The University of Manitoba

Psychoeducational Treatment of Erectile Dysfunction with Men whose Partners do not Participate in Therapy

by

David Jackson

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for the
Degree of Master of Arts

Department of Psychology
Winnipeg, Manitoba
November 1985

DR. J. BAILLE, PH.D., COUNSELLING PSYCHOLOGIST

Dear David:

I grant you permission to use the CFSEI in your research project. I would surely appreciate receiving a summary of your findings.

Good luck

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January 9, 1986

Walter W. Hudson, Ph.D.
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Dear Dr. Hudson,

I am writing to request your permission to include a copy of the Index of Sexual Satisfaction in my Masters Thesis. The thesis will be put on microfishe and distributed to various university libraries in Canada. Naturally, yourself and your colleagues are cited.

I look forward to hearing from you. Thank you.

Granted.

Yours sincerely,

David Jackson
University of Manitoba

PSYCHOEDUCATIONAL TREATMENT OF ERECTILE DYSFUNCTION WITH MEN WHOSE PARTNERS DO NOT PARTICIPATE IN THERAPY

BY

DAVID JACKSON

A thesis submitted to the Faculty of Graduate Studies of
the University of Manitoba in partial fulfillment of the requirements
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MASTER OF ARTS

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Abstract

In the past, many therapists would only treat men with erectile dysfunction if the men had partners who would also come in for treatment. Recently, psychoeducational treatment programs in individual and group therapy have been successfully used with men who do not have partners. The present study evaluated the effectiveness of a 10-week individual psychoeducational treatment approach for erectile dysfunction in men who do have partners but whose partners do not participate in therapy. Five clients began treatment and three completed the program and the follow-ups. The five clients were screened and then assessed in three or four sessions before beginning formal treatment. Questionnaires were completed at pretreatment, posttreatment, and at approximately 7, 13, 25, and 64 weeks following treatment. A repeated measure of the clients' report of their erectile functioning was collected each day during the assessment and treatment phases, and periodically after treatment ended using a natural baseline across clients design. Outcome was examined on the following variables: (1) frequency of difficulty in obtaining and maintaining erections in coital opportunities; (2) overall erectile functioning; (3) degree of sexual satisfaction; (4) sexual attitudes; (5) anxiety associated with sexual activity; (6) self-esteem; (7) quality of the relationship; and (8) defensiveness concerning the marital and sexual relationship. One client demonstrated significant improvement in his erectile functioning in partner sex and masturbation, one client experienced improved erections in partner sex only, and the third demonstrated improved masturbatory erections. The former two clients considered treatment to have successfully alleviated their sexual dysfunction.

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I would like to thank my supervisor, Dr. Derek Jehu, for his valuable advice and support through all stages of this research. I would also like to thank the other members of my committee, Drs. Kathryn Saulnier and Mary Warmbrōd for their guidance.

A special thank you is in order for the men who were part of this study. Without their willingness to complete numerous data forms and questionnaires, this research would not have been possible.

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Psychoeducational Treatment of Erectile Dysfunction
with Men whose Partners do not Participate in Therapy

In his review of treatment models for erectile dysfunction, Reynolds (1977) defines this disorder as "the persistent inability to obtain or sustain an erection that is sufficient to allow intromission, pelvic thrusting, and in the absence of ejaculatory difficulties, ejaculation during sexual intercourse" (p. 1218). Individuals classified as experiencing primary erectile dysfunction "have never been able to obtain and maintain an erection during intercourse with a partner" (Jehu, 1979, p. 82). Jehu describes clients with secondary erectile dysfunction as "those clients whose erectile capacity with a partner was at one time adequate, but who became impaired at some later stage."

The term erectile dysfunction avoids the pitfalls associated with its commonly used equivalent, impotence. The term impotence has been poorly defined and has been used to describe a variety of sexual problems including a lack of interest in sex (Reynolds, 1977), premature ejaculation and retarded ejaculation (Katchadourian & Lunde, 1975). Also, the term impotency suggests a broader range of difficulties than those actually manifested. Finally, being labeled impotent may cause clients to feel that they are unable to make changes in their lives. This may lead to an over-reliance on the therapist, contributing to difficulty in effectively applying most intervention methods.

Erectile dysfunction can be classified according to the etiology of the problem. That is, erectile problems may be due to organic factors, psychogenic factors, or to a psychological reaction to organic factors. This study addressed psychogenic erectile dysfunction, where any known organic basis had been ruled out. From a psychological viewpoint, previous learning

experiences (e.g., traumatic sexual experiences, adverse family relationships) and/or contemporary factors (e.g., performance anxiety, deficient or false information) can lead to erectile difficulties (Jehu, 1979). The approach employed in this study consisted of a treatment package in which contemporary stress reactions, such as anxiety and spectatoring (i.e., monitoring and evaluating one's own erectile responses), which likely underlie the dysfunctional behavior were counteracted. The treatment package was used in an individual context with men who do have partners but whose partners did not participate in therapy.

Until very recently many therapists tailored their treatment for couples (Masters & Johnson, 1970) and would not treat unpartnered men with erectile difficulties (Jehu, 1979; Price, Reynolds, Cohen, Anderson & Schochet, 1981) or men who do have partners but whose partners do not participate in treatment. Concerning men without partners, Jehu notes that "a vicious circle develops in which these clients cannot obtain treatment for sexual dysfunction because they do not have a regular partner, and they cannot obtain such a partner because of their sexual dysfunction" (p. 183).

Masters and Johnson's (1970) treatment guidelines preclude couples in which the man experiences erection difficulties and the woman does not attend treatment sessions. Some reasons which may contribute to partners not being directly involved in treatment were illustrated in the present study, where the couples did not live together, had been dating for seven months or less, had few opportunities to be sexual, had little privacy when they were sexual, and the degree of commitment in the relationships did not warrant the woman attending treatment sessions. If the therapist will only offer therapy if both partners attend sessions, many clients will likely decline the opportunity for treatment. Segraves, Schoenberg, Zarins, Knopf,

and Camic (1982) found that only 62% of the men with erectile dysfunction referred to a sexual dysfunction clinic by a urologist made the recommended intake appointment. Of the men for whom sex therapy was recommended, 68% did not accept this recommendation, and over half of the men who did, prematurely terminated treatment against medical advice. Most of the men who scheduled an intake appointment did not bring their partners as instructed, and the clinic's policy of only seeing couples was often given as a reason for not scheduling an intake appointment and for declining the opportunity for treatment. In fact, one client, while acknowledging that the cause of his problem was undoubtedly psychogenic, insisted that surgery (implantation of an inflatable penile prothesis) was preferable to 12 sessions of conjoint marital therapy. Unless one only sees highly selected groups of clients, as was the case with Masters and Johnson (Segraves, 1980), alternative treatment formats must be developed for the benefit of clients whose partners do not come in for therapy.

Several studies (Albert, Olds, Davis & Hoffman, 1980; Altman, 1985; Altman, Gahan, & Jehu, 1985; Lobitz & Baker, 1979; McCarthy, 1980; Price et al., 1981; Reynolds, Cohen, Schochet, Price & Anderson, 1981; Zilbergeld, 1975, 1980) indicate that the erectile difficulties experienced by men who do not have sexual partners can now be effectively addressed in individual or group therapy. The present study evaluated the effectiveness of individual psychoeducational treatment of erectile dysfunction in men who do have partners but whose partners do not participate in therapy.

Treatment Formats

Group Therapy

Recently, there has been a great deal of interest in group treatment of sexual dysfunctions, since this form of treatment is potentially cost-

effective in terms of professional resources (Hogan, 1978; Jehu, 1979; Zilbergeld, 1980). Many forms of sexual dysfunction have been successfully treated in therapy groups. The groups have consisted of individuals or couples, have been homogenous or heterogenous in terms of presenting problems and sexual orientation, have included clients who do not have a partner and/or clients who have partners but whose partners are not willing to participate in treatment (Dekker, Dronkers, & Staffeleu, 1985; Everaerd, Dekker, Dronkers, van der Rhee, Staffeleu, & Wiselius, 1982), and have employed co-therapists or single therapists. However, despite the recent proliferation of group studies, many of these studies have been plagued by methodological flaws.

Some of the better studies are those which have examined psychoeducational group therapy approaches with partnerless men experiencing erectile difficulties (Altman et al., 1985; Lobitz & Baker, 1979; Price et al., 1981). These studies have demonstrated that a homogenous group of men can benefit from group treatment.

Lobitz and Baker (1979) conducted two therapy groups for nine men with erectile difficulties. Treatment was conducted by two male co-therapists and lasted 12 weeks. The program consisted of a series of relaxation, masturbation and sensory awareness exercises, fantasy training, the provision of information, guidance in discussing sex with women, and homework assignments.

Six of the nine men reported decreases in the frequency of their erectile problems and a greater ability to cope with episodic erectile failure. Statistically significant results were obtained for the group of nine men on measures of sexual satisfaction. The investigators

recommended the use of social skills training in future studies, feeling this was an important ingredient of their program.

Lobitz and Baker's (1979) encouraging findings are somewhat dampened by the fact that they did not control for possible alternatives to treatment as sources of therapeutic improvement. Price et al. (1981) compensated for this weakness by carrying out the first control group design with men with erectile problems. Twenty-one partnerless men formed two treatment groups and one waiting-list control group. Two dual sex co-therapy teams ran the weekly groups for eight weeks. The program was comprised of didactic presentations and discussions concerning human anatomy and physiology, myths of sexuality, sex-role stereotypes, sexuality and aging, sexual problems, and sexual activities with a partner. A series of masturbation and sensitivity homework assignments were also utilized. Although the treatment groups did not significantly differ from the control group regarding decreases in the frequency of erectile difficulties, significant differences were obtained on measures of overall sexual satisfaction, attitudes toward masturbation, and satisfaction with overall sexual self-image. Six months following treatment, there had been a significant decline in the subjects' satisfaction with their overall self-image.

In considering reasons why their subjects did not experience the alleviation of erectile difficulties obtained in the Lobitz and Baker (1979) study, Price et al. (1981) concluded that the greater emphasis on the social skills component in the Lobitz and Baker study may have accounted for the difference. Price and associates suggested that social skills training provides the clients with the confidence and skills to implement the knowledge they gain in treatment.

In an attempt to improve upon the results of the Price et al. (1981) study, the same researchers carried out another study, adding two treatment components (Reynolds et al., 1981). A series of social interaction homework assignments were employed, and three guest female therapists helped the men role-play social interactions. Results indicate that there was a trend toward the reduction of erectile difficulties while engaging in intercourse, and a significant reduction of erectile problems prior to intercourse. Also the clients' level of social anxiety significantly decreased over the course of treatment, as measured by the Social Anxiety Scale of the California Inventory (Fenigstein, Scheier, & Buss, 1975).

Altman et al. (1985) tested a psychoeducational approach in group therapy. Seven older men who did not have a current sexual partner and had erectile difficulties were seen by a dual sex co-therapy team weekly for 10 sessions. Treatment consisted of the provision of information regarding human sexual anatomy and functioning, discussion of changes in sexual response brought on by aging, modification of attitudes and beliefs judged to be interfering with the clients' sexual functioning, identification of the conditions the client requires for enjoyable sex, social skills training and assignments, a ban on intercourse for the duration of treatment, masturbation and sensitivity homework exercises, sensate focus and non-demand intercourse with a partner, and a client-designed plan for maintaining treatment gains.

The results obtained at termination and the two-month follow-up were statistically significant, revealing that the clients were better able to obtain and maintain erections with a partner, experienced less performance anxiety and distress when failing to erect, were more confident in their ability to cope with erection problems in the future, and were more

satisfied with their ability to obtain and maintain an erection. A 14-month follow-up was conducted and the treatment gains were still statistically significant. Further, six of the seven men had gone out on a date and five had successfully engaged in intercourse.

The three studies with the best outcome (Altman et al., 1985; Lobitz & Baker, 1979; Reynolds et al., 1981) included social skills training but did not control for possible alternatives to treatment as sources of therapeutic improvement. It would be advisable for researchers to include social skills training in future treatment studies of non-partnered men. Further, researchers should utilize designs which allow them to rule out confounding factors.

While they did not have a no-treatment control group, Everaerd et al. (1982) and Dekker et al. (1985) did report data from several different male-only groups. Their subjects included men with a steady partner (in some of the cases the partner did not want to be involved in treatment), men with varying partners, and men without partners. The groups were heterogeneous in regard to the presenting problems and the sexual orientation of the men. Treatment consisted of 15 to 21 2-hour sessions employing Rational Emotive Therapy, masturbation exercises, and social skills training. They found that the presence of a partner enhanced treatment effectiveness (men with varying partners demonstrated the greatest improvement). The lack of improvement in the partnerless group may have been due to the men not having acquired a partner by posttreatment and thus responding on the basis of their previous failures. Unfortunately individual results are not presented, and much valuable information is not retrievable from their group-format presentation.

Individual Therapy

The few studies which have examined the effectiveness of brief individual treatment of erectile dysfuction in clients without partners have had serious methodological flaws. McCarthy (1980) offers only a very brief anecdotal summary of his treatment experiences when using his insightful and detailed treatment model. Albert et al. (1980) set out to experimentally test their behavioural-psychodynamic treatment approach for sexual dysfunction in clients without partners, but used the same approach with males and females with a wide variety of sexual problems.

Altman (1985) conducted the only study comparing the efficacy of group treatment and individual treatment of erectile dysfunction in partnerless men. Six men completed individual treatment and follow-ups at 10 and 20 weeks. Four men completed group treatment and the 10-week follow-up. Altman found that individual treatment was more effective in improving the men's erectile functioning and sexual satisfaction, although the differences were not statistically significant. Although it could be concluded that the individual attention the men in individual treatment received may be an important factor in these findings, it should be noted that a relatively small number of men were seen under each treatment format.

Future research should investigate the effectiveness of this treatment method when given in individual treatment, the comparative effectiveness of the psychoeducational approach when used in a group format and individual format, the relative efficacy of the various components of the treatment package, and the effectiveness of the psychoeducational approach with other sexual dysfunctions.

Rationale for the Present Study

The present study is the first to examine the efficacy of brief individual treatment of erectile dysfunction in men who have partners but whose partners do not participate in therapy. The comprehensive psychoeducational treatment package employed in this study was based on a wide variety of techniques used by Price et al. (1981) and Altman et al. (1985) in a group context with men who do not have partners.

The present study did not attempt to demonstrate the effectiveness of the treatment approach compared to other treatment methods, nor to uncover the crucial components of the treatment package. As Kazdin (1980) states, "only after the main question is resolved--that is, whether the treatment package alters the problem--is a finer-grained analysis warranted" (p. 83). Thus, these other questions should be addressed after the treatment package has been proven effective.

Some may find fault with the treatment package, suggesting that it is not flexible enough to adapt to unique aspects of the clients. However, the package is vast in scope and touches upon most areas viewed as contributing to and maintaining erectile problems. Furthermore, the clients received a thorough assessment which covered the nature, frequency, timing, and surrounding circumstances of the erectile problem. This information enabled the therapist to individualize discussions and homework asignments as the need arose.

This treatment was based on the premise that standardized treatment packages can be effectively used to help men who are experiencing erectile difficulties and whose partners do not participate in therapy. Application of the psychoeducational approach described here constitutes an early

attempt to meet the needs of such clients who usually receive a poor prognosis and who have traditionally been excluded from sex therapy.

Method

Subjects

The clients were men referred to the Sexual Dysfunction Clinic at the University of Manitoba for treatment of erectile difficulties. Of the five men who began treatment, three completed treatment and the follow-up sessions. Only these three clients will be discussed here. Summaries of the treatment for the two clients who terminated treatment early are presented in Appendicies A and B.

The three subjects met the following criteria:

1. They each had a regular female partner who was sexually involved with them, but did not come in for treatment. In order for a partner to be considered as a "regular" partner, the couple had to be married, co-habiting, or have been dating at least once a week for a minimum of three months prior to treatment. It should be noted that a regular partner does not necessarily mean that the client had frequent sexual access to her. In the present study the men were only dating their partners and had to be discreet for the sake of family members. The average duration of the sexual relationships prior to the commencement of treatment was five months (Arthur, three months; Barry, seven months; Charles, five months).

2. The subject's primary complaint was secondary erectile dysfunction as defined earlier.

3. The treatment goals of the men were (a) to develop self-control skills to facilitate the acquisition and maintainance of erections sufficient to complete heterosexual intercourse, and (b) to enhance their sense of adequacy and comfort with heterosexual relations (Lobitz & Baker, 1979).

4. All subjects had to report at least one of the following conditions: (a) full erections upon awakening. The subject believes that the erection was firm enough for vaginal penetration if attempted; (b) normal masturbatory erections; and (c) frequent, full and sustained erections during petting/foreplay (e.g., for five minutes of foreplay with detumescence occurring only when penetration is planned). Meeting at least one of these conditions is a strong indication that the erectile dysfunction is psychogenic rather than organic in origin.

5. The men were free of any psychopathology (e.g., psychosis, alcohol or drug addiction, etc.) as determined in the initial screening interview.

6. The men had to agree to fully participate in the study by attending the treatment sessions, completing assignments and questionnaires, and taking part in the follow-up sessions.

Client characteristics are listed in Tables 1 and 2.

Insert Tables 1 and 2 about here

Assessment

The director of the clinic saw prospective subjects in a 60-minute screening interview to determine their suitability for the study.

The clients were seen in either three or four assessment sessions once they were deemed suitable for participation in the study. The average length of the total interview time during the assessment period was 5 hours, 35 minutes (the range was 5 hours to 5 hours, 55 minutes). The therapist began by explaining the nature of the research in which the men were asked to participate, the time commitment involved, the confidentiality of participation, and answered the men's questions

Table 1

Demographic Characteristics of the Clients

Characteristics	Arthur	Barry	Charles
Age:	19	53	54
Occupation:	student	welder	livestock attendant
Education:	some university	vocational training	grade 8
Relationship with partner:	steady dating	steady dating (extra marital affair)	steady dating
Age of partner:	18	appoximately 48	51
Accommodations:	lives with his parents and siblings	lives with his wife and children	lives alone
Ethnic background:	British, Belgium, and Metis	Ukrainian	Germanic
Religious affiliation:	none	nominal Ukrainian Catholic	nominal Mennonite
Past drug use:	moderate use of alcohol, mild use of cannibis and LSD	severe alcohol abuse	periodic alcohol abuse
Present drug use:	mild use of alcohol and cannibis	none	heart pills
Health:	excellent	improved over past history of health problems	heart problems

Table 2

Sex-Related Characteristics of the Clients

Characteristics	Arthur	Barry	Charles
Referral source:	family doctor	urologist	urologist
Duration of present sexual relationship:	3 months	7 months	5 months
Reason the partner did not attend treatment sessions:	the partner was not aware of his sexual problems	fear of the affair being discovered and anticipated embarrassment	lack of commitment and incon- venience
Onset of erectile difficulties:	age 15	age 51	age 48
Years of relatively problem-free sexual activity:	0	37	30
Months of satis- factory sex with present partner:	0	0	0
Diagnosis of problem:	difficulty achieving and maintaining erections (not life-long, situational); premature ejaculation, less than 1 min. (life- long, situational)	difficulty achieving erection (not life-long, situational); difficulty maintaining erection (not life-long, global)	difficulty achieving erection (not life-long, situational); difficulty maintaining erection (not life-long, global)
Presence of full erections upon awakening:	yes	no	yes

(table continues)

Characteristics	Arthur	Barry	Charles
Presence of full erections during petting:	periodically	no	periodically
Presence of full erections during masturbation:	near-full	no	periodically
Satisfaction with masturbation:	no	no	no
Past difficulty with ejaculatory control:	yes	no	no
Present difficulty with ejaculatory control:	yes	no	no

concerning treatment (see Appendix C). The men were informed that if they preferred not to participate in the study, they would be given the opportunity of receiving regular service at the Sexual Dysfunction Clinic, although this would likely involve a long waiting period. The men then signed the Client Consent Form (see Appendix D).

Part of the assessment period involved interviews in which the therapist gathered information regarding the nature of the client's sexual problem and his relationship with his partner. The content of the assessment interviews generally followed the scheme outlined in the Treatment of Sexual Dysfunction: Protocol for Assessment Interviews (Jehu, unpublished manuscript; see Appendix E). The therapist gathered details on the duration, onset, and course of the problems, examined the contemporary conditions influencing the sexual difficulties, and assessed the clients' personal resources (Jehu, 1979). This was partially accomplished by the use of the Sexual History Questionnaire (Schover, Friedman, Weiler, Heiman, & LoPiccolo, 1980; see Appendix F) and by examining the pretreatment data on the other six questonnaires listed below. The assessment information enabled the therapist to adapt the treatment package to each client's individual needs.

Pretreatment data was also obtained in the assessment sessions. The men completed the Erection Difficulty Questionnaire (Price et al., 1981; see Appendix G), the Goals for Sex Therapy questionnaire (Lobitz & Baker, 1979; see Appendix H), the Index of Sexual Satisfaction scale (Hudson, Harrison, & Crosscup, 1981; Appendix I), the Culture-Free Self-Esteem Inventory (Battle, 1981; see Appendix J), the Dyadic Adjustment Scale (Spanier, 1976; see Appendix K), and the Marriage and Sexual Relationship Questionniare (Jemail & LoPiccolo, 1982; see Appendix L). Since the sexual partners of the

clients were not spouses, they responded to questions which asked about their spouses on the basis of their relationship with their sexual partner. The clients were given copies of the Sexual Activities Checklist (see Appendix M) and were instructed to complete one of the forms every day until the termination of treatment. The therapist phoned two of the clients during the assessment period to ensure that they were correctly completing the checklist. All these measures are described below.

Erection Difficulty Questionnaire

This scale was designed by Price et al. (1981; see Appendix G) to identify the nature and severity of erection problems, as well as emotional and attitudinal reactions to the dysfunctions. The questionnaire is comprised of 24 items such as "I have trouble getting an erection during foreplay with a partner" and "My erection problem makes me feel like less than a man". The items are rated along a five-point continuum ranging from either always to never, or completely true to completely false.

A significant correlation was found between pre-post change on this scale and client self-reports relating to both frequency of erectile difficulties and overall improvement in erectile functioning (Price et al.,1981; Reynolds et al.,1981). Further, these researchers obtained significant changes for the total scores on the questionniares following treatment.

Goals for Sex Therapy Questionnaire

Lobitz and Baker (1979; see Appendix H) designed this scale to assess a man's satisfaction with various sexual behaviors, feelings and attitudes. The 14 items which comprose the scale are rated on a seven-point continuum ranging from much less than satisfied to much more than satisfied.

The studies with nonpartnered groups of men with erectile problems (Lobitz & Baker, 1979; Price et al., 1981; Reynolds et al., 1981) have demonstrated that this measure is sensitive to changes due to treatment. Lobitz and Baker (1979) found that significant increases in satisfaction accompanied self-reports of a significant decline in the frequency of erectile problems.

Index of Sexual Satisfaction (ISS)

Hudson, Harrison and Crosscup (1981; see Appendix I) developed this 25-item self-report scale as a global measure of one's dissatisfaction with one's sexual relationship with a partner. Statements such as "My sex life is monotonous" and "My partner dwells on sex too much" are assigned a rating on a five-point scale which ranges from rarely or none of the time to most of the time.

Internal consistency and test-retest reliability exceeds .90, and discriminant validity, factoral validity, and construct validity are all very good (Hudson et al., 1981).

Culture-Free Self-Esteem Inventory (SEI)

Battle (1981; see Appendix J) developed the Self-Esteem Inventory to measure an individual's perception of self. Self-esteem is defined as "the perception the individual possesses of his own worth" (Battle, 1981). Items such as "Do you feel you are as important as most people?" and "Do most people respect your views?" are responded to with a yes or no. The inventory consists of 40 items.

Test-retest reliability for males is .79 and concurrent validity ranges from .72 to .84. The scale was designed so that it would have content validity.

Dyadic Adjustment Scale

Spanier (1976; see Appendix K) developed this scale to assess the quality of marriage and similar dyads. The scale assesses dyadic satisfaction, dyadic consensus, dyadic cohesion, and affectional expression. Most of the questions are rated on scales ranging from always agree to always disagree, extremely unhappy to perfect, etc.

A factor analytic study, using married and divorced persons in the sample, empirically verified the meaningfulness of the four factors--dyadic staisfaction, dyadic consensus, dyadic cohesion, and affectional expression (Spanier, 1976). In a follow-up study using recently separated persons, Spanier and Thompson (1982) confirmed that the four factors are robust. Spanier found highly significant differences in scores between married and divorced persons (divorced persons responded in the context of the last month they spent with their former spouse). Spanier presented evidence suggesting that the scale has content, criterion-ralated, and construct validity. Internal consistency (overall reliability) for the scale was .96 with a mixed population of married and divorced persons (Spanier, 1976), and .91 with a population of recently separated persons (Spanier & Thompson, 1982).

Marriage and Sexual Relationship Questionnaire

This scale was designed by Jemail and LoPiccolo (1982; see Appendix L) to measure the defensiveness about the marital and sexual relationship. Defensiveness was defined as "the tendency to endorse socially desirable items which are unlikely to occur and deny socially undesirable items which characterize most honest responders" (p. 33). There are separate scales for males and females, and for marital defensivness and sexual defensiveness. All items are in the form of statements which are answered true or false.

Jemail and LoPiccolo (1982) provide norms taken from a sample of 217 couples. Internal consistency measures of reliability are .90 for the marital scale and .80 for the sexual scale. Construct validity is relatively good. Furthermore, these scales were found to be a better measure of defensiveness regarding the marital and sexual relationship than a global defensiveness scale.

Sexual Activity Checklist (SAC)

This checklist (see Appendix M) was designed by the present author as a continuous measure of sexual functioning and satisfaction that the client can complete each day at home. The client monitors the fulness of his erections and his satisfaction with the duration of his erections in various sexual encounters alone and with a partner. The man checks the sexual activities experienced in the previous 24-hour period from the list of common alternatives provided. He then rates the fulness of erection using a seven-point scale ranging from completey soft (1) to completely hard (7). The man's satisfaction with the duration of the erection is rated on a seven-point scale which ranges from completely unsatisfied (1) to completely satisfied (7).

When the client engaged in more than one sexual activity in an encounter, the activity in which he obtained the firmest erection is reported. The only exception to this rule is where an erection in intercourse was less firm than in concurrent sexual activities. In such a case, intercourse is reported.

These various outcome measures enabled the researcher to determine whether treatment had effects beyond the client's ability to obtain and maintain erections.

Treatment

Treatment consisted of 10 sessions for two of the clients, and 9 sessions for the third client. The average length of the treatment sessions was 1 hour, 40 minutes (the range was 1 hour to 2 hours, 15 minutes). The average total treatment time was 15 hours, 15 minutes (the range was 13 hours to 16 hours, 25 minutes). The program was delivered by a male therapist who is also the researcher. Two different female therapists each participated in a few sessions.

All but the first treatment session began by reviewing the homework assignments given the previous week. Clients had an opportunity to raise any concerns they had about the homework and to discuss any problems they encountered. Didactic presentations and discussion topics followed the homework review. The aim of the presentations and discussions was to increase the sexual and communication skills of the clients. These were sometimes supplemented by film presentations.

The clients purchased a copy of Male Sexuality (Zilbergeld, 1978), which contains most of the readings and exercises that were assigned. Readings and assignments coincided with the material presented and discussed in therapy. From time to time, other handouts were distributed which related to the discussion topics, presentations, and homework assignments (e.g., The Variety of Sexual Expression: see Appendix P; Arousal and Erection Guidelines: see Appendix Q).

Sessions concluded with the assignment of exercises to be completed by the clients at home. The homework assignments were described in detail by the therapist.

Information collected primarily during the assessment period enabled the therapist to adapt the psychoeducational treatment package to meet the

individual needs of each client. The basic components of the treatment package, and the rationale for incorporating these components are outlined below. A detailed account of the treatment protocol (including homework assignments) for the three clients is given in Appendices N and O.

Relaxation Training

One technique intended to counter stress reactions is relaxation training. A popular form of relaxation training is an abbreviated version of Jacobsonian relaxation training, in which the client tenses and relaxes various muscle groups. Clients readily acquire these relaxation skills (Goldfried & Davison, 1976).

It was hoped that upon learning these skills, clients would use them in a variety of stressful situations. In particular, relaxation exercises were intended to counter the anxiety clients may experience in their sexual encounters. Thus, to facilitate generalization of these skills from the therapist's office to actual sexual encounters, clients were encouraged to use relaxation when carrying out the various sexual, sensual and social homework assignments.

Provision of Information

Since ignorance in sexual matters may contribute to the difficulties that clients with sexual dysfunctions experience, provision of information is an important component in every treatment approach and for every problem.

Information concerning male and female anatomy and the human sexual response was presented to the clients. This information was intended to alter any incorrect views these men had concerning the human sexual response. For example, the misconception that the female orgasm should occur due to penile-vaginal contact in the absense of any concurrent clitoral

stimulation, which Lobitz and Lobitz (1978) coined the "Look, Ma, no hands" syndrome, may have a detrimental effect on their sexual relationship with their partner. Changing such beliefs was hoped to help the men view themselves as more competent sexual partners. Similarly, the clients received information stressing the importance of sufficient and appropriate sexual stimulation for men.

Presentations and discussions concerning the wide variation in sexual behavior were intended to teach the men that absolute norms do not exist in this area (Jehu, 1979). Anxiety that arises from beliefs concerning the frequency of sex (i.e., feeling one is not engaging in it often enough) or the role of intercourse (i.e., that sex equals intercourse) may be attenuated or eliminated when recognizing that our society does not have immutable standards. Provision of information was also intended to undermine any unrealistic expectations of sexual failure and reduce the anxiety these men have associated with sexual activites (Jehu, 1979).

Formal presentations were made on the myths of male and female sexuality (e.g., sex requires an erection), and counteracting myths was an ongoing process in therapy (Zilbergeld, 1975). The therapist initiated discussions regarding the conditions required to have good sex. Further, the clients and therapist discussed non-sexual stresses, stress reactions and the adverse effect stress has upon sexual functioning (Jehu, 1979).

The topic of male sexuality and the aging process was discussed with the two older subjects. Some issues that were covered were the increased length of time required to achieve an erection, to ejaculate, to obtain another erection following ejaculation and the fact that the erection may not be as hard and the ejaculation less powerful than in the past (Zilbergeld, 1978). The men were also told that changes in sexual functioning due to age

alone need not result in erectile difficulties or decreased pleasure in intimate contacts for the rest of their lives (Jehu, 1979).

The therapist introduced these various topics to the clients, allowing them an opportunity to respond in terms of how misinformation or a lack of information in the areas discussed may have compounded their current difficulties. As Jehu (1979) points out, "talking with the therapist about such matters may have the important spin-off of sanctioning, facilitating, and enhancing communication between the partners themselves" (p. 125). Also, the exchange of information and feelings between males is a behavior which rarely occurs in this society and may have beneficial effects (Goldberg, 1979). The men were expected to encourage their partners to read Zilbergeld (1978). The therapist discussed with them how they could best go about doing this. This was expected not only to counteract incorrect views and myths that the partners hold, but to also make it easier for the clients to discuss sexual matters with their partners, since the couples would then have a new common source of knowledge concerning sexuality.

Four films were used to supplement the didactic presentations and reading material. Becoming Orgasmic (LoPiccolo & Herskovitz, 1976) was shown in the first session to desensitize the client to discussing sexuality in a very open manner, to introduce and desensitize the client to two sensual homework assignments (i.e., Exploring Your Genitals and Self-Body Rub with Lotion), and to familiarize the client with the nature of sexual dysfunction therapy. The Sexually Mature Adult (Norman, 1973) was viewed in order to educate the client regarding sexual physiology and functioning. Further, this film stressed individuality in sexual preferences. Treating Erectile Problems (LoPiccolo & Friedman, 1980) illustrated some non-demand sensual and sexual exercises which were later assigned. A Ripple in

Time (Sutton, 1974) vividly illustrated the point that communication and affection are more crucial to a good sexual relationship than a firm erection. These additional educational sources were intended to lend credence to the therapist's presentations.

Procedures to Facilitate Attitude Change

It was assumed that if the provision of information increased the client's knowledge about sexual matters, attitude change would also result. Some of the commonly held misconceptions that were countered are: a) all physical contact with a partner should lead to sex; b) men always want and are always ready to have sex; c) a man must initiate and orchestrate sex; d) sex and intercourse are synonomous; e) sex requires an erection; and f) women value performance more than eroticism and intimacy.

The extent of attitude change was expected to be a function of the therapeutic relationship that existed between the client and therapist, the quality of the explanations offered to the clients concerning possible causes of their difficulties, and the fostering of a positive prognostic expectancy (i.e., the client believes he will benefit from therapy) by discussing the rationale and efficacy of the various treatment components (Jehu, 1979).

As well as ensuring that these conditions were present in therapy, the therapist made use of a variety of specific procedures intended to facilitate attitude change. These procedures included sanctioning, self-disclosure, role playing and cognitive restructuring. The procedures examined and attempted to modify the client's beliefs, emotional reactions, and the behavior he was engaging in or avoiding.

Sanctioning. The therapist is able to sanction various sexual attitudes and behaviors once he has established a positive relationship with the client based on mutual respect and trust (Jehu, 1979). Some clients experienced

feelings of guilt after masturbating, and viewed masturbation as both sinful and potentially harmful. The therapist discussed the pleasure that can be derived from masturbation, outlined its role in helping clients to overcome sexual difficulties, and attempted to alleviate the client's guilt from masturbating.

Self-disclosure. Self-disclosure is a characteristic of human interaction and can be employed in a deliberate fashion to change a client's attitude (Jehu, 1979). This form of communication was used by the therapist at various times throughout therapy, after a good therapeutic relationship had been established. All of the clients appeared to respond well to hearing relevant, personal examples concerning the therapist.

Role playing. Role playing is a technique that the therapist utilized to vividly illustrate some points. For example, the therapist modeled poor and good communication, and then had the client act out these situations. A guest female therapist took part in either one or two sessions to help the men role-play various behaviors. The men practiced discussing their erectile difficulties with a partner, and initiating a partner to nondemand exercises.

Cognitive restructuring. Cognitive restructuring (relabelling) is a procedure which can be used to modify the cognitive processes which are involved in the control of emotional and behavioral reactions. For example, upon becoming intimate with his partner, a client may be thinking that he will not achieve an erection and that the encounter will be a failure. As a result, the client may become anxious and the anxiety may effectively disrupt the processing of the internal and external stimulation necessary for arousal.

Cognitive restructuring was used in conjunction with the techniques previously discussed and complemented the provision of information which took place throughout therapy. Following Goldfried and Davison's (1976) guidelines for implementing a cognitive restructuring approach, the therapist provided a rationale of the cognitive approach to the client, presented an overview of common irrational assumptions, offered an explanation of the client's difficulties in rational terms, and by using imaginal presentations, behavioral rehearsals, modeling and in vivo assignments, taught the clients how to modify their own internal sentences.

Development of Ejaculatory Control

Since one possible cause of erectile problems is previously having been a premature ejaculator (Jehu, 1979; Lowe & Mikulas, 1978; McCarthy, 1980), part of one session focussed on the topic of ejaculatory control. One of two Stop-Start Masturbation exercises described in Zilbergeld (1978) were used to supplement the material presented in therapy. One client (Arthur) wished to wait until he was comfortable with his erectile functioning before working on developing greater ejaculatory control. He at least was given the resources to aid him in developing this skill. Researchers indicate that clients can make use of written material in developing ejaculatory control (Lowe & Mikulas, 1978; Zeiss, 1978).

Communication Skills

The importance of teaching social skills to help clients benefit from treatment has been demonstrated in group therapy with partnerless men (Lobitz & Baker, 1979; Reynolds et al., 1981; Altman et al., 1985). It stands to reason that men who have current partners do not need to learn social skills such as where and how to meet women, but could instead benefit from learning a related behavior, that is, how to communicate with their

partners. Thus, each client was taught (a) to effectively send and receive messages when communicating (see Appendix R), (b) to be assertive by telling his partner when he does not want to be intimate, (c) to be assertive by communicating his likes and dislikes regarding sex, (d) to find out what his partner likes and dislikes regarding sex,(e) to solicit his partner's collaboration in sensual/sexual homework assignments, and (f) to discuss his sexual problems and other sexual matters with his partner. These skills were taught through didactic presentation, role playing, reading material, and homework asssignments designed to exercise and refine the skills aquired in treatment.

Female Guest Therapist Involvement

Reynolds et al. (1981) found that the participation of a guest female therapist was rated as efficacious by their clients. Two female therapists participated in either one or two sessions in the present study. They gave a presentation and led a discussion on female sexuality, what different women prefer in sex, the varieties of sexual expression, and discussion and role playing concerning initiating a partner to nondemand exercises and discussing erectile difficulties with a partner.

Sexual Directives and Homework

Ban on intercourse. In order to alleviate performance anxiety and to encourage alternate forms of sexual activity, the men were instructed not to engage in sexual intercourse until the end of treatment (the ban on intercourse might be more appropriately labelled a ban on pressure to erect, and thus any activity which involves pressure on the men to become erect was prohibited). Since the men's partners were not seen in therapy, the men were directed to communicate this directive to their partners. One client's partner was not aware of his sexual problem since he had not attempted

intercourse with her. Therefore, the first step was to communicate the fact that he had experienced sexual problems.

It was reasoned that if clients broke the ban and successfully engaged in intercourse, they would have reached a goal set at the beginning of therapy. If they experienced difficulties following penetration (e.g., detumescence during pelvic thrusting), the therapist could assign appropriate asssignments (e.g., nondemand intercourse) and could advise the clients that this difficulty signifies that they are not yet ready to have the ban on intercourse lifted. In fact, one client broke the ban and successfully engaged in intercourse.

Sensual/sexual assignments. Beginning with the first session, clients were expected to get to know their bodies, increase their sexual skills, and reduce sexual anxiety through a set of sensual/sexual assignments, which were developed and described by Zilbergeld (1978). In the sessions the clients heard the rationale underlying each exercise and had the exercises described in detail.

The first of these exercises consisted of the clients visually and tactually exploring their genitals, followed by a tactile exploration homework assignment in which the men discovered which parts of their bodies provide the most pleasure. The purpose of these exercises was to make the clients comfortable with their bodies and to demonstrate that there are other sources of sensual/sexual pleasure apart from genital stimulation.

Following these, a series of masturbation exercises were employed to help the clients reduce their sexual anxiety and increase their sexual skills. "Masturbation with focusing" was designed to enable the man to focus on the sensations in his penis and to discover what types of stroking feel best.

"Losing and regaining erection" was intended to teach the men that losing an erection is not devastating, since stimulation can again bring about erection. This exercise provided the clients with control over their sexual responses, something which they perceived to be lacking at the start of treatment. Sexual anxiety can be alleviated through the association of positive imagery with sexual arousal in "masturbation with fantasy of losing and regaining erection". In the exercise, "masturbation with fantasy of sex with a partner", the client ceases masturbation when anxiety increases, and then tries to relax by focussing on a pleasant image. The client imagines a hierarchy of stressful situations without being anxious. It was hoped that this in vivo desensitization would generalize to intimate situations with their partners. "Masturbation with fantasy of no erection" was meant to desensitize the men to situations in which they do not achieve an erection. "Masturbation incorporating erotic material" was designed to facilitate the use of fantasy in increasing sexual arousal. Regarding the masturbation exercises, the clients were instructed not to ejaculate through a flaccid penis.

Each session (except the first) began with the clients reporting on their homework assignments and any difficulties they may have encountered in doing the exercises. If a client reported that he did not become erect when doing the assignment, the therapist enquired as to what was going on for the client and then offered suggestions to help the individual overcome this problem. For example, where the therapist determined that impoverished sexual imagery was one of the causes of the difficulties (e.g., in the case of Arthur), he provided additional sexual fantasy training and an exercise to overcome this problem (i.e., "masturbation incorporating erotic material").

Whether or not the clients felt free to discuss difficulties or failures with their assignments was likely highly dependent upon the unspoken norms in the therapist/client relationship. Had the therapist focussed only on successes and appeared put off by difficulties, the men may have been reluctant to disclose problems, impeding the course of therapy. Thus, the therapist paid equal attention to successes and failures.

Finally, the clients were instructed in the use of the general pleasuring partner exercises (nondemand snuggling, sensate focus or nonsimultaneous body rubs, and the nondemand coitus procedure described by Jehu, 1979). These exercises were given as assignments and were expected to be incorporated into sexual encounters with the partner.

Written/conceptual assignments. Four written exercises were assigned. The myths essay (see Appendix S) had the clients read relevant sections in Zilbergeld (1978) and determine which myths they held. They examined misconceptions and poor attitudes which may have played a role in the development of their sexual problems, and/or in maintaining the problems. One client (Charles) with poor writing skills was assisted by the therapist in doing all written/conceptual assignments.

The conditions essay (see Appendix T) is based on the assumption that clients are better able to change the conditions and behaviors which led to their problems by understanding the conditions that gave rise to the problem. In this assignment, the clients compared successful and unsuccessful sexual encounters in an attempt to identify the conditions necessary for them to perform well and enjoy sexual involvement. Throughout therapy the clients were encouraged to continue to discover their conditions required for good sex.

After treatment had proceeded for a few sessions the clients were asked to develop a problem scenario for why their erectile difficulties developed and persist (see Appendix U). The clients were expected to incorporate all they learned to date in doing this exercise, and hopefully increased their understanding of their problems by reducing the mystery and confusion which often accompanies sexual dysfunctions. Finally, the development of a problem scenario was intended to make clear the importance of individualized homework assignments and helped determine the nature of these assignments.

The client's success in maintaining treatment gains will depend to a great extent on his ability following treatment to cope with and solve minor sexual set-backs (Lobitz & LoPiccolo, 1972). Near the end of treatment, the clients received a handout designed to assist them in identifying the behaviors and conditions they will require to maintain and even improve upon the gains they made in therapy (see Appendix V). Through discussions with the therapist, the clients identified the self-statements and behaviors contributing to their dysfunction, what they have learned in treatment, possible set-backs which may occur following the program, and how they plan to overcome these set-backs if they occur.

<u>Posttreatment and Follow-up</u>

Following completion of the final treatment session, the clients completed the Erection Difficulty Questionnaire, the Goals for Sex Therapy Questionnaire, the Index of Sexual Satisfaction, the Culture-Free Self-Esteem Inventory, the Dyadic Adjustment Scale, and the Marriage and Sexual Relationship Questionnaire.

The clients were followed up at an average of 7 weeks (Arthur, 6; Barry, 6; Charles, 9), 13 weeks (Arthur, 12; Barry, 13; Charles, 14), 25

weeks (Arthur, 24; Barry, 24; Charles, 27), and 64 weeks (Arthur, 65; Barry, 65; Charles, 63) following treatment. Data was collected on the same measures administered at posttreatment. Furthermore, the men were given the opportunity to discuss any progress and/or problems they encountered since their previous session.

The clients completed the Sexual Activity Checklist (SAC) everyday from the first assessment session through to the final treatment session. Although the men were only asked to complete the checklist periodically throughout the follow-up period (at specified times), Arthur completed the forms everyday until the 24-week follow-up, and for a 3 1/2-week period following the 65-week follow-up. Barry completed the SAC data for 3-week periods following posttreatment and the 6-week follow-up. Charles completed the forms for a 4-week period encompassing the 14-week follow-up, and for a 3-week period following the 27-week follow-up. Overall, the men were very consistent in completing the SACs. However, they reported occasionally neglecting to complete the forms when they were not sexually active.

Experimental Design

The design employed for the repeated measure was a natural multiple baseline across people design (Barlow, Hayes, & Nelson, 1984)). Whereas Baer, Wolf, and Risley (1968) believed the multiple baseline across persons design requires the subjects to be seen concurrently in order to rule out the possible impact of extraneous events, the logic of the design does not require this. In the concurrent multiple baseline, extraneous variables are held constant across clients. In the natural multiple baseline, possible confounding events are randomized. It is unlikely that an extraneous event will lead to therapeutic change in various clients seen at various times.

With the natural multiple baseline across people design, differing lengths of baseline control for time effects (e.g., that three weeks of assessment and/or treatment lead to behavior change). Although it is ideal to randomly assign varying baseline lengths to avoid the possible problem of the factors indicating a time for phase change being correlated with processes which produce clinical improvement, this is not always possible in clinical practice. This problem can be avoided when other factors determine baseline length, such as scheduling limitations. In the present study, the baselines of the first two subjects were set by a pre-determined procedure. That is, the number of weeks of baseline corresponded to the number of assessment sessions. Where one client would normally have had a baseline of the same length as a previous client, the baseline was extended for the second subject. The baseline of the third subject differed due to a previously scheduled holiday. Accordingly, baseline lengths were 21 days (Arthur), 29 days (Barry), and 47 days (Charles).

The repeated measure was the subjects' self-reports on the Sexual Activity Checklist. Data was gathered daily during the baseline period and treatment phase. The subjects also gathered data using the checklist periodically during the follow-up period.

Questionnaires were given at pretreatment (during the assessment sessions), at posttreatment (immediately after the final treatment session), and during the follow-up sessions.

Self-report measures present a fundamental problem: How can you be sure that the clients are accurately reporting the data? The men may not be totally candid due to personal embarassment, concerns regarding confidentiality, and/or due to a wish to please the therapist. Some critics may say that treatment primarily affects the client's tendency to report

socially desirable behaviors. Theoretically, this concern could be addressed by obtaining corroborative data from the female partner. However, since one of the partners was not willing to have the woman participate in therapy, it would be unethical and the data might not be reliable if the therapist pressured the woman to assess her partner's erectile functioning.

Despite such problems with this type of data, self-report measures have certain advantages as Kazdin (1980) points out:

> Self-report measures permit assessment of several aspects of behavior that are not readily available with other assessment techniques. Obviously, the client is in a unique position to report upon his or her own thoughts, feelings, wishes, and dreams, and even many overt behaviors. Also, the client can report on his or her behavior across a wide range of differect situations and hence can provide a comprehensive portrait of everyday performance (p. 227).

This comment is especially relevant in terms of sexual dysfunction. Unlike other treatment areas (e.g., treatment of obesity or phobias), the therapist cannot directly observe the client's behavior. Further, one aspect of treatment is to encourage the client to discard societal standards and to determine his own ideas of good sexual functioning. Thus, it is the client's view of his progress which matters.

<u>Data Analysis and Interpretation</u>

Although statistical techniques have been developed for single-organism research (Hersen & Barlow, 1976), statistically significant results are not necessarily clinically significant, and vice versa (Kazdin, 1980). Jacobson, Follette, and Revenstorf (1984) suggest that statistical significance tests do not address clinical significance, and have little to do with the practical importance of the treatment effect. They state that "the significance test itself imposes a criterion for determining a treatment effect which often has little clinical relevance" (p. 337). They argue that

data reporting the proportion of clients who benefited from treatment should be presented since the reader wants to know the probability that a given client will benefit from treatment.

Jacobson and Follette (1984) found several definitions of clinical significance in the literature. Clinical significance has been defined as improvement in a large proportion of the clients (Hugdahl & Ost, 1981), improvement of a large magnitude (Barlow, 1981), improved daily functioning on the part of the client (Kazdin & Wilson, 1978), improved functioning validated by peers and significant others (Kazdin, 1977; Wolf, 1978), the elimination of the presenting problem (Kazdin & Wilson, 1978), and post-treatment functioning which is in the range of nondeviant peers (Kazdin & Wilson, 1978; Kendall & Norton-Ford, 1982). These definitions all concern the practical importance of improvements rather than statistical criteria.

Setting a criteria for clinical significance (especially for a particular study) is more difficult than arriving at a general definition of the concept. Although some suggestions have been made such as a 50% reduction of the problem (Jansson & Ost, 1982) or a change of two or more on an eight-point scale (Emmelkamp & Kuipers, 1979), justifying the use of any single criterion is difficult and the criterion choosen is inevitably arbitrary or subjective (Jacobson et al., 1984).

Researchers testing for statistical significance often think in terms of false dichotomies (i.e., one either has a problem or one does not). This conceptual flaw is also apparent with definitions of clinical significance such as "the resolution of the presenting problem" (Kazdin & Wilson, 1978) and "the client moving from the dysfunctional to the functional range during the course of therapy" (Jacobson et al., 1984). Problems with such false

dichotomies become apparent when one attempts to define the functional and dysfunctional categories. Some researchers view clinically significant change as a range of possible outcomes rather than simply as a dichotomous categorization (Kendall & Norton-Ford, 1982; Patterson, 1974).

Since clients are only concerned that treatment significantly alleviates their problem, clinical significance takes precedence over statistical significance. As noted above, clinical significance provides a flexibility in data analysis which is not possible with tests of statistical significance alone. Further, as was the case in the present study, statistical tests such as time-series analyses often require more data points than can be obtained in clinical research.

The data from the repeated measure was visually inspected to determine whether a significant effect had occurred. The researcher considered the magnitude of change, the number of times the effect replicated, and the consistency of the findings with existing data and accepted behavioral theory (Martin & Pear, 1978). Since much of the treatment involved the clients learning new skills (e.g., relaxation training) or developing new attitudes, it was predicted that improvements would occur gradually.

Questionnaire data collected at pretreatment, posttreatment and the four follow-up sessions were visually inspected to judge the efficacy of the treatment program and the clinical significance of the behavior and attitudinal change.

Consumer Evaluation of Treatment

Two forms of consumer evaluation of treatment were employed in the present study. After each treatment session, the clients were asked to identify what they perceived to be the most helpful intervention in that

session. Secondly, at posttreatment and at each of the follow-up periods (except at the 27- and 63-week follow-ups for Charles), the clients rated the perceived effectiveness of the various kinds of interventions on the Consumer Evaluation of Treatment questionnaire (see Appendix W). The interventions were grouped in 25-28 catogories, with an additional item, "the treatment program as a whole." These ratings were made on a scale ranging from not at all helpful (1) to extremely helpful (5).

Integrity of Treatment

Integrity of treatment refers to "the degree to which treatment is delivered as intended" (Yeaton & Sechrst, 1981, p. 160). Indeed, it makes little sense to carry out several research studies on a given treatment program unless the therapist is actually doing in therapy what he/she claims to be doing. Accordingly, the therapist recorded the topics covered and assignments assigned after each session. This was done in order to monitor the degree to which the therapist followed the treatment package outlined. When the therapist covered topics or assigned assignments not anticipated, this was recorded.

Results

Individual results for the clients will be presented in detail below. Overall results for the men as a group will also be presented.

Arthur

This client was a 19-year-old university student when he presented for treatment. He had been dating a young woman on a steady basis for three months. He had been avoiding significant sexual contact with this partner due to a history of past failure in sexual encounters. Although there was some commitment in their relationship, Arthur was not willing to inform

his partner of his past sexual difficulties. Thus, his partner did not participate in treatment.

Arthur's primary complaint was that of difficulty in obtaining and maintaining erections with a partner. Prior to assessment, he had only attempted intercourse on a few occasions with previous partners and had only successfully completed it twice. On these two occasions his erections were only semi-firm and penetrating his partners was a difficult task. Thus, Arthur had never satisfactorily completed intercourse. He had avoided having intercourse with his present partner and even tended to avoid petting when possible.

Arthur also reported having little ejaculatory control. On the two occasions when intercourse was completed, he ejaculated after thrusting a few times. His masturbatory erections were not always firm, but this was not a source of distress for him. Finally, Arthur reported being unable to communicate with his partner concerning sex. A medical examination was not warranted since he was consistently experiencing full erections upon awakening.

Arthur had improved very little by the end of treatment. The lack of improvement was thought to be due to his extreme hesitancy to initiate sexual activity with his partner. By the 12-week follow-up, his erections had still not improved. He had attempted intercourse for the first time with his present partner, but was unsuccessful since he was only semi-erect. This problem was compounded by his partner not lubricating and experiencing pain.

By the 24-week follow-up, Arthur had attempted intercourse on two more occasions with the same partner. On the first of these occasions, he initially failed to penetrate his partner, but was successful upon attempting

intercourse again (although he ejaculated very rapidly). On the second attempt, he penetrated his partner with little difficulty and engaged in two intercourse positions before ejaculating.

At the 65-week follow-up, Arthur reported successfully engaging in intercourse on a regular basis with his partner. He now routinely obtains and maintains full erections. He no longer avoids sexual activity and reports being able to communicate with his partner about sex. He is still experiencing ejaculatory control problems and his masturbatory erections are sometimes softer than at pretreatment.

Arthur's remaining difficulties are hampered by a relatively negative view of masturbation, and a lack of privacy and conducive circumstances with his partner (Arthur and his partner live in their respective parental homes).

Arthur's Sexual Activity Checklist data reflects his improved erectile capacity with a partner (see Figure 1). Although significant improvement was not apparent by the 12-week follow-up, a steady improvement occurred shorly thereafter. The data following the 65-week

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Insert Figure 1 about here

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follow-up is more variable (high ratings as well as low ratings) and may be accounted for in part by the increased number of attempts at intercourse. Figure 2 depicts the fact that his masturbatory erections did not significantly improve.

Insert Figure 2 about here

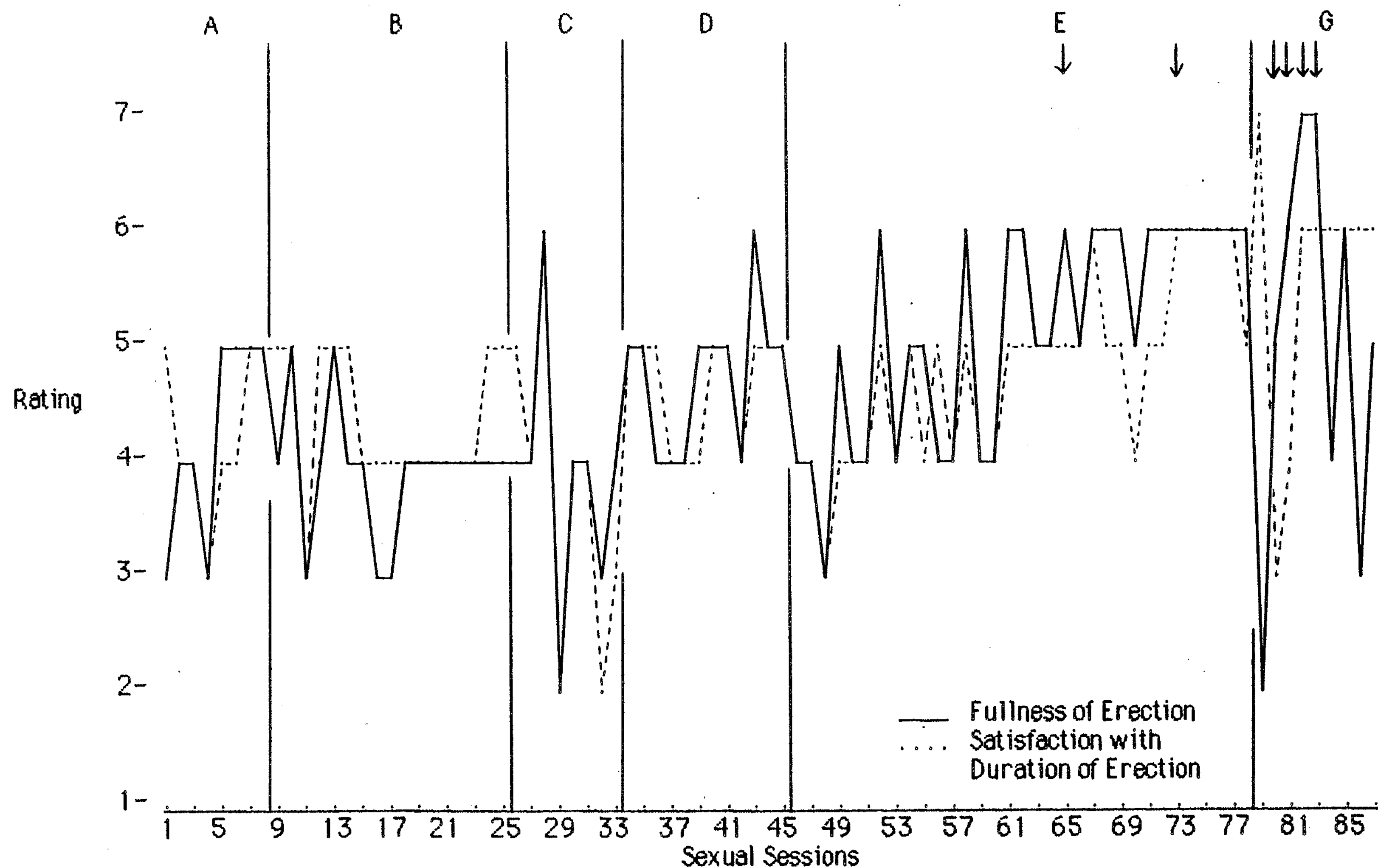

Figure 1: Arthur's Sexual Activity Checklist (SAC) data pertaining to sex with his partner. A rating of "7" represents a full erection or being very satisfied with the duration of the erection. The arrows indicate instances of intercourse. A,B, and C correspond to the assessment period, the treatment period, and the period following posttreatment. D, E, F, and G correspond to the periods following the first, second, third and final follow-ups.

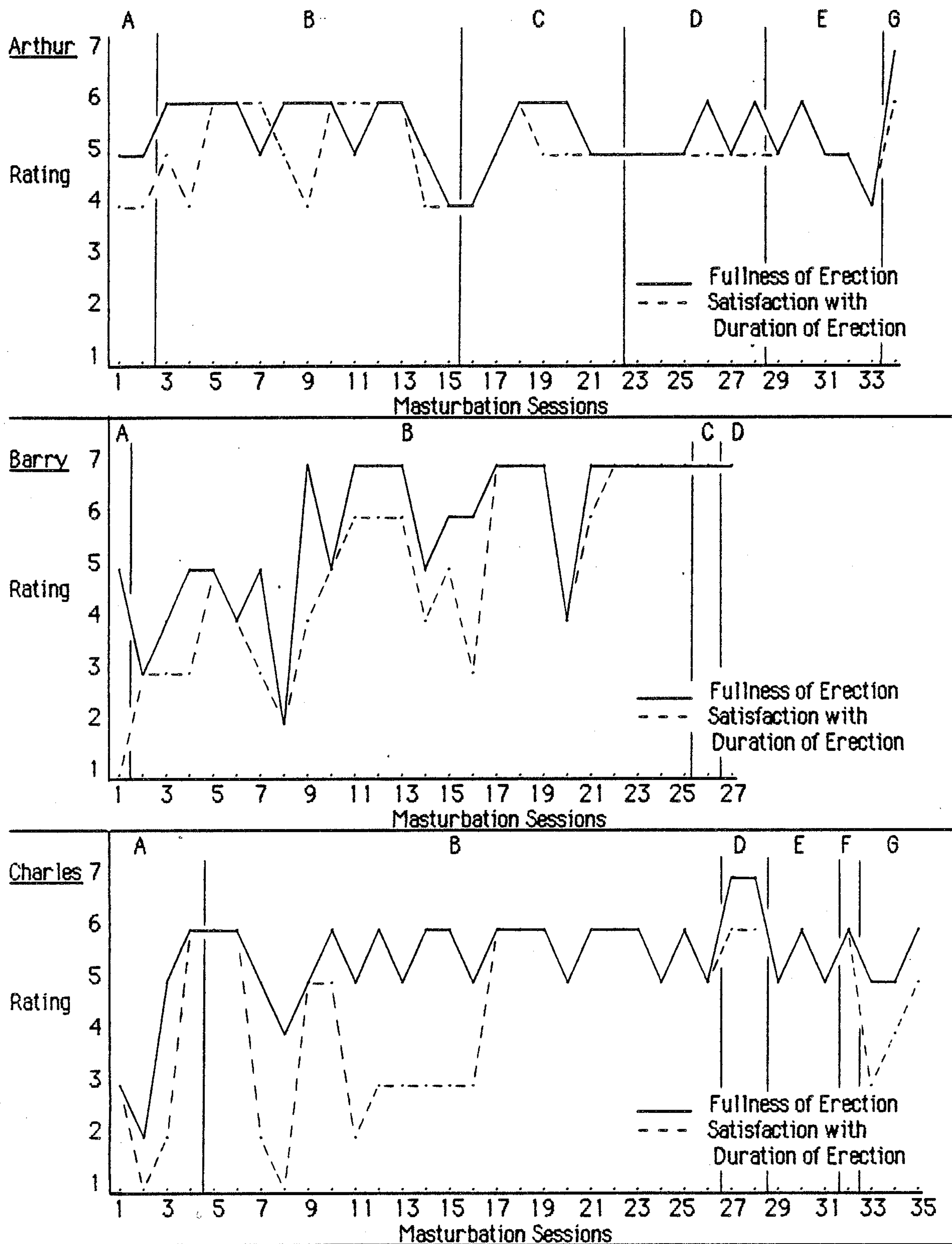

Figure 2: The Sexual Activity Checklist (SAC) data pertaining to masturbation for the three clients. A rating of "7" represents a full erection or being very satisfied with the duration of the erection. A,B, and C correspond to the assessment period, the treatment period, and the period following posttreatment. D, E, F, and G correspond to the periods following the first, second, third and final follow-ups.

On the Erection Difficulty Questionniare, Arthur reported a rather steady improvement in erectile functioning and comfort with heterosexual relations (see Figure 3). These changes indicate that he

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Insert Figure 3 about here

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maintains erections in intercourse for a longer period of time and is less likely to make excuses for his sexual functioning. He is less likely to avoid sex, worry regarding sex, experience low self-esteem, feel humiliated or dissatisfied concerning sex, and less likely to feel angry and resentful. He reported being more likely to communicate with his partner regarding sex, and being knowledgeable regarding instilling improvements in his sexual functioning.

Although Arthur obtained higher scores on the Goals for Sex Therapy Questionnaire at follow-up as compared to his pretreatment scores, the increases were not large (see Figure 4). Arthur had an average score of 3.58 at pretreatment and an average score of 4.50 at the final follow-up

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Insert Figure 4 about here

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session (a score of four represents satisfied with my current behavior or feelings). Improvements of two points from pre-treatment to the 65-week follow-up were obtained on "being able to regain an erection if I lose it during foreplay" and "being able to get an erection sufficient to begin intercourse." Prior to treatment he had avoided being nude with his partner. At the final follow-up, he reported being more than satisfied with his ability to get an erection during foreplay while they were nude.

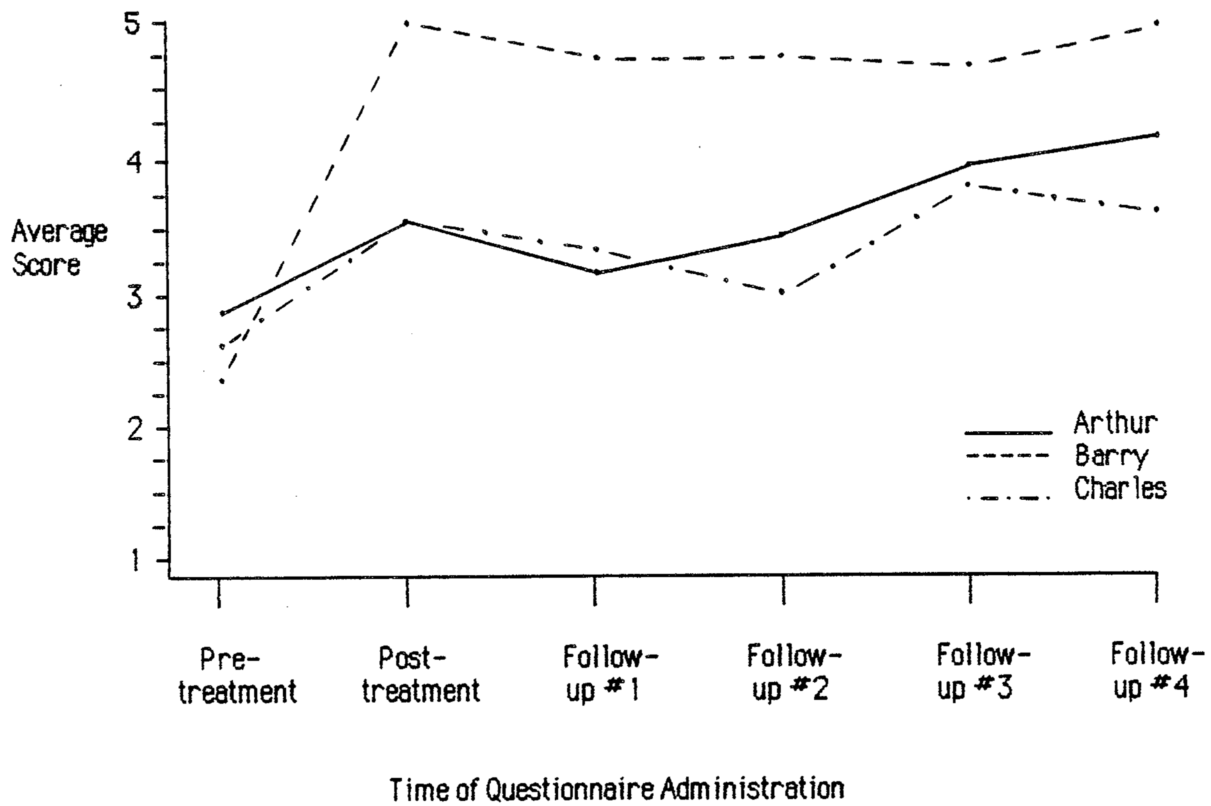

Figure 3: Average Erection Difficulty Questionnaire scores for the three clients. A rating of "5" is desirable and a rating of "1" is undesirable.

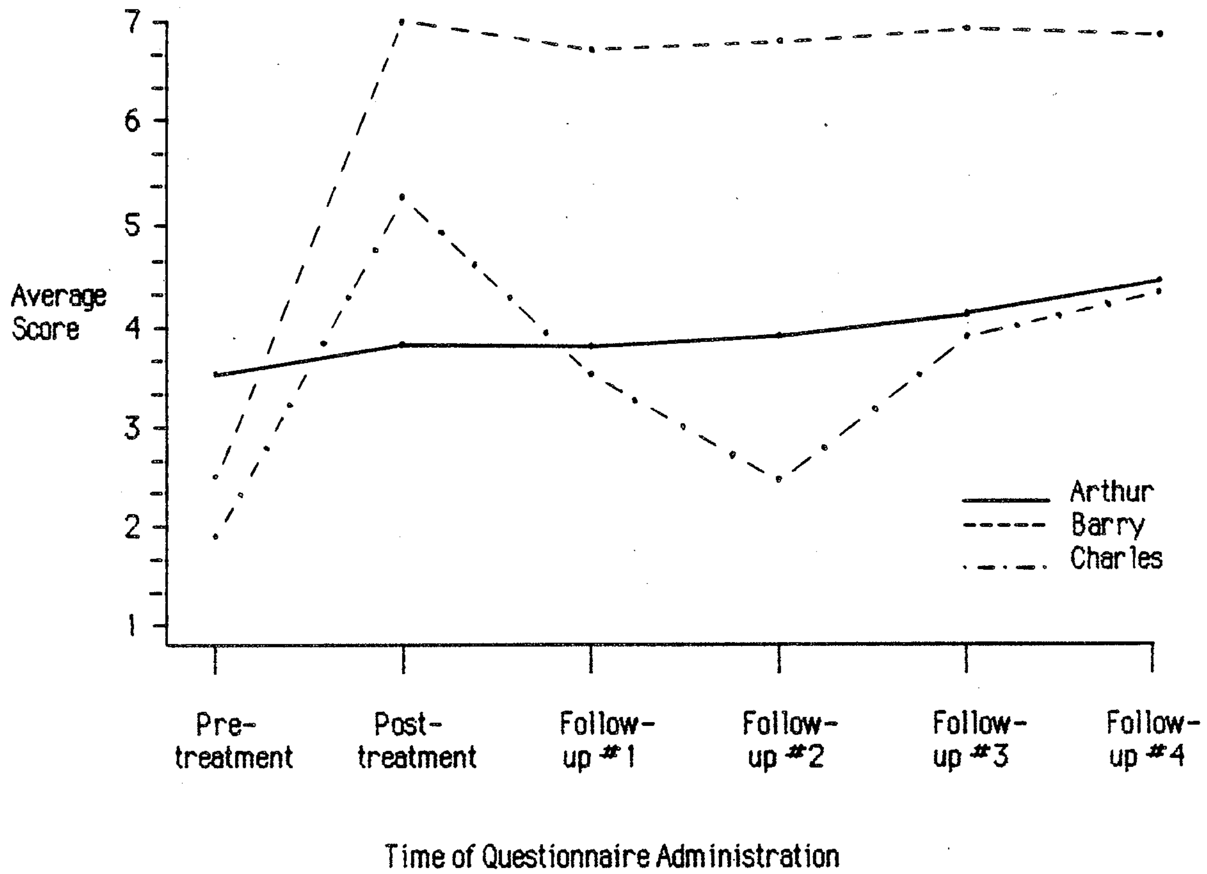

Figure 4: Average Goals for Sex Therapy scores for the three clients. A rating of "7" is desirable and a rating of "1" is undesirable.

All of Arthur's ISS scores were well within the satisfied range. His score at the final follow-up period his score was one standard deviation closer to the completely satisfied end of the continuum than at pretreatment(see Figure 5). He reported improvement of two points on the item, "I enjoy the sex techniques that my partner likes or uses."

Insert Figure 5 about here

On the Culture-Free Self-Esteem Inventory, Arthur's score changed from the 34th. percentile at pretreatment to the 75th. percentile at the 65-week follow-up (see Appendix Y). Significant increases were obtained in social, personal and general self-esteem (54th. vs. 88th., 80th. vs. 100th., and 23rd. vs. 61st. percentile, respectively). Contrary to his responses at pretreatment, at posttreatment he reported feeling that he is as nice looking as most people, that he is not usually tense or anxious, is not easily depressed, is not lacking in self-confidence, does not have only a few friends, and does not find it difficult to express his views or feelings. His responses on the lie items indicate that he was not responding in a socially desirable manner.

A temporary deterioration in dyadic adjustment was obtained on the Dyadic Adjustment Scale (see Appendix Y). At pretreatment his score was 104, dropped to a low of 91 at the 6-week follow-up, and recovered to 102 at the 65-week follow-up. A drop of almost one standard deviation in dyadic satisfaction was obtained from pretreatment to the final follow-up period. By the 65-week follow-up, Arthur reported spending more time with his partner, confiding in his partner more often, engaging in outside interests to a greater extent with his partner, and working with his partner

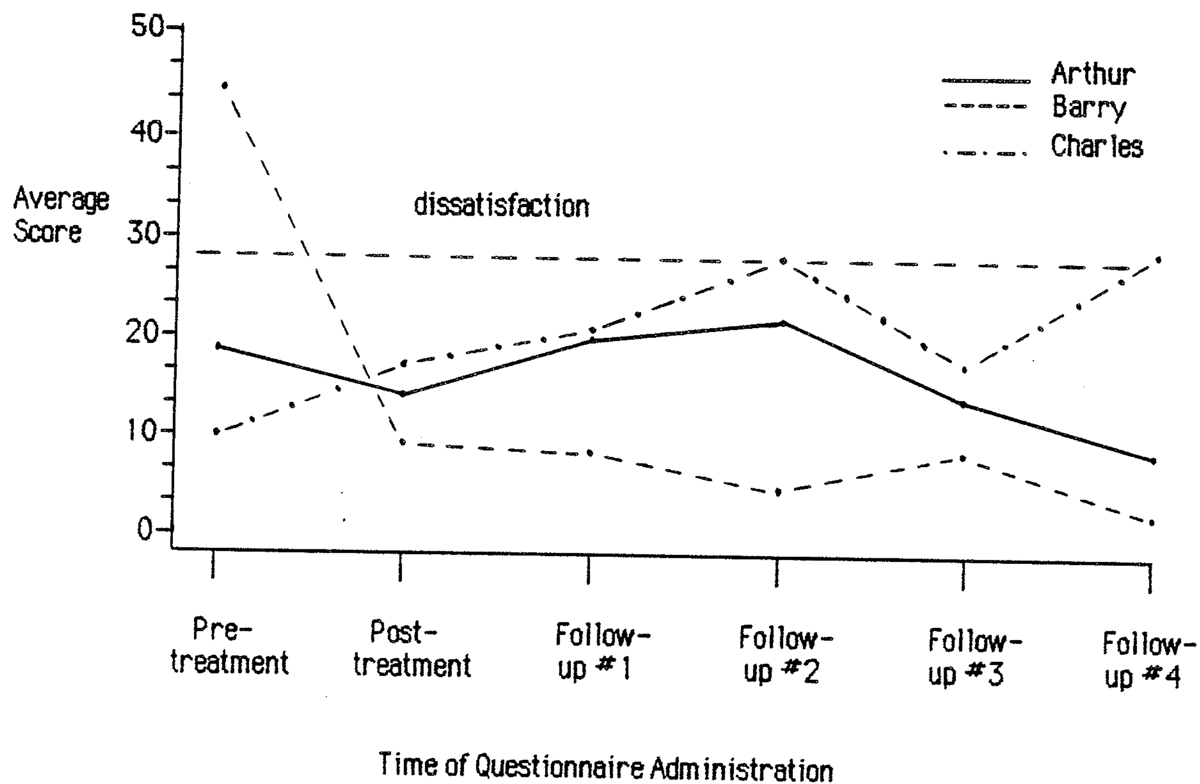

Figure 5: Index of Sexual Satisfaction scores for the three clients. Scores of 28 or more represent dissatisfaction with the sexual relationship.

more often on a project. He reported an increase in the number of quarrels, getting on each other's nerves more frequently, and occasionally considering terminating the relationship whereas at pretreatment this was not the case.

On the Marriage and Sexual Relationship Questionnaire, Arthur was consistently in the normal range, indicating that he is not defensive concerning his general relationship and sexual relationship with his partner. Thus, it is implied that he tends to report honestly on all the questionnaires. Appendix X contains a detailed presentation of Arthur's questionnaire data.

As of the final follow-up period, Arthur has been in a steady relationship with his partner for almost two years. They are now engaging in intercourse on a regular basis and he is satisfied with his ability to obtain and maintain erections in intercourse. He reports being able to communicate with his partner regarding sex, something he was unable to do prior to treatment. His self-esteem has also improved significantly. His masturbatory erections are not as firm as his erections in partner sex, but this does not concern him. He would, however, like to improve his ejaculatory control.

<u>Barry</u>

Barry is a 53-year-old welder. He sought treatment after experiencing erectile difficulties with a partner that he had been seeing for seven months. He began a sexual relationship with this woman since his wife had not consented to sexual activity with him, nor to even discuss the issue, in two years ("partner" will refer to his extra-marital partner and the questionnaires were completed on the basis of his relationship with her). Due to the nature of his relationship with his partner, and Barry's determination to overcome his erectile difficulties without her input, his partner did not attend treatment sessions.

In the first assessment session, Barry reported having difficulty obtaining and maintaining erections in partner sex. In five sexual experiences with his partner, he only obtained erections on three occasions, and these erections were semi-firm. All three semi-erections were lost upon attempting intercourse. He had decided not to attempt intercourse with his partner until his erectile problem was resolved.

Barry had not had intercourse with his wife in two years, and only had intercourse a few times in the past five years. His erections were less than completely firm the last few times he engaged in intercourse with his wife.

Barry had extreme difficulty obtaining masturbatory erections and consistently was unable to maintain them. He no longer had nocturnal emissions or morning erections, and was experiencing fewer spontaneous erections than was the case a couple of years earlier. A urological examination failed to reveal any organic cause of his erectile dysfunction.

By the end of the assessment period, Barry had achieved two morning erections and became semi-erect on two occasions when kissing his partner. He had become semi-erect petting with his wife on four occasions, eventhough she was not active in these sessions.

By posttreatment, Barry had broken the ban on intercourse and had successfully engaged in intercourse with his partner with a firm erection. He was regularly experiencing morning erections, nocturnal erections, spontaneous erections and was obtaining and maintaining firm masturbatory erections. He no longer had difficulty obtaining firm erections under any circumstances.

By the 6-week follow-up, his erectile functioning was still very satisfactory, and he had successfully engaged in intercourse with his wife three times. At the 13-week follow-up, he reported having successfully

engaged in intercourse once with his wife and twice with his partner since the previous follow-up session. At the 24-week follow-up, his erections were still firm. His wife was no longer engaging in sex with him, and he and his partner were having difficulty finding time and privacy to engage in sex. His masturbatory erections were still fine.

At the 65-week follow-up, Barry reported a significant deterioration in his erectile functioning which developed a couple of months earlier. This deterioration corresponded to the development of a life-threatening aneurysm. Surgical implantation of a synthetic artery saved his life and fully restored his erectile functioning. He then developed an ulcer, and began experiencing slightly softer erections. His physician believes the ulcer medication accounts for this situation. Nevertheless, he is still very happy with his erectile functioning with his partner and his masturbatory erections are also satisfactory. He explained that he is not masturbating very often now due to having regular sexual relations with his partner.

His improved erectle functioning with his partner and wife is reflected in the Sexual Activity Checklist data, displayed in Figures 6 and 7. Following a short but level baseline with his partner, he quickly experienced improved erectile functioning when petting early in the

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Insert Figures 6 and 7 about here

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course of treatment. These improvements were maintained, even once intercourse was initiated. His erectile functioning improved during assessment with his wife. This sexual contact consisted of caressing her breasts and genitals before going to sleep. The erections improved steadily and were firm even once his wife reluctantly consented to intercourse.

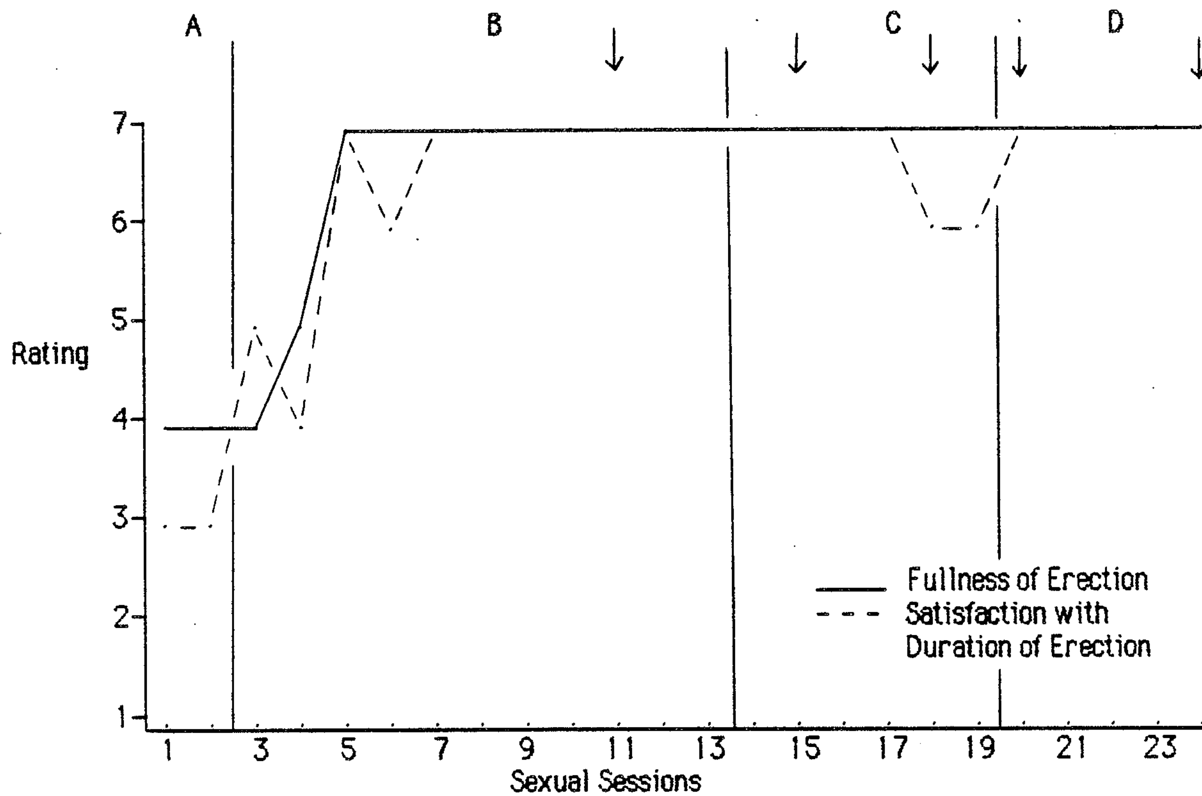

Figure 6: Barry's Sexual Activity Checklist (SAC) data pertaining to sex with his partner. A rating of "7" represents a full erection or being very satisfied with the duration of the erection. A,B, and C correspond to the assessment period, the treatment period, and the period following posttreatment. D, E, F, and G correspond to the periods following the first, second, third and final follow-ups.

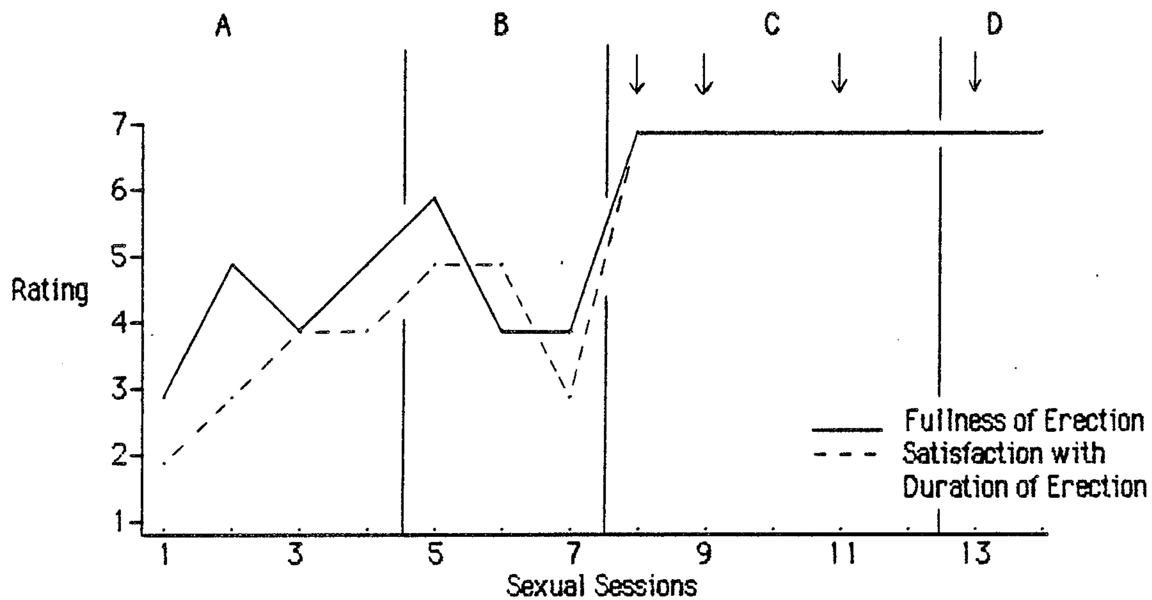

Figure 7: Barry's Sexual Activity Checklist (SAC) data pertaining to sex with his wife. A rating of "7" represents a full erection or being very satisfied with the duration of the erection. A,B, and C correspond to the assessment period, the treatment period, and the period following posttreatment. D corresponds to the period following the first follow-up.

Figure 2 illustrates a steady improvement in masturbatory erections throughout treatment.

Barry's scores on the Erection Difficulty Questionnaire reflect his significant improvement in erectile functioning (see Figure 3). From a low pretreatment level, he achieved a very high posttreatment level which was essentially maintained. These changes indicate better erectile functioning (i.e., more erections in more situations, not losing erections at the point of intercourse, and erections lasting longer in intercourse). He reported less worry, humiliation, avoidance, dissatisfaction, anger, and resentment regarding sex. He was experiencing less guilt regarding his partner's satisfaction or lack there of. He reported more enjoyment concerning sex and more knowledge regarding instilling improvements in his sexual functioning.

Figure 4 illustrates a marked improvement in erectile functioning as reflected by the Goals for Sex Therapy questionniare. Barry's average score on the Goals for Sex Therapy questionniare increased from 2.46 at pretreatment to 6.86 at the 65-week follow-up period (a score of three represents <u>somewhat less than satisfied</u> and a score of seven represents <u>much more than satisfied</u>). He reported improvement in erectile functioning in several situations, feeling more comfortable with his sexuality, less anxiety regarding intercourse, and a less rigid attitude toward the role of intercourse in a sexual relationship.

His Index of Sexual Satisfaction score also improved sharply at posttreatment and was maintained (see Figure 5). Barry's score of 44 at pretreatment on the Index of Sexual Satisfaction indicates dissatisfaction with his sexual relationship. At the 65-week follow-up, his score was

three (over three standard deviations below his pretreatment score) which is well within the satisfied range.

Barry's pretreatment score at the 83rd. percentile on the Culture-Free Self-Esteem Inventory rose to the 97th. percentile by the 65-week follow-up (see Appendix Y). His general and personal self-esteem increased over this period of time (from the 71st. to the 97th. and from the 90th. to the 100th. percentile, respectively). Contrary to his responses at pretreatment, at the final follow-up he reported feeling that he can do things as well as others, feeling that he is as nice looking as most people, and that he is at least as happy as most people appear to be. His responses on the lie items suggest that Barry responds in a socially desirable manner.

Barry's score on the Dyadic Adjustment Scale changed from being 1 1/2 standard deviations below the mean for married respondents at pretreatment to 1 standard deviation above the mean at the 65-week follow-up (see Appendix Y). The greatest increases took place on the dyadic consensus and dyadic cohesion scales. At the final follow-up, Barry reported an increased frequency in working on projects with his partner, kissing his mate, laughing together, and calmly discussing something with his partner.

Concerning the Marriage and Sexual Relationship Questionnaire, Barry was consistently in the extremely defensive range on the Marital Attitudes Scale and in the extremely defensive range, or within one point of it, on the Sexual Attitudes Scale (see Appendix Y). This may indicate that Barry responds in a socially desirable manner, but alternative explanations will be considered below. Appendix Z contains a detailed presentation of Barry's questionnaire data.

As of the 65-week follow-up, Barry was successfully obtaining and maintaining erections with his partner. He had succesfully engaged in intercourse with his wife on a few occasions, but once again she has refused to engage in sex. He is now obtaining and maintaining firm erections in masturbation. Although he reported improvements in his relationship with his partner, they had no plans to terminate their respective marriages.

Charles

Charles is a 54-year-old livestock attendant. He had been in a steady relationship for five months with a woman, but there was little commitment on the part of his partner. Charles believed that the future of the relationship depended upon him improving his erectile functioning. The lack of commitment was the main reason for his partner not attending treatment sessions.

In the first assessment session Charles reported difficulty obtaining and maintaining erections with his partner. Of nine attempts at intercourse, he was able to penetrate his partner on only three occasions. On all three occasions he quickly lost his erections shortly after penetration. During the assessment period, he attempted intercourse once. He failed to penetrate his partner due to his penis being too flaccid. He sometimes obtained full erections with his partner, but only when they would definitely not be attempting intercourse (e.g., when they are in his car). Charles had not had a satisfactory sexual experience with his partner. Charles' difficulty obtaining and maintaining erections began prior to his wife's death five years earlier.

Charles also reported having difficulty maintaining, and occasionally obtaining erections in masturbation. This problem had developed over the previous year. Charles had not had a morning erection in six months.

During assessment, Charles reported having heart problems and being on medication for these problems. His doctor reported that he had an irregular pulse. Blood was clotting in the chambers of his heart and would later be discharged. Charles' physician said these problems would not affect blood flow in his arteries or his erectile functioning. A urological examination failed to reveal any organic cause of his erectile problems.

Between the last assessment session and the first treatment session, Charles reported experiencing a morning erection and experienced a nocturnal emission for the first time in his life.

By posttreatment, Charles had experienced several morning erections and his masturbatory erections were greatly improved, although they were significantly better when he used erotic movies to enhance arousal. His erectile functioning in partner sex had not improved. His main obstacles were not having much sexual privacy with his partner and being too anxious.

At the nine-week follow-up, Charles reported having experienced a minor stroke. Thus, he had not been sexually active on many occasions since posttreatment. He and his partner had only attempted intercourse once, and for the first time in their sexual relationship, Charles maintained an erection until he ejaculated. However, he ejaculated rapidly upon entry and was not satisfied with his sexually functioning on this occasion (this occasion is not recorded on his SAC data).

At 14-weeks, his masturbatory erections were still firm and satisfactory when he used erotic movies for arousal. He and his partner had

decided to be sexually intimate less often since they were discouraged by sexual failure.

At 27-weeks, Charles reported that he was waking up with firm erections on approximately 75% of the mornings. His masturbatory erections were still firm and were being maintained, although he was masturbating less often. His erectile functioning in partner sex had not improved.

As of the 63-week follow-up, Charles was getting firm masturbatory erections on approximately 50% of occasions, and semi-firm masturbatory erections the rest of the time. He was not satisfied with the duration of his masturbatory erections. He was still getting firm morning erections on a regular basis. In partner sex, he would get firm or semi-firm erections with his partner. He typically loses the erections while petting or upon attempting intercourse. Although he enjoys petting with his partner, he is rather disappointed that they are not successfully engaging in intercourse. The circumstances underwhich they have sex are still not conducive to a good sexual relationship (e.g., they are never able to spend the night together). Their relationship is going well and his partner is going to maintain the relationship even if his erectile functioning does not improve.

At assessment, Charles' primary difficulties appeared to be his high level of anxiety concerning sex and problems obtaining privacy and appropriate settings to engage in sex. Charles still experiences the problem of having few opportunities to be fully sexual with his partner. He still experiences extreme anticipatory anxiety concerning sex with his partner since he did not complete any of the non-demand sensual/sexual assignments which might have reduced this anxiety.

Although the Sexual Activity Checklist data pertaining to sex with his partner demonstrates improved erections toward the end of treatment and early in the follow-up period, he was still unable to successfully complete intercourse at this time (see figure 8). Figure 2 reflects his report that the firmness of his masturbatory erections improved greatly, but these erections were not always maintained for as long as he would have liked.

Insert Figure 8 about here

Charles displayed an increase in his score on the Erection Difficulty Questionniare from pretreatment to follow-up (see Figure 3). These changes indicate that Charles was getting erections in more situations, was more likely to attempt intercourse when engaging in sexual activity, and his erections in sexual activity were lasting longer. He reported less humiliation, anger, resentment and worry regarding sex, and reported more knowledge regarding instilling improvements in his sexual functioning. By the final follow-up, Charles reported a significant deterioration on one item, "If I (would) have difficulty getting or keeping an erection during sex, I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need." At pretreament his response was mostly false but at the final follow-up it was completely true.

On the Goals for Sex Therapy questionnaire, Charles' average scores fluctuated greatly but increased from pretreatment to the 63-week follow-up (see Figure 4). He indicated increased ability to regain an erection if he were to lose it during foreplay, being able to keep an erection during intercourse until ejaculation, to enjoy a sexual encounter without having intercourse or becoming anxious thinking about intercourse, to anticipate a

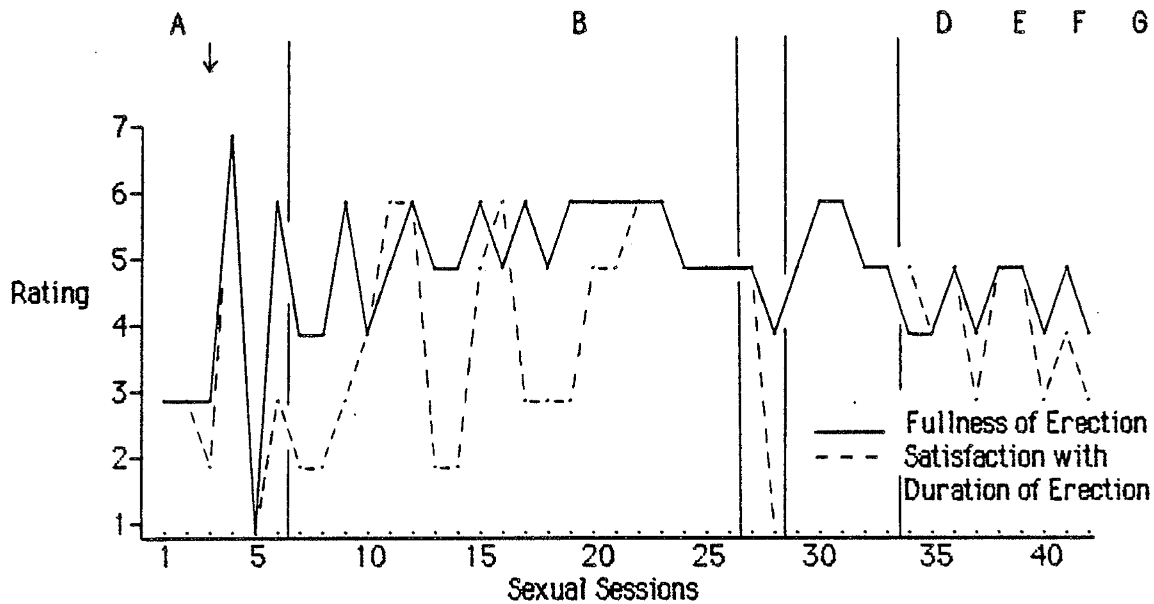

Figure 8: Charles' Sexual Activity Checklist (SAC) data pertaining to sex with his partner. A rating of "7" represents a full erection or being very satisfied with the duration of the erection. A,B, and C correspond to the assessment period, the treatment period, and the period following posttreatment. D, E, F, and G correspond to the periods following the first, second, third and final follow-ups.

sexual encounter without feeling pressured to have intercourse, to get an erection during foreplay while nude or clothed, to obtain an erection in masturbation, and to stimulate his partner to orgasm. By the final follow-up, however, he reported feeling less sexually desirable to his partner than was the case at pretreatment.

Charles' Index of Sexual Satisfaction score at pretreatment was well within the satisfied range (see Figure 5). His scores fluctuated but generally moved in the direction of less satisfaction throughout posttreatment and the follow-up periods. By the 63-week follow-up, he scored in the dissatisfied range. He reported improvements on two items by the final follow-up ("I feel that my sex life is lacking in quality" and "I feel that I should have sex more often"). He reported a significant deterioration on nine items (see Appendix AA). Four of the items are best categorized as general satisfaction, three concern characteristics of his partner, and two concern the circumstances under which sex takes place.

Charles' pretreatment percentile score on the Culture-Free Self-Esteem Inventory of 97 was obtained at the 63-week follow-up, but declined between these periods (see Appendix Y). Contrary to his response at pretreatment, his subsequent responses indicated that he feels he is usually successful when he attempts important tasks or assignments. He reported significant deterioration on five items, four of which were lie items. In addition, at the 63-week follow-up he reported usually being tense or anxious. Although at pretreatment he did not appear to be responding in a socially desirable manner (i.e., he only endorsed two of the eight lie items), his posttreatment and follow-up responses on the lie items were more frequent (five, five, five, four, and six of eight items).

Charles' pretreatment score on the Dyadic Adjustment Scale was over one standard deviation above the mean for married respondents (see Appendix Y). Although most of his subsequent scores declined, his score at the 63-week follow-up was close to one standard deviation above the mean for married respondents. At the final follow-up, Charles reported an increase in the frequency of calmly discussing something with his partner and laughing with her. Charles reported a significant increase in the frequency with which he has considered terminating the relationship.

Charles' scores on the Marital Attitudes Scale of the Marriage and Sexual Relationship Questionniare were always within the extremely defensive range. On the Sexual Attitudes Scale, his scores were consistently in the moderately defensive range. This may indicate that he was responding in a socially desirable manner, but alternative explanations will be discussed below. Appendix AA contains a detailed presentation of Charles' questionniare data.

As of the 63-week follow-up, Charles was enjoying petting with his partner, but had not significantly improved his erectile functioning in intercourse, nor significantly improved in terms of his adequacy and comfort with heterosexual relations. He thought he might seek further treatment once his partner could participate in the sessions, and once they obtain more privacy for sex.

Combined Results

As noted above, two of the three clients (Arthur and Barry) demonstrated significant improvement in their erectile functioning in partner sex. These clients are now satisfied with their ability to obtain and maintain erections. One of these clients (Barry) is fully satisfied with his sexual expression in partner sex, while the other (Arthur) is experiencing

poor ejaculatory control. The third client (Charles) demonstrated some minor improvement in his erectile functioning in partner sex, but is still generally dissatisfied since he has not successfully engaged in intercourse with his partner.

Two of the three clients (Barry and Charles) demonstrated significant improvements in masturbatory erectile functioning. They were satisfied with their erections at termination, and the client (Arthur) who failed to exhibit significant improvement was functioning reasonably well at pretreatment and was never very concerned about his erections in masturbation. Thus, all of the clients demonstrated significantly improved erectile functioning in either partner sex or masturbation, with one client (Barry) improving in both areas.

On the Erection Difficulty Questionnaire, all three clients reported significant improvement in terms of not feeling humiliated if they were to experience erection problems again, not feeling anger or resentment if they were to experience erectile problems, and knowing how they could help themselves if they were to experience erection problems again. Whereas they responded _mostly true_ or _completely true_ to the item, "my erection problem makes me feel like less of a man" at pretreament, they all endorsed the response _completely false_ at the final follow-up.

On the Goals for Sex Therapy Questionnaire, all the men reported significant improvement in being able to get an erection during foreplay while nude with a partner, and an improved ability to engage in intercourse for as long as desired without ejaculating.

On the Erection Difficulty Questionnaire, two of the three men reported less worry regarding what their partner may think of their performance, whether or not they will get or keep an erection, and concerning the

possibility of not regaining an erection if it were lost. Two of the men reported significant improvement in their ability to remain erect long enough in intercourse until they ejaculate, and reported greater satisfaction with their sexual functioning. The two clients who responded mostly true to the item, "I do not (would not) get an erection during any type of sexual activity (e.g., intercourse, masturbation, oral sex, etc.)" endorsed completely false at the final follow-up.

On the Goals for Sex Therapy Questionnaire, two of the men reported significant improvement in their ability to get masturbatory erections, obtain erections during foreplay with a woman while clothed, regain an erection if it is lost during foreplay, and maintain an erection during intercourse until ejaculation. Two of the men also reported improvement in being able to anticipate intercourse without fear or anxiety, being able to anticipate a sexual encounter without feeling they should have intercourse, and being able to enjoy a sexual encounter without having intercourse.

On the Index of Sexual Satisfaction two of the three men reported significant improvement on the item "I feel that my sex life is lacking in quality." On the Culture-Free Self-Esteem Inventory, two of the men changed their response from pretreatment on the item, "Are you as nice looking as most people?" to the response yes at the final follow-up. On the Dyadic Adjustment Scale, two clients reported a significant increase in the frequency of laughing with their partner and calmly discussing something with them. On the sexual attitudes scale of the Marriage and Sexual Relationship Questionnaire, two of the men reported that they sometimes push their mate to have sex more often than she wants. This was considered to be the most realistic response.

Two clients demonstrated deterioration on three items, two of which were lie items on the Culture-Free Self-Esteem Inventory. Whereas all the men reported never having considered terminating their relationship at pretreatment on the Dyadic Adjustment Scale, two of the men reported occasionally considering this prospect at the final follow-up.

Compliance with Homework Assignments

Therapists working in the area of sexual dysfunction have long realized that clients who do their homework assignments improve and clients who do not do work on their dysfunction between therapy sessions demonstrate less improvement, or none at all. In the present study this trend was supported. Clients were considered to have completed their homework assignments provided they attempted and appeared to have made a sincere effort to carry out the assignment. The client who showed the least improvement in sexual functioning in partner sex had the lowest compliance rate (85% for Charles). Further, the homework assignment thought to be crucial for improving his erectile functioning with his partner (nonsimultaneous body-rubs) was never completed although it was assigned on several occasions. The two clients who obtained the greatest improvements in their sexual functioning in partner sex (Arthur and Barry) had the highest compliance rates (94% and 96%, respectively). Further, Barry completed four written/conceptual assignments and two sensual/sexual assignments that were not assigned. He read descriptions of these assignments in Zilbergeld (1978) and decided to try them.

Consumer Evaluation of Treatment

When the results of the two forms of consumer evaluation of treatment are combined, two interventions emerge as being rated most effective and two are rated as least effective. The presentation on the importance of

relaxation and the therapist-guided relaxation exercise were very popular. The presentation on the conditions required for good sex was also highly rated.

One of the least effective interventions, as rated by the clients, was asking the partner to read Zilbergeld (1978). It should be noted that this assignment was that which most visibly drew the client's partner into the treatment process--something which the clients and/or their partners did not want. Furthermore, the two partners who were asked to read Zilbergeld (1978) rarely did so, although they initially expressed enthusiasm. It should be noted that one of the two clients rated this highly but slightly less so than the other interventions.

The partial ban on intercourse was also rated as less effective, contrary to the therapist's expectation that the clients would welcome the ban in order to sanction and legitimize them not engaging in a behavior which led to humiliation. The clients may have sincerely preferred most other interventions, or may have been attempting to keep up appearances as virile men who love having intercourse at any time. It should be noted that their devaluation for this intervention is a comparative devaluation. Two of the clients (Arthur and Barry) never rated this intervention lower than three on the five-point scale (three represents <u>moderately helpful</u>).

Takefman and Brender (1984) found that a ban on intercourse did not add to the effectiveness of encouraging sexual communication between partners, and thus, likely did not contribute to therapeutic change in their study. However, in the present study the therapist felt that the ban was effective in helping the clients to see that a good sexual relationship involves more than an erection. Further, the long-recognized advantage of the ban of alleviating anxiety concerning sex was thought to play an

important role in the improvements in partner sex on the part of two clients. The third client's reluctance to do the non-demand exercises which were assigned can be viewed as non-compliance with the intent of the ban on intercourse.

Discussion

Therapeutic Effects of Assessment

Some improvements were achieved in the sexual functioning of the two older men during the assessment period. Barry experienced his first morning erection in a couple of years, and obtained a second one before treatment began. During the assessment period, Charles experienced his first morning erection in six months and the first nocturnal emission of his life. Thus, it appears that assessment had a limited therapeutic effect, likely due to the clients lowering their level of anxiety by talking about their difficulties, and by getting implicit direction (and in some cases, explicit direction) from the therapist. Although it is desirable to have a steady baseline during pretreatment, it is important to provide the clients with encouragement and positive expectations. Clients have often been experiencing erection problems for years and may have been seeking intervention for several months prior to obtaining a therapist. Withholding encouragement and direction in all cases could lead to some clients dropping out of treatment, decrease a client's prospects for improvement, and/or leave the clients suffering longer than necessary.

Component Effectiveness

It is difficult to point to a few components as being key components in the psychoeducational treatment protocol. All of the components were intended to contribute to a few processes--reducing anxiety, increasing knowledge of sexuality, boosting confidence and changing attitudes which

may have interfered with their sexual functioning. It is not possible to classify the treatment components according to their effect on the men. For example, the discussion of the myths of male sexuality was intended to decrease anxiety by shattering unrealistic expectations that the men may have held, to increase knowledge by replacing the myths with accurate information, to boost confidence by showing the men that an erection is an adjunct to a good sexual relationship and not a requirement, and to change attitudes by replacing the myths with realistic guidelines to sexuality. Each component of treatment was delivered with the underlying themes that enjoyment is more important than performance and that people should do as they like in sexual activity rather than following learned sexual scripts.

Finally, separating anxiety reduction, knowledge, confidence, and attitude change would be exceedingly difficult. Future studies which conduct a component analysis would not be able to separate these aspects, but could examine the effects of homework assignments, information which could be imparted through readings, and attitude change initiated in treatment sessions. Nevertheless, three assessment sessions and ten treatment sessions is not a lengthy treatment protocol and does not likely need to be condensed.

Obstacles to Improvement

An important obstacle to improvement in erectile functioning for the three men was difficulty securing privacy for sexual activity. One aspect of treatment helped the men explore their options and consider their priorities (e.g., Charles decided that keeping knowledge of the relationship from the partner's children was more important than having the partner spend a night at his home). Thus, the nature of the relationships limited some aspects of

the treatment and assigned exercises, and may have affected their degree of improvement.

Two factors likely account for Arthur's lack of significant improvement in his masturbatory erections. First, Arthur expressed a very negative view of masturbation during the assessment sessions. By the end of treatment, he still viewed masturbation as an inferior form of sexual activity. He felt that masturbation was a way to relieve his erections and sexual desire, and consistently experienced guilt after masturbating. When his sexual functioning with a partner was inadequate, Arthur could at least partially justify masturbating by thinking that he had to relieve his sexual tension in some manner. Once he was successfully engaging in intercourse with his partner, he would not have been able to use the same means of justification. Secondly, Arthur was satisfied with his semi-firm erections since he was consistently achieving orgasm in masturbation. Because he did not desire to improve his masturbatory erections, he had little motivation to alter his view of masturbation. Arthur was engaging in intercourse frequently with his partner by the end of treatment. On some occasions he would ejaculate in intercourse two or three times within a two-hour period. Thus, he may have had less of a need and desire for masturbation.

Arthur's acceptance of and comfort with masturbation may increase in the future, but may take much time. Arthur was slow to realize that he had to attempt sexual activity with his partner in order to decrease his anticipatory anxiety. Once he acknowledged this fact, he was still very cautious in initiating petting and intercourse. This hesitation was thought to account for his erectile functioning significantly improving during the follow-up period rather that during treatment. Similarly, it may take a

considerable amount of time for him to realize that self-stimulation is as natural as partner sex.

Charles' lack of improvement in partner sex was thought to be due to the anxiety he was experiencing. He did not complete the nondemand homework assignments and did not follow the therapist's advice of simply spending time while naked with his partner rather than feeling pressured to attempt intercourse. It is hoped that the possible future involvement of his partner in treatment may lead to them engaging in nondemand sexual activity. Further, as his partner's children move away from home, the couple will have more opportunities and privacy for sexual activity.

Another possible reason for Charles' lack of improvement is that the psychoeducational program may not have been appropriate for someone of his intellectual functioning--Charles was the least educated and likely the least intelligent of the clients. One of the key components of the psychoeducational program is the educational component. The men are expected to read one book on male sexuality (Zilbergeld, 1978) and to read a few handouts. The sessions revolve around didactic presentations and discussions based on reading materials and information provided by the therapist. Further, the men were asked to complete a few written/conceptual assignments. Even the sensual/sexual assignments have a rationale which might be best understood by the more intelligent and better educated clients. Charles indicated that he had poor writing skills and would not do written assignments. Thus, the therapist helped him do the written assignments during treatment sessions. The therapist also geared the presentation of information and discussions to his cognitive level. Nevertheless, these modifications of the format of treatment may not have been sufficient. The entire nature of the educational component of

the program may have been intimidating to him or simply less effective. Future studies should systematically examine the differiential effect of the psychoeducational program on men of different intellectual abilities.

Difficulties with the Treatment of Men whose Partners do not Participate in Therapy

There are various reasons why the female partner may not participate in treatment. The man may view the erectile dysfunction as being soley his problem, or the woman may feel that she plays no role in the dysfunction or its alleviation. Hostility between partners may inhibit the co-operation and collaboration that is necessary in treatment, or prevent agreement as to whether treatment is warranted. In the present study, several other reasons were given by the men for not directly including their partner in treatment. Arthur was able to conceal his sexual problems from his partner and was not willing to disclose his secret by asking her to participate in treatment. Barry's primary sexual partner was not his wife, and he feared that the affair would be discovered if his partner accompanied him to the treatment centre. He also indicated feeling that the problem was soley his own, and feeling uncomfortable with the prospect of having his partner participate in treatment. Charles did not feel it would have been appropriate for his partner to attend treatment sessions since his partner's participation would have implied more commitment to the relationship than was present. Further, his partner did not live in the city in which treatment was obtained and attending sessions would have been inconvenient for her.

There are several advantages to treating couples rather than individuals. When couples are treated, the therapist can directly observe and assess the female's contribution to the dysfunction and capacity to facilitate treatment. The partner can express her opinions and concerns

directly to the therapist in the couple format, being a valuable source of information or corroboration. When the man is seen alone, his report of his partner may be biased, inaccurate and/or incomplete. In couples therapy, the partner can often be used to carry the responsibility for an intervention in cases where the therapist would be ineffective (e.g., the man discounts the therapist's views due to perceived liberalness) or uninvolved (e.g., the woman can initiate sexual exercises if the man is unlikely to do so). On-going discussion of information and attitudes concerning sexuality between the partners can be an important component of intervention. If only the man attends treatment sessions, the woman may never be drawn into discussions, or may feel that she has less to contribute to discussions than her partner. Confusion on the part of the partner concerning the nature of sexual dysfunction treatment may not be adequately clarified by the man. This confusion could lead to increasing her discomfort with their sexual relationship, thereby compounding the sexual problems the couple are experiencing. Finally, co-operating in overcoming a sexual problem can be a rewarding and relationship-enhancing experience for a couple. When only one partner participates in treatment, these benefits are not likely achieved.

In cases in which there appears to be significant discord in the relationship, the therapist may encounter many difficulties in trying to improve the sexual relationship. Further, the therapist could potentially be used by the client to hurt his partner (e.g., the client may misinterpret one of the therapist's statements and use it against his partner). Therapists would be wise not to treat men individually where there appears to be signficant problems in the relationship.

Strengths and Weaknesses of the Measures

Some of the measures were more sensitive to changes in erectile functioning than others. As was hoped, the Sexual Activity Checklist (SAC) data closely corresponded to the men's self-reports of their erectile functioning, and has the advantage of being quantifiable. Although each client reported partner sex sessions which went well but were not included in the SAC recordings, the data was assessed to be generally representative of the men's verbal report. Two drawbacks of this measure are the inconvenience of completing the SAC daily and the fact that therapy should discourage self-monitoring of erectile functioning. The former problem was countered by employing periodic use of the checklist during the lengthy follow-up period. The latter limitation was handled by acknowledging the contradiction to the men and explaining the reasons for using the checklist.

The Erection Difficulty Questionnaire and Goals for Sex Therapy Questionnaire contain many specific questions which inquire about various aspects of erectile functioning. Although plotting average scores gave a fairly accurate indication of the men's degree of improvement in their erectile functioning, averaging across questions leads to the loss of much important information. Thus, each question should also be examined individually on these questionnaires (see Appendices X, Z, and AA).

In contrast to the above measures, the Index of Sexual Satisfaction (ISS) requires general evaluative responses, rather than simply providing specific data. This may account for the fact that two clients obtained scores in the satisfied range at pretreatment. Although they were very unhappy with their erectile functioning with their partner, the fact that they were in new sexual relationships with partners for whom they cared may have influenced their evaluative responses. That is, these clients may

have been generally satisfied with the sexual relationship according to the ISS since they enjoyed being nude with their new partner regardless of the state of their penis. In contrast, the client who was initially dissatisfied (Barry) on the ISS likely generalized his dissatisfaction with his erections to the entire sexual relationship. This speculation receives support from the fact that his DAS score was also very low at this time. Thus, whereas individual questions on the ISS were sources of useful information, overall scores were not very meaningful.

Culture-Free Self-Esteem Inventory (SEI) scores closely reflected improved erectile functioning for Arthur and Barry. Charles' SEI scores fluctuated greatly whereas his erectile functioning did not.

The two older clients (Barry and Charles) consistently responded in a socially desirable manner according to the lie items on the SEI. Although it is possible that they were not being fully honest, the therapist felt that their responses were consistent with the way they tend to view things. Throughout the course of the program, they displayed a dichotomous view of life. They tended to think in terms of good people, such as themselves, as always doing good, and vice versa. Thus, their failure to endorse items such as "Do you ever lie?" and "Have you ever taken anything that did not belong to you?" was not surprising. Possibly as a result of their dichotomous thinking, their overall self-esteem scores appeared to have been elevated (often being at the 97th. percentile). Other measures of self-esteem may be as effective as the SEI, or even more so.

Changes on the Dyadic Adjustment Scale (DAS) did not accompany improved erectile functioning in two of the clients. Further, each client experienced a significant drop in their DAS scores at some point throughout the program. However, interviews revealed that the scores were likely

affected by non-sexual issues in the relationship more so than by sexual stresses and successes. The one exception to this would be the observation that Barry's DAS scores improved dramatically after his erectile functioning in partner sex improved. Since the state of the relationship influences many sexual factors (e.g., desire to have sex with the partner, ability to discuss sensitive issues such as sex), a measure of the state of the general relationship such as the DAS can be extremely helpful in delivering treatment.

On the Marriage and Sexual Relationship Questionnaire, Arthur was consistently in the non-defensive range. Barry and Charles scored in the moderately defensive or extremely defensive categories. Although this may reflect defensiveness, it may also be due to their dichotomous way of viewing life and/or the fact that they were both involved in new romantic relationships and were very much in love. Some of the items such as "Our sex life seems a little routine and dull to me at times" and "I have never felt that my spouse lacks anything as a lover" could sincerely be considered to be false and true respectively early in a relationship. It is clear that many of the items are most appropriate for couples who have been in a relationship for some time. Perhaps the greatest surprise is that Arthur scored in the non-defensive range, since his relationship was also of recent origin. However, Arthur tended to be very realistic, almost to the point of being negative. His rational and slightly pessimistic way of viewing most things even tended to take the edge off the euphoria of being in love. Defensiveness scales should be included in future studies but must be interpreted carefully with a special population such as men who have just formed steady relationships.

Weaknesses in the Design of the Study

In employing a natural multiple baseline across people design, it is desirable to have several data points during the assessment period, and to have a level baseline. Although a satisfactory number of data points reflecting sessions of partner sex can easily be obtained with co-habiting couples, sexual relations were more sporadic with the population employed in the present study. Also, the men had difficulty securing privacy for sex, thereby further reducing the number of data points obtained. In terms of masturbation, men may not be masturbating very often for a couple of reasons. Many men are not comfortable with masturbation, or may be discouraged with it due to having difficulty with erections in masturbation. Finally, some men may underreport their frequency of masturbation due to feelings of shame.

One solution to this problem is to extend the length of baseline. However, there are difficulties with delaying treatment in the hope of obtaining more data points. When the men give a report of their erectile problems which correspond to the data obtained (e.g., erections of poor quality in most situations) there is little justification for delaying the onset of treatment. Finally, the men would not seek treatment if they were not experiencing erectile problems, and have little to gain and much to lose by misrepresenting their sexual problems.

In studies of sexual functioning in which both partners participate in treatment, corroborative data concerning erections can be obtained from the women. In the present study it would have been possible to send questionnaires to the partners in order to confirm that the clients were reporting accurately. However, the therapist was certain that all of the men would have strongly objected to this procedure. This problem must be

considered a limitation of working with men who have partners but whose partners do not participate in treatment.

Conclusion

The present study demonstrated the effectiveness of individual psychoeducational treatment of erectile dysfunction in men who have partners but the partners do not participate in treatment. In contrast to the case prior to treatment, two of the three men were successfully engaging in intercourse at the time of the final follow-up. All three men experienced improvement in other areas of their sexual and general functioning.

For the two clients who experienced significant improvement in their erectile functioning with their partners, further improvement can be expected as they become more comfortable with, and experience more success in partner sex. The success they have experienced with their present partners may generalize to future partners as they gain confidence in their sexual abilities.

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Appendix A

Summary of Doug's Treatment

Doug was a 38-year-old part-time social service paraprofessional when he presented for treatment. He had been married for nine years, but was separated from his wife and daughter. He had always experienced occasional erectile failures (usually after consuming alcohol or other drugs), but had never worried about this transient problem.

Doug referred himself to the Sexual Dysfunction Clinic after experiencing erectile difficulties with Jenny, a woman he had been dating for three months. Doug failed to obtain an erection with Jenny on several occasions. On a few occasions when he did obtain erections with her, he became flaccid upon attempting intercourse. He was sexually intimate with her once after initiating contact with the Sexual Dysfunction Clinic, but did not have any sexual contact with her thereafter. He knew by the second treatment session that he would not likely be in a sexual relationship with Jenny. The lack of committment in the relationship was given as the reason for Jenny not attending treatment sessions.

The presenting problem was difficulty achieving and maintaining erections (not life-long, and situational). He had premature ejaculation (four to seven minutes), but this was not a presenting problem. His masturbatory erections have always been normal. He was obtaining full erections upon awakening on a regular basis.

During treatment he had sex with a new regular partner, Bonnie, and did not have any erectile difficulties with her after failing to maintain an erection on one occasion. He was also sexual on a few occasions with a

previous partner with whom he had never experienced erectile difficulties. His erections continued to be fine while with her.

His primary goal for treatment was to be able to successfully engage in intercourse with Jenny. Once he realized their sexual relationship was over, he wanted to come to an understanding as to why he had experienced erectile difficulties with her. He also wanted to improve his ejaculatory control, although he was basically satisfied with it.

His average Goals for Sex Therapy Questionnaire score was 2.8 indicating significant dissatisfaction with his sexual functioning. His Index of Sexual Satisfaction score was 16 indicating general satisfaction with his sexual relationship with Jenny. His Culture-Free Self-Esteem Inventory score was at the 68th. percentile.

Doug's family of origin displayed and communicated very negative views of sexuality. He was severely physically abused by his father, and always felt insecure, alone, "different", effeminate (his fear of being gay caused him to push himself sexually with women to prove the contrary), and had a general feeling of ineffectualness (he feared success since his father would abuse him when Doug experienced success).

The two-month period prior to Christmas had always been a difficult time for Doug. During this period he would remember how terrible Christmas had always been with his family. He often felt effeminate at Christmas since he had to play with his female cousins rather than his male cousins. He also felt that intercourse with Jenny symbolized becoming emotionally involved with her. He felt that he may even have used his erectile problem to avoid becoming emotionally involved with a woman 16 years younger than himself at this inopportune time of year.

Near the end of treatment he reported better communication (concerning general matters as well as sexual matters) and being more relaxed in sex with Bonnie. He attributed these changes to treatment.

Doug attended eight treatment sessions. He had postponed several sessions and therapy was not a high priority since his sexual functioning with his present partners was very good. After cancelling a session to attend a funeral, he did not phone for another appointment. The therapist was unsuccessful in contacting him.

Appendix B

Summary of Ernie's Treatment

Ernie was a 43-year-old sales representative when he presented for treatment. He was referred by his doctor. He had been treated for depression two years earlier (six months of pharmacological and psychological treatment). He had been dating his present partner for nine months. He was divorced from his first wife and was separated from his second. He had one 10-year-old son. His present partner, Dora, did not come in for treatment due to a lack of committment on her part to the relationship. This is in part due to her not wanting to be just another conquest of his. Ernie realized that his erectile problems were psychogenic, but originally wanted a penile prosthesis. He did not follow through with the surgery since his partner was horrified at this prospect.

Ernie had always experienced occasional erectile failure, but had not become distressed by this. He would only get semi-erect when petting with Dora, and on six occasions did not become at all erect. Twice he ejaculated upon entering her. On a couple of occasions when there was no possiblility of having intercourse (e.g., they did not have any birth control available), he became fully erect. He was uncomfortable with having intercourse at his sister's place (where he lived), and was also uncomfortable being sexual at Dora's home due to her children living there and the fact that he was resentful of Dora's husband's wealth. They also had difficulty finding time to be together since both had very busy schedules. They also had little privacy. They were not happy with the form of birth control they were using, condoms. He was now experiencing significant anxiety regarding

intercourse. They dated as teeenagers and Ernie was eventually rejected by his partner. He believed he had a "Madona/Prostitute Complex."

His masturbatory erections were only semi-firm, but he was obtaining full morning erections. He regularly experienced enormous guilt after masturbating, promising himself that he would never masturbate again.

Ernie was a little shy concerning his genitals being seen, even by a lover. He also reported considerable embarrassment when urinating in the washroom when guests in his living room might hear him.

Ernie was born in London, England. His father and mother were 53 and 45, respectivley, when he was born. His father had a severe drinking problem and physically abused his wife, Ernie and most of Ernie's siblings.

After his parents separated, Ernie moved to Canada with his mother and older sister. They often lived in low rental housing and he was exposed to a fair bit of nudity and sex. He developed an exploitive attitude towards woman and sexuality (e.g., a woman means "yes" when she says "no"). He presently lives with his older sister and nephew. His partner is separated and has three children.

Ernie had about a dozen affairs during the course of his first marriage. At this time he failed to erect on a few occasions with extra-marital partners and on two occasions when with prostitutes. He explained this in part by saying that "the challenge is in getting the woman," in reference to his failures with the prostitutes.

His self-concept appeared to be quite good (his Culture-Free Self-Esteem Inventory score was at the 83rd. percentile). His Goals for Sex Therapy Questionnaire score was 3.35 which represents being slightly less than satisfied. His Index of Sexual Satisfaction score indicated satisfaction with the sexual relationship. His Dyadic Adjustment Scale

score was at the mean for married respondents, but his dyadic consensus score was 1 1/2 standard deviations below the mean.

Ernie completed four treatment sessions and then informed the therapist that he no longer had a sexual relationship with his partner. His partner was considering reconciliation with her husband, feared a long-term relationship with Ernie, and worried that he might obtain custody of his son. He did not want to continue treatment.

Ernie found the myths essay, masturbation with focussing, losing and regaining erection (he was impressed with how easy one can lose an erection), and reading Male Sexuality (he recommended the book to a few of his friends) to be the most helpful aspects of treatment. His masturbatory erections improved quickly during the course of therapy and were consistently firm by the time he terminated treatment. He reported enjoying masturbation more and felt that this improvement would carry over to partner sex.

At the six-week follow-up he was dating another woman and had dated his partner a couple of times. He lost his erection prior to intercourse on one occasion, and successfully penetrated his partner but ejaculated rapidly on another occasion. He was getting firm erections on some occasions when petting and was remaining flaccid on other occasions. Thus, his erectile functioning with a partner had not significantly improved as he had expected.

Appendix C

Introductory Script

"I am doing a study concerning a therapy program designed to help men overcome their erectile difficulties, and would like you to be involved in the program. The goals of this program are: 1) to help you develop self-control skills to facilitate the acquisition and maintenance of an erection sufficient to complete heterosexual intercourse; and 2) to enhance your sense of adequacy and comfort with heterosexual relations. In general, this psychoeducation program will deal with you attitudes and expectations about yourself, woman, and sexual situations so that your erections may improve. Treatment will consist of two or three assessment sessions followed by 10 weekly treatment sessions which will deal specifically with the following topics: 1) getting to know one's body; 2) the human sexual response; 3) the myths of male and female sexuality; 4) the conditions necessary to have good sex; 5) anxiety surrounding sexual performance; 6) learning how to communicate with your partner; 7) learning how to relax in sexual situations; 8) learning to be assertive concering your sexual desires; 9) learning to discuss your sexual problems with your partner; 10) sexuality and aging, and 11) techniques that aid in the development of ejaculatory control, and those which help overcome erectile problems. These topics will be explained more precisely as treatment progresses. Once these 10 sessions are completed, we will schedule three more meetings approximately 6, 12 and 24 weeks after our last session. These appointments will give you the opportunity to discuss any progress and/or problems you may have encountered since the program ended. This program does not differ from the treatment you would receive if you were not in a

study program. The only difference is the thorough recording of progress and outcome.

There are a number of activities that you will be asked to engage in, in order for you to participate in this program. Homework asignments will be given out at each session and you will be expected to complete these assignments between sessions and to report on them. These activities will help you overcome your erectile difficulties. You will be requested to complete questionnaires during the assessment period, after the final treatment session, and at each of the three times we meet after treatment. In addition, you will be expected to complete a brief checklist each day which reports on your sexual activities. Any information gathered in the sessions and from the questionnaires will be confidential as to your identity.

If you agree to participate in the program you will be expected to continue in it to the end of treatment, that being the third follow-up meeting 24 weeks following the 10-week program. The time committment involved will be 90 minutes per week, plus the time you take to complete the homework assignments. Do you have any questions?"

Appendix D

Sexual Dysfunction Clinic
University of Manitoba
Winnipeg, Manitoba

STUDY OF ERECTION PROBLEMS

CLIENT CONSENT FORM

CLIENT ______________________________ DATE ________________

1. The procedures to be carried out during this study have been explained to me and I understand this explanation.
2. I understand that I can ask for and obtain any further information concerning the procedure at any time.
3. I am also informed that I am free to withdraw my consent and discontinue participation in the study at any time.
4. I understand that all information gathered and the results of the study will remain confidential with regard to my identity.
5. I hereby agree to participate in the study of erection problems at the Sexual Dysfunction Clinic, carried out by David Jackson.

______________________ ______________________

Signature of Therapist Signature of Client

Appendix E

Treatment of Sexual Dysfunction:
Protocol for Assessment Interviews[1]

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[1] Derek Jehu F.B.Ps.S., Professor and Director, Sexual Dysfunction Clinic, Psychological Service Centre, University of Manitoba, Winnipeg, Manitoba R3T 2N2

INTRODUCTION

1. This protocol is based on the following sources, where more extensive discussion of the topics covered is available:

   (a) Jehu, D. Sexual Dysfunction: A Behavioural Approach to Causation, Assessment, and Treatment. Chichester: Wiley, 1979, pp. 175-193, 211-214.

   (b) Kaplan, H. S. The Evaluation of Sexual Disorders: Psychological and Medical Aspects. New York: Brunner/Mazel, 1983, pp. 13-113, 197-276.

   (c) Lo Piccolo, J., and Lo Piccolo, L. (Eds.) Handbook of Sex Therapy. New York: Plenum, 1978, pp. 85-112.

   (d) Munjack, D. J., and Oziel, L. J. Sexual Medicine and Counselling in Office Practice. Boston: Little, Brown, 1980, pp. 3-24.

2. It is intended that therapists will select and sequence items from this protocol to suit individual clients and their partners, rather than following it in a rigid or chronological fashion.

3. With some couples therapists may find it appropriate to cover the sections on Description of Problem(s) and Personal and Family Backgrounds with both partners together, while the remaining sections are covered with each partner separately.

DESCRIPTION OF PROBLEM(S)

Nature

1. Review relevant responses on:
   (a) Sexual History Form,
   (b) Index of Sexual Satisfaction,
   (c) Sexual Relationship Questionnaire,
   (d) Client Self Monitoring Records,
   (e) Sexual Arousal Inventory (if applicable),
   (f) Erection Difficulty Questionnaire (if applicable).
2. Check whether or not there are any problems in the following aspects of sexual functioning:
   (a) desire
   (b) aversion
   (c) arousal
   (d) orgasm/ejaculation
   (e) satisfaction
   (f) dyspareunia
   (g) vaginismus (females only).
3. Description of problem(s) in sufficient detail to categorize according to Multi-Axial Classification Scheme.

   Frequency

   1. Does problem occur on every sexual encounter or only on certain occasions?

   Timing

   1. At what point in sexual encounters does problem occur?

Surrounding circumstances

1. Does the problem occur in all circumstances or does it vary according to certain conditions?
2. If it varies, what are the relevant conditions?

Duration

1. Has the problem always been present in the client's sexual functioning or was he/she at some time able to perform satisfactorily in that particular aspect of sexual response?

Onset

1. When did problem first begin?
2. Was the onset sudden or gradual?
3. What were the surrounding circumstances in which it first occurred?
4. How satisfactory was the client's relationship with his/her partner prior to the onset of the problem?
5. What other important events were happening in the client's life at the time the problem started (e.g., health, work, family)?
6. How did client react to onset of problem at the time?
7. How did partner react to onset of problem at the time?

Course

1. Has the problem been constant since onset or has it fluctuated?
2. If it has fluctuated, what circumstances seem to have accompanied these variations?
3. How have the client and partner attempted to resolve the problem themselves and with what result?
4. What previous treatment has the client undergone for the problem and what was the progress and outcome?

PERSONAL AND FAMILY BACKGROUND

Client and partner

1. Age.
2. Occupation.
3. Marital status and history.
4. Educational level.
5. Ethnic background.
6. Religion.

Children of client and/or partner

1. Relationship with client and partner (e.g., natural/adoptive/step/foster).
2. Age.
3. Sex.

Parents of client and partner

1. Relationship with client and partner (e.g., natural/adoptive/step/foster).
2. Dead/alive.
3. If dead, age at time.
4. If alive, age now.
5. Occupation.
6. Marital status and history.
7. Educational level.
8. Ethnic background.
9. Religion.

Siblings of client and partner

1. Relationships with client or partner (e.g., natural/ adoptive/step/foster).
2. Dead/Alive.
3. If dead, age at time.
4. If alive, age now.

5. Occupation.

6. Marital status and history.

7. Educational level.

<u>Quality of relationships in the families of origin of the client and partner</u>

1. Quality of informant's relationships with his or her parents:

e.g., (a) description of parents,

(b) were parents emotionally distant, close warm, cold?

(c) was attachment greater to one parent than the other?

(d) how affectionate were parents towards informant?

(e) was affection usually verbal or physical?

(f) was one parent more affectionate than the other?

(g) would informant have liked more, less, or the same amount of affection from parents?

(h) was either parent competitive or in conflict with the informant?

(i) how punitive were parents toward informant?

2. Quality of the relationship between the informant's parents:

e.g., (a) how affectionate were parents toward each other?

(b) was this affection usually verbal or physical?

(c) was one parent more affectionate than the other in their relationship?

(d) did informant get the feeling that his or her parents cared a lot for each other, whether or not they were visibly affectionate?

(e) how much anger, hostility, or conflict was there between the parents?

(f) were these negative feelings usually expressed verbally or physically?

3. Quality of the informant's relationships with siblings:

e.g., (a) how close emotionally was informant to siblings?

(b) how much competition or conflict was there between informant and siblings?

(c) did informant relate better to same-sex or opposite-sex siblings?

Other domiciles

1. Settings other than family of origin in which client or partner lieved prior to age 17 years (e.g., foster home, group home, with grandparents, prolonged period in hospital).

SEXUAL HISTORY

Parental attitudes

1. What were parents' attitudes toward sex as informant grew up?
   (a) toward each other?
   (b) towards informant's emerging sexuality?
2. Did parents impose strongly puritanical religious or cultural standards on the family?

Parental messages

1. What sort of messages about sex did informant receive as he or she grew up (Kaplan, 1983)?

e.g., (a) "sex is not nice",

(b) "sex is wrong",

(c) "sex is sinful",

(d) "your genitals, body, erections, secretions, etc. are disgusting",

(e) "masturbation is dangerous/will drain you/will make you impotent",

(f) "sexual thoughts are wrong, sinful, and you will be punished for them",

(g) "nice girls don't",

(h) "don't do that to a nice girl",

(i) "men are only after one thing",

(j) "s-e-x is so bad we don't even talk about it".

Talking about sex in the home

1. Did informant feel free to ask questions about and to discuss sexual matters in the home?
2. How did parents respond to such questions or discussion?
3. Did informant get the feeling that his or her parents would be uncomfortable with such question or discussion?
4. Was there a taboo on talking about sex in the home?
5. What kind of comments or jokes were made by the informant's parents about their own sexual relationship or the sexual lives of other people?

Nudity/modesty

1. What were the standards concerning nudity and modesty in the informant's home as he or she grew up?

Vicarious exposure to intercourse

1. Did informant ever see or hear anyone having intercourse in the home as he or she grew up?
2. If so, what were informant's reactions at the time?

Sex games

1. What kind of sex games did informant play as a child (e.g., "doctor", "postoffice" etc.)?
2. Was he or she ever caught by parents?
3. If so, what was their reaction?

Influence of siblings or friends

1. Did informant discuss sex with siblings or friends as he or she grew up?
2. Was sex the subject of jokes and embarrassment?
3. Did informant consider sex dirty, frightening, curious, interesting?

First pleasurable genital feelings

1. At what age does informant recall having his or her first pleasurable genital feelings?
2. Were these in connection with any particular thoughts, activities, or situations?
3. Did informant define these feelings as good or bad at the time?

Masturbation

1. At what age did informant first experiment with masturbation?
2. Where did he or she masturbate?
3. How did he or she masturbate?
4. How often did he or she masturbate?
5. How did he or she feel about masturbating?
6. Did he or she fantasize during masurbation?
7. If so, what did he or she fantasize?
8. Did he or she use erotic materials during masturbation?
9. If so, what was the preferred content of these materials?
10. Was the informant ever discovered masturbating?
11. If so, what was the reaction of the person discovering him or her?

Sexual dreams

1. (Females only).
   (a) had informant ever had sexual dreams in which she felt aroused in her sleep?
   (b) has she ever had an orgasm in her sleep?

(c) what were her reactions to these experiences at the time?

2. (Males only).

(a) how old was informant when he had his first nocturnal emission (wet dream)?

(b) what were his reactions to this experience?

(c) had he been told about nocturnal emissioons in advance. If so, by whom and in what way?

Menstuation (females only)

1. At what age did informant start to mentruate?
2. Had menstruation been explained to her in advance? If so, by whom and in what way?
3. Was menstuation discussed among her friends?
4. What terms did she use to refer to it?
5. What were her feelings in anticipation of menstruation?
6. How did she feel after menstruation began?
7. Did it influence her lifestyle in anyway?
8. Did it lead to her feeling differently about herself and her body?
9. Has she ever had any menstrual difficulties?
10. Has she ever had intercourse during a period? How does she feel about this?

Knowledge of reproduction

1. At what age did informant learn about reproduction?
2. From whom and in what way did he or she learn?
3. What was his or her reaction to this information at the time?

Dating

1. At what age did informant start to date?

(a) in groups.

(b) on single dates.

2. Did informant date many different people simultaneously or did he or she usually have a steady relationship with one person at a time?
3. What early fears did informant have about dating?
4. What expectations did informant have about how each person should behave when on a date?

Petting before current partnership

1. What kinds of petting did informant engage in?
2. Was there any touching or manipulation of the genitals involved?
3. How did he or she respond sexually to stimulation during petting?
4. How did he or she feel about engaging in petting?
5. Any negative petting experiences?
6. Where and in what circumstances did petting usually occur?
7. With approximately how many partners did informant pet?
8. What kind of emotional relationship did informant have with a partner before becoming involved in petting?
9. How would the informant's parents have reacted if they had known about the petting?

Sexual intercourse before current partnership

1. Did informant have intercourse before current partnership?
2. If so, under what circumstances did first experience of intercourse occur and how did he or she react to it?
3. Under what circumstances did intercourse usually occur?
4. How frequently did intercourse occur?
5. With how many partners?
6. What emotional conditions did informant need to have intercourse with someone?

e.g., (a) to be in love with each other,

(b) to care for each other,

(c) to be committed to a long term relationship,

(d) to be engaged,

(e) to be married,

(f) no emotional involvement required.

7. How did informant respond sexually during intercourse?
8. Did informant fantasize during intercourse? If so, what did he or she fantasize?
9. What feelings usually accompanied intercourse?

e.g., (a) satisfaction,

(b) pleasure,

(c) guilt,

(d) embarrassment,

(e) anxiety.

10. What form(s) of contraception was used?
11. Was intercourse ever intruded upon by a third person?
12. How would the informant's parents have reacted if they had known about his or her engagement in intercourse?

Romantic relationships before current partnership

1. Has informant ever been in love before?
2. What does being in love mean to him or her?
3. Does he or she fall in love easily?
4. What kinds of person does he or she usually fall in love with?
5. How many loving relationships has he or she had?
6. How long did these relationships last?

7. In what circumstances did they come to an end and how did informant react to this?

Traumatic experiences

1. Has informant ever had an upsetting or disturbing experience associated with sex?

   e.g., (a) sexual victimization prior to attaining age 17 years,

   (b) rape or sexual assault after attaining age of 17 years,

   (c) indecent exposure,

   (d) unwanted pregnancy,

   (e) abortion,

   (f) venereal disease.

2. How did informant react to such experiences?

Erotic materials

1. What experience has informant had with erotic materials?

   e.g., (a) written,

   (b) photographs,

   (c) films.

2. What is the preferred content of such material for the informant?

Homosexual experiences

1. Did the informant have any sexual encounters with a member of the same sex?

2. If so, how did he or she react at the time?

Deviant experiences

1. Has the informant been involved in any unusual or unconventional forms of sexual activity?

2. If so, how did he or she react at the time?

Sexual experience with current partner

1. What was the nature of the informant's sexual experiences with his or her current partner?
   (a) when they were dating,
   (b) during their engagement,
   (c) on their honeymoon,
   (d) during the marriage or cohabitation up to the present time.
2. How did the informant respond sexually during these experiences?
3. What feelings usually accompanied these experiences for the informant?

CURRENT CONDITIONS

Sexual practices

1. Review relevant responses on:
   (a) Sexual History Form,
   (b) Index of Sexual Satisfaction,
   (c) Sexual Relationship Questionnaire,
   (d) Client Self Monitoring Records,
   (e) Sexual Arousal Inventory (if applicable),
   (f) Erection Difficulty Questionnaire (if applicable).
2. How sexually attractive is the partner to the informant?
   How sexually attractive does the informant believe he or she is to the partner?
3. How often are the informant and partner physically affectionate with each other without necessarily expecting intercourse to follow?
   How satisfied is the informant with amount and type of physical affection he or she gets from the partner?

4. Which partner usually initiates sexual activity?

   What types of sexual advance are made?

   What are the informant's reactions to these advances?

   In what ways would he or she like the initiation of sex to be different?

5. How does the informant feel:

   (a) about seeing the partner nude?

   (b) about the partner seeing the informant nude?

6. In general, for how long do the couple engage in foreplay prior to intercourse?

   What types of sexual activity occur during foreplay?

   What are the informant's sexual responses and emotional reactions during these activities?

   In what ways would he or she like foreplay to be different?

7. How frequently does sexual intercourse take place?

   How long does intercourse usually last?

   What positions and techniques are used during intercourse?

   Does the informant fantasize during intercourse? If so, what is the preferred content of these fantasies?

   What are the informant's sexual responses and emotional reactions during intercourse?

   In what ways would he or she like intercourse to be different?

8. What do the couple do after they have intercourse?

   What would the informant like them to do differently?

9. What form of contraception is used?

   How satisfactory is this for the informant?

What are the informant's attitudes towards and intentions concerning the possibility of conception?

10. How frequently does the informant masturbate?

    What techniques/aids does he or she use?

    Does he or she fantasize during masturbation? If so, what is the preferred content of the fantatsies?

    What are the informant's sexual responses and emotional reactions during masturbation?

    How does he or she feel after masturbating?

    In what ways would he or she like masturbation to be different?

11. Does the informant use erotic materials (e.g., written, photographs, films)?

    If so, what is the preferred content?

    What are the informant's sexual responses and emotional reactions to such materials?

12. At what times does sexual activity usually occur between the informant and partner?

    In what ways would the informant like the timing to be different?

13. Where does sexual activity usually take place between the informant and partner?

    What changes would the informant like in these settings?

<u>Sexual stresses</u>

1. In what respects does sexuality entail frustration, threat, or conflict for the informant?

    e.g., (a) sexual anatomy or responses;

    e.g., (i) seeing, touching, or smelling his or her genital organs or secretions, or those of the partner,

(ii) losing control during orgasm,

(b) anticipation of harm;

e.g., (i) causing or receiving pain or injury during intercourse,

(ii) venereal disease,

(iii) unwanted pregnancy,

(iv) sexual frustration,

(v) threatening degree of intimacy or commitment,

(c) anticipation of failure;

e.g., (i) in obtaining/maintaining erection,

(ii) in controlling ejaculation,

(iii) in reaching climax,

(iv) in being able to arouse and satisfy partner,

(d) moral or religious contraventions;

e.g., (i) masturbation,

(ii) premarital intercourse,

(iii) idealization of partner ("prostitute/Madonna complex"),

(iv) symbolic recapitulation of tabooed sexual relationship.

<u>Negative emotional reactions</u>

1. Is sex accompanied by negative emotional reactions for the informant?

e.g., (a) anxiety,

(b) guilt,

(c) depression,

(d) anger.

2. If so, what particular aspects of sexuality are associated with these reactions?

Physical avoidance reactions

1. Does the informant physically avoid stressful sexual experiences by means such as:

   e.g., (a) vaginismus?

   (b) inhibition of orgastic/ejaculatory reflexes?

   (c) reduction in frequency of sexual activity?

   (d) constriction of variety of sexual activity?

   (e) restriction of physical affection?

   (f) cessation of communication about sex?

   (g) avoidance of social contacts that might entail sexual encounters?

Negative cognitive reactions

1. Is sex accompanied by negative cognitive reactions for the informant?

   e.g., (a) cognitive monitoring of sexual activities and reponses,

   (b) cognitive avoidance of sexual sensation, feelings, or thoughts,

   (c) negative thoughts,

   e.g., (i) "nice girls are not interested in sex",

   (ii) "I won't be able to get an erection/stop coming too quickly/reach climax",

   (iii) "If I fail she'll be angry/laugh at me/tell all the guys/never go out with me again/take a lover/think I'm gay",

(d) negative imagery,

e.g., (i) flashbacks to sexual victimization experiences in childhood,

(e) impaired imagery,

(i) inability to fantasize.

2. If any such negative cognitive reactions occur, with which particular aspects of sexuality are they associated?

Sexual attitudes

1. What is the informant's attitude towards sex in general?

e.g., (a) good,

(b) pleasurable,

(c) dirty,

(d) sinful,

(e) degrading.

2. Does the informant believe that men and women should have distinct and different roles in sexual activities?

e.g., (a) men should initiate and control sex,

(b) it is unnatural for women to be on top during intercourse,

(c) it is inappropriate or unacceptable for women to show a strong interest in sex,

(d) women should satisfy the sexual needs of their partners and not be concerned about their own satisfaction.

3. What conlicts does the informant experience between his or her own attitudes towards sex and those of:

(a) his or her partner?

(b) his or her religion?

(c) the social groups in which he or she lives?

4. What importance does the informant attach to sex in his or her relationship with a partner?

Sexual information

1. Are there any deficiencies or inaccuracies in the informant's knowledge about sexual matters that may be contributing to a sexual dysfunction?

General relationship

1. Review relevant respnses on Dyadic Adjustment Scale and Marital Relationship Questionnaire.
2. Does the informant:
   (a) like the partner?
   (b) find the partner attractive?
   (c) love the partner?
   (d) feel emotionally close to the partner?
3. In general, how does the informant feel about the marriage/cohabitation?
   How satisfied is he or she with it?
   What are some of the good things about it?
   In what ways would the informant like it to be different?
4. How do sexual difficulties affect other aspects of the relationship?
5. How closely do the informant and partner agree on:
   (a) the appropriate roles for the man and woman in their marriage/cohabitation?
   (b) who should exercise the most power and make the decisions in certain aspects of their relationship?
6. How well do the informant and partner communicate with each other?
   e.g., (a) talk about most things,

(b) avoid certain topics or argue over them,

(c) discuss their sexual problems,

(d) speak openly and honestly,

(e) listen, empathize, and validate,

(f) get their points across,

(g) resolve their conflicts,

(h) express criticism, resentment, and anger,

(i) express affection, appreciation, and praise,

(j) express specific sexual preferences.

7. How committed to the relationship is the informant?
   Has he or she ever considered separation or divorce?

8. How much does the informant trust the partner?
   Does the informant fear that he or she may be hurt, rejected, or abandoned by the partner?

9. How often do the informant and partner have arguments/rows/fights?
   What are these conflicts usually about?
   What happens during a conflict?
   How are conflicts handled or resloved?

10. Does the informant feel angry, bitter, resentful, or hostile towards the partner?
    If so, what evokes these feelings?

11. Does physical violence ever occur between the informant and partner?
    If so, in what circumstances does such violence happen?

<u>Organic conditions</u>

1. Are there any organic conditions that might contribute to sexual dysfunction, either physically or psychologically?
   e.g., (a) disease,

(b) disabiltiy,

(c) surgery,

(d) medication,

(e) aging,

(f) menopause,

(g) method of contraception,

(h) pregnancy,

(i) post-partum period,

(j) miscarriage,

(k) abortion,

(l) drug abuse,

(m) alcohol abuse.

Psychopathological conditions

1. Are there any other psychopathological conditions that might contribute to sexual dysfunction?

   e.g., (a) depression (if may be present review responses on Beck Depression Inventory).

Self concept

1. Are there features of the informant's self concept that might contribute to sexual dysfunction (review reponses on Self Esteem Inventory)?

   e.g., (a) negative body image,

   (b) impaired gender identity,

   (c) low self esteeem,

   (d) self perceived unpopularity or unattractiveness in social relationships.

Non-sexual stresses

1. Are there any non-sexual sources of frustration, threat, or conflict in the informant's life situation that might contribute to sexual dysfucntions?

   e.g., (a) unemployment,

   (b) problems at work,

   (c) financial difficulties,

   (d) family illness,

   (e) child behavior problems.

Lifestyle

1. Are there any features in the informant's and/or partner's lifestyle that might contribute to sexual dysfunction?

   e.g., (a) lack of comfort, warmth, or privacy,

   (b) couple spend litttle time together becuase of;

      (i) long working hours,

      (ii) markedly discrepant working hours,

      (iii) work requiring location away from home,

   (c) separate rather than shared leisure time,

   (d) discrepant career plans and objectives,

   (e) children adversely affecting marital/sexual relationships,

   (f) low priority accorded to sexual activity,

   (g) feeling tired, hurried, or preoccupied with things other than sex.

Extra-marital relationship

1. During the current marriage or cohabitation has the informant been involved in a sexual or romantic relationship with an opposite-sex parnter?

2. If so, how serious was this relationship?
3. How did the informant react sexually and emotionally during the relationship?
4. Did the spouse or cohabitee know about the relationship?

   If so, what was his or her reaction?

<u>Homosexual encounters</u>

1. During the current marriage or cohabitation has the informant been involved in any homosexual encounters?
2. If so, how did the informant react sexually and emotionally to these?
3. Did the spouse or cohabitee know about the encounters?

   If so, what was his or her reaction?

ATTITUDES TO TREATMENT

1. Who made the decision and arrangements to seek treatment?
2. Why was it decided to seek treatment at this particular time?
3. What are the reasons for seeking tratment?
4. How would the informant like things to be different both sexually and non-sexually after treatment?
5. What concerns or worries does the informant have about treatment and its anticipated consequences?
6. How effective does the informant expect treatment to be?
7. How willing is the informant to participate and actively cooperate in treatment?

Appendix F

Sexual History Form

(Please find the most appropriate response for each question.)

1. How frequently do you and your mate have sexual intercourse or activity?

   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

2. How frequently would you like to have sexual intercourse or activity?

   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

3. Who usually initiates having sexual intercourse or activity?

   1) I always do
   2) I usually do
   3) my mate and I each initiate about equally often
   4) my mate usually does
   5) my mate always does

4. Who would you like to have initiate sexual intercourse or activity?

   1) myself, always
   2) myself, usually
   3) my mate and I equally often
   4) my mate, usually
   5) my mate, always

5. How often do you masturbate?
   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

6. How frequently do you feel sexual <u>desire</u>? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to a lack of sex, etc.
   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

7. For how many years have you and your mate been having sexual intercourse?
   1) less than 6 months
   2) less than 1 year
   3) 1 to 3 years
   4) 4 to 6 years
   5) 7 to 10 years
   6) more than 10 years

8. For how long do you and your mate usually engage in sexual foreplay (kissing, petting, etc.) before having intercourse?
   1) less than one minute
   2) 1 to 3 minutes
   3) 4 to 6 minutes
   4) 7 to 10 minutes
   5) 11 to 15 minutes
   6) 16 to 30 minutes
   7) 30 minutes to 1 hour

9. How long does intercourse usually last, from entry of the penis until the male reaches orgasm (climax)?

   1) less than one minute
   2) 1 to 3 minutes
   3) 4 to 6 minutes
   4) 7 to 10 minutes
   5) 11 to 15 minutes
   6) 16 to 30 minutes
   7) 30 minutes to 1 hour

10. Does the male ever reach orgasm while he is trying to enter the woman's vagina with his penis?

   1) never
   2) rarely, less than 10% of the time
   3) seldom, less than 25% of the time
   4) sometimes, 50% of the time
   5) usually, 75% of the time
   6) nearly always, over 90% of the time

11. Overall, how satisfactory to you is your sexual relationship with your mate?

   1) extremely unsatisfactory
   2) moderately unsatisfactory
   3) slightly unsatisfactory
   4) slightly satisfactory
   5) moderately satisfactory
   6) extremely satisfactory

12. Overall, how satisfactory do you think your sexual relationship is to your mate?

   1) extremely unsatisfactory
   2) moderately unsatisfactory
   3) slightly unsatisfactory
   4) slightly satisfactory
   5) moderately satisfactory
   6) extremely satisfactory

13. When your mate makes sexual advances, how do you usually respond?

   1) usually accept with pleasure
   2) accept reluctantly
   3) often refuse
   4) usually refuse

14. When you have sex with your mate, do you feel sexually aroused (i.e., feeling "turned on," pleasure, excitement)?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never

15. When you have sex with your mate, do you have negative emotional reactions, such as fear, disgust, shame or guilt?

    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

16. If you try, is it possible for you to reach orgasm through masturbation?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

17. If you try, is it possible for you to reach orgasm through having your genitals caressed by your mate?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

18. If you try, is it possible for you to reach orgasm through sexual intercourse?
    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

19. What is your usual reaction to erotic or pornographic materials (pictures, movies, books)?
    1) greatly aroused
    2) somewhat aroused
    3) not aroused
    4) negative--disgusted, repulsed, etc.

20. Does the male have any trouble in getting an erection, before intercourse begins?
    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

21. Does the male have any trouble keeping an erection, once intercourse has begun?
    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

22. Does the male ejaculate (climax) without having a full, hard erection?
    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

23. Is the female's vagina so "dry" or tight that intercourse cannot occur?
    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

24. Do you feel pain in your genital during sexual intercourse?
    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

25. (WOMEN ONLY, MEN GO ON TO QUESTION 28) Can you reach orgasm through stimulation of your genitals by an electric vibrator or any other means such as running water, rubbing with some object, etc.?
    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

26. (WOMEN ONLY) Can you reach orgasm during sexual intercourse if at the same time your genitals are being caressed (by yourself or your mate or with a vibrator, etc.).

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

27. (WOMEN ONLY) When you have sex with your mate, including foreplay and intercourse, do you notice some of these thing happening: your breathing and pulse speeding up, wetness in your vagina, pleasurable sensations in your breasts and genitals?

    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never

28. (MEN ONLY) Do you ever ejaculate (climax) without any pleasurable sensation in your penis?

    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

Appendix G

Erection Difficulty Questionnaire

Instructions: This questionnaire is designed to provide information about various aspects of the erection problems which a man and his partner may experience.

For each question, check the response which best fits your answer from the list of alternative responses.

1. During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.

____Always ____Usually ____Sometimes ____Rarely ____Never

2. Even though I admit that I have an erection problem, I tell my partner(s) that "I've had too much to drink", "I guess I'm just tired", or something else so they may not know about my problem.

____Always ____Usually ____Sometimes ____Rarely ____Never

3. If I get a partial or full erection during foreplay, my penis gets soft again when I try to insert my penis into my partner.

____Always ____Usually ____Sometimes ____Rarely ____Never

4. I get (would get) an erection when I see, hug, dance with, or otherwise interact with a dressed, attractive potential partner.

____Always ____Usually ____Sometimes ____Rarely ____Never

5. If I (would) experience erection difficulty, I (would) feel guilty because my partner might be frustrated and sexually unsatisfied.

____Always ____Usually ____Sometimes ____Rarely ____Never

6. I have trouble getting an erection during foreplay with a partner.

____Always ____Usually ____Sometimes ____Rarely ____Never

7. Because of my erection problem I avoid having sex with the same person more than once.

___Always ___Usually ___Sometimes ___Rarely ___Never

8. My erection problem makes me feel like less of a man.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

9. Because of my erection problem, I do not (would not) try to get involved in relationships which might lead to sex.

___Always ___Usually ___Sometimes ___Rarely ___Never

10. During sexual activity I worry about whether or not I will get or keep an erection.

___Always ___Usually ___Sometimes ___Rarely ___Never

11. I do not enjoy sexual activity when I do not have an erection.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

12. My problem with erections occurs with all of my sexual partners or types of partners.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

13. I would feel humiliated if I experienced erections problems again.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

14. I do not (would not) get an erection during any type of sexual activity (e.g., intercourse masturbation, oral sex, etc.).

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

15. If I lose (would lose) my erection during sexual activity, I worry (would worry) that I won't get an erection again.

___Always ___Usually ___Sometimes ___Rarely ___Never

16. I am less interested in sex than I used to be.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

17. I (would) talk about my erection problem with my sexual partner(s).

___Always ___Usually ___Sometimes ___Rarely ___Never

18. Because of my erection problem, I do not attempt sexual intercourse (entering my partner and moving until orgasm) even if I am engaging in other sexual activities with my partner.

___Always attempt ___Usually attempt ___Sometimes attempt ___Rarely attempt ___Never attempt

19. My penis remains hard enough for me to stay inside of my partner until I ejaculate (reach orgasm).

___Always ___Usually ___Sometimes ___Rarely ___Never

20. I am dissatisfied with my sexual functioning.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

21. If I (would) have difficulty getting or keeping an erection during sex, I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

22. I would rather avoid sex altogether than to experience erection problems again.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

23. I know how I could help myself if I had an erection problem again.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

24. I feel (would feel) anger or resentment if I have (would have) erection difficulty during sexual activities with a partner.

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___Completely false

Appendix H

Goals For Sex Therapy Questionnaire

Please rate how satisfied you are with your current behavior or feelings in the 14 areas described below.

Use the following guide which describes the meaning of each number.

1	2	3	4	5	6	7
Much less than satis-fied	Less than satisfied	Somewhat less than satisfied	Satisfied with my current behavior or feelings	Somewhat more than satisfied	More than satisfied	Much more than satisfied

Now circle the number that describes how satisfied you are currently on each of the 14 items. If any item describes a behavior that you have never tried, please write "never tried" next to that item.

1 2 3 4 5 6 7 1. Being able to anticipate (think about) having intercourse without fear or anxiety.

1 2 3 4 5 6 7 2. Being able to get an erection by stimulating myself when I am alone.

1 2 3 4 5 6 7 3. Being able to get an erection during foreplay with a woman while both of us are clothed.

1 2 3 4 5 6 7 4. Being able to get an erection during foreplay while both of us are nude.

1 2 3 4 5 6 7 5. Being able to regain an erection if I lose it during foreplay.

1 2 3 4 5 6 7 6. Being able to get an erection sufficient to begin intercourse.

1 2 3 4 5 6 7	7. Being able to keep an erection during interourse until I ejaculate.
1 2 3 4 5 6 7	8. Being able to regain an erection if I lose it during intercourse.
1 2 3 4 5 6 7	9. Being able to engage in intercourse for as long as I like without ejaculating.
1 2 3 4 5 6 7	10. Being able to stimulate my partner to orgasm.
1 2 3 4 5 6 7	11. Feeling like I am sexually desireable to my partner.
1 2 3 4 5 6 7	12. Feeling comfortable about my own sexuality.
1 2 3 4 5 6 7	13. Being able to enjoy a sexual encounter without having intercourse.
1 2 3 4 5 6 7	14. Being able to anticipate a sexual encounter without feeling I should have intercourse.

Appendix I

Index of Sexual Satisfaction (ISS)

NAME: ______________________ TODAY'S DATE: ______________

This questionnaire is designed to measure the degree of satisfaction you have in the sexual relationship with your parnter. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 Good part of the time
5 Most or all of the time

Please begin:

1. I feel that my partner enjoys our sex life . . . . ___
2. My sex life is very exciting . . . . ___
3. Sex is fun for my partner and me . . . . ___
4. I feel that my partner sees little in me except for the sex I can give . . . . ___
5. I feel that sex is dirty and disgusting . . . . ___
6. My sex life is monotonous . . . . ___
7. When we have sex it is too rushed and hurriedly completed . . . . ___
8. I feel that my sex life is lacking in quality . . . . ___
9. My partner is sexually very exciting . . . . ___
10. I enjoy the sex techniques that my partner likes or uses . . . . . . ___
11. I feel that my partner wants too much sex from me . . . . ___

12. I think that sex is wonderful . . . . ____
13. My partner dwells on sex too much . . . . ____
14. I feel that sex is something that has to be endured . . . . ____
15. My partner is too rough or brutal when we have sex . . . . ____
16. My partner observes good personal hygiene . . . . ____
17. I feel that sex is a normal function of our relationship . . . . ____
18. My partner does not want sex when I do . . . . ____
19. I feel that our sex life really adds a lot to our relationship . . . . ____
20. I would like to have sexual contact
    with someone other than my partner . . . . ____
21. It is easy for me to get sexually excited by my partner . . . . ____
22. I feel that my partner is sexually pleased with me . . . . ____
23. My partner is very sensitive to my sexual needs and desires . . . . ____
24. I feel that I should have sex more often . . . . ____
25. I feel that my sex life is boring . . . . ____

Appendix J

CULTURE-FREE SEI, FORM AD

Name ______________ Age __________ Date of Birth __________
Examiner __________ Today's Date __________ Total____G____S____P____L____

Please mark each question in the following way: If the question describes how you usually feel, make a check mark in the "yes" column. If the question does not describe how you usually feel, make a check mark in the "no" column. Please check only one column (either "yes" or "no") for each of the 40 questions. This is not a test, and there are no "right" or wrong answers.

		Yes	No
1.	Do you have only a few friends?	___	___
2.	Are you happy most of the time?	___	___
3.	Can you do most things as well as others?	___	___
4.	Do you like everyone you know?	___	___
5.	Do you spend most of your free time alone?	___	___
6.	Do you like being a male? / Do you like being a female?	___	___
7.	Do most people you know like you?	___	___
8.	Are you usually successful when you attempt tasks or assignments?.	___	___
9.	Have you ever taken anything that did not belong to you?	___	___
10.	Are you as intelligent as most people?	___	___
11.	Do you feel you are as important as most people?	___	___
12.	Are you easily depressed?	___	___
13.	Would you change many things about yourself if you could?.	___	___
14.	Do you always tell the truth?	___	___
15.	Are you as nice looking as most people?	___	___
16.	Do many people dislike you?	___	___
17.	Are you usually tense or anxious?	___	___
18.	Are you lacking in self-confidence?	___	___
19.	Do you gossip at times?	___	___
20.	Do you often feel that you are no good at all?	___	___
21.	Are you as strong and healthy as most people?	___	___
22.	Are your feeling easily hurt?	___	___
23.	Is it difficult for you to express your views or feelings?	___	___
24.	Do you ever get angry?	___	___
25.	Do you often feel ashamed of yourself?	___	___
26.	Are other people generally more successful than you are?	___	___
27.	Do you feel uneasy much of the time without knowing why?.	___	___

28. Would you like to be as happy as others appear to be? . . . . . ___ ___
29. Are you shy? . . . . ___ ___
30. Are you a failure? . . . . ___ ___
31. Do people like your ideas? . . . . ___ ___
32. Is it hard for you to meet new people? . . . . ___ ___
33. Do you ever lie? . . . . ___ ___
34. Are you often upset about something? . . . . ___ ___
35. Do most people respect your views? . . . . ___ ___
36. Are you more sensitive than most people? . . . . ___ ___
37. Are you as happy as most people? . . . . ___ ___
38. Are you ever sad? . . . . ___ ___
39. Are you definitely lacking in initiative? . . . . ___ ___
40. Do you worry a lot? . . . . ___ ___

Appendix K

Name: ____________

Dyadic Adjustment Scale

Date: ____________

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreements or disagreements 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

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	Occa-sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5

18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married? (or lived together)	0	1	2	3	4	5
21. How often do you and your partner quarrel?	0	1	2	3	4	5
22. How often do you and your mate "get on each other's nerves?"	0	1	2	3	4	5

	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
23. Do you kiss your mate?	4	3	2	1	0

	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
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 sometime 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, of your relationship.

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

5 I want despaerately 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.

Appendix L

Marriage and Sexual Relationship Questionnaire (M)

Initials ______________________ Date ______________________

Age ______________

Sex ______________

Client Couple *________

How may years have you been married? ________

INSTRUCTIONS

This questionnaire asks about your marriage and sexual relationship. All your answers will be kept confidential, and will be seen only by the clinic staff. Your answers should give an accurate picture of your relationship. Please answer truthfully.

Answer each question by completely crossing out the answer "True" or "False", which ever best applies to you at the time.

Example:

Sometimes when I am tired I am short tempered with my mate. T F

If you feel this statement is mostly "True" about you,
cross out "T" like this . . . . ~~T~~ F

If you feel this statement is mostly "False" about you,
cross out "F" like this . . . . T ~~F~~

Please answer every question, either T or F.

MARRIAGE ATTITUDES SCALE (M)

		True	False
1.	No matter what my spouse is saying, I'm always a good listener.	T	F
2.	I have never felt displeased with my spouse.	T	F
3.	I have never been upset when my spouse expressedviews very different from mine.	T	F
4.	On occasions I have had doubts about my ability to succeed in my marriage.	T	F
5.	When disagreements arise they are always settled in a peaceful, fair and democratic manner.	T	F
6.	There have been times when I felt like hitting my spouse.	T	F
7.	I do not always tell my spouse the truth.	T	F
8.	My mate occasionally makes me feel miserable.	T	F
9.	I have never felt my spouse was angry at me without a cause.	T	F
10.	My mate completely understands and sympathizes with my every mood.	T	F
11.	I don't think any couple could live together with greater harmony than my mate and I.	T	F
12.	My mate and I understand each other completely.	T	F
13.	There are moments when I dislike my spouse.	T	F
14.	I never hesitate to go out of my way to help my spouse.	T	F
15.	I confide in my mate about everything.	T	F
16.	I have never deliberately said something to hurt my spouse's feelings.	T	F

17.	I have never regretted my marriage, not even for a moment.	T	F
18.	There is never a moment that I do not feel "head over heels" inlove with my mate.	T	F
19.	Some of my dealings with my mate are prompted by selfish motives.	T	F
20.	I have some needs that are not being met by my marriage.	T	F
21.	I sometimes resent my spouse when I can't get my own way.	T	F
22.	Every new thing I have learned about my mate has pleased me.	T	F
23.	My spouse and I are always happy with the amount of affectionwe show each other.	T	F
24.	Once in a while I am not completely truthful with my mate.	T	F
25.	I have some thoughts I wouldn't want my spouse to know about.	T	F
26.	There is nothing about my mate's appearance that I would want to see changed in any way.	T	F
27.	My marriage is not a perfect success.	T	F
28.	I think I would lie to my spouse to keep out of trouble.	T	F
29.	My marriage could be happier than it is.	T	F
30.	There are times when I do not feel a great deal of love and affection for my mate.	T	F
31.	I am always courteous to my spouse.	T	F
32.	Sometimes I'm tempted to say thing to my spouse which I would regret.	T	F

SEXUAL ATTITUDES SCALE (M)

		True	False
1.	I think I am much sexier than most people.	T	F
2.	My spouse and I never feel unhappy about how often we have sex together.	T	F
3.	I sometimes push my mate to have sex more than he/she wants to.	T	F
4.	I never feel resentful when my spouse turns me down for sex.	T	F
5.	I do not always initiate sex when I would like to.	T	F
6.	My spouse always knows exactly what I would like him/her to do when we are making love.	T	F
7.	My spouse always does the things I like during sex.	T	F
8.	Our sex life seems a little routine and dull to me at times.	T	F
9.	I always satisfy my spouse sexually.	T	F
10.	I have always been satisfied with how often my spouse and I have sex.	T	F
11.	I must admit that sometimes I am not considerate of my mate when we make love.	T	F
12.	I have never felt that my spouse lacks anything as a lover.	T	F
13.	Sex always lasts as long as I would like it to.	T	F
14.	My spouse and I are never too busy to have sex.	T	F
15.	Every now and then my mate does not please me sexually.	T	F
16.	Intercourse is always more enjoyable for me than other sexual activities.	T	F

Appendix M

Name: ____________________ SEXUAL ACTIVITIES CHECKLIST (MALES) Date: ____________________

Please fill in this form each day at the same time (e.g. 6:00 pm) whether or not you have had a sexual experience in the previous 24-hour period. Record the date you complete the checklist and circle the number(s) corresponding to the experience(s) you have had in the previous 24 hours. Rate the fullness of your erection(s) and your degree of satisfaction with the duration of your erection(s) by circling the appropriate number.

Activity	Fullness of Erection							Duration of Erection						
	Completely soft			Semi-hard			Completely hard	Completely unsatisfactory						Completely satisfactory
ALONE														
1. General pleasuring alone, excluding genitals – caressing your body, excluding genital areas, for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
2. General and genital pleasuring alone – caressing your body, including genital areas for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
3. Masturbation	1	2	3	4	5	6	7	1	2	3	4	5	6	7
WITH PARTNER														
4. General pleasuring with a partner, excluding genitals – caressing each other's bodies, excluding genitals, for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
5. Gerneral and genital pleasuring with a partner – caressing each other's bodies, including genitals, for feelings of pleasure	1	2	3	4	5	6	7	1	2	3	4	5	6	7
6. Oral sex by your partner – your partner caressing your genitals with her mouth	1	2	3	4	5	6	7	1	2	3	4	5	6	7
7. Oral sex on your partner – caressing her genitals with your mouth	1	2	3	4	5	6	7	1	2	3	4	5	6	7
8. Intercourse with a partner	1	2	3	4	5	6	7	1	2	3	4	5	6	7
9. NO SENSUAL/SEXUAL ACTIVITY														

Appendix N

Didactic Presentations and Discussion Topics*

Films

1) Film: "Becoming Orgasmic" (reel 1) (Arthur, Barry & Charles)
2) Film: "The Sexually Mature Adult" (Arthur, Barry & Charles)
3) Film: "Treating Erectile Problems" (Arthur, Barry & Charles)
4) Film: "A Ripple in Time" (Arthur, Barry & Charles)

Presentations and Discussions

1) Discussion of the importance of getting to know one's body and touching (Arthur, Barry & Charles)
2) Presentation and discussion of the rationale underlying the masturbation exercises (Arthur, Barry & Charles)
3) Presentation and discussion on male sexuality (Arthur, Barry & Charles)

Presentations and Discussions

1) Presentation and discussion on how to effectively communicate sensitive material (e.g., the partial ban on intercourse, or disclosing the fact you have a sexual problem) (Arthur, Barry & Charles)
2) Discussion on how to encourage the partner to read Zilbergeld (1978) (Barry & Charles)
3) Discussion on communicating one's sexual likes and dislikes (Arthur & Charles)
4) Discussion on finding out what the partner likes and dislikes in sex (Arthur & Charles)

Presentations and Discussions

1) Presentation and discussion on being assertive with one's partner (Arthur, Barry & Charles)
2) Discussion on how to decline an opportunity for sexual activity with the partner (Charles)
3) Discussion and role-playing concerning how to correct inappropriate thoughts (e.g., thoughts of insecurity) by using relabelling (Arthur)

Presentations and Discussions

1) Review of "Arousal and Erection Guidelines" (McCarthy, 1980; see Appendix Q) (Arthur, Barry & Charles)
2) Presentation and discussion of myths of male and female sexuality (Arthur, Barry & Charles)

3) Presentation and discussion on developing ejaculatory control (Arthur & Charles)
4) Presentation and discussion on sexuality and the aging process (Barry & Charles)
5) Discussion of 3 articles on menopause and sexual activity (Barry)
6) Presentation and discussion on ways to maintain treatment gains (see Appendix V) (Arthur, Barry & Charles)

Presentations and Discussions
1) Presentation and discussion of the role stress and anxiety play in disrupting one's sexual responses (Arthur, Barry & Charles)
2) Presentation and discussion on the importance of being aroused (Arthur, Barry & Charles)
3) Presentation and discussion of the conditions required for good sex (Arthur, Barry & Charles)
4) Presentation and discussion on the use of fantasy to increase sexual arousal (Barry & Charles)
5) Presentation and discussion on the use of fantasy to increase sexual arousal (plus one non-sexual and one sexual fantasy training exercise) (Arthur)

Presentations and Discussions
1) Review of exercises that can be carried out with a partner (Arthur & Barry)
2) Reintroduction of topics relating to discussion of erectile difficulties and initiating the partner to nondemand activity (Arthur)

Relaxation Training
1) Presentation on the importance of relaxation, and training in the skill (Arthur, Barry & Charles)
2) Developed an abbreviated relaxation exercise (Charles)

Guest Female Therapist Involvement
1) Presentation and discussion on female sexuality (Arthur & Charles)
2) Presentation and discussion on what different women prefer in sex and on the varieties of sexual expression (Arthur, Barry & Charles)
3) Discussion as to why his wife (not his sexual partner) may not be interested in sex (Barry)
4) Discussion and role-playing concerning initiating a partner to nondemand exercises and discussing erectile difficulties with a partner (Arthur & Charles)

<u>Therapist-aided Written/Conceptual Assignments</u>

1) The therapist helped Charles do the Myths Essay since he has minimal writing skills (Charles)
2) The therapist helped Charles do the Conditions Essay
3) The therapist helped Charles do the Problem Scenario
4) Discussion of the reasons his erectile problems may have come about (was done since he did not do the Problem Scenario homework asssignment) (Barry)

<u>Miscellaneous</u>

1) Overview of treatment Program (Arthur; Barry & Charles)
2) Review of homework (in 8 or 9 sessions) (Arthur, Barry & Charles)
3) Feedback: client impressions of the first five sessions (Arthur, Barry & Charles)
4) Review of treatment experience (Arthur & Barry)
5) Arrangement of follow-up sessions (Arthur, Barry & Charles)
6) Posttreatment data collection (Arthur, Barry & Charles)

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*Adapted from Altman (1985). The order of presentation was altered in order to be most appropriate for each client.

Appendix O

Homework Assignments*

Reading Assignments
1) Chapters 1-10, and12-23** (Arthur, Barry & Charles)
2) Chapter 11 (Barry)
3) Three articles on menopause and sexual activity (Barry)

Sensual/Sexual Assignments
1) Exploring Your Genitals (p. 119)*** (Arthur, Barry & Charles)
2) Self Body-Rub with Lotion (p. 141) (Arthur, Barry & Charles)
3) Masturbation with Focussing (p. 174) (Arthur, Barry & Charles)
4) Losing and Regaining Erection (p. 304) (Arthur, Barry & Charles)
5) Nonsimultaneous Body-Rubs (p. 144) (Barry & Charles)
6) Masturbation with Fantasy of Sex with a Partner (p. 305) (Arthur, Barry & Charles)
7) Masturbation with Fantasy of Losing and Regaining Erection (p. 308) (Barry & Charles)
8) Masturbation Incorporating Erotic Material (Arthur & Charles)
9) Nondemand Snuggling (Arthur)
10) Nondemand Snuggling including breasts and genitals (Arthur)
11) Masturbation with Fantasy of no Erection (p. 309) (Arthur, Barry & Charles)
12) Maintaining a Sexual Fantasy while playing with your penis (Arthur)
13) Maintaining a Sexual Fantasy while playing with your penis, ensuring a clear sexual fantasy at climax) (Arthur)
14) Petting with the partner (Arthur)
15) Penis in Vagina with Minimum Movement (p. 322) (Barry)
16) Stop-Start Masturbation with Fantasy (p. 273) (Arthur)
17) Writing a sexual fantasy and incorporating it while masturbating (especially just prior to orgasm) (Arthur)

Communication Assignments
1) Communicating the partial ban on intercourse to the partner (Barry & Charles)
2) Disclosing sexual concerns in front of a mirror (Arthur)
3) Asking the partner to read Zilbergeld (1978) (Barry & Charles)
4) Disclosing the fact that you have sexual difficulties to the partner (Arthur)
5) Communicating one like and one dislike in sex to the partner (Arthur & Charles)

6) Finding out one like and one dislike in sex of the partner (Arthur & Charles)
7) Disclosing your feelings about your sexual difficulties to the partner (Arthur, Barry & Charles)
8) Making a date with the partner to spend an evening and night at a hotel (Arthur)

Written/Conceptual Assignments

1) Myths Essay (see Appendix S) (Arthur & Barry)
2) Conditions Essay (p. 87; see Appendix T) (Arthur & Barry)
3) Problem Scenario (see Appendix U) (Arthur & Barry)
4) Development of a program to help maintain treatment gains (see Appendix V) (Arthur)

Relaxation Assignments

1) Practising relaxation skills (Arthur & Charles)
2) Abbreviated relaxation exercise (Charles)

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* Adapted from Altman (1985). Some assignments were assigned more than once

** All chapters are taken from Zilbergeld (1978)

*** All assignments with page numbers are taken from Zilbergeld (1978)

Appendix P

Varieties of Sexual Expression

The following list of types of sexual expression with a partner is by no means exhaustive. The list is simply intended to stimulate your imagination in finding new sexual activities which your partner and youself will enjoy.

- Massage your partner's body and then let her do the same for you
  - with or without clothes on
  - with or without an oil or powder

- "Pet" for the purpose of arousal and pleasure
  - simultaneous or nonsimultaneous
  - with or without clothes on
  - can lead to orgasm, if desired

- Shower with your partner and lather her body--let her lather your body

- Your partner and yourself can play with a vibrator, trying it on various parts of your bodies

- Have one partner lie nude while the other kisses and touches various parts of the partner's body--get feedback regarding how it feels

- Do a strip show for your partner or ask her to strip for you
  - be imaginitive, using sexy music, flinging your clothes, etc. (make it a fun time together)

- Try oral sex
  - simultaneous (position 69) or nonsimultaneous
  - this can lead to orgasm but doesn't have to

- Engage in some form of sex wearing some sexy clothes
  - encourage your partner to do the same
  - don't always remove the clothes as you proceed with the encounter

- Act out a fantasy when engaging in some form of sex (your parnter and yourself can share in this fantasy or your can keep it to yourself)
  - you can both verbalize and create the fantasy while engaging in some form of sexual play
  - you can use clothes and props in the fantasy/sex session

- Manually stroke your partner's genitals with your hand--let her do the same for you
  - this can lead to orgasm, but doesn't have to

- Have your partner masturbate while you stroke the rest of her body--then reverse roles
  - try simultaneous masturbation

- Try intercourse in any of the numerous positions
  - can be done in bed or anywhere else that provides privacy (e.g., your car, the great outdoors, other rooms in your house)
  - can be done at various times in the day (e.g., at lunch time, in the morning, at night)
  - can be done for the purpose of orgasm or just as a very arousing and enjoyable activity
  - the penis can remain motionless in the vagina while feeling each other's bodies and/or kissing and/or even just talking (you don't have to be thrusting all the time)

- Your mood can be different in different sexual encounters--at times be romantic (e.g., use candles, music, etc.), and at other times just have fun
  - at times be gentle and at other times be more physical, so long as you don't hurt your partner

- Play "food games"--put your favorite food all over your partner's naked body and eat it off
  - have your partner do the same for you

Appendix Q

<u>Arousal and Erection Guidelines</u>

1. By age 40, 90% of males experience at least one erectile failure; this is a normal occurrence, not to be overreacted to as a sign of a major sex problem.

2. The great majority of potency problems are caused by psychological or relationship factors, not medical or physiological malfunctions.

3. Erectile problems can be caused by a wide variety of factors including drinking too much, anxiety, depression, anger, frustration, fatigue, and just not feeling very aroused at that time or by that partner.

4. The key element is to accept the erectile difficulty as a situational problem, not to overreact and label yourself "impotent" or put yourself down as being a "failure" as a man.

5. A myth is the "male machine," ready to have an erection and intercourse at any time, with any woman, in any situation. You and your penis are human, not a performance machine.

6. One of the most pervasive myths is that if a man loses his initial erection, that means he's sexually turned off and must work to regain it. In reality, it is a natural physiological process for erections to wax and wane during a prolonged pleasuring period.

7. In a typical 45 minute pleasuring session before intercourse, the male's erection will wax and wane an average of three times. Subsequent erections are usually firmer and the ensuing orgasm more pleasureable.

8. You don't need an erect penis to satisfy a woman. Orgasms achieved through manual or oral stimulation are just as sexually satisfying. If you do have problems getting or maintaining an erection, the worst thing you can do is to stop the sexual interaction and put yourself down. Many women find it arousing to have the penis (erect or flaccid) used to stimulate the clitoral shaft or labia minora (inner lips).

9. A key element in potency is to actively involve yourself in the pleasurable and sexually arousing interaction. An erection is a natural result of sexual arousal.

10. You cannot will or work at getting an erection. The worst thing you can do to yourself is to passively take a "spectator" role and observe the state of your penis. Sex requires active involvement. It is not a spectator sport.

11. It makes most sense for the woman to both initiate the moment of intercourse, and for her to guide your penis into her vagina. It takes pressure off you, and since the woman is the expert on her own sexuality, it is the most practical procedure.

12. You can learn to feel comfortable saying to your partner something like "I want the sex and pleasuring to go at a pace I'm comfortable with. When I feel pressure to perform sexually, I get uptight and sex is less good for you and me. Let's make it enjoyable for us by taking it at a comfortable pace."

13. Erectile problems do not affect the ability to ejaculate. Thus, many males learn to ejaculate with flaccid or semiflaccid penises. The male can again learn to ejaculate to the cue of an erect penis.

14. One way to learn to feel comfortable with potency is through masturbation experiences. During masturbation you could practice gaining and losing erections, relearn to ejaculate to the cue of an erect penis, and focus on cues and fantasies which can be carried over to partner sex.

15. Morning erections should not generally be used for intercourse initiations. The morning erection can be a sign of arousal because of dreaming or because of being close to your parnter; on the other hand it can be caused by a need to urinate. Too many men try to use their morning erections before they lose them. Remember arousals and erections are regainable.

16. An important component in learning to feel comfortable with arousal and potency is to make clear, direct, assertive requests (not demands) of your partner for the type of sexual stimulation you find most arousing. It is important to learn to verbally guide your partner in how to pleasure and arouse you.

17. Stimulating a totally flaccid penis is usually counterproductive for sexual arousal. The male simply becomes more aware of the state of his penis. Instead you could engage in sensuous, non-genital, non-demand stimulation until there is some initial arousal and erection. The male can just lay back and enjoy this stimulation rather than trying to "will an erection."

18. Your attitude and self-thoughts can very much influence your arousal. We suggest that the key self-thought is that "sex and pleasure" go together, not "sex and performance."

19. In thinking about a particular sexual experience, your feelings about it are best measured by your sense of pleasure and satisfaction rather than whether you got an erection, how hard it was, whether your partner was orgasmic. Accept that some sexual experiences will be great for both you and your parnter, some will be better for one than the other, some will be mediocre, and there will be some which are poor. Do not put your sexual self-esteem on the line each time.

20. It is interiesting to know that when you are sleeping, you get an erection every 90 minutes--4 or 5 erections a night. Sex and arousal are natural physiological functions. Don't block it by performance anxiety or putting yourself down. Give yourself (and your partner) permission to enjoy the pleasure of sexuality.

Appendix R

SENDING AND RECEIVING MESSAGES EFFECTIVELY

Sending Messages Effectively

The first aspect of effective communication is the sending of a message. What can you do to make sure your ideas and feeling are effectively communicated? Research supports the conclusions that the skills of sending messages involve:

1. Clearly "own" your messages by using personal pronouns such as I and my; personal ownership includes clearly taking responsibility for the ideas and feelings that are expressed. We "disown" our messages when we use terms like "most people," or "our group." Such terms make it difficult to tell whether the person really thinks and feels what he is saying or whether he is repeating the thoughts and feelings of others.

2. Make your messages complete and specific. Include clear statements of all necessary information the receiver needs in order to comprehend the message. Being complete and specific seems so obvious, but often a person will not communicate the frame of reference he is taking, the assumptions he is making, the intentions he has in communicating, or the leaps in thinking he is making. Thus while a person may hear the words she will not comprehend the meaning of the message.

3. Make your verbal and nonverbal messages congruent with each other. Every face-to-face communication involves both verbal and nonverbal messages. Usually these messages are congruent, so if a person is saying that he has appreciated your help, he is smiling and expressing warmth nonverbally. Communication problems arise when a person's verbal and nonverbal messages are contradictory. If a person says "Here is some information that may be of help to you" with a sneer on his face and a mocking tone of voice, the meaning you receive is confused by the two different messages being simultaneously sent.

4. Be redundant. Repeating your messages more than once and using more than one channel of communication (such as pictures and written messages as well as verbal and nonverbal cues) will help the receiver understand your messages.

5. Ask for feedback concerning the way your messages are being received. In order to communicate effectively you must be aware of how the

receiver is interpreting and processing your messages. The only way to be sure is to continually seek feedback as to what meanings the receiver is attaching to your messages.

6. Make the message appropriate to the receiver's frame of reference. The same information will be explained differently to an expert in the field than to a novice, to a child than to an adult, to your boss than to a co-worker.

7. Describe your feelings by name, action, or figure of speech. When communicating your feelings it is especially important to be descriptive. You may describe your feelings by name ("I feel happy"), actions ("I feel like dancing my happiness"), or figures of speech ("I feel like I'm floating on a pink cloud"). The description will help communicate your feelings clearly and unambiguously.

8. Describe other people's behavior without evaluating or interpreting. When reacting to the behavior of other people be sure to describe their behavior ("you keep interrupting me") rather than evaluating it ("you're a rotten, self-centered egotist who won't listen to anyone else's ideas").

Receiving Messages Effectively

Developing sending skills meets only half the requirements for communicating effectively; you must also have receiving skills.

The skills involved in receiving messages deal with giving feedback about the reception of the message in ways that clarify and aid continued discussion. Receiving skills have two basic parts: (1) communicating the intention of wanting to understand the ideas and feelings of the sender, and (2) understanding and interpreting the sender's ideas and feelings. It is highly important for the receiver to indicate that he wants to fully understand the sender before he makes an evaluation. The specific receiving skills are paraphrasing, perception checking for feelings, and negotiating for meaning.

1. Paraphrase accurately and nonevaluatively the content of the message and the feelings of the sender. The most basic and important skill involved in receiving messages is paraphrasing. Paraphrasing involves restating the words of the sender; it should be done in a way that indicates an understanding of the sender's frame of reference. The basic rule to follow in paraphrasing is: you can speak up for yourself only after you have first restated the ideas and feelings of the sender accurately and to the sender's satisfaction. When paraphrasing it is helpful if you restate the sender's expressed ideas and feelings in your own words rather than mimicking or parroting her exact words, avoid any indication of approval or disapproval, do not add or subtract from the sender's message, and place yourself in the sender's shoes and try to understand what she is feeling and what her message means.

2. Describe what you perceive to be the sender's feelings. Sometimes it is difficult to paraphrase the feelings of the sender if they are not described in words in the message. Thus a second receiving skill is the perception check for the sender's feelings simply describing what you perceive as the sender's feelings. This description should tentatively identify those feelings without expressing approval or disapproval and without attempting to interpret them or explain their causes. It is simply saying, "Here is what I understand your feelings to be; am I accurate?"

3. State your interpretation of the sender's message and negotiate with the sender until there is agreement as to the message's meaning. Often the words contained in a message do not carry the actual meaning. A

person may ask, "Do you always shout like this?" and mean, "Please quiet down." Thus sometimes paraphrasing the content of a message will do little to communicate your understanding of the message. In such a case, you negotiate the meaning of the message. You may wish to preface your negotiation for meaning response with, "What I think you mean is . . ." If you are accurate, you then make your reply; if you are inaccurate, the sender restates the message until you can state what the essential meaning of the message is. Keep in mind that it is the process that is important in negotiating meaning, not the actual phrasing you use. After the process becomes natural, a variety of introductory phrases will be used. Be tolerant of others who are using the same phrases over and over as they are developing this skill.

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Appendix S

Myths Essay

Instructions

Read the 10 myths of sexuality that are discussed in Zilbergeld (1978) in chapters 3 and 4. In thinking about the myths, determine which ones have affected you in the past and which are currently affecting your sexual functioning and attitudes concerning sex. Record these observations.

Myths Essay (Arthur)

1. MEN SHOULDN'T EXPRESS CERTAIN FEELINGS: This myth has affected me in the past and still does affect me now, although maybe not quite as much. I know that I should express certain feelings but it does not come easy for me, because I find myself being embarrassed about expressing certain feelings even when I know that if I were to express that feeling it would probably make things that much better. Although, once I'm in the right sort of situation and we both are expresing our feelings, I find it somewhat easier to express feelings of all kinds.
2. SEX IS A PERFORMANCE: This myth has affected me all along. I always felt the need to be doing something when I'm in a sexual situation. It's as if the silence and inactivity indicate that you are inept at sex or not interested in the girl. There are certain things that are expected of a man and that (is) all there is to it. It was never easy for me to communicate to my partner that we should do things differently, rather I would stumble through the encounter, making it way less than satisfying.
3. A MAN MUST ORCHESTRATE SEX: This myth definitely affected me in the past more than it does now. Now I think that I would be able to get my partner to do the things that turned me on but in my past it was always the guy who made the moves, it was as if it was an unwritten rule. A man's knowledge is suppose to be such that he knows exactly what to do or else you might get a female with a dumbfounded look on her face as if to say "well what do we do now?"
4. A MAN ALWAYS WANTS AND IS ALWAYS READY TO HAVE SEX: This myth did affect me, but in a complex sort of way. I knew from just knowing

myself that there was no way I always wanted or was always ready to have sex, but again it was communicating this to the would-be-partner that was difficult. Usually I would go through with it, and sometimes fail, rather that say I didn't want sex or wasn't ready. This would put you in a fool's limelight amongst whoever was involved and whoever they relayed this information to.

5. ALL PHYSICAL CONTACT MUST LEAD TO SEX: This is the myth that I feel I was least affected by. Often both me and my partner were sort of relieved when we knew that an encounter would not end in sexual intercourse. When physical contact did arouse and stimulate (me), I naturally wanted to have sex and/or intercourse. There was not a lot of problem there. The problem was where physical contact did not arouse or stimulate (me) and my partner did want it to lead to sex.
6. SEX EQUALS INTERCOURSE: This myth did affect me, it was the accepted final step in an encounter. But over time I found myself becoming more open to the idea that sex didn't need to equal intercourse, and that just as long as both are satisfied with a sexual encounter that doesn't include intercourse then it was perfectly alright. Although I find that often there is a less than satisfied feeling when a sexual encounter has taken place and there has not been any intercourse.
7. SEX REQUIRES AN ERECTION: I do equate the two very much, but I also realize that there are lots of other things that a couple can do that don't require an erection. I always felt that I should get an erection when having sex, but I know that certain things must be done to me, or for me, in order that I can get an erection.

8. GOOD SEX IS INCREASING EXCITEMENT TERMINATED ONLY BY ORGASM: This myth does not really affect me. I know and feel that good sex is an encounter that enables both participants to come away with a good feeling inside, and this can be obtained without increasing excitement and orgasm. Although these often facilitate such a feeling.
9. SEX SHOULD BE NATURAL AND SPONTANEOUS: This myth has not really affected me, and I know that it is fairly impossible to go through with an encounter without at least some communication as to what each other would like to do or would like to have done. I don't expect this of myself, although I may have to some degree in the past.
10. IN THIS ENLIGHTENED AGE THE PRECEEDING MYTHS NO LONGER HAVE ANY INFLUENCE ON US: This myth was one that I never believed. I knew for a fact that many of these myths do exist, and to a great degree. This was one myth that I was never taken in by. I had first hand knowledge that the myths existed and had an effect on people.

As an overall statement I would say that the myth about sex that had the most devastating effect on me is that a sexual encounter should run smoothly, and be carried out fully without any problems. This is just not the way it is, and partners must realize this and put in an effort to make the encounter a successful one.

Appendix T

Conditions Essay

INSTRUCTIONS (from Zilbergeld, 1978; p. 87-88): Compare the three or four best sexual experiences you have had with an equal number of ones that did not turn out well, and list all the factors that differentiate between the good and bad ones (for example, "In all the good experiences, I knew the women well; this wasn't true in the bad one"). The elements that characterize the good experiences and are lacking in the bad ones are your conditions for good sex. Be sure to be as specific as possible. If you have not had any good experiences, or if it is difficult to remember them in sufficient detail, simply use your imagination and list those things you think would be necessary and helpful for you to have good sex.

Whether you use comparisons or your imagination, consider all these areas: your physical health; amount of anxiety or tension; use of alcohol and other drugs; your feelings about yourself; the extent to which you were preoccupied with other matters; fears about performance, pregnancy, and verereal disease; your feelings about your partner (how much you are turned-on to her; your conviction that she cares for you; your confidence that she will not put you down if you are not a perfect lover; and any anger or resentment toward her).

When you have finished with your list, put it away for a day or two, then reread it and see if there is anything you want to change or add. Now go through each item and reword it so that it is specific enough to be put into practice. Let's assume that one of your conditions is "knowing it won't be a disaster if I don't get an erection." This is too vague. You need to ask youself: "What would have to happen for me to know that it won't be a disaster if I don't get an erection?"

Conditions Essay (Barry)

One of the best experiences was when we were parked in the car and started necking and kissing. We were both relaxed and just let things happen slowly. Our hands explored each others' bodies, then we talked about what we'd like to do to one another and although there was no intercourse, it was very pleasent and very relaxing in each others arms.

Another time was when we had spent about half an hour kissing and slowly stripping each other. I began to kiss her naked body and she was responding with little moans and gestures with her hips and her hands. I performed oral sex on her and was really worked up at that time. We had intercourse and it felt so great I didn't want it to stop.

The bad ones were the time my partner and I were in bed naked, for some time. We had both gone past the stage of arousal and were well into intercourse when my partner brought up a subject which had nothing to do with sex. It so happened that the first few times it did not bother me.

The next time she had brought something up, it turned me off and my erection went down and intercourse was not completed.

Another bad experience was when my partner went through menopause. Regardless of how much time I would spend trying to arouse her it was of no avail. She was always dry and there was no response from her body. She said she had no interest in sex and that was that.

The third time with a new partner the arousal was there and after much foreplay we tried to have intercourse. All this time I did not have a full erection. We finally managed to have intercourse with a semi-erect penis, but it did not last too long and before I could ejaculate it went soft. Ever

since that time, intercourse was not attempted again. Right after that experience I realized there was something wrong, as it had never happened to me before.

(Now, that's why I'm here)

For Good Sex:

1) Relaxation
2) Good Health
3) Communication
4) Surroundings
5) Attitude
6) Arousal of Both Parties
7) Stimulation by Both Parties
8) Erection
9) Both Parties Experience Orgasm

Appendix U

Problem Scenario

Instructions

Think about the material we have covered to date and try to come up with some likely explanation for why your problem developed, and why it is currently persisting.

The example below will help you complete the exercise.

EXAMPLE: Sex with my partner has not been as exciting lately as it used to be. I guess we had slipped into a rut. Sex had become intercourse alone, and the purpose for me (in my mind) was to become erect, penetrate my partner and ejaculate. I was so concerned with unrealistic standards for my performance, I had forgotten how to relax and simply enjoy sexual play with my partner.

When I failed to become erect, I panicked and felt that sex was at least temporarily over for me. The next time I was intimate with my partner, I was so concerned with becoming erect, that I was a nervous wreck. It was impossible for me to enjoy sex when I was so anxious, and my penis wouldn't function when I was in that condition.

Problem Scenario (Charles)

The following is an explanation of why my erection problem may have developed and persists.

1. We were both raised to believe sex outside of marriage is wrong. Maybe that affected me a little.
2. Nettie was a new sex partner and men of all ages often fail to get an erection the first time they are with a new partner.
3. Nettie found intercourse painful the first time we tried intercourse (there was not enough lubrication). I was very concerned about the painfulness and this may have worried me the next few times we tried intercourse.
4. I felt very tense and anxious. This may have been due to the above three reasons as well as due to the pressure. I was pressuring myself to get an erection and keep the erection for intercourse.
5. After my first failure to get an erection I kept thinking of and worrying about that failure when I attempted intercourse with her again. This made me tense and anxious and I was not able to relax enough to allow the erection to occur on its own.
6. I did not know that sex can be enjoyable without an erection or intercourse. I did not know what to do in sex if I did not have an erection.

Appendix V

Maintaining Treatment Gains

Instructions*

1) What thoughts and/or behaviors contributed to my difficulties?
   e.g. -Feeling I had to be the world's greatest lover
   -Not telling my partner how I liked to be stimulated
   -Rushing into an intimate encounter without really knowing whether I cared to engage in sex at that time

2) What has been learned?
   e.g. -Sex does not only entail intercourse
   -I need to let my partner know when I'm not in the mood to have sex
   -If I feel anxious and a strong need to perform sexually, I will probably encounter some difficulty achieving an erection

3) Anticipated potential difficulties:
   e.g. -If I encounter this problem again, I'm afraid I'll carry this into my next encounter
   -My partner may not reveal to me how she likes to be stimulated
   -Once the program is completed, I will not be able to follow through with what I have learned

4) Solutions to these difficulties:
   e.g.-Going over the topics discussed in the 10-week program, and carrying out several of the exercises once again
   -Realizing there will be times when I will not be able to achieve an erection
   -Thinking about whether the conditions I require for good sex were met or not
   -Exploring sexual activities with my partner that do not necessarily entail intercourse, or having an erection
   -Recognizing when I'm tense, and getting more relaxed

---

*Adapted from Altman (Note 2).

Maintaining Treatment Gains (Arthur)

1. What thoughts and/or behaviors contributed to my difficulties.
   (See my problems scenario)

2. What has been learned?
   - I have learned that I must have my conditions met in order to have a good sex life.
   - I have also learned that communication in a free and easy manner is very important for me to feel relaxed.
   - That I must be more comfortable with my body and with masturbation.
   - That sex is not something that comes easy, it is something that has to be worked on. Many things are not easy about it but I must force myself to put the effort into it. That my body will not function properly unless I take care to ensure that I feel right about a situation before stumbling through a situation and risking failure. I have also learned more about how to explain the problem to my partner.

3. Anticipated potential difficulties.
   - The only fear I have is that the program will not have worked with me and that once I've gotten into a situation I either won't attempt to put to work the things I have learned, or if I do they will not have the effect on me that they are suppose to have (i.e., that the treatment don't work with me).

4. Solutions to these difficulties.
   - Going over the topics discussed in the 10-week program and carrying out several of the exercises once again
   - Thinking about whether the conditions I require for good sex were met or not.
   - Exploring sexual activites with my partner that do not neccesarily entail intercourse, or having an erection.
   - Recognizing when I'm tense, and getting more relaxed.
   - Actually doing the things rather than convincing myself that it's easier and less of a hassle to not bother.

12-Week Maintainence Program

1st. Week
- Reading chapters--doing exercises in these chapters
- exercises with a partner--simple at first
- masturbation exercise--simple at first

2nd. Week

-Reading

-Reviewing last weeks assignments--to get the main issues and then focussing on the onesthat are most relevant to your own particular case--with a discussion of these relevant topics

-masturbation exercise

-communication exercise with partner

Appendix W

Consumer Evaluation of Treatment

Arthur

Rate the usefullness of each of the following treatment components using the following scale:

1 - Not at all helpful
2 - Slightly helpful
3 - Moderately helpful
4 - Very helpful
5 - Extremely helpful

1. Partial ban on intercourse.
2. Reading Male Sexuality by Zilbergeld (1978).
3. Film: "Beconing Orgasmic" (reel 1).
4. Film: "The Sexually Mature Adult."
5. Film: "A Ripple in Time."
6. Film: "Treating Erectile Problems."
7. Discovering (and recording) which myths have affected you.
8. Discovering (and recording) the conditions you require for good sex.
9. Constructing a problem scenario.
10. Designing your own program to help maintain treatment gains.
11. Presentation on the importance of relaxation, training in the skill, and practising relaxation exercises at home.
12. Presentations and/or discussions concerning:
    a) the importance of getting to know your body;
    b) the rationale underlying the masturbation exercises; and
    c) male sexuality.

13. Presentations and/or discussions concerning:
    a) how to effectively communicate sensitive material;
    b) how to disclose the fact that you are having sexual difficulties;
    c) how to communicate one's sexual likes and dislikes; and
    d) how to find out what the partner likes and dislikes in sex.

14. Presentations and/or discussions concerning:
    a) being assertive with one's partner; and
    b) how to decline an opportunity for sexual activity with the partner.

15. Presentations and/or discussions concerning:
    a) the "Arousal and Erection Guidelines";
    b) myths of male and female sexuality;
    c) how to develop ejaculatory control;
    d) sexuality and the aging process; and
    e) ways to maintain treatment gains.

16. Presentations and/or discussions concerning:
    a) the role of stress and anxiety play in disrupting one's sexual responses;
    b) the importance of being aroused;
    c) the conditions reuqired for good sex; and
    d) the use of fantasy to increase sexual arousal (including doing 2 fantasy-training exerciese).

17. Discussion concerning nonsexual aspects of relationships with specific reference to Arthur's current relationship.

18. Discussion concerning how to correct inappropriate thoughts (e.g., thoughts of insecurity) by using relabelling.

19. The first session with the guest female therapist (presentation and discussion of female sexuality, what different women prefer in sex, and the varieties of sexual expression).

20. The second session with the guest female therapist (role-playing initiating the partner to nondemand exercises and discussing erectile difficulties with the partner).

21. Social exercises:
    a) disclosing sexual concerns in front of a mirror;
    b) disclosing to the partner the fact that you have had sexual difficulties; and
    c) disclosing your feelings about your sexual difficulties to the partner.

22. Social exercises:
    a) communicating one like and one dislike in sex to the partner;
    b) finding out one like and one dislike in sex of the partner;
    c) declining sex with the partner and suggesting an alternate activity;
    d) getting the partner to agree to spend a night at a hotel.

23. Sensual partner exercises;
    a) nondemand snuggling; and
    b) nonsimultaneous body-rubs.

24. Sexual partner exercise:
    a) moderate petting with the patner.

25. Masturbation exercise:
    a) masturbation with focusing.

26. Masturbation exercises:
    a) masturbation with fantasy of sex with a partner; and
    b) writing a sexual fantasy and incorporating it in masturbation.

27. Masturbation exercises:
    a) losing and regaining erection;
    b) masturbation with fantasy of no erection; and
    c) stop-start masturbation with fantasy.

28. The treatment program as a whole.

Appendix X

Detailed Discussion of Arthur's Questionnaire Data

On the following items, the single asterisk represents Arthur's response at pretreatment and the double asterisk represents his response at the final follow-up. When numbers follow an item, the first number represents his response at pretreatment and the second number represents his response at the final follow-up. The same is true when "Yes", "No", "True", and "False" follow an item.

The term "fairly consistent" is defined as true consistency with one exception. "Fluctuation" is defined as more than one exception to true consistency.

Erection Difficulty Questionnaire

Arthur demonstrated improvement of three points on the following items. His reported improvement progressed in a consistent fashion.

-I (would) talk about my erection problem with my sexual partner(s).
___Always ___**Usually ___Sometimes ___Rarely ___*Never

Arthur demonstrated improvement of three points on the following items. His reported improvement progressed in a fairly consistent fashion.

-My erection problem makes me feel like less of a man.
___Completely true ___*Mostly true ___Equally true and false ___Mostly false ___**Completely false

Arthur demonstrated improvement of two points on the following items. His reported improvemnt progressed in a consistent fashion.

-Because of my erection problem I avoid having sex with the same person more than once.
___Always ___Usually ___*Sometimes ___Rarely ___**Never

-My penis remains hard enough for me to stay inside of my partner until I ejaculate (reach orgasm).
___**Always ___Usually ___*Sometimes ___Rarely ___Never

-I would feel humiliated if I experienced erection problems again.
___Completely true ___*Mostly true ___Equally true and false ___**Mostly false ___Completely false

-I feel (would feel) anger or resentment if I have (would have) erection difficulty during sexual activities with a partner.
___Completely true ___*Mostly true ___Equally true and false ___**Mostly false ___Completely false

-I know how I could help myself if I had an erection problem again.
___**Completely true ___Mostly true ___*Equally true and false ___Mostly false ___Completely false

Arthur demonstrated improvement of two points on the following items. His reported improvement progressed in a fairly consistent fashion.

-Even though I admit to myself that I have an erection problem, I tell my partner(s) that "I've had too much to drink," "I guess I'm just tired," or something else so they may not know about my problem.
___Always ____*Usually ___Sometimes ____**Rarely ___Never

Arthur demonstrated improvement of two points on the following items. His reported improvement fluctuated throughout posttreatment and follow-up.

-I am dissatisfied with my sexual functioning.
___Completely true ___*Mostly true ___Equally true and false ___**Mostly false __Completely false

-During sexual activity I worry about whether or not I will get or keep an erection.
___Always ___*Usually ___Sometimes ___**Rarely ____Never

-If I (would) have difficulty getting or keeping an erection during sex, I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need.
___Completely true ___*Mostly true ___Equally true and false ___**Mostly false __Completely false

Arthur reported improvements of one point on the following items. His reported improvement was consistent.

-I do not enjoy sexual activity when I do not have an erection.
-My problem with erections occurs with all of my sexual partners or types of partners.
___Completely true ___Mostly true ___*Equally true and false ___**Mostly false __Completely false

-I am less interested in sex than I used to be.
-I would rather avoid sex altogether than to experience erection problems again.
___Completely true ___Mostly true ___Equally true and false ___*Mostly false ___**Completely false

-Because of my erection problem, I do not attempt sexual intercourse (entering my partner and moving until orgasm) even if I am engaging in other sexual activities with my partner.

___Completely true ___**Mostly true ___*Equally true and false ___Mostly false ___Completely false

Arthur reported improvements of one point on the following items. His reported improvement fluctuated.

-During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.

___Always ___*Usually ___**Sometimes ___Rarely ___Never

-If I get a partial or full erection during foreplay, my penis gets soft again when I try to insert my penis into my partner.

___Always ___Usually ___*Sometimes ___**Rarely ___Never

-If I (would) experience erection difficulty, I (would) feel guilty because my partner might be frustrated and sexually unsatisfied.

___Always ___*Usually ___**Sometimes ___Rarely ___Never

On the following item pretreatment and final follow-up scores were identical, and responses between these times were fairly consistent.

-If I lose (would lose) my erection during sexual activity, I worry (would worry) that I won't get an erection again.

___Always ___Usually ___Sometimes ___* **Rarely ___Never

On the following items pretreatment and final follow-up scores were identical, but responses between these times fluctuated.

-I have trouble getting an erection during foreplay with a partner.

___Always ___Usually ___Sometimes ___* **Rarely ___Never

-I do not (would not) get an erection during any type of sexual activity (e.g., intercourse, masturbation, oral sex, etc.).

___Completely true ___Mostly true ___Equally true and false ___Mostly false ___* ** Completely false

Arthur reported a deterioration of one point on the following item at posttreatment as compared to pretreatment. Subsequent responses were consistent to his posttreatment response.

-I get (would get) an erection when I see, hug, dance with, or otherwise interact with a dressed, atteactive potential partner.
____Always ____*Usually ____**Sometimes ____Rarely ____Never

Note: The ninth item on this measure was deleted due to the men finding the alternative responses to be very confusing. The item is: "Because of my erection problem, I do not (would not) try to get involved in relationships which might lead to sex." The alternative responses are: "Always", "Usually", "Sometimes", "Rarely", and "Never."

The responses on the Erection Difficulty Questionnaire were converted into scores, with (1) being the most undesirable response and (5) being the most desirable rsponse. Arthur's average scores were 2.83, 3.57, 3.18, 3.48, 3.96, and 4.17 at the various testing times.

Goals for Sex Therapy Questionnaire

The response-choices are listed below.

1	2	3	4	5	6	7
Much less than satis-fied	Less than satisfied	Somewhat less than satisfied	Satisfied with my current behavior or feelings	Somewhat more than satisfied	More than satisfied	Much more than satisfied

Arthur showed an improvement of two points from pretreatment to the final follow-up on the following items.

-Being able to regain an erection if I lose it during foreplay. (3) (5) (consistent)

-Being able to get an erection sufficient to begin intercourse. (3) (5) (fairly consistent)

Arthur had not been nude with his partner until treatment ended. Accordingly, the first digit represents his response at the six-week follow-up. He demonstrated an improevement of two points on this item.

-Being able to get an erection during foreplay while both of us are nude. (4) (6) (fairly consistent)

Arthur demonstrated an improvement of one point on seven items.

-Being able to keep an erection during intercouse until I ejaculate. (3) (4) (consistent)
-Being able to regain an erection if I lose it during intercourse. (3) (4) (consistent)

-Being able to anticipate (think about) having intercourse without fear or anxiety. (3) (4) (fairly consistent)
-Being able to get an erection by stimulating myself when I am alone. (4) (5) (fairly consistent)
-Being able to get an erection during foreplay with a woman while both of us are clothed. (4) (5) (fairly consistent)

-Feeling like I am sexually desireable to my partner. (4) (5) (fairly consistent)
-Feeling comfortable about my own sexuality. (4) (5) (fairly consistent)

All of Arthur's responses were identical on two items.

-Being able to stimulate my partner to orgasm. (4) (4) (consistent)
-Being able to enjoy a sexual encounter without having intercourse. (4) (4) (consistent)

Arthur's pretreatment and final follow-up responses were identical on the following item.

-Being able to anticipate a sexual encounter without feeling I should have intercourse. (4) (4) (fairly consistent)

Arthur had not had intercourse until following the 12-week follow-up. Accordingly, the first digit represents his response at the 24-week follow-up. He reported a deterioration of one point on the item.

-Being able to engage in intercourse for as long as I like without ejaculating. (4) (3) (consistent)

Arthur's average scores were 3.58, 3.78, 3.58, 3.85, 4.14, and 4.50 at the various testing times.

Index of Sexual Satisfaction

The response-choices are listed below.

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 Good part of the time
5 Most or all of the time

Arthur showed an improvement of two points on the following item.

-I enjoy the sex techniques that my partner likes or uses (2) (4) (fluctuated)

Arthur demonstrated an improvement of one point on the following items.

-Sex is fun for my partner and me (4) (5) (consistent)
-My partner is sexually very exciting (4) (5) (consistent)
-It is easy for me to get sexually excited by my partner (4) (5) (consistent)
-I feel that my partner is sexually pleased with me (4) (5) (consistent)
-My partner is very sensitive to my sexual needs and desires (3) (4) (consistent)

-I feel that my partner enjoys our sex life (4) (5) (fairly consistent)
-My sex life is very exciting (3) (4) (fairly consistent)

-I feel that my sex life is lacking in quality (2) (1) (fluctuated)

All of Arthur's responses were consistent and desirable on the following items.

-My partner observes good personal hygiene (5) (5) (consistent)
-I feel that sex is a normal function of our relationship (5) (5) (consistent)
-I feel that our sex life really adds a lot to our relationship (5) (5) (consistent)
-I feel that my partner sees little in me except for the sex I can give (1) (1) (consistent)

-I feel that sex is dirty and disgusting (1) (1) (consistent)
-I feel that my partner wants too much sex from me (1) (1) (consistent)
-My partner dwells on sex too much (1) (1) (consistent)
-I feel that sex is something that has to be endured (1) (1) (consistent)
-I feel that my sex life is boring (1) (1) (consistent)

On the following item, Arthur's responses were consistent, but neither desirable nor undesirable.

-When we have sex it is too rushed and hurriedly completed (3) (3) (consistent)

On the following items, Arthur's responses at pretreatment and the final follow-up were identical and desirable.

-My sex life is monotonous (1) (1) (fairly consistent)
-My partner is too rough or brutal when we have sex (1) (1) (fairly consistent)

-My partner does not want sex when I do (1) (1) (fluctuated)
-I think that sex is wonderful (5) (5) (fluctuated)
-I would like to have sexual contact with someone other than my partner (2) (2) (fluctuated)

On the following item, Arthur's responses at pretreatment and the final follow-up were identical, but neither desirable nor undesirable.

-I feel that I should have sex more often. (3) (3) (fluctuated)

Arthur's scores were 18, 14, 20, 22, 14, and 8. A score of 28 or greater represents dissatisfaction with the sexual relationship at the various testing times.

Culture-Free Self-Esteem Inventory

On the following items, Arthur's responses improved from pretreatment to postreatment. The responses during follow-up were consistent with the posttreatment response.

-Do you always tell the truth? Yes No
-Are you as nice looking as most people? No Yes

On the following items, Arthur's responses improved from pretreatment to the final follow-up, however the change did not occur at postreatment. Once the change occurred, subsequent responses were consistent.

- Are you usually tense or anxious. Yes No
-Are you easily depressed? Yes No
-Are you lacking in self-confidence? Yes No

On the following item, Arthur's response improved from pretreatment to the final follow-up, and was fairly consistent between these times.

-Do you have only a few friends? Yes No

On the following item, Arthur's response improved from pretreatment to the final follow-up, but fluctuated between these periods.

-Is it difficult for you to express your views or feelings? Yes No

On the following items Arthur's responses were consistent and desirable.

-Can you do most things as well as others? Yes Yes
-Do you like being a male? / Do you like being a female? Yes Yes
-Do most people you know like you? Yes Yes
-Are you usually successful when you attempt important tasks or assignments? Yes Yes
-Have you ever taken anything that did not belong to you? Yes Yes
-Are you as intelligent as most people? Yes Yes
-Do you feel you are as important as most people? Yes Yes
-Do you gossip at times? Yes Yes
-Are you as strong and healthy as most people? Yes Yes
-Do you ever get angry? Yes Yes
-Are you ever shy? Yes Yes
-Do you ever lie? Yes Yes

-Do most people respect your views? Yes Yes
-Are you as happy as most people? Yes Yes
-Are you ever sad? Yes Yes
-Do you like everyone you know? No No
-Would you change many things about yourself if you could? No No
-Do many people dislike you? No No
-Do you often feel that you are no good at all? No No
-Do you often feel ashamed of yourself? No No
-Are other people generally more successful than you are? No No
-Are you a failure? No No
-Are you often upset about something? No No
-Are you definitely lacking in initiative? No No

On the following item Arthur's responses were desirable at pretreatment and at the final follow-up, and were fairly consistent between these times.

-Do you feel uneasy much of the time without knowing why? No No

On the following items Arthur's responses were desirable at pretreatment and at the final follow-up, but fluctuated between these times.

-Are you happy most of the time? Yes Yes
-Do you spend most of your free time alone? No No
-Do people like your ideas? Yes Yes

On the following items Arthur's responses were consistent, but undesirable.

-Are your feelings easily hurt? Yes Yes
-Would you like to be as happy as others appear to be? Yes Yes
-Is it hard for you to meet new people? Yes Yes
-Do you worry a lot? Yes Yes

On the following item Arthur's responses were undesirable at pretreatment and at the final follow-up, and were fairly consistent between these times.

-Are you more sensitive than most people? Yes Yes

- Arthur's total scores were at the 34th., 38th., 43rd., 34th., 38th., and 75th. percentile at the various testing times.
- Arthur's general self-esteem sub-scores were at the 54th., 71st., 71st., 41st., 54th., and 88th. percentile.
- Arthur's social self-esteem sub-scores were at the 80th., 51st., 80th., 80th., 51st., and 100th. percentile.
- Arthur's personal self-esteem sub-scores were at the 23rd., 32nd., 32nd., 32nd., 45th., and 61st. percentile.
- His raw scores on the lie items were 7, 8, 8, 8, 8, and 8 (there were 8 items and a score of "8" represents not answering at all in a socially desirable manner).

Dyadic Adjustment Scale

Arthur's responses improved consistently but non-significantly on the following item.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Amount of time spent together.

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	**	*			

Arthur's responses improved fairly consistently but non-significantly on the following items.

-Do you confide in your mate?

All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
	**	*			

-Do you and your mate engage in outside interests together?

All of them	Most of them	Some of them	Very few of them	None of them
	**	*		

Arthur's responses improved non-significantly on the following item. His responses fluctuated.

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

-Work together on a project?

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
	*	**			

There were no changes on the following items from pretreatment to the final follow-up session (including the sessions between these times).

- -Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.
  - -Friends
  - -Conventionality (correct or proper behavior)

Always Agree	Almost Always Agree	Occa- sionally Disagree	Fre- quently Disagree	Almost Always Disagree	Always Disagree
		* **			

- -How often would you say the following events occur between you and your mate?
  - -Laugh together
  - -Calmly discuss something

Never	Less than Once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
			* **		

- -Which of the following statements best describes how you feel about the future of your relationship?

______ I want desperately for my relationship to succeed, and <u>would go to almost any length</u> to see that it does.

<u>* **</u> I want very much for my relationship to succeed, and <u>will do all I can</u> to see that it does.

______ I want very much for my relationship to succeed, and <u>will do my fair share</u> to see that it does.

______ It would be nice if my relationship succeeded, but I <u>can't do much more than I am doing now</u> to help it succeed.

______ It would be nice if it succeeded, but I <u>refuse to do any more than I am doing</u> now to keep the relationship going.

______ My relationship can never succeed, and <u>there is no more that I can do</u> to keep the relationship going.

Arthur's responses were the same at pretreatment and the final follow-up session on the following items, and were fairly consistent between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Matters of recreation

-Leisure time interests and activities

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
		* **			

-Sex relations

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	* **				

-In general, how often do you think that things between you and your partner are going well?

All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
	* **				

-Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks.

	Yes	No
-Being too tired for sex.		* **

Arthur's responses were the same at pretreatment and the final follow-up session on the following items, but fluctuated between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Ways of dealing with parents or in-laws

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
		* **			

-Demonstrations of affection
-Aims, goals and things believed important
-Career decisions

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	* **				

-How often would you say the following events occur between you and your mate?
-Have a stimulating exchange of ideas

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
			* **		

-Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks.

	Yes	No
-Not showing love.		* **

Arthur did not respond to the following items at pretreatment because he felt the items were not applicable at that time. Thus, the single asterix corresponds to his response at posttreatment. His postreatment and final follow-up responses were identical, and were fairly consistent between these times.

-How often do you or your mate leave the house after a fight?
-Do you ever regret that you married? (or lived together)

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
				* **	

Arthur did not respond to the following items in the pretreatment session because he felt the items were not applicable at that time. Thus, the single asterix corresponds to is response at posttreatment. His postreatment and final follow-up responses were identical, but fluctuated between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Philosophy of life

-Making major decisions

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	* **				

Arthur's responses consistently deteriorated by one point on the following items.

-How often do you and your partner quarrel?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
			**	*	

-How often do you and your mate "get on each other's nerves?"

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
			**	*	

-Do you kiss your mate.

Every Day	Almost Every Day	Occa-sionally	Rarely	Never
*	**			

-Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3**	4*	5	6
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

Arthur's responses deteriorated fairly consistently by two points on the following items.

-How often do you discuss or have you considered divorce, separation, or terminating your relationship?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
			**		*

Arthur's responses deteriorated by one point and fluctuated on the following item.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Religious matters

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
		*	**		

Arthur did not respond to the following items in the pretreatment session and in some of the subsequent sessions because he felt the items were not applicable.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Handling family finances

-Household tasks

-Arthur's total scores were104, 101, 91, 94, 97, and 102 at the various testing times. The mean for married respondants is 114.8 with a standard deviation of 17.8.

-His diadic consensus scores were 42, 43, 40, 41, 40, and 43. The mean for married respondants is 57.9 with a standard deviation of 8.5.

-His affectional expression scores were 10, 9, 8, 8, 7, and 10. The mean for married respondants is 9.0 with a standard deviation of 2.3.

-His dyadic satisfaction scores were 40, 36, 33, 34, 37, and 35. The mean for married respondants is 40.5 with a standard deviation of 7.2.

-His dyadic cohesion scores were 12, 13, 10, 11, 13 and 14. The mean for married respondants is 13.4 with a standard deviation of 4.2.

Marriage and Sexual Relationship Questionnaire

Marriage Attitudes Scale

On the following items Arthur's responses at pretreatment was undesirable (indicated possible defensiveness) but all of his subsequent responses were desirable (not defensive).

- -On occasions I have had doubts about my ability to succeed in my marriage. False True
- -When disagreements arise they are always settled in a peaceful, fair and democratic manner. True False
- -My mate occasionally makes me feel miserable. False True
- -I have never deliberately said something to hurt my spouse's feelings. True False

On the following items, Arthur's responses at pretreatment were undesirable, but changed and remained changed sometime after posttreatment.

- -There have been times when I felt like hitting my spouse. False True
- -I have never felt my spouse was angry at me without a cause. True False
- -I have never regretted my marriage, not even for a moment. True False

On the following items, all of Arthur's responses were consistent and desirable.

- -I do not always tell my spouse the truth. True True
- -There are moments when I dislike my spouse. True True
- -Some of my dealings with my mate are prompted by selfish motives. True True
- -I have some needs that are not being met by my marriage. True True
- -Once in a while I am not completely truthful with my mate. True True
- -I have some thoughts I wouldn't want my spouse to know about. True True
- -My marriage is not a perfect success. True True
- -My marriage could be happier than it is. True True

-I have never felt displeased with my spouse. False False
-I have never been upset when my spouse expressed views very different from mine. False False
-My mate completely understands and sympathizes with my every mood. False False
-I don't think any couple could live together with greater harmony than my mate and I. False False
-My mate and I understand each other completely. False False
-I confide in my mate about everything. False False
-There is never a moment that I do not feel "head over heels" in love with my mate. False False
-Every new thing I have learned about my mate has pleased me. False False
-There is nothing about my mate's appearance that I would want to see changed in any way. False False
-I am always courteous to my spouse. False False

On the following items Arthur's responses were desirable at pretreatment and the final follow-up, and were fairly consistent between these times.

-No matter what my spouse is saying, I'm always a good listener. False False
-I sometimes resent my spouse when I can't get my own way. True True
-My spouse and I are always happy with the amount of affection we show each other. False False
-Sometimes I'm tempted to say things to my spouse which I would regret. True True

On the following item, Arthur's responses were consistent and undesirable.

-I never hesitate to go out of my way to help my spouse. True True

On the following item, Arthur's response at pretreatment was desirable but his response changed sometime after posttreatment. Once the change took place, it remained changed.

-There are times when I do not feel a great deal of love and affection for my mate. True False

On the following item Arthur's response was desirable at pretreatment, undersirable at the fianl follow-up, and fluctuated between these times.

-I think I would lie to my spouse to keep out of trouble. True False

Arthur's scores were 8, 8, 5, 3, 1, and 3. A score of 0 is perfectly non-defensive, and a score of 32 is perfectly defensive. The mean for a sample of 164 "normal" males is 10.48. The normal range is considered to be between 5 and 15.

Sexual Attutudes Scale

On the following items, Arthur's undesirable initial responses changed to a desirable response at posttreatment and subsequent responses were consistently desirable.

-I have never felt that my spouse lacks anything as a lover. True False
-Every now and then my mate does not please me sexually. False True

On the following items, Arthur's undesirable initial responses changed sometime after pretreatment and remained changed.

-I sometimes push my mate to have sex more than he/she wants to. False True

On the following items, Arthur's responses were consistent and desirable.

-I do not always initiate sex when I would like to. True True

-I think I am much sexier than most people. False False
-My spouse and I never feel unhappy about how often we have sex together. False False
-I never feel resentful when my spouse turns me down for sex. False False
-My spouse always knows exactly what I would like him/her to do when we are making love. False False
-My spouse always does the things I like during sex. False False
-I always satisfy my spouse sexually. False False
-I have always been satisfied with how often my spouse and I have sex. False False
-Sex always lasts as long as I would like it to. False False
-My spouse and I are never too busy to have sex. False False

On the following item, Arthur's responses were identical and desirable at pretreatment and the final follow-up, and were fairly consistent between these times.

-I must admit that sometimes I am not considerate of my mate when we make love. True True

Arthur responded at pretreatment that the following item did not apply to him since he had not had sex with his partner. The first response is his posttreatment response. His posttreatment and final follow-up responses at identical and desirable, but fluctuated between these times.

-Intercourse is always more enjoyable for me than other sexual activities. False False

On the following item, his response deteriorated from pretreatment to the final follow-up, and was fairly consistent between these times.

-Our sex life seems a little routine and dull to me at times. True False

Arthur's scores were 3, 2, 3, 2, 2, and 1 at the various testing times. A score of 0 is perfectly non-defensive and a score of 16 is perfectly defensive. The mean for a sample of 164 "normal" males is 5.52. The normal range is considered to be between 3 and 8.

Appendix Y

Culture-Free Self-Esteem Inventory (SEI), Dyadic Adjustment Scale (DAS), Marital Attitudes Scale (MAS), and Sexual Attitudes Scale (SAS) scores for the clients at pretreatment, posttreatment and follow-up. The SEI scores are percentiles. The mean DAS score for married respondents is 114.8 with a standard deviation of 17.8. The mean DAS score for divorced respondents is 70.7 with a standard deviation of 23.8. The normal range is 5-15 on the MAS and 3-8 on the SAS. Lower scores also indicate non-defensiveness.

Arthur

	SEI	DAS	MAS	SAS
Pretreatment	34	104	8	3
Posttreatment	38	101	8	2
Follow-up #1	43	91	5	3
Follow-up #2	34	94	3	2
Follow-up #3	38	97	1	2
Follow-up #4	75	102	3	1

Barry

	SEI	DAS	MAS	SAS
Pretreatment	83	89	27	4 (7 N/A)
Posttreatment	93	139	28	14
Follow-up #1	97	120	31	12
Follow-up #2	93	124	31	13
Follow-up #3	97	124	32	14
Follow-up #4	97	133	30	15

Charles

	SEI	DAS	MAS	SAS
Pretreatment	97	139	30	10
Posttreatment	83	117	31	12
Follow-up #1	93	126	28	9
Follow-up #2	75	131	29	10
Follow-up #3	88	139	31	11
Follow-up #4	97	130	30	9

Appendix Z

Detailed Discussion of Barry's Questionnaire Data

On the following items, the single asterisk represents Barry's response at pretreatment and the double asterisk represents his response at the final follow-up. When numbers follow an item, the first number represents his response at pretreatment and the second number represents his response at the final follow-up. The same is true when "Yes", "No", "True", and "False" follow an item.

The term "fairly consistent" is defined as true consistency with one exception. "Fluctuation" is defined as more than one exception to true consistency.

Erection Difficulty Questionnaire

Barry demonstrated an improvement of four points on the following items. The change occurred at posttreatment and subsequent responses were consistent with the posttreatment response.

-During sexual activity I worry about whether or not I will get or keep an erection.
-If I lose (would lose) my erection during sexual activity, I worry (would worry) that I won't get an erection again.
__*Always ___Usually ___Sometimes ___Rarely ___**Never

-My penis remains hard enough for me to stay inside of my partner until I ejaculate (reach orgasm).
__**Always ___Usually ___Sometimes ___Rarely ___*Never

-I do not enjoy sexual activity when I do not have an erection.
-I am dissatisfied with my sexual functioning.
___*Completely true ___Mostly true ___Equally true and false ___Mostly false **Completely false

-I know how I could help myself if I had an erection problem again.
__**Completely true ___Mostly true ___Equally true and false ___Mostly false _*Completely false

Barry demonstrated an improvement of four points on the following items. His reported improvement progressed in a fairly consistent fashion.

-My problem with erections occurs with all of my sexual partners or types of partners.
___*Completely true ___Mostly true ___Equally true and false ___Mostly false **Completely false

Barry demonstrated an improvement of four points on the following items. His reported improvement fluctuated throughout the posttreatment and follow-up period.

-If I get a partial or full erection during foreplay, my penis gets soft again when I try to insert my penis into my partner.
-I have trouble getting an erection during foreplay with a partner.
___*Always ___Usually ___Sometimes ___Rarely ___**Never

Barry demonstrated improvement of three points on the following items. The change occurred at posttreatment and subsequent responses were consistent with the posttreatment response.

-My erection problem makes me feel like less of a man.
-I would rather avoid sex altogether than to experience erection problems again.

___Completely true __*Mostly true ___Equally true and false ___Mostly false **Completely false

Barry demonstrated an improvement of three points on the following items. His reported improvement progressed in a fairly consistent fashion.

-If I (would) experience erection difficulty, I (would) feel guilty because my partner might be frustrated and sexually unsatisfied.

___Always ____*Usually ___Sometimes ___Rarely **Never

-I do not (would not) get an erection during any type of sexual activity (e.g., intercourse, masturbation, oral sex, etc.).

___Completely true __*Mostly true ___Equally true and false ___Mostly false **Completely false

Barry demonstrated an improvement of three points on the following items. His reported improvement fluctuated throughout the posttreatment and follow-up period.

-During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.

___Always ____*Usually ___Sometimes ___Rarely __**Never

Barry demonstrated improvement of two points on the following items. The change occurred at posttreatment and subsequent responses were consistent with the posttreatment response.

-I feel (would feel) anger or resentment if I have (would have) erection difficulty during sexual activities with a partner.

___Completely true ___Mostly true __*Equally true and false ___Mostly false **Completely false

Barry demonstrated improvement of two points on the following items. His reported improvement progressed in a fairly consistent fashion.

-I get (would get) an erection when I see, hug, dance with, or otherwise interact with a dressed, attractive potential partner.
___Always **Usually ___Sometimes *Rarely ___Never

-I would feel humiliated if I experienced erection problems again.
___Completely true ___Mostly true *Equally true and false ___Mostly false **Completely false

Barry reported improvements of one point on the following items. The change occurred at posttreatment and subsequent responses were consistent with the posttreatment response.

-Because of my erection problem I avoid having sex with the same person more than once.
___Always ___Usually ___Sometimes *Rarely **Never

-I (would) talk about my erection problem with my sexual partner(s).
**Always *Usually ___Sometimes ___Rarely ___Never

Barry demonstrated improvement of one point on the following item. His reported improvement progressed in a fairly consistent fashion.

-If I (would) have difficulty getting or keeping an erection during sex, I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need.
___Completely true ___Mostly true ___Equally true and false *Mostly false **Completely false

There were no changes on the following items. That is, all of Barry's subsequent responses were consistent with his pretreatment response.

-Even though I admit to myself that I have an erection problem, I tell my partner(s) that "I've had too much to drink," "I guess I'm just tired," or something else so they may not know about my problem.
___Always ___Usually ___Sometimes ___Rarely * **Never

-Because of my erection problem, I do not attempt sexual intercourse (entering my partner and moving until orgasm) even if I am engaging in other sexual activities with my partner.

* ** Always attempt ____Usually attempt ____Sometimes attempt ____Rarely attempt ____Never attempt

On the following item, Barry's pretreatment and final follow-up responses were identical, and responses between these times were fairly consistent.

-I am less interested in sex than I used to be.

__Completely true __Mostly true __Equally true and false __Mostly false * **Completely false

Note: The ninth item on this measure was deleted due to the men finding the alternative responses to be very confusing. The item is: "Because of my erection problem, I do not (would not) try to get involved in relationships which might lead to sex." The alternative responses are: "Always", "Usually", "Sometimes", "Rarely", and "Never."

The responses on the Erection Difficulty Questionnaire were converted into scores, with (1) being the most undesirable response and (5) being the most desirable response. The average scores were 2.35, 4.96, 4.73, 4.73, 4.65, and 4.96 at the various testing times.

Goals for Sex Therapy Questionnaire

The response-choices are listed below.

1	2	3	4	5	6	7
Much less than satis-fied	Less than satisfied	Somewhat less than satisfied	Satisfied with my current behavior or feelings	Somewhat more than satisfied	More than satisfied	Much more than satisfied

Barry showed an improvement of six points from pretreatment to the final follow-up on seven items.

-Being able to get an erection during foreplay with a woman while both of us are clothed. (1) (7) (consistent)
-Being able to get an erection during foreplay while both of us are nude. (1) (7) (consistent)
-Being able to get an erection sufficient to begin intercourse. (1) (7) (consistent)
-Being able to keep an erection during intercouse until I ejaculate. (1) (7) (consistent)
-Feeling comfortable about my own sexuality. (1) (7) (consistent)

-Being able to regain an erection if I lose it during foreplay. (1) (7) (fairly consistent)
-Being able to regain an erection if I lose it during intercourse. (1) (7) (fairly consistent)

Barry demonstrated an improvement of four points on one item.

-Being able to get an erection by stimulating myself when I am alone. (2) (6) (fluctuated)

Barry demonstrated an improvement of three points on three items.

- -Being able to enjoy a sexual encounter without having intercourse. (4) (7) (consistent)
- -Being able to anticipate a sexual encounter without feeling I should have intercourse.(4) (7) (consistent)

- -Being able to anticipate (think about) having intercourse without fear or anxiety. (3) (6) (fairly consistent)

Barry demonstrated an improvement of one point on two items.

- -Being able to stimulate my partner to orgasm. (6) (7) (consistent)
- -Feeling like I am sexually desireable to my partner. (6) (7) (consistent)

Barry had not had intercourse with his partner by pretreatment and thus did not answer the following item. The first digit represents his posttreatment response.

- -Being able to engage in intercourse for as long as I like without ejaculating. (7) (7) (fairly consistent)

His average scores were 2.46, 7.00, 6.65, 6.71, 6.93, and 6.86 at the various testing times.

Index of Sexual Satisfaction

The response-choices are listed below.

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 Good part of the time
5 Most or all of the time

Barry showed an improvement of four points on the following items. The improvement occurred at posttreatment and was consistently maintained throughout the follow-up period.

- -I feel that my partner enjoys our sex life (1) (5) (consistent)
- -My sex life is very exciting (1) (5) (consistent)
- -Sex is fun for my partner and me (1) (5) (consistent)
- -I think that sex is wonderful (1) (5) (consistent)
- -I feel that sex is a normal function of our relationship (1) (5) (consistent)
- -I feel that our sex life really adds a lot to our relationship (1) (5) (consistent)
- -I feel that my partner is sexually pleased with me (1) (5) (consistent)
- -I feel that my sex life is lacking in quality (5) (1) (consistent)

Barry demonstrated an improvement of three points on the following item. The change occurred at posttreatment and was consistently maintained.

- -I feel that my sex life is boring (4) (1) (consistent)

Barry reported an improvement of two points on the following items.

- -I enjoy the sex techniques that my partner likes or uses (3) (5) (consistent)

- -I would like to have sexual contact with someone other than my partner (3) (1) (fairly consistent)

Barry showed an improvement of one point on the following items. The change occurred at postreatment and was maintained throughout the follow-up period.

-It is easy for me to get sexually excited by my partner (4) (5) (consistent)
-My partner is very sensitive to my sexual needs and desires (4) (5) (consistent)

On the following items, Barry's responses at pretreatment and the final follow-up were identical and desirable.

-My partner is sexually very exciting (5) (5) (consistent)
-My partner observes good personal hygiene (5) (5) (consistent)
-I feel that my partner sees little in me except for the sex I can give (1) (1) (consistent)
-I feel that sex is dirty and disgusting (1) (1) (consistent)
-My sex life is monotonous (1) (1) (consistent)
-My partner dwells on sex too much (1) (1) (consistent)
-I feel that sex is something that has to be endured (1) (1) (consistent)
-My partner is too rough or brutal when we have sex (1) (1) (consistent)
-My partner does not want sex when I do (1) (1) (consistent)

-I feel that my partner wants too much sex from me (1) (1) (fairly consistent)

-When we have sex it is too rushed and hurriedly completed (1) (1) (fluctuated)

On the following item, Barry's response at pretreatment was identical to his response at the final follow-up. These responses were not desirable.

-I feel that I should have sex more often (4) (4) (fluctuated)

Barry's scores were 44, 9, 8, 5, 8, and 3. Scores of 28 and more indicate dissatisfaction with the sexual relationship at the various testing times.

Culture-Free Self-Esteem Inventory

On the following items, Barry's responses improved from pretreatment to postreatment. The responses during follow-up were consistent with the posttreatment response.

-Can you do most things as well as others? No Yes
-Are you as nice looking as most people? No Yes

On the following item, Barry's response improved from pretreatment to the final follow-up, however the change did not occur at postreatment. Once the change occurred, subsequent responses were consistent.

-Would you like to be as happy as others appear to be? Yes No

On the following items Barry's responses were consistent and desirable.

-Are you happy most of the time? Yes Yes
-Do you like being a male? / Do you like being a female? Yes Yes
-Do most people you know like you? Yes Yes
-Are you usually successful when you attempt important tasks or assignments? Yes Yes
-Are you as intelligent as most people? Yes Yes
-Do you feel you are as important as most people? Yes Yes
-Are you as strong and healthy as most people? Yes Yes
-Do people like your ideas? Yes Yes
-Do most people respect your views? Yes Yes
-Are you as happy as most people? Yes Yes

-Do you have only a few friends? No No
-Do you spend most of your free time alone? No No
-Are you easily depressed? No No
-Would you change many things about yourself if you could? No No
-Do many people dislike you? No No
- Are you usually tense or anxious. No No
-Do you often feel that you are no good at all? No No
-Are your feelings easily hurt? No No
-Is it difficult for you to express your views or feelings? No No
-Do you often feel ashamed of yourself? No No
-Do you feel uneasy much of the time without knowing why? No No

-Are you a failure? No No
-Is it hard for you to meet new people? No No
-Are you often upset about something? No No
-Are you most sensitive than most people? No No
-Are you definitely lacking in initiative? No No
-Do you worry a lot? No No

On the following item Barry's responses were desirable at pretreatment and at the final follow-up, and were fairly consistent between these times

-Are you lacking in self-confidence? No No

On the following items Barry's responses were consistently undesirable.

-Are other people generally more successful than you are? Yes Yes
-Do you like everyone you know? Yes Yes

-Are you ever shy? No No
-Are you ever sad? No No
-Do you ever get angry? No No

On the following item, Barry's response deteriorated from pretreatment to postreatment. The responses during follow-up were consistent with the posttreatment response.

-Have you ever taken anything that did not belong to you? Yes No

On the following items, Barry's responses deteriorated from pretreatment to the final follow-up, however the change did not occur at postreatment. Once the change occurred, subsequent responses were consistent.

-Do you always tell the truth? No Yes
-Do you ever lie? Yes No

On the following item, Barry's response deteriorated from pretreatment to the final follow-up, and was fairly consistent between these periods.

-Do you gossip at times? Yes No

-Barry's total scores were at the 83rd., 93rd., 97th., 93rd., 97th., and 97th. percentile at the various testing times.
-Barry's general self-esteem sub-scores were at the 71st., 88th., 97th., 88th., 97th., and 97th. percentile.
-Barry's social self-esteem sub-scores were at the 100th., 100th., 100th., 100th., 100th., and 100th. percentile.
-Barry's personal self-esteem sub-scores were at the 90th., 100th., 100th., 100th., 100th., and 100th. percentile.
-His raw scores on the lie items were 4, 3, 0, 0, 1, and 0 (there were 8 items and a score of "8" represents not answering at all in a socially desirable manner).

Dyadic Adjustment Scale

Barry significantly and consistently changed his response in a positive direction on the following item (a change four categories).

-How often would you say the following events occur between you and your mate?
-Work together on a project?

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
*				**	

Barry significantly and fairly consistently changed his response in a positive direction on the following item (a change of three categories).

-Do you kiss your mate.

Every Day	Almost Every Day	Occa-sionally	Rarely	Never
**			*	

Barry significantly and fairly consistently changed his response in a desirable direction on the following items (a change of two categories).

-How often would you say the following events occur between you and your mate?
-Laugh together
-Calmly discuss something

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
			*		**

The improvement in Barry's response from pretreatment to the final follow-up was consistent and amounted to one category on the following item.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.
-Amount of time spent together.

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	**	*			

The improvement in Barry's response from pretreatment to the final follow-up was fairly consistent and amounted to one category on the following items.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Demonstrations of affection

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
**	*				

-Do you and your mate engage in outside interests together?

All of them	Most of them	Some of them	Very few of them	None of them
	**	*		

-Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4*	5**	6
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

The improvement in Barry's response from pretreatment to the final follow-up amounted to one category on the following item but fluctuated.

-Please indicate below the approxiamte extent of agreement or disagreement between you and your partner for each item on the following list.

-Friends

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
**	*				

Barry felt that the following items did not apply to him at pretreatment. Thus, the single asterisk represents his posttreatment response. On the following item he demonstrated a slight and fairly consistent improvement from posttreatment to the final follow-up.

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

-Have a stimulating exchange of ideas

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
				*	**

There were no changes on the following items.

-Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks.

	Yes	No
-Being too tired for sex.		* **
-Not showing love.		* **

Barry's responses were the same at pretreatment and the final follow-up session on the following items, and were fairly consistent between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Sex relations

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
* **					

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Philosophy of life

-Aims, goals and things believed important

-Leisure time interests and activities

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	* **				

-How often do you discuss or have you considered divorce, separation, or terminating your relationship?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
					* **

-Do you confide in your mate?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
	* **				

-Do you ever regret that you married? (or lived together)

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
					* **

-How often do you and your partner quarrel?
-How often do you and your mate "get on each other's nerves?"

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
				* **	

Barry's responses were the same at pretreatment and the final follow-up session on the following items, but fluctuated between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Conventionality (correct or proper behavior)

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	* **				

-How often do you or your mate leave the house after a fight?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
					* **

-Which of the following statements best describes how you feel about the future of your relationship?

_____ I want desperately for my relationship to succeed, and <u>would go to almost any length</u> to see that it does.

* ** I want very much for my relationship to succeed, and <u>will do all I can</u> to see that it does.

_____ I want very much for my relationship to succeed, and <u>will do my fair share</u> to see that it does.

_____ It would be nice if my relationship succeeded, but <u>I can't do much more than I am doing now</u> to help it succeed.

_____ It would be nice if it succeeded, but <u>I refuse to do any more than I am doing</u> now to keep the relationship going.

_____ My relationship can never succeed, and <u>there is no more that I can do</u> to keep the relationship going.

Barry felt that the following items did not apply to him at pretreatment. Thus, the single asterisk represents his posttreatment response. On the following items, all of his responses were identical.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Household tasks

-Career decisions

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
	* **				

Barry felt that the following items did not apply to him at pretreatment. Thus, the single asterisk represents his posttreatment response. On the following items his posttreatment and final follow-up responses were identical, but fluctuated between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Ways of dealing with parents or in-laws

-Making major decisions

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
* **					

Barry showed slight deterioration and fluctuation on the following response.

-In general, how often do you think that things between you and your partner are going well?

All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
*	**				

Barry felt that the following items did not apply to him at pretreatment. Thus, the single asterisk represents his posttreatment response. On the following items he demonstrated a slight deterioration from posttreatment to the final follow-up.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Handling family finances

-Matters of recreation

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
*	**				

Barry felt that the following item did not apply to him at pretreatment and at the final follow-up.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Religious matters

-Barry's total scores were 89, 139, 120, 124, 124, and 133 at the various testing times. The mean for married respondants is 114.8 with a standard deviation of 17.8.
-Barry's dyadic consensus sub-scale scores were 27, 58, 53, 50, 49, and 55. The mean for married respondants is 57.9 with a standard deviation of 8.5.
-Barry's affectional expression sub-scale scores were 11, 12, 12, 12, 10, and 12. The mean for married respondants is 9.0 with a standard deviation of 2.3.
-Barry's dyadic satisfaction sub-scale scores were 41, 48, 38, 44, 46, and 44. The mean for married respondants is 40.5 with a standard deviation of 7.2.
-Barry's dyadic cohesion sub-scale scores were 10, 21, 17, 18, 19, and 22. The mean for married respondants is 13.4 with a standard deviation of 4.2.

Marriage and Sexual Relationship Questionnaire

Marriage Attitudes Scale

On the following item Barry's response was undesirable (indicated possible defensiveness) at pretreatment but was desirable (not defensive) at the final follow-up. The responses between these times were fairly consistent.

-I have some thoughts I wouldn't want my spouse to know about. False True

On the following items Barry's responses were desirable at pretreatment and the final follow-up, but fluctuated in between.

-I do not always tell my spouse the truth. True True
-Once in a while I am not completely truthful with my mate. True True

On the following items, all of Barry's responses were consistent and undesirable.

-No matter what my spouse is saying, I'm always a good listener. True True
-I have never felt displeased with my spouse. True True
-I have never been upset when my spouse expressed views very different from mine. True True
-When disagreements arise they are always settled in a peaceful, fair and democratic manner. True True
-I have never felt my spouse was angry at me without a cause. True True
-My mate and I understand each other completely. True True
-I never hesitate to go out of my way to help my spouse. True True
-I have never deliberately said something to hurt my spouse's feelings. True True
-I have never regretted my marriage, not even for a moment. True True
-There is never a moment that I do not feel "head over heels" in love with my mate. True True
-Every new thing I have learned about my mate has pleased me. True True

-My spouse and I are always happy with
the amount of affection we show each other. True True
-There is nothing about my mate's appearance
that I would want to see changed in any way. True True
-I am always courteous to my spouse. True True

-On occasions I have had doubts about my ability to succeed in my marriage. False False
-There have been times when I felt like hitting my spouse. False False
-My mate occasionally makes me feel miserable. False False
-There are moments when I dislike my spouse. False False
-Some of my dealings with my mate are prompted by selfish motives. False False
-I sometimes resent my spouse when I can't get my own way. False False
-My marriage is not a perfect success. False False
-I think I would lie to my spouse to keep out of trouble. False False
-My marriage could be happier than it is. False False
-There are times when I do not feel a
great deal of love and affection for my mate. False False
-Sometimes I'm tempted to say things to my spouse which I would regret. False False

Barry did not feel the following item applied to him at pretreatment. His posttreatment score (the first response listed) and all of his subsequent scores were undesirable.

-I don't think any couple could live together with greater harmony than my mate and I. True True

On the following items Barry's responses were undesirable at pretreatment and the final follow-up, and were fairly consistent between these times.

-My mate completely understands and sympathizes with my every mood. True True

On the following item Barry's response at pretreatment was desirable but all of his subsequent responses were undesirable.

-I have some needs that are not being met by my marriage. True False

On the following item Barry's response was desirable at pretreatment and undesirable at the final follow-up. The responses between these times fluctuated.

-I confide in my mate about everything. False True

Barry's scores were 27, 28, 31, 31, 31, 32, and 30. A score of 0 is perfectly non-defensive, and a score of 32 is perfectly defensive. The mean for a sample of 164 "normal" males is 10.48. The "extremely defensive" range is considered to be between 25 and 32.

Sexual Attutudes Scale

On the following items, Barry's responses were consistent and undesirable.

-My spouse and I never feel unhappy about how often we have sex together. True True
-I have never felt that my spouse lacks anything as a lover. True True

-I sometimes push my mate to have sex more than he/she wants to. False False
-Intercourse is always more enjoyable for me than other sexual activities. False False

Barry did not answer the following questions at pretreatment, feeling they did not apply to his case. The first response listed represents his response at posttretment. All of his responses were consistent and undesirable.

-My spouse always knows exactly what I would like him/her to do when we are making love. True True
-My spouse always does the things I like during sex. True True
-Sex always lasts as long as I would like it to. True True
-My spouse and I are never too busy to have sex. True True

-Our sex life seems a little routine and dull to me at times. False False
-I must admit that sometimes I am not considerate of my mate when we make love. False False
-Every now and then my mate does not please me sexually. False False

On the following item, Barry's responses were undesirable at pretreatment and the final follow-up, and were fairly consistent between these times.

-I never feel resentful when my spouse turns me down for sex. True True

On the following items, Barry's responses at pretreatment were desirable but subsequent responses were undesirable.

-I always satisfy my spouse sexually. False True
-I have always been satisfied with how often my spouse and I have sex. False True

On the following item, Barry's responses were desirable until the final follow-up.

-I think I am much sexier than most people. False True

On the following item, his response changed from a desirable response at pretreatment to an undesirable response at the final follow-up, and fluctuated between these times.

-I do not always initiate sex when I would like to. True False

Barry's scores were 4,14,12,13,14, and 15 at the various testing times. A score of 0 is perfectly non-defensive, and a score of 16 is perfectly defensive. The mean for a sample of 164 "normal" males is 5.52. The "extremely defensive" range is considered to be between 13 and 16.

Appendix AA

Detailed Discussion of Charles' Questionnaire Data

On the following items, the single asterisk represents Charles' response at pretreatment and the double asterisk represents his response at the final follow-up. When numbers follow an item, the first number represents his response at pretreatment and the second number represents his response at the final follow-up. The same is true when "Yes", "No", "True", and "False" follow an item.

The term "fairly consistent" is defined as true consistency with one exception. "Fluctuation" is defined as more than one exception to true consistency.

Erection Difficulty Questionnaire

Charles demonstrated improvement of four points on the following item. His improvement progressed in a consistent fashion.

-I would feel humiliated if I experienced erection problems again.

__*Completely true __Mostly true __Equally true and false __Mostly false **Completely false

Charles demonstrated improvement of four points on the following item. His improvement was fairly consistent.

-My erection problem makes me feel like less of a man.

__*Completely true __Mostly true __Equally true and false __Mostly false **Completely false

Charles demonstrated improvement of four points on the following item. His improvement fluctuated throughout postreatment and follow-up.

-I feel (would feel) anger or resentment if I have (would have) erection difficulty during sexual activities with a partner.

__*Completely true __Mostly true __Equally true and false __Mostly false **Completely false

Charles demonstrated improvement of three points on the following item. His improvement fluctuated throughout the posttreatment and follow-up period.

-I do not (would not) get an erection during any type of sexual activity (e.g., intercourse, masturbation, oral sex, etc.).

__Completely true __*Mostly true __Equally true and false __Mostly false **Completely false

Charles demonstrated improvement of two points on the following item. His improvement progressed in a consistent fashion.

-If I lose (would lose) my erection during sexual activity, I worry (would worry) that I won't get an erection again.

__*Always __Usually __**Sometimes __Rarely __Never

Charles demonstrated improvement of two points on the following items. His improvement progressed in a fairly consistent fashion.

-I have trouble getting an erection during foreplay with a partner.
___Always __**Usually ___Sometimes ___*Rarely ___Never

-Because of my erection problem, I do not attempt sexual intercourse (entering my partner and moving until orgasm) even if I am engaging in other sexual activities with my partner.
__** Always attempt ___Usually attempt ___*Sometimes attempt ___Rarely attempt ___Never attempt

Charles demonstrated improvement of two points on the following item. His responses fluctuated throughout the posttreatment and follow-up period.

-I know how I could help myself if I had an erection problem again.
__Completely true __Mostly true __**Equally true and false __Mostly false __*Completely false

-During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.
___*Always ___Usually ___**Sometimes ___Rarely ___Never

Charles demonstrated improvement of one point on the following items. His improvements progressed in a fairly consistent manner.

-If I get a partial or full erection during foreplay, my penis gets soft again when I try to insert my penis into my partner.
___*Always __**Usually ___Sometimes ___Rarely ___Never

-I get (would get) an erection when I see, hug, dance with, or otherwise interact with a dressed, atteactive potential partner.
___Always __**Usually ___*Sometimes ___Rarely ___Never

Charles demonstrated improvement of one point on the following items. His responses fluctuated throughout posttreatment and follow-up.

-My penis remains hard enough for me to stay inside of my partner until I ejaculate (reach orgasm).
___Always ___Usually ___Sometimes ___**Rarely ___*Never

-During sexual activity I worry about whether or not I will get or keep an erection.
___*Always ___**Usually ___Sometimes ___Rarely ___Never

On the following items, Charles' responses at pretreatment were identical to his responses at all of the follow-up periods.

-Even though I admit to myself that I have an erection problem, I tell my partner(s) that "I've had too much to drink," "I guess I'm just tired," or something else so they may not know about my problem.
___Always ___Usually ___Sometimes ___Rarely * **Never

-I am less interested in sex than I used to be.
__Completely true __Mostly true __Equally true and false __Mostly false * **Completely false

-I (would) talk about my erection problem with my sexual partner(s).
* **Always ___Usually ___Sometimes ___Rarely ___Never

On the following items, Charles' responses at pretreatment were identical to his responses at the final follow-up. The responses between these times were fairly consistent.

-Because of my erection problem I avoid having sex with the same person more than once.
___Always ___Usually ___Sometimes ___Rarely * **Never

-I do not enjoy sexual activity when I do not have an erection.
-I would rather avoid sex altogether than to experience erection problems again.
__Completely true __Mostly true __Equally true and false __Mostly false * **Completely false

-I am dissatisfied with my sexual functioning.
* **Completely true __Mostly true __Equally true and false __Mostly false ___Completely false

Charles demonstrated deterioration of three points on the following items. His improvement fluctuated throughout the posttreatment and follow-up period.

-If I (would) have difficulty getting or keeping an erection during sex, I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need.

__**Completely true __Mostly true __Equally true and false __Mostly false __*Completely false

Charles demonstrated a slight deterioration in his responding from pretreatment to the final follow-up on the following item. His responses fluctuated between these times.

-If I (would) experience erection difficulty, I (would) feel guilty because my partner might be frustrated and sexually unsatisfied.

____Always ____Usually ____**Sometimes ____*Rarely ____Never

The following item was not relevant to Charles since he only had one sexual partner.

-My problem with erections occurs with all of my sexual partners or types of partners.

Note: The ninth item on this measure was deleted due to the men finding the alternative responses to be very confusing. The item is: "Because of my erection problem, I do not (would not) try to get involved in relationships which might lead to sex." The alternative responses are: "Always", "Usually", "Sometimes", "Rarely", and "Never."

The responses on the Erection Difficulty Questionnaire were converted into scores, with (1) being the most undesirable response and (5) being the most desirable response. Charles' average scores were 2.64, 3.57, 3.32, 3.05, 3.80, and 3.68 at the various testing times.

Goals for Sex Therapy Questionnaire

The response-choices are listed below.

1	2	3	4	5	6	7
Much less than satis-fied	Less than satisfied	Somewhat less than satisfied	Satisfied with my current behavior or feelings	Somewhat more than satisfied	More than satisfied	Much more than satisfied

Charles showed an improvement of four points from pretreatment to the final follow-up on four items.

-Being able to get an erection by stimulating myself when I am alone. (2) (6) (fairly consistent)
-Being able to enjoy a sexual encounter without having intercourse. (1) (5) (fairly consistent)

-Being able to stimulate my partner to orgasm. (1) (5) (fluctuated)
-Being able to anticipate a sexual encounter without feeling I should have intercourse. (1) (5) (fluctuated)

Charles demonstrated an improvement of three points on three items.

-Being able to anticipate (think about) having intercourse without fear or anxiety. (2) (5) (fluctuated)
-Being able to get an erection during foreplay with a woman while both of us are clothed. (2) (5) (fluctuated)
-Being able to get an erection during foreplay while both of us are nude. (3) (6) (fluctuated)

Charles demonstrated an improvement of two points on three items.

-Being able to regain an erection if I lose it during foreplay. (1) (3) (fluctuated)
-Being able to keep an erection during intercouse until I ejaculate. (1) (3) (fluctuated)

Charles demonstrated an improvement of one point on three items.

-Being able to regain an erection if I lose it during intercourse. (1) (2) (fairly consistent)

-Being able to get an erection sufficient to begin intercourse. (3) (4) (fluctuated)

-Feeling comfortable about my own sexuality. (1) (2) (fluctuated)

Charles' responses deteriorated on two items.

-Feeling like I am sexually desireable to my partner. (6) (4) (consistent)

-Being able to engage in intercourse for as long as I like without ejaculating. (7) (6) (fluctuated)
(The first digit is Charles' response at posttreatment, since at the time of pretreatment he had not maintained an erection in intercourse long enough to have been able to judge his ejaculatory control).

His average scores were 1.92, 5.21, 3.77, 2.43, 3.85, and 4.36 at the various testing times.

Index of Sexual Satisfaction

The response-choices are listed below.

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 Good part of the time
5 Most or all of the time

Charles showed an improvement of three points on the following item.

-I feel that my sex life is lacking in quality (5) (2) (fairly consistent)

Charles reported an improvement of two points on the following item.

-I feel that I should have sex more often (5) (3) (fairly consistent)

On the following items, all of Charles' responses were consistent.

-I think that sex is wonderful (5) (5) (consistent)
-I feel that my partner sees little in me except for the sex I can give (1) (1) (consistent)
-I feel that sex is dirty and disgusting (1) (1) (consistent)
-My partner is too rough or brutal when we have sex (1) (1) (consistent)
-I would like to have sexual contact with someone other than my partner (1) (1) (consistent)

On the following items, Charles responses at pretreatment and the final follow-up were identical.

-My partner dwells on sex too much (1) (1) (fairly consistent)
-It is easy for me to get sexually excited by my partner (5) (5) (fairly consistent)
-I feel that my sex life is boring (1) (1) (fairly consistent)

-Sex is fun for my partner and me (4) (4) (fluctuated)
-I feel that my partner wants too much sex from me (1) (1) (fluctuated)
-My partner is very sensitive to my sexual needs and desires (5) (5) (fluctuated)

Charles reported a deterioation of three points on the following items.

-My partner does not want sex when I do (1) (4) (fairly consistent)
-I feel that our sex life really adds a lot to our relationship (5) (2) (fairly consistent)
-I feel that my partner is sexually pleased with me (5) (2) (fairly consistent)

-My sex life is very exciting (5) (2) (fluctuated)

Charles demonstrated a deterioation of two points on the following items.

-I enjoy the sex techniques that my partner likes or uses (5) (3) (consistent)
-My partner observes good personal hygiene (5) (3) (consistent)
-I feel that sex is a normal function of our relationship (5) (3) (consistent)

-My sex life is monotonous (1) (3) (fluctuated)
-When we have sex it is too rushed and hurriedly completed (1) (3) (fluctuated)

Charles showed a deterioration of one point on the following items.

-I feel that sex is something that has to be endured (1) (2) (consistent)

-I feel that my partner enjoys our sex life (4) (3) (fairly consistent)
-My partner is sexually very exciting (5) (4) (fairly consistent)

Charles' scores were 10, 17, 21, 28, 17, and 30. Scores of 28 or more indicate dissatisfaction with the sexual relationship at the various testing times.

Culture-Free Self-Esteem Inventory

On the following item, Charles' response improved from pretreatment to postreatment. The responses during follow-up were consistent with the posttreatment response.

-Are you usually successful when you attempt important tasks or assignments? No Yes

On the following items all of Charles' responses were consistent and desirable.

-Are you happy most of the time? Yes Yes
-Can you do most things as well as others? Yes Yes
-Do you like being a male? / Do you like being a female? Yes Yes
-Do most people you know like you? Yes Yes
-Are you as intelligent as most people? Yes Yes
-Do you feel you are as important as most people? Yes Yes
-Do you gossip at times? Yes Yes
-Are you as strong and healthy as most people? Yes Yes
-Do people like your ideas? Yes Yes

-Do you have only a few friends? No No
-Do you spend most of your free time alone? No No
-Would you change many things about yourself if you could? No No
-Are you lacking in self-confidence? No No
-Do you often feel that you are no good at all? No No
-Are your feelings easily hurt? No No
-Is it difficult for you to express your views or feelings? No No
-Do you often feel ashamed of yourself? No No
-Do you feel uneasy much of the time without knowing why? No No
-Would you like to be as happy as others appear to be? No No
-Are you a failure? No No
-Is it hard for you to meet new people? No No
-Do you worry a lot? No No

On the following items, Charles' responses were desirable at pretreatment and at the final follow-up, and were fairly consistent between these times.

-Are you as nice looking as most people? Yes Yes
-Do most people respect your views? Yes Yes
-Are you as happy as most people? Yes Yes

-Are you easily depressed? No No
-Do many people dislike you? No No
-Are other people generally more successful than you are? No No
-Are you often upset about something? No No
-Are you most sensitive than most people? No No
-Are you definitely lacking in initiative? No No

On the following item, Charles' responses were desirable at pretreatment and at the final follow-up, but fluctuated between these times.

-Are you ever sad? Yes Yes

On the following items Charles' responses were consistent, but undesirable.

-Do you like everyone you know? Yes Yes
-Do you always tell the truth? Yes Yes

On the following items, Charles' response deteriorated from pretreatment to postreatment. The responses during follow-up were consistent with the posttreatment response.

- Are you usually tense or anxious. No Yes
-Do you ever lie? Yes No

On the following items, Charles' responses were consistent from pretreatment to the second last follow-up, but deteriorated at the last follow-up.

-Do you ever get angry? Yes No
-Are you ever shy? Yes No

On the following item, Charles' responses deteriorated from pretreatment to the final follow-up, and were fairly consistent between these periods.

-Have you ever taken anything that did not belong to you? Yes No

-Charles' total scores were at the 97th., 83rd., 93rd., 75th., 88th., and 97th. percentile at the various testing times.
-Charles' general self-esteem sub-scores were at the 97th., 100th., 97th., 97th., 88th., and 100th. percentile.
-Charles' social self-esteem sub-scores were at the 100th., 80th., 100th., 80th., 100th., and 100th. percentile.
-Charles' personal self-esteem sub-scores were at the 100th., 61st., 90th., 61st., 90th., and 90th. percentile.
-His scores on the lie items were 6, 3, 3, 3, 4, and 2 (there were 8 items and a score of "8" represents not answering at all in a socially desirable manner).

Dyadic Adjustment Scale

Charles reported significant (a change of two categories) and consistent improvement on the following item.

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

-Calmly discuss something

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
			*		**

Charles reported significant (a change of two categories) and fairly consistent improvement on the following item.

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

-Laugh together

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
			*		**

All of Charles' responses on the following items were identical across sessions.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Friends

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
* **					

-How often do you or your mate leave the house after a fight?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
					* **

-Do you confide in your mate?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
* **					

-Do you ever regret that you married? (or lived together)

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
					* **

-Do you and your mate engage in outside interests together?

All of them	Most of them	Some of them	Very few of them	None of them
* **				

-Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks.

	Yes	No
-Being too tired for sex.		* **
-Not showing love.		* **

-Which of the following statements best describes how you feel about the future of your relationship?

* ** I want desperately for my relationship to succeed, and <u>would go to almost any length</u> to see that it does.

______ I want very much for my relationship to succeed, and <u>will do all I can</u> to see that it does.

______ I want very much for my relationship to succeed, and <u>will do my fair share</u> to see that it does.

______ It would be nice if my relationship succeeded, but I <u>can't do much more than I am doing now</u> to help it succeed.

______ It would be nice if it succeeded, but I <u>refuse to do any more than I am doing</u> now to keep the relationship going.

______ My relationship can never succeed, and <u>there is no more that I can do</u> to keep the relationship going.

Charles' responses were the same at pretreatment and the final follow-up session on the following items, and were fairly consistent between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

-Aims, goals and things believed important

-Making major decisions

Always Agree	Almost Always Agree	Occa- sionally Disagree	Fre- quently Disagree	Almost Always Disagree	Always Disagree
* **					

-Do you kiss your mate.

Every Day	Almost Every Day	Occa- sionally	Rarely	Never
		* **		

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

-Have a stimulating exchange of ideas

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
			* **		

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

-Work together on a project?

Never	Less than once a month	Once or Twice a month	Once or Twice a week	Once a day	More often
* **					

Charles' responses were the same at pretreatment and the final follow-up session on the following items, but fluctuated between these times.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.
-Religious matters
-Conventionality (correct or proper behavior)

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
* **					

-In general, how often do you think that things between you and your partner are going well?

All the time	Most the time	More often than not	Occa-sionally	Rarely	Never
* **					

-Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5* **	6
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

Charles felt that the following item did not apply to him at pretreatment and thus the single asterisk represents his response at posttreatment. His responses were identical across sessions.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.
-Handling family finances

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
* **					

Charles' responses on the following item significantly and consistently deteriorated.

-How often do you discuss or have you considered divorce, separation, or terminating your relationship?

All the time	Most the time	More often than not	Occasionally	Rarely	Never
			**		*

Charles' responses consistently deteriorated one category from pretreatment to follow-up on the following items.

-Please indicate below the approxiamte extent of agreement or disagreement between you and your partner for each item on the following list.
-Demonstrations of affection
-Philosophy of life
-Leisure time interests and activities

Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
*	**				

-How often do you and your partner quarrel?
-How often do you and your mate "get on each other's nerves?"

All the time	Most the time	More often than not	Occasionally	Rarely	Never
				**	*

Charles' responses deteriorated one category (fairly consistently) from pretreatment to follow-up on the following items.

-Please indicate below the approxiamte extent of agreement or disagreement between you and your partner for each item on the following list.
-Matters of recreation
-Sex relations

Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
*	**				

Charles' responses deteriorated one category and fluctuated from pretreatment to follow-up on the following item.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.
-Amount of time spent together.

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
*	**				

Charles felt that the following item did not apply to him at pretreatment and thus the single asterisk represents his response at posttreatment. His response deteriorated fairly consistently.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.
-Ways of dealing with parents or in-laws

Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
*	**				

Charles felt that the following item did not apply to him at pretreatment and some of the follow-up sessions.

-Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.
-Household tasks
-Career decisions

-Charles' total scores were 139, 117, 126, 131, 139, and 130 at the various testing times. The mean for married respondants is 114.8 with a standard deviation of 17.8.

-Charles' dyadic consensus sub-scale scores were 65, 49, 52, 62, 61, and 60. The mean for married respondants is 57.9 with a standard deviation of 8.5.

-Charles' affectional expression sub-scale scores were 12, 10, 12, 12, 12, and 10. The mean for married respondants is 9.0 with a standard deviation of 2.3.

-Charles' dyadic satisfaction sub-scale scores were 49, 45, 47, 44, and 43 (there was no dyadic satisfaction for the 27-week follow-up). The mean for married respondants is 40.5 with a standard deviation of 7.2.

-Charles' dyadic cohesion sub-scale scores were 13, 13, 15, 13, 20, and 17. The mean for married respondants is 13.4 with a standard deviation of 4.2.

Marriage and Sexual Relationship Questionnaire

Marriage Attitudes Scale

On the following item Charles' response at pretreatment was undesirable and his response at the final follow-up was desirable. His responses fluctuated between these times.

-Some of my dealings with my mate are prompted by selfish motives. False True

On the following item Charles' responses were undesirable until the final follow-up when it was desirable.

-My marriage could be happier than it is. False True

On the following items, all of Charles' responses were consistent and undesirable.

-No matter what my spouse is saying, I'm always a good listener. True True
-I have never felt displeased with my spouse. True True
-When disagreements arise they are always settled in a peaceful, fair and democratic manner. True True
-I have never felt my spouse was angry at me without a cause. True True
-My mate completely understands and sympathizes with my mood. True True
-I don't think any couple could live together with greater harmony than my mate and I. True True
-My mate and I understand each other completely. True True
-I never hesitate to go out of my way to help my spouse. True True
-I confide in my mate about everything. True True
-I have never deliberately said something to hurt my spouse's feelings. True True
-I have never regretted my marriage, not even for a moment. True True
-There is never a moment that I do not feel "head over heels" in love with my mate. True True
-Every new thing I have learned about my mate has pleased me. True True
-My spouse and I are always happy with the amount of affection we show each other. True True

-There is nothing about my mate's appearance
that I would want to see changed in any way. True True
-I am always courteous to my spouse. True True

-There have been times when I felt like hitting my spouse. False False
-I do not always tell my spouse the truth. False False
-My mate occasionally makes me feel miserable. False False
-There are moments when I dislike my spouse. False False
-I sometimes resent my spouse when I can't get my own way. False False
-Once in a while I am not completely truthful with my mate. False False
-I think I would lie to my spouse to keep out of trouble. False False
-There are times when I do not feel a
great deal of love and affection for my mate. False False
-Sometimes I'm tempted to say things to my spouse which I would regret. False False

Charles did not answer the following item at pretreatment. The first response listed is his response at posttreatment. His responses were consistent and undesirable.

-I have some thoughts I wouldn't want my spouse to know about. False False

On the following items Charles' responses were identical and undesirable at pretreatment and the final follow-up, but fluctuated between these times.

-On occasions I have had doubts about my ability to succeed in my marriage. False False
-I have some needs that are not being met by my marriage. False False
-My marriage is not a perfect success. False False

On the following item Charles' response at pretreatment was desirable but subsequent responses were undesirable.

-I have never been upset when my spouse expressed views very different from mine. False True

Charles' scores were 30, 31, 28, 29, 31 and 30. A score of 0 is perfectly non-defensive, and a score of 32 is perfectly defensive. The mean for a sample of 164 "normal" males is 10.48. The "extremely defensive" range is considered to be between 25 and 32.

Sexual Attutudes Scale

On the following items, Charles' response at pretreatment was undesirable, his response at the final follow-up was desirable, and his responses were fairly consistent between these times.

-I sometimes push my mate to have sex more than he/she wants to. False True
-My spouse and I are never too busy to have sex. True False
-Intercourse is always more enjoyable for me than other sexual activities. True Fals

On the following items, Charles' responses were consistent and desirable.

-I always satisfy my spouse sexually. False False
-I have always been satisfied with how often my spouse and I have sex. False False

On the following items, Charles' responses were desirable at pretreatment and the final follow-up, but fluctuated in between.

-I think I am much sexier than most people. False False
-I do not always initiate sex when I would like to. True True

On the following items, Charles' responses were consistent and undesirable.

-I never feel resentful when my spouse turns me down for sex. True True
-My spouse always knows exactly what I would like him/her to do when we are making love. True True
-I have never felt that my spouse lacks anything as a lover. True True

-Our sex life seems a little routine and dull to me at times. False False
-Every now and then my mate does not please me sexually. False False

On the following items, Charles' responses were undesirable at pretreatment and the final follow-up, but fluctuated in between.

-My spouse and I never feel unhappy about how often we have sex together. True True
-My spouse always does the things I like during sex. True True

On the following item, Charles' response was desirable at pretreatment but subsequent responses were undesirable.

-I must admit that sometimes I am not considerate of my mate when we make love. True False

On the following item, Charles' response at pretreatment was desirable, his response at the final follow-up was undesirable, and his responses were fairly consistent between these times.

-Sex always lasts as long as I would like it to. False True

Charles' scores were 10, 12, 9, 10, 11, and 9 at the various testing times. A score of 0 is perfectly non-defensive, and a score of 16 is perfectly defensive. The mean for a sample of 164 "normal" males is 5.52. The "moderately defensive" range is considered to be between 9 and 12.

Appendix BB

Key Items for the Men as a Group

Improvements

On the following items on all the questionnaires, "significant" is defined as a change of two or more categories, or a change in response on "true or false" items and "yes or no" items from pretreatment to the final follow-up.

Erection Difficulty Questionnaire

On the following items, all three clients showed significant improvement.

-My erection problem makes me feel like less of a man.

	Pretreatment	Posttreatment
Comepletely True	1	
Mostly True	2	
Equally True and False		
Mostly False		
Completely False		3

-I would feel humiliated if I experienced erection problems again.

	Pretreatment	Posttreatment
Comepletely True	1	
Mostly True	1	
Equally True and False	1	
Mostly False		1
Completely False		2

-I know how I could help myself if I had an erection problem again.

	Pretreatment	Posttreatment
Comepletely True		2
Mostly True		
Equally True and False	1	1
Mostly False		
Completely False	2	

-I feel (would feel) anger or resentment if I have (would have) erection difficulty during sexual activities with a partner.

	Pretreatment	Posttreatment
Comepletely True	1	
Mostly True	1	
Equally True and False	1	
Mostly False		1
Completely False		2

On the following items, two of the three clients showed significant improvement.

-During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.

	Pretreatment	Posttreatment
Always	1	
Usually	2	
Sometimes		2
Rarley		
Never		1

-During sexual activity I worry about whether or not I will get or keep an erection.

	Pretreatment	Posttreatment
Always	2	
Usually	1	1
Sometimes		
Rarley		1
Never		1

-I do not (would not) get an erection during any type of sexual activity (e.g., intercourse, masturbation, oral sex, etc.).

	Pretreatment	Posttreatment
Comepletely True		
Mostly True	2	
Equally True and False		
Mostly False		
Completely False	1	3

-If I lose (would lose) my erection during sexual activity, I worry (would worry) that I won't get an erection again.

	Pretreatment	Posttreatment
Always	2	
Usually		
Sometimes		1
Rarley	1	1
Never		1

-My penis remains hard enough for me to stay inside of my partner until I ejaculate (reach orgasm).

	Pretreatment	Posttreatment
Always		2
Usually		
Sometimes	1	
Rarley		1
Never	2	

-I am dissatisfied with my sexual functioning.

	Pretreatment	Posttreatment
Comepletely True	2	1
Mostly True	1	
Equally True and False		
Mostly False		1
Completely False		1

<u>Goals for Sex Therapy Questionnaire</u>

All three men showed significant improvement on the following items. Note: Items which were not applicable at pretreatment were assigned appropriate responses (e.g., Since the three clients had not engaged in intercourse or maintained an erection in intercourse by pretreatment, they were assigned the response "Much less than satisfied" for the item "Being able to engage in intercourse for as long as I like with out ejaculating").

-Being able to get an erection during foreplay while both of us are nude.

	Pre-treatment	Final follow-up
Much less than satisfied	2	
Less than satisfied		
Somewhat less than satisfied	1	
Satisfied with my current behavior or feelings		
Somewhat more than satisfied		
More than satisfied		2
Much more than satisfied		1

-Being able to engage in intercourse for as long as I like without ejaculating.

	Pre-treatment	Final follow-up
Much less than satisfied	3	
Less than satisfied		
Somewhat less than satisfied		1
Satisfied with my current behavior or feelings		
Somewhat more than satisfied		
More than satisfied		1
Much more than satisfied		1

Two of the three men demonstrated significant improvement on the following items.

-Being able to anticipate (think about) having intercourse without fear or anxiety.

	Pre-treatment	Final follow-up
Much less than satisfied		
Less than satisfied	1	
Somewhat less than satisfied	2	
Satisfied with my current behavior or feelings		1
Somewhat more than satisfied		1
More than satisfied		1
Much more than satisfied		

-Being able to get an erection by stimulating myself when I am alone.

	Pre-treatment	Final follow-up
Much less than satisfied		
Less than satisfied	2	
Somewhat less than satisfied		
Satisfied with my current behavior or feelings	1	
Somewhat more than satisfied		1
More than satisfied		2
Much more than satisfied		

-Being able to get an erection during foreplay with a woman while both of us are clothed.

	Pre-treatment	Final follow-up
Much less than satisfied	1	
Less than satisfied	1	
Somewhat less than satisfied		
Satisfied with my current behavior or feelings	1	
Somewhat more than satisfied		2
More than satisfied		
Much more than satisfied		1

-Being able to regain an erection if I lose it during foreplay.

	Pre-treatment	Final follow-up
Much less than satisfied	2	
Less than satisfied		
Somewhat less than satisfied	1	1
Satisfied with my current behavior or feelings		
Somewhat more than satisfied		1
More than satisfied		
Much more than satisfied		1

-Being able to keep an erection during intercouse until I ejaculate.

	Pre-treatment	Final follow-up
Much less than satisfied	2	
Less than satisfied		
Somewhat less than satisfied	1	1
Satisfied with my current behavior or feelings		1
Somewhat more than satisfied		
More than satisfied		
Much more than satisfied		1

-Being able to enjoy a sexual encounter without having intercourse.

	Pre-treatment	Final follow-up
Much less than satisfied	1	
Less than satisfied		
Somewhat less than satisfied		
Satisfied with my current behavior or feelings	2	1
Somewhat more than satisfied		1
More than satisfied		
Much more than satisfied		1

-Being able to anticipate a sexual encounter without feeling I should have intercourse.

	Pre-treatment	Final follow-up
Much less than satisfied	1	
Less than satisfied		
Somewhat less than satisfied		
Satisfied with my current behavior or feelings	2	1
Somewhat more than satisfied		1
More than satisfied		
Much more than satisfied		1

Index of Sexual Satisfaction

Two of the men demonstrated significant improvement on the following item.

-I feel that my sex life is lacking in quality.

	Pretreatment	Final follow-up
Rarely or none of the time		2
A little of the time	1	1
Some of the time		
Good part of the time		
Most or all of the time	2	

Culture-Free Self-Esteem Inventory

Two of the men demonstrated improvement on the following item.

-Are you as nice looking as most people?

	Pretreatment	Final follow-up
Yes	1	3
No	2	

Dyadic Adjustment Scale

Two of the men reported improvement on the following items.

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

	Pretreatment	Final follow-up
Never		
Less than once a month		
Once or twice a month		
Once or twice a week	3	1
Once a day		
More often		2

-How often would you say the following events occur between you and your mate calmly discuss something?

	Pretreatment	Final follow-up
Never		
Less than once a month		
Once or twice a month		
Once or twice a week	3	1
Once a day		
More often		2

Marriage and Sexual Relationship Questionnaire

Sexual Attitudes Scale

Two of the men demonstrated significant improvement on the following item.

-I sometimes push my mate to have sex more than he/she wants to.

	Pretreatment	Final follow-up
True		2
False	3	1

Key items for the Men as a Group

Deterioration

Culture-Free Self-Esteem Inventory

On the following items, two of the clients showed significant deterioration.

-Have you ever taken anything that did not belong to you?

	Pretreatment	Final follow-up
Yes	3	1
No		2

-Do you ever lie?

	Pretreatment	Final follow-up
Yes	3	1
No		2

Dyadic Adjustment Scale

On the following item, two of the clients showed significant deterioration.

-How often do you discuss or have you considered divorce, separation, or terminating your relationship.

	Pretreatment	Final Follow-up
All of the time		
Most of the time		
More often than not		
Occasionally		2
Rarely		
Never	3	1