SEXUAL REHABILITATION: THE ASSESSMENT AND TREATMENT OF SEXUAL DYSFUNCTIONAL PROBLEMS RELATED TO COMPLEX MEDICAL CONDITIONS

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Dr. Ted Gupton--whose high standards of professionalism and expertise in the field of sexual therapy had inspired the author to seek further knowledge in the area of sexual problems related to complex medical conditions; namely sexual rehabilitation.

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INTRODUCTION

As stated in my Practicuum Proposal, the main objective of this learning experience is the desire of this clinician to study and apply a theoretical framework of the various assessment procedures and treatment modalities which may be utilized in counseling clients who have sexual dysfunctional problems related to complex medical condition/s.

The prime reason to pursue the study of sexual rehabilitation per se was inspired by the clinician's belief that since illness or disability of any magnitude affects the individual's physio-psycho-emotional-sexual-social well-being that total medical and rehabilitative care of the patient and/or partner should invariably include counseling in the areas of sexual functioning.

Although "authorities assert the importance of sexual adjustment at the core of total medical and psycho-social rehabilitation of disabled patient" (Shaked, 1978, p. IX), at present the sexual concerns and difficulties of the chronically ill and disabled patients are not adequately addressed by health-care professionals.

Zilbergeld (1978) stated that one of the 'most confused' and 'least understood' areas of sexuality is in the knowledge of the relation between sexuality and medical illness. Colp & Colp (1981) concurred with these views.

This discrepancy is not surprising in view of the fact that there are vast differences of opinion within

the medical profession itself as to which diseases, injuries, and medications are thought to affect sexual functioning. It also does not help the situation in view of Zilbergeld's (1978) statement that "most doctors know very little about sex and don't feel comfortable discussing it with their partners" p. 347.

Hence, in light of this disparity, this clinician was determined to gain a sound knowledge base which is required to provide the basic conceptual framework for work in this area. It was hoped that at the end of this investigation that the clinician will have accomplished what Kolodny et al (1979) contend "is important for the therapist becoming involved in this aspect of health care to have a knowledge base that integrates the relevant psychosocial facts from the biomedical domain" p. 357.

Sexual rehabilitation per se is a relatively new field and the availability of well-documented studies and literature in this specific area is sparse. The clinician has referred to the information contained in three major textbooks pertaining to medically related sexual dysfunctional problems. Hence, the clinician has utilized the theoretical knowledge base acquired from:

(1) Textbook of Sexual Medicine, Kolodny, Masters and Johnson (1979).

(2) Sexual Dysfunction: A Behavioural Approach to Causation, Assessment, and Treatment, Jehu (1979).

(3) New Sexual Therapy, Kaplan (1974).

There are many other texts which were considered and reviewed by the clinician, however, the above-mentioned textbooks were chosen as the main source of reference from which the conceptual, organizational and discussional framework of this report was derived. An annotated bibliography of each of the above texts is also available in this report. In addition, an annotated bibliography is available on the other texts which were utilized by the clinician (significant but to a lesser degree).

Numerous literature reviews which were compiled from various texts, journals, articles, etc. were examined in order to provide the clinician with a basis of rationale for the hypothesis, clinical diagnosis, and formulation of an effective therapeutic interventive approach which was eventually implemented. These additional sources provided a much wider scope of detailed information on a particular subject area than could be provided in the above-named textbooks. The hypothesis and subsequent formulation of the interventive strategies which were arrived at by the clinician from these sources were incorporated into a sexual rehabilitation program.

It should be noted that whenever and wherever it was applicable and appropriate (assessment procedures, clinical diagnosis, and subsequent treatment program), the clinician endeavored to utilize the 'conventional' or 'standardized' sexual therapy model (Masters and Johnson) which has been proven 'successful' in remedying

sexual dysfunctional problems in otherwise healthy individuals. (Refer to 'Sexual Rehabilitation versus Conventional Sexual Therapy).

However, since the sexual dysfunctional problems encountered by the client/s can vary as much as the presenting medical condition/s, it is virtually impossible for the clinician to arrive at one conclusive theoretical model for the assessment and treatment of all sexual rehabilitative problems.

There are certain situations and factors which play an important role in the type of assessment procedure/s and interventive strategies which were utilized by this clinician. Some of these are:

(1) Various medical disorders have different prognosis and require different management (physically and psychologically).

(2) The sexual dysfunctional problems of different patient/s with similar medical condition/s can vary considerably.

(3) The psycho-social-emotional response of the client and/or sexual partner to a specific medical condition will affect the sexual functioning of the individual and/or partner in varying degree.

Hence, it is this clinician's opinion that sexual rehabilitation should be approached in a similar manner as one approaches other aspects of health care--that is, with special attention to the needs of each individual: objectively and sensitively.

In order to meet these requirements, the assessment procedures, the clinical diagnostic process, the formulation of the sexual rehabilitation program, as well as the actual therapeutic interventive strategies of each case has to be highly individually planned.

For the purpose of clarity, each of these sexual dysfunctional problems will be discussed separately in relation to the medical condition/s presented by the client. Overall the intent of this report is for the clinician to demonstrate the following:

(1) to demonstrate the application of the various assessment procedures (including instruments) and treatment strategies and to apply these to individual case studies which were encountered by the clinician during the practicuum study.

(2) to demonstrate the process of arriving at a clinical diagnosis by utilizing the information derived from various literature reviews, research, studies, etc. on the effects of complex medical condition on sexual functioning.

(3) to show the process of integrating the sexual dysfunctional problem eg. impotence, with the medical condition such as diabetes and arriving at an accurate diagnosis of the etiology of the problem--whether the condition is organic, psychological or mixed in etiology.

(4) to differentiate the plausible etiologic factors and to arrive at an accurate clinical diagnosis.

(5) to formulate a sexual treatment or rehabilitative program based on the findings of the clinical diagnostic procedure.

(6) to formulate and implement a rehabilitative program for the client and/or partner from a preventive perspective rather than treating the presenting symptoms.

(7) to evaluate the results of the treatment program which was instituted, wherever applicable.

ANNOTATED BIBLIOGRAPHY

Jehu, D. (1979)

Sexual Dysfunction: A Behavioural Approach to Causation, Assessment, and Treatment

The clinician has utilized the contents of this textbook as the main source of reference for her studies and this Practicuum Report.

This textbook provides an invaluable source of information for the helping professional who is confronted with the clinical assessment of various sexual dysfunctional problems encountered by the clients.

This text gives the clinician guidance in examining the many physiological, psychological and social causal factors which may have precipitated the onset of the sexual dysfunctional problem; influenced its maintenance; and the various techniques and strategies which may be utilized in the treatment program. The effectiveness and outcome of the various treatment modalities are thoroughly investigated and reported by the author.

The assessment and treatment strategies contained in this book are behavioural in approach.

Kolodny, R., Masters, W. H., Johnson, V. (1979)

Textbook of Sexual Medicine

This publication offers the clinical practitioner a comprehensive guide to the biological and psychosocial implications of the various medical and surgical conditions on sexuality and sexual functioning.

A detailed examination, supported by recent research findings of the various sexual dysfunctional problems associated with specific illnesses and conditions, surgery and medication, eg. diabetes, prostatectomy, drugs, are addressed by these authors.

The author of this report has 'relied' considerably on the advice offered by these experts in making a differential diagnosis (whether the etiology is organic, psychogenic or mixed) in cases where a sexual dysfunctional problem precipitated or occurred concurrently with a complex medical condition. The recommendations offered by these authors regarding sexual functional management and treatment of the various medical conditions are invaluable to the inexperienced clinician attempting therapeutic intervention in this area. These suggestions were incorporated into a sexual rehabilitation program.

Kaplan, H. S. (1974)

The New Sex Therapy: Active Treatment of Sexual Dysfunctions

This publication describes the author's method for the 'new' treatment of sexual dysfunctional problems which represents an integration of psychoanalytic, learning theories and sexual therapy techniques. The basic conceptual foundation is 'multicausal' and 'eclectic'.

The prime goal of the therapeutic intervention is on the 'relief of the sexual problem' and to attain improved sexual functioning.

This textbook also provides a comprehensive explanation of the anatomy and physiology of the sexual response system, including the biological and psychological causes of sexual dysfunction.

Renshaw, W., (1979)

Treatment of Sex Problem

This is a collection of 26 papers and studies by professionals in the field of human sexuality. The majority of these papers, which are reprints from various medical journals and workshop presentations, focuses on specific sexual problems as related to different medical conditions, eg. diabetes, CVA, etc.

The psycho-social-emotional implications of sexual dysfunctional problems which are related to complex medical conditions are recognized and addressed by the author. Renshaw's main theme emphasizes viewing the treatment of sexual problems as an integral part of preventive and therapeutic health care.

Shaked, A., (1978)

Human Sexuality in Physical and Mental Illnesses and Disabilities

A publication of annotated bibliographies which provide a comprehensive and extensive reference resource for health-care practitioners who recognize that "sexual adjustment is an integral part of the total medical and rehabilitative care of patients" p. X.

This book provides the practitioner with ready access to the findings of various clinical research and studies which have been conducted in this field.

Fisher, J., Gochros, H. (1977)
Handbook of Behavior Therapy with Sexual Problems, Volume I, General Procedures: Volume II, Approaches to Specific Problems

These two volumes provide a behavioral theoretical framework to the assessment and treatment of sexual dysfunctional problems. The PLISSIT model (Annon) is an example of a 'simple' treatment procedure which is contained in this book. This model is especially helpful to the professional who is required to assess and counsel in this area.

The second volume provides case studies exemplifying the utilization of a variety of behavioral techniques, eg. systematic desensitization or aversive conditioning which were utilized in the treatment of specific sexual problems.

Caird, W., & Wincze, J. (1977)
Sex Therapy A Behavioral Approach

This textbook outlines case studies which were encountered by the authors in their clinical practice. The variety of case studies which covered a multitude of different sexual problems gave this clinician added insight and knowledge as to the manner in which therapeutic strategies could be 'flexibly' handled in order to

compensate for the individual differences.

The general approach to their treatment modality of various sexual dysfunctional problem is behavioural with the emphasis on systematic desensitization with relaxation training.

The history and role of masturbation in sexual dysfunction as well as the topic of masturbation in therapy is examined in detail by the authors and this area was of particular interest to this clinician.

Kaplan, H. S. (1979)
Disorders of Sexual Desire and Other New Concepts and Techniques in Sex Therapy

This publication describes by case studies, a comprehensive, integrated psychosexual approach to therapy in treating the more difficult intrapsychic and relationship problems of patients with disorders of sexual desire. The author's 'tri-phasic model of sexual response' provides the theoretical base in the treatment of sexual disorders. The appendix tables which cover the effects of drugs and medical illnesses on sexual response prove to be of special value to this clinician in the differentiation between organic and psychogenic causes of sexual problems in the assessment procedure.

Tollison, C. D. & Adams, H. E. (1979)
Sexual Disorders, Treatment, Theory and Research

An informative textbook which examines the treatment, theory and research of sexual dysfunction and

deviations. The book consists of three major sections: (1) foundation of sexual behavior; (2) sexual dysfunctions; (3) sexual deviations.

Treatment of specific sexual disorders are viewed not only from the psychological mode of therapy but also from the chemotherapy and surgical interventive perspective.

Of particular interest to this clinician was the discussion of the traditional (psychodynamic, psychoanalytic) assessment model and the comparison of these techniques with the behavioural approach.

Heiman, J., LoPiccolo, L., & LoPiccolo, J., (1976)
Becoming Orgasmic: A Sexual Growth Program for Women

A book which provides a complete explanation of the female sexual response cycle leading to steps to becoming orgasmic, etc. The information contained in this text provides additional 'self-help' explanations to female clients who are encountering considerable difficulties overcoming certain obstacles which impedes their sexual fulfillment and sexual growth due to misinformation or negative attitudes.

LoPiccolo, J., LoPiccolo, L. (1978)
Handbook of Sexual Therapy

A comprehensive textbook which compiles together numerous articles taken from various sources (journals, addresses, books) for the professional who is interested in the field of sexual therapy. Of particular interest to this clinician was the sections on 'assessment of

sexual function and dysfunction' (p. 85-137) and 'sexual dysfunction in special population'.

Cormier, W. H. & Cormier, L. S., (1979)
Interviewing Strategies for Helpers: A Guide to Assessment, Treatment and Evaluation

This is an informative textbook which provides in detail, the important components of the assessment, treatment and evaluation procedures from a behavioural perspective.

The authors also provide a theoretical framework for the various interviewing strategies which is helpful to the clinician. The book gives descriptive examples of cases, utilizing the various modes of interventive strategies.

Stahmann, R. F., Williams, J. K. (1977)
Klemer's Counselling in Marital and Sexual Problems
A Clinician's Handbook

This is a concise informative handbook for clinicians on the various aspects of counseling by contributing authors who have had considerable expertise and experience in the areas of marital and sexual relationships.

Special issues such as alcoholism, sexual problems, illness, extra-marital affairs, etc. were of particular interest to this clinician as the information on these particular areas provided additional knowledge which was integrated and applied to the various case studies undertaken by the clinician.

Jacobson, N. S., Margolin, G., (1979)

Marital Therapy, Strategies Based on Social Learning and Behavior Exchange Principles

This comprehensive textbook on marital and couple therapy, based on the behavioural social exchange principles provided the clinician with considerable theoretical knowledge especially under the treatment section relating to relationship enhancement.

The authors approach complemented the other behavioural assessment and treatment strategies which were employed by this clinician in her studies.

Zilbergeld, B. (1978)

Male Sexuality: A Guide to Sexual Fulfillment

An excellent self-help book which allows the client to better understand male sexuality. This book provided this clinician with an additional 'teaching aid' from which the client could gain additional information and suggestions of his sexual problem.

SEXUAL REHABILITATION

The author of this report perceives the concept of sexual rehabilitation as being part of a total rehabilitative process (physical, psycho-social and emotional) of the individual and/or the partner of the individual who suffers from the sexual dysfunctional problem/s, usually as a result of a physical or medical condition which precipitated or maintains the sexual problems.

Hence, in sexual rehabilitation, the individual is not evaluated and treated in isolation but the problem is addressed within the context of the individual's intrapsychic, interrelational and environmental circumstances.

Referring to their experiences of counseling clients with physical illness, Gripton and Valentich (1981) stated "Sex counselling as used here is more encompassing than sex therapy (Jehu 1979, Kaplan, 1974, Masters and Johnson 1970) which is concerned with sex problems of individuals and couples that include orgasmic and erectile difficulties, level of sexual interest and painful intercourse" p. 233.

The 'conventional' or standardized sexual therapy, on the other hand, entails the utilization of specific therapeutic methods and techniques (Lazarus, LoPiccolo, Masters and Johnson, Kaplan, Jehu) in order to overcome specific sexual dysfunctional problem/s.

Hence, with the social learning framework, sexual dysfunction without any physical pathology is viewed as: a learned phenomenon which is self-maintained by perfor-

mance anxiety and sustained externally by a non-reinforcing partner or environment. The dysfunction is treated by re-learning specific sexual techniques to alter the couple's sexual interactions LoPiccolo & LoPiccolo (1978).

The sexual rehabilitation program referred to by this clinician addresses a much broader assessment and treatment perspective than the conventional or standardized sexual therapy program. Refer to 'Sexual rehabilitation versus 'conventional' sexual therapy'.

The sexual rehabilitation program utilized by this clinician comprise of various treatment techniques and strategies including those which are part of the conventional sexual therapy program, eg. general pleasuring exercises and relationship enhancement training.

However, since many of the sexual dysfunctional problems encountered by this 'special' population were precipitated or exacerbated by the medical condition or disorder, eg. an impotence problem with its etiology in the medical condition--diabetes, the clinician must be cognitive that the goals of a sexual rehabilitative program for these clients and partners may not entail the resolution of the sexual dysfunctional problem itself, which may be irreparable, but rather in alleviating the contemporary, adversive psychological reactions stemming from the medical problem or sexual impairment.

Hence, the objective of the sexual rehabilitation program is to maximize the level of sexual functioning for the individual and the partner to a state which is

satisfactorily acceptable to both. The level of sexual attainment is subjective depending on the couple's expectations in relation to the pathological condition. Zilbergeld's (1978) advice to his patients that "no matter what kind of impairment you have, some kind of enjoyable sex life is possible for you" p. 348 has considerable meaning in the context of sexual rehabilitation.

In sexual rehabilitation, as stated previously, the assessment and treatment modalities must be highly individualized in order to suit the needs of the clients. As no two cases are the same, the approach will vary considerably. It will also vary from therapist to therapist, depending on the knowledge, skill and experience she/he possesses. Therefore, it would be totally inappropriate to suggest that one particular approach is suitable to all.

Although the majority of the theoretical framework of this report follows the behavioural perspective, a therapist must complement the behavioural approach with other therapeutic models especially when dealing with cases which fall within the broader perspective of sexual rehabilitation rather than the 'conventional' sexual therapy model. Other theoretical models which may be more amenable to sexual rehabilitation cases, due to its multicausal factors include: the psycho-analytical approach, marital and couple therapy, grief or loss counseling, crisis intervention counseling, and the task-oriented approach.

Although this clinician has relied considerably on the behavioural approach (Cormier, 1979, Jacobson & Margolin, 1979; Jehu, 1979) for the basic conceptual framework for the assessment and treatment of sexual dysfunctional problems related to complex medical conditions, it is also recognized that the therapist must be flexible and utilize an eclectic approach whenever it is suited to the client and the situation.

SECTION I

SECTION I

ASSESSMENT PROCEDURES

Introduction

The purpose of the assessment procedure is primarily to identify problem areas by means of precise and calculated methods of gathering information (Jehu, 1979). This process enables the clinician to identify and/or to eliminate the various causal factors to the problem and to make a hypothesis of the etiology of the problem (Jehu, 1979). A clinical diagnosis allows establishment of the appropriate focus on a therapeutic intervention for remediation of the problem/s. Hence, the assessment procedure can be compared to that of a 'tool' which serves the clinician to establish the direction of treatment (Cormier, 1979, Jehu, 1979).

The process of defining the problem enables the clinician and the client to see what is or what is not occurring in the environment. This process should continue throughout the entire counseling sessions "in order to make any necessary changes in treatment plans and to base treatment plans on data rather than intuition" (Kanfer & Phillips, 1970) in Cormier, 1979, p. 126.

The ability to evaluate accurately the problem situation, resource availability and planning of a treatment program, according to Jehu (1979) "probably requires more knowledge and skill than any other aspect of the behavioural approach" p. 5.

Method of Assessment

Caird & Wincze (1977) stated that the "assessment and diagnosis can be made on the basis of information from a number of different sources". They expressed that the therapist should be aware that "each method of assessment possesses different degrees of reliability, validity, and utility" p. 72.

One of the methods of arriving at a hypothesis of the causal factors of the sexual dysfunctional problem is by conducting assessment interviews with the client and the partner. The "interviews are the most frequently used methods of assessment in the field of sexual dysfunction" (Jehu, 1979, p. 211). Caird and Wincze (1977) deemed "the initial interview with a client is one of the most important sources of information for determining the exact nature of sexual problem" p. 49.

Other methods of collecting information are questionnaires, self-monitoring, medical examinations and physiological techniques (Jehu, 1979).

Since the information or history obtained from the clients during the interview session provide such important diagnostic clues to the assessment procedure (Caird & Wincze, 1977; Jehu, 1979; Kolodny et al, 1979), this method of information-gathering will be discussed.

Conduct of Assessment Interviews

Caird & Wincze (1977) reported that Masters and Johnson "rely heavily on interview procedures for their initial assessment of the problem and measurement of

change. Their criterion for successful treatment of sexual dysfunction is determined by a report from their patients during an interview" p. 49. Other therapists and researchers who utilized this method to determine whether or not their therapeutic interventions were successful are: Brady, 1965; Cooper, 1969; Kraft & Al-Issa, 1968; Lazarus, 1963; Madsen & Ulmann, 1967 (Caird & Wincze, 1977).

Jehu (1979) stated that "the conduct of assessment interviews in the field of sexual dysfunction is essentially the same as for any other type of psychological problem (see reviews by Korchin, 1976; Linehan, 1977, Morganstern, 1976; Wiens, 1976)" p. 212.

In order to obtain optimum results from the interview session, certain therapeutic conditions should be observed. This includes conducting the interview in a non-judgmental manner; without embarrassment and in a language which is clear and understandable by the clients (Jehu, 1979).

Caird & Wincze (1977) noted that the client-therapist relationship is "an intensely personal one and is most clearly manifested in a way a client will discuss the most intimate details of his or her sex life with an opposite-sex stranger" p. 6. Therefore, it is suggested that the clinician and the client build up a relationship based on trust which will enable the client to reveal information of such a sensitive and personal nature (Jehu, 1979). This is in keeping with studies which has shown that a client's willingness to make self-disclosing

statements to express himself freely are positively related to the clinician's ability to actively participate in the helping process by sharing his own personal feelings and emotional reactions with the client (Kanfer & Goldstein, 1980).

Confidentiality must be assured and respected especially where an extra-marital affair is revealed (Jehu, 1979).

The experts in the field of sexual therapy do not concur in their opinion regarding which is the best arrangement for conducting interviews when both partners are involved in the treatment (with a dual sex team as there does not appear to be sufficient data to suggest that one arrangement is superior to another (Caird & Wincze, 1977; Jehu, 1979).

Masters and Johnson (1970) advocated two assessment interviews with each partner separately, the first conducted by the therapist of same sex, the second by opposite sex (Caird & Wincze, 1977; Jehu, 1979); whereas Hartman and Fithian (1974) reversed this order and claim to achieve better results.

The clinician conducted the initial assessment interviews with the client and the partner separately which provided "an opportunity for them to give relatively independent accounts of the problem and other related matters, and to disclose any information that they have not revealed to their partners" (Jehu, 1979, p. 213).

Purpose of Assessment Interviews

Caird & Wincze (1977) stated that "the initial interview should provide the therapist answers to diagnostic questions, is this a medical or a psychological problem" p. 49. They considered this question extremely important emphasizing that "it is the responsibility of each therapist to determine whether or not the organic causes can be ruled out (Wolpe 1969)" p. 49.

In order to collect the relevant information therefore, it is adviseable that an assessment outline of the appropriate topics be followed which allows the clinician to select and sequence certain questions that are appropriate for the client.

Hartman & Fithian (1974) stressed the importance of having complete details of the client's background. They felt this information was necessary in order that "the presenting symptoms of dysfunction may be seen in their relationship to the general life and specific sexual history of each client" p. 25.

Lobitz and Lobitz (1978), LoPiccolo and Heiman (1978), Masters and Johnson (1970), Hartman & Fithian (1974) and Jehu (1979) are a few of the authors who have published detailed outlines of the topics to be covered in the assessment interviews.

Jehu's "Checklist of topics for assessment interviews with sexually dysfunctional clients and partners" (table 1) Appendix I was chosen as a general guideline in order to assist the clinician to conduct the initial assessment

interview.

Methods of Data Collection

Other instruments which were utilized during the assessment interviews as an adjunct to the "Checklist of topics" by Jehu, Appendix I were as follows:

Questionnaires

Questionnaires are helpful in providing additional data to the total assessment scheme. Jehu (1979) cited some of the advantages of using this method of collecting information as: (a) requires less expenditure of time by the clinician than in a one-to-one interview session; (b) disclosure of embarrassing material may be facilitated easier in writing than in a personal face-to-face contact with the therapist; (c) specific questionnaires may be selected to assess a particular problem such as the client's social skills or the quality of the relationship between the partners.

Kolodny et al (1979) emphasized "consideration be given for psychological evaluation to those couples in whom no physical or metabolic abnormality is identified" p. 415 or "in whom personality problems, psychosocial immaturity, or other emotional difficulties seem to be present" p. 415.

The following questionnaires were administered to clients who presented with some of the above-mentioned situations and/or where the clinician required further verification as to the existence or extent of the problem.

Sexual History Form (Schoever et al, 1980) Appendix II

This 28 item self-administered questionnaire is completed by all clients who are referred to the Sexual Dysfunction Clinic. This form gives a profile of the sexual behaviour and the preferences of the individual.

Sexual Arousability Inventory (Appendix III)

The S.A.I. is a self report scale which was designed for women with arousal problems was developed by Hoon, Hoon, & Wincze (1976) in which 28 sexual activities and situations are rated on a 7 point Likert scale. The instrument shows good reliability and validity (Jehu, 1979).

Dyadic Adjustment Scale (Appendix IV)

The D.A.S. was developed by Spanier (1976) and consists of "full scale of 32 items to which subjects are asked to rate their responses and four subscales that measure satisfaction, consensus, cohesion, and affectional expression in the dyad" (Jehu, 1979, p. 220). The scale has good reliability and validity and is appropriate for unmarried as well as married couples. It is useful for revealing discrepancies of general relationship between partners.

Semantic Differential Method (Appendix V)

S.D.M. was originally developed by Marks and Sartorius (1968) and was revised by Whitehead and Mathews (1977) for assessing certain attitudes among sexually dysfunctional clients. The S.D.M. gives concept

of the self or partner. In the course of treatment, the gap between myself as I am and My ideal self closes. The same occurs with the partner. (Jehu, 1979).

Beck Depression Inventory

This inventory (Beck 1972; Beck et al, 1961) consists of 21 items representing "cognitive, physiological and overt symptoms of depression, each accompanied by a ranked list of 4 or 5 statements describing varying degrees of severity for the symptom" (Jehu, 1979, p. 221). Reliability and validity are very satisfactory.

Other methods of assessment include:

Self-Recording or Monitoring

The clients are asked to observe and record specific aspects of their sexual behaviour and the circumstances in which it occurs. This method is deemed as the nearest to direct observation by the clinician. One of the purposes of the self-monitoring method is that it provides a baseline in order to evaluate the subsequent efficacy of the treatment in producing beneficial behavioural changes (Jehu, 1979).

Medical Examination and Records

The importance of arranging a medical examination as part of a comprehensive assessment for clients complaining of sexual dysfunction is emphasized (Jehu, 1979; Kolodny et al, 1979). For the clinician who is specializing in treating sexual dysfunctional problems

related to a complex medical condition, the findings of the medical examination contained in the referral letter is very essential to the total assessment procedure (Kolodny et al, 1979; Tollison & Adams, 1979). Kolodny et al (1979) maintained, however, that "while additional data gleaned from the physical examination or laboratory assessment will provide further input to making such a distinction it is the details of the history that usually provide the most important diagnostic clues" p. 590.

Penile Plethysmography

Refer to literature review under case study no. 4.

Assessment Procedural Format of the Sexual Dysfunction Clinic

It should be noted at this time that the cases which were referred to this clinician follow a different assessment procedural route than the procedures which might be encountered by a clinician in 'private' practice. Whereby, in a private clinical setting, rarely would a supervisor first see the client in order to conduct the initial screening interview to determine the appropriateness of the case for the intern clinician's practicuum study. This procedure (a necessary one in a teaching setting) is, in fact, similar to a preliminary assessment procedure described by Kolodny et al (1979).

In the preliminary assessment interview, the supervisor evaluates the case, for the following reasons:

(1) to ascertain whether the dysfunctional problem is defined as sexual; (2) in order to differentiate whether the presenting sexual problem may be influenced by other causal factors such as marital discord, illnesses or other circumstances; (3) to determine whether the problem may be treated by the Sexual Dysfunction Clinic.

Information which is provided to the prospective client by the supervisor include: status of the intern clinician; confidentiality; time commitment for treatment; nature of treatment, etc. At the time of the preliminary assessment interview, the Sexual History Form (Appendix II) may or may not be completed by the client and the partner, if one is available.

This procedure is brought to the attention of the readers in order to avoid confusion and to clarify the reason why a preliminary assessment interview was not, in fact, completed by this clinician at the time of the initial assessment interview. One exception is case no. 2 where the referral was made directly to the clinician (via the hospital facility where she is employed). Hence, in this case, the preliminary assessment was conducted by the clinician. This fact is stipulated in the case study.

Assessment of Problems

The assessment of the problem situation requires (a) "comprehensive and detailed description in operational terms of those aspects of the client's

functioning that are judged to be inadequate", (b) "the contemporary conditions that may influence the occurrence of the dysfunctional behaviour" (Jehu, 1979, p. 6).

Description of Problem/s

Nature of the dysfunction

The client determines the problem as he/she interprets it. The identification of the problem is, therefore, subjective. It is for this reason that the individual is seeking help or treatment. "The initial task is to obtain a specific and comprehensive description of the nature of the problem in clear operational terms" (Jehu, 1979, p. 176).

Frequency and timing

It is important to establish whether the current problem occurs during every sexual encounter or whether its occurrence is on certain occasions. The issue of timing 'is quite central' for some types of problem (Jehu, 1979).

Surrounding circumstances

Is there any particular situation in which the problem occurs? For example, information is gathered to ascertain whether the problem "occur only in the presence of a partner who exhibits certain characteristics, such as being dominant or demanding, or in certain physical setting," eg. the couple cannot function if the children are around (Jehu, 1979, p. 176).

Duration

It is essential to establish whether the sexual dysfunctional problem has always existed (primary) or not (secondary). This has important diagnostic and treatment implications (Jehu, 1979; Caird & Wincze, 1977).

Onset

It is important to determine what was happening in the person's life "including the age of the client at the time, whether the problem developed suddenly or gradually, any possible precipitating factors and the reactions it evoked in the individuals concerned" (Jehu, 1979, p. 176).

Course

The course of dysfunction--whether it remains same or fluctuates. Additional information is required about "any factors accompanying these variations. Such factors yield clues to the determinants of the problem" (Jehu, 1979, p. 177). The fact that the couple has attempted to resolve the problem themselves or tried other treatment will provide clues of the emotional atmosphere within the relationship (Jehu, 1979). Of particular importance to the clinician who is specializing in sexual dysfunctional problems related to a complex medical condition is "persistence of a sexual dysfunction after a relevant organic condition has yielded to medication may indicate the influences on the dysfunction of the client's psychological reactions to his illness" (Jehu, 1979, p. 177).

Contemporary Influences on Problems

The information which is yielded from the description of problems should provide "some indication of the contemporary conditions that influence its occurrence" (Jehu, 1979, p. 177). For instance, an organic condition or a previous learning experience may be deemed to have contributed to the origin and development of the dysfunctional behaviour but "it constitutes a dysfunction only when it is judged to be inadequate in the current situation" (Jehu, 1979, p. 41). The information which is derived from three broad categories, namely: situational antecedents; organismic variables and situational consequences provide the clinician with some clues as to the conditions that caused its occurrence and its maintenance.

Example: "previous experiences can constitute useful sources of hypotheses about possible contemporary influences on the problem" (Jehu, 1979, p. 178). In case no. 1, the information gathered regarding the client's restrictive upbringing and traumatic rape experience in her teen years provided valuable clues as to the plausible causal factors relating to the sexual dysfunctional problem that the client is presently encountering.

The clinician will now briefly discuss the manner in which each of the three categories of contemporary influences can be responsible for the precipitation, maintenance or even the exacerbation of the dysfunctional

problem. Case studies which represent the presenting symptoms will be referred to in this report to exemplify the utilization of the theoretical framework into practice.

Situational Antecedents

Situational antecedents are 'environmental conditions' which might have immediately preceded the sexual dysfunctional behaviour and which promotes its occurrence. Jehu (1979) has described these situational antecedents to include certain aspects of the sexual encounter; the sexual partner; timing and setting of sexual encounter or any stressors of a non-sexual nature.

Sexual stresses

Certain features of the sexual anatomy and response, eg. dislike of genital smell or appearance have been known to create stress reactions for some individual (Jehu, 1979). Another group of stress reactions which fall within this category is the anticipation of harm from sexual activity. These may include fear of physical pain or injury; fear of pregnancy, etc. Psychological stressors may include lack of satisfaction during intercourse or the fear of intimacy (physically or emotionally) with another person (Jehu, 1979).

Sexual stresses due to anticipation of failure, according to Kaplan (1974) and Masters and Johnson (1970) about sexual performance appear to be one of the most prevalent stressors which contribute to sexual problems. Eg. refer to case no. 4.

Another form of sexual stress is participation in "any form of sexual activity that contravenes a person's moral or religious standards" (Jehu, 1979, p. 44). Eg. refer to case no. 1.

Deficient or inappropriate stimulation

This problem may occur through lack of knowledge in the techniques of lovemaking where the partner may not be providing sufficient stimulation. This may create a situation where the sexual partner is unable to become sufficiently aroused (Jehu, 1979). Eg. refer to case no. 1. One category of clients who are particularly subject to and affected by deficient stimulation, according to Jehu (1979) are the physically handicapped and the aging male.

Relationship with partner

When coitus is attempted with an unattractive or discordant partner, sexual performance may also prove inadequate (Jehu, 1979). There appears to be a strong correlation between marital discord and sexual dysfunction (Kaplan, 1974; Sager, 1974). Eg. refer to case no. 3.

Timing and setting of encounter

Stressors may be created for one or both of the partners if the sexual encounter is hurried, uncomfortable, or where there is lack of privacy (Jehu, 1979). Hence, any one or a combination of the above conditions can evoke sexual dysfunctional behaviour. Eg. refer to case no. 3.

Concomitant non-sexual stresses

A busy work schedule, hectic child care, in-law concerns, illness in the family, etc. can affect the sexual behaviour of the clients, especially if the pattern of stress is long-standing (Jehu, 1979). Eg. refer to case nos. 2 and 3.

Organismic Variables

Sexual behaviour may be affected by "organismic or person variables that function within the individual and serve to mediate how he responds to external influences" (Jehu, 1979, p. 178). These include how a person perceives a situation, thought processes, emotional feelings and organic state (Jehu, 1979).

Thought processes

Thought processes can either enhance or impair sexual behavior and therefore the clinician must evaluate the extent or degree of these influences through the assessment procedure. We will now briefly discuss how these can impair sexual behaviour.

Cognitive avoidance

This is the process of consciously or unconsciously avoiding the feelings evoked by stimulation from activities such as kissing, caressing, clitoral manipulation. The client fails to perceive the sexual stimulation or feel the pleasurable sensations that are associated with it and hence the individual's sexual

arousal and gratification are impaired (Jehu, 1979). If one particular aspect of the sexual act is not pleasurable, then the sexual arousal will shut off or if the sexual arousal is alarming to the individual then it is switched off as soon as a stressful point is reached. "In extreme cases, such sensations and feelings are totally lacking, a condition sometimes referred to as 'sexual anaesthesia' occurs" (Jehu, 1979, p. 48). Eg. refer to case nos. 1 and 3.

Cognitive monitoring of sexual performance

Once a man anticipates failure, he is prone to observe if he is getting an erection, observing its rigidity, or loss of erection. Masters and Johnson (1970) have called this behaviour 'spectatoring'. They also observed that where the person is so busy watching his actions, it has the effect of taking him out of the situation resulting in detachment from the pleasurable sexual sensations which evoke sexual arousal (Jehu, 1979). Eg. refer to case nos. 3 and 4.

Deficient or false information

Sexual dysfunctional problems may arise from 'ignorance' and 'misconception' (Jehu, 1979). The sexual information which a person may possess may not be accurate and consequently affect his sexual behavior (Jehu, 1979). Other factors such as previous learning conditions (eg. traumatic experience, restrictive family upbringing or adverse family relation) "may deprive

individuals of sufficient knowledge about sexuality or transmit false information to them" (Jehu, 1979, p. 63). Eg. refer to case no. 1.

Emotional reactions

Negative emotional reactions such as depression, anger, guilt, anxiety, etc. can impair sexual behavior (Jehu, 1979) and therefore information must be collected in order to evaluate to what extent these reactions prevail. Various instruments and inventories may also be utilized to serve this purpose.

Anxiety

Masters and Johnson (1970) strongly emphasized the damaging effect of anxiety on sexual arousal. They contend that sexual arousal cannot be willed by the individual but is a product of the natural response to sexual stimulation. They feel that when 'performance anxiety' occurs then sexual arousal is disrupted, eg. refer to case nos. 1, 3 and 4.

Anticipation of failure in lovemaking tends to distract the individual "from the ongoing sexual stimulation and thus to prevent arousal occurring, so that a man may present with impotence or a woman with vasocongestive dysfunction" (Jehu, 1979, p. 45). Eg. refer to case no. 4.

Guilt

Guilt feelings which are encountered by an individual

regarding his sexual activities may disrupt his sexual responsiveness. This is particularly valid where the sexual activity contravenes the individual's religious teachings or moral standards (Jehu, 1979). Eg. refer to case no. 1.

Depression

"Stresses which entail profound disappointment and lowered self-esteem for an individual may be particularly likely to result in depressive reactions" (Jehu, 1979, p. 45). Eg. refer to case no. 3.

Anger

Anger whether overt or covert, can disrupt sexual response and ultimately effect sexual behaviour. Anger may be experienced towards the partner for various reasons: dominance conflict, rejection of partner, deficient reinforcement of rewards, sexually dysfunctional partners (Jehu, 1979). The exact physiological mechanism which disrupts sexual arousal by anger is not presently known (Jehu, 1979). Kaplan (1979) however, noted a strong correlation between women suffering from inhibited sexual desire and anger. Eg. refer to case no. 3.

Organic Factors

Organic conditions such as chronic illness, natural changes of the aging process, ingestation of therapeutic drugs and surgical procedures are known to cause, influence, contribute or maintain the client's

sexual dysfunctional problem (Bancroft, 1983; Jehu, 1979; Kaplan, 1974).

The assessment procedures of the various organic conditions which contribute to sexual dysfunctional problems will be elaborated upon more fully under the heading 'Organic factors which affect sexual functioning'.

Situational Consequences

In this category of influences, it necessitates investigation of "those environmental consequences of the problem which serve to maintain and perhaps exacerbate, its occurrence" (Jehu, 1979, p. 179).

Partner's reactions

The negative response or reaction such as anger, rejection, and criticism to the sexual dysfunctional behaviour by the partner will maintain or further exacerbate the dysfunctional behaviour (Jehu, 1979). Eg. refer to case no. 3.

The sexual dysfunctional behaviour may also be maintained by one partner especially if the relationship is bad and chronic disinterest in sex becomes a way to hurt the partner (Jehu, 1979). Eg. refer to case no. 3.

Absence of sexual relationship due to avoidance reactions

If one partner feels rejected, then the behaviour which usually follows is to avoid the situation which brought on those emotions in the first place. Therefore, instead of improving the situation, the absence

of sexual relationship creates additional problems in areas such as communication and shared activities as there tends to be a spill-over of these negative feelings into other non-sexual areas (Jehu, 1979). Eg. refer to case nos. 2 and 3.

In the case where the individual does not have an existing sexual partner, he may avoid social contacts in which his inadequacies will be exposed (Jehu, 1979). Thus, by stopping to engage in social relationship with the opposite sex, it takes the pressure away from having to engage in coitus. Eg. refer to case no. 4.

Personal and Family Background

Knowledge which is derived from the personal and family history of the client and the partner provides "a helpful framework of viewing the crucial psychologic tasks at various points throughout the life cycle" (Woods, 1975, p. 45).

Bancroft (1983); McCary (1973); Otto (1971) provided additional insight into the biologic changes, psycho-sexual development, psychosocial changes and problems around sexuality throughout the life cycle. Sexual problems with respect to the client and his environment were thoroughly covered by Bancroft (1983).

Jehu's 'Checklist of topics for assessment interviews' Appendix I, provided an extensive guideline of topics on personal and family background.

Traumatic experiences, restrictive upbringing and adverse family relationship have been cited as

experiences that provide conditions (learning) which may contribute to sexual dysfunction (Jehu, 1979).

If a client initially experiences sexual intercourse traumatically eg. rape, then it may well contribute to sexual dysfunction (Jehu, 1979). Eg. refer to case no. 1.

In a significant number of Masters and Johnsons' (1970) patients, severe religious orthodoxy was indicated as the cause for sexual dysfunction (Jehu, 1979). Eg. refer to case no. 1.

Assessment of Resources

"A second major area for assessment concerns those potentialities and limitations in the available resources that may facilitate or hinder treatment" (Jehu, 1979, p. 179). These may be categorized as to whether they relate to: (a) the client's environmental situation; (b) to the client personally; (c) to the availability of therapeutic services.

(a) Situational Resources

Under this category, it is essential to collect information in order to evaluate whether the following factors may facilitate or hinder treatment progress. These are:

General relationship between the partners

The evaluation as to the quality of the relationship between the partners is important because it

answers the question whether treatment should be attempted if there is discord (Sager, 1974). When marital discord and sexual problems coexist in the same partners, a decision may have to be made to choose between offering treatment for relief of sexual dysfunctional behaviour or to recommend marital therapy aimed at improving the general relationship of the partners (Jehu, 1979; Jacobson & Margolin, 1979). There are many pros and cons presented for conducting sexual therapy while marital discord coexists between the partners (Masters & Johnson, 1979; Gill & Temperley, 1974; Sager, 1974; Kaplan, 1974; Jehu, 1979). For further elaboration on this topic, see literature review on case no. 3.

Sexual dysfunction in both partners

Where some degrees of sexual dysfunction exists in both partners, it is necessary to assess for a "variety of possible combinations, as well as many other individual differences between the couples, precludes the prescription of any ideal method of treating dysfunctions in both partners" (Jehu, 1979, p. 186).

Availability of a regular partner

It is recognized that difficulties and deficiencies will occur in the treatment of a client who lacks a regular sexual partner due to the importance placed on the involvement of two willing and cooperative partners inthe treatment of sexual dysfunction (Jehu, 1979).

Therefore, it is important to assess the availability of the regular partner, eg. refer to case no. 4.

Socioeconomic resources

In this category, information is collected in order to evaluate whether the couple's environmental situation or life style may facilitate or hinder undertaking a treatment program. For example: Is there sufficient privacy to allow the couple to carry out 'prescribed' sexual assignments? Or are there undue financial pressures which would not allow one partner to attend therapy during the working hours.

The assessment of these mundane and practical matters should not be neglected as they may greatly influence the process and outcome of the therapy (Jehu, 1979).

(b) Personal Resources

The assessment of the following personal resources would indicate more accurately whether the outcome of the treatment would meet with success.

Motivation

The motivation of each partner is considered to be an important resource as it will likely influence the couple's capacity to co-operate, persist and response to the treatment (Jehu, 1979). The couple's actual behaviour is often indicative of the motivation they may possess towards overcoming the sexual dysfunctional problem (Jehu, 1979). Behaviour such as keeping regular appointments; carrying out prescribed sexual assignments,

and verbal expression of wanting help, provides valued clues to other interactional processes occuring between the individuals, eg. whether the symptomatic client was motivated to seek out treatment or was the client seeking help because of pressures placed on him by the partner. (Refer to case no. 3).

Organizational capacity (time, commitment)

According to Goldfried (1976), the "client's capacity to organize his own time and commitment in an important resource affecting the process and outcome of those treatment programmes that require the implementation of any kind of homework assignment" (in Jehu, 1979, p. 188). For instance, it is important to evaluate accurately whether the couple would have difficulties in setting aside sufficient time to comply with prescribed sexual tasks or avoid the tasks because they may feel threatened.

Educational and socio-economic level

These factors are aspects for appraisal during the assessment interview. Although it would be helpful to draw clients from the higher educated (apparently 72% of the clients who entered Masters and Johnson's treatment programme had college or university education (Jehu, 1979), this is not always possible. Jehu (1979) commented from his experience that "this form of treatment is quite viable with patients from lower socio-economic and educational level" p. 188.

Religious and moral belief

The client's religious beliefs concerning sexual behaviour or practice require appraisal during the assessment interview (Jehu, 1979). If a client or the partner considers 'self-stimulation' to be sinful or immoral, then these beliefs may hinder the scope of the treatment and subsequently affect the outcome, eg. refer to case no. 1.

(c) Professional Resources

The appraisal of the availability of a knowledgeable therapist (or cotherapy team) who can conduct the treatment as well as the availability of therapeutic time is required (Jehu, 1979).

Behavioural Treatment Model

The rationale for the utilization of the behavioural treatment model will be discussed next.

"The major contribution of behavioural treatment per se is to provide effective ways of achieving these goals only after they have been selected on personal, social and ethical grounds" (Jehu, 1979, p. 195). These are very important factors to consider in view of the varied composition of the clienteles who are referred to the Sexual Dysfunction Clinic.

Since the "goals of behavioural treatment do not entail any absolute norm or standard of sexual performance rather they reflect the judgments of adequacy in sexual functioning made by the couple concerned" (Jehu, 1979,

p. 195), this particular treatment model was considered to be more amenable to this 'special' population (sexual dysfunctional problems related to a complex medical condition), than to the other theoretical approaches.

Similar to Kaplan (1974), it is recognized that much of the clinical work relating to the complex medical condition (sexual rehabilitation) is multicausal, and that an eclectic perspective may have to be considered and utilized at times. However, for the most part, this clinician favors and follows the behavioural assessment and treatment modality.

Caird & Wincze (1977) also recognized that "while one has general principles to dictate the direction of therapy, the uniqueness of men and women ensures that one will frequently have to be imaginative and creative one's therapeutic endeavor" p. 3. They believed that within the general parameters of a theoretical model (theirs is behavioural--systematic desensitization), it is essential for the therapist to recognize the individual differences and to adopt a flexible approach and "if necessary, tailor or adjust the modus operandi to suit the case" p. 3.

Behavioural Formulation

The behavioural formulation of the client's problem situation is based on the data collected through the assessment procedures; specification of the problem; hypotheses about the contemporary conditions which are initiating and maintaining the problem and appraisal of the resources available for treatment (Jehu, 1979). On

the basis of these findings, therapeutic goals are negotiated and specified with the clients.

Planning Treatment

Before drawing up a treatment plan that reflects the behavioural formulation and the selection of goals, it necessitates making certain decisions regarding the provision of a therapist or clinician; the physical setting of treatment, and the procedures used (Jehu, 1979).

Provision of a therapist

Masters and Johnson (1970) have insisted that any treatment program they undertake be conducted by co-therapists of each sex (Kaplan, 1974; Jehu, 1979). They adhere to this duo therapists policy because of their belief that it is important for the same sex client to be able to understand and to empathize with a therapist of the same gender. Other arguments supporting the dual sex team concept are: each partner has an advocate of the same gender; this arrangement facilitates easier communication; it reduces the risk of one partner feeling neglected (Jehu, 1979). Kaplan (1974) on the other hand, believed it was possible to train therapists to become empathetic with sexual concerns and problems of a different gender.

There are limitations and disadvantages, however, of using the duo sex team which need to be considered. These include: two working therapists may be more cos-effective than working in a team; equally qualified

and suitable therapists may not be available; conflicts in values, theoretical orientation, and therapeutic style may occur between therapists (Jehu, 1979). There is very little research evidence to indicate the difference in process or outcome of either modalities (Jehu, 1979).

Qualifications and competence

Therapists in the treatment of sexual dysfunction are comprised of various professions and specialities. At present, there is no systematic evidence which shows that one is more superior than another in conducting sexual dysfunctional treatment (Jehu, 1979). Interestingly, studies have shown that "attitudes, knowledge and skills that a therapist brings to the treatment of sexual dysfunction are more important than the particular professional discipline (Kaplan, 1977; LoPiccolo, 1978; Waggoner et al, 1973)" (in Jehu, 1979, p. 201.).

Treatment setting

The decision as to where the treatment is going to be conducted would be dependent on the type of problem being treated (Jehu, 1979).

Masters and Johnson (1970) preferred the couple to leave their own home environment and to stay elsewhere during the treatment period. They felt this allowed the couple to concentrate and work on their sexual relationship without the pressures of everyday life. This arrangement may be ideal but not practical in terms of time and expense for most couples (Caird & Wincze, 1977).

There is no conclusive evidence to support that living at home or away from home during the treatment has significant effect on the process and outcome of treatment (Jehu, 1979). It is suggested, however, that treatment be conducted in a general or day hospital setting in preference to a psychiatric institution (Jehu, 1979).

Timing of treatment

This entails the appraisal of the number of therapy sessions, length, spacing, and overall duration of the treatment program. Jehu (1979) reported that "no controlled studies have yet been conducted into the relative effectiveness of very intensive (Masters & Johnson) versus more prolonged programes" p. 203. Spacing the treatment over a period of 10 to 20 weeks is probably the most practical (Jehu, 1979).

Selecting Goals

In the process of selecting treatment goals, the clinician, the client and the partner must choose the therapeutic strategy which is most appropriate for them. "The aim is to negotiate a therapeutic contract in which mutually agreeable goals are specified" (Jehu, 1979, p. 195). This is in keeping with the behavioural approach procedures which reflects subjective and individualized judgment of adequacy in sexual functioning (Jehu, 1979). In other words, the choice of goals are made by the couple which adhere to their own wishes and values.

If the client selects unreasonable or unrealistic

goals (eg. refer to case no. 4) and if the clinician is unable to accept these goals (due to reservations from a professional or ethical nature); then it would necessitate suggesting alternative goals. Or the clinician and the client may reach an impasse in regards to the selection of goals which are mutually acceptable to both, then it may be necessary to refer the client to another therapist (Jehu, 1979).

In the case of an exacerbation of an illness, it may be more appropriate to have the identified condition treated first rather than to proceed immediately with intervention of a psycho-sexual nature (Caird & Wincze, 1979; Jehu, 1979). Eg. refer to case no. 2.

After the clients and the clinician have decided on the goals of treatment, the next step is to "specify them very precisely in terms of the responses desired in particular situation. This specification serves to clarify the goals for both the clients and the therapists, to guide the choice of treatment procedures and to facilitate the assessment of progress and outcome of treatment" (Jehu, 1979, p. 196). Hence, the more specific the goals are, the better it is to evaluate the progress and "to enhance the precision and reliability of this ongoing assessment process" (Jehu, 1979, p. 196). Goals are open for renegotiation and the more specific, the more negotiable.

After defining the problem and goals, it necessitates the selection of the appropriate counseling

procedure (Cormier, 1979).

Evaluating Progress

When a treatment program is negotiated between the clinician and the clients, it is essential that "the progress and outcome are systematically monitored and evaluated on a continuous basis throughout the implementation and follow-up periods" (Jehu, 1979, p. 209-210), as this process provides feedback to the client on his progress. Tangible results must be seen if the client is to be encouraged to move forward (Egan, 1975).

Evaluating the counseling outcome and/or progress of the treatment may be accomplished in the following manner:

(1) Interview

(2) Self-monitoring

(3) Direct observation

(4) Systematic record keeping procedure

(a) Interview

A verbal self-report which elicits the client's perception about the value of the treatment (Cormier, 1979). This method has been used extensively by Masters and Johnson and other researchers (Caird & Wincze, 1977). If, presumably, changes are occurring, (as helping strategies are introduced and implemented), the client will indicate the decrease of the severity of the problem (Cormier, 1979).

The interview method has limitations, however, in that it is the least systematic and standardized method

of collecting data with the resultant information not being very precise or specific. The reliability of the information is subject to the client's ability to verbalize the required data (Cormier, 1979).

(b) Self-monitoring

Self-monitoring as a measurement method allows the client to "collect data about the amount (frequency, percentage or duration) of the goal behaviors" (Cormier, 1979, p. 211). Studies have shown that self-monitoring can have more 'criterion validity' than some other data collecting inventories or instruments (Cormier, 1979).

(c) Direct Observation

This method can be used to cross-validate the data collected from the other procedures such as interviewing, self-monitoring, self-report, questionnaire and role-play assessment. The advantages of this method of observation are objectivity and reliability (Cormier, 1979). However, this method has several disadvantages when dealing with a sensitive and personal area as sexual dysfunction. It poses ethical problems; can affect or damage the client-clinician therapeutic relationship; and by using outside observers, the client may interpret this as mistrust (Cormier, 1979).

(d) Systematic record keeping procedure

Systematic record keeping procedure (Bloom and Fischer, 1982) was referred to as "the most useful and accurate way of establishing the effectiveness and

efficiency of our interventions" p. 74. Due to the multicausal and multifactorial nature of the sexual dysfunctional problem associated with a complex medical condition, it required a system which allowed measurement of the progress of the many treatment goals. This method was used extensively in the case studies, in the following manner:

During the initial assessment interview, a information baseline was established by using the client's memories or archival (medical) records. The clinician focused on one or more identified problems and then proceeded to priorize them. The problems were specified in measurable or observable terms, eg. in case no. 2, where the wife of a CVA patient presented with numerous 'crisis' problems. The clinician focused on a few 'manageable' problems and developed a record keeping system which allowed the clinician to be cognitive of the tasks or goals which were to be undertaken by the client. Overall, this particular method was most helpful in handling the extraneous factors which needed to be considered.

(e) Follow-up assessments

After the termination of counseling, follow-up assessments of some form should be conducted (Cormier, 1979). Short term follow-up fall within the three to six months post counseling period while long term follow-up occurred six months to a year or more after termination of counseling. Ideally, the same type of measures which were used to collect data before and during

counseling should be employed during the post treatment data collection (Cormier, 1979).

Follow-up assessments also provide comparative information as to the pre and post performance of the goal behaviour--whether the client has been able to maintain the desired behavior as well as prevent undesired ones from forming without the assistance of counseling (Cormier, 1979). The follow-up assessment also communicates 'genuine caring and interest' for the client's well being (Okun, 1976).

Follow-up assessments may be conducted by a personal interview; by mailing an inventory or questionnaire; sending a letter to the client; telephoning the client and requesting an oral report (Cormier, 1979). Eg. refer to case no. 4.

Up to this point, the clinician has compiled detailed information from various assessment procedures and has completed a preliminary assessment report on each client and partner.

According to Jehu (1979) the assessment report ends with:

"(1) a clinical formulation which includes:

(a) specification of the problem/s

(b) some hypothesis about the contemporary conditions that influence its initiation and maintenance and

(c) an appraisal of resources available for treatment.

(2) a statement of:

(a) the therapeutic goals that have been negotiated and specified with the clients and

(b) the criteria and measures that are to be used in monitoring progress and outcome in respect to these goals and any positive or negative side effects of treatment.

(3) an individualized treatment plan which follows from the clinical formulation and treatment goals" p. 6.

Crisis Intervention

The assessment and intervention strategies of crisis intervention were investigated when many of the spouses of the symptomatic clients displayed exaggerated forms of emotional and behavioral symptoms which required some type of remedial therapeutic intervention before a sexual rehabilitation program could be implemented, eg. refer to case no. 3.

Aquilera and Messick's model (Appendix XV) provided a suitable framework of the crisis intervention theory and its application to practice. Puryear (1979) advised putting the focus on the current situation during the initial stage of assessment, then addressing the question of the system and resources. Golan (1978) concurred with the above, however, emphasized the identification and definition of the crisis situation.

Puryear (1979) suggested that during the assessment procedure, the client's inadequacies in perception, network and coping mechanisms should be noted which seemingly caused the situation to become a crisis. The goal is to "unravel and outline a chain of events--of stresses, reactions, and problem-solving efforts. To accomplish this requires a complex shifting of focus from present to past and back again" (Puryear, 1979, p. 110).

Eight principles form all of the work and activities in crisis intervention. These principles are: "immediate intervention; action; limited goal; hope and expectations; support; focused problem solving; self-image and

self-reliance" (Puryear, 1979, p. 20). Puryear (1979) also considered focused problem-solving to be the "backbone of crisis intervention" as "it provides the structure that shapes and supports the whole process" p. 21.

In dealing with crisis intervention situations, Puryear (1979) recommended "taking charge, monitoring anxiety, and setting the atmosphere" (p. 84), as the three basic procedures of establishing communication and rapport with the client. These recommendations were followed in case no. 2 where the client was given specific instructions that she may follow in order to overcome the identified (crisis) problems. Only when the crisis situation was resolved, was the client able to discuss and work on alleviating the sexual dysfunctional problems which existed within the couple relationship. Hence, the implementation of this model facilitated better organization and formulation of an appropriate intervention strategy.

SECTION II

SECTION II

TREATMENT PROCEDURES

Sexual Rehabilitation Versus 'Conventional' Sex Therapy

The difference between the 'conventional' or 'standardized' sexual therapy program (Masters and Johnson) and the sexual rehabilitation program per se has already been discussed elsewhere and therefore will not be elaborated further.

The treatment strategies and techniques which will be discussed in the forthcoming section can relate to both the conventional sexual therapy program and to the sexual rehabilitation program. The treatment modality is applicable to both, depending on the etiology and situations revolving around the sexual dysfunctional problem.

In order to work within the conceptual framework, however, it is necessary to distinguish between the two, mostly for ease of discussion. Hence, in viewing the treatment program for sexual dysfunctional problems on a continuum, the sexual rehabilitation program is viewed to be much broader in scope, while the conventional sexual therapy program is narrower. In other words, sexual rehabilitation encompasses a much broader spectrum of associated problems.

Gripton and Valentich (1981) categorized the range of sexual problems addressed in sex counseling of clients with physical illnesses and organic conditions as: "developmental problems; compatability problems; performance problems; preference problems; sexual oppression

problems; life style related problems; reproduction related problems; sexual trauma related problems; gender identity problems; sexual orientation problems; sexual obsessions; forensic problems" p. 233-234.

These classifications of sexual problems and related issues and concerns would not only affect the functional level of the symptomatic client but would invariably affect the partner's psycho-sexual and social functional level as well (Kaplan, 1974).

Therefore, the other important area of concern in sexual rehabilitation is the treatment which is required for the spouse or partner of the symptomatic client. According to Kaplan (1974) "the effects of sexual therapy on the psychological status of the partner of the symptomatic spouse also range from highly beneficial to dangerously disruptive" p. 450.

Psychological and emotional problems such as dealing with loss, grief, coping, adjustment and acceptance to the sexual dysfunctional problem which is manifested by the disease process are often encountered by the partner or spouse (Jehu, 1979; Kolodny et al, 1979). These problems must be addressed, once they are identified during the assessment procedure in order to prevent disruptive blockages in the couple relationship.

In view of the many 'special' problems created by the physical or organic condition, eg. irreparable sexual functioning, the section on 'Relationship enhancement' is considered very significant to all aspects of sexual rehabilitation.

This is not to discount the importance of relationship enhancement training which is employed in the conventional sexual therapy program, however, (in the opinion of the clinician) the emphasis of relationship enhancement is more crucial in sexual rehabilitation type cases. For instance, if a couple is faced with impotence due to an irreversible organic condition such as diabetes or MS, then the couple will have to work at enhancing other aspects of their relationship eg. seeking out alternate forms of expressing loving and caring feelings than in the 'normal' manner which are exhibited by healthy individuals (Bancroft, 1983).

In the conventional sexual therapy program, the focus is "a task-centered form of crisis intervention which presents an opportunity for rapid conflict resolution" (Kaplan, 1974, p. 199). The therapist is, according to Kaplan (1974) "primarily concerned with modifying the specific factors in the sexual system which impair sexual adequacy, the lack of authentic communication about sexual feelings, the sexual sabotage, the ineffective sexual interactions" p. 168. Hence, relationship enhancement is important only in terms of how the lack of it can interfere with "the prescribed sexual interactions which are required to modify the couple's previously destructive sexual system" (Kaplan, 1974, p. 168).

A treatment program for a client and the partner with a sexual dysfunctional problem related to a complex medical condition necessitates the utilization of a broad

theoretical knowledge base which would encompass both the concepts of the conventional sexual therapy and the sexual rehabilitation programmes. Both of these are closely interconnected with each other and therefore to describe both of these concepts simultaneously in a clear, concise and organized manner presented with some difficulties.

In order to facilitate less cumbersome handling of the literature review material, the treatment model is divided into two distinct subsections: (1) therapeutic intervention methods for the conventional sexual therapy per se; (2) a treatment program for cases more suited under the heading of sexual rehabilitation.

Therefore, if the assessment procedures revealed that the case required the remediation of a specific sexual dysfunctional problem, eg. erectile failure due to psychogenic etiology, then the treatment model followed the conventional sexual therapy program. Example: refer to case no. 4.

Whereas, if the assessment procedures revealed that a sexual rehabilitation program is more appropriate (due to the pathogenic etiology of the sexual dysfunctional problem as well as other multicausal factors), then the treatment program may entail portion of the conventional sexual therapy model, eg. general pleasuring, in addition to strategies and techniques more suited to sexual rehabilitation, eg. refer to case no. 1.

The treatment section of this report will comprise of the following:

A general overview of the components of the behavioural treatment model for clients with sexual dysfunctional problems is presented, following the Masters and Johnson model, and PLISSIT model approach. Discussion of the treatment model for a specific sexual dysfunctional problem; namely, impotence will be presented together with the literature review on the treatment procedures recommended for the erectile disorder. Refer to case no. 4. There will be a brief discussion on the other behavioural intervention techniques and strategies as an adjunct to the conventional sexual therapy model.

There will also be a discussion on the methodology and recommendations which are more suited to the realms of sexual rehabilitation. Relationship enhancement training will be viewed from a sexual rehabilitation perspective.

Specific treatment proposals for a particular type of organic condition (eg. MS) with the resultant sexual dysfunctional problem (eg. sexual aversion) will be discussed in the literature review section at the beginning of each individual case study. This method of grouping is to facilitate easier referencing of the various material.

General Therapeutic Conditions

In order to facilitate appropriate behavioural changes, Jehu (1979) recommended that certain general therapeutic conditions be established during the course of the early interview sessions with the clients. These general conditions include: (a) therapeutic relationship;

(b) causal explanation; (c) prognostic expectancy. These conditions are "necessary or facilitative rather than sufficient for treatment" (Jehu, 1979, p. 129).

Therapeutic relationship

Research by Truax & Carkhuff (1967); Gurman (1977); and Mitchell et al (1977) have provided supportive evidence that "the quality of relationship and the outcome of treatment are both strongly influenced by the levels of empathy, warmth and genuineness exhibited by the therapist and perceived by the client (Jehu, 1979, p. 126). When these qualities are part of the therapeutic relationship, then reduction in demoralization and improvement in communication occurs. The clients become more amenable to treatment and enjoy greater beneficial changes in attitude and behaviour (Jehu, 1979).

Causal explanation

The provision of an acceptable explanation by the clinician is recommended for effective treatment results. Causal explanations which are provided regarding the difficulties experienced by the client, attributing the problem to be temporary rather than permanent, and arising from external sources rather than from a personality characteristic will influence the outcome of the treatment (Jehu, 1979).

Prognostic expectancy

Studies have shown that when a client has an adequate expectation of help from the therapist and has confidence

in the treatment program that positive attitude change occurs (Jehu, 1979).

Treatment Programmes

In the selection of an appropriate treatment model, it is necessary to make a decision whether to implement the conventional sexual therapy program, a sexual rehabilitation program per se, or a combination of both.

The conventional treatment programmes are those developed by Masters and Johnson (1970). The "first part of each being common to all types of dysfunction, and the latter part to particular dysfunction" (Jehu, 1979, p. 203).

The first part of the conventional sexual therapy program involves the following: (1) an initial interview where the therapist provides the clients with an explanation of the program; (2) assessment interviews are conducted with each partner separately, using the conjoint therapists approach; (3) medical examination is conducted; (4) the findings from the interviews, examinations and proposals for treatment are shared with the couple in a 'round-table' discussion; (5) sexual intercourse or orgasm is prohibited; (6) the couple proceed with 'sensate focus' assignments and when these are done satisfactorily, the couple move onto the second part of the treatment program.

In the second part of the conventional treatment program for a specific sexual dysfunctional problem, such as erectile disorder or impotence, the non-demand coitus method (Masters and Johnson, 1970) would be one of the methods which may be used to remediate the problem

(Jehu, 1979; Kaplan, 1974). For further elaboration on treatment of impotence problem, refer to literature review in case no. 4.

In certain respects, the behavioural approach follows the same treatment program as the conventional sexual therapy model. In fact, Kaplan (1974) noted "sexual therapy is similar to behavior therapy" p. 182.

The behavioralist approach to treatment of sexual dysfunction differs from the conventional approach in that greater emphasis is placed on the "individual composition of programmes to suit particular clients" (Jehu, 1979, p. 204). The 'individualized' approach takes into account that differences exist in a client's personal characteristics and life situations so therefore a treatment plan or program must be tailored to suit each client. The fact that the behavioural therapy program is "drawn from a wider range of component procedures and assignments" (Jehu, 1979, p. 204) allows for more flexibility in the improvision of a sexual rehabilitation treatment program.

This approach basically seeks to ask 'what procedures are the clinician going to follow for the individual client?' In the selection of the treatment components, the following factors must be considered:

Suitability for a particular therapeutic task

If the client suffers from anxiety, the clinician must determine whether desensitization or flooding is more appropriate for the client (Jehu, 1979). Eg. refer

to case no. 1. If a complex medical condition such as cardiac disorder coexists with the sexual dysfunctional problem, any therapy may impose a health hazard (Kolodny et al, 1979). Eg. refer to case no. 2.

Acceptability of a particular procedure by the client and therapist

If the therapist follows the behavioural approach, she may not want to implement a certain type of therapeutic intervention such as genital pleasuring for orgasmic dysfunction, especially if the assessment procedures reveal that the client adheres to a religious or moral belief that 'masturbation is sinful' (Jehu, 1979). The treatment goals must be acceptable to the client. Eg. refer to case no. 1.

Feasibility

The availability of therapeutic resources has to be considered. Eg. the client may not be able to complete the mutual 'pleasuring' assignments if the client has no sexual partner, eg. refer to case no. 4.

Efficacy of achieving goals

Basically asks, which procedure is the best? Knowledge of scientific evidence is essential as to which procedures are most effective. This may present problems for the clinician seeking information in the treatment of sexual rehabilitation cases.

Efficiency in utilization of therapeutic resources

The availability of manpower should be investigated with questions such as: would clients in groups obtain better results than in one-to-one counseling and which type of counseling is most efficient. In the treatment of phoebia, will the clinician use the one and one-half hour treatment of flooding or twelve hours of desensitization treatment (Jehu, 1979). Eg. refer to case nos. 1 and 2.

The intent of the above-mentioned treatment components is that "the goals of treatment are formally conceptualized in terms of reduction of problematic responses, and the promotion of more acceptable alternatives, in specified sexual situation" (Jehu, 1979, p. 205).

Sequencing of Components

After the selection of the components of a treatment program, sequences of treatment must be planned toward the ultimate goal/s by the "arrangement of a series of intermediate steps" (Jehu, 1979, p. 206). A series of intermediate goals are considered beneficial for the client in that they minimize the experience of failure and reinforce successful achievement. They also tend to build up confidence for the client in order that he may go onto more difficult tasks (Jehu, 1979). Eg. refer to case no. 1.

Maintenance of treatment effects

It is presumed that performance of adequate sexual

behaviour after treatment intervention ends "is intrinsically rewarding, so that it is constantly reinforced and thus maintained" (Jehu, 1979, p. 207). This does not always remain constant and the clinician must be prepared to handle the fluctuations of sexual interest (even during treatment) and the relapses of adequate sexual behaviour by building in various procedures which would assure the maintenance of positive effects (Jehu, 1979).

One method which is recommended for promoting the maintenance of treatment effects is by setting up a series of follow-up interviews at gradually lengthening intervals (Jehu, 1979). (Eg. refer to case nos. 1, 2, and 4).

Provision of Information

Purpose

Most clients make claims to being knowledgeable in the art of making love; instead their knowledge often encompass the area of reproduction (Caird & Wincze, 1977). The purpose of information-giving during the therapeutic interview serves "to provide clients with the information they need to rectify any deficiencies or inaccuracies in their knowledge of sexual matters that may contribute to their dysfunction or impede its successful treatment" (Jehu, 1979, p. 119).

The client may require information many times during the therapeutic interview in order to: (a) to deal with their problems and goals in a constructive manner (E. C. Lewis, 1970); (b) to help the client to identify

alternative choices based on information (Gelatt, Varenhorst, Carey & Miller, 1973); (c) to correct data which are invalid or unreliable or to dispel a myth (Cormier, 1979).

Format

Various methods of imparting information may be utilized during the therapeutic interview. One method included providing didactic instruction (Jehu, 1979). Renshaw (1978) favored sex education to be an important component of providing relevant and accurate information to the clients who are desiring direction in their sexual behaviour. Provision of information may be further enhanced by utilization of illustrated books, selected magazines, erotic literature, diagrams, taped recordings, and audio-visual aids (films) (Jehu, 1979). Example: refer to case nos. 1 and 4.

Contents

The following discussion will focus on the manner in which the provision of information was utilized in the therapeutic interview for specific situations as referred to in the case studies.

Illnesses, surgery or drugs

"Prophylactic and therapeutic advantages are likely to accrue from the provision of information about the implication for sexual functioning of an illness, surgical intervention or drug" (Jehu, 1979, p. 120).

The provision of accurate information allows the clients to gain a better understanding of the effects and limitations which are imposed on their sexual activity relevant to the organic condition (Jehu, 1979). Example: refer to case no. 2. It also allows discussion about the residual potentials and the modification of the aspirations concerning coitus (Jehu, 1979). Example: refer to case nos. 2 and 4.

Kolodny et al (1979) recommended that the clinician be well versed in the area of sexual medicine for the dissemination of accurate therapeutic information.

Sexual anatomy and responses

The provision of information relevant to sexual anatomy and responses entails providing accurate knowledge about the genital anatomy and responses of both partners (Jehu, 1979). In addition to providing information about the genital anatomy, Bancroft (1983) recommends using an illustrated diagram of the female and male sex organs. This method allows the clinician to visually clarify any misunderstanding which may have been held by the couple, eg. location of the clitoris. Example: refer to case nos. 1 and 4. The information regarding the functional significance of the genital organs may also be required if the client indicates that he/she lacks an understanding of the underlying mechanism (Bancroft, 1983). Example: refer to case nos. 1 and 4.

Clients may be helped with the provision of information regarding the sexual responses, variations and

forms of sexual behavior (Jehu, 1979). Example: refer to case nos. 1, 2 and 4.

Anticipation of harm

The provision of relevant information will "serve to reduce any anticipation of harm from sexual activities" (Jehu, 1979, p. 122). Example: refer to case no. 1.

The client or the partner may expect sexual activity to cause exacerbation of the medical condition or may have false notions that sexual activity may cause the relapse or death of a postcoronary patient (Kolodny et al, 1979). Example: refer to case no. 2.

Anticipation of failure

"Information is very often given to clients in order to counteract some unrealistic anticipation of sexual failure" (Jehu, 1979, p. 122). Example: refer to case no. 4. The anticipation of failure may be due to many factors including aging, drug effect, illness or previous surgery (Jehu, 1979).

Moral or religious beliefs

The provision of certain kinds of information can alleviate the stressors which are created when couples participate in sexual practice which contravenes their moral or religious beliefs (Jehu, 1979). Example: refer to case no. 1.

Non-sexual stresses or partner discord

Appropriate information may be provided to the

clients in order to make them aware that non-sexual stresses or marital discord can affect their sexual functioning (Jehu, 1979). The manner in which marital discord can affect sexual functioning is exemplified in case no. 3 where the provision of information was sufficient for the couple to decide whether they wished to proceed with sexual therapy.

Stress reactions

Information may need to be provided to the couple regarding the disruptive effects that stress reactions may have on their sexual functioning (Jehu, 1979). Example: refer to case no. 1.

Deficient or inappropriate stimulation

Provision of relevant information may be required when it is revealed that lack of appropriate knowledge is preventing the couple from exchanging sufficient and appropriate sexual stimulation (Jehu, 1979). For instance, in case no. 1, by providing the partner of the symptomatic client with information regarding the implementation of a non-threatening, sexually stimulating technique was sufficient to lead to greatly enhanced sexual arousal level for the client.

Modification of Attitudes

If certain attitudes are impeding sexual functioning or therapeutic progress then the attitudes which are creating these problems will have to be changed or modified.

This is the second function of the therapeutic interview. There are similarities between the modification of attitudes and the provision of information which were discussed earlier. In addition to the general therapeutic conditions which are the foundation for successful outcome of treatment, Jehu (1979) stated that specific procedures are also required in the "modification of adverse attitudes towards sexual behavior" p. 129.

For instance, when adverse attitudes towards sexuality per se (such as those exhibited by the client in case no. 1) eg. sex is dirty or painful, created considerable impairment to her sexual functioning level, it necessitated the modification of these attitudes in order to hasten therapeutic progress. These deleterious attitudes were usually accompanied by strong negative emotions which were not conducive to the enhancement of sexual arousal since they created heightened anxiety.

Other attitudes which may impede sexual functioning are: achievement orientation towards reaching certain goals in sexual performance; adverse attitudes such as hostility, and rejection between partners (Jehu, 1979) Eg. refer to case nos. 1 and 3.

Jehu's outline 'Some methods of sexual rehabilitation' Appendix X was helpful in providing a guideline for the techniques which may be used for the promotion of positive sexual attitudes.

Sanctioning

Positive sexual attitudes may be encouraged when the

source of sanction derives from a therapist who is liked, trusted and constitutes authority (Jehu, 1979).

Self Disclosure

As a "means of conveying sanction and promoting positive attitudes in clients, it is sometimes appropriate and helpful for the therapist to disclose his own sexual attitudes and practice (Jourard, 1964)" (in Jehu, 1979, p. 130). Sharing views on the enjoyable aspects of sexual activities, masturbation, oral-genital sex are some of the topics which will be covered. Self-disclosure should not be done too prematurely, however, at least not until the client has built up respect and trust for the therapist (Jehu, 1979).

Roleplaying training

Another technique which may be used to change the attitudes of the client in the interview situation (Corsini, 1966) is roleplaying. The client's public commitment to alternative attitudes, improvisation, and biased scanning are some of the factors which have been attributed for the change of attitudes which takes place (Jehu, 1979). Example: refer to case no. 1.

Modeling training

The use of modeling training (Jacobson & Margolin, 1979) will be discussed in detail under the heading of 'Relationship Enhancement'.

Cognitive restructuring

This procedure "assume that maladaptive emotions and overt responses are influenced or mediated by one's beliefs, attitudes and expectations--ones "cognition" (Cormier, 1979, p. 360).

Clients are taught to stop the continuance of thoughts which are deemed self-defeating or irrational and to replace these negative thoughts with positive, self-enhancing thoughts and skills. The strategy is directed towards replacement (and not elimination) of self-defeating cognitions (Cormier, 1979).

Jehu (1979) has translated the principles of RET (Ellis, 1975a) into the realm of sexual dysfunctional problems. Imaginal presentation, behavioural rehearsal and in vivo assignments are other procedural aids which may be utilized in the training of clients in rational restructuring (Jehu, 1979).

In sexual rehabilitation counseling, cognitive restructuring techniques were particularly helpful when it necessitated the change of belief for the client or the partner who holds that penile-vaginal intercourse was the only satisfactory way to have sex and that the penis had to be rigid in order for it to be inserted into the vagina, eg. refer to case nos. 2 and 4.

Thought stopping

Thought stopping is a thought control procedure and used "to help a client control unproductive or self-

defeating thoughts and images by suppressing or eliminating these negative cognitions" (Cormier, 1979, p. 339). Example: refer to case nos. 1 and 2.

Studies have revealed that this particular procedure is not appropriate for those individuals who have such intense troubling thoughts which are uncontrollable (Olin, 1976).

Sexual Assignments

Sexual assignments serve the purpose of reducing stress reactions to sexual behaviour, of promoting more effective sexual stimulation and responses, and revealing any impediments to adequate sexual functioning (Jehu, 1979).

Several types of 'obstacles' or 'resistances' to the sexual assignments were identified by Munjack & Oziel (1978) during their study. Kaplan (1974) concurred that resistances may occur in the symptomatic patient or in the partner, eg. refer to case no. 1.

Resistances in the treatment may take the form of the failure of avoidance to respond to the prescribed sexual assignments. Resolution of such resistances may be overcome in the following manner: (a) provision of additional information; (b) modification of attitudes; (c) specific behavioural or physical treatment procedures; (d) prescription of other assignment (Jehu, 1979). Kaplan (1974) suggested simple confrontation of analytic work as techniques for handling resistances.

General pleasuring

Masters and Johnson (1970) developed the general pleasuring type of sexual assignments referring to them as 'sensate focus' exercises. They stipulated that all clients must commence their treatment program with these exercises.

Kolodny et al (1979) expressed that "sensate focus has sometimes been misinterpreted as comprising the entirety of sex therapy. In actuality, sensate focus is simply a component of a much more comprehensive psychotherapeutic armamentarium" p. 504.

'Sensate focus' exercises basically encompass the following: (a) the rationale and emphases for the sexual assignments are explained to the participants; (b) sexual intercourse is not allowed nor is any attempt made to bring the partner to orgasm by other means; (c) couples are encouraged to discover, explore, and feel the sensual feelings derived from touching and caressing each other's body in a private, uninterrupted setting; (d) touching and caressing of breasts and genital areas are not included at the commencement of the pleasuring exercises; (e) other relaxing and sharing experiences, eg. taking a bath or shower together are encouraged to bring about feelings of warmth and closeness; (f) the therapist nominates which partner is to lead off the pleasuring assignment (Jehu, 1979).

The function of these exercises are: (a) it will reveal any impediments to adequate sexual functioning;

(b) reduction of stress reaction to sexual situation; (c) the reduction of risks of failure, performance anxiety and spectatoring and avoidance concerns for the client; (d) allows the client to focus their attention to the sensations, stimulations, feelings and enjoyment they are experiencing (Jehu, 1979).

According to Jehu (1979) the behavioural approach differs in that these exercises "are employed more selectively and flexibly to suit individual clients" p. 138. The behavioural approach to general pleasuring assignments would seem more amenable to situations which involved sexual dysfunctional problems which were related to complex medical conditions, eg. refer to case nos. 1, 2 and 4.

Genital stimulation

Genital pleasuring is incorporated into the treatment program once the clients respond positively to the general pleasuring exercises (Jehu, 1979). The principles are basically the same as the general pleasuring assignments, preceding with information regarding the anatomical function of the genital organs, communication of preferences between the partners, and reduction of stress reactions to performance (Jehu, 1979).

There are variations to the rule of genital pleasuring, whereas in some cases, touching the genital area is prohibited initially while in other situations, gentle 'genital caresses' are encouraged from the beginning (Kaplan, 1974, p. 269).

Specific Behavioural Procedures and Ancillary Physical Treatment

Relaxation training, desensitization, flooding, vaginal dilatation, classical conditioning, biofeedback, phantasy training and hypnosis are the third major category of treatment components suggested in Jehu's 'Some methods of sexual rehabilitation', Appendix X. These procedures serve the same functions as the sexual assignment in that some emphasize reduction of stress, others promote more adequate sexual behavior while others reveal impediments to appropriate sexual functioning (Jehu, 1979).

The first four procedures are primarily for reducing stress while classical conditioning, biofeedback procedures, phantasy training and certain hypnotic techniques are, according to Jehu (1979) "concentrated more on the acquisition, performance and maintenance of satisfactory sexual response. It is important to recognize that this difference in emphasis is relative rather than absolute" p. 152.

Due to the scope of the report, only the specific behavioural procedures and ancillary physical treatment which were utilized in the case studies will be mentioned.

Relaxation training

This procedure is used to reduce stress for clients who encounter high levels of tension and anxiety when they attempt to undertake sexual assignments or similar activities (Jehu, 1979). Example: refer to case nos. 1

and 2. The basic concept is that "muscle tension is in some way related to anxiety and if an individual can learn to relax his muscles then this is commonly accompanied by some allevation of the associated anxiety reactions so that a feeling of calmness prevails" (Jehu, 1979, p. 152).

Both Jehu (1979) p. 153 and Caird & Wincze (1977) p. 182 provide complete instructions for the relaxation techniques.

Desensitization treatment procedures

These procedures involve the process of identifying the events which evoke anxiety and ranking them in a hierarchical manner from the least to the most disturbing (Jehu, 1979). The therapist then helps the client to select a response which is an alternative to anxiety, eg. a state of relaxation and calmness (Jehu, 1979).

Systematic and in vivo desensitization are two variations of the above-mentioned procedure. In the systematic desensitization procedure "the client imagines the hierarchy items and muscular relaxation is used as the alternative response to anxiety" (Jehu, 1979, p. 157). The therapist must ensure that the client is able to imagine the scenes vividly and relax sufficiently.

In vivo desensitization "the hierarchic items are presented in a real life situation rather than through the medium of imagination" (Caird & Wincze, 1977, p. 85). Case no. 1 exemplifies utilization of this procedure to

inhibit the anxiety with sexual arousal.

Phantasy training

This procedure has been used primarily as a source of erotic stimulation for sexual dysfunctional clients whose capacity is limited. Flowers and Booraem (1975) who developed a 13 step programme of phantasy training found that the clients who had undergone this training had experienced improvement in sexual interest and behavior (Jehu, 1979). It is difficult to determine whether other components of the treatment program might have been responsible for the change (Jehu, 1979). Eg. refer to case no. 4.

Hormone and drug therapy

Since erectile disorders (impotence) in males appeared to be so prevalent in the clinician's caseload, special attention was focused on investigating whether a drug therapy per se could be administered in order to rectify this particular sexual problem. The findings revealed the following: (a) administration of androgens had little value to impotent males including even "those whose urinary testoterone level is low (Cooper, 1972, 1974a; Johnson, 1968, 1975; Schiavi & White, 1976)" (in Jehu, 1979, p. 167); (b) the evidence of efficacy of the therapeutic success of certain combinations of androgens and aphrodisiacs substances eg. Afrodex for the treatment of erectile dysfunction have not been promising (Roberts and Sloboda, 1974) (Jehu, 1979).

Prosthetic or mechanical aids

Various aids are available to assist men suffering from erectile dysfunction (Jehu, 1979; Kolodny et al, 1979; Renshaw, 1978d). The literature review on case no. 4 provides full elaboration on the types of penile prostheses which are available for implantation.

Relationship Enhancement

The relationship enhancement component of therapy is usually required when a sexual rehabilitation program is being formulated and instituted for a client and the partner who are encountering sexual dysfunctional problems (Jacobson & Margolin, 1979; Jehu, 1979: Kolodny et al, 1979). This is understandable in view of the fact that any impediments to the 'normal' sexual response will create tensions and stressors which will subsequently begin to affect other areas of the couples relationship (Kolodny et al, 1979).

Several factors need to be considered when dealing with relationship enhancement within the parameters of sexual dysfunctional problems related to medical problems. For instance, the ability to develop the emotional aspects of the relationship which includes the ability to negotiate, comprise, support, trust and to be flexible are essential for the couple relationship when undergoing the surgery or disease process (Lamont, 1979). Kaplan (1974) observed from her clinical work that if the couple attributed all their problems on the sexual symptoms rather than the emotional aspects of the relationship,

then the couple will face disappointment even with the alleviation of the sexual problem.

Relationship enhancement, (in the opinion of this clinician) is deemed very important to the progress and outcome of the treatment program when dealing with a client or a couple who are encountering difficulties in adjusting to changes in their sexual activity level due to an organic condition, eg. resuming coital activity which has been disrupted as a result of a medical condition such as CVA. One individual may avoid initiating 'loving' or sexual activities and this may evolve into a relationship problem, especially if the partner interprets the avoidance of sexual activity as a form of rejection.

This problem is not uncommon in sexual dysfunctional clients who are otherwise healthy, however, when it occurs in a client who has an organic or physical condition, these problems may be directly or indirectly related to the reactions of the client or the partner to the medical problem, eg. the avoidance of sexual activity by either individual has been known to create a multitude of adverse psychological reactions (Jehu, 1979).

In order to resolve the above-mentioned situation, it necessitates that the individuals learn to communicate their concerns about the medical problem and whether they are satisfied with the present quality of sexual activity (Jehu, 1979). These problems may revolve around lack of interpersonal communication relating to non-sexual stressors as well (Kolodny et al, 1979). Hence, one of

the purposes of relationship enhancement training serves this end.

Jacobson & Margolin (1979) suggested collecting data of the 'pleasing' and 'displeasing' aspects of the couple's sexual interactions as an indicator of the type of intervention which might be useful.

When planning a comprehensive sexual rehabilitation program which includes relationship enhancement (where one partner has a medical condition), it necessitates the clinician to be cognizant of the special needs of the symptomatic client, eg. coital positioning for the disabled person; restriction in movement for someone in pain with severe arthritis; or someone suffering from varying degrees of neurological deficits as the result of MS or CVA condition (Renshaw, 1975) and to seek methods in which to incorporate these restrictions into a viable relationship enhancement treatment program, eg. refer to case no. 2.

Considerable emphasis has to be placed on the building of trust and intimacy focusing on 'loving' activities such as hugging, stroking, petting, kissing as well as verbally communicating their feelings for each other rather than on the coital act itself (Chernick & Chernick, 1977; Renshaw, 1979; Jehu, 1979).

A situation may arise where relationship enhancement training may not be deemed to be sufficient or acceptable alternatives to the usual manner of sexual expression. One partner in the relationship may find the 'non-coital'

situation difficult or intolerable, eg. refer to case no. 2. In addition, the couple seeking the therapy may already have developed maladaptive behavior patterns which does little to sustain a relationship devoid of normal sexual expression, eg. refer to case nos. 2 and 3. In such situations, resistance may be anticipated from the well-partner when a treatment program is being implemented (Kaplan, 1974).

Enhanced relationship may be acquired through the acquisition of specific skills by the couple (Chernick & Chernick, 1977; Jacobson & Margolin, 1979). Jehu's guideline 'Some methods of sexual rehabilitation' Appendix X suggested some categories in this area. These are: (1) increasing positive exchanges; (2) communication training; (3) problem-solving training; (4) assertiveness training; and (5) heterosocial skills training. The various therapeutic techniques and strategies which were utilized in the case studies will be presented in the following discussion.

The clinician has, for the most part, followed the approaches and interventive strategies espoused by behaviorists (Jacobson & Margolin, 1979; Cormier & Cormier, 1979; Jehu, 1979) as it has been the clinician's experience that the behavioural approach has provided the best results in bringing about the desired changes in the clients requiring relationship enhancement. Chernick & Chernick's (1977) techniques on developing communication skills and acquiring intimacy were also incorporated into

the relationship enhancement program. The review of the overall efficacy of the behavioural approach in couple relationship is provided at the conclusion of this section.

(a) Increasing Positive Exchanges

Increasing positive exchanges was one of the therapeutic procedures which was utilized in order to achieve the treatment goals which were formulated by the client and the clinician.

Jacobson & Margolin (1979) have provided rationale for focusing on positive behaviours when seeking improvement in the couple relationship. "Spouses are directed to emit behaviors that 'please' the other person and increase his/her overall relationship satisfaction" p. 158.

General strategies for improvement of couple relationship which were suggested by Jacobson & Margolin (1979) included:

Production targets where the "strategy arranges for a percentage increase over baseline rates of pleasing behaviors by setting a target number of pleasing behaviors that each spouse is to emit each day" p. 164.

Love days where the strategy involves the increase of each individual's pleasant events. This is a widely advocated method of "encouraging spouses to give more pleasures to one another (Weiss et al, 1973; Wills et al, 1974) or caring days (Stuart, 1976)" p. 165.

The main objective of the above strategies is to increase in number of total pleases with each spouse

being able to make requests and for the other to agree to and fulfill them. The 'giver-recipient' distinction is emphasized in the above strategies with the person who is emitting the behavior deciding how she/he will be more pleasing. The spouse is taught to make specific requests in an assertive, nondemanding manner in order that an exchange of pleasing behaviour can be facilitated, eg. refer to case nos. 1 and 2.

An alternative to verbal request is drawing up a written contract of 'behavior exchange agreements' which may facilitate the likelihood of the request being met.

The ultimate goal of the strategy is to direct the couple to pleasing activities which are mutually desired and which may be worked on together (Jacobson & Margolin, 1979). This is accomplished by means of the spouses separately identifying and listening to the desireable event each want to receive and then having the couple work towards the target of 'couple pleases'. This strategy may receive more favorable response compared to the individual pleases since the spouses are working with each other rather than for one another (Jacobson & Margolin, 1979). On the other hand, this strategy may limit the variety of pleasing behaviours.

Companionship activities is an interventive strategy where the therapist assists the couple to increase their pleasing activities by expanding their repertoire of shared activities (Jacobson & Margolin, 1979), eg. refer to case nos. 1 and 2.

Shared avocation or interest is another therapeutic strategy which is used where each partner receives reinforcement from the activity as well as from the partner (Jacobson & Margolin, 1979). The basic rationale for utilizing this strategy is that the shared interest will "offer them a focal point for interaction that is entirely divorced from the tensions of their past" (Jacobson & Margolin, 1979, p. 174), eg. refer to case no. 2.

(b) Communication Training

Communicationg deficits have been implicated to be responsible for generating or maintaining relationship problems (Jacobson & Margolin, 1979; Kolodny et al, 1979).

Viewing the function of communication between partners from a behavioural social exchange approach, Jacobson & Margolin (1979) stated that the reason why communication plays such as important role is that "it is primarily through the medium of communication that couples provide benefits to one another" p. 190.

Needless to say that when a couple is faced with a problem concerning their lack of sexual activities or unsatisfactory feelings related to sexual activities, it necessitates skillful communication in order to alleviate or rectify the problem. The need for good communication skills is very significant if one accepts Kaplan's (1974) statement that "one needs reciprocal feedback to develop a good sexual interaction and to secure and give effective erotic stimulation" p. 134.

Failure to effectively resolve the sexual problem due to lack of communication skills can exacerbate the tensions and frustrations which are encountered by either or both of the sexual partners and may ultimately affect other areas of the marital relationship (Kolodny et al, 1979). According to Kolodny et al (1979), the most frequently seen non-sexual problem at the Masters and Johnson Institute is difficulty in communication.

According to Chartier (1974), "five interpersonal components offer clear distinctions between good communicators and poor communicators. They are: self-concept, listening, clarity of expression, coping with angry feelings and self disclosure" p. 37. These components are also discussed in detail by experts such as Satir (1972); Reik (1972).

If, according to Chartier (1974), "the most important single factor affecting people communicating with others is their self-concept--how they see themselves and their situation" p. 37, then it is conceivable that the manner in which an individual views his/her sexual self or how the partner perceives him/her sexually, will determine their communicative behaviour. This was aptly exemplified in case no. 4, where the client became a 'recluse' when he encountered chronic erectile difficulties--he stated he 'felt inadequate and inferior'. However, once he overcame his erectile problems through surgical means, his overall perception towards life changed dramatically including his communicative style (more self-confident,

self-assured and vibrant).

If the assessment procedures reveal that communication deficits are hindering the relationship or impeding progress in the sexual rehabilitation program, then the problem may be addressed by considering communication training. The role of effective communication skills between the couple is important in any sexual therapy or rehabilitation program. Kaplan (1974) has commented that "Masters and Johnson rely heavily on improving the partners' ability to communicate their sexual feelings and sensations, wishes and fears to each other" p. 203.

Communication training requires the participants to acquire skills in both speaking, listening, verbal and non-verbal responses. The behavioural perspective for communication training, are distinguished by the content of skills which are taught to the couple and the procedures which are characteristic of this type of training (Jacobson & Margolin, 1979). Jacobson and Margolin's (1979) clinical strategies to train couples in communication skills involve three major training components: (1) provision of feedback; (2) instruction; (3) behavior rehearsal.

Feedback, from a behavioral skills perspective "provides information about the nature of their interaction, the cues which seem to elicit particular responses, and the functional relationships between various aspects of the interaction sequence" (Jacobson & Margolin, 1979, p. 191). For optimum results, Jacobson & Margolin (1979) recommended the following utilization of feedback:

(1) the therapist includes immediate feedback especially at the beginning stages of communication training; (2) verbal feedback can be augmented by videotype; (3) provision of positive feedback prior to negative feedback; (4) the therapist should be critical of behaviour only, not of the client.

Under the instruction component, there are two strategies of providing the couple with alternative responses, once they discover their problems. These are: (1) modeling; (2) coaching.

Modeling provides an alternative to simple instructions. The advantages, according to Jacobson & Margolin (1979) are: (a) an efficient way of providing information; (b) allows the therapist an opportunity to demonstrate appropriate communication; (c) allows the couple to observe desired behavior first hand. They cautioned that the major disadvantage of modeling is that the couple may imitate the therapist rather than comprehending the principles. This may be avoided by having the clients actively involved in the learning process in a carefully structured situation.

Behavior rehearsal is the practice skills session which follows the feedback. These procedures allow alternative suggestions through verbal coaching or modeling sessions. This component can be viewed as a 'shaping' process.

According to Jacobson & Margolin (1979) "behavior rehearsal is probably the most important part of the

triadic training sequence" p. 197, and they believed that "actual practice, with continued feedback and modeling by the therapist, is a necessary precursor to the mastery of new communication skills" p. 197.

Some of the communication skills which can be mastered by using a behaviour rehearsal model are: empathy and listening skills; validating; feeling talk; negative feeling expression; positive expressions; assertiveness and problem solving (Jacobson & Margolin, 1979).

(c) Problem-Solving Training

Problem-solving training is defined "as structured interaction between two people designed to resolve a particular dispute between them" (Jacobson & Margolin, 1979, p. 215). The techniques and strategies which are described in their Manual (p. 215) provided helpful advice for the application of this treatment modality. This modality has its strength therapeutically in that it focuses simultaneously on process and content.

Couples are taught problem-solving skills which have a reinforcing effect and thereby allow the couple to solve their own problems more effectively in the future. It also fosters greater corroboration of working with each other than as adversaries. It forces the couple to "confront their real goals in discussing relationship problems" (Jacobson & Margolin, 1979, p. 258) and thus this modality may be deemed beneficial from a preventive perspective.

Acquisition of problem-solving skills probably play a greater function for individuals with physical or neurological deficits than for otherwise 'healthy' individuals due to the numerous problematic situations which have to be resolved by the client and the partner. Even a seemingly simple matter such as deciding which is the best time for coital activity requires corroboration by the couple, taking into account such factors as the various aspects of the disease process and problem-solve the 'obstacles' which the couple may encounter, eg. fear of loss of spontaneity in lovemaking; coital positioning, etc. Example refer to case nos. 1 and 2.

(d) Assertiveness Training

Assertiveness training entails the clinician to teach the client skills which will result in productive behaviour, eg. standing up for one's own rights. Refer to case no. 2.

Assertiveness training skills "are often best taught in situations other than that of conjoint relationship therapy. Individual therapy or better yet, assertiveness groups seem more conducive to the production and perfection of assertiveness skills" (Jacobson & Margolin, 1979, p. 211).

(e) Efficacy of Behaviour Exchange Approach to Treating Couples

The overall efficacy of behavioural therapy is a method of treating couples is well-documented in Chapter 10 by Jacobson & Margolin (1979).

In summary, the findings of various studies revealed "when results from controlled, analog and comparative outcome studies are combined, seven out of nine controlled investigations unequivocally found behaviour therapy to be more effective than a control baseline, an eighth study found behavior therapy effective on the basis of behavioral but not self-report measures, and a ninth found support for behavior therapy on self-report, but not on behavioral measures" p. 359.

Jacobson & Margolin (1979) reported that "there is no empirical assertion that behavior therapy is more effective than other approaches to treating relationship problems due to inconclusive comparative studies and limitations in methodology" p. 361. However, they contend from other studies (Jacobson 1978b, Jacobson & Weiss 1978) that "it is fair to assert that behavior therapy is the only treatment for relationship problems which is demonstrably effective" p. 361.

According to Gurman (1978), the behavioural approach, due to its "highly instructive, educational tone, are likely to be met with greater cooperation, than say psychoanalytically oriented methods, from couples who are not psychologically sophiscated or insight-oriented" p. 505.

SECTION III

ORGANIC FACTORS WHICH AFFECT SEXUAL FUNCTIONING

The scope of this report does not allow for detailed elaboration on all aspects of the organic conditions which may contribute, maintain, or even exacerbate sexual dysfunctional problems. Instead the clinician will explore the organic conditions under the general headings: aging, illness, surgery and drugs, and discuss the implications that these conditions have on the assessment procedures of identifying the etiology of the sexual dysfunctional problem.

The 'normal' sexual response cycle of both the male and female are aptly described by Masters and Johnson (1966); Kaplan (1974); Kolodny et al (1979); and Jehu (1979) to name a few, and therefore will not be elaborated here.

Organic factors such as the aging process, chronic illnesses, surgical procedures and medications are known to affect the physiological components of the normal sexual response system and to cause impairment to sexual functioning (Kaplan, 1974; Jehu, 1979).

For the clinician who is working specifically with clients whose sexual dysfunctional problems are related to a complex medical condition, it necessitates obtaining relevant information regarding the organic conditions which may exist, and to identify the causal factors contributing to the sexual problem (Caird & Wincze, 1977).

The importance of the physiological-medical data in the assessment of sexual disorder is thoroughly

covered by Tollison & Adams (1979). Knowledge about the ramifications of certain organic conditions on sexual functioning, eg. diabetes and impotence (Kolody et al, 1979) is emphasized. (Refer to literature review for details on 'Effects of diabetes mellitus on sexual functioning').

Oftentimes, the adverse psychological reactions or responses to the organic conditions are deemed to have far greater impact on the sexual behaviour than the organic condition itself (Jehu, 1979). Eg. refer to case no. 2.

The types of adverse psychological reactions which may be encountered by the client and the partner are discussed more fully under the literature review 'Psychological reactions to organic condition'.

The sexual partner's reaction or response to the organic condition is equally important as the client's own response to the condition (Bancroft, 1983; Griffith & Trieschman, 1976). Therefore it is essential to obtain detailed information regarding the partner's perceptions and concerns about the medical condition and the limitations which are imposed on the sexual capacity as the result of the sexual problem. This is important in view of the fact that the success of any sexual rehabilitation program is dependent on the understanding and co-operation of a willing partner (Jehu, 1979). Any disruptive psychological or emotional reactions or responses which may be encountered by the partner can greatly impede the progress or outcome of the treatment.

Kolodny et al (1979) stated that the information pertaining to the individual's medical condition may be derived from a "relatively brief interview and review of medical records" p. 357. They recommend completion of an outline format (similar to Appendix VII) which consists of primary categories. Admittedly, these categories are more suited to the handicapped client, nevertheless, the suggested categories are beneficial in assisting to complete the assessment of clients with medically related sexual problems.

Hartman and Fithian (1974) offered similar suggestions in addressing the problem of obtaining relevant information regarding the health and general development of illness. They suggested such topics as: "history of chronic illnesses and handicaps; history of general disease; history of diabetes--self; history of diabetes--family; any major illnesses" p. 29.

Effects of Aging Process Relevant to Sexual Functioning

According to Renshaw (1978a), sexual changes for persons over 50 have been well studied and documented. Since aging does produce sexual changes and can ultimately affect the sexual behaviour of the individual, the proper identification of these changes during the assessment procedure is important.

Some of the implications of the aging process on sexual functioning are:

(a) In males, partial and delayed erections are common; "reduced ejaculation time, fluid, force and contractions; prolonged plateau" (Renshaw, 1978a, p. 58).

(b) "Older men take longer than the few seconds required by younger men to get an erection (Solnick & Birren, 1977)" (in Jehu, 1979, p. 17).

(c) If the aging male loses an erection before orgasm, he may experience some difficulties in recovering it (Jehu, 1979).

(d) The older man may require more prolonged 'direct genital stimulation' to achieve an erection than a younger man (Kolodny et al, 1979).

(e) For men over the age of 60, the firmness of the erection is decreased as compared to younger men (Kolodny, 1979).

One of the most vulnerable aspect to the effects of aging is the male orgasm (Kaplan, 1974). With age, for most men, the refractory period (the time interval after ejaculation) increases or lengthen, and the ejaculatory

force decreases (Kolodny et al, 1979; Jehu, 1979; Renshaw, 1978a).

For females, "expectable sexual changes after fifty include reduced vaginal lubrication (estrogen responsive); and, less tight, sometimes constricted vagina (reduced elasticity of connective tissues)" (Renshaw, 1978a, p. 58).

Renshaw (1978a) observed that "for both sexes, expectable sexual changes after fifty include reduced objective intensity or orgasm; sustained and even increased subjective enjoyment into the nineties; and decreased frequency of coitus (in some instances)" p. 58. Kaplan's (1974) findings show that aging couples frequently complain about impotence, loss of interest or avoidance of sexual activity.

The "aging process does not necessarily produce sexual dysfunction in either men or women and when this does occur in the healthy old person it may be due to psychological factors such as performance or rejection anxiety" (Jehu, 1979, p. 5).

It is important to remember, especially for the disabled, aging individual, (as in a younger person), that one cannot separate the physical changes from the social and emotional changes.

Effects of (Chronic) Illness on Sexual Functioning

"Sexual performance can be impaired by an illness that is debilitating, painful or incapacitating" (Jehu, 1979, p. 18). Therefore illnesses such as cardiac, vascular, renal, arthritic disorders can have a significant impact on the sexual functioning of an individual (Jehu, 1979; Kolodny et al, 1979). Understandably, when an individual suffers from the physical effects of any illness, the interests would not be strong in pursuing erotic matters (Jehu, 1979).

Kolodny et al (1979) stated that "although the relationship between chronic illness and sex will vary considerably from person to person for reasons ranging from severity of health impairment to variables of age, personality, previous sexual health, and social circumstances, it is helpful to understand the ways in which certain types of chronic illness will be likely to influence sexual functioning" p. 233.

Kaplan's (1974) comprehensive list of 'Effects of medical illness on male and female sexuality' (Appendix VIII) aptly covers the various illnesses and the possible implications these conditions may have on sexual functioning and their presumed pathogenic mechanism.

Shaked's (1978) offered an informative bibliography of the findings of various experts and researchers on the effects of certain diseases on sexual functioning (See annotated bibliography in this report).

Some of the mechanism or action of the disease process which causes the damaging effect on sexual functioning are: "pathogenic mechanism which specifically injure the sex organs or their nervous or vascular supply. The disease may have endocrine effects on the sex centers of the brain, or the process of the disease may diminish androgen or damage the genital organs directly" (Kaplan, 1974, p. 77).

Kolodny et al (1979) cited conditions which may interfere with sexuality via indirect mechanism of both men and women. These are: Illness such as chronic obstructive lung disease "may be too hypoxic to tolerate the increase oxygen demands of sexual excitation; or a person with chronic arthritis may find it difficult to participate in coitus due to limitations of movement and position" p. 233.

Diseases which produce symptoms such as weakness, listlessness, pain, fever, poor appetite, skin rashes are also likely to affect interest in sex or to interfere with sexual functioning (Kolodny et al, 1979).

Certain diseases may affect sexual functioning prior to the symptoms of the disorder becoming apparent (Kaplan, 1974; Rubin, 1967), and it is imperative that the clinician be cognitive of these factors during the assessment procedure. For instance, "diabetes is notorious for affecting the effective response of men very early, often before any other signs of symptoms appear. Similarly, impotence or ejaculatory problems may be the presenting symptom in multiple sclerosis" (Kaplan, 1974, p. 77).

"Hepatic and renal disorders, which impair detoxification and excretion of metabolic products and estrogen, are especially likely to be accompanied by diminished sexual interest" (Kaplan, 1974, p. 77). In view of the above implications of the disease process on sexual functioning, it is adviseable that a complete medical examination be conducted by a physician before any psychological therapy is considered (Caird & Wincze, 1977).

Scrutinization of the following areas is also advised in the assessment of the effects of chronic illness on sexual functioning: "antecedent sexual history; nature and severity of the illness; concurrent illness(es); drugs, surgery, or other treatment modalities being used; social circumstances; personality variables; sex partner's reaction to the illness; coping abilities, attitudes toward sex" (Kolodny et al, 1979, p. 234).

Medications which may be ingested by the client in order to control the exacerbation of the illness can also be instrumental in impeding the normal sexual functioning of the individual (Kaplan, 1974; Kolodny et al, 1979). Refer to literature review on this subject.

It is equally important to recognize that the resultant sexual dysfunctional problem may not be caused by the illness itself but rather, the client's psychological reaction or response to the illness may be directly or indirectly responsible for the impaired sexual functioning (Jehu, 1979).

Therefore, by following the aforementioned guideline by Kolodny et al (1979) and integrating it with Jehu's topic outline 'Psychological reactions to disability, surgery and medications' (Appendix XI), sufficient data may be collected which will allow an accurate evaluation of the manner in which the disease entity may contribute, maintain or even exacerbate to the contemporary sexual problem.

Effects of Diabetes Mellitus on Sexual Functioning

Diabetes and its effects on sexual functioning is reported separately since the clinician feels that the literature review on this particular illness contributes much to the understanding of the manner in which a specific disease process can impede sexual functioning.

The case study associated with the diabetic condition is not reported as many of the assessment procedures and treatment modalities which were utilized were similar to case no. 4.

"The parasympathetic and sympathetic division of the autonomic nervous system are involved in the control of sexual responses, any damage to this system may adversely affect these responses" (Jehu, 1979, p. 24).

Diabetes mellitus, a metabolic disorder, is one of the commonest causes of such damage and is known to cause impotence in almost 30% to 60% of the men who are impaired by this condition (Jehu, 1979). There is also general consensus that approximately "one out of every two men with clinically apparent diabetes is sexually dysfunctional" (Rubin & Babbott, 1958; Schoffling et al, 1963; Ellenberg, 1971; Kolodny et al, 1974) (in Kolodny et al, 1979, p. 128).

Diabetic impotence can occur at any age, with published studies reporting the prevalence of impotence being 25-30% of men in their 20's and 30's; 50-70% of men over age 50 (Kolodny et al, 1979). Additional medical condition in the aging diabetic population such as accelerated arteriosclerosis may be accountable for the

higher prevalence rate of impotence (Kolodny et al, 1979).

Impotence have been found to "occasionally be the presenting complaint in men who are later diagnosed as having diabetes mellitus" (Rubin, 1967) (in Haswell, 1978, p. 268). The frequently observed pattern of impairment in sexual functioning in diabetic men are: (1) dysfunction problems occurs several years or more after diabetes is discovered; (2) mild to moderate decrease in firmness of erection; (3) alteration in sexual functioning--sporadic episodes of impotence or diminished responses to erotic stimuli during sexual activity; (4) little or no decline in libido, ability to ejaculate or awareness of orgasmic sensations (Kolodny et al, 1979). Kolodny et al's (1974) studies have shown "gradual deterioration in the quality of the erection (ie. decreased firmness) as well as in the durability of the erection occurs over a period of 6 to 18 months" (in Kolodny et al, 1979, p. 129).

There seems to be considerable controversy as to the exact pathogenic mechanics leading to impotence. The organic cause of impotence may be due to any of the following: neurologic factors; vascular factors alone or; combination of vascular and neurologic factors (Renshaw, 1976). Endocrine factors alone apparently do not seem to be related to diabetic impotence. Hence, a "careful medical workup should be done to exclude an organic cause, so that emotional factors may be considered" (Renshaw, 1976, p. 47).

Reports have shown that diabetic neuropathy, "a

Process of microscopic damage to nerve tissue that occurs throughout the body of the diabetic" may be partly responsible for impotence among diabetics (Ellenberg, 1971) (in Kolodny et al, 1979, p. 130). Diabetic neuropathy has also been implicated to cause 'dry-run' orgasm (Money & Yankowitz, 1967) where the man experiences orgasm but without the "sensation of emission or ejaculation" (Bancroft, 1983, p. 60).

Retrograde ejaculation problem is also deemed to be caused by autonomic neuropathy (Jehu, 1979). One to two percent of diabetic men are affected by this disorder (Kolodny et al, 1979, p. 135) and diabetic men with this condition may or may not be impotent; often experiencing orgasm. Since the seminal fluid flows backwards into the bladder at the time of orgasm, retrograde ejaculation may be a cause of infertility (Kolodny et al, 1979; Bancroft, 1983).

At present, "there is no effective way of treating erectile or ejaculatory problems arising from diabetic autonomic neuropathy, they are irreversible even if the disease itself is well controlled" (Jehu, 1979, p. 25). However, studies by Mills (1976) and Renshaw (1978d) show better results with sexual treatment in diabetic patients (in Jehu, 1979, p. 25).

Impotence occurring in a male diabetic need not necessarily be caused by the disease entity itself (Kolodny et al, 1979). They advised that those experiencing potency problems "must be evaluated thoroughly

to determine whether or not the distress is primarily psychogenic or whether it is caused by an organic process apart from the diabetes itself. Diabetics are just as susceptible as others to the psychic stresses of life" p. 131. Other factors which may prove to be significant are: medications used to control diabetes may trigger mechanism for the "loss or impairment of erectile capacity" (Kolodny et al, 1979, p. 131); diabetes have increased risk for many other diseases--infection, cardiovascular, endocrine.

Tryer et al, (1982) have shown that "women with controlled diabetes are relatively free from sexual problems although there were some evidence of impaired vaginal lubrication" (in Bancroft, 1983, p. 322). Diabetic women are prone to vaginal infection, dyspareunia, fertility problems such as spontaneous abortion, premature birth or intrauterine death (Bancroft, 1983). Careful assessment as to the etiology of the diabetic condition in women is recommended by various authors (Bancroft, 1983; Kolodny et al, 1979).

In men, Bancroft (1983) stated that the "presence of absence of libido and/or morning erections are not sufficient evidence" p. 324, to confirm that the problem is organic. Psychophysiological technique such as recording nocturnal erection is recommended as a more objective method of investigation (Bancroft, 1983).

A course of counseling is also recommended even "if no substantial improvement in the erectile function results,

the couple may be helped to adjust to the physical disability and to enjoy their sexual relationship with the physical limits (Bancroft, 1983). Only after psychophysiological tests and treatment have been attempted, do most experts recommend surgical intervention. Refer to literature reviews on penile prosthetic implantation, types and problems under case no. 4.

Effects of Surgical Procedures on Sexual Functioning

Surgery may be responsible for interfering directly with the sexual function of the client due to damage to the functional anatomy or to the nerve or blood supply (Bancroft, 1983; Jehu, 1979).

In order to gather relevant data which will lead to the accurate diagnosis of the sexual dysfunctional problem, the clinician must be cognitive of the ramifications of the surgical procedure on sexual functioning. Kaplan (1974) provided a list of the surgical conditions which are known to affect sexual functioning. (Appendix VIII).

The assessment procedures of the effects of surgery on sexual functioning are similar to those already alluded to by Hartman & Fithian (1974), and Kolodny et al (1979), and therefore will not be repeated here except where specific reference is made to the surgical procedure.

Relative to surgery, Bancroft (1983) recommends that the clinician obtain a complete medical history focusing on the associated conditions which may be encountered by the client and the partner.

Evaluation of the client's or the partner's psychological reactions or vulnerabilities to the associated condition or secondary components which interfere with sexual functioning is emphasized (Bancroft, 1983; Griffith & Trieschmann, 1976). Assessment of the psychological-emotional component to surgery is essential since "devaluation and desexualization of the patient by himself and others occur frequently (Wright, 1960)" (in Meyer, 1976).

Considerable information regarding the client's and/or partner's response to the surgical procedure may be derived by following Jehu's guideline 'Psychological reactions to disability, surgery and medication', Appendix XI. If the client presents with considerable psychological or emotional difficulties dealing with the effects of the surgical intervention on sexual functioning, the clinician may wish to confirm the extent of the problem by employing other instruments such as the SDM for impaired self concept or Beck's Depression Scale for reactive depressional symptoms.

In considering the sexual implications of the surgical treatment, Bancroft (1983) cited several factors which should be observed. One, the condition itself which warranted the surgical treatment, eg. if the condition is cancerous; is it life threatening and does it entail mutilation of the sexual organs? (vulvectomy or bilateral orchidectomy) Or, does the surgery affect the client's (sexual) body image, eg. mastectomy or amputation of the limbs. Often mastectomy surgery is performed for the removal of malignancy of the breast which is usually followed by radiotherapy or chemotherapy. The sexual repercussions of such surgery affects not only the client but the partner as well (Bancroft, 1983).

The psychological reactions to cancer itself are very pervasive with depression being very common (Bancroft, 1983). It is a common practice that when survival is at stake, other aspects such as the sexual consequences are

overlooked or not addressed with a feeling that "people whose lives are in danger are perhaps assumed to have more important things to worry about than sex" (Bancroft, 1983, p. 343). It should be reassuring that "evidence is now accumulating that such factors can play a particularly important part in the post-treatment adjustment and well-being of some individuals and should therefore receive more attention than has been usual in the initial assessment and decisions about treatment methods" (Bancroft, 1983, p. 343).

In gynaecological surgical interventions, in a study of 98 women who had hysterectomy operation, via the abdominal route (McFarlane & Kincey, 1981), 44% reported improvement in their sex life; 31% reported no change; while in 19% of the cases, their sex life had deteriorated. This deterioration was classified as 'loss of libido' (Bancroft, 1983).

A surgical procedure such as a prostatectomy may result in retrograde ejaculation for a majority of men undergoing this operation (Jehu, 1979). Refer to case no. 4, literature review for further elaboration on the effects of a prostatectomy operation on sexual functioning.

Patients who undergo amputation of limb/s will undoubtedly encounter some difficulties in managing their sexual functioning due to "mechanical problems for coital positioning" (Jehu, 1979, p.28). Although the surgery may have precipitated the sexual dysfunctional problem, various authors (Jehu, 1979; Kaplan, 1974; Bancroft, 1983;

Meyer, 1976) concurred that it is often the psychological reactions to the physical change which ultimately create the sexual problem.

Effects of Prescription Drugs on Sexual Functioning

Sexual behaviour may be affected by drugs which are prescribed by the physician and are ingested by the client as part of the pharmacological therapy for a medical condition (Jehu, 1979; Kaplan, 1974). The term 'drugs' accurately used, include alcohol, analgesics, antispasmodics and antihypertensives and many other classes of drugs such as hypnotics and psychoactive agents (Renshaw, 1978e).

Jehu (1979) stated "as in the case of illness, any drug that is generally debilitating or incapacitating, or which specifically affect the neural, endocrine or vascular mechanisms concerned, may contribute to sexual dysfunction" p. 28.

Some drugs, according to Kaplan (1974), "alter libido or the intensity of sexual interest and pleasure, while other substances affect only the physiological response of the genital; erection, orgasm and ejaculation" p. 68. There are several different mechanisms by which drugs can influence sexuality. Some drugs "act primarily on the brain"; other influence the "peripheral nerves which regulate the functioning of the sex organs"; another "involves altering the response of the genital blood vessels"; some drugs modify sexual behaviour directly while other "produce secondary changes in sexuality as a by-product of their primary psychotropic action" (Kaplan, 1974, p. 86).

The drug effect review on sexual functioning by Kaplan (1974), Appendix IX is very comprehensive and

detailed, and provides a good source of reference during the drug information-gathering section of the assessment procedure.

> As Kaplan (1974) observed "it is difficult to assess the effects of drugs on sexual behavior accurately and reliably because the response to a pharmacologically active substance represents the resultant of the complex interactions between multiple factors, which include the pharmacological action of the drug and the dose, such situational psychological forces as the person's set and expectations of what the drug will do, his mental state and his relationship with the partner, and finally his permanent personality characteristics" p. 87. In addition, "the drug is only one variable in a complex system, the same drug may produce different sexual effects depending on the input of the other forces" p. 87.

Renshaw (1978b) concurs that this area requires careful and scientific study by all concerned.

Due to lack of comparable studies on both females and males on the effect of drugs, it is difficult to ascertain whether there is substantial gender differences in drug response (Kaplan, 1974).

Kaplan (1974) cautioned that very few systematic and controlled studies on the effects of drugs on the sexual responses have been conducted in this field and therefore the data which she has posited are "based on anecdotal and impressionistic claims" p. 97.

Since the ingestion of tranquilizers and alcohol are common, the effects of these substances on sexual functioning must be considered. Alcohol, barbiturates, sedatives and hypnotics "have a depressing effect on brain functioning, including its influence on sexual responsiveness" (Jehu, 1979, p. 28). No doubt a person who ingests large quantities of alcohol "is likely to lose his

interest in sexuality as well as his ability to function" (Kaplan, 1974, p. 94).

In a study by Wilson (1977) it was found that "a persistent pattern of heavy drinking or alcoholism may sometimes lead to chronic impotence, although the evidence is not very extensive" (in Jehu, 1979, p. 28). Other researchers have reported testicular atrophy and impotence to be "common sequelae of alcoholic liver disease (Scheig, 1975; Van Thiel, 1976; Van Thiel & Lester, 1977)" (in Jehu, 1979, p. 28). Wilson (1977) noted ovarian failure and atrophic changes in the vagina leading to dyspareunia as the product of the effects of alcohol abuse on female sexual functioning (in Jehu, 1979).

Minor sedatives are commonly prescribed to the client or to the partner as a means to counteract or to relieve the anxiety which is precipitated by the sexual dysfunctional problem. Eg. refer to case no. 2. Renshaw (1978a) cautioned that in addition to their addictive risk, minor tranquilizers, "particularly Valium, ten mg. per day, may cause enough muscle relaxation to interfere with climax in both sexes" p. 61.

With psychotropic drugs, the sexual side-effects appear to be dose-related. Ex. the drugs trifluoperazine or Thiothixene (two mg.) can either have a calming effect which "affect sexuality indirectly in a positive way" or at a higher dosage the "drugs may impede either arousal or the orgasmic phase of the sexual response by autonomic nervous system effects--centrally or peripherally".

Major tranquilizers are known to cause 'ejaculatory delay or dry ejaculate' (Renshaw, 1978b, p. 325).

A common method of controlling hypertension is to modify the activity of the autonomic nervous system (Clancy & Quinlan, 1978). Antihypertensive agents for the control of high blood pressure may impair the sexual response either directly or peripherally. Anti-adrenergic drugs may cause difficulties with the ejaculatory response; while ganglionic-blocking agents may impair "both the adrenergic and the cholinergically controlled phases of the sexual response, because they block the transmission in the intermediate ganglia of both components of the autonomic nervous system" (Kaplan, 1974, p. 96).

Psychological Reactions to Organic Conditions

The medical problem, depending on its severity and the affect it has on the physical body, can place additional psychological and emotional strain on the couple relationship (Kolodny et al, 1979). Griffith & Trieschman (1976) agreed that "anxiety and fear about the primary problem can inhibit sexual satisfaction" p. 208.

Kolodny et al (1979) in referring to sex and the handicapped stated that "physical difficulties may be amplified by factors such as guilt, anxiety, depression or poor self-esteem" p. 361.

Norell (1976) marvelled at how some couples that he has seen in his medical practice cope or are resigned to overt physical disease such as gross obesity, severe arthritis of the hip or spine, or ileostomy with little psychosexual problems. He acknowledged, however, that some couples may not volunteer the apprehension they may feel over their sex life. He advised that the clinician may need to raise the issue.

Hence, in order to deal therapeutically with any problems which may arise from the psychological reactions or responses to the organic condition, it is essential that the relevant information be obtained from the client and the partner.

Jehu's 'Table 1, Psychological reactions to disability, surgery and medication', Appendix XI proved to be helpful in providing a guideline of the topics which may be investigated. These particular topics were utilized

especially when the client or the partner indicated that they were experiencing some physiological problems, under the heading 'Organic states' in Jehu's general checklist of topics, Appendix I.

The psychological reactions to organic conditions which were encountered in the case studies were:

Anxiety and avoidance reactions

Fear of harm or anticipation of harm which is elicited by the client or the partner as a reaction to the organic condition can create psychological stressors which will invariably affect their sexual behaviour (Jehu, 1979). This reaction may be precipitated by a medical condition or illness which may be serious and where sexual activity may bring apprehension of sudden death (eg. MI or CVA) or damage to the surgical site (Jehu, 1979). Eg. refer to case no. 3. Where such concerns exist, it is important that the clinician establish whether the client's fears are based on facts or as a result of misinformation (Jehu, 1979).

Fear of failure or anticipation of failure

These reactions in the sexual area may be associated with illness or surgery (Jehu, 1979). The illness or surgery may produce temporary weakness to the physical body, thus affecting the level of sexual activity at that particular time. The individual may interpret this lack of coital activity to continue or to be permanent which will evoke fear of failure in future sexual encounters. Eg. refer to case no. 2. In another situation, the partner

may not wish to want to become sexually aroused because the client is unable to participate in coitus due to the organic condition. Eg. refer to case no. 3.

Any of these physical difficulties can elicit feelings of guilt, anxiety, depression or poor self-esteem in the client and the partner (Kolodny et al, 1979). Eg. refer to case nos. 2 and 3.

Depressive reactions

"Illness or surgery can also be accompanied by depressive reactions that adversely affect sexual bekavior, and there are a variety of reasons why such reactions might arise" (Jehu, 1979, p. 58). These include: (a) chronic pain; (b) life threatening illness; (c) changes in form and functioning of the body; (d) dependence on others; (e) restriction of social-occupational activities; (f) lowering of social status and self-esteem (Jehu, 1979). Eg. refer to case nos. 1, 2, 3 and 4.

Impaired self concept

The result which commonly follow a 'damaging' effects of illness or surgery is impairment to the self concept (Jehu, 1979; Mims & Swenson, 1980). This impairment can have an adverse effect on the individual's concept of body image, gender identity and self-esteem, which in turn, has implications on the couple's sexual functioning level and general relationship. Eg. refer to case nos. 2, 3 and 4.

Relationship difficulties

Partner discord can occur when the psychological reactions to the illness or surgery (eg. rejection, anxiety, depressed mood, etc.) begin to affect the couple's interaction in other spheres of daily functioning such as finances, communication, social activities, etc. Any of these stressors can have an adverse effect on the couple's sexual relationship (Jehu, 1979). Eg. refer to case nos. 1, 2 and 3.

Grief Reaction to Loss

Grief reaction associated with loss is a very well known phenomenon (Kubler-Ross, 1969). Varying degrees of the grief reaction symptoms were noted in many of the clients and/or partners who were being assessed for sexual dysfunctional problems related to complex medical conditions. (Refer to Conclusion for details).

Quigley (no date) aptly described the effects of grief resulting from the loss of a physical function. He stated "grieving is the process which everyone inevitably goes through after any significant loss". Hence, an individual who has undergone changes in his/her sexual functioning as a direct or indirect result of an organic condition, will undoubtedly react to the loss, both of the bodily function as well as the sexual functioning, and this reaction may invariably produce behavioural changes (Jehu, 1979; Kolodny et al, 1979).

During the assessment procedure, it is not uncommon to observe that the client and/or partner are in one of the stages of grief--shock, denial, anger, acceptance, reconstitution or integration (Kubler-Ross, 1969). For instance, various emotional and behavioural changes may be overtly exhibited by the client and/or the partner due directly or indirectly to the loss of physical and sexual functioning. These emotional symptoms and behavioural changes (eg. reactive depression which is common following a disabling loss (Quigley) may have significant implications to the formulation of a clinical diagnosis, planning

of treatment goals and subsequent implementation of an appropriate treatment program.

It is therefore important to ascertain the manner in which the client and/or partner are handling or coping with the loss of functioning (either physically or sexually) and to examine the methods which they have utilized in order to remediate or to adjust to the situation (Kolodny et al, 1979).

Where a situation exists where the couple have not been able to mutually adjust to the loss, there may be an adverse effect on the relationship. If one partner is unable to cope with the other partner's loss of sexual functioning, as in case no. 3, then it may necessitate an evaluation as to whether the individual will require some form of crisis intervention initially before sexual rehabilitation per se is undertaken.

SECTION IV

INTRODUCTION TO SEXUAL REHABILITATION CASE STUDIES

The following case studies were selected in order to demonstrate the following: (1) how diverse and complex medical condition/s can affect sexual functioning; (2) the various assessment procedures which may be utilized by the clinician in order to determine the etiology of the sexual dysfunctional problem; (3) the formulation of a clinical diagnosis; (4) the treatment strategies and modalities which were utilized in order to resolve the problem.

A literature review is provided at the beginning of each case study in order to provide the reader with some relevant information from various sources regarding the medical condition's and its effect on sexual functioning. This information was then applied to the assessment procedures and subsequently integrated into a treatment program of the individual case study.

The lack of published data related to the treatment modalities utilized in this area presented some difficulties for the clinician. However, this proved to be a challenge and it is hoped that this report will provide additional knowledge in the area of sexual rehabilitation.

STUDY NO. 1

Bernice and Allan: Sexual aversion and lack of sexual arousal associated with multiple sclerosis condition and traumatic rape experience

A case where the various assessment procedures are utilized in order to determine the etiology of the sexual dysfunctional problem itself; then to identify whether the sexual problem was due to a multiple sclerosis condition or a traumatic rape experience.

This case demonstrates the method in which the 'conventional' sexual therapy model can be incorporated with the behavioural treatment model in order to formulate a comprehensive sexual rehabilitation program.

STUDY NO. 1

Effects of Multiple Sclerosis on Sexual Functioning

Multiple Sclerosis (MS) is the neurological disease of the central nervous system. The disease affects the myelin sheath which is the coating around the nerve fibres in the brain and spinal cord. If scar tissues have replaced the myelin with hardened tissues in a number of places within the nervous system, nerve impulses may be disrupted (Stone, 1977).

The cause of MS is still undetermined (Burnfield, 1979). The disease seems to come in bouts or attacks (exacerbation) which cause symptoms such as spasticity, weakness, tingling, impaired sensation, visual impairment (pain, sudden blindness, double vision) or bladder dysfunction to occur (Kolodny et al, 1979).

Since MS is a disease of the central nervous system, patients may display behavior or personality deviations stemming from the disease itself (Stone, 1977). Changes such as "intellectual deterioration, euphoria, personality changes and exaggeration of emotional expression are like the physical disability, symptomatic of the disease" (Surridge, 1969).

Emotional upset, infections, overexertion or fatigue, injuries, surgery and pregnancy have been cited to be possible causes of an attack or relapse (Kolodny et al, 1979). Chronic illness such as MS has a significant impact on many facets of a person's life. Not only must a

person cope with the symptoms referred to above, in varying degrees but must also deal with the complex psychosocial issues that may arise--including sexual problems.

Various authors reported that patients with MS have many different types of sexual problems (Ivers & Goldstein, 1963; Lilius et al, 1976; Lundberg, 1978).

Lundberg (1978) described the etiology and the kinds of sexual problems which have been encountered by MS patients as "the pathological lesion may disrupt the nerve tracts in the central nervous system conveying impulses to the genital organs resulting in such symptoms as impotency or loss of ejaculation. Paraesthesiae and decreased sensibility, especially in the genital region, may interfere with the perception of pleasurable sensations and also diminish the capacity to achieve a sexual response such as an erection or vaginal lubrication through tactile stimulation. Brain lesions may in multiple sclerosis affect the mechanisms regulating sexual libido and alter the sensation of orgasm" p. 219.

MS could also affect the psychological state of the patient which in turn, could influence the sexual area. Lundberg (1978) described these as: "the feeling of being a disabled person, the sense of insecurity as regarding individual prognosis, loss of self-respect, dependency upon other people, changes in the relations with the partner and the rest of the family, unfulfilment of the expected parental role, and so on" p. 219.

Lilius and coworkers (1976) found substantial evidence of sexual difficulties from a questionnaire study administered to 302 men and women with MS. 69% of the men and 39% of the women in this group reported having an unsatisfactory sex life or having stopped participation in sexual activity.

Among the sexual difficulties reported by this group included: difficulties with erection, diminished frequency of sexual intercourse and diminished libido. The reasons cited for these sexual difficulties were: general weakness, spasticity, loss of penile sensations. Impotence presented a primary difficulty. Women in this study reported: decreased or absent interest in intercourse, diminished or absent clitoral sensitivity and difficulty in attaining orgasm (Lilius et al, 1976).

Kolodny et al (1979) commented that although the Lilius survey comprised of patients with advanced stages of MS, "it is important to realize the sexual difficulties may be among the first manifestations of this disorder" p. 258. They added "this symptom can present problems in differential diagnosis since the dysfunction may remit after a period of weeks or months, only to return at a later time. Because episodic sexual dysfunction is generally regarded as psychogenic in origin and because people early in the course of multiple sclerosis may appear to be in excellent overall health, clinicians should be alert to this diagnostic difficulty" (Kolodny et al, 1979, p. 258).

Suggested Sexual Rehabilitation Treatment for MS Patients

Lundberg (1978) advised that "the sexual dysfunction in patients with multiple sclerosis may be transitory" p. 221. Therefore it would be helpful to the patient and the sexual partner if general counseling were given

in early and mild cases about the disease itself and the nature of the sexual problem.

Lundberg (1978) noted that from the interview studies he had conducted, that most of the patients were of the opinion that sexual counseling was necessary for a disabled person. However, it was found that very few patients actually asked for or received such advice.

Burnfield (1979) suggested that some problems "may turn out to be largely psychological and normal psychosexual counseling methods will help" p. 38. She commented that with counseling many of the sexual problems which arise could be overcome. She stated "it is sad that counseling has been ignored for so long, as emotional problems are perhaps the most treatable part of MS" p. 34.

Among the instructions which may be given to the patient for the treatment of sexual dysfunctional problems related to MS condition are: (1) the use of specific sexual stimulation or alternative methods of sexual activity, such as cuddling, petting, masturbation, oral sex or use of technical devices (Burnfield, 1979; Lundberg, 1978); (2) pelvic floor muscles can be trained in cases of motor dysfunction; (3) local anaesthetic or pharmacologic management (drugs given orally) were recommended to alleviate sensory disturbances, ex. spasticity (Kolodny et al, 1979); (4) loss of bladder control during the sex act can be prevented by catheterizing prior to coitus; (5) planning for sexual activity, eg. choice of time when energy is high, resting beforehand, creating relaxing and

erotic atmosphere will assist to counteract the effects of fatigue; (6) the penile prosthetic implantation surgery may also be suggested as a method of enhancing self-esteem and socialization for men having potency problem which is untreatable by psychotherapy (Kolodny et al, 1979).

Effects of Rape Trauma on Sexual Functioning

Forcible rape has been characterized as a crime that "degrades, dehumanizes and violates the victim's sense of self" (Hilberman, 1976; Metzger, 1976) p. 427.

In various studies on the consequences of rape, it has been shown to alter the victim's perception of self, others, and the environment (Burgess, 1974; Gager, 1976; Notman, 1976; Sutherland, 1970). Yet it remains a poorly understood phenomenon from numerous perspectives. According to Kolodny et al (1979) well-researched data are not currently available to document the incidence and frequency of sexual difficulties following rape.

In a study of 1000 rape victims, Bart (1975) found that one-third of them experienced sexual problems from the rape. These problems ranged from vaginimus, secondary nonorgasmia, decrease in sexual drives and fear of any type of sexual involvement.

Becker et al (1978) reported in a study of 20 victims and 20 attempted rape victims one year after the sexual assault, that 45% of both groups continued to have nightmares, and 66% of the attempted victims and 70% of the victims continued to experience some form of trauma or phobia.

'Rape trauma syndrome' was designated by Burgess and Holmstrom (1974) as a cluster of reaction patterns which were typically described by rape victims. These involved "an immediate stage with major disruption of life-style, accompanied by emotional and physical symptoms and a

long-term stage of reorganization" p. 441. In the long-term phase of the rape trauma syndrome, recurring nightmares and appearances of various fears or phobias were common behavioral changes. Kolodny et al (1979) stated that "anxiety, depression, and phobic responses to situations reminiscent of the rape may persist for many years and may alter the victim's reaction to subsequent sexual encounters" p. 441.

Among the sexual difficulties faced by women who have been raped are: an aversion to all sexual activity (Kolodny et al, 1979, Chapter 22); difficulties with sexual arousal including impaired vaginal lubrication, loss of genital sensations, pain during intercourse, vaginismus, and loss of orgasmic facility. Kolodny et al (1979) reported "the underlying causes of such responses are often complex, involving diminished self-esteem, guilt, fear of rejection by the sexual partner, anger toward men in general, depression and feelings of learned helplessness reinforced by the rape experience" p. 441.

Becker & Abel (1981) cited the adult victims' reaction and sequelae to rape as: feelings--vulnerability, guilt, anger, shame and embarrassment; physiological disturbances; diffuse anxiety, phoebia; fear of people; being alone, men, and cognitive disturbances--rape or homicidal and chronic ruminations of the assault.

According to Burgess & Holmstrom (1979) in their longitudinal study, it was revealed that 'flashbacks' were frequently reported by victims. Some women described

flashbacks in varying situations, eg. when having pelvic examination, during sexual relations.

Suggested treatment for Sexual Problems of Rape Victims

When dealing with clients who have experienced rape, the clinician must be cognitive of the physical, psychological, social and emotional consequences of the rape experience and how all these factors may have contributed to the sexual dysfunctional problem. In addition, assessment of the sexual partner's reactions to the rape experience are essential as it can be as complex as those of the victim (Kolodny et al, 1979).

Annon (1975), Kaplan (1974) and Masters and Johnson (1966) have investigated and reviewed the treatment of sexual dysfunction in females. Becker & Abel (1981) have reported successfully utilizing a behavioral approach based on Lobitz and LoPiccolo's (1972) model in the treatment of orgasmic dysfunction which resulted from a rape experience. The treatment program included: clarification of views of sexuality; correcting any misinformation or myths the client had regarding her sexual responsiveness; homework assignment consisting of exploratory and sensate focus; exercise which would re-educate the client to come to view sex as pleasurable and the reinforcement of this. These authors suggested that in working with sexual assault victims, "it is most important that they feel in control and they do not view any of the therapist's recommendations as being aggressive; should we have pushed the issue of using a vibrator the

patient may have terminated therapy" p. 368.

In working with sexual dysfunction problems in females resulting from a sexual assault, Becker & Abel (1981) stated that they found the following books helpful: Liberating Masturbation (Dodson, 1974); My Secret Garden (Friday, 1974); Becoming Orgasmic: A Sexual Growth Program for Women (Heiman, LoPiccolo & LoPiccolo, 1976).

Causes and Treatment of Sexual Aversion

In this particular case, the sexual dysfunctional symptoms which were related by the client during the assessment procedures (description and details to follow) appear to fall into the categories of either sexual aversion or inhibited sexual desire (Kolodny et al, 1979).

Interestingly, Kolodny et al (1979) classified sexual aversion and inhibited sexual desire as "two nondysfunctional diagnostic categories that are characterized by impeded initiatory sexual behavior or impeded sexual receptivity" p. 557.

The literature reviews were therfore conducted on both of these topics. It was suggested from the readings that the diagnosis of sexual aversion was more applicable. Hence, a thorough literature review was conducted on the causes and treatment of sexual aversion and it revealed the following:

Sexual aversion, according to Kolodny et al (1979), "is a consistent negative reaction of phobic proportions to sexual activity or the thought of sexual activity" p. 557. Its occurrence may be: (a) situational (one particular partner); (b) either male or female (but the majority of cases involve women); and (c) usually under the age of 40.

Kolodny et al (1979) cited other characteristics which included: (a) a person with sexual aversion syndrome experiences "irrational, overwhelming anxiety at the thought of sexual contact" (p. 557); (b) the sexual

arousal response are apt to be inact; (c) some individuals encounter "greater difficulties with undressing and touching in a sexual context than they do with participation in intercourse" (p. 557); (d) sexual aversion may be a guise as lack of interest or low frequency of sexual activity.

The etiology of sexual aversion can range from overly negative parental sexual attitudes to sexual trauma such as incest or sexual assault. "Sexual trauma occurring during adolescence (rape, incest, or painful early coital experience) may lead to an association between sex and exploitation or pain and may thus serve as the precipitation of sexual aversion as a protective posture" (Kolodny et al, 1979, p. 559).

Suggested Treatment for Sexual Aversion

In the treatment of sexual aversion, the main objective is to overcome or extinguish the aversive consequences and recondition ways in which sexual activity is experienced (Kolodny et al, 1979). Motivation to change is the first and foremost requirement in the treatment of this disorder. Basically the treatment methodology follow the fundamental techniques of behavior modification (Kolodny et al, 1979).

Suggestions in the treatment of this disorder include:
(1) The therapist provides the couple with the etiologic factors leading to sexual difficulties and gives insight of the problem (Kolodny et al, 1979).
(2) The therapist enlists the co-operation of the partner since during the early stages of treatment, the partner's

interests are placed secondary to the client's.
(3) As therapy begins, the client with the sexual aversion problem "must be put in complete control (temporarily) of all situations involving sexual activity" (Kolodny et al, 1979, p. 561). This allows the client with the sexual aversion symptoms to "lower his or her anxiety at a particular level of sexual interaction by knowing that there will be no sudden progression to another more involved or more threatening level and by gaining comfort with that specific type of sexual contact" (Kolodny et al, 1979, p. 561).
(4) 'Sensate focus' exercises are prescribed with precise instructions. The sensate focus exercise for treatment of sexual aversion differs from the mutual, general pleasuring assignments (Masters and Johnson's 'conventional' sexual therapy) in that the person with the sexual aversion syndrome decides on the amount of anxiety she is able to tolerate--she initiates the activity (begins by touching the partner and concentrates on the physical sensation associated with this; and she decides when to stop the activity for reasons of anxiety, fatigue or disinterest (Kolodny et al, 1979, p. 561).

Kolodny et al, (1979) emphasized that the "touching is not designed primarily for the pleasure of the person being touched but rather that the touching should reflect the interests of the person doing the touching" p. 562. If any discomfort is experienced as a result of touching, the person with sexual aversion is responsible for informing the other partner. Hence, the aim of the sensate

focus exercise is for anxiety reduction, in addition to mastering and increasing confidence.

In cases where anxiety cannot be controlled, in vitro desensitization is recommended in order to build up tolerance. However, the same authors (Kolodny et al, 1979) cautioned use of an imagery hierarchy of graded anxiety-provoking situations since "this method slows the progress of therapy, may at times actually intensify the terror of the real-life contact" p. 562.

Some of the problems which could arise during the sensate focus segment of the therapy are: (a) the anxiety may surface without any reason and under certain situation; (b) the partner impressed that progress is being made, may push faster (sexually) than the person struggling with sexual aversion symptoms may be able to cope (Kolodny et al, 1979). This overzealousness by the partner may create difficulties within the relationship and impede the overall progress in the treatment of this disorder. It may necessitate the clinician to confront and resolve the situation in order to give the person with the sexual aversion, positive reinforcement and feelings of self-actualization.

Problems of resistance to therapy are to be expected. However, experts (Kolodny et al, 1979) were of the opinion that there should be considerable lessening of the phoebic component of sexual aversion after 7 or 8 sessions.

Concomitantly with the sensate focus assignments, (Kolodny et al, 1979) suggested that the clinician maintain

a careful assessment and to help in the development of new communication skills between the dyad in order to assist the couple to overcome any sexual or non-sexual issues which may have created problems for them. Other therapeutic issues which may require attention are: body-image, self-esteem or sexual fantasy.

CASE 1

ASSESSMENT REPORT

Bernice is a 34 year old female who referred herself to the Sexual Dysfunction Clinic.

Following Jehu's (1979) 'Checklist of Topics of Assessment Interviews with Sexually Dysfunctional Clients and Partners' (Appendix I), the clinician proceeded to gather relevant information regarding the client's psycho-social-sexual and medical history in order to identify some causal factors which may be contributing to or maintaining the sexual dysfunctional problem. The client also completed the Sexual History Form (Appendix II). Hence, the following information which was collected by the clinician will be presented in this report in a summarized and sequential manner. The method of assessment reporting will differ from the other case studies due to the obstacles which were encountered during the assessment procedure. The clinician deems this progression method of assessment to be important in exemplyfing the manner in which various changes and deviations are required in the assessment interviews. The initial assessment interview may be considered the preliminary procedure which allows the clinician to decide on the proceeding direction of information-gathering. To report this case in any other manner (assessment-to-treatment format) would take away from the true meaning of sexual rehabilitation where the clinician is having to deal with multicausal and multifactorial variables.

Description of Problems

Bernice is presently encountering difficulties enjoying a 'loving' relationship with a man she has known since last winter. She is questioning whether her lack of arousal or lack of desire for sex is due to her health condition, multiple sclerosis.

Bernice tolerates hugging and kissing, however, if her partner should touch her breast, she draws back with a sense of panic and is overwhelmed with feelings of 'anxiety'. As she is noticing a similar pattern of responsiveness at every physical contact which may lead to any semblance of sexual activity, she is recently starting to question why she is behaving in this manner.

The onset of the problem is within this relationship. She relates however that she has never experienced any desire for sexual contact with any other male.

Contemporary Influences on Problems

Situational antecedents

Bernice has been taught that sexual activity should take place only within the sanctity of a marriage. She derives these views primarily from the teachings she received in the religious institutions where she received her schooling. Bernice is a very religious person who has always derived considerable comfort from her faith.

Bernice has always been shy when it came to any personal interaction or involvement with the opposite sex. She has never considered herself sexually attractive or

desirable. She liked to view the men in her life as 'friends'. Her experience with these men consisted mainly of holding hands, hugging and kissing. She did not derive any pleasurable feelings from these activities.

Organismic variables

At times Bernice admits to wanting to feel physically close to Allan especially when they are embracing. However when she has these desires, she immediately shuts off her feelings as she does not know how to handle the guilt feelings which seem to overcome her. Consequently, she feels torn between wanting to get closer to Allan while at the same time she knows she should not have these feelings. She is experiencing tremendous amounts of tenseness and anxiety whenever she gets into this situation. As she realizes that her heightened anxiety is precipitated by her loving feelings, she is not wanting to think about her desires.

Organic factors

Bernice was diagnosed as having multiple sclerosis two years ago. The symptoms had appeared one year earlier. She states her functional level is now 75% from what it had been. Some of the physical symptoms she experiences are: extreme fatigue, weakness in the arms and legs due to the wasting of the muscles, and spasms. She requires antispasmodic medication, anti-arthritic medications, and antibiotics intermittently in order to keep the infection of the bladder under control. She receives periodic medical examinations from a specialist.

Situational Consequences

Bernice is feeling uncomfortable about her feelings towards sex and is also concerned about how this attitude and resultant behavior will affect her relationship with her present boyfriend. Her boyfriend, Allan, has been very tolerant of her feelings of anxiety, however, she feels their relationship is becoming very tense as a result of the conflict in their sexual needs.

Allan has suggested to Bernice that her 'aversion' to sex may be the result of her traumatic experience in her teen years and he is encouraging her to go and see a counselor. Bernice states she is more inclined to believe that the resultant sexual dysfunctional problem is due to her multiple sclerosis condition.

Personal and Family Background

Bernice presents as an extremely shy, introverted person who was born outside of Canada. Her family moved between several continents at regular intervals during most of her childhood. She describes her early childhood years as being 'happy' surrounded by relatives and friends. Her schooling on the continents took place in religious institutions.

Bernice is the youngest of three siblings. Her siblings consist of two brothers who reside in Winnipeg, and an older sister with whom she shares an apartment. Bernice and her siblings have a very close relationship. Her brothers and sisters and very 'protective' of her, especially after Bernice was diagnosed as having multiple sclerosis. Bernice is presently employed in the accounts

department of a large medical supply firm. Both of her parents are deceased. The family was 'close' when her parents were alive. Bernice relates having had a 'special' relationship with her father in particular; she was much closer to him emotionally than with her mother.

Sexual history

Bernice started her menses period at age 11, and did not recall having any strong feelings about this event. She never participated in any 'sex' games during her childhood years. She had one special boyfriend when she was 16 years of age. There was hugging and kissing but no fondling or petting. She describes her life as being rather uneventful for most of her teen years until she had a very traumatic sexual experience at age 19.

At this point of the information-gathering interview, the client became extremely anxious, tearful and very hesitant about answering specific questions related to the rape incident as "it brought back too many bad memories". Focus of the interview was therefore shifted to other areas which would enable the clinician to evaluate the client's past and present life style, values, religious and moral beliefs, etc. This strategy was utilized because: (a) obtaining information of a general nature at this particular stage of the assessment procedure was less threatening to the client than focusing on the rape incident; (b) it allowed the clinician to build an empathetic and trusting therapeutic relationship with the client in order to be able to assess the full

extent of the emotional and psychological effects of the rape experience on sexual functioning at a later interview session.

At present Bernice shares an apartment with her sister. Due to her medical condition, her sister insists on helping Bernice with the chores, etc. Bernice does not mind living with her sister as they are emotionally very close to each other. They confide in each other on most subjects, but Bernice admits she has not told her sister about Allan, as she does not feel her sister would approve of her dating a man who is separated from his wife.

Bernice has known her present boyfriend casually for many years. However, it was not until he became separated from his wife that they started dating each other. She has great admiration for him as a person and she very much enjoys his companionship. They are very compatible in every way, except sexually. She enjoys when Allan hugs and kisses her, however, she literally 'freezes' whenever he attempts to go beyond that stage. She cannot understand why he wants to go further as she is contented as things presently stand.

Allan has, according to Bernice, shown great understanding and patience, however, Bernice admits that she too is feeling the strain. She would like to enjoy being closer to him physically, however, she does not know how to feel comfortable doing so.

By the third interview session, Bernice is able to discuss the events leading to the rape incident and to

relate the accompanying feelings she had experienced at the time of the assault and proceeding the event.

Bernice had just finished secondary school and had gone to a party which her parents had forbidden her to attend. Someone spiked her drink and she was raped by several fellows. Since Bernice had never had sexual intercourse previously, this rape experience was physically very painful.

This experience had a tremendous impact on her psychological and emotional state. Her immediate reaction after this experience was 'revulsion'. She felt dirty and abused. Other feelings which were later experienced by Bernice included feelings of intense hatred towards her brothers whose ages were similar to those of her assailants. She did not have the same hateful feelings towards her father though. She turned to him for emotional and protective support although she did not divulge any information regarding her experiences to him.

Her mother became very concerned with Bernice isolating herself and withdrawing from other people. Bernice often refused to leave the house, being content to play with her cat. She eventually went out of the house but only when she was accompanied by her father. Her father would get her out of her despondent moods by teasing her in a gentle, kind way.

For a period of three years after the sexual assault incident, Bernice refused to date. When she finally started to date, she would only go out when it included other couples. She would only allow holding hands, with

some kissing. She states emphatically, she never participated in any sexual activity. After the rape incident, sexual intercourse came to represent something fearful and painful to her. Sex had come to represent what she terms 'aversive'.

Assessment instruments utilized

The Sexual Arousal Inventory (Appendix III) was administered to determine how sexually aroused Bernice can feel or think she would feel if she were actually involved in the experience. The clinician in interpreting the results, observed from Bernice's responses, that out of a total of 28 questions, she answered 14 questions of affecting the client in 'adversely affecting arousal; unthinkable, repulsive, distracting'. This instrument and subsequent evaluation provided a 'profile' of the client's present arousal level. This clinician also utilized this instrument as an indicator in establishing the types of sexual behaviour which this client may consider acceptable in therapy, without feeling repulsed.

Motivation for treatment

Bernice is wanting help to overcome her sexual difficulties, however, she is stating she is not certain whether the contemporary problem she is encountering is due to her negative attitudes or as a result of her multiple sclerosis condition. She states she is wanting to receive a diagnosis, however, at this point, she is not wishing to commit herself to any treatment plan.

The clinician has, up to this point, identified two major factors; namely, the rape trauma and the MS condition which may presumably be affecting the client's sexual responsiveness and be contributing to the sexual dysfunctional problem.

In order to evaluate to what extent the medical condition and/or rape trauma may be affecting the psycyological state of the client and subsequently her sexual behaviour, Jehu's guideline 'Psychological reactions to disability, surgery and medication' (Appendix XI) is utilized in order to gather the necessary information.

Assessment for psychological reaction to disability, surgery and medication

Anxiety and avoidance reactions to the rape incident

Bernice having experienced her only sexual act in a degrading and painful manner, she admits her reluctance of wanting to engage in sexual intercourse. She is feeling extremely anxious about participating in a sexual act and she also anticipates harm. She does not wish to relive the 'horrors' she had experienced during the sexual assault incident. She is fearful of failure due to her lack of experience and knowledge in the area of sexuality.

Reactions to MS condition

Bernice expresses concern that this condition or the medications may be affecting her sexual arousal level. She also is concerned because she has a catheter and she is not sure how this might affect the sex act.

Depressive reactions to MS condition

Bernice feels helpless, frustrated and angry because of her dependence on her siblings for an increasingly number of her daily chores due to the extreme fatigue that she is experiencing. This tiredness and lack of energy is also restricting her leisure-time social activities with Allan, limiting her to seeing him once weekly or on weekends. She admits feeling very low at times because she wants to spend more time with him. She is very discouraged regarding the lack of progress that she and Allan are making in trying to overcome their sexual difficulties.

Impaired self concept--specifically related to the MS condition or rape experience

Bernice does not have a very good image about herself, especially of her body due to the wasting of muscles caused by the MS condition. She does not feel that her body is appealing or attractive and therefore she cannot understand why her boyfriend would want to get close to her physically. She is extremely shy about revealing any parts of her nude body. Her self-esteem in other areas, eg. work, church activities are within normal range. She lacks self-confidence in certain areas, eg. how to effectively communicate her concerns regarding her MS condition or her past experience related to the rape experience.

Relationship difficulties due to MS condition

The physical, psychological and social difficulties presented by Bernice's medical condition and the effects

these have on their relationship have already been alluded to earlier, therefore, will not be repeated. According to Bernice, Allan does not complain that she is not able to join him in the social or sports activities due to her medical condition. However, she feels guilty about not being able to join him and she is stating that Allan should find someone who is healthy and who is able to participate in the activities he enjoys.

Relationship difficulties due to rape trauma experience

Bernice states that Allan maintains the sexual problems which they are encountering presently are related to the rape experience and he continues to encourage her to seek treatment in order to overcome her blockages.

Relationship discord not specifically related to MS condition or rape incident

There are some dissensions between the dyad revolving around religious beliefs and values. Bernice is a very devout church-goer, while Allan does not attend any specific church or adhere to any specific belief system. Bernice is wanting Allan to explore further about obtaining an annulment of his marriage. She says that if she knew that her boyfriend was progressing towards an annulment, she would "find it easier to go through with having sex". She maintains that it is alright between a couple if the feelings are good and the relationship is stable.

Allan is hesitant in pursuing the available avenues of annulment and this situation is making Bernice unsure of Allan's feelings towards her--whether in fact he wants to marry her. This particular situation is creating additional stress and anxiety for Bernice.

Process utilized by clinician in the formulation of a hypothesis or clinical diagnosis of the sexual dysfunction

In order to arrive at an accurate hypothesis of the etiology of the sexual dysfunctional problem, it is necessary to go through a process similar to those described by Jehu (1979) in the assessment of this report.

From the various assessment procedures which were conducted, it can be determined that there are two major factors which may be contributing or maintaining the sexual dysfunctional problem. The process which was followed in order to arrive at identifying the causal factors are discussed.

The following literature reviews were undertaken in order to assist in determining whether the sexual problem encountered by the client was due to her present medical condition--namely, multiple sclerosis. Refer to literature review on the effects of MS on sexual functioning.

The conclusions which were drawn from the findings inthe literature review showed that MS patients do indeed suffer from many types of sexual problems, however, it is noted that the particular type of sexual problem encountered by this client is not normally one resultant

of a MS condition. It is a fact that decreased libido or diminished sexual response which are found in MS patients are also experienced by this client, however, the most prevalent symptom experienced by this client appears to be 'extreme irrational anxiety at the thought of sex' and this does not 'fit' the categories of sexual dysfunctional problems attributed to a MS condition.

Post traumatic rape experience can also be contributory to a sexual dysfunctional problem and therefore a literature review was undertaken in this particular area. Refer to the literature review on the effects of rape trauma on sexual functioning.

The findings of the preceding literature reviews reveal and gave supportive evidence that a traumatic experience such as rape can indeed result in sexual dysfunctional problems--one being sexual aversion. The clinician then proceeded to examine the literature reviews on sexual aversion to determine whether the symptoms exhibited by this client were similar to those individuals who were suffering from sexual aversion. Refer to literature review on the cause and treatment of sexual aversion.

Hence, the hypothesis which was drawn from the information gathered during the assessment procedures and the findings of the various literature reviews showed that the sexual dysfunctional problem experienced by this client, namely sexual aversion, more than likely had its origin from the traumatic sexual experience she suffered in her teen years.

The physiological and psychological secondary effects of the MS condition cannot be totally discountred, however, due to the fact that the client is encountering symptoms such as extreme fatigue or tiredness after a day of work which, in turn, can affect her sexual responsiveness and produce low sexual desire. Spontaneous sexual behaviour is also hampered by the catheter which she is required to use due to her MS condition. There is also no conclusive evidence to show that the medications that Bernice is taking for her MS condition does not, in fact, have some effect on her lowered sexual responsiveness. Refer to literature review on effects of prescription drugs on sexual functioning.

A feedback session is arranged at which time Bernice and the clinician review the findings of the assessment procedures. The hypotheses about the conditions initiating and maintaining the sexual problem are reviewed with the client. These include:

Sexual dysfunctional problem which is identified as sexual aversion

Psychological distress--sex specific: Bernice is having difficulties understanding the reason her partner would feel 'aroused' when prolonged kissing is undertaken. When her partner cannot control his urges, she feels very hurtful. Bernice lacks knowledge of the phases of sexual response and this contributes to her inability to comprehend why Allan behaves in this manner when aroused.

Emotional conflicts: Due to incongruency between sexual desire and religious belief, Bernice does not understand that the inner conflicts that she is experiencing is due, in part, to her moral values. Although she seemingly sanctions sexual activity in a loving relationship, her strict religious upbringing and present belief system does not fully support this.

Psychological distress (non sexual areas): (a) living up to her sister's moral expectations; (b) the concerns relating to exacerbation of her MS condition and the deterioration of her functional level; (c) concerns whether she can continue to work at her present job.

Negative attitude: The rape trauma that Bernice had experienced has predisposed her to respond negatively towards anything 'sexual'. She has the notion that 'men are only after one thing' or that 'sexual act is painful and dirty'. These beliefs lead to additional tension and anxiety.

Anxiety: Tension from various sources is contributing to her heightened anxiety. Lack of information and knowledge in the area of sexuality is causing her concerns on how to behave in a sexual situation. She admits she lacks self-confidence in this area and this adds to her level of anxiety as well.

Control issues: Bernice has a need to maintain control. She refuses to have the clinician contact her physician in order to obtain additional medical information related to her MS condition. She states she does not wish

him to have knowledge about her sexual problems even though her physician could clarify the question she is asking in regards to whether her sexual dysfunctional problem could be caused by her MS condition.

She is also adamant about not wishing her boyfriend to be involved in therapy as she believes she is the source of the problem. She is also not wishing to have her siblings know about her seeking professional help.

She also feels that by participating fully in the sexual act, that, she is, in essence, 'giving up control of her body'. Therefore, she is constantly facing tension and anxiety created by her desires of wanting to get physically close to Allan and at the same time, maintaining control of not 'going all the way' to coitus.

Communication problems: Bernice and Allan are experiencing some difficulties in expressing their needs and concerns to each other.

Relationship discord: Basically revolving around the issue of obtaining an annulment through the church; communication, and sexual activity.

Motivation for treatment: The clinician is having difficulties at this point in determining accurately whether Bernice's reluctance to commit herself to treatment is due to a control issue, resistance, or to uncertainty. She is requesting help, yet she is also setting up many obstacles to prevent facilitating a direction towards treatment. It was concluded that a major portion of Bernice's indecisiveness to therapy is attributed to her high level

of anxiety which is impeding her abilities to make a firm decision.

Commitment for treatment

Up to this time, the client has not formally committed herself to proceed with a treatment program. Bernice is asked again whether she has made a firm decision as to the course of direction she wishes to take in order to resolve the sexual problem which has been identified and discussed. Bernice states she wishes to go into therapy. She appears to be well motivated, co-operative and enthusiastic.

The assessment of the other resources indicate that treatment can commence immediately at a designated setting with the therapy time alloted to one and one-half hours per week.

Since therapy of a sexual nature is difficult to do successfully without a partner, Bernice is encouraged to ask her boyfriend to come to speak with the clinician. In a subsequent session, the clinician has a joint meeting with Bernice and Allan. After hearing the diagnosis of the sexual problem, Allan states he is in agreement to participate in any therapy which would assist Bernice to overcome her 'aversion to sex'. Allan displays considerable care and love for Bernice and these feelings are very obvious in their interpersonal interaction. He admits he is feeling the stressors of 'unconsumated love' but he is also stating that he will be patient. He is willing to co-operate with any prescribed assignments which will assist them to overcome their sexual difficulties.

Allan is requested to complete the Sexual History Form (Appendix II). In addition, a brief history of his past sexual activities and experiences are obtained in order to establish a sexual behaviour profile.

Although his marriage had failed, Allan reports that he has never encountered any sexual difficulties with his wife or any other sexual partners. He feels his sexual needs are within the normal range and this is confirmed by the results of the various assessment procedures.

Both the client and the partner are provided with a detailed explanation of the sexual problem encountered by Bernice, namely that the rape experience that she had experienced in her adolescence had induced considerable trauma and pain (psychologically and physically). She still associates the sex act which she had experienced within the rape situation to be similar as sex in a loving relationship and the 'fear' of this experience causes her tremendous anxiety.

Since many of the identified problems, both sexual and non-sexual evolve from Bernice's perception of the rape experience together with its 'sex-pain' association which is entrenched in her mind, it is decided that the best interventive plan is to deal with this 'mind-set' on an individual therapeutic basis. It is, therefore, suggested to the couple that it would be adviseable that Bernice attend individual counseling for a few sessions before proceeding with conjoint sexual therapy. Both Bernice and Allan are agreeable to this plan.

The rationale for recommending individual sexual rehabilitation counseling are as follows: (1) by having the client (Bernice) first overcome certain 'mind-set' perceptions on a one-to-one basis, the clinician believes that the client would feel less threatened of losing 'control' and of revealing her vulnerabilities in front of her boyfriend. If her boyfriend were present in a conjoint therapeutic situation, it would undoubtedly raise her already high state of anxiety to an unmanageable level due to her pattern of not wishing to reveal her 'true self' to others; (2) the one-to-one therapeutic relationship of a helping nature between the clinician and the client would allow for a better opportunity to establish a trusting relationship which, in the long run would be more beneficial in preventing resistance and obstacles from occurring during the conjoint sessions.

Sexual Rehabilitation--Treatment Strategies

'Table 2. Some methods of sexual rehabilitation' (Appendix X) by Jehu, illustrates the types of strategies and techniques which may be employed in a sexual rehabilitation program. These suggestions were incorporated into a treatment program together with the recommendations and advice espoused by the various authorities in the treatment of sexual aversion. Similarly, the recommendations from the readings on rape and multiple sclerosis conditions were also incorporated into a therapeutic treatment modality.

Behavioral Treatment Formulation

The following areas have been defined by the client and the clinician to require individual therapeutic intervention encompassing a sexual rehabilitation format:

(1) to reduce the level of anxiety by implementing some of the treatment strategies for sexual aversion as recommended in the literature reviews; (2) to educate and to raise Bernice's level of awareness on sexuality through the provision of information; the utilization of audio-visual aids; and by suggesting certain readings; (3) to correct any negative attitudes or misinformation which are impeding her progress in resolving the sexual aversion problem by implementing therapeutic intervention techniques such as: cognitive restructuring, thought-stopping, PLISSIT approach, etc. (Refer to treatment section for details); (4) to communicate and reinforce to the client that sex is an important way of conveying affection and caring and to help her to disassociate her perception of 'sex being painful' to 'sex as pleasurable'; (5) to present accurate information or clarify any misinformation that the client may have regarding the effects of MS on sexual fucntioning and to work on the adjustment and coping skills which are required in dealing with the MS condition in non-sexual areas. (Refer to literature reviews on effects of multiple sclerosis on sexual functioning and grief reactions to organic conditions); (6) to provide homework assignments which will include relaxation techniques, self-exploration of the body,

focusing on 'pleasurable' sensations in a non-threatening environment. To allow the client to maintain control (within reason); and not to place pressure for results. The rationale for this approach is discussed under the section on treatment for sexual aversion.

Method of Evaluation

The systematic record keeping procedures (Bloom & Fischer, 1982) is utilized in order that the clinician may deal with the multifactorial system such as those associated with a complex medical condition and sexual dysfunctional problem. Refer to literature review for elaboration on merits of this method of evaluating the client's progress.

The other methods which will be used in measuring progress of the treatment program is the self-monitoring method and periodical feedback and review sessions between the client and clinician. (This specific procedure is considered in order to closely monitor any changes in the client's cognition and subsequent behaviour). This is done primarily in order to prevent additional 'anxiety' from increasing within the client due to her own expectations of having to attain certain goals within a prescribed period of time. No formal contract for a set number of sessions is negotiated between the client and the clinician. It was left 'open-ended' in order that the client would not add to her present level of anxiety if she were not able to meet certain goals in a specified time.

Treatment Procedures

The treatment procedures followed the goals which were formulated between the client and the clinician. The clinician incorporated the recommendations from the literature reviews together with any theoretical constructs which are applicable to sexual rehabilitation. For instance, on the treatment of sexual dysfunctional problems of rape victims it was recommended that clarification on views on sexuality per se be implemented into a treatment program. This was done through various strategies such as information giving, cognitive restructuring, modification of attitudes, etc.

In order to change Bernice's sexual dysfunctional behaviour, it is essential to change her perception of sexuality and this necessitates convincing her that her sexual experience during the rape incident is not similar to the experience she will encounter within a 'normal' sexual relationship. This will entail providing Bernice with the assurance that the one sexual act she experienced during the rape incident represented deviant and violent behaviour whereas sexual activities between two people in a 'caring' relationship is an extension of their verbal communication and represents another form of expressing 'loving' feelings for each other.

Interestingly, Bernice states that she had never perceived that there was a difference between the two and she expresses her amazement at this new awareness. Additional information is provided in order to correct any

misinformation or myths she may hold regarding her sexual responsiveness and her medical condition. (Refer to merits of information-giving as an educational aid).

Detailed information regarding the sexual physiology and anatomy (didactic with diagram) and the sexual response cycle of the female and male are also provided at this time. Bernice states that she is totally unfamiliar with the 'normal' sexual response and sensations which emanate from various parts of her body. She expresses looking forward to experiencing these sensations.

As part of the homework assignment, it is suggested that she explore her own body in the privacy of her own bedroom. She subsequently reports that she finds the exploratory assignment to be both 'pleasurable' and 'comfortable'.

Self-examination of the genital area is recommended next. Bernice, upon completion of this assignment, reports that she does not feel revulsed. At this time, Bernice verbalizes her feelings of 'inadequacy' due to her lack of knowledge in the area of sexual arousal and the normal sexual behaviour leading to coitus. In order to provide her with additional information regarding the female sexual response cycle, sections from the book 'Becoming Orgasmic: A Sexual Growth Program for Women' (Heiman et al, 1976) is assigned. After reading the material Bernice reports having gained a better understanding in this area and overall, she reports feeling much more positive and confident about her own sexuality.

It is repeatedly reinforced to the client that the more knowledge she acquires in the sexual area and the more comfortable she feels with it, the greater the reduction of anxiety she should experience.

She relates that her boyfriend is very patient and he is not making any sexual demands on her. (This prohibition of coitus had been agreed upon at the time of the joint interview). She states, however, she is starting to feel frustrated as she wants to 'get closer' to him sexually but she admits she is 'afraid'. She comments that she is surprised at her desire for wanting this closeness. She also mentions that she wanted to spend the night with Allan again but had not because of her sibling's disapproval.

Bernice states she does not wish to displease her sister, in particular as she is reliant on her for the supportive care her sister provides for her. The fact that Bernice requires some physical and emotional support from her sister is acknowledged, however, it is emphasized that if Bernice is wanting to overcome some of her inner conflicts, she must work at being her own person and to make decisions which are suited to her own needs.

This incident presents an opportunity to deal with Bernice's problem of lowered self-confidence and self-esteem in a therapeutic context. She is provided with counseling in order to give her insight into these areas so that she can work at making the appropriate behavioural changes. Bernice has a tendency to make decisions relating to her daily activities based, for the most part,

on the expectations other people may have of her--in particular, her sister. This problem stems from her lowered self-esteem as well as not wishing to accept responsibility of being an 'adult' who is capable of making her own decisions.

Role playing and behavior rehearsal techniques are incorporated into the therapy in which she can 'act out' various ways in which she can deal effectively with situations she may encounter with her sister. If Bernice encounters negative feelings or heightened anxieties when she is rehearsing this practice confrontation, Bernice is shown how to reduce the anxiety by implementing various strategies such as relaxation training, cognitive restructuring and assertiveness training.

After six sessions of individual counseling in which the goals of the treatment plan are dealt with therapeutically, Bernice states she wishes to include Allan into the counseling sessions.

Evaluation of Progress--Individual Sexual Rehabilitation Counseling

The systematic record keeping method is examined continuously throughout the therapeutic interviews. It shows that the goals which had been formulated were systematically achieved. The self-report and feedback monitor evaluation which were also reviewed by the client and the clinician reveal that Bernice feels much more confident about her sexuality, self-esteem, self-confidence, etc. as a result of the counseling sessions, the information

which was derived from the assigned readings and from the prescribed homework assignments. Bernice also expresses feeling very comfortable about the client-clinician 'helping' relationship.

Conjoint Sexual Rehabilitation Program

Since Bernice is requesting that Allan be included into the therapy sessions, it is emphasized to her exactly what sexual counseling will encompass and that the couple would be required to include specific sexual assignments into the treatment program, eg. general pleasuring. Again, Bernice is asked to re-examine whether her religious beliefs on premarital sex might present obstacles in her acceptance and participation in the prescribed sexual assignments. She assures the clinician that her views will not hinder the proposed treatment plan.

Allan, Bernice and the clinician agree on a set of proposed treatment goals which are devised from the suggestions offered in the literature review for the treatment of sexual aversion due to rape trauma. These in turn are incorporated with the conventional sexual therapy model.

Treatment Plans for Conjoint Sexual Rehabilitation

In order to reduce the heightened anxiety that Bernice encounters, specific intervention models are used. These include: relaxation training, systematic desensitization procedures, increasing positive exchanges, communication training, assertiveness training, general pleasuring and provision of information. When Bernice's anxiety is

reduced sufficiently, it is hoped that she is able to engage in coitus.

Treatment Procedures for Conjoint Sexual Rehabilitation

The therapeutic intervention strategy of increasing positive exchange is assigned (see literature review under relationship enhancement). This strategy is incorporated with the general pleasuring assignment. The purpose of this exercise is to help Bernice overcome her anxieties due primarily to her lack of knowledge regarding the type of behaviour which is considered acceptable and pleasing to her partner in a sexual situation.

Specific instructions of the 'love days' strategy is provided where the client is encouraged to give pleasure to her boyfriend and subsequently receive pleasing behavior. As she proceeds to learn the techniques of exchanging pleasing behaviour (non-sexual at first), she gains more confidence in this area and subsequently her anxiety is lessened. Bernice reports that she is deriving considerable pleasure from these exercises and feels less anxious with Allan. Allan states he feels good about the exercises and has noticed considerable reduction of anxiety in Bernice.

Other therapeutic techniques are instituted gradually. These are assertiveness training, communication skills training and problem-solving training, focusing on the sexual behaviour. These treatment strategies allows Bernice to feel that she and her partner are 'working' together towards resolving the 'sexual' problem which was identified

while at the same time, the strategies allows her to maintain 'control' of the amount of tension she is able to tolerate. (The importance of the client being able to maintain 'control' is emphasized in the literature review on cause and treatment of sexual aversion).

Next, the first stage of the 'general pleasuring' task is assigned, however, in this case, with 'clothes on'. In the following session, Bernice is queried whether there were any negative or reoccurring thoughts about the past rape experience. Bernice admits that the rape scene had intermittently flashed in her mind whenever she perceived herself in a sexual posture. Bernice is taught the thought-stopping procedure whenever the rape scene is encountered. (Refer to literature review under treatment procedures).

Since Bernice states that she feels very uncomfortable with nudity in the presence of Allan, it is decided to gradually desensitize her through a series of planned assignments. The relaxation and desensitization procedures are incorporated into the therapy in order to fulfill the function of reducing anxiety and tension when clothing is being removed. (Refer to literature review under treatment procedures). Systematic desensitization procedures follows next and finally the 'in vivo' desensitization exercises where the couple apply the procedures in a life's situation. (Refer to literature review under treatment procedures).

The 'in vivo' desensitization exercise which is devised for this couple consists of working on a continuum

from the least threatening activity to the most threatening eg. the couple starts with cuddling; then when Bernice feels comfortable in this pose to stretch together on the chesterfield and cuddle, then to lie side by side, etc. It is recommended that clothing be removed in stages in order to keep anxiety at a minimum. It is emphasized also that Bernice may stop the tasks at any time.

In the next session, they both report deriving 'good' feelings from these assignments. This particular exercise is repeated two more times and on each of these occasions, no heightened anxiety is reported by Bernice--in fact, she reports feeling less tense each time. They state that they wish to proceed with further sexual assignments. In order to ensure that the reduction of anxiety has taken place, it is decided to repeat the same assignment two more times, starting with only panties.

In order to assure continued reduction of anxiety (which may be exacerbated by these assignments) constant monitoring (by the feedback method) is maintained of the couple's feelings, responses, attitudes, physical symptoms. They report feeling much closer to each other and state that their relationship is 'more stable' than ever before.

Their communication skills have improved considerably--both non-sexually and sexually and they attribute this to the relationship enhancement training (roleplaying, behavior rehearsal, communication training, assertiveness training) which were provided. Bernice reports she is

starting to feel very responsive sexually. She is noticing lubrication in her vagina.

During the next counseling session, the focus is placed on providing information in areas such as sexual anatomy, techniques in lovemaking, and enhancing intimacy. (Refer to literature review under treatment procedures). Since Bernice and Allan both express feeling comfortable and good about the results of the prescribed assignments, it is decided to proceed to the general pleasuring tasks without any clothing.

At this point, Bernice admits that she would like to have the sexual intercourse ban lifted and to have coitus included in the assignment. Allan expresses that he would like the prohibition lifted. Coitus is sanctioned, only if they both desire it. It is also stressed that to have coitus is not the goal. Bernice interjects, clarifying that she wishes to have 'permission' to have coitus if 'it lead up to it'.

Bernice expresses concern about the bladder incontinence which she may experience during coitus. She is advised to catheterize herself just prior to the sexual act. (Refer to literature review on effects of MS on sexual functioning).

In the next counseling session, Bernice reports having experienced considerable arousal, noticed flushing around the nipples, and felt more intense sensitivity in the genital area including lubrication. They encountered no problems in the assigned tasks. She did not feel tense

or anxious and they both wanted to 'go all the way'.

Allan was able to penetrate and continue coitus for a few minutes. Bernice states she stopped the act even though she was enjoying it as she started to experience overwhelming feelings of guilt once she became cognizant of her behaviour.

An additional problem (associated with her MS condition) occurred when she could not reinsert her catheter and consequently she encountered problems voiding. This experience frightened her considerably, thus raising her level of anxiety regarding participation in the sexual act. Therefore, it was decided to halt the conjoint therapy for the present time in order to re-evaluate the feasibility of this treatment strategy.

Since the problem appears to revolve around Bernice's intra-psyche conflicts, it is decided that only she will see the clinician. Individual counseling is again resumed with Bernice in order to investigate the extent that the guilt feelings play in her inability to participate in coitus.

Evaluation of Sexual Rehabilitation Program

Crucial to the entire problem is identifying whether Bernice's inability to have coitus is due to guilt feelings because of her strong religious beliefs or whether it is, in fact, an avoidance or an aversion which she is feeling towards the sex act. These issues are thoroughly discussed with the client. The following conclusions are drawn from the preceding treatment results. They are:

Bernice has come to enjoy the foreplay tremendously. She has progressed to a stage where she feels comfortable and is easily aroused by the sexual foreplay prior to penetration. She becomes lubricated easily and she desires coitus with her boyfriend. She no longer experiences negative 'flashback scenes' from the rape experience. Even on penetration, she states she found the experience 'pleasurable'. It is only when she becomes cognitive of having sex with a separated man that she becomes overwhelmed with guilt. Bernice explains that according to her religious beliefs, Allan is still considered to be married and to have intercourse with a married man is a sin.

The clinician suggests that Bernice spend a week re-evaluating the conflicts which she is facing and to make some firm decision regarding the direction that she wishes to proceed in therapy.

In the following session, Bernice reports that she and Allan had a lengthy discussion regarding her guilt feelings and the conflicts she is encountering. He expresses loving feelings towards her and that he is willing to do anything towards alleviating the obstacles which stand in the way of their relationship. Allan is agreeing to pursue obtaining information regarding annulment of his marriage.

Sexually, Bernice reports encountering no difficulties in becoming aroused, lubricated, etc. She states that she is wanting Allan to pursue the annulment procedures as she is wanting to complete the sex act with him. She adds that

his present marital status impedes this sexual expression on her part. She admits she is feeling much more open with him by being able to express loving feelings. She is starting to introduce him to her relatives.

Another session is arranged with both clients in order to discuss the outcome of the annulment proceedings. Due to conflict of time schedule, an appointment cannot be made with a religious advisor of her choice for several weeks.

Allan confirms that his 'loving' feelings for Bernice are still very strong, and other than not being able to complete the sex act, they enjoy each other's company immensely. He agrees that Bernice has no problems becoming sexually aroused, giving (manual stimulation) and receiving sexual pleasures.

Termination of Treatment

At this time, it is decided to re-evaluate the merits of continuing the treatment program. The clinician and the clients agree that since the problem which had been identified as causing the sexual dysfunctional problem; namely, sexual aversion, is no longer the primary source of the problem, it is decided to terminate the sexual rehabilitation program.

Evaluation of Treatment Program

Follow-up (Feedback method--one month after termination of therapy).

Bernice contacted the clinician by telephone stating that she and Allan had seen the religious advisor and he

had given them some hope towards proceedings for annulment. She reports their relationship is still very good. Although they do not engage in coitus, she is able to participate in other forms of sexual expression. She states she enjoys being able to demonstrate her loving feelings.

Follow-up (Feedback method--six months post therapy)

Bernice reports that their 'relationship' is still good'. She continues to enjoy participating in sexual foreplay, etc. She reports no feelings of aversion or revulsion. She still has considerable difficulties in dealing with the guilt feelings pertaining to vaginal-penile intercourse.

Follow-up (Feedback method--one year post therapy)

The client contacted the clinician in order to seek advice regarding certain communication problems which she and Allan are encountering. A short review of the communication training which she had received during the treatment program is discussed. In querying whether she and Allan are encountering any problems sexually, Bernice states that they have learned to adjust to a non-coitus situation.

Clinician's Observations and Comments

It is difficult to ascertain with precise accuracy that the guilt problems Bernice is facing is solely produced by her religious beliefs. This inability to participate in coitus may, in fact, be due to the clinician encountering difficulties in attaining 'extinction' of the original learning, that is, sex associated with pain and fear. This may be the case if Bernice's memory of the

rape incident precipitating the anxiety is very strong.

Equally difficult to ascertain is whether this problem may have been prevented or averted had it been revealed during the assessment procedure the extent to which Bernice's religious beliefs would have affected her ability to participate in the completion of the sexual act. The client herself states that she is amazed at how entrenched the teaching of her religion were instilled in her. She remarks that she did not anticipate this reaction to coitus until she was faced with the actual situation.

The methods of therapeutic intervention which were implemented for the treatment of sexual aversion seemingly produced reduction of anxiety for the client. Bernice progressed from being revulsed at the mere thought of sexual contact to a level where she could enjoy all forms of sexual foreplay and expression including coitus. It is only when she becomes cognizant of her religious beliefs that guilt sets in and she is unable to proceed with coitus.

The clinician is inclined to agree with Jehu (1979) who acknowledged that some dysfunctional clients misinterpret "religious dogma concerning sexual behavior or are unable to rid themselves of the guilt and inhibitions associated with moral or religious beliefs which they have long abandoned, and that the correction of such inaccurate information or the modification of such negative attitudes are often important therapeutic tasks of varying difficulty" (p. 188).

The information which was derived from the individual counseling sessions regarding Bernice's interpretation of the sexual standards of her religion, the clinician tends to conclude that Bernice does, in fact, have genuine beliefs in the moral standards of her religion and intends to adhere to them. In this particular case, "it would be improper for a therapist to try to persuade them otherwise, but the beliefs might impost significant limitations on the process and outcome of treatment for dysfunction" (Jehu, 1979, p. 189).

STUDY NO. 2

Wilma and Bob W: Sexual rehabilitation counseling with the wife of a patient with erectile disorder associated with cerebrovascular accident (CVA)

This is a case where conjoint sexual rehabilitation was requested for a post-stroke patient and his wife. Due to the severe emotional and psychological symptoms which are exhibited by the wife as a reaction to the husband's medical condition, a conjoint sexual rehabilitation program cannot be recommended. Instead a course of individual sexual rehabilitation (psychotherapy) is implemented using the behavioural approach. Prior to instituting a conjoint sexual rehabilitation program, the husband encounters further medical problems; namely, a myocardial infarction.

STUDY NO. 2

Effects of a CVA Condition on Sexual Functioning

It would appear that well-documented clinical studies on the sexual functioning of post-stroke patients have not been published (Kolodny et al, 1979; Renshaw, 1975), and this fact was substantiated by the lack of general information available in the literature search.

Cerebrovascular accident (CVA) or more commonly, stroke can be defined as "a symptom complex resulting from cerebral hemorrhage or from embolism or thrombosis of the cerebral vessels, characterized by alterations in consciousness, seizures and development of focal neurologic deficits" (Definition from Gould Medical dictionary, p. 284).

In order to fully comprehend the sexual problems which are encountered by the post-stroke patients it is essential for the clinician to be cognizant of the variety of physical manifestations that the patient may exhibit as a result of the stroke condition. These include: dysphasia, sensory deficits, hemiplegia, dizziness, blindness, dysarthria, and these physiological conditions would invariably affect the psychological-sexual functioning of the patient and/or the partner (Kolodny et al, 1979). For example, a resultant condition of the stroke condition such as a loss of sphincter control for some stroke patients can be an obvious source of psychological and sexual problems (Kolodny et al, 1979).

The sexual dysfunctional problems which are encountered by stroke patients are presumably dependent on the extent

of the cerebral damage. Renshaw (1975) stated that "unless the cerebral insult is very severe, the sexual response, both anatomically and physiologically, presumably mediated through the limbic system and spinal cord is usually spared" p. 68.

Sexual problems such as partial erections, impotence, ejaculation delay, retrograde ejaculation and decreased lubrication in the female can occur if the higher center of the autonomic nervous system has been damaged. However, Renshaw (1975) reported "these were unusual occurrences" P. 69.

Some sexual difficulties related to psychogenic etiology are: overwhelming fear of recurrent stroke; anxiety about performance; anger or feelings of resentment towards the partner. Most often, however, post-stroke sexual problems "reflect a combination of mechanical difficulties (poor motor strength or lack of co-ordination) and emotional factors such as depression" (Kolodny et al, 1979, p. 255). Depression to a clinical degree often occurred when the patient feels overwhelmed and helpless in adjusting to his disability (Kolodny et al, 1979).

The incidence of sexual problems were noted in several studies. In one report by Ford and Orfirer (1967) of 105 stroke patients under 60 years of age, 60% said their sexual libido was the same or greater, 43% had decreased frequency of coitus, 22% had increased coitus, and 35% gave incomplete information. Most of the stroke patients reported the same subjective sexual desire but

due to the partner's fear or abhorrence they had lessened opportunity to satisfy their desire (Kolodny et al, 1979).

Observations made in other clinical studies on post-stroke patients under age 60 and incidents of sexual problems were: (1) "decreased libido was more common in right side paralysis than in left-side paralysis" (Kalliomaki et al, 1961); (2) if the dominant hemisphere is damaged, diminished libido was common, but unlikely if the stroke affects only the non-dominant hemisphere (Goddness et al, 1979).

For those clinicians who work in a hospital setting or a rehabilitation center, several steps have been suggested in the management of the post-stroke patients in the matter of sexual adjustment. These are:

(1) The clinician arrange a pre-discharge conference with both partners in order to have an explicit, clear discussion of sexual functioning (Renshaw, 1978c).

(2) Prior to discharge from the hospital, the clinician should take a prestroke sex history, preferably with both partners present. Renshaw (1975) suggested "a good sexual history should always include details of alcohol intake" p. 74 since excessive alcohol can cause secondary impotence.

(3) The clinician should reassure the couple that according to the physician's report, pre-stroke sex can be expected but perhaps with some limitations (Renshaw, 1975).

For the client who is referred to the clinician after discharge from the hospital (where sexual counseling was not available), the clinician will have to depend on the pre-stroke sexual history which is provided by the client at that time in order to make a valid evaluation of the situation.

Crucial to any sexual rehabilitation program is the question of when the patient may resume sexual activity (or to limit sexual participation). This is, according to Kolodny et al (1979), difficult to generalize. The clinician may encounter a situation where the physician may have avoided mentioning to the patient that sexual activity may be safely resumed or have been vague about this topic. Kolodny et al (1979) recommended that until more research data are available, the clinician must proceed largely by "guesswork and inference" p. 256. Renshaw (1975) on the other hand, maintained that "the sooner the better for the patient's self-esteem and recovery" p. 74.

The medical data which is provided by the physician should enable the clinician to assess whether pre-cautionary measures restricting sexual activity should be enforced. For example, in the instance where the stroke was due to intracranial hemorrhage, the clinician should consider participation in sexual activity for the patient to be a theoretical risk, "since the possibility of re-currence of a bleed as a result of elevated blood pressure associated with high levels of sexual arousal is of

unknown magnitude" (Kolodny et al, 1979, p. 256).

Post-stroke patients with hypertensive condition require special consideration when formulating a sexual rehabilitation program, especially where drugs are required for the treatment of hypertension. (Refer to literature review on effects of prescription drugs on sexual functioning). The antihypertensive medications, in itself, may cause difficulties with sexual functioning or "lowering of libido, but these effects are often reversible with proper management" (Kolodny et al, 1979, p. 256).

According to Renshaw (1975), various reports have revealed that "internists differ widely in what they tell their hypertensive patients about future sexual activity and of sexual effects of antihypertensive medications" p. 68.

Other implications of post-stroke condition which should be addressed when conducting sexual rehabilitation counseling are as follows:

(1) For the left hemiplegia, in addition to motor weakness, there may be absence of or excessive sensation on the entire affected body side (Renshaw, 1975).

(2) Accompanying a left hemiplegia, a visual change condition known as homonomous hemianopia will prevent recognition of persons or objects in the range of the left outer and right inner semicircle of the visual field. Renshaw (1975) suggested that the clinician advise the partner making the sexual overtures to approach the patient from the intact visual field; in addition to using stimulating touch on the intact body half.

(3) The patient should be encouraged to give verbal feedback regarding the side of the bed he/she may prefer for optimal sexual agility (Renshaw, 1975).

(4) In order for the patient to cope with mechanical difficulties as a result of muscle weakness and unstable joints on the paralyzed body side, Renshaw (1975) suggested the use of pillows, a higher footboard, a handle on the headboard, or alternative coital position be considered.

(5) Emptying the bladder before sex should assist the patient with the problem of loss of sphincter control (Renshaw, 1975).

(6) Use of nonverbal cues between the patient and the partner should be encouraged where there may be some degree of speech loss (Renshaw, 1975).

(7) If there is mutual desire, the partner of the stroke patient should be encouraged to approach the patient. This would provide a tremendous boost to the patient's self-esteem to be considered sexually desirable (Renshaw, 1975).

A sexual rehabilitation program does not follow a rigid format but the therapy becomes one of addressing the physiological and psychological needs (attitudinal and interpersonal) of the individual patient and integrating these into an appropriate mode of therapy (Kolodny et al, 1979). Since each patient will vary in the extent of his/her physiological deficits, a highly individualized approach to management and rehabilitation is required.

CASE 2

ASSESSMENT REPORT

The following cites an example of a sexual rehabilitation case, whereas the wife of a patient with a complex medical condition became the primary client of the Sexual Dysfunction Clinic.

Wilma is a 41 year old wife of a CVA (stroke) patient, Bob, aged 45. She was referred to the clinician by an intern psychologist who was assessing the couple's psychological-social needs prior to the husband's discharge from the hospital. The psychologist had recommended sexual rehabilitation counseling for the couple since the wife was having considerable emotional and psychological difficulties coping with the present non-sexual situation.

This case is being reported as the events occur and progress. This sequential form of case reporting is typical in many of the cases which deal with clients with complex medical conditions, where the usual assessment-to-treatment format cannot be followed due to the multiplicity of factors which are involved or are created, eg. the partner's medical condition does not allow commencement of any therapy; no medical clearance is received from the husband's physician to commence with a sexual rehabilitation program, etc.

An interview session is arranged with Wilma in order to assess and identify the problem areas and to ascertain whether a sexual rehabilitation program is appropriate for this couple.

Description of Problem

According to Wilma, her husband is intermittently able to get an erection but on penetration, the penis becomes flaccid. She masturbates him to climax but he is unhappy about her having to do this. Oral sex does not satisfy him either.

Contemporary Influences to Problem

Situational antecedent

The sexual dysfunctional problem was precipitated by a CVA condition. The couple encountered no sexual dysfunctional problems prior to the medical condition. The sexual activities were an integral part of their relationship.

Organismic variables

Mrs. W. appears extremely nervous, distraught, and weepy. She states that she is so frustrated with the fact that she is not able to have sex with her husband that she is 'very depressed' and 'extremely anxious'. She has become to preoccupied with wanting sex that she is experiencing obsessive thoughts about finding it with any man.

Situational consequences

Bob is able to obtain intermittent erection, however, due to his physical disability (immobility, spasticity) he is unable to participate in sexual activities unless it is initiated by his wife. He also suffers from asphasia

which does not allow for verbal expression of loving feelings.

In order to cope with this problem, Wilma is starting to drink heavily again and says she feels 'trapped' as she cannot desert her husband nor is she able to continue to function living in the present manner.

Wilma's family physician, who is aware and sympathetic of the situation has prescribed some tranquilizers (Valium). As she is encountering considerable difficulties in daily functioning, the physician has referred her to a psychiatrist whom she is planning to see the following day.

Wilma is informed that it is not a wise policy for two professionals to be attempting therapy on the same individual. In order to expedite matters, the clinician advises Wilma that she will conduct a preliminary assessment which will help her to identify whether the main problems are related to the sexual dysfunctional area or to the other factors.

The assessment questions are focused on Wilma's immediate complaints in order to assist in making a preliminary clinical diagnosis and thereby identify the type of therapeutic intervention which should be undertaken. These questions focused on: brief family history; length of marriage; practical concerns; any prior sexual problems; past and present health problems on her part; whether she is presently taking other prescribed medications; relationship with husband prior to CVA: emotional and physical support from children or other family members; her coping

mechanism; her needs and desires; conflictual issues causing problems.

Since Wilma has identified her husband's medical condition as contributing to their sexual dysfunctional problems, a brief assessment is also undertaken (as suggested by Kolodny, 1979) of her husband's present medical condition, disability, physical limitations, any improvements or progress of sexual functioning, or any sexual limitations. The information derived from these questions assists the clinician to assess the following: (a) to what extent his medical condition is contributing to the sexual dysfunctional problems, and invariably to the spouse's present psycho-social and emotional state; (2) how much potential and motivation the husband and/or wife may have in participating in a sexual rehabilitation program, if deemed appropriate.

Due to the disruptive nature of her bio-psycho-emotional state, it is decided to conduct an assessment to grief reactions to loss and also an evaluation for the necessity of crisis intervention. (Refer to literature reviews on these subject areas).

Instead of following the usual assessment report which provides details of the assessment procedure, the clinician will instead provide a brief summary of her findings.

Summary of Preliminary Assessment

Wilma is faced with many life transitional crises which are of therapeutic issues: These are:

(1) Grief reaction to husband's medical condition.

(2) Non-acceptance and inability to cope with loss sustained by husband's CVA condition which is affecting the couple's whole life style, in particular their sexual activities. She states that the 'best' part of their marriage was the sexual interplay which they both enjoyed. He is no longer able to take a lead in the sexual fore-play due to his disability. Instead he is withdrawn and despondent when Mrs. W. interpretes this behaviour as a form of rejection of her personally.

(3) Wilma presently has to assume the independent role, when in fact she wishes she could remain in the de-endent role she had assumed prior to her husband's CVA condition. With this new role, she is required to make many decisions such as those revolving around finances, looking after the maintenance of the house, work, etc. which had previously been managed by her husband.

(4) She also has to discipline and deal with the children, who at age 21 and 18 are acting out their re-actions to their father's illness by being critical of their mother's behaviour and proceeding to 'pull away' from her rather than offering her emotional and physical support. Since the children do not willingly offer to help look after her husband, Wilma feels angry and resent-ful towards the children, which in turn, makes her feel very guilty and depressed.

(5) She is having an extremely diffcult time coping with all of the changes and adjustments of daily living.

The psychological stressors and the resultant unbalanced emotional state that she is experiencing are creating heightened anxiety and tension. Medications (Valium and Bellegral) are not helping to alleviate these symptoms. A sense of helplessness has set in and she is desperately seeking new directions.

(6) Her husband was discharged from the hospital and after having him at home for two weeks, Mrs. W. says she is feeling the tremendous burden of having to look after him. She works during the day as a waitress from 7 a.m. to 3 p.m. Her husband is provided with community home care support services during the day, however, Wilma must look after him the rest of the time, including weekends. She complains that she no longer has any time to be alone.

(7) Her husband shows his frustration and irritation and is very often depressed. He directs these feelings to Wilma, who in turn, tends to internalize them. Her attitude and perception towards life in general is one of feeling 'trapped'.

(8) Wilma has reported that their marriage was good prior to the CVA, in particular, the sexual part. In obtaining more indepth information from her, it becomes obvious that there were problems in the marriage prior to the illness. These problems are identified as: (a) very limited verbal communication between husband and wife; (b) no common interests between them; (c) lack of shared participation in different activities; (d) increased consumption of alcohol on both their parts.

(9) Wilma finally admits that she has been very dissatisfied with the marriage for a few years prior to this stroke condition and had even verbalized her concerns to her mother and to her husband. At the time, she had also been experiencing depressive episodes due to the 'void' she felt. She felt very close to her husband, however, whenever they were having sexual activity, eg. bathing together, touching each other, etc. She says she misses the physical contact and erotic interplay so much that she has become 'obsessed' with finding it again.

After acquiring the aforementioned information for diagnostic purposes, the client is given a feedback of the clinician's findings.

The client is going through all the stages associated with the grieving process of a sustained loss--husband's CVA condition which has affected his health, their life style including sex life, ability to work, etc. She has passed through the various stages: numbness, denial and is presently in the anger stage (Kubler-Ross, 1969).

She is showing symptoms of clinical depression--not sleeping; no appetite with considerable weight loss; weepiness; preferring isolation rather than being with others. The depression is being recognized by her family physician who is referring her to see a psychiatrist.

In addition to a brief diagnostic summation, the client is given the clinician's findings on the issues which should be recognized, addressed and resolved. For instance, the clinician explains that although the client

is craving for physical contact with 'any man', this longing is a manifestation of a deeper desire to share intimacy with someone. In essence, she is wanting to feel protected, cared for, and she is perceiving that she will find this through physical contact with any man. The clinician and the client discuss whether Wilma can, in fact, handle the feelings of guilt, inner conflicts and ostracization which would be resultant if she were to proceed to seek out someone for a sexual liasion other than her husband.

Wilma is informed that attempting conjoint sexual rehabilitation at this time is not adviseable as the treatment would undoubtedly put additional stressors on their relationship, eg. pressure for her husband to obtain an erection as Wilma perceives that an erect penis is the only satisfactory way to have coitus.

Wilma is advised that individual sexual rehabilitation (including crisis intervention and grief work) is probably the most appropriate mode of treatment which should be conducted at the present time. She can work at resolving the presenting conflictual issues while, at the same time, receive supportive counseling for coping, adaption and change (task-oriented or problem-solving model).

The clinician recommends that Wilma visit the psychiatrist as has been arranged. She is advised to explain to the psychiatrist the clinician's reluctance to do conjoint sexual rehabilitation on the couple at this particular time and the rationale for this recommendation.

The clinician also points out that in view of the multifarious problem areas which were identified, it would present problems if Wilma were to see two clinicians at the same time due to the divergent approaches to therapy. Wilma requests that she be able to meet with the clinician again after her appointment with the psychiatrist in order to discuss the direction she wishes to take.

At the subsequent meeting, Wilma informs the clinician that she had explained to the psychiatrist what this clinician had deemed to be therapeutic issues. He apparently identified similar problematic issues and he also agreed that only one therapist should be involved. He advised Wilma that he felt that the clinician would be better qualified to undertake the counseling since the clinician could continue to see the couple for sexual rehabilitation once individual psychotherapy was completed with Wilma.

Wilma announces that she wishes to begin therapy with the clinician. Before any firm commitment for treatment is made by the clinician, it is explained to Wilma that sexual therapy per se will not be attempted until the major conflictual issues which are present in her life are resolved or at least manageable.

Formulation of Treatment Plan (Wilma)

Wilma is assured, however, that the non-sexual situation which has been identified by her to be a major problem cannot be totally ignored until individual psychotherapy is completed and therefore some of the problems associated with the non-sexual activity will be addressed

during the individual sessions. It is emphasized that any counseling of a sexual nature will focus mostly on providing information related to relationship enhancement.

The clinician also agrees to provide education in the area of sexuality pertaining to the disabled (refer to literature review) in order that the information may help Wilma to gain a better understanding of her husband's medical condition and the resultant effects on sexual functioning. Individual psychotherapy sessions are agreed upon in order to assist her to resolve the issues which are identified to be of concern to her.

Treatment Strategies (Wilma)

(1) Grief work towards acceptance of loss. Provide 'active' listening, support, empathy (Kanfer & Goldstein, 1980) in Helping People Change.

(2) Implement crisis intervention strategies from Puryear's (1979) Helping People in Crisis.

(3) Stabilize client's unbalanced bio-psychological state by using relaxation training techniques, then provide modification of attitude techniques such as thought stopping, cognitive restructuring. (Refer to literature review in treatment procedures).

(4) Help the client to deal with her feelings of anger by allowing the client to ventilate her feelings of frustration regarding lack of sexual activity and reassure her that this reaction is normal under these circumstances. Provide her with hope that although 'normal' coitus may

not be possible at this time, give her assurance that alternate forms of sexual expression are possible and may be just as satisfying.

(5) Provide specific techniques for enhancement of communication between husband and wife, mother and children, etc. (Refer to literature review on communication skills training).

(6) Provide assertiveness training and suggest other task-oriented strategies in which Wilma can obtain children's support and co-operation for the physical care of their father.

(7) Provide information on the different resources which are available in the community, eg. bank manager, lawyer, etc. who can assist Wilma in handling financial matters.

(8) Advise on the hazards of consuming too much alcohol while ingesting prescribed medications such as Valium and Bellegral.

Results of Treatment Program

Each of the above areas of concerns were dealt with therapeutically, and by the end of the sixth therapy session, Wilma had reached a level whereas:

(1) She is more accepting of her husband's disabled condition and coping with the responsibilities this entails.

(2) She no longer requires tranquilizers.

(3) She no longer drinks excessively.

(4) She is no longer weepy or depressed. She seems to have an optimistic and happier outlook on life.

(5) She is adapting and dealing with her husband's physical deficits and is mobilizing various resources (which the clinician suggested to her) to help her in caring and entertaining her husband, eg. the children are taking turns staying with their father, while Wilma is enrolled in a typing course.

(6) She acknowledges that she is not expected to 'know everything', eg. she admits she does not know how to manage the monies as wisely as her husband and therefore she is seeking out a banker who can act as her advisor.

(7) She is resolving her 'obsessive' thought patterns of viewing 'normal' coitus as the one and only goal. Instead she is beginning to place more emphasis on the 'sharing and caring' aspects of their relationship. She initiates arranging and carrying out plans for outings, eg. going for car rides, to weddings, to a local pub to see old friends, and at present is in the process of planning a trip to California, pending physician's approval.

(8) Through assertiveness training, she has gained a tremendous amount of confidence in her abilities to be more assertive and is meeting each new problem she encounters with optimism instead of self-pity and defeatism.

(9) The sexual aspect is not disregarded however, the focus is minimized to didactic instructions. Information which is required regarding any sexual concerns or situations are provided, eg. how to facilitate sexual expression satisfactorily, incorporating the suggestions contained in the literature review on CVA and sexual

functioning. During each of the six sessions, a brief period of time is designated to discuss questions relating to the techniques of enhancing sexual communication. For instance, Wilma is encouraged to continue to make sexual overtures towards her husband thus building up his self-esteem. Even though he is not able to maintain a firm erection to penetration, she is encouraged to keep reassuring him that an erection is not important. (Refer to Renshaw's 1975 suggestions on CVA and sexual functioning).

It is explained to the client exactly how 'spectatoring' or 'performance anxiety' can contribute to or maintain secondary erectile failure. Also that anxiety can be alleviated by taking the emphasis off the 'act' itself with more attention being given on the 'feeling' level. This advice is stressed in order to ensure that the client will not put undue pressure on her husband to obtain an erection. Usually the clinician does not advocate or recommend that the couple participate in coitus unless the physician gives medical clearance, however, in this particular case, their physician (who was aware of the situation) had not prohibited them from undertaking this form of expression.

One can argue whether this particular aspect of therapy does not, in fact, approximate the 'conventional' sexual therapy. The difference between providing causal information of sexual problems and suggestions for sexual enhancement versus the provision of the actual sexual therapy is that no 'prescribed' assignments are given to

overcome or modify certain sexual behaviour patterns. Prohibition of coitus, as would have been the case in the conventional sexual therapy program is not enforced either, unless specified by the physician. The results of the above strategies produced the following:

Wilma was instructed and encouraged to give (and receive) positive behaviors to/from her disabled husband, as well as combine companionship activities and shared interests. As a result, the relationship was, according to the client, greatly enhanced.

Wilma devised many 'romantic' ways in which she and her husband enjoyed the pleasures of 'pleasing' and 'loving day' behavior. For example, while attending a wedding at a local hotel, Wilma booked a room in the same hotel in order that she and her husband could enjoy a 'second' honeymoon. She set the mood for romance, love, and sex, if it happened. She reports she placed no importance on the completion of the sex act.

During this particular weekend at the hotel, she relates that there were many erectile problems during their lovemaking, however, this was not important to her compared to the feeling of closeness and intimacy that their lovemaking produced. When the opportunity for 'normal' coitus presented itself, she 'backed away' from it due to her fears of endangering her husband's health. The clinician shared with her the information from the literature reviews regarding the precautions which are recommended during coital activity. (Refer to literature review on effects of CVA on

sexual functioning). The client was also advised to speak to her husband's physician regarding her concerns in this matter.

Evaluation of Treatment Program Results

At this point in therapy, the clinician and the client conducted a review and evaluation (by the feedback method) of the progress which was being made by the client. The clinician maintained the systematic record keeping procedure in order to evaluate the progress which was being made.

Wilma states that the individual psychotherapy sessions has given her the necessary insight of the problems and has also provided direction and guidance as to the methods of alleviating the many problems she was encountering.

As an indication of her changed attitude and perception, she comments that since she and her husband are sharing in so many activities, the necessity for a 'normal' sexual act has lessened considerably for her. She adds she does not feel lonely and is much happier with life in general. She claims that "for them to be able to have sexual intercourse 'normally' would be a bonus, but not a necessity".

Both the client and the clinician agree that it is appropriate to start with a conjoint sexual rehabilitation program. A letter is sent to the husband's physician requesting in-depth medical data regarding Mr. W's condition and prognosis. (Refer to literature review on importance of obtaining medical information). An explanation is given to the physician that the purpose of the therapeutic intervention is sexual rehabilitation for the couple. Since

Wilma's present bio-psycho-emotional status is perceived by the clinician to be an integral part of the total medical care of her husband's condition as well, a brief summary of the problems and subsequent counseling she is undergoing and the resultant changes in perception, attitude and behavior are provided to the physician. While awaiting a reply from the physician, supportive counseling is provided to the client.

Due to holidays and a heavy work commitment, the physician does not respond to the request for the medical information for approximately six weeks. During this interval, Wilma repeatedly expresses her eagerness to proceed with the conjoint sexual rehabilitation program. The client is informed that a sexual rehabilitation program cannot be undertaken for the couple without the physician's medical consent and the patient's medical data.

In normal practice, the clinician would request a referral from the physician before any involvement is given to any sexual rehabilitation therapy involving either the patient or the spouse of the patient. However, deviation from the normal practice occurred in this particular case, for the following reasons: (a) if Wilma is unable to deal with her own unstable bio-psycho-emotional problems through individual psychotherapy, then sexual rehabilitation for the couple would not have been an appropriate mode of therapy at the time; (b) at the beginning of individual therapy, the husband's medical condition was not at its optimum level of functioning. (Refer to clinician's

observations and comments for elaboration).

A referral letter is eventually received from the physician providing the necessary information regarding Mr. W's medical condition. According to the physician,

> Mr. W. suffered a right hemispheric stroke which resulted in severe left hemiplegia, asphasia and left homonymous hemianopia. There has been minimal improvement in the left arm and leg and asphasia. Left arm is non-functional. He is able to transfer and ambulate short distances with a tripod with supervision for safety. He is dependent for most activities of daily living. He is presently attending day hospital three times a week. Further neurological recovery is not expected and the severe neurologic deficit will probably be permanent. Other medical problems he had in the past was mild hypertension but his blood pressure has been normal at present and he is not on any medications. His cardio-respiratory status is stable.

The above information provided by the physician allows the clinician to examine the patient's total medical condition together with the extent of disability incurred by the CVA condition. The clinician is better able to make an accurate assessment of the patient's functional level, potentials and to translate these into an appropriate sexual rehabilitation program.

From the medical report, it can be assumed that Bob will not be able to actively initiate sexual interplay either physically or verbally due to paralysis of the left arm and leg and asphasia. For effective treatment outcome, the clinician must: (a) consider the limitations which might be imposed on the couple's sexual activities due to the physiological-neurological condition; (b) select an appropriate mode of sexual rehabilitation which will maximize his functioning level; (c) instruct the couple in the appropriate methods of sexual rehabilitation.

By integrating the suggestions offered by the various experts in this field (refer to literature review regarding management of stroke patients during sexual activity), a treatment program may be planned which will fulfill the sexual needs of the individual and invariably provide satisfaction to the couple relationship.

In order to institute a comprehensive sexual rehabilitation program, the clinician and the client decide to proceed with obtaining the other information which is required. An individualized history-taking session is conducted in order to establish whether any problems of a sexual nature had existed prior to the stroke condition.

The clinician deviated from the normal assessment procedure by having Wilma provide the information on behalf of her husband since Bob's speech is very garbled and his tolerance level for frustration is low. Up to this time, any communication regarding Bob's desires to participate in a sexual rehabilitation program has been conveyed to the clinician by his wife.

An earlier information-gathering session had not been initiated with the husband for the following reasons: (a) reluctance on the part of the clinician to build up 'hope' if his medical condition does not allow him to participate in a conjoint sexual rehabilitation program; (b) medical clearance had not been given by his physician; (c) Wilma's pre-psychotherapy attitude and perception on the necessity of 'normal' coitus had to change prior to considering a sexual rehabilitation program as 'performance

anxiety' and probable irreparable erectile problem may have resulted. The clinician did not wish to perpetuate the dysfunctional problem had Wilma continued to prescribe to these expectations.

In the following assessment procedure, the clinician had to deviate from the standard method of collecting information from the husband (due to his asphasic condition) and ask the wife to provide the answers for both of them. The reliability of the information provided on behalf of the husband is subjective to her interpretation of the situation. The purpose of conducting this assessment is to establish whether other causal factors (eg. negative attitudes, restrictive upbringing, religious beliefs, etc) may be contributing to or maintaining the continuance of the sexual dysfunctional problems by either of the parties. The basic information-gathering procedure is undertaken following the assessment format recommended by Jehu (1979) Appendix I and Appendix II. A shorter version of the assessment procedures are utilized for this report.

Assessment of Problems (Wilma and Bob)

Description of problem

Wilma states that she and her husband are not able to have satisfactory coitus due to his disability. This problem was precipitated by a CVA condition. Bob experiences erectile failure most of the time when coitus is attempted, however, there are times when he can get an erection firm enough for penetration.

Organic factors

Wilma was taking tranquilizers up until recently. She is enjoying relatively good health now.

Bob suffers from a severe CVA condition. Detailed information regarding his medical condition, extent of disability and prognosis is contained in physician's medical report.

Personal and family background

Both Wilma and Bob are church goers although they belong to different religious faiths. There are no conflicts regarding the teachings of their respective belief system versus their sexual practice. Wilma had been married previously (at age 18) but it was annulled by the church.

Wilma's mother is deceased. Her father is alive. He has been an invalid for many years. Her parents were separated when Wilma was 12 years of age. Both parents were religious. Her father worked in lumber camps while her mother was a housewife. After the mother and father separated, her mother went to live with her brother-in-law. Wilma and her father do not presently maintain contact with each other due to his alcoholism problem.

Bob's parents are both deceased. His mother died when he was 4 years of age. His father remarried but the stepmother left his father when Bob was 16 years of age due to the father's alcoholism problem. Bob's father was employed as a truck driver, mother's occupation was a domestic.

Wilma's childhood and puberty--sexual experiences

Wilma never received a formal sex education but 'learned on her own in the streets'. She started her menstrual periods at age 11. She first experienced petting, kissing, fondling when she was 11. She says she felt good about these activities. She started masturbating at age 14. She masturbated 'whenever she felt like it'. She experienced sexual intercourse at age 15 with a fellow she had been dating for a while. She did not know about birth control methods. She remembers the experience as being 'good' with no pain. Sexual activities with her steady date were intermittent. She suffered no traumatic sexual experiences.

Bob's childhood and puberty--sexual experiences

Wilma could not recall her husband stating he had had any sexual problems nor suffering from any sexual trauma in his childhood. This was later confirmed.

Wilma's sexual experiences in adulthood

There has been six different sexual partners before her present partner. She was married very briefly but due to difficulties in compatability, the marriage was annulled. She started dating her present husband when she was 18. He was 23. They met at work. She was attracted to his 'clear green eyes' and 'happy' nature. They went to many parties together and enjoyed each other's company immensely. When they had sex, the experience was good. She became pregnant after having sex with him a few

times. He insisted on marrying. She was one month pregnant when they were married. Pregnancy created some stressors in the relationship but there were no problems, sexually. They both enjoyed all aspects of the sex act. Prior to her husband's present illness, she describes their sexual experiences as being very erotic and stimulating, eg. drinking champagne while soaking in the tub together, etc.

Wilma states she wants to learn to accept her husband's disability, to cope with it and to help one another. She says Bob wants sex 'the normal way' as he has verbalized it many times.

Other Instruments Utilized in Assessment Procedures

The Sexual History forms (Appendix II) were completed by each of the clients. Due to the husband's vision problem and inability to respond verbally, the wife is requested to read the questions to her husband, and for him to indicate his response. (Some bias can occur with the wife collecting information of a personal nature, however, under the circumstances, there are very few alternatives).

The Dyadic Adjustment Scale (Appendix IV) is also utilized. All instruments show the scores within the normal range. Both individuals indicate respectively that they wish to have more sexual activity than they were receiving presently. Sexual activity appears to have played a very important role in this couple's life as a form of creativity, recreation and communication.

Formulation of Hypothesis

The aforementioned assessment procedures (following Jehu's (1979) suggested outlines of questions, with some alterations, together with the other instruments, enables the clinician to arrive at a hypothesis or a clinical diagnosis--that is, that the erectile difficulties were more than likely due to the organic etiology since onset of the problem occurred after the CVA condition. There is nothing to indicate that the couple's past sexual experiences or upbringing would have contributed to the sexual dysfunctional problem. However, the fact that the husband is able to have intermittent erections, firm enough to penetrate, indicates that there is likelihood of some psychological components involved in the maintenance of the sexual problem. Sexual rehabilitation is recommended as an appropriate method of treatment.

Formulation of Sexual Rehabilitation Treatment Plan

The clinician and the wife discuss the manner in which a treatment plan for sexual rehabilitation can be formulated. The treatment plan will follow the suggestions made in Jehu's outline on 'Methods of sexual rehabilitation' (Appendix X). Various modifications and changes will be required to the components in order to 'fit' the individual's psycho-emotional-social needs while at the same time addressing the medical condition and its implication on sexual functioning.

The strategies and techniques which are to be utilized takes into account Mr. W's special needs. The

sexual rehabilitation program which is agreed upon by the clinician and Wilma consists of: (a) provision of information on sexuality; (b) relationship enhancement--especially on couple's verbal and non-verbal communication skills; (c) sexual education through use of audio-visual aids, eg. 'Touching' which explores alternative forms of making love; (d) specific love-making techniques prescribed for CVA patients (as discussed in the literature review) in order to accommodate the client's physical deficits and limitations. This will expand the information which has already been provided to Wilma during her individual psychotherapy sessions.

Assessment of Motivation for Sexual Rehabilitation

Since so much time has elapsed since Wilma had first requested a sexual rehabilitation program to the date of treatment planning, she is asked to reaffirm her feelings towards the program of treatment which is presently being formulated. She reiterates that she and her husband are still very enthusiastic about going ahead with the program. Since the husband is unable to come to the clinician's office without great effort (requires special transportation for wheel chair), it is decided that the clinician would meet with the couple at their home on a designated date.

Since the outcome of any rehabilitation program is dependent on the partner's psycho-social-emotional well-being, frequent inquiries are made regarding any changes which may be noted in the husband's medical condition,

attitude, physical abilities, etc.

Changes which have occurred recently are as follows: Mr. W. is now walking with a cane, for short distances. The speech therapist is indicating that there is improvement in his speech. There is a definite improvement in his overall attitude, he laughs more often. He is not as depressed as before. He takes great pleasure in planning and participating in outdoor activities, eg. he enjoys going for rides in the car, stopping for ice cream. His latest example of self-sufficiency is going shopping (with the help of his children) for his wife's birthday gift.

Since both individuals are making good progress in their psychological-emotional adjustments to the CVA condition, it is decided to start the sexual rehabilitation program the following week. Just one day prior to the first therapy session, however, the husband's physical examination reveals elevated blood pressure. After seeing the physician, Wilma brought her husband to meet the clinician. This meeting presents an opportunity to personally assess whether the clinician would be able to communicate with the husband. He has considerable difficulties with his speech (extremely slow and very garbled), however, it is understandable. The clinician also took the occasion to explain to the husband exactly what the treatment program will encompass and he shows much enthusiasm about starting therapy immediately. Due to the elevated blood pressure readings, however, it is agreed unanimously to postpone therapy until further test results

are available to the physician. Bob is assured that at no time would any form of activity (sexual or other) be suggested where his health might be jeopardized.

Termination of Treatment

Two weeks later, the wife contacted the clinician to inform her that Bob had suffered a seizure and a myocardial infarction and had to be hospitalized. It is decided that any plans for conjoint sexual rehabilitation must be postponed indefinitely until his medical condition is stabilized. The physician would, once again, be requested to provide the medical clearance that there are no physiological dangers involved in proceeding with a sexual rehabilitation program. Wilma is assured that the clinician will be available for any supportive counseling regarding her husband's present condition.

Clinician's Observations and Comments

This case exemplifies a situation where the clinician (due to extraneous circumstances) is not able to proceed with the normal assessment procedures or to follow through with a planned sexual rehabilitation program.

Whenever a crisis exists, whether physiological, psychological, emotional, or social, it is imperative to give priority to the prevailing issues and to bring the situation under control, eg. Wilma's psycho-emotional problems in accepting and coping with her husband's CVA condition had to be stabilized and her daily functioning level had to be manageable before conjoint sexual

rehabilitation could be attempted with the couple. To proceed with conjoint sexual rehabilitation in her unstable state together with the perceptual and attitudinal problems she was encountering, would undoubtedly have had undesirable effects to the outcome of any planned conjoint therapy. To proceed with conjoint sexual rehabilitation first or to initiate individual psychotherapy (including some components of sexual rehabilitation) is a judgment which must be made by the clinician.

It is also noted that when any medical condition exists, the most up-to-date information regarding the patient's physiological problems, neurological and physical deficits or limitations, etc. are essential as it allows for the most accurate evaluation when addressing the question of whether to proceed with a conjoint rehabilitation program. This fact is important to the assessment-treatment procedures, as the patient's physical condition (sensory, ambulatory, responses) can change drastically with any type of active treatment program which is presently being administered, such as physiotherapy or occupational therapy. Any changes in the person's physical or mental status will, of course, reflect on the type of sexual rehabilitation program which is to be implemented, eg. if Mr. W's mobility and ambulation improves, then it can be presumed that he can take a more active role in initiating some sexual activity than if he requires assistance in transferring.

Through the experiences gleaned from this case, it has become obvious that whenever any illness or condition becomes acute, that sexual rehabilitation per se must be postponed and continuation of the treatment program must take a secondary role due to the health hazards it may impose. This is especially true for organic conditions of a cardiovascular nature. At no time must the client be exposed to any risks which may contribute to or exacerbate the medical condition.

In this particular case, although a 'formalized' sexual rehabilitation program cannot be presently continued with the couple, it is felt that Wilma has gained sufficient awareness and knowledge from her individual therapy sessions which should allow her to deal with most situations (sexual or non-sexual) that she may encounter.

STUDY NO. 3

Frank and Amy: Erectile difficulties associated with back problems and marital discord

A case demonstrating the importance of the assessment procedures in evaluating whether the sexual dysfunctional problem was caused by an organic condition, namely; chronic back pain or whether marital discord precipitated or contributed to the sexual dysfunctional problem.

Effects of Chronic Back Pain on Sexual Functioning

Various authors cited many potential causes for both acute and chronic back pain. Eighty-one percent of all back pain have been shown to be due to muscle weakness and inelasticity (Friedman, 1980). Other less common causes of back pain may be herniated intervertebral disc with sciatica. The resultant symptom common to almost all back pain is "muscle spasm causing a vicious cycle to pain leading to further muscle spasm which acts as a biologic splint, protecting the back against movement" (Friedman, 1977, p. 65.

In the case of chronic back condition, where pain, weakness, and easy fatigability are often involved, sexual dysfunctional problems become even more likely (Osborne & Maruta, 1980). Although Kolodny et al, (1979) did not make specific reference to back pain, they acknowledged that pain was likely to "affect the sex drive of a man or a woman, just as it would reduce their desire to engage in other forms of physical exertion" p. 237. Anticipation of pain or pain itself are known to interfere with the buildup of sexual arousal (Jehu, 1979; Osborne & Maruta, 1980).

Osborne & Maruta (1980) cited the results of a 'frequency of sexual problems' study which monitored the sexual activity of 66 married patients who were referred to a pain management center. These patients had non-malignant chronic pain for six months or longer. There were no specific medical or surgical approaches used.

The study revealed approximately 2/3 of these patients reporting deterioration in sexual adjustment and more than 1/3 reporting deterioration of non-sexual aspects of marriage as well. Frequency of sexual activity in both men and women were reduced after the onset of pain problem.

This study also revealed that in female pain patients, the most common sexual problem was difficulty in reaching orgasm. Complaints of loss of interest in sex and difficulty becoming aroused followed closely. Men were more affected than women. In male patients, difficulty getting and maintaining an erection was the most frequently reported problem, followed by loss of interest in sex (Osborne & Maruta, 1980).

In another research study on 'The effect of chronic pain on sexuality', Goad (1978) found that "sexual expression can be affected by chronic pain. Half of the subjects reported difficulties in their sexual relationship because of pain" p. 242.

Among the implications of chronic back pain to sexual problems are: pain and sexual avoidance; increased distance between partners; anger and guilt; medication; emotional factors; attitudinal factors (Osborne & Maruta, 1980).

Pain and sexual avoidance

The patient experiencing painful sexual experience or increased pain as a result of physical activity involved in sex will gradually, as a matter of defence, lose

interest in sexual activity (Osborne & Maruta, 1980). Fear or anticipation of injury (even when pain is not an immediate problem) will distract the patient sufficiently to change his sexual behaviour (Osborne & Maruta, 1980).

Increased distance between partners

This can occur either physically, psychologically or emotionally as a response or reaction to the chronic pain which is suffered by one of the partners. For instance, if the well-partner makes sexual demands to have her/his needs met, the well-partner may feel guilty and decide instead to avoid any sexual contact. The pained partner may, at the same time, interpret this as rejection. This situation could easily be reversed in that the pained-partner may avoid sexual contact in order to avoid pain symptoms and the well-partner may interpret this as rejection (Osborne & Maruta, 1980).

Anger and guilt

These emotions are often felt by the well-partner when the pained-partner is unable to work or perform daily tasks such as the housework and the increased burden falls on the healthy partner. The anger and frustration are often unexpressed with the well-partner feeling it would be unfair to express feelings of resentment towards the pained-partner. Osborne & Maruta (1980) also stated that the "guilt felt by the healthy partner over the anger interferes with the communication and in doing so, reduces the closeness of the marital relationship" p. 99.

Medication

Analgesic medications which are taken at a high dosage can interfere with the patient's daily life as well as sexual functioning. Although the medication may reduce the pain sufficiently in order to make sexual activity possible, it also diminishes the ability to become aroused. 'Preoccupation' for the next dose of medication, can impede the development of sexual interest (Osborne & Maruta, 1980).

Emotional factors

Depression is common with patients with low back pain and is a significant factor in loss of sexual desire (Osborne & Maruta, 1980). This is often due to impaired self-concept as a result of not being able to mutually contribute to daily tasks and share recreational activities with family members.

Attitudinal factors

When any of the aforementioned factors exist either singularly or in combination, it can create loss of interest in sexual activity; cause impotence and create difficulties in the ability to reach orgasm (Osborne & Maruta, 1980). Once the individual sees himself or herself with a sexual problem, then there is an attitudinal change in his/her self-concept.

Sarno's (1980) etiologic and pathophysiological concept of chronic back pain differs from most of his colleagues in that he attributed chronic back pain in most patients as "result of a psychophysiological process

in the muscle and nerve tissue which is derived from conflictual states rooted in certain personality characteristics" p. 113.

Sarno (1980) reported that "chronic anxiety, depression, loss of self-esteem, anger and guilt are universal in people suffering this disorder and clearly contribute primarily to the individual's inability to engage in normal sexual activity" p. 113. He also noted that "the sexual dysfunction might very well have preceded the onset of persistent back pain in some of these patients" p. 113.

With these differing views on the causal factors on back pain and its effect on sexual functioning, it is imperative that an accurate diagnosis as to the origin of the back pain be made by a physician. This information should enable the clinician to arrive at an accurate clinical diagnosis of the etiology of the sexual problem and to subsequently formulate an appropriate management or treatment program within the realm of sexual rehabilitation.

Management or Treatment Program of Back Pain and Sexual Functioning

With Sarno's (1980) particular view on the cause of back pain, he suggested that a lengthy, integrated program of psychotherapy and physical therapy be undertaken in order for all spheres of activity including the sexual to return to normal.

Friedman (1977) suggested psychological testing such as MMPI (The Minnesota Multiphasic Personality Inventory) be given to the patient so that psychological factors may

be revealed aside from the organic cause. This is important in view of his comments that "backache is used as a way of punishing and manipulating the spouse" (Friedman, 1977, p. 66). Counseling was recommended for every patient with back pain in order "to determine his or her reaction to pain in general and whether the patient has a tendency to somatization" (Friedman, 1977, p. 66).

Osborne & Maruta (1980) suggested that "a general program focusing on the rehabilitation of the chronic pain patient is frequently the best approach to sexual problems" p. 102. They prescribed to a total rehabilitation of the patient which included: increase of physical exercise in order to build up tolerance; learn coping mechanisms to deal with chronic pain; and the involvement of the spouse in the rehabilitation program (Osborne & Maruta, 1980).

Once the couple is able to have mutually pleasurable intercourse, they suggested "the most frequently recommended coital position for back pain patients is the rear-entry position with both partners on their sides. Some physicians also suggest that the patient with back pain minimize the amount of pelvic thrusting" (Osborne & Maruta, 1980, p. 107).

Effects of Marital Discord on Sexual Functioning

Although the relationship between sexual functioning and marital happiness has been a subject of much theoretical debate, Hartman (1980) pointed out that it has received little attention in scientific literature.

It is not always obvious to what degree marital and sexual factors interact in a relationship and clinicians have varied in their findings in this area (Hartman, 1980; Sager, 1974). Ables (1977) viewed sexual dysfunction problem as "experiences of underlying dynamics in the relationship rather than the cause of marital conflict" p. 576. In other words, secondary as the result of problems in other aspects of the couple's relationship. Nonsexual marital distress may also result from sexual dysfunctional problem.

According to Sager (1974) the "manifestations of marital discord are infinite, but the most common complaints are usually symptomatic of the unconscious aspects of the couple's relationship, of their deeper disappointments and frustrations, and not necessarily the basic etiological factors that cause the marital discord" p. 502.

Green (1970) listed the ten most complaints of couples seeking marital counseling as: (1) lack of communication; (2) constant arguments; (3) unfulfilled emotional needs; (4) sexual dissatisfaction; (5) financial disagreements; (6) in-law trouble; (7) infidelity; (8) conflict about children; (9) domineering spouse; (10) suspicious spouse (in that order). Sager (1974) commented that 'sexual

dissatisfaction', the fourth most frequent complaint in Green's study may "be related to most of the others" P. 502.

Hence, when the assessment procedures reveal that sexual dysfunctional problems and partner discord coexist, the clinician is faced with the decision whether to pursue sexual therapy or to refer the couple to a therapeutic program which includes marital or individual therapy. The clinician must also determine whether to conduct marital therapy consecutively or concurrently with sexual therapy (Jehu, 1979).

This could be a perplexing decision since few cases are so clearly defined as either sexual or marital. And yet the approaches for sexual therapy with its specific goal-directed focus of "overcoming of the sexual dysfunction and that alone" (Sager, 1974, p. 504), are different than marital or individual therapy.

Evidential data on the beneficial effects of marital therapy on sexual dysfunction does not appear to be available (Jehu, 1979). Jehu (1979) stated "in the present state of knowledge there are no well founded guidelines as to which of these several possible courses is likely to prove most beneficial to an individual couple" p. 180. He recommended "the capacity and willingness of each of them to participate and cooperate in a programme for the direct treatment of sexual dysfunction" p. 181 as the bases for assessing the general relationship. The quality of the relationship would invariably influence the degree of involvement in the treatment and subsequently affect

the outcome of the treatment.

Caird & Wincze (1977) found that in 50% of the male sexual dysfunction cases, the wife has proven to be an interfering variable. They stated, however, that a clear explanation was not available as to the preponderance of problem of the 'interfering' or 'unco-operative' wives.

Sager (1974) has identified three general categories of marital discord relative to sexual dysfunction. These categories, it would seem, would also be helpful in evaluating if and when sexual therapy is appropriate. These are:

Group 1--Where secondary discord within the relationship is provided as a result of the sexual dysfunction. Sex therapy is usually the recommended choice of treatment (Sager, 1974).

Group 2--This group is the most common and comprise of couples who have some degree of marital discord which cause impairment to their sexual functioning. If the couple possess positive feelings and have a desire to improve their sexual functioning, then sexual therapy is indicated. However, the positive aspects must outweigh the negative aspects of their relationship (Sager, 1974).

Group 3--Comprise of those couples where severe discord exists with basic hostility. Sex therapy is not likely to be successful because the couple cannot corroborate in the program geared for the 'rapid' treatment of the sexual dysfunction. (Sager, 1974). "Sabotage may ensue, or frank desires not to proceed further may be expressed or psychiatric or other psychomatic symptoms may develop that

necessitate terminating sex therapy. In these cases the motivation to help oneself or one's mate to improve sexual functioning is not strong enough to keep the anxiety or hostility under control. Instead, treatment offers another opportunity for the hostile or overly anxious partner to prove that his mate or he is a failure" (Sager, 1974, p. 512).

Sager (1974) cautioned clinician who are faced with a situation of severe discord and hostility, not to proceed with sexual therapy. He also advised that sex therapy is not feasible when the sexual dysfunction results from rejection of one partner by the other or where the rejecting spouse is seeking to end the relationship but has not made his/her position known, as there would be no motivation for treatment.

A study by Mathews et al (1976) of 36 dysfunctional couples provided some empirical support for an association between partner discord and lack of success from the direct treatment of sexual dysfunction. They reported a "significant tendency for less change in sexual functioning to occur when the initial general relationship is poor" (in Jehu, 1979, p. 182).

CASE 3

ASSESSMENT REPORT

Frank was referred to the Sexual Dysfunction Clinic by an urologist. In the referring letter, the physician stated that Frank had a two-year history of sexual problems.

A clinicial supervisor interviewed the client for the preliminary assessment. Frank was considered a suitable candidate for the Clinic and was referred to this clinician.

Following the assessment guideline suggested by Jehu (1979), Appendix I, the clinician proceeded to conduct an information-gathering interview in order to obtain sufficient data to make a clinical diagnosis as to the etiology of the sexual dysfunctional problem. The client was interviewed by the intern clinician on two separate occasions and the following is a summary of the findings from these interviews. At the completion of the initial interview, the client was requested to complete the Sexual History Form (Appendix II), and the Dyadic Adjustment Scale (Appendix V).

Description of the Problem by the Client

For the past three years the client has been unable to get a full erection unless he is completely rested. The erectile difficulties are situational. He is able to obtain waking or resting erections. Frank has desire for sex and he is able to attain a full erection for five minutes, however, when coitus is attempted with his wife,

his penis becomes flaccid. Frank states that his wife is not responsive to any foreplay and that she is very 'cold' to any attempts at sexual activity on his part. Although he says his wife will not discuss the problem with him, she is agreeable to come in for therapy.

Contemporary Influences on Problem

Situational antecedents

Frank states that he and his wife, Amy enjoyed good sexual relationship until he sustained a back injury at work seven years ago. After the back injury, he apparently felt extremely tired and slept a great deal of the time upon returning home from work. Sexual activity was severely limited due to the back discomfort and the rest period he required. He also experienced penile pain whenever he attempts to penetrate.

Organismic variables

Frank expresses feeling very nervous, irritable and tense as the result of not having satisfactory sex with his wife. He cannot understand the reason his wife, Amy is being so unresponsive to his sexual overtures. He thinks she should be more compassionate and understanding of his back problems. He is not able to verbally communicate his sexual needs to his wife.

Organic factors

In the referring letter, the physician stated that Frank has a two-year history of sexual dysfunctional

problems. Frank has experienced severe low back and left thigh pain and had received Depomedrol injection into the L5 nerve root. Since his injection he is only able to obtain a satisfactory erection after resting for a period of twelve hours. The physician is also seeing him for a hydrocele condition. Frank enjoys relatively good health otherwise, is on no medications. No high alcohol consumption is reported by the client.

Situational consequences

Frank says his wife has become very frustrated and angry with him, however, she does not express her anger openly. There has been no foreplay (kissing, petting) before having coitus for the last two years. Frank states just being close to Amy or touching her 'turns him on'. 'Turn off' is when she does not respond. He wants to receive love from her. Although she has said she loves him, he no longer believes this as there is no show of affection such as kissing or cuddling. Recent frequency of 'attempted' coitus is less than a few times a month.

Personal and family background

Frank is 42 years of age and his wife is 36 years old. Frank was recently laid off due to a strike dispute at the company where he was employed. His occupation was that of a machine operator while Amy works as a technical operator.

Frank was raised in a fairly strict religious family in rural Manitoba. His mother died when he was 12 years old and his father remarried when he was 14. He received

a Grade 8 education. He left home to go out to work at age 15. He has three siblings. He views his childhood as being happy and close--receiving affection from both parents.

As his mother was sickly with a heart disorder, he received most of his disciplining and advice from his father. Frank felt equally close to both of his parents. He presently maintains a 'visiting' relationship with his father and stepmother. Frank feels closer to his wife's parents who reside in the same house as he does. They live in separate quarters.

Frank attended a country school and professes to have been average in popularity. His friends at school consisted of both girls and boys. His favorite recreation as a child was baseball. He does not recall ever playing any sex games as a child nor had he watched anyone else involved in sexual activity. He was 16-17 years of age when he first experimented with masturbation, but he did not pursue this activity very often. He has never masturbated since his marriage.

He had his first nocturnal emission at age 19 and his reaction to this was 'mad'. He did not discuss this with anyone. He received his sexual knowledge from the streets, having never received any advice from his parents. As his parents never discussed sexual matters with him, he did not know what their attitudes were towards sex.

Frank never had any homosexual opportunity. He started dating when he was 19-20 years of age and this consisted of going out in groups rather than on single dates. The most popular recreation on a date was drinking, going

to drive-in movies, and dancing. He never steady dated any longer than six months until he met his present wife at age 30. He participated in everything from kissing to coitus prior to marriage. Contraceptives were never used.

Frank was seriously involved with a woman before meeting his present wife and had fathered a daughter. This woman subsequently went south to work and gave up the child who would have been 16 or 17 years of age now. Frank did not encounter any sexual difficulties in the various relationships prior to marriage.

Sexual and marital history

Frank met his wife when he came to visit a friend living in Winnipeg. The qualities which attracted him to Amy most which led to marriage were: 'nice, gentle, lady-like'. She was 24 years of age. He maintains she still possesses the same qualities which existed prior to their marriage. He was 30 years of age when he met his wife.

During their first year of marriage, they encountered no problems regarding lovemaking or sex. Frequency of coitus was twice weekly. However, due to his occupation in construction which required him to work out of town, there were periods when he was gone for three months at a time.

The couple have been married for 11 years. They knew each other for 1½ years prior to marriage. Pre-marital sexual experiences were good.

Amy has a son from a previous relationship. He admits having good feelings towards her son. This is the first

and only marriage for both individuals. They have a daughter, aged 9 years of age. Frank views his marriage as being 'good' in other areas than sex.

Frank and Amy both attend the same church. The wife presently works shift, and she enjoys her job. She is making more monies than he is even when he is gainfully employed.

He does not think his wife is involved in any extra-marital sexual activity, and he denies any involvement with anyone else. Any leisure time they spend together is spent watching television. She goes out with the girls more often now; in fact, does not come home 'too early'. He gets along well with her family who live downstairs in the same house. This arrangement presents no problems as her parents do not interfere.

Frank chooses the time for lovemaking. He has tried everything but Amy does not respond to him sexually and is 'cold'. She used to express her sexual desires but she no longer approaches him, nor do they exchange any verbal communication as to what pleases or displeases them sexually.

Motivation for treatment

Frank states that he and his wife cannot solve their own sexual problems, therefore he is seeking the help of the Clinic. As he is presently unemployed, he is able to attend therapy at any time, however, Amy works shift and therefore therapy will have to fit into her schedule.

Hypothesis of Problem

At the end of the assessment interviews with Frank, the clinician formulates a preliminary diagnosis from the data which was gathered from the assessment procedures. Plausible causal factors contributing to the sexual problem are: (a) organic condition; namely, chronic back pain; (b) marital discord; (c) combination of both. In order to establish the extent or severity of the marital discord which exists within this relationship, the wife is requested to come in for an assessment interview and to also complete the other instruments.

Amy agrees to participate in the assessment procedures. She is requested to complete the following instruments in addition to the information gathered during the assessment interview. She completes the Sexual History Form, Dyadic Adjustment Scale, Sexual Arousal Inventory, Semantic Differential Test. Refer to assessment procedures for explanation on use of each of these. The results of these instruments assist the clinician to further corroborate the hypothesis which has been derived by the clinician.

Assessment (Amy)

Definition of the Problem by Amy

Amy reports that she no longer wants to have sex with her husband. In fact, she says she would like to end the marriage, if it were not for the children and her parents. She likes her husband as a 'friend' and has told him that she feels 'nothing for him sexually' about one

year ago. The problem began shortly after their marriage, with his extreme tiredness and not wanting any sex, even when she begged him. Later he began experiencing considerable pain whenever he had an erection which curtailed their sexual activity even further.

Contemporary Influences on Problems

Situational antecedents

Amy states lovemaking and sex was good prior to their marriage and she remarks that they had 'fun'. However, shortly after they were married, she began to feel that the whole sexual act was a 'bother to him'. He was unresponsive which depressed her arousal and 'killed any natural feelings' she had for him, sexually.

When he injured his back 7 years ago, he experienced considerable pain when he attempted coitus. Amy says he always felt very tired when he was at home and would go to lie down as soon as he arrived home from work and go to sleep. Up to a period of three months would pass before he would even show any interest in any sexual activity. Although she repeatedly asked him what the problem was, he never explained. She asked him to go see a doctor repeatedly, but he always refused. This condition persisted for many years until he finally consented to see a doctor and he received treatment which helped alleviate the pain. However, he is now encountering problems getting and maintaining an erection.

Organismic variables

Amy felt 'unattractive' and very humiliated and rejected when she had to 'beg' her husband for sex shortly after they were married. She is shy and does not have a good self-image of herself. (This is confirmed by the results of the Semantic Differential Test).

Amy cannot contain her emotions during the interview and she starts to cry and is tearful throughout most of the interview session. She expresses her anger at: (a) her husband for not seeing a doctor sooner. His reason for not going to see one was due to the fact that he was told that he may require a back operation and was fearful of this--instead he continued to see a chiropractor; (b) at the situation she finds herself presently because she cannot leave the marriage due to guilt feelings revolving around her children and her parents. She expresses feeling 'very trapped'.

Organic factors

Amy says she is feeling very depressed about the whole situation. She is not receiving any medical treatment. Her sleep pattern is normal and eating habits appear normal. She smokes more than previously.

Situational consequences

Amy admits to being 'unresponsive' and 'cold' to her husband. When she informed him that she no longer loved him about a year ago, his behavior changed. He became very jealous and questioned her activities constantly.

She says the situation is worse now than ever before and she feels like a prisoner. Amy is feeling very frustrated at the lack of intimacy with her husband and she states she has gone out with friends in order to alleviate the loneliness. She denies having any extramarital affairs.

Personal and Sexual History

Amy is 36 years of age. She was born on the continent and came to Canada when she was 16. She feels very close to her family of origin. She received a Grade 8 education. She attended a school in the city but did not feel she was popular. Her favourite pasttime activity as a child was music. She did not participate in any sex games as a child nor did she experiment with masturbation. She does not pursue this now as she says she has no urge to do so. She received a programmed sex education in school.

She started dating at age 17. Dating consisted of going out in groups. Kissing was the only activity which she would allow. At age 18, she experienced her first sexual intercourse. She said the experience was good. At age 21, she was dating one fellow for a short time. She became pregnant with his child. She did not wish to marry him, however. She conceived a son at age 22. She met her present husband when she was 24 years old.

She was attracted to him because he was very 'open'. They dated each other for more than a year. No sexual difficulties were experienced during the courtship period. There was considerable foreplay prior to coitus. This consisted of hugging, kissing, petting and was 'fun'.

Shortly after they were married, however, he seemed to lose interest in sex and often three months would go by before he would initiate sexual activity. There was little or no foreplay.

At about this time, he began to work up north on various construction sites and she would not see him for a three month period. She says this did not seem to bother him. He then injured his back and started experiencing severe pain whenever he had an erection. The pain persisted for many years until he received treatment from a doctor.

Motivation for treatment

Amy expresses that she does not feel that sexual therapy will help them with their sexual problems as she is of the opinion that the problem is marital. However, she states she is willing to come in for therapy as she feels the situation cannot continue in its present manner.

Hypothesis of Problem

In order to assist the clinician in identifying the causal factors of the sexual problems and in arriving at an accurate clinical diagnosis, the following literature reviews were conducted: (a) effects of chronic back pain on sexual functioning; (b) effects of marital discord on sexual functioning.

The findings from these literature reviews in addition to the information derived from the assessment procedures, various instruments and inventories allowed the clinician to evaluate the situation and to arrive at a hypothesis.

Formulation of a Clinical Diagnosis

Upon completion of the assessment interviews with each individual client, a joint meeting was arranged in order to provide the couple with the findings of the assessment procedures. (This is similar to Masters and Johnson's 'roundtable' discussion referred to earlier).

A summary of the clinician's evaluation of the problem and recommendations were presented to the couple. These are:

It is conclusive that sexual activity was satisfactory and enjoyable for both parties prior to their marriage. The data collected during the assessment interviews indicate that there was nothing traumatic in both their personal background or sexual history which would indicate that environmental factors would have caused the contemporary sexual problem. Their sexual arousal and sexual activities appear normal during the courtship period.

Shortly after the marriage, however, Amy noted that Frank seemed to lose interest in sex and sex was, according to her, 'no longer fun'. She interpreted this lack of interest on his part as rejection of her personally. Such interpretation or assumption by one partner is detrimental to the building of trust and closeness within the relationship, both sexually and emotionally and subsequently they proceeded to drift apart.

In retrospect, Frank does not seem to be aware (according to the information given by him) that Amy had felt humiliated and rejected at the beginning of their

marriage. Instead Frank assumed that everything eg. in the area of lovemaking, was fine during the first years of their marriage.

The fact that they were not able to communicate their needs and feelings with each other compounded the problem. This is further aggravated by the extreme tiredness and pain that Frank suffered from the back injuries he sustained at work. This condition was further complicated by the pain he endured in his penis whenever he had an erection. Refer to literature review for implications of chronic back pain on sexual functioning.

Although Amy had repeatedly asked Frank to go to the doctor regarding his back pain, he refused to go because he was fearful of requiring an operation. Amy interpreted this resistance to seeing a doctor as Frank not wanting to overcome the organic condition in order that they could resume normal sexual activities. Frank, in turn, felt Amy should be more understanding of his medical problem.

A tremendous amount of frustration and tension have continued to build up within each of the individuals due to lack of communication, both verbally and sexually. Amy copes with the situation by withdrawing and holding in her angry feelings. She informed Frank about one year ago that she no longer loved him. He reacted by becoming jealous and more possessive.

At present, both individuals cannot openly discuss their marital or sexual problems with each other. Amy internalizes her feelings of helplessness and anger, and is

presently showing signs of clinical depression. Although she is functioning at her workplace, Amy becomes very weepy when discussing the problems related to her home situation. Amy's feelings of anger towards her husband in regards to his reluctance to seek medical treatment in order to alleviate the sexual problem has lowered her feelings of respect for him. She also no longer finds him 'attractive'. Consequently Amy has 'shut off' her sexual responsiveness for him.

Frank is able to get an erection if the mood is conducive. However, he gets turned off at Amy's unresponsiveness and he starts to watch whether he can maintain an erection--and assumes a 'spectatoring' role. Or when he is able to maintain an erection to penetration, he has 'performance anxiety' and the result is erectile failure.

The chronic back pain he has experienced from his back injury has undoubtedly contributed to and maintained the sexual dysfunctional problem. (Refer to literature review on effects of chronic back pain on sexual functioning). Shortly after the injury, the severe pain he experienced physically restricted any sexual activity. The pain was lessened once he received cortisone treatment.

No doubt, in the past, Frank's erectile problems were precipitated by an organic condition; namely, back injury and the resultant pain. However, at the present time, his erectile difficulties appear to have a psychogenic component contributing to its maintenance because Frank is able to sustain an erection under certain situations.

Frank and Amy are compatible and agree on functional matters as indicated by the DAS. The DAS also show that lack of communication is apparent on both their parts. Amy presents with all the associated psychological reactions (mentioned in the literature review) towards her husband. Unless Amy is able to resolve some of these negative feelings, sexual therapy or rehabilitation, (according to the findings of the literature review on the effects of marital discord on sexual functioning) is not deemed appropriate. In fact, due to the goal-directed, prescribed nature of the assignments in sexual therapy (Masters and Johnson), this type of therapy will more than likely put additional stressors onto an already 'precarious' relationship.

Other non-sexual situations which are putting additional strain on the relationship are: (a) Frank is presently unemployed; (b) Frank's inability to be a good provider as well as having erectile difficulties have had a negative effect on his self-image as a 'man', and this lowered self-esteem in coming out in 'acting out' forms of behaviour, eg. jealousy, possessiveness, and demanding.

In discussing the aforementioned evaluation with the couple, both clients were in agreement with the findings--that the problem is primarily marital rather than sexual, and that the resultant sexual problems are symptomatic of a severe marital discord situation.

They were advised to obtain marital therapy first and both were in agreement to this suggestion. The clinician

also assured them that by working out some of their marital problems, they would in fact, be working towards resolving their sexual problems at the same time. It was suggested that Frank and Amy contact the Family Services Agency for couple counseling or to see a therapist in private practice.

Clinician's Observations and Comments

This case illustrates a sexual dysfunctional problem related to a medical condition which was first evaluated as being amenable to treatment. However, the assessment procedures revealed that the sexual dysfunctional problem was related to the discord which exists within the relationship. Had the discord not been so severe, marital counseling may have been undertaken which would eventually lead into sexual therapy. However, in this particular situation, the feelings of anger and hostility are so intense that there would be no motivation for on-going therapy. (Refer to literature review for effects of severe marital discord on sexual dysfunctional treatment).

It would appear from the information gathered during the assessment procedures that the wife is seeking to end their relationship but has not made her husband aware of when it will take place.

STUDY NO. 4

Roy R: Impotence associated with prostatectomy procedure together with psychological problems

This is a case where the erectile disorder; namely, impotence may have been precipitated by a surgical procedure (prostatectomy) or by psychogenically induced (performance anxiety and spectatoring).

Various assessment procedures are utilized in order to make a differential diagnosis as to the etiology of the sexual dysfunctional problems. To assist the client in making a firm decision regarding the selection of the treatment program, a series of the 'conventional' sexual therapy tasks are provided.

The basis for the recommendation to the referring urologist for the penile prosthesis implantation surgery which includes a psychological evaluation on the suitability of the PPI is discussed.

Pre and post operative counseling for the PPI surgery is undertaken with the client. A follow-up questionnaire which was designed by the clinician is utilized in order to demonstrate the level of satisfaction which the penile prosthesis provided to the client and the partner from the psychological-sexual-emotional and social perspectives.

Assessment Procedures to Determine Etiology of Erectile Dysfunction--Impotence

Impotence is the persistent inability to obtain or maintain a sufficiently firm erection to permit and complete coitus (Jehu, 1979; Kolodny et al, 1979). Impotence may be classified as primary or secondary. Primary impotence are those males who have never been able to achieve or maintain an erection during coitus; whereas secondary impotence signifies a male who began encountering erectile difficulties after a period of normal sexual functioning. The erectile difficulties may be episodic and situational, precipitated by fatigue, excessive alcohol consumption, acute illness and distractions (Kolodny et al, 1979).

The types of disease processes found in association with erectile impotence are: post perineal trauma, post prostatectomy, post cystectomy, neurologic disorders, diabetes, Peyronie's disease, protocolectomy, postradiation, estrogen therapy, peripheral vascular disease, coronary artery disease (Kolodny et al, 1979). Other etiologic factors for impotence are: aging, use of therapeutic medications, psychologic factors, vascular insufficiency in the small vessels or arteries of the penis (McKendry et al, 1983).

McKendry et al (1983) in their discussion of the assessment procedures for erectile impotence stated "the possible causes or contributing factors are so many and varied that a systematic approach is needed to ensure that every possibility is considered" p. 654.

According to the findings of various authors, Masters and Johnson (1970); Levine (1976); Kaplan (1974); Reckless & Geiger (1975), it is estimated that approximately 10 to 15% of men affected by impotence have an organic basis for the dysfunctional problem (Kolodny et al, 1979). Appendix XII demonstrates the various classifications of the physical causes of secondary impotence (Kolodny et al, 1979, p. 508-509).

Due to the implications of the physical and metabolic causes on sexual functioning, it is imperative that the physical health of the individual be thoroughly examined during the assessment procedure (Kolodny et al, 1979).

Smith (1981) from his investigations into the causes and classifications of impotence concluded that "one must actively seek these causes examining the patient carefully, and proceeding with necessary special investigations that will help elucidate the actual cause of impotence for a specific patient. In many cases, the underlying disease may not be able to be treated and the problem may have to be circumvented by inserting a penile prosthesis. This eventuality should not deter one from establishing the cause however" p. 88.

Bullard et al (1978) noted "it is critical to emphasize that the diagnosis of a particular disease process or the presence of a physical disability cannot be assumed to account for the current erectile dysfunction of any individual" p. 185. Annon (1974a) observed "of two men with exactly the same organic problem, one may have impotence

problems and other none at all; there seems to be no clear cut predictors in many cases as to how a particular individual will function sexually" (in Bullard et al, 1978, p. 185).

The organic or physical condition causing the erectile problem can, in turn, affect the psychological or behavioral state of the individual (Jehu, 1979; Kolodny et al, 1979); or "changes may themselves affect sexual function so that even if the primary organic cause is discovered and successfully treated, sexual difficulties may persist on a psychogenic basis" (Kolodny et al, 1979, p. 507).

The 85 - 90% of the erectile difficulties which have their etiology in psychological factors (Annon, 1974a) may similarly be affected by physical and metabolic factors such as aging or sexually depressing drugs (Kolodny et al, 1979).

Mirowitz's (1966) study estimated that although 95% - 99% of all impotence was caused by psychological rather than organic problems, the male seemingly "do not want to accept that their problem is psychologically caused" (in Fisher & Gochros, 1977, p. 264).

Psychogenic causes of impotence may conceptually fall into four major categories: developmental, affective, interpersonal and cognitional (Kolodny et al, 1979). Appendix XIII provides a detailed description of various variables falling under the major categories of psychogenic impotence (Kolodny et al, 1979, p. 510).

Kolodny et al (1979) considered the "sexual history as the most useful single indicator" (p. 513) of whether the erectile difficulties are organic or psychogenic in etiology. Therefore, information such as onset and progression of impotence problem, type of erection, under what circumstances, and the time, all have important clinical significance in the diagnostic procedure.

The guideline, "Aetiological Screening Checklist (Erectile Dysfunction) by Kockott et al, 1980" (Appendix IV) was useful in obtaining concomitant information in determining the extent of the erectile disorder.

Other factors which are helpful in determining whether the impotence problem is psychogenic or organic in etiology are: (a) the impotence is probably due to psychogenic causes if a man is able to achieve erection under certain conditions but not in others (Kolodny et al, 1979); (b) a firm erection at the time of awakening is usually indicative of the normal erectile response (Kolodny et al, 1979); (c) the pattern of relative frequency of morning erections is important (Kolodny et al, 1979).

"Impotence is not synonymous with the absence of erections" however (Kolodny et al, 1979, p. 514). They also maintained that "evaluation of the patient's current physical and psychological status is important in determining the best course of treatment" (Kolodny et al, 1979, p. 515).

Since the direction of the therapy or treatment program is invariably dependent on the etiology of the

impotence problem in addition to identifying "the objectives each client has in terms of therapy" (Kolodny et al, 1979, p. 502), it is imperative that all available assessment procedures (both physiological and psychological) be employed by the clinician and the physician in order to obtain an accurate clinicial diagnosis.

Kolodny et al (1979) stated "determining whether a rapid, intensive form of sex therapy is suitable for a given couple is not always an easy task. Certain situations an unresolved medical problem, uncontrolled mania or psychosis--may preclude such an approach, while in other cases, the decision must be based on criteria that are less easily defined" p. 502.

The 'Flowsheet for Management of a Case of Secondary Impotence' (See Appendix XIV), from Kolodny et al, 1979, p. 598 is helpful to those clinicians who may be encountering some difficulties in discerning the direction of the therapy or the alternative treatments which are available.

If the impotence problem was precipitated by an organic condition, the client and the partner should be informed that having a medical problem does not necessarily preclude that the impotence is organic in etiology only but that the problem may be maintained by psychogenic factors which are often amenable to psychosexual therapy (Bullard et al, 1978). Jehu's 'Table 1. Psychological reactions to disability, surgery and medication' (Appendix XI) will also provide additional guidelines for collecting the relevant

information. The data should demonstrate the various areas of concerns which may be acting as impediments to the sexual functioning level of the client and/or the partner.

If the information derived from the sexual history taking and medical reports prove to be inconclusive as to the etiology of the impotency, it is suggested that more specific diagnostic testing procedures be conducted by the physician in order to assist the clinician further in arriving at an accurate clinicial diagnosis (Jehu, 1981; Kolodny et al, 1979).

The nocturnal penile tumescence (NPT) is one of the many procedures which are available in order to assist in differentiating between the physiological and psychological etiology of the impotence disorder (Jehu, 1981; Kolodny et al, 1979).

Penile Plethysmography

The technique of measuring nocturnal penile tumescence (NPT) has been available in recent years to assist the physician to systematically, objectively, and 'fairly accurately' differentiate whether a patient's impotence problem is due to organic or psychological causes (Jehu, 1981; Karacan, 1978).

Karacan (1978) is of the opinion that "this method should be employed in the diagnostic evaluation of every patient who complains of and seeks treatment of impotence" p. 144. This is important in that although psychogenic factors have been attributable to most causes of impotence, a significant number of men are impotent due to irreversible organic causes (Kolodny et al, 1979).

The measurement of the NPT which is the "physiologic monitoring of erection patterns during sleep" (Kolodny et al, 1979, p. 517) for the diagnostic assessment of impotence is conducted by a test known as the penile plethysmography.

This technique "derives its usefulness from the fact that men with organic impotence have impaired erections or no erections at all during sleep, whereas men with psychogenic impotence have normal erection patterns" (Kolodny et al, 1979, p. 517). This is based on the assumption that sleep is an uninhibited state and "the removal by the state of sleep of anxiety, internal conflicts, or other psychological factors that may impede erection during wakefulness allows normal body reflex pathways to take over and produces

measurable episodes of penile tumescence" (Kolodny et al, 1979, p. 517).

Jehu (1981) stated "during an average night's sleep people have four or five periods of dreaming during which they exhibit rapid eye movements (REM). In physiologically unimpaired males these periods of REM sleep are invariably accompanied by full or partial erections" p. 248.

By taking a 3mm increase in penile circumference as their criterion for the occurrence of NPT, Marshall, Surridge and Delva (1981) could correctly differentiate 95% of their subjects to either the organic or psychogenic categories by the number of episodes of NPT which were exhibited.

Although the NPT testing appears to be fairly accurate in differential diagnosis of functional and organic forms of impotence, the NPT tracing does not differentiate between the various types of organic impotence (Kolodny et al, 1979). In addition, there are two areas where there are questions as to the validity of NPT measurements as a diagnostic tool for impotence (Kolodny et al, 1979). These are: (a) in the depressed patients whose normal sleep patterns are affected; (b) the effects of drugs on sleep associated erections (Kolodny et al, 1979).

Hence, additional diagnostic tests are recommended in to reveal the exact pathogenic mechanism leading to the impotence problem as it may have implications on the treatment (Kolodny et al, 1979). These techniques include: penile pulse and blood pressure measurements, and the arteriography to assess vascular competency and cystometrography

or direct neurophysiologic test (Kolodny et al, 1979, p. 518).

A simplified instrument giving comparable results as the one conducted in the sleep laboratory holds significant potential according to Kolodny et al (1979). This instrument measures NPT patterns by recording changes in penile circumference during sleep without the patient having to stay in a sleep laboratory for two or three nights.

Karacan (1978) cautioned, however, when using "the circumference change data from the portable unit necessitates the assumption that the circumference of the penis is a reliable index of its degree of rigidity. This assumption is valid for about 90% of patients but the physician should make the assessment of penile rigidity so that its validity for the patient under study can be established" p. 142.

The findings of Kockott, Feil, Revenstorf, Aldenhoff and Besinger (1980) provides promise for differential diagnosis based on replies to six questions in a semi-structured clinical interview (Jehu, 1981).

Sexual Therapy--Treatment of Erectile Dysfunction

Since this clinician concentrated her discussion on the assessment of erectile dysfunction; namely, impotence, in the preceding literature review, the focus will now be on the treatment of erectile dysfunction (impotence), according to the methods followed in the 'conventional' sexual therapy programmes.

Caird and Wincze (1977) viewed Lobitz & LoPiccolo's (1972) and Masters and Johnson's (1970) comprehensive treatment for impotency as an efficient and effective behavioural procedure in a package. This package (whether behavioural or eclectic in perspective), has three essential ingredients. These are: (1) re-education about sexual techniques, attitudes, communication or sexual functioning; (2) redirection of sexual behavior; (3) graded sexual exposure either by systematic desensitization or direct practice of sexual behaviors with their partners (Caird & Wincze, 1977).

In the treatment of impotency, there are several methods which are recommended under the 'conventional' sexual therapy approach. These are:

(1) Non-demand coitus (Masters and Johnson, 1970) where, once the client is able to obtain erections by the general and genital pleasuring techniques, the "erect penis is then inserted in the vagina where it is contained with only limited movement of a non-demanding kind. After a brief period, the penis is withdrawn and the assignment is repeated on several occasions during a session, at

the conclusion of which the partners may give each other an extra-vaginal orgasm by manual or oral means if they so wish" (Jehu, 1979, p. 150). The purpose of repeated insertions and containment is: (a) for the reduction of stress reactions; (b) to provide the couple with the opportunity to enjoy the sensations which they feel when the penis is in the vagina (Jehu, 1979).

Two variations of the non-demand coitus are: 'quiet vagina' and 'stuffing' technique (Annon, 1974; Hartman & Fithian, 1974) (in Jehu, 1979, p. 151).

(2) The stop-start and squeeze techniques (Kaplan, 1974, 1979; Masters and Johnson, 1970) are recommended "where a client fears that a lost erection cannot be recovered, the couple may be advised to produce such losses deliberately by means of stopping genital stimulation or squeezing the penis, and then to continue with stimulation so that an erection is usually regained" (Jehu, 1979, p. 148).

(3) Another technique consists of Annon's (1974) program of self-stimulatory assignments where "the association of these phantasies with self-stimulation and orgasm, facilitates the generalization or erections from masturbation to shared sexual activities" (Jehu, 1979, p. 149). This technique is deemed to have possibilities to those without a partner.

P-LI-SS-IT Treatment Model

The P-LI-SS-IT model of therapy, developed by Annon (1977) was devised to provide the following: (1) a more flexible and comprehensive scheme of handling sexual disorders than the other forms of therapy; (2) to benefit clients who could profit from a brief therapy approach; (3) a model which could be used by a wider variety of helping professions with the range of treatment choices according to the level of competence of the clinician; (4) a framework for the clinician to screen patients to determine the level likely to be the most effective in treating the individual client.

The acronym is formed from the initials of the four levels: Permission-Limited Information-Specific Suggestion-Intensive Therapy. Annon (1977) suggested employing these levels sequentially, starting from the simplest and moving to the more complex. The first three levels of this model can be viewed as brief therapy while the fourth level would involve intensive therapy.

In the first level of treatment: Permission (P)-- The clinician provides reassurance that the client's thoughts, fantasies, dreams, feelings and behavior are normal and gives the client permission to continue his/her sexual behaviour. This is sufficient, in some cases, to resolve what might otherwise become a major problem. Permission-giving can be deemed as a preventive measure as well as a treatment technique.

In the second level of treatment: Limited Information (LI) is seen as providing the client with factual information directly relevant to his particular sexual concerns and is usually given in conjunction with P-giving. It too can be viewed as a preventive measure as well as a treatment technique.

Annon (1977) has provided further evidence that significant changes occurred in the client's attitude and behaviour when limited information was presented which related directly to the client's problem. Dispelling sexual myths such as those pertaining to genital size, men and women's capacity for responsiveness to sexual stimulation are some areas which may be addressed by the limited-information giving method. This second level of treatment was utilized as an interventive strategy in all of the case studies of this report. Case no. 4 represents the one where this method was used more frequently.

The third level of treatment: Specific Suggestions according to Annon (1977) are "direct attempts to help the client to change behavior in order to reach his stated goals. This is done with a brief therapy framework which means that the approach is time and problem limited" p. 80.

Heterosexual dysfunctional problems such as arousal, erection, ejaculation, orgasm or painful intercourse can be effectively dealt with on this level of treatment. Specific suggestions which are given to the client (eg. re-direction of attention, graded sexual responses,

sensate focus techniques, squeeze techniques, etc.) will be dependent upon the information obtained in the sexual problem history. The sexual problem history referred to here differs from the sexual history which implies intensive therapy.

According to Annon's (1977) model, a comprehensive sexual history is not deemed as essential at this level. As part of the treatment technique, the clinician may wish to recommend readings as another means of providing permission or limited information of a sexual nature pertaining to the client's problem, eg. refer to case nos. 1, 2 and 4.

If a number of problems still remain unresolved by this approach, then the clinician may apply the fourth level of treatment, or if this level is beyond the clinician's level of expertise and time, she should refer to the appropriate resources.

The fourth level of treatment: Intensive Therapy--This level of treatment should be undertaken only when the brief therapy approach has not produced results. It should be conducted by a clinician who had already received training in this area of specialization, namely a behavioural approach to the treatment of sexual problems. A complete sexual history will be the first step which is required for intensive therapy.

The Plissit model proved to be a beneficial therapeutic tool when dealing with clients whose sexual problems were related to complex medical conditions, especially with

reference to those clients or partners who required a brief therapy approach, (eg. case nos. 1, 2, & 4) before proceeding to a more intensive level of counseling.

Effects of a Prostatectomy Surgery on Sexual Functioning

When severe symptoms such as urinary hesitancy, frequency, urgency hematuria, and acute urinary retention occur as a result of an obstruction of the bladder outlet by a benign prostatic hypertrophy, surgery is usually required (Kolodny et al, 1979).

Four different types of surgical approaches are utilized in the treatment of benign prostatic hypertrophy. They are: (1) transurethral resection or TUR; (2) suprapubic prostatectomy; (3) retropubic prostatectomy; (4) perineal prostatectomy.

'Loss of sexual capability' seems to be a fear which is misunderstood by patients who undergo surgery for benign prostatic hypertrophy (Kolodny et al, 1979, p. 215). According to the available literature, it does not indicate that this condition diminishes sexual functioning (Madorsky et al, 1976). Variance of sexual functioning or behaviour can occur, however, following a prostatectomy operation depending on the type of surgical procedure that is performed (Kolodny et al, 1979).

For the patient undergoing the transurethral approach which involves endoscopic resection (for smaller prostatic adenomas), the occurrence of post-operative organic impotence is unusual since the TUR operation "does not interfere with the nerve fibers that control erection, nor does it cause disruption of blood flow to the penis" (Kolodny et al, 1979, p. 216).

However, about 90% of men experience retrograde ejaculation after a transurethral prostatectomy due to damage

to the internal sphincter of the bladder. In a study by Finkle and Prian (1966), it was reported that 5% of men who had transurethral prostatectomies experienced loss of potency but these cases seem to be caused by psychogenic factors.

In the suprapubic approach to prostatectomy (where an incision is made in the anterior wall of the bladder and dissection of mucosa surrounding the bladder neck, 75 to 80% of the men undergoing this type of surgery experienced irreversible postoperative retrograde ejaculation (Madorsky et al (1976); Finkle & Prian (1966). Only about 10 to 20% of men became impotent following a suprapubic prostatectomy (Madorsky et al (1976); Finkle & Prian (1966).

The same authors reported that in the retropubic approach there does not appear to be any difference in the rate of potency disorders occurring postoperatively compared with the other approaches already mentioned.

The perineal approach to prostatectomy has a higher rate of postoperative impotence (Kolodny et al, 1979). According to Nelson's (1978) findings, the rate of impotence is approximately 40 to 50% postoperatively when a radical perineal prostatectomy is performed because this operation damages the nerve pathways that control erection.

The figure rises to 90% or greater incidence of impotency post-operatively when a radical perineal prostatectomy is performed for the treatment of prostatic carcinoma (Kolodny et al, 1979).

Some incidence of impotence can occur irregardless of the type of procedure for prostatectomy, however, Kolodny et al (1979), contended that most of the cases of impotence are psychologically induced rather than organic in etiology. According to Smith (1981), "impotence rarely follows prostatectomy for benign disease" p. 84.

Potency may be affected for a number of psychological reasons, such as: (a) the man's fear of surgery which may affect his genital-urinary functioning; (b) the psychological reaction to the alteration in ejaculation that commonly occurs following surgery; (c) the operation may provide a convenient excuse for the man to avoid sexual activity; (d) unwillingness of the partner to participate in coitus after the surgical and/or medical factors (Kolodny et al, 1979).

Kolodny et al (1979) suggested that men with psychogenic impotence which resulted from an "urologic surgery will often respond well to psychotherapy" p. 218. When impotence occurs after a prostatectomy operation, it has been suggested that monitoring of the nocturnal penile tumescence would allow the clinician to differentiate between organic and psychogenic impairment (Kolodny et al, 1979). They recommended that a preoperative sex history be obtained in order to establish baseline levels of sexual functioning for medicolegal and patient management purposes if the client should decide on the penile prosthetic implantation. (Kolodny et al, 1979).

Penile Prostheses--Types and Problems

Patients who are considered to be suitable candidates can now have a device surgically implanted by the urologist which would enable them to participate in coital activity (Jehu, 1979; Kolodny et al, 1979; Renshaw, 1975a).

There are a variety of penile prosthetic devices which have been developed and which offer surgical solutions to the treatment of male impotence (Lange & Smith, 1978). The basic difference of the prosthetic devices appears to be between the fixed-rod type (Small-Carrion) and the inflatable type (Scott-Bradley) prosthesis (Furlow, 1976; Gottesman et al, 1976; Scott et al, 1973; Small et al, 1975).

Fixed-rod type

The fixed rod devices (of which the Small Carrion is one), are made of different materials such as Silastic (silicone rubber, polyethylene and acrylic) (Small, 1978). The main advantage of using this type of device is due to the simplicity of insertion surgically (Kolodny et al, 1979).

The Small-Carrion penile prosthesis consists of two partially foam-filled silicone rods of varying lengths and widths which are implanted by the perineal approach (Gottesman et al, 1976; Small, 1975, 1978).

The silastic penile prosthesis is implanted by placing the device between "the undersurface of the tunica albugi-nea and the corpora cavernosa" (Pearlman, 1972, p. 224). The result is a "permanent state of partial erection suffi-cient to permit intromission and without impairment of penile

sensation, orgasm or ejactulation" (Jehu, 1981, p. 246). Although the erection can usually be concealed by normal clothing, the perpetual state of semi-erection can create both physical, psychological and social distress for some patients (Lange & Smith, 1978).

The main postoperative complication of the silastic type of penile prosthesis appears to be a severe wound infection with extrusion of the prosthesis. Aseptic necrosis, hemorrhage, lymphatic edema, and herniation albuginea are some of the other complications which have been known to have resulted from this procedure (Pearman, 1972).

In a study by Sotile (1979) of 623 patients with silicone rod implants, 89.1% of cases were reported to have satisfactory outcome of engaging in sexual intercourse with sufficient penile rigidity. 16.7% of the cases had surgical complications, mainly infection.

Kramer and coworkers (1979) in another study noted that 20 of 76 patients who underwent insertion of the Small-Carrion prosthesis had postoperative complications including 7 men who lost one or both prosthesis by spontaneous extrusion or surgical removal.

In general, a lower rate of complication is reported with the Small-Carrion implantation than the other silastic rod type devices (Gottesman et al, 1976; Small, 1975, 1978).

Inflatable penile prosthesis

The history and development of the inflatable penile prosthesis is well documented in reviews and studies by Furlow (1981).

The inflatable penile prosthesis (IPP) is a more sophiscated, surgically time-consuming and technically, a more difficult device than the fixed-rod device.

> The IPP consists of "two tapered inflatable cylinders which are placed within the tunica albuginea adjacent to the corpora cavernosa. These cylinders, which come in varied sizes, are connected by tubing to a simple pump that is placed low in the scrotum, outside the tunica vaginalis. A fluid storage reservoir is implanted in the prevesical space. The patient activates the pump by compressing the bulb in the scrotum; radiopaque fluid is then transferred from the fluid reservoir to the penile cylinders, causing the cylinders to expand and producing penile tumescence. The erection is released by pressing a valve in the lower portion of the scrotal bulb, which allows fluid to be evacuated from the penile cylinders back to the reservoir" (Kolodny et al, 1979, p. 226).

The inflatable penile prosthesis enables the patient to mechanically achieve an erection which allows vaginal penetration and sexual intercourse. The device allows the patient to maintain an erection for an indefinite period of time. Once sexual activity is completed, the cylinders are deflated and the penis resumes the flaccid state.

The advantages of the IPP over the fixed rod device are: (a) reduction of risk of tissue erosion or perforation due to more favorable pressure dynamics; (b) rate of post-operative infection are less; (c) greater degree of acceptance of the IPP by both the patient and the sexual partner (Kolodny et al, 1979).

Mechanical failure of the cylinders or tubing system were cited in various studies to be the major complication with the IPP (Furlow, 1978; Scott et al, 1973).

Comparison between semi-rigid and inflatable prosthesis

In Sotile's (1979) study of literature (Ambrose, 1975;

Goulding, 1977) reporting outcome data in which he compared the relative merits of the semirigid rodlike prosthesis with the inflatable hydraulic prosthesis, the findings from 28 studies revealed:

Advantages of the rodlike device were: it was surgically easier to insert, implied lower costs, less complications due to the design which was simpler than PPI.

Advantages of the hydraulic device were: it has greater control of erection by the patient which resembled a normal one.

From the same study, satisfactory outcome was reported for 89.1% of rodlike recipients and for 95.7% of the recipients of the hydraulic device (Sotile, 1979, p. 99). In comparing the nature of complications, Sotile's (1979) data indicated: "wound infection is the most frequently reported complication with the rodlike prosthesis while the hydraulic device appears most vulnerable to mechanical problems. Surgical removal of the prosthesis as the result of complications appears to occur much more frequently with the rodlike device" p. 99.

Lange & Smith (1978) recommended that patients should become thoroughly familiar with the advantages and disadvantages of both types of devices which would then allow the patient and his sexual partner to make the proper choice. Narayan and Lange (1981) concurred with this suggestion as well.

It was also suggested that each case be evaluated on an individual basis and special considerations be given to

the disabled or medically infirmed patients (Lange & Smith, 1978). For instance, for the young, physically active male, the use of the Small-Carrion device may possibly cause social embarrassment due to its perpetual semirigid state. On the other hand, it may be adviseable that the patient who is mentally or physically handicapped (which makes the manipulation of the Scott-Bradley pump difficult and combersome) to consider having a Small-Carrion prosthesis (Lange & Smith, 1978). Likewise the Small-Carrion prosthesis is recommended for patients who have the likelihood of subsequent lower-abdominal surgery, (eg. ileal loop urinary diversion (Lange & Smith, 1978). For patients who might require repeated cystoscopy due to a renal transplant, the Small-Carrion prosthesis is recommended (Lange & Smith, 1978).

Complication rate, comfort and social acceptance, cost and special medical condition requiring special considerations ex. catheterization, were considered important factors to be discussed with the patient when choosing between the semirigid and the inflatable prosthesis (Narayan and Lange, 1981).

Penile Prosthetic Implantation Counseling

In undertaking penile prosthetic implantation (PPI) counseling, the clinician will, more than likely be encountering clients who fall into the following categories:

(1) Where the client's erectile failure (impotence) has been diagnosed by the physician as organic in etiology eg. diabetes, and sexual therapy would not, in all probabilities, be beneficial to reverse the condition due to pathological damage. PPI has been chosen as the alternate form of treatment, and the physician and/or the client is requesting additional information and counseling be provided to the client and/or partner on the implications of the PPI surgery.

(2) Whereas the client has attempted a course of sexual therapy and the treatment outcome had not been successful in correcting the impotence problem. The client is now requesting information on the PPI in order that he can be referred to a surgeon as a PPI candidate.

(3) Where the erectile problem has been diagnosed as psychogenic in etiology and brief sexual therapy has been undertaken but the results of correcting the impairment is not successful due to various factors such as: unavailability of sexual partner, advancing age or a complex medical condition. PPI is being considered as an alternate form of treatment (eg. case no. 4) and the client wishes to obtain additional information in order to make a firm decision.

(4) Where the spouse of the client who is impotent wishes to receive information regarding the implications

of the PPI surgery and other related concerns as she is reluctant to have her husband seek surgical treatment due to her fears of complications of the PPI surgery.

In each of these situations (or combination of other factors) the clinician can play an important role of providing the necessary information, based on factual data, which will assist the client to make a firm decision as to the course of treatment he wishes to pursue.

This procedure of providing accurate information is imperative in view of Furlow's (1981) statement that "it is important that both the decision to implant and the selection of a device be determined on the basis of not only the physician's clinical assessment but also on the information provided to the patient and his partner" p. 184.

The procedural schedule which is utilized for the implantation orientation is similar to Appendix XVI. It allows the patient and his partner to ask relevant questions and to permit them to become familiar with all aspects of the prosthetic implantation. According to Furlow (1981) their overall goal is "the appropriate selection of those patients who are both physically and psychologically suited for implantation of a penile prosthesis" p. 184. Furlow (1981), Gerstenberger et al (1979) both reported that the above procedures have been successful in selecting patients for implantation but also in maintaining a high level of patient-partner satisfaction in long-term postoperative follow-up.

In addition, in order to help the client make a decision whether to proceed with the PPI surgery and to choose the proper type of prosthesis, certain practical concerns need to be considered (Melman, 1978). These practical concerns include the following:

(a) The types of penile prostheses which are available. The differences or comparison between the semirigid type and the inflatable PPI. The complication rate of each and the types of complications.

(b) Information regarding the PPI surgery: preoperative preparation to PPI surgery (X-rays, antibiotic regime, etc.) (Furlow, 1981). Length of operative time, hospital stay.

(c) Costs--whether the operation and the apparatus are covered under the government health services plan.

Karmarsky-Binkhorst (1980) recommended the following topics be covered as well when undertaking PPI counseling:

(a) Appearance--whether the prosthesis can be detected.

(b) Sensation--whether penile shaft sensitivity will be affected.

(c) Injury--concerns of injury to partner; or questions regarding any discomfort or injury to penis or vagina.

(d) Female partner's role--the need for the partner to ventilate her feelings regarding concerns whether the partner may be unfaithful, dealing with feelings of guilt and inadequacy.

(e) Male partner's role--the need for the male to assure the woman of her desirability and his desires to

satisfy her in coitus.

(f) Couple's responsibility to offer suggestions to help each other to overcome anxieties regarding resuming coitus with the PPI.

(g) Specific suggestions--giving the couple assurance that the implant surgery can restore mutual sexual fulfillment. Provide additional instructions to aid in postoperative sexual functioning.

Selection of Candidates for Penile Prosthesis Implantation

The penile prosthetic implantation (PPI) has recently become an effective form of therapy for clients who suffer from impotence (Kolodny et al, 1979). An accurate evaluation, therefore, as to the etiology of the impotence problem becomes very crucial to the type of treatment (psychotherapy versus surgery) that the client would seek.

Gerstenberger et al (1979) in their study have utilized the recommendations made by Osborne (1976) that all patients whose chief complaint is impotence undergo psychological evaluation for the following reasons: (a) identify the cause of the erectile problem; (b) identify patients who would derive help from a nonsurgical treatment; (c) evaluate the patient's motivation for surgery; (d) identify the patients who may encounter emotional problems when they have to contend with the surgery; (e) prepare the patient and his partner for adjustment after surgery.

As part of the evaluation procedure for the selection of candidates for the PPI, it necessitates the prosthetic candidate and the partner to explore what they may expect from the operation and whether it will improve their sexual functioning (Bullard et al, 1978).

Cole et al (1982) recommended that the "PPI should not be adopted without adequate assessment and evaluation of each individual case" p. 903. Bullard et al (1978) concurred that the surgical approach to the treatment of erectile dysfunction should only be considered after extensive assessment and counseling procedure as to the

suitability of the client for the PPI.

Renshaw (1978f) agreed that the prosthesis may be helpful to a partner in providing sexual pleasure, however, she cautioned that "a prosthesis may also bring to the surface the ultimate in destructive interaction". She also advised that "both partners should know that a prosthesis does not provide an ejaculation or an orgasm" p. 146.

Although Stewart and Gerson (1976) did not consider a routine psychiatric evaluation to be a necessary prerequisite to the PPI surgery, however, they do recommend that a psychiatric consultation be made if there are any doubts about the patient's motivation or where psychosis is present. They agreed with Gee et al (1974) who advised that the motives and attitudes of the patient should be carefully screened.

From the recommendations derived from the various sources, it is evident that surgical treatment for erectile dysfunction in an otherwise healthy male is contraindicated. Instead sexual counseling should be attempted first since it has been known to reverse erectile dysfunction for a certain percentage of men whose dysfunction is assumed to be organically based. For example, Renshaw (1975a, 1978c) has provided clinical evidence that a group of men with diabetes or multiple sclerosis have regained their erectile capacity after participating in sex therapy. Their erectile problems were assumed to be neurologically based.

Jehu's guideline 'Psychological evaluation of candidates for penile implant surgery', Appendix XVII is helpful

in determining the suitability of the individual for consideration of the PPI surgery. This evaluation is, according to Jehu, to "ascertain any psychological factors that might adversely affect adjustment to the penile implant and which may indicate the adivseability of pre and post-operative counseling" (in Appendix XVII).

Renshaw's (1979) 'Evaluation for sexual surgery' outline, Appendix XVIII, which includes specific questions for the PPI candidate and the partner provided an additional guideline for the PPI surgery. A comprehensive evaluation outline was derived by incorporating Jehu's and Renshaw's respective guidelines into one.

Preoperative Counseling for Penile Prosthetic Implantation

Surgery of any type can be stressful to the client and the partner. Therefore, any questions which are posed by the client pertaining to the surgical procedures should best be addressed in order to lessen the anxiety.

In situations where the client has not had the opportunity to consult with an urologist for consideration of the penile prosthesis implantation surgery (eg. case no. 4) or where further information is required in order to make a firm decision, it would be beneficial to the client if the information regarding the operational procedures, hospitalization stay, etc. can be provided by the clinician. For example, a diagram or an illustration of the penile prosthesis is helpful in demonstrating to the client and/or spouse, the mechanical workings of the apparatus (Furlow, 1981).

Furlow (1981) p. 184-189 also provided an excellent detailed description of the penile prosthesis implantation for those who are not familiar with the surgical techniques which are required. An equally excellent narrative of the semi-rigid penile prosthesis surgical procedure was provided by Narayan & Lange (1981).

Once a firm decision has been made by the couple to proceed with the operation, recommendations are made to the urologist who would be performing the operation. The urologist will provide a more thorough explanation regarding the medical aspects of the penile prosthesis implantation procedures.

Bullard et al (1978) suggested that the clinician and the physician who are offering surgical treatment for erectile difficulties, "work together to provide solution likely to ensure the total well-being of each individual client" p. 189. They also suggested that if the couple preferred a prosthesis, they would recommend that the couple obtain preoperative counseling. This procedure will enable the clinician to assess the couple's expectations and to determine the likelihood whether their expectations could be met by the use of a prosthesis. It is very important to assure the couple's "ability to assimilate a prosthesis without disqualifying it because it is not the real thing" (Bullard et al, 1978, p. 186).

It is also advised that whenever possible both partners be interviewed as studies have indicated that the evaluation of both partners provide better insight "to the resumption of mutual sexual satisfaction" (Kramarsky-Binkhorst, 1980).

Post-Operative Counseling

There is very little scientific evidence and literature available on the merits of post-operative counseling specific to penile prosthetic implantation.

However, the case study problem related by Stewart & Gerson (1976) where the wife left home to seek a divorce within seventy-two hours of the husband arriving home with the penile prosthesis implantation provides an excellent example of the importance of providing both the pre and post surgical sex counseling for the client and the partner.

Divita & Olson (1975) favored post operative counseling in situations where "the sexual dysfunction may have been adaptive for any particular relationship and sudden removal may have a couple unprepared and in need of a new adaptive method" p. 310. Hence, the couple's vulnerabilities must be recognized in this area and the implementation of an appropriate therapeutic intervention would also be required in order to help the couple adjust to this new level of sexual functioning.

Sotile (1979) recommended instituting a course of marital therapy preceding and following the penile prosthetic implantation for those couples whose assessment indicate pathological problems in their relationship.

Bullard et al (1978) stated that if the couple should decide to proceed with a prosthetic implantation surgery, that "post-operative counseling can be offered to help them adapt to the surgically produced change" p. 188.

It would appear that the various authors agree that post-operative counseling should be undertaken in order to ensure successful outcome of the surgical procedure.

Post-Operative Follow-Ups

It would appear from the findings of the literature reviews which were examined that most follow-up studies conducted by researchers such as Kessler (1980); Furlow (1978); Sotile (1979), seemed to place emphases on the physical-mechanical functioning level of the penile prosthetic device (eg. with data being collected on the number of patients who encountered complications or the physical performance of the device).

This type of information is undoubtedly important to the physician who is interested in improving the surgical techniques of the PPI surgery and desire knowledge of the outcome of the PPI surgery and desiring knowledge of the outcome of the PPI surgery, however, this data is not adequate to the social scientist who is primarily interested in the behavioral aspects of the PPI surgery on the patient and the partner.

Sotile (1979) commented that "the need for well-controlled research in this area is apparent. Specific research topics that are of particular significance include (1) assessment of the subjective as well as the objective results of the implantation, (2) comparison of long and short-term results for the major forms of prostheses, and (3) delineation of significant prognostic factors in adjustment to penile implant surgery" p. 101.

Macaluso & Berkman (1984) recommended long-term follow-up in evaluating the results of sex counseling program in other areas besides attitudinal change.

Segraves, Schoenberg, Zarins' (not yet published) study research the psycho-sexual adjustments after the PPI surgery, however, it is difficult for the reader to ascertain to what degree the patient and/or partner's psycho-sexual functioning level had improved due to the lack of information provided on the psycho-sexual functioning level prior to the operation.

The study conducted by Gertenberger et al (1979) provided a broad perspective on the type of questions that may be incorporated into a questionnaire which would indicate the level of satisfaction for the patient/partner who has undergone the PPI surgery.

Questionnaire

In order to fulfill some of the deficits in the area of post operative follow-up and evaluation of the penile prosthetic implantation surgery from a psychological-sexual-emotional and social perspective, a questionnaire was devised by the clinician which could be utilized at various time intervals (3 months; 12 months & 18 months) in order to ascertain whether the PPI provided any improvement and/or any notable changes in the sexual functioning level of the client and the partner. In comparing the progress which was/was not being made from one designated time frame to the next, the information derived from the questionnaire should indicate changes in sexual satisfaction; attitudinal change; changes in self concept; changes in relationship, dating and social skills.

The purposes of this post-operative follow-up questionnaire are as follows: (a) to obtain direct 'feedback' information on the results of the PPI operation; (b) to collect data for future research in this specific area which, when perfected, could longitudinally measure the satisfaction level from the physiological, psychological, sexual, emotional and social perspectives; (c) from a strategy of preventing post-operative problems which could arise, by having access to information of potential problematic areas.

The value of such an instrument is subjective and its reliability must be tested with many patients. A measurement of the physical-mechanical functioning levels of the

PII was not purposely included in the sample questionnaire as the clinician had utilized a questionnaire which had already been devised by researchers Gerstenberger et al (1979), and which seemed more than adequate to guage the PPI's postoperative physical-mechanical functioning level.

The above-mentioned questionnaire was also utilized for a client who had undergone PPI surgery to correct impotence problems due to an organic etiology--diabetes melitus. Since this particular case is not included in this report, the clinician will not elaborate on the findings, however, the data which was collected from the questionnaire revealed that there was very little difficulty of the couple adjusting to the PPI from a psychological, sexual, emotional, and social functioning level and that the couple were more than satisfied with the outcome of the PPI.

In order to derive some information regarding the pre and post surgical counseling which was conducted on the patient, specific questions were included as an addendum to the above-mentioned questionnaire. The purpose was to obtain information from the consumer, the client, regarding the merits of pre and post operative counseling; on the relevancy of the type of information which was provided to the client; and the scope of the information and counseling techniques and skills which were employed during the assessment-to-treatment procedures.

CASE NO. 4

ASSESSMENT REPORT

Roy R. was referred to the Sexual Dysfunction Clinic by an urologist. The client had visited his physician complaining of increasing erectile difficulties since having a TUR operation of the prostate. He is requesting that the physician consider him as a penile prosthetic implant candidate.

The evidence supporting whether the etiology of the impotence problem is psychogenic or organic is not conclusive according to the tests conducted by the physician. Therefore the physician is requesting the Clinic to conduct a diagnostic assessment to ascertain whether psychotherapy (sexual therapy) will be beneficial to the client, and/or to make the necessary psychological evaluation regarding the suitability of this client as a penile prosthntic implant candidate.

The client was first assessed by the supervisor at the Clinic to determine whether he would be a suitable candidate for the clinician.

The case will be reported as it progresses in order to demonstrate the following: (a) how the various assessment procedures were utilized in the process of arriving at a clinical diagnosis; (b) the formation and implementation of a plan which would allow the client to choose the alternative course of treatment; (c) the process of arriving at a decision for a penile prosthetic implantation surgery by the client; (d) the procedure of

psychological evaluation for PPI; (e) provision of information regarding the PPI surgery; (f) recommendation to the physician; (g) pre operative counseling for PPI; (h) post operative counseling; (i) follow-up evaluation by means of a questionnaire to determine the psycho-sexual-emotional-social level of satisfaction to the PPI by the client and the partner.

The deviation from the normal assessment-to-treatment format is due to the many extraneous variables which are involved when dealing with a client who presents with a sexual dysfunctional problem related to a complex medical condition. Due to the length and depth of the various assessment procedures, the clinician has not purposely reported all the data which was collected. Only those facts that were most relevant to the formulation of a hypothesis are discussed.

In order to arrive at a preliminary hypothesis, the clinician proceeded to gather information utilizing the brief assessment procedure similar to the format described by Kolodny (1979), Appendix VII. The Sexual History Form was also completed by the client at this time. The information which was collected from the above-mentioned assessment procedures allowed the clinician to make a tentative diagnosis as to the identity of the problematic areas and to formulate a series of appropriate questions focused on arriving at a conclusive clinicial diagnosis.

Contemporary Influences on Problems

Description of problem

Roy R. is a 58 year old male who is having erectile dysfunctional problems. He is getting only partial and fleeting erections during lovemaking and masturbation. He has only recently recovered full erections on waking but this is intermittent and situational.

Situational antecedents

Roy had a prostatectomy operation 8 years ago and he reports the erectile problems started shortly after the operation. During the same period of time, Roy states he was being turned off sexually by his common-law wife because of her 'dirty talk'.

Organismic variables

Roy reports that he is attracted to young girls in their late teens and early 20's, and not women of his own age. He has an abundant supply of potential young sexual partners who are available. He says he is reluctant, however, to take the steps to get to 'know and love' a woman as he is unable to get an erection and complete the sex act. He admits he cannot function in an 'instant sex' situation but instead he needs to get to know and care for his sexual partner. He is wanting companionship--someone who is willing to 'stick by him as he gets older'. Roy is aware that a younger person may not be inclined to do this.

Organic factors

In the referral letter to the Clinic, the physician states that the results of the physical examination of the client was well within the normal range, as was the serum testosterone level. The penile blood pressure studies are also normal. The nocturnal penile tumescence tests which were conducted on two separate occasions were contradictory as to conclusion.

On the first occasion, the client apparently had one erection which appeared to be of satisfactory strength and time. Repeat monitoring on the following evening did not show any evidence of erections. The client informed the physician that recently while reading some erotic literature, he did get some erections.

Roy has an implanted pacemaker. He is not on any medication for his heart problem.

Situational consequences

Roy is presently experiencing considerable 'performance anxieties' in his sexual encounters. He is considering undergoing a penile prosthesis implantation operation but he wants to try sexual therapy first as he admits that he is fearful of the operation.

Motivation for treatment

Client is wanting to come in daily to 'get fixed up in two or three weeks'. When he is informed what sexual therapy entails and that only weekly appointments are possible, he reluctantly accepts this alternative.

The aforementioned brief assessment procedure assists the clinician to identify certain areas which are, in fact, of therapeutic concerns, eg. organic condition, surgical procedure, and psychological factor. The information allows the clinician to focus on a certain direction of questioning.

The following will describe the procedures which were utilized in order to derive the necessary information which allowed the clinician to make a differential diagnosis of the impotence problem--whether it is organic, psychogenic or mixed in etiology.

The clinician proceeds to gather additional indepth data regarding the client's psycho-sexual-social history endeavoring to identify certain behavioural patterns which may be contributory to the erectile problem. This is done by following the Topic of assessment checklist by Jehu (1979), Appendix I. This procedure includes seeking out information regarding the client's past sexual experiences with his partners; of which there were many, in order to establish whether a common sexual dysfunctional behaviour pattern may have occurred. This clinician will not, however at this time, elaborate on the findings of these assessment interviews due to the length and details of the events. In order to avoid repetition of the data, the clinician will include the relevant information in the recommendation letter which was sent to the referring physician.

Since the client is expressing strong notions that he 'felt sure that his impotence was caused by a nerve being

cut by the surgeon', particular attention is focused on obtaining detailed medical information which may either substantiate or disprove this statement. A literature review is also undertaken in order to ascertain whether a surgical procedure; namely, a prostatectomy can, in fact, affect sexual functioning.

Literature reviews are also conducted on the reliability of the NPT testing procedures that are used as a means of establishing differential diagnosis of the erectile problem since the physician has mentioned in his letter that the two NPT tests which were conducted on this client were 'contradictory to conclusion'.

The Aetiology Screening Checklist (Erectile Dysfunction) by Kockott et al (1980), Appendix IV, is also utilized in order to establish the extent of the erectile dysfunction. The results of this procedure reveal that the client is able to obtain a 'firm' erection intermittently.

Formulation of hypothesis

Hence with the assistance of the information derived from the assessment procedures, literature review findings, and other instruments, the clinician is able to arrive at a hypothesis that the erectile difficulties are more than likely caused psychogenically--the impotence problem appears to be situational, eg. occurring with a new sexual partner. (Refer to the rationale given in the recommendation letter to the physician for further elaboration on the process of determining the etiology of the sexual dysfunctional problem).

Treatment plan

After arriving at a diagnosis, both the client and the clinician review the findings. Both agree that Roy requires more time and information in order to make a firm decision as to whether he should proceed with sexual therapy or seek another alternate form of treatment; namely, the PPI surgery. Three sessions are arbitrarily contracted in order to give Roy a time frame in which he can obtain sufficient information and counseling which will assist him to make a firm decision as to the direction of treatment he wishes to take.

Treatment

In the ensuing counseling sessions, Roy is encouraged to ask questions especially in the areas of medical education, sexuality, etc. which may be creating conflicts for him and thus impeding his decision-making process. The purpose of these sessions is primarily to provide information in a semi-structured context, the goal being, to help Roy arrive at a conclusive decision regarding the direction of treatment. The information-giving procedure and its contents are in keeping with the recommendations found in the literature reviews.

These counseling sessions include: (a) brief therapy--PLISSIT model concerning issues and concerns regarding residual effects of the negative experience revolving around TUR surgery, performance anxieties with new partners, etc; (b) counseling regarding the alternatives which are available to him--PPI versus sexual therapy; (c) medical

education relating to physiological and anatomical functioning level of the male sexual system; (d) information regarding the sexual response cycle of the male and (by Roy's request) of the female; (e) penile prosthesis information are given utilizing diagrams, etc.

The discussion in these sessions differ little from the areas of concerns which are covered in the process of doing actual therapeutic intervention. The difference is primarily on the ultimate goals of these sessions--that is, to identify and to determine which treatment mode the client wishes to pursue.

Roy is encountering considerable difficulties in settling in his mind whether he should contemplate the 'conventional' sexual therapy program and/or to proceed with the PPI operation. He repeatedly verbalizes his inability to be decisive about which course of treatment he should follow.

Since the client is showing more interest in pursuing the sexual therapy, the clinician agrees to take him through the beginning stages of the 'prescribed' instructions in the treatment of erectile failure. (Refer to literature review). This is not the usual practice, however, since this client continues to vacillate between the two alternatives without coming to a firm decision, the clinician is of the opinion that his method is beneficial in assisting him.

Since the assessment procedures reveal that the client lacks information in the area of sexuality per se, it is

decided that in addition to the 'trial' sexual therapy assignments, educational aids such as the book 'Male Sexuality' by Zilbergeld (1978) will be helpful in providing him with a much broader knowledge base on the physiological and psychological aspects of sexuality.

Following the completion of the sessional, 'prescribed' sexual therapy assignments and the recommended readings, both the client and the clinician arrive at the following conclusion--that is, 'conventional' sexual therapy will not be beneficial to this client in restoring erectile capabilities due to the following factors:

(1) The etiology of the erectile problem has been diagnosed as psychogenic, however, the client (even with brief psychotherapy in this area) is not able to overcome his belief that the prostatectomy surgery has 'damaged' the nerves governing erection, resulting the impotence problem'. This mind-set persists even though the findings of the literature review regarding the effects of urological surgery on sexual functioning are repeatedly explained to him. The client is also advised to speak to the physician who had performed the prostatectomy operation and had allegedly 'cut the nerve'. Roy is not wishing to pursue this however. Moreover, the client refuses to contact his present physician nor will he authorize the clinician to discuss this matter with the physician in order to confirm or disclaim the validity of his beliefs.

(2) Situational 'performance anxiety' is deemed as contributing to and maintaining the client's erectile problems. Since the 'conventional' sexual therapy program for

overcoming performance anxiety recommends an understanding and co-operative sexual partner (Jehu, 1979), and the fact that this client (at the time of therapy) does not have a regular sexual partner, much less share a 'close' relationship with someone of the opposite sex, presents obstacles to the likelihood of a successful outcome of overcoming this particular type of sexual dysfunctional problem.

(3) The client is 58 years of age with an additional medical condition--heart problem which requires a pacemaker. The client states that he does not feel either psychologically and emotionally that he has the required time to spend on lengthy sexual therapy sessions, especially when assurance cannot be given for a successful result. He feels that the impotence problem is 'holding him back from forming a loving relationship which he desires'. Physically, Roy is very spry and vibrant--likes activities such as dancing, boating, going out to movies.

The clinician proceeds to help Roy work towards making a firm decision as to the course of treatment he wishes to pursue. Discussion focuses around the alternatives which are available to him--either to have the PPI surgery or not to have the surgery.

The findings of the literature reviews on the types of penile prosthesis, problems and implications of the penile prosthetic implantation surgery, practical concerns, etc. provides the client with the necessary information in order to help him to make a firm decision whether to proceed with the penile prosthetic implantation surgery.

The client is given an opportunity to query the clinician for any information regarding the PPI surgery. This procedure reveals the following:

(a) whether the client has sufficient information regarding the penile prosthetic implantation surgery in order to make a decision based on factual knowledge. If Roy is of the opinion that the PPI surgery will solve his other problems such as lowered self-esteem, relationship conflicts, etc. then clarification will need to be provided prior to the surgery. The importance of this process is emphasized in the literature review.

(b) this procedure also assists the clinician to identify any stressful situations which need to be addressed prior to surgery. In Mr. R's case, he is very anxious as to whether his heart condition and his pacemaker will withstand the operation. Another pervasive fear seemingly held by this client is that of contacting cancer if he has the PPI surgery. These concerns indicate that the client will require further counseling in regards to these issues in addition to supportive counseling prior to the operation in order to help alleviate undue anxiety. (Refer to literature review on pre-operative counseling).

Once a firm decision is made by the client--that is, to proceed with the PPI surgery rather than continuing with the 'conventional' sexual therapy, the clinician then proceeds to the next step of the assessment procedure--that is, the psychological evaluation for the suitability of the client for PPI surgery.

Literature review findings on the selection of candidate for PPI are investigated and the suggestions are incorporated into the psychological evaluation procedure (Appendix XVII). Upon completion of this evaluation, a recommendation is sent to the physician who is requesting an assessment report. These recommendations are based on: (1) the information gathered during the assessment interviews; (2) findings from various instruments, eg. Sexual History Form, Aetiology Screening Checklist (Erectile Dysfunction); (3) the results of the 'trial' sexual therapy program which was undertaken by the client; (4) the decision of the client to proceed with the PPI surgery; (5) results of the psychological evaluation of candidate for PPI surgery.

Recommendations to the referring physician

The purpose of the assessment is to determine whether the erectile dysfunction is of organic or psychological etiology and to make recommendation for treatment of the problem.

Description of problem

Roy R. is a 58 year old widower who has been experiencing considerable erectile difficulties since his prostatectomy operation 8 years ago. He states he gets only partial and fleeting erections during lovemaking and masturbation and has only recently recovered full erections on waking but only intermittently. The NPT monitoring showed little or no erection.

Personal and sexual history

Roy was married at age 18 to his wife, age 16. They had 4 children. During their marriage, although Roy drank excessively, he never experienced any erectile problems. He claims 'erection was always instant'. After 20 years of marriage, he divorced his wife. After the marriage terminated, he reports he was not involved in any sexual activity for 6 years.

When Roy was 44 years of age, he became very attracted to a girl, 16½ years of age and subsequently married her. Although he encountered some performance anxiety at the beginning of their relationship, he was able to have coitus five to seven times daily or/and nightly. Erection was not instanteous as previously (took him longer) but he encountered no erectile failure. The couple's relationship deteriorated and the wife subsequently left her husband. She was later killed in a motor vehicle accident.

Roy then had other sexual partners after the separation from his second wife. He states he had relatively little difficulty in having a firm erection.

Roy lived in a common-law relationship which lasted for 4 years. The wife, according to Roy, had considerable psychiatric problems. He professes he never loved this wife. The frequency of their sexual activity was once weekly, to none by the end of their relationship. Apparently he encountered no erectile problems until he had his prostatectomy operation.

Roy expresses the belief that the doctor who performed the operation had cut a nerve when he had the operation. He was able to have a firm erection only once during a six-month period after the operation.

After Roy and his common-law wife parted, he had eight (plus) sexual partners in succession. All of these partners were young (in their 20's or younger). In each case, after considerable foreplay, he was able to achieve a partial erection but then his penis would become flaccid. Roy is presently becoming very discouraged as he is wanting to have a relationship with a woman, however, at the same time he feels he does not want to subject a woman to not being able to have sexual intercourse.

Roy admits that he is isolating himself from becoming involved with a woman due to his past erectile problems. He is finding the loneliness he is experiencing increasingly difficult to cope with as he enjoys the closeness, warmth and feelings of intimacy that the sexual act allows.

The information gathered during the assessment procedures reveal that there were considerable age differences between the client and the last six partners. This fact was pointed out to Roy and that there would be a greater probability of finding a more suitable type of relationship if the partners were closer to his own age, ex. more mutual interests, etc. He states he has always been attracted to younger women.

Roy discounts the fact that he may need someone young to boost his ego and/or as a denial of his own advancing

age. Apparently he has always had a great appreciation for the young due to his giving nature as well as finding the role of the 'sage' fulfilling. However, Roy says he will not turn away from an older woman, if she were presentable and compatible. The opportunities presently available for sexual encounters are mostly with young women, however, he has not pursued this activity lately.

Roy appears to have a great deal of love to give. Through counseling, he is fully aware of the implications of the 'performance anxiety' he encounters (especially with a new sexual partner) when he is anticipating erectile difficulties--and as a result, he is avoiding any situation which may cause him to get into this predicament. Roy reports he is 'scared of failure' and admits to being very frustrated with this problem. He voices his concerns whether his impatient nature will see him through any lengthy psychotherapy program.

The clinician has reviewed fairly extensively with this client what the sexual therapy program will entail. In this particular case, the most important component to the successful outcome of sexual therapy is missing--that of an understanding and co-operative sexual partner. Until Roy is able to find such a sexual partner, sexual therapy per se can only consist of readings, information-giving, counseling, self-administered assignments to reduce anxiety, cognitive restructuring of negative attitudes, correction of misinformation, etc.

Roy is highly motivated in his desires to overcome his sexual problem. He has read the book which was suggested to him and did the self-masturbatory exercises. He obtained an erection the first time, however, failed on the second and third times.

As the alternative course to sexual therapy appears to be a penile prosthetic implantation, the clinician has discussed with Roy the physiological-psychological and social advantages and disadvantages which can be derived from the prosthesis. Other information which was provided included: the different types of prostheses which were available, differences in the mechanisms, complication rates, etc. (Refer to literature review).

As Roy seems very concerned of contracting cancer from such an implant, it has been suggested to him that further questions of this nature should be directed to the physician. Overall, sufficient knowledge has been presented to Roy in order that he may decide on which course of treatment he wishes to pursue.

From the various assessment procedures it can be concluded that the etiology of the erectile problem is psychogenic. Recommendation for sexual therapy is this clinician's first choice if a sexual partner were presently available, however, lacking one, the prognosis for good results are minimal.

Roy is a man who has a great deal of love to give, both emotionally and physically. He projects a positive outlook to life in view of the fact that he has a heart

problem and a pacemaker. He has more than sufficient monies (due to his substantial real estate holdings) to be able to enjoy life to the fullest. However, due to his anticipated fear of failure in achieving an erection, he is presently living a lonely, reclusive life.

Hence, in taking into consideration his age, psychological and social ramifications of the sexual problem, the clinician would strongly recommend that surgery for penile prosthesis implantation be considered. Pre and post operative counseling will also be beneficial for this client and this can be undertaken by this clinician, if desired.

This recommendation (along with an evaluation report) was forwarded to the physician who subsequently agreed to accept the client as a candidate for the PPI surgery. The physician requested that the clinician undertake pre and post operative counseling with the client. (Refer to literature review).

Treatment

In the course of an ensuing discussion, it is revealed that Roy is very apprehensive regarding the procedures involved in the PPI surgery. He feels more assured, however, regarding the operational procedures when the clinician informs him that she has had an opportunity to view the actual operation. This tends to lend more validity to the information which is provided as part of the presurgical and supportive counseling.

Since Roy does not wish the members of his immediate family to be informed of the nature of his operation, he

lacks the psychological and emotional supports which are usually provided by close family members during the entire time of his hospital confinement.

Information regarding the medical procedures which are to be followed by the medical personnel prior to the surgery such as an antibiotic regime, preparation procedures for the operation, etc. are provided to the client in order to give awareness of the procedures he may expect--the purpose is to alleviate the anxiety of dealing with the unknown. Any medical questions which cannot be answered satisfactorily by the clinician is directed to the physician.

Results of the surgical intervention

The PPI surgery is successful, taking approximately one and one-half hours to complete. Post-operatively, Roy has considerable discomfort in the scrotum and penile areas. Some of the pain is alleviated by the application of ice packs to the surgical site.

Post operative and supportive counseling is undertaken immediately after the operation. (Refer to literature review on post-operative counseling). This type of counseling includes answering any questions which may be causing the client concerns or anxieties regarding the PPI surgery with the clinician acting as liaison person between the medical staff and client if any patient-care problems should arise.

By being cognizant that the client is undergoing considerable physiological and psychological trauma as a result of the PPI surgery enables the clinician to provide

the type of supportive counseling which is required. This type of counseling is similar to the medical social work interventions which are conducted on other patients undergoing any medical or surgical procedures.

Prior to discharge from the hospital, both the physician and the clinician reinforce the following advice in regards to the PPI: (a) to allow at least a three week post-operative period before the PPI is utilized in coital activity; (b) to watch for any signs of infection.

Additional information regarding the technical aspects of the PPI apparatus is also thoroughly covered. Discussion also revolves around other matters such as: (a) how and when to inflate the pump in preparation for coital activity; (b) the question of whether the client should inform his sexual partner about the PPI in a newly formed relationship.

Techniques of relationship enhancement (refer to literature reviews) are also taught. The rationale for the above post-operative advice is from a 'preventive' strategy. Example: the purpose of providing the client with the newly implanted prosthesis with information regarding relationship enhancement techniques is so that the client will not encounter difficulties in this area in the future.

Upon discharge from the hospital, the client is encouraged to contact the clinician if any sexual problems or psychological concerns should arise. A three-month; one year; and one and one-half year post-operative follow-up evaluation is agreed upon.

Information Derived from Post-Operative Follow-Ups

The clinician was unable to find a questionnaire which was suitable to her requirements of evaluating the level of psycho-sexual-emotional and social satisfaction after a PPI surgery, therefore, the clinician designed a questionnaire. The questionnaire can be utilized at any designated time intervals. This allows the clinician to check at specific times whether there has, in fact, been any changes in the different areas which are being observed.

The main purpose of this questionnaire is: (a) data collecting on the psycho-sexual-emotional and social level of satisfaction of the PPI; (b) to utilize the information which was collected from the questionnaire in order to identify any areas of concerns and to proceed with counseling to resolve the problem.

This clinician has completed and included in this report, the questions and answers from the questionnaire which were provided by the client at the 18 month post-operative time frame.

The areas of concerns which were revealed from the questionnaire at the designated time intervals were as follows:

Three-month post-operative follow-up--Roy relates he encountered some embarrassing moments when he first proceeded to inflate the hydraulic pump of his PPI and nothing happened. He later discovered that in his state of apprehension, he had been squeezing the wrong part. Roy is not having any other problems adjusting psychologically or

emotionally to the PPI. He is going out more socially but he maintains he is being 'cautious' about getting involved in a relationship. He has had sexual intercourse with one woman during this interval. He is encountering no difficulties in this area.

Twelve month post-operative follow-up--As was revealed previously, Roy still reports less interest in pursuing women for sexual encounters after the PPI operation. He states he has had sexual intercourse with three women in the last nine months (since the last follow-up). When queried why he experienced this lack of interest, he states, 'he knows he can have an erection at any time, therefore there is no 'nagging' urge to pursue many sexual partners in order to prove his 'virility'. He does not identify any other major problems in the areas related to the PPI or relationship problems.

Eighteen month post-operative follow-up--Refer to questionnaire for complete details of questions and answers by this client.

POSTOPERATIVE PSYCHO-SEXUAL-EMOTIONAL AND SOCIAL QUESTIONNAIRE PERTAINING TO THE LEVEL OF SATISFACTION FOR PATIENT/PARTNER WITH PENILE PROSTHESIS IMPLANTATION (PPI) J. Kato

Time duration--18 months post operatively

(The answers to the following questions were given by Mr. R. in verbatim form, 18 months after his PPI surgery)

General:

-Were there any difficulties in acceptance of PPI? "No, I promised myself that if the PPI worked, I would never abuse it. I felt the PPI was like 'gift from God'".
-Did the PPI meet up to your expectations? "Yes, I have not had any problems with the equipment. I think it is great".
-Do you regret having had the PPI operation? "No, never".
-Did you feel it was natural or mechanical? "I never concerned myself with those thoughts--probably because I had a pacemaker implanted for heart problem and I had accepted the mechanical device as an aid. I had no psychological conflict or concerns whether the PPI was natural or mechanical".

Sexual Activity Level

-How soon after the PPI operation did you attempt intercourse? "Three weeks".
-Were there any changes in frequency of sexual activity? Increased; same; or decreased? "Increased, because before the PPI I wasn't able to have an erection so didn't have sexual intercourse".
-Did PPI make difference of enjoyment during coitus? "Yes".

Psycho-Sexual Adjustment

-Were there any psychological-emotional difficulties in acceptance of PPI? "No, because without it I encountered so many psychological and emotional problems, therefore I was happy to receive a device which would help me. I had also given the matter a tremendous amount of thought before consenting to the operation. I had one fear--that is, if I have it removed, I would never function sexually. The physician had stressed this fact strongly and I was fearful that I would be 'ruined for life'. Any pain I encountered or any unusual sensations in the groin area, made me feel anxious".
-Did the PPI create anxiety, guilt, depression? "Anxiety was created by fear of complication".
-Do you feel differently about your body image as result of the PPI? "Yes, I feel it has made me psychologically 20-30 years younger due to my ability to have sexual intercourse".
-Did you notice any improvement in gender identification with other men? "Yes, I feel like a man again".

-Did the PPI improve how you felt about your self esteem? "Yes, because when I couldn't perform, I felt very degraded. Now I do not feel I have to prove to myself that I can do it".
-Did the PPI affect your self-confidence? "Yes, I felt I could pursue courting, leading to sexual intimacy if I so desired".
-Do you think it has increased your popularity? "Yes, I feel it has because I am less inhibited to make a sexual pursuit".
-Has your feelings towards women changed as result of PPI? "Yes, I feel more confident that I can please without concern of rejection".

Social Adjustment (Life Style)
-Did the PPI improve your social life? "Yes, definitely. I feel much freer to participate in all aspects of socializing--dating, dancing".
-Do you go out more often? "Yes, since there is nothing to stop any of the social activities".
-Do you feel more comfortable in social contact with the opposite sex since you had PPI? "Yes, since I know I will not be rejected if I cannot perform".
-Have you noticed a change in your own appearance since PPI? "I am more casual in dress. I do not feel I have to fall into a certain stereotype in order to attract a date. I can be myself".
-Have you noticed a change in your life style since PPI? "Yes, it is much freer, less depressing".
Loneliness was one of my greatest problems--wanting to share physically and emotionally with a partner".
-Has the PPI created any problems in sexual or non-sexual areas of your life? "The only problem, if you can call it that, is a physical awareness at times, due to the pressure from the equipment. This pressure is felt in the penis".
-If so, would you like to receive further counseling in order to alleviate problem? "Not necessarily, since I have learned how to solve the problem. I just release some of the pressure in the pump".
-Overall, do you feel a greater sense of happiness as result of PPI? "Yes, as I said in the signed statement, I think the PPI is great".

Sexual Partner's Response or Adjustment to PPI
-Did you explain to your partner about the PPI? "No, I did not. Not to any one of my partners--not even to the one with whom I lived for 8½ months".
-How did your partner react to PPI? "She did not know, but she thought the sex act was terrific".
-Due to the mechanical function of PPI, do you feel pressure to perform when you do not want to have intercourse? "No. I know that I can have intercourse more than once and often I do".
-How many partners have you had since PPI operation? "Five. The duration of the last relationship was 8½ months.

Breakup of relationship was not due to any sexual problems".
-Do you feel that the PPI has improved your interpersonal relationship, especially in the sexual area? "Yes, definitely".
-In non-sexual area? "Yes, I do not feel so defensive about having sexual problems".
-Has the PPI increased the frequency of sexual contact? "No, not really because I swore I would not 'abuse it'".

Subjective Rating of PPI by Client

If you had to rate the outcome of the PPI, how would you rate it from psycho-sexual-emotional and social functioning level:

Satisfactory X
Fair
Poor

Physical Functioning Level:

Satisfactory X
Fair
Poor

Questions Specific to Merits of the Pre and Post Surgical Counseling (Conducted 3 mth. post PPI)

-Did the information-giving sessions which were given prior to PPI operation help you to adjust postoperatively? "Yes, the information you provided to me gave me assurance as to what I might expect, therefore, I did not have any unrealistic expectations. The counseling was especially helpful in allowing me to make the final decision as to whether to go ahead with the PPI operation since I was so fearful of cancer or chance of getting infection".
-Did you feel pressured into agreeing to have PPI operation by the clinician or the physician? "No, not ever".
-Did you gain knowledge (broader perspective of implications of PPI) from the counselling sessions? "Yes, the sessions provided me with a total picture of what to expect. It also provided me with an awareness of what the PPI would not do as far as enhancing a relationship. The information regarding the techniques and skills was helpful--especially around the topic of how to go about using the equipment without embarrassment".
-Was the supportive counseling you received from the clinician when you were admitted into the hospital, helpful to you? "Yes, besides it was nice to know that someone was concerned and was there if I wanted to know what to expect from the operation".

Table Used to Measure Level of Satisfaction with PPI
by: D. Gerstenberger; D. Osborne; W. Furlow 'Inflatable Penile Prosthesis: Follow-Up Study of Patient-Partner Satisfaction'
Urology, Dec. 1979.

Level
Very Satisfied..... ✓
Fairly satisfied.....
No strong feelings one way or another.....
Fairly dissatisfied.....

Reasons for dissatisfaction
Inadequate firmness.....
Cylinder Ballooning.....
Device reinflation.....
Pain..... ✓
Loss of sensation.....

Complications in patients with inflatable penile implant
Mechanical
- Loss of fluid
- Kinking of tubing
- Ballooning of cylinder

Nonmechanical
- Decreased sensation
- Decreased temperature in glans penis

Too painful for intercourse
Cylinders self-inflate
Deflates too slowly
Pump too high in scrotum
Uneven length of cylinder
Deflates during intercourse

Degree and sites of discomfort in patients with inflatable penile implant

Discomfort	None	Mild	Moderate	Severe
Associated with implant				
Associated with site				
Glans penis				
Penile shaft			✓	
Scrotum				
Base of penis				
Abdomen				

Frequency of intercourse by patient with PPI

Before onset of impotence	After onset of impot	Postop.
0-not at all ✓		
1-once a month or less	✓	
2-every two or three weeks		
3-once or twice weekly		
4-three or four times weekly		
5-five or more times weekly		✓

Comparison of postoperative erections with previous normal erections in patients who received PPI

Erection	
Same	
Shorter	
Softer	
Harder	✓
Deviates to side	
Glans penis softer	

Clinician's Observations and Comments

When a clinician deals mostly with sexual dysfunctional problems related to an organic condition, it is not uncommon to deal with many situations where the client's adverse or negative psychological reaction/s to the condition has a profound effect on his sexual functioning. This particular case exemplifies the preceding observations as well as demonstrates the complexity of the mind-body interplay which is involved within the sexual response system.

For instance, Roy had a prostatectomy operation eight years ago, shortly after which time he started encountering erectile problems. According to the literature reviews on the effects of a prostatectomy operation on sexual functioning unless this client had obtained the prostatectomy operation by the perineal route (Zinsser, 1975), he should not have sustained any long-lasting effects on sexual functioning. However, psychologically, this client is presently of the belief that the 'surgery was responsible for his sexual problem'. No amount of evidential information would change Roy's perception or 'mind-set' that this operation had caused his impotence problem.

Interestingly, the assessment procedure revealed that this client had surgery for a pacemaker implantation many years previous to his prostatectomy operation. According to the literature review findings regarding the pacemaker and sexual functioning, Cortes (1974) observed that "the implantation of a cardiac pacemaker may limit the patient's sexual activity of the pacemaker is not properly set" p. 252.

Apparently, the fixed-rate type pacemakers should be set at a "rate equal to or slightly greater than the heart rate" while the demand-type pacemaker, "should be sufficient for the heart rate attained during sexual activity" (Cortes, 1974, p. 252).

When Roy was queried regarding the type of pacemaker he had had implanted and whether there were any disruptions to his sexual functioning at any time in the past, he was not aware of the type of pacemaker he had implanted nor had he encountered any sexual problems after the pacemaker was implanted.

This is not to infer that all pacemaker recipients would encounter sexual difficulties. However, it would have been of interest to note if the client would have experienced sexual problems had he been informed of the possible consequences of the pacemaker implantation to his sexual functioning as he had been advised regarding the prostatectomy operation.

Having an awareness of the 'preoccupation' problem that the client had encountered previously with the prostatectomy operation presented a dilemma when the penile prosthesis implantation surgery Roy was seeking required the clinician to provide information as to the consequences of an operation which met with complications, (eg. if an infection or extrusion should occur, the prosthesis will have to be removed and he may never function sexually again).

Ethically and professionally the clinician cannot withhold information of this nature and yet by providing

and subsequently implanting this pattern of thought into the client's mind, the end results of a negative reaction to the condition can almost be assured.

The post-operative evaluation verified this prediction of a negative response. Roy stated that he was so fearful of an infection after the PPI operation that the slightest sensation in his penis caused him tremendous worry. However, he refused to consult his physician in this regard.

This situation created a greater appreciation of the 'influencing' factor of the mind-body system which might be encountered when dealing with sexual dysfunctional problems related to organic conditions.

In order to assure the collection of relevant information of the PPI, this clinician is of the opinion (from her own experiences in dealing with the client and partner of PPI) that it is a good policy to establish prearranged postoperative counseling sessions or follow-ups at designated time intervals. With this method, it is possible to obtain a commitment from the couple that they will attend these sessions.

If they are unable to attend in person after the first post-op follow-up sessions, then an interview may be conducted by telephone. The motivating factor which appears to influence the couples to comply with these follow-up sessions is an explanation that the post-operative counseling sessions allowed the client/s and the clinician to detect, resolve and prevent future problems (sexual or non-sexual) from developing within the relationship.

By informing the clients that a follow-up questionnaire is required in order to collect data which will be utilized for further research produced beneficial results. It is emphasized to the clients that any advancement of knowledge in this field would be helpful to prospective PPI candidates from a technical and psychological-sexual perspective.

CONCLUSION

In concluding this report, the clinician would like to make a few comments regarding some of the general observations which were noted during her practicuum studies and the subsequent learning that she derived from her experiences.

From the experience of undertaking the various cases, this clinician has observed certain behavioural patterns which seemed to occur more frequently among clients and/or the partners who were encountering sexual dysfunctional problems related to complex medical conditions than were present in clients who sought the 'conventional' type of sexual therapy (with no pathology involved).

The client and/or the partner of this 'special' population seemed to have a much higher level of psychological, emotional or social problems to contend with which often impeded the continuation and completion of the assessment procedures in an orderly manner, eg. refer to case nos. 1, 2, and 3. The client or partner who was being evaluated presented with exaggerated symptoms which had manifested themselves, eg. anger, anxiety, depression, hostility, etc. These symptoms had to be resolved or stabilized prior to the clinician being able to complete the assessment in order to identify the causation of the sexual dysfunction.

In other words, the response to the organic condition seemed to create psychological-emotional reactions of such heightened intensity that these prevented the client and/or the partner from rationally identifying or dealing with

their problems, even those of a non-sexual nature. For example, in case no. 2, the wife presented with such an extremely high level of anxiety together with despondency as the result of the psychological reactions to her husband's disabled condition that considerable psychotherapy revolving around crisis intervention, grief and problem-solving counseling had to be undertaken before the remediation of the sexual dysfunctional problem can be considered.

Dealing with a client who is suffering from an aphasic condition presented another type of therapeutic situation which this clinician had never experienced previously in 'conventional' sexual therapy. The inability of the client to communicate coherently occurred in several of the cases and this handicap greatly impeded the progress of the assessment procedure.

The above-mentioned situations revealed clearly the necessity for the improvisation of the normal information-gathering procedure. The recommended method of information collecting were thus altered and the clinician had to accept the information which was provided by the third party, being fully cognizant of the fact that since the partner had a vested interest in accomplishing certain treatment goals, that the information forthcoming may be biased.

The ideal is to be able to complete the assessment procedure, to arrive at an accurate clinicial diagnosis, and to formulate a treatment plan which leads into treatment. However, due to the multiplicity of variables which have to be considered and dealt with, even the completion

of an assessment-to-treatment format met with numerous obstacles.

The clinician recognizes that some of these psychological barriers or resistances which were encountered are often an integral part of the client's defence or coping system, however, these obstacles presented problems for the clinician when they surfaced during the assessment interview and subsequently hindered the completion of the evaluation in a methodical manner, eg. case nos. 1, 2 and 4.

Whenever a situation of resistance is encountered during the assessment procedure, the clinician has learned from experience that the best solutiion (to expedite matters) is to stop the assessment procedure immediately and to start focusing on helping the client to resolve the problem which produced the symptoms. To ignore the symptoms and to continue with the assessment interview is unproductive. By helping the client to overcome the problem which is causing the imbalanced emotional state tends to firmly establish the clinician-client helping relationship and to allow continuation of the assessment interview.

It is true that during the 'conventional' sexual therapy program, the same process of the 'helping' relationship must be observed and established between the clinician and the client. However, it is noted that in dealing with this 'special' population, the degree of interpersonal interaction which is required in establishing credibility within a client-clinician relationship seems far greater than required in the 'conventional' sexual therapy program,

with much energies being expended by the clinician towards motivating the clients to undertake a certain therapy or treatment program, eg. refer to case nos. 1, 2, and 4.

The majority of the clients seem to be confused and undecisive as to the direction which should be pursued due seemingly to their lack of knowledge associated with the organic condition and the sexual dysfunctional problem.

Hence, it was revealed that in order to assist the client and the partner to comprehend the ramifications of the organic condition/s, it is essential for the clinician to have knowledge in the rudiments of medical terminology which is used in the various textbooks, journals, and literature reviews and to be able to translate these into simple 'layman's' language.

In conclusion, the clinician has been made very aware by her experiences of working with this 'special' population that numerous factors need to be considered in arriving at an accurate clinical diagnosis and the subsequent selection of an appropriate treatment plan. And even after the best strategies are pursued, unpredictable circumstances seem to interrupt the assessment or treatment procedures and consequently the goals which are carefully planned, negotiated and established, quite often have to be altered.

This clinician has developed a 'philosophy' which has more meaning and truth as one proceeds in doing counseling in this area--that is, 'success' is not always measured in terms of the number of cases which reach the goals

originally formulated or prescribed. Instead, the best perspective to adopt when undertaking sexual rehabilitation counseling, is that of instituting a comprehensive therapeutic program which will assist the client and the partner to the maximum level of sexual functioning within their own capabilities and potentials. If 'success' were to be measured by the client's ability to achieve 'normal' sexual functioning as prescribed to the average individual, then the clinician may become very discouraged.

The overall purpose of pursuing this particular area of studies; namely, sexual rehabilitation is to enable the clinician to broaden her present knowledge of the 'conventional' sexual therapy and to acquire additional theoretical knowledge and counseling skills in order to assist the clients and the partners who are afflicted with sexual dysfunctional problems or encountering sexual difficulties as a result of a complex medical condition.

The challenges were many, mixed at times with feelings of frustration and helplessness, however, this clinician can truly state that this practicuum experience has broadened her learning in this area. It is this clinician's intent to continue specializing in this particular area and perhaps contribute some additional knowledge to what Zilbergeld (1978) referred to as 'the least known area of sexuality'.

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APPENDICES

APPENDIX TABLE

APPENDIX I

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

*Reproduced from Jehu, D. Sexual Dysfunction: Behavioural approaches to causation, assessment and treatment, Wiley, London, 1979.

9. Organismic variables

    (a) thought processes

        e.g. (i) cognitive avoidance

        (ii) cognitive monitoring

        (iii) deficient or false information

    (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) owns parents (ii) parents-in-law

13. Partners' 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

(eg. 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

SEXUAL HISTORY FORM* APPENDIX II

(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 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

2. How frequently would you like to have sexual intercourse 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 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 mintues
   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
2) 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
4) seldom, about 25% of the time
5) never

3) sometimes, about 50% of the time
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 beings?

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 the 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
4) seldom, about 25% of the time

2) usually, about 75% of the time
3) sometimes, about 50% 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 speeding 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

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 III

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 you 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 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

SEXUAL AROUSAL INVENTORY - (CONTINUED)

-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 you were actually involved in this experience.						
10. When you dance with a loved one.	-1	0	1	2	3	4	5
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
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

SEXUAL AROUSAL INVENTORY - (CONTINUED)

-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 you were actually involved in this experience						
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 you partner has an orgasm	-1	0	1	2	3	4	5

October 13, 1977

Aetiogical Screening Checklist (Erectile Dysfunction)

(Kockott etal., 1980)

	0. No erection	1. Slight erection	2. Moderate erection	3. Almost full erection	4. Full erection
Strength of erections during foreplay					
Strength of erections during masturbation					
Strength of spontaneous erections (including morning erections)					
	0. Masturbation as bad as or worse than sexual contact	1. Masturbation somewhat better than sexual contact	2. Masturbation better than sexual contact	3. Masturbation definitely better than sexual contact	4. Equally good in masturbation and sexual contact
Comparison of erections during masturbation and sexual contact					
	Yes	No			
Anxiety feelings during sexual contact					
Avoidance of sexual activity					

Additional Topics

Does erectile capacity vary across occasions and/or across partners?

Time and circumstances of onset/course (in relation to onset/course of relevant organic condition).

Any possibly relevant organic factors (e.g. illness, surgery, medication, alcohol).

Any possibly relevant psychogenic factors (e.g. stress, discord, depression, deficient information/stimulation).

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. Demonstration 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. Conventionality (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

DYADIC ADJUSTMENT SCALE - (CONTINUED)

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
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	Occa-sionally	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 you 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	Occa-sionally	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 on a project	0	1	2	3	4	5

These are some things about which couples sometimes agree and sometime disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Ches yes or no)

	Yes	No	
29.	0	1	Being too 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 any more 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.

APPENDIX VI

SDM

INSTRUCTIONS

At the top of each page you will find the name of a real or ideal person, and below it are some pairs of words.

Here is how to use these pairs of words:

If you feel that the real or ideal person at the top of the page is very closely related to one of the words, you should place a cross as follows:

PLEASANT __x__ : ____ : ____ : ____ : ____ : ____ : ____ : UNPLEASANT

CALM ____ : ____ : ____ : ____ : ____ : ____ : __x__ : ANXIOUS

OR

If you feel that the thing is quite closely related to one or other word, you should place a cross as follows:

PLEASANT ____ : ____ : __x__ : ____ : ____ : ____ : ____ : UNPLEASANT

CALM ____ : ____ : ____ : ____ : __x__ : ____ : ____ : ANXIOUS

OR

If you consider the thing to be equally related to both words, or if the words are completely unrelated to it, you should place your cross in the middle space:

PLEASANT ____ : ____ : ____ : __x__ : ____ : ____ : ____ : UNPLEASANT

IMPORTANT (1) Place your crosses in the centre of the spaces not on the dots between them.

This	Not this
____: ____: _x_: ____: ____:	____x ____:

(2) Be sure to put a cross between every pair of words on every page - do not leave any out.

(3) Never put more than one cross between a pair of words.

Please do not look back and forth through the pairs of words through the pages, and do not try to remember how you placed your crosses earlier. Make each cross a separate judgment. Work at fairly high speed. Do not worry or puzzle over individual items. It is your first impressions, your immediate feelings that are needed.

MYSELF AS I AM

Pleasant	:	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	:	Unaffectionate
Inhibited	:	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	:	Hard to arouse

MYSELF AS I WOULD LIKE TO BE

Pleasant	:	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	:	Unaffectionate
Inhibited	:	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	:	Hard to arouse

MY PARTNER

Pleasant	:	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	:	Unaffectionate
Inhibited	:	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	:	Hard to arouse

MY IDEAL PARTNER

Pleasant	:	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	:	Unaffectionate
Inhibited	:	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	:	Hard to arouse

APPENDIX VII

ASSESSMENT OF SEXUAL PROBLEMS OF A HANDICAPPED CLIENT

Quoted from Kolodny, Masters & Johnson (1979) p. 356.

1. Demographic data: age, sex, educational background, occupation, and marital status.
2. Origins of the handicap: physical, mental or combined.
3. Time course of the handicap: congenital or acquired; antedating to subsequent to establishing patterns of dating or other correspondence social skill attainment; antedating or subsequent to coital experience.
4. Limitations associated with handicap: motor, sensory, coordination, social, cognitive, or multiple limitations.
5. Adjustment to the handicap: coping abilities, acceptance, motivation for rehabilitation, self-esteem, affect, body image, denial, repression, or other ego-defense mechanisms.
6. Relevant sexual history: prehandicap patterns of sexual activity (if applicable) including difficulties or dysfunctions, sexual orientation, sexual satisfaction, estimate of libido, range of sexual behaviors, sexual attitudes and values, reproductive history; posthandicap patterns of sexual activity, as above; current sexual relationship; current and future sexual expectations (including reproductive goals), worries, and problems.
7. Relevant medical history: concurrent illnesses or drugs that may affect sexuality.
8. Social resources: family support system, marital relationship, friends or peer group, others (clergy, health-care professionals, etc.).

TABLE 1—*Effects of Medical Illness on Male Sexuality*

DISORDER	POSSIBLE EFFECT ON SEXUAL FUNCTIONING	PRESUMED PATHOGENIC MECHANISM
A. *Systemic Diseases*	*May decrease libido and impair erection; usually do not affect ejaculatory response*	*General debility and pain and depression*
General ill health and any chronic painful illness		
pulmonary disease renal disease cardiac disease degenerative diseases malignancies infections		
B. *Liver Diseases*		*Failure of damaged liver to conjugate estrogens properly, with consequent build-up of estrogen*
cirrhosis hepatitis mononucleosis		
C. *Endocrine Disorders*	*May decrease libido and impair erection*	*Various mechanisms: depression of CNS, general debility, lower androgen levels, depression*
hypothyroidism Addison's disease hypogonadism hypopituitarism acromegaly feminizing tumors Cushing's disease Klinefelter's syndrome		
diabetes melitus	30% are impotent Early impotence	Neuropathology and vascular damage
D. *Local Genital Disease*		
1. *Any condition which produces pain on intercourse*	*May decrease libido and produce impotence*	*Damage to genital organs and pain on coitus*
priapism chordee Peyronie's disease penile trauma balanitis phimosis diseases of the penile skin (e.g., herpes simplex) lower back pain		

[CONTINUED]

TABLE 1—*Continued*

DISORDER	POSSIBLE EFFECT ON SEXUAL FUNCTIONING	PRESUMED PATHOGENIC MECHANISM
2. *Any condition which causes irritation during the sexual response*	*Impotence and secondary premature ejaculation*	*Local irritability and damage to the genitals, which interfere with the reflex mechanism*
urethritis prostatitis urethral pathology		
3. *Any condition mechanically affecting intromission*	*Impotence*	*Negative psychic association*
chordee hypospadias penile injury or absence hydrocele large inguinal hernias		
4. *Conditions affecting testicular functioning*	*Impotence and loss of libido*	*Lowered androgen level*
bilateral orchitis due to mumps TB trauma feminizing tumors		
E. *Surgical Conditions*		
1. *Damage to genitals and their nerve supply*	*Impotence with no loss of libido*	*Destruction of nerve supply to genitals*
prostatectomy (radical perineal)—only occasionally on supra-pubic procedures abdominal perineal bowel resections		
lumbar sympathectomy	Ejaculatory disturbance	
abdominal aortic surgery	Ejaculatory disturbance	
some rhizotomies for pain relief	Impotence and ejaculatory disturbance	
2. *Castration*	*Loss of libido, impotence, retarded ejaculation*	*Lowered androgen level*

[CONTINU

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TABLE 1--*Continued*

DISORDER	POSSIBLE EFFECT ON SEXUAL FUNCTIONING	PRESUMED PATHOGENIC MECHANISM
F. *Neurologic Disorders*		
1. *Damage to lower neurological apparatus*	*May affect either erection or ejaculation or both; libido is not primarily affected*	*Interference with peripheral nerves or spinal cord reflex centers that subserve the sexual responses*
combined system disease		
malnutrition and vitamin deficiency		
tabes dorsalis		
amyotrophic lateral sclerosis		
syringomyelia		
spina bifida		
surgery or trauma of sacral or lumbar cord, cauda equina, pelvic parasympathetic nerves (e.g., herniated disc, tumor)		
multiple sclerosis	Frequently sexual disturbance is an early sign	
2. *Damage to higher sex centers*	*May cause increase or decrease of libido and changes in sexual behavior*	*Affects brain sex centers in limbic cortex*
temporal and frontal lobe (e.g., tumor, epilepsy, cardiovascular accident, trauma)		
G. *Vascular Diseases*	*Impair erection only; ejaculation and libido remain intact*	*Interference with penile blood supply*
thrombotic obstruction of the aortic bifurcation (Leriche syndrome)		
thrombosis of veins or arteries of penis		
leukemia		
sickle cell disorders		
trauma		

TABLE 2--*Effects of Medical Illness on Female Sexuality*

DISORDER	POSSIBLE EFFECT ON SEXUAL FUNCTIONING	PRESUMED PATHOGEN MECHANISM
A. *Systemic Diseases*	*May decrease libido and impair arousal*	*General debility and pa and depression*
General ill health and any chronic painful illness		
renal disease		
pulmonary disease		
malignancies		
cardiac disease		
degenerative diseases		
infections		
B. *Liver Diseases*		*General debility; failure of damaged liver to conj gate estrogens properly, with consequent build of estrogen*
hepatitis		
cirrhosis		
mononucleosis		
C. *Endocrine Disorders*	*May decrease libido and impair arousal*	*Various mechanisms: depression of the CNS, general debility, lower a drogen levels, depressio*
hypothyroidism		
Addison's disease		
hypopituitarism		
acromegaly		
Cushing's disease		
diabetes mellitus	Impairs sexual response in advanced stage	Neuropathology and vascular damage
D. *Local Genital Disease*		
Any condition which produces pain or difficulty on intercourse		
1. *Vulval and vaginal pathology*	*Dyspareunia and consequent loss of interest and responsiveness, and vaginismus; orgasm may remain unaffected*	*Damage to genital org and pain on coitus*
imperforate hymen		
hymenal tags		
congenital absence of vagina		
infection		

TABLE 2—*Continued*

DISORDER	POSSIBLE EFFECT ON SEXUAL FUNCTIONING	PRESUMED PATHOGENIC MECHANISM
low estrogen levels with senile vaginitis		
diabetes		
post-irradiation vaginitis		
allergy to vaginal sprays and deodorants		
vulvitis		
leukoplakia		
Bartholin cyst infection		
urethral caruncle		
2. *Pelvic pathology*		
pelvic inflammatory disease		
endometriosis		
fibroids		
prolapse of the uterus		
anal fissures or hemorrhoids		
pelvic masses		
ovarian tumors and cysts		
uterine tumors		
3. *Other local pathology*		
clitoral adhesions	Impair orgasm?	Prevent rotation of clitoris
tight clitoral hood	Impairs orgasm	Pain on stimulation
pubococcygeus muscle weakness or fibrosis	Impairs orgasm?	Poor orgastic contractions
E. *Surgical Conditions*		
1. *Damage to sexual organs*	*Impairs sexual response but not libido; may cause pain on intercourse*	*Patulous introitus, painful scars, or shortened vagina sometimes resulting from surgery*
poor episiotomy		
obstetrical trauma		
poor hysterectomy		
2. *Damage to androgen supply*	*Impairs libido and responsiveness*	*Lower androgen levels*
oophorectomy plus adrenalectomy		

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TABLE 2—*Continued*

DISORDER	POSSIBLE EFFECT ON SEXUAL FUNCTIONING	PRESUMED PATHOGENIC MECHANISM
F. *Neurologic Disorders*		
1. *Damage to lower neurological apparatus*	*May affect orgasm and/or general arousal—libido is generally not affected*	*Interference with peripheral nerves or spinal cord reflex centers, which subserve the sexual response*
combined system disease		
amyotrophic lateral sclerosis		
malnutrition and vitamin deficiency		
syringomyelia		
spina bifida		
surgery or trauma of sacral or lumbar cord, cauda equina, pelvic parasympathetic nerves (e.g., herniated disc, tumor)		
2. *Damage to higher sex centers*	*May cause increase or decrease of libido*	*Affects brain sex centers in limbic cortex*
temporal and frontal lobe (e.g., tumor, epilepsy, cardiovascular accident, trauma)		

Tables 1 and 2 were prepared in collaboration with Bry Benjamin, M.D. He is Assista Attending Physician, New York Hospital, Assistant Professor of Clinical Medicine, Corn University Medical College, and Consultant in Medicine at Rockefeller University. I Benjamin conducts the medical examinations of the patients who are seen in the s therapy program at the New York Hospital-Cornell Medical Center.

TABLE 3—*Drugs Which May Decrease Libido and Impair the Sexual Responses*

DRUG	PRESUMED MECHANISM OF ACTION AND EFFECT	SOME COMMON MEDICAL INDICATIONS
A. *Drugs Which Act on the Brain*	*Primarily decrease libido and the sexual responses*	
1. *Sedatives*		
alcohol and barbiturates	General depression of CNS in acute dose; in chronic doses, neurologic damage	Hypnotics and sedatives
narcotics	General depression of the CNS plus depression of the sex centers(?)	Analgesics (methadone is used in the treatment of narcotic addiction)
heroin morphine codeine methadone		
2. *Antiandrogens*	*Oppose the stimulating action of androgen on the brain and on the sexual organs*	
estrogens		Replacement therapy in post-menopausal women and in men with prostatic cancer
cyproteroneacetate		Experimental, employed in treatment of compulsive sexual disorders
adrenal steroids		Allergic and inflammatory disorders
cortisone ACTH		
aldactone		Edema
aldactazide		Hypertension

[CONTINUED]

TABLE 3—*Continued*

DRUG	PRESUMED MECHANISM OF ACTION AND EFFECT	SOME COMMON MEDICAL INDICATIONS
B. *Drugs Which Act on the Genitals*	*With the exception of some of the antiadrenergic drugs, these do not impair libido except as a secondary reaction. These drugs block the nerves controlling the smooth muscles and blood vessels of the genital organs which are involved in the sexual responses*	
1. *Anticholinergic drugs*	*Inhibit the action of acetylcholine on structures innervated by postganglionic parasympathetic nerves and so may cause* impotence *because erection is an autonomic parasympathetic response; do not affect libido*	*Peptic ulcer, dyskinesias, glaucoma and other ophthalmologic disorders*
banthine probanthine atropine quaternary ammonium compounds		
2. *Antiadrenergic drugs*	*Block the autonomic adrenergic nerves and structures innervated by them and so may cause* ejaculatory problems *because the emission phase of ejaculation is an autonomic* sympathetic *response. Some of these substances may have peripheral effects which impair ejaculation as well as some central effects which may diminish libido and erection*	*Hypertension, peripheral vascular disorders*
phentolamine ergot alkaloids halo-alkylamines guanethidine Rauwolfia alkaloids methyldopa (aldomet)	Impotence is a frequent complication	Psychosis

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TABLE 4—*Drugs Which May Enhance Libido and Sexual Functioning*

DRUG	PRESUMED MECHANISM OF ACTION AND EFFECT	SOME COMMON MEDICAL INDICATIONS
A. *Drugs Which Act on the Brain*	*These drugs presumably stimulate the sex centers of the CNS and so increase libido and the genital response*	
1. *Hormones*		
androgen	Stimulates sex centers of both genders. Fetal androgen causes gender differentiation of behavior. Androgens also act on periphery to enhance the growth, development, and functioning of the male genitals and of the clitoris.	Impotence, replacement therapy, anabolic agent, breast cancer
progesterone and estrogen	Do *not* increase libido, in fact may decrease sexual interest; act on the cells of the female genitalia to enhance their growth, development, and functioning	Replacement therapy in menopause, endometriosis, menstrual disorders, birth control, prophylactic for prostatic CA, post GU surgery to prevent erection
2. *Neurotransmitters*		
L-Dopa	Antiserotonin effect in sex centers of the brain	Parkinsonism
PCPA (parachlorphenylalanine)	Increases libido (?)	Experimental—no medical indications
3. *Stimulants*		
amphetamines	General brain stimulation. In acute doses, reported to enhance libido; in chronic doses, diminish libido and sexual functioning as well as causing general debility	Stimulant, appetite suppressants, minimal brain damage in children
cocaine	General brain stimulant, reported to enhance libido in acute doses	Highly addicting—no medical indications
nux-vomica (strychnine)	Increases reactivity of neurons in the spinal cord which mediate orgasm and erection reflexes; may cause priapism	Deadly poison—no medical indications

[CONTINUED]

TABLE 4—*Continued*

DRUG	PRESUMED MECHANISM OF ACTION AND EFFECT	SOME COMMON MEDICAL INDICATIONS
4. *Hallucinogens*	*Disrupt neurotransmission in limbic system and RAS. Reported by some to enhance libido and orgasm, by others to have no effect, while some users report impaired sexuality*	*No medical indications; LSD is used experimentally for alcoholism*
LSD DMT mescaline THC (marijuana)	May have some effects on muscle contractions; some reports of enhanced erotic feelings (?)	
B. *Drugs Which Act on the Genital Organs*		
cantharides (Spanish fly)	Irritates GU tract—causes priapism	Poisonous—no medical indications
amyl nitrite	Enhances vascular response of genitals (?) and reported to improve orgasm (?)	Vasodilator, angina pectoris

TABLE 5—*Effects of Psychotropic Drugs on Sexuality*

DRUG	PRESUMED MECHANISM OF ACTION AND EFFECT	SOME COMMON MEDICAL INDICATIONS
All neuroleptic drugs	Probably have no direct effects on the brain's sex center (with the possible exception of haldol, which may affect the sexual response directly). These drugs may affect sexuality indirectly because of their favorable effects on the psychic state. In addition, some agents *infrequently* are reported to cause erectile and ejaculatory difficulties, probably because of their mild antiadrenergic and/or anticholinergic or antidopamine effects.	Psychiatric disorders
A. *Antipsychotic Drugs*	*Mechanism of antipsychotic action is not clearly understood; sexual response may be improved as by-product of recovery from mental illness*	*Psychosis, notably schizophrenia*
1. *Phenothiazines* thorazine trilafon stelazine mellaril	"Dry" ejaculation—may be caused by effects on internal vesical sphincter paralysis, causing semen to empty into bladder	
2. *Butyrophenones* haldol	*Reported to reduce libido and potency and cause retarded ejaculations in some patients; mechanism unknown—may involve central or peripheral antiadrenergic and/or antidopamine actions*	*Gilles de la Tourette syndrome, schizophrenia*

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TABLE 5—*Continued*

DRUG	PRESUMED MECHANISM OF ACTION AND EFFECT	SOME COMMON MEDICAL INDICATIONS
B. *Antianxiety Drugs* 1. *Chlordiazepoxides* librium valium tranxene 2. *Meprobamate*	*Depress limbic system centrally and effect synapses in spinal cord to cause muscle relaxation—probably have no direct sexual effects, but sexual interest may increase as anxiety diminishes; muscle relaxing effects may account for the rare orgasm disturbances which are reported*	*Anxiety—muscle relaxers*
C. *Mood Regulators*		
1. *Antidepressants* tricycle antidepressants clavil tofranil	*No direct effects on sexuality; sex drive and performance may improve as depression lifts. The antidepressants have some peripheral autonomic effects which rarely cause some potency and ejaculatory problems in men*	*Depression, phobic anxiety states*
MAO inhibitors nardil marsilid marplan		Premature ejaculation
2. *Lithium*	*No reported effects on the sexual response, except that sexual urgency may diminish along with generally diminished manic activities*	*Manic states and possible prevention of depression in bipolar illness*

TABLE 6—*Miscellaneous Drugs Which May Affect Sexuality*

DRUG	PRESUMED MECHANISM OF ACTION AND EFFECT	SOME COMMON MEDICAL INDICATIONS
Disulfiram (antabuse)	Occasional impotence reported	Alcohol abuse
Chlorphentermine (presate)	Occasional impotence reported	Weight reduction

Tables 3, 4, 5, and 6 were prepared in collaboration with Dr. Avidah Offit. She is a Clinical Instructor in Psychiatry at the Cornell University Medical College and an Assistant Psychiatrist to Outpatients at the Payne Whitney Clinic. Dr. Offit is assistant to Dr. Kaplan in directing and coordinating the Sex Therapy and Education Program at the New York Hospital-Cornell Medical Center.

APPENDIX X

Table 2. Some methods of sexual rehabilitation

General Therapeutic Conditions
Therapeutic relationship
Causal explanation
Prognostic expectancy
Sexual Assignments
General pleasuring
Genital stimulation
Sexual intercourse
Specific Procedures
Provision of information
Verbal
Bibliographical
Audio-visual
Modification of attitudes and beliefs
Sanctioning
Self disclosure
Role playing
Cognitive restructuring
Thought stopping
Reduction of stress
Relaxation training
Desensitization
Flooding
Guided imagery

Thought imagery

Modeling

Vaginal dilatation

Sexual enhancement

Classical conditioning

Biofeedback

Hypnosis

Exposure to erotic material

Pelvic muscle exercises

Drugs/hormones

Prosthetic/mechanical aids

Relationship enhancement

Increasing postive exchanges

Communication training

Problem solving training

Assertiveness training

Heterosocial skills training

APPENDIX XI

Table 1. Psychological reactions to disability, surgery and medication

by D. Jehu

Anxiety and Avoidance Reactions

Fear of harm

Fear of failure

Depressive Reactions

Chronic pain

Life threatening illness

Changes in form and functioning of body

Dependence on others

Restriction of social/occupational activities

Lowering of social status and self esteem

Impaired Self Concept

Body image

Gender identity

Self esteem

Relationship Difficulties

Fear of rejection

Partner discord

Appendix XII

Table 20-1. Classification of the Physical Causes of Secondary Impotence

Anatomic Causes
Congenital deformities
Hydrocele
Testicular fibrosis
Cardiorespiratory Causes
Angina pectoris
Coronary insufficiency
Emphysema
Myocardial infarction
Pulmonary insufficiency
Rheumatic fever
Drug Ingestion
Addictive drugs
Alcohol
Alpha-methyldopa
Amphetamines
Antiandrogens (cyproterone acetate)
Atropine
Barbiturates
Chlordiazepoxide
Chlorprothixene
Cimetidine
Clofibrate
Clonidine
Digitalis (rarely)
Guanethidine
Imipramine
Marihuana
Methantheline bromide
Monoamine oxidase inhibitors
Nicotine (rarely)
Phenothiazines
Propranolol
Reserpine
Spironolactone
Thiazide diuretics
Thioridazine
Endocrine Causes
Acromegaly
Addison's disease
Adrenal neoplasms (with or without Cushing's syndrome)
Castration
Chromophobe adenoma
Craniopharyngioma
Diabetes mellitus
Eunuchoidism (including Klinefelter's syndrome)
Feminizing interstitial-cell testicular tumors
Hyperprolactinemia
Infantilism
Ingestion of female hormones (estrogen)
Myxedema
Thyrotoxicosis
Genitourinary Causes
Cystectomy
Perineal prostatectomy (frequently)
Peyronie's disease
Phimosis
Priapism
Prostatitis
Suprapubic and transurethral prostatectomy (occasionally)
Urethritis
Hematologic Causes
Hodgkin's disease
Leukemia, acute and chronic
Pernicious anemia (with combined systems disease)

Sickle cell anemia

Infectious Causes
Elephantiasis
Genital tuberculosis
Gonorrhea
Mumps

Neurologic Causes
Amyotrophic lateral sclerosis
Cerebral palsy
Cord tumors or transection
Electric shock therapy
Multiple sclerosis
Myasthenia gravis
Nutritional deficiencies
Parkinsonism
Peripheral neuropathies
Spina bifida
Sympathectomy
Tabes dorsalis
Temporal lobe lesions

Vascular Causes
Aneurysm
Arteritis
Sclerosis
Thrombotic obstruction of aortic bifurcation

Miscellaneous Causes
Chronic renal failure
Cirrhosis
Obesity
Toxicologic agents (lead, herbicides)

appear to have a primarily psychogenic origin for their dysfunction, physical or metabolic factors may contribute to the difficulty as well in a significant number of instances. Some men with sexual dysfunction that is already marginal may be pushed into frankly dysfunctional status by the onset of illness, by the use of sexually depressing drugs, or by physical changes (including aging) that would not ordinarily be sufficient grounds for impotence. There is currently no means of identifying men who are particularly susceptible to the subsequent development of impotence or other sexual problems.

The psychogenic causes of impotence may be conceptualized as falling into four major categories: developmental, affective, interpersonal, and cognitional. The most common elements of these categories are summarized in Table 20-2. It must be stressed that such etiologies are conjectural in that they have not been rigorously studied from a research viewpoint; they are based on clinical impression. No inference is made that all men, or even many men, with similar histories will be impotent. In fact, it appears that quite the opposite is true: Men frequently overcome potentially negative background factors that might appear to place them at substantial risk for the development of sexual

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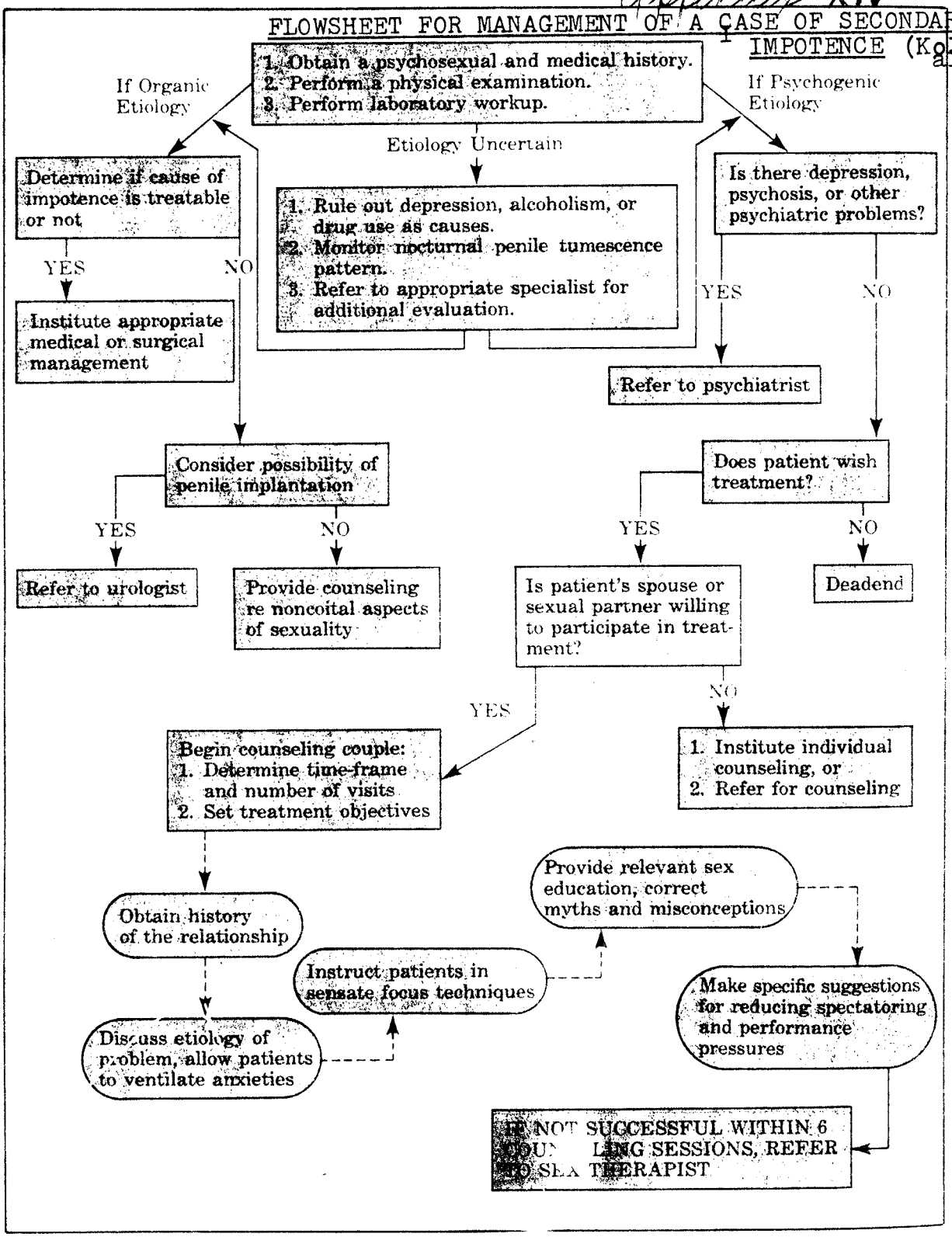
Table 20-2. Major Categories of Psychogenic Impotence

Developmental Factors
Maternal or paternal dominance
Conflicted parent-child relationship
Severe negative family attitude toward sex (often associated with religious orthodoxy)
Traumatic childhood sexual experience
Gender identity conflict
Traumatic first coital experience
Homosexuality
Affective Factors
Anxiety (particularly fears of performance, anxiety about size of penis)
Guilt
Depression
Poor self-esteem
Hypochondria
Mania
Fear of pregnancy
Fear of venereal disease
Interpersonal Factors
Poor communications
Hostility toward partner or spouse
Distrust of partner or spouse
Lack of physical attraction to partner or spouse
Divergent sexual preferences or sex value systems (regarding types of sexual activity, time of sexual activity, frequency of sexual activity, etc.)
Sex role conflicts
Cognitional Factors
Sexual ignorance
Acceptance of cultural myths
Performance demands
Miscellaneous Factors
Premature ejaculation
Isolated episode of erectile failure (often due to fatigue, inebriation, acute illness, or transient anxiety)
Iatrogenic influences
Paraphilias

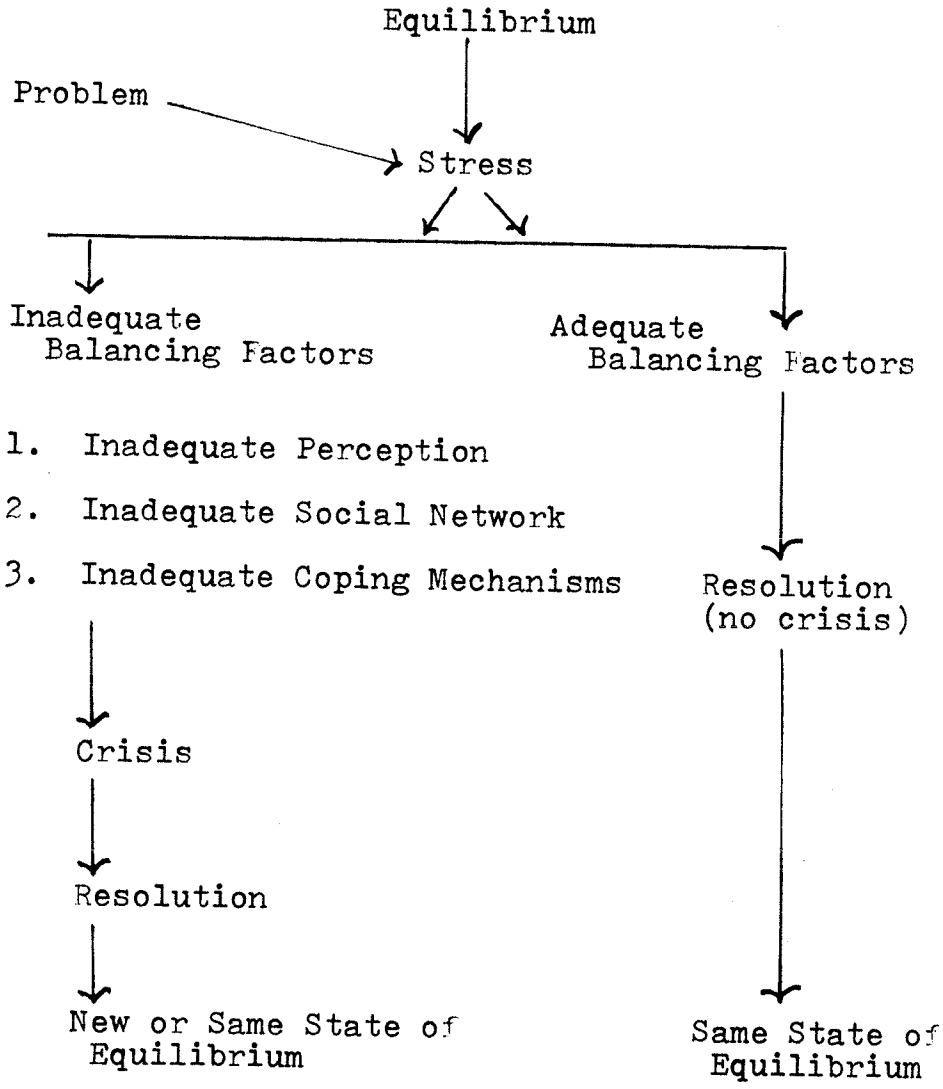
Appendix XIV



Taken from: Helping People in Crisis, D. Puryear, 1979, The Jossey-Bass, S. F. p. 13

APPENDIX XV

AQUILERA AND MESSICK'S CRISIS INTERVENTION MODEL



APPENDIX XVI

INFLATABLE PENILE PROSTHESIS: ORIENTATION FOR IMPOTENCE

Before visit:	Sex questionnaire
	Brochure on prosthesis
	Educational film on impotence
	Psychologic and urologic assessment
	Discussion and demonstration of prosthesis
After implant:	Orientation and demonstration of pump
	Model scrotum and same prosthesis
	Instruction brochure on pump
	Activation of prosthesis by patient
	Discussion with urologist
	Identification card
Follow-up:	Questionnaire
	Clinic visitation
	Telephone

The above guidelines have been used by the Mayo Clinic for implant orientation. (Copied from Furlow, W. (1981). Use of the Inflatable Penile Prosthesis in Erectile Dysfunction, Symposium on Male Sexual Dysfunction, The Urologic Clinics of North America, 8:1, p. 184.

APPENDIX XVII

PSYCHOLOGICAL EVALUATION OF CANDIDATES FOR PENILE IMPLANT SURGERY (OUTLINE FOR DISCUSSION)

by: D. Jehu.

Purposes of Evaluation

The first purpose is to contribute to the differential diagnosis of erectile dysfunction of organic, psychogenic, or mixed aetiology.

Indicators of an organic aetiology include:

a) presence of an organic condition known to cause erectile dysfunction,
b) depressed nocturnal penile tumescence record,
c) decreased penile blood pressure,
d) no full and sustained erections under any conditions for at least 6 months (e.g. upon awakening, masturbatory, extra-marital, spontaneous),
e) time course that fits organic condition,
f) insidious onset unless related to clear organic insult (e.g. priapism),
g) no obvious psychological precipitating events: if there is such an event, a) and b) must be noted for an organic aetiology.

Indicators of a psychogenic aetiology include:

a) absence of any detectable organic abnormality that is probably contributory to the erectile dysfunction,
b) normal penile tumescence record,
c) normal penile blood pressure,
d) full erections upon awakening occurring two or more times per week for the past 3 months and lasting until micturation; patient judges the erection rigid enough for vaginal penetration if such attempted,
e) normal masturbatory erections,
f) normal erections with an alternative partner,
g) normal erections after a trial of psychological treatment,
h) frequent, full and sustained erections during petting/foreplay (e.g. for 5 minutes of foreplay with detumescence occurring only when penetration planned.

2. A second purpose of the psychological evaluation is to determine whether psychological treatment is likely to be effective in:

either a) restoring erectile capacity,
or b) enabling the couple to achieve a sexual relationship that is satisfactory to them through activities that do not depend upon the man having an erection.

3. A third purpose is to ascertain any psychological factors that might adversely affect adjustment to the penile implant, and which may indicate the advisability of pre- and post operative counselling.

Such factors might include various stressful situations, discord in the marriage, psychopathological conditions, and any deficiencies in the information and skills needed for satisfactory sexual functioning.

Instrument

1. Sexual History Form: description of current sexual functioning to be completed independently by each partner.

2. Dyadic Adjustment Scale: global measure of marital relationship to be completed independently by each partner.

3. Crown-Crisp Experiential Index: screening instrument for anxiety, phobias, obsessions, somatization, depression, and hysteria, to be completed by the patient.

4. Interviews: with each partner, to include a) selected items from Checklist b) discussion of couple's goals for their sexual relationship c) their knowledge of, and attitudes towards, the implant, d) their reactions to the prospect of psychological treatment if this is a viable alternative.

Administration

One way of administering the above instruments would be to send the appropriate packages of the Sexual History Form, Dyadic Adjustment Scale, and Crown-Crisp Experiental Index, with instructions for completion by each partner before the first appointment by Dr.....

This would have the advantages of:

a) providing him with the information on the Sexual History Forms,
b) enabling me to score and interpret all the instruments before interviewing the couple,
c) integrating the psychological evaluation with the physical investigations in one protocol, thus reducing any tendency for some patients to perceive the psychological evaluation as unnecessary and possibly obstructive to their desire for an implant.

APPENDIX XVIII

Proposed AMA: Sexual Medicine

Chapter XI

Evaluation for Sexual Surgery

Outline: Domeena C. Renshaw, M.D.

A. Penile Prosthes
   a) Constant or semi-erect types
   b) Inflatable and deflatable types
   c) Comparative cost
   d) Debate
   e) Surgical success, avoidable personal failure
   f) Validity of use in psychogenic impotence

B. Physical Evaluation
   a) General
   b) Vascular
   c) Neurological
   d) Endocrine
   e) Nocturnal Plethysmography

C. Personal and Interpersonal Evaluation
   a) Patient individually
   b) Partner
   c) Together
   d) Suggested line of questions

For Partner:

1. Does he have partial erections now? _____ Freq./wk. _____
2. Does he have orgasms now? _____ Freq./wk. _____
3. Does he ejaculate now? _____ Freq./wk. _____
4. Does he masturbate now? _____ Freq./wk. _____
5. Does he have masturbatory ejaculation? _____ Freq./wk. _____
6. How frequently do you now note morning erections? _____
7. Do you attempt to have sex in the morning?
8. What does the penile implant mean to you?
9. What do you expect to feel after he has it?
10. What does he expect to feel after he has it?
11. Do you expect a climax/ejaculation for him?
12. Does he expect a climax/ejaculation for himself?
13. Does he expect to masturbate after he has it?
14. How accepting (relieved?) or upset (pre-occupied) are you about his being impotent?
15. What does your sexual enjoyment mean to him?
16. Does he feel satisfied to share your climax now?
17. Prior to his becoming impotent, was he concerned with your having orgasm?
18. Since becoming impotent, what alternative sexual techniques (masturbation/oral/vibrator) have you both employed to provide sexual stimulation for each other?
19. What was your weekly coital frequency pre-impotence?
20. What has been your weekly sex play frequency since the impotence?
21. How frequently per week do you feel sexual desire?
22. How frequently per week does your partner feel sexual desire?
23. Are you pressuring him to have an implant?
24. What do you think your coital demands will be post-implant?
25. What do you think his coital demands wil be post-implant?
26. Have you discussed divorce in the past year?
27. Have you thought of or tried sex therapy?
28. Have you thought of or tried marital therapy?
29. What were the gains and the problems of therapy?
30. Would you agree to a trial of 8 weeks of sex therapy first?

For Candidate:

1. Do you have partial erections now? _____ Freq./wk. _____
2. Do you have orgasms now? _____ Freq./wk. _____
3. Do you ejaculate now? _____ Freq./wk. _____
4. Do you masturbate now? _____ Freq./wk. _____
5. Do you have masturbatory ejaculation? _____ Freq./wk. _____
6. How frequently do you now note morning erections? _____
7. Do you attempt to have sex in the morning?
8. What does the penile implant mean to you?
9. What do you expect to feel after you have it?
10. Do you expect a climax/ejaculation?
11. Do you expect to masturbate after you have it?
12. How accepting (relieved?) or upset (pre-occupied) are you about being impotent?
13. What does your partner's sexual enjoyment mean to you?
14. Do you feel satisfied to share her climax now?
15. Prior to becoming impotent, were you concerned with your partner's having orgasm?
16. Since becoming impotent, what alternative sexual techniques (masturbation/oral/vibrator) have you employed to provide sexual stimulation for your partner?
17. What was your weekly coital frequency pre-impotence?
18. What has been your weekly sex play frequency since the impotence?
19. How frequently per week do you feel sexual desire?
20. How frequently per week does your partner feel sexual desire?
21. Is your partner pressuring you to have an implant?
22. What do you think her coital demands will be post-implant?
23. Have you discussed divorce in the past year?
24. Have you thought of or tried sex therapy?
25. Have you thought of or tried marital therapy?
26. What were the gains and the problems of therapy?
27. Would you agree to a trial of 8 weeks of sex therapy first?
28. Would your partner agree to a trial of 8 weeks of sex therapy first?