resources for treatment

Selection of therapeutic goals

1. Nature of goals
2. Choice of goals
3. Specification of goals

Planning Treatment

1. Therapists
   (a) dual sex teams
   (b) qualifications and competence
2. Treatment setting
3. Timing of treatment
4. Treatment programme
   (a) initiation of treatment
   (b) selection of components
   (c) sequencing of components
   (d) maintenance of treatment effects
   (e) group treatment

APPENDIX FOUR

SEXUAL HISTORY FORM*

(Please find the most appropriate response for each question).

1. How frequently do you and your mate have sexual intercourse or activity?

   1) more than once a day
   2) once a day
   3) 3 or 4 times a day
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

2. How frequently would you like to have sexual intercourse or activity?

   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

3. Who usually initiates having sexual intercourse or activity?

   1) I always do
   2) I usually do
   3) my mate and I each initiate about equally often
   4) my mate usually does
   5) my mate always does

4. Who would you like to have initiate sexual intercourse or activity?

   1) myself, always
   2) myself, usually
   3) my mate and I equally often
   4) my mate, usually
   5) my mate, always

5. How often do you masturbate?

1) more than once a day
2) once a day
3) 3 or 4 times a week
4) twice a week
5) once a week
6) once every two weeks
7) once a month
8) less than once a month
9) not at all

6. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to a lack of sex, etc....

1) more than once a day
2) once a day
3) 3 or 4 times a week
4) twice a week
5) once a week
6) once every two weeks
7) once a month
8) less than once a month
9) not at all

7. For how many years have you and your mate been having sexual intercourse?

1) less than 6 months
2) less than 1 year
3) 1 to 3 years
4) 4 to 6 years
5) 7 to 10 years
6) more than 10 years

8. For how long do you and your mate usually engage in sexual foreplay (kissing, petting, etc.) before having intercourse?

1) less than one minute
2) 1 to 3 minutes
3) 4 to 6 minutes
4) 7 to 10 minutes
5) 11 to 15 minutes
6) 16 to 30 minutes
7) 30 minutes to 1 hour

9. How long does intercourse usually last, from entry of the penis until the male reaches orgasm (climax)?

1) less than 1 minute
2) 1 to 2 minutes
3) 2 to 4 minutes
4) 4 to 7 minutes
5) 7 to 10 minutes
6) 11 to 15 minutes
7) 15 to 20 minutes
8) 20 to 30 minutes
9) more than 30 minutes

10. Does the male ever reach orgasm while he is trying to enter the woman's vagina with his penis?

1) never
2) rarely, less than 10% of the time
3) seldom, less than 25% of the time
4) sometimes, 50% of the time
5) usually, 75% of the time
6) nearly always, over 90% of the time

11. Overall, how satisfactory to you is your sexual relationship with your mate?

1) extremely unsatisfactory
2) moderately unsatisfactory
3) slightly unsatisfactory
4) slightly satisfactory
5) moderately satisfactory
6) extremely satisfactory

12. Overall, how satisfactory do you think your sexual relationship is to your mate?

1) extremely unsatisfactory
2) moderately unsatisfactory
3) slightly unsatisfactory
4) slightly satisfactory
5) moderately satisfactory
6) extremely satisfactory

13. When your mate makes sexual advances, how do you usually respond?

1) usually accept with pleasure
2) accept reluctantly
3) often refuse
4) usually refuse

14. When you have sex with your mate, do you feel sexually aroused (i.e. feeling "turned on", pleasure, excitement)?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never

15. When you have sex with your mate, do you have negative emotional reactions, such as fear, disgust, shame or guilt?

    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

16. If you try, is it possible for you to reach orgasm through masturbation?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

17. If you try, is it possible for you to reach orgasm through having your genitals caressed by your mate?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

18. If you try, is it possible for you to reach orgasm through sexual intercourse?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

19. What is your usual reaction to erotic or pornographic materials (pictures, movies, books)?

1) greatly aroused
2) somewhat aroused
3) not aroused
4) negative--disgusted, repulsed, etc.

20. Does the male have any trouble in getting an erection, before intercourse begins?

1) never
2) rarely, less than 10% of the time
3) seldom, less than 25% of the time
4) sometimes, 50% of the time
5) usually, 75% of the time
6) nearly always, over 90% of the time

21. Does the male have any trouble keeping an erection, once intercourse has begun?

1) never
2) rarely, less than 10% of the time
3) seldom, less than 25% of the time
4) sometimes, 50% of the time
5) usually, 75% of the time
6) nearly always, over 90% of time

22. Does the male ejaculate (climax) without having a full, hard erection?

1) never
2) rarely, less than 10% of the time
3) seldom, less than 25% of the time
4) sometimes, 50% of the time
5) usually, 75% of the time
6) nearly always, over 90% of the time

23. Is the female's vagina so "dry" or "tight" that intercourse cannot occur?

1) never
2) rarely, less than 10% of the time
3) seldom, less than 25% of the time
4) sometimes, 50% of the time
5) usually, 75% of the time
6) nearly always, over 90% of the time

24. Do you feel pain in your genitals during sexual intercourse?

1) never
2) rarely, less than 10% of the time
3) seldom, less than 25% of the time
4) sometimes, 50% of the time
5) usually, 75% of the time
6) nearly always, over 90% of the time

25. (WOMEN ONLY, MEN GO ON TO QUESTION 28) Can you reach orgasm through stimulation of your genitals by an electric vibrator or any other means such as running water, rubbing with some object, etc.?

1) nearly always, over 90% of the time
2) usually, about 75% of the time
3) sometimes, about 50% of the time
4) seldom, about 25% of the time
5) never
6) have never tried to

26. (WOMEN ONLY) Can you reach orgasm during sexual intercourse if at the same time your genitals are being caressed (by yourself or your mate or with a vibrator, etc.)?

1) nearly always, over 90% of the time
2) usually, about 75% of the time
3) sometimes, about 50% of the time
4) seldom, about 25% of the time
5) never
6) have never tried to

27. (WOMEN ONLY) When you have sex with your mate, including foreplay and intercourse, do you notice some of these things happening: your breathing and pulse speed up, wetness in your vagina, pleasurable sensations in your breasts and genitals?

1) nearly always, over 90% of the time
2) usually, about 75% of the time
3) sometimes, about 50% of the time
4) seldom, about 25% of the time
5) never
6) have never tried to

28. (MEN ONLY) Do you ever ejaculate (climax) without any pleasurable sensation in your penis?

1) never
2) rarely, less than 10% of the time
3) seldom, less than 25% of the time
4) sometimes, 50% of the time
5) usually, 75% of the time
6) nearly always, over 90% of the time

APPENDIX FIVE

INDEX OF SEXUAL SATISFACTION (ISS)

NAME: _____ TODAY'S DATE: _____

This questionnaire is designed to measure the degree of satisfaction you have in the sexual relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 Rarely or none of the the time
2 A little of the time
3 Some of the time
4 Good part of the time
5 Most or all of the time

Please begin:

1. I feel that my partner enjoys our sex life ..... ____
2. My sex life is very exciting ..... ____
3. Sex is fun for my partner and me ..... ____
4. I feel that my partner sees little in me except for the sex I can give ..... ____
5. I feel that sex is dirty and digusting ..... ____
6. My sex life is monotonous ..... ____
7. When we have sex it is too rushed and hurriedly completed ..... ____
8. I feel that my sex life is lacking in quality ..... ____
9. My partner is sexually very exciting ..... ____
10. I enjoy the sex techniques that my partner likes or uses ..... ____
11. I feel that my partner wants too much sex from me ..... ____
12. I think that sex is wonderful ..... ____
13. My partner dwells on sex too much ..... ____
14. I feel that sex is something that has to be endured ..... ____
15. My partner is too rough or brutal when we have sex ..... ____

16. My partner observes good personal hygiene ..... ____

17. I feel that sex is a normal function of our relationship ..... ____

18. My partner does not want sex when I do ..... ____

19. I feel that our sex life really adds a lot to our relationship ____

20. I would like to have sexual contact with someone other than my partner ..... ____

21. It is easy for me to get sexually excited by my partner ..... ____

22. I feel that my partner is sexually pleased with me ..... ____

23. My partner is very sensitive to my sexual needs and desires ... ____

24. I feel that I should have sex more often ..... ____

25. I feel that my sex life is boring ..... ____

APPENDIX SIX

SEXUAL AROUSAL INVENTORY

INSTRUCTIONS: The experiences in this inventory may or may not be sexually arousing to you. There are no right or wrong answers. Read each item carefully, and then circle the number which indicates how sexually aroused you feel when you have the described experience, or how sexually aroused you think you would feel if you actually experienced it. Be sure to answer every item. If you aren't certain about an item, circle the number that seems about right. The meaning of the numbers is given below.

- 1 adversely affects arousal; unthinkable, repulsive, distracting
- 0 doesn't affect sexual arousal
- 1 possibly causes sexual arousal
- 2 sometimes causes sexual arousal; slightly arousing
- 3 usually causes sexual arousal; moderately arousing
- 4 almost always sexually arousing; very arousing
- 5 always causes sexual arousal; extremely arousing

ANSWER EVERY ITEM	How you feel; or think you would feel if your were actually involved in this experience.						
1. When a loved one stimulates your genitals with mouth and tongue.	-1	0	1	2	3	4	5
2. When a loved one fondles your breasts with his/her hands.	-1	0	1	2	3	4	5
3. When you see a loved one nude.	-1	0	1	2	3	4	5
4. When a loved one caresses you with his/her eyes.	-1	0	1	2	3	4	5
5. When a loved one stimulates your genitals with his/her finger.	-1	0	1	2	3	4	5
6. When you are touched or kissed on the inner thighs by a loved one.	-1	0	1	2	3	4	5
7. When you caress a loved one's genitals with your fingers.	-1	0	1	2	3	4	5
8. When you read a pornographic or "dirty" story.	-1	0	1	2	3	4	5
9. When a loved one undresses you.	-1	0	1	2	3	4	5
10. When you dance with a loved one.	-1	0	1	2	3	4	5

(CONTINUED ON SECOND PAGE).

SEXUAL AROUSAL INVENTORY - (CONTINUED)

KEY

- 1 adversely affects arousal; unthinkable, repulsive, distracting
- 0 doesn't affect sexual arousal
- 1 possibly causes sexual arousal
- 2 sometimes causes sexual arousal; slightly arousing
- 3 usually causes sexual arousal; moderately arousing
- 4 almost always sexually arousing; very arousing
- 5 always causes sexual arousal; extremely arousing

	How you feel; or think you would feel if your were actually involved in this experience.						
11. When you have intercourse with a loved one.	-1	0	1	2	3	4	5
12. When a loved one touches or kisses your nipples.	-1	0	1	2	3	4	5
13. When you caress a loved one (other than genitals).	-1	0	1	2	3	4	5
14. When you see pornographic pictures or slides.	-1	0	1	2	3	4	5
15. When you lie in bed with a loved one.	-1	0	1	2	3	4	5
16. When a loved one kisses you passionately.	-1	0	1	2	3	4	5
17. When you hear sounds of pleasure during sex.	-1	0	1	2	3	4	5
18. When a loved one kisses you with an exploring tongue.	-1	0	1	2	3	4	5
19. When you read suggestive or pornographic poetry.	-1	0	1	2	3	4	5
20. When you see a strip show.	-1	0	1	2	3	4	5
21. When you stimulate your partner's genitals with your mouth and tongue.	-1	0	1	2	3	4	5

(CONTINUED ON THIRD PAGE).

SEXUAL AROUSAL INVENTORY - (CONTINUED)

KEY

- 1 adversely affects arousal; unthinkable, repulsive, distracting
- 0 doesn't affect sexual arousal
- 1 possibly causes sexual arousal
- 2 sometimes causes sexual arousal; slightly arousing
- 3 usually causes sexual arousal; moderately arousing
- 4 almost always sexually arousing; very arousing
- 5 always causes sexual arousal; extremely arousing

	How you feel; or think you would feel if your were actually involved in this experience.						
22. When a loved one caresses you (other than genitals).	-1	0	1	2	3	4	5
23. When you see a pornographic movie (stag film).	-1	0	1	2	3	4	5
24. When you undress a loved one.	-1	0	1	2	3	4	5
25. When a loved one fondles your breasts with mouth and tongue.	-1	0	1	2	3	4	5
26. When you make love in a new or unusual place.	-1	0	1	2	3	4	5
27. When you masturbate.	-1	0	1	2	3	4	5
28. When your partner has an orgasm.	-1	0	1	2	3	4	5

October 13, 1977.

APPENDIX SEVEN

ERECTION DIFFICULTY QUESTIONNAIRE

Instructions: This questionnaire is designed to provide information about various aspects of the erection problems which a man and his partner may experience.

For each question, check ( ) the response which best fits your answer from the list of alternative responses.

1. During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.

   ____Always ____Usually ____Sometimes ___Rarely ___Never

2. Even though I admit to myself that I have an erection problem; I tell my partner(s) that "I've had too much to drink", "I guess I'm just tired", or something else so they may not know about my problem.

   ____Always ____Usually ____Sometimes ___Rarely ___Never

3. If I get a partial or full erection during foreplay, my penis gets soft again when I try to insert my penis into my partner.

   ____Always ____Usually ____Sometimes ___Rarely ___Never

4. I get (would get) an erection when I see, hug, dance with, or otherwise interact with a dressed, attractive potential partner.

   ____Always ____Usually ____Sometimes ___Rarely ___Never

5. If I (would) experience erection difficulty, I (would) feel guilty because my partner might be frustrated and sexually unsatisfied.

   ____Always ____Usually ____Sometimes ___Rarely ___Never

6. I have trouble getting an erection during foreplay with a partner.

   ____Always ____Usually ____Sometimes ___Rarely ___Never

7. Because of my erection problem I avoid having sex with the same person more than once.

   ____Always ____Usually ____Sometimes ___Rarely ___Never

8. My erection problem makes me feel like less of a man.

____Always ____Usually ____Sometimes ___Rarely ___Never

9. Because of my erection problem, I do no (would not) try to get involved in relationships which might lead to sex.

____Always ____Usually ____Sometimes ___Rarely ___Never

10. During sexual activity I worry about whether or not I will get or keep an erection.

____Always ____Usually ____Sometimes ___Rarely ___Never

11. I do not enjoy sexual activity when I do not have an erection.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

12. My problem with erections occurs with all of my sexual partners or types of partners.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

13. I would feel humiliated if I experienced erection problems again.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

14. I do not (would not) get an erection during any type of sexual activity (e.g., intercourse, masturbation, oral sex, etc.).

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

15. If I lose (would lose) my erection during sexual activity, I worry (would worry) that I won't get an erection again.

____Always ____Usually ____Sometimes ___Rarely ___Never

16. I am less interested in sex than I used to be.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

17. I (would) talk about my problem with my sexual partner(s).

____Always ____Usually ____Sometimes ___Rarely ___Never

18. Because of my erection problem, I do not attempt sexual intercourse (entering my partner and moving until orgasm) even if I am engaging in other sexual activities with my partner.

____Always attempt ____Usually attempt ____Sometimes attempt ___Rarely attempt ___Never attempt

19. My penis remains hard enough for me to stay inside of my partner until I ejaculate (reach orgasm).

____Always ____Usually ____Sometimes ___Rarely ___Never

20. I am dissatisfied with my sexual functioning.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

21. If I (would) have difficulty getting or keeping an erection during sex, I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

22. I would rather avoid sex altogether than to experience erection problems again.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

23. I know how I could help myself if I had an erection problem again.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

24. I feel (would feel) anger or resentment if I have (would have) erection difficulty during sexual activities with a partner.

____Completely true ____Mostly true ____Equally true and false ___Mostly true ___Completely false

APPENDIX EIGHT

Name: _____
Date: _____

DYADIC ADJUSTMENT SCALE

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionally (correct or proper behavior)	5	4	3	2	1	0
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents or in-laws	5	4	3	2	1	0
10. Aims, goals and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0
14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married? (or lived together)	0	1	2	3	4	5
21. How often do your and your partner quarrel?	0	1	2	3	4	5
22. How often do you and your mate "get on each other's nerves?"	0	1	2	3	4	5

	Every Day	Almost Every Day	Occasionally	Rarely	Never
23. Do you kiss your mate?	4	3	2	1	0

	All of them	Most of them	Some of them	Very few of Them	None of them
24. Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or Twice a month	Once or Twice a Week	Once a Day	More Often
25. Have a stimulating exchange of ideas	0	1	2	3	4	5

26. Laugh together	0	1	2	3	4	5
27. Calmly discuss something	0	1	2	3	4	5
28. Work together on a project	0	1	2	3	4	5

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

	Yes	No	
29.	0	1	Being to tired for sex.
30.	0	1	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point "happy" represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0 1 2 3 4 5 6

Extremely Unhappy Fairly Unhappy A Little Unhappy Happy Very Happy Extremely Happy Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

5 I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

4 I want very much for my relationship to succeed, and will do all I can to see that it does.

3 I want very much for my relationship to succeed, and will do my fair share to see that it does.

2 It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

1 It would be nice if it succeeded, but I refuse to do anymore than I am doing now to keep the relationship going.

0 My relationship can never succeed, and there is no more than I can do to keep the relationship going.

DYADIC ADJUSTMENT SCALE: Scoring Sheet Couple _____

Dyadic Consensus Item #	Content	Scores M	F
1	Finances		
2	Recreation		
3	Religion		
5	Friends		
7	Conventionality		
8	Philosophy-life		
9	In-laws		
10	Goals		
11	Time Together		
12	Decisions		
13	Household		
14	Leisure		
15	Career		
	(a) Subtotal (65):		

Dyadic Satisfaction Item #	Content	M	F
16	Divorce		
17	Leave-fight		
18	Going well		
19	Confide		
20	Regret marrying		
21	Quarrel		
22	Annoyance		
23	Kiss mate		
31	Happiness-scale		
32	Future hope		
	(b) Subtotal (50):		

Affectional Expression Item #	Content	Scores M	F
4	Affection		
6	Sex-agree		
29	Tired for sex		
30	Not show love		
	(c) Subtotal (12):		

Dyadic Cohesion Item #	Content	Scores M	F
24	Outside interests		
25	Exchange ideas		
26	Laugh together		
27	Calm Discussions		
28	Work together		
	(d) Subtotal (24):		

	Male	Female
(a) Dyadic Consensus (65)		
(b) Dyadic Satisfaction (50)		
(c) Affectional Expression (12)		
(d) Dyadic Cohesion (24)		
DYADIC ADJUSTMENT (151)		

TABLE 4. Summary Scores and Standard Deviations for the Dyadic Adjustment Scale and Its Subscales, Marital Status[2]

	Married		Divorced		Total	
	Mean	SD	Mean	SD	Mean	SD
Dyadic Consensus Subscale	57.9	8.5	41.1	11.1	52.8	12.1
Dyadic Satisfaction Subscale	40.5	7.2	22.2	10.3	35.0	11.8
Dyadic Cohesion Subscale	13.4	4.2	8.0	4.9	11.8	5.1
Affectional Expression Subscale	9.0	2.3	5.1	2.8	7.8	3.0
DYADIC ADJUSTMENT SCALE	114.8	17.8	70.7	23.8	101.5	28.3
	N=218		N=94		N=312	

APPENDIX NINE

Marriage and Sexual Relationship Questionnaire (F)

Initials _____ Date _____

Age _____

Sex _____

Client Couple # _____

How many years have you been married? _____

INSTRUCTIONS

This questionnaire asks your marriage and sexual relationship. All your answers will be kept confidential, and will be seen only by the clinic staff. Your answers should give an accurate picture of your relationship. Please answer truthfully.

Answer each question by completely crossing out the answer "True" or "False", which ever best applies to you at the time.

Example:

Sometimes when I am tired I am short tempered with my mate T F

If you feel this statement is mostly "True" about you, cross out "T" like this ..... T F

If you feel this statement is mostly "False" about you, cross out "F" like this ..... T F

Please answer every question, either T or F.

MARRIAGE ATTITUDES SCALE (F)

		True	False
1.	There are times when I wonder if I made the best of choice	T	F
2.	Once in a while I make fun of my spouse	T	F
3.	No matter what my spouse is saying, I'm always a good listener	T	F
4.	I sometimes exaggerate my troubles in order to gain sympathy from my spouse	T	F

	True	False
5. I have never been upset when my spouse expressed views very different from mine	T	F
6. I am careful to say something nice to my spouse every day	T	F
7. I can't imagine ever wanting to have an affair	T	F
8. On occasions I have had doubts about my ability to succeed in my marriage	T	F
9. When disagreements arise they are always settled in a peaceful, fair and democratic manner	T	F
10. There have been times when I felt like hitting my spouse	T	F
11. My mate occasionally makes me feel miserable	T	F
12. I have never felt my spouse was angry at me without a cause	T	F
13. I am always happy with how affectionate my spouse is to me	T	F
14. My mate completely understands and sympathizes with my every mood	T	F
15. I don't think any couple could live together with greater harmony than my mate and I	T	F
16. My mate and I understand each other completely	T	F
17. There are moments when I dislike my spouse	T	F
18. I never say anything bad about my spouse even to my close friends	T	F
19. I have never deliberately said something to hurt my spouse's feelings	T	F
20. I have never regretted my marriage, not even for a moment	T	F
21. There is never a moment that I do not feel "head over heels" in love with my mate	T	F
22. I get impatient if my spouse interrupts me when I am working on something important	T	F
23. Some of my dealings with my mate are prompted by selfish motives	T	F

	True	False
24. If I had my life to live over I wouldn't even think of marrying another person	T	F
25. I sometimes try to get even with my spouse, rather than forgive and forget	T	F
26. I sometimes resent my spouse when I can't get my own way	T	F
27. My mate has all of the qualities I've always wanted in a mate	T	F
28. Every new thing I have learned about my mate had pleased me	T	F
29. My spouse and I are always happy with the amount of affection we show each other	T	F
30. There have been occasions when I took advantage of my spouse	T	F
31. Once in a while I am not completely truthful with my mate	T	F
32. I have some thoughts I wouldn't want my spouse to know about	T	F
33. There is nothing about my mate's appearance that I would want to see changed in any way	T	F
34. My marriage is not a perfect success	T	F
35. There are times when I do not feel a great deal of love and affection for my mate	T	F
36. I am always courteous to my spouse	T	F
37. Sometimes I'm tempted to say things to my spouse which I would regret	T	F

SEXUAL ATTITUDES SCALE (F)

	True	False
1. Sometimes I dislike my body	T	F
2. Occasionally I feel sexual intercourse is tedious	T	F
3. My spouse and I never feel unhappy about how often we have sex together	T	F

	True	False
4. I do not always initiate sex when I would like to	T	F
5. My spouse always knows exactly what I would like him/her to do when we are making love	T	F
6. My spouse always does the things I like during sex ...	T	F
7. Our sex life seems a little routine and dull to me at times	T	F
8. I have always been satisfied with how often my spouse and I have sex	T	F
9. I never turn my spouse down for sex because I am angry with him/her	T	F
10. Sometimes I just can't seem to get turned on sexually	T	F
11. I must admit that sometimes I am not considerate of my mate when we make love	T	F
12. Sex always lasts as long as I would like it to	T	F
13. My spouse and I are never too busy to have sex	T	F
14. I have never made an excuse to get out of having sex .	T	F
15. Every now and then my mate does not please me sexually	T	F

Marriage and Sexual Relationship Questionnaire (M)

Initials _____ Date _____

Age _____

Sex _____

Client Couple # _____

How many years have you been married? _____

INSTRUCTIONS

This questionnaire asks your marriage and sexual relationship. All your answers will be kept confidential, and will be seen only by the clinic staff. Your answers should give an accurate picture of your relationship. Please answer truthfully.

Answer each question by completely crossing out the answer "True" or "False", which ever best applies to you at the time.

Example:

Sometimes when I am tired I am short tempered with my mate T F

If you feel this statement is mostly "True" about you, cross out "T" like this ..... T F

If you feel this statement is mostly "False" about you, cross out "F" like this ..... T F

Please answer every question, either T or F.

MARRIAGE ATTITUDES SCALE (M)

		True	False
1.	No matter what my spouse is saying, I'm always a good listener	T	F
2.	I have never felt displeased with my spouse.....	T	F
3.	I have never been upset when my spouse expressed views very different from mine	T	F
4.	On occasions I have had doubts about my ability to succeed in marriage	T	F

	True	False
5. When disagreements arise they are always settled in a peaceful, fair and democratic manner	T	F
6. There have been times when I felt like hitting my spouse	T	F
7. I do not always tell my spouse the truth	T	F
8. My mate occasionally makes me feel miserable	T	F
9. I have never felt my spouse was angry at me without a cause	T	F
10. My mate completely understands and sympathizes with my every mood	T	F
11. I don't think any couple could live together with greater harmony than my mate and I	T	F
12. My mate and I understand each other completely	T	F
13. There are moments when I dislike my spouse	T	F
14. I never hesitate to go out of my way to help my spouse	T	F
15. I confide in my mate about everything	T	F
16. I have never deliberately said something to hurt my spouse's feelings	T	F
17. I have never regretted my marriage, not even for a moment	T	F
18. There is never a moment that I do not feel "head over heels" in love with my mate	T	F
19. Some of my dealings with my mate are prompted by selfish motives	T	F
20. I have some needs that are not being met by my marriage	T	F
21. I sometimes resent my spouse when I can't get my own way	T	F
22. Every new thing I have learned about my mate has pleased me	T	F
23. My spouse and I are always happy with the amount of affection we show each other	T	F

	True	False
24. Once in a while I am not completely truthful with my mate	T	F
25. I have some thoughts I wouldn't want my spouse to know about	T	F
26. There is nothing about my mate's appearance that I would want to see changed in any way	T	F
27. My marriage is not a perfect success	T	F
28. I think I would lie to my spouse to keep out of trouble	T	F
29. My marriage could be happier than it is	T	F
30. There are times when I do not feel a great deal of love and affection for my mate	T	F
31. I am always courteous to my spouse	T	F
32. Sometimes I'm tempted to say things to my spouse which I would regret	T	F

SEXUAL ATTITUDES SCALE (M)

	True	False
1. I think I am much sexier than most people.....	T	F
2. My spouse and I never feel unhappy about how often we have sex together	T	F
3. I sometimes push my mate to have sex more than he/she wants to	T	F
4. I never feel resentful when my spouse turns me down for sex	T	F
5. I do not always initiate sex when I would like to	T	F
6. My spouse always knows exactly what I would like him/her to do when we are making love	T	F
7. My spouse always does the things I like during sex ...	T	F
8. Our sex life seems a little routine and dull to me at times	T	F

	True	False
9. I always satisfy my spouse sexually	T	F
10. I have always been satisfied with how often my spouse and I have sex	T	F
11. I must admit that sometimes I an not considerate of my mate when we make love	T	F
12. I have never felt that my spouse lacks anything as a lover	T	F
13. Sex always lasts as long as I would like it to	T	F
14. My spouse and I are never too busy to have sex	T	F
15. Every now and then my mate does not please me sexually	T	F
16. Intercouse is always more enjoyable for me than other sexual activities	T	F

APPENDIX TEN

CULTURE-FREE SEI, FORM AD

Name _____ Today's Date _____

Directions

Please mark each question in the following way: If the question describes how you usually feel, make a check mark (✓) in the "yes" column. If the question does not describe how you usually feel, make a check mark (✓) in the "no" column. Please check only one column (either "yes" or "no") for each of the 40 questions. This is not a test, and there are no "right" or "wrong" answers.

	YES	NO
1. Do you have only a few friends?		
2. Are you happy most of the time?		
3. Can you do most things as well as others?		
4. Do you like everyone you know?		
5. Do you spend most of your free time alone?		
6. Do you like being a male?/Do you like being a female?		
7. Do most people you know like you?		
8. Are you usually successful when you attempt important tasks or assignments?		
9. Have you ever taken anything that did not belong to you?		
10. Are you as intelligent as most people?		
11. Do you feel you are as important as most people?		
12. Are you easily depressed?		
13. Would you change many things about yourself if you could?		
14. Do you always tell the truth?		
15. Are you as nice looking as most people?		
16. Do many people dislike you?		
17. Are you usually tense or anxious?		
18. Are you lacking in self-confidence?		
19. Do you gossip at times?		
20. Do you often feel that you are no good at all?		
21. Are you as strong and healthy as most people?		
22. Are your feelings easily hurt?		
23. Is it difficult for your to express your views or feelings?		
24. Do you ever get angry?		
25. Do you often feel ashamed of yourself?		
26. Are other people generally more successful than you are?		
27. Do you feel uneasy much of the time without knowing why?		
28. Would you like to be as happy as others appear to be?		
29. Are you every shy?		
30. Are you a failure?		
31. Do people like your ideas?		
32. Is it hard for your to meet new people?		
33. Do you ever lie?		
34. Are you often upset about something?		
35. Do most people respect your views?		
36. Are your more sensitive than most people?		
37. Are you as happy as most people?		
38. Are your ever sad?		
39. Are you definitely lacking in initiative?		
40. Do you worry alot?		

APPENDIX ELEVEN

BECK INVENTORY

Name _____ Date _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, cirle each one. BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but not I can't cry even though I want to.

11 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
I am purposely trying to lose weight by eating less.
Yes _____ No _____
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

20 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

APPENDIX TWELVE

NAME: _____

DATE: _____

Belief Inventory

Please check (✓) one column from 1 to 5 that best indicates how strongly you believe each statement to be true in your own case. Please answer according to what you really believe yourself, not what you think you should believe.

	Absolutely Untrue	Mostly Untrue	Partly True Partly Untrue	Mostly True	Absolutely True
	0	1	2	3	4
1. I must be an extremely rare woman to have experienced sex with an older person when I was a childex with an					
2. I am worthless and bad					
3. You can't depend on women, they are all weak and useless creatures					
4. No man can be trusted					
5. I must have permitted sex to happen because I wasn't forced into it					
6. I don't have the right to deny my body to any man who demands it					
7. Any man can be seduced					
8. Anyone who knows what happened to me sexually will not want anything more to do with me					
9. I must have been seductive and provocative when I was young					
10. It doesn't matter what happens to me in my life					
11. No man can care for me without a sexual relationship					
12. It is dangerous to get close to anyone because they always betray, exploit, or hurt you					

	Absolutely Untrue	Mostly Untrue	Partly True Partly Untrue	Mostly True	Absolutely True
	0	1	2	3	4
13. I must have been responsible for the sex when I was young because it went on so long					
14. I will never be able to lead a normal life, the damage is permanent					
15. Only bad, worthless guys would be interested in me					
16. It must be unnatural to feel any pleasure during molestation					
17. I am inferior to other people, because I did not have normal experiences					
18. I've already been used so it doesn't matter if other men use me					

(P.T.O.)

DJ/ac

APPENDIX THIRTEEN

Name: _____ Sexual Activity Checklist (Female) Date: _____

Please fill in this form when you are by yourself. Check all activities in which you have engaged in the 24 hours preceding 6 P.M. today. Rate your degree of arousal and indicate whether you achieved orgasm.

ACTIVITY	Check if engaged in	Degree of Arousal					Was Orgasm Reached	
		Very Low 1	Medium 2	3	4	Very High 5	Yes	No
General pleasuring, excluding genitals (alone) - exploration of your body, excluding genital areas, for feelings of pleasure.								
General pleasuring, excluding genital areas (together) - exploration of each other's bodies, excluding genital areas for feelings of pleasure.								
General and genital pleasuring (together) - exploration of each other's bodies for feelings of pleasure.								
Masturbation alone.								
Masturbation alone - with erotica.								
Masturbation alone - with vibrator.								
Masturbation alone - with roleplaying an orgasm.								
Masturbation with partner observing.								
Manual masturbation by partner.								
Mutual masturbation.								
Engaging in mutual mouth-genital caressing with partner.								
Caressing partner's genitals with your mouth.								
Partner caressing your genitals with his mouth.								
Intercourse with manual clitoral stimulation.								
Use of vibrator during foreplay.								
Use of vibrator during intercourse.								
None of the above activities.								

Name: _____

SEXUAL ACTIVITIES CHECKLIST (MALES)

Date: _____

Please fill in this form each day at the same time (e.g., 6:00 PM) whether or not your have had a sexual experience in the previous 24-hour period. Record the date you complete the checklist and circle the number(s) corresponding to the experience(s) you have had in the previous 24 hours. Rate the fullness of your erection(s) and your degree of satisfaction with the duration of your erection(s) by circling the appropriate number.

	Fullness of Erection							Duration of Erection						
Alone	Completely hard			Semi-hard			Completely soft	Completely satisfactory						Completely unsatisfactory
1. General pleasuring alone, excluding genitals - caressing your body, excluding genital areas, for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
2. General and genital pleasuring alone - caressing your body, including genital areas, for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
3. Masturbation	1	2	3	4	5	6	7	1	2	3	4	5	6	7
With Partner														
4. General pleasuring with a partner, excluding genitals - caressing each other's bodies, excluding genitals, for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
5. General and genital pleasuring with a partner - caressing each other's bodies, including genitals, for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
6. Oral sex by your partner - your partner caressing your genitals with her mouth	1	2	3	4	5	6	7	1	2	3	4	5	6	7
7. Oral sex on your partner - caressing her genitals with your mouth	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8. Intercourse with a partner	1	2	3	4	5	6	7	1	2	3	4	5	6	7
9. NO SENSUAL/SEXUAL ACTIVITY														

APPENDIX FOURTEEN

INTERPRETATION OF SCORES

1. Index of Sexual Satisfaction (I.S.S.)

Score	Interpretation	Standard Deviation
41.5	problem group	11.28
15.2	no problem group	11.28

2. Sexual Arousal Inventory (S.A.I.)

Mean Score	Cumulative Percentile	Standard Deviation
80.9	40	22.7

Maximum possible score - 140

Based on this mean (score), higher scores indicate higher levels of sexual arousal; lower scores indicate the lower levels of sexual arousal.

3. Dyadic Adjustment Scale

Maximum Scores

Dyadic Adjustment	151
Dyadic Consensus	65
Dyadic Satisfaction	50
Affectional Expression	12
Dyadic Cohesion	24

Summary Scores and Standard Deviations for the Dyadic Adjustment Scale and Its Subscales, by Marital Status[2]

	Married		Divorced		Total	
	Mean	SD	Mean	SD	Mean	SD
Dyadic Consensus Subscale	57.9	8.5	41.1	11.1	52.8	12.1
Dyadic Satisfaction Subscale	40.5	7.2	22.2	10.3	35.0	11.8
Dyadic Cohesion Subscale	13.4	4.2	8.0	4.9	11.8	5.1
Affectional Expression Subscale	9.0	2.3	5.1	2.8	7.8	3.0
DYADIC ADJUSTMENT SCALE	114.8	17.8	70.7	23.8	101.5	28.3
	N=218		N=94		N=312	

4. Marriage and Sexual Relationship Questionnaire

Female

Marriage Defensiveness (scores):

Mean = 12.58
Mode = 15.0
Standard Deviation = 8.37
Range = 0 - 34

Interpretation

Normal Range = 7-18 (50% of normals)
Extreme Defensiveness = 29+ (2% of normals)
Moderate Defensiveness = 21+ (16% of normals)

Sexual Defensiveness (scores):

Mean = 5.29
Mode = 2.0
Standard Deviation = 3.59
Range = 0-15

Interpretation:

Normal Range = 3-8 (50% of normals)
Extreme Defensiveness = 12+ (2% of normals)
Moderate Defensiveness = 9+ (16% of normals)

Males

Marriage Defensiveness (scores):

Mean = 10.48
Mode = 10.00
Standard Deviation = 7.32
Range = 0-31

Interpretation:

Normal Range = 5-15 (50% of normals)
Extreme Defensiveness = 25+ (2% of normals)
Moderate Defensiveness = 18+ (16% of normals)

Sexual Defensiveness (scores):

Mean = 5.52
Mode = 6.00
Standard Deviation = 3.55
Range = 0-15

Interpretation:

Normal Range = 3-8 (50% of normals)
Extreme Defensiveness = 13+ (2% of normals)
Moderate Defensiveness = 9+ (16% of normals)

5. Self Esteem Inventory (S.E.I.)

Table 51. Form AD. Percentile Ranks and T-Score Values of Total Scores for Adults (N-252; n=90 males, 162 females).

	MALES		FEMALES	
RAW SCORE	%	t	%	t
1	1	7	1	13
2	1	9	1	15
3	1	11	1	17
4	1	13	1	18
5	1	15	1	19
6	1	17	1	21
7	1	19	1	23
8	1	21	2	25
9	1	23	4	26
10	2	25	5	28
11	2	27	6	30
12	2	29	6	32
13	3	31	6	33
14	5	32	7	35
15	7	34	8	37
16	11	36	11	39
17	13	38	17	41
18	16	40	22	42
19	23	42	26	44
20	28	44	30	46
21	34	46	35	48
22	38	48	41	50
23	43	50	47	51
24	53	52	54	53
25	63	54	64	55
26	68	56	73	57
27	75	58	78	58
28	83	60	84	60
29	88	62	91	62
30	93	64	95	64
31	97	66	98	66

Table 52. Form AD. Percentile Ranks and T-Score Values of General Subscale Scores for Adults (N=252; n-90 males, 162 females).

	MALES		FEMALES	
RAW SCORE	%	t	%	t
1	1	12	1	19
2	1	16	1	22
3	2	19	3	25
4	2	23	4	28
5	2	27	5	32
6	4	31	7	35
7	7	34	11	38
8	13	38	17	41
9	18	42	24	44
10	26	46	33	47
11	41	49	44	50
12	54	53	58	53
13	71	57	70	57
14	88	61	81	60
15	97	64	93	63

Table 53. Form AD. Percentile Ranks and T-Score Values of Social Subscale Scores for Adults (N-252; n=90 males, 162 females).

	MALES		FEMALES	
RAW SCORE	%	t	%	t
1	1	13	1	12
2	1	21	1	20
3	3	29	4	28
4	11	37	10	35
5	30	44	22	43
6	51	52	44	51
7	80	60	78	59

Table 54. Form AD. Percentile Ranks and T-Score Values of Personal Subscale Scores for Adults (N-252; n=90 males, 162 females).

	MALES		FEMALES	
RAW SCORE	%	t	%	t
1	14	37	14	38
2	23	41	25	43
3	32	46	39	47
4	45	50	54	52
5	61	54	67	56
6	73	57	82	61
7	90	63	95	65

6. Beck Depression Inventory (B.D.I.)

Levels of Depression

1 - 10	Normal range
11 - 16	Mild mood disturbance
17 - 20*	Borderline clinical depression
21 - 30	Moderate depression
31 - 40	Severe depression
40+	Extreme depression

*Persistent score of 17 or above - possibly needs help.