THE ASSESSMENT AND TREATMENT OF SEXUAL DYSFUNCTION

A Practicum Report

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THE ASSESSMENT AND TREATMENT OF SEXUAL DYSFUNCTION

BY

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Practicum
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This is a book for the man who needs instruction in loving.

Let him read it and love, taught by the lines he has read.

Art is a thing one must learn....love must be guided by art.

Ovid. The Art of Love. (Translated by Rolfe Humphries). Indiana University Press, 1957.

The practicum on which I have worked over the last year concerns "ASSESSMENT AND TREATMENT OF SEXUAL DYSFUNCTION". I worked under the auspices of the Sexual Dysfunction Clinic at the Psychological Service Centre, University of Manitoba, and under the supervision and direction of Prof. Derek Jehu. Some of the clients treated were referrals from Family Services of Winnipeg where I have been employed as a marriage and family counsellor.

There are several interrelated aspects to this practicum:

1. knowledge of human sexuality
2. knowledge of research in the area of sexual dysfunction
3. development of appropriate clinical skills
4. application of the above to assessment and treatment of clients presenting with sexual dysfunctions
5. evaluation of treatment

In order to explain the practicum, I have divided the material into two sections.

Part I: Literature review and relevance to the practicum

Part II: Case reports discussing assessment, treatment, and evaluation

Part I

Literature Review and Relevance to Practicum

Introduction

Professionals working with sexually dysfunctioning clients need to have a comprehensive and broad knowledge in, as well as a critical approach to, the areas of human sexual response, categories of dysfunctions, assessment methods, treatment modalities, and evaluative techniques. This knowledge is acquired through awareness and study of relevant literature in the field. Effective clinical intervention requires broad knowledge of genetic, biological, physiological, and socio-psychological aspects of sexuality (Higginbotham and Farkas 1977:223). I suggest also that the practitioner needs to be aware of related research in contributing disciplines such as psychology, sociology, anthropology, and theology. This kind of material enables the practitioner to gain a broad knowledge base on which to draw when working with clients presenting problems to do with their sexual functioning. As Ullmann states in his forword to Fischer and Gochros (Eds.) Handbook of Behavior Therapy with Sexual Problems (1977:xiii):

> "The clinician should know not only procedures, but also the professional literature and thinking that underlie his or her daily efforts. Without such additional study and thought, the practitioner becomes a technician rather than an open, flexible, creative professional. Repetition of new procedures without understanding leads to dogmatism, ritual and a conservatism as damaging as the ones they replace."

In order to present this review of the literature in an orderly and systematic manner, I have divided it into categories which, by nature of the material, overlap and are interrelated. Several references fall into more than one category and, therefore, may be referred to several times within separate contexts. An explanation will be given at the beginning of each section to outline the relevance of the material to the practicum. It is not my intent to describe in detail the various research articles and publications listed in the bibliography. Some of it which is related specifically to case reports (part II of this report) will be discussed while other related literature will be mentioned only in passing. The reader will gain an overview of relevant material and an idea of what is involved in the field. In general, this review of literature serves as support for the clinical assessments and treatment strategies discussed in Part II of this practicum report.

The literature review will follow the outline:

1. General Overview
2. Human Sexual Response
3. Sexual Dysfunctions - Categories and Definitions
4. Assessment
    a. General Outline
    b. Some Factors to Consider
        i. illness, disabilities
        ii. aging
        iii. pregnancy
        iv. incest
        v. societal conditioning, attitudes, values
        vi. relationship discord
5. Treatment
    a. General Overview of Treatment Procedures
    b. Treatment of Specific Dysfunctions
        i. vaginismus
        ii. orgastic dysfunctions
        iii. retarded/absent ejaculation
        iv. erectile dysfunctions
        v. premature ejaculation
        vi. lack of desire: inadequate sexual pleasure or interest
        vii. relationship discord
    c. Some Specific Components of Treatment dealt with in the Literature
        i. information-giving as part of treatment
        ii. masturbation training as part of treatment
        iii. films, tapes, and books as part of treatment

1. General Overview

The field of assessment and treatment of sexual dysfunction is in its infancy. Not long ago and not far away, sexual problems were seen as a single clinical entity (Kaplan 1979). Research and publication by such people as Kinsey (1953), Semens (1956), and Masters and Johnson (1966 and 1970) has established a base for further enquiry in the field. This is an interdisciplinary field of research and practice, not confined to one discipline nor to one theoretical framework. We are in the process of building theory and applying it to practice. Professionals from various disciplines such as psychology, psychiatry, social work, and medicine have all contributed to and are participating in this area. This means that we are able to borrow, adapt, and integrate various theoretical positions into an ecclectic and broad-spectrum approach to the assessment and treatment of sexual dysfunctions. Kaplan (1979:xv) states that"the sexual response and its disorders have proved a catalyst for integration and amalgamation of a wide spectrum of ideas and experiences, along with the development of new and vital hybrids". In line with this view, Hogan (1978:79) states that "future

research in the area of sexual dysfunction should be carried out within a broad framework in which etiology is viewed from an interactional approach and treatment techniques are derived from a multitheoretical approach".

As treatment packages are developed, they can be studied, components of the packages can be researched and modified. New (and hopefully, more effective) methods of treatment can be developed. This can only happen through ensuring that research is made available through publication in journals (e.g., Journal of Sex Research; Journal of Sex and Marital Therapy) as well as through publication of books in the field.

To give an overview of some of the major contributors to the field in recent years, I will very briefly mention a few on which I have relied during the course of this practicum.

1. Fischer and Gochros 1977. Handbook of Behavior Therapy with Sexual Problems. Volumes I and II. This is a two volume publication dealing with various aspects of causation, assessment, and treatment of various sexual dysfunctions by using behavioural techniques. The articles are written by professionals in the field and present a comprehensive and varied body of research ranging from "general procedures" in Volume I to "specific problems" in Volume II.

2. Hartman and Fithian 1974. Treatment of Sexual Dysfunction. This publication describes an intnsive two-week standardized program within which various dysfunctions are treated. Assessment, history-taking, treatment techniques, and evaluation are discussed. The program follows the Masters and Johnson approach to treatment.

3. Jehu 1979. Sexual Dysfunction: A Behavioural Approach to Causation, Assessment and Treatment. This publication presents a comprehensive overview of the area, within a behavioural framework. General features of the behavioral approach which are used in the assessment and treatment of sexual dysfunctions include an attempt to apply general psychological principles to explanation, assessment and treatment; use of an empirical stance, based on gathering data; and the use of operational definitions (Jehu 1979:1-3). The assessment scheme presented was closely followed in this practicum.

4. Kaplan 1974. The New Sex Therapy. Although trained in a psychoanalytic model, Kaplan has managed to combine this approach with a behavioural approach. The primary objective of sex therapy, as she sees it, is "the relief of the sexual symptom. It is the

integrated use of systematically structured sexual experiences with conjoint therapeutic sessions which is the main innovation and distinctive feature of sex therapy"(Kaplan 1974:xii). This publication deals with the anatomy and physiology of sexual response as well as etiology from both a biological and psychological view, as well as classification of dysfunctions, treatment, and evaluation.

5. Kaplan 1979. Disorders of Sexual Desire. This publication deals with the specific dysfunction of lack of desire which Kaplan sees as the most difficult dysfunction to treat. In this book, she also develops the "triphasic model of human sexual response" which provides a theoretical base for dealing with desire dysfunctions.

6. Leiblum and Pervin 1980. Principles and Practice of Sex Therapy. This publication, again, presents an overview of the field, incorporating articles by various professionals focusing on treatment strategies for various dysfunctions.

7. LoPiccolo and LoPiccolo 1978. Handbook of Sex Therapy. This is a collection of readings by professionals in the field and deals with assessment, treatment,

criticism, dysfunctions in special populations, and innovative approaches to treatment, such as group programs.

8. Masters and Johnson 1966. Human Sexual Response. This publication provided a base in many ways for subsequent research and theory development. It describes human sexual response as studied under laboratory conditions. Dispite much criticism over the research methods employed (Zilbergeld and Evans 1980), it has provided a framework of knowledge on which much of assessment and treatment plans are based.

9. Masters and Johnson 1970. Human Sexual Inadequacy. This later publication uses the findings from the earlier book and applies this to a treatment package for sexual dysfunctions. This is described and, again, although receiving criticism, has prompted further research and modifications for more effective and precise means of dealing with the problems.

10. Schlesinger 1977. Sexual Behaviour in Canada: Patterns and Problems. Although containing only three articles pertaining directly to treatment of sexual dysfunction, this publication does provide an overview of research in the general area of sexuality under topics such as "attitudes and sexuality", "sexuality and the aged", "sexuality and the physically handicapped". Therefore, this publication was useful in terms of gaining a broad knowledge base related to human sexuality.

The publications discussed have all been most helpful for me in my acquisition of knowledge and application of that information to working with clients in this area of sexual dysfunction. The literature will be referred to later in this review as I deal with more specific issues to do with assessment and treatment.

2. Human Sexual Response

As previously stated, knowledge of human sexual response, both psysiological and psychological, is crucial in assessment and treatment of sexual dysfunction. While Masters and Johson (1966) provide a comprehensive and detailed description, other writers (Kaplan 1974, 1979; Jehu 1979; Zilbergeld 1978; Heiman, LoPiccolo and LoPiccolo 1976) also are sources of information in this area. While it is beyond the scope of this review to describe human sexual response in its totality, I will describe the sexual response phases outlined by (1) Masters and Johnson 1966; (2) Kaplan 1979; and (3) Zilbergeld and Ellison 1980. It is important to look at these three models because understanding human sexual response enables practitioners to assess the dysfunction with greater precision. By determining at what phase the dysfunction is taking place, we can then develop the most appropriate treatment plan for the client concerned.

Masters and Johnson (1966:3-8) describe four phases of sexual response: (1) excitement, involving lubrication for the female and erectile response for the male; (2) plateau, involving an intensification of the excitement

responses; (3) orgasm, involving contraction of the genital organs and muscles; and (4) resolution, involving a gradual return to the pre-excitement condition. There is, of course, a good deal of variation among individual responses and reactions. It is important here to note that these phases are characterized by physiological reactions to sexual stimuli.

Kaplan (1979) refers to Masters and Johnson's concept as "biphasic", pertaining to the excitement (including "plateau") and orgasmic phases of response. She states that the "understanding of the sexual response and its dysfunctions was still incomplete and the clinical data were still not sufficiently accounted for until the recent recognition of a third, a central phase, the phase of sexual desire"(Kaplan 1979:5). This development resulted from Kaplan's recognition that many clients complained of absence of sexual desire and, therefore, were "blocked" in response at a level earlier than the "excitement" phase. This is an important theoretical development because it implies intervention at an earlier level, as well as different therapeutic techniques to deal with lack of desire. Behavioural techniques which may be very effective for treatment of an excitement phase disorder such as erectile dysfunction will not be effective for a

desire disorder. The reasons for this are many and varied; however, one factor may be that a lack of desire disorder has its roots in more profound intrapsychic conflicts and treatment must deal with these issues. She proposes a method of "psychosexual therapy" for desire dysfunctions which combines features of traditional insight therapies and behavioural techniques.

A further refinement of theory to do with sexual response is proposed by Zilbergeld and Ellison (1980). The components of sexual response include both physiological and psychological aspects (as opposed to Masters and Johnson's phases which are based strictly on physiological states). Zilbergeld and Ellison carry Kaplan's "triphasic" model a step further to encompass the following stages: (1) interest, referring to frequency an individual wants to have sex and not ability or arousal; (2) arousal, involving the subjective experience of arousal; (3) physiological readiness, involving vaginal lubrication/swelling and erection; (4) orgasm, and (5) satisfaction, involving how one feels about or evaluates what has gone before (Zilbergeld and Ellison 1980:71). The point they make is that physiological arousal may or may not mirror subjective arousal. Thus, the assumption that increased physical stimulation will result in increased arousal and interest is not necessarily valid. When one considers

that many treatment strategies are based on this assumption (i.e., "pleasuring" exercises), the theory presented by Zilbergeld and Ellison is worth pondering. Another point worthy of consideration (and an area noticeably missing from the literature) is the focus on phase 5: satisfaction. I believe that this is an important phase in the sexual response cycle and one which can influence the other phases. A very simple example of this might be when one partner consistently falls asleep immediately after orgasm, while the other partner desires to use this intimate, warm time to talk or share time. The dissatisfaction felt by one partner could have an effect on the future sexual response.

These three theoretical models of human sexual response are mentioned here for several reasons. One is to illustrate the kind of knowledge a practitioner in this field needs in order to work in an ethical and effective manner. The second reason is to illustrate how ongoing research and theoretical constructions are developing in order to further refine understanding and knowledge in the area of sexuality. As knowledge grows, assessment and treatment strategies can be developed and refined to accommodate it and, ultimately, to benefit the clients seeking help for various dysfunctions.

3. Sexual Dysfunctions - Categories and Definitions

As Kaplan (1979:3) points out, it is only very recently that sexual dysfunctions were seen as separate clinical entities. This occurred only after research published by Semens (1956) and Masters and Johnson (1966, 1970). Since different categories require different treatment strategies, it is extremely important to be aware of the various categories of dysfunctions. It should be noted that these "diagnostic labels" are to be viewed as assessment "tools" and that more than one category may apply to a single client or a couple. For example, a woman with a vasocongestive dysfunction may also suffer from an orgastic dysfunction.

Jehu (1979:75) presents the following categories of sexual dysfunction:

Aspect	Male	Female
Interest	Inadequate sexual Interest	Inadequate sexual Interest
Arousal or Intromission	Erectile Dysfunction	Vasocongestive dysfunction Vaginismus
Orgasm or Ejaculation	Premature Ejaculation Retarded/Absent Ejaculation Retrograde Ejaculation	Orgastic dysfunction
Pleasure	Inadequate sexual Pleasure Dyspareunia	Inadequate sexual Pleasure Dyspareunia

Although this use of categories is extremely valuable, it must be remembered that each category can be further subdivided to take into account such variables as degree of dysfunction, whether it is primary (has always been present), or secondary (has developed after a period of "normal" sexual response). These points will be discussed in more detail under "Assessment".

Now that the dysfunctions have been labelled, the next step is to provide a definition for each.

Male and Female Dysfunctions

1. Inadequate Sexual Interest: This is a difficult area to define in that there are no absolute or prescriptive standards of sexual interest. Jehu (1979: 77) states that "this can only be defined as inadequate on the basis of the subjective judgements of those concerned".

2. Inadequate Sexual Pleasure: The definition, as above, is based on the subjective judgements of the client, who may state that he/she "feels nothing" or that sexual activity is not pleasurable or satisfying (Jehu 1979:98).

3. Dyspareunia: Generally, this is defined as painful intercourse. In males, discomfort may be experienced only during erection, insertion, thrusting, or ejaculation, or throughout more than one of these processes. Men may also experience pain during certain non-coital forms of sexual activity, such as masturbation and manual or oral stimulation by a partner (Jehu 1979: 101). In women, pain may be experienced during intromission or intercourse and after it has ended. This pain may center at the entrance to the vagina, the clitoris, the vaginal barrel, or in the internal pelvic organs (Jehu 1979:115). Also to be noted for both men and women is that painful sexual activity or intercourse may lead to inadequate interest or pleasure in sex, as well as to a disruption or orgastic response.

Female Dysfunctions

1. Vasocongestive Dysfunction: This involves some impairment of the lubrication-swelling or vasocongestive phase in the female response cycle, so that vaginal lubrication, the ballooning of the inner two-thirds of the vagina, the formation of an orgasmic platform, and the other physiological changes characteristic of this phase, do not occur normally. Vasocongestive dysfunction in the female is analogous to erectile dysfunction in the male (Jehu 1979:103).

2. Vaginismus: This can be defined as a spastic contraction of the muscles at the outer third of the vagina and the perineum, which occurs as an involuntary reflex response to a threat of vaginal penetration. Intromission is either prevented or only possible with difficulty and pain (Jehu 1979:106).

3. Orgastic Dysfunction: This type of dysfunction consists of an involuntary impairment of the orgasm phase in the female response cycle, so that difficulty or failure is experienced in releasing the reflex contractions of the vaginal and pelvic musculature. The problem is analogous to that of retarded or absent ejaculation in the male (Jehu 1979:109).

Male Dysfunctions

1. Erectile Dysfunction: This involves some impairment of the erection phase of the male sexual response cycle. Vasocongestion of the penis does not proceed normally. "It might be defined as a persistent inability to obtain a sufficiently firm erection, or to maintain this during intromission and intercourse" (Jehu 1979:81). Of not here, also, is that the definition is subjective, based on the client's judgement. There are many factors involved in determining if and when a man has an erectile dysfunction.

2. Premature Ejaculation: This may be defined as a lack of adequate voluntary control over the orgastic and/or ejaculatory reflexes. Ejaculatory or orgastic response can only be defined as inadequate on the basis of subjective judgements by the man and his partner (Jehu 1979:87). In terms of female dysfunctions, premature ejaculation may correspond to some women reaching an orgasm (often weak and unsatisfying) too soon.

3. Retarded/Absent Ejaculation: This may be defined as a persistent delay or failure in the occurrence of orgasm and ejaculation despite the presence of an adequate erection (Jehu 1979:93). This is analagous to orgastic dysfunctions in females.

4. Retrograde Ejaculation: This may be defined as the involuntary discharge of semen into the bladder rather than through the urethra. The client still has erections and orgasms but there is no visible ejaculate (Jehu 1979:97).

Determining the type of dysfunction is part of the assessment process when working with clients. Once the kind of dysfunction is known, the practitioner can begin to plan for treatment.

4. Assessment

a. General

Assessment is the crucial component in dealing in the area of sexual dysfunction. In order to be an effective tool, the assessment method must be structured and directed towards finding out pertinent information. The information gathered is for a specific purpose -- to enable the therapist to work with the client to alleviate the sexual dysfunction if in fact this form of treatment is appropriate. Part of the initial assessment process is determining if treatment of the stated dysfunction appropriate or even feasible. Times when treatment may not be appropriate include when the dysfunction co-exists with, for example, a physical illness, is an effect of medication, if there are concurrent non-sexual stresses, or if there is serious relationship discord. This is all important data and must be explored early in the assessment process.

Setting of goals and planning treatment follow from a thorough assessment. This requires gathering information in a number of related areas. It is just as important to rule out certain causations or contributing factors as to determine them, as

this kind of information gives the practitioner hypotheses about the etiology and development of the dysfunction and thus provides treatment goals.

It is clear from the literature search that writers are aware of the importance of the assessment process (Green 1977; Group for the Advancement of Psychiatry 1974; Hiebert 1977; Kaplan 1974; Ellis 1980). Heiman (1978) advocates the recording of both physiological and subjective responses in the ongoing assessment process which, of course, overlaps with and is a part of the treatment process. Lobitz and Lobitz (1978) see assessment as gathering information necessary to understand the etiology and maintenance of a particular dysfunction. Assessment is crucial in planning treatment and involves, from their perspective, an initial evaluation, history-taking, formulation of goals and feedback to the client, and assessment of treatment. LoPiccolo and Heiman (1978) agree with Lobitz and Lobitz' concepts of assessment, but add that it also functions to build rapport with the client. They present an outline of areas to be explored in history-taking and current information. LoPiccolo and Steger (1978) present their "Sexual Interaction Inventory" and explain its use as a means of assessing the dysfunction and planning treatment. Masters and Johnson (1970) spend

two full days of their two-week sex therapy program on "history-taking". They present a "history-taking outline" (Masters and Johnson 1970:33-48). There is some question as to the usefulness of this extensive history-taking in view of the fact that the Masters and Johnson treatment strategies tend to be somewhat standardized for specific dysfunctions. While assessment is extremely important, there appears to be no indication that some sixteen hours of history taking produces any better results in treatment than one of shorter duration. Schover et.al. (1980) are in the process of developing a multi-axial descriptive system for the sexual dysfunctions with a purpose of assessing with greater precision and thus facilitating planning treatment. As a secondary goal, this descriptive system will facilitate further research and data collection which, as stated earlier, is crucial to the development of knowledge and practical application in the area.

Assessment forms a major component of this practicum. As Jehu (1979:5) points out: "The assessment of a problem situation and the resources available for its remediation, together with the consequent planning of a treatment programme, probably require more knowledge and skill than any other aspect of the behavioural approach".

I have used the assessment scheme proposed by Jehu (1979): "Checklist of topics for assessment interviews with sexually dysfunctional clients and partners". This is explained in detail in Chapter 11 (Jehu 1979:175-193). Appendix A is attached to this report and details the items which can be used as guidelines to gaining relevant information from the client/s. The case reports in Part II of this paper are examples of how this assessment approach is used.

As part of the initial assessment, as well as ongoing evaluation of treatment, the following scales were used:

1. Sexual Arousal Inventory. This was developed by Hoon, Hoon and Wincze (1976) and is a scale for the measurement of female sexual arousability. (Please see Appendix B.)
2. The Semantic Differential Scale. This can be used as a measure of how the client sees her/himself, her/his partner, her/his ideal self and ideal partner. It is useful in determining what changes the client wants for her/himself and partner. (Please see Appendix C.)
3. The Dyadic Adjustment Scale. This provides a measure of the relationship state of a couple. (Please see Appendix D.)

The purpose of using these measurements and others is to provide a means of assessing each situation as well as a way to measure change during the course of treatment. Sharing the measures of change with clients can also have positive therapeutic value.

The above is an overview of assessment -- the rationale and process. As has been stated, the therapist must "check out" many areas with the client with a view to setting goals and planning treatment. While it is beyond the scope of this report to discuss these areas in detail, the literature does point out various factors of which the practitioner should be aware and which are important to explore in assessment.

b. Some Factors to Consider

i. illness, disabilities

These are certainly factors effecting an individual's or couple's sexual functioning. Illness was a factor I had to consider when working with a woman who suffered from Chron's Disease in that this debilitating illness had to be taken into consideration when setting toals and planning treatment. Kaplan (1979) provides a table outlining "effects of illness on the sexual response", which is useful in finding out how sexual response is effected by various illnesses. Other writers address themselves to specific medical

conditions, some of which will be mentioned as a means of illustrating how illness and disabilities are related to sexual dysfunction.

Abram et.al. (1978) reports that 80% of dialysis or kidney transplant male patients reported sexual function impairment. Ellenberg (1978) reports a 50% erectile failure rate in male diabetes. He urges research in the area in that knowledge about the influence of edocrine, neurologic, urologic factors as well as the effects can lead to ways to deal with sexual dysfunction through counselling, hormonal therapy, use of mechanical aids, or removal of contributing drugs. Renshaw (1978) reports that psychological as well as physiological factors contribute the erectile dysfunction in diabetics and she stresses the importance of assessment in determining the reasons for the erectile failure. If the basis is physiological, penile implant may be an appropriate form of treatment. Friedman (1978) addresses himself to sexual issues with the postcoronary patient, stressing that anxiety, fear, as well as depression, age, drugs, and partner's reaction may be the bases of the sexual problem. He advocates "adjustment counselling". Higgins (1978) discusses spinal cord injuries and the effects on sexual functioning. While the physiological effects are varied and may

include erectile, ejaculatory, orgasmic, or desire dysfunctions, the psychological adjustment to the disability is crucial. Like Friedman, Higgins stresses the need for effective counselling as well as further research in this area to establish treatment programmes. Malcolm (1977) discusses the influence of drugs on sexual behavior and outlines several variables in how drugs may effect an individual's sexual functioning: the kind of drug and dose relative to body weight; the personality, mental and physical health of the user; and the environment in which the drug is taken. Kaplan (1979) also gives a listing of "effects of drugs on sexual response". Sha'ked (1978) provides an annotated bibliography of research related to human sexuality in physical and mental illnesses and disabilities. He stresses a need for treatment and counselling programmes for physically and mentally ill and disable people. Schlesinger (1977) discusses sexuality and the physically handicapped person, outlining the need for education, counselling, and the role of the professional in helping handicapped people enhance this aspect of their lives.

ii. aging

The aging process has a direct effect on human sexual functioning and this must be taken into account when working with clients. Schlesinger and Mullen (1977) present information on the response cycles of young and old males and young and old females. For example, while it may take a young man only seconds to gain a full erection, this time period may be minutes for an older male. The important point to consider here is that this longer excitment phase is normal for an older male. What naturally follows from this is the importance of provision of information of this type in the counselling situation. The debunking of myths and unrealistic expectations is part of the educational/therapeutic process (Rutherford and Rutherford 1977). Sviland (1978) discusses the psychosocial issues in helping elderly couples become sexually liberated, mentioning negative social attitudes to do with sexuality and aging, as well as the lack of information or misinformation. This is an area receiving increasing attention, as is seen by the publication of such self-help books as Butler and Lewis (1976), "Sex After Sixty: A Guide for Men and Women in their Later Years".

iii. pregnancy

The effects of pregnancy on sexual functioning was of interest to me as one of the women with whom I worked became pregnant during the course of treatment and this, again, had to be considered in the process of treatment and ongoing assessment. Certainly, while fear of pregnancy may be a factor in sexual dysfunction, the state of pregnancy also influences a couple's sexual activity. Solberg, Butler and Wagner (1978) present a study of the sexuality of pregnant women. They report a linear decrease in sexual interest, frequency of coitus, and orgasm over the course of pregnancy. They stress that in clinical work, it is important to enquire about the pregnancy period and the post-delivery period during assessment of sexual dysfunction. This kind of information is important to the clinician in that it is a factor in planning treatment when working with a pregnant woman. LaRossa (1979) discusses reasons given by men and women to explain changes in their sexual behaviour during pregnancy. He points to other reasons than the usual physiological/anatomical to explain changes in sexual behaviour. While there is not a plethora of information to do with sexuality and pregnancy, this is cited as an example of the kind of information a practitioner needs to be aware when working in this area.

iv. incest

When dealing with sexual dysfunction in women (desire disorder, dyspareunia, vaginismus, orgastic dysfunction), it is important to explore whether the woman has been an incest victim. Incest is one of may sexually traumatic incidents which could be a factor in sexual dysfunctioning (Jehu 1979:32). Tsai and Wagner (1978, 1979) discuss the effects of incest or sexual molestation on women: guilt, negative self-image, depression, problems in interpersonal relationships, mistrust of men, and sometimes inadequate social skills. In the area of sexual functioning, a desire disorder may be present in women. They advocate the use of group treatment as a vehicle of treatment for women. McGuire and Wagner (1978) agree that the arousal phase of sexual response rather than the orgasmic phase is effected in women who were molested as children. Their proposed treatment consists of identification and expression of anger, dealing with guilt about sex and pleasure, and use of "sensate focus" exercises. Clearly, the determining by the therapist if incest or sexual molestation is a factor in sexual dysfunction is important, as the client's emotional reaction and consequential behaviour has to be dealt with in treatment. Again, this is of special interest to this practicum as one of the women worked with had a history of sexual molestation as a child.

v. societal conditioning, attitudes, values

As Spector Persons (1980:611) points out: "In humans, sexual behaviour appears to depend more on learning and experience and less on hormonal and genetic contributions". In other words, what we learned about sexuality as children and what we continue to learn as adults effects the way in which we view ourselves as sexual beings, effects our expectations and attitudes. These naturally are seen in our behaviour. Miller and Fowlkes 1980:800) stress the social conditions under which female sexuality is learned: "It may be true, as Freud contends, that the sexual sits at the center of personality. But it sits there, nonetheless, as 'the changer and the changed', both shaping and being shaped in its dynamic relationship to the self and the society". Reed (1977) discusses male sexual conditioning and outlines the learning process of males in our society. In essence, we are all taught, both explicitely and implicitely, attitudes and values which are often harmful. These learned attitudes and values must be explored during assessment as a way of determining what beliefs are effecting an individual's sexual functioning. Traditional teaching about sexuality have often promoted feelings of guilt, shame, and anxiety (Barrett 1977). One glance at most

magazine stands is sufficient to be aware of the flood of sexually-oriented material which introduces "misinformation and increased preoccupation with genital performance" (Barrett 1977:8).

"Treatment" for some clients presenting with sexual problems may be as limited and brief as giving information about sexuality and helping the person explore the way in which he/she thinks about sexuality. The "dysfunction" may have its roots in misinformation, myths, or unrealistic expectations. "Cognitive restructuring" may be part of a treatment plan for any client; however, when working with a single (no partner) client, it may form the basis for treatment. This will be illustrated through a case report in Part II of this paper.

vi. relationship discord

It is my experience when working with a couple that relationship factors are usually a part of their expressed dissatisfaction with the sexual relationship. In assessment, it is crucial to gather information about the relationship. Marital discord may be defined as the existence of strife or a lack of harmony between a couple. Assessment as to the degree of discord with a goal of determining whether it is possible to deal with the specific dysfunction or whether relationship counselling must take place first is necessary.

The therapist must made a decision as to whether to deal with the presented sexual problem or the relationship (Gochros 1977). Kaplan agrees that brief sex therapy techniques are not effective for individuals whose symptoms are rooted in more profound marital conflicts (Kaplan 1979). In fact, for a person to function sexually in a destructive dyadic system would be dysfunctional (Kaplan 1974:155). Aspects of the relationship discord include: partner rejection, lack of trust, power struggles, disappointment, anger, communication difficulties, and sexual sabotage. As Kaplan (1974:167) points out, "the goal of sexual treatment is to cure the sexual difficulties, while the goal of marital therapy is broader and includes a more extensive modification of the transactional dynamics which lie at the root of the couple's difficulties". Sager (1974) suggests that a therapist should not deal with relationship discord and the sexual issue simultaneously. He offers three categories of discord related to sexual dysfunction and suggests the appropriate treatment:

1. sexual dysfunction producing secondary discord ranging from mild to severe could be treated through sex therapy;

2. some marital discord which impairs sexual functioning can usually be treated through the modality of sex therapy;

3. severe discord and hostility which prevents partners from cooperating in treatment are not appropriate candidates for treatment of the sexual dysfunction and must be seen for marital counselling.

As can be clearly seen, the assessment process is critical when marital discord appears to be a factor. Often, resistance to or sabotage of sexual assignments are an indication of more severe relationship difficulties and may force a change of direction to deal with the areas of marital stress before the sexual issues can be treated. This, in fact, occurred with several of the cases discussed in Part II of this report.

This review of literature has related to the assessment process of dealing with sexual dysfunction. Besides presenting an overview, I have dealt briefly with some of the factors with which the practitioner needs to be aware during the initial as well as the ongoing process of assessment.

5. Treatment

a. General Overview of Treatment Procedures

This section will deal with treatment procedures, conceptual frameworks for approaching treatment, and some "innovative" procedures in dealing with treatment of sexual dysfunctions. Treatment of specific dysfunctions will be covered under part b. of Treatment.

Masters and Johnson (1970) must be credited with the development of a systematic program for the treatment of sexual dysfunction. Major components of their approach include: both partners participating in treatment (they do not deal with individual clients); a male-female cotherapy team; and a two-week intensive program utilizing such features as sensate focus and the "squeeze technique". Many of the treatment programs developed since the publication of "Human Sexual Inadequacy" have adapted aspects of the program in an attempt to find more effective techniques for treatment of specific dysfunctions (Hartman and Fithian 1972). McCarthy (1977) uses a modification of Masters and Johnson sex therapy model where, in contrast to Masters and Johnson, there is only one therapist involved and the couple are seen once a week for treatment. The advantages of this modified approach is that there is a longer period of time for the couple to integrate new behaviour. Again, based

on Masters and Johnson, Arber (1977) works only with couples, with a focus on the dysfunction within a relationship. These approaches all utilize behavioural techniques in treatment, as do many of the effective models of dealing with sexual dysfunction (Fischer and Gochros 1977).

Annon(1977) proposes a "conceptual scheme for the behavioural treatment of sexual problems". The PLISSIT Model refers to levels of treatment: 1. Permission; (2) Limited Information; (3) Specific Suggestions; and (4) Intensive Therapy. The first three levels are viewed as brief therapy and the fourth is seen as being required only if the "brief therapy" levels of intervention are not successful in dealing with the dysfunction. This model provides a systematic means of both assessment and treatment.

Lobitz and LoPiccolo (1977) use a treatment model based on procedures developed by Wolpe (1969); Hastings (1963); and Masters and Johnson (1970). They contend that "in the absence of any physical pathology, sexual dysfunction is viewed as a learned phenomenon, maintained internally be performance

anxiety and externally by a nonreinforcing environment, principally the partner. In addition, a lack of sexual skill, knowledge and communication on the part of one or both partners contributes to the dysfunction" (Lobitz and LoPiccolo 1977:7). Treatment involves both partners in 15 sessions with a male-female therapy team. Intercourse is not permitted during the course of treatment. The treatment package is composed of:

1. clients keeping data on sexual activity as part of ongoing assessment and planning;
2. clients paying a "deposit" to ensure they follow instructions and to promote motivation;
3. use of erotic material, fantasy, and masturbation to enhance arousal;
4. teaching of interpersonal skills;
5. disinhibiting of sexuality; e.g., role-playing orgasm as a means of reducing anxiety;
6. maintaining of treatment gains by having clients participate towards the end of treatment in setting goals and procedures.

Lobitz and LoPiccolo report that this program is successful in treating sexual dysfunctions. They plan to evaluate components of the treatment package as a way of refining it.

LoPiccolo (1978) provides an overview of dysfunctions and treatments. He outlines basic principles of sex therapy which include: mutual responsibility of both partners, information, education, attitude change, eliminating performance anxiety, increasing communication and effectiveness of sexual techniques, changing destructive life-styles and sex roles, and changing specific sexual behaviours.

Laughren and Kass (1975); Wolpe (1977) write about desensitization of anxiety for the elimination of sexual dysfunctions. Obler (1977) found that systematic desensitization was superior to group therapy or no treatment in eliminating dysfunction, reducing related situational and social anxieties, and lowering anxiety to sexual stimulation. Lazarus (1978) uses systematic desensitization in conjunction with assertion training, behavioural rehersal, attitude change, and understanding prior learning. He refers to this as an "eclectic, broad-spectrum approach" to the treatment of sexual dysfunction.

The group treatment approach for treating dysfunctional couples has been used by McGovern, Kirkpatrick, and LoPiccolo (1978). They stress the reinforcing value of the group process. LoPiccolo and Miller (1978) also see the group method useful in helping non-

dysfunctional couples realize their full potential for sexual expression and satisfaction.

McWhirter and Mattison (1980) report that they use the same techniques for treatment of heterosexual and homosexual clients. What is important in dealing with homosexual clients is the attitude of the therapist who needs to be both accepting and to be committed to helping the client. The attitudes of clinicians to sexual techniques used with clients has also been explored by Len and Fischer (1978). Williams (1978) reports on using a female cotherapist as a participant in body work exercises with male clients. This procedure is based on the premise that real-life situations are useful places for exploring fears and learning conditions conducive to sexual functioning. There is no data on treatment outcome for long range effectiveness nor is there data on what kinds of clients may benefit from this type of treatment.

Dengrove (1977) discusses the "mechanotherapy" of sexual disorders, outlining the use of various "gadgets" as part of treatment. Related to this aspect of treatment, Gawin (1978) refers to an "expanded

definition of aphrodisiacs" and looks at the effect of various substances such as alcohol, marijuana, and LSD on sexual response. Both these writers imply that there may be clinical applications for these variations in treatment. However, there certainly are ethical considerations to be taken into account here.

This brief review of some of the literature related to treatment in general was provided to illustrate the range of treatment concepts and modalities available. Treatment, as has been stated several times earlier, follows from a thorough and systematic assessment. I want to stress that treatment plans which are designed to deal with <u>each individual</u> client or couple (as opposed to categories of dysfunctions) must be developed by the practitioner. This can be done by being aware of the various treatment techniques for specific dysfunctions and then adapting those techniques to meet the very specific and individual needs of the client/couple seeking treatment. The following section will look at treatment strategies for specific dysfunctions.

b. Treatment of Specific Dysfunctions

i. vaginismus

"Vaginismus is defined as the involuntary spasm of the pelvic muscles surrounding the outer third of the vagina, specifically the perineal muscles and the levator ani muscles. In severe cases of vaginismus, the adductors of the thighs, the rectus abdominis, and the gluteus muscles may be involved. This reflex contraction is triggered by imagined or anticipated attempts at penetration of the vagina or during the act of intromission or coitus" (Lamont 1978:632).

Vaginismus is often seen as a "conditioned anxiety response" -- it is a learned response which occured as a result of the first attempted introduction of something into the vagina under conditions of stress, tension, pain, or fear. The anxiety experienced by the woman as a result is the cause of the condition. Using Wolpe's (1958) theory and technique to decondition anxiety, many researchers advocate systematic desensitization as the main focus of treatment (Lamont 1978; Haslam 1977; Fuchs et.al 1978; Lazarus 1980; Leblum, Pervin, and Campbell 1980; and Kaplan 1974).

While systematic desensitization is often seen as the basis of treatment, there are variations developed by various therapists. Lamont (1978) uses a treatment package which includes: deep muscle relaxation,

progressive sexual fantasies, physical and verbal communication, pleasuring exercises, Kegel exercises, and vaginal dilation. Intercourse is forbidden until the woman has been successful in the "vaginal insertion" component of treatment. Both Lamont and Cooper (1977) view the inclusion of the male partner in treatment as being important for dealing with the dysfunction.

Fertel (1977) and Kline-Graber and Graber (1978) see the use of Kegel exercises as an important aspect of treatment. Poor tone of the perineal muscles is seen as a factor in vaginismus (Abarbanel 1978).

Kaplan (1974) uses a treatment package which combines systematic desensitization with the insertion of objects in the vagina. She states that "treatment is aimed primarily at modifying the immediate cause -- the conditioned response. Deeper causes are dealt with only when these present an obstacle to desensitization" (Kaplan 1974:417). The treatment package includes:

1. woman and partner examining woman's genitals
2. education - locating vagina
3. finger insertion: woman alone or with partner
4. insertion of two fingers into vagina
5. penile insertion with no thrusting
6. penile insertion with slow thrusting and the woman in control

This behavioural approach is combined with "therapy" to deal with fears and resistances which emerge. Education and encouragement play an important role in treatment and, again, the partner should be involved in treatment. "Sex therapy which combines in vivo desensitization of the spastic vagina with conjoint therapy appears to constitute the treatment of choice for this disorder" (Kaplan 1974:428).

This particular dysfunction is well suited to behavioural methods of treatment. Masters and Johnson (1970) report 29 cases in 11 years, all of which they evaluated as successful treatment. Lamont reports a high success rate in his study of 80 women diagnosed as having vaginismus (Lamont 1978). While there are certainly many variables present in treating vaginismus, the use of systematic desensitization in conjunction with the vaginal insertion component appear to be the most effective means of treating this dysfunction. Unless they present a block to treatment, there is no need to deal with underlying intrapsychic causes. An interesting aspect of this disorder is that it is often associated with premature ejaculation in the partner which then oftens has to be treated after dealing with vaginismus in the female partner. A case report dealing with assessment and treatment of vaginismus is included in Part II of this repo

ii. orgastic dysfunction

Orgastic dysfunction refers to the involuntary impairment of the orgasm phase in the female response cycle, so that difficulty or failure is experienced in releasing the reflex contractions of the vaginal and pelvic musculature (Jehu 1979:109).

In determining the treatment for an orgastic dysfunction, it is important to know whether this is a primary or secondary dysfunction. McGovern, McMullen and LoPiccolo (1978) point out that secondary orgasmic dysfunctions may be associated with relationship discord and thus are more problematic to treat than primary orgastic dysfunctions. Once again, we see the importance of exploring this issue in the assessment phase of contact with the client. They recommend that most secondary dysfunctioning couples be referred for short-term marital therapy before dealing with the dysfunction or that treatment be expanded to allow for dealing with marital issues in the context of sex therapy. With primary dysfunctional couples, sex therapy is appropriate with a goal of alleviating the symptom. Gebhard (1978) and Snyder, LoPiccolo and LoPiccolo (1977) also stress the relationship between the marital relationship and sexual functioning. Gebhard sees as strong correlation between female orgasm and marital happiness and duration of marriage; a definite correlation between duration

of precoital foreplay and female orgasm, and a moderate (but complex) correlation between duration of intromission and orgasm.

Wolpe (1977) states that anxiety inhibits sexual responding...because it involves some of the autonomic functions concerning sexual response. Therefore, he and others (LoPiccolo and Lobitz 1978; Husted 1978; Lazarus 1977; Madsen and Ullman 1977; Zeiss, Rosen and Zeiss 1978; Neiger 1977; and Masters and Johnson 1970) all advocate the use of systematic desensitization as a means to alleviate the anxiety which is blocking the sexual response of orgasm.

LoPiccolo and Lobitz (1978) use a nine-step masturbation program as part of treatment, although they stress it is not necessary for all inorgasmic women. Husted (1978) states that desensitization of anxiety is a factor in the treatment of dysfunctions but is not an effective means of increasing orgasmic capability alone. Kline-Graber and Graber (1978) prescribe the use of Kegel exercises for nonorgasmic women, emphasizing the role of the vaginal muscles in producing orgasm. Lazarus (1977) makes the statement that "frigidity"(which he defines as enjoyment of sex without orgasm to disliking sex) is a result of learned habits of anxiety relating to sexual participation. Desensitization through use of

relazation combined with a hierarchy of stressful situations established with the client has been a successful means of treating orgastic dysfunction. Madsen and Ullman (1977) generally follow Lazarus' method with some innovations. They view the husband's presence during construction of the hierarchy and desensitization as crucial. Zeiss, Rosen and Zeiss (1978) use a treatment program which includes: (1) fantasy during masturbation; (2) use of a dildo; (3) intercourse. Masters and Johnson (1970) also use desensitization to extinguish performance anxiety.

Barbach (1980) and Schneidman and McGuire (1978) both used the group approach to treatment with differing results. Barbach reports success with a program utilizing individual treatment within a group setting. Schneidman and McGuire report results for group treatment which compare poorly with individual treatment results.

Heiman, LoPiccolo and LoPiccolo (1976) present a program which is designed to teach a woman to become orgasmic. As a part of the therapy package, this publication has been assigned to clients and their partners and has been followed through in treatment.

iii. retarded/absent ejaculation

This is defined as the inability or difficulty in ejaculating during intercourse. Razani (1978) reports it is very difficult to treat and advocates the use of systematic desensitization to deal with the underlying anxiety which may be blocking the sexual response. Apfelbaum (1980) views the dysfunction as a desire as well as a performance disorder. Treatment, again, focuses on the performance anxiety. Others (Jehu 1979; Newell 1978) see inadequate stimulation as a factor and suggest use of a vibrator as part of the treatment package. Masters and Johnson (1970) have dealt with this dysfunction through a program where the couple learns to give and receive sensual pleasure (sensate focus). They report only 17 patients suffering from retarded or absent ejaculation in 11 years.

As with all dysfunctions, assessment to determine the contributing factors is important in determining causation and planning treatment.

iv. erectile dysfunctions

These are defined as a persistent inability to obtain a sufficiently firm erection, or to maintain this during intromission and intercourse (Jehu 1979:81). This dysfunction has been treated with psychoanalytically oriented psychotherapy where the dysfunction is seen as symptomatic of underlying conflict (Cooper 1978). Drugs have also been used as part of treatment (Cooper 1978). Masters and Johnson's (1970) treatment plan involving an intensive two-week program involving both partners has been reported as reasonably successful for erectile dysfunctions.

Shusterman (1977) views erectile dysfunctions from a learning theory framework and discusses various forms of treatment, ranging from behavioural techniques (systematic desensitization, relaxation training, training in assertive sexual responses), group treatment, the Masters and Johnson program, drug therapy, and hypnosis. Lazarus (1977:568) explains the reasons for erectile dysfunctions in terms of high anxiety levels which produce almost complete inhibition of sexual responsiveness. He sees treatment as involving desensitization: training in relaxation, construction of anxiety hierarchies, and systematically presenting anxiety items in conjunction with relaxation.

Garfield et.al.(1977) refer to a "broad spectrum approach" to treatment which includes: (1) desensitization to temporal and spacial stimuli producing anxiety; (2) thought-stopping and thought-substitution with reference to preoccupation with the partner's orgasm; and (3) practice in sexual assertiveness, to lag a few steps behind the above components (Garfield et.al. 1977:276). Kockett, Dittmar and Nusselt (1978) report on an evaluation of systematic desensitization in treating erectile dysfunctions. The measures included behavioural description, subjective report, and physiological response. They state that systematic desensitization has limited therapeutic value when used alone as treatment. The treatment package they recommend is a combination of desensitization in conjunction with education and the involvement of the man's partner.

Ellis (1980) uses a "rational-emotive" therapeutic approach to treatment. He states that "our society's emphasis on performance rather than pleasure, on the goal rather than the process of physical intimacy" produces pressure which inhibits sexual response (Ellis 1980:235). Emphasizing the importance of assessment in dealing with this dysfunction, Ellis sees treatment goals as including dealing with performance anxiety, unrealistic sexual expectations, insufficient arousal, suitable conditions, overemphasis on erection, and partner pressure.

Methods of treatment involve "cognitive restructuring" (Ellis 1980:240) which includes: disputing irrational beliefs,information-giving, myth-attacking, anti-puritanical teaching, cognitive distraction, imaging methods, sexual focusing, partner education, as well as bibliotherapy and audiovisual aids. Ellis' "emotive methods" include: acceptance of client by the therapist, reassurance and support, risk-taking, emotive self-verbalizations, and rational-emotive imagery. He also incorporates behavioural methods such as in vivo flooding, operant conditioning, skill and assertion training into his treatment package.

Other literature which deals with erectile dysfunction includes Malatesta et.al.(1979) who discuss the effects of alcohol on sexual response. Welsh and Kartub (1978) attempt to identify some sociological correlates of impotence. They report that the degree of a society's sexual restrictiveness is related to a prediction of incidence of impotence. In assessing the basis for erectile dysfunction, Karacan (1978) states that penile erection is one component of REM sleep. Monitoring of "nocturnal penile tumescence" has been shown as a means to evaluate erectile dysfunction which, of course, leads to determining treatment. Reckless and Geiger (1978) present a review of anatomy and physiology of penile erection and discuss organic and psychogenic factors leading to dysfunction.

LoPiccolo, McMullen and Watkins (1978) discuss treatment of erectile failure and ejaculatory incompetence of homosexual etiology and use arousal reconditioning techniques to increase heterosexual arousal. They state a behavioural approach can produce effective results even though the underlying psychodynamic issues are not dealt with.

This review of treatment strategies for erectile dysfunctions indicates that anxiety is a factor contributing to the problem, and must be dealt with in treatment. It is also clear that involvement of the partner is an important factor in successful treatment. A case report on erectile dysfunction is included in Part II. Of significance is the fact that the client was a single man (no partner involved in treatment) and the treatment plan had to be designed to meet this restriction.

v. premature ejaculation

While definitions of premature ejaculation have varied, it can generally be described as a condition wherein a man reaches orgasm very quickly (Kaplan et.al. 1978:278). Treatments have included psychoanalytic therapy based on the premise that premature ejaculation is an expression of unconscious conflicts regarding women; behavioural approaches using desensitization to relieve anxiety which is the cause of prematurity; techniques to diminish the excessive erotic sensations which, from this viewpoint, cause premature ejaculation. Semans'(1956) "stop-start" technique consisted of "extravaginal stimulation of the man by his wife, until the sensation premonitory to ejaculation was attained, then interruption of the stimulation until the man could tolerate this stimulation indefinitely without ejaculating" (Kaplan et.al. 1978:279). Masters and Johnson (1970) modified Semen's approach by using the "squeeze technique" which involves the man's partner squeezing the penis just below the rim of the glans at the time of ejaculatory premonition. In essence, the man learns the sensations around ejaculatory inevitability and to control his ejaculatory response. These latter treatment techniques have been very successful.

Neiger (1977) reports a number of non-intercourse techniques to treat premature ejaculation, including: widening the range of sexual behavior, reducing stimulation and receptivity, and systematic desensitization including sensate focus exercises. Lowe and Mikulas (1978) report high success rates with a self-help program including a written guide. Important variables here are that the couple's relationship is not under stress and that the partner is willing to cooperate. Assessment is crucial in using this treatment approach, as this procedure may be appropriate for certain people.

Perlman (1980) discusses a group treatment approach to premature ejaculation. Of interest here is that a "men only" (no partners involved) group had a high success rate in alleviating the symptom which implies that Masters and Johnson's conjoint model is not a prerequisite for success.

LoPiccolo et.al. (1978:278) define prematurity as the inability of a man to tolerate high (plateau) levels of sexual excitement without ejaculating. They report high success with a "group treatment" program involving four couples. This involved use of the stop-start technique combined with dealing with each couple within the group context.

Clearly, the stop-start or squeeze techniques are most effective for dealing with this dysfunction. Tanner (1977) refers to studies by Semens (1956), Wolpe and Lazarus (1966), and Masters and Johnson (1970) which indicate that these techniques are not appropriate when the client has "psychiatric symptoms". Tanner goes on to discuss several case studies which suggest that the squeeze technique can be effective for treatment of premature ejaculation with clients who have been diagnosed as "psychiatric".

Once again, there may be no need to deal in an intensive manner with the underlying reasons for the dysfunction, although I believe it is important for both the client and the therapist to explore this aspect during the assessment process. Understanding some reasons for the dysfunction can have therapeutic value in that it removes the "mystery" in the client's mind, as well as providing direction in planning treatment.

vi. lack of desire: inadequate sexual pleasure or interest

Of all sexual dysfunctions, lack of desire is the most difficult to both assess and treat (LoPiccolo 1980; Kaplan 1979). As has already been shown, successful treatments have been developed for other dysfunctions, but this has not happened in the case of desire disorders. LoPiccolo (1980) concludes that there are a host of interrelated and complex factors which contribute to lack of desire. They include psychological, physiological, sociological, learning, conditioning, hormonal, neuroendocrine, and cognitive factors. Needless to say, in cases of desire disorders, assessment is particularly important to determine the multicausal factors involved. Only then can an appropriate treatment plan be formulated. Treatment could incorporate such components as hormonal therapy, anxiety reduction, dealing with depression, increasing sensory awareness, dealing with relationship factors, enhancing sexual/sensual experiences, facilitating erotic responses, and dealing with intrapsychic conflicts (LoPiccolo 1980: 44-5). LoPiccolo also discusses some of the issues which might arise in therapy and which should be noted by the therapist when dealing with a desire

disorder. They include the client-therapist relationship, the couple relationship, the client's ambivalence about therapy and resistance to change, and issues to do with maintenace of therapy gains.

As stated earlier, assessment is crucial in dealing with desire disorders. Although each treatment plan for any dysfunction is individually formulated for the client(s) involved within a treatment framework which has been supported by research, in the case of desire disorders there is no one strategy which appears to "work". The treatment plan is, therefore, very individually oriented to meet the needs of the client. Areas which must be explored in assessment include whether the desire dysfunction is primary or secondary, if there is relationship discord, attitudes towards sexuality, depression, illness, medication, and so on. Assessment tends to be ongoing and overlaps much more with treatment than with other dysfunctions. Treatment also tends to be of much longer duration than the more behaviourally-oriented treatment strategies for dysfunctions such as vaginismus.

Kaplan's publication, Disorders of Sexual Desire (1979), is the result of her awareness of and concern over "treatment failures" in sexual dysfunction.

She reports "the discovery that the prognosis of desire phase disorders is substantially poorer than that of excitement and orgasm phase dysfunctions. Further, even in the cases of successful treatment of inhibited sexual desire, the course of treatment tends to be stormier and more complex" (Kaplan 1979: xvi). Kaplan's "triphasic" model of sexual response has already been discussed. This provides a theoretical framework for her proposed assessment and treatment strategies for desire disorders. While it is far beyond the scope of this paper to summarize her publication, Kaplan's "working hypothesis"about the antecedents to the inhibition of sexual desire is important to consider in terms of understanding the dysfunction and planning treatment.

Similar to other dysfunctions, sexual desire is inhibited by anxiety. The difference lies in that the "blocking" of sexual response occurs earlier in the sexual response cycle -- at the "desire" phase which preceeds the "excitment" phase. Kaplan states that "inhibited sexual desire" clients usually have no insight into the way they suppress desire. "...libido is not low because desire does not arise, but rather such patients have learned to 'turn it off', usually at the point when the first erotic sensations are felt or anticipated" (Kaplan 1979:37).

Sexual activity is seen as "dangerous" for a multitude of reasons and a way to deal with the danger is to "block" the response. One of the treatment tasks, therefore, is to explore with the client the underlying reasons for his/her suppression of desire. Kaplan refers to this form of treatment as "psychosexual" therapy which employs an integration of techniques and intervention at multiple levels (i.e., behavioural as well as levels of "insight" therapy). For example, clients could be instructed in and assigned "pleasuring" tasks. In the likely case that they are unable to carry out the assignment, treatment could then focus on exploring the reasons underlying their resistance. Kaplan mentions such factors as fear of romantic success, fear of intimacy, and fear of pleasure. If the client is able to understand the reasons he/she is inhibiting his/her desire for sex, the insight may be a beginning factor in remedying the dysfunction.

As can be appreciated, the desire disorder is the most complicated and interesting dysfunction with which the practitioner has to work. While several of the case reports in Part II deal with clients reporting lack of desire for sex, only one of these cases was a bonafide desire disorder which, needless to say, presented a challenge to both clients and therapist.

vii. relationship discord

As this practicum report deals with sexual dysfunction, it is not my intention to discuss the various modes of dealing with relationship discord. This is mentioned only to point out that it is often a factor (and may even be the factor) in presenting problems of sexual dysfunction. As Jehu(1979:49) points out, "sexual dysfunction and marital discord are related in some couples, in which case the dysfunction may have caused the discord, or the opposite may have happened, or perhaps most probably there was a reciprocal causal relationship between the two problems". Relationship discord has been discussed under the "Assessment" portion of this paper. The crucial factor for the therapist lies in determining whether to address the sexual difficulty or to first deal with the relationship discord. The therapist must assess the degree to discord and decide with the clients where the initial focus will fall.

This has been of significance to this practicum in that several couples seeking help with sexual issues were experiencing considerable stress and conflict in their marriages. As this became clear during assessment, a decision was made by me (with their agreement) that we must first relieve the relationship pressures before dealing with the sexual issues. Interestingly, for

some of these people, treatment of the dysfunction was not necessary once they made changes within their relationship. This indicates that the major reason for the sexual "dysfunction" was rooted in relationship discord. Annon's (1977) PLISSIT model of treatment discussed on page 35 of this report appears to be particularly appropriate for treating couples with sexual problems within a framework of relationship therapy.

Another factor of which to be aware when dealing with sexual dysfunction and relationship discord is that the sexual issue may be presented as a means to end the relationship. If treatment is undertaken with such clients, their consistent sabotaging of treatment needs to be explored to determine if, in fact, they are searching for an excuse to terminate the relationship (Sager 1974: 516). Sager does go on to state that very few couples who come for sex therapy end in divorce as compared to those who seek marriage therapy. However, this is yet another factor to consider when working with couples where relationship discord is clearly related to the sexual dysfunction presented by them.

c. Some Specific Components of Treatment Dealt with in the Literature

This section will deal very briefly with literature related to specific components of a treatment package designed for a client.

i. information-giving as part of treatment

Story (1979) reports on a "longitudinal study of the effects of a university human sexuality course on sexual attitudes" and states that students taking a two year university course in that area developed more accepting attitudes and became more accepting of behaviour of others than the control group who did not take the course. In line with this Chernick and Chernick (1977) state that ignorance about sexuality, lack of information, and misinformation have a role in sexual dysfunction. "Ignorance is not bliss when it comes to sex" (Chernick and Chernick 1977: 76). Assessment provides information to the therapist about the client's knowledge and attitudes and education and providing information is seen as part of the treatment procedure. This serves to reduce anxiety which, as has been discussed, may be inhibiting sexual response. With Annon's (1977) PLISSIT model, intervention (based on assessment) may take place at any of the four levels. Therefore, "therapy" may consist of giving information or "debunking" a myth related to sexuality.

ii. masturbation as part of treatment

Masturbation is used as a component in many treatment packages (Masters and Johnson 1970; Heiman, LoPiccolo and LoPiccolo 1976; LoPiccolo and Lobitz 1978. Used mainly with female clients, it serves to enable the woman to become aware of her own sexual responsiveness and to transmit this to her partner (Annon 1977). Heiman, LoPiccolo and LoPiccolo (1976) use masturbation training early in their treatment package for women who have not experienced orgasm. Marshall (1977) writes about reducing masturbatory guilt through desensitization prior to using masturbation as a therapeutic technique. Kohlenberg (1977) cite the results of a study which supports the use of masturbation as an effective technique in the treatment of orgasmic dysfunction. Masturbation can also be used with male premature ejaculation clients as a way of teaching them the sensations accompanying ejaculatory inevitability.

During this practicum, I have used masturbation training with women as one of the first steps of treatment for a desire dysfunction. One woman learned to masturbate to orgasm which not only changed her perception of herself as a sexual being but she was able then to share her discoveries about sexuality with her partner.

iii. Films, tapes, and books as part of treatment

Annon and Robinson (1978) discuss the use of vicarious learning as a treatment technique. Learning takes place when a change in behaviour occurs as a result of observing behavior of another person. While there is need for further research in this area, Annon and Robinson suggest this is a valid therapeutic modality. It is important, however, to give a clear explanation to clients of what they will see and how it relates to them as well as using judgement as to the material presented to clients. Some material may be too stressful and anxiety-provoking for some clients.

Some erotic material can be assigned to clients as a means to promote sexual stimulation; e.g., Nancy Friday's Forbidden Flowers (1975). This kind of "bibliotherapy" can be used in conjunction with masturbation training as a way to increase arousal. What is crucial here is helping the client identify what kinds of reading material serves this purpose for her/him. In line with this, Schmidt and Sigush (1974) report no appreciable differences in male and female responses to psychosexual stimulation by films and slides which may be another treatment component selected for clients.

As part of this practicum, I have assigned reading material to clients as part of treatment. The purpose was to provide information about sexuality, both related to physiology and to attitudes. This material may also serve to "normalize" clients fears about sex and doubts about her/himself. Literature which is extremely helpful in this regard include:

Heiman, LoPiccolo and LoPiccolo 1976. Becoming Orgasmic: A Sexual Growth Program for Women.

Hite 1976. The Hite Report.

Zilbergeld 1978. Male Sexuality: A Guide to Sexual Fulfillment.

Steinman and Fox 1974. The Male Dilemma.

This concludes my review of literature concerning treatment of sexual dysfunction. I have attempted to provide an overview as well as specific treatment procedures designed to deal with specific dysfunctions.

d. Other Related Research

As was stated earlier, in order to be an effective practitioner in the area of assessment and treatment of sexual dysfunction, one needs to be aware of related research. This may be the factor that separates the "technician" from the "professional".

Research arising out of related fields will assist in the refinement and sophistication of assessment schemes and treatment strategies. As a means of illustrating this view, I will cite a few studies which have increased my knowledge in the area as well as having provided "food for thought".

Tannahill (1980) discusses "sex in history" and provides an overview of sexual behavious, attitudes, and values from ancient times to the present. In line with this, Wyatt, Strayer and Lobitz (1978) stress that cultural differences are factors that must be considered when dealing with minority or ethnic groups. Mancini and Orthner (1978) report sex differences with sexuality preferences among middle-class husbands and wives. Morokoff (1978) discusses determinants of female orgasm as relating to physiological, sociological, psychological, interpersonal, and cultural factors. Singer and Singer (1978) advocate that female orgasms can be categorized into three types: vulva orgasm, uterine orgasm, and blended orgasm (which is a combination of the first two types). If there is supporting research in the future, this can certainly have a practice application. Similarly, Robbins

and Jensen (1978) discuss multiple orgasms in males.

I have cited only a few of the related research articles which provide the practitioner in this field with increased information. This kind of knowledge should serve to enable us to better serve clients coming to seek help for sexual dysfunctions.

6. Criticism and Evaluation of Assessment and Treatment of Sexual Dysfunction

The procedures currently used in assessment and treatment of sexual dysfunction have been developed over a short period of time and, as has been pointed out, are continuing to develop. Approaches integrating behavioural strategies with "insight" therapies are being utilized by some of the leading researchers in the field. There has been a certain amount of "trial and error" learning, both on a practical and an ethical basis. The questions around the use of surrogates in sex therapy clearly illustrates this (Wolfe 1978).

There has also been careful and thoughtful "soul-searching" among researchers. LoPiccolo (1978) addresses himself to the issues and problems related to the "professionalization" of sex therapy, raising questions about training, professional status, and even exploring the reasons for the existence of "sex therapy". Adams (1980) as well as Zilbergeld and Evans (1980) raise valid and important issues related to the ethics involved in sex therapy. These are all important issues and ones which the practitioner should continue to consider when working in this area.

Another important area of enquiry has to do with evaluation of the assessment and treatment strategies. How is "success" defined? What treatment packages are effective? What components of treatment packages are more effective than others? How can these factors be measured? Zilbergeld and Evans (1980) criticize Masters and Johnson's (1970) research by pointing out the methodological errors and problems with missing data. They stress that there is a need to be critical of research in the area.

Pervin and Leiblum (1980) present an overview of some critical issues in the evaluation and treatment of sexual dysfunction. They stress the importance of assessment including ways to evaluate the treatment procedures.

The practice of being critical about research in the area as well as constantly evaluating one's own endeavours in the area of sexual dysfunction is a necessary ingredient in the further development of assessment and treatment strategies.

7. Summary and Conclusion

I have presented a review of literature relating to the assessment and treatment of sexual dysfunction. Some of the literature cited serves as support and justification for the assessment and treatment plans discussed in Part II of this Practicum Report. In other words, I have used the published research to develop ways of helping clients deal with the sexual dysfunction each has presented. It has been my practice to create a treatment package designed to deal with the unique and individual needs of the client or couple. The selection of various components of the treatment package have been based on a thorough assessment of the particular situation as well as an awareness of research in the area. I believe the broad-spectrum or eclectic approach best serves the needs of clients.

Part II

Case Reports Discussing Assessment, Treatment, and Evaluation

In order to be an effective practitioner in the area of assessment and treatment of sexual dysfunction, the therapist must be aware of the range of research, be able to adapt this to her/his particular therapeutic "style" and to the unique needs of the client/s. An eclectic or broad-spectrum approach appears to be an appropriate conceptual framework from which to view treatment. This is a very new field of treatment with theorists, researchers, and practitioners exploring assessment and treatment methods for the various types of dysfunctions presented by clients. The review of the literature in Part I clearly illustrates this. While behavioural techniques appear effective for some kinds of dysfunctions (vaginismus, premature ejaculation), a "psychosexual" approach appears more appropriate for other dysfunctions, such as desire disorders (Kaplan 1979). Where relationship discord is a contributing and primary cause of a particular dysfunction, relationship issues may have to be resolved to a workable extent before dealing with the sexual issues.

When working with clients, the following process takes place:

1. definition of the problem by the client
2. initial assessment to determine if dealing with the sexual dysfunction is appropriate
3. assessment interviews to gather information
4. clinical formulation of problem, including specification of problem, hypotheses about conditions initiating and maintaining problem, and resources available for treatment
5. Goals of treatment arrived at through negotiation with client(s)
6. Treatment plan formulated
7. Treatment plan implemented, including ongoing assessment and evaluation of progress
8. Termination and evaluation of treatment

These guidelines were following during my involvement with clients seeking help for various sexual dysfunctions. The following case reports will illustrate this process.

In order to respect the confidentiality of clients, names and other identifying information have been changed or omitted from the reports.

Case 1 - Erectile Dysfunction

Assessment

Dave is a 26 year old student at the University of Manitoba who was referred to the Sexual Dysfunction Clinic by a counsellor at the Student Counselling Service. His reason for seeking help is that he was experiencing an erectile dysfunction. Dave is presently involved with a woman; however, has not had intercourse with her. The relationship is fairly new (several months) and during that time there have been several occasions when intercourse could have taken place. Dave reports that he gained a partial erection on one of these occasions when the woman manually stimulated his penis. However, he was extremely anxious, to the extent of shaking throughout his body, and he was unable to have intercourse. Dave is very concerned about his inability to have an erection and has come to the Sexual Dysfunction Clinic requesting help in overcoming this problem.

Dave states that the erectile problem dates from his first sexual encounter at age 20. During the first attempt at intercourse, he was unable to have an erection. The woman became angry, blaming, and was unsympathetic. This relationship lasted for some two years and it was not until six months after the

above incident that they had intercourse. Dave states that there were no erectile problems after than until towards the end of the relationship.

Dave began masturbating at about 20 years of age and has no problem having an erection when masturbating. However, in all relationships with women, he reports the same pattern. There is an extended period of not being able to have an erection, but if he finally does maintain an erection and intercourse follows, there is no further problem. Dave also stated that once he has an erection, premature ejaculation is not a problem for him.

The erectile dysfunction thus appears to have stemmed from his first sexual encounter and the woman's negative reaction to his not being able to have intercourse. A later relationship which appears to be significant to Dave began when he was 22 and lasted for 1½ years. There was no sexual contact initially and Dave reports that he could not gain an erection for some six months. This woman was understanding and supportive, though she later told him she was very concerned. After a time, Dave reports that he "quit worrying" and subsequently was able to have an erection and intercourse, with no further problems. This pattern repeated with one other woman, although that relationship was shorter

in duration. During the next few years, Dave dated several women but there were no long-term relationships. He did attempt intercourse with one woman during this time but was unable to have an erection, and did not try again. While he could gain an erection through manual stimulation by his partner, intercourse was not possible.

Contemporary influences on the problem -
Dave's anxiety appears to be a major factor in his inability to have an erection. His concern over whether he will be able to have intercourse (and anticipating that he will not) results in high levels of anxiety. His relationship with a partner also appears a significant factor. It seems that some level of trust and intimacy must exist in order for Dave to risk a sexual encounter which he feels may well end in failure (i.e., no erection, no intercourse = failure). At the time of first contact with the Sexual Dysfunction Clinic, Dave was preparing for final exams which was certainly stressful for him, but which he felt was not contributing significantly to his problem, which is of some seven years in duration.

Dave has obviously thought a great deal about the problem. However, it is my impression that much of

the way he thinks about sexuality is based on limited and inaccurate information. For example, he assumes that most other men can "get it up" whenever they choose. Also, he seems to believe that intercourse is the only sexual activity which will satisfy a partner. Therefore, if intercourse does not follow from a sexual encounter, the woman will be angry and frustrated. In line with these kinds of assumptions and beliefs, Dave feels a great deal of pressure to "perform" sexually. His present inability to do so in the manner he expects he should results in anxiety, stress, and an avoidance of situations where he may find himself in a position where he might have to "perform". Dave denies any severe depression over his situation, stating that it does concern him a great deal, that he thinks about it, but that it doesn't incapacitate him. The fact that he does continue to seek out relationships with women seems to support this, although one must also take into account peer and societal expectations of a young man.

Dave stated that after sexual encounters which were "failures", he felt angry, frustrated, and disappointed. He expressed some distrust of the women who reassured, supported, and said they understood. The underlying assumption seems to be "how can she care for me if I can't have intercourse?". Dave also stated that

the only time he felt comfortable with a woman was if he knew her very well or if intercourse was out of the question. Thus, any indication that intercourse might be possible is a trigger for anxiety. Further, even in other sexual encounters (kissing, petting), Dave feels he "should" have an erection even though intercourse is not possible due to the physical setting or situation.

Personal and family background -

Dave is 26, single, and lives with his parents and sister. Apart from summer jobs away from Winnipeg and one academic year at another university, he has always lived at home. The ethnic background of the family is Scandinavian. The religious background is Lutheran. There are no indications that religious teaching is a factor in the erectile dysfunction. Dave appears to have been involved in the usual childhood activities (swimming, Air Cadets) and he belonged to a fraternity during his first years at university. There are no health problems. Dave did take some relaxation training several years ago. A physician has recently prescribed a mild sedative to deal with teeth-grinding, but Dave has not taken it.

Dave's father works for an airline and his mother works in their home. The parental relationship is reported as satisfactory by Dave. He states that his father is the disciplinarian while his mother is more open and demonstrative. Dave does not appear to have a close relationship with any of his family, including his sister. It does appear that Dave's mother is the parent holding most influence over him. She disliked several of his women friends and it seems is somewhat over-concerned and protective of her 26 year old son. This, of course, may be due to Dave's still being at university and, thus, not being an "adult" fully.

Childhood and puberty -

Family attitudes to sex were somewhat disapproving and repressive. However, the parental attitudes are not atypical for many people of their generation and background. Most learning about sex took place through peers, with one uncomfortable "man-to-man" chat with Dave's father. Dave began dating at age 16 or 17 and recalls that he first became curious about sex at about 14 or 15. He did not masturbate until about 20 years of age and states that he masturbates 2-4 times a week, but less when he's been sexually involved with a woman. Masturbation is accompanied by sexual fantasies of encounters with attractive women.

As stated earlier, Dave does have an erection and can reach orgasm when masturbating. He also has nocturnal erections. These are strong indications that there is no organic cause for the erectile dysfunction and indicate that anxiety is most likely the primary inhibitor of the sexual response of erection. There is no indication that homosexuality is a factor here.

Dave appears to lack confidence in himself in many aspects of his life. He is very concerned about the opinions of others, stating that he wants everyone to like him and to look up to him. He is quite unsure of himself and appears to invest a good deal of energy in not letting other people see this. The Semantic Differential Scale was administered and the scores support the clinical impression that Dave sees himself as anxious.

Dave appears highly motivated to deal with the erectile dysfunction. It is my impression that he will be able to organize both time and resources to work on the problem. The desired outcome for him is, of course, to be able to have an erection and be able to engage in intercourse with his present partner.

The prognostic expectation for dealing with this type of dysfunction is good. (Please refer to pages 47-50 for treatment strategies for erectile dysfunctions.) The major obstacle to treatment is that Dave does not want his partner involved directly in the process. He stated that the relationship was too "new" and was not a serious one at this point. This decision naturally placed restrictions on the treatment methods for the dysfunction; however, this did not prove to be an insurmountable barrier to effective treatment.

Clinical formulation -

The erectile dysfunction appears to stem from Dave's first attempt at intercourse when he was unable to have an erection and was subsequently treated with anger and hostility by the woman involved. The anxiety stemming from this incident has perpetuated the problem in subsequent attempts at intercourse. It appears that when the anxiety level is lowered through gaining trust and intimacy in the relationship, Dave can have an erection and intercourse. Dave is also operating on the basis of erroneous and limited information concerning both male and female sexuality. This prevents him from understanding and accepting

the conditions under which he needs to operate in order to have an erection and a sexual relationship. Another factor contributing to the dysfunction is the somewhat repressive attitudes to sexuality which Dave learned both from his parents and his social environment. Other factors which must be considered include his lack of confidence, difficulty in trusting others, and underdeveloped social skills.

Before formulating a treatment strategy, it is important to assess what resources are available for treatment and how these may facilitate or hinder the treatment (Jehu 1979:179). Certainly, Dave is highly motivated to make changes in this area. I feel he has the organizational capacity to understand and follow planned tasks and assignments. He is an intelligent man who reads a good deal, so assignment of reading material can be included in the treatment package. The major limitation in working with Dave will certainly be the fact that he is requesting help as a single client and that he does not want his present partner involved directly. This limits the

strategies available for treatment. While a Masters and Johnson (1970) kind of approach may be effective when dealing with a couple where the erectile dysfuction is present, this strategy is, of course, not appropriate when dealing with a single client. However, various other strategies (e.g., provision of information, modifying attitudes, relaxation training, desensitization) may be applied to working with a single client (Jehu 1979:183).

The goal of treatment is alleviation of the erectile dysfunction.

The treatment plan included:

1. education about sexuality. In line with this, Zilbergeld's Male Sexuality was assigned as reading with a goal of providing information as well as modifying Dave's attitudes towards sexuality.

2. training in and assignment of relaxation techniques as a means of dealing with anxiety which is acting to inhibit Dave's sexual response.

3. cognitive restructuring. The basic premise underlying this approach is that a person's assumptions, expectations, and beliefs about a situation have a significant influence on the emotional and behavioural response to that situation. By having Dave explore

and understand the way he was perceiving himself and his environment, his unrealistic expectations could be challenged with a goal of his being able to identify those conditions under which he could expect to "perform" in a sexual situation.

4. Indirectly including the partner in the treatment by suggesting Dave talk with her about the therapy sessions and share the reading material with her. It was my hope that she could be included directly in treatment at some point if this could be seen as less threatening by the client. A secondary goal here was to improve communication between them, with a hope that this would facilitate Dave's progress in dealing with the erectile dysfunction.

Treatment consisted of 15 sessions with Dave. The process involved discussion about sexuality in general, usually based around the assigned reading, but also including my responding to questions and statements about male and female sexuality. This not only served to increase Dave's knowledge about sexuality, but also played a major role in his slowly changing his attitudes towards sexuality. In turn, this served as a way to lessen anxiety and to begin to identify those conditions under which he

could realistically expect to respond in a sexual situation. Relaxation techniques also served to lower his anxiety level.

Dave was asked to keep a written record of "dysfunctional thoughts". This involved his noting when he was experiencing an unpleasant emotion, his noting the situation that stimulated the emotion, and then noting the automatic thought associated with the emotion. An example in Dave's situation is as follows: His woman friend called to tell him that her parents were going out for the evening and asking if he would come over. He experienced anxiety and tension which he could associate with the invitation. His automatic thought associated with the emotion was that she would expect him to have intercourse with her. Once Dave was able to identify the kinds of assumptions he was making which were resulting in anxiety for him, he was able to begin to look at other ways of perceiving the situation. For example, perhaps his friend wanted to talk with him or just share some time together, or, on the other hand, maybe she did expect intercourse. Dave began to see that much of his thinking was myopic and based on assumptions which weren't necessarily correct. From this realization also came an awareness of the need to "check out" assumptions both within

himself and with other persons involved. He was able to begin communicating more effectively with his partner which, from his report, improved their relationship. He eventually informed her that he was seeking help for the erectile dysfunction and she did share some of the reading material with him. This served to further decrease the anxiety which Dave was experiencing and which, as stated, was the primary factor in his erectile dysfunction.

The treatment process was evaluated on an ongoing basis, primarily through client self-report. Issues resulting from the week's activities and as a result of assigned reading and tasks were discussed during the weekly sessions. Dave was instructed not to attempt intercourse until this had been discussed with me. The purpose of this was to further reduce the situation-related anxiety. This instruction also served to enable him to engage in other forms of sexual activity without the expectation or pressure that intercourse would be expected if any kind of sexual activity were initiated. He was able to share this "instruction" with his partner, as well as explaining to her the rationale.

As might be anticipated, the couple did engage in intercourse at a time when Dave assessed that the "conditions" were right for him to be able to achieve and maintain an erection. This "success" not only had therapeutic value in that it decreased Dave's anxiety yet further, but it also served as a way for him to identify those conditions which were appropriate and realistic for him.

Termination was mutually agreed upon. Dave stated that the goals we had established had been achieved through the course of treatment. He felt that the significant factor in treatment was the "cognitive restructuring" component where he learned to challenge his assumptions and beliefs. This, coupled with education, relaxation training, and increased communication and interpersonal skills contributed to Dave's dealing with the erectile dysfunction.

Case 2 - Vaginismus

Assessment

Anita is a 24 year old woman who was referred to the Sexual Dysfunction Clinic by her physician. She reports that she has been unable to have intercourse due to a physiological tensing of the vaginal muscles when penetration seems imminent. She is unable to insert tampons and past gynaecological examinations have been distressing for her. At the time of the first assessment interview, Anita reported that Don, her partner, is able to insert his finger about an inch into her vagina before she tenses and experiences the muscle spasm. She reports no pain at this time, but rather that the response is automatic and she is unable to control it. Don and Anita have been living together for two years. While this problem has been present from the beginning of their relationship, they thought that they could overcome it in time. This has not happened. For a period of time, they avoided sexual contact; however, they now engage in sexual activity several times a week. This includes a variety of sexual behaviour. Anita does experience arousal and is orgasmic with manual or oral stimulation. She experiences the tension only when intercourse is attempted.

The couple are considering marriage and this has provided motivation for dealing with the dysfunction.

From Anita's description of the problem, a tentative assessment of vaginismus was formulated. Anita was referred to a gynacologist, who confirmed this diagnosis. Vaginismus is defined as "the involuntary spasm of the pelvic muscles surrounding the outer third of the vagina, specifically the perineal muscles and levator ani muscles....This reflex contraction is triggered by imagined or anticipated attempts at penetration of the vagina or during the act of intromission or coitus" (Lamont 1978:632).

In Anita's situation, this is a primary dysfunction. She has never been able to have intercourse. As a teenager, she attempted intercourse (with partners pressuring her and Anita being very reluctant). She reports that she always tensed up when intromission was attempted and was not able to continue. These responses to attempts at intercourse have continued to the present. While this did not concern Anita with the earlier casual relationships, she is seriously involved with Don and wants to be able to have intercourse with him.

Anita and Don have attempted to deal with the situation over the three years they have been involved. Anita reports that she tried relaxation exercises but did not persist with them when results were not immediate. To make intercourse more likely, they have tried using lubricants (although Anita reports that she has no difficulty lubricating when sexually aroused). This, however, did not prevent her from tensing. Don has attempted to arouse Anita sexually with the idea that if she is extremely aroused, she will be distracted enough to have intercourse. Anita states that she does get very aroused; however, when intercourse is attempted it is similar to "a switch going on" and she immediately tenses. They have tried to use alcohol as a "relaxer" but this was not successful. Another tactic was for Anita to assume the "female superior" position so that she could better control penile insertion. What happened here is that Don was unable to control his thrusting response and the usual result occurred. The couple have been persistent and somewhat innovative in dealing with the problem but, naturally enough, were both feeling somewhat discouraged.

Contemporary influences on problem -
This situation is stressful for Anita. She appears a somewhat anxious woman, reporting that she does feel tense much of the time. She attributes this anxiety mostly to her concern over her inability to engage in intercourse with Don. Anxiety appears to stem from her anticipated harm from intercourse and from anticipation of yet another failure when intercourse is attempted.

The relationship between Anita and Don is without serious difficulty. Both from their own report and from my observations, they appear happy together, committed to their relationship, and fond of each other. Anita sees Don as supportive, understanding, and caring about her. He is willing to participate in treatment.

There appear to be no concomitant non-sexual stresses. Anita is generally satisfied with her employment and, apart from the sexual issue, there appear to be no other major stresses in her life.

Although the sexual problem was avoided in terms of dealing with it in the past, Anita is anxious to deal with it now. This emphasis on "getting over it" is contributing to the anxiety which she now experiences. Adding to this is the fact that Anita

appears to constantly monitor her sexual response, again, anticipating that she will tense up if intercourse is attempted. This "spectatoring" does detract somewhat from her experiencing maximum sensual and sexual pleasure. Also, both Anita and Don have limited information about sexuality. Anita was relieved to learn that "her" problem actually had a name, and that other women also experienced vaginismus.

Her emotional reactions to the situation are those of anxiety primarily. She also feels guilty because she is "cheating" Don by not being able to have intercourse with him. Coupled with this is concern about her "femaleness" and fear that there is something "wrong" with her. She also reports that she sometimes feels depressed because of the situation.

Anita reports no major illnesses and she is not taking any medication. While she was taking oral contraceptives earlier, she is not at present. As already indicated, she was terrified of pregnancy as a teenager, which is a factor relating to her responses to sexual situations at that time. She states that pregnancy is not a concern at present. (Anita began taking oral contraceptives again during the treatment process.) However, if they were able to have intercourse, she

would like to have a baby.

Personal and family background -
Anita's family immigrated from England some ten years ago. Her parents live in another part of Canada and she has a sister living in Winnipeg. Anita is the oldest child, with three sisters and one brother. She reports her parents as being affectionate to each other, but that the family was not especially close. Her father was strict and the children were expected to set an example in the small town in which they lived.

Anitalearned about sex from her mother and this appears to have consisted of a short and embarassing talk on menstruation. When Anita began menstruating at age 11, she reports it was a "shock". She began dating at age 14 and appears to have had an uneventful adolescence. There is no indication of incest or sexual assault. Family attitudes towards sexuality were restrictive and negative.

Anita recalls the first attempt at intercourse when she was 16 or 17. Her current boyfriend at that time pressured her into having intercourse with him, though she was very reluctant and frightened. She was using no form of birth control and was afraid of pregnancy, partly due to her family's expectations

that the children provide a good example. She reports "tensing up" when intercourse was attempted. This behaviour has maintained to the present.

When asked how she saw herself, Anita responded that she was "fat" and that she does not feel attractive. (She is neither "fat" nor unattractive.) She appears to be lacking in confidence and self-esteem. Anita is highly motivated to change the situation and, as mentioned, Don is willing to be involved in treatment. It is my impression that Anita has the organizational capacity to handle assignments. Because of the nature of the problem, prognosis is good. Treatment of vaginismus has a high success rate (Jehu 1979:248) with researched treatment packages which, of course, can be modified to deal with individual clients. The desired outcome is elimination of the vaginismus so that Anita and Don can enjoy intercourse.

As a part of the assessment process, several scales were administered. On the Sexual Arousal Inventory, Anita scored 106, which places her between the 85th and 88th percentile range. This indicates that her report of being able to be aroused sexually is accurate. On the Dyadic Adjustment Scale which is an indicator of disagreements within a relationship, both Anita and Don indicated that "sex relations"

were a problem for them. On the Semantic Differential Scale, Anita sees herself as very anxious, not sexually attractive and not easy to arouse.

Clinical formulation -

The vaginismus Anita experiences involves involuntary spasms of the pelvic muscles when intromission is attempted. Anxiety is a major factor in maintaining this learned behaviour. Her fears about pregnancy as a teenager appear to have resulted from her strict upbringing and parental expectations that she "set an example" in the community. Her way of avoiding intercourse as a teenager was to maintain the spastic response so that intercourse was not possible. This obviously was successful for her. However, the learned behaviour has maintained and has been reinforced through repeated "failures" at intercourse. Anxiety related to the anticipation of failure has also been a factor in the maintenance of the vaginismus.

Anita's lack of knowledge about sexuality in general and vaginismus in particular has contributed to the persistence of the condition.

Resources available for treatment appear to be adequate. Both Anita and Don are highly motivated. The general relationship between them seems to be good, which is an important factor in the process

of treatment. Socioeconomic resources are adequate for treatment. Anit and Don are both employed and they have sufficient privacy to undertake assignments. Professional resources include the therapist's awareness of treatment plans for this dysfunction.

The goals of treatment include:

1. elimination of the vaginismus
2. educational: giving information to both Anita and Don to help them gain a better understanding of sexuality and, thus, contribute to their sexual relationship

Measures in monitoring progress will largely be done through client self-report as Anita moves through each stage of the treatment plan.

The treatment plan is based on methods outlined by Fuchs et.al. 1978; Abarbanel 1978; Lamont 1977; and Fertel 1977. The treatment package has been divided into stages. This is partly for clarity of explanation, as the stages will overlap to a certain extent. However, the more important reason is that Anita will not move on from one stage to another until we are comfortable that she has mastered the preceding stage with minimal anxiety.

The stages are:

1. explanation of vaginismus and of proposed treatment. I feel that having a clear picture of how treatment is going to take place has positive therapeutic value for the client. It is also essential that she and her partner understand the dynamics of vaginismus. Although the first portion of the treatment will include Anita alone, Don should be present for this "information" session so that he also understands the treatment plan, goals, methods, and, above all, the nature of vaginismus.

2. relaxation exercises - explanation, instructions, and assignment with a view to being one means of lowering the anxiety Anita feels and as preparation for in vitro desensitization.

3. Kegel exercises - strengthening and control over the pelvic muscles is an important aspect of treatment (Fertel 1977; Kline-Graber and Graber 1978).

4. in vitro desensitization - establishment of a hierarchy of sexual situations which produce anxiety. Beginning with the least anxiety provoking, Anita will be asked to imagine the situation while in a relaxed condition. When this is accomplished, she will move to the next least threatening situation until she can be relaxed while imagining the most anxious situation.

5. Finger insertion into vagina, combined with relaxation exercises. This stage should begin with Anita inserting her own finger. When she can achieve this without tensing by using relaxation training, she will be instructed to insert two fingers. When comfortable with this, Don will be instructed to insert his finger, then two fingers. It is important that Anita feel in control of the situation here and that neither she nor Don attempt this if Anita is not relaxed.

6. Non-demand coitus. The couple will be instructed in beginning with penile insertion with no thrusting, and gradually moving into more active intercourse as Anita feels more confident and comfortable.

7. education about sexuality will be ongoing throughout this process. Towards the end of treatment, several sessions with Anita and Don will be undertaken where we can deal with any issues which might arise from the process.

Treatment to date has consisted of ten sessions over four month period. This extended period was due to both my and their being away on vacation. Therefore, treatment has been somewhat slower than anticipated for this kind of dysfunction. At the time of writing, we have progressed to step 5 of the treatment plan. The use of <u>in vitro</u> desensitization for the associated

anxiety has resulted in Anita's being able to imagine the items she saw as "most stressful" - intercourse - and remain relaxed. The sessions to this point had involved only her, though Don was kept informed as to the progress.

When discussing step 5, Anita stated she would be more comfortable having Don insert his finger rather than her doing it first herself. I agreed with this plan, though I was prepared to return to the original plan if this was not effective. However, it does appear to be effective and, at the time of writing, Don is able to insert two fingers fully into Anita's vagina without her experiencing muscle spasms.

Treatment is not completed with this couple; however, I feel that within a short period of time, they will be engaging in intercourse.

Case 3 - Desire Disorder

Mary was referred to the Sexual Dysfunction Clinic by a local social service agency. Her request was for "help with a sexual problem". Mary clearly identified the "problem" as her's but indicated that her husband, Don, was willing to join her in attempting to deal with the difficulty.

Mary is 22 years old; Don is 28. She is employed on a part-time basis in a cafeteria of a department store. Don is a diesel mechanic. He works on a night shift and has done so for some time, which interfers with the couple's social life. Mary is suffering from Chron's Disease, which was diagnosed a year ago. During her illness, she has lost some 35 pounds and is only now beginning to gain weight. The couple have been married 3½ years; there are no children.

Description of problem -

Mary's concern involves her lack of interest in sexual activity in the marriage. This dates from a few months after the couple married. They had intercourse prior to the marriage and Mary stated that it was "great" then. She describes the change from enjoying

sex with Don to being unable to respond sexually and feeling that sex was "dirty" as being very abrupt. Her lack of response, reluctance to engage in any kind of sexual activity (for fear it would lead to intercourse) has resulted in a steady decline of sexual activity between the couple. At the time of the first interview, they had not had either intercourse or any other sexual encounters for some three months. There was an avoidance on both of their parts of situations which might lead to sex (i.e., lack of touching, avoidance of physical contact, going to bed at different times, watching television rather than talking, etc.). Don reported that he avoided any intimate situations with Mary for fear that she would reject him again. At the point of contact with these clients, Mary especially and Don to a lesser extent, expressed concern that the sexual difficulties would harm their marriage if not dealt with soon.

Contemporary Influences on Problem -
Mary's illness is certainly a source of stress in this situation. With Mary and Don's permission, Mary's physician was contacted as a means of determining the effect of Chron's desease on the sexual

difficulties. The debilitating effect of Chron's disease and the fatigue the effected person experiences certainly could be a factor in Mary's lack of interest and desire for sex. Although the illness was diagnosed a year ago (and Mary's lack of interest dates from two years prior to that), it is possible she was suffering from the disease in a latent form for some years. This factor will certainly have to be taken into consideration during treatment. Another effect of the disease is the strain it has put on the marriage. Mary feels that Don resents the fact that she is ill and is unable to do many of the activities in which a "normal" person engages. She frequently feels fatigued and has to force herself to socialize. This, coupled with Don's night shift, curtails their social life considerably. Apart from seeing their families from time to time, Don and Mary have no close friends and tend to spend their free time together, usually at home in front of the television. They both stated that they are "bored" with their lives. Mary also stated that she feels useless and that she is not pulling her weight in the marriage because she is unable to work full-time and thus contribute financially. She feels Don resents this as one of his major goals in life is to "get ahead" financially (which means buying a larger house, a new car, etc.). She stated that she feels like a

"ball and chain". I feel there is considerable stress between these people. They do not communicate well with each other. Don tends to avoid confrontation by removing himself, either physically (getting in his car and going away for a few hours) or by refusing to speak to Mary. She, of course, finds this extremely frustrating. There appears to be something of a power struggle going on with Don and Mary, with Don using his silence and Mary using her weakness as weapons against each other. This may well relate to Mary's lack of interest in sexual activity with Don. He did state that he feels Mary uses her illness as an excuse to avoid what she doesn't want to do. For example, when visiting his family, Mary will plead fatigue as a way to leave, but with her family this tends not to happen. Mary, of course, denies this and can cite examples to support her denials. Sexually, she also states that Don is not concerned with her needs, that he "goes too fast", that she sometimes has felt "raped" and "used" by him to satisfy his own needs. Interestingly, she also reported that she has never communicated this to Don. Both Don and Mary state that Don has never experienced any sexual difficulty in terms of erectile or premature ejaculatory difficulties.

While they tend to see the difficulty as primarily Mary's problem, the relationship stresses are certainly contributing largely to the difficulty. The Semantic Differential Scale was administered during the assessment phase of contact with the couple. Both Mary and Don perceive themselves and each other as quite anxious. Neither sees themselves as particularly sexually attractive. Don does not find Mary to be sexually attractive. Both of them perceive Mary to be extremely difficult to arouse sexually.

Another factor which appears to be related to the problem is their lack of information about sexuality, both in terms of knowledge of human sexual functioning and in attitudes towards their sexuality. Mary, for example, does not know if she has ever had an orgasm; she is not familiar with her own body and stated that she didn't know what she was supposed to feel sexually. The Sexual Arousal Inventory was administered, with Mary scoring 43 (between the 5th and 8th percentiles), indicating a low arousal level. Similarly, Don also appears to know little about sexual functioning. For Mary, this uncertainty results in her monitoring her own sexual behaviour which, again, contributes to her lack of interest. She appears to be so occupied wondering if she's

doing it "right" or if she's feeling what she's "supposed to" that she loses awareness of her own sexual sensations. All these stresses have resulted, over time, in the couple avoiding any activity which may lead to sex.

This couple appear to have little stimulation in their marriage, sexually or in a broader perspective. Although both Mary and Don deny any feelings of depression, I feel there are elements of this emotion for both of them, and especially for Mary. With the prospect of an uncertain future due to her illness, her feelings of dependency and worthlessness, it would be natural for her to feel depressed at least some of the time. Along with this, I perceive there is a good deal of anger between this couple, with each of them blaming the other for the difficulties they are encountering both sexually and in the marriage in general. Don is angry about Mary's illness while Mary's hurt at this also carries an element of anger.

Mary's illness has been discussed earlier, but it should be added that while she is taking a variety of drugs, none of them should be effecting her desire for sex. She is also on a birth control pill, so fear of pregnancy is not an issue here.

Personal and family backgrounds -

Mary and Don met in 1974 when she was working at a fast food establishment and he was a gas station attendant. She was 16 years old and he was 22. Mary's parents objected to her seeing him and Don was not allowed near their house for seven months. At that time, Mary had told her parents that she would leave home if Don were not allowed to see her. They both state the relationship between Don and Mary's parents is fine now. Don and Mary courted for three years before their marriage in 1977. Mary states that their sexual relationship before the marriage was "great". Mary had no previous sexual experiences. Don was her first serious relationship. She lived at home up until her marriage and the transition from being a daughter to being a wife seems to have been a difficult one. She states now that she had preconceived notions as to what a wife does (cooks, cleans, etc.) and that these activities took precedence over sexual activity soon after the marriage. Sex with her husband was another "duty" and one in which she soon lost pleasure. Mary comes from a Polish-Catholic background. Sex was never discussed at home and her parents were not openly physically demonstrative with

each other. Mary learned what she knows of sex from Don and from a girlfriend. Don stated that he was brought up in a more repressive home than Mary. The family was "run by mother" and family members tended to keep their feelings to themselves which explains, in part, Don's inability to express his feelings.

Sexual experiences -

Don had some sexual experiences prior to meeting Mary; however, it is my perception that both of them are very inexperienced and somewhat naive. Some shock was registered by both of them at the mention of masturbation. Mary has never masturbated although she stated that it might be "o.k." if no one knew. Don stated that he never masturbates and feels that it is wrong. In an interview with Mary alone, I asked her about sexual fantasies and she replied that she does fantasize occasionally about having sex with someone other than Dave, but then feels guilty about it. Neither of them has used or considered using erotic literature for sexual stimulation and pleasure.

As stated earlier, the sexual relationship prior to their marriage and for a short time afterwards appears to have been satisfactory. Mary states

that after the marriage, sex became routine and without excitement. She attributes this partly to the fact that it was no longer forbidden. While there was more variety and unpredictability before marriage, sex soon became boring and predictable. She seldom took the initiative sexually and was not able to tell Don about her frustrations and wishes. Instead, when conditions were not right for her (place, timing), she complied with increasing disinterest. The pattern appears to be that when Don initiated sexual activity, Mary would either find an excuse, avoid the situation, or comply with no response. Don now is very reluctant to approach her for fear of being rejected again. Neither of them feels attractive or desirable to the other at this point.

Self concept -

This couple appear to lead a somewhat restricted, narrow lifestyle with few interests and social contacts. Don, at 28, feels he is not getting the things he wants quickly enough and seems dissatisfied with his life in general, yet feels somewhat caught due to his job, lack of education, and responsibilities. In particular, he gives an impression of having few pleasures in his life at present. As stated earlier, they both find their life and relationship together "dull".

Mary sees herself as skinny, flat-chested (stating that Don liked women with large breasts), and unattractive. Especially in the first two interviews, she made several negative statements about herself ("I'm a nobody"; "I have no purpose in life"; "I'm a prude"). She also seems to have some doubts about Don's caring for her. During her illness, she lost what confidence and sense of herself that she had. At this point, she has difficulty in ever thinking of herself first, of stating her needs, fears, and wishes. She dislikes her dependency on Don, but is unsure as to what she can do about it.

Attitudes towards treatment -

I feel that Mary is well-motivated to attempt to bring about change in the relationship in general and in the sexual aspect specifically. Don is less verbal about his committment, seeming to want to see the "problem" as Mary's. They state they are committed to the marriage, though, and have made a committment to treatment.

I feel treatment will be a slow, long-term process given the nature of the problem (lack of sexual interest) coupled with the relationship difficulties, lack of communication, and the complicating factor

of Mary's illness. The expressed desired outcome of treatment for both Mary and Don is a satisfying sexual relationship. This entails Mary's being able to respond in sexual activity with Don. Her current lack of desire is Mary's main concern. At the same time, both Mary and Don recognize that there are areas of difficulty in their marriage as a whole with which they will also have to deal.

Clinical formulation:

a) Specification of the problem -

The problem presented by the clients is Mary's lack of interest in sexual activity with her husband. Related to this lack of desire are other marital difficulties such as lack of communication. Another factor which complicates the specific problem is Mary's illness.

b) Contemporary conditions influencing initiation and maintenance of the dysfunction -

There are a number of factors which I feel have contributed to the problem:

1. Both Mary and Don grew up in homes where sex was not discussed openly. Mary's Catholic, traditional European background did not provide her with healthy attitudes to sexuality and intimacy. This is true also for Don.

2. Related to the above, Mary especially has very limited knowledge regarding sex in general, on either an academic level or a personal level. Don certainly lacks awareness of female sexuality.

3. The adjustment to marriage was a difficult one for Mary in that she was a very young 19 years old, with no sexual experience apart from that with Don. The shift from the role of daughter to that of wife was difficult for her and, even now, she has some trouble in balancing these roles. The "wife role" learned from her mother includes seeing sex as a duty, and not a pleasure. Don's stereotypic view of women and female roles has also contributed to this factor.

4. The fact that Mary suffers from Chron's disease certainly contributes to the sexual problem. Besides the debilitating effects of this illness, the psychological stresses resulting from it could certainly effect Mary's sexual functioning, just as it effects her in other ways, both physically and psychologically (e.g., fatigue lowering her interest in various activities).

5. There is discord in the marital relationship, stemming partly from the stresses produced by the illness. The communication pattern between

Mary and Don is dysfunctional. Don, especially, is "moody" and frequently incommunicative. Mary finds it very difficult to be assertive in the marriage and often fears confronting Don because of his lack of response or anger.

6. Related to this is Mary's lack of confidence in herself and low self-esteem. This is partly due to her illness and, I would guess, partly due to her marrying very young, before she attained any sense of independence.

7. It would appear that Mary is lacking some of the conditions she requires in order to be able to respond sexually. This, again, may be due to lack of experience and lack of information about sexuality. The type of stimulation she requires in order to be sexually aroused is not present. In line with this, Kaplan (1979:48) refers to "active though unconscious and involuntary avoidance of sexual feelings and activities and/or the tendency to focus on negative images and thoughts and to suppress sexual feelings which may emerge despite the patient's defenses against this". It may be that the negative thoughts which confront Mary in a sexual situation are inhibiting her desire for sex.

8. Finally, I see this couple as living a somewhat restricted and, to use their word, "boring" lifestyle where neither of them are getting much stimulation or pleasure. This, of course, could effect their sexual relationship, resulting in inadequate stimulation for Mary to respond.

c) An appraisal of resources available for treatment - While there is stress in the relationship, the couple have agreed to attempt to work together to improve their sexual relationship. Through this focus on the sexual aspect, it will be possible, hopefully, to improve communication between them and promote intimacy and trust. With this couple in particular, I feel it is important to work with them both, dealing primarily with the sexual issue, using this at times to deal with more general marital issues. As mentioned earlier, the sexual dysfunction relates to Mary's lack of sexual interest. However, since this is effecting the marriage in general, it follows that the couple will be involved in treatment. Socioeconomic resources (Jehu 1980:186) are sufficient for the couple to undertake treatment. Although Don works a night shift, Mary works only two days a week which gives them sufficient time

to carry out assignments. There are no pressing financial problems at present which would interfere with treatment.

Both Mary and Don appear motivated to deal with the situation. Mary, especially, is eager to make some changes. I feel that Don may offer resistance at some point when treatment begins, so paying attention to this factor will be necessary. While it will be necessary to assign reading material during the course of treatment, I feel this material will have to be reviewed and frequently explained to the couple. Their educational level is that of high school and reading is not a part of their day-to-day activities. Therefore, they may need some guidance and encouragement here, as well as careful selection of reading material so that it is not overly technical).

As mentioned earlier, the presence of Chron's disease may be an important factor in the sexual dysfunction. Further exploration of the effects of this disease in general and its effects on Mary specifically will have to be undertaken.

Professional resources in this case will involve my working with this couple, dealing with the sexual difficulty and marital therapy in general. My role will involve providing information (verbally, through assigned reading, and films), reframing certain situations or attitudes (helping them to view their beliefs, attitudes, assumptions from other angles), teaching communication skills, assigning appropriate tasks, and reviewing outcome of tasks with the couple.

Goals were negotiated and specified with the clients.

1. Educational: Don and Mary will be presented with literature dealing with sexuality (e.g., photocopies of portions of Male Sexuality, Woman's Body, and Becoming Orgasmic). Their assignment is to read this material. Together we will discuss their impressions. I will clarify where necessary and provide additional information. The purpose of this goal is to provide them with an adequate knowledge base regarding sexuality and sexual response. It will also desensitize them to discussing their sexual needs and wishes.

2. Deal with Mary's lack of interest in sex: This will involve helping Mary to look at some of her negative thoughts regarding sexual activity which may be blocking her ability to respond.

Also related to this goal, we will attempt to discover what kinds of conditions and stimulation she requires in order to respond sexually.

3. Marital therapy: Mary and Dave have agreed that there are areas of stress in their relationship. We will, therefore, work on communication skills, learning to share feelings and thoughts, discovering expectations and assumptions about each other. Underlying this goal is my assumption that the sexual difficulties are, in part, related to relationship discord as well as to Mary's low self-esteem and lack of self-confidence. Hopefully, these areas can all be dealt with by working with the couple on both the sexual and more general issues.

Criteria and measures:

1. Semantic Differential Scale
2. Sexual Arousal Inventory
3. Clients self-report during weekly sessions
4. Mary will be asked to keep a record of her thoughts related to sexual situations as a means of her becoming aware of what thoughts may be blocking her sexual response.

The treatment plan will involve meeting weekly for an undefined period of time. (Kaplan suggests that treatment for desire phase dysfunctions is a considerably longer process than for other dysfunctions.) During interviews we will discuss assigned tasks and, based on the couple's progress, determine appropriate new assignments.

Treatment -

Contact with Mary and Don involved seven in-person interviews, including three focusing on assessment, setting goals, and negotiating the treatment plan with them. Subsequent contact has been by telephone.

Reading material was assigned early in the treatment. This consisted of parts of Heiman, LoPiccolo and LoPiccolo's Becoming Orgasmic and Zilbergeld's Male Sexuality. My purpose was to begin the educational segment of treatment and also to use the material as a means of desensitizing their anxiety around discussing sex. (It was my plan also to use the "Becoming Orgasmic" and Chernick films later in treatment for the same reasons.) Sensate focus tasks (Masters and Johnson 1970) were explained to Mary and Don and they agreed to undertake these three times in the next week. The tasks involved their spending time together where each of them would in turn touch, stroke, and caress the other, avoiding

the genital areas and breasts. They were to communicate to the other how this felt, what each liked and didn't like. Through the sensate focus tasks they could begin to experience sensual pleasure with each other, as well as begin to communicate their feelings about this task.

For me, assignment of this task was a further assessment tool. Their reactions to the procedure would be discussed at the next session and would provide information to be used in refining the process of treatment. If, for example, they found the sensate focus task enjoyable, the next step could be to continue, including the breasts and genital areas. On the other hand, if there were problems for either of them (discomfort, tension, anxiety), this would be dealt with through identifying the problem areas in the therapy session. They both assured me that it was "fine" and that they both enjoyed the task, and there were no problems. Besides dealing with the sexual issue, part of our sessions were spent on discussing areas of more general concern in the marriage (e.g., in-laws, different goals and expectations, the effects of Mary's illness, ways of communicating effectively with each other). I felt the resent-

ments and stresses they were both experiencing in the relationship had to be dealt with as a part of treatment as a way of lessening the discord in this relationship which could influence treatment. I was anticipating that therapy would be fairly long-term as there appeared to be considerable stress and discord.

Before treatment progressed any further (session 7), Mary came in alone for what was to have been a conjoint session. She stated that she had been doing a lot of thinking and decided that she was very unhappy in the marriage and that she was sure this was the reason for her lack of interest in sex with Don. She had reached a point where she decided to confront Don with her unhappiness and was considering separation if he was unwilling to commit himself to working on the marriage. Despite their verbal reports to me, Mary felt Dave was not interested in maing any changes and that he expected her to take full responsibility for their difficulties.

Contact after this point was by telephone. The couple had decided to separate. Shortly after this, Don was involved in an accident and Mary reported

that this crisis had proved to them that they care for each other and want to stay together. Don's injuries had apparently given him an understanding of what it means to feel ill, weak, and dependent. We discussed meeting and resuming therapy which would at this time focus on the marital issues. Before this could occur, Mary suffered a relapse in her Chron's disease and resuming treatment was neither feasible nor appropriate.

This case clearly illustrates that "the best laid plans of mice and men....". I believe the treatment package proposed could have been effective in dealing with the desire disorder were it not for the severe degree of discord in this relationship which was not assessed accurately. Without a committment to a relationship and to each other, strategies for dealing with the sexual dysfunction are not only ineffective but, I would suggest, unethical. This removes sexual experience from the context of a relationship and demotes it to a mechanized, dehumanized and cold activity.

Case 4 - Desire Disorder

In contrast to the case just discussed, the desire disorder presented by these clients did not have its roots in relationship discord.

Assessment

Kay is a 27 year old woman who came to the Sexual Dysfunction Clinic requesting help with difficulties in the sexual relationship with her husband, Len, who is 28 years of age. They have been married for three years and lived together for two years before that. Kay and Len have one son, aged 1½ years. They are both teachers.

Kay identified the problem as primarily hers, stating that apart from her lack of desire for sex, the marriage is very successful. There is a firm committment by both of them to the marriage but Kay expressed fear than unless the sexual aspect changes, the marriage may suffer.

Kay stated that she has no interest in sex, never experiences arousal, does not reach orgasm, and, in the past two years, is repulsed by the prospect of having intercourse and by intercourse itself.

She experiences a feeling of "don't touch me" and a desire to push away from Len if he behaves in any way which indicates he would like to have intercourse. This, for Kay, could be as innocent as Len's touching her hand or arm. In the first interview, Kay expressed a goal of wanting to be rid of these feelings of revulsion which, as she states, are "awful" and "scary".

This is Kay's second marriage and she relates that her present sexual difficulties were present in the first marriage and contributed to its ending, although there were may other factors present. She found her first intercourse experience to be extremely painful and unpleasant. This took place on the wedding night. Until then she was a virgin, although she had considerable sexual experience, excluding intercourse, prior to this. This sexual contact (petting, etc.) was exciting and enjoyable for her.

After separating from her first husband, she met Len and they began living together shortly after that. For the next two years, their sexual relationship was active and, according to Kay, satisfactory. Although her interest in sex was not great and she did not experience orgasm, she did not experience the revulsion she now feels. Kay and Len married

three years ago and she reports that the disturbing feelings of hating intercourse began about that time and have accelerated to the present. This has resulted in her avoiding any situation where intercourse could take place. If Len does initiate sex, she usually complies for fear of hurting him, but the experience is extremely negative for her. "I feel I'm going to throw up". Frequently, she bursts into tears. While she and Len can acknowledge and do talk about the difficulty, it is embarrasing for both of them. Kay reports that Len is very understanding and supportive, and is willing to participate in treatment.

At the time of first contact with this couple, they had not engaged in sexual activity for several months. Len does not initiate sex because he is aware of Kay's feelings about it. This lack of physical contact has generalized somewhat with both of them avoiding any contact which could be interpreted as sexual. Due to medical reasons, the couple did not have intercourse during her pregnancy and for three months after their son was born. Kay reported that it was a relief to have a legitimate reason for avoiding intercourse.

Kay's main concern at this point is with her feelings of revulsion and disinterest in sex. She reports no other major stresses in her life. Kay is happy with

her job, likes being a mother, and Len and Kay are basically happy together. She is uncomfortable and concerned about her feelings about sex and also concerned about how her attitude and behavior effects Len and their marriage.

Personal and family background -

Kay is the youngest of three children. Her two older sisters are only a year apart in age and very close to each other. Kay was 8 years younger than her next sister. She reports the family being very close while the sisters were at home but when they moved away to marry, her mother "fell apart". Kay was 13 at that time. The mother began drinking heavily and her parents separated several times. Kay reports that the parents had been very strict with her sisters but were much more permissive with her. However, there was a clear message of "we trust you - don't disappoint us" which Kay obeyed. The family background is British. Kay's father was a professional man; her mother worked in the home. Education and success were values expressed by the parents and it seems that Kay expended a good deal of energy into living up to her parents' expectations. She describes herself as an "overachiever" since childhood and was very conscious of not letting her parents down. She gave the

impression that she tried very hard to win their love and approval by being successful at whatever she attempted. Underlying this is Kay's belief that nothing she did was ever enough for her parents.

Family attitudes towards sex were not atypical. Kay learned about sex through her older sisters, not her parents. She describes her parents as being undemonstrative with each other; they seldom touched or showed affection. Kay reports little physical contact with her mother. Her father, however, had a practice of teasing Kay by poking her or tickling her. She "hated" this and would sometimes scream for him to leave her alone. She states that even now, any prodding or sudden movements by Len will evoke a similar response. When asked if she perceived any of her father's behaviours as sexual, she responded negatively. She feels they were teasing (and very annoying) behaviours, but not sexual in nature.

Kay feels she was a "nuisance" to her parents and that she was not wanted by them. As mentioned, her mother appears to have experienced a kind of "breakdown" when Kay was in her early teenage years. Prior to that, Kay describes her mother as a "tower

of strength". After that, Kay seems to have assumed a parenting role with her mother, taking on even more responsibility. Both parents are now dead; her mother died very recently and her father, several years ago. Their deaths are a source of pain and sadness of Kay and she is still in a mourning process, which may be a factor in her present situation.

Kay reports being popular and academically successful in high school and university. She had a number of male friends and enjoyed sexual encounters with them. During university, she won a scholarship to study in France for a year and, while there, had an "intimate" relationship with another student. They travelled together and "did everything except intercourse". Kay states that her parents' expectations and trust were the factors which prevented her from having intercourse with him, but the sexual contact they shared was very exciting for her.

Upon returning to Canada, she found the problems between her parents were even more severe. Kay re-established a friendship with a man she'd grown up with who shared some of Kay's family problems. They soon decided to marry and left for a year in Europe soon after. Kay reports intercourse with her first husband was "awful. I hated it. I expected pain, but it was terrible".

It seems that after years of enjoying sexual activity, Kay had expected intercourse to be an earth-shaking experience. It was quite the opposite, leaving Kay extremely disappointed, resentful, and with a sense of revulsion. Sex with her first husband was always poor; she never enjoyed it and avoided sexual encounters. The couple remained married for three years but Kay reports they were more like brother and sister. They eventually separated.

Kay is an intelligent, pleasant and attractive woman. She is successful in her career and is self-confident. She and Len have some close friends, but they also spend much of their free time together. They enjoy each other's company and like being parents.

Kay often feels under pressure with people other than Len to keep up a "front" of cheerfulness even when she's feeling sad or depressed. She assumes the responsibility for keeping conversations going and it seems important for her to be in control of situations. She sees a connection between her fear of losing control and her inability to enjoy sex. She describes herself as somewhat compulsive and perfectionistic. With any task she assumes, she strives to do well. When feeling pressures

due to time deadlines or work-related stresses, she recognizes that she needs time to herself yet is reluctant to take it if she feels that would conflict with her role as wife and mother. She sees a need to be more assertive in this area.

Kay sees herself as attractive. When asked to describe her body, she listed a number of characteristics she liked. Yet, at the same time, she is shy about being nude around Len. Although she can walk around a women's locker room nude, she makes a point of wearing non-revealing (conservative, as she puts it) clothing around men. She has never masturbated, saying she has no desire to do so. When asked if she ever explored her body by touching, she responded that she finds the idea uncomfortable. She even has trouble with a breast self-examination. She does not find male bodies especially attractive and, while not repulsed by male genitals, she states she is more disinterested. At this point, Kay sees herself as "frigid". There is physical contact between Len and she and, as long as this is not going to lead to intercourse, Kay can respond with affection. She loves hugging and cuddling her son, so apparently can respond to physical contact of a sensual rather than sexual nature.

Contemporary influences on problem -

The fear of losing control seems to be an issue for Kay in many aspects of her life, including the sexual. She expresses fears of what others may think of her and a fear of looking "stupid" or "silly". There are times when Kay feels she "should" feel like making love, but doesn't. This is of concern to her and results in her doubting her "femaleness". These expectations result in a good deal of pressure for Kay. She "should" want sex, doesn't want it, feels guilty, focuses on her negative thoughts and feelings, becomes even more tense because of fears as to what might happen, and so on. Kay also has some questions about how she "should" feel about sex. She and Len are both operating under limited information about sexuality. Zilbergeld and Ellison (1980) believe that individuals with low sexual interest are presumed to have an overly limited or narrow range of cues which are associated with sexual interest and this certainly appears true for Kay. She states that she really doesn't know what to expect in a sexual encounter.

Due to her lack of arousal, she does not lubricate sufficiently so intercourse has been painful for her at times. Naturally enough, she never initiates

sexual contact and is unable to express to Len what feels good for her physically, since she doesn't know this. She has not identified those conditions which would be conducive to her ability for sexual arousal. At this point, any contact is stress-producing and unpleasant.

Kay reports no medical problems; there have been no serious illnesses and she is not taking any medication. Fear of pregnancy is not a contributing factor here. Both Len and Kay would like another child. Although the sexual problem is of concern, Kay is not depressed and is experiencing no difficulties with her work. She does experience anxiety, however, over her inability to perform adequately sexually. Her concern centers around wondering what is the matter with her, wondering about the effects on the marriage, worrying that Len is not getting his sexual needs met, and that she is somehow failing him as a wife. The many questions and the lack of answers as well as the feeling of being "stuck" is very frustrating.

As mentioned earlier, what has occurred in this relationship is that sexual contact between Kay and Len has become progressively less frequent. Any

indication that intercourse might take place immediately evokes fear and negative expectations for Kay. Since her past experiences related to intercourse have been negative, she, of course, anticipates that any future attempts will be the same. Over the past year, Len has avoided initiating sex as he is aware of Kay's feelings. She finds it impossible to relax and concentrate on feelings of pleasure. Her thoughts center around how awful it will be and how terrible she will feel. She is too busy "spectatoring" to allow herself to feel pleasure. It became clear during the assessment interviews that Kay and Len are operating under various "myths" about sexuality (i.e., sex = intercourse; "normal" people have sex twice a week, etc.).

Both Len and Kay are highly motivated towards treatment. They are both intelligent people and a pleasure to work with. It is my expectation that we can deal with the presenting problem by working first with Kay alone, bringing Len directly into treatment at a later phase. The outcome, as expressed by Kay, is that she will be able to respond in sexual activity with Len.

Clinical formulation -

Kay reports a lack of interest in sex, no sexual arousal, and frequently feelings of revulsion at the prospect of intercourse or in engaging in intercourse. There are no major problems in the relationship between Kay and Len.

Family attitudes towards sexuality coupled with lack of information about sex may well have laid the basis for Kay's present difficulty. Kay's parents did not provide a positive role-model for male-female intimacy. Further to this, her childhood and adolescence were stressful periods, as has been discussed. The first intercourse experience was traumatic and painful for Kay. She was never able to respond sexually with her first husband, thereby establishing expectations of herself as "failing" and being unable to respond. After two years of satisfactory sexual activity in the present relationship, Kay began to feel many of the earlier reactions to sex. We have been unable to determine what seems to have triggered these feelings. Kay and Len did marry at about this time, which may have some connection; however, the marriage seems very satisfactory for them both. It may be that Kay's need for control may have been threatened by marrying and assuming the role of "wife" and later "mother".

Kay's perception of herself as a sexual being may be a factor in her lack of desire. Although Len and her are "good friends", there is an intimacy about sexual relationships which Kay seems to find difficult to share. She is also operating under a number of "should's" and has not identified what conditions she needs in order to respond sexually. Her "spectatoring" is a further block to sexual response. To apply Kaplan's (1979) "triphasic model of sexual response, Kay is inhibiting her response at the "desire" phase. While being unaware of how she is doing this, Kay may be using negative thoughts as a means of blocking her response to sexual stimulation which, for her, is dangerous in some way.

Resources for treatment appear adequate. As stated, Len is willing to be involved in the process. The relationship between Len and Kay is generally good. They appear to like each other and are committed to their marriage. Socioeconomic resources are adequate and will not hinder treatment. Both Len and Kay are intelligent, thoughtful people and I believe have the organizational capacity to carry out assignments. They are highly motivated for treatment. Professional resources involve my working with them for an undetermined period of time to deal with the issue of Kay's lack of

desire for sex. The major liability lies in the complexity and difficulty in dealing with desire disorders (Kaplan 1979; Jehu 1979). Unlike some of the other dysfunctions, no specific treatment plan has been researched and indicated as effective. While case 3 which also had to do with a lack of desire dysfunction indicated that relationship discord was the major reason for the dysfunction, this is not true for Kay and Len. Desire disorders are very difficult to treat and, once relationship discord can be eliminated as a contributing factor, one of the tasks for the therapist is to attempt to determine what factors as, in fact, contributing to the maintenance of the lack of desire. Unfortunately, at this point, it seems to be a matter of "trial and error" with no systematic treatment plan developed to deal with the issues.

The goal of treatment is alleviation of the lack of desire sexual dysfunction presented by the client.

The treatment plan negotiated with the clients will involve:

1. Kay using the Becoming Orgasmic program (Heiman, LoPiccolo and LoPiccolo 1976). Initially, this will involve chapters 1 - 7, which focuses on a woman learning about her own body and learning to

become comfortable with her own sexuality. Len is not directly involved in this segment of treatment; however, Kay was requested to share the reading material with him, and to communicate her reactions and feelings about the programme.

2. When Kay has completed the above component of treatment and is comfortable with her progress, they will be instructed to continue the program with Len now being directly involved in treatment. This will include assignment of sexual tasks (i.e., sensate focus), communicating their reactions, and discussing their concerns.

This process will likely be slow and this is acceptable in that it may take time for Kay's anxiety to be reduced. The use of the above behavioural techniques is a first step in dealing with the lack of desire issue. While they serve to desensitize anxiety, to provide the clients with information about sexuality, and to help them identify those conditions where they can respond sexually, the techniques will also provide us with a further assessment tool. Identifying what "works", what doesn't "work" and then using this information for the clients to gain insight into their own behaviour is a valuable therapeutic procedure.

Treatment -

Treatment consisted of 23 sessions (including three sessions focused on assessment, negotiation of goals and treatment procedures). Although Len was involved directly in only 8 of these sessions, he was kept informed of treatment and progress by Kay and was very much a part of the treatment process.

Initially, treatment consisted of Kay using the Becoming Orgasmic program with a view to her becoming more comfortable with her own body and to learning what physical sensations are pleasant for her. Readings were assigned from Becoming Orgasmic and The Hite Report, which Len shared with her. This served to educate them about sexuality and sexual response. Because the issue was painful and embarrasing for both of them, they had avoided discussing their problem in any detail. The assigned reading and discussion of this in therapy sessions desensitized them in this area.

Kay initially found the assigned exercises (self-explorating of her body, masturbation) difficult. However, we dealt with her negative reactions in therapy sessions and Kay began to gain insight into how she was inhibiting her sexual response through fears of losing control and concerns around experiencing pleasure. She eventually was able to masturbate to

orgasm which, again, she initially found to be "scary" for her but which she eventually could enjoy.

At this point, we moved on to the general, non-genital "pleasuring" exercises for them both. While they found these exercises pleasant, Kay was unable to move past this point, stating that she still felt no desire for intercourse with Len even though she was much more comfortable with physical interaction with him.

Kaplan (1979:164) refers to the "fear of romantic success and intimacy" as being a factor in inhibited desire. In line with Sullivanian theory, "conflicts about success and pleasure and intimacy are engendered in early childhood by the negative emotional reactions of 'significant others' to success and competition" (Kaplan 1979:165). Although instructed to proceed with the "pleasuring" tasks, therapy now also included exploring Kay's fears of being successful sexually. The final six sessions of treatment were devoted largely to exploring Kay's childhood in an effort to uncover some of the origins of her fears concerning intimacy and success. Underlying this treatment strategy was a hope that by having insight into the origin of her feelings about sexuality, Kay would be able to use this insight to challenge

her assumptions and beliefs, eventually replacing them with more positive, healthier attitudes. While I believe this was helpful for her, it has not produced immediate changes in her behaviour.

As stated, Len and Kay continued with assigned "pleasuring" tasks during this period. As a result, they were able to talk much more freely about their problem, with Len being supportive, cooperative, and understanding throughout treatment. The three films in the "Becoming Orgasmic" program were shown to them and this further desensitized them to discussion about their sexuality and sexual relationship. With the problem "out in the open", both of them felt under less pressure and stress. The couple did have intercourse during this period (although they had been instructed to avoid intercourse during this phase of treatment). Kay became pregnant and they were both pleased (albeit surprised!).

As another way to deal with Kay's lack of desire, we established a hierarchy of situations related to physical encounters, beginning with the least threatening and moving to the most threatening. Kay was instructed to use relaxation exercises in conjunction with the imagined situations (<u>in vitro</u> desensitization).

She was asked to note her thoughts and reactions to the imagined situations. This was done with a goal of having her become aware of how she is "blocking" her sexual response. While, again, she did gain some insight into her reactions, this did not permit her to change the manner in which she responded.

I believe the combined behavioural approach and "insight" therapy approach which Kaplan (1979) refers to as psychosexual was at least partially effective in beginning to deal with the desire disorder dysfunction. The couple are much more comfortable with physical contact with each other, although Kay still does not desire intercourse with Len. She no longer feels the revulsion at physical contact which she reported at the beginning of treatment. I believe that she is now processing some of the reasons for her fears which are effectively blocking her sexual response.

Two scales were administered during the course of treatment: The Sexual Arousal Inventory and the Semantic Differential Scale. At the beginning of treatment, Kay scored 36 (5th percentile) on the

Sexual Arousal Inventory, indicating a very low level of sexual arousal. At termination, her score was 56 (12th percentile), indicating a positive change in this measure. Similarly, the Semantic Differential scores indicated that Kay's perceptions of herself and her partner were more positive. She sees herself as slightly less anxious, more loving, and easier to arouse. Kay also perceives Len as more loving and more sexually attractive, according to this measure. The measure for "sexual attractiveness" remained the same score for Kay. In view of the fact that she was some eight months pregnant when the repeated measure was taken (and by her self-report was feeling clumsy and heavy), her pregnancy must be considered a factor in this measure. It is also a factor in the slow process of treatment and the limited changes that have occurred for this couple.

Clearly, from the scales administered, from clients' self reports, and from my observations, some progress has been made. However, I feel this is a long-term process for Kay and I am hopeful that further gains can be made in longer-term treatment. At the time of writing, the family has moved to another city. A referral has been made to a practitioner in the area of sexual dysfunction in that city.

The case reports discussed involve clients with whom I worked through both assessment and treatment of the presented sexual dysfunction. During the course of this practicum, I have had contact with other clients who, for various reasons, did not continue treatment. As a means of illustrating some of the problems and complications of working in the area of sexual dysfunction, I will very briefly discuss several of these cases.

Case 5 - Desire Disorder

Lisa was referred to the Sexual Dysfunction Clinic by her physician. The presenting problem was a lack of desire on her part for intercourse or any other sexual activity with her husband. Lisa and Mathew have been married for seven years and have two children. Contact with this couple consisted of three interviews: two with Lisa alone to begin an assessment of the situation, and one with both Lisa and Mathew to continue the assessment and to set goals for treatment. During the assessment interviews, it became clear that there was considerable stress in this relationship, apart from the sexual issue. Lisa appeared to be extremely angry and hostile towards her husband. She stated that they seldom talk, that he either ignores or degrades her, and that he looks after his own needs with no concern

for her.

On the basis of these assessment interviews with Lisa and through observing both Lisa and Mathew in the conjoint assessment interview, I believed it would be premature, ineffective, and inappropriate to deal with the sexual issues until some of the more general marital issues could be resolved. I presented my opinion that there were stresses in their relationship which could be contributing to the sexual difficulties. I felt that we needed to deal with some of these stresses prior to contracting specifically around Lisa's expressed lack of desire for sexual contact. They agreed with this proposal.

Due to a shift change for Mathew, we were unable to arrange an appointment until three weeks later. They reported at that time that they were getting along much better, had spent time talking with each other, and had both made some concessions in the relationship. Lisa was feeling much more content in the marriage and was hopeful that these improvements would continue. They had engaged in intercourse and Lisa reported that she was feeling much more sexual towards Mathew. They did not wish to continue (or, rather, begin) treatment at this time. At follow-up, some four months later, Lisa reports that the relationship has continued to improve and that she

is enjoying the sexual relationship with her husband.

Is this a treatment "success"? It seems clear that Lisa's lack of interest or desire for sex with her husband was directly related to the relationship discord present. By making a statement that she was unhappy in the relationship and by seeking help in the form of "sex therapy", the couple began to confront the relationship issues which were harming their relationship. My role was simply in helping them identify the stressful issues and to provide some guidance as to how these could be handled. The sexual issue was "treated" only in terms of recognizing and sharing with the clients that it is difficult, if not impossible, for a person to experience sexual desire for a partner with whom she/he is angry. This giving of "permission" and normalizing the situation, as well as providing limited information and some suggestions (Annon 1977) seems to have been effective in helping these clients handle and solve their own difficulties.

Case 6 - Desire Disorder

Susan and Sam were referred by their physician. The presenting problem was one of lack of desire for sex for both of them. Again, during the assessment interviews, it became quickly clear that there was no intimacy between this couple. The marriage seemed

to consist of sharing the same house. Although having a very busy social life, they seldom spent any time together alone and, by both their reports, never discussed personal or intimate matters with each other. They tended, rather, to operate on a very superficial level with each other and, as it was revealed during the assessment interviews, neither of them were happy with the manner in which they were living, yet did not know how to make changes. We contracted to work on the relationship issues -- identifying them, setting goals for change, and finding ways to make the changes. This has occurred over the past four months and we have recently recontracted to work on issues around enriching their sexual relationship. This will take the form of a Masters and Johnson (1970) program, combined with information-giving about sexuality, and further communication training. I feel confident that treatment will be brief and effective.

Case 7 - Desire Disorder

In contrast to Case 6 above, Pat and Peter's attempts to deal with the discord in their relationship has resulted in their separating. They, too, presented a desire disorder which was assessed as a symptom of the discord in their relationship. We contracted to deal with this discord; however, they were not motivated for treatment and decided against continuing the relationship. At best, the "therapy" was effective

in helping them make a decision about their relationship.

These three cases have been mentioned because they illustrate the necessity for a thorough assessment when dealing with presenting problems of sexual dysfunctions. To have implemented a treatment plan to deal with the sexual dysfunction without investigating the conditions under which the situation exists would be not only ineffective but also unprofessional and unethical. Relationship discord is not always a major factor in desire disorders; however, it is one variable which I believe needs to be investigated very carefully before setting goals and planning for treatment.

Case 8 - Premature Ejaculation

Jan and Les were referred by a counsellor at a local agency. She had worked with the couple for some months related to their relationship problems. The couple had been married for 20 years and, at the time of referral, were planning to move in together after a separation of seven months. The referring counsellor had helped them resolve many of the general issues in

their marriage and Jan and Les felt they were ready to live together again. One issue which was of longstanding duration concerned Les' ejaculating prematurely and this had not been dealt with in the counselling.

Contact with this couple has been limited to only two appointments to date. One of these was spent giving them information about the manner in which we would be proceeding in order to deal with the premature ejaculation dysfunction. They appeared to feel comfortable with the proposal and agreed to begin the assessment phase at the next appointment.

Les reports that premature ejaculation has been a problem for the past 11 years. When questioned about events or incidents around this time, Les stated that he had been working in the north for several months. When he returned home and had intercourse with Jan, he was unable to control his ejaculation and "came" almost immediately after intromission. This behaviour has persisted since that time. During the last five years, the couple has had intercourse only 4 or 5 times, with Jan refusing to have intercourse because she gained no pleasure from it. They do not engage in any other sexual activity and, indeed, have very little other physical contact.

Len masturbates regularly and notes that he can control his ejaculatory response better at these times. He has not experienced erectile problems.

The above information was gathered during one interview with the couple. I outlined how I could work with them to resolve the sexual problem. First of all, it would be necessary to gather more information from them on their sexual relationship with a view of determining more precisely the basis for the dysfunction. They expressed a committment to enter treatment. I suggested to them that until we begin treatment, they refrain from attempting intercourse (not a difficult directive if one considers their last five years together). The reason for this was shared with them: that it was a way to relieve pressure for them both and thus to relieve their anxiety. This anxiety is probably one of the factors contributing to the problem for Len. It was suggested that they spend time together in a physical sense (touching, lying together) as a means for them to become comfortable with each other again.

My tentative treatment plan for them includes:

1. sensate focus exercises to help them become more comfortable with each other in a "non-demand" sexual situation;

2. instruction and use of either the "stop-start" or "squeeze technique" method for treatment of premature ejaculation;

3. information and education regarding sexuality to help them reframe their way of looking at their sexual relationship. My hope would be that they could broaden their view of sexuality to include various kinds of sexual activity, thus taking the focus off the need to have intercourse at every sexual encounter.

Of course, during treatment, I would have to deal with whatever resistances or difficulties might arise as a result of the assigned tasks.

Treatment has not yet begun and the proposed treatment plan may have to be amended as new information emerges. Prognosis for treatment of premature ejaculation is good.

Conclusion

Part II of this practicum report has related to clients I have worked with over the past year in the area of assessment and treatment of sexual dysfunction. The assessment method utilized has been based on that described by Jehu (1979). Treatment packages have been created for clients on the basis of research and literature in the field, which is discussed in Part I of this report. Information about and knowledge of sexual response and sexuality in general has also been gleaned from various literature in the field, some of which is mentioned also in Part I. Practice skills have been developed through training at the School of Social Work and through my employment as a counsellor. The other element of awareness and acceptance of one's own values and ethics to do with sexuality comes only from a great deal (and sometimes labourious) soul-searching and analyzing. These various criteria are required for anyone practicing in the area of sexual dysfunction. I believe that the therapist-client relationship is an important aspect of effectively helping people to deal with their difficulties. In an area as sensitive and value-laden as sexuality, the personal style of the therapist is perhaps even more influential.

I believe the "broad spectrum" or eclectic approach to treatment is, at present, the most effective model. Each human being is unique and, as such, do not fall into neat pre-established molds. Existing treatment packages must be modified and adapted to meet the individual needs of our clients. It is the responsibility of the practitioner to be aware of the continual search for new and, hopefully, more effective treatment methods. The application of research findings and treatment strategies to the problems presented by clients is a challenge and an exciting experience for the therapist.

Sexuality is a unique and precious form of human communication. Having the ability to share this aspect of ourselves can be a powerful and enriching force in our lives. Helping people to realize their unique sexuality and to develop the potential to share this with another person is the reward of professionals in this field.

APPENDIX A

Checklist of Topics For Assessment Interviews with Sexually Dysfunctional Clients and Partners

(Reproduced from Jehu, D. Sexual Dysfunction: Behavioural Approaches to Causation, Assessment and Treatment. Wiley, London. 1979.)

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)
5. Duration
6. Onset
7. Course

CONTEMPORARY INFLUENCES ON PROBLEM(S)

8. Situational antecedents
    a. sexual stresses
    b. deficient or inappropriate stimulation
    c. relationship with partner
    d. timing and setting of encounter
    e. concomitant non-sexual stresses

9. Organismic variables
    a. thought processes
        i. cognitive avoidance
        ii. cognitive monitoring
        iii. deficient or false information
    b. emotional reactions
        i. anxiety
        ii. guilt
        iii. depression
        iv. anger
    c. organic states
        i. aging
        ii. illness
        iii. surgery
        iv. drugs

10. Situational consequences
    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. religious 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. Partners' parents
    a. year of birth
    b. year and cause of death
    c. marital status and history
    d. occupation
    e. education
    f. ethnic background
    g. religion and moral beliefs
    h. health
    i. relationship between parents
    j. relationships between each partner and (i) own parents, (ii) parents-in-law
13. 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 or orgasm from all outlets
28. Traumatic sexual experiences

CURRENT PARTNERSHIP

29. Date of marriage or cohabitation
30. Engagement
31. Sexual experience with current partner before marriage or cohabitation
32. Honeymoon
33. Sexual relationship during marriage or cohabitation
34. Contraceptive methods and wishes concerning conception
35. General relationship between partners

SEXUAL EXPERIENCE OUTSIDE CURRENT PARTNERSHIP

36. Nocturnal emissions or orgasms
37. Masturbation
38. Sexual fantasies and dreams
39. Erotic literature, pictures and films
40. Sexual partners
41. Petting
42. Intercourse
43. Traumatic sexual experiences

SEXUAL EXPERIENCE SINCE LAST PARTNERSHIP ENDED
(e.g., by death, separation or divorce)

44. Nocturnal emissions or orgasms
45. Masturbation
46. Sexual fantasies and dreams
47. Erotic literature, pictures or films
48. Sexual partners
49. Petting
50. Intercourse
51. Traumatic sexual experiences

SEXUAL VARIATION

52. Homosexuality
53. Bestiality
54. Paedophilia
55. Voyeurism
56. Exhibitionism
57. Fetishism
58. Transvestism
59. Transsexualism
60. Sadomasochism
61. Sexual assualt and rape
62. Incestuous behaviour

SELF CONCEPT

63. Body image
64. Gender identity
65. Popularity and attractiveness
66. Self-esteem

ATTITUDES TOWARDS TREATMENT

67. Motivation
68. Organizational capacity
69. Prognostic expectancy
70. Desired outcome

APPENDIX B

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 with his/her hands	-1	0	1	2	3	4	5
3. When you see a loved one nude	-1	0	1	2	3	4	5
4. When a loved one caresses you with his/her eyes	-1	0	1	2	3	4	5
5. When a loved one stimulates your genitals with his/her finger	-1	0	1	2	3	4	5

6. When you are touched or kissed on the inner thighs by a loved one	-1	0	1	2	3	4	5
7. When you caress a loved one's genitals with your fingers	-1	0	1	2	3	4	5
8. When you read a pornographic or "dirty" story	-1	0	1	2	3	4	5
9. When a loved one undresses you	-1	0	1	2	3	4	5
10. When you dance with a loved one	-1	0	1	2	3	4	5
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
25. When a loved one fondles your breasts with mouth and tongue	-1	0	1	2	3	4	5
26. When you make love in a new or unusual place	-1	0	1	2	3	4	5
27. When you masturbate	-1	0	1	2	3	4	5
28. When your partner has an orgasm	-1	0	1	2	3	4	5

APPENDIX C

Semantic Differential Scale

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

OR

CALM __:__:__:__:__:__:_X ANXIOUS

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

OR

CALM __:__:__:__:__:_X:__ ANXIOUS

If the thing seems only slightly related to one or other of the words, then you should place your cross as follows:

PLEASANT __:__:_X:__:__:__:__ UNPLEASANT

OR

CALM __:__:__:__:_X:__:__ ANXIOUS

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

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 judgement. 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 D

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	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionality (correct or proper behaviour)	5	4	3	2	1	0

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents or in-laws	5	4	3	2	1	0
10. Aims, goals and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0
14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	0	1	2	3	4	5
19. Do you confide in your mate?	0	1	2	3	4	5
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
24. Do you and your mate engage in outside interests together?	4	3	2	1	0

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	0	1	2	3	4	5
26. Laugh together	0	1	2	3	4	5
27. Calmly discuss something	0	1	2	3	4	5
28. Work together on a project	0	1	2	3	4	5

These are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no.)

	Yes	No	
29.	0	1	Being 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, in 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 that I can do to keep the relationship going.

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