THE ASSESSMENT AND TREATMENT OF SEXUAL DYSFUNCTIONS

A Practicum Report

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THE ASSESSMENT AND TREATMENT OF SEXUAL DYSFUNCTIONS

BY

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MASTER OF SOCIAL WORK

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Introduction

As a marital and family counsellor with Family Services of Winnipeg I often felt somewhat limited in terms of knowledge and skill when clients presented with sexual dysfunctions or when sexual dysfunctions were identified during the assessment or treatment process. It was with the intention of filling this gap thus giving clients a more comprehensive counselling program that I set out to undertake this practicum.

I feel that the following statistics by Kaplan (1974) are fairly representative of the client population that I work with. She states that 75% of her patients who presented with marital problems of a non-sexual kind were found to have a sexual complaint, while among those presenting with such complaints some 70% also had non-sexual marital problems. In other words it's often an issue that requires attention.

As a result I have spent the past year becoming better informed about the total sphere of human sexuality in conjunction with improving my therapeutic knowledge and skills in using a Behavioural Approach to Causation, Assessment and Treatment of Sexual Dysfunctions.

Therapy was conducted under the auspices of the Sexual Dysfunction Clinic at the Psychological Service Centre, University of Manitoba and under the direction and supervision of Prof. Derek Jehu.

Clients were all from Psychological Services generally

referred by the medical profession, (due to diagnosed sexual dysfunctions) and screened by Professor Jehu.

The Practicum report is separated into two parts which are in turn divided into interrelated categories. It is my intention to give the reader a general overview of relevant material with as much specific information as was seen relevant and possible in view of the scope of this Practicum. The literature review will provide a base for Part II which consists of actual Case Reports dealing primarily with assessment, treatment and evaluation.

PART I - Literature Review

A - Human Sexual Response

THE TRIPHASIC CONCEPT OF HUMAN SEXUALITY

Desire, Excitement and Orgasm

Knowledge of the human sexual response is of vital importance if we are to develop effective and appropriate treatment plans for people experiencing sexual problems. "Until just a few years ago, the human sexual response was seen monistically, as a single event that passed from lust to excitement and was climaxed by the orgasm. All the sexual dysfunctions were also perceived as though they were a single clinical entity. No distinction was made between premature ejaculation or impotence or lack of libido or sexual avoidance. All males who could not perform or enjoy intercourse were termed impotent, while all women with sexual difficulties were labelled frigid.

It followed that treatment was also undifferentiated. Since all sexual dysfunctional patients carried the same diagnosis, they also received the same therapy.... It was thought that all sexual problems were produced by specific and serious unconscious conflicts about sex which were

acquired during specific developmental phases in early childhood... The old monistic view of the human sexual response thus impeded advances in the field. Progress in understanding human sexuality required the separation of the component parts from the undifferentiated mass. As soon as this was understood, the multiplicity of determinants that can impair sexuality were recognized, which in turn opened the way for the development of rational treatment procedures" (Kaplan 1979: 3-4). It was hence recognized that the sexual response is composed of three separate but interlocking phases which are each vulnerable and affected by multiple factors which in turn produce a variety of disorders that are responsive to specific treatment strategies.

Masters and Johnson's work provided us with the first clear and accurate description of the human sexual response. They divided the sexual response into the four presently well known stages: excitement, plateau, orgasm and resolution. Although this was a breakthrough it is important to note that the "desire" phase is not included in the Masters and Johnson scheme which describes only the genital phases of the sexual response and in essence as Kaplan (1979) points out, refers to only two actual phases — excitement and orgasm.

This resulted in an incomplete understanding of the sexual response and it's dysfunctions until the recent recognition of a third and central phase, the phase of sexual

desire. Kaplan (1979) explains; "The three phases are physiologically related but discrete. They are interconnected but governed by separate neurophysiological systems. Metaphorically, orgasm, excitement and desire may be thought of as having a 'common generator', but each has its own 'circuitry'. And the existence of a separate 'wiring' system or neural circuits creates the possibility for separate and discrete inhibitions of the three phases. Certain kinds of trauma, if sufficiently intense, disturb the entire system, but often only one component is disrupted. One set of causes is likely to "blow the fuses' of the orgasm circuits, another type of conflict may 'disconnect the erection wires', while a different group of variables is likely to cause interference in the 'libido circuits' of the brain" (p.6).

This helps explain why some clients who desire sex, have problems with erection, but can ejaculate with a flaccid penis; or men who are very interested in sex, have no erectile difficulties, but cannot control their orgasms; or women who have no desire for sex but who can lubricate and even have an orgasm on stimulation.

It also follows that lack of sexual desire requires a different treatment focus therefore specific therapies need to be developed, utilized and evaluated for this dysfunction. Until recently men who experience lack of sexual desire would have been described as being impotent and would have

been treated accordingly. The distinctions within the human sexual response has opened new doors and serves to support the need for further understanding, knowledge and research in the area of sexuality.

B - Sexual Dysfunctions - Categories and Definitions

As mentioned earlier different categories of sexual dysfunction call for different treatment strategies. It therefore follows that proper classification or diagnosis is imperative but we need always keep in mind that such "diagnostic labels" are merely assessment "tools" and do not necessarily imply anything more about that person.

Jehu (1979) presents the following categories based on the two assumptions:

Categories of sexual dysfunction

Aspect	Male	Female
Interest	Inadequate sexual interest	Inadequate sexual interest
Arousal or intromission	Erectile dysfunction	Vasocongestive dysfunction Vaginismus
Orgasm or Ejaculation	Premature ejaculation Retarded or absent ejaculation Retrograde ejaculation	Orgastic dysfunction
Pleasure	Inadequate sexual pleasure Dyspareunia	Inadequate sexual pleasure Dyspareunia

The first assumption is that "various aspects of sexual behaviour can be separately impaired" and the second assumption is that "most of these aspects can be disrupted in different ways yielding several categories of dysfunction in males and females respectively" (p.75).

Having categorized a problem does not by itself determine the treatment i.e., similar problems may be treated in different ways as the clients who exhibit these problems are very varied in terms of their personal characteristics and life situations.

Male and Female Dysfunctions

1. Inadequate Sexual Interest: In view of the tremendous range of sexual variation among males and females it is necessary to stress that until we have more scientific information the subjective judgements of those concerned (except perhaps for extreme cases) will serve as the main factor in determining inadequacy.

In the Diagnostic and Statistical Manual of the APA, Desire Phase Inhibition is defined as follows by Kaplan (1979); "302.71 Phychosexual Dysfunction with Inhibited Sexual Desire

A. Persistent and pervasive inhibition of sexual desire. The basis for the judgment of inhibition is made by the clinician taking into account age, sex, occupation, the individual's subjective statement as to intensity and frequency of sexual desire, a knowledge of norms of sexual behavior, and the context of the individual's life. In actual practice, this diagnosis will rarely be used unless the lack of desire is a source of distress either to the individual or to his or her partner. Fre-

quently this category will be used in conjunction with one or more of the other dysfunction categories.

B. The disturbance is not caused exclusively by organic factors and is not symptomatic of another clinical psychiatric syndrome"(p.58).

We need to use caution in using the above definitions as a complaint of low sexual desire may be the result of unrealistic expectations of sexual functioning.

2. <u>Inadequate Sexual Pleasure</u>: This definition is also based on the subjective judgements of the client whose main complaint is that they "feel nothing during intercourse, or that it is insufficiently pleasurable or satisfying for them" (Jehu 1979:98). A male client with such a complaint may still easily obtain erections, achieve orgasm and ejaculation in a normal manner. Similarly female clients with similar complaints may experience normal vaginal lubrication and swelling as well as muscular contractions of orgasm.

3. <u>Dyspareumia</u>: Also known as painful intercourse both for men and women. For women the pain may be at the entrance of the vagina, the clitoris, the vaginal barrel, or the internal pelvic organs and dyspareunia may be associated with any other sexual dysfunction in the same client.

Males may experience discomfort only during erection, insertion, thrusting or ejaculation or throughout more than one of these processes but pain may also be experienced during

certain non-coital forms of sexual activity, such as masturbation and manual or oral stimulation by a partner.

As can easily be expected anticipation of pain may lead to anxiety and avoidance thus sometimes leading to other sexual difficulties.

Male Dysfunction

1. Erectile Dysfunction: This is basically a more accurate term for impotence, which is in simple terms an impairment of penile erection or a problem with obtaining and/or sustaining an erection.

According to Jehu (1979) erectile dysfunction "involves some impairment of the erection phase of the male sexual response cycle, so that vasocongestion of the penis does not proceed normally. It might be defined as persistent inability to obtain a sufficient firm erection, or to maintain this during intromission and intercourse" (p.81).

There are numerous factors involved in determining whether a man has erectile dysfunction therefore there is again much room for subjective judgements of inadequacy. For example "some men can only obtain partial erections; and whether these are considered to be insufficiently firm may well be strongly influenced by the man's capacity to achieve intromission" (Jehu 1979:81).

2. Premature Ejaculation: This is regarded as an extremely frequent problem, i.e., actually suggested by many therapists as being the commonest of all male sexual dysfunction. It may be defined as a "lack of adequate voluntary control over the orgastic and/or ejaculatory reflexes".

Again this can only be defined as inadequate on the basis of subjective judgements and the factors most likely to influence these judgements are "the persistence of inadequate control, the timing of orgasm and ejaculation, and the degree of dissatisfaction experienced by the couple" (Jehu 1979:87). Generally, rapid ejaculation becomes problematic in cases where either partner is repeatedly left in a state of dissatisfaction.

3. Retarded/Absent Ejaculation: This has also been termed "ejaculatory incompetence" by Masters and Johnson as it is basically a specific inhibition of the ejaculatory reflex ie. ejaculation is selectively impaired with the erectile component remaining intact. This may be defined as a "persistent delay or failure in the occurence of orgasm and ejaculation despite the presence of an adequate erection" (Jehu 1979:93). Such an individual "is unable to ejaculate, however, although he urgently desires orgastic release and although the stimulation he receives should be more than sufficient to trigger his orgastic reflex"(Kaplan 1974:316-317). This type of situation is in direct contrast to that of the men with erectile problems

where the erectile mechanism is inhibited, but where the individual may be able to ejaculate with a limp penis with sufficient stimulation.

4. Retrograde Ejaculation: This is defined by Jehu(1979) as "the involuntary discharge of semen into the bladder rather than through the urethra, so that the client still has erections and orgasms but there is no visible ejaculate"(p.97). He makes a distinction between some men who are able to achieve voluntary suppression of ejaculation and the problem of retrograde ejaculation. Also pointing out that recently Robbins and Jensen (1978) presented evidence indicating that some men are able to have multiple orgasms within a short interval, only to ejaculate on the last of these.

Retrograde ejaculation may cause concern to couples who want children but this need not be a problem as live spermatozoa may be removed from the man's urine following ejaculation to inseminate his partner.

The causation of retrograde ejaculation is seen as almost entirely organic in nature. Jehu (1979) has a table (p.98) showing the organic factors contributing to retrograde ejaculation.

Female Dysfunctions

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

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

Although vaginismus may be occasionally limited to penile insertion it generally extends to penetration of any object such as the self-insertion of a tampon or a physician's examining finger into the vagina.

"Vaginismus must be differentiated from simple phobic avoidance of intercourse and also from physical conditions which can obstruct vaginal entry" (Kaplan 1974:413). It follows that a pelvic examination is necessary for a definitive diagnosis of vaginismus.

3. <u>Orgastic Dysfunction</u>: This problem is analogous to that of retarded or absent ejaculation in that women who are inorgastic get "stuck" at or near the plateau phase of the sexual response and are unable to achieve orgasm or at least have great difficulty in reaching climax with what is considered sufficiently intense stimulation.

It is important to note that "some women do not reach climax but still obtain a great deal of pleasure from their sexual activities, while others complain of inadequate pleasure in addition to their orgastic dysfunction" (Jehu 1979: 109).

C - Causes and Maintaining Conditions

Numerous factors may lead to, or contribute to sexual dysfunctions. Both Jehu (1979) and Kaplan (1979) provide us with physiological and psychological sources which include the following; depression, stress, drugs, surgery, hormones, medical illness, pregnancy, anxiety, anger, partner discord, turn-off mechanism, inappropriate stimulation, traumatic experiences, fear of romantic success and fear of intimacy.

Depression

Although it is important to understand that a particular sexual dysfunction may be a symptom of depression it is also

important to note that depression may also be a symptom of sexual dysfunction. For example, a woman experiencing secondary lack of desire may become depressed as a result of this dysfunction disturbing her life. Jehu (1979) cautions us not to make quick assumptions, e.g., the above may have resulted from a third condition such as psychiatric disorder in one of the partners. Kaplan (1979) suggests that "Depression is marked by a diathesis of vegetative symptoms which includes sleep, eating and libido disturbances ... the loss of sexual appetite may be an early symptom of depressive states and may appear even before the patient's mood becomes perceptibly sad" (p. 80). Cassidy et al. (1957) studied 66 women with manic depressive illness and reported that about 53% noted a decrease in libido while depressed. About 35% of these women described no change in libido while approximately 10% noted an increase in libido. The above and other research tend to suggest that inhibited sexual desire is a symptom of depression but it still cannot be considered as absolute.

Sexual and Non-Sexual Stress

Jehu (1979) points out that "a client who anticipates that sexual activity will prove unpleasant, harmful or unsuccessful, may well avoid these threats by losing interest in sex, and this avoidance reaction may occur at both an

overt and cognitive level" (p. 79).

Non-sexual stress also affects a person's sexuality. Kaplan (1979) suggests that severe stress is often associated with various sexual dysfunctions and that sex therapy is inappropriate while an individual is in a real state of crisis and or experiencing severe stress.

Drugs

Certain drugs may unbalance the natural equilibrium of the body functioning. Such drugs as narcotics, psychotropic or antihypertensive medication and even oral contraceptives are believed to decrease sexual interest in certain individuals. Kaplan (1979) has an extensive list of drugs and their effects on sexual functioning in table 1 of the Appendix, pp. 203 to 211 inclusive. This table describes in a summarized fashion the Drug, Medical Indications, Possible Mechanism of Action and the Phase of Sexual Response Affected i.e., Desire, Excitement and Orgasm.

Kaplan (1979) also stresses that if a patient is abusing alcohol ,sedatives or narcotics, he should not be accepted for therapy until this habit is controlled. This is based on the poor prognosis of these individuals and not on moral judgement.

Case 2 of part II is a good example of alcohol playing a significant role in maintaining an erectile problem.

Surgery

Knowledge of a client's surgical history is important as specific surgical procedures can result in organic damage that may play a part in the inhibited sexual desire. Such damage may be incurred through removal of or repair of specific hormone-producing glands such as testes, ovaries or adrenals or by neurological surgery. Surgical interventions such as perineal prostatectomy, sympathectomy, cystectomy or ostomy may contribute to problems of erectile dysfunction according to Jehu(1979).

Following surgery e.g., heart surgery, some individuals may fear that sexual intercourse will result in a heart attack therefore this fear may inhibit the desire phase.

Hormones

Kaplan (1979) states that "Because the activity of the sex centers depends on testosterone, insufficient levels of this hormone or its physiologic unavailability may produce a diminution of sexual interest in both males and females. This can result from any condition or drug or psychic state which impairs the production of androgen by the testes, ovaries and adrenals. Common factors in testosterone deficiency include the aging process, prolonged stress, surgical removal or disease of the testosterone-producing glands, and hormones and medications such as provera and estrogen which antagonize

the action of testosterone"(p.81). It follows that prior to beginning sex therapy a low testosterone level must be ruled out.

Illness

Illness can have a psychological as well as a physiological effect. Jehu (1979) states that "any general systemic illness that is debilitating, disabling or distressing, such as a renal disorder, might be accompanied by loss of sexual interest, or more specifically this may arise from an endocrine condition such as Cushing's syndrome"(p.79).

Kaplan (1979) again has the effects of Illness on The Sexual Response summarized in table form in the Appendix; Table II: Effects of Illness on the Sexual Response, page 212 to 219 inclusive.

Pregnancy

The studies undertaken over the years (although some with design problems) would seem to suggest that pregnancy may be a contributing factor in lack of sexual desire. Masters and Johnson (1966) studied 101 women at different stages of pregnancy and the results although limited warranted further exploration. The findings suggested that women (during their first pregnancy) reported a decrease in sexual interest whereas previously pregnant women reported little

change in their desire. In the second trimester, there was a reported improvement in sexuality. In the third trimester, 74 of the 101 women reported a loss in interest. Some of this lack of desire in the third trimester may have had some bearing on physician's recommendations to refrain from having intercourse.

Wagner and Solberg (1974) interviewed 260 women during early postpartum and the results tend to support Masters & Johnson's results.

Tolor and DiGrazia (1976) also undertook a study which reported a general decrease in desire.

<u>Anxiety</u>

Mild sources of anxiety can inhibit sexual feelings and sometimes lead to what is more commonly known as performance anxiety, or fear of failure. This can lead to excitement or orgasm dysfunctions and eventually to unconscious feelings such as refusing to feel desire rather than be disappointed again. Sexual desire or arousal can be suppressed by evoking, failing to put aside or focusing on negative thoughts. Once the expectation of failure has been established then an escape from the situation seems impossible. The individual would rather anticipate failure and be right than expect a positive experience and be disappointed. Kaplan (1979) points out that most clients who experience this anxiety tend to be

females. This is interesting in view of the fact that the performance demands are often greater for men than for women, as women can function without being aroused whereas men cannot fake an erection.

LoPiccolo (1980) supports the belief that sexual dysfunction can stem from anxiety "such as feelings of guilt, performance fears, and fears of intimacy or commitment. For those individuals in whom anxiety is associated with the arousal process, suppression of sexual thoughts and feelings and avoidance of sexual situations and stimuli will serve to reduce anxiety and maintain a pattern of low sexual desire"(p.34). goes on to say that the presence of anxiety has not been demonstrated in all cases hence it's role needs to be clarified by further research.

Anger/Partner Discord

There are contradicting views regarding the relationship between anger and sexuality. Kaplan (1979) reports that according to her experience, "it is not possible for normal persons to experience sexual desire for a partner with whom they are angry"(p.91). Hence they are seen as mutual inhibitants. She goes on to explain that "sadistic and/or sadomasochistic fantasies and acts" are for some persons for the purpose of discharging anger. Anger is not seen here as an erotic stimulus. To the contrary, it is "gotten out of the

way" to enable a person to experience sexual pleasure.

Kaplan(1979)talks about Stoller and others who believe that anger and aggression are the normal and universal aspects of erotic experience, that good sex requires the integration of angry and erotic impulses.

Jehu (1979) refers to partner discord as perhaps being one of the "commonest reasons for a loss of interest in sex ... In such circumstances, the inadequate interest may be restricted to the spouse, and sexual desire may remain unaffected as far as masturbatory activities and extra-marital affairs are concerned"(p.79).

Masters and Johnson have also reported that "partner rejection" is a significant factor in treatment failure. To the extent that "partner discord" and "partner rejection" refer to anger at the partner, this supports the argument that anger activates built in inhibiting systems and serves as a "turn off".

"Turn-Off" Mechanism

Defined by Kaplan (1979) as "the involuntary and unconscious but active suppression of sexual desire"(p.83).

Individuals place themselves into negative emotional states, by selectively focusing their attention on a perception or thought or by retrieving some memory or allowing an association to emerge that carries a negative emotional valence.

In this manner they make themselves angry, fearful or distracted, and so tap into the natural physiologic inhibitory mechanisms which suppress sexual desire when this is appropriate and in the person's best interest.

This can be done in a variety of ways such as focusing on his/her partner's unattractive physical features, or remembering past and or present unacceptable behaviors. Negative thoughts about one's self will similarly interfere with feeling sexy: "I am too fat"; "My breasts are too small or too large to be attractive"; "Iam too old"; "I will come too soon"; "It will take me too long to come"; "I will not be able to have an erection".

If an individual suffers from a global sexual problem, sexual situations elicit anxiety hence negative thoughts/associations and triggers the "turn-off" response. If the desire, excitement or orgasm inhibition is "situational", then only certain situations will result in anxiety and trigger the "turn-off" mechanism.

It is important to note that as individuals are capable of turning themselves off in the face of anxiety or a threatening sexual situation, the reverse is also true. Kaplan (1979) says that the person who is conflict free about sex mentally does the opposite of the inhibited one, in the sense that he does not allow negative feelings or thoughts or distractions to intrude upon his sexual pleasure . This person

will attempt to maximize erotic experiences by avoiding arguments, focusing on positive attributes and helping his/her partner feel special. When faced with a sexual situation this person's behavior will instinctively maximize the erotic experience.

Kaplan (1979) strongly supports the view that "we have the capability to control our sexual pleasure, as well as our other feeling states, to a far greater extent than we have been taught to believe"(p.85-86).

Inappropriate Stimulation

According to Jehu (1979) inadequate sexual interest may arise in conditions of deficient or inappropriate stimulation , for example; "individuals who require unconventional forms of stimulation for satisfactory sexual functioning, may well lack interest in sexual relationships that do not provide these conditions" (p.8). Some individuals believe that everything has to happen naturally, i.e., s/he is suppose to know and to tell someone what feels good makes it mechanical or artificial. Such persons may tolerate inappropriate stimulation which may result in irritation or pain hence interfering with the excitement or orgastic phase and can in time lead to inhibited sexual desire.

Deficient or False Information

This can range from an individual being afraid of sexual contact because she is unaware of what to expect from her own body to beliefs that a penis is two feet long when erect and will cause excruciating pain.

Inappropriate or false information can take many forms e.g., sex is sinful, dirty, a duty and not to be enjoyed etc..

Such negative thoughts based on false or deficient information can as indicated earlier result in various sexual dysfunctions. Deficient or false information can also lead to previously mentioned inappropriate stimulation simply because a person doesn't know better.

Traumatic Experiences

Traumatic experiences can take many forms and in some ways can be perceived as resulting in a "phobic" effect i.e., as Bandler and Grinder (1979) put it; "can be thought of as nothing more than a one-trial learning that was never updated"(p.112). Traumatic incidents can take the form of; an unsuccessful first attempt at intercourse, rape, being molested as a child etc.. Such incidences can leave some individuals with a frightening and or negative view of sexuality and can result in a variety of sexual dysfunctions.

Fear of Romantic Success

According to Kaplan (1979) "all phases of the sexual response may be affected by the unconscious fear of success"(p.170). This is not considered a new idea. In 1915 Freud recognized the existence of success anxiety and "wrote a paper describing two persons who were "wrecked by success".

Kaplan explains that clients usually lack insight into this phenomena and rather tend to complain of fear of failure. In fact this can sometimes simply be the case but one should be alerted especially in cases where resistance arises as improvement becomes evident and where a history suggests fluctuations in sexual and romantic functioning.

Fear of Intimacy

There are similarities in the behaviour of persons who fear intimacy and the success avoiding personality. Kaplan (1979) suggests that they are "governed by an invisible 'comfort zone', one involving the parameter of emotional closeness. They will show characteristic fluctuations in emotional distance"(p.184).

On occasion both partners may be afflicted with intimacy conflicts. Such couples will long for closeness but become anxious at a certain point and thus behave in such a manner as to create distance. Once distance reaches a certain point, anxiety and longing for closeness will result in behaviour

which will enable them to move closer to each other again - but not too close; and so on.

Psychoanalytic theory suggests that intimacy conflicts are derivative of preoedipal and oedipal problems while others support a developmental theory i.e., people develop fears of intimacy in adult life because of negative and disappointing experiences with intimate relationships in early childhood .

Jehu (1979) also makes reference to intimacy dysfunctions as resulting in loss of interest in sex. He refers to (Levay and Kagle, 1977) who in turn describe clients who "have difficulty in functioning sexually under conditions of involvement and commitment with a regular partner, although they may be able to do so quite adequately during relatively impersonal or transient sexual encounters. As the latter give way to an increasingly close and stable relationship during courtship, engagement and marriage, there may be progressive loss of interest in sex on the part of the primarily affected partner towards the other"(p.80).

Before moving on to Assessment and Evaluation, I would like to comment on aging as it is often seen by many as the end of sexual life.

The Role of Aging

The "aging process itself does not necessarily produce sexual dysfunction in either men or women, and when this does occur in the healthy person it may be due to psychological factors such as performance or rejection anxiety" (Jehu 1979 :57). He further supports this point with statistics from longitudinal studies of large groups from the general population which were conducted at Duke University; "it was found that at age 68 years, some 70% of men still regularly enjoyed sexual activity, while 25% still did so even when they were 78 years old"(Pleiffer, 1974, 1975). There is some corroboration of these proportions in the work of Kinsey et al. (1948) who reported that about 80% of men aged 60 years, and 20% of those aged 80, were still capable of sexual intercourse" (Jehu 1979:55). This is also similarly true of women and Jehu (1979) points out studies by Christenson and Gagnon(1965) which report that 70% of married women aged 60 were still engaging in sexual intercourse and that this was discontinued mainly when women had lost their husbands.

As mentioned earlier however if a man regards the natural organic changes of the aging process (such as a slowing down of erection, a decline of the forcefulness and frequency of ejaculation, and a lengthening of the refractory period) as

signifying the onset of impotence or the end of his sexual life, this is likely to result in anxiety, depression, spectatoring and avoidance reactions and eventually may result in the incapacity he fears.

Similarly women are expected to be devoid of sexual interest following their menopause and this can result in considerable anxiety, guilt and depression over their continuing sexual desires. This may be regarded as unnatural or immoral hence result in avoidance of sexual activity in their later years.

The above mentioned causes or maintaining conditions may operate singly or in combination in particular cases of dysfunction. It is my intention to point out that there is a wide range of organic as well as psychological factors that can contribute to sexual dysfunction and these must be taken into account when assessing or treating clients complaining of sexual dysfunction.

D - Assessment/Evaluation

As mentioned earlier having categorized a problem does not by itself determine the treatment. Although it is vital to have an accurate picture of the client's problems, it is also crucial to have an understanding of the "contemporary conditions that influence them, to ascertain the re-

sources available for treatment, to select and specify goals, and to plan a suitable programme." (Jehu 1979:175). In fact Jehu (1979) states that the above require more knowledge and skill than any other aspect of the behavioural approach.

The assessment phase consists of information gathering regarding all aspects of sexual functioning that are judged to be inadequate. The information obtained covers "the nature, frequency, timing, and surrounding circumstances of the problem at the current time as well as it's duration, onset and course up to that point" (Jehu 1979:175). It also includes a comprehensive and detailed description in operational terms of those aspects of the clients sexual functioning that are judged to be inadequate. Each category includes whether the problem is lifelong or not lifelong. In other words whether the problem is of a primary or secondary nature. Also included is whether the problem is situational or global in terms of current functioning. Situational problems occur only with some partners or only in some activities, whereas global suggests that the problem occurs in all situations.

I followed Jehu's "Checklist of Topics For Assessment Interviews with Sexually Dysfunctional Clients and Partners". See Appendix A (pp.180-187) for this checklist which is intended to be used as a guideline and not in a rigid or chrono-

logical fashion.

While the information gathered is to enable the therapist to work with the client in alleviating the sexual problem it also serves to identify whether in fact treatment is appropriate or even feasible. There are occasions when a dysfunction may be secondary to other factors such as a physical illness, alcohol or drug abuse, serious marital discord etc.. A thorough assessment is necessary in that it is equally as important to rule out certain possible causations or contributing factors as it is to determine them. Such information provides the therapist with hypotheses about the etiology and development of the dysfunction(s) and forms the groundwork for goal setting.

Depending on the nature and complexity of the problem a sexual "problem" history may be sufficient whereas where intensive therapy is warranted a sexual history is necessary.

Clearly assessments have constituted a major portion of my practicum experience and I have certainly come to acquire considerable respect for its true meaning and value.

For purpose of assessment and evaluation, I have used assessment interviews, questionnaires, self-monitoring and medical examinations, some of which involved physiological techniques. The questionnaires and scales which were utilized are the following;

1. Sexual History Form. (See Appendix B.)

2. Dyadic Adjustment Scale. Used to measure the state of a couple's relationship. (See Appendix C.)

3. Sexual Arousal Inventory. For measurement of female sexual arousability developed by Hoon, Hoon and Wincze (1976). (See Appendix D.)

4. Semantic Differential Scale. To measure how a client sees self and partner, ideal self and ideal partner. Useful to identify what changes the client wants for self and partner. (See Appendix E.)

5. Beck Depression Inventory (1972). Used to identify degree of depressive state. (See Appendix F.)

Although on going self reports are necessary when dealing with assigned sexual tasks a great deal of information is also obtained by observing the client(s) during therapy i.e., in terms of the way they relate to each other and the therapist.

The progress of the client(s) is assessed on an ongoing basis and as a result any necessary revisions may be made to the treatment plan so that it may become more effective and efficient.

It is important that a suitable combination of the above methods be utilized in order to arrive at a balanced and comprehensive assessment as well as meaningful evaluation of progress.

E - Treatment

(a) General overview

The primary goal of sex therapy is limited to the

relief of the sexual symptom. Although many remote and deeper intrapsychic and interpersonal influences which may underlie some sexual symptoms are recognized as important, the first site of therapeutic intervention is the alleviation of the immediate causes and defenses against sexuality. Such remote influences are delt with only to the extent that is necessary to relieve the sexual problem and to insure that the problem will not recur.

Treatment is considered complete when the dysfunction is relieved and when the factors which were directly responsible for the problem have been identified and resolved sufficiently so that sexual functioning is reasonably permanent and stable (Kaplan 1974)(Jehu 1979)(Perelman 1980).

Although traditional psychiatric theories would predict that such an approach would not be effective, evidence suggests otherwise; "98% to 100% of premature ejaculators can achieve good sexual functioning within a few weeks if they carry out the sensory training procedure properly" and "an extremely high proportion of sexually dysfunctional patients, approximately 80% can be relieved of their symptoms by sex therapy which limits intervention to modifying the immediate obstacles to sexual functioning, without concomitant changes in basic personality structure or of the fundamental dynamics of the marital relationship" (Kaplan 1974:190).

Without underestimating the tasks or home assignments suggested by the therapist it is important to underline that

dynamically oriented sex therapy does not rely exclusively on prescribed sexual interaction. Rather it employs an "integrated combination" of sexual experiences and psychotherapy and it is this combination that constitutes the main innovation of sex therapy and holds the secret of its power.

"The sessions and experiences mutually reinforce each other to reveal and resolve personal and marital difficulties" (Kaplan 1974:194).

Although sex therapy is somewhat uniquely standardized with most therapists using similar exercises as the chief ingredient to enhance the clients functioning it does not necessarily follow that sex therapy requires the integration of behavioral tasks within a psychoanalytic theoretical model, as suggested by Kaplan (1974). It is also obvious from the literature that specific formats employed by various groups differ considerably.

The Masters and Johnson program for example which served as the prototype for the sex therapy treatment format calls for a male-female co-therapy team (one of whom must be a physician) and a two week period of intensive therapy. Each spouse is interviewed separately by each co-therapist and must undergo a medical examination as part of the intake process. The couple is seen daily (including Sundays) for varying periods of time. The couple is generally seen in

joint sessions by both therapists and should individual sessions be necessary each partner is seen individually by one or the other co-therapist.

Masters and Johnson insisted on seeing couples therefore if a client had no partner or if a partner was not available they would provide a surrogate partner.

Regardless of diagnosis, Masters and Johnson's treatment begins with coital abstinence and sensate focus exercises moving on to specific sexual tasks which are indicated for their particular sexual disorder.

Lobitz and LoPiccolo (1977) follow a treatment model based on procedures developed by Wolpe (1969); Hastings (1963); and Masters and Johnson (1970). They claim that "in the absence of any physical pathology, sexual dysfunction is viewed as a learned phenomenon, maintained internally by performance anxiety and externally by a reinforcing environment, principally the partner" (Lobitz and LoPiccolo 1977:7). Their treatment involves both partners in 15 sessions with a male-female therapy team. A ban is placed on intercourse. The treatment package is as follows;

1. Clients keep data on sexual activity as part of ongoing assessment and planning;

2. Clients pay a "deposit" to ensure they follow instructions and to promote motivation;

3. Erotic material, fantasy, and masturbation are used to enhance arousal;

4. Teaching of interpersonal skills;

5. Disinhibiting of sexuality; e.g., role-playing orgasm as a means of reducing anxiety;

6. Treatment gains maintained by having clients participate towards the end of treatment in setting goals and procedures.

Lobitz and LoPiccolo see this program as effective in treating sexual dysfunctions.

Other therapists such as Kaplan (1974), Jehu (1979), McCarthy (1977) will see individuals and or couples on their own, involving a co-therapist as seen necessary and couples or individuals are generally seen once a week for treatment unless otherwise called for. This modified approach allows the client(s) a longer period of time to integrate new behaviour.

Jehu (1979) has a list of procedures (p.170) that he suggests may be drawn upon to constitute comprehensive treatment programs for sexually dysfunctional clients.

<u>Possible components of treatment</u>

<u>for sexual dysfunction</u>

Therapeutic Interviews

1. Provision of information
2. Modification of attitudes
3. Management of sexual assignments

Sexual Assignments

4. General pleasuring
5. Genital stimulation

6. Sexual intercourse

Specific Behavioural Procedures

7. Relaxation training
8. Desensitization
9. Flooding
10. Vaginal dilatation
11. Classical conditioning
12. Biofeedback
13. Phantasy training
14. Hypnosis

Ancillary Physical Treatment

15. Vaginal muscle exercises
16. Hormone or drug therapy
17. Prosthetic or mechanical aids.

He goes on to emphasize "that such programmes are individually planned and implemented to suit particular clients, in the light and nature of their problems, the resources available for treatment and the goals of therapy" (Jehu 1979:171).

Annon and Robinson (1978) propose a conceptual scheme for the treatment of sexual problems. Their model referred to as the P-LI-SS-IT model provides for four levels of approach; Permission - Limited Information - Specific Suggestions - Intensive Therapy. The first three levels are viewed

as brief therapy and the fourth is seen as "highly individualized treatment that is necessary because standardized treatment was not successful in helping the client to reach his or her goals" (Annon et al. 1978:47). This usually means having to deal with resistance. It is important to note that there is a danger of using the concept of resistance to blame clients for failures.

All sex therapy, at some point in time requires clients to confront secondary gains they may derive from their difficulties. This usually means having to tolerate and deal with uncomfortable levels of anxiety necessary for change.

It is not only important to be sensitive and aware of resistance, considerable skill is required to move beyond the impasse. Resistance is handled in varying ways by different therapists. (McWhirter & Mattison; Perelman; Zilbergeld & Ellison) suggest bypassing the resistance, going with it, or working around it while Kaplan's approach suggests carrying out behavioral tasks until difficulty arises and then explore, interprete, analyze or confront the resistance.

It is important to note that resistance may be in the symptomatic client or in the partner. For example, a spouse may realistically or irrationally expect that improvement with her partner's erectile problem will lead to him abandoning her for a more attractive partner.

I have personally found that having the client(s) identify

automatic thoughts and feelings when engaging in prescribed exercises as a very effective means of obtaining a clearer picture of the actual source of resistance. This can also sometimes be done using cognitive reviews and or imagery procedures as per Beck & Emery (1979).

Before moving on to treatment of specific dysfunctions I would like to underline that although there exists specific treatment strategies for each dysfunction that the treatment plans need to be designed to deal with each individual or couple taking in consideration their uniqueness.

(b) Treatment of Specific Dysfunctions

i. Inadequate Sexual Desire

As was mentioned earlier lack of sexual desire is a relatively new phenomena and to date only a few therapists have published material regarding the etiology and treatment of this dysfunctional phase of sexuality. Jehu (1979) and Kaplan (1979) both stress that every client has his/her own set of life experiences, thoughts and feelings which can contribute to desire disorders. Kaplan suggests that only a small proportion of ISD clients respond favorably to standard traditional, time limited, behaviorally oriented sex therapy. She suggests that such an approach is often effective with the simpler genital phase dysfunctions, but is usually not sufficient to reduce desire inhibitions. She believes that past

unrecognized desire problems account for many of the failures of sex therapy and offers alternate points of view. However we do not really know this to be true at this time as she presents no systematic evidence to support her point. Some low desire clients are and have been helped with the more standard traditional methods.

The findings thus far raise many questions about the treatment of choice for ISD and although somewhat promising certainly indicates how much more we need to know and raises the importance of badly needed adequate evaluations.

Kaplan (1979) suggests that "clinical experience and, most particularly, studies of treatment failures indicate that the prognosis is poor with 'classic' or symptom-focused sex therapy' and 'there are no outcome data available attesting to the efficacy of long-term individual and couples treatment for these disorders', additionally, there is no actual proof of the usefulness of long-term individual and/or couples treatment"(p.122-123).

The findings thus far suggest that "low libido patients have a guarded prognosis with all of the treatment modalities" even in cases where the underlying conflicts appear to have been resolved.

In view of the above Kaplan utilizes the following criteria (although still considered unsatisfactory) to govern her decisions regarding the treatment of choice for sexual

dysfunction associated with inhibited sexual desire.

1) Those few patients who show clear evidence that their desire inhibition stems from mild causes such as performance anxiety and who thus have an excellent probability of deriving help from brief treatment are accepted for sex therapy. We are, however, prepared to shift to the lengthier mode if resistances should arise.

2) When there is clear evidence that a patient's desire inhibition is associated with profound intrapsychic and/or marital pathology, appropriate long-term therapy is considered to be the treatment choice. In such cases prognosis with the more rapid and economic sex therapy techniques is too poor to justify even a trial of sex therapy.

3) For those patients who fall in the middle group with respect to seriousness of etiology, or for those patients where the evaluation does not allow for a reasonably accurate prognosis, it makes sense to recommend a brief trial of psychosexual therapy.

4) Patients with sexual symptoms, including inhibited desire, who have been treatment failures in previous therapy, brief sex therapy or lenghty individual or couples therapy are suitable condidates for psychosexual therapy. Treatment is particularly worthwhile in such cases if the evaluation reveals that either the remote or the immediate causes of the inhibition have not been specifically or adequately dealt with in the prior therapy" (Kaplan 1979:125).

The above is considered unsatisfactory due to the fact that they are subjective and based totally on clinical experience and intuition and not solid outcome data, however may offer hope for clients who weren't helped with traditional sex therapy either because insight was not gained into the specific antecedents of the desire suppression or due to the underlying conflicts not being dealt with sufficiently.

Although Kaplan (1979) claims that ISD patients will

seldom improve unless they gain some measure of insight into the underlying conflicts, into why they do not want sex, she does give accounts of successful outcomes (of inhibited sexual desire) without attaining insight.

It should be noted here that prior to beginning sex therapy phobic avoidances must be attended to. Kaplan will sometimes deal with phobic reactions through psychological management, on occasion accompanied by medication. Combining medication with in vivo desensitization can reduce anxiety to a manageable level so as to eliminate phobic reactions for certain clients. Sexual treatment is not seen as an appropriate modality when loss of libido is a secondary factor for example such as secondary to depression, severe stress, abuse of alcohol, sedatives and narcotics.

Otherwise the beginning stages of inhibited sexual desire treatment involve behavioural tasks such as those employed for excitement phase disorders i.e., of course if the evaluation doesn't reveal reasons to the contrary. These are;

1) Sensate focus i
2) Sensate focus ii
3) Sensate focus iii
4) Non-demanding coitus.

Sensate focus i or pleasuring consists of gentle caressing of the partner's body without touching the primary erotic area; the clitoris, nipples, vaginal entrance, or penis and scrotum . Sensate focus ii involves general pleasuring of each other's bodies including the genitals and teasingly, without the rhythmic

motion that produces orgasm. Sensate focus iii involves stimulating each other's genitals to orgasm manually following a period of bodily pleasuring. Non-demand coitus involves gentle penetration without orgasm and the final stage includes penetration with orgasm for both.

"The tasks are designed to provide a non-demanding, reassuring, non-threatening and intimate ambiance which will resolve such common obstacles to sexual pleasure as performance anxiety, anxieties and angers arising out of poor communications with the sexual partner, as well as out of disappointing, rapid, and mechanical sex and unrealistic expectations due to sexual ignorance and inexperience" (Kaplan 1979:108).

Resistances are expected and usually arise between task one and two and this marks the beginning of insight therapy. Resistance "creates the first therapeutic crisis and provides the opportunity to confront the patient with the existance of his block, with the inexplicable and involuntary suppression of erotic feelings, with his previously unrecognized tendency to focus on angry or frightening thoughts at the time of love-making" (Kaplan 1979:108). The process of exploration can then begin as such negative responses to the exercises can be used to enable the client to gain insight on progressively deeper levels and recognize that he/she is not necessarily a "victim of a mysterious loss of libido". This awareness can

sometimes do a great deal to help the client improve and intensive work into earlier problems is not always necessary.

Kaplan stresses the importance of a close and trusting bond between the therapist and client(s) if the client is to sustain the rapid changes and high emotional tensions of this (psychosexual therapy) active intervention which is characterized by its supportive and confrontative components;

"The therapist can raise the level of anxiety when resistances arise during the therapeutic process by confrontation and the creation of controlled crisis. He can reduce the tension level when this is of counterproductive intensity by support and by fostering reassuring ambiance in the couple's sexual interaction" (Kaplan 1979:142).

Psychosexual therapy focuses on both the immediate and remote levels of causality with an integrated use of behavioral and psychotherapeutic methods.

Although I have focused primarily on Kaplan's most recent work on Treatment of Sexual Desire Disorders, I am not suggesting that her contributions are the only one's worthy of mention. In fact the alternatives she presents (Psychosexual Therapy) have not been applied to large samples i.e., her conclusions are based on her clinical work rather than specific studies. She is however clearly devoting much of her energies towards exploring creative alternatives to the more traditional methods. Her volume on "Disorders of Sexual Desire" is truly a work of

art and an inspiration to all those interested in making further advancement in this challenging field.

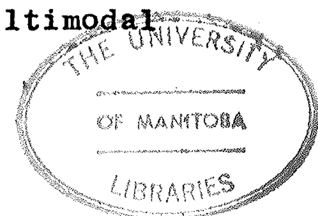
There is clearly a need for further innovation, exploration and research and an attitude or belief that we can all play a part.

ii. Dyspareunia

The literature tends to suggest that dyspareunia is most commonly treated by gynecologists who often identify a physical cause for such pain or discomfort during intercourse.

Abarbanel (1980) describes the steps involved in the medical evaluation of problems of coital discomfort. This account is quite useful for the clinician who must assess the need for a medical consultation and certainly brings home the point that a complete and thorough medical assessment is quite extensive.

Lazarus (1980) suggests that males who complain of dyspareunia almost invariably have a medical problem. As the originator of multimodal therapy, he suggests that three general classes of factors may contribute to psychological dyspareunia: developmental, traumatic, and relational. He also cautions that psychological difficulties have multiple antecedents hence he recommends a comprehensive multimodal assessment of the following;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1. Behavior - Are there problems with sexual technique?
2. Affect - Is guilt, anger, fear, or shame a primary or contributary factor? Is love and or physical attraction present or absent?
3. Sensation - When does pain or discomfort occur? Is it sudden or gradual, mild, moderate or severe? Is orgasm a trigger of pain? Does a lubricant make a difference?
4. Imagery - Are there intrusive images during sexual activity?
5. Cognition - Are there intrusive thought processes?
6. Interpersonal - What is the nature of the relationship?
7. Drugs (biological) - Are medications used especially antihypertensive drugs, tranquilizers or sedatives? Is attention paid to hygiene?

This is undertaken in order to arrive at a solid understanding of the factors contributing to and maintaining dyspareunia. The results of such an assessment is then used to determine treatment. Lazarus uses an assortment of treatment techniques i.e.,he intervenes in many modalities with a variety of methods, from relaxation to imagery rehearsal. He also raises the question of sexual mismatches between mates as prime consideration in psychological dyspareunia rather than specific traumatic or developmental events. "It would not surprise me if it were true that after ruling out organic factors, at least half the women who suffer from dyspareunia are having sexual intercourse with the wrong man!" (Lazarus 1980:164).

iii. Erectile Dysfunction

"Depending on their theoretical orientation, authorities in the field of sexual dysfunction have variously advocated hormonal, psychoanalytic, behavioral, and marital therapy as the treatment of choice for impotence. And in fact, a review of the literature reveals that all these modalities are effective in some cases" (Kaplan 1974:266). She goes on to say that there is however evidence to suggest that brief conjoint treatment techniques are superior to office behavioral approaches which use only relaxation and desensitization procedures.

Her initial treatment strategy includes the manipulation of the sexual system so as to enhance the stimulating factors and diminish those which promote anxiety in the client. The content of the therapeutic sessions is as usual dictated by the assessment of the source(s) of anxiety which impairs the erectile mechanism. This may require insight-fostering techniques, marital therapy as well as behavioral methods and medication if necessary, the sexual tasks include such things as non-demand pleasuring, dispelling the fear of failure, distracting obsessive thoughts, permission to be selfish and coitus.

Ellis (1980) uses a rational-emotive approach to treatment of erectile dysfunction. He points out the multiple cognitive, emotional and behavioral antecedents of the problem

and suggests that success often requires intervention in all three areas. He sees treatment goals as including dealing with performance anxiety, unrealistic sexual expectations, insufficient arousal, unsuitable conditions, overemphasis on erection, and partner pressure.

The following is a list of suggested most effective and frequently used methods in RET for overcoming erectile dysfunctions;

Cognitive Methods: Disputing Irrational Beliefs, Information-Giving, Myth Attacking, Antipuritanical teachings, Cognitive Distracting, Imaging Methods, Sexual Focusing, Partner Education, Bibliotherapy and Audiovisual Aids.

Emotive Methods: Unconditional Acceptance, Reassurance and Support, Shame attacking Exercises, Risk-Taking Exercises, Rational-Emotive Imagery, Emotive Self-Verbalizations and Group Procedures.

Behavioral Methods: Homework assignments, In Vivo Flooding, Operant Conditioning, Skill Training and Assertive Training.

Zilbergeld (1978) put together a self-help program (Male Sexuality) which among many things includes resolving erectile problems. Not only does he suggest that this program is successful for men without steady partners, but also by men with partners who would not co-operate in treatment, and by men who had co-operative partners but who didn't want to do partner exercises. He makes it clear that; "Success-

fully dealing with erection problems requires that the following criteria be met:

1. Having sex only when you get aroused and only the kinds of sex you want;
2. Meeting all your conditions for good sex;
3. Recognizing when you are tense, and getting more relaxed;
4. Getting the kinds of stimulation you like and focusing on this stimulation.

In short, you need to be able to take charge of a sexual situation so that you are enjoying rather than performing" (Zilbergeld 1978:303). This of course for someone with an erectile problem is far from being as simple as it sounds. It requires a number of skills which are often lacking in the individual with the problem. One needs to be aware of the conditions that enhance a positive sexual experience, as well as confident and assertive in order to ensure that the conditions are met. This means being able to communicate needs and expectations in a positive non-threatening manner, capable of relaxing to a comfortable level and able to focus on sensations and or fantasies which enhance arousal.

Zilbergeld's self help manual guides a motivated individual through the conditions, assertiveness, relaxation, talking and focusing exercises required in order to enhance sexual functioning. Should this not be sufficient to alleviate the problem he then includes a series of masturbation exercises with comments related to possible problems and ways of dealing

with the problems as they arise. The first part of the masturbation exercises are similar to that of Lobitz and Baker's (1979) exercises which deal with fears over losing an erection;

- Losing and regaining erection
- Masturbating with fantasy of sex with a partner
- Masturbation with fantasy of no erection with a partner.

These exercises are done as many times as necessary in fantasy in order to gain a feeling of confidence that it could be carried out in reality with a partner.

Zilbergeld is also particularly concerned with modifying attitudes and beliefs (myths) that are likely to contribute to the dysfunction.

When dealing with men without regular partners Zilbergeld (1978) also suggests the following as being of utmost importance;

1. Get to know her and give her an opportunity to know you.
2. Be sensual with her before you even think of doing anything sexual.
3. Do whatever is necessary to feel comfortable with her and get your conditions met.
4. Consider a session or two of massage before having sex.
5. When your conditions are met, when you are comfortable and when you are feeling aroused, feel free to engage in whatever sexual activities you like.
6. Give feedback about your experiences with her.
7. Express your feelings when appropriate.
8. Don't do anything you don't want to do. Take care of yourself.

Masters and Johnson (1970), attempted to deal with the problem of no partner by using surrogates i.e.,a substitute for regular partners. For a variety of legal and professional, ethical and practical reasons, the original example set by Masters and Johnson has been followed by few therapists.

Lobitz and Baker (1979) report results that suggest that their group treatment of single males with secondary erectile dysfunction is a viable, cost effective treatment.

Their psychoeducational therapy group consisted of specific interventions directed at the following areas: Sexual Performance Anxiety, Inhibited Communication with Women, Ignorance About Human Sexual Response, Insensitivity to Physical Sensations and Impoverished Sexual Imagery.

Their positive results of this program with nine men, six of whom suffered from secondary erectile dysfunction and three from primary erectile dysfunction are seen as statistically significant and the data pertaining to the specific incidence of erectile dysfunction are shown in Lobitz, Baker Table II, (1979), p. 133. They emphasize the need for a stronger social skill training component which tends to be supported by a number of clinicians. For example Price, Reynolds, Cohen, Anderson and Schochet ran a program referred to as "Dating Skills Training in the Group Treatment of Erectile Dysfunction for Men Without Partners" and in a 1981 report support the importance of a social skills component in producing improvement

in sexual functioning.

It would seem that we have come a long way in a relatively short period of time and although more research is necessary many new doors are being opened.

iv. Premature Ejaculation

"In 1955, James Semans described a procedure which was to become the basis for all sex therapy approaches to premature ejaculation. This simple technique requires the partner to stimulate the penis manually until premonitory sensations (PS) are experienced. Stimulation is interrupted until the PS diminish, the process is then repeated. When the patient is able to tolerate extravaginal lubricated stimulation 'indefinitely (the patient could then expect) normal coitus without premature ejaculation' (Semans, 1956, p.357)" (Perelman 1980:204).

According to Kaplan one of the key elements in the treatment of premature ejaculation at Cornell "is to get the man to focus his attention repeatedly on the sensations of impending orgasm while he is making love to his partner" (Kaplan 1974:303). They employ a variation of the Semans "stop-start" method which is conducted by the couple within the sexual situation. The sexual tasks prescribed in their simplest form consist of the following;

Stimulation of the penis (by partner) manually (or orally

if preferred) with concentration on the sensations. Stimulation is stopped as soon as he feels the premonitory orgastic sensations and resumed once the sensations disappear but prior to the loss of erection. The couple is to repeat this procedure a second and third time prior to stimulation being continued to the point of orgasm on the fourth time. No effort is to be made to exert conscious control over the orgasm. Following a few experiences the male is instructed to place his hand over his partner's and to experiment with the sensations produced by varying the speed, pressure, and excursions of stimulation. The next step includes lubrication of the penis which serves to more closely simulate the sensations provided by containment within a lubricated vagina. Intercourse in the female superior position is the next stage with the stop-start procedure still being employed and following the same steps initially described. The following stages include gradually more rapid thrusting to intercourse lying on their sides to the male superior position. Following treatment the couple is instructed to repeat the stop-start exercises once every two weeks.

Kaplan (1974) notes that it cannot be emphasized too strongly that the focus of attention is "the active ingredient," i.e., the curative factor, in the treatment of prematurity.

Treatment is sometimes complicated by resistance and it is in such instances that the therapist's skill is called to

the test i.e.,in clarifying and resolving resistances to treatment.

Zilbergeld (1978) while also preferring the original Semans approach, emphasized the benefit of first teaching the procedure during masturbation. This is followed with a sequence very similar to Kaplan's except for the introduction of a 15 minute time factor within which to do the exercise with the option of reaching orgasm at the end of the 15 minutes.

Premature ejaculation is rarely caused by an organic condition but "may arise both as a developmental disorder in which adequate control is not acquired, and as a stress disorder in which it breaks down in conditions of threat" (Jehu 1978:91).

As previously mentioned resistance almost invariably emerges and can usually serve to clarify the disorder's etiology. This resistance can be precipitated by the client or partner and a number of techniques may then be used to manage the resistance. The techniques used will depend on the therapist's orientation and skills.

v. Retarded/Absent Ejaculation

According to Jehu (1979) the fundamental principle in treating this dysfunction is to gradually shape the

client's ejaculatory response towards the goal of ejaculating in his partner's vagina during sexual intercourse . This is done using an individually tailored program which gradually works towards the desired goal. The best place to begin being with whatever existing ejaculatory capacity. Jehu (1979) gives a summarized illustration of what such a program could look like;

"1. his existing capacity to masturbate to orgasm when he is alone in the house, and then proceed through the following further steps,
2. masturbating to orgasm with his wife in the next room,
3. going to the bathroom to masturbate after having had intercourse without ejaculating,
4. remaining with his wife to masturbate after intercourse,
5. the wife manually stimulating her husband to orgasm after intercourse,
6. repetition of 5, with ejaculation being produced progressively nearer to the vagina,
7. the wife stimulating her husband almost to ejaculation, at which point he enters her vagina and a combination of manual and vaginal stimulation is continued until he ejaculates inside his wife,
8. at this stage, Kaplan (1975) advocates the use of what she calls 'the male bridge manoeuvre', which consists of the same combination of vaginal and manual stimulation, but with the man signalling to his partner when he is approaching ejaculation, so that she discontinues her manual stimulation and he reaches orgasm by penile thrusting alone,
9. finally, it is often possible to fade out the manual element in the combined stimulation if the couple wish to do so"(p.147).

This is a relatively rare form of sexual dysfunction. Masters and Johnson (1970) reported only seventeen cases (out of 448 males requesting treatment for sexual problems) in an eleven year period.

Razani J. (1978) gives a successful illustration of a case of ejaculatory incompetence being treated by deconditioning anxiety.

Newell, A. (1978) presents a successful outcome where treatment included a mechanical aid. This is a case where the spouse was unwilling to take part in treatment.

Jehu (1979) also sees inadequate stimulation as an important factor and suggests the use of a vibrator (whenever necessary) as part of the treatment package.

vi. Vasocongestive Dysfunction

Kaplan (1974) refers to problems of arousal in women as general sexual dysfunction. Jehu (1979) prefers to use the term 'vasocongestive dysfunction' and uses it to refer more specifically to an impairment of physiological changes with the lack of erotic feelings being considered a separate problem of inadequate pleasure. He supports this separation of syndromes because they may or may not be associated in the same client. He explains; "some women neither exhibit the lubrication - swelling responses nor do they experience erotic feelings. Other clients lack these physiological responses although they do become psychologically excited. Conversely, there are others in whom lubrication - swelling occurs normally, but without the usual accompanying feelings

of sexual pleasure" (Jehu 1979:104).

Treatment according to Kaplan (1974) requires enabling the woman to abandon herself within the sexual experiences by changing the sexual system in which she functions. The therapist works towards this objective by creating a non-demanding, relaxed and sensuous ambiance which permits the natural unfolding of the sexual response during lovemaking . She uses the usual sequence of prescribed sexual tasks which include - sensate focus or non-demand pleasuring exercises, genital stimulation, and non-demand coitus to clarify the actual therapeutic process.

As is to be expected these sexual experiences are likely to evoke feelings of resistance in the client(s) and this in turn serves to identify the specific obstacles which impede her sexual responsitivity. Kaplan (1974) deals with these obstacles both on an experiental level and with psychodynamically oriented interpretations.

vii. Vaginismus

For years gynecologists have used vaginal dilation procedures to treat women suffering from vaginismus. These procedures have more recently been incorporated as an important component in more comprehensive programs for treatment of this condition. Kaplan uses a combination of systematic

desensitization with the insertion of finger(s) or dilators in the vagina. This is seen as primarily focused on the immediate cause i.e.,the conditioned response and deeper causes are delt with only if seen as necessary. She underlines that any phobic reactions must first be resolved prior to therapy. This generally involves exposing the woman repeatedly to the feared situation - in vivo, in actuality, or in fantasy.

Kaplan (1974) provides therapy along the following lines (with flexibility);

- Conditions need to be such that the woman knows she is always in control.
- Examination of woman's genitals by herself and partner in privacy of their bedroom.
- Gentle tactile exploration by woman and partner to find the exact location of vaginal opening.
- Gradual, gentle insertion of own or partner's finger into vagina - remaining still until uncomfortable feeling disappears. This exercise may be initially done by the client alone or with partner.
- Gradual back and forth movement of one finger inside vagina until this can be done without discomfort.
- Insertion of two fingers.
- Intravaginal rotary digital movement and gentle stretching of the vagina with the fingers.
- Penile insertion without movement.
- Penile insertion with slow, gentle thrusting at the woman's signal.

This behavioural approach is combined with various relaxation exercises such as vaginal relaxation which includes voluntary tensing and relaxation of vaginal muscles. This reinforces a sense of voluntary control over her vaginal inlet. The above steps are followed in combination with education,

encouragement and therapy to deal with whatever resistance may emerge.

Although there are minor variations the literature suggests that most sex therapists approach the treatment of vaginismus in a similar fashion.

viii. Orgastic Dysfunction

According to Kaplan (1974) treatment is based on the premise that the orgastic reflex has merely been inhibited and not destroyed and the initial objective is to help these women reach their first orgasm. This is important in that it helps dispel the fear that she is not capable of an orgastic response.

To reach the above goal "every effort must be made to diminish the inhibitory forces, while at the same time maximizing stimulation" (Kaplan 1974:387). If orgasm is not reached using joint treatment tactics designed to enhance her general arousal, the treatment strategy at Cornell is often shifted to self-stimulation exercises" and may if necessary go on to include stimulation by vibrator, resolution of unconscious fears of orgasm, use of distraction and vaginal muscle exercises.

LoPiccolo and Lobitz (1978) report on a nine-step masturbation program shich they use as part of their treatment.

Although they have only used this on a small sample they feel that it offers considerable promise in the treatment of primary orgastic dysfunction;

Step 1: Self awareness exercise i.e.,exploring her nude body with an effort to appreciate it's beauty. Genital exploration (following a bath) using a hand mirror and diagrams to become more familiar with various areas of the body. Many clients express amazement at the extent of their new discoveries.

The client is also started on a program of Kegel's (1952) exercises with the intention of increasing the tone and vascularity of the pelvic musculature which can increase her orgasmic potential.

Step 2: Tactile and visual exploration of the genitals without expectations of arousal. Although this often leads to some anxiety it is intended to do the opposite and can do just that with support and encouragement from the husband and therapist.

Step 3: Continued tactile and visual exploration of genitals with the object of locating sensitive and pleasurable areas especially the area immediately adjacent to the clitoris.

Step 4: Manual stimulation of located sensitive areas. This is further discussed with a female therapist in view of identifying the variety of lubricants and techniques that can be used to enhance pleasure and prevent soreness.

Step 5: (If step 4 does not lead to orgasm)

Increased intensity and duration of genital stimulation. Stimulation may be required for as long as 45 minutes at a continuous and intense rate. Clients are encouraged to use erotic phantasies, literature and pictures to further increase arousal and to distract themselves from any performance anxiety or spectatoring.

Step 6: (Should step 5 not result in orgasm)

Clients are encouraged to continue step 5 with the additional use of a vibrator. Clients who still have difficulty after a series of exercises in step 6 are encouraged to roleplay their conception of the orgastic response in an exaggerated manner. This is intended to desensitize them of their fears of loss of control.

Step 7: Once orgasm has been achieved through masturbation the focus shifts to enabling her to experience orgasm through stimulation by her husband. She is first asked to stimulate herself with her husband watching. This serves as a learning experience for him and desensitizes her to visibly displaying arousal and orgasm in his presence.

Step 8: This consists of the husband putting into practise what he has learned with his wife's expert coaching.

Step 9: Once orgasm has been reached in step 8, the couple is asked to engage in intercourse while the husband concurrently stimulates his wife's genitals either manually or with a vibrator.

The female superior sitting, lateral or rear-entry coital position is recommended for this activity as these three positions allow the male easy access to the female's genitals during intromission.

"Given the initial goal of a first orgasm, there are several reasons for thinking that this is most likely to be achieved by the woman stimulating her own genitals. Kinsey et al. (1953) found that more women could reach orgasm through masturbation than any other means, including sexual intercourse. Indeed among the women in their sample, 62% had masturbated at sometime in their lives, and 58% had reached climax in this way"(Jehu 1979:144).

Herman, LoPiccolo and LoPiccolo (1976) present an easily understood self-help manual "Becoming Orgasmic; A Sexual Growth Program for Women" which they claim demonstrated it's effectiveness with numerous women during seven years prior to the publication of the above named manual.

PART II - Case Reports

Assessment

Treatment

Evaluation

Part II of this Practicum Report consists of eleven actual Case Reports and relies heavily on the aforesaid information. As therapy can hardly be learned by merely reading the theories, observing therapy or talking about it, the experiential aspect proved invaluable to my learning.

In this section the following process is followed;

1. Assessment interviews to gather information and to determine how the problem is perceived by the client(s).
2. Clinical formulation of the problem, including specification of the problem(s), hypotheses about conditions initiating and maintaining the problem(s), and resources available for treatment.
3. Goals of treatment or desired outcome, arrived at through negotiation with client(s).
4. Treatment plan.
5. Ongoing assessment and evaluation of progress.
6. Termination and evaluation of treatment.

CASE 1 Garry
Erectile Dysfunction

Garry is a 56 year old male, referred to the Sexual Dysfunction Clinic by a Urologist. He was originally seen by his family physician who gave him a course of Testosterone Linguettes and Testosterone injections (due to complaints of impotence) but without any improvement. Garry also complained of Peyronies Disease and an examination report indicated that his gonads were in excellent condition, his prostate normal in size and consistency and a plaque on the lateral aspect of his penis. The Urologist indicated that he had little to offer Garry for his Peyronies Disease except for Vitamin E. treatments suggesting that this problem will correct itself in due time (six months or so). The Urologist also gave Garry a specialist's name and address regarding the possibility of a prosthetic device in the event that treatment at the Sexual Dysfunction Clinic not work.
Garry was seen at the Clinic one month later by another therapist for an intake interview and was informed that his wife would be instrumental in effective treatment. He expressed strong doubts about his wife's willingness to cooperate and after agreeing to explore this with her, waited four more months prior to requesting another appointment. Garry was assigned to myself at this time and he reaffirmed that his wife was not prepared to be involved. He was seen twice thereafter, one session for purpose of a beginning

assessment and one session dealing with termination.

Description of problem

Nature

Garry has a problem of premature ejaculation and also complains of not being able to acquire a full erection during foreplay and sexual intercourse, as well as during masturbation.

Frequency

He claims to ejaculate before he wishes and usually with a partially erect or flaccid penis.

Timing

He ejaculates before penetration over 50% of the time and on other occasions can last from 4 to 7 minutes from the point of entry until reaching orgasm.

Surrounding circumstances

He is unable to obtain an erection or ejaculate through self masturbation or through partner stimulation using any means other than intercourse.

Duration

His first experience with being unable to obtain an erection in a context where he normally would goes back 27 - 28 years (sporadic) but approximately 10 years ago the problem became more pronounced and was seen as significant.

Onset

The first signs of impotence occurred 2 - 3 years after they were first married. At a time when (according to Garry) his wife started being involved with other men, (one in particular).

Course

The course of this problem was of a sporadic nature and not seen as significant by Garry until approximately 10 years ago when his wife apparently "gave up running around". Since that time he has been under more pressure to perform sexually and impotence has been a serious problem identified by himself as well as his wife.

Contemporary influences on the problem

Situational antecedents

Garry's problem with impotence became more pronounced once his wife "gave up her extra marital involvements" however it is difficult to tell what started operating at that time.

Possibilities

1. More pressure to perform sexually for fear of losing wife to other men again.

2. More sexual demands placed on him therefore more stress.

3. Anger with wife re: the years of anguish waiting for her to come home etc. thus paying her back.

4. State of emotional divorce, loss of interest emotionally and sexually due to long standing marital discord.

Garry reports feeling a great deal of anxiety when approaching his wife sexually. He has been told things like;

"You're not a man".

"You're not normal".

"I simply put up with this".

In effect he reports that over the past 10 years he has <u>never</u> felt sexually aroused when involved sexually with his wife. Up until 7 - 8 months ago they on occasions engaged in fore-play for several hours, still failing to get an erection. "We tried everything without success". He reports having been very angry in the past "it ate at me, depressed me" but claims to have put this behind him, "the past doesn't bother me anymore, for many years now".

Garry worries a great deal, sees himself as a very nervous person. He would like to be able to have greater purchasing power and travel with his wife feeling that this is important to her. This is not possible in the present but he is still optimistic for the future.

Organismic variables

"When I approach my wife sexually (less than once per month) I think what's the use". He constantly thinks about the fact that he will not get an erection and his wife will be upset and frustrated <u>AGAIN</u>. We're at a point where we avoid each other sexually most of the time because we know the outcome".

There is no evidence to suggest that illness, surgery or drugs play any part in his erectile dysfunction. Garry suffers from sinus discomfort and arthritis in shoulders and back but this is not seen as significant. He underwent a small ear operation, seen as uneventful.

Situational consequences

Garry's wife stands firm that she "doesn't have the problem therefore sees no reason to become involved" in therapy. Garry clearly doesn't want to bother her with this or put any undue pressure on her. At this time both spouses are dealing with the problem through avoidance of sexual contact with each other.

Personal and family background

Both Garry and his wife are French Canadians. Although he speaks and reads English he is much more comfortable with French. They have four children with one 20 year old daughter still living at home. Garry has an elementary school education and is employed as a janitor while his wife (also in her middle fifties) is occupied with the care of the home. This is their first marriage and both are Roman Catholic but to what degree actively practising is unclear. Religion appears to play a fairly significant part in relation to Garry's values towards masturbation, fantasizing and freedom with pornographic material. This was not explored sufficiently in order to have a clear picture of the implications it could have for possible

treatment.

Garry's wife underwent surgery for a hysterectomy (due to cancer) some 12 years ago shortly prior to when he reports that she discontinued extramarital activities. She also underwent major sugery since that time and according to Garry she has since been sickly and unable to do much in terms of physical activities and active housework.

Childhood and puberty

Garry speaks of his childhood as offering him no sex education whatsoever at home or in school except for the rigid approach his father had regarding sexual taboos, i.e., what was sinful. Although masturbation was seen as sinful he still successfully masturbated while feeling guilty. He has some difficulty talking about masturbation and had left out answering #5 and #16 in the Sexual History Form.

#5 How often do you masturbate?

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

Similarly he has religious reservations regarding pornography indicating that "there are limits". At the same time his response to #19 in the S.H.F. is that he is "not aroused" when exposed to pornographic materials.

Sexual experience before current partnership

Limited information in this area except that Garry did have experiences with other women before marriage.

Motivation

Garry saw no reason to carry on with the assessment process without there being serious improvement in the marital relationship. "It's of no use, my wife and I are so far apart". His mind was clearly made up and only returned for a second session in order to explain that he was planning to accept the status quo unless his wife showed some signs that she wanted to work on the relationship. He has no intentions of leaving his wife and plans to make the best of the existing situation. "I can manage quite well, there are people who have it a lot worse. I was brought up in the 30's and have lived through difficult times".

Clinical formulation

In view of having an incomplete assessment and an unmotivated client I am lacking much information.

For example:

"Even when I approach my wife for sex I am not sexually aroused". What therefore motivates Garry to approach his wife for sex?

- Sexual activity before marriage?
- Did loss of erection in masturbation coincide with loss of erection with intercourse? Which came first? What were the circumstances.
- Garry feels sexual desire 2 - 3 times per week, desire for sex with whom? What form of desire? Sexual arousal how experienced? Thinking it would be nice to have sex or fantasizing sexual thoughts? If a fantasy, with whom?

- How often Garry masturbates - circumstances etc.
- Is orgasm with flaccid penis normal in terms of pleasure or hedonic with flaccid penis?
- Religious implications re: fantasizing, masturbating, pornographic materials, etc. How rigid, flexible?

During the session dealing with termination I shared with Garry that even if his wife refused to be involved at this time that there was an option of exploring the causes as well as what could be done regarding his inability to obtain an erection and/or orgasm through masturbation. Garry didn't feel that this was important, preferred leaving it open to return for therapy should his relationship with his wife improve. I pointed out that this was unlikely to happen "by itself" and explained that marital and or family counselling was available to them from a number of sources.

The following case report will provide an example of what can be accomplished without the involvement of a partner.

CASE 2 BOB

Erectile Dysfunction
Premature Ejaculation

Bob age 48, was referred by his family Doctor to a Urologist who in turn referred him to P.S.C. Sexual Dysfunction Clinic. Bob was previously treated at P.S.C. in 1975-76, for

two years mainly for problems of self concept, socializing skills and depression. In 1973 he underwent 10 sessions of acupuncture treatment for his sexual problems and earlier in 1971 participated in 15 training sessions on self hypnosis, again for his sexual problems, all without any success. He also had one session with a "specialist" in Europe during a holiday and was told that his problem was of a subconscious nature. He also understood from his therapist at P.S.C. that his sexual problem is likely due to unresolved anger towards women and that he is possibly subconciously getting back at them.

Description of problems

Nature

Bob has trouble achieving a full erection during sexual activity. Although he feels pleasure and arousal subjectively during most parts of a sexual experience he still has trouble getting an erection. He also usually ejaculates with a slightly erect penis under all conditions (including masturbation) and usually sooner than he would like when having intercourse. Bob's primary concern is that of erectile dysfunction and he doesn't appear to be (at least at present) overly concerned with his history of premature ejaculation.

Frequency and timing

His problem with erectile dysfunction exists all the

time during foreplay and intercourse and over 90% of the time in masturbation. His problem with ejaculatory control exists over 90% of the time with a partner, usually upon entry or shortly thereafter.

Surrounding circumstances

Bob's erectile problem appears to be most significantly affected when he is in the presence of a woman that he sees as controlling and demanding sexually.

At this stage, when masturbating, Bob immediately looses whatever slight erection he may have the moment he moves his buttocks while assuming a position suggesting intercourse.

Duration

Bob experienced what he considered a "good sexual relationship" with a girl in Germany during a three year courtship, 19 to 21 years of age. This was his first sexual experience. Although he would always ejaculate quickly his refractory period was short therefore this was not seen as a problem by him.

Onset

Bob's first reported recollection of not being able to obtain a full erection dates back to when he was 22 years of age. He had spent the night with his 28 year old girlfriend at a cottage where they had their first sexual experience.

He had a full erection and no ejaculatory difficulty on the first night but the following morning he was unable to get a full erection. He doesn't recall this to have been particularly significant at the time yet remembers the incident 28 years later.

As far as premature ejaculation is concerned, Bob tended to ejaculate quickly during mostly all his initial sexual experiences.

Course

Following his first failure to obtain an erection, Bob functioned satisfactorily approximately 90% of the time, until he met his wife to be. His first attempts at intercourse with his wife to be (when dating) resulted in his ejaculating as soon as he would attempt penetration. Once he became more comfortable with her (approximately three or four months after they were married), he reports that everything was fine. He was married for ten years and the last five years were plagued with marital discord. During the first five years everything was fine, he describes himself as being like a bull in that all he could think of was getting it (penis) in. The last five years were full of misunderstandings and fighting. Even from that time "she had to play with it in order for me to get an erection". Bob was accustomed to becoming sexually aroused and erect very quidkly therefore

became very disappointed once he needed added stimulation in order to get an erection. From that point on and especially since his divorce 14 years ago he has experienced difficulty obtaining and maintaining an erection. There was some improvement with a few partners "who knew how to make it work", but as he can be turned on instantly, he can also be turned off instantly. Bob makes reference to one occasion during the last 14 years where this small young woman would move in such a way that he couldn't help but get an erection. This was a one night stand.

Contemporary influences on problems

Situational antecedents

Bob is first of all a highly anxious individual, especially in the presence of women who are demanding sexually or place pressure on him for an erection. He believes that there is a right and normal way to have sex, this being intercourse. Failure to perform intercourse leads to shame, frustration and guilt. He has always been of the attitude that when he is "horny", he has to "get it in there".

It is not enough that Bob puts pressure on himself but his last four month common-law relationship presented him with a woman who felt the same way and insisted on his providing her with an erection, which he couldn't. He felt strongly that he loved this woman and was afraid of losing

her if he didn't satisfy her sexually. As he couldn't, she left him.

Aside from being with someone who was very demanding sexually, he was working long 12 hour days and drinking heavily after work. He tends to push himself in whatever he does as is exemplified by the following statement, "I don't want to brag, but I can work harder than men half my age, I can lift heavier etc.".

If Bob is made aware that a certain woman masturbates using a vibrator or other artificial means he is automatically turned off. For example on one occasion, he was told by one woman (with whom he claims to have had very enjoyable sex) that she used the end of a broomhandle to masturbate, he never had anything to do with her again.

Organismic variables

Bob has not given up on sex but has just about given up hope of ever gaining a full erection. Whenever he begins to get an erection he automatically expects to lose it. He is constantly preoccupied with actively achieving or "willing an erection" which results from a fear of continued erectile difficulty. He has become a spectator to his own sexual experience rather than a participant thereby blocking his access to the physical and psychological stimulation that would normally produce heightened sexual arousal and "spontaneous"

erection.

Bob claims to have been once told by a Doctor that his penis is like a muscle and unless he uses it regularly he would lose it. This was when he was still married and after a period of not having intercourse for three months. Although he claims to not believe this anymore, rather that emotional and physical factors need to be right, he still made the comment "I'm a physically very strong guy, I can't understand why that little thing won't get big."

As mentioned earlier, Bob is a highly anxious person especially in the presence of women, more so with sexually demanding women. He feels pressure to please women with his penis and with his past negative experiences, he feels a need to rush once an erection begins. Failure to produce an erection leads to guilt, frustration and anger.

He deals with his depression by using positive thinking. He claims to have a strong mind and says this works for him.

Much of the anger he feels is directed at himself for not being a better man, he feels he is "strong, in good physical shape therefore should be able to get that little thing up".

Bob does present as being in good physical shape at 48 years of age. His health has been good except for the damage done to his liver due to drinking. His family doctor ordered

him off alcohol one year ago as his liver was three times it's normal size. He stopped drinking for four months and his liver returned to normal. He then resumed drinking but "moderately". His family Dr. again ordered him off alcohol one week ago (end of Nov. 1981) as his liver was again affected.

Bob was treated for gonorrhea at age 21, perceived as uneventful.

No reported surgery.

Bob reports that he went to a Urologist and was asked whether he ever woke up with an erection. He said yes, and was told that there is therefore nothing wrong physically.

Bob reports that he periodically takes Valium (5 mgms.) when feeling really stressed. This could mean four pills per day over a period of one or two days. Since his first warning regarding alcohol and his liver, he claims to consume approximately four to five beers a day. Prior to this he could consume many times that amount in whiskey. One year ago when visiting in Europe he claims to have consumed approsimately 35 doubles over a one day drinking bout. This is just prior to being ordered to stop drinking due to his liver being affected.

Situational consequences

No doubt from his accounts Bob has had his share of

criticism and rejection due to his inability to produce an erection. He has experienced numerous put downs even going way back to some of his first sexual experiences. When he ejaculated immediately upon penetration, some of the comments then were "is that all". More recently while still living with a woman aged 41 years for four months, she said (over his inability to get an erection) that she was only human and could not continue with him unless this was resolved. Shortly there-after he approached P.S.C. and on his first assessment session indicated that they had separated. In order to deal with his performance anxiety Bob figured that the more women he would meet and have sex with the calmer he would get and eventually overcome his feelings of anxiety and fear.

Bob had a few experiences where he was most relaxed, once with a young native girl age 21 and on another occasion with a woman he saw as unattractive. In both these instances his partners treated him with a great deal of patience and really "turned him on". He feels that they knew how to treat him right.

During his last year of marriage, Bob was charged with molestation of a neighbour's child. He reports that by bouncing this young girl on his lap he would obtain an erection and ejaculate. This information was initially obtained from the Therapist who saw Bob for two years and was then presented to him. He finds this very disturbing, to the point where

he encouraged me to talk to this therapist knowing that I would then introduce the subject for discussion. These episodes with the young girl clearly suggest to Bob that he is disturbed and not normal.

This episode also apparently helped bring their emotionally divorced relationship to an end. His wife lost whatever respect she had for him and terminated the marriage.

Personal and family background

Bob was born, raised and lived in Germany until 22 years of age, at which time he came to Canada. He has a grade ten equivalency and for the past 12 years has been employed as a drywall taper. He married in 1957 and was divorced in 1967. He has two children from this marriage, a son Larry age 19 living at home with his mother in Winnipeg, a daughter Jane age 23, who is married and also living in Winnipeg. He still sees his son periodically and feels they have a good relationship but he claims his daughter is much like his wife and they never got along with each other. They haven't seen each other for one year. Bob has four or five good friends and sees himself as much easier to get along with since his two years of therapy. He believes in God, but doesn't care which church he attends when he attends. As far as morals are concerned, he was always faithful while married and now although he doesn't feel quite right about

taking a married woman to bed he still does without too much concern. Usually it's done under the influence of alcohol and in the morning he experiences some negative feelings but then again the woman he finds himself with doesn't always look as good the morning after.

As I mentioned earlier Bob is in good physical health and physically fit except for the alcohol abuse to his system which he claims is his way of dealing with nervousness. He mentioned once that "once I get over this sex problem, I will quit drinking".

Childhood and puberty

Bob feels he was given a very negative attitude regarding sex at a very young age. All that he remembers clearly has to do with his father's employees on the farm where they lived. For example at age five or six the men made him lay on a little girl with their pants down. "It still bothers me, it was wrong, I didn't even have a hard on, they were a bunch of dirty outspoken scums, I don't know why I should feel guilty I was so young and they made me do it". On another occasion, when Bob was seven or eight "they made me take down my pants and made me look up a little girl's rectum". Bob went on to say that "at age eight or nine I would get an erection while sliding behind a girl in winter, I think this is all wrong I got into sex with the wrong attitude". Aside from what is

mentioned above, Bob has no recollections of his childhood and puberty related to sex other than that he enjoyed masturbation and perhaps started too early. In describing some of his experiences he mentioned that he would get a "big hard on" and would "jerk off far"; typical of Bob's need to be number one.

Self concept

Bob sees himself in the following manner; a sensitive slob, often anxious, frustrated and somewhat depressed at times, more bark than bite, having a clear mind and will power, a physically strong man, in good shape and a hard worker.

Attitudes towards treatment

Motivation

Bob wants to overcome his erectile problem to the degree where it is nearly an obsession, he presents as extremely motivated but his impatience for a solution makes for a demanding and manipulative individual who initially wanted several sessions weekly so that the problem could be solved earlier. Having had warning of Bob's demanding nature enabled me to set the limits early and clearly.

Organizational capacity

The willingness is certainly there and if given suffi-

cient structure and guidelines, Bob may have the organizational capacity to follow through with treatment. One of my major concerns is that I am dealing with someone who has a serious alcohol problem.

Prognostic expectancy

Fair, but a little early to tell. One key factor is that Bob does not have a regular partner and has a drinking problem.

Desired outcome

A. Our more short term goal is for Bob to obtain and maintain an erection through masturbation, with control over when he ejaculates. Once this is achieved, we will assess whether the conditions in Bob's life are such that we could work on the more ultimate desired outcome.

B. Ultimately the desired outcome is for Bob to maintain a full erection while having intercourse to the point of ejaculation, under satisfactory circumstances, again with control over when he ejaculates.

Clinical formulation

a) Specification of the problems

(1) Bob has trouble achieving a full erection during sexual activity. Although he feels pleasure and arousal subjectively during most parts of a sexual experience he still

has trouble getting an erection.

(2) Bob usually ejaculates with a semi-erect penis under all conditions (including masturbation) and usually sooner than he would like when having intercourse.

b) Hypothesis about the contemporary conditions that influence it's initiation and maintenance.

Re: Bob's erectile dysfunction:

In Bob's case there are a number of causal as well as maintenance factors.

- His first experience with not getting a full erection at age 22 could have simply been the result of fatigue and or too much alcohol. They had driven over 200 miles the night before, consumed a fair amount of liquor and had sex till late in the night.
- Later experiences may very well have been due to;
    - too much alcohol
    - marital discord and marital breakdown/anger
    - secondary reaction to premature ejaculation
    - attempting intercourse under inappropriate conditions such as: when exhausted, anxious, depressed, pressured by demanding partners and involved in spectatoring his sexual experiences.

At this point in time the principal maintenance factors are likely the following;

- High level of alcohol consumption
- Spectatoring and expectations of failure

- Anxiety in relation to repeated failures and constant new sexual partners, usually of the one night stand type. Bob tends to only approach women that he finds very sexually appealing and doesn't want to waste any time getting to know the person unless things work out well sexually. As this of course never happens he keeps on approaching new partners.

- Attempting to will an erection

- An obsession with intercourse as being <u>the</u> only important part of a sexual experience.

- An urgency to get his penis in the vagina the moment he begins to feel a beginning erection.

Re: Bob's premature ejaculation with a semi-erect penis.

Historically it appears that Bob never exercised any control over when he would ejaculate. This was something that happened when it happened and he would simply start again later. The object of the sexual act was to get it in there as soon as he could.

Bob never really learned to pay attention to the point of inevitability and at the present time he is so preoccupied with getting a better erection and not losing what he does get that this point comes and goes before he realizes.

On our fourth session I presented my hypothesis to Bob and we discussed the treatment program as per Zilbergeld as well as the conditions required in order for the goals to be attained.

Desired Outcome - A

1. Obtain a full erection by masturbating without a partner.

2. Gain, lose and regain erections by masturbation (to become desensitized to fears of losing erections).

3. Obtain a full erection by masturbating without a partner with control over when he ejaculates.

The pace of these goals and the graduated series of steps connected with each goal are to be self determined with anxiety being a sign not to proceed until anxiety has abated.

As Bob has anxieties about ejaculating prematurely, he has been instructed in the use of the stop-start (Semans, 1956) technique. This technique is described in more detail in case four.

The goals were discussed with Bob and he recognized that in order to go beyond A would take some time as it would depend on the availability of a suitable partner i.e., suitable in terms of someone with whom he could learn to relax and communicate with.

Weekly sessions with telephone contact in between sessions at the beginning.

Conditions

1. No alcohol
2. No sexual intercourse

First task or exercise -

Sensate focus I exercise - non sexual.

Bob is to select a relaxed time.

- shower
- lay down and relax with soft music
- using a lotion massage his body gently
- concentrate on the sensations
- 15 to 20 minutes
- not to expect or attempt to get an erection.

Bob is aware that his thoughts will wander, and as he realizes this, he is simply to concentrate again on his sensations.

Bob was to phone me in four days.

Bob phoned as instructed, had done the sensate focus I exercise once and immediately says, "it didn't work". Although I knew what he was referring to (no erection) I said that I didn't understand, what didn't work? He answered by saying you know and I keptinsisting that I didn't know what could have possibly not worked except that perhaps he couldn't relax or that his concentration wandered but that this is not uncommon. Bob went as far as saying that it didn't feel the same way as when a woman does it and I assured him that this was a perfectly accurate observation and asked him if he expected that it would? His voice became more relaxed and he said "from the way you are talking, it sounds like this is an important exercise". I assured him that it was and he eagerly agreed to do it again before our next meeting.

Bob presented at the next session with alcohol on his breath (again) and without having done the exercise.

I pointed to the no alcohol agreement and also shared my concern regarding his ability to stop drinking (on his own) in view of his history of alcohol abuse. I shared the following information taken from a September-October 1980 Public Health Report Vol. 95 No. 5497.

"Drinking an average of a pint or more of hard liquor per day for 5 to 8 years may cause loss of sexual functioning entirely, suggests Van Theil. Seventy to 80 percent of male alcoholics suffer decreased libido, impotence and sterility ... although many men may regain some sexual function if they stop consuming liquor, for others the damage may be irreversible".

In view of such statistics Bob would have to change his position from "If I solve my sexual problem I will stop drinking" to if he really wants to solve his sexual problem he will certainly have to begin by solving his drinking problem.

Bob assured me that he could do this on his own and if he couldn't he would go to AA. for help.

Prior to going on with our program the following two conditions would be required:

(1) Bob would need to be dry for at least three months.

(2) A thorough urological examination would be conducted including penile pressure tests and possibly nocturnal penile tumescence studies. Bob had already seen a Urologist but during the assessment it was identified that no tests had been done. Arrangements were made for him to see another Urologist for a thorough assessment.

Around this time Bob was informed by his Dr. that his liver was seriously affected due to alcohol abuse and it was critical that he stop drinking.

Bob agreed to these conditions and arrangements were made for more complete tests to be done. He knew that his lifestyle would have to change quite drastically.

Five months later Bob's urological results were completed and he had been off alcohol during this total period. The results fairly definitely ruled out organic impotence therefore further psychological treatment was seen as in order.

Phone contact had been maintained with Bob during this period of time and he had been assigned relevant reading materials. We agreed to pick up where we left off as he had kept up his part of our agreement.

Bob was a bit more relaxed at this point, much less preoccupied with seeking out women for sex, feeling physically much better and had refrained from sexual encounters during the total waiting period.

He did the sensate focus I exercise without difficulty but reported some anxiety with sensate focus II i.e., general

pleasuring of the body including the genitals and teasingly without the rhythmic motion that produces orgasm. Bob (with much difficulty) shared that he had "strange feelings" when doing this exercise i.e., he associated this with being Gay, "being stimulated by a man" even though in this case it is himself. Having recognized where his resistance was coming from he was ready to go on.

Bob had begun to integrate some of the material we had discussed which he had read in Male Sexuality by Zilbergeld (1978). He was beginning to be more insightful regarding the constant pressure he places on himself in all areas of his life as well as to gain an erection. He was beginning to appreciate the importance of "conditions". He experienced three spontaneous erections "firm erections" during the previous months while relaxing.

The following exercise included gaining and losing an erection using visual and physical stimulation as well as fantasy. The purpose of this exercise is to dispel the fear of failure i.e., the fear that he will not be able to regain a "lost" erection, that the present erection will be the "last" one he will ever achieve.

Bob was instructed to be selective in terms of when to do the exercises i.e., to make sure that his conditions were right, that he be in a positive frame of mind, relaxed and not to ejaculate with a soft penis.

He did this exercise on three occasions within a two week period. He was very successful on the first occasion - He had fantasized about a woman with a warm smile, gained - lost and regained an erection followed with ejaculation. He had a mental flash (momentary) involving a difficult situation with a demanding woman but didn't dwell on this.

On the other two occasions he managed to gain, lose and regain a partial erection and went on to orgasm.

The following conditions were again stressed;

- The conditions need to be right.
- Don't attempt to push for an erection.
- Not to ejaculate with a soft penis.

Bob was asked to repeat the exercise during the next month as I would be away and to keep notes of his thoughts and feelings as well as what he feels constitutes positive and negative conditions.

This was accomplished with complete success on two occasions and with marginal success on one occasion. He learned a great deal from this experience, he recognized that when he had marginal success he had been pushing wanting a quick ejaculation, he was anxious and in all fairness to himself should have accepted that the conditions weren't right and either see what he could do about his anxiety or stop masturbating.

This became an important milestone for Bob, he was

beginning to feel more confident and gained considerable respect for the therapeutic approach being used. He recognized that the therapeutic pace could not be rushed and that he was carrying a great deal of unfinished business which caused him ongoing anxiety. Existing issues relating to his relationship with his son were identified. He was experiencing rejection from his son which dated back to when he and his wife were first separated. We made an agreement to deal with such and other similar issues while continuing with our program.

At the time of writing this report, Desired Outcome A has been accomplished and Bob has begun to talk more openly with his son. This has to date required a total of eleven sessions over a period of ten months and although Bob still has a long way to go he is a believer that we all have conditions that must be met in order to function sexually. Bob recognizes that as he had to change his motto "I'll stop drinking once I can get an erection"; he will also need to change the following old attitude; "If I can function with them (women) sexually it will be worth spending time getting to know them personally".

CASE 3 JOAN AND JIM
Inhibited Sexual Drive
Anorgasmia

Joan age 22 was self referred and although troubled about her sexuality appeared equally if not more disturbed about the fact that she was not getting ahead in terms of her career and in terms of settling down in a permanent fulfilling relationship. Jim age 25, is a struggling young artist who can offer Joan little financial security and is quite content with his lifestyle.

Description of problems

Nature

Joan presents as a fairly complicated young woman who complains of lack of sexual desire and an inability to experience satisfying orgasms. Although she does have orgasms she reports them to be no more satisfying than a sneeze and only attainable through self stimulation with the use of a vibrator and on approximately 50% of the times attempted.

She is unable to reach orgasm when sexually stimulated by her partner by any means, including the use of a vibrator.

Frequency and timing

She is not able to obtain satisfying orgasms through self masturbation, with or without the use of a vibrator. She has never been able to obtain an orgasm while sexually involved with her partner. She experiences sexual desire less than once per month.

Surrounding circumstances

Joan's present circumstances offer numerous supporting or contributing factors regarding her presenting problems.

For example their living conditions are totally void of privacy ie., Jim's sister (age 21) resides with them and is always around. She even feels free to walk into their bedroom without notice at any time. This is aside from the fact that the walls are paper thin and offer no sound proofing. Jim's sister is totally dependent on Jim and Joan for socializing purposes within and outside the household.

Duration

Joan has never experienced orgasms which she felt were anything to make a big deal about although of a somewhat slightly greater intensity initially. To attain orgasm has always required the use of mechanically induced vibrations and always under her own control.

Onset

Joan's first orgasm was at age 17 with the use of a vibrating device after being told by a girlfriend how she had done it. This experience as reported earlier was somewhat dull.

Her first sexual encounter with a partner was also experienced as "dull, sterile and clinical". This experience

was carefully planned ahead of time and involved her boyfriend whom she had dated for one year. "I was amazed that men like it so much".

Course

Joan initially found sexual activity with a partner as acceptable although certainly not great. For awhile she later became disgusted with partner sex and felt exploited. "I'm apalled, women are often exploited, you are always sought after for that reason". If you are good to them (women) they will give you (men) what you want (sex). At the present time sex is much like hugging, it can feel good but not exciting.

Regarding masturbation Joan reports that although she initially obtained slight pleasure her orgasms are presently no more satisfying than a sneeze and still only attainable through the use of a vibrator.

Contemporary influences on problems

Situational antecedents -

Joan has been pretending for so long that sex is fun that the game is the only response that she now has. "I play the role (feeling sexual) and I don't know what I'm feeling anymore". This has been the case for the past year and is a repeat of her previous c/l experience.

Joan has given up on attempting to reach orgasm in partner sex yet when masturbating she goes for the climax only. Rather than enjoy pleasuring she is preoccupied with the end result. "Sometimes I try too hard, I get frustrated".

She and Jim attempted to incorporate the use of a vibrator in their lovemaking on a few occasions but found it awkward and the effort was without success.

Her two year old relationship with Jim is on the one hand meeting her needs for companionship ie. she describes their relationship as that of a "buddy type", "we both rely on each other to protect ourselves against the world, we're psychologically dependent on each other". Although she felt sexually attracted to Jim when they first met she doesn't have this feeling anymore. "It bothers me that we're such good friends".

Oral sex has been excluded from their sexual repertoire as a result of repeated vaginal infections which were believed to be a yeast infection but which within the last few weeks was diagnosed by her gynaecologist as a reaction to condoms.

Joan on the one hand clearly sees herself as the dominant one in terms of Jim believing that he needs her more than she needs him. On the other hand it would appear that Jim is somewhat of a social isolate and that she doesn't have much power re: involving him in some of the interests she has

such as dancing and socializing. As a result their lives circle around each other, Jim's sister, Jim's painting and Joan's struggle to be recognized as a writer.

There is no doubt that being unemployed is seriously wearing down Joan's shaken esteem.

Organismic variables -

As mentioned earlier Joan has given up trying for orgasm in partner sex yet focuses only on reaching orgasm when masturbating.

She expects to be bored with intercourse and in order to not convey this message she pretends to be getting enjoyment.

It appears that Joan has become a spectator to her own sexual experience rather than a participant thereby blocking her access to the physical and psychological stimulation that would normally produce heightened sexual arousal.

In addition she is very highly disappointed with herself as a person, "I don't seem to finish anything that I start; I feel ashamed; I don't have a job; I can't tolerate being alone; I'm insecure about my future; I have no security; half the time I'm afraid to get up, afraid to write, afraid to meet people".

For the last two years since out of University Joan has felt depressed and as a result has turned to amphetamines. Joan reports feeling somewhat more sexual, in a better mood,

more confident and more awake after taking this drug. She claims to have been taking one pill every four days for the past two years.

Until recently Joan has tended to blame other people for all her relationship problems and she is presently trying very hard to identify the parts she plays. For instance when things weren't working well in a relationship she would undermine it, blame her partner and wait for an occasion to end it.

Situational consequences

Joan claims that she cannot always tell how Jim feels as a result of her lack of sexual desire and her inability to reach orgasm but she does see him as unhappy.

They continue to have intercourse a few times per week even though Joan would be content with intercourse once every two weeks and actually feeling sexual desire less than once a month.

Both very insecure within a relationship plagued with emotional games. Joan rages and threatens while Jim teases and withdraws. Joan rages at Jim in the hope that he will be strong and stand up to her while Jim teases to appease Joan as he is frightened of her anger outbursts.

Personal and family background

Joan at age 22 is presently into her second year of her

second c/l relationship. She has part-time employment on an on call basis as a stage electrician and has a dream to be recognized as a writer. Although she wants to write and was told by a teacher that she should be a writer she feels it is pretentious to describe herself as a writer in view of the small amount of work she has done.

Joan has a sister (age 33) and a brother (age 34) but due to their ages she was raised much as an only child. She attended parochial school till grade X then went on to public school and University.

Her mother and father (both age 63) live in Toronto. Her father is retired (owned and operated two barber shops) and her mother still works for Bell Telephone. Joan describes her mother as domineering, she rules the house and will nag you, do for you and love you to death. Father is described as more intuitive, more selfish and tries to avoid confrontation. The message from mother is that Joan is still a little girl and con't do anything right.

Both Joan's brother and sister also live in Toronto. Her brother is married and sister divorced. Joan claims she gets it from them too; "The family is always undermining my self worth, you are not good, not generous, don't go to Church, you are spoiled and stubborn etc..".

Childhood and puberty

Memories of childhood range from neutral to negative.

Joan remembers parents as looking guilty when surprised holding each other.

At age nine - ten she and a friend were caught twice looking at a Playboy and were told that this was bad.

Remembers being frightened once at age 16 when she and her boyfriend were all alone at the University smoking marijuana but nothing came out of this experience. This was the same boyfriend with whom she later had her first "dull and clinical" sexual experience.

Sexual concept

Joan sees herself as slightly overweight (approx. 10 lbs.) and feels quite strongly that she feels much more confident and more sexual when she is at a certain weight.

She carries a lot of anger regarding the exploitation of women "you are always reminded of your position as a woman, constantly undercut because of being a woman, a cunt ---- perhaps I'm overreacting".

It's interesting that Joan goes on to explain that she generally gets along better with men than with women. "I have little in common with most women, they are not masculine enough, I find them boring".

Due to her low self-esteem and lack of confidence Joan tends to feel unattractive and prone to be very defensive.

Although this is likely of a circular nature Joan's

present state of affairs wears at her self-esteem and confidence in such a way that it is difficult for her to feel attractive.

Attitude towards treatment

Motivation -

When in the office and for a few days thereafter Joan claims to be very highly motivated and presents as such but this sense or feeling is soon lost and she finds it very hard to remain optimistic.

Organizational capacity

Joan presents as having the organizational capacity to follow through with required assignments and treatment although this will likely be hampered by her mood swings.

Prognostic expectancy

Some of the concerns I have regarding reaching a successful outcome with Joan and Jim are as follows;

- Joan's lack of attraction towards Jim as a sexual being.
- Joan's continual use or abuse of amphetamines and their possible negative side effects.
- Joan's depression (severity).

Clinical formulation

(a) Specification of the problem

Anorgasmic except for vibrator or other mechanical stimulation. This is considered a situational category and in Joan's case it is of lifelong duration. She can only have orgasms of very mild intensity when on her own. General lack of sexual desire also situational. Joan has a tendency to feel more sexual desire when living alone.

(b) Hypothesis about the contemporary conditions that influence it's initiation and maintenance.

In Joan's case there are a number of possible causal, as well as maintenance factors.

1 - Negative first sexual experiences both with masturbation and intercourse. As mentioned earlier, at age 17 she masturbated with the use of a vibrating device after being told by a girlfriend how she had done it. This resulted in a dull experience; somewhat of a let down from what she had been told to expect.

Her first sexual encounter with a partner was also experienced as dull, sterile and clinical. Joan expects to be bored and has become a spectator to her own sexual experiences rather than a participant thereby blocking her access to the physical and psychological stimulation that would normally produce heightened sexual arousal.

2 - Strong feelings of guilt as a result of strong (Roman Catholic upbringing) religious attitudes and influences regarding sex. Past guilt feelings regarding petting on dates and intercourse. For example on a scale of 1 to 7 pertaining to degree of guilt in relation to petting on dates with 1 - no guilt and 7 - much guilt Joan rated herself at seven. Joan's value system suggests that sex out of marriage is wrong.

3 - Partner discord - insecure relationship. Joan is unsure of her feelings for Jim.

4 - Fear of pregnancy.

5 - Health problems - constant vaginal infections.

6 - Use of amphetamines since she finished school two years ago which is when she began to experience feelings of "depression."

Greaves (1981) writes a very interesting article clearly pointing out to several relationships between continuing amphetamine abuse and disturbed sexual functioning; "(1) an increase in libidinal drive, leading to disturbances in equilibrium and a breakdown in sexual defenses that result in regressed (aberrant) sexual behaviour; (2) an increase in sexual activity in the direction of promiscuity; (3) increased sexual frustration and depression, focused on sexual performance; (4) increased tendencies toward frigidity and antipathy toward sexual performance by females"(p.83).

7 - Need of unconventional sexual stimulation - claiming to require an assertive, controlling, demanding partner who can include spankings into his lovemaking. Jim is a gentle and sensitive artist who on occasion could agree to role play certain scenarios but his heart wasn't in it.

8 - Dependency conflict and hostile feelings towards men regarding the exploitation of women. Joan would not introduce Jim to her friends as her boyfriend or her lover as this would suggest she was dependent on a man for affection and perhaps support, something that is seen as unacceptable. There is also the possibility that Joan would not allow a man to help stimulate her to orgasm as this would then make her more vulnerable and seemingly dependent or submissive.

9 - Depression: Joan initially suggested she was very depressed with the following factors being of primary importance;

(a) Unemployed and seeing herself as not having any directions or future in terms of career.

(b) Living in a relationship primarily because she is horrified at being alone.

(c) Having lost complete interest in sex.

10 - Lack of privacy.

Treatment

The first four sessions consisted of meetings with Joan alone. There were two reasons for this; (1) Joan wanted to be seen individually and (2) I wanted to get a good understanding of her (the individual) prior to getting into a deeper assessment of the relationship.

Following the first two sessions, I suggested to Joan that although she was presenting with a sexual problem, it seemed apparent that there were numerous factors in her life that needed attention which if dealt with would likely place her into a much more favorable position to deal with the

sexual issues. This was not to suggest that once the factors under "clinical formulation" were resolved that the sexual problems would disappear but that the chances of success would be enhanced.

Joan agreed that the specific sexual problems could be placed on hold temporarily while we attempt to resolve some of the other significant (likely) contributing factors.

By the fifth session Joan had discontinued using amphetamines. She had been medically examined, her infection was cleared and she had made contact with a highly reputable person in Montreal under whom she wished to train. This was a dream of hers that she could now possibly realize. Although exciting it would possibly mean leaving Jim (at least for one year) unless he was prepared to follow her out East. Joan was starting to feel better and in consultation with her Dr., she had decided to lose 10 lbs.. She was also ready to involve Jim in therapy. The Beck Depression Inventory (1972) was applied at this stage and she scored ten ie. the base of the mildly depressed range. At this point therapy had consisted of; Life goal setting and planning with considerable positive reinforcement. I was very warm, accepting and supportive. For instance with regards to her use of amphetamines I used the following style as suggested by Greaves (1981); I want you to know that I have no particular interest in whether or not you use drugs, or in how you conduct your personal affairs.

What I am concerned with is the distress you seem to feel and in helping you understand where it comes from . Recent literature suggests that those who select amphetamines as a drug of choice for abuse already suffer from major problems of interpersonal shyness and self-esteem. The last thing needed, therefore, is a stern parent-figure in the role of counsellor lecturer as this would only lead to more resistance. I had also provided Joan with the paperback of LoPiccolo (1976) Becoming Orgasmic: A "Sexual Growth Program for Women". I had asked her to merely look it over but not to begin with the program. This was only as information, primarily to make her aware that there was a clear program available for her once she was ready.

Jim is a sensitive and caring young man struggling to cope with repeated rejection by Joan. Whenever Joan starts to feel stronger she pulls away and loses interest in Jim claiming that it is unhealthy to be dependent on another individual. When she is feeling low and not getting strokes elsewhere she clings to Jim and demands all of his time and attention.

I confronted Joan's "independence theory" and although she reacted with anger she recognized that she had been playing games trying to compensate for strong feelings of insecurity. Joan often wondered why she was feeling so dominated if she was the dominant one.

Insight into the underlying feelings and dynamics of the relationship led to beginning negotiations as to how they could cut down on some of the destructive game playing.

By the eighth session Joan was feeling much more confident, she had received confirmation from Montreal i.e., she had been accepted and was to be in receipt of a grant. She was definitely going and was planning to live alone for the following few months prior to leaving. Living alone would give her time to; think, write and date other men. Jim was taking this very hard initially but within a few weeks had met and become sexually involved with a young female artist. Joan fell apart the minute she became aware of this news. She lost all interest in dating other men, went back to taking amphetamines and expressed her desire to come back. She initially felt totally defeated yet managed to find enough strength and courage to go to Montreal on her own.

The presenting sexual problems had not been rectified by the time Joan left for Montreal but she is aware that further help is available out there and that we would help her make a connection as well as submit some of our records if this was seen as necessary.

CASE 4 ROBERT AND RACHELLE
Premature ejaculation

Robert is French Canadian and neither speaks nor reads

much English. His understanding of English is somewhat better, but even then it is not very good. His wife is also French Canadian, and communicates in English more easily than her husband, although, again not exceptionally well.

Description of problems

Nature

Robert has a problem of premature ejaculation and also complains that he experiences a difficulty in maintaining his erection during love-making.

Frequency

He claims to ejaculate before he could desire to at every orgasm, irrespective of the situation. With regard to his loss of erection, this is a phenomenon which has increased in frequency over the past year, he now experiences some kind of loss in his erection at every attempt at sexual intercourse.

Timing

He only ejaculates after penetration, but always very shortly afterwards. He usually manages no more than three or four thrusts before ejaculation. He is not able to last much longer with either masturbation or oral stimulation, although it is a little longer. Nevertheless, he does not

feel in control of his ejaculatory reflex under any conditions.

He is able to gain an erection at the arousal stage but he then loses it at varying times up to the point of intromission. He is more satisfied with his erection in situations other than intercourse, i.e., in masturbation, general fantasizing and oral stimulation. He has not complained of losing his erection once he has managed penetration.

Duration

Robert has said that he experienced the problem of premature ejaculation during his second attempt at intercourse, but regards himself as never having control since he never actually penetrated his first partner due to some difficulty of her own. He did not ejaculate prior to penetration on that occasion. Also, he only attempted intercourse with her on one occasion. He also offers the same information about the duration of his problem in maintaining an erection.

Onset

The first time he experienced both problems, i.e., during his second sexual attempt, was in Germany while he was serving with the Canadian Armed Forces. It was about a year after his first attempt when he was age 19.

Course

The course of his problem of premature ejaculation has remained unchanged, according to Robert, in each situation and with each partner. His erectile dysfunction has worsened in the last year.

Contemporary influences on the problem

Situational antecedents

One reason why there has been a tendency in the last year for him to lose his erection more often after arousal is the fact that fear of premature ejaculation makes him more tense recently than it used to. This is because he felt that his inability to function in sexual situations, either to his own or his wife's satisfaction is risking the loss of his marriage, something which he values greatly. He also feels, and is reinforced in this by his wife's responses, that, outside of the problems associated with tension there is very little in sexual intercourse which is positively reinforcing for her, since she has never, throughout the marriage, had an orgasm during intercourse. So her tendency is to approach sexual intercourse with negative feelings, again compounding on his own anxiety, and contributing to him losing his erection.

Antecedent conditions associated with his lack of ejaculatory control are essentially those of approach behaviour

being characterised by tension and anxiety. He is pre-occupied with thoughts that he will ejaculate prematurely and although indulging in foreplay for a time in the region of thirty minutes on most occasions, views this as only necessary to arouse his wife, although he has also said he enjoys it himself. Nevertheless, his attention has been on trying to think himself into lasting longer in some way. He has adopted the same pattern of behaviour once he has penetrated his wife, which is to begin thrusting immediately, without attempting behavioural variations which are less sensitive, and so likely to develop some control.

This behaviour pattern relates to his very first sexual encounter and subsequent events. He damaged himself during his first sexual attempt, waking the following morning with a swelling in his scrotum which was later diagnosed as a varicocele, and for which he underwent surgery approximately a year after its development. Also, shortly before his first sexual attempt, the exact date being unknown to Robert he underwent circumcision. This was necessitated by an in-flammation of the foreskin. He feels, firstly that the cir-cumcision left him with too sensitive a penis, and the "damage" caused during his first sexual attempt has left him with some residual physiological disability. In summary, he has invested a great deal over the years in belief that there is something physiologically wrong with him which is the

cause of his poor ejaculatory control.

He also recalls seeking the advice of a doctor while in the Forces in Germany who suggested to him that the problem of premature ejaculation may go away if he got married. Robert took this comment to be some kind of moral condemnation of his sexual behaviour at the time, since his request to the doctor coincided with treatment for venereal disease which he contracted while in Germany. In fact that the problem appears to have worsened after his marriage has added to his anxiety.

He had sexual intercourse while suffering the varicose condition in the veins of his scrotum on one occasion, which was the second attempt at intercourse, and recalls that he experienced some discomfort, but his experience has not left him with any fears of a recurrence of pain or discomfort in anticipation of intercourse in his current functioning.

His relationship with his wife was described as very good and they both enjoy other forms of sexual stimulation. She has been stimulated to orgasm manually by her husband on a number of occasions, but feels a strong desire for orgasm in intercourse.

Organismic variables

Robert has said that the strategies which he has adopted in an attempt to "last longer" following penetration have

been in the form of cognitive monitoring. He constantly thinks about the fact that he may ejaculate early, and tries to force himself, somehow, to delay ejaculation. He has also tried to take his mind off what he is doing and thinks about nothing at all.

The clearest organismic factor is the level of his anxiety. This has developed until he is tense almost all the time. Prior to intercourse he has noticed himself going hot and cold, and physically shaking. He has complained that he cannot concentrate in his job because he is always tense. He has expressed strong fears that he is scape-goating his five year old son, constantly criticising him and scolding him. Both he and his wife have expressed concern about the deteriorating relationship between Robert and his son as a result of Robert's irritability, which he sees as caused by tension and anxiety.

Situational consequences

His wife has resorted to self-blame, asking such questions as, "what am I doing wrong?", etc., which then has the circular effect of providing inappropriate antecedent discriminative stimuli, in that she often approaches love-making with negative expectations, i.e., that it will not be pleasurable.

She has also said that she feels she is losing interest in sex, and they both agree that they avoid intercourse be-

cause they feel it to be unsatisfactory.

Personal and family background

Robert is a driver with the Canadian Army, and his wife is a secretary. This if the first marriage for both of them and they now have two children, Francois age five and Paul age three. Robert is 34 years old and his wife, Rachelle is 30. Neither of them feel that religious belief affects their sexual functioning in any way. One difficulty they do experience, which is unrelated to religion is with contraception.

At the moment they use no contraceptive device, prefering combinations of "coitus interruptus" and the "rhythum" method. Rachelle has experienced problems in the past with contraceptive devices and is now reluctant to use them. They have tried using the condom, and this also had the effect of slightly delaying Robert's orgasm, but he did not like using it at all.

They are both quite healthy, Robert is undergoing medical examination on a regular basis.

Childhood and puberty

Robert recalls little which was remarkable about his childhood except that he was offered no sex education whatsoever in the home and very little which he feels benefited him while at school. He recalls having no idea what was re-

quired of him when he first attempted intercourse at age 18.

Motivation

Their ability to organize themselves for treatment is somewhat suspect since they require a baby-sitter in order to attend clinic, in addition to the fact that his job takes him out of Winnipeg and he cannot always guarantee when he will be back.

Clinical formulation

On the basis of the information available, and bearing in mind the fact he is medically healthy and quite fit, there is no evidence to suggest other than his problem of premature ejaculation is a behavioural deficit, in that he has never learned to gain control of his ejaculatory reflex.

His problem of an inability to maintain an erection is seen as specific to the situation of sexual intercourse and is a product of anxiety caused by an anticipation of failure to satisfy either himself or his partner in intercourse, by ejaculating prematurely.

Treatment

A treatment plan was negotiated with the couple for them to undertake stop/start exercises on a partner basis, ie., the stimulation to be undertaken by Rachelle.

They have agreed to try the exercises at least 3-4 times per week. They will continue with their current sexual behaviour so long as they keep the exercise sessions separate.

During each session, which I recommended to take place in a place and at a time when they can both relax, Robert is to do nothing other than concentrate his thoughts and feelings on the physical sensation in his penis. His wife is to raise his to a point when he feels an urge to ejaculate. When he will signal to her to stop. She will then wait until the urge to ejaculate subsides and repeat the exercise. I recommended an appropriate number of 6-8 stop/starts and then finish the session by raising him to orgasm, or a 15 minute session, whichever was shortest. Monitoring is on a weekly basis and they have been asked to keep records.

Resistance surfaced soon following the beginning of treatment in terms of tasks being avoided and or modified. On the third session sources of stress related to Robert's relationship with his 6 year old son and partner discord became clearly apparent. Rachelle reported that it was next to impossible for her to feel affection towards her husband as long as he related to their son in a military manner. Robert showed indications that this "military approach" with his son was not working and that he was considering "Parent Effectiveness Training".

In view of the tension in the relationship we revised

our contract to the following;

(A) Robert was instructed to do the masturbation exercises on his own to begin with as this would make it easier for him to learn the rudiments of control without the distraction of his wife's presence.

(B) We would explore the relationship and family issues in more depth.

I placed a one month ban on intercourse encouraging them to continue pleasuring each other in whatever other way is seen as acceptable.

Therapy was further interrupted due to Robert being out of town and on two occasions due to their inability to find a babysitter. Robert came in alone to work on his ejaculatory problem. It became more and more evident that Robert harboured anger towards his wife and six year old son. Robert had been away during the first six months following his son's birth and he resented the closeness that existed between him and his wife. He constantly felt left out, jealous and this was only reinforced by his son's rebellious reactions to his authoritarian parenting style. All this in addition to Robert's depressed world view. He felt like a failure as a parent, as a lover and for the past few years living in Winnipeg working in English was torture for Robert. His wife being very bright and articulate had picked up the language with ease but Robert was just getting by and resenting

it with a passion.

This all presented as far more serious than initially presented and Robert was making references to the possibility of a separation. In describing what he meant as a separation Robert suggested possibly being stationed away for extended periods (five - six months) ie. shelving the problem for a time. This had been done in the past.

We had one more joint session (where the children were asked to attend but didn't). Rachelle came in to confirm that the problem with premature ejaculation was certainly secondary to serious marital discord. She took a firm stand and made it clear to Robert that unless he was able to make drastic changes regarding his moods, attitude, approach to parenting and life in general that she wanted a permanent separation.

Rachelle agreed to further counselling should Robert want to work on their relationship and especially on his relationship with their sons.

Robert agreed to think this through and later decided that he would try to make the necessary adjustments required by his wife and felt he could do this without counselling.

A telephone conversation with Robert four months later indicated that things were the same sexually but he reported considerable improvement regarding the family situation and feeling less stressed generally.

Both Robert and Rachelle are aware that marital and or family counselling is available.

CASE 5 DON
Premature Ejaculation

Don, age 25 was initially seen at Klinic (regarding a concern with premature ejaculation) by a physician who gave him a physical examination, found nothing wrong physically and referred him to P.S.C. Sexual Dysfunction Clinic.

Don is of gay orientation, has been for as long as he can remember and this is not in itself seen by him as an issue or a concern. He is presently living with his parents but planning to move. He has one younger brother who is aware of his sexual orientation, and his parents may have some notions, but this is not in the open. According to Don his mom is an alcoholic and doesn't need anything else to worry about.

Description of problem

Nature

Don complains of premature ejaculation during all forms of stimulation such as manual, oral, anal in gay relationships and even during what he refers to as deep kissing. He also

indicates that he ejaculates earlier than he wishes while masturbating but doesn't see this as a significant problem.

Frequency

He always ejaculates before he wishes when sexually involved with a partner and over 50% of the time with masturbation.

Timing

Over 90% of the time he ejaculates while attempting anal penetration or on rare occasions if later well within less than one minute. He does not feel in control of his ejaculatory reflex under any conditions yet claims to recognize the sensations which come prior to the point of inevitability.

Duration and Onset

Don indicates that looking back he feels that he has always been very quick to ejaculate but it is only since reaching the age of 18 that he recognized this as a problem. Prior to age 18 sex play would involve petting and kissing and these activities would stop once he ejaculated. As these sexual activities with a partner were very infrequent (few times each year from age 12 to 18) this was not a problem.

At age 18 when he experienced his first attempt at anal sex he ejaculated prior to penetration and was very embarassed.

He also felt subtle messages of disappointment and frustration from his partner.

Course

According to Don this experience simply repeated itself with every partner with some partners being overtly frustrated and disappointed. The course of this problem has remained unchanged to this day - only worsened largely due to increased anxiety.

Contemporary influences on the problem

Don's concern regarding his lack of ejaculatory control became considerably more serious once he and his partners began to expect more than casual petting from sexual encounters. Although at this point Don is some ways felt better in that he found it appropriate to remain involved sexually once he had ejaculated he also experienced more pressure in that once having ejaculated he feels inhibited, self conscious, at his partners beck and call and places himself in a passive, submissive position feeling he has no choice in the matter. Sexual encounters (except for a six month period 2 yrs. ago) have always been casual encounters "chance meetings" and not conducive to good sex. There is an element of anxiety in that it's a new experience, more anxiety in that it is always at the other party's place which according to Don adds con-

siderably to his feeling inhibited. In addition Don anticipates ejaculating too early, frustrating himself and his partner and being forced into a submissive role.

Don is also of the opinion that it is gauche to suggest to one's partner that certain conditions are important for him if he is not to ejaculate too early. A key factor which appears to contribute to Don's P.E. is that he claims to recognize the approaching point of inevitability but feels that something is lost if he eases off and loses some of his sensations. In a sense it's as if he wants control without taking the responsibility to exercise control.

Don claims that although he was a little more comfortable expressing his needs in the six month, more intimate relationship which ended two years ago, that things were much the same.

Situational consequences and organismic variables

Don is and has been avoiding sexual encounters for over 5 months now, mainly due to feelings of inhibition, embarassment, frustration and disappointment associated with past sexual encounters.

He has an unrealistic definition of control, unrealistic expectations of himself and unrealistic expectations of how sex needs to take place.

No significant illnesses, no surgery and no medication.

Personal and family background

Don has a Bachelor of Arts degree, presently employed by the city of Winnipeg. This is seen as boring temporary employment for the time being. His father is French (from Quebec) Canadian employed with the Armed Forces, mother English Canadian and he has one younger brother age 15. The family came to Wpg., from Quebec in 1965 and has been here since. He sees his upbringing as uneventful, describes father as someone who doesn't say much, doesn't show emotions and is relatively easy going. He has little to say about mother other than that she is an alcoholic who starts the day with a drink. Don is involved in a Public Speaking and Story telling course at the U. of M., as well as theatre classes and belongs to the Assoc. for the Deaf & Hearing Impaired of Man.. Other forms of involvement or entertainment includes reading, eating out with friends and movies.

His family did not talk about sex openly and the only incident which came to mind involved a situation where his mother caught him and a friend playing with each other sexually at around age ten. He remembers her saying, "you could get in trouble for doing that", and feeling embarassed at the time. His homosexual orientation dates back to as long as he can remember and this is at this time accepted without question.

Self Concept

He sees himself as an optimist, feels he has always done well and is not worried about his future. He describes himself as narcisstic and somewhat of an ego maniac, a great person. He claims to have many acquaintances but only two good friends with whom he can confide and he dislikes groups. Some of his acquaintances suggest that he is uptight but he shrugs this aside by saying that he is simply different from the norm, taking pride in this difference.

Attitudes towards treatment

He is well motivated and presents as someone who takes pride in being well organized and structured. One possible obstacle may be in that he is very rigid in his thinking, although on the other hand he presents as ready to listen to views differing from his own.

Prognostic expectancy following the third session is positive.

Clinical formulation

(a) Specification of the problem

Don usually ejaculates at some point during sexual activities usually prior to anal sex or while attempting intromission.

(b) Hypothesis about the contemporary conditions that influence it's initiation and maintenance.

He appears to recognize the sensations prior to the point of inevitability but has never learned to do what is necessary to exercise control. This is due to a number of factors.

- False definition of control i.e., attempting to hold back from ejaculating once having reached the point of inevitability.
- Having sex with very controlling "macho" individuals who insist he ejaculate first.
- Lacking assertiveness re: expressing his needs and preferences even when with sensitive partners. Not believing that it is appropriate to do so.
- Associating having ejaculated with needing to be passive, submissive and being very resentful of this.
- Always having sex at someone else's residence which for him reinforces feelings of inhibition and raises his anxiety level.
- Not wanting to modify or ease up on the stimulation as "something is lost if I ease up".

A treatment plan was negotiated with Don once he accepted that he needed to change some of his beliefs and attitudes towards how sex should be. Reading Male Sexuality by Zilbergeld was a real eye opener for him.

The therapeutic goals include:

1) being selective in his choice of sexual partners ie. have sex with people with whom he feels comfortable and can communicate.
2) communicate his needs, preferences etc., and not attempt to hold back the ejaculatory reflex, rather modify the degree and manner of stimulation in order to develop ejaculatory control.

3) to maintain an active role even should he ejaculate first.

4) exercise some influences as to where the sexual act is to take place.

5) assertiveness training.

It is clearly understood that treatment will require time, effort, experience and patience. As Don was very confident with his new found knowledge after the third session he felt that experiential learning was now necessary and I supported this.

Our contract was to meet once he had some sexual experience with a partner and deal with whatever obstacles to ejaculatory control that are experienced.

Don expects that there will be obstacles but recognizes that they will be part of the learning process.

Four weeks later Don requested a meeting. Although he had not had any sexual experiences he has put some of his new found knowledge into practise i.e., he had avoided situations which lead to unsatisfactory sexual experiences. He was very specific in his request for another session. He wanted to go over our list of therapeutic goals. This time he wrote down notes and we discussed possible areas of anxiety. He was mixing up assertiveness and aggressiveness; clarifying the differences resulted in somewhat less anxiety being attached to his need to be assertive. Being

assertive in the sense of communicating his needs, preferences, conditions etc..

Don was feeling quite relaxed at this time and saw no need for further sessions until he had met a suitable partner and put some of what he had learned into practise.

Seven months following our last session he reported doing well although he was not yet emotionally or sexually involved with anyone.

CASE 6 HARRY
Rapid Ejaculation with semi-erect penis

Harry (age 56) employed as a bartender for the past 15 years, has an elementary school education and was first married 25 years ago with a divorced woman with two children. This marriage ended in a divorce three years later. Harry then lived alone for ten years, remarried, had one daughter and was later left by his second wife 11 years later. He has since been separated for approximately one year and would immediately return to his wife if she would have him. She apparently declined his last request for reconciliation six months ago.

Harry was referred to the Sexual Dysfunction Clinic by

a Psychiatrist from St. Boniface Hospital based on the following diagnosis; "lack of sexual desire and erectile dysfunction". Harry was also prescribed medication for depression but denied any clinical signs of depression on intake.

He was seen twice following intake for purpose of identifying the problems and the contemporary influences on the problems. Following these two sessions Harry failed to keep two further sessions (without cancellation) with myself and one session with his psychiatrist. Although his reasons for termination while in the assessment stage are not clear, he was frustrated and disappointed on the second session when informed that we were not in a position to provide or connect him with a female partner as he expected, and which he claimed was the main factor in his referral to the Sexual Dysfunction Clinic. This was discussed at length with Harry as he would not let go of the subject. In an attempt to put the issue to rest and move on, or accept that this was an inappropriate referral I contacted his psychiatrist, with Harry in my office. After explaining the situation to him I had him clarify his intentions to Harry. Even after this was done Harry insisted that he was initially told that we would be in a position to have him meet a woman and that this was the main reason why he came. When I questioned him regarding what this meant in terms of ongoing sessions he in-

dicated a wish to continue but as I indicated earlier failed to return.

Description of problem

Nature

Rapid ejaculation without having a firm erection and sooner than he would like, usually upon entry or almost immediately thereafter. Lack of desire is not described by Harry as a concern while erectile difficulty is seen as a secondary concern and premature ejaculation is his major concern. Harry is able to obtain a full erection with masturbation during which he also reports ejaculatory control. He has never had a problem obtaining a "partial erection" with a partner or during masturbation.

Frequency

Since the break up of his marriage, Harry has experienced the above problems with all partners, usually with women who were known to him.

Timing

He usually ejaculates immediately upon entry with a partial erection.

Onset

Four years ago when Harry was 53 years of age he began to feel that he was ejaculating earlier than he wished. He reported that this appeared to be more of a concern for him than for his wife initially, although from some of his accounts thereis room for question. Within two years of that time he also began experiencing erectile problems i.e., he was only able to obtain a very moderate erection when involved sexually with his wife. Harry suggests that their relationship went downhill from that point on. He felt incompetent and claims that his wife only made matters worse with her very negative attitude.

Course

Since onset Harry has become increasingly more anxious and frustrated regarding his sexual problems. He has experienced rejection on numerous occasions, first from his wife, later from other casual partners and he cannot imagine ever finding anyone who would be patient enough to work this through with him, (this could account for his request for a surrogate partner). He is fearful that even if he was to find someone who cared enough to work this through with him that she may tell him to "go to hell" as he says his wife did if things didn't work out.

Contemporary influences on the problem

Situational antecedents

The degree of marital discord between Harry and his wife may have played a significant role in maintaining and reinforcing the sexual dysfunctions. According to Harry, his wife was less than sensitive regarding his ejaculatory problem and even less so with his erectile dysfunction. Sexual intercourse became something rare and something to get over with. From my brief contact with Harry, I can appreciate that they must have had serious communication problems.

Organismic variables

Although extremely anxious when faced with a situation which may lead to intercourse, Harry is by no means avoiding sexual contact. Upon identifying a situation which may lead to sex he becomes somewhat overwhelmed with the monitoring of his own sexual performance or what Masters and Johnson (1970) call 'spectatoring'.

Situational consequences

The following example of Harry's last sexual encounter is a typical example of how he manages to constantly reinforce and maintain his dysfunctional behaviour. He found himself in a situation which appeared to be leading towards a sexual involvement. This was with a woman that he had known

for a while but not sexually. They were at his home and both were making sexual advances. Harry reports having had the following going through his mind; "Can I go through with this? Should I tell her about my problem? I am aroused! I want to, but I won't be able to go through with it. Is it solid enough for penetration? If it was only lubricated enough. Yes, it will, just entered and there it was, it was gone, that was the end of it. She also decided that that was the end of it, she just got dressed and left, I don't imagine she will ever see me again". According to Harry, this all took place in complete silence, not a word was said by either party.

Due to my limited contact with Harry, this was the extent of my assessment.

During the second session, I suggested that for the time being he refrain from having intercourse and should he become sexually involved with a partner that he suggest mutual pleasuring without intercourse, explaining to his partner that he needs to know and feel comfortable with a partner otherwise he tends to ejaculate quickly. Harry seemed quite accepting of this when I asked for comments, but the rest is history.

CASE 7 HAROLD
Erectile Dysfunction

This couple consisted of Harold, a 48 year old warrant officer and his 48 year old girlfriend employed as a bookkeeper. Both had previously been married and their spouses were deceased.

Harold's presenting complaint was that he would lose his erection or fail to get an erection at least 50% of the time during love-making. This problem had begun approximately 11 years ago with his previous wife and again with Hilda (girlfriend) following his wife's death.

Harold and Hilda had been in sex therapy for approximately 3 months (terminated 7 months ago) at Psychological Services and although he had not achieved complete success, it was obvious from the recording that Harold had made considerable progress in therapy and had obtained a good understanding of what was necessary in order to resolve his problem.

Harold had been given a complete medical check up when he was initially referred for therapy. He presented alone at Psychological Services Centre and expressed some concern about the fact that he (over the summer months) had been experiencing problems in obtaining an erection. He described the problem as being the same as prior to therapy.

I asked him to do two things - to share with me (based on what he had learned in therapy) what he believed could have been contributing to his erectile problem and what he could do to resolve the problem. I told him that based on the way he was presenting i.e., clear, aware and sensitive and in view of the records on file that he was quite capable of doing this.

Harold went on to share that the summer had been especially difficult for him because of the following reasons;

(1) His son Art (age 17) had taken his car (without permission) and smashed it while under the influence of alcohol.

(2) He had been neglecting his son in terms of spending very little time with him.

(3) He and Hilda were supposed to be married this month (December) but his son Art had made it clear that he would move out on his own if this was to happen.

Harold also shared that although the above was of major importance that there were other factors which interfered with his functioning.

(1) He had on occasion attempted to have intercourse when overtired and not relaxed.

(2) Attempted intercourse at Hilda's home with some concern in the back of his mind that her mother could overhear them or possibly surprise them. Although he recognizes that this is highly unlikely he is still on occasions thinking of this.

(3) Although very rarely he still anticipates losing his erection.

As Harold was sharing the above, he would occasionally smile and say, "I guess I need to remind myself of the con-

ditions that are necessary for good sex". I encouraged Harold to continue listening to himself and respect what he thinks and feels. For example; when he comes home from work overtired, he knows that to rest by having a one half hour nap makes all the difference in the world. If overtired, he knows he cannot function in the same manner sexually. This is not to be ignored.

We both agreed that Harold possibly only needed to refresh his memory re: what he had learned in therapy and again ensure it is put into practise. He is to keep notes over the next three weeks at which time we will get together and examine whether more intensive work is required.

Harold also shared that over the last few months he had examined his priorities and has decided that he will not get married while his son is still with him (at home), unless he (Art) agrees to accept Hilda and live with them. He feels that his son is of major importance to him right now and he will not subject him to more pressure than he already has. Art, in a relatively short period of time has lost his mother (deceased) and his two older brothers left home, and are out of the province.

As Harold often feels pulled in two different directions, Art on one side and Hilda on the other, I encouraged him to look at ways they (Art and Hilda) could get to know each other better i.e., ways where he could get away from being in

the middle.

The following appointment was scheduled for one month later and I later had to postpone it one more week due to my work schedule.

I wanted to give Harold a fair amount of time so that he would not feel pressure to have sex due to our session.

Five weeks later Harold was seen alone and he reported that sexually and otherwise he was feeling better than he had ever felt before. All his sexual experiences since our first session had helped him reaffirm the importance of making certain that the conditions for sex are satisfactory. One major factor is that he reports being at peace with himself in terms of the way he is taking an active interest in his son. Having his priorities in order is extremely significant and also facilitates clear and positive communication with Hilda.

I shared with Harold, that there will be occasions where he will not obtain an erection (or a full erection) and asked him how he would deal with this. His response was that this would simply be an indication that the conditions weren't right and he would not push for one. I congratulated him on the fact that he had clearly integrated the material he and the previous therapist had gone through and encouraged him to continue making sure that he continue listening to his common sense and respect what he thinks and feels.

He was clearly very pleased with himself and shared the following;

- he had concerns about coming back when he did as he feared he would need to go through the same process over again
- he now knew he could never be back at the same place again
- he would continue to respect the fact that the proper conditions are necessary
- he wouldn't wait for a crisis to call back, and
- he wished to express his gratitude in person

Harold and Hilda have postponed their wedding plans and will be discussing this again in the future.

CASE 8 PAUL AND PAULETTE
Premature ejaculation
Inhibited sexual desire

Paul age 32 and Paulette age 29 are of French Canadian origin, have been married for eight years and have a 14 month old son. Both Paul and Paulette have a university education and Paulette is presently involved as a full time mother and homemaker.

This couple is self referred having heard about the Sexual Dysfunction Program from Paul's brother-in-law who

until recently was also attending the program for a similar problem.

Description of problems

Nature

This couple presented with the following problems;

- Paul tends to ejaculate within less than one minute of sexual intercourse. This is of a primary nature.
- Paulette reports a global lack of subjective sexual desire, consequently they engage in sexual intercourse approximately once a month although Paul's desire for intercourse or sexual activity is generally around that of twice a week.

Frequency and timing

Paul's lack of ejaculatory control results in his always ejaculating within less than one minute of intercourse.

Surrounding circumstances

One factor which is contributing extra stress at the moment is the fact that Paulette is still breastfeeding their one year old child. This has implications as in the past Paulette has only been able to reach orgasm through Paul's stimulation of her breasts and while she is breastfeeding she has been unable to reach orgasm in that or any other manner. Her state of arousal and ability to reach orgasm is very important to Paul as otherwise he feels he is merely masturbating in her vagina. Another factor which both Paul

and Paulette see as being a hindrance to having a satisfactory sexual relationship is their lack of privacy. Their 14 month old son sleeps with them.

Duration

Both problems are of a primary nature i.e., Paul has never had ejaculatory control and the differences in their sexual desire (as mentioned earlier) has remained constant since the beginning of their marital relationship. On a scale of Sexual Desire where 1 = Little Desire and 7 = Much Desire, Paul rates himself at six and Paulette rates herself at two and they are both in agreement of each other's self rating score.

Course

The only changes reported to date have to do with the fact that Paulette has not been orgasmic since the birth of their son. The reasons given are that she is a nursing mother. This has not altered the frequency with which they have intercourse but has resulted in only Paul reaching orgasm.

Although Paulette is not seeing this as a major concern she has expressed a desire for longer periods of penile penetration.

Contemporary influences on problems

Situational antecedents

The sexual stresses are felt as follows by Paul and Paulette. Paul experiences frustration at two levels; first he would like to see the frequency of intercourse increased and secondly he would like to be able to delay his own orgasm.

Paulette would like for Paul to delay ejaculating when having intercourse which would in turn enable her to obtain the longer period of stimulation which she needs for orgasm. She is often left feeling anxious following intercourse. She also recognizes the importance of their being more compatible re: frequency of desire.

As mentioned earlier their son's arrival 14 mths., ago and the fact that he still breastfeeds and sleeps with them has introduced additional stresses. Paulette's sleep is often interrupted and their privacy infringed on somewhat.

Organismic variables

Paul is conditioned to expect rapid ejaculation upon entry and this is reinforced by his high level of anxiety and the infrequency of intercourse (approx. once per mth.). Paul believes that Paulette should have orgasms during vaginal intercourse therefore feels like he is letting her down whenever he ejaculates within seconds after penetration.

Somehow when he ejaculates this tends to signal the end of their sexual activity.

Situational consequences

Paulette on occasion feels uneasy and anxious following intercourse and this suggests to Paul that he is unable to satisfy her, leading to more performance anxiety. This has resulted in frustrations but has not discouraged Paul from approaching Paulette sexually. It appears that Paulette's conditions are also not being met.

Personal and family background

Both Paul and Paulette report very normal and uneventful backgrounds. Both born and raised in St. Boniface, got along well with brothers and sisters, went from High School into University and following a few years of dating were married.

Childhood and puberty

Paulette reports that she doesn't feel her parents got along too well sexually and the message was that sex was okay but not to be talked about. Most of her knowledge about sex was acquired from books and from her mother. Although Paulette reports that she sees masturbation as generally natural and acceptable, she has rarely masturbated. This

may in part be due to the fact that masturbation has led to little satisfaction and orgasms of minimum intensity.

Paul also describes his parent's relationship as poor. His mother has (as long as he can remember) been ill and confined to a wheelchair. He can remember his mother's verbal objections expressed at his father's insistance to have intercourse.

Sex was never discussed in the home, the message being that sex in marriage was okay but not to be talked about. Sexual information was obtained from books and other literature.

Attitude towards treatment

Motivation

Both are well motivated to work on the problem of premature ejaculation but Paulette has some reservations about starting "The Becoming Orgasmic Program" by LoPiccolo (1976).

Organizational capacity

Both present as having the organizational capacity to follow through with the required assignments and treatment.

Prognostic expectancy

For resolution of the ejaculatory problem the prognosis

is good but desire disorders are far more complicated and further assessment into the deeper roots and maintenance factors may be necessary once Paulette is ready to deal with this concern. At this point she feels that working on one of their problems at one time will require as much energy as she has to offer.

Clinical formulation

(a) Specification of the problems

(1) Paul tends to ejaculate within less than one minute of sexual intercourse.

(2) Paulette has a global and primary lack of sexual desire.

(b) Hypothesis about the contemporary conditions that influence it's initiation and maintenance

Re: Paul's premature ejaculation -

(1) Accustomed to masturbating without paying attention to the point of inevitability or control.

(2) Orgasm oriented and not so interested in enjoying the sensations prior to orgasm.

(3) Anxious whenever engaging in sexual activity therefore spectatoring and expecting failure. This would in turn interfere with his recognizing the sensations prior to the point inevitability.

(4) Quickly aroused and highly sensitive when engaged in partner sex, possibly in part due to infrequent intercourse.

(5) Possibility of anger with wife due to her unwillingness to engage in more frequent sexual activity yet wanting more prolonged penile penetration.

Treatment

At the beginning of the assessment process the couple was provided with Male Sexuality by Zilbergeld (1978) and asked to read the following chapters; Ch. 1 - Men and Sex, 2 - Learning about Sex, 3 - The Fantasy Model of Sex, 4 - The Process and Goals of Sex, 5 - Where You are Now, 8 - Your Conditions for Good Sex and How to Get Them, 7 - The Physical Aspects of Sex, 8 - Touching, 9 - The Importance of Relaxation, 12 - Dealing with a Partner, 13 - Some Things You Should Know about Women, 14 - On Not Lasting Long Enough, 15 - Starting to Develop Ejaculatory Control, 16 - Lasting Longer with a Partner.

This serves a number of functions;

(1) it's educational

(2) helps to desensitize the couple hence

(3) facilitates communication.

By the third session, they were familiar with the exercises to begin developing ejaculatory control. These exercises were developed by Semans and elaborated on by Masters and Johnson and others. It starts off with various masturbation exercises by the partner and progresses to penis in vagina without movement (female superior position) to including movement, to using different positions for intercourse with the final stage being an intentional quickie. This is of course only the bare skeleton of the approach used

and it is important to make sure that the couple doesn't restrict the physical activities to these exercises i.e., it is important to allow time and space for holding hands, talking, hugging, kissing, taking baths together, and any other mutually enjoyable expressions of physical affection.

Paul and Paulette progressed very well from stage to stage until they reached the penis in vagina with movement (female superior position) stage.

Therapy was interrupted at this stage for a period of approximately six weeks due to Paul's work which took him out of Winnipeg followed by a period of time in the hospital for cosmetic surgery.

Both were a little disappointed with being stuck at this stage, but recognized that the interruptions had slowed down progress. Paul had also been under considerable stress at work. Paulette shared some concern that she was starting to feel used as Paul is having orgasms and she is not. She also felt that Paul could be spending more time with her and their son. Paul is a "sports nut" and can easily withdraw into the world of television if not careful.

Compromises were agreed to and they devoted more time to their exercises going back to the penis in vagina without movement stage. They then progressed very quickly and Paul was soon able to maintain ejaculatory control using various coital positions without a condom.

Both were very pleased recognizing that ongoing attention will be required for some time in order to maintain the progress. They were advised to repeat the exercise with the 15 minute limit every two weeks on an ongoing basis.

Inhibited sexual desire was not seen (by Paulette) as a major issue at this point. She felt quite interested and willing to engage in sexual activity but was now more concerned with the fact that she had not been orgasmic since her pregnancy.

Paul and Paulette indicated that they believed she would likely be orgasmic once no longer breastfeeding but that this could be a while yet. Paulette has been orgasmic through oral breast stimulation. Since she is nursing this has not been sexually stimulating for her therefore she remains inorgasmic.

We contracted to work towards broadening their sexual repertoire so as to enable Paulette to have orgasms via other means. The prognosis is good and at this time they have been instructed to begin with Sensate Focus II.

CASE 9 CAROL AND CAREY
Inhibited Sexual Desire
Dyspareunia
Premature Ejaculation

This young couple (both age 19) were self referred to the

Sexual Dysfunction Clinic.

They have known each other for approximately three years and have been officially engaged for eight months. They wanted therapy prior to marriage as past and present sexual difficulties are affecting their relationship. Carey is presently living with his father (whom he claims to dislike as a person) and Carol is living with a girlfriend. They are scheduled to move into an apartment (by themselves) in a few months and plan to be married in the next few years.

Neither have been previously married and both have a partial high school education.

Description of problem

Nature

Carol reports a global, not life long lack of sexual desire and dyspareunia on a situational basis, also not lifelong.

Carey ejaculates prematurely but at present does not identify this as a problem in that he quickly regains an erection.

Frequency and timing

Carey and Carol have an understanding (going back four months), that Carol be the one to initiate sexual advances when she is in the mood - as a result they engage in sexual intercourse less than once per month. Carey would like to have

sexual activity three or four times a week but came to realize that their relationship was being negatively affected by his pressuring Carol sexually.

Carol does not experience pain during every sexual encounter but rather on occasions when certain conditions exist.

Surrounding circumstances

Carol is seldom totally relaxed when engaging in sexual activity due to some of the following reasons;

- lack of privacy - there is usually someone around or someone might show up at any time.
- lack of lubrication or awkward positioning leads to painful intercourse.
- feeling physically tired and tense.
- once very aroused and about to have orgasm Carey may stop stimulation or direct attention elsewhere leading to frustration on her part.
- Carey may ejaculate, then stimulate Carol to orgasm and with a second erection continue thrusting. This usually results in painful intercourse due to lack of arousal and lack of lubrication on Carol's part.
- Fear of pregnancy (although on the pill) due to previous pregnancy at age 16 while on the pill.

Note: Carol recognizes that when she did get pregnant it was during a time when her Dr. was experimenting with different pills due to side effects she was experiencing. She knows now that they should have been using another form of protection during that time.

Duration

Carol's lack of sexual desire and dyspareunia are of a secondary nature but Carey's lack of ejaculatory control is life-long.

Course

Up until two years ago Carol reports having had no conderns regarding lack of sexual desire, lack of arousal or painful intercourse. Two years ago at age 16 she became pregnant and had an abortion. For one year thereafter she and Carey pleasured each other sexually to orgasm but refrained from having intercourse. During the following nine months (until four months ago) they began engaging in intercourse and on occasions due to feelings of guilt Carol engaged in intercourse when not aroused and found this to be painful.

Contemporary influences on the problems

Concomitant non-sexual stresses

Carol regularly suffers from headaches and backaches which is seen as related to her work which requires being bent over a brightly lit drawing table. Carol also complains of fatigue and "feeling uptight" i.e., having an uncomfortable feeling in her stomach and feeling prone to anger outbursts.

Organismic Variables

Thought processes

Although Carol is not preoccupied with a fear of pregnancy she does think about it periodically.

Her concern regarding lack of privacy also appears somewhat significant but she believes that this will be alleviated when they move into their own apartment. Rather than communicate her needs to Carey when involved sexually (or otherwise) Carol allows things to be and reacts with anger, sometimes in sharp unexpected outbursts. Carey then attempts to pacify her.

Neither Carey nor Carol have had any significant illnesses, surgery, nor are they on any medication or drugs.

Situational consequences

Carey and Carol's move into their own apartment will likely help provide privacy but will also add an additional dimension of committment and added responsibilities, likely leading to more pressures.

Personal and family background

Carol's parents were divorced when Carol was eight years old and this came as a somewhat of a surprise. As far as Carol remembers she first realized there was something wrong when she saw her father leaving with a suitcase.

Carol sees herself as an "afterthought" with two older sisters age 26 and 31 and two older brothers age 30 and 33.

Carol stayed with her mother till age 15 and then left to live with her brother for one year. From there she moved in with a girlfriend. She has very little family contact at this time. Religion has not been a significant factor although Carol remembers experiencing much guilt while petting on dates.

Parents attitudes about sex was that it was okay but not to be talked about. Modesty in the home was considered somewhat important and Carol was discouraged from being sexually active.

Most of Carol's learning about sex took place at school and with friends.

Carol had her first experience with intercourse at age 14 - 15 with an 18 yr. old neighborhood boy. This episode was followed by a series of overnight or very short unsatisfying encounters. She feels that these encounters had a compulsive quality about them.

Carol had an encounter with an older man from the neighborhood when in grade four. She was invited into the house, he sat her on his lap and fondled her genitals. She kept this a secret and claims to not have thought of this very much.

Sexual experiences before current partnership

Carol is orgasmic by self masturbation or by partner

stimulation other than intercourse. She has sexual dreams but fantasies or daydreams do not play a part in arousing her. She is usually somewhat aroused by erotic or pornographic materials such as pictures, movies and books.

Carol's feelings regarding past dating and sexual relationships leave her quite dissatisfied. Petting and intercourse in previous relationships usually left her feeling guilty.

Although she was sexually molested at around age 10, she does not recall this as a traumatic experience.

Self concept

Carol has a poor self image which is largely based on her memories of involvement with alcohol, drugs and past sexual activities. Her teenage years consisted of being perceived as an "easy lay", a "pick up". Boys wanted to date her just for sex and would become angry with her if she didn't respond.

Attitudes towards treatment

Carol and Carey are quite eager to resolve the presenting problems and see this as necessary prior to getting married. Both appear quite motivated. Carol presents with a persistent sense of tension throughout her body, especially in her stomach area. She doesn't recall feeling differently

and has more or less accepted this as normal. This sensation (under pressure) is accentuated to the point where she feels nauseas and usually results in anger outbursts.

Clinical formulation

Carol is quite tense at the best of times and it would appear that a great deal of this tension stems from feelings of pressure, guilt and helplessness.

<u>Pressure</u>: to function sexually when not feeling sexual desire.

: to make more of a committment to the relationship than she is ready for - living c/l and possibly purchasing a house together.

: to show love to someone when unsure of her feelings.

Carol is actually experiencing very much the same type of pressures she so strongly resents from her past but without full consciousness. Her fear of rejection and abandonment leads to a compromising of her own needs resulting in a state of ongoing frustration and anxiety.

Desired outcome

The specified desired outcome by Carey and Carol are the following; (1) that Carol experience sexual desire on a more regular basis (a few times per week) and (2) that this

may lead to pleasurable (not painful) intercourse.

Treatment

The first three sessions were spent gathering information surrounding the presenting problem during which time the couple was also asked to read the following four chapters from Male Sexuality by Zilbergeld (1978); Your Conditions for Good Sex and How To Get Them, The Physical Aspects of Sex, Touching and The Importance of Relaxation. The purpose of this exercise was partly for educational purposes as well as to encourage discussions of that nature.

As the beginning behavioral task, I prescribed Sensate Focus I ie. gentle caressing of the partner's body without touching the primary erotic areas. This was done with relative comfort, was seen as pleasurable and somewhat relaxing although they put off the exercise to the last minute therefore were only able to do it once and not three times as required. Carol didn't feel like doing the exercise claiming it seemed mechanical (by the book) yet she actually began to feel sexual arousal.

Within a few more sessions Carol was clearly resisting the sensate focus II exercise i.e., mutual pleasuring of each other's bodies including the genitals and teasingly without the rhythmic motion that produces orgasm. She reacted to feelings of arousal with anger pushing Carey away. "Unless

I have the feeling naturally something takes over me, I can work myself up into a state of anger and I want to push him away". Carol had been asked to monitor her thoughts and feelings during the exercise.

This served as a breakthrough for Carol as she came to recognize that feelings of sexual desire came hand in hand with very negative thoughts of her past; "all my life my sexual experiences have been bad, pressured; things happened 4 - 5 years ago I still get sick about". Carol realized that blocking feelings of sexual desire was a way of looking after herself and not just something that was happening to her. She commented " I feel like I'm finally getting somewhere".

Carol was then seen individually to explore the "horrible experiences" of her past that she found too painful to think about. With much difficulty and periodically holding her stomach as she talked she began to let go. On the third individual session Carol shared that she had finally admitted to herself that she is not sure she wants to marry Carey and if she could have her way the following would take place;

"I would be at home with my mother or my brother".

"I wouldn't see Carey beyond a dating situation and only a few times each week".

"I would not have any serious sexual involvements until after marriage".

"I am not ready for marriage".

"I am not sure I love Carey or want to marry him".

Now that Carol had confronted herself she was ready to be more open with Carey recognizing that she was also being unfair to him by living a lie.

Although she was now confronting herself, her fear of abandonment was still strong and unless delt with would likely lead to further compromising beyond what is healthy for Carol.

The following sessions included Carey as Carol was ready to share what she had finally admitted to herself. She had already begun this process outside of therapy and Carey seemed to recognize that it was in both their best interest for her to be honest about what she really wanted. Both Carey and Carol accepted that in view of our findings that the contracted desired outcome could only possibly take place in the distant future.

This would mean introducing new goals -

A. Joint therapy for purpose of working towards a mutually acceptable relationship contract.

B. Individual therapy with Carol to help her sort out and deal with past negative life experiences.

- Unfinished business with mother & father
- Poor self image regarding past behaviours
- Fear of being alone
- Need for control

Although Carol recognized that living with her mother

or brother would not be wise, she knew she wanted to make ammends with her mother.

At the time of writing Carey and Carol had agreed to live apart and see each other on a more casual basis. Carol had discontinued taking the birth control pill at her Dr.'s advice due to side effects. She is slightly more relaxed, has made contact with her mother and is looking forward (with some anxiety) to being on her own. She reported feeling sexual desire on two occasions during the past two weeks, much to her surprise.

I expect to have to deal with a great deal of resistance on Carey's part once they are living on their own i.e., they could very well find themselves with very similar circumstances regardless of their living accomodations. Carol is asking for something (space) which is perceived by Carey as a threat therefore as much as he intellectually recognizes that failing to allow her space will merely maintain the status quo, he has a tendency to work against himself as his life circles around Carol.

I expect that once Carol is on her own, she is likely to begin experiencing sexual desire on a more frequent basis.

I also anticipate the possibility of working with Carey individually regarding some of his own personal and family issues.

CASE 10 FRANK AND FRANCES
Lack of sexual desire
Vaginismus

Frances was being seen by a female student therapist at Psychological Services Centre and it was decided that once Frank was in a position to attend that a male/female co-therapy team would be very much in order. It was at this point that I was brought in.

Frank is a 31 year old Service Co-ordinator and Frances is a 28 year old receptionist. They have been married slightly over one year and have not to date consumated their marriage. Frank has been in therapy with the referring psychologist for many years and continues to require psychotherapy. This is the first marriage for both Frank and Frances.

Description of problems

Nature

Frances has never been able to allow penetration thus her marriage to Frank has not been consumated. Frances has physiological and subjective arousal but this is affected by her aversion to intercourse. This aversion developed out of her beliefs that intercourse is always painful and that the male genitals are very powerful. She has never reached orgasm.

Frank is experiencing a lack of sexual desire. He does

not experience subjective arousal and does not achieve erections. Frank blocks any sexual desire before he needs to act upon it.

Frequency and timing

Frances feels her fear of painful intercourse and the male genitals have always been present. She was unaware of her vaginismus until she and Frank attempted intercourse.

Frank's lack of sexual desire began in the fall of 1981. He has not experienced any desire since that time although he says if he does experience any sexual feelings, he blocks them.

Duration

Frances's and Frank's difficulties both appear to be primary.

Onset

Frank's lack of desire reoccurred about eight months ago. There appeared to be a gradual decline but there was a period of distress that may have acted as added stress which may have had an extreme effect on his sexual desire. The stress was Frank's court case where he was to meet charges of assault.

Course

Frances feels that before Frank's lack of interest she was becoming very aroused and was near the point of engaging in intercourse. She is now able to use tampons which she was unable to use a year ago.

Frank's stress re: court case has been resolved. When under this stress, Frank became involved in more rituals and these have not lessened since the court case.

Contemporary influences on problems

Situational antecedents

a) sexual stresses

Frances's fear of painful intercourse and the unknown power of the male genitals affects her feelings of sexual intercourse.

At one point in his life, Frank was very inhibited and naive about sexuality. Presently, he is concerned that he is back at that stage because his sexual desire seems blocked.

b) deficient or inappropriate stimulation

Presently, this couple is only engaging in holding each other. When they were first married, they were involved in foreplay - caressing each others' genitals, oral sex, etc..

c) relationship with partner

Frank and Frances feel their relationship is good.

Their communication appears to be restrictive and structured. They do not open up to each other and restrict what they say in the presence of each other. This couple spends a great deal of time analyzing what is happening in their relationship.

They are insecure in their relationship and act this out by demanding attention from each other. If one of them is quiet for more than five minutes, the other one is asking what is wrong or is this the "silent treatment".

Frances feels very insecure. She likes Frank to go to bed at the same time as her, and wants to fall asleep before him. She appears to need his attention a great deal of the time.

d) timing and setting of encounter

Presently, the couple is avoiding sexual encounters, although they have time together and have privacy.

e) concomitant non-sexual stresses

Frank has a large number of compulsive rituals that he involves himself in. He is concerned that these rituals may be interfering with his sexual life.

These compulsive behaviours cause his wife stress and she reacts to them with anger and guilt. Her anger is directed at the amount of time Frank spends away from her and the guilt occurs when she feels she may have caused Frank to start his rituals.

Organismic Variables

a) thought processes

1) cognitive avoidance

Frank says that he avoids any sexual thoughts and feelings that may lead to arousal.

Frances avoids sexual behaviours that may lead to sex but on the other hand wants to be involved in the closeness of a sexual relationship. She is both attracted and repulsed by sexual involvement. She feels desire once a day.

2) cognitive monitoring

Frank and Frances are very caught up in monitoring their behaviours. They spend a great deal of time analyzing situations.

3) deficient or false information

Frances is working from a great many misconceptions such as intercourse is always painful, male genitals are very powerful and should be feared and that orgasm equals bright lights, pain and loss of control.

Frank appears to have a more realistic idea of intercourse.

Both feel sex should be spontaneous and unstructured. They believe they should fall together and intercourse will just occur.

b) emotional reactions

1) anxiety

Frances feels a great deal of anxiety which is mostly

created by her need to please Frank.

Frank finds himself blocking his sexual desire. He is anxious about a great many stresses in his life and spends a great deal of time worrying about them.

2) guilt

Frank feels guilty about masturbating.

Frances feels guilty when she feels she has caused Frank to engage in his rituals.

3) anger

Frances's present reaction to Frank's lack of responsiveness is anger. She has reached the point where she has indicated she is going to leave. She later describes this as "being childish".

c) Organic states

1) surgery

Neither Frank or Frances have had any surgery.

2) drugs

Neither are taking any medication.

Situational consequences

a) partner's reactions

Before their marriage, Frank and Frances decided not to have intercourse. At this time, Frank was experiencing intense arousal to the point of creating stomach cramps. (??)

At this time, Frances felt extremely guilty about Frank's pain.

Now, Frances is concerned about Frank's lack of interest and her inability to arouse him. She appears to take on responsibility for arousing Frank.

b) absence of sexual relationships, due to avoidance reactions

Presently, this couple avoids anything sexual beyond holding each other.

Personal and family background

Frank is the oldest of three children and was born and raised in Saskatchewan. His father is a successful businessman and his mother has since before his birth been a homemaker. His childhood was seen as uneventful until in grade seven, he began to show psychiatric symptomatology, beginning with difficulties in concentration, lack of self confidence and some marked ritualistic behaviours. His functioning deteriorated and he eventually became home-bound. To this day he is employed by his father. He feels his parents have a good relationship and claims to get along well with them.

Frances is an only child and both her parents are deceased. She says she was close to her parents, although she was not as open with them as she would have liked to be. She claims her parents had a good relationship, but she remembers her father sulking or using the silent treatment

whenever he and her mother had a disagreement.

Frances claims to get along well with Frank's parents and gets a lot of support from Frank's mother around handling the compulsive behaviours.

Childhood and puberty

Frank

Sex was not discussed at home, the unspoken message being that it was okay but not to be talked about. Modesty was considered very important by both parents and Frank believes that his parents likely got along reasonably well sexually. Frank did not feel that he was either encouraged or discouraged by his parents to date or be sexually active and most of his learning regarding sex was with friends and a therapist.

He describes himself as asexual prior to age 20 i.e., at least not interested in sex or aroused when in situations which he understood should have been sexually arousing.

He has no recollection of traumatic sexual experiences. Frank claims to have avoided masturbation during most of his life and when he did, felt extremely guilty as he still does. When he did masturbate he claims the orgasm was always of minimum intensity.

Frances

Parental attitudes regarding sex was that it was okay

but not to be talked about and modesty was seen as very important by both parents. Although she did receive some information about sex and reproduction from her mother, most of her learning about sex comes from her friends and all types of books. At age 13 her mother explained menstruation to her but stressed it was not to be talked about with boys. Frances remembers feeling frightened at the time - the unknown.

She dated very little although encouraged to by her mother. She remembers two experiences which she describes as traumatic. The first experience took place at age 13 and is not very clear. She describes being pushed against a wall by a boy age 14 who exposed himself. Although she didn't actually see anything that's what she figures he did and she ran home. This boy was then kept away by her father.

At age 17, she experienced a second traumatic experience; (first date) she went out with a boy whom she described as a "strange guy" and ended up in his bedroom. Although nothing physical actually happened she knew it was not okay and felt ashamed as she had "nearly committed the worst sin".

Sexual experience before current partnership

Frances

Although this is not altogether solid information, Frances reports never having reached orgasm via self stimulation and possibly once with oral stimulation, although she is not

sure. She reports feeling little arousal from self stimulation.

She started to fantasize what she read (in her early teens) as a means of replacing what she was missing due to not dating. Dating consisted of what she calls one nighters - going to dances "being danced" and dropped.

Frances experienced much guilt from petting on dates and never experienced intercourse to this day.

Her orgasms usually occur in her fantasies where it is safe. She has been frightened of "the penis" since even before she ever dated. She used to think the penis was the same size as that of a horse and this would haunt her. To this day she claims the organ literally frightens her.

Frank

Frank started dating when he entered his twenty's and had sexual experiences with a few women which he found to be reasonably satisfying. Arousal occurred through physical contact and orgasm through partner stimulation. He has reached orgasm through masturbation.

Current partnership

Frank and Frances have been married for approximately one year and very shortly after that time Frank lost all interest in sex, including masturbation. As per an agreement they had no pre-marital sex, although during that time Frank

was very interested and very aroused to the point where he reports having felt pain due to pelvic congestion.

Their first sexual encounter following marriage turned out to be an awkward, frustrating and highly stressful experience. Their anxiety was reinforced by further frustrating attempts until eventually sex was avoided completely which to this day has been the case.

Frances has never had intercourse and for the time being is very anxious at the thought of intercourse and horrified at the notion of childbirth. She is on the birth control pill and has been for some time.

Their relationship is presently highly stressed and it would appear to be primarily as a result of the following factors;

- Frances's fears and attitudes surrounding intercourse (vaginismus) - the power she associates with the penis - the pain she associates with intercourse and childbirth - fear of letting go sexually - feelings of inadequacy - not knowing what pleases or arouses Frank - her frustration regarding his obsessive compulsive behaviour, her tendency to put herself down, the myths she has adopted as reality.
- Frank's obsessive, compulsive nature, his fear of regressing to a state he experienced during his teenage years i.e., a lack of sexual feelings in a context which

he associates as sexual.

Self concept

Frances sees herself as a quiet understanding person who tends to put herself down - "If I do it then others won't", - "I know I'm a failure therefore you can't put me down".

Frank describes himself as pessimistic by nature. "I never presented myself with an acceptable image - I want to be my own person and sometimes this gets me into trouble. I wasn't very popular as a kid, maybe because of my own doing".

Attitudes towards treatment

Motivation

Frances presents as fairly motivated although Frank tends to resist and block by intellectualizing and analyzing.

Frank has made fairly strong statements to the effect that he will not change - "things are as good now as ever will be, so perhaps I will never be sexual."

Prognostic expectancy - Poor

Both spouses are very disillusioned with marriage - it has turned out to be quite different from that expected. Frank felt that marriage and sex would likely be a cure for his compulsive behaviour - to his disappointment it wasn't.

Frances is trying to be understanding, but her patience is stretched fairly thin. There has been talk of separation on a number of occasions.

Treatment

Following the first assessment (information gathering) session we prescribed Sensate Focus I (as previously described) in an attempt to get a clearer picture of where they were at in terms of level of comfort with each other. This was introduced along with a ban on sexual intercourse for a period of one month and to be discussed at that time. Sensate Focus I proved to be extremely anxiety producing and avoided. It was re-introduced along with suggested reading of two chapters in Male Sexuality by Zilbergeld (1978); Touching and Importance of Relaxation. This was again met with much resistance and the vagueness of the information obtained revealed little to work with. We continued to improvise in attempts to give them successful experiences but kept getting messages from Frank that he was not wanting to overcome his lack of sexual desire.

Following a consultation session with Frank's psycotherapist we directed the focus on involving Frank in helping Frances overcome her fear of the penis. This was based on a belief that Frank likes to play the role of therapist. The outcome was that Frances became eager to be helped but Frank

would not co-operate, simply being content to hold Frances and fall asleep in this position.

Frank came as far as being able to tolerate being touched on the stomach (a very sensitive area) but carefully covered or hid his penis out of Frances's view or reach.

Frances has managed to introduce one finger into her vagina, has stimulated herself to orgasm once and is eager to proceed with the Becoming Orgasmic Program as well as deal with her anxiety towards the penis.

Frank on the one hand is saying he wants therapy and on the other hand saying that he doesn't want to become sexual.

On our last session a review was done and new plans established. Following a two month break, Frank will be involved in further assessment and Frances will begin the Becoming Orgasmic Program.

Prognosis appears very good for Frances but not promising for Frank which is likely to result in considerably more relationship stress as time goes by.

CASE 11 GEORGE

Lack of sexual desire

George is a 37 year old single male who works for P.W.A. and currently lives by himself. He recently saw a psychiatrist

in Edmonton for a year and one-half for problems of impotence and concerns regarding sexual orientation. The impotence was attributed to a "basically low sexual drive as well as a great deal of anxiety and inexperience when it came to heterosexual activities." He was also diagnosed as having a very low testosterone level and on that basis was given oral Methyltestosterone 25 mgms. a day which apparently improved his sexual drive somewhat. This was in addition to a program of orgasmic reconditioning using masturbation and heterosexual fantasies to strengthen his heterosexual urges. As well he was encouraged to look for possible ways in which to obtain a regular sexual partner.

At the beginning of psychotherapy, George was referred to a psychologist for psychophysiological assessment but the test results failed to differentiate his sexual orientation.

In essence the findings all added up to suggest the following;

(1) George basically has a homosexual constitution with the very occasional heterosexual contact.

\- or -

(2) He may be basically heterosexual however because of extreme anxiety has been pushed into a less anxiety provoking situation, that is homosexuality, for sexual satisfaction.

More recently, following the intake assessment at P.S.C., George was referred to a Winnipeg Urologist and the results

did not suggest any organic problem nor evidence of testosterone deficiency.

Description of problem

George is still confused regarding his sexual orientation and concerned about his general lack of sexual interest.

Nature

He reports having always been less "turned on" by erotic stimuli than most of his friends. He has had very few homosexual experiences over his lifetime beginning with mutual masturbation while attending a boarding school. Sexual contacts thereafter has involved rather cursory homosexual encounters, generally through public houses and have consisted of nothing more than mutual masturbation. These experiences have been somewhat stressful not particularly pleasurable, resulting in some degree of guilt and disgust. His masturbating activity, beginning in adolescence has been no more frequent than once a week and for periods of time approximately once a month. He has also had a number of heterosexual contacts over the years (although quite infrequent) and has found these reasonably enjoyable with somewhat less guilt attached.

His last sexual experience took place with a prostitute while in therapy, at the recommendation of his therapist.

This was intended to provide George with heterosexual experience but resulted in a fiasco. After one encounter he refused to participate in such activities. George was extremely anxious throughout this encounter and ended up being masturbated to orgasm with a flaccid penis. He felt thoroughly embarassed and disgusted.

His concerns are described as global and of a lifelong nature.

Contemporary influences on problem

George has been devoting a great deal of energy attempting to distinguish whether he is heterosexual or homosexual and as a result has never devoted any significant amount of time towards developing a meaningful interpersonal relationship. He has as a result very limited dating experience and although presenting as a very bright young man, he is very naive with regards to areas of sexuality.

Personal and family background

He comes from a rather well to do family in England. He came to Canada approximately 12 years ago for financial reasons and presents as quite happy and well adjusted. George sees himself as somewhat of a black sheep with his siblings being very successful in the legal profession. Although he visits his parents on a yearly basis he finds it extremely

difficult after a few days and has to get away. He has always had a strong need for privacy and independence, something which concerns him in terms of the possibility of marriage.

Attitude towards treatment

George is well motivated and extremely verbal.

Clinical formulation

A brief assessment revealed that George was still struggling with the following;

- "I want to be rid of any homosexual inclinations."
- "I want to satisfy my curiosity re: homosexuality."
- "I can't accept the concept of bisexuality for myself."
- "I want to have a family and settle down."
- "I don't know if I could cope without my independence."

It was also clear that George had very limited experience both homosexually and heterosexually.

As a result the following was presented to him.

In view of the assessments done to date and his past life experiences, it was basically a matter of his selecting which lifestyle he wished to pursue. This would mean making a choice and then working towards reinforcing the positives within whatever limitations of the choice he would make.

The choices at his disposal being the following - a homosexual, a bisexual or a heterosexual orientation.

I assured him that should he select a heterosexual lifestyle that there would be no way of guaranteeing that he would not still have homosexual inclinations, dreams or fantasies but that should these be a serious source of conflict that masturbation conditioning techniques as well as therapy could be used to enhance his overall functioning in heterosexual relationships.

This proposal made sense to him and he agreed to working towards a decision of direction.

The problem had been somewhat re-framed - George now had a choice to make.

Treatment

Following the first assessment session, I provided George with a copy of Male Sexuality by Zilbergeld (1978) and suggested he read the first nine chapters; Men and Sex / The Fantasy Model of Sex / The Process and Goals of Sex / Where Are You Now? / Your Conditions for Good Sex and How To Get Them / The Physical Aspects of Sex / Touching & The Importance of Relaxation.

As sophisticated as he presented this was a revelation for George who had been operating with numerous myths as his sources of information.

Following our second session, George opted to follow up on the choice of heterosexual lifestyle and immediately pur-

sued a relationship with a young woman from his Single Gourmet Club.

Our contract was to meet on a monthly basis (or more often if seen as necessary) where I would serve as a resource person and sounding board for George during his courtship.

George's objective was to get to know this woman and see whether a meaningful relationship would develop. He was instructed to take his time, not to rush things including becoming sexually involved.

George initially found her to be pressing for a more serious relationship than he was comfortable with - planning their schedules, introducing him to her family etc.. Through our sessions George recognized that he needed to talk more openly with her regarding his needs and expectations and that if he allowed himself to be pressured into situations that he wasn't ready for, that this would be detrimental to their relationship. By this time they had also had several sexual experiences; mostly mutual self pleasuring to orgasm without intercourse. Although this was experienced as pleasurable, Gail is somewhat more interested in sex than he is. George can maintain an erection during intercourse without a condom but tends to lose his erection when using a condom and foam. They are going to discuss alternate methods of birth control.

George was again cautioned about paying attention to his feelings, needs and values. He still often feels that his need for privacy and independence are being infringed on and although he wants to nurture this relationship, he wishes there was less emphasis placed on sex. This in part due to his feelings about sex outside of marriage.

At the time of writing, George had been dating Gail for approximately three months. He had introduced her to his mother and reported that everything was working out very well. He was experiencing sexual desire and was functioning quite adequately sexually. It appeared that George was presently more concerned with thoughts of what it would be like to lose his freedom should he get married rather than whether he was or wasn't experiencing sexual desire.

Homosexual issues have not been a concern to this date.

Summary and Conclusion

In Part 1 of the Practicum Report, I presented a review of pertinent material taken from the literature which I later utilized to formulate the assessment and treatment plans discussed in Part II. The assessment method which I utilized was primarily based on Jehu's (1979) model. I personally found that conducting a thorough assessment not only provided me with the information necessary to design an appropriate treatment plan but it provided the client(s) and I with a very positive experience within which to begin developing a therapeutic relationship. A therapeutic relationship as described by Goldstein (1980) is as follows;

(a) feelings of liking, respect and trust by the client towards the therapist

combined (b) with similar feelings on the part of the therapist towards the client.

As interventions usually involve having to deal with resistance which serve a purpose for the client, the therapeutic relationship becomes an important ingredient in helping the client cope with the stress that accompanies confronting such resistance and letting go of the status quo. This factor (therapeutic relationship) seems to be seen as important in almost every approach to therapy.

In formulating my treatment programs, I found that the uniqueness of each individual and their life experiences needed to be considered seriously. While it is certainly

wise to utilize the traditional tactics and strategies, should these not work it is important to try and devise new ones that may fit the particular needs of a certain client.

The behavioral and experiential methods described in Part I can often be used to modify the immediate causes which support the problem and I personally found that these methods used in combination with cognitive monitoring methods can serve as very effective means of identifying deeper underlying problems which can support the dysfunctions. Carol (case nine) is a good example of a situation where the behavioral task served to elicite strong negative cognitions from her past which, once identified enabled her to begin making some meaning out of her lack of sexual desire.

Paul (case eight) on the other hand, managed to learn ejaculatory control by merely focusing his attention on the sensations associated with high levels of sexual arousal. At this time we don't know whether his distractions were simply a learned habit with no special psychic meaning, or whether it was a reflection of deeper sexual conflicts.

Harold (case seven) needed to learn, appreciate and respect the conditions that are necessary in order to obtain and maintain an erection. Once having done this he was able to function quite adequately.

Bob (case two) may very well be harboring unresolved anger towards women but the behavioral tasks, along with some education regarding necessary conditions, while controlling

his alcohol problem all appear to be going a long way towards helping him change some of his attitudes, while providing him with significant improvements. Some of his hostility towards women i.e., at least some women have already emerged and are likely to surface further once he begins the part of treatment which involves masturbatory exercises using fantasies of anxiety producing situations.

Joan (case three) and Frank (case ten) both presented as very complicated individuals and are more likely to require long term insight oriented therapy in order to deal with their resistance. Frances (case ten) seems to be responding to the more traditional behavioral approach and is experiencing far more frustrations related to her relationship with Frank as she is overcoming her fear of intercourse. The implications for their relationship are serious and at this time difficult to assess. Her need to consummate the marriage may very well serve to accentuate Frank's resistance while on the other hand the pressure she will place on Frank may well be what he needs to confront his resistance.

Don (case five) may have acquired sufficient information to function adequately once he can find a suitable partner but he is also aware that further help is available if seen as necessary.

Robert and Rachelle (case four) will likely need marital and or family counselling before Robert will feel up to learning

control over his ejaculatory reflex. His very high state of anxiety appears to be primarily related to family, work and environmental pressures.

George (case 11) responded very quickly to a reframing of the problem, which in turn gave him choices. He saw fit to accept this different way of seeing the problem and to date is quite satisfied with his decision. He is not presently concerned with lack of sexual desire or his sexual orientation. George is quite a complex individual and there is no telling how homosexuality might in the future serve a purpose for him. In the meantime he is gaining heterosexual experiences which will in time provide him with more information on which to base future decisions.

Garry (case one) and Harry (case six) both saw fit not to engage in treatment even though some gains would have likely been possible. Both were without partners willing to participate in treatment and they presented this as their reasons for failing to contract. Perhaps in time once the works (with individuals without partners) of people like Zilbergeld (1975)(1978), Lobitz and Baker (1979), Price, Reynolds, Cohen, Anderson and Schochet (1981) become more popular, people such as Garry and Harry will be more likely to have hope and see fit to seek therapy again.

As is evident by my reports, at the time of writing, I am still working with some of my clients. When using a more individual and flexible treatment format, termination of treat-

ment becomes a matter of clinical judgement. This is quite different from the Masters and Johnson model programs where the clients are seen daily for two weeks after which treatment ends, regardless of outcome. It is more along the lines of Kaplan (1979) who tends to be "tenacious" i.e., she sees a difficult case as "a new challenge which presents the opportunity to innovate, to try to create new methods and strategies in the course of attempting to understand, resolve or bypass a particularly difficult resistance" (p. 198). This of course has its limits and there may come a time where treatment is reviewed and a decision is made, together with the client(s) either to (1) accept failure and terminate therapy, (2) to turn to a different modality of treatment or (3) to refer to a different therapist. This requires that evaluation of treatment take place on an ongoing basis.

As previously outlined in section D, (pp. 25-28 inclusive) of this paper in order to evaluate the effectiveness of a therapeutic intervention, the goals of therapy need to be defined in such a manner as to be measurable. In view of the nature of the problems I worked with, I chose to utilize an evaluation modality which relies heavily on client's self monitoring or self recording. This involved getting clear operational descriptions of the problem(s) as well as desired outcomes.

Having clear operational descriptions of the desired outcomes does make it considerably easier to assess whether

the goals are in fact achieved. However, to be able to support with strong evidence that the therapy in question in fact produced the recorded changes or for that matter to isolate the more effective parts from the less effective parts of the interventions would require clinical research beyond the scope of this paper.

In closing, I am pleased to emphasize that my objectives have been met. This past year of reading, research, consultation and practise has placed me in a much better position to do justice to the requests of many of my clients. I sincerely hope the clients that I have worked with have been enriched by our experiences as much as I feel I have.

APPENDIX A

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

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

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

DESCRIPTION OF PROBLEM(S)

1. Nature
2. Frequency
3. Timing
4. Surrounding circumstances (see also 8,9, and 10)
5. Duration
6. Onset
7. Course

CONTEMPORARY INFLUENCES ON PROBLEM(S)

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

9. Organismic variables
    a. thought processes
        i. cognitive avoidance
        ii. cognitive monitoring
        iii. deficient or false information
    b. emotional reactions
        i. anxiety
        ii. guilt
        iii. depression
        iv. drugs

10. Situational consequences
    a. partner's reactions
    b. absence of sexual relationships, due to avoidance reactions

PERSONAL AND FAMILY BACKGROUNDS

11. Both partners

    a. age

    b. sex

    c. marital status and history

    d. occupation

    e. education

    f. ethnic background

    g. religious and moral beliefs

    h. leisure activities

    i. friendship pattern

    j. health (including inter alia venereal disease, infertility, pregnancies, abortions, menstruation, menopause, use of alcohol or illicit drugs, and psychiatric disorders).

12. Partners' parents

    a. year of birth

    b. year and cause of death

    c. marital status and history

    d. occupation

    e. education

    f. ethnic background

g. religion and moral beliefs

h. health

i. relationship between parents

j. relationships between each partner and
(i) own parents, (ii) parents-in-law

13.. Partners' siblings

a. age

b. sex

c. marital status and history

d. occupation

e. education

f. health

g. relationship with parents

h. relationship with each partner

14. Children

a. age

b. sex

c. education

d. occupation

e. health

f. relationship with each partner

CHILDHOOD AND PUBERTY

15. Family attitudes towards sex

16. Learning about sex

17. Sexual activities

18. Traumatic sexual experiences

19. Puberty

    a. menstruation or first emissions

    b. secondary sexual characteristics

SEXUAL EXPERIENCE BEFORE CURRENT PARTNERSHIP

20. Nocturnal emissions or orgasms

21. Masturbation

22. Sexual fantasies and dreams

23. Erotic literature, pictures and films

24. Dating and previous partnerships

25. Petting

26. Intercourse

27. Frequency or orgasm from all outlets

28. Traumatic sexual experiences

CURRENT PARTNERSHIP

29. Date of marriage or cohabitation

30. Engagement

31. Sexual experience with current partner before marriage or cohabitation

32. Honeymoon
33. Sexual relationship during marriage or cohabitation
34. Contraceptive methods and wishes concerning conception
35. General relationship between partners

SEXUAL EXPERIENCE OUTSIDE CURRENT PARTNERSHIP

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

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

44. Nocturnal emissions or orgasms
45. Masturbation
46. Sexual fantasies and dreams
47. Erotic literature, pictures or films
48. Sexual partners

49. Petting

50. Intercourse

51. Traumatic sexual experiences

SEXUAL VARIATION

52. Homosexuality

53. Bestiality

54. Paedophilia

55. Voyeurish

56. Exhibitionism

57. Fetishism

58. Transvestism

59. Transsexualism

60. Sadomasochism

61. Sexual assault and rape

62. Incestuous behaviour

SELF CONCEPT

63. Body image

64. Gender identity

65. Popularity and attractiveness

66. Self-esteem

ATTITUDES TOWARDS TREATMENT

67. Motivation

68. Organizational capacity

69. Prognostic expectancy

70. Desired outcome

APPENDIX B

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 1 minute
   2) 1 to 2 minutes
   3) 2 to 4 minutes
   4) 4 to 7 minutes
   5) 7 to 10 minutes
   6) 11 to 15 minutes
   7) 15 to 20 minutes
   8) 20 to 30 minutes
   9) more than 30 minutes

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

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

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

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

12. Overall, how satisfactory do you think your sexual relationship is to your mate?
    1) extremely unsatisfactory
    2) moderately unsatisfactory
    3) slightly unsatisfactory
    4) slightly satisfactory
    5) moderately satisfactory
    6) extremely satisfactory

13. When your mate makes sexual advances, how do you usually respond?
    1) usually accept with pleasure
    2) accept reluctantly
    3) often refuse
    4) usually refuse

14. When you have sex with your mate, do you feel sexually aroused (i.e. feeling "turned on", pleasure, excitement)?
    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never

15. When you have sex with your mate, do you have negative emotional reactions, such as fear, disgust, shame or guilt?
    1) never
    2) rarely, less than 10% of the time
    3) seldom, less than 25% of the time
    4) sometimes, 50% of the time
    5) usually, 75% of the time
    6) nearly always, over 90% of the time

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

17. If you try, is it possible for you to reach orgasm through having your genitals caressed by your mate?
    1) nearly always, over 90% of the time
    2) usually, about 75% of the time
    3) sometimes, about 50% of the time
    4) seldom, about 25% of the time
    5) never
    6) have never tried to

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

19. What is your usual reaction to erotic or pornographic materials (pictures, movies, books)?

    1) greatly aroused
    2) somewhat aroused
    3) not aroused
    4) negative--disgusted, repulsed, etc.

20. Does the male have any trouble in getting an erection, before intercourse begins?

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

21. Does the male have any trouble keeping an erection, once intercourse has begun?

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

22. Does the male ejaculate (climax) without having a full, hard erection?

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

23. Is the female's vagina so "dry" or "tight" that intercourse cannot occur?

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

24. Do you feel pain in your genitals during sexual intercourse?

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

25. (WOMEN ONLY, MEN GO ON TO QUESTION 28) Can you reach orgasm through stimulation of your genitals by an electric vibrator or any other means such as running water, rubbing with some object, etc.?

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

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

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

27. (WOMEN ONLY) When you have sex with your mate, including foreplay and intercourse, do you notice some of these things happening: your breathing and pulse 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 C

Dyadic Adjustment Scale

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

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

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

		All the time	Most of the time	More often than not	Occasion-ally	Rarely	Never
16.	How often do you discuss or have you considered divorce, separation, or terminating your relationship	0	1	2	3	4	5
17.	How often do you or your mate leave the house after a fight	0	1	2	3	4	5
18.	In general, how often do you think that things between you and your partner are going well?	0	1	2	3	4	5
19.	Do you confide in your mate?	0	1	2	3	4	5
20.	Do you ever regret that you married? (or lived together)	0	1	2	3	4	5
21.	How often do you and your partner quarrel?	0	1	2	3	4	5
22.	How often do you and your mate "get on each other's nerves?	0	1	2	3	4	5

	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
23. Do you kiss your mate?	4	3	2	1	0
24. Do you and your mate engage in outside interests together?	4	3	2	1	0

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

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

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

	Yes	No	
29.	0	1	Being too tired for sex.
30.	0	1	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point "happy" represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, in your relationship.

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

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

5 I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

4 I want very much for my relationship to succeed, and will do all I can to see that it does.

3 I want very much for my relationship to succeed, and will do my fair share to see that it does.

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

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

0 My relationship can never succeed, and there is no more that I can do to keep the relationship going.

APPENDIX D

SEXUAL AROUSAL INVENTORY

INSTRUCTIONS: The experiences in this inventory may or may not be sexually arousing to you. There are no right or wrong answers. Read each item carefully, and then circle the number which indicates how sexually aroused you feel when you have the described experience, or how sexually aroused you think you would feel if you actually experienced it. Be sure to answer every item. If you aren't certain about an item, circle the number that seems about right. The meaning of the numbers is given below.

- -1 adversely affects arousal; unthinkable, repulsive, distracting
- 0 doesn't affect sexual arousal
- 1 possibly causes sexual arousal
- 2 sometimes causes sexual arousal; slightly arousing
- 3 usually causes sexual arousal; moderately arousing
- 4 almost always sexually arousing; very arousing
- 5 always causes sexual arousal; extremely arousing

ANSWER EVERY ITEM	How you feel or think you would feel if you were actually involved in this experience.						
1. When a loved one stimulates your genitals with mouth and tongue	-1	0	1	2	3	4	5
2. When a loved one fondles your breasts with his/her hands.	-1	0	1	2	3	4	5
3. When you see a loved one nude.	-1	0	1	2	3	4	5
4. When a loved one caresses you with his/her eyes.	-1	0	1	2	3	4	5
5. When a loved one stimulates your genitals with his/her finger.	-1	0	1	2	3	4	5

6. When you are touched or kissed on the inner thighs by a loved one.	-1	0	1	2	3	4	5
7. When you caress a loved one's genitals with your fingers.	-1	0	1	2	3	4	5
8. When you read a pornographic or "dirty" story.	-1	0	1	2	3	4	5
9. When a loved one undresses you.	-1	0	1	2	3	4	5
10. When you dance with a loved one.	-1	0	1	2	3	4	5
11. When you have intercourse with a loved one.	-1	0	1	2	3	4	5
12. When a loved one touches or kisses your nipples.	-1	0	1	2	3	4	5
13. When you caress a loved one (other than genitals.)	-1	0	1	2	3	4	5
14. When you see pornographic pictures or slides.	-1	0	1	2	3	4	5
15. When you lie in bed with a loved one.	-1	0	1	2	3	4	5
16. When a loved one kisses you passionately.	-1	0	1	2	3	4	5
17. When you hear sounds of pleasure during sex.	-1	0	1	2	3	4	5
18. When a loved one kisses you with an exploring tongue.	-1	0	1	2	3	4	5

19.	When you read suggestive or pornographic poetry.	-1	0	1	2	3	4	5
20.	When you see a strip show.	-1	0	1	2	3	4	5
21.	When you stimulate your partner's genitals with your mouth and tongue.	-1	0	1	2	3	4	5
22.	When a loved one caresses you (other than genitals).	-1	0	1	2	3	4	5
23.	When you see a pornographic movie (stag film).	-1	0	1	2	3	4	5
24.	When you undress a loved one.	-1	0	1	2	3	4	5
25.	When a loved one fondles your breasts with mouth and tongue.	-1	0	1	2	3	4	5
26.	When you make love in a new or unusual place.	-1	0	1	2	3	4	5
27.	When you masturbate.	-1	0	1	2	3	4	5
28.	When your partner has an orgasm.	-1	0	1	2	3	4	5

APPENDIX E

SEMANTIC DIFFERENTIAL SCALE

INSTRUCTIONS:

At the top of each page you will find the name of a real or ideal person, and below it are some pairs of words. Here is how to use these pairs of words:

If you feel that the real or ideal person at the top of the page is very closely related to one of the words, you should place a cross as follows:

PLEASANT __X__:_____:_____:_____:_____:_____:_____ UNPLEASANT

OR

CALM _____:_____:_____:_____:_____:_____:__X__ ANXIOUS

If you feel that the thing is quite closely related to one or other word, you should place a cross as follows:

PLEASANT _____:__X__:_____:_____:_____:_____:_____ UNPLEASANT

OR

CALM _____:_____:_____:_____:_____:__X__:_____ ANXIOUS

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

PLEASANT _____:_____:__X__:_____:_____:_____:_____ UNPLEASANT

OR

CALM _____:_____:_____:_____:__X__:_____:_____ ANXIOUS

If you consider the thing to be equally related to both words, or if the words are completely unrelated to it, you should place your cross in the middle space:

PLEASANT _____:_____:_____:__X__:_____:_____:_____ UNPLEASANT

IMPORTANT (1) Place your crosses in the centre of the spaces not on the dots between them.

This Not this

____:____:_X__:____:____X____:____

(2) Be sure to put a cross between every pair of words on every page - do not leave any out.

(3) Never put more than one cross between a pair of words.

Please do not look back and forth through the pairs of words through the pages, and do not try to remember how you placed your crosses earlier. Make each cross a separate judgement. Work at fairly high speed. Do not worry or puzzle over individual items. It is your first impressions, your immediate feelings that are needed.

MYSELF AS I AM

Pleasant	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	Unaffectionate
Inhibited	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	Hard to arouse

MYSELF AS I WOULD LIKE TO BE

Pleasant	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	Unaffectionate
Inhibited	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	Hard to arouse

MY PARTNER

Pleasant	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	Unaffectionate
Inhibited	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	Hard to arouse

MY IDEAL PARTNER

Pleasant	:	:	:	:	:	:	Unpleasant
Calm	:	:	:	:	:	:	Anxious
Sexy	:	:	:	:	:	:	Sexless
Loving	:	:	:	:	:	:	Unloving
Sexually Frustrated	:	:	:	:	:	:	Sexually Satisfied
Bad	:	:	:	:	:	:	Good
Jittery	:	:	:	:	:	:	Placid
Repulsive	:	:	:	:	:	:	Seductive
Warm	:	:	:	:	:	:	Cold
Sexually Attractive	:	:	:	:	:	:	Unattractive
Cruel	:	:	:	:	:	:	Kind
Erotic	:	:	:	:	:	:	Frigid
Affectionate	:	:	:	:	:	:	Unattractive
Inhibited	:	:	:	:	:	:	Uninhibited
Easy to arouse sexually	:	:	:	:	:	:	Hard to arouse

APPENDIX F

BECK INVENTORY

Name ______________________ Date ______________________

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry anymore than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

    I am purposely trying to lose weight by eating less. Yes ___ No ___

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems, that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

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