

SEXUAL DYSFUNCTION: ITS ASSESSMENT AND TREATMENT

by

M. Carole D. Klassen

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This practicum report is dedicated to the clients, herein mentioned, who helped to renew the author's faith in man's potential to change, grow and love.

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## INTRODUCTION

The purpose of this practicum is to examine that area of a sexual relationship that may cause contention. This, specifically, can often be a multi-faceted problem that can involve a host of psychological, physiological, sociological, learning/conditioning, hormonal/neuro-endocrine and cognitive factors. Given the variety of the factors that can be involved in the genesis and maintenance of a sexual dysfunction, a professional working in this area must have a comprehensive, and thorough knowledge of the field. In addition, this same person must possess the flexibility to adapt this erudition to the needs of the client; without conveying personal prejudices or preferences regarding sexual behavior.

Sexuality is as much an expression of self, as it is a means of communication. It can fulfill and it can destroy. It leaves a person, oftentimes, in his most vulnerable state; naked, literally and metaphorically. For these and other reasons, the therapist working in this area must possess an ability to convey a non-judgemental, supportive, trusting, and open persona.

Though these aforementioned professional qualifications are not unique to the area of sexual dysfunction; the writer believes that they are especially important in this milieu. Societal, family, religious, peer and moral pressures exert sufficient pressure upon a person that he has had little choice in his own sexual development. If the professional is not aware of his own ability to carry on this shaping process; then that person will just continue to mold his client without giving that person an informed choice.

The material in this practicum has been presented in four sections. Each classification, though by no means comprehensive, does give an

overview of the relevant material and an idea of what is involved in the field. The peruser can liken his reading experience to learning the rudiments of how to dance without having been given a formula to transform the movements into art. This ingredient can only be supplied by the elocutionist.

PART I LITERATURE REVIEW

### A. HUMAN SEXUAL RESPONSE

In human beings, sexual responses can be evoked by visual, auditory, olfactory, gustatory and tactile stimuli. Probably the most important stimuli, touch, is "the only form of stimulation that can evoke arousal as a spinal reflex, independently of the brain" (Jehu, 1979, p.11). "The other forms of sensory stimulation can only evoke sexual responses through the mediation of the brain, where they are interpreted and evaluated to determine whether or not a particular pattern of stimulation will evoke sexual arousal" (Jehu, 1979, pp. 11-12).

In addition to sensory stimulation, sexual responses can be evoked by the person's own erotic fantasies. Fantasies, when used in combination with sensory stimulation, can elicit and heighten sexual response; and as can be seen in Part III - are a valuable tool for use by the client for their own sexual enhancement. "Although different kinds of sexual stimulation may produce very different psychological experiences at a physiological level, the sexual response is essentially the same" (Jehu, 1979, p.12). Two basic physiological reactions occur in response to sexual stimulation. "Initially, blood flows into the sexual organs and other areas of the body, without a corresponding outflow, so that engorgement or vasocongestion occurs. This process is most clearly demonstrated by the male erection. The second reaction is increased muscle tension or myotonia throughout the body, which culminates in the muscular contractions of orgasm for both sexes" (Jehu, 1979, p.12-13; Masters and Johnson, 1966; Kaplan, 1974).

Masters and Johnson (1966) described the human body's reaction to sexual stimulation. They illustrated a four phase model (see Table 1) which served as a descriptive reference and provided some basis for their conceptualization of treatment. Another model by Kaplan (1974) presented a two rather than four phase concept (see Table 1). Kaplan preferred this bi-phasic cycle because the two phases had "different anatomical and neural bases, and they "varied" in their vulnerability to the influence of aging, illness, surgery and drugs". There were also "different forms of sexual dysfunction associated with each phase", which responded "to different treatment procedures" (Jehu, 1979, p. 13).

Kaplan's bi-phasic cycle is used in the following summaries of male and female responses; based on the original findings of Masters and Johnson.

TABLE 1. Phases of Sexual Response

MASTERS AND JOHNSON (1966)	KAPLAN (1974)	
	MALE	FEMALE
1. Excitement 2. Plateau	1. Erection	1. Lubrication - Swelling
3. Orgasmic 4. Resolution	2. Ejaculation	2. Orgasm

(Jehu, 1979, p.13)

#### Male Response Cycle

##### Erection Phase

The first phase of the male response cycle is signaled by the attainment of penile erection which usually occurs rapidly - within a few seconds - in young men. In the early stages, erections can be lost and regained with fluctuations in stimulation; and with extraneous distractions. Later, as engorgement reaches its peak, they become persistent and resistant to distraction. Other reactions in the sexual organs during the erection phase include "contraction and thickening of the skin of the scrotal sac so that it loses its baggy appearance, and progressive raising of the testicles within the scrotum together with their engorgement by vasocongestion to between 50% and 100% of their usual size. Sometimes, at an advanced stage of erection, a small amount of clear fluid is exuded from the penis, and this is probably produced by Cowper's gland" (Jehu, 1979, p. 14; Masters and Johnson, 1966; Kaplan, 1974). Some general bodily reactions often accompany the changes in the sexual organs. Muscular tension, blood pressure, and heart and respiration rates may all increase, as well, as nipple erection and skin flushing may occur (Jehu, 1979; Kaplan, 1974; Masters and Johnson, 1966).

### Ejaculation Phase

Though the general reactions, during the ejaculation phase, usually increase to a peak following the erection phase; this is not necessarily so in each and every case. Moreover, there is some preliminary evidence to suggest that orgasm and ejaculation do not necessarily always occur together in some males who are capable of having multiple orgasms (Robbins and Jensen, 1978; Jehu, 1979).

Within the ejaculation phase there are two components, emission and expulsion. The former comprises "contractions of the internal sexual organs (the prostate gland, seminal vesicles, vas deferens and testes) as they collect the semen and deposit it at the entrance of the urethra" (Jehu, 1979, p. 14). At this point, the male usually feels that ejaculation is inevitable and finds it difficult to delay his climax once emission has occurred. The expulsion component "consists of rhythmic contractions of the penile urethra and the muscles at the base of the penis, which begin at intervals of 0.8 second but become less regular and frequent. They force the semen to spurt out of the penis and are accompanied by the intense pleasure of orgasm" (Jehu, 1979, p. 14; Masters and Johnson, 1966; Kaplan; 1974). After this has happened, the male enters a refractory period during which he is physiologically unresponsive to further physical stimulation. Within a variable length of time, which increases with age, he cannot attain a full erection or ejaculate again.

### Resolution Phase

"The refractory period extends into what Masters and Johnson called the 'resolution phase'. During this period, the penis returns to its unstimulated state in two stages. It initially loses about half of the erection almost immediately after ejaculation; and then gradually detumescens over a period of about half an hour. The testicles resume their usual size and position and the scrotal sac regains its baggy appearance. The general somatic reactions, first noted in the erection

phase, subside; and the male may find a thin film of sweat covering the palms of his hands, the soles of his feet or other parts of his body. (Jehu, 1979; Kaplan, 1974; Masters and Johnson, 1966).

#### FEMALE RESPONSE CYCLE

##### Lubrication-Swelling Phase

The female sexual response is characterized by both local genital and general vasocongestion of the skin and myotonia. The distinguishing feature, in reference to local genital responses, is vaginal lubrication which usually occurs within 10 to 30 seconds of sexual stimulation and is probably due to vascular engorgement of tissues deep in the vagina. The inner two thirds of the vagina lengthen and expand, while the outer third becomes engorged and swollen to the point that the vaginal entrance is narrowed (called 'the orgasmic platform' by Masters and Johnson, 1966). Venous congestion causes a colour change in the labia minora, "from pink to red in women who have never given birth, and from red to a deep wine colour in those who have" (Jehu, 1979, p. 15). (This colouration has been called the 'sex skin' by Masters and Johnson, 1966). "Furthermore, in premenopausal women, once the colour change has occurred then orgasm follows inevitably providing that sexual stimulation is continued" (Jehu, 1979, p. 15). Vasocongestion of the clitoris takes place at a fairly late stage of arousal; and, just prior to orgasm it "turns up 180° and retracts in a flat position behind the symphysis pubis" (Kaplan, 1974, p. 11). In addition, during this stage the uterus becomes enlarged through vascular engorgement and rises from its usual position in the pelvic cavity; and the outer third of the vagina becomes widely ballooned (Jehu, 1979; Kaplan, 1974; Masters and Johnson, 1966). As in the male, "there are increases in muscle tension, blood pressure, heart rate, and respiration, but nipple erection and skin flushing are usually

much more marked in women" (Jehu, 1979, p. 15). (This skin mottling in women has been called by Masters and Johnson, 1966, the 'sex flush').

#### Orgasm Phase

As in the male, the female's general bodily reactions reach their peak during the orgasm phase. Regardless of the manner of stimulation, the female orgasm always consists of .8-second reflex rhythmic contractions of the "circumvaginal and perineal muscles and the swollen tissues of the 'orgasmic platform'. The characteristics of the orgasm are identical in all females and clinical evidence suggests that the female orgasm may always be triggered by some form of stimulation of the clitoris" (Kaplan, 1974, p. 12).

While the rhythmic contractions of local muscles in women has been seen as analogous to those occurring in the male during the expulsion component of ejaculation, no female equivalent for the emission component was thought to exist. However, work done by Lowndes, Sevely and Bennett (1978) has reviewed some anatomical, physiological, and anecdotal evidence which has suggested to them that women can discharge prostatic fluid, void of spermatozoa, through the urethra during orgasm.

The pleasurable feelings that accompany the contractions, in this phase, vary considerably in intensity according "to the nature of the stimulation and other circumstances (Clifford, 1978; Singer and Singer, 1978)" (Jehu, 1979, p. 16). For women, there is no refractory period following orgasm, and they are capable physically of experiencing a series of orgasms with intervals of only a few seconds between them. This can continue until the woman is either physically exhausted and/or no longer wishes further stimulation. (Jehu, 1979; Kaplan, 1974; Masters and Johnson, 1966).

### Resolution Phase

During this final stage, women can be brought to orgasm again at any time if they are suitably stimulated; otherwise, local sex-specific physiological responses abate and the entire body returns to its basal state. There is rapid detumescence of the orgasmic platform; and the 'sex skin' of the labia minora loses its deep coloration 10 to 15 seconds after cessation of orgasmic contraction. The rest of the vagina, Masters and Johnson (1966) say, may take as long as 10 to 15 minutes to return to its relaxed and pale resting state. Similarly, the clitoris "reemerges from its retracted position within a few seconds of orgasm, although complete detumescence usually takes 5 to 10 minutes" (Jehu, 1979, p. 16; Kaplan, 1974; Masters and Johnson, 1966). "The cervical os continues to "gape" for 20 to 30 minutes after orgasm, at which time the uterus has also completed its descent into the true pelvis and cervix descends into the seminal basin" (Kaplan, 1974, p. 12). As in the male resolution phase, it can be seen that women's local vasocongestive responses are resolved in two stages, the first being rapid and the second much slower. (Jehu, 1979). The general bodily reactions also subside and a film of perspiration, which is independent of activity, may appear over much of the body (Jehu, 1979).

From these summaries, it can be seen that the male and female response cycles, have similarities and differences. For instance, "local vasocongestion produces penile erection and other reactions in the male, as well as vaginal lubrication and swelling in the female. Similarly, the orgasmic response consists of muscular contractions in both sexes. On the other hand, the existence of an emission component is uncertain and there is no refractory period in the female orgasmic phase, in contrast to the male ejaculation phase" (Jehu, 1979, p. 16).

### AGING

"The sexual response cycle remains essentially the same throughout life; but the natural aging process produces some changes in the reactions of middle aged and older people. They are still capable of reaching orgasm but their responses tend to be slower and more attenuated than when they were younger" (Jehu, 1979, p. 17; Masters and Johnson, 1966).

### Male Response Cycle

The natural aging process creates a number of specific physiological changes in the male cycle of sexual response. As well, from a psychosexual point of view, the male must contend with the "widespread psychosocial acceptance of the fallacy of sexual incompetence as a natural component of the aging process" (Masters and Johnson, 1970).

The variants that the aging process imposes on the male population alters the previously established patterns of sexual functioning. Older men will take longer to gain an erection than their younger counterparts (Jehu, 1979; Solnick and Berren, 1977; Masters and Johnson, 1970). Where it might have taken a few seconds to establish erective responsiveness in days gone by, the older man now finds that a few minutes of effective sexual stimulation are needed to gain an erection. The erection may not be as full or demanding as that to which he was previously accustomed. Once the erection is attained, the older man is able to maintain it for longer periods of time before he reaches orgasm. If he does lose the erection, however, before orgasm, then he is likely to experience greater difficulty to recover it. The usual changes in testicular elevation, scrotal-sac vasocongestion, vascular engorgement of the testes and the pre-ejaculatory emission of fluid, may all be reduced or absent during the erection phase of the aging male (Masters and Johnson, 1970; Jehu, 1979).

The majority of the physiological changes occur in the ejaculatory phase. "The emission component with its accompanying feelings of ejaculatory inevitability may be shortened or not happen at all, so that the orgasm is sometimes experienced as a one stage process. During the expulsion component there are fewer muscular contractions and the semen spurts out with less force. The refractory period lengthens, so that many men in their fifties and older cannot obtain another erection within 12 to 24 hours after they have ejaculated. There is a lowering of the subjective demand for orgasm, which occurs less frequently in older men" (Jehu, p. 17; Masters and Johnson, 1970; Kaplan, 1974). The older male

may not ejaculate and/or reach orgasm at every sexual encounter. Once orgasm has occurred, the resolution phase is less prolonged in older men; and their erections disappear more rapidly as compared to the slower two stage process evident in younger males. (Jehu, 1979; Masters and Johnson, 1970; Kaplan, 1974). These physiologic changes do not impair the healthy, male's ability to enjoy intercourse and to experience it as pleasurable.

#### Female Response Cycle

"Female sexuality appears to be subject to far greater individual variations than is the male, although direct comparison is, of course, impossible" (Kaplan, 1974; p. 109). Women, too are subject to the fallacy that sexuality is the domain of the young. Post-menopausal women are often thought to have no personal interest in, nor possess the facility for active sexual expression (Masters and Johnson, 1970;

Sviland, 1978). The female's anatomical changes to menopause are reflected in the sexual response cycles. During "the lubrication-swelling phase, it may take 4 to 5 minutes for the vagina to become lubricated compared to 15 to 30 seconds in younger women, and the transudate is also less profuse. The vagina does not lengthen and expand to the same extent or as quickly. Although an orgasmic platform is produced, this is not as full as in the earlier years. The labia minora do not swell so much and the sex skin reaction may be absent or reduced. There may be no enlargement of the uterus in post-menopausal women and its elevation from the pelvic cavity is less marked and longer delayed. However, there do not appear to be any changes in the clitoral responses of older women" (Jehu, 1979, pp. 17-18; Kaplan, 1974; Masters and Johnson, 1970).

Older women are capable of having multiple orgasms throughout life; but, there are fewer muscular contractions during the climax. "As in men, the female resolution phase is completed much more immediately and rapidly with increasing age" (Jehu, 1979, p. 18; Masters and Johnson, 1970; Kaplan, 1974). The healthy aging female, just as her healthy male counterpart, can retain the capacity for pleasurable sexual performance until well into the seventh and eighth decades of life.

B. Sexual Dysfunctions: Categories and Definitions

Sexual dysfunction is probably experienced by most people at some point in their lives. The inability to function sexually may be due to a great many related and/or interrelated organic and psychological factors. What is deemed as an acceptable sexual failure (i.e., inability to obtain or sustain an erection due to tiredness or drinking) in one context; may be viewed with alarm in another (i.e., a general inability to gain and sustain an erection with a loved partner).

Without absolute standards of sexual competence and satisfaction, it is difficult to define and ascertain at what point a sexual failure amounts to a sexual dysfunction. A place to start could be the client's or other persons subjective judgement of sexual inadequacy. However, since no one is expected to perform perfectly and be satisfied on each and every occasion; a less than satisfactory sexual encounter is not sufficient in itself to constitute a dysfunction (Jehu, 1979). In addition, the client's judgement may be influenced by a variety of factors such as "the nature of the sexual behaviour, the context in which it occurs, its consequences, the extent to which it deviates from normative standards, and certain personal characteristics of the client and other judges" (Jehu, 1979, p. 69).

The nature of the sexual behaviour is important to the definition of the sexual dysfunction. The main forms judged to be dysfunctional are various impairments of erection or ejaculation in men, of vasocongestion and orgasm in women, and of interest and pleasure in both sexes. These problem areas are discussed further in this section and in Part IV.

The context of the behavior can have far-reaching effects on sexual ability. The type of sexual stimulation, partner suitability, temporal

variables such as those related to the sexual response per se, the persistence of the impaired sexual behavior, and the frequency of the behavior being judged; as well as conditions in the setting where the sexual behavior occurs may influence judgements of inadequacy (Jehu, 1979).

Consequences accompanying the impaired sexual behavior that are viewed as adverse, are likely to increase the probability of its being defined as dysfunctional. Physical pain, feelings of humiliation, disappointment, anger, depression, guilt or anxiety; as well as any adverse effects to a person's self-concept will probably affect the judgement of sexual dysfunction. These occurrences in the client, as well as in the client's partner, can be viewed as disturbing to both themselves and to the general relationship. The effects of discord in a relationship, arising out of sexual difficulty in the union, is discussed at greater length in Part 1:C.

"Sexual behavior that deviates from normative standards of various kinds is liable to be considered inadequate" (Jehu, 1979, p. 72). Any sexual difficulty that would deviate from the health standard that demands an absence of pathology (see Part 1:C); contravenes legal and religious norms (i.e., sexual dysfunctions that prevent the consummation of marriage), statistical norms (Frank et al, 1978), or society norms (Libby, 1977; Ross, 1977; Zuckerman, 1976; Ginsberg et al, 1972) may be interpreted as a dysfunction.

The client's personal characteristics, such as age and sex, may influence judgements of inadequacy. Also the perspective of the person making the evaluation of sexual inadequacy can affect the judgement. Depending on the priority given different criteria - be it from a

personal, a legal, a medical, a religious, a relative's or a spouse's point of view - the concerns elicited regarding the dysfunction may reflect the role of the judge as much as the dysfunction itself. It is therefore important that therapists involved in the treatment of these disorders take into account all and more of these factors to aid them in making broadly based judgements of what constitutes sexual adequacy.

The sexual dysfunctions are classified according to various aspects of sexual behavior that can be separately impaired; including interest, arousal, intromission, orgasm, ejaculation and pleasure. These aspects in turn can be disrupted in different ways yielding several categories of dysfunctions in males and females respectively (See Table 2). These classification categories imply nothing about the person, only about the problems. These categories also do not entirely determine the treatment. As can be seen in Part III, similar problems may be treated in different ways, because the clients who exhibit these problems can greatly vary in terms of their personal characteristics and life situations (Jehu, 1979).

TABLE 2. Categories of Sexual Dysfunction

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

(Jehu, 1979, p. 75)

The sexual dysfunctions, themselves, are reviewed in two sections of this report. The problems that were encountered in the writer's caseload at the Sexual Dysfunction Clinic are dealt with in Part IV. Those that were not, are presented in the segment that directly follows.

#### Dysfunction of Interest

Inadequate sexual interest, a disorder seen in both the male and female populations, is defined within the context of this practicum report as meaning the frequency with which an individual wants (or not) to have sex; (which implies nothing about the ability to do so or arousal experienced during it) (Zilbergeld, 1980). This dysfunction is discussed at some length in Part IV; A; and the reader is asked to refer to that section for further detail.

#### Dysfunction of Arousal or Intromission

##### Erectile Dysfunction

"Erectile dysfunction or impotence, involves some impairment of the erection phase of the male sexual response cycle, so that vascogestion of the penis does not proceed normally" (Jehu, 1979, p. 81). The man, who experiences this difficulty, is persistently unable to obtain a sufficiently firm erection, or to maintain this during insertion and intercourse (Jehu, 1979, Masters and Johnson, 1970; Kaplan, 1974; Ellis, 1980; Reckless and Geiger, 1978). This dysfunction was encountered in the writer's practicum and therefore is reviewed in Part IV: F.

##### Vasocongestive Dysfunction

"This type of problem involves some impairment of the lubrication-swelling or vasocongestive phase in the female response cycle, so that vaginal lubrication, the ballooning of the inner two-thirds of the vagina, the formation of an orgasmic platform, and other physiological

changes characteristic of this phase, do not occur normally. Thus, vasocongestive dysfunction in the female is analogous to erectile dysfunction in the male" (Jehu, 1979, p. 103).

Impairment of arousal is a distinct problem in women, separate from orgasmic dysfunction (Kaplan, 1974; Jehu, 1979). A woman could, for example, become extremely aroused without attaining a climax; and, in some instances, the reverse might also be true. In such a case, a woman would have the ability to reach an orgasm; but, would experience some impairment of arousal. It is also possible that these two problems could co-exist in the same client, for "most women who have difficulty in becoming aroused are also unable to reach orgasm" (Jehu, 1979, p. 103).

The term 'vasocongestive dysfunction' refers specifically to an impairment of physiology and does not include the lack of erotic feelings or inadequate pleasure. This lack of pleasure or subjective feelings of satisfaction also does not include lack of desire or interest which could affect the woman's ability to become physiologically aroused (further discussion of dysfunctions of interest and pleasure are available elsewhere in this section).

These problems may be experienced in all activities and encounters (global) or only in some of them (situational). The arousal difficulties also may be of a primary nature whereby the client has never been able to become adequately aroused by a partner; or "it may be secondary in that it commences after a period of normal functioning in this respect" (Jehu, 1979, p. 105; Levine and Yost, 1976).

The information on the incidence of impaired arousal among women is sparse. A study by Levine and Yost (1976) reported that 10 (17%) out of 59 black women, aged 30-39 years, were unable to achieve orgasm with a partner by any means. Seven out of the ten women had 'excitement-phase

dysfunctions'. It was seen that 6 out of the 7 women had secondary onset of arousal difficulty; while the remaining woman had always lacked both lubrication and excitement. Another study, done by Bancroft and Cole (1976) cited that 63 out of 102 women were suffering from this dysfunction. Another 18 were diagnosed as orgasmically dysfunctional; and it is unknown how many of the 63 generally unresponsive women also were unable to reach orgasm.

Kaplan (1974) has suggested that women may experience the impairment of arousal differently than men. In the latter case, erectile dysfunction is almost always a psychological disaster; while the response of women "to a comparable sexual inhibition range from similar great distress to a casual acceptance of their condition" (Kaplan, 1974, p. 362). It can be seen that some women will engage in intercourse to please their partner and are able to accept this state of affairs without rancor. Others, however, become resentful and angry as their frustration and disappointment mount in the face of their partner's gratification. These women can develop a strong antagonism towards sex and an intense hostility towards their partners.

The partners of these women experience different consequences. Some men accept the lack of response as a matter of course, "because it conforms with their culturally-induced expectation" (Kaplan, 1974, p. 363). Others may experience the woman's lack of responsiveness as a personal rejection; a reflection on their own sexual attractiveness and competence; or as distressing because their partner is lacking sexual gratification (Jehu, 1979; Kaplan, 1974).

The only organic factors that have been shown to affect vasocongestive functioning are those known to reduce vaginal lubrication. Estrogen deficiencies arising from menopause, premature ovarian failure,

or from a lesion anywhere in the hypothalamic-pituitary-ovarian axis; neurological disorders; diabetes mellitus; and possibly some of the organic factors that have been shown to contribute to lack of interest and orgasmic dysfunction might adversely effect arousal (Jehu, 1979).

Any of the stresses discussed in Part 1:C may contribute to this dysfunction. Stress reactions, negative emotional reactions i.e, anger, anxiety, cognitive monitoring an avoidance, partner discord, and deficient and/or inappropriate sexual stimulation may be implicated in the problem. (Jehu, 1979).

### Vaginismus

"This type of dysfunction can be defined as a spastic contraction of the muscles at the outer third of the vagina and the perineum, which occurs as an involuntary reflex response to a threat of vaginal penetration. Consequently, intromission is either completely prevented or only possible with great difficulty and pain" (Jehu, 1979, p. 106; Kaplan, 1974; Leiblum, Pervin and Campbell, 1980; Fuschs et al, 1978). As this difficulty was represented amongst the writer's clients, this review of the literature is available in Part IV: C.

## Dysfunction of Orgasm or Ejaculation

### Premature Ejaculation

"A persistent lack of adequate voluntary control over the orgasmic and/or ejaculatory reflexes constitutes premature ejaculation" (Jehu, 1979, p. 3). Most men exercise some control over these reflex responses up to the point of ejaculatory inevitability; which, in turn, coincides with the emission stage when the semen is collected from the internal sexual organs and deposited at the entrance of the urethra" (Jehu, 1979, p. 87). Though, in most men, these two reflexes occur almost simultaneously, it is possible for premature orgasm to occur without the expulsion of an ejaculate in men suffering from retrograde ejaculation;

or for men who suffer from erectile dysfunction to ejaculate prematurely through a flaccid penis without any accompanying sensation of orgasm (Jehu, 1979).

There is a strong subjective component in the assessment of premature ejaculation since there are no standards for the degree of voluntary control to be expected over the orgasmic and ejaculatory reflexes. The man or his partner may judge that there is a problem in this area based on the persistence of inadequate control, the timing of orgasm and ejaculation, and the degree of dissatisfaction experienced by the couple. (Jehu, 1979; Perelman, 1980).

It is possible that most men experience occasional or transient episodes of premature ejaculation. This, however, is not thought worthy of treatment by the client unless it becomes more persistent.

"The timing of ejaculation is also likely to be an important consideration in reaching this decision. It may occur before, during or shortly after intromission" (Jehu, 1979, p. 87). Whether ejaculating at any of these points merits the label of premature ejaculation depends on the views of the couple concerned. The actual time limit of intercourse is not as important as whether either partner is repeatedly left in a state of dissatisfaction.

For many men, rapid ejaculation is a disturbing experience. If they feel guilty about depriving their partners of sufficient sexual gratification and/or they feel that their own pleasure was truncated, then they may label their performance as dysfunctional. Other men, however, will neither be concerned that they ejaculated quickly; nor that their partner was left sexually unsatisfied.

The sexual capacity and pleasure of the female partner is an important determinant in ascertaining the degree of dissatisfaction the

couple holds in regards to the male's premature ejaculation. If the couple believe that sexual intercourse is primarily a male gratification; then they may have little problem with the consequences of rapid ejaculation (Jehu, 1979). However, if the female believes that she should be brought to orgasm via penile stimulation; then the male's problem will definitely be seen as dysfunctional. "Interestingly enough, it appears that one consequence of the increased emphasis on orgasms in women has been an inclination on the part of some women to label their partners as "premature" if they themselves required extensive penile thrusting in order to achieve orgasm during intercourse or if they regard penile stimulation as the only acceptable source of genital stimulation" (Perelman, 1980, p. 199; Reckless and Geiger, 1978). Norms and sexual expectations, therefore, can be seen to exert influence over the description of what is premature ejaculation. Kinsey et al. (1948) reported that 75% of all American males ejaculated within two minutes of intromission. It is unknown what percentage of these males considered this to be satisfactory; but, it is known that today men consider it a major problem if they cannot satisfy their partner, "usually defined as giving her at least one, but preferably more, good orgasms in intercourse" (Zilbergeld, 1978, pp. 255-256). If the women, cited by Perelman, do indeed expect men to be able to perform longer; and the men, in turn, expect this of themselves, then we definitely can see the influence of changing norms and sexual expectations on sexual behavior.

Premature ejaculation is considered the most common of the male sexual dysfunctions (Jehu, 1979; Frank et al., 1978; Perelman, 1980; Kaplan et al., 1978; Masters and Johnson, 1970). It may be of a primary nature, whereby the male has never been able to exert control over his orgasm and ejaculatory reflexes; or secondary, in which case the man developed premature ejaculation after a period of normal sexual functioning. The difficulty may also be of a 'global' or 'situational'

nature; whereby, the problem occurs on every occasion (masturbation and sexual encounters) in the first instance, or only under particular circumstances in the second (Zilbergeld, 1978).

The consequences of premature ejaculation on the man can often include feelings of disappointment, humiliation, depression, guilt and anxiety arising from both his own frustration and inability to satisfy his partner. The partner, who may have been initially understanding, is likely to misconstrue the man's lack of control as his lack of interest or rejection of her. The feelings of resentment and anger that can arise in the woman, can further compound and extend the male's sexual difficulties. This whole pattern of reaction to premature ejaculation can sometimes result "in the increasing withdrawal of both partners from their relationship; and perhaps to engagement in extra-marital affairs by the wife in an attempt to obtain the sexual gratification she lacks, as well as reassurance concerning her attractiveness and femininity (Masters and Johnson, 1970)" (Jehu, 1979, p. 89).

Premature ejaculation is probably only rarely caused by an organic condition. Neurological disorders, such as spinal cord tumour or multiple sclerosis, may affect his disorder; but, there is no systematic evidence currently available to corroborate this point (Jehu, 1979).

"In contrast to organic factors, a man's previous learning experiences may be particularly important in the aetiology of premature ejaculation. This is because the voluntary control of the orgasmic and ejaculatory reflexes is assumed to be acquired by learning, and the success or otherwise of this process will depend on the conditions to which the man is exposed" (Jehu, 1979, p. 90).

Any of the contemporary stress conditions discussed in Part 1:C may contribute to premature ejaculation. Anxiety (Kaplan, 1974) has been hypothesized to contribute to premature ejaculation. Kaplan (1974) proposed that anxiety reactions distracted a man from fully perceiving the build up of erotic sensations towards orgasm and ejaculation. He, therefore, would be unable to ascertain the point of ejaculatory

inability; thereby, eliminating the exercise of adequate voluntary control.

Like anxiety, cognitive avoidance can contribute to premature ejaculation. Also like anxiety, it is not clear how precisely cognitive avoidance reactions contribute to this dysfunction. It is possible that these reactions impair the man's recognition of his mounting arousal and his voluntary control over orgasm and ejaculation (Kaplan, 1974; Jehu, 1979).

Finally, certain overt stress reactions of an avoidance or escape nature, and partner discord may contribute to premature ejaculation. For example, a man may want to terminate a sexual encounter as quickly as possible when, for him, it is for some reason seen as threatening. Likewise, relationship problems may cause the man to feel humiliated, criticized or angered by his mate; thereby, impairing his voluntary control over orgasm and ejaculation.

#### Retarded or Absent Ejaculation

This problem may be defined as a "persistent delay or failure in the occurrence of orgasm and ejaculation despite the presence of an adequate erection" (Jehu, 1979, p. 93; Apfelbaum, 1980; Kaplan, 1974; Munjack and Kanno, 1979; McCarthy, 1981; Pryde and Woods, 1980; Razani, 1972; Morse and Morse, 1981). This disorder is described in detail in Part IV:G for the reader's perusal.

#### Retrograde Ejaculation

" Essentially, retrograde ejaculation is 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. This is collected from the internal sex organs and deposited at the entrance to the urethra in the usual way, but the normal reflex closure of the internal sphincter at the neck of the bladder does not occur. Consequently, the semen flows backwards to the bladder instead of being propelled forwards by the muscular contractions of orgasm. One

indication of this problem is the cloudiness of urine passed after masturbation or intercourse, and it can be diagnosed from the presence of sperm in the urine at these times" (Jehu, 1979, p. 97).

In some men, voluntary repression of ejaculation is possible. Johnson (1968) reported that this has been a method of contraception for many centuries; and that yogis are able to redirect its flow into the bladder where it can be absorbed to improve the intellect.

The absence of visible ejaculate does not impair erection or orgasm. In fact, concerns a couple may possess over their ability to conceive a child can be laid to rest because it is quite possible to collect the live spermatozoa from the man's urine after masturbation or intercourse and to inseminate his partner with these (Jehu, 1979).

"The causation of retrograde ejaculation is probably almost entirely organic in nature. It may consist of any illness, surgical intervention or drug, that disrupts sympathetic control of the internal bladder sphincter, or that prevents complete closure of the bladder neck" (Jehu, 1979, p. 98). Some of the more commonly implicated factors in the causation of this problem are summarized in Table 3.

TABLE 3. Organic Factors Contributing to Retrograde Ejaculation

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Neurological Disorders	
1. Spinal Cord lesions	
2. Pelvic fractures (with injury to bladder neck or sacral nerves)	
Endocrine Disorders	
3. Diabetes mellitus	
Surgical Interventions	
4. Prostatectomy	
5. Lumbar sympathectomy	
6. Colectomy	
7. Retroperitoneal lymph node dissection	
8. Bladder neck surgery	
9. Aortic aneurysm surgery	
Drugs	
10. Major tranquilizers	
11. Antihypertensives	

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### Orgastic Dysfunctions

"Orgastic dysfunction involves some persistent difficulty or failure in releasing the reflex contractions of the vaginal and pelvic musculature that comprise the female orgasm" (Jehu, 1979 , pp. 3-4; Kaplan, 1974; Masters and Johnson, 1970; Morokoff, 1978; Gebhard; 1978; Singer and Singer, 1978; Heiman et al., 1978; Barbach, 1980). This disorder is presented in detail in Part IV:G; and the reader is asked to refer to that section for further elucidation.

### Dysfunction of Pleasure or Satisfaction

#### Inadequate Sexual Pleasure

There is very little knowledge available about this category of dysfunction that afflicts men and women alike. The disorder has been described by clients as 'feeling nothing' during intercourse, or that it is insufficiently pleasurable or satisfying to them (Jehu, 1979). In some cases, the lack of erotic sensation to genital or all forms of sexual stimulation, extends to an actual anaesthesia in this area.

A male client whose main complaint is of inadequate pleasure would have no difficulty with his erections, and would be able to achieve orgasm and ejaculation in a normal manner. However, his subjective responses would not reflect the pleasure and satisfaction that should normally accompany his physical behavior. Likewise, a female client would also lack subjective pleasure and satisfaction though she had normal vaginal lubrication and swelling and the muscular contractions of orgasm.

How the clients would interpret their physical responses might fall on a continuum which ranged from erotic feelings being viewed as attenuated to a total lack of erotic pleasure. The amount of pleasure

that a client experienced could also vary in different circumstances. The pleasurable feelings could "fluctuate across occasions, perhaps due to variations in stimulation received, the recency and frequency of intercourse, and the attractiveness of the partner (Clifford, 1978; Singer and Singer, 1978)" (Jehu, 1979, p. 99). Masters and Johnson (1966) also stated that although the physiologic components of the female orgasm were essentially the same for all women; that the orgasms themselves could vary in intensity and duration both between individuals and in the same individual at different times. It was also suggested by these writers that the physical and psychological quality of the stimulation being provided could influence the woman's orgasmic experience (Jehu, 1979).

A client may enjoy the emotional closeness afforded by love-making although no erotic feelings are experienced. "However, this deficiency may also be a source of frustration and distress for the client as well as being threatening and humiliating to the other spouse" (Jehu, 1979, p. 100). The primary complaint, in such circumstances, can be complicated by the "development of erectile dysfunction in males, the impairment of vasocongestion or orgasmic dysfunction in females, or inadequate sexual interest in clients of either sex" (Jehu, 1979, p. 100).

Only one organic factor has been implicated in the etiology of inadequate pleasure. It has been suggested that poor vaginal and pubo-coccygeal muscle tone may cause this area to be very relaxed and relatively insensitive to stimulation. All other causative factors have been attributed to a psychological origin.

The contemporary conditions cited in Part 1:C may influence inadequate pleasure. Stresses may evoke reactions, such as cognitive

avoidance, that reduce the awareness the person has towards certain forms of sexual stimulation or response. The erotic feelings, in turn, are not experienced due to the lowered or eliminated awareness level (Jehu, 1979). Kaplan (1974) also indicates that the sexual response is subject to influences from a number of sources: memories, experiences, emotions, thoughts and associations, that can inhibit or enhance. She suggests that the sexual reflexes can readily be impaired by multiple potential inhibitory influences such as fear or hatred; or conversely, sexual responsiveness could potentially be increased by other psychic forces such as love and fantasy.

"Hysterical disorders are sometimes implicated as causes of certain cases of inadequate pleasure. When this involves genital anaesthesia it might be considered a 'conversion symptom', comparable to other hysterical anaesthesias, sensory losses or paralyses (Kaplan, 1974; Weisberg, 1977)" (Jehu, 1979, p. 100). A study done by Purtell et al. (1951) noted that 73% of the women with a diagnosis of hysteria reported an absence of sexual pleasure, compared to 15% of healthy control subjects. Levay and Kagle (1977) found that some individuals suffering from hysterical and obsessive-compulsive disorders had difficulty in identifying, experiencing, or enjoying pleasurable sensations, including those normally associated with sexual activities (Jehu, 1979).

"Lastly, inadequate pleasure may be experienced in sexual relationships that have become boring, routinized, and lacking in variety, or in the absence of some preferred form of unconventional sexual stimulation" (Jehu, 1979, pp. 100-101).

#### Dyspareunia

Dyspareunia is defined as painful intercourse; a discomfort that is experienced differently between the sexes, though both males and females can be affected by this dysfunction. As the writer cannot improve upon the comprehensive review of dyspareunia presented by Jehu (1979); she

will largely be drawing the material from this source.

In men, this "discomfort may be experienced only during erection, insertion, thrusting or ejaculation, or throughout more than one of these processes. The client most commonly refer to pain to his prepuce, glans penis, penile shaft, testicles, groin, pubic area, rectum, thighs or lower back, although other locations are sometimes involved. He may or may not also experience pain during certain non-coital forms of sexual activity, such as masturbation and manual or oral stimulation by a partner" (Jehu, 1979, p. 101).

For most men, the anticipation of pain may evoke reactions of anxiety and avoidance which could lead to other sexual dysfunctions. These difficulties could serve the function of avoiding the aspects of sexual activity that are expected to produce pain. Even when the organic basis for the pain has cleared up, the man may continue to avoid the components that produced stress because they continue to elicit negative responses in the individual (Jehu, 1979).

"The aetiology of dyspareunia in males is predominantly of an organic nature, although not exclusively so for psychological factors are involved in some cases (e.g., Sharpe and Meyer, 1973)" (Jehu, 1979, p. 101). Jehu (1979) presented an outline of the relevant organic causes of this disorder that was based on Wear's (1976) review. The following is a synopsis of this review.

Certain conditions of the female genitalia were seen to cause male dyspareunia. The most common condition "was seen to be inadequate vaginal lubrication; but congenital anomalies; episiotomies accompanied by attempts to 'tighten up' a gaping introitus; and the distortion, scarring, or shortening of the vagina by surgery or radiation" could be responsible in some cases. A related group of causes could be inflammatory allergic reactions to "contraceptive solvents, rubber condoms or diaphragms, hygienic preparations, artificial lubricants, or even the acidity of the normal vaginal secretions."

"Certain conditions of the external male genitalia may also cause dyspareunia." Curvature of the penis, such as "hypospadias, chordee, Peyronie's disease, penile trauma, and phimosis" could cause pain upon

erection. Inflammatory conditions and infections that affect the external genitalia, "such as balanitis, urethritis and orchitis" could also cause pain.

Acute prostatitis and/or seminal vesiculitis, pathological conditions of the internal male sex organs; as well as certain general illnesses, such as arthritis, angina pectoris, can also prove painful.

In women, dyspareunia may be experienced during intromission, intercourse or after it has ended. They may experience pain at the entrance of the vagina, the clitoris, the vaginal barrel, or the internal pelvic organs. This dysfunction can be associated with any of the other sexual dysfunctions; or in turn, the other disorders may contribute to the dyspareunia.

The organic causes of female dyspareunia can be derived from local genital disorders, or they can arise from the discomfort experienced during intercourse from certain systemic diseases (i.e., inflamed joints in arthritis, or from angina in cardiac disorders). The following review is taken from that done by Jehu (1979), who drew his material from Masters and Johnson (1970), Musaph and Haspels (1977), and Wabrek and Wabrek (1975).

"The commonest causes of pain at the entrance of the vagina are hymenal problems, tender scars, inelastic tissues, certain conditions affecting Bartholin's glands, and vaginismus" which is discussed in a later section. "The hymen may be imperforate, micro-perforate, rigid, or scarred, making intercourse impossible or painful (Greer, 1975). Tender scar tissue may form at the hymen or elsewhere in the genital area, sometimes as a result of trauma or sexual assault, but most usually following the obstetrical procedure of episiotomy. In post-menopausal women, the tissues of the labia and vagina sometimes become relatively inelastic due to the withdrawal of oestrogen. Most rarely, introital pain may arise from an enlargement of Bartholin's gland in the labia minora, perhaps due to an infection or cyst.

Painful inflammation or irritation of the clitoris can arise from an accumulation of smegma under the hood, and from lesions or scar tissue on the shaft (Fordney-Settlage, 1975). Another cause of discomfort is too vigorous manual stimulation of the clitoris during masturbation or love-making.

Pain in the vaginal barrel is usually experienced in the form of burning, itching, or aching sensations, and it is likely to occur both during and after intercourse. Perhaps the most prevalent source of such discomfort is insufficient lubrication, due to any of the factors discussed in the earlier section on vasocongestive dysfunction. A related source of vaginal pain is atrophic vaginitis, arising either from oestrogen deficiency on post-menopausal women, or from radiation in those who have had radium treatment for cancer, both of which lead to a thinning of the lining of the vagina so that its resistance to infection, trauma, and chemical agents is lowered. Whether or not atrophic vaginitis is present, a woman may experience irritation and inflammation in the vaginal passage as a result of a variety of infections, or of allergic sensitivity reactions to certain chemical agents in contraceptive substances or devices, in hygienic preparations, or in clothing fabrics or detergents.

Pelvic pain occurs with deep penile thrusting (as if the penis is hitting something inside), or it may commence shortly after intercourse has ended. Many types of pathology affecting the internal pelvic organs are sometimes responsible, including infections, cysts, tumours, fibroids, and endometrial tissue growths. The vagina may be foreshortened or scarred after hysterectomy; or the broad ligaments that support the uterus may be lacerated, usually accompanied by retroversion and enlargement of this organ. Lastly, pelvic may arise from intense vasocongestion resulting from prolonged sexual stimulation and not relieved by orgasm (Medical Aspects of Human Sexuality, 1978)" (Jehu, 1979, pp. 115-116).

In addition to the organic pathology mentioned above, dyspareunia can be effected by psychological factors. Any of the stress conditions mentioned in Part 1:C could possibly evoke reactions that might contribute to painful intercourse. "Among the more obvious examples of these are the anxiety or anger reactions that disrupt vaginal lubrication, and the overt reaction represented by the muscular spasm in patients suffering from vaginismus" (Jehu, 1979, p. 116).

### C. CAUSES AND MAINTAINING CONDITIONS

An overview of the possible causes of sexual dysfunction is offered in this section. The causes are considered in the general categories of organic factors, previous learning experiences and contemporary conditions. It should be understood that the causes from any of these categories may operate singly or in combination in particular cases of dysfunction (Jehu, 1979).

## Organic Causes

### Illness

Sexual dysfunction does sometimes arise from organic etiology. It is beyond the scope of this report to consider the many causes in any detail. Sufficient to say that any illness that is debilitating, painful, or incapacitating can impair sexual performance. Cardiac, renal and arthritic disorders, as well as more transient symptoms (i.e., sunburn, bone fracture, migraine) can affect sexual behavior.

"In addition to the general effects on sexual functioning which accompany many such illnesses, there are more specific effects arising from certain morbid conditions involving the genital organs themselves or the neural, endocrine, or vascular mechanisms that subserve sexual behavior" (Jehu, 1979, p. 18). What is important to note is that, even when there is an organic cause for impairment of sexual functioning, its effects may prevalently be due to the psychological reactions to the organic etiology.

### Surgery

Certain surgical or obstetrical interventions either "directly, as a result of the organic damage ensuing from the operation, or indirectly from the patient's psychologic reactions to its consequences" (Jehu, 1979, p. 27; Kaplan, 1974) can cause problems of sexual functioning.

Surgical conditions that damage the genitals and the nerve supply; castration in men; as well as surgery that damages the sexual organs and androgen supply in women (see Appendix A) can cause sexual dysfunction. Similarly, in both sexes, limb amputation can pose mechanical problems for coital positioning (Cummings, 1975; Mourad and Chiu, 1974).

### Drugs

"As in the case of illness, any drug that is generally debilitating or incapacitating, or which specifically affects the neural, endocrine or vascular mechanisms concerned, may contribute to sexual dysfunction"

(Jehu, 1979, p. 28). It, again, is beyond the scope of this report to consider such drug effects in any depth and some comprehensive reviews are already available (Kaplan, 1974; 1979; Kolodny, 1979; Renshaw, 1978; Jehu, 1979). (See Appendix A). A brief review of the effects of sedatives, major tranquilizers, antidepressants, antihypertensives, narcotics and oral contraceptives is covered in Part IV, Section A of the etiology of lack of sexual desire.

### Previous Learning Experience

"Although organic factors must not be overlooked in the assessment and treatment of sexual dysfunction; it is commonly held that psychological causes are more prevalent" (Jehu, 1979, p. 31). These causes may stem from previous learning experiences, or they may be contemporary conditions that are impairing the client's sexual functioning.

Though many historical and contemporary factors have been alleged to have contributed to sexual dysfunction, only those which were seen as affecting clients in this practicum will be discussed. Previous learning experiences will be presented in this section and contemporary conditions will follow.

### Traumatic Experiences

Sexually traumatic incidents have been seen with some regularity in the histories of dysfunctional clients. These experiences may have occurred in childhood or at some later date. Children who were caught masturbating, having nocturnal emissions or playing doctor might have elicited strong parental disapproval for such behavior. The children may also have been sexually assaulted or involved in incestuous acts (Jehu, 1979, 1982; Heiman, 1976). (Further detail is given on the possible repercussion of early sexual assault in Part IV:D).

The initial experience of sexual intercourse may prove traumatic due to anxiety, doubtful privacy, a rushed nature, feelings of disappointment and humiliation. "Similar incidents, occurring after the initial experiences, may also prove damaging to sexual functioning" (Jehu, 1979, p. 32). A couple, for instance, who are surprised during intercourse by their children entering the bedroom may have subsequent sexual problems. Premature ejaculation might ensue due to the husband's wish to proceed quickly with intercourse for fear that they might be again be interrupted by the children.

While traumatic experiences of the kind cited may appear in the histories of sexually dysfunctional clients; they do not invariably lead to such difficulties. In fact there is some evidence (Schofield, 1965) to suggest that many people in the general population have had similar experiences, without apparent adverse repercussions on their sexual performance.

#### Restrictive Upbringing

A restrictive upbringing may also affect sexual functioning in some people. An excessively strict, moral or religious upbringing is commonly reported in the histories of dysfunctional clients (Jehu, 1979; Masters and Johnson, 1970).

In restrictive homes, the writer found that there was little or no discussion of sexual matters and censorship of television, radio and reading material. The clients had been admonished about the sinfulness, immorality and dirtiness of sex. Sex's sole purpose was often only that of procreation. The girls were instilled with the fear of an unmarried pregnancy and taught that they had to preserve themselves against pre-nuptial sexual advances of men. Once married, sex was a duty that

would prove unpleasant and painful. The boys were warned of the mental and physical illnesses that would accompany impure thought, masturbation, nocturnal emissions, and petting or intercourse before marriage (Jehu, 1979).

The alleged outcome of deeply imbued negative sexual attitudes, a lack of accurate sexual knowledge, and the long association of fear, guilt and disgust with sexuality may be some form of sexual dysfunction (Jehu, 1979). On the other hand, studies done by Fisher (1973), Uddenberg (1979), Terman (1938, 1951) and Kinsey et al. (1953) suggest that many people do survive such early experiences without suffering any apparent impairment of their sexual behavior in later life (Jehu, 1979).

#### Adverse Family Relationships

The nature of the family relationships experienced during childhood and adolescence may also give rise to contributing factors of sexual dysfunction. Instances where clients experienced parents who were dominating, demanding and perfectionistic (Masters and Johnson, 1970); where the clients had a negative experience with the father or mother (Uddenberg, 1974; Fischer, 1973; Jehu, 1979); or where death, discord or traumatic separation in the family (Jehu, 1979) occurred; have been implicated with some degree of sexual dysfunction.

#### Contemporary Conditions

The contemporary conditions that may impair a client's sexual functioning may exist in his environment or his own thoughts and feelings. The affects of these conditions on the sexual dysfunction can be threefold. In the first place, "although organic factors and previous learning may have contributed to the origin and development of the behavior, it constitutes a dysfunction only when it is judged to be inadequate in the current situation" according to the kind of criteria

discussed in Part 1:B. (Jehu, 1979, p. 41). Likewise, the dysfunctional behavior is initiated and maintained by the contemporary conditions even if the previously cited influences are at play. Lastly, the dysfunctions may have arisen in response to the contemporary conditions independent of organic factors or previous learning (Jehu, 1979).

Given that the therapist followed a therapeutic intervention process that was largely behavioral, the focus of treatment was to modify the client's current sexual behavior in relation to the circumstances prevailing at the time of therapy. This approach was taken even if the origin of the dysfunction had been greatly affected by organic factors or learning experiences (Jehu, 1979). Some of the contemporary conditions that the therapist encountered are briefly reviewed in the ensuing paragraphs.

#### Psychological Stresses

Contemporary psychological stresses of a sexual or non-sexual nature may initiate and maintain sexually dysfunctional behavior (Jehu, 1979). Stress is a highly subjective response of an emotional, overt or cognitive kind. Circumstances that are seen as frustrating, a threat or as conflict provoked by one individual may produce dissimilar or even opposite reactions in another. Therefore, it can be seen that both the conditions and the person's reactions to stress need be taken into account.

Certain components of the sexual anatomy or response can be stressful to some people. Two of the writer's clients experienced fear and distaste for touching their own genitalia and transudate. "A closely related group of stresses involves the anticipation of some kind of harm" (Jehu, 1979, p. 43). The client may fear physical harm, as in the case

of a woman who fears pain from intercourse or an unwanted pregnancy; or the harm may be of a psychological kind, such as a lack of satisfaction or threatened degree of intimacy in sexual relationships (Jehu, 1979).

One of the most significant sexual stresses is the anticipation of failure in the sexual act (Jehu, 1979; Kaplan, 1974; Masters and Johnson, 1970). A man, for example, may dread sexual activity with a new partner if he has had previous difficulties in sustaining an erection. Such anticipation of failure can be compounded by certain other conditions. If excessive performance demands, that cannot be met, are made by the partner; or if the expectation is held that failure will lead to ridicule, criticism, or rejection by the partner; the overconcern that arises from these perceived threats can contribute to sexual dysfunction (Jehu, 1979). Likewise, "any form of sexual activity that contravenes a person's moral or religious standards may be stressful to that individual" (Jehu, 1979, p. 44).

Stresses of a non-sexual kind can also impair sexual behavior. It can be affected by "the negative emotional reactions that tend to accompany all forms of stress which include depression, anger, guilt and especially anxiety" (Jehu, 1979, p. 45; Masters and Johnson, 1970). Reduction of anxiety associated with the avoidance of certain aspects of overt activity can also affect sexual functioning. Responses that prevent penetration, orgasm, or ejaculation from occurring; that reduce the frequency of sexual encounters; that restrict other aspects of the couple's relationships (i.e., kissing and cuddling); or that stop single clients from making social contacts with the opposite sex, can all be extensions of avoidance responses towards sex. Unfortunately, "all forms of avoidance behavior tend to be very persistent because its performance is constantly reinforced by the reduction of anxiety, and sometimes by inappropriate reward as well. A particular disadvantage of this, is that

it deprives the client of new learning opportunities, which might otherwise have modified the stressful nature of the conditions that evoked the anxiety and avoidance reactions" (Jehu, 1979, p. 46).

Cognitive monitoring, or what Masters and Johnson (1970) called 'spectatoring' can affect sexual behavior. The person who does this detaches himself from the sexual experience. He distracts himself by monitoring his own sexual responses which in turn successfully cuts him off from experiencing the sexual stimulation that would otherwise evoke sexual arousal.

Another kind of cognitive reaction, that of 'cognitive avoidance', is "the avoidance of erotic thoughts and feelings that are stressful to the person concerned, so that his awareness of this disturbing material is to some extent reduced" (Jehu, 1979, p. 47). The avoidance may range from slight desensitization to physical stimulation and ensuing pleasurable feelings to a situation where erotic sensations and feelings are totally lacking - a condition referred to as 'sexual anaesthesia'. "The actual process of 'cognitive avoidance' may be under the conscious and voluntary control of the individual, or in varying degrees it may operate involuntarily and without his awareness" (Jehu, 1979, p. 47).

It should be noted that, as yet, it is unknown why some individuals' sexual functioning is impaired by the aforementioned types of stress, while others are left virtually unaffected. Given this fact, individual variations can only be identified via careful assessment by the therapist.

#### Partner Discord

Sexual dysfunction and marital discord seem to be related in some couples. Whether the dysfunction caused the discord, the opposite, or perhaps most probably a reciprocal causal relationship existed between the two problems is unknown (Jehu, 1979; Kaplan, 1974).

What is known is that various factors in the relationship itself can have an ultimate effect on the sexual relationship. Many behavioral writers (Jacobson and Margolin, 1979; Jehu, 1979; Stuart, 1969) have suggested that marital discord arises from some failure of reciprocal positive reinforcement between the spouses. This conceptualization is useful as a general framework; but, in addition, some patterns of marital discord are seen to be commonly associated with sexual dysfunction.

It has been noted that rejection of a partner who is perceived to be unattractive or disliked is one of the most frequent causes of female orgasmic dysfunction (Masters and Johnson, 1970). The same feeling of distaste by a man for his mate, could cause him to have various male specific dysfunctions. In either case, the rejecting partner may desire to terminate the marriage, thereby causing a source of anxiety in the sexually dysfunctional couple (Jehu, 1979).

Dominance-submissive conflicts (Harbin and Gamble, 1977; Jehu, 1979) have also been known to affect partner discord. Whether the spouses compete for dominance in the marriage; or the conflict stems from one partner's desire for his/her mate to take an assertive position to their submissive, hostility and friction can result.

When one partner suffers from some form of sexual dysfunction, this can "contribute to discord between the spouses, sometimes with additional adverse effects on the sexual capacity of either or both of them" (Jehu, 1979; p. 52). An example of this can be seen in the case of vaginismus presented in Part IV:C. In this particular instance, the husband believing that his wife no longer loved him as much as in times past (evidenced to him by her inability to respond to him sexually) tried to gain reassurance that this really wasn't the case by making sexual

advances. These advances, however, only served to exacerbate her difficulty. Feelings of frustration, resentment, anger, and rejection were accelerated in both parties.

These stated feelings, as well as aggression, fear, humiliation, anxiety and others can prove disruptive to the process of becoming sexually aroused. Though the precise physiological mechanisms involved in the disruption of sexual arousal by emotions are currently unknown, the effects have been known to disrupt sexual behavior (Jehu, 1979).

To conclude this discussion on the stressful nature of marital discord, it seems clear that such conditions as deficient reinforcement, partner rejection, dominance-submissive conflicts, and the existence of sexual dysfunction in a spouse, may involve negative emotions that are likely to evoke stress reactions in some of the individuals exposed to them (Jehu, 1979).

#### Psychological Reactions to Organic Factors

The organic factors discussed earlier in this section, as it was noted, constitute possible sources of psychological stress. The aging process, physical illnesses, surgery and drug effects that, in and of themselves, caused minimal or transitional impairment of an organic nature can be greatly exacerbated if they evoke reactions such as performance anxiety, avoidance and spectating (Jehu, 1979).

The normal organic changes in the sexual response cycle of the older person, discussed at some length in Part 1:A, can cause sexual difficulty. If the man or woman believes in the cultural stereotype of the older person as sexually impaired (Masters and Johnson, 1970), then they may view the decline in their sexual abilities as indicative of a continuing trend. Reactions of avoidance, fear of failure and of

and of declining attractiveness, performance anxiety, depression, spectating, of becoming devoid of sexual interest and incapable of pleasurable sexual performance may result in the incapacity that he/she fears. In fact, studies (Vankeep and Gregory, 1977; Christenson and Gagnon, 1965; Martin, 1977; Pfeiffer, 1974, 1975; Kinsey et al. 1948) have shown that there is no indication that the normal aging process should necessarily disrupt or terminate pleasurable sexual performance in a healthy person.

"The organic changes involved in a physical illness are sometimes entirely responsible for any associated sexual dysfunction, but in many cases this is the result of an interaction between these changes and the individual's psychological reactions to them" (Jehu, 1979, p. 57).

Some of the many psychological reactions to illness and surgery that can impair sexual behavior are: anticipation of harm, anticipation of failure, depressive reactions, impairment of self-concept, rejection anxiety partner discord and avoidance reactions. It is beyond the scope of the paper to discuss any of these aspects in depth and the reader would be directed to explore Kolodny (1978), Jehu (1979), and Polivy (1977) for further information in this area.

The effects of medication prescribed for a physical or psychological illness may wholly or in part be responsible for an associated sexual dysfunction. This may be a direct effect of the drugs as discussed earlier in this segment under organic causes; or it may be from the individual's psychological reactions to them (Jehu, 1979). "Thus, a temporary or partial impairment during the administration of tranquilizing, antidepressant, or antihypertensive medication, may be prolonged and exacerbated if it elicited performance anxiety and other stress reactions" (Jehu, 1979, p. 60).

Psychiatric syndromes and sexual dysfunction do exist in some individuals; but, there is not an inevitable association between the two types of problems (Jehu, 1979). Anxiety disorders seem to have little

effect on sexual functioning (Winokur and Holeman, 1963); while depressive disorders have been implicated, via anecdotal accounts, in the impairment of sexual interest and performance (Jehu, 1979). Only in the case of hysterical disorders has empirical study demonstrated an association between this syndrome and sexual functioning, although they are not invariably linked (Winokur and Leonard, 1963). In various studies (Purtell et al., 1951; Winokur and Leonard, 1963; Kinsey et al., 1953) it was found that women with a diagnosis of hysteria had sexual problems that included sexual indifference, absence of sexual pleasure and dyspareunia. The incident rates of these problems ranged from 76% to 98% in hysterics as compared to 7% - 15% in healthy controls, and 52% in the medically ill controls.

Individuals who have had false or deficient information transmitted to them about sexuality, may find that their ignorance and misconceptions can contribute to sexual dysfunction. Previous learning conditions, such as traumatic experiences, a restrictive upbringing or adverse family relationships can deprive people of sufficient knowledge about sex. The provision of adequate information may only evoke avoidance reactions such as ignoring, distorting, forgetting, or failing to discuss material with their partner, in the stressed individual (Jehu, 1979). The most common sources of false or deficient information are discussed in Part III in the context of the provision of information during interviews.

The lack of adequate and appropriate stimulation for the achievement of satisfactory arousal and orgasm may be the cause of dysfunction in some clients. Sheer ignorance, the avoidance of stressful physical activities, and the deliberate withholding of sex as in an act of aggression have all been known to contribute to the aforementioned

difficulty. Clients with special needs (i.e., the handicapped, people with unconventional activities, etc.) may require specific advice re: how to manage their particular situation.

Having given an overview of human sexual response, the various sexual dysfunctions, and their causes and maintaining conditions; it becomes evident that sexual functioning results from a complex interaction of a variety of organic factors, previous learning experiences and contemporary conditions. In the subsequent sections, the implications of this etiological approach for the assessment and treatment of sexual dysfunction are examined.



PART II ASSESSMENT AND EVALUATION

### A. Assessment

The assessment process for sexual dysfunction entails the specification of the client's problem(s) and the contemporary conditions that influence them. In addition, the therapist should ascertain the resources available for treatment; select and specify the goals; and plan a suitable treatment plan prior to proceeding into the intervention phase.

#### 1. Assessment of Problem(s) and Resources

Meeting the above stated directives was simplified for the writer due to the existence of a clearly established assessment process at the Sexual Dysfunction Clinic. This process began with all referred clients being screened at an intake interview by the director of the clinic, Dr. D. Jehu. Dr. Jehu initially assessed whether 1) the client needed treatment outside of this specialty clinic; 2) the client did not need treatment at all; or 3) the client had been appropriately referred, and therefore could be accepted into treatment at the Sexual Dysfunction Clinic. The cases that were approved were then assigned to the appropriate therapist (in this case, the writer).

Once the case was assigned, the writer did a detailed behavioral assessment of the client(s)' difficulty(s) (see Appendix B for an outline of the assessment format). This outline was used as a reference point from which categories were selected and sequenced to suit individual clients and their partners. In addition to this checklist, the writer had at her disposal another guideline (see Appendix C) that summarized the salient points to consider when formulating the problem, selecting the therapeutic goals, and planning treatment.

During the assessment interviews, information was gathered about all aspects of sexual functioning that was judged to be inadequate by either partner or some other relevant person, such as the referral agent or therapist. (Jehu, 1979). The information gathered covered the nature, frequency, timing, and surrounding circumstances of the problem as it existed at the time of the interview; as well as its duration, onset and course up to that point (Jehu, 1979). A brief description of each of these aspects ensues in the following paragraphs.

The nature of the problem was explored in considerable detail. A specific and comprehensive description of the dysfunction was obtained in clear operational terms that included the emotional and cognitive aspects of the problem, as well as its overt behavioral manifestations.

Information was gathered on the frequency and timing of the current problem; as well as the rate of occurrence of the dysfunction, (i.e., whether it occurred during every sexual encounter or only on certain occasions), and the timing of the problem per se (i.e., a complaint of inorgasmia may be related to the duration of stimulation that the client had received in the past, or a person with erectile difficulties might have problems as soon as he becomes aroused or only after some longer interval of time).

The surrounding circumstances (discussed in greater detail in the section devoted to contemporary influences on problem(s)) were explored for significant relationship to the sexual dysfunction. For instance, the influence of the physical setting and a particular partner are examples of circumstances that affected sexual activities for some of the writer's clients.

As far the duration of the problem, it was either 'primary', in the sense that it had always existed, or 'secondary' in that at some time

he or she "had been able to function adequately in that particular respect" (Jehu, 1979, p. 176). The onset of the difficulty, especially in the case of secondary problems, was usually significant. To assist in determining onset, it was important to determine the "circumstances of their onset, including the age of the client at the time, whether the problem developed suddenly or gradually, any possible precipitating factors and the reactions it evoked in the individuals concerned" (Jehu, 1979. p. 176).

Finally, information was gathered on the course of the problem since its onset. Fluctuations in the problem necessitated the exploration into the factors accompanying these variations. Such factors as the 'global', whether the problem existed in all situations and under all circumstances, versus the 'situational', whether the sexual dysfunction only occurred with certain people or in certain locale or at certain times etc., aspects of the dysfunction (Schover et al., 1982) were explored to yield clues as to the determinants of the problem. Fluctuations in the problem, for example, due to organic conditions, partner discord, or previous attempts to solve the problem either by the couple or through earlier therapeutic interventions assisted the therapist to pinpoint the causal nature of the sexual disorder.

The contemporary influences on the problem(s), as can be seen on the checklist (Appendix B), were further explored under the headings of situational antecedents, organismic variables and situational consequences. The information gathered maintained the precision and reliability of the whole assessment process via its being collected and defined in very specific and operational terms. The information, though contemporary, was partially derived from an historical examination of the client's previous learning experiences of the kind discussed in Part 1:C and in the latter part (pp. 4-6) of the checklist (Appendix B). These previous experiences, at times, constituted "useful sources of hypotheses

about possible contemporary influences on the problem" (Jehu, 1979, p. 1978). As well, these experiences were used to check similar hypotheses derived from an assessment of the current situation (Jehu, 1979). For instance, a traumatic experience in the past could suggest that a client anticipated some harm in a sexual encounter in the present; but, a thorough investigation of this possibility would have to be undertaken, for it would not be an inevitable consequence of previous sexual trauma (Jehu, 1979).

The three categories of contemporary influences that might affect the sexual problem were individually assessed. The first category, situational antecedents, referred to "those environmental conditions that immediately" preceded "the sexually dysfunctional behavior, and which" served "to promote its occurrence" (Jehu, 1979, p. 178). Thus, certain features of the sexual encounter itself, the partner with whom it was undertaken, its timing and setting and any concomitant stresses of a non-sexual kind are examples of such situational antecedents (Jehu, 1979).

Variables that functioned within the individual and influenced how he/she responded to external conditions, at times, affected the sexually dysfunctional behavior. Such organismic variables as the individual's thought processes, emotional feelings and organic states had the ability to impair sexual performance.

Lastly, situational consequences or those environmental consequences of the problem which served to maintain and exacerbate its occurrence were a group of influences that were explored. The reactions of a partner to the sexual dysfunction; as well as the secondary benefits to be gained by the dysfunction - for the client - were seen to be particularly important instances of such consequences.

Following the assessment of the problem and its contemporary influences, the assessment of potentialities and limitations of resources was undertaken. These were considered in three broad categories according to whether they related to "the client's environmental situation, to the client personally, or to the professional therapist and the services" at his/her disposal (Jehu, 1979, p. 179).

Briefly, the situational resources available to a client were examined. These potentialities and limitations of the client's sexual partnership were evaluated. The quality of the general relationship between the partners, at times, was seen to be problematic. In such instances, the therapist was faced with the choice of offering treatment which was directly focused upon the relief of the dysfunction, or marital therapy aimed at improving the general relationship between the partners. The former type of treatment was composed of components drawn and from those outlined in Part III, while the latter followed the writer's theoretical orientation (Jacobson and Margolin, 1979; Paolino and McCrady, 1978; Rogers, 1972). In this practicum, three clients marital relationships were seen to be of a problematic nature. The therapist initially chose to focus on the sexual discord in order to draw out and exemplify the problems in the marital union. The writer attempted to delineate for the clients how their sexual difficulties were oftentimes a battleground for much larger issues (i.e., inability to be assertive, feelings of hostility, fear, lack of emotional intimacy etc.). Once the clients recognized for themselves these larger issues, the focus of the therapy became twofold. The major focus of intervention was to clarify and work upon issues of contention in the dyadic relationship apart from sexual matters. The secondary focus was to continue sexual therapy. The

sexual therapy was either contracted with the couple to continue on a simultaneous (in 2 cases) or on a separate (in 1 case) course than the general relationship therapy. The decision for marital and/or sexual intervention was based on the writer's evaluation of the severity of the marital discord; with very problematic relationships precluding sexual therapy.

The availability of a partner to the client proved to be significant to the degree of progress he/she could make in treatment. Three clients who did not have regular partners were unable to generalize their personal sexual growth to the couple's situation. These people were instructed by the therapist, should they form sexual unions at a future time, how to continue their sexual exercises in a couple context. The psychological implications of partner involvement were discussed in very general terms given that these clients had to assess their reactions to hypothetical situations.

The therapist, herself, chose to work with the clients and their partners whenever possible. This preference grew out of her feeling that the clients progress was limited, at some stage of treatment, unless the client was unable to test out their sexual competence with a partner. Also, without this direct experience, obstacles that arose in the client's sexual functioning with a partner would not have become evident during individual treatment.

In the case of the three clients without partners or regular partners some deficits of heterosocial and performance skills were in evidence. These deficits in social adequacy and/or the inability to implement these to relate to a potential partner were focused on by the therapist. She either attempted to work with the client, via role-

playing, to develop their social skills (Barlow et al. 1977; Heimberg et al, 1977); or she referred them to social skills and relationship skills groups being run at the Psychological Services Centre. An attempt was also made to build up the sexual confidence and competence in individual clients by deploying any of the procedures outlined in Part III. These included "the provision of information, modification of attitudes, self-stimulation assignments, relaxation, desensitization",..... "phantasy training"....and ancillary physical treatment" (Jehu, 1979, p. 185).

Sexual dysfunction in both partners was not an uncommon occurrence. Masters and Johnson (1970) found that 43.7% of the couples they treated had bilateral sexual inadequacy. Such combinations of dysfunction in both partners affected the therapeutic resources that had to be provided for each partner; as well, they needed to be taken into account by the therapist when planning treatment. The writer found that out of 8 partnered clients - 6 of whom had regular sexual partners, and two who had partners for a portion of the time that they were in treatment - 3 out of the 8 partners experienced secondary dysfunctions of arousal, intromission or ejaculation. An additional 3 partners experienced a lack of interest in sexual activity that was of a secondary and situational nature.

Finally, socio-economic resources were considered for their impact upon treatment. For instance, the writer found that couples' work commitments did not permit them sufficient time together to perform the sexual assignments in a relaxed and intimate atmosphere; while others lacked privacy due to the intrusion of young children etc. These aspects, as well as others, were seen to be important when assessing the situational resources for treatment.

The personal resources of both the main complainant and of his/her partner were assessed. Very succinctly, these resources included the

partners degree of motivation and its influence on their cooperation, persistence, and their response in treatment (for further information on this area see Jehu, 1979). The organizational capacity of the clients; their educational and socio-economic levels; their religious and moral beliefs; their physical and mental health status; and any unconventional sexual variations that either or both partner practised were also explored in-depth during the assessment period (Jehu, 1979).

Lastly, the professional resources relating to the therapist and the services at her disposal were appraised for each client. The procedures for the treatment of the client's problem were drawn from the pool cited in Part III. The therapist also had at her disposal a very competent advisor, Dr. Derek Jehu, who readily shared his knowledge and skills with her throughout the therapy process. The writer also had the good fortune to have access to related experts (i.e., urologists, gynecologists, psychologists, etc., again through the auspices of the Psychological Services Centre and Dr. D. Jehu) to whom clients could be referred when the writer thought that consultative or an alternate therapeutic strategy was needed.

## 2. Selecting Goals and Planning Treatment

Once the assessment process was completed, the writer initially determined the feasibility of the client(s) seeking sexual counselling. In some instances, for example, the case presented in Part IV - Erectile Dysfunction, it seemed more appropriate to refer this client to an urologist for medical evaluation before proceeding with psychological intervention. As the writer had hypothesized, this man's erectile problem was ascertained by the medical practitioner to be organically

based. Psychological counselling would not have been able to assist this man in regaining his erectile ability. Thus, it can be seen that in this instance, a direct attempt to treat the sexual dysfunction would not have the most suitable therapeutic strategy.

After this preliminary point was established, that is whether or not a program of behavioral treatment focused upon the sexual dysfunction was the most appropriate therapeutic strategy for a client, the goals of treatment were determined.

The goals were directed upon the alleviation of the sexual dysfunction. They were formally conceptualized as "the reduction of problematic responses and the promotion of more acceptable alternatives, in specified sexual situations" (Jehu, 1979, p. 194). The responses that were changed were of an overt, emotional or cognitive kind (See Part 1, B and C).

The goals of therapy were selected by the client, his/her partner where applicable, in consultation with the therapist. It was necessary, to establish mutually agreeable goals that did not breach personal, social and/or ethical grounds.

When the goals of treatment had been selected they were operationalized in clear, concrete, measurable and/or observable terms (Bloom and Fischer, 1982). This applied equally to the overt, emotional, and cognitive aspects of the goals. Thus, for instance, the overt aspects of inorgasmia were specified in terms of adequate vaginal lubrication, orgasmic contractions, etc. The emotional aspects were specified in terms of the woman's verbal and written reports of enhanced excitement and pleasure during sexual encounters. Finally, the cognitive aspects were specified in terms of similar reports indicating that the client no

longer monitored her own sexual responses; and that she now had a more realistic perception of her own sexual performance.

The next stage was to draw up a treatment plan that reflected the behavioral formulation and the selection of goals (Jehu, 1979). This included the decisions concerning the "provision of therapists, the setting and timing of treatment, and the choice of procedures to be employed in certain combinations and sequences" (Jehu, 1979, p. 197).

The writer worked individually with her clients out of the Sexual Dysfunction Clinic at the University of Manitoba. The clients were seen on a weekly basis, for 1- 1 1/2 hours per session. The assessment period entailed 3 interviews, on average, during which the client (and partner were applicable) were made aware that this time was available to them and to also assess the therapist. The client was given the opportunity to become an involved customer; thereby becoming an active participant in their own therapy from the onset. It was also the writer's intention that the clients be made to feel that risk-taking and a free flow of communication were acceptable in the interview session. This she attempted to do via the aforementioned consumer involvement; open, frank discussion of the writer's therapy approach; use of test material, etc.; and the use of personal example where appropriate.

Once the assessment was completed, a detailed report (following Appendix B) was written up; causal explanations were hypothesized and an individualized treatment plan was formulated. The preceding information was shared with the clients along with all paper/pencil instrument results (see Evaluation). A review of the possible treatment programs was then given the clients. The components of the program were covered, as were its timing, the respective roles of the clients and

therapist and some indication of its likely progress and outcome. At this point, the clients having been made fully aware of their treatment options, were asked to make a decision re: their commitment to therapy. All of the writer's clients negotiated treatment contracts and remained committed and involved in this process.

The selection of the components for an individualized treatment program were made on the basis "of their suitability for a therapeutic task, their acceptability to the clients and the 'therapist', their feasibility in terms of the available therapeutic resources, their probable efficacy in achieving the goals of treatment, and their efficiency in utilizing therapeutic resources" (Jehu, 1979, p. 205). These components (as seen in Part III) were largely drawn from Jehu's (1979) behavioral approach to treatment of sexual dysfunctions. This mode of intervention was the framework for the therapy done with the clients cited in this practicum report. Four other programs were also implemented in concert with this approach. Heiman's et al. (1976) program for inorgasmic women was the treatment of choice for clients exhibiting this difficulty. For clients that had disorders of sexual interest and/or desire, Kaplan's (1979) psychosexual program was implemented. Male disorders were treated following Zilbergeld's (1978) program; and finally, women who have been sexually abused with resulting sexual dysfunctions were treated following Jehu's (1982) treatment approach. All of these ancillary programs had behavioral components and were compatible with Jehu's (1979) approach.

The components of treatment were sequenced in a series of intermediate steps to the ultimate goal of treatment. The program was graded in such a manner that the client was "not traumatized, precipitated into avoidance or escape reactions" (Jehu, 1979, p. 206). An example of this graded approach is the program cited in Part IV-Section B, for the client

who had a phobia reaction to sexual involvement. This woman who had been unable to participate in sexual activity without a complete loss of memory, was able to consecutively achieve her goal of tolerating sex with total recall by: self-stimulation, genital stimulation by her partner, intercourse which she initiated and finally via mutually initiated sexual activity.

As the suitable treatment program was systematically monitored during the treatment, thought was given to generalization and maintenance of therapeutic gain. The writer was not in a position to provide long-term follow-up to clients due to the limited time frame of her practicum (Sept. '82 - May'83). Therefore, the therapist attempted to help the client become his or her own therapist via having them regard treatment as a training in self-management (Jehu, 1981).

This viewpoint was stimulated by impressing upon the client that he or she was fundamentally responsible for changing his or her own behavior. The client was taught to think about his or her behavior in a manner that could be applied to problems that could arise in the future. The client was then taught means of changing his or her behavior, via new knowledge and skills, that could be used in the absence of the therapist should the client note any indications of impending difficulties. The writer also tried to emphasize that improvement was a function of the client's own efforts, "thus enhancing the perception of effective self-control and the self-attribution of change" (Jehu, 1981, p. 18). Finally, a good treatment program that altered 'natural contingencies' in a client's life situation had the potential to aid in maintaining therapeutic gains (i.e., by altering interaction patterns with significant others or by facilitating the transition to new environments) (Jehu, 1981).

The focus of treatment was for the client to develop coping strategies for classes of problems rather than specific difficulties. They were, hopefully, given the skill and the assurance, by the writer, to feel that they had acquired ways of changing their behavior that could be applied to future problems that might not be identical to the difficulties which led them to seek therapy.

#### B. Evaluation

The progress and outcome of treatment was systematically monitored and a continuous basis throughout the assessment, implementation and follow-up stages (Jehu, 1982). This was accomplished via the use of a multi-modal evaluation program which included the use of pen and paper instruments, the interview, client self-reports, physiological measures, and archival records. The information that was accumulated from the above mentioned evaluation program was used to a) give feedback to the client(s); b) ferret out any need for the revision of treatment; and c) aid in the demonstration of effective service (Jehu, 1982).

Evaluation was begun by first specifying the goals for treatment and the mode of intervention. The goals were operationalized in clear, concrete, measurable, and/or observable terms so that it would lead to a more precise selection of measures and intervention methods, clearer evaluation of results, and, hopefully, the provision of a more effective service (Bloom and Fischer, 1982). The specification of treatment objectives, that were negotiated with the client, stemmed from the primary goal. For instance, if achieving a subjectively enjoyable orgasm was the treatment goal; then this was further broken down to include how the orgasm would be attained (i.e., via self-stimulation -

manual, oral, coital and/or the use of a vibrator). With the above stated goal in mind, the objectives were specified in terms of: a) the client reporting on her increased physiological responses to self and partner stimulation (i.e., degree of vaginal lubrication, nipple erection, increased heart and/or pulse rates, etc.) (Jehu, 1979; Heiman, 1976); and b) the client reporting on her psychological responses to increasing physical responsiveness (i.e., increase in desire level, tracking her positive emotions and cognitions, etc.).

Due to the ethical question of the therapist actually observing a client's sexual activity, it was doubly important that the objectives to be evaluated be clearly defined, concretized and made measurable to the client. The reason for this was the first hand information about the occurrence of target responses in the natural setting came from the subjective observations and evaluations of the client (and where applicable, the partner). It was, therefore, imperative that the client (and partner) be able to report responses as reliably and consistently as possible. Of course, reactivity - whereby the very act of asking the client to observe his/her own behavior might influence his/her responses (i.e., spectating) - was always a possibility. The client and partner were placed in the unique position of being both client and trained observer for themselves. Therefore, with as much care as the therapist would have taken to train staff observers, the client was made aware of the definition of the behavior to be observed, whose behavior was to be recorded (in the case of the partner accurately observing the client's responses), how it was to be recorded, when, where, and for how long (Bloom and Fischer, 1982). The client's log, as well as the activity

checklist (where applicable), also monitored physiologic and psychologic objectives.

The specification of the intervention used for the treatment of a sexual dysfunction was chosen from the packages and/or components that have already been outlined in Part III. What can be reiterated at this point is that the wide range of treatment options (Jehu, 1979, 1982; Helman, 1976; Zilbergeld, 1978; Kaplan, 1979) allowed for a great deal of flexibility in the therapy format. This permitted the writer to both adapt the program to the individualistic needs of the client and to revise the treatment program where indicated.

Once the objectives of the intervention were specified, target (or dependent) variables and independent variables (the treatment program) were identified. Following the example given for the dysfunction of inorgasmia, the independent variable in this case would be Helman's (1976) program for inorgasmic women. The dependent variables could be: 1) reaching orgasm; 2) sexual arousal (levels); 3) sexual desire; and 4) sexual satisfaction.

In order to evaluate these variables throughout the therapeutic relationship, any or all of the methods cited in the multi-modal evaluation program could be used. A brief description of these various methods of evaluation ensues in the following paragraphs.

#### 1. Methods of Evaluation

The instruments used to measure change were selected on the basis of several criteria. First, the purpose of the instrument had to be appropriate to the nature of the problem or variable as well as to the specific client group. Furthermore, in examining the instrument itself,

its directness, sensibility to change, reliability, validity, and utility (i.e., ease of administration, quality) had to be favorable (Bloom and Fischer, 1982).

After considering these criteria, as well as the dependent variable to be evaluated, a multi-modal evaluation program was selected. The multi-modal evaluation program had several advantages. First, the instruments reviewed for this purpose exhibited certain strengths and weaknesses, and their combined use gave the therapist greater confidence that the improvements were real and reliably checked. Second, the multi-faceted nature of the target problem often indicated the need for several measures to represent all of these components. This was especially important when both target and secondary variables have been identified for measurement. Third, the instruments were selected to measure both the overall change in the clients' sexual functioning as well as the daily (and weekly) changes in more specific aspects of the problem (such as client perceptions, thoughts, and feelings). Fourth, the combination of instruments included both obtrusive and unobtrusive measures in order to reduce the potential for bias in the responses due to client reactivity due to the act of recording (Bloom and Fischer, 1982).

On these bases, the following methods were selected (as indicated) to measure change in the clients' sexual functioning:

1) (i) Paper and Pencil Instruments

- a) Sexual Arousal Inventory (Hoon et al., 1976) (Appendix D)
- b) Sexual History Form (Schover et al., 1980) (Appendix E)
- c) Index of Sexual Satisfaction (Hudson et al., 1981)  
(Appendix F)
- d) Dyadic Adjustment Scale (Spanier, 1976) (Addendix G)

- e) Semantic Differential Scale (Whitehead and Mathews, 1976) (Appendix H)
  - f) Erectile Difficulty Questionnaire (Price et al., 1981) (Appendix I)
  - g) Goals for Sex Therapy Scale (Lobitz and Baker, 1979) (Appendix J)
  - h) Beck Depression Inventory (Beck, 1981) (Appendix K)
- 2) (ii) The Interview
  - 3) (iii) Client (self) Reports/Activity Checklists (Appendix L)
  - 4) (iv) Archival Records
  - 5) (v) Physiological Tests
- (i) Paper and Pencil Instruments

Paper and pencil instruments, such as the questionnaires, inventories, scales, and test mentioned above, were useful in the evaluation program. These standardized instruments tapped a wide range of client problems in a somewhat more objective manner than the interview. The paper and pencil instruments were often less expensive and easier to administer than interviews; and the data collected could be coded, quantified and perhaps subjected to a statistical analyses (Jehu, 1982).

Sources of errors and biases do afflict paper and pencil instruments. For instance, clients may misunderstand questions and answer accordingly; or response sets - such as social desirability and compliance - are likely to influence the data (Jehu, 1982). For these reasons, instruments were coupled with other evaluation forms to strengthen the overall program.

The instruments used in this practicum were examined for their directness, sensitivity to change, reliability, validity and utility.

These factors, as they pertain to each instrument, can be reviewed in the attached articles included with the measurements in Appendixes D through K.

(ii) Interviews

The interview was probably the most frequently used evaluation method. Among its advantages were:

- "a) the provision of information that "was" too subtle to be elicited by other modalities, such as paper and pencil instruments, and
- b) its comprehensiveness and flexibility, so that promising lines of inquiry 'could' be pursued by the therapist" (Jehu, 1982, p. 12).

On the other hand, interviews were also prone to several sources of bias. For instance,

- "a) various therapist and client characteristics - such as interviewing skills, personal qualities, and demographic factors - "could" lead to biased information,
- b) subjective selectivity and interpretation of client responses by the therapist "was" a further possible source of bias,
- c) other sources "included" various response sets such as social desirability or compliance with what the client "perceived" the therapist would like to hear" (Jehu, 1982, p. 12). The

interview generated a broad spectrum of information; some of which might not have been revealed by other methods. However, since they were subjective and susceptible to numerous biases it was advisable to supplement the interviews with additional methods of evaluation (Jehu, 1982).

(iii) Self-Monitoring

The client was instructed to maintain a (daily) record ("Client log") of sexual activity and the thoughts and feelings which occurred simultaneous to it. For example, again keeping to the case of inorgasmia, the client's records described her attempts to do the sexual assignments (pleasuring, sensate focus, etc.) and perhaps her thoughts and feelings, in reaction to them. The purpose of these records was to

more closely measure the client's (behavior) change as well as the cognitive and affective responses (and changes) during the program.

Self-monitoring is widely used as an inexpensive and practical measure for collecting data which are otherwise known only to the client (non-observable or private). It has also been asserted that self-monitoring is therapeutic, in itself, by making the client more aware of certain cognitive and emotional reactions to sexual activity, which she may otherwise be unaware.

Client records were kept as a written diary, unless he/she had difficulty expressing him/herself, in which case an activity checklist was provided. The client was instructed to use the logs for greater accuracy. A verbal contract was enlisted to increase his/her commitment to this measure. As well, the importance of the log in the treatment program was impressed on the client.

The problems encountered in the use of this measure are common to paper and pencil instruments. The client may neglect to record this information daily, as instructed or may respond according to his/her perceived notion of social desirability or therapist expectations. It is noted that these problems are somewhat compensated by verbal reports by client and partner during interviews (Bloom and Fischer, 1982).

#### iv) Archival Records

Archival records were usually provided by physicians upon referral to the Sexual Dysfunction Clinic. These records varied in detail and length; and described the medical background of the client, especially any problems which might have been relevant to therapy. When these were not provided, the therapist requested a medical examination and provision of medical records, if considered appropriate to the presenting problem

and details of the case (Bloom and Fischer, 1982).

v) Physiological Measures

"The major use of these techniques in the assessment of sexually dysfunctional clients" was "to measure directly the physiological aspects of their sexual arousal by means of penile or vaginal plethysmography" (Jehu, 1979, pp. 223-224). The techniques and instruments available for the measurement of erectile responses in the male are reviewed in Jehu, 1979. The penile plethysmograph test was used, in the writer's practicum, to differentiate a case of organic impotence from those of psychogenic or mixed origin (see Part IV, F). This particular test was administered to the client by an urologist at the Health Sciences Center. A marked discrepancy was not seen to exist between this client's erectile capacity during sleep and in the waking state thereby indicating an organic aetiology.

Vaginal plethysmography is a physiological test commonly used to measure vaginal vasocongestion (vaginal blood volume during arousal) when organic causes for sexual dysfunction are suspected. The device, itself, consists of a vaginal probe with a light source at one end and a photo detector cell on the side. It measures the amount of light reflected from the walls of the vagina, which changes with the degree of vasocongestion during sexual arousal. The probe can be inserted and removed by the client and causes no discomfort when placed correctly.

This device was not used in the writer's practicum; however, it has obvious benefits in accurately measuring the physiological response during arousal (therefore is less vulnerable to error or bias). It does require testing in a medical setting and may involve time lags that delay therapy (Jehu, 1979).

## 2. Evaluating the Outcome of Treatment

As the writer did not collect baseline data, nor did she administer her paper and pencil instruments at specified intervals, the outcome data could not really be recorded and presented in the form of a line graph to clients for visual inspection.

Instead, the outcome of the intervention was evaluated by the client, the partner (where applicable), and the therapist in terms of clinically significant behavior change. Two basic methods of determining clinical significance used in this practicum were subjective evaluation and social comparison.

Again, using the example for orgasmic dysfunction, the subjective evaluation method was determined by the client and her partner in terms of their own sexual satisfaction after therapy; their overall (dyadic) happiness; as well as the client's ability to reach orgasm. The social comparison method of evaluation was determined primarily by the therapist, on the basis of the client's ability to have orgasms (after therapy). In this case, the outcome of therapy (reaching orgasm) was compared to the averages for women (as indicated in Frank et al., 1978; and Jehu, 1979), and through the therapist's clinical experience.

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

### Conclusion

The clinical evaluation of the outcome of treatment was intended to serve several basic functions, including: providing feedback to the client; revealing the need, if any, for revising the treatment; aiding in the demonstration of effective service; and contributing to a general body of knowledge concerning the intervention (Jehu, 1982). With this general objective, the intervention was structured and completed with careful attention given to collecting and recording outcome data (to the extent possible in the clinical setting and the writer's limited knowledge of evaluation designs). Had the writer been more familiar with the use of various A-B evaluation designs at the commencement of her practicum, she would have implemented them so that causality could have been determined in the evaluation.

PART III TREATMENT

An overview of the range of components that can be drawn up to constitute treatment programs for sexual dysfunction is presented in this part of the practicum report. These components are selected and utilized to suit individual clients in the planning and implementation phases of treatment. Great flexibility is available to the therapist when formulating a treatment program for a particular client. The components, their sequence in therapy, even the length of time that a particular component is implemented in treatment, is at the therapist's discretion. With certain dysfunctions: inorgasmia, lack of sexual desire, male sexual disorders and female incest victims, specific treatment packages were implemented. Brief descriptions of the components and treatment packages used will be presented in the following paragraphs.

In broad terms, the types of intervention for sexual dysfunction can be broken down under the general headings of: general therapeutic conditions, sexual assignments and specific procedures. Each of these areas will be discussed along with their subdivisions as indicated in Table 4.

The general therapeutic conditions that should be met in the course of the early interviews with clients are: establishing a therapeutic relationship, giving them plausible causal explanations for their dysfunction, and giving a realistic prognostic expectancy.

Clients, often times, enter therapy holding strong adverse beliefs and attitudes about sexuality, their relationship with their partner, their own problem, and/or the therapy itself. These attitudes are often accompanied by feelings such as anxiety, depression, guilt, anger or embarrassment.

TABLE 4 Types of Intervention for Sexual Dysfunction

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General Therapeutic Conditions

Therapeutic relationship

Casual explanation

Prognostic expectancy

Sexual Assignments

General pleasuring

Genital stimulation

Sexual intercourse

Specific Procedures

Provision of information

Verbal

Bibliographical

Audio-visual

Modification of attitudes and beliefs

sanctioning

self-disclosure

role playing

cognitive restructuring

Reduction of stress

Relaxation training

Desensitization

Flooding

Guided imagery

Thought stopping

Modeling

Vaginal dilatation

Sexual enhancement

Classical conditioning

Biofeedback

Hypnosis

Exposure to erotic material

Pelvic muscle exercises

Drugs/hormones

Prosthetic/mechanical aids

Relationship enhancement

Increasing positive exchanges

Communication training

Problem solving training

Assertiveness training

Hetersocial skills training

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In order to modify these adverse attitudes, and to facilitate the whole treatment program; a warm, empathetic genuine relationship between the therapist and clients must be established (Kanfer and Goldstein; 1980; Wilson and Evans, 1978; Jacobson and Margolin, 1979; Jehu, 1979). In addition, if the client feels that the therapist is genuinely concerned with his welfare, then there is likely to be a reduction in the client's demoralization (Frank, 1973). In consequence, the quality of the therapeutic relationship can serve as a powerful influence upon the openness, the communication, the persuasibility and ultimately, the positive change in the client (Jehu, 1981).

A second general condition for effective treatment is the provision of any plausible explanation to the client for their previously thought strange and inexplicable sexual difficulties. These causal explanations derive most benefit when they are described as normal occurrences rather than pathological (Ross et al., 1969); as being of a temporary rather than a permanent nature (Jehu, 1979); and as having arisen from external rather than internal causes (Phares, 1973).

"A third general condition for positive change in clients is that they have some expectation of receiving effective help" (Jehu, 1979, p. 128). If the client has a strong expectation that he will gain relief from his problem, then there is also likely to be a positive correlation with symptom reduction (Jehu, 1979, Frank, 1973). The expectation of help (Frank, 1973); the relief of fear of the unknown when the illness is assigned to its responsible determinants (Wolberg, 1967); the confidence the client has in the therapist; and the treatment procedures all help to formulate a foundation for the facilitation of treatment. However, the deployment of more specific procedures aimed at particular therapeutic targets is also required in most cases.

The sexual assignments, before they are implemented in the treatment process, should be introduced to the clients. The rationale for the procedure(s) as well as negotiating the nature of the assignment should be done with them. They should be reassured that they are learning new skills; therefore, if the assignments seem contrived or artificial this is not a reflection on their personality. Just as they gain expertise in playing the piano with practise; so, will they gain skill and confidence in their sexual performance. At this time it should also be presented to the client that their progress will not necessarily

proceed smoothly or quickly. Setbacks are normal for most clients and this knowledge should prove reassuring to them if and when they have their own setbacks. This should also prove to them that they have not fallen short of any standard and should heighten their confidence in the therapist since he/she was able to predict the client's temporary lack of progress.

The client should also be informed that his/her progress in attempting a sexual assignment will be closely monitored. Thus, as any negative reactions arise, the necessary steps can be taken to circumvent or resolve the obstacles to therapeutic progress. "This may involve any appropriate combination of providing information and modifying attitudes...; the prescription of further sexual assignments, either repetitions in the same or amended form of those already attempted, or others of a different kind; and the use of one or more of the specific behavioral procedures, or physical treatments" that are discussed below (Jehu, 1979, pp. 135-136).

The sexual assignments can be delineated into those for promoting general pleasuring, genital stimulation and sexual intercourse. "The functions of these assignments can be summarized as the reduction of stress reactions to sexual behavior, the promotion of effective sexual stimulation and responses, and the revelation of impediments to adequate sexual functioning" (Jehu, 1979, p. 137).

The assignments, hopefully, are structured to accomplish a host of tasks. They are set up in a non-threatening manner so that stress reactions such as cognitive monitoring, avoidance behavior and performance anxiety are likely to be reduced (Jehu, 1979). They are intended "to promote more effective stimulation and responses, by enabling couples to commence or resume their participation in sexual activities; to experience positive emotional reactions to these activities; to develop positive attitudes of acceptance and liking towards a variety of sexual practices; and to facilitate communication between the partners about their sexual reactions and preferences so that they become more stimulating and attuned to each other" (Jehu, 1979, p. 137). Lastly, the assignments may reveal hitherto unrecognized impediments to the client(s) sexual functioning that will enable the

therapist to modify or extend the tentative formulation of the problem that they made during the initial assessment and to conduct treatment accordingly (Jehu, 1979).

General pleasuring, called by Masters and Johnson (1970) 'sensate focus' exercises, is a procedure employed with a larger proportion of cases. With couples, the therapist has the option of asking them to abstain from intercourse as well as all attempts to bring the partner to orgasm by any other means during the exercise period itself; or during the complete time that the partners are involved in non-coital homework. This decision would depend on the level of stress that sexual behavior elicits in the couple. High stress situations oftentimes can benefit from a period of sexual abstinence because it either excuses the clients from "further stressful attempts a sexual performance" or it "legitimizes their existing abstinence" (Jehu, 1979, p. 138).

The couple are asked to take turns to explore the sensual pleasures of touching and caressing each other's bodies with care and affection. The initial stage excludes breast and genital stimulation; but, the extent to which the clients can expand on this stipulation is left to their own imagination. It is also suggested to the clients that they attempt to ensure their privacy during the pleasuring sessions; that they create an atmosphere that is to them physically inviting (e.g., candle-light and soft music); and that they undertake the exercises when they feel psychologically close to each other.

The couples, that the therapist saw, were at times instructed to structure their sessions (i.e., specific period of time, number of times per week) when previous time commitments, work schedules, or avoidance tactics were interfering with regular performance of homework

assignments. This structuring of homework was used with any and/or all assignments as indicated by client need.

The couples commenced pleasuring at a level that was not displeasing to them. If total nudity was uncomfortable for them or if touching certain areas of the body was distasteful; they were instructed in how to implement imaginal and actual desensitization and/or relaxation training to help them cope with their anxiety reactions to these forms of behavior.

"Couples were advised to pleasure each other for as long as this was enjoyable to them both, but never to the point of fatigue or boredom" (Jehu, 1979, p. 139). They were also instructed to pay close attention to the reactions of their partner as well as their own to being the 'giver' and 'receiver' of the touching exercises.

The rationale for the assignments, as outlined earlier, should be clearly stated to the couples. The positive feelings and attitudes that are elicited from the activity should be reinforcing to the couple, in and of itself. Should obstacles to the therapeutic process be revealed by the pleasuring assignments and reported in the interviews; then, as previously mentioned, the necessary steps should be taken to "circumvent or resolve them by providing additional information, modifying attitudes, utilizing specific behavioral or physical treatment procedures, or prescribing further assignments" (Jehu, 1979, p. 141).

Once couples are able to respond favourably to general bodily pleasuring, then this can be extended to include the breast and genital areas. This segment is gradually approached and incorporated into their couples' sensate focus exercises. They are instructed to move back and forth between caressing the genitals and the rest of the body, with each

partner communicating his or her preferences concerning genital touching to the other. The ban on intercourse remains in force; and the clients are instructed to touch their partner's genitals in a teasing and tender manner meant to "enhance sensual and sexual feelings, while avoiding the vigorous, rhythmic, demanding kind of stimulation that is aimed directly at bringing the partner to orgasm" (Jehu, 1979, p. 141). The rationale and principles for such genital pleasuring are explained in much the same terms as they were for general pleasuring.

The couple may need general information about the structure and function of the genital organs prior to being able to perform effective mutual stimulation. Diagramatic and audio-visual aids can be implemented to assist the clients in this learning process.

Again, just as for the general pleasuring exercises, the genital pleasuring exercises can reduce stress reactions and promote more effective stimulation; or it can heighten stress reactions such as performance anxiety, cognitive avoidance, etc. If any such obstacles are revealed by the pleasuring assignments, then appropriate steps can be taken to resolve these impediments by the means already discussed in the context of general pleasuring.

Given that genital pleasuring, either by self-stimulation or by their stimulation by a partner, is used with regularity in treatment with a variety of sexual dysfunctions; the clients attitudes towards masturbation should be explored prior to prescribing this task. The therapeutic rationale for, and accurate information about masturbation should be given to clients. If they hold negative attitudes towards it; then attempts should be made to modify this.

Genital stimulation is used in programs directed at reducing stress reactions (Jehu, 1979; Beck, 1979; Husted, 1978; Barbach, 1980); premature ejaculation (Masters and Johnson, 1970; Kaplan, 1974, 1975; Perelman, 1980; Kaplan et al., 1978; Zilbergeld, 1978); retarded or absent ejaculation (Apfelbaum, 1980; Jehu, 1979; Kaplan, 1974; Pryde and Woods, 1980; Razani, 1972; McCarthy; 1981) and erectile dysfunction (Kaplan, 1974; Masters and Johnson, 1970; Zilbergeld, 1978; Ellis, 1980; Jehu, 1979).

It is not the writer's intent to outline the modifications or extensions in genital stimulation to which each sexual dysfunction programme makes use. Rather, the reader is invited to explore these adaptations in the previously cited literature.

"A third group of sexual assignments involve some form of penile - vaginal intercourse" (Jehu, 1979, p. 149). For women, these assignments may include Kaplan's (1974) 'non-demand coitus' or her (1975) 'bridge manoeuvre'. In the former case, the woman is first aroused by general and genital pleasuring, and then she adopts the female superior position and inserts her partner's penis into her vagina. The aim of this exercise is for the woman to experience the arousing and teasing vaginal sensations and erotic feelings evoked by her partner's penis, without demands being placed on her to please or perform for anybody else but herself.

The latter case is used for women who can achieve an orgasm via direct clitoral stimulation; but, not be penile thrusting alone. If the couple would like to attain an orgasm via this method, the clitoris is given manual stimulation "until the woman is near to climax, at which point the clitoral stimulation is stopped and the woman thrusts vigorously on the penis in order to trigger off her orgasm" (Jehu, 1979,

p. 150). If the woman's arousal level falls due to the cessation of manual stimulation; the bridge maneuver may be repeated several times before she is able to attain orgasm. Stimulation of the clitoris may be done by the woman, her partner or a vibrator. Also, if the male reaches climax before his partner; this complete procedure may again be attempted at the next opportunity for intercourse.

For men, a type of non-demand coitus is often used for the treatment of erectile dysfunctions. Once the client can reliably achieve an erection by general and genital pleasuring, "the erect penis is then inserted in the vagina where it is contained with only limited movement of a non-demand kind" (Jehu, 1979, p. 150). The purpose of this exercise is to reduce stress reactions to these aspects of intercourse; and to provide the opportunity to enjoy the sensations and feelings arising from the penis being contained in the vagina (Jehu, 1979).

In the case of ejaculatory dysfunctions, the use of the male bridge maneuver can be used for retarded or absent ejaculation as mentioned above. The treatment of premature ejaculation, commonly an extension of the stop-start or squeeze techniques (Semans, 1956; Kaplan, 1974, 1975; Masters and Johnson, 1970) into vaginal intercourse, can be employed extravaginally, and then repeated intravaginally (Jehu, 1979).

Having generally described a range of sexual assignments including general pleasuring, genital stimulation, and sexual intercourse; a review of the specific procedures outline in Table 4 will ensue.

An integral part of the therapist's function is to provide information to the client. This may be in the form of didactic instruction to rectify any deficiencies or inaccuracies the clients may possess in their knowledge of sexual matters that may contribute to their

dysfunction or impede its successful treatment. It may be in a 'reflective teaching' or 'mirroring' manner, as Masters and Johnson (1970) called it, where the therapist objectively restates what the clients say about their difficulties and reactions.

The use of bibliographical material can also be used to instruct clients. References were used by the writer to aid in the provision of information to clients. The women who were treated for inorgasmia read Heiman's (1976) Becoming Orgasmic: A Sexual Growth Program for Women. This book not only outlined the treatment program; but, gave information on the human sexual response cycle and how to communicate sexual preference to one's partner. For men, Zilbergeld's (1978) Male Sexuality, gave a good overview of treatment; as well, it focused on societal sexual myths and men's feelings associated with sexual performance. The writer also gave copies of chapters from these books, and relevant articles to her clients - were applicable - for an expansion of their knowledge on the aetiology and treatment of their particular dysfunction. For women who had experienced sexual assault and/or incest, reading was suggested in Herman's (1981) Father-Daughter Incest, as well as articles by Tsai and Wagner, 1978, 1979; Geiser, 1979; and articles from the Winnipeg Free Press, 1981.

Audio-visual aids were used to supplement the therapist's verbal instruction. In addition to the use of illustrations to demonstrate genital anatomy; films were shown that demonstrated sexual responses and techniques. The two films that were used with regularity were: LoPiccolo et al.'s (1980) film 'Program on Diagnosis and Treatment of Erectile Problems' and Heiman's (1976) film 'Becoming Orgasmic'. These films augmented the bibliographical material and the therapist's input.

They also helped to reduce the client's inhibitions re: speaking about their sexual difficulties. The frank presentation of the treatment of sexual dysfunctions like the client's own, often opened the lines of communication between the sexual partners, and the client and the therapist. Behavior that the client had been reticent or unable to describe was sometimes clearly depicted in the film; thus facilitating the client's explanation of his/her own situation.

The provision of information to the clients in the interview sessions, via the previously stated methods, also helped the partners to feel more comfortable about discussing sexual issues amongst themselves. Talking with the therapist about such matters sometimes had the important spin-off effect of sanctioning, facilitating, and enhancing communication, in general, between the partners.

The therapist is often placed in the position, when he/she is providing information, of discovering certain client attitudes that are impairing sexual functioning or impeding its therapeutic improvement. For instance, some clients may view sex as dirty, degrading, sinful; particular activities as perverse, such as oral-genital stimulation; or hold a high achievement orientation towards sex where the result of the performance is of greater importance than simply relaxing and enjoying the activity.

In addition to holding deleterious attitudes towards sexual behavior per se, the client can hold negative attitudes towards his partner, and visa versa, that affect the sexual problem and its treatment. In such instances, the therapist will have to modify such adverse attitudes to facilitate the whole treatment program. Some of the tools at his/her disposal for accomplishing this task are: sanctioning, self-disclosure, role-playing and cognitive restructuring.

"A therapist who is liked, respected and trusted constitutes an authoritative source of sanction for positive sexual attitudes" (Jehu, 1979, p. 129). This person can give a client the permission and reassurance he needs to regard his sexuality in a positive light. The therapist can impart accurate information that can modify performance oriented or idealistic attitudes towards sex.

Though the therapist's role is not to attempt to change a client's moral or religious beliefs concerning various forms of sexual behavior; he/she can give the clients the permission to practise and enjoy activities that they might have been avoiding due to the guilt and inhibitions associated with abandoned beliefs.

"As a means of conveying sanctioning and promoting positive attitudes in clients, it is sometimes appropriate and helpful for the therapist to disclose his own sexual attitudes and practises (Jourard, 1964)" (Jehu, 1979, p. 130). This technique can be useful to help modify attitudes providing that it is used sensitively and within the context of a relationship of mutual liking, respect and trust. Without these components, the client may simply reject the therapist and his views (Jehu, 1979).

Role-playing is another technique that can be used to change attitudes in the interview situation. "The client is asked to take the role of another person and to present the attitudes of that person in an involved manner" (Jehu, 1979, p. 130). This type of participant role-playing, and this is supported from laboratory studies, produces greater attitude change than passive exposure to the same argument (Goldstein and Simonson, 1971).

Currently, it is unknown exactly why attitudes can be changed via role-playing. A number of factors such as 'public commitment' (Cohen, 1964); and the degree of 'improvisation' it involves for the client (Hovland et al., 1953; Tanis and Gilmore, 1965) have been implicated in the degree of success of this method. In spite of the ongoing theoretical debate, clinically "there are strong indications for the pragmatic usefulness of the technique" (Jehu, 1979, p. 131). As with self-disclosure, unless the client feels confident in the therapist and that there is a mutual liking, respect and trust; the client is unlikely to risk role-playing.

Cognitive or rational restructuring (Beck, 1979; Ellis, 1980; Jehu, 1979; Meichenbaum, 1976; Jacobson and Margolin, 1979; Mahoney, 1974) is based on the premise that a person's beliefs, assumptions and expectations about a situation can influence his emotions and behavior. If the person's beliefs are of an irrational nature, "then they are likely to be conducive to feelings and actions that are inappropriate responses to the situation itself, although they may be quite appropriate to the person's subjective interpretation or labelling of that situation" (Jehu, 1979, p. 131).

When a client's beliefs appear to be relevant to his sexual difficulties then the application for treatment is to persuade the client to think more logically and rationally and thereby to undermine his own disturbances (Ellis, 1962). Towards this end, Goldfried et al. (1974) formulated a set of therapeutic guidelines for systematic rational restructuring. This process is outlined in Jehu's (1979) book, and is only briefly described below.

The first step is to present the rationale for the method to the client. The client's own commonly held irrational assumptions are reviewed and the client is encouraged to present his own arguments

against them. If the client can agree that, in principle at least, that a person's beliefs can influence his emotions and behavior, and that some beliefs are of an irrational kind; then the focus shifts to the client's own thoughts and underlying beliefs evoked by his problem(s).

Extreme assumptions are not disputed by the therapist, rather, the clients are taught to do something different in those situations that cause them to become disturbed. To facilitate rational restructuring, procedural aids such as imaginal presentation and behavioral rehearsal of the disturbing situations are practised during the therapeutic interview, as well as in vivo assignments for the client to carry out in his natural environment (Jehu, 1979).

Another major category of treatment components is aimed at the reduction of stress. Specific behavioral procedures such as relaxation training, desensitization, flooding, guided imagery, thought stopping, modelling, and vaginal dilatation are used to meet this end.

Relaxation training (Jacobson, 1938; Heiman, 1976; Jehu, 1979) is meant to reduce anxiety via the reduction of muscle tension. The basic rationale for this is that if an individual can learn to relax his muscles, then this will be accompanied by some alleviation of the associated anxiety reactions so that a feeling of calmness prevails (Jacobson, 1938; Jehu, 1979).

The actual procedure involves the systematic tensing and relaxing of various muscle groups while learning to discriminate the associated sensations. A person using this system can markedly reduce muscle tension and feel deeply relaxed. The system for progressive relaxation training is presented in works done by Jacobson (1938), Wolpe (1958), Bernstein and Borkovec (1973), Jehu (1979), and Heiman (1976) and the

reader is directed to consult these authors for further understanding of this procedure.

Desensitization is a second method of reducing negative emotional reactions to stress. As the method is discussed at some length in the treatment of sexual phobia Part IV:B, the reader is asked to refer to that section for further elucidation.

"Whereas desensitization involves only gradual and brief exposures to stressful situations with explicit use of an alternative response to alleviate any anxiety reactions that are evoked, the method of 'flooding' consists of more rapid and prolonged exposures to such situations without the deliberate use of an alternative response" (Jehu, 1979, p. 159). The use of such a method is aimed at individuals who avoid or escape stressful sexual situations. These people's avoidance behavior can be so persistent that they never enter or remain in sexual situations where they could learn that these circumstances are really quite pleasant and harmless rather than being aversive or damaging. The avoidance behavior often persists even when there is no risk of aversive consequences because "it is negatively reinforced by an accompanying reduction in anxiety, but also in some cases because it is positively reinforced by certain rewards" (Jehu, 1979, p. 159). The "aim of flooding is to correct this deficiency by exposing the client to the stressful situation for a prolonged period while preventing avoidance and escape responses. As these responses and the associated anxiety reactions are not reinforced during the period of exposure, they will eventually be extinguished by the flooding procedure" (Jehu, 1979, p. 159).

The stressful situation can be presented in imaginal, graphic or real form, and the client must remain exposed to it until a significant reduction in anxiety occurs (Gauthier and Marshall, 1977). Though flooding has not been used with any regularity for the treatment of sexual dysfunction, it could have practical application. For instance, a couple who were embarrassed, uncomfortable or disturbed about being nude

together could be advised to spend prolonged periods with each other undressed, so that any anxiety or avoidance reactions this evoked could thereby be reduced (Jehu, 1979).

Guided imagery is a tool that can be used in various procedures such as cognitive restructuring, fantasy training and in desensitization processes. The client is asked to use his imagination in combination with certain coping skills to reduce any adverse emotional reactions. Thus in cognitive restructuring, having formulated a hierarchy of problematic situations, the client could be asked "to imagine the situation that is least disturbing to him, and to try to discover and speak aloud any irrational ideas that may be contributing to the feelings he is experiencing". He then would attempt "to rationally restructure these ideas, sometimes with prompting by the therapist" (Jehu, 1979, p. 133).

In fantasy training, guided imagery is used in the Flowers and Booraem's (1975) program to augment sexual arousal. The client sharpens his ability to use mental imagery beginning at a point where he looks at an object, then shuts his eyes and describes it in great detail. The person progresses to reading non-sexual literary material and then closes his eyes and tries to visualize the passage with himself in the major role. The client's fantasy skills are honed at the same time that sexual material of a low, mid and high anxiety level are introduced into the client's imaginal material. The sexual fantasies and ensuing excitement levels are then produced to current experiences of attraction.

In desensitization processes, the therapist often uses guided imagery as a preliminary step to 'in vivo' desensitization. In cases where anxiety eliciting conditions would prove too intense in real life; the client could proceed through the hierarchy of these conditions in his imagination. To facilitate imagery in systematic desensitization, fantasy training, and cognitive restructuring; the individual items

should be highly specific, concrete and realistic situations, in which the client has actually experienced anxiety or where he would expect to do so if exposed to him.

Another tool often used when restructuring a client's cognitions is thought stopping. Very succinctly, this process requires that the client, when he becomes aware of negative 'internal sentences' or 'self-verbalizations', consciously stop these thoughts; and that he change them to neutral or positive cognitions. For instance, one client who viewed vaginal lubrication as disgusting was asked by the writer to monitor her thought processes. It soon became evident that she was telling herself (internal sentences) that they were repugnant. She actively incorporated, with a systematic desensitization program, thought stopping; whereby she drew her mental focus away from this negative thought and replaced it with a thought similar to "lubrication is normal and good". In this manner, she overcame her aversion towards a natural somatic function.

Modelling refers to active demonstration - by the therapist, others, audio-visual aids etc. - of alternate forms of behavior, new skills, or techniques etc. to the client. Modelling is an appealing alternative to simple instructions because: it is an efficient way to provide information, for the clients can observe the behavior first-hand; partners will emulate an esteemed model with minimal cost to themselves (i.e., without losing face; Eisler and Hersen, 1973); and modelling provides the therapist with a direct opportunity to demonstrate appropriate communication first-hand (Jacobson and Margolin, 1979).

When modelling is used, the context for the demonstration should be drawn from the client's own situation (i.e., model anger management techniques based on a disagreement the client(s) have experienced). This

way the client's problem-solving skills can be compared to the new techniques; and they can learn that they can communicate more effectively. The therapist should structure the situation so that the clients are actively involved in the learning process via behavior rehearsal and discussions following the modelling and behavior rehearsal segments. (These strategies are presented in Jacobson and Margolin, 1979).

Modelling and behavior rehearsal are not applicable to situations that are of a specifically sexual kind. It is likely undesirable and unethical to contravene their customary private nature by asking the therapist and/or clients to simulate them in the interview session. However, it would not be unethical for the client to view a film whereby appropriate sexual behavior was modelled by the actors involved (as in the instructional films previously mentioned).

Vaginal dilatation is used in the treatment of women suffering from vaginismus (Kaplan, 1974; Masters and Johnson, 1970). After the reality of vaginal muscular spasm is explained to both partners (with some medical practitioners the spasms are also demonstrated to the couple during a physical examination - Masters and Johnson, 1970); the prescribed mode of treatment is the insertion of graded sizes of vaginal dilators (Masters and Johnson, 1970) or the client's or spouse's finger (Kaplan, 1974) into the vagina, over a period of time. The client begins the program with insertion of a very small dilator or part of her own or her spouse's finger into her vagina. When she can tolerate this with less of a spasm, the procedure is repeated with progressively larger dilators, or one finger than two etc., until she can accept an object that approximates the size of her mate's penis.

There is little evidence at present, to suggest that dilators or fingers are preferable; or that the commencement of their use should be by either the woman or her partner (Jehu, 1979). These procedural variables can be negotiated by the therapist with the individual couples concerned.

We now turn from the procedures that have a relative emphasis on stress reduction, to those that are predominantly directed towards sexual enhancement. The latter procedures include classical conditioning, biofeedback, hypnosis, exposure to erotic material, pelvic muscle exercises, drugs/hormones and prosthetic/mechanical aids.

Classical conditioning has been used to enhance interest amongst dysfunctional clients who were bored or indifferent towards sexual activity (Asirdas and Beech, 1975). The procedure was not used by the writer in her practicum because she did not feel that she possessed the theoretical background, nor the inclination to set up the experimental situation to meet the procedure's requirements. Interested readers are directed to review studies done by Asirdas and Beech (1975); Langevin and Martin (1975); Freeman and Meyer (1975); Herman et al. (1974); and McConaghy (1975); for further information in the use of classical conditioning for various forms of unconventional sexual behavior and the promotion of sexual interest.

Another approach that is in the preliminary stage of exploration is the use of biofeedback in the treatment of sexual dysfunction. "The procedure provides the individual with immediate information about his own bodily processes, so that he can exercise greater control over them" (Jehu, 1979, p. 162). Again, since the writer neither had the theoretical background, nor the equipment necessary to monitor bodily

responses, this approach was not used in this practicum. The reader is again directed to studies done by Blanchard and Young (1974); Yates (1975); Hoon et al. (1977b); Rosen (1976)(1977); and Csillag (1977); for the use of biofeedback in the treatment of sexual dysfunctions.

The use of hypnosis has most commonly been used in the investigation, recall and abreaction of traumatic sexual experiences. It also has been used to facilitate the stress reducing procedures of relaxation, desensitization, flooding and vaginal dilatation (Jehu, 1979). Hypnotic suggestion were discussed by Jehu (1979) for its use to promote sexual responses either during the trance state or after it was terminated. This technique was outside the scope of the writer's expertise, and was not implemented in her treatment approach. Again, the reader is directed elsewhere for further elucidation into this procedure (Cheek, 1976; Alexander, 1974; Crasilneck and Hall, 1975; Jehu, 1979).

Exposure to erotic material (Heiman, 1976; Zilbergeld, 1978; LoPiccolo, 1980), it has been suggested, can help a client get into the mood for sexual activity and can enhance feelings of sexual pleasure. Looking at erotic pictures and reading erotic literature can enable a client to become more comfortable with it and can cause arousal (LoPiccolo, 1980). It can help to alleviate boredom in cases where a narrow, rigid pattern of sexual activity has been established by changing the routine (Zilbergeld, 1978). Exposure to erotic material has also been used to enhance fantasy training (Jehu, 1979; Heiman, 1976).

Pelvic muscle exercises have been implemented to increase vaginal sensations and to improve general health and muscle tone. In the film, "Becoming Orgasmic" (Heiman, 1976), pelvic exercises were demonstrated to improve muscle tone in this area. As well, Kegel (1952) exercises have

been found to improve urinary incontinence and have the potential to increase genital sensation and orgasm (Heiman, 1976). The improvement of muscle tone in the pubococcygeus muscle probably increases the blood flow to this area. Increased blood flow has been related to the ease of arousal and orgasm thereby accounting, in part, for the increase in feelings or genital pleasure. A detailed account of the exercise procedure can be found in Heiman's (1976) book.

Hormone or drug therapy has been used to treat impotent males (Cooper, 1972, 1974a; Schiavi and White, 1976), gonadal failure in men (Cooper, 1974a), erectile dysfunction, (Cooper et al., 1973), atrophic vaginitis causing dyspareunia (Greenblatt et al., 1972), and lack of sexual interest and arousal (Greenblatt, 1980; Kaplan, 1974; Jehu, 1979; LoPiccolo, 1980).

The administration of androgens and other substances has generally been conducted to be of little value to impotent males and for the treatment of erection difficulties. Gonadal failure seems to be positively affected by drug therapy; but, the specific or placebo nature of any such effects has not been distinguished. The administration of estrogens to women appears to have little influence on sexual functioning, except when they are prescribed to relieve atrophic vaginitis (Jehu, 1979). In contrast, preliminary evidence suggests that women treated with varying doses of testosterone do exhibit an increase in libido suggesting that desire level can be affected by hormonal level (Greenblatt, 1980).

Certain drugs administered regularly for the management of physical illness, can facilitate sexual activities. Medication taken by cardiac patients, or clients suffering from arthritis etc. can aid in reducing

possible pain that might be experienced during intercourse. The client who exhibits anxiety and fear about the affects of intercourse on their physical illness with the proper medical maintenance, his physical disability - unless otherwise indicated - need not interfere with his enjoyment of sex.

Prosthetic or mechanical aids can be used to assist clients suffering from erectile dysfunction, impotence, certain disabilities, and those who need extended or intense stimulation. Vibrators can be used to enhance stimulation and may therefore facilitate arousal and orgasm in men and women in whom these responses are impaired.

Prosthetic devices may be used in cases of total impotence. Penile implants, various forms of artificial penises, and external penile splints can enable an impotent man to perform sexually with his partner; which may, in turn, have positive repercussions such as rising the client's own self-esteem and possibly improving the relationship between the couple (Jehu, 1979). These and various other devices (i.e., such as penile rings, weighted hollow balls worn intravaginally, various forms of clitoral stimulators, etc.), though lacking systematic evaluation, may play a useful role in the treatment and management of some dysfunctional clients who find the aid acceptable and are able to use it without revulsion or guilt (Jehu, 1979).

A client's sexual functioning can be adversely affected by partner discord; by a client's maladaptive views of male-female roles and deficits in expressive and cooperative skills; and by an inability to communicate and/or to express desires to the partner. In such instances, relationship enhancement may be a necessary part of treatment for the relief of these conditions and the original sexual impairment. Focusing

on increasing positive exchanges, communication training, problem solving training, assertiveness training and heterosexual skills training can improve partner discord to the extent that a couple can work cooperatively on their sexual problem. The reverse, where sexual dysfunction is a symptom of a poor general relationship, can be directly treated at the source with these skills. In certain cases, a single person's sexual dysfunction may be affected by his inability to formulate a lasting partnership (i.e., due to poor heterosexual skills, or severe shyness, etc.). In such instances, treatment might prove beneficial if it focuses on building confidence and skills that could enhance the development of a relationship.

The aforementioned relationship enhancement skills are, for the most part, based on the behavior exchange model (Jacobson and Margolin, 1979). Relationship distress is viewed largely as a function of the rate of reinforcement (and/or punishment) directed by partners toward one another, and the relationship between each person's delivery of reinforcement. It is believed that if high rates of positive reinforcement can be generated between the couple, then not only will the partner's behavior be viewed as more pleasing; but, the degree of satisfaction with the marriage will also be greater. Of course cognitive events, and each partner's appraisal of alternatives to the present relationship can also enter into the equation (Jacobson and Margolin, 1979).

The focus, of treatment is to teach the client(s) a set of relationship skills that they will be able to successfully generalize outside of the situational context of the therapy sessions. The first of these skills could be increasing the positive exchanges between the couple.

Increasing positive exchanges refers to identifying and accelerating those behaviors that would enhance the relationship and paying little attention to the undesirable behaviors (Jacobson and Margolin, 1979; Weiss, 1978; Margolin and Weiss, 1978). The partners first learn to identify important relationship behaviors by monitoring their own behavior and its relationship to the partner's daily satisfaction. An increase in significant relationship behaviors is then engineered with the expectation that relationship satisfaction will also increase. "The overall strategy addresses both the erosion of relationship reinforcement and spouses' abdication of control over their relationship" (Jacobson and Margolin, 1979, p. 188).

The couple's response at this stage is indicative of the flexibility that exists in the relationship. Some couples find that they can solve a great variety of problems by employing positive exchange strategies (explained at some length in Jacobson and Margolin, 1979). More difficult problems may only be ameliorated when further change strategies are implemented.

Communication training is germane to any treatment program for relationship problems. The perspective that was taken in this practicum was a behavioural one, though there is considerable overlap with other orientations. Perhaps the distinguishing characteristics of this approach are the content of the skills which clients are taught, and the procedures of such training.

A behavioral approach to communication training implements a systematic program of skill training involving provision of feedback, instruction, and behavioral rehearsal. The skills taught in a behavioral program follow uniquely from a behavioral exchange model. This is

evident in problem-solving training, a sub-component of behavioral communication training. During problem-solving training, couples are taught "behavioral management skills in order to render them more effective in bringing about desirable behavior changes in the relationship through direct negotiation" (Jacobson and Margolin, 1979, p. 189). The use of such a strategy can be important in treating relationship distress.

Communication training is applicable far beyond the correction of deficits in problem-solving. Distressed couples are often unable to generate or maintain a satisfying relationship because they are lacking a variety of communications skills. A behavioral therapist will train clients in a variety of communication skills, using the aforementioned clinical strategies of feedback, instructions and behavioral rehearsal, to help facilitate a more productive relationship.

Some of the skills that can be mastered using a behavioral program are empathy and listening skills, validation, feeling talk, negative feeling expression, positive expressions, assertiveness and problem-solving (Jacobson and Margolin, 1979). Though all of these skills are elucidated in Jacobson and Margolin (1979), the last two will be briefly reviewed in the following paragraphs.

Problem-solving training is based on principles of reinforcement focused on overcoming the undesirable patterns of exchange in a relationship. Often clients seem to rely on aversive control tactics, like punishment, negative reinforcement and verbal abuse. If these tactics are effective in suppressing the aversive behavior to which they are applied, then their use can become more generalized, and the partner may tend to reciprocate with like aversive control strategies.

In order to break this pattern of behavior, the most expeditious area on which to focus is the process by which agreements are reached (Jacobson and Margolin, 1979). The method by which this is accomplished is presented in a problem-solving manual by Jacobson and Margolin (1979). This manual discusses both the setting and the proper set of problem-solving; the proper attitude for problem-solving; the basic structure of problem-solving sessions and the conditions under which they occur; and the two distinct phases of a session - a definition phase and a solution phase.

Some clients have a difficult time standing up for their rights and need to be taught more effective ways of accompanying this end. Assertiveness training can be a method used to impart this knowledge. Individual therapy and assertiveness groups have been found to be the best situations for acquisition of assertiveness skills (Jacobson and Margolin, 1979).

For this reason, conjoint relationship therapy sessions may not be the appropriate area for training and clients should be referred to the alternate possibilities. As there are an abundance of sources describing assertiveness training (Alberti and Emmons, 1975), the writer will not discuss this tool any further.

The last procedure, listed in Table 4 for the treatment of sexual dysfunction, is heterosexual skills training. This type of skills training is used, as the namer implies, to develop social skills. The avoidance of heterosexual social situations (Jehu, 1979); maladaptive views of male-female roles; and deficits in expression and cooperative skills (McCarthy, 1981) can contribute to a sexual dysfunction. This occurrence necessitates rectifying this deficit prior to, or concurrently with sexual therapy.

In the writer's own practicum, 3 of her client population exhibited deficient heterosocial skills. Being as it is an involved and time-consuming endeavor, improving heterosocial skills and attitudes is best focused upon, the writer believes; independently from sexual therapy. She, therefore, referred two of the clients to groups directed at this problem area. In therapy itself, as these deficits became evident, these factors were dealt with separate and apart from the on-going treatment program for sexual dysfunction.

The use of specific treatment packages, as aforementioned, was utilized for certain sexual dysfunctions. Heiman's et. al. (1976) program for inorgasmic women was the treatment of choice for women exhibiting this difficulty. For clients that had disorders of sexual interest and/or desire, Kaplan's (1979) psychosexual program was implemented. For male sexual disorders, the writer used Zilbergeld's (1978) treatment module; and, finally, for female incest victims, Jehu's (1982) treatment program was employed.

These ancilliary treatment packages encompassed behavioral components and were compatible with Jehu's (1979) approach. The writer found tha the wide range of treatment options greatly facilitated molding therapy to suit the client, and allowed the therapist flexibility and a degree of creativity in her treatment approach.

With the theoretical background, assessment, evaluation and treatment of sexual dysfunction largely reviewed; the writer now turns to case presentation of the specific dysfunctions she encountered in her practicum out of the Sexual Dysfunction Clinic.

PART IV. SPECIFIC DYSFUNCTIONS

A. Lack of Sexual Desire

1. Description

Since the pioneering work of Alfred Kinsey and his associates in the 1940's, human sexuality has been increasingly the subject of scientific investigation. With the publication of Masters and Johnson's Human Sexual Response (1966) and Human Sexual Inadequacy (1970), many health professionals thought that a non-Freudian, all-inclusive, conceptual scheme (the sexual response cycle) for understanding sexuality, and brief and effective methods for intervention were now available.

As the field progressed, the conceptual adequacy and clinical usefulness of the sexual response cycle were questioned (Kaplan, 1974; Zilbergeld, 1978). Clinicians began to see problems that did not fit into the dysfunction scheme (i.e., problems that regarded sexual frequency and subjective elements of sexuality). As Kaplan (1979) noted, in neither of Masters and Johnson's books nor in her own The New Sex Therapy (1974) was sexual desire even mentioned. (Masters and Johnson do mention a case, however, of what they called 'low sexual tension').

Of course, in clinical practise Masters and Johnson and most other therapists had dealt with how their clients felt and how they interpreted their experiences. But, because of the very strong influence of an almost entirely physiological paradigm - the sexual response cycle - clinicians had been slow to recognize the importance of subjective factors like interest and excitement (Zilbergeld, 1980).

It soon became evident that problems in desire and arousal were quite common (Kaplan, 1977; Jehu, 1979; Zilbergeld, 1980; LoPiccolo, 1980; Schover, 1982). It also seemed, as the years passed, that there was

an increasing prevalence of desire-phase sexual dysfunctions (LoPiccolo, 1980; Schover, 1982). Schover (1982) reported in his study that out of 152 couples, 58 (38%) had a diagnosis of low desire in the husband, 67 (49%) had a diagnosis of low desire in the wife, and 27 (18%) were instances of female aversion to sex. LoPiccolo (1980) "reported that out of 39 consecutive completed treatment cases at Stony Brook, 27 (69%) included a diagnosis of low sexual desire in at least one spouse. This included 44% of all male partners seen, and 26% of the female." Lief (1977) "stated that 28% of the patients seen at a slightly earlier period at the Marriage Council of Philadelphia had a PRIMARY diagnosis of inhibited sexual desire, including 37% of the women but only 18.7% of the men. (Schover, 1982 p. 180). In a study done by Frank, Anderson and Rubinstein (1978) with 100 couples, who were not seeking marital therapy and who had stable relationships, it was found that 35% of the women and 16% of the men had little interest in sex. It was also found that 28% of the women and 10% of the men reported being "turned off" sexually. What these studies brought to light was that incidence of low sexual desire - long considered predominantly a female problem - had become more common among men. Schover's study (1982) saw only a slight gender difference in rates of low sexual desire (9% of cases including female low desire vs 7% of cases including male low desire). Possible reasons offered for this change were (1) the new societal pressures to engage more frequently in sexual activity; and (2) the overt message women had a right to enjoy sex. This message was thought to have led to more assertiveness by wives whose husbands had lost interest in the bed. Couples, it was suggested, might now be more likely to label a lack of sexual activity as a problem worthy of professional attention (Schover, 1982, p. 194).

With the increasing number of desire disorders coming to the attention of clinicians; what also was becoming increasingly evident was that there was an absence of established norms on sexual frequencies for individuals of varying ages and socioeconomic groups; that there was not

an agreement on what constituted a desire deficit or excess; and that there was not even a clear consensus of what was entailed within the rubric of "sexual desire or interest". "Desire" and "arousal" were often used interchangeably; as were "excitement" and "sexual aversion" (Masters and Johnson, 1966, 1970); "hypoactive sexual desire" or "low libido" (Kaplan, 1977); "inhibited sexual desire" (Lief, 1977); "inadequate sexual interest" (Jehu, 1979); "lust", "passion", and "drive" etc. Not only were these terms used interchangeably; but, their meanings could be manifold.

Masters and Johnson (1966) used "sexual excitement" to denote the first phase of their sexual response cycle; but, this term as they used it had little relationship to the way most people understood the word. They defined the term solely by physiological reaction and not at all by subjective experience (Zilbergeld, 1980). "Men with erections and women with vaginal swelling/lubrication" were "considered to be in the excitement phase, whether or not they 'felt' excited" (Zilbergeld, 1980, p. 67). To complicate matters further "sexual aversion", originally developed by Masters and Johnson to encompass problems they saw with unwillingness to participate in sex, had also taken on a multitude of meanings. Kaplan (1982) equated a sexual aversion with a sexual phobic anxiety reaction; and Kolodny (1979) agreed with this idea that a sexual aversion would be a consistent negative reaction of phobic proportions to sexual activity or the thought of sexual activity.

What had arisen, to the writer, from the paucity of any absolute description for a lack of sexual desire, were three distinct concepts: sexual aversion (or phobia); lack of sexual interest; and lack of sexual arousal. The definitions for these terms were understood to be: sexual aversion, as meant by Kolodny (1979) and Kaplan (1982); lack of sexual

interest, meaning the frequency with which an individual wanted (or not) to have sex, (which implied nothing about the ability to do so or arousal experienced during it) (Zilbergeld, 1980); and lack of sexual arousal, which referred to the subjective experience of excitement to which the individual attached erotic significance (Zilbergeld, 1980).

Given the interpretation of the concepts stated above, physiological arousal might or might not mirror subjective arousal. An individual who had a low frequency of sexual involvement might have good satisfaction; while another individual who had low satisfaction might report an ability to be involved moderately in sexual activity and to experience prompt physical arousal. An increase in physical stimulation, contrary to what many professionals thought, would not result in increased arousal, and possibly, sexual interest. The picture could be further complicated by the addition of other forms of sexual dysfunction (vaginismus, erectile difficulties for example) which might accompany a lack of sexual interest. In some cases, men and women might function adequately once involved in sexual activity while experiencing little or no desire to participate at the onset; in other instances, inadequate interest could be associated, for example, with an ability to climax, to experience pleasurable feelings during activity etc. (Jehu, 1979).

Due to the complexity of diagnosing a lack of sexual interest, the variety of factors that can be involved in the genesis and maintenance of the problem, it is imperative that a thorough investigation be made of the multi-causal determinants of the problem. This means that an assessment should examine the host of psychological, physiological, sociological, learning/conditioning, hormonal/neuroendocrine, and cognitive factors that may be implicated in cases of low sexual interest.

## 2. Etiology

### Organic Components

A variety of organic conditions can lower sexual interest. (Appendixes A, L, M). In fact any chronic disease process may potentially inhibit sexual desire "but, this does not always mean that this affect is directly attributable to biochemical change or tissue pathology. Psychosexual adaptation to chronic disease" may "also have an adverse impact on sexuality" (Kolodny, 1979, p. 565). Similarly, evidence suggests that some drugs may produce a diminution of sexual desire; these include narcotics, high doses of sedatives and alcohol, certain centrally acting antihypertensive agents such as those, for example, which contain reserpine and methyl dopa, drugs which antagonize the action of testosterone, antispasmodics, antihistamines, and possibly as a side effect of oral contraceptives (Renshaw, 1978; Kaplan, 1979; Jehu, 1979; Kolodny, 1979). (See Appendix A & M). It has also been reported that "certain non-pathological organic conditions such as pregnancy or aging may also be accompanied by a loss of sexual interest in some individuals" (Jehu, 1979, p. 79).

Hormonal levels have been implicated as affecting sexual interest. Testosterone deficiency caused by "the aging process, prolonged stress, surgical removal or disease of the testosterone-producing glands, and hormones and medication, such as provera and estrogen which antagonize the action of testosterone" (Kaplan, 1979, p. 81) have been known to diminish sexual interest. A study by Greenblatt (1980) reports on the increase in libido of women treated with varying doses of testosterone; thereby, suggesting that desire level can be affected by hormonal level. Constitutional factors, conceivably, may also affect individual differences in sexual interest (Lief, 1977; Jehu, 1979). "This factor might account for the apparently lifelong lack of desire and activity exhibited by some clients" (Jehu, 1979, p. 79).

Severe stress, such as that experienced during a traumatic divorce, loss of a job or problems with the children has often been associated with a loss of sexual interest (Kaplan, 1979; Averbach and Haeberle, 1981; Kolodny, 1979). "Clinical observations suggest crisis and stress are also associated with a physiological depression of the sexual apparatus" (Kaplan, 1979, p. 80). What likely is occurring in an instance such as this is that the additional cost in emotional and cognitive terms of coping with the stress, have markedly reduced the interest in sexual activity.

Finally, depression is perhaps one of the most common physiologic causes for a lack of sexual interest (Kaplan, 1979; Jehu, 1979; Zilbergeld, 1980; Lief, 1977; Spencer and Raft, 1977). Depression is marked by disturbances in sleeping, eating and libido. Depression can have both physiological and psychological implications.

People who experience depressive states (the following excerpt is largely based on Spencer and Raft, 1977)<sup>11</sup> can have some diminution of the capabilities for pleasure, intimacy, motor activity, initiative, assertiveness, risktaking, and humour, all of which are essential aspects of sexual interest and experience. In particular, a depressed client may lose his capacities to engage in, and to enjoy, sexual phantasizing, which plays a vital role in sexual stimulation. Furthermore, some depressed clients may lose interest in sex as a means of depriving and punishing themselves, because they feel undeserving and guilty. Somewhat paradoxically, this may result in the accentuation of these feelings, because the clients may then blame themselves for denying sexual satisfaction to their spouse and for not being a good wife or husband. At a physiological level, it is possible, though not yet established, that diminished sexual interest may be due to certain changes in amine levels in the hypothalamus which occur in depressed patients" (Jehu, 1979, p. 80). It has also been observed that characteristically during depression that erection and orgasm are not impaired at all or not to the same extent as in libido (Kaplan, 1979).

### Psychological Components

Though physiological components have largely been presented as if they are independent of psychological components, this in actuality is very difficult to ascertain. It is often a value judgement on the part of the therapist to draw plausible hypotheses as to exactly to what degree the two are independent and interdependent. A method that aids in the evaluation of low sexual interest is determining if the problem is primary or secondary, global or situational.

Primary inadequate sexual interest designates an instance where "the client has never experienced much desire or engaged in any fairly common activities such as childhood sex play, masturbation, phantasizing, persuing erotic material, petting and pre-marital intercourse".

Secondary instances would be where "clients seem to have experienced and exhibited an adequate degree of sexual interest until specific points in their lives, at which their interest declines to an unacceptable level" (Jehu, 1979, pp. 78-79).

When inadequate sexual desire is global, the client would not experience desire under any circumstance. However, if lack of desire were purely situational - that is, interest in sexual activity with another person(s) or in other contexts (such as masturbation) were intact - this would be an indication of a psychosocial etiology (Kolodny, 1979).

Inhibited sexual desire would be "a state marked by a simultaneously low level of sexual receptivity and initiatory sexual behavior" (Kolodny, 1979, p. 567). The low receptivity is sometimes interpreted by the normal functioning partner as rejection and can leave that person alone and frustrated. The person who is unreceptive could be left feeling guilty for withholding sex from their mate; or in some instances they might feel in a position of power - voluntarily withholding sex to control the situation for their own purposes. As becomes evident,

marital friction could ensue and exacerbate the problem.

Lack of sexual desire can oftentimes be covered up if the woman is the partner experiencing the difficulty. If the wife accepts, however reluctantly, her husband's advances, they may never reach therapy because of the continued rate of sexual activity. If the husband, however, doesn't want sex, it is difficult for the wife to ignore his lack of interest. Evidence by Schover (1982) supports this in that there is a higher rate of sexual activity at intake for couples in which the wife has low desire as compared to couples in which the husband has low desire. It is also of note that a woman's low sexual desire is more likely to be global and lifelong than is male low desire or female aversion to sex. This reflects, perhaps, the magnitude of a problem necessary to goad a couple to seek therapy (Schover, 1982).

Other etiologies that can affect desire are traumatic experiences such as sexual assault or incest. Certain inhibitions and fears, that are not of phobic proportion, but nevertheless impinge upon the freedom to be sexual could be: "hygienic concerns; fear of pregnancy and venereal disease; fear of losing control (physically or mentally) during sexual arousal; fear of disturbing sexual imagery with themes such as incest, homosexuality, sadomasochism, or adultery; and fear of rejection" (Kolodny, 1979, p. 568).

Anxiety, Kaplan (1979) believes may be considered "the 'final' common pathway through which multiple psychopathogens may produce sexual dysfunctions" (Kaplan, 1979, p. 24). Under this common heading, she differentiates causes via three depth determinants: mild, mid-level and profound remote causes. Mild anxiety would entail mild performance anxieties; mild power struggles; lack of assertiveness; mildly negative childhood messages; mild residues of childhood guilt and shame about masturbation and sexual pleasure and the like.

In the mid-level of remote causes would be success and pleasure anxieties; fear of intimacy and commitment; and deeper fears of rejection.

In the profound remote cause category would be serious relationship problems; intense performance fears and fears of rejection; neurotic power struggles based on infantile transference towards the partner; severe anger, mistrust and envy of the partner; deep sexual conflicts that have their roots in the client's early development; strong family messages that make sex or love or pleasure dangerous and guilt provoking; and unresolved oedipal and preoedipal problems.

It can be seen that there are a myriad of interpersonal and intrapersonal conflicts that may affect desire level. Besides those already stated, routinized sex; role conflicts, for example between being a mother and a lover; fatigue; simple sexual ignorance; an outside affair (Renshaw, 1979; Kolodny, 1979; Goldberg, 1977); as well as suppression of desire or the use of the "turn-off" mechanism (Kaplan, 1979); and inappropriate cognitions (Lobitz and Lobitz, 1978; LoPiccolo, 1980; Jehu, 1979) can affect sexual interest.

### 3. Assessment

Assessment of this dysfunction follows the outline presented in Part 11:A (Appendix B). Specific paper and pencil instruments administered to clients exhibiting this dysfunction would be: the Sexual Arousal Inventory (Hoon et al., 1976); Sexual History Form (Schover et al., 1980); Index of Sexual Satisfaction (Hudson et al., 1981); Semantic Differential Scale (Whitehead and Mathews, 1976); Dyadic Adjustment Scale (Spanier, 1976); and where applicable, the Beck Depression Inventory (Beck, 1981). Interviews, client self-monitoring, and archival records would also be used as indicated in Part 2:B.

#### 4. Treatment

"With the exception of causes of inhibited desire resulting from depression or attributable to organic factors such as drug use or illness; most patients with this difficulty require an extensive psychotherapeutic approach" (Kolodny, 1979, p. 569). Lief (1977) and Kaplan (1979) would tend to agree that desire phase disorders would seem, with some exceptions, to be associated with more severe and tenacious underlying psychopathology than is typically associated with the genital dysfunctions. Consequently, Kaplan would also believe "that psychosexual treatment of these disorders often necessitates much more psychotherapeutic intervention than does the treatment of orgasm and excitement phase disorders." (Kaplan, 1979, p. 48). Interestingly, Schover's (1982) study would dispute Kaplan's statement. He found his treatment gains with clients with this disorder to be comparable to those obtained for dysfunctions in the orgasm and arousal phase.

Kaplan (1979) states that she, as yet, knows of no outcome statistics for the treatment of desire phase dysfunctions. She, however, believes that these disorders carry the worst prognosis; estimating that 10 to 15% of patients would be cured within the average 14 sessions which are traditional in sex therapy.

"The variety of treatment interventions necessary in cases of low sexual interest parallels the variety of contributing etiological factors" (LoPiccolo, 1980, p. 29). Interventions such as: 1. Hormonal therapy in cases where hormonal deficits have been established (Greenblatt, 1980; Kaplan, 1979; Jehu, 1979; LoPiccolo, 1980); 2. Treatment of a specific dysfunction if present (Kaplan, 1979; LoPiccolo, 1980; Jehu, 1979). 3. Anxiety reduction - desensitization of aversive or phobic responses, relaxation training, sensate-focus exercises, flooding, education and information, rational-emotive therapy (RET), guilt reduction, removal of performance demands, dealing with issues concerned

with conception and contraception (Kaplan, 1979; Zilbergeld, 1980; Kolodny, 1979; Heiman, 1976; LoPiccolo, 1980). 4. Treatment of depression - medication, RET, behavioral techniques such as increasing activity levels and reinforcement, social and interpersonal skill training, assertiveness training, dealing with environmental/life factors (Spencer and Raft, 1979; Jehu, 1979; Zilbergeld, 1980; LoPiccolo, 1980; Kaplan, 1979). 5. Increasing sensory awareness - biofeedback techniques, sensate-focus exercises, tracking sexual thoughts and feelings, Gestalt techniques; increasing accuracy of perception and accurate labeling of sensations and responses, education about sexual responses, increasing awareness of situational variables and environmental influences (Jehu, 1979; Kaplan, 1979; LoPiccolo, 1980; Heiman, 1976; Lobitz and Lobitz, 1978; Zilbergeld, 1980). 6. Improving the relationship - conflict resolution, communication training, increasing positive reinforcers and decreasing negatives, reduction of negative affect such as anger and resentment and facilitation of positive affect (LoPiccolo, 1980; Jacobson and Margolin, 1979; Kolodny, 1979; Jehu, 1979; Kaplan, 1979). 7. Enhancing sexual/sensual experiences - education and information, sexual communication, encouraging the use of facilitating fantasies, increasing comfort and skill of initiation and refusal of sexual activity, expanding the sexual repertoire, removing performance demands, increasing effectiveness of sexual technique, creating a sensual environment (LoPiccolo, 1980; Jehu, 1979; Heiman, 1976; Kolodny, 1979; Kaplan, 1979). 8. Facilitation of erotic responses - improving body image, fantasy training, encouraging masturbation, exercises on "letting go", increasing expressiveness during sex (physical movement as well as verbal and non-verbal communication), exposure to erotic stimuli, learning

particular techniques to enhance arousal (LoPiccolo, 1980; Jehu, 1979; Kaplan, 1979; Heiman, 1976). 9. Dealing with intrapsychic conflicts such as fears of intimacy, dependence/independence conflicts, fears of the opposite sex, and fears of loss of control (LoPiccolo, 1980; Kaplan, 1979; Jehu, 1979) are not unique to treatment of the cases of low sexual interest. (The previous 9 points are from LoPiccolo, 1980 pp. 44-45). What is unique, however, is the degree to which the "multi-causal" nature must be kept in focus; and the depth to which certain dimensions (i.e., intrapsychic conflicts) must be explored. Treatment is individually molded for each unique case, incorporating any of the previously cited elements and interventions.

## 5. Case Histories

Pat - Lack of Sexual Desire, Avoidance of Sex

### Demographic Data

Pat, age 34 and her husband, Len, age 36 had been married for 13 years. They had two children, a boy, age 8 and a girl, age 5. They were an upwardly mobile, upper-middle class family with a strong ethnic affiliation. Len was a private businessman who travelled extensively keeping him away from home frequently. Pat worked part-time as an aerobics dance instructor and a full-time housewife.

### Assessment

Description of Problem. Pat presented with a long-term, global lack of sexual desire. Throughout 13 years of marriage, she has always found the sexual relationship with her husband, Len, uncomfortable. Len has been her only coitus partner. Before she met him, she dated another boy who she found very exciting sexually. Though Pat and this boy never had intercourse; the sexual activity (which encompassed everything but

coitus) was highly arousing. Pat broke off the 4 year relationship with this person because he was untrustworthy, chased other women etc.

Pat and Len's sexual relationship had been on the decline, noticeably, for about five years. Up until that time, Len was oblivious to any dissatisfaction on Pat's side. He initially began to notice that Pat and he were having fewer sexual relations. Particularly in the last year, Len has seen that Pat's attitude towards sex was one of avoidance. He felt that his wife just went through the motions to satisfy his needs as quickly as possible. He felt emotionally rejected and that he was just being masturbated; and not made love to by Pat. He said that they have intercourse approximately twice a month and that the lack of sex left him frustrated. His negative feelings around the sexual relationship had generalized to the total marital relationship.

Pat had always been dissatisfied with their sexual relationship. She viewed Len as a good provider, a good father, a trustworthy person and someone whom she liked and loved. She, however, wasn't aroused sexually by him. While they were dating, Pat felt that she had to 'put out' once the relationship became serious. The couple's first sexual encounters took place in Pat's parents rumpusroom. Pat felt very uncomfortable having intercourse in this setting, but did not voice her discomfort. Her inability to voice her concerns in the relationship exist even today. She does not feel that she can tell people anything that might drive them emotionally away. Therefore she is unable to voice dislike, anger, disapproval, etc.

Pat put up with the sexual relationship at first. She could reach orgasm by self-stimulation and occasionally through intercourse. She had her first child, R., eight years ago and found this traumatic. She

neither felt close; nor even liked this child. Her attitude towards sex began to deteriorate. After her second child's birth, A., Pat began to avoid physical contact with Len. She did feel loving towards this second child; but, continued to have negative feelings towards R. The sexual relationship deteriorated to such an extent that she and Len practically were living platonically. She neither felt desire, nor arousal in Len's company. She realizes that the marital relationship was now suffering because of her attitude. Len felt rejected and would no longer make any physical advances towards Pat. However, when the couple did have intercourse, Pat was able to have an orgasm occasionally. She, however, was neither physically nor psychologically aroused, in most instances (only times arousal occurred (i.e.) was when she viewed pornographic films prior to sex with Len).

#### Contemporary Influences on Problem

Situational Antecedents - Con-comitant Non-sexual Stresses. Len because of the nature of his business, was away from home about two weeks out of every month. Pat had had to make a life for herself in his absence. She began to take dance aerobic classes about 2 years ago; and eventually became good enough at it to instruct 4 classes a week. She also became involved in the planning aspects of the program, and on occasion, went to business meetings. Teaching classes and going to meetings at night cut into her time with Len when he was home from trips. He began to resent the loss of family time because of her commitment. Pat was not willing to completely give up this creative outlet to satisfy Len's needs. She felt that it gave her a purpose, something to do while Len was away.

Their son, R., had also been a great source of stress to the couple. R. had been diagnosed as hyperactive and was on Ritalin this

fall. He was also seeing a psychologist here at the P.S.C. for his behavioral problems. Pat and R. had never bonded, though Len felt close to his son. Pat felt that Len and R. sided against her; and she wanted to feel that she and Len formed a unit in order to parent the boy more effectively.

Relationship With Partner. As mentioned, the marital relationship was seriously beginning to feel the stresses in the sexual relationship. Len felt that life was passing him by. He felt that he should be able to enjoy the pleasures of sex. He felt that he was only being tolerated by his wife because of the lifestyle he could supply her. He didn't feel that Pat could give emotionally - he felt that she was afraid to "give of herself".

Pat, also saw that the relationship was starting to be severely affected. She seemed to take a lot of the blame for what was happening upon herself; but, at the same time she was very angry at Len and could not express this fully.

Sexual Stresses. Pat and Len had never really voiced to each other their sexual preferences. Len took it for granted, for the first 10 years of their relationship, the Pat was satisfied with the sexual relationship. Because of the presenting situation - where Len would not make advances unless Pat initiated - sex was a showcase for rejection, hurt, frustration, anger, bitterness, recriminations, etc.

Organismic Variables. Len was frustrated, angry and upset with his wife. Though he, as yet, had had no sexual dysfunction, he avoided sexual encounters. Even when he became so frustrated that he occasionally made a sexual advance (2 times a month) he didn't find the experience gratifying. He felt used by Pat; he felt that she just accomodated him

to get it over with. He started to blame Pat for the poor sexual relationship. He saw it as her fault that he was having little physical pleasure. He, however, would not leave the marriage easily because he took his commitment to Pat and the children very seriously.

Len was in good general physical health, though he was approximately 20 lbs. overweight and looked 10 years older, than his age of 36, due to the greying of his hair and the stress lines in his face.

Pat didn't find Len physically attractive and was unable to face up to this fact. She told Len that he was attractive in session; yet, admitted the opposite to the writer. She also has felt unable to voice her anger, disappointment, etc. at Len, re: their sexual relationship. She felt guilty that the relationship wasn't exciting; but, also angry that Len had never drawn her out on the topic.

She avoided sex; and tried to overtly deny that Len was unattractive to her. She focused on Len's negative traits; on the fact that she found his breath and body odor offensive; and often thought about how exciting her first boyfriend had been in comparison to Len.

Pat was in good physical health. She was very slim and had stated that at times she had almost become bulimic.

Family Background. Suffice it to say that Pat's mother and father were Polish immigrants that had been interned in concentration camps during World War II. Her parents had been financially very successful. Her father had been brain damaged in a car accident four years previously; therefore, he was in retirement and completely cared for by his wife. Pat felt that she had to live up to an image for her parents; and often felt guilty because she wasn't doing as well as her sister. Len felt that he, himself, had a good relationship with his in-laws.

Len's Parents. Len's parents were of a much more modest background than Pat's parents. Their marital relationship was good and he felt that they were kind and loving parents. His family was the antithesis of Pat's. Where in Len's family the children and personal relationships always came first; in Pat's family social connections and obligations were in the forefront.

Because of the differences in wealth, Mrs. W. tried to gain Pat's affections by giving her many small presents. Pat felt like she was being bought off and resented this. Also, because she was used to a much greater emotional distance in her own family; she viewed Len's mother's constant attention as meddling. Relations between Pat and in-laws were so poor, that Pat sought counselling with a psychiatrist to help clear up her feelings.

Siblings. Pat had 1 sister with whom she had a love-hate relationship. R. was 32 years old, married, had 2 children and was extremely wealthy. Pat was jealous of the fact that everything came easily to R. She felt that she had always been in competition with her sister (for her parents approval and affection; to be as beautiful as R.; to do as well with family and finances as R.). Her parents viewed R. as more successful - even though she put out less emotionally - she got more praise in return.

Len had 1 sister, 32 years old, who was divorced with 1 son. He felt that he was overly protective of his sister and that they had a good - though not particularly close - relationship.

Children. R., age eight, was described as a boy who was hyperactive, bright, proficient with his speech, but has handwriting/perceptual difficulties. He was easily distracted and had a short attention span.

Pat never liked this child and felt very guilty about it. Len got along well with the boy. R. was said to be very jealous of his sister A.

A., age 5, was described as being a child who was bright, beautiful, and whom, learnt easily. Pat loved her from the minute she first laid eyes on her. Len loved his daughter as much as his son.

Childhood and Puberty. Pat. Sex was never discussed at home. Her mother only told her to be a good girl and not to make her ashamed; which implied never getting pregnant out of wedlock. Pat was pudgy as a child and did not feel particularly attractive. She learnt about sex from friends and at school.

She began to menstruate at 12 years old and about the same time she developed secondary sexual characteristics.

Her only steady boyfriend outside of Len, was the previously mentioned male she dated from ages 14-19 years. Other than heavy sexual petting with this boy, Pat's sexual experience had solely been with Len.

Len. Sex was never discussed in his home, either. He picked up his sexual information from street talk. Secondary sexual characteristics began to develop around age 12 as did night emissions.

Sexual Experience Before Current Partnership. Both Len and Pat had had limited other sexual partnerships. Pat had had only 1 boyfriend with whom she'd petted heavily, before Len. She uses masturbation on a regular basis (1 x a week) to relieve sexual tension. She used erotic films, literature and fantasies to enhance her desire and arousal levels. She had not experienced any traumatic sexual experiences though she had experienced long-termed dissatisfaction in her current relationship.

Len enjoyed sex with the few sexual partners he had had before Pat. He had never had a serious relationship before meeting his wife.

He used masturbation as a sexual outlet (approx. 2 x a week) and also found that erotic films, literature, strip shows, etc. were moderately arousing. Both partners had been faithful throughout their marriage.

Current Partnership. Len and Pat were married 14 years this June ('83). They became sexually active during their engagement period though it was not a particularly pleasant experience for Pat. As mentioned, she was nervous about having sex in her parents home and had sex only because Len wanted to.

The honeymoon was a disaster as far as Pat was concerned. It did not meet her romantic, nor her erotic expectations. Len used the same techniques and mannerisms that he'd used in her parents' basement (which he thought she liked). They had their first arguments on their honeymoon trip and returned home unhappy.

Len then got mononucleosis, which kept him bedridden (only a couple of weeks after their wedding). He was not able to shake the infection for almost a year; and during that time he had little sexual interest.

Len also had pressures at school; he had withdrawn from city planning and had started law school. Finances were limited; Pat was teaching school and the couple were living in her parents' home. Pat was back to being a daughter.

Pat's parents then moved to another city and asked Pat and Len to take care of their house and to look after her little sister, R. Pat was now placed in the position of mothering her sister.

Finally, after 3 years of marriage, the couple moved out and bought their first home. Len had quit school and had started working. Pat's parents had moved back to Winnipeg and her sister had married.

Pat resented sex. She started to say that she didn't feel like it; and felt guilty because she was putting Len off. She felt resentment because he pushed her for sex - and a vicious cycle was established.

The birth of the first child was, as mentioned, a traumatic experience for Pat. She didn't bond to this baby and felt guilty for this behavior. He had been a placid baby; but, began to show hyperactive behavior by the time he started daycare.

Her feelings towards her second child were the complete opposite. She loved A. at first sight and often took A.'s side in family disagreements.

Len was very family oriented and saw Pat as not being able to give herself emotionally to the children or to himself. On the surface level she was a good homemaker, a good companion, a good mother, a good entertainer for guests, etc. He believed, however, that she was more concerned with appearances (or perhaps more comfortable at this level) than dealing with love, hate, etc.

Len was a strong personality who could overpower Pat easily in any argument. Pat felt that it was futile to vent her negative emotions because Len would argue that they were not rational. Len felt that he'd been very understanding, that he'd stood by Pat (through her 3 1/2 years of analysis) etc. The guilt was placed with Pat for the problems in the relationship and she overtly accepted it; however, covertly, she harbored anger, frustration, etc. at this situation.

The sexual relationship had deteriorated to such an extent that it was seriously affecting the marital relationship. The lack of sex denoted to Len a lack of caring and love for him. For Pat, it was a way to get back at Len.

Pat had a tubal ligation 4 years ago, so, there wasn't any fear of pregnancy. She was quite happy with the operation and had no medical problems.

Self-Concept. Pat saw herself as attractive and fit. She also saw herself as having some problems with her skin (hardly noticeable); and held a 'fat kid' image in her head because she had been overweight as a child. This fear of being fat had led her to have bad eating habits; and she had stated that at times she had almost been bulimic.

She felt feminine and felt confident about her ability to teach dance aerobics. She wasn't as comfortable with male friends as female friends. She spent years in analysis to build up her self confidence so that she could relate to others.

Len saw himself as about 20 lbs. overweight and balding. He was 36 and looked and felt 10 years older. He was a confident businessman and was able to express himself easily. He felt male and wanted to enjoy the physical pleasures that came to a man. He didn't want life to pass him by without having had some fun.

Attitudes Towards Treatment. Both people were motivated to come to treatment. They felt that their marriage was in a precarious situation and that they could not let it go unattended. They wanted to be able to draw closer together emotionally and physically.

Len was away on business trips, home and abroad, frequently; and sessions were sporadic. However, he thought it was imperative that they work on their marriage because he was afraid of the alternative (being divorce).

Pat saw that she needed more mental stimulation from Len. He said that he was often mentally exhausted from trips and hadn't realized how

much emotional exchange Pat needed. He had thought that just being home should have been enough for his wife because it had been enough for him.

Formulation of the Problem. Succinctly, it was hypothesized by the writer that Pat had low sexual desire that seemed to stem from: (1) covert feelings of anger, frustration, hostility for Len; (2) a general uncomf-ort-ableness with expressing any type of emotion that might expose her vulnerable nature; (3) a family background in which emotions were seldom expressed, and where family was secondary to the public image - social obligations (parents very controlling); (4) a poor sexual relationship of long-term standing (inappropriate physical and mental stimulation) in which Pat felt unable to express her own desires; (5) a powerful, verbal husband with whom she felt unable to disagree or fight; (6) even though Len was successful, he was not successful enough -didn't meet up to her competitive standards (in order to gain parental and sibling approval); and (7) a general dissatisfaction with her life - emotional intensity is lacking. It was hypothetically possible that Pat's parents-concentration camp victims-were unable to give free flow to their emotions; an adaption to their own severe hardships, therefore, their daughter patterned after this.

#### Progress and Outcome

To date, the writer has seen this couple 16 times. Initially, after the assessment was completed, marital counselling was contracted with the couple to run simultaneously with the sexual therapy.

The couple, upon coming into therapy, held a great deal of anger, animosity, suppressed hurt, etc. towards each other. This backlog of feelings headed in a therapy session in which Len blew up because Pat had forgotten his birthday. From this point onwards it became clear to the

couple that they lacked sufficient communication skills to express their feelings within their own relationship. Outside of their private sphere, the couple held a sophisticated ability to express themselves in a social and business arena. Also, because of Pat's and her son's years of therapy, the couple were quite able to use the technical concepts and language common to psychological intervention.

Presentation to the couple of their communication dynamics; assertiveness training for Pat; and problem-solving and listening skills for both clients has aided in rectifying their marital disequilibrium. The couple now feel that they are better able to communicate their feelings to each other and feel emotionally much closer.

The sexual difficulties between Pat and Len have seen a less dramatic change to date. Because of Pat's lack of confidence in herself (doesn't believe that she is intelligent), she oftentimes does not express her opinion to Len. His direct, powerful conversation style overwhelms her; and Pat gives up trying to make her point and concedes to his wishes. This inability to express her desires also holds in the sexual sphere.

Although assertiveness skills training helped Pat begin to express herself in other topic areas; she has held back in stating her sexual preferences. This she does, partially, out of fear. For instance, Pat was afraid that if Len knew that she masturbated, or that she didn't find him sexually attractive that he would be very hurt (and consequently, might leave her).

After 16 sessions, Pat was able to express her above stated concerns to Len. This was brought about via role-playing (Pat practised with the therapist discussing these issues); the therapist challenging

Pat to face her fears (which could not have been done prior to the establishment of a trusting relationship between client and therapist); and the gradual loosening of Pat's inhibitions re: openly discussing sex with Len via the homework assignments (following Heiman's (1976) couple exercises) and in the therapy sessions.

Disclosure of Pat's sexual preferences did not disturb Len. During the 7 months that the couple had been seeing the therapist, he had lost 15 lbs. and had begun to look more rested and youthful. Always a stylish dresser, he also had attempted to make himself more physically attractive to Pat. He was supportive of Pat expressing her sexual preferences and was amused at Pat's assumption that he would feel 'betrayed' by the fact that she masturbated. He handled her disclosure of these feelings in a caring and non-judgmental manner. Len also was able to clearly state that he could not always perform sexually when he felt that Pat was not interested in him. He told her that he lost his erections, at times, when she did not emotionally and physically respond to his love-making. These disclosures, on both sides, helped the couple to draw emotionally closer together.

At the time of writing, the couple are at the lake for the summer months. Therapy has progressed in a halting manner because of Len's extended business trips and the couple's vacation plans. However, improvement is noticeable in the overall marital relationship. The couple's communication ability has greatly improved; they have fewer disagreements; and they feel closer and are generally more physically demonstrative towards each other. These improvements are substantiated by the clients and the therapist's observations. Paper and pencil instruments were administered at the commencement of treatment; but, not at

regular intervals throughout therapy. Therefore, it is not possible to substantiate these stated improvements via test results.

Sexual therapy will continue once the couple return to the city in late summer. The onus has been placed upon the two to, again, progressively work through the Heiman (1976) program on a bi-weekly basis. Specific steps have been delineated for the pair to follow. The feelings and emotions that the exercises elicit are to be recorded in Pat and Len's personal diaries, including any avoidance problems etc., for discussion once therapy recommences.

Monda - Lack of Sexual Desire, Decreased Physiological and Subjective Arousal, History of Cyclical Depression

#### Demographic Data

Monda and her husband, Gordon, were both 29 years old and had been together for 7 years. They were the co-owners of a private business in the city and were an upwardly mobile young couple. Gordon had met Monda in Britain while travelling; and she had subsequently immigrated to Canada to be with him when he returned home. They lived together for 3 years prior to getting married in 1978.

#### Assessment

Description of the Problem. Monda presented with a complete lack of desire for sexual activity with her husband. She avoided sex with Gordon and noticed decreased physiological and subjective arousal when they did make love. She was able to climax with self-stimulation and had been able to reach orgasm during intercourse in times gone by. Monda and Gordon had noticed a particular decline in their sexual relations over the past two years. Problems in this area, however, had existed for approximately seven years. For about 5 months before they married, Monda completely

avoided sexual activity. At this point, they had been living together for a couple of years. Monda had returned to England at this difficult time to acquire her immigration papers. She had fully believed that she would be staying there never to return to Gord. Gord, however, proposed over the phone; and Monda, realizing how much she missed Gord, accepted. The two were married in England, and then returned to Canada. Monda participated in sex without much enthusiasm. This contrasted with the couple's initial sexual experience. The first six months that Monda and Gord dated had been a fun, relaxed, happy time - in and out of bed. However, once Monda had been in Canada for about six months, the lack of sexual interest and avoidance commenced.

At the point of therapy, the couple had not had intercourse for several months. The average length of time between sexual relations seemed to be between 4-6 weeks. Monda was still orgasmic via self-stimulation and on occasion via intercourse. Gord was frustrated by the lack of sexual activity; and felt that the strain that this put upon himself adversely affected his attitude towards the marriage. He could not see how they could maintain the relationship without sexual involvement. The couple expressed love for each other; but, felt that they interacted on the level of good business partners, good friends - not as lovers.

The sexual relationship was also affected to a degree by Monda's phobic reaction to touching or inserting objects (i.e. tampons) into her own vagina. She had never been able to be internally examined by a doctor because of her adverse reaction to this. She would break out in a sweat, become dizzy, lose her ability to concentrate and experience vaginismus. Interestingly enough, insertion of a partner's penis and

cunnilingus didn't bother her. She, however, could not tolerate manual stimulation by a partner of her genitals. She also didn't like to look at her partner's genitals, nor had she ever performed fellatio.

Monda also had experienced severe bouts of depression. These episodes left her unable to participate in daily activities. At these times, Monda would eat and sleep all day. The depressions usually lasted 3-4 days each month. There didn't seem to be any set pattern for the depression; in that she could skip a month or two without experiencing the severe lethargy of needing to sleep around the clock.

Contemporary Influences on Problem. As mentioned, the lack of sexual activity had been putting a strain on the marital relationship. Gord was feeling that his frustrated feelings were spilling over into the general relationship. Monda agreed that her depressive episodes contributed to the general unhappiness in the union.

The couple also had completely divergent life goals that proved to be the achilles heel for their marriage. Gord had a successful business in this city that he wanted to nurture and see grow. Monda wanted to return to England and become a stage actress. She did not enjoy living in Canada; it did not suit her temperament, nor her lifestyle. Gord was willing to eventually move to England; but, not until he could sell his business for a substantial profit. This difficulty eventually caused the break-up of their marriage.

Sexually, the couple were relatively inexperienced. They had had previous partners, but knew little about appropriate stimulation. Because of Monda's particular phobia they had refrained from sexual activity that involved manual stimulation. Oral stimulation, though acceptable to Monda for herself, had never been practised in the rela-

tionship because of Gord's shyness about attempting a technique with which he was unfamiliar. He also would have enjoyed fellatio; but, Monda's negative feelings about this practise deterred this activity.

The couple avoided attempting and/or voicing their sexual preferences because of the negative reactions they had received from their partner. Monda felt anxious and guilty that she was depriving Gord of sex; yet, she didn't want to partake in the activity. Gord wanted Monda to enjoy their physical relationship; but, felt at a loss about how he could go about accomplishing this. The couple harboured unvoiced anger towards each other; Gord for being deprived of sex and Monda for being forced into sex.

The couple were both in good physical health; though Monda felt that she was approximately 25 lbs. overweight. The couple found each other relatively attractive; though Monda was put off by Gord's receding hairline; and he was slightly disturbed by her weight gain.

Personal and Family Background. Monda was 29 years old, had a high school education, was actively involved in the performing arts here in the city and was of British extraction. She had had a strict Roman Catholic upbringing in England. Her father had been in the Royal Air Force and the family had moved around the country quite a bit.

Her parents had been married for approximately 35 years and had had 5 children. Monda's oldest brother (age 34) is a dancer and choreographer in Germany. Her youngest brother (age 24) is a playwright and lives in London. Her third brother (age 32) committed suicide in 1976, likely due to severe depression. Her sister, age 31, is married, has one child and lives with her husband in Edmonton.

Monda says that depression is evident in her family. Her brothers, sister and father have depressive episodes; also her paternal grandfather and aunt were often depressed. Her brother, who committed suicide, had been on antidepressants at the time of his death. The physical health of the family is good. Sex was a topic that was not discussed in the home freely. Monda got the impression that sex was dirty from her parents. Her parents, however, were not opposed to Monda and Gord living together prior to their marriage.

Gord also was 29 years old, had a high school education and was owner of three businesses here in the city. He did not feel strongly affiliated to any religion though his parents and siblings had converted from the United Church and had become Jehovah Witnesses approximately 4 years ago. They were now actively involved in this religion and it was a topic that Gord veered away from. Gord was in good physical health; and he had little leisure time due to the stresses of running his businesses.

Gord's parents have been married for 30 years and live in a rural area of this province. His father is a farmer and his mother is a telephone operator. He has three brothers and two sisters, all of whom are married. Sex was also a forbidden topic in his family and he acquired his sex education largely upon his move into the city in '72.

Childhood and Puberty. Monda was raised by strict catholic standards. She attended a private girls school until she was 13 years old. She believed that this upbringing helped to maintain the prudish attitudes she now holds towards her body and some sexual activity. She gained her sex education largely through school films and peers. She exhibited primary and secondary sexual characteristics around the age of 13. She had not experienced any traumatic sexual experiences to her knowledge.

Gord, as mentioned, gained his sexual knowledge from the farm (animals giving birth) and from his peers once he had moved to the city. He exhibited primary and secondary sexual characteristics around the age of 13.

Sexual Experience Before Current Relationship. Monda had six sexual partners prior to Gord. She found sex pleasurable and positive with most of these fellows. She had been close to marrying an Italian when she met Gord; but, broke off that relationship with little regret once she became involved with him. Intercourse and oral sex were practised with her other partners, and she found herself orgasmic in these activities.

Gord had two steady relationships prior to meeting Monda in which he was sexually active. He found sex fun and enjoyable, but, stuck strictly to intercourse as a means to sexual expression. He was not unwilling to try other modes of stimulation; however, he had not had a partner who wanted to teach him the new techniques and was shy about attempting this on his own.

Current Partnership. The couple had lived together for three years prior to getting married. As mentioned, a two month separation - during which Monda had returned to England to file for immigration status - prompted the couple to marry.

The first six months that the couple were sexually active was fun and enjoyable. However, once Monda had moved to Canada to be with Gord, their sexual relationship slowly deteriorated. For 5 months prior to Monda's return to England, the couple had not physically touched each other. Monda had thought that her return to England would herald the end of their relationship. However, instead, they found that they very much missed each other and Gord flew to Britain to marry Monda.

The sexual relationship continued to deteriorate to the point that for the last two years the couple had been having sex approximately once a month. Monda was at the point where a completely platonic relationship would have been adequate for her. Gord, on the other hand, couldn't see the merit of continuing a marriage that was void of sexual activity. Neither person was sexually or romantically involved outside of their marriage. They believed themselves to be in love, best friends and competent business partners.

Attitudes Towards Treatment. The couple presented with a desire to work on their sexual problems, which were affecting the general marital relationship. It seemed, however, to the writer that Monda's lack of sexual desire was largely tied into her commitment to the marriage and her desire to return to England. The prognostic expectancy was not positive since the couple presented very different life goals.

Progress and Outcome

The writer saw this couple for fourteen in-office interviews. Numerous contacts were made between sessions by phone. Sessions focused on sexual therapy, since the couple seemed not to recognize the instability of their marital union. The divergent life goals - Gord's wish to remain in the city and to continue to expand the business, while Monda wanted to return home to England and become a stage actress - were initially seen by the couple as workable.

The couple did not seem to realize on a conscious level that Monda's lack of sexual interest also showed her ambivalence about her marriage to Gord and her strong desire to leave this city and her lifestyle here. She felt that her artistic temperament was not allowed free expression in this milieu; and she desired to return to a European climate (socially and temperature wise).

Therapy followed Heiman's (1976) program. Monda found it relatively easy to achieve orgasm through self-stimulation. The couple progressed into mutual pleasuring sessions after two weeks of treatment. Resistance was encountered at this stage by both partners. The couple would not find the time to do their homework sessions. They would refer to their busy schedules and various time commitments. Homework assignments were then specifically scheduled for time and day. The couple still had a difficult time meeting these minimum requirements.

At this time, the therapist pointed out the futility of coming for sexual counselling when they did not follow through with their treatment. The couple agreed with this viewpoint and renewed their commitment to work on their problems.

Concurrently with the sexual therapy, a treatment program had been set up for Monda to deal with her phobic reaction to touching her vaginal area and inserting a tampon. She also had been referred to a psychiatrist for assessment of her depressive episodes. It seemed likely, to the writer, that she might be suffering from endogenomorphic depression and might need some type of drug therapy to modify her mood swings.

Sexual therapy gradually brought to the forefront the couple's deep seated marital difficulties. The couple began to focus in on their different life goals and eventually decided to separate. Monda went back to England and Gord remained in this city. At the time that treatment was terminated because of this development; Monda had successfully been working on her phobia. She had progressed from feeling nauseated and dizzy at the thought of touching herself, to being able to insert the tip of her finger into her vagina. The psychiatrist, to whom she had been initially referred, had referred her to another doctor who specialized

in endogenomorphic depression for further assessment. Monda left for England before she could follow through on this aspect.

The couple terminated treatment on a positive note with the writer. They saw counselling as having been a necessary catalyst that had made them look at their relationship and its future direction.

## B. Sexual Phobia

### 1. Description

A sexual aversion "is a consistent negative reaction of phobic proportions to sexual activity or to the thought of sexual activity" (Kolodny, 1979, p. 557). Kaplan (1982) agreed with this definition. She saw an aversion to sex as a phobia, qualitatively different from "inhibited" or "hypoactive" sexual desire. Schover (1982) however, argued - based on the Multi-Axial Problem-Oriented Diagnostic System (Schover et al., 1982) - that an aversion to sex was a more severe point on a continuum of sexual avoidance behavior and not a separate entity.

In this paper the terms sexual aversion and sexual phobia will be used interchangeably to denote the phenomena described by Kolodny (1979) and Kaplan (1979, 1982). Sexual aversion will be considered a unique and separate entity from that of low sexual desire and its continuum as understood by Schover et al. (1982).

Sexual phobias can be situational, in that the aversion occurs in only one context or with one partner; or more typically, the negative reaction will occur in all aspects of sexual contact with another person. The problem can also be a lifelong problem; or one of shorter duration (for example, a phobia towards sexual activity developing only after a brutal sexual attack).

Sexual phobias and avoidance patterns are highly prevalent among clients with sexual complaints (Kaplan, 1982). Avoidance patterns can be elements in all psychosexual dysfunctions; but, are an essential feature of sexual phobias (Kaplan, 1982; Murphy, Sullivan and Leland, 1979; Murphy and Sullivan, 1981). Thus, for example, the premature ejaculator might avoid sexual contact with a new partner to escape the humiliation and rejection he anticipates might follow his rapid ejaculation. He is, however, not afraid of sexual gratification; so, as soon as he is able to learn ejaculatory control, he will happily seek out sexual opportunities. The sexually phobic patient, on the other hand, is not afraid of failure, which is considered a 'rational' fear. He "is afraid of sex, which is, of course 'irrational' in the sense that sex is pleasurable and not harmful. But sex evokes intense anxiety or panic in phobic patients so their avoidance of these highly uncomfortable sensations is eminently understandable" (Kaplan, 1982, p. 8).

The phobia can manifest itself physiologically by profuse sweating, nausea or vomiting, diarrhea, palpitations, rapid breathing, difficulty in concentration and recall, and intense anxiety (Beck, 1979; Kolodny, 1979); or in other instances, the phobic components are internalized and do not appear in this manner.

"Sexual aversion can occur in either males or females; but the preponderance of cases involves women" (Kolodny, 1979, p. 557). Schover (1982) also discovered a striking gender difference in aversion to sex. He hypothesized that women needed to exhibit more intensely negative reactions to sex in order to avoid participation (exemplified by the higher rate at intake of sexual activity for couples in which the wife had low sexual desire as compared to couples in which the husband had low desire or the wife found sexual activity aversive). He also suggested that extreme avoidance behaviors, such as expressing revulsion, weeping and/or fighting a sexual approach might be considered stereotypically feminine in our culture. This, however, the writer would suggest could

again reflect the woman's need to exhibit more extreme behavior in order to ward off sexual activity.

Sexual aversion can appear in the guise of either a lack of interest in sex or a low frequency of sexual activity (Kolodny, 1979; Kaplan, 1982). "A complaint of low sexual frequency always involves the differential diagnosis between true inhibited sexual desire (I.S.D.) and phobic avoidance of sex" (Kaplan, 1982, p. 9). Inhibited sexual desire involves an impairment of sexual interest that is not associated with panic. The person with a sexual phobia experiences irrational, overwhelming anxiety at the thought of sexual contact. The phobic experiences intense fear or an extraordinary desire to avoid the dreaded event. The anticipation of the event is often more intensely anxiety - provoking than the actual situation itself. "In fact, patterns of sexual arousal are apt to be largely intact in persons with sexual aversion, so that it is not unusual to discover that men with sexual aversion are fully potent and able to ejaculate or that women with sexual aversion experience orgasm" (Kolodny, 1979, p. 557). The person, on the other hand, who has inhibited sexual desire "will not feel erotic interest when sexual contact is resumed or initiated in the course of treatment" (Kaplan, 1982, p. 9).

Phobic reactions can be associated with other sexual dysfunctions, for example with vaginismus (Fuchs, Hoch, Paldi, Abramovici, Brandes, Timor-Tritsch and Kleinhaus, 1973; Kaplan, 1974, 1979, 1982; Murphy and Sullivan, 1981). It is, therefore, important to differentiate the dysfunctions that are associated with phobic reactions from those which are not (as exemplified with the man who had premature ejaculation who avoided sexual activity out of embarrassment; vs a woman who is phobic of vaginal penetration and exhibits primary spasm of the vaginal inlet (vaginismus)).

Sexual aversion should also be distinguished from anxiety neurosis, "which is characterized by free-floating anxiety attacks with cardio-

respiratory symptoms unrelated to a specific and consistent stimulus" (Kolodny, 1979, p. 558; and supported by Beck, 1979; Kaplan, 1982).

## 2. Etiology

A variety of etiological factors have appeared to be important in cases of sexual aversion. Such factors as severely negative parental attitudes (Kolodny, 1979); a history of sexual trauma - in childhood, adolescence and less frequently in adulthood (Kolodny, 1979; Murphy and Sullivan, 1981; Jehu and Gazan, 1982); a severe difficulty in an adolescent with either body image or self-esteem (Kolodny, 1979); a pregnancy scare (Kolodny, 1979); other intrapsychic pathology such as obsessive-compulsive neurosis, character disorders or anxiety neurosis (Kolodny, 1979; Kaplan, 1979, 1982); a history of turmoil in the family, i.e. divorce (Murphy and Sullivan, 1981); finding one's nude body and genitals unattractive (Murphy and Sullivan, 1981); having guilty feelings during masturbation (Murphy and Sullivan, 1981); conflicts with sexual identity (Kolodny, 1979; Murphy and Sullivan, 1981); and associated with other phobias, such as those related to cancer, venereal disease or pregnancy (Kolodny, 1979) have been linked with sexual phobia.

Psychological formulations of anxiety have taken two major forms: (1) psychoanalytic and (2) those derived from social learning theory. Behavior therapists have asserted that a phobia is basically an "accidental conditioning". Wolpe (1969) postulated that a phobia developed from (1) a frightening incident that had produced anxiety, another (neutral) stimulus had also been present at the time of, or prior to, the frightening event; and (2) the neutral stimulus became linked to the anxiety through this adventitious association. Thereafter, the person

became anxious in the presence of the "neutral" stimulus i.e., he had developed a phobia to this stimulus (Beck, 1979).

Psychoanalysts would similarly postulate an indirect connection between the source of the fear and the specific content of the fear that the patient experienced. The individual would displace his "real" fear onto some innocuous external object (Beck, 1979). The anxiety the person felt would be attributed to neurotic processes; as a signal that the equilibrium between conflictual psychological wishes were about to transcend the bounds of psychic safety. The anxiety would erupt in the service of maintaining psychological homeostasis (Kaplan, 1982).

Psychodynamic and learning theories might "seem dichotomous, but actually there are only a few essential contradictions between these two models. Implicit in both is the notion that individual differences in the capacity for anxiety or fear are irrelevant for the understanding and treatment of psychopathology, and both theories are based on the assumption that neurotic symptoms and irrational anxieties are learned or acquired. The two theories differ in that they analyze the acquisition and maintenance of irrational anxiety and maladaptive behavior from different levels of description. Psychoanalysis focuses on the early genesis of neurosis and postulates unconscious processes to account for the lag between childhood experiences and adult manifestations of psychological symptoms. Behaviorists, on the other hand, focus on data about the specific circumstances that evoke and maintain disturbed behavior in the current situation" (Kaplan, 1982, p. 4).

### 3. Assessment

Assessment of this dysfunction follows the outline presented in Part 2:A (Appendix B). Specific paper and pencil instruments administered to clients exhibiting this dysfunction would be the Sexual Arousal Inventory (Hoon et al., 1976); Sexual History Form (Schover et al., 1980); Index of Sexual Satisfaction (Hudson et al., 1981); and the Dyadic Adjustment Scale (Spanier, 1976) where applicable. Interviews, client self-monitoring, and archival records would also be used as indicated in Part 2:B.

#### 4. Treatment

The treatment approaches that grow out of psychoanalytic and behavior theories differ substantially in several respects. Psychoanalytic theory would assert that the neurotic sexual anxiety that produced the phobic reaction should be cured by insight; while learning theory would predict that behavior therapy designed to extinguish the learned fear response would eliminate the sexual phobia.

Though behavioral therapy has produced much better treatment results than has psychoanalysis; a combination of the two is often thought most beneficial (Kaplan, 1982). In essence, the sexual and communication tasks are admirably suited to modify the "immediate causes and anxieties associated with the psychosexual symptom, while psychodynamic techniques" can be employed "to illuminate and resolve deeper and unconscious sexual conflicts, if and when this "seems" appropriate and necessary for the relief of the sexual symptom" (Kaplan, 1982, p. 5).

The prognosis for successful treatment of a sexual phobia is very positive. Out of 116 cases of sexual aversion seen at the Masters and Johnson Institute between the years of 1972-1977, 77 out of 85 cases of female sexual aversion were successfully treated (failure rate: 9.4%); and 29 out of 31 cases of male sexual aversion were treated successfully (failure rate: 6.5%). Thus, the overall failure rate for the treatment of sexual aversion was 7.6 percent (Kolodny, 1979).

The basic principle of all treatments of sexual phobias is to reduce the client's irrational fear and consequent avoidance of sex (Beck, 1979; Kaplan, 1979, 1982; Kolodny, 1979; Murphy and Sullivan, 1981; Murphy, Sullivan and Leland, 1979). "This holds true whether the sexual phobia is the only problem or is merely one manifestation of a complex psychopathologic pattern; whether it is the product of simple conditioning or has deeper intrapsychic meaning or relationship roots" (Kaplan, 1982, p. 11).

The phobia is always treated first, in cases where a sexual dysfunction also exists. The reason for this is that it is impossible to treat the client's other symptoms while he or she is too uncomfortable and anxious to carry out or benefit from the sexual exercises. Thus, for example, in the case presented in this paper, Kerri's phobic reaction had to be dealt with via a desensitization hierarchy; before treatment could begin for her lack of sexual desire, dyspareunia with intercourse and inorgasmia.

Treatment for phobias is highly individualized. It is important not to make a prior judgement regarding the ideational content of phobias. The meaning of particular phobic objects or situations can vary considerably from client to client just as a varied assortment of fears experienced by a single client can have a common underlying meaning (Beck, 1979).

Therapy usually follows a format whereby the phobia is identified. It is important to remember that it is not the object, event or situation per se that the phobic fears; but, the consequences of his being in the situation or in contact with the object (Beck, 1979) including fear of fear. Thus, for example, for Kerri it was not sexual activity itself that she feared; but, the pain she anticipated would accompany intercourse.

A rationale is then presented to the client, by the therapist, for approaching the feared object, situation etc. It must be one with which the person can agree. "The standard rationale is to tell the patient he might have acquired this fear through a traumatic experience, either his own or someone else's which he reacted to vicariously; and because he then religiously avoided the situation, he never had a chance to "unlearn" his fear" (Beck, 1979, p. 171). Almost complete control must be given the client, for a time, of all sexual activity. The client must

be assured that he or she will be able to shed the fear by approaching the object that is anxiety provoking at his/her own speed. This may either be in a gradual manner as is the case in desensitization (Jehu, 1979; Kaplan, 1979, 1982; Kolodny, 1979; Beck, 1979; Wolpe, 1958; Lazarus, 1976; Madsen and Ullman, 1967; Averbach and Kilmann, 1977; Wenyé and Cairn, 1976; Obler, 1973); or in prolonged exposure to the dreaded event, as in flooding (Jehu, 1979). The client can be also told that what one avoids is often expected to be much more painful than what one actually lives through. Beck (1979) suggested that the research done by (Bandler, Madaras and Bem, 1968) be cited to support this statement. Therefore, as rationale for the cited case history, the therapist linked Kerri's avoidance of sexual activity with a fear of pain; and a restrictive upbringing. She also pointed out the positive gains to be made when Kerri overcame her phobia (i.e., marriage to Abe). For Kerri, this rationale for treatment was acceptable; and it reinforced her strong motivation to tackle her fear.

Since flooding has been used infrequently in the treatment of sexual dysfunction (Jehu, 1979); it will not be dealt with in this paper. Desensitization, however, has been used extensively; and was the next step that the writer utilized when treating the sexually phobic client.

"Desensitization treatment procedures have come to consist essentially of, first, selecting a response which is an alternative to anxiety, and if necessary training the patient to perform it satisfactorily. The second step is to identify the events which evoke anxiety and to rank them from the least to the most disturbing, in one or more hierarchies. Desensitization itself starts with the elicitation of the alternate response to anxiety: for example, a state of relaxation and calmness might be induced in the patient. The least disturbing event is then presented to him, and when this no longer provokes anxiety, the procedure is repeated for the next most disturbing event in the hierarchy and continues until the patient has been desensitized to every event requiring treatment" (Jehu, 1979, p. 155).

Methods that can be used to induce relaxation in the client are Jacobson's (1938) progressive relaxation techniques; hypnosis (Wolpe, 1969; Wolpe et al., 1973); and the use of certain drugs, for example Brevital (Brady, 1966, 1967, 1971; Friedman, 1966, 1968; Friedman and Lipsedge, 1971; Kraft and Al-Issa, 1968; Mawson, 1970 as cited in Jehu, 1979). Some clients may not be ready to actually face the feared situation and may need to practise doing this via the use of imagery (Jehu, 1979; Beck, 1979; Heiman, 1976).

Sexual avoidance may be an isolated psychogenic symptom or it may be secondary to the phobic anxiety syndrome described by Donald Klein (1964, 1980). Some phobic patients do not respond to sex therapy, as described in this paper; and, in some cases, their phobias and avoidances are actually aggravated by treatment. "Their fears are so intense" that they tend "to avoid the erotic behavioral assignments or, if they do force themselves to do them, experience anxiety and panic of counterproductive intensity. Such patients also seem immune to psychotherapeutic support and to confrontations and interpretations designed to resolve resistances" (Kaplan, 1982, p.11). Klein (1964, 1980) and Kaplan (1979, 1982) found that a significant proportion of this population could be protected to a large degree from panic attacks when given medication of the tricyclic and/or MAO inhibitor class. Another group of psychoactive drugs, the diazepines, could protect many of these people from anticipatory anxiety that may have been acquired as a consequence of the painful panics.

In addition to treating the phobic client, it is important, where applicable, to enlist the complete cooperation of the patient's partner. This is imperative because this person will probably have to put his/her own interests behind that of the patient's for, at least, the early phases of treatment. Support supplied by the partner can be very valuable in motivating the client to overcome his/her fears.

It has been found that often a partner, encouraged by the progress that the aversive individual is making in trying to change his/her own behavior, will push too fast or for too much sexual contact; in direct violation of the therapist's request for the client to set the tempo for sexual activity. "Such episodes often create a microcosm of the maladaptive relationship dynamics important to the genesis of sexual aversion. Rapid confrontation and resolution of the situation" "to validate the positive reinforcement the sexually aversive person is getting from the therapists and from feelings of self-actualization" is mandatory (Kolodny, 1979, p. 563).

Resistances can arise in the course of treatment. The client's phobic avoidance of sex can turn out to have symbolic meaning of which he or she is not aware, or the phobic symptom could function as a defense against unrecognized or unconscious psychic danger. These resistances must be either 'by-passed' or resolved so that treatment can proceed to a successful conclusion (Kaplan, 1982). Insight is usually used, within the context of brief therapy, to bring out the self-destructive and anti-pleasure behavior tendencies which operate outside of the patient's awareness (Kaplan, 1982). Deeper conflict analysis (i.e., unresolved oedipal conflicts) is not seen as appropriate within the sex therapy format.

## 5. Case History

Kerri - Sexual Phobia, Avoidance of Sex, Inhibited Sexual Desire and Dyspareunia

### Demographic Data

Kerri, age 23, and her fiance, Abe, age 24, had been dating for approximately 1 1/2 years at the time therapy was initiated. Kerri was employed as an assistant in the accounting department of an automotive firm; and Abe worked as a mechanic. Kerri came from a strict Anglican upbringing; while Abe's religious background was much more relaxed.

## Assessment

Description of Problem. Kerri had presented as having an aversion to sexual intercourse and petting below the waist. She experienced pain in her genitals (at the vaginal entrance and in the areas near her cervix) during sexual intercourse. This pain lasted for approximately 1-2 hours after intercourse had ceased. She had seen a doctor in regards to the pain and there hadn't seemed to be any organic cause. Vaginismus had been ruled out since penile insertion was possible without undue difficulty.

Kerri became physically ill, her stomach went into knots, and she threw up when she knew that intercourse was to be attempted. As soon as attention was paid to her genital region; Kerri completely "turned off". This meant that she had no recollection of any activity from the time that intercourse and/or genital petting was started; until her partner had reached orgasm and then terminated sexual activity. This meant no physical sensation or mental awareness (including memory recall) of this event.

The client had stated that she did experience pleasure at being kissed, hugged and petted above the waist. Both she and her partner had said that vaginal lubrication and swelling did occur in the initial stages of love-making. This initial physiological, arousal response quickly dissipated (within 1-2 minutes) once penetration - manual or penile - was achieved.

Kerri had mentioned that she desired to have sex with her partner approximately 3 times a week. She, however, was seldom emotionally aroused by sexual activity. She was unaware of the discrepancies between her body's initial reaction to stimulation (lubrication etc.) and her mental blocking of any recollection of vaginal penetration.

She had never reached orgasm, either manually, by a vibrator or with a sexual partner. She had no idea what an orgasm should feel like; and she had never experienced any positive feelings (that she could identify) from her genitals.

Kerri tried to avoid sexual activity with Abe as much as possible; usually by ignoring his physical advances.

Much of what occurred once genital petting and intercourse commenced had to be recounted by Abe, since, Kerri had no memory of these activities.

Abe had not noticed any constriction of vaginal muscles when he had attempted penetration. He did say that lubrication was ample when he initially entered the vagina; but, that this dried up after 1-2 minutes of thrusting. He, typically, thrust for 7-10 minutes before he reached orgasm.

He said that it was very difficult to ascertain exactly what Kerri was feeling throughout their love-making. Her face would register pain, pleasure and "blankness"; and shift between these moods, quickly, at each encounter.

Kerri could not validate this observation since she could not remember what had occurred during actual intercourse.

She tried to respond to Abe initially, (i.e.) moved, touched him; but, in November 1981, could no longer participate. At the initiation of treatment, she just lay in bed - not moving - when Abe proceeded past petting.

The above mentioned difficulties occurred in each sexual attempt. As mentioned, Kerri's anesthetized bodily and mental reactions occurred once petting below the waist and/or vaginal penetration was attempted.

Abe attempted sexual intercourse each time that this couple was together (2-3 times a week); and, this endeavor had been completed to orgasm approximately 3 times in 1982. Kerri would usually break off the attempt once petting went below the waistline. This explained the low rate of completed intercourse for Abe.

Both partners had verified that initial cuddling, kissing and fondling lasted approximately 45 minutes - 1 hour. Abe then proceeded to stimulate the clitoris for 14-16 minutes (including massaging the genital region, being pushed away by Kerri, going back to massaging etc.); then he entered the vagina, thrust for 7-10 minutes and, then reached his orgasm.

Surrounding Circumstances. Kerri's reaction to sex occurred in all situations, in all locales and with any type of advance that Abe made (gentle, forceful etc.). Abe had been Kerri's only sexual partner.

Duration. Kerri had had this difficulty since she initially became involved with Abe. Since this was also her first sexual experience, the problem could be said to be 'primary'.

Onset. Kerri never had had sexual intercourse, nor had she experienced petting below the waist prior to her relationship with Abe. The couple first met in November 1980, and they had attempted (and had completed) sexual intercourse 10 days after their first date. This couple had started to live together 2 weeks after having met; and the sexual problems, as outlined, had begun with the first sexual encounter.

Kerri had been totally unaware that sexual intercourse was about to occur until the pain associated with the penetration took place. Her hymen was broken at that time. This was verified by the blood that she observed on the couch after their sexual encounter.

Course. Initially, Kerri tried to suppress her extremely negative feelings towards sexual intercourse. She, over the period of several months, was able to learn to touch Abe's body and legs (not his genitals).

She learnt positions, where to touch Abe to pleasure him, by his direction. Abe thought that her displeasure was lessening with experience. As aforementioned, he was unable to read her facial expressions - and the topic was not overtly discussed at that time.

Abe was not overly concerned with her behavior re: sexual activity because he, initially, put it off to Kerri's inexperience. He did not push oral sex; since Kerri totally refused to participate in this activity.

The couple began to experience some problems in their overall relationship. Abe was unable to manage money well and the couple went into debt. Kerri was also beginning to feel that Abe needed to gain some maturity in general.

In November 1981, 1 month before they were to get married, Abe called off the wedding. He stated that his feelings towards Kerri hadn't changed and that his reasons for terminating the wedding plans were personal. He felt that he needed to discover what his goals in life were; and if he could take care of himself before he took on the responsibility of a wife. The couple separated, took up new dwellings, and began to talk about their relationship problems.

At the time of therapy, the couple felt that they had dealt with the money, personal and commitment difficulties. The sexual problems, however, had persisted; but both people were willing to try to improve this difficulty.

Contemporary Influences of Problem. The stress factor for Kerri was very high whenever petting below the waist and/or intercourse was attempted. She experienced an amnesia-like reaction whereby she had no recall of any actions, feelings or thoughts that occurred after sexual activity went beyond the aforementioned point.

She believed that sexual intercourse was painful, especially intromission and thrusting about the cervical area. This was an interesting belief to be stated by a person who had no conscious recall of any such activity. She was quite limited in her sexual knowledge. She also believed that sex was dirty; and that is was practised solely in marriage. Kerri was anxious and fearful of sexual intercourse. She disliked it intensely; yet, felt guilty about these feelings because they deterred her from giving pleasure to Abe. She also feared that he would eventually leave her if she could not overcome her feelings of disgust towards sex.

Kerri's physical health was good and a physical examination had determined no organic cause for experiencing painful intercourse. She did have arthritis in her elbows and knees (took entrofen for this) which deterred her from using certain positions during intercourse.

Abe's reaction to Kerri's sexual phobia was one of hurt and confusion. He greatly enjoyed sex and had been active since the age of 12. He expressed genuine love and friendship for Kerri. He, however, initially attempted intercourse with Kerri even when it was strictly forbidden by the therapist. He had attempted coitus at every opportunity he received over the two years that the couple had been dating. He, by his own admission, was not a person to be easily deterred. This was certainly the case given that Kerri had turned him down 3-4 times a week, every week for the past 2 years.

Family History. Kerri grew up in a strict, Anglican, Irish family. The family messages regarding sex were negative and guilt provoking. Sexuality, and its association with pleasure, were taboo topics and relegated to the position of a necessity solely for the purpose of procreation.

Abe grew up in an easy-going family. Sex was talked about openly in the family and amongst friends. He had liked sex from his first experience at age 12 with the 16 year old babysitter. He did not masturbate and had been regularly, sexually active since his first experience.

Sexual Experience Before Current Partner. Kerri had never masturbated, had sexual fantasies or experienced an orgasm prior to therapy. She had only petted below the waist with Abe. She did not recall any sexually traumatic experiences other than her very negative reaction to her first sexual experience with Abe. She had been previously engaged; but, that young man died. She had only allowed this person to touch her breasts prior to their intended marriage.

Abe enjoyed sexual fantasies and had dated frequently, with sex as a natural by-product of an evening's activities. He had lived common-law with 2 women prior to Kerri. His first relationship was at the age of 17. His girlfriend was pregnant and they had intended to marry. She, however, was killed in a auto accident 7 months into their relationship. His second common-law relationship lasted 18 months. They broke up because of incompatible life goals. He had had frequent and satisfying sex with these two women.

Current Partnership. Kerri and Abe co-habited from November 1980 to November 1981. They had planned to marry in December of 1981; but, the

engagement was broken off because of disagreements over money management; their personal growth goals differed; and Kerri felt that Abe lacked commitment to the relationship. At this time their sexual problems were, as yet, not an issue.

The couple moved into separate apartments and began to work on their differences. They were able to handle most of their difficulties. The sexual relationship, however was too difficult for them to handle.

At first Abe thought that the problem was one of sexual inexperience on the part of Kerri. He, therefore, patiently tried to teach Kerri his likes and dislikes and to get her to express her preferences. He did not even know that there was a problem until November 1981, when Kerri finally told him. Up to this point she had successfully fended off his advances and vague attempts at discussion.

Abe was not easily deterred, and he made sexual advances "all the time" (Kerri's admission). Abe was hurt, disappointed and concerned over Kerri's dislike of one of his major enjoyments. He felt that sex was a large part of a marriage relationship and he didn't want to have a platonic friend as a wife.

Kerri would have been happy to completely ignore sex. She enjoyed cuddling, kissing and showing love via gestures in every day activity. She, however, wanted very much to become "tolerant" of sex because she wanted to make Abe happy. Her treatment goal was to be able to put up with sex; and maybe, to even enjoy it. She had no wish to become orgasmic.

Attitudes Towards Treatment. The couple was highly motivated to pursue treatment since their impending marriage rested on positive results. Kerri hoped to be able to tolerate sex by December 1983 (their new

wedding date); and Abe hoped to see results in 3-4 weeks. They thought that a goal of intercourse once a week would be a suitable outcome to both of them.

### Progress and Outcome

#### Treatment

The immediate cause of Kerri's avoidance seemed to be her anticipatory anxiety about love-making. Fearing a panic attack of becoming physically ill, and of being unable to remember what had happened to herself during intercourse; Kerri avoided sexual activity. The sense of relief that she felt from avoiding intercourse led to a reinforcement of the pattern of avoidance. When Kerri was unable to escape a situation physically; she did so psychologically (via her amnesic reaction). It was difficult to ascertain if Kerri's lack of sexual desire was a primary problem or secondary to her phobic avoidance of sex, at the time of assessment. Later in treatment, it seemed that constitutionally, Kerri had a low interest in sex. Surprisingly, however, Kerri's desire for sex seemed to pick up once she was able to complete intercourse without adverse reactions. Since this is only a very recent response, the writer is unable to say, at this time, if this heightened level of sexual interest will be maintained.

From the onset of therapy, it was evident that Kerri was phobic towards sexual activity. The etiology and high probability for a successful outcome were presented to her. Kerri was reassured that there was a better than 90% chance of her overcoming her difficulty. She had come into therapy highly motivated to tackle her phobia; because it represented to herself her willingness to commit to her relationship with Abe. It also soon became evident that the relationship, and impending

marriage, hinged on her successful ability to overcome her aversion. What could have been extreme pressure on Kerri to function sexually - thereby, hindering her progress; turned out to be her constant inspiration in hurdling her sexual aversion. Abe also felt somewhat reassured that Kerri's avoidance of sex was just that and not a personal rejection.

Kerri willingly commenced the desensitization process once she realized that she would be in control of the sexual activity. It was a great sense of relief, to her, to know that she would become comfortable with her own body and its physiological and psychological responses; before Abe would join in the exercises. Kerri started an individualized program which (Heiman's Becoming Orgasmic: A Sexual Program for Women, 1976) followed a desensitization hierarchy: from looking at her genitalia with a hand mirror; through to manual stimulation resulting in physiological arousal.

It took Kerri 7 weeks, following the Heiman program, to reach the point where she was able to tolerate self-stimulation of her genitals. The adverse physiological reactions she had been experiencing - knots in her stomach, tense back muscles, clenched fists; as well as the disgust at vaginal lubrication (a desensitization program had been set up using gradual exposure to K-Y jelly, and then her own secretions) and amnesia were totally eliminated. Throughout this period, Kerri actively practised relaxation exercises (Heiman, 1976) and positive cognitive restructuring (Jehu, 1979). Kerri, for example, used these tools, during her self-pleasuring exercises, when she noticed tension in her back and buttock muscles. She, then, would consciously relax the region and would think of how pleased Abe would be when she could participate in their lovemaking.

Kerri's own personal goal did not include becoming orgasmic. She had found the thought of proceeding in this direction offensive. She put up a great deal of resistance to exploration of this conflict area; and it was thought more productive to proceed in an alternate direction, couple interaction.

The couple began with Kaplan's (1974) gentle, non-demanding Sensate Focus I exercises. They remained at this level for three weeks because of Kerri's inability to trust Abe. She feared that he would "go farther" than the exercises indicated; thereby, uncovering her unpreparedness to handle the more advanced step. Prior to treatment, and on one occasion early on in therapy, Abe had pressured for sexual activity. However, once his actions had been interpreted to him as reinforcing Kerri's negative response pattern; he desisted from further such incidences. He shared that he had fears of losing his own desire for sex. He stated that having to control his sexual impulses often left him feeling empty, "killed his desire".

Abe, interestingly, chose not to masturbate to relieve his sexual tension. An exploration into his belief system revealed that sex was seen as a mode of expressing love to a cherished partner, and not to be used as a purely physical release.

Treatment progressed quickly once Kerri felt secure that Abe would respect the limitations of treatment; her guilt feelings about denying Abe physical pleasure were resolved (via having Kerri masturbate Abe to orgasm); and she felt released from the pressure to work towards having a climax. This last aspect had been explicit in the reading material, and in the attitudes of her partner and the therapist. Once the therapist joined her resistance not to follow through on this aspect; Kerri no

longer felt she had to fight. She not only began to participate more actively in the final segment of treatment (tolerating intercourse); but, actually began to look forward to her homework sessions. By session 17, Kerri not only willingly participated in intercourse; but, had set a new goal for herself - attaining orgasm.

Only one incident occurred within this time period that concerned the couple. On one occasion, during week 14, Abe had become too excited during the homework exercise (gentle, non-demand thrusting) and had ejaculated. Kerri had quickly jumped off Abe and had run to the bathroom to take a bath. Abe, horrified at what he thought he had done - that being completely destroying the therapeutic gains that had been made up to this point - had remained in bed. The couple had not discussed the episode until their next session with the writer.

Exploration of Kerri and Abe's feelings revealed much different interpretations regarding the incident than they had attributed to each other. Kerri, far from being repulsed by the accident, was simply angry that she had not anticipated Abe's reaction. She was surprised and touched to find out that Abe had been afraid of destroying her progress and had felt guilty about loosing ejaculatory control.

The couple not only learned the importance of sharing their feelings after this incident; but, it was after this session that Kerri stated that she looked forward to their sexual activity. Kerri had also expanded her mind to include the possibility that she could become orgasmic; and she decided that it was a viable long-term goal. The reasoning that she gave for such a dramatic change of position was that sex was now in perspective for herself; and no longer held the fear of the unknown.

Therapy terminated by mutual agreement after 22 sessions. The therapist saw this couple increasingly less frequent (bi-monthly, and then once a month for two months) to determine the generalization and maintenance of treatment gains. Kerri enjoyed and initiated sex 3-4 times a week, on average, at the end of therapy. Both clients were extremely happy with their treatment gains. Test results on assorted paper and pencil instruments showed marked improvement:

(1) Sexual History Form (Sept. 1982)

Kerri - low sexual desire (life-long, global) (presenting problem)

- aversion to sex (L,G) (P)
- decreased subjective and physiological arousal
- inorgasmic (G,L)
- dyspareunia (situational, G) (P)
- desired frequency much lower than current activity level)  
(P), (G,L)

Abe - desired frequency much higher than current activity level)  
(situational, not life-long) (P)  
- no dysfunction (P)

(April 1983)

Kerri - inorgasmic

Abe - no dysfunction

(2) Sexual Arousal Inventory (Maximum possible score 140, mean 80.9,  
SD = 22.7)

	(Sept. '82)	(Nov. '82)	(Feb. '83)	(Mar. '83)	(April '83)
Kerri	4	3	46	58	76

(3) Dyadic Adjustment Scale

	Married		Divorced		Total	
	Mean	S&D	Mean	S&D	Mean	S&D
Dyadic Consensus Subscale	57.9	8.5	41.1	11.1	52.8	12.1
Dyadic Satisfaction Subscale	40.5	7.2	22.2	10.3	35.0	11.8
Dyadic Cohesion Subs	13.4	4.2	8.0	4.9	11.8	5.1
Affectual Expression Subscale	9.0	2.3	5.1	2.8	9.8	3.0
Dyadic Adjustment Scale	114.8	17.8	70.7	23.8	101.5	28.3
	N=218		N=94		N=312	

Sept. '82)

Kerri	Abe		Kerri	Abe	(April '83)
38	44	Dyadic Consensus	50	52	
33	35	Dyadic Satisfaction	35	36	
7	5	Affectual Expression	7	7	
<u>12</u>	<u>12</u>	Dyadic Cohension	<u>12</u>	<u>12</u>	
90	96		104	107	

(4) Index of Sexual Satisfaction (cutting point  $30 \pm 4$ )

	(Sept '82)	(Nov. '82)	(Feb. '83)	(Mar. '83)	(Apr. 83)
Kerri	68	60	48	43	41
Abe	78	75	43	37	35

It is possible that Kerri will yet work towards becoming orgasmic. The couple left this option open for exploration privately. They did not feel, at the termination of therapy, that it was a goal that they wanted to pursue in treatment. If they have difficulty with this final step, they have no qualms about returning for further therapy.

### C. Vaginismus

#### 1. Description

"This type of dysfunction can be defined as a spastic contraction of the muscles at the outer third of the vagina and the perineum, what 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" (Jehu, 1979, p. 106).

In addition, some clients will have contractions in the adductor muscles in the thighs so that they cannot be separated; and they will assume a particular posture involving an arched spine and backward extension of the head, which perpetuates the muscular spasms.

Many clients who suffer from vaginismus also experience considerable fear of penetration. This fear, coupled with the muscular spasms, may lead to non-consummation of a marriage, sometimes over a period of many years. "However, such clients are often quite able to become aroused and to reach orgasm by means of other forms of sexual stimulation that do not involve or threaten vaginal penetration" (Jehu, 1979, p. 106).

Vaginismus, occasionally will be limited to penile insertion, but, more frequently it will extend to penetration by any object, including, for example, the self-insertion of a tampon, and a physician's attempt to introduce an examining finger or speculum into the vagina.

The disorder is generally considered rare (Jehu, 1979; Masters and Johnson, 1970; Kaplan, 1974), though one author (Ellison, 1972) suggests that it is more common than people think. Statistical figures concerning incidence are very limited. Masters and Johnson (1970) cited 9% (29 out of 342 women) of their treatment population as having suffered from vaginismus; and an equivalent figure in the Bancroft and Coles (1976) study 11% (12 out of 102 clients) was also evidenced. Other than this limited information, there are no further incidence rates of vaginismus in the general population (Jehu, 1979).

The husbands of women suffering from vaginismus have been described as "timid, gentle, over permissive men who have either overt or hidden anxieties about their own sexual role and potency" (Ellison, 1972, p. 45). However, no comparable information is available on the prevalence of similar characteristics in partners of women suffering from vaginismus or from another form of sexual dysfunction. It, therefore, is unknown if Ellison's (1972) allegations hold any significance re: determining if a certain personality type does affect this sexual disorder (Jehu, 1979).

The consequences of vaginismus for the women concerned include anxiety; pain if intromission is attempted; feelings of humiliation, disappointment and inadequacy arising from her inability to engage in intercourse; fear of desertion by the partner; and distress over inability to conceive a child (Jehu, 1979).

The male partner may also face consequences. He may experience frustration and disappointment; feel rejected as a lover; and may develop sexual dysfunctions perhaps due to "these psychological reactions and a long history of denied or failed attempts at intromission" (Jehu, 1979, p. 107).

"Like other sexual dysfunctions, vaginismus may be primary, in that the threat of penetration has always evoked muscular contraction, or it may be a secondary problem that developed after some period of time during which penetration could be accepted without difficulty" (Jehu, 1979, p. 107).

## 2. Etiology

### Organic Components

The earlier section on dyspareunia, Part 1:B, includes information about the many factors that can cause pain during intromission and intercourse. Whenever painful intercourse is threatened, the presence of any of these factors may result in the occurrence of vaginismus.

### Psychological Components

Previous learning experiences have been implicated in the etiology of vaginismus. Memories of intromission and coital experiences that were painful and/or distressing might carry over into current situations; whereby, even though these aversive conditions no longer exist, the woman would respond to the threat of penetration with muscular contraction and anxiety. In addition to the problem of dyspareunia per se, traumatic events, such as sexual assault (Jehu, 1979; Masters and Johnson, 1970; Leiblum et al., 1980); a response to homosexual identification (Masters and Johnson, 1970; Leiblum et al., 1980; Jehu, 1979); guilt caused by an underlying sexual conflict (Ellison, 1972); a response to a male sexual dysfunction (Masters and Johnson, 1970; Jehu, 1979; Duddle, 1977); stress due to fear of punishment (Ellison, 1972), fear of pain, injury, failure, unwanted pregnancy, or contracting venereal disease, and of contravening some moral or religious objection to sexual activity that the client no longer holds but which has overgeneralized into her marriage (Jehu, 1979; Masters and Johnson, 1970); fear of penetration (Fuchs et al., 1978; Kaplan, 1974; Jehu, 1979) and deficient or false information (Ellison, 1972; Jehu, 1979) can contribute to this dysfunction.

Etiological factors are considered to be an important contributing factor in the maintenance, if not the cause, of vaginismus. "Interestingly, the syndrome has a high percentage of association with primary impotence in the male partner, providing still further clinical evidence to support procedural demand for simultaneous evaluation and treatment of both marital partners" (Masters and Johnson, 1970, p. 252).

### 3. Assessment

Assessment of this dysfunction follows the outline presented in Part 2:A. Specific paper and pencil instruments administered to clients exhibiting this dysfunction would be the: Sexual Arousal Inventory (Hoon et al., 1976), Sexual History Form (Schover et al., 1980); Index of Sexual Satisfaction Scale (Spanier, 1976); and Semantic Differential Scale (Whitehead and Mathews, 1976). Interviews, client self-monitoring, and archival records would also be used as indicated in Part 2:B.

### 4. Treatment

Though there is agreement among writers concerning the structure of the vaginismus response, it is alternately described as a psychosomatic disorder (Masters and Johnson, 1970), a phobia (Fuchs et al., 1978), a conditioned response (Ellison, 1972; Jehu, 1979), and a conversion reaction (Kaplan, 1974).

"Regardless of the etiological hypothesis, the authors agree that the treatment method of choice is the gradual insertion into the vagina of objects (i.e., fingers, tampons, dilators) of increasing size under conditions of relaxation and patient control. Systematic desensitization is often used, particularly in the treatment of the phobic elements. Views concerning the participation of the husband vary from recommending full involvement at each stage of the treatment, to inclusion once the wife has begun to make progress, to a varied response depending on the dynamics of the case" (Leiblum et al., 1980; Jehu, 1979; Masters and Johnson, 1970; Fuchs et al., 1978, Kaplan, 1974). Further information on treatment methods can be sought in Part 3, under vaginal dilatation.

The prognosis for a successful treatment outcome is very good. Masters and Johnson reported they had successfully treated 29 out of 29 cases once the cooperation of the partners in the dilatation therapy had been obtained. Kaplan (1974) reported virtually 100% successful

outcomes; while Fuchs et al. (1978) and Ellison (1972) also reported, for the most part, very few failures.

## 5. Case History

### Paula - Situational Vaginismus and Dyspareunia

#### Demographic Data

Paula, age 24, was a high school graduate who worked as a bookkeeper. Ted, age 25, was also a high school graduate who had taken a mechanic's course at R.R.C.C. and worked at the profession. The couple had been married for 3 years; but, had dated for 6 years prior to that.

#### Assessment

Description of Problem. Paula had experienced situational dyspareunia and vaginismus for approximately the past two years. The difficulty had begun about the same time as marital discord. A precipitating incident that loomed markedly in Paula's mind was an incident where Ted had forced himself upon her. He had been drinking and had come home looking for her. He had torn off his clothes and hers; and had attempted intercourse. Paula had pushed him off, but, had masturbated him to climax. This she had done to redirect his attention from herself and to relieve his sexual tension. He had then fallen asleep without further discourse.

Paula had been extremely put off by this incident and remembered tightening her vaginal muscles to prevent penetration. She had also disliked having to masturbate Ted under duress because it had reminded her of an episode that had occurred when she was 14 years old. She had been forced by one of her father's friends to masturbate him. She had been working for this man and the incident occurred when he was driving her home one day.

Paula then kept away from Ted for approximately two weeks after this episode. Ted did remember what he had done and had been humiliated. He did apologize profusely to Paula and has never done such a thing again. Paula said that they had discussed this incident and that they had cleared the air between them. In actuality, this did not seem to be the case.

Dating from this episode, their sexual relationship had deteriorated significantly. Paula had experienced a marked decrease in her ability to have an orgasm during intercourse. The change had been from orgasm with almost every sexual experience prior to marriage; to no intercourse in the past four months - and 1 orgasm from manual manipulation by partner.

The pain and the tightening of vaginal muscles had also increased over the past two years. In the past, Paula was able to have intercourse and an orgasm no matter what her feelings were towards Ted. At the time of treatment, unless the emotional atmosphere was ideal between them; she wouldn't even let him near her. Paula had decreased physiological and subjective arousal levels that also coincided with Ted's attempted rape of his wife.

#### Contemporary Influences on Problem

Situational Antecedents. The major factors that seemed to affect the current sexual relationship appeared to be Paula's attitudes regarding fidelity, trust, alcoholism and commitment. She had had sexual difficulties since early on in the marriage. This seemed to have been brought about by the episode cited when Ted had forced himself upon her. However, there seemed to be other problems that exacerbated the importance of this. Prior to the couple's marriage, Ted's drinking had

been a problem. Paula had broken off the engagement because she felt that Ted was drinking too heavily and that he hung around his male friends too much. Alcoholic consumption really bothered Paula because her father had been an alcoholic (he has been sober for 5 years now). When Ted got his jaw broken in a bar fight, he was forced to give up drinking for a time. He also re-evaluated his relationship with Paula; and realized that if he wanted to keep her that he would have to give up his previous lifestyle. This he did, and six months later the two were married.

There were also signs at that time that their sexual relationship was changing. Paula started to feel used because in this pre-marriage time, Ted would phone up in the middle of the night (Paula lived at home with her parents) expecting "a roll in the hay". Though this didn't affect Paula's physical desire or response to Ted; her feelings were affected.

She also questioned if Ted has remained faithful to her while they were not engaged. She had lost some trust in him, and this was accentuated by the attempted rape episode once they were married. She also seriously questioned his ability to control his drinking.

#### Organismic Variables

Thought Processes. Paula needed to feel absolutely positive about the relationship before sex could be initiated. She had to feel close to Ted in other areas of their relationship before she attempted sexual involvement. She avoided physical contact with Ted to such a degree that the couple had not had sexual intercourse for 4 months prior to therapy.

The couple had had a varied and good sexual relationship up until approximately two years ago. They had had intercourse every time they saw

each other during their dating history (1974-1979). They had both experienced great excitement and orgasm at each encounter. Their present situation was constantly compared to this past idealic time. This put pressure on Ted to give Paula an orgasm like he used to do. Ted was at the point where he questioned his ability to please her. His confidence was shaken; though, as yet, it hadn't affected his performance capabilities.

Their sexual practises had been completely satisfying to both partners; and the couple wanted to return to this state. They did have the vague realization that their difficulty lay somewhere in their relationship and was not in their sexual performance, per se.

Emotional Reactions. Paula felt pressured and tense about sex. She said that there had been times when she had disliked Ted (i.e., pre-marriage, when drinking, attempted rape, etc.) and that they were able to talk through their differences.

It seemed, however, to the writer that Paula harboured a great deal of anger towards Ted. She didn't quite believe that he was always truthful with her and questioned if he had been faithful to her prior to marriage (they are each others only sexual partners).

She held a very strict, moral attitude whereby any infidelity, prior to marriage or current, warranted divorce. She also tended to put her perceptions onto Ted (i.e., read his behavior without checking it out verbally). Ted was put into the bind that: (1) if he said that during the six months prior to their marriage he had been unfaithful - he lost Paula; and (2) if he said that he'd been faithful - she didn't believe him.

Paula also harboured strong emotions towards her father's alcoholism and the incident of masturbating her father's friend. These emotions, the writer thought, might be fueling her likewise strong feelings towards her husband's similar past behavior.

Organic States. Paula had always experienced a burning sensation in her vagina after intercourse. The therapist put forth several hypotheses for this occurrence. It was possible that Paula experienced an allergic reaction to her husband's sperm; that she had a vaginal infection; and/or that intromission was attempted prior to adequate lubrication. The last one was ruled out after carefully evaluating this factor with the couple. For the first two possibilities, the therapist asked Paula to seek medical advise.

Situational Consequences. Paula had been avoiding sex with Ted; and he with her. She avoided sex because it was painful and she didn't want him close. He avoided it because his advances would have been rejected. Both felt desire for each other and often felt very frustrated by the current state of affairs. They realized that their marriage was troubled by this problem; and they wanted very much to correct it. Ted said that he first realized that the problem was serious when he had had a hard time getting Paula sexually aroused (approximately 1 1/2 years ago). Before this it had always been easy to arouse her and he had taken this fact as a given. It turned out that, at this time, Paula had had a crush on a man at work who had treated her kindly and with respect. Ted realized that he'd have to pay more attention to Paula if he wanted to keep her. The couple said that they loved each other a great deal.

Personal and Family Background. Ted's parents were farmers who had been happily married for 32 years. He had 3 brothers and one sister, and the whole family were practising Roman Catholics.

Paula's parents had been married for 30 years and her father was a business man. She felt that her father treated her mother very poorly and she did not want the same 'door mat' treatment from Ted. She had 2 brothers and her family were non-practising Roman Catholics.

Childhood and Puberty. Sex had never been talked about in either parental home. Both Ted and Paula learnt what they knew from peers and each other. The two had started to date in 1973 and had remained each other's only sexual partner. Their relationship had progressed from dating, to going steady, to becoming engaged and finally, marriage.

Paula's only traumatic early sexual episode was at the age of 14. This was the aforementioned incident where a friend of her father's had forced her to masturbate him in his car.

Current Partnership. Paula and Ted had started to date in 1973. Within six months they had become sexually active with each other. Sex had been fun, varied and at every opportunity that they could manage. They had both experienced orgasm on all of their sexual encounters, and couldn't get enough of each other. They had had intercourse everytime they saw each other (4-5 times a week).

In 1979, because Ted had been out too much with the boys and drinking heavily; Paula broke off their engagement. He had then broke his jaw in a bar fight and had had to stop drinking because his jaw was wired shut. He, at this time, had re-evaluated the relationship, had stayed off liquor and the two had become re-engaged. Ted realized that he also had been feeling pressured into getting married by relatives at this time; and estimated that he had been running from this responsibility. He, however, came to realize that he did love Paula and really did want to marry her and began to adapt his behavior accordingly.

Once the two were married, the sexual relationship had started to decline. In the first year, Paula felt that Ted stayed out too many nights drinking with his male friends (2-3 nights a week). Their sexual relationship became less frequent (a couple of times a week). In the first year of marriage, Paula felt that Ted drank to excess and therefore was negative towards his soirees with the boys. Then, approximately 2 years ago, Ted attempted to force himself upon Paula and the first incidence of non-penetration occurred. Their sexual relationship deteriorated significantly from that point onward.

#### Progress and Outcome

To date the writer has seen this couple 23 times. Sexual therapy has followed that outlined in the literature review presented earlier in this section, in combination with couple exercises from Helman's (1976) program.

Treatment has been largely focused, in addition, on marital therapy. Communication skills, problem-solving skills and listening skills have been taught to the couple. The couple have reviewed their common life goals and underlying belief systems about the roles of males and females. Paula's strong feelings about fidelity, trust and commitment in their marriage; and her fears about Ted's heavy drinking (father was an alcoholic who mistreated her mother) have been brought out in the open. The overall marital relationship has greatly improved both in the couple's and the writer's observation.

The sexual problem has been somewhat more resistant to treatment. As Paula's vaginismus is strongly tied into her emotional relationship with Ted; it has been observed that as her feelings have fluctuated towards him, so has her progress in overcoming her difficulty. For

instance, when communication skills were taught in a session and were successfully practised at home, the sexual exercises were also seen to go well. When problem-solving skills, that had been taught in therapy, were judged by Paula not to have been applied in an argument outside of the session, Paula often got upset with Ted and could not participate in the sexual homework.

As the marriage improved, and as the pair practised their couple exercises for pleasuring, from the Heiman (1976) program, Paula's vaginismus began to ameliorate. Eventually, vaginal dilatation exercises (using fingers) were incorporated into the treatment format.

The ban on sexual intercourse is, as yet, still in place for this couple. They, of their own volition have attempted intercourse on two occasions (once successfully, one not). The successful penetration occurred when manual stimulation and insertion into the vagina was assessed by Paula as having gone so well that she was 'swept away' to attempting coitus. She experienced an orgasm with intercourse. The unsuccessful episode was when Ted was excited to the point that he initiated penetration.

At this point in treatment, the couple practise all of their sexual preferences except intercourse. Paula is able to tolerate digital penetration; and is able to achieve orgasm approximately 50% of the time.

The couple have been greatly frustrated by their sexual problem. Much time has been spent discussing how they could have gone from 'loving sex' to avoiding it. Ted also began to worry that he was losing interest in sex. He began to avoid the homework exercises when Paula pressured him to do them. It got to a point that for a couple of weeks Ted refused to touch Paula.

This avoidance issue has been thoroughly discussed, and it has again brought to light to the couple how important it is to tell the other person what they are feeling without fear of rejection. This habit of keeping emotions inside and then mind-reading the other's feelings has been a re-current theme across issues for this couple. They, however, have quite successfully been able to identify their old behavior patterns and communication styles that have been detrimental to their relationship; and have replaced them with new behaviors and skills practised in treatment.

Currently, this couple is making the transition from digital to penile penetration. The prognostic outlook seems to be favorable. Paper and pencil instruments were administered during the assessment period; but, will not be re-administered until termination. It is therefore impossible to present test results at this time to substantiate treatment gains.

#### D. Incest Victims in Adulthood

##### 1. Description

Women who were sexually victimized as children have been found, in a substantial proportion of cases, to exhibit various difficulties of adjustment in adulthood (Jehu and Gazan, 1982; Heiman, 1981). These difficulties which fall under the general categories of emotional, interpersonal, and sexual adjustment, cannot necessarily be directly attributed to the sexual victimization per se. Such factors as family discord and disruption, parental blaming of the child for the victimization, and insensitive handling of the child victim by parents; police, courts and social agencies, are also included in the histories of many of these

victims and may well have contributed to their later problems (Jehu and Gazan, 1982). The incidence rates of various problems among victimized and non-victimized cannot be stated with any certainty:, since the samples on which estimates are made are biased and limited in many ways" (Jehu and Gazan, 1982, p. 22).

Sexual victimization, as it is understood in this paper refers to "sexual experiences between juveniles and older persons that are exploitive because of the juvenile's age, lack of sexual sophistication, or relationship to the older person. The experiences covered range from exhibitionistic display of the offender's genitals through to sexual intercourse. They may or may not involve the use of force, and it is assumed that a juvenile is not competent to give an informed consent to the sexual activity. The age discrepancy criteria suggested are: (a) all experiences between a child aged 12 or under and a person who is five or more years older, or (b) all experiences between an adolescent aged 13 to 16 and a person at least 10 years older, which are considered by the adolescent at the time to be non-consensual and non-romantic in nature" (Jehu and Gazan, 1982, p. 2).

Herman reports (1981), from her review of the major surveys, that the incidence rate of sexual victimization in childhood is between one-fifth to one-third of all women. She also states that "between four and twelve percent of all women reported a sexual experience with a relative, and one women in a hundred reported a sexual experience with her father or stepfather" (Herman, 1981, p. 12).

Victims who seek treatment in adulthood frequently exhibit emotional problems such as guilt, low self-esteem and depression (Tsai and Wagner, 1978; Herman, 1981; Meiselman, 1978; Jehu and Gazan, 1982).

The interpersonal relationships of adult victims are often characterized by feelings of isolation, mistrust, insecurity, alienation, and of being different from other people (Courtois, 1979; Herman, 1981; Meiselman, 1978). Some victims appear to avoid lasting relationships with a man and may engage in a series of transient and casual relationships (Meiselman, 1978; Courtois, 1979; Tsai et al., 1979). Prostitution may also be associated with sexual victimization in childhood (James and Meyerdinq, 1977). Female victims are described as

having a "tendency to oversexualize all relationships with men, to engage repeatedly in ill-matched and punitive partnerships, and to exhibit a fear of intimacy" (Jehu and Gazan, 1982, p. 22; Tsai and Wagner, 1978). Feelings of hostility towards men was not found to be held by all victimized women. These attitudes were supported by Courtois (1979) and, Meiselman (1978). In contrast, Herman (1981) found that the majority of women in her study tended to overvalue and idealize men. The incidence of homosexuality among women victims has not been conclusively determined. High incidence rates have been reported by Meiselman (1978) and Gundlach (1977); while Herman (1981) has reported only low figures.

"Sexual problems, and more particularly sexual dysfunctions, appear to be more frequent among victimized compared to non-victimized women" (Jehu and Gazan, 1982, p. 22). The dysfunctions exhibited include impaired sexual motivation, sexual phobias, vaginismus, impaired arousal, difficulty in reaching orgasm, dyspareunia and sexual dissatisfaction (Jehu and Gazan, 1982).

## 2. Etiology

### Organic Components

Though one rightfully cannot categorize sexual victimization under the rubric of organic etiology, it can be said to indirectly affect somatic functions (lubrication and swelling, muscle spasms, lesions and scar tissue due to past forceable intercourse etc. which currently affects coital activity). Pain during intercourse may be attributable to dyspareunia (see Part 1:B), vaginismus (see Part IV:C), poor pelvic health, pelvic pathology and inadequate lubrication.

### Psychological Components

Sexual trauma is, in and of itself, a previously learnt experience that may have implications in the etiology of the aforementioned sexual dysfunctions. Memories of sexual experiences that were painful and/or distressing could carry over into current situations. Even though the aversive conditions no longer exist with her current partner, the woman might respond to the threat of sexual activity with any number of sexual dysfunctions.

A common sexual problem among victims appears to be some impairment of sexual motivation, performance, or satisfaction (Jehu, 1979; Kaplan, 1974, 1979). "Glasner (1980) found that sexual dysfunction in adulthood was experienced by 64% of 28 women who were sexually molested in childhood, while the comparable proportion for 15 unmolested women was 28%" (Jehu and Gazan, 1982, p. 14). Baisden and Baisden (1979) found that 90% of the 240 women seeking counselling for sexual dysfunctions reported sexual encounters before they were 18 years old with males who were at least four years older.

"Often these dysfunctions are not manifested until sometime after a sexual relationship commences. Initially, the impairment may be masked by the novelty and limited commitment of many early sexual contacts. Once a relationship becomes more established and closer, then feelings associated with victimization by an adult who was "related" to the child may be reactivated" (Jehu and Gazan, 1982, p. 15).

A number of possible causes have been set for impairment of motivation in victims. Some of these are: depression, conflict between the partners, fear of intimacy or romantic success, and the avoidance of sex because it is a painful, distressing, or unsatisfying experience for the woman (Jehu, 1979; Kaplan, 1979).

Sexual phobias may also be a result of past sexual victimization. Fear; anxiety; recapitulations of traumatic aspects of the victimization experience, such as "flashbacks", avoidance of eliciting events, which in turn might impair sexual motivation, restrict the range of foreplay, reduce the frequency of intercourse; any feelings of being coerced, used or controlled by the partner; or feelings of guilt and distress towards sexual pleasure because it is associated with the earlier victimization are factors that can prove so distressing that they evoke strong phobic reactions in the victim (Jehu and Gazan, 1982).

Vaginismus may be a phobic reaction to the anxiety elicited from the anticipated vaginal penetration. This reflex spasm may have been acquired during the earlier victimization experience. Dyspareunia may also accompany this difficulty.

The pain experienced during penetration may be due to pelvic pathology; but, it may also be caused by inadequate lubrication during the arousal process and the muscular contractions involved in vaginismus.

Impaired arousal may be of a physiological and psychological nature. The usual responses of vaginal lubrication and swelling, accompanied by erotic sensations and feelings may not be in evidence during sexual stimulation. The woman may be able to experience these responses during masturbation, but, not in sexual activity with a partner. The impaired arousal may be due to phobic reactions elicited during lovemaking (as previously mentioned); avoidance of sexual activity; inadequate stimulation; cognitive avoidance; and reduced awareness (i.e., sexual anaesthesia (Jehu and Gazan, 1982).

"Some victims experience difficulty in reaching climax during their current sexual encounters", while others are able to do so under specific circumstances, or even, quite easily, though they may not be sexually motivated or aroused (Jehu and Gazan, 1982, p. 18).

The lack of sexual satisfaction has been found to be one characteristic of sexually victimized women. However, it is not universally associated with either the existence of some impairment of sexual motivation, performance or sexual molestation (Tsai et al., 1979; Jehu and Gazan, 1982).

There is little systematic information to account for the wide individual differences in the emotional, interpersonal and sexual adjustment of victims when they reach adulthood. However, some of the factors "that may contribute to these individual differences are the age of the child victim, the duration of the victimization, the nature of the sexual activity involved, and the perceptions of the woman concerning her feelings at the time of the victimization and its effects on her life" (Jehu and Gazan, 1982, p. 23)

### 3. Assessment

The assessment scheme comprises interviews, questionnaires, and, in certain cases, medical examination.

The assessment interviews with each victim, and her partner if any, follow the Checklist attached as Appendix B (Jehu, 1979). As with most assessments, approximately three sessions are devoted to this procedure.

The first session, with the woman alone, covers items 1 to 7 in the checklist. In the second session, the woman alone covers items 8 to 14 and 20 to 62. Her partner covers items 10 to 43, either alone or with the woman depending on the wishes of both partners and any clinical indications.

Items 15 to 19 and 63 to 70 are completed in the third session with the woman alone. These items are left to the last assessment interview because they relate directly to the victimization experience, and it is expected that, by this time, sufficient rapport will have been established between the client and therapist to permit the exploration of this traumatic area.

Concurrently with the assessment interviews the client completes the following set of questionnaires:

1. Belief Inventory (Appendix P)
2. Beck Depression Inventory (Appendix K)
3. Semantic Differential Scale (Appendix H)
4. Dyadic Adjustment Scale (Appendix G)
5. Sexual History Form (Appendix E)
6. Index of Sexual Satisfaction (Appendix F)

These questionnaires are completed pre and post intervention to aid in determining change in the client.

When a medical examination has not already been done on a client or her partner, and it appears to be indicated during the assessment, then the person is asked to have one by the physician of his or her choice. Such an examination would be necessary, for example, in cases of vaginismus and dyspareunia, or whenever organic factors might be contributing to the problems of a client and her partner. (All information for this assessment segment has been taken from a proposal submitted to the Canadian Government by Dr. Jehu, 1982).

#### 4. Treatment

Treatment of sexual dysfunction in victimized women follows an intervention package (Jehu, 1982) that has specific modules that are deployed to suit particular victims and their partners. The modules are included, sequenced and implemented in individually tailored treatment packages according to each client's needs and circumstances (Jehu, 1982).

As mentioned in Part III - Treatment, the same general therapeutic conditions must be met in order to establish a trusting, respectful and mutually caring therapeutic relationship. Also, any and/or all assignments and/or procedures delineated in Part III may be incorporated into the client's treatment package.

As shown in Table 7, the intervention package entails relaxation training, cognitive restructuring, interpersonal skills, and specific treatment of the sexual dysfunction. The components, themselves, are described in Appendix Q.

Table 7. Intervention Package

Module	Major Objectives
Relaxation training	Coping with anxiety
Cognitive Restructuring	Reducing guilt Enhancing self-esteem Alleviating depression
Interpersonal Skills	Facilitating the establishment and/or maintenance of satisfying intimate relationships
Specific treatment of sexual dysfunction	Resolving impairment of sexual motivation, performance, and satisfaction

(Jehu, 1982, p.34)

Post treatment success rates are unknown at this point in time, using this treatment package. The writer can only say, from her own experience and those at the clinic currently following this format, that the prognosis of successful treatment is very good.

## 5. Case History

Jesse - Incest as a Child, Inorgasmic Except for Masturbation

### Demographic Data

Jesse was a thrice married, 36 year old woman who, at the time of treatment, had separated from her husband. She had two children, a boy aged 17 (1st marriage) and a girl aged 5 (3rd marriage) who lived with her. She held a masters degree and presented as a successful career woman. She had been born in a southern U.S. state and had immigrated to Canada with her third husband. She was very attractive, had a witty humour, and presented a sexually uninhibited mannerism. She was involved with a new male friend with whom she felt close enough to work through certain aspects of her sexual problem.

### Assessment

Description of the Problem. Jesse initially came to the clinic because she'd heard, from a friend, that people were available to talk to re: early incest experiences. Jesse was interested in pursuing how her early sexual involvement with her step-father might be affecting her current attitudes towards men and sex.

Jesse presented herself as a sexual being. She felt that she enjoyed sexual activity. She did find, however, that though she was able to reach orgasm; that it required a lot of concentration and work on her part. She was able to reach climax only from clitoral stimulation

administered by herself. This she could accomplish in the presence of a partner during or in adjunct to intercourse. She said that the sensations in her clitoral area "jumped around so much" that it would have been impossible for a partner to pinpoint the sensitive area. Her desire and arousal levels seemed to fall within the normal ranges. Jesse's sexual past, however, was extremely varied and was of concern to her. These concerns are presented in a later segment of this assessment.

Contemporary Influences on Problem. Jesse was separated from her third husband and was actively involved with another man. She kicked her husband out in March 1982 because he had had an affair. One of her close girlfriends had become involved with B. After Jesse had asked B. to leave, he began living with this woman. That relationship was close; and Jesse has been replaced. The separation agreement was rocky at the time of treatment because there were disagreements over custody issues (re: their daughter T.) and division of assets.

Jesse was having, and has had, problems with her children. T. was upset that her father had left and didn't visit her a lot. Her son, J., had been sexually molested by her 2nd husband, and presented a lot of behavioral problems. He currently didn't seem to care very much that his step-father B. was out of the home. He did show very judgemental and negative behavior towards the new boyfriend H.

Jesse had been going out with H. since October 1982. He was also a professional and someone that Jesse had known for approximately four years. He had separated from his own wife, of seventeen years, in October due to sexual and intimacy difficulties.

Jesse felt that their sexual relationship was perhaps the best she'd ever had. She felt that she could talk to H. about sex. He seemed to be receptive to discussing the topic because of the problems he'd had

in his own marriage. His wife also had been an incest victim as a child. She, however had become completely repulsed by sex; and they had terminated their sexual involvement approximately 8 years previously. H. gradually had become so dissatisfied with the lack of physical, as well as emotional closeness, that he left his wife.

Organismic Variables. Jesse had not been aware of any negative thought processes and/or emotions associated with sexual activity. She, however, was aware that she had to concentrate, to the exclusion of all else, on the sensations coming from her clitoris before she could climax. She could not look at her partner or be aware of his reactions without losing her intense feelings of excitement. The physical sensations evaporated.

Jesse smoked marihuana regularly; but didn't notice any change in her bodily responses if she did or didn't smoke up during love-making.

Situational Consequences. Jesse's current partner, H., was supportive and interested in their sexual relationship. He initially had some problems in his sexual performance with Jesse. At first he had been unable to sustain an erection. After a few weeks, he could maintain an erection for as long as Jesse wanted; but, was unable to climax. Now, he was able to do both without difficulty. Jesse attributed these problems as having been associated with his long abstinence from sexual activity, and his marital relationship difficulties.

Personal and Family Background. Jesse was a 36 year old woman, who had been married 3 times, has 2 children and hailed from a southern U.S. state. She had a masters degree in drama and was employed in this city. She had come up to Canada 10 years ago with her 3rd husband, B., who was a Canadian. Her family were Baptist fundamentalists; and Jesse was currently non-practising. She had many friends, and was very straight-

forward and energetic. She had 1 close girlfriend whom she trusted. This woman was moving to another city; and, this was upsetting to Jesse. What she felt she had learnt from this woman were the lessons of how to care and trust. She felt that this relationship was a good learning experience and that it had helped her reach out to others.

Parents. Jesse's natural father and her mother were married for approximately 3 years. They divorced because her father had had numerous affairs with other women. When Jesse turned 5, her mother remarried. This man, J., was the only person Jesse had ever known as a father-figure. It was with this man that the incest occurred. Her parents have been married for 32 years. Her step-father (age 63) worked as an electrician and her mother (age 65) worked in a Levi factory as a seamstress. Her step-father also fooled around on her mother. Her mother was well aware of this fact; and told Jesse about it. She also confided in Jesse about their sexual relationship; she told her when she "liked it and when he hurt her". Her parents did not show her love, nor did they build a trusting relationship with their daughter. The only relatives whom Jesse felt loved her were her natural father's mother and sister. Both of Jesse's parents were practising Baptists. Her relationship with her parents was "guarded, tense, and sad".

Siblings. Jesse had two brothers, B.1 (age 30) and B.2 (age 31). These were the children of her mother and step-father. Jesse didn't feel close to either of these men. In fact, she felt that she hardly knew them.

B.1 was an unstable character. He took alot of drugs and had been a dealer for awhile. He was married to a woman 10 years his junior. He and M. had married 4 years previously. His marriage had always been rocky, and he currently was separated. B.1 was up in one state working,

and M. was in another, pregnant. M., Jesse said, was pregnant with her son (J.'s) child. She had sent J. to visit B.1 last fall, and he had slept with his aunt. Both J. and B.1 had fathered two other children.

B.2, Jesse felt, was more stable. He was separated from his wife of 8 years and had no children. He worked as a carpet layer in a southern U.S. state.

Children. Jesse had two children, J. (age 17) and T. (age 5 1/2). J. was the offspring from her 1st marriage; and T. was the product of her third.

J. was a child with many problems. He had had 3 father figures and numerous other surrogate models. He had dyslexia and had had a great deal of difficulty with school. He hadn't attended class since he was 14 years old. He had just recently enrolled into a high school and was taking Grade 10. He had moved in and out the parental home 3 times. He was heavily into drugs, stealing and lying. He had impregnated 3 women. At age 14, his girlfriend of the time, had become pregnant and subsequently had given the baby up for adoption. His 2nd girlfriend had had an abortion. His aunt (age 20) was currently carrying his baby.

J. openly slept with his girlfriend, R., at his mother's house. His mother condoned this because she preferred her son 'safe' at home; and she saw nothing wrong with sexual activity.

J. had been sexually molested by her 2nd husband, J.2, at the age of seven years. Jesse felt that the deviant lifestyle she had led with J.2 (he was gay) had deeply affected her son.

T. was a friendly, happy, aggressive child. She was outgoing where her brother was withdrawn. She was in a french-immersion kindergarten and was doing very well. T. was quite upset that her father wasn't at home;

she missed him a great deal. She was also dyslexic, like her mother and brother. She tended to act out, hit, bite, etc. when she was upset.

Childhood and Puberty. Jesse's mother had told her about the facts of life; but, in an uptight manner. Jesse didn't remember any of the information only the impression of uncomfortableness.

Jesse began to develop secondary sexual characteristics at age 12, and began, menstruating at age 13. She remembered being very startled when she began to menstruate because she thought that this meant that she was pregnant.

Between the ages of 5-14, Jesse experienced sexual trauma. Her earliest recollections of being sexually molested were at the age of 5. A boarder in her mother's home - Doc (age 55) - would take her to the basement and rub her crotch. He gave her little trinkets in exchange for the activity.

Her step-father, though he never actually had intercourse with her, did show various degrees of sexual interest in her. Between the ages of 7-8, he used to ask her to jump off a ladder into his arms. He'd always catch her between her legs. He also used to rub her legs in bed. One night her mother caught him doing this; and Jesse felt that she had to cover up for him. When questioned, she told her mother that nothing was going on.

At age 9, he began to stimulate her genital area with his fingers. He did this very infrequently, but he told her not to tell mum.

At age 11, her step-father tried on 1 occasion to have intercourse with her. She yelled and put up such a fuss that he let her go, and told her to take a bath. Once in the bathtub her father came into the

bathroom and told her what a good girl she was. She was very angry at him for violating her privacy.

Finally, when Jesse was 13, her mother became aware that her husband was showing sexual interest in her daughter. Her mother never left her husband and Jesse alone. She, however, interpreted her husband's interest as a response to Jesse's teasing behavior. She blamed Jesse for coming on to her father. For 2 years she slept on a couch in front of her daughter's bedroom door to prevent any "hanky-panky".

Jesse's dad made 1 final sexual advance when she was 14 years old. He tried to tease her sexually and kiss her, but she wouldn't participate. He discontinued any further advances at that time. Once when she was 22 her dad cornered her in the attic and tried to seduce her. When she again pushed him off; he told her that she'd be sorry one day.

#### Sexual Experience Before Current Partner 1st husband J.1

Jesse first married at the age of 18. J. was 21 and it was his 2nd marriage. He had 4 children prior to the arrival of J. - Jesse's and J.'s 1st child. J. played around with the help at the K-Mart where he worked. Jesse manipulated, pouted, played mind games, anything to get J. to pay attention. After 3 years, Jesse left him with very little regret. J. remarried shortly after their divorce.

She saw a psychiatrist at the time that the marriage fell apart. He put her on tranquilizers and helped her to see that she was manipulative and angry in the marriage.

#### 2nd Husband - J.2

Jesse then completed university and started to teach. At 24 she married her 2nd husband. He was homosexual and their relationship was completely platonic. He and Jesse moved to New Jersey. J. was into an

altered lifestyle. He sexually preferred men and children. At this time, Jesse became involved in 3 affairs with her high school students. She also began to prostitute. She had a pimp and thought the life was glamorous as well as profitable.

She gave up prostituting when her pimp was busted on drug charges. She left J. once she realized that he had been playing around with her son. They were together for two years.

Jesse then went back to university to take her masters degree in drama and education. It was while she was in school that she met her 3rd husband, B.

3rd Husband - B.

When they met, B. was attending a Church of Christ Bible college. He was 22 years old and Jesse was 26 years old. B. and Jesse soon became an inseparable couple. B. had had as equally a checkered past as Jesse. He had been into drugs, in prison etc. He left the bible college several months after the couple started going out. They married and moved up to Canada.

Both B. and Jesse worked as children's treatment workers (8 years); both to help J. (who was really acting out) and to find answers for themselves.

Approximately 1 1/2 years previously B. had had an affair with a friend of Jesse's and the marriage ended. Jesse felt that it had taken 8 years for her to learn to trust B.; and then, within 2 years, the marriage had deteriorated. In between marriages, Jesse had said that she'd had literally hundreds of lovers.

Sexual Variations. Jesse's experience had involved homosexual tendencies, self-mutilation, sadomasochism, sexual molestation and prostitution. She had begun to masturbate at the age of 14. She would inflict pain upon herself by tying rubber bands around her nipples. She

loved the pain and couldn't control her actions. She stopped the self-infliction of pain once she married J.1.

When that marriage broke up she again began to inflict pain to her breasts. She'd push earrings into her nipples while she masturbated. She continued this activity while married to J.1. She stopped hurting herself physically when she started prostituting.

Also, at this time Jesse thought that she was gay. She was into a lifestyle where homosexuality was the norm. She was strongly attracted to women and wanted to experiment sexually with them. Though she never carried through with the urge, she still felt sexual attraction for women and had to stop herself from touching them too much.

Once she broke off with J.2 she began to consider suicide. She'd stopped prostitution because her last trick had been old enough to be her father; and had wanted her to be his mistress (sans fils). She couldn't say no to men anymore, and she realized she had to leave her sick lifestyle to preserve herself.

The marriage to B. had been sexually uneventful, in the sense that they stuck to oral, manual and "straight" sex. She was faithful to him throughout their co-habitation.

In the summer of '82, Jesse met F. at a public beach. With him she began to experiment with sadomasochistic techniques. She tried the dominant, but preferred the subordinate positions. She liked to fight without getting hurt. Neither F. nor herself had orgasms with this activity.

In December 1982, Jesse told F. that she didn't want to continue their involvement for awhile. She was unable to completely end the relationship because she said she just couldn't say no to men. Her current lover, H., knew nothing of her activities with F.

Jesse was turned on by S & M movies. The pain in the movies - or in magazines was sexually stimulating to her. Though she had terminated the actual acting out behavior, she kept the fantasy life vivid by using the above mentioned material.

Current Relationship. At the commencement of treatment, Jesse has been seeing H. for 3 months. He was involved in a non-sexual relationship with his wife. Though he and A. have two children; since the birth of the youngest, she had refused to have sex with him. A. had also been the victim of child incest; and had only told H. this once they were separated.

H. had had erectile and ejaculatory difficulties at the beginning of his sexual relationship with Jesse. As mentioned, these problems soon cleared up. H. was into pornographic movies to quite an extent. He told Jesse that he started to collect these films when his sexual relationship with his wife went bad. He watched the films to help his fantasy life and as vengeance towards his wife.

At this time, H. watched these films only when Jesse was in the mood. In fact, the whole family sat down to watch the "Story of O" together, several weeks ago (H., Jesse, R., J.). J. had found the film gross and had left the room. Jesse had found it very stimulating to watch.

H.'s children (2 boys, 14 and 11 years old) had spent time over at Jesse's house. They did not know, as yet, that dad was not going back to their mom or that he and Jesse were lovers.

Self Concept. Jesse felt that she was sexually attractive to males. She felt that she had a good image about herself and her ability to make and keep friends. She felt that she was an attractive female.

Attitudes Towards Treatment. Jesse wanted to put her life into perspective. She wanted to understand if her father's advances towards her had had an effect on her subsequent behavior. She wanted to be able to respond quicker to sexual stimulation; she wanted to understand why she overreacted to male responses; and to know why men's desires came before her own.

She felt that she had a dual nature - a hard, defiant side that referred to herself as a "cunt"; and a soft, caring side that saw herself as a person. She wanted to enhance the caring side.

#### Progress and Outcome

The writer saw this client for 15 sessions. Treatment followed the package supplied by Jehu (1982) for women who have experienced early sexual victimization. Specific treatment of Jesse's sexual dysfunction, orgasmic only via self masturbation, did not commence until she had dealt with the victimization experience.

The focus of therapy for the first 10 sessions was Jesse's beliefs and feelings around her victimization and her self-concept. She did not feel sexually "healthy" because of her former deviant lifestyle, current sadomasochistic tendencies, and inability to climax from partner stimulation.

Each aspect of her "unhealthy" self-concept was explored with the writer. As she concentrated on her feelings and cognitions related to these aspects, she began to realize that she held false beliefs about her victimization. Reading material supplied to Jesse (Herman, 1981; Tsai and Wagner, 1978) helped her to intellectually understand that she had not been responsible for her sexually traumatic experiences. Time, self-exploration, and avid support and discussion with the therapist helped her to emotionally incorporate this new attitude into her belief system.

Jesse also actively changed her behavior in her own milieu. She terminated her sadomasochistic relationship with F.; and she became more assertive in her discussions with her husband over property settlements and their child custody issue. This occurred after several sessions had been devoted to discussion re: her tendency to value men, their opinions, and her value in their eyes above her belief in herself and her own worth to herself.

Jesse also came to terms, around session 10, with the fact that she had not asked to be sexually approached as a child. She faced the fact that she had felt dirty and guilty about being sexually attractive to men. At the same time she recognized that she experienced a sense of power in being able to 'sexually excite any man'. She had enjoyed making them 'grovel' to her for sex.

Her sexual fantasies also began to change at about this same time. She became very excited when she realized that for the first time she did not use pain inducing images to arouse herself. She also, as mentioned, gave up her sadomasochistic relationship when she realized that she had never climaxed in this situation; and that in some manner she had used it to punish herself for enjoying the somatic sensations of sexual arousal.

Sexual therapy began when Jesse felt that she had adequately dealt with the victimization; and that she had a more 'normal' view of sex. Treatment followed Heiman's (1976) program. Jesse practised the self-exploration exercises and found it even easier to bring herself to climax than it had been previously.

By session 12, Jesse was practising the couple exercise with H. In session, H. stated that he had seen a marked improvement in Jesse's attitude towards herself and sex. Where he felt that, initially, Jesse

had been "fucking" and he had been "making-love"; he now felt that Jesse also was emotionally giving to their sexual relationship.

Treatment terminated, by mutual concensus, after 15 sessions. Jesse was able to climax via self-stimulation during coitus and the couple felt confident that this could be generalized to orgasm via stimulation by H. Jesse felt that she had accomplished what she had set out to do in therapy - explore the effects of her sexual victimization on her current attitudes towards men and sex. She felt that the improvement in their sexual performance was an unexpected bonus. The writer also suggested that Jesse seek family therapy directed at exploring her relationship with her children, and that her son obtain individual treatment at the P.S.C.

Pen and paper instruments were administered in a haphazard manner by the writer at a time when she was not familiar with their use. These results, therefore, cannot be submitted to determine therapeutic gains. Gains, however, were evident via client and partner verbal reports; and via the therapist's observation.

### E. Orgastic Dysfunctions

#### 1. Description

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

This type of sexual difficulty may be accompanied by other forms of dysfunction, such as lack of sexual interest, vasocongestive dysfunction etc., or it may be the sole area of complaint. The inability to reach orgasm does not imply that pleasure cannot be derived from sexual activity. Some woman do enjoy making love in spite of the fact that they do not climax; while others will complain of inadequate pleasure in addition to their orgastic dysfunction.

As with erectile dysfunctions, the female client is also placed into a position of determining when their dysfunction is of sufficient concern to themselves to warrant treatment. For instance, a relatively small number of women can achieve climax during every sexual experience. For example, various studies reported 44% (Terman, 1951), 39-47% (Kinsey et al., 1953), 23% (Wallin, 1960), 38% (Fisher, 1973), 53% (Hunt, 1974) and 12% (Butler; 1976) of women who had always or almost always achieved orgasm during intercourse.

Other criteria that women might judge when determining orgasmic dysfunction could be "the persistence and frequency of orgasmic failure, and circumstances in which it occurs, and the degree of dissatisfaction that it entails" (Jehu, 1979, p. 110).

Inorgasmia can be of a primary nature, whereby the woman has never achieved orgasm by any means. The inorgasmia may also be situationally determined; in which case the woman would have experienced at least one orgasm but was inorgasmic either with masturbation or with coitus or was infrequently and inconsistently orgasmic by these means (Masters and Johnson, 1970).

When considering the circumstances in which orgasmic failure occurs, one should look at the nature of the sexual stimulation that is being experienced at the time (Jehu, 1979). It is also important to look at the client and her partner's viewpoints re: what constitutes the 'right' and/or 'normal' way to achieve orgasm. These aspects may contribute significantly to the current difficulty. For instance, if a client believes that intercourse is the only normal way to achieve orgasm; then additional modes of stimulation may not have been attempted, or thought necessary to overcome the difficulty.

Expansion of the client's knowledge, re: the wide range of stimulation that can effectively elicit orgasm in women (Kaplan, 1974), may help her make a more informed and realistic decision when determining under what conditions she would like to become orgasmic. Also; it can be presented that a woman's "responsiveness to a range of stimulation may in part reflect the normal variation of thresholds for the female orgasmic reflex, although various pathological factors will also contribute to individual differences in orgasmic capacity" (Jehu, 1979, p. 111).

One of the relevant features that affect judgements of orgasmic inadequacy can be a woman's feelings associated with her sexual partner. Some women can not achieve an orgasm with any man, while others can do so with a partner who possesses certain attributes. For instance, some women may only achieve orgasm with a loved partner; while others can only do so in high-risk, extra-marital affairs. The selectivity of the orgasmic responsiveness can indicate significant influences affecting the woman's orgasmic functioning.

"The degree of dissatisfaction that orgasmic failure entails for the woman and her partner will very probably be an important factor in their judgements of inadequacy and the need for treatment" (Jehu, 1979, p.112). While some women will still derive pleasure and satisfaction from their sexual relations, even though they do not culminate in orgasm; other women will be left feeling frustrated, disappointed and concerned about this state of affairs. They may feel that their self-concepts are damaged, that their partners will be angry or will reject them; that they are failures or any number of self-depreciating attitudes. Actual physical pain can also be experienced by some women, during or after intercourse, because of unresolved pelvic vasocongestion. Some women will also loose interest in sex, and will do everything they can to avoid or shorten their sexual encounters due to their negative reactions to the above mentioned circumstances (Jehu, 1979).

The partners of these women may or may not be sympathetic about their mates inability to climax. They may become frustrated, angry, resentful, view the dysfunction as a reflection of their lack of attractiveness or sexual competence. If the woman holds similar views, then it is understandable that discord can occur in the relationship.

## 2. Etiology

### Organic Components

Few organic factors have been implicated as direct causes of orgasmic dysfunction. When intercourse is painful, due to any of the reasons discussed in the section devoted to dyspareunia, then this can impair a woman's ability to reach orgasm. Also, renal disorders and diabetes mellitus (Jehu, 1979) have been known to contribute to this dysfunction.

### Psychological Components

Previous learning experiences, as cited in Part 1:C, may contribute to a woman's orgasmic dysfunction. They, however, are not inevitably linked with the subsequent development of any form of sexual dysfunction. The only previous learning experience that is significantly associated with this kind of difficulty is "a poor daughter/father relationship, or one that is disrupted by the father's early death or prolonged absence from home (Fisher, 1973; Uddenberg, 1974)" (Jehu, 1979, p. 113).

Any of the stressors discussed in Part 1:C may also evoke reactions that disrupt the orgasmic reflex. The woman may fear a loss of control over herself (Barbach, 1980), that she will scream or lose bodily functioning (i.e., urinate or defecate), or that she will appear ugly to her partner if she has an orgasm. She may question her performance and/or fear her partner's reaction to her inability to climax.

It is possible that anxiety and spectating also disrupt the orgasmic reflex, though precisely how this might happen is unknown at present (Jehu, 1979). Clearly however, the voluntary or involuntary inhibition of muscular contractions serves to avoid the attainment of a climax which is threatening, for some reason, to the women concerned.

Marital discord and orgasmic dysfunctions are associated in some couples (Jehu, 1979; McGovern et al., 1975). It seems more likely that this is the case when orgasm impairment is of a secondary nature. Issues such as conflict over control in a relationship; anger; insufficient sexual attraction; hatred; fear of commitment or dependence; pressure by a partner to achieve orgasm, or anticipation of a negative reaction from this person should the woman fail to do so can cause the discord to affect the orgasmic dysfunction.

Finally, insufficient or inappropriate sexual stimulation can be a contributing factor to a woman's orgasmic difficulties. A woman or her partner may be ignorant of what constitutes suitable stimulation; or she may be reluctant to communicate her sexual preferences to her partner; either or both partners may avoid the stimulation that is required because it is stressful; or it may be withheld by the male partner as an expression of hostility towards the woman (Jehu, 1979).

### 3. Assessment

Assessment of this dysfunction follows the outline presented in Part II:A (Appendix B). Specific paper and pencil instruments administered to clients exhibiting this dysfunction would be: the Sexual Arousal Inventory (Hoon et al., 1976); Sexual History Form (Schover et al., 1980); Index of Sexual Satisfaction (Hudson et al., 1981); and the Dyadic Adjustment Scale (Spanier, 1976) where applicable. Interviews,

client self-monitoring, and archival records would also be used as indicated in Part II:B.

#### 4. Treatment

The mode of intervention that is used for the treatment of orgasmic dysfunction is Heiman's (1976) program. Both her book Becoming Orgasmic; A Sexual Growth Program For Women, as well as the accompanying film are used as bibliographic and visual aids to facilitate the client's learning process during treatment.

The Heiman (1976) program allows for a great deal of flexibility in the treatment format, due to the various training components - desensitization training; relaxation training; an educational component re: physiological and emotional responses; vaginal strengthening exercises; the use of role-playing; the use of fantasy; communication skills; and the sexual exercises themselves for the client and her partner. (Further elucidation of these methods can be reviewed in Heiman's book and in Part III of this report). The flexibility in this particular program (as is true with the treatment of the other dysfunctions) allows the therapist to both adapt the program to the individualistic needs of the client; and to revise the treatment program where indicated. Thus, for example, if the client began to see her progress as going slowly or that she interpreted it as tedious or fruitless; then the treatment package would allow for needed alterations. Exploration of the client's cognitions (i.e., examining if the person had high performance expectations; and/or changing or adding to her activity schedule (i.e.) using relaxation training, fantasy, the use of a vibrator etc.) would be examples of possible treatment adaptations.

Outcome statistics for the treatment of primary orgasmic dysfunctions seem to indicate favorable success rates. However, because of variation in outcome criteria and assessment methods it is impossible to make valid direct comparisons across studies. Still, if one takes "the proportion of clients who were able to attain orgasm during intercourse at the latest point of assessment in each study, then the appropriate figures for those suffering from primary orgasmic dysfunction are probably as follows: Masters and Johnson 92.4%,...Kohlemberg 100.0%; McGovern et al. 100.0%; Wallace and Barbach 87.0%" (Jehu, 1979, pp. 254-255).

Turning now to the outcome for the situationally inorgastic patients on the same criterion, the appropriate figures appear to be as follows: Masters and Johnson 75.2%, Munjack et al. 60.0%, McGovern et al. 33.0%. A possible indication for the lower success rates in situationally dysfunctional couples may be the higher rate of serious discord between the partners noted by the cited researchers.

## 5. Case Histories

Lonnie - Inorgasmia, Decreased Physiological and Subjective Arousal

Demographic Data. Lonnie was a 24 year old, clerical worker who was separated from her husband at the time of treatment. She had a 5 year old daughter from a previous relationship. She was involved in a new relationship with a 26 year old man. Dan was single, worked as an electrician and a farmer, and had never been married. He was serious about Lonnie and very supportive of her wish to pursue treatment.

### Assessment

Description of the Problem. Lonnie had primary inorgasmia that was global and lifelong in nature. She did experience subjective and

physical arousal to a certain extent. She was aware of lubrication and a tingling sensation in her genital area when she was sexually excited.

Lonnie turned herself off when the arousal level became too great. She would cognitively monitor her behavior. When she noticed that she was relaxed and was losing control over her responses, she would mentally stop the proceedings. She would continue with the lovemaking; but, aimed to bring the male to orgasm as quickly as possible. This she did by diverting the physical stimulation from herself to that of her partner (i.e., by using fellatio).

As mentioned, Lonnie's inability to reach orgasm was in all situations, with all partners and with all types of stimulation - manual, oral, penile.

Past Partnerships. This difficulty began with her first sexual partner at the age of 17. The boy was also 17 years old and not an adept lover. To complicate the matter, Lonnie became pregnant by this young man. She chose to keep the baby besides opposition from her parents. Lonnie lived with this boy and became engaged to him; however, once the baby arrived the relationship deteriorated. Lonnie called off the engagement one month before the wedding. The sexual relationship wasn't highly developed because Lonnie was either pregnant or recuperating from the delivery for the major portion of their time together. Lonnie's relationships with men has been highly influential towards her attitude towards sex.

Lonnie had had 3 sexual partners at the time of treatment. The first partner was at the age of 17. This man made her pregnant, as mentioned, with her child, S. This proved to be an unhappy union emotionally and sexually. Lonnie neither felt that the emotional climate, nor the physical stimulation was adequate for a good sexual relationship.

At the age of 18, Lonnie met her husband. He made her feel worthwhile because he accepted her and the baby. She lived common-law with him for 3 years before marrying him out of a sense of gratitude. Throughout this relationship, she felt pressured to have sex with her husband (it was her wifely duty to submit).

Neither of these two relationships met the criteria Lonnie had needed for a satisfying sexual relationship. The criteria, as she saw it was: (1) to feel emotionally secure and close to her partner; (2) to have an environment that was pleasing and romantic (i.e., candlelight, soft music); (3) to feel unhurried and unpressured in the lovemaking; (4) to feel that the sexual activity was an extension of the emotional bond - a oneness of partners; and (5) that Lonnie, herself, felt physically attractive to her partner.

With her husband, the relationship was the major factor that affected the lovemaking. Lonnie felt gratitude to this man for having taken care of herself and her daughter. This feeling led her to marry him; however, once married - Lonnie realized that she'd made a big mistake. Less than one year after the wedding, the couple separated (Feb. '82).

Throughout the 4 year relationship, Lonnie felt pressured by her husband for sex. Even if she were ill, (i.e., recounted an incidence when she had pneumonia) her husband would attempt intercourse.

When they married, Lonnie felt trapped. Sex became a duty and the times she refused her husband exceeded the times she accepted. She also felt that even though their sexual relationship was varied - oral, penile, manual stimulation - that her negative attitude towards their marital and/or common-law relationship deeply affected her responses.

Lonnie realized that her husband was a kind and caring man; but, that she just didn't love him or physically desire him.

Current Relationship. In the summer of '82, Lonnie started to date a man she'd known for approximately 3 years. The relationship flourished and the couple began living together on weekends in November of that year.

Dan was the man whom first questioned Lonnie about her physical response. He was concerned over her inability to reach orgasm. Lonnie was surprised that he knew that she could not climax. He gently questioned her if there was something that he could change in his love-making that might alter this situation. Lonnie found this novel that a man would be concerned about her needs.

He neither pressured her to have sex; nor hurried through the time he spent pleasuring her. Dan spent as much time as Lonnie needed to talk and get comfortable before any type of sexual activity was attempted.

When Lonnie decided to attempt counselling, Dan was very supportive of this plan. He, however, was realistic in stating to Lonnie not to put too much pressure on herself to obtain this goal. Dan had been willing to attend counselling sessions with Lonnie, and he was committed to the relationship. He had asked Lonnie to marry him, but, leaving it up to her to decide if she would accept the proposal - no time limit set at this time.

Dan was a 26 year old man who worked as an electrician and a farmer. He had never been married and didn't have any children. He was more concerned about Lonnie's development; her feelings about sexuality; than about any personal gain from counseling.

### Contemporary Influences on Problem

Situational Antecedents. With Lonnie's two partners, prior to Dan, the emotional relationships had been a problem. She had been heavily stressed in her first relationship because of the pregnancy. She had felt insecure; afraid; alienated from peers and family; frustrated in her personal goal to attend university; and prematurely forced to take on the responsibility of caring for a baby. She and the father of her baby were sexually inexperienced and their relationship had not survived the cited stressors. They had no knowledge of what constituted adequate stimulation or a conducive atmosphere for lovemaking.

With her husband, Lonnie had the problems of raising a small child; working full-time; not possessing the knowledge of what she needed for a satisfying sexual relationship; and living with this man more out of need and convenience than because of an emotional tie.

With her current partner, Dan, Lonnie didn't feel pressured to have intercourse. She felt that he was an unselfish, loving person whom she was beginning to love and trust. Dan, also, seemed to be willing to talk about and listen to Lonnie's concerns. He had also volunteered sharing his embarrassing sexual experiences so that Lonnie could feel more at ease discussing this sensitive area with himself.

Dan had allowed Lonnie to set the pace, time and environment for their lovemaking. He had managed to make Lonnie feel nurtured and supported without allowing her to gain complete control in their relationship.

Organismic Variables. (a) Thought processes. Lonnie was aware that she put herself into a spectator role during lovemaking. She cognitively monitored her physical reactions; and when it looked like she might lose control (lose herself to the experience), she'd turn off her physical responses.

(b) Emotional reactions. Lonnie had had a strict upbringing where nudity and sexuality were taboo topics. She felt that sex was dirty and shameful. This was partly due to the fact that, when she got pregnant, it was viewed by parents, relatives and some peers as an embarrassment; she was a social disgrace.

Her delivery was also a painful and extended one. The delivery room atmosphere was cold and impersonal.

The doctor was not a warm and supportive person to the naive, scared, young girl. The delivery room did not have a mirror set up; so, Lonnie could not watch the birth. She felt alone and, because she was physically exposed to strangers, oddly violated. She also possessed a deadly fear of becoming pregnant again which colored every sexual encounter.

(c) Organic states. Since the baby's delivery, Lonnie hadn't felt as physically attractive. Because she now had stretch marks, sagging breasts, larger hips - she didn't believe it when the men have told her that she was beautiful. She had a poor self-image. In actuality, Lonnie was very attractive physically, and her 3 sexual partners have told her so. In her mind, however, Lonnie compared her current body to that one she had possessed prior to the pregnancy when she was very athletic.

Lonnie's episiotomy was also painful when healing. She felt that she was sewn too tightly. It took over 8 months for the pain to diminish so that intercourse could be pleasant. At times, if Lonnie was tense or not well lubricated, the scar could still give her problems.

Situational Consequences. Dan found Lonnie physically attractive. He was not turned off by her stretch marks or Lonnie's perceived figure alterations. Because of his gentle and supportive nature, Lonnie said

that their sexual relationship had been the best that she had experienced.

Lonnie also found Dan physically attractive - which he was - and he met the very important criteria of being willing to attempt emotional closeness prior to physical closeness.

Family and Personal Background. Lonnie's parents have been married for 32 years. She had 3 sisters and 1 brother. In her home, sex was only brought up in dirty jokes; otherwise it was never talked about. Lonnie's pregnancy was seen as a family disgrace. Her father had taken cheap shots at her and had worried what the neighbors would think. Her mother had wanted her to get an abortion and had worried that she would ruin her future. Nudity embarrassed Lonnie because she'd been severely reprimanded by her parents whenever she had played in the yard without being dressed.

Children. Lonnie's child was a pretty, blond, five year old girl who looked a lot like her mother. She was shy with strangers and tended to use her mother as a mediator in her own disputes. She was also an insecure child who lacked confidence. She'd play off one child against another to get her own way. She didn't like men very much because they usually took her mum away from her. She was quite manipulative and would use other little children to back her up in her escapades.

Lonnie had had difficulty taking on the parenting role for the first two years of S.'s life. She had seen a counsellor to help herself come to terms with this new responsibility. At the time of treatment, Lonnie seemed to be handling her daughter to the best of her ability.

Childhood and Puberty. Sex was a forbidden topic in Lonnie's home. As aforementioned, it was only brought up in unpleasant contexts (i.e., dirty jokes and her pregnancy). She remembered herself as never being

able to please her parents; which may have contributed to her current low self-esteem (i.e., a disappointment to them because she got pregnant).

She had a strong reaction to nudity which Lonnie felt stemmed from her experiences cited at the ages of 3-4. Unless she was very comfortable with the person, she found nudity an embarrassment. Her pregnancy and delivery experience really had affected her because of the fact her body had no longer been her own; she hadn't been in control of it; and her privacy had constantly been invaded (i.e., physical check-ups, and the delivery itself).

Lonnie remembered developing breasts, pubic hair at approximately the age of 13 and beginning to menstruate at the age of 15. Her sexual education was mostly trial and error; picking up information from peers and health books.

She also remembered herself as being quite a flirt as a teenager. She knew that she was attractive to men, but she'd set them up to fail. For instance, she'd dance suggestively and make eye-contact, but when the man showed interest, she'd send him away. She dated little, and was actually very involved in sports. She was not secure in her ability to keep a man interested. This was the major reason, at 17, that she'd become involved with her boyfriend sexually (to keep him).

Self-Concept. Lonnie , in actuality, was a very pretty woman. She, however, had an idealized concept of how she should look and she could not attain this image. Because of this she lacked confidence in her ability to attract men. On the other hand, she knew that she was attractive and shunned men because they were drawn to her because of this. (They should want me for my personality). She had caught herself in a double-bind.

She was popular socially, especially with women. She also did well as a bookkeeper for the provincial government. She had plans to return to university on a full-time basis when her circumstances allowed it.

Attitudes Towards Treatment. Lonnie had high expectations of what treatment would do for her. It would give her security (long-term relationships); heightened self-confidence, an ability to trust men; and it would be an emotional release.

It had been pointed out to her by Dan and by the writer that reaching climax would not automatically include the rest. Lonnie then altered her expectations, to an extent, to incorporate the notion of just learning to accept her own limitations. This attitude was still colored by the fact that her insecurities, at times, caused her to withdraw from what she most valued. She had stated that she'd stop attempting to form close relationships with men, because if therapy didn't work, she didn't want to hurt them or her daughter (too many father figures). Dan was trying to help her see that this was a negative attitude - both to help her and because he'd emotionally invested in the relationship.

#### Progress and Outcome

Lonnie was seen 8 times by the writer. Since she was from out of town, this constituted 3 trips to the city for several days (3 interviews, 3 interviews, 2 interviews) spaced out over 6 months. The Heiman (1976) treatment program was followed in sequence throughout this time period.

A ban on intercourse was placed on the couple from the onset of treatment. Lonnie found this very beneficial because it relieved her of performance anxiety. Dan also found this a positive experience because it lifted the pressure he had placed upon himself to give Lonnie a climax.

Lonnie's first set of interviews constituted going over the treatment program as it was to be implemented by herself. Discussion also centered around her attitudes towards sex, men and her self-concept. She then returned home and practised the outlined program for an 8 week period. Contact was maintained by phone and mail with the therapist to discuss difficulties, as they arose, with her homework exercises.

When Lonnie returned to this city two months later, she had become more aware of her sensual and sexual preferences, but had been unable to bring herself to climax via manual stimulation. She had experienced performance anxiety re: obtaining an orgasm, and the necessity for keeping the pressure off herself was again discussed.

It was suggested, at this time, that Lonnie use a vibrator to enhance stimulation. The purchase and use of this device was carefully explored between client and therapist. Lonnie then went and bought a vibrator and attempted to use it that same evening.

The next day when she returned for her second session, she stated that she had felt almost on the brink of climaxing, but the feeling had gone away when she attempted "to will" an orgasm. Her self-pressuring was again discussed, and Lonnie left the session with heightened awareness of how trying to make something happen usually brought about the opposite result.

The following day, on Lonnie's 3rd visit that week, she shyly exclaimed that she'd had an orgasm using the vibrator. She said that the sensations had been nice, but not as overwhelming an experience as she'd always thought they'd be. She stated that the writer had been right about not putting so much worth on a physical sensation, and she seemed to have put the experience in perspective for herself; and seeming more relaxed about what pleasure she could expect from her body.

Lonnie had also brought her vibrator into the session and a frank discussion and theoretical demonstration of its use greatly aided her in becoming more comfortable with its place in treatment.

Dan was, at this point, incorporated into treatment. The couple followed the exercises outlined in the program with the only prohibition being placed on attempting any sessions that were orgasmically goal-oriented. Lonnie continued her program with the use of the vibrator in order to incorporate her new somatic responses, without any pressure to perform in a couple context.

When Dan and Lonnie returned two months later, they were enjoying their sexual relationship. Lonnie had not climaxed in sexual activity with Dan, but had been able to do so while showing him the vibrator's use.

Dan's support and positive attitude was probably the most influential aspect of the eventual, successful outcome of treatment. He continually put the sexual relationship and orgasm into perspective for Lonnie. He remained loving, understanding, romantic; in short anything that Lonnie wanted without losing strength or his own sense of self. He remained steadfastly by her while she worked through issues regarding trust, control and maintenance of self-esteem in an intimate relationship with a male.

At the time of writing, July '83, Lonnie is orgasmic with Dan via an initial combination use of manual and vibrator stimulation, culminating in intercourse. They both feel that their sexual relationship is "excellent". Lonnie feels that she is becoming more relaxed and receptive towards their sexual relationship as time passes. Lonnie's divorce is final and the two are engaged to be married.

In addition to the client's, and her partner's, and the writer's observation of positive improvement; paper and pencil instruments administered noted positive change.

1. Sexual History Form

Nov. '82	July ' 83
inorgasmic	orgasmic

2. Sexual Arousal Inventory (mean 80)

Nov. '82	July '83
71	84

3. Index of Sexual Satisfaction (cutting point 28-30)

Nov. '82	July '83
46	31

Jane - Inorgasmia, Situational Dyspareunia, Situational Low Sexual Desire, Decreased Physiological and Subjective Arousal.

Demographic Data

Jane was a 33 year old, single woman with a history of incest and psychopathology in her background. She presented as a depressed person with little emotional affect. She worked as a make-up, door to door salesperson which gave her just enough money to live on a subsistence level.

Assessment

Description of Problem. Jane had primary inorgasmia of a global and long-term nature. She had decreased subjective and physical arousal also of a long-term and global nature. She experienced dyspareunia about 50% of the time, depending upon the situation (i.e., a situation where this problem might occur was with a man she didn't want to sleep with). Low sexual desire could also be a problem in the previously cited example. An overriding factor was Jane's moderately depressive mood.

She had had a long history of depression. She had experienced somatic disorders for approximately 10 years. Her sleeping habits had changed from regular hours, 10 years ago, to the current routine of going to bed at 3 a.m. to 6 a.m. and sleeping until early to mid afternoon. She didn't eat regularly; rather, she ate when she felt like it, mostly t.v. dinners. She had received medication for her depression in the past; but, found that it didn't help her mood. She hadn't taken any medication, other than sleeping pills, for the last 1-1/2 years.

Jane had experienced sexual arousal and desire on a few occasions with her first boyfriend. She knew him for about 1 year; but, only dated him for 19 days. She liked him a lot and felt that that played a major part in why she found sex enjoyable.

Jane was aware that she lubricated, enjoyed kissing, hugging and petting. She, however, didn't like to feel pressured into sex. This was tied into her background where she had been the victim of sibling incest and attempted rape. She was also aware that at times she was distrustful, afraid and did not like men.

It didn't seem that Jane had ever had a man spend much time pleasuring her. Her five relationships had varied from a one night stand to one that lasted for five months. It would seem, from her description, that these men usually used her for their own purposes.

Jane had had erotic dreams on two occasions that she found very exciting; and she knew that she also remembered them as being sexually gratifying.

Contemporary Influences on Problem. Situational antecedents. Jane had never had a close and loving relationship with a man. The men that she had been intimate with did not spend a great deal of time on foreplay;

though Jane enjoys this form of activity. She did not ask for specific stimulation because she did not know how to ask for what she wanted. Jane was also quite naive about her anatomy and didn't know what exactly would be most pleasurable to herself.

Jane had low self-esteem; and didn't feel that she was very attractive or interesting. She had few friends and was quite lonely. Her hours made it impossible to maintain a regular lifestyle. She had stopped working as a secretary because she had felt too constricted, several years ago. Her current selling job kept her in contact with people; but, also it kept them on a client basis - not conducive to meeting friends.

Because of her past family history - where she had been made to feel a nuisance, and best kept out of sight, - Jane had little confidence in herself. This coupled with her depressive state did not make her adept at social interaction. For these and other reasons, Jane's choice of sexual partner was inappropriate. She chose men that were less than desirable because she felt that that was the best that she could do.

Organismic Variables. (a) Thought processes. Jane was naive about her anatomy and what its responses should be. She had great difficulty locating her clitoris and clitoral shaft. It would have been appropriate, in this instance, should a medical doctor have been available, to have had that person help Jane locate various parts of her genitals. As it stood, films and drawings were used with success to aid Jane to identify the different areas.

Jane cognitively monitored her sexual response and tried to concentrate on having an orgasm. Usually she got bored during intercourse and didn't enjoy the experience. She said that she was

emotionally dead to "just intercourse". She also felt resentful when pressed to have sex, and usually 'gave in' to the male's advances

(b) Emotional reactions: Men frightened Jane. She was afraid of their advances (i.e., especially between the years when she was 18-26, and at that time just kept away from them). Her mother had ground it into her that sex was dirty; and when she was young she had believed so too. Jane said that she was over having these feelings, but that she still didn't like to look at male genitals. She did like to look at the rest of mens' bodies and she wasn't terrified of males - most of the time.

Jane was depressed most of the time and it seemed to range from mild to moderate episodes - depending on how lonely she felt. It seemed that this depression could affect her libido and might have accounted for her lack of desire in part.

Jane didn't avoid sex. She actively strove to meet men as best she could. However, the places she went to, most of the time alone and made-up a little too garishly, gave the wrong impression. She was looking for friendship, but got sexual advances instead. This inability to have a close relationship, coupled with her intentions being misunderstood; depressed her even more.

Organic States. Jane might have had a biologically based depression. However it was difficult to determine just who in the family - other than Jane - might have suffered from this disorder. Even though the family members were unemployed to a large extent, her father had committed suicide, one brother was incestuous with her and possibly with his own daughter, the siblings marriages were unstable, her mother was rejecting emotionally, and one paternal uncle was institutionalized for an

emotional disorder - no one other than this uncle has been treated for psychological instability.

Jane, herself, had been in and out of counselling since 1973. She had seen three psychiatrists, several psychologists and some social workers. She had spent 6 months in counselling at this university in 1973. She had gone to a community clinic in '77 and '78 for a few sessions; and to another service for 6 months in 1980. In 1981 she attended a private agency for about six sessions. She had received antidepressants off and on from '73 to '80. She had voluntarily taken herself off medication when she had felt that she was becoming addicted.

Jane had hypoglycemia, scoliosis and took sleeping pills (3 times a week approximately) and Valium (1 time a week).

Personal and Family Background. Jane's mother had always been a cold and rejecting person. She had wanted her out of her sight most of the time; and Jane had spent a great deal of her time in her own bedroom. Her father had committed suicide when she was 4 years old and she knew nothing about his background.

Jane had 3 brothers and 3 sisters. Her siblings have never been close to her. The only brother with whom she felt a bond died accidentally 10 years ago. Her 2nd oldest brother was the person who forced her to have a four year incestuous relationship with him. He is 7 years her senior. Her brothers and sisters have not done well. They have been divorced, unemployed, had children out of wedlock, been adulterous and she suspects, some have been incestuous with their own children.

Childhood and Puberty. Jane's family was very restrictive about sex. The topic was taboo; and Jane got the very clear message that sex was

dirty. She had no sexual education from mother; and when she started to menstruate at age 13 - she hadn't known what was happening.

At 16 years of age, Jane had thought that you could get pregnant from kissing a boy. She didn't remember very much about her youth because she spent much of the time in her room away from the rest of the family. She had felt unwanted and an outsider in her own family.

She did remember that her brother had made sexual advances to her from about the age of 10-14. She has blocked out of her mind completely what they had done and how often. Her brother was then age 17-21. At the age of 18, Jane was attacked by a 20 year old male she knew; who threatened her at knife point to have sex with him. She told him at the time to go ahead and kill her because she didn't care. He had become frightened; and had stopped the proceedings. He then walked her to the bus and told her to tell no one about the incident.

Jane was fearful of men and wouldn't remain in the same room alone with one. She hated men at that time and literally couldn't look at them. However, at the age of 26, she met a young man whom she liked very much.

Sexual Experience With Various Partners. Jane has had five sexual partners. The relationships were all short-term and she didn't believe that any of these men had loved her.

Jane's 1st relationship was at the age of 26. She knew this boyfriend before she started to date him for approximately 1 year. She went out with him for 19 days. The man then went to Mexico for a holiday and never called her again. Jane had tried to contact him; but he always made excuses as to why they couldn't see each other. Jane felt that of any of the men she had dated, that this had been the man for her. She

had enjoyed their sexual relationship, but had never experienced an orgasm.

The 2nd relationship was when Jane was 28 years old. She was intimate a few times with a man who turned out to be an alcoholic. She ended the relationship because of his drinking problem.

Jane's third sexual partner was a man that she'd known for 5 years. They tried sex once and it proved a complete failure. The man came within five minutes from the initiation of their lovemaking. The relationship ended on this note.

The 4th sexual relationship was a one night stand with a man from Toronto. Jane was 31 years old and had been celibate for over two years. The man had told her that she was a "dead log"; implying that she was completely unresponsive in bed.

Jane's 5th and most recent relationship had lasted for five months in '82. Originally, Jane had the intention to attend counselling with this person. However, 10 days before her 1st appointment, she broke off the relationship. She had been feeling pressured into sex and marriage by this man. Jane hadn't even been sure if she liked this person. She eventually stopped seeing him because he had had too many emotional problems.

R. had erectile difficulty when Jane met him. He had wanted to work out his sexual problem with her. At first she had thought that they could help each other. Eventually, after a few weeks of trying to have sex; R. had been able to maintain an erection. He, however, had wanted to have sex seven days a week. Jane hadn't desired this, so approximately 75% of the time she'd had problems with tight vaginal muscles and dyspareunia. This was the only man with whom she'd ever had this

type of difficulty. The other 4 men with whom she'd been intimate were no problem.

R. had been anxious to get married, but Jane hadn't wanted to live with him. She'd also thought that his background was questionable. He had had two children by two different women. The oldest child had just recently died and that was quite a blow to R. Both children had been living with their respective mothers. He was also 7 years younger than Jane and acted immaturely at times.

The two had gone on a trip together in September and had spent alot of time fighting. Jane had figured that the relationship was poor and that proximity to R. had only brought out his bad points. She had also found him physically unattractive and had avoided sex with him. After the two had returned to Winnipeg; Jane ended the relationship.

#### Progress and Outcome

Jane was seen by the writer for 17 sessions. Her treatment program followed the Heiman (1976) package for inorgasmic women. Her progress in working towards this goal went smoothly; within 10 sessions, Jane was able to achieve an orgasm via 10-15 minutes of stimulation by a vibrator. She did not have a partner at her disposal with whom she could have generalized her treatment gains into the couple context.

Running simultaneously with Jane's sexual dysfunction treatment, was a program geared at changing her sleeping habits. She had been going to bed between 2-5 a.m. each day and sleeping until 2-4 p.m. This pattern left her devoid of much human contact. Her goal was to go to bed by midnight and get up by 11 a.m. A systematic program was initiated whereby Jane tracked her sleeping habits for two weeks. After a pattern had been established, she progressively went to bed 15 minutes earlier

and got up 15 minutes earlier each week. She also was instructed to exercise for at least 30 minutes each day, and not to nap if she could at all avoid it during the day. She also recorded how she'd felt and what she'd done each day to see if it coincided with her ability to sleep. She recorded all this information on a make-shift checklist the therapist drew up for her.

Jane made significant gains in her sleeping pattern over the six months that she was in therapy. She followed the outlined program, and eventually was going to bed between 12-1 a.m. and getting up around noon. Her depressed mood also seemed to have lifted somewhat, and she began to talk about getting a new job. It was likely that the positive gains that she'd made in overcoming her inorgasmia, and the human contact she received in the heterosocial skills group (referred by the writer to this group at the P.S.C.) also contributed to her improved state of mind.

Near the close of treatment, Jane met a newly separated man and began to date him. She discussed becoming sexually involved with him with the therapist. She was instructed on how she could continue her treatment program if he became a regular partner.

Jane continued attending the hetero-social group after her treatment terminated with the writer. Her ability to meet and converse with men was limited; and this skills group provided her, not only with an arena to improve her communication skills, but a place where she could have human contact.

Jane, by her own admission, was pleased with her therapy gains. It seemed likely that the regular contact with the therapist provided as

much to her treatment gains as the therapy itself. Her extremely limited social circle (only 1 friend) did not provide her with adequate physical or emotional stimulation.

Paper and pencil instrument results also showed improvement.

	Oct. '82	March '83
Beck Inventory	15 (mild depression)	3 (normal)
Sexual Arousal Inventory	26	51 (mean 80.9)
Sexual History Form	inorgastic dyspareunia 50% of the time	orgasmic with vibrator No dyspareunia

#### F. Erectile Dysfunction

##### 1. Description

"Erectile dysfunction or impotence, 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 a persistent inability to obtain a sufficiently firm erection, or to maintain this during intromission and intercourse" (Jehu, 1979, p. 81). This condition can be classified as being of a primary nature when the man has never been able to achieve or maintain an erection of sufficient strength to accomplish coital connection successfully (Masters and Johnson, 1970; Ellis, 1980; Kaplan, 1974). This same condition can also be of a secondary nature when a man who has experienced successful intromission, either homosexual or heterosexual, fails in subsequent experience (Reckless and Geiger, 1978; Jehu, 1979). Some writers have

also classified erectile dysfunction according to whether its onset is of an acute or insidious nature (Cooper, 1968; Johnson, 1968; Ansari, 1975).

The definition delineated above leaves much room for subjective judgements of inadequacy. Most men experience erectile failure at one point or another in their lives; be it the teenager just beginning to explore his sexuality, the male at the peak of his vigour, or the septuagenarian who fears that age has robbed him of his virility forever (Kaplan, 1974; Jehu, 1979; Zilbergeld, 1978). Partial erections that are or are not sufficient to achieve intromission; the partners expectations re: the length of time the male should maintain an erection during inter course; and the persistence of the dysfunction all work together to influence the client's subjective judgement of inadequacy.

The prevalence of erectile dysfunctions has not been statistically established. A report by Kinsey et al. (1948) found that among a group of 4108 males, aged 10 to over 80 years, that 66 were considered to be permanently impotent. They estimated the incidence rates of impotence to be 1.3% by age 35 years, 6.7% by age 50, 18.4% by age 60, 27% by age 70, and 55% by age 75. A study of Stafford-Clark (1954) found that 45% of the american husbands they saw were dissatisfied with their sexual capacity. "It was also found that primary erectile dysfunction was much rarer than the secondary type; for instance only 32 out of 243 impotent clients treated by Masters and Johnson (1970) were categorized as primary in nature" (Jehu, 1979, p. 82).

"An impairment of erectile capacity may or may not be accompanied by other forms of sexual dysfunction" (Jehu, 1979, p. 81). A man, for instance, may have strong sexual desire though he is unable to get an erection.

The timing of erectile failure, whether it occurs before or during sexual intercourse, within the context of certain situations or with certain partners points to the importance of surrounding circumstances when determining its occurrence.

For most men, erectile dysfunction is experienced as a extremely frustrating, embarrassing and humiliating problem to which they commonly react with anxiety, depression, and avoidance of sexual encounters (Jehu, 1979; Zilbergeld, 1978; Reckless and Geiger, 1978; Kaplan, 1974; Ellis, 1980). "Their confidence, self-esteem and gender identity are likely to be impaired" (Jehu, 1979, p. 82). As with premature ejaculation, the partners of impotent men may at first be sympathetic and understanding of the situation; but, in time they come to share the negative reactions experienced by the men. The women may feel unloved and unattractive and may seek reassurance by increasing sexual demands upon their partners (Clifford, 1977).

## 2. Etiology

### Organic Components

In our culture men with sexual dysfunctions find it considerably more acceptable to blame their disorder on physical disability than on psychologic difficulty, and indeed, anything that affects the neuro-muscular, vascular or hormonal components of the male sexual response can produce functional and sometimes even structural impotence (Kaplan, 1974; Ellis, 1980; Reckless and Geiger, 1978; Masters and Johnson, 1970; Jehu, 1979). The erectile problem may arise directly from the organic events or "to the changes in sexual response that accompany aging" (Jehu, 1979, p. 83).

Various physical deformities of the genitalia (Reckless and Geiger, 1978); diseases (eg. diabetes and multiple sclerosis) (Ellis, 1980); glandular deficiencies, vascular disorders, drug abuse, surgical trauma, and dietary deficiencies can cause erectile dysfunction. Some of those commonly implicated in the causation of erectile dysfunction are summarized in Table 5 and 6. It should be iterated that most of the

Table 5. Drugs That May Lead to Impotence

Drugs of addiction	Barbituates, morphine, heroin, cocaine, alcohol, amphetamine, and bromide
Tranquilizers and antidepressants	Chlordiazepoxide, chlorprothixene, imipramine, certain phenothiazines, such as chlorpromaxine and thioridazine, and drugs of the monoamineoxidase inhibitors
Drugs of the vascular system	Reserpine, nicotine, digitalis, guanethidine and methanetheline

(Reckless and Geiger, 1978, p. 302)

items in these two tables are not inevitably accompanied by impotence or any other form of sexual dysfunction. "Furthermore, in only a portion of impotent men is there any evidence of the operation of a relevant organic factor" (i.e., in a Masters and Johnson (1970) study, only 7 out of 213 secondarily impotent men had relevant organic aetiology) (Jehu, 1979, p. 83).

#### Psychological Components

Strauss (1950) estimated that 90% of all impotence was psychogenic in origin. The possible factors that have been implicated as having an influence on impotence have been: certain types of previous learning experience (Jehu, 1979; Masters and Johnson, 1970); many sexual and non-

sexual stresses, as discussed in Part 1:C; the anticipation of failure (Jehu, 1979; Ellis, 1980; Zilbergeld, 1978); sexual activity that is seen as taboo or that transgresses against a man's moral or religious standards (Jehu, 1979; Ellis, 1980; Reckless and Geiger, 1978); anxiety

Table 6. Physiopathologic Conditions That May Cause Impotence

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Anatomic defects	Congenital absence of the penis, diphallus, hypoplasia of the penis, hypospadias, cryptorchidism, and anorchism
Endocrinologic	Addison's disease, adrenal neoplasms, chromophobe adenoma, craniopharyngioma, diabetes mellitus, acromegaly, pituitary insufficiency, feminizing interstitial cell tumor, infantilism, castration, eunuchoidism, the ingestion of feminine hormones, myxedema, thyrotoxicosis, testicular failure, Frohlich's Syndrome, Lawrence-Moon-Biedl Syndrome
Neurologic	Amyotrophic lateral sclerosis, cord compression, tumors of the spinal cord, Parkinson's disease, multiple sclerosis, peripheral neuropathies, tabes dorsalis, and general paresis
Inflammatory	Prostatitis, seminal vesiculitis
Vascular	Aortic dostruction (Leriche's Syndrome), calcific obliteration or thrombosis of the vessels supplying the penis
Other	Trauma, side effects of surgery, Klinefelter's Syndrome, Peyronie's disease, lead and herbicide poisoning
Psychogenic	Religious orthodoxy, negative sexual education and experience, plus situations that lead to shame, fear, guilt, and demand for performance, also lack of confidence in sexual performance

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(Reckless and Geiger, 1978, p. 303)

(Jehu, 1978; Ellis, 1980; Reckless and Geiger, 1978, Kaplan, 1974; Zilbergeld, 1978; Masters and Johnson, 1970); partner discord (Reckless and Geiger, 1978; Ellis, 1980; Jehu, 1979; Kaplan, 1974; Masters and Johnson, 1970); conditions of deficient or inappropriate stimulation (Jehu, 1979; Ellis, 1980); general emotional stimulation (Jehu, 1979; Ellis, 1980); general emotional disturbance (i.e., feelings of anxiety, depression, worthlessness, self-pity and hostility) (Ellis, 1980; Apfelbaum, 1977; Reckless and Geiger, 1978); external pressures to succeed (Ellis, 1980; Zilbergeld, 1978); a life-long inadequate interest in sex of a constitutional nature (Cooper, 1968; Ansari, 1975; Jehu, 1979); and a need for certain forms of unconventional stimulation in order to become aroused (i.e., fetishism, cross-dressing, or having a partner of the same sex) (Masters and Johnson, 1970; Jehu, 1979).

### 3. Assessment

Assessment of this dysfunction follows the outline presented in Part II:A (Appendix B). Specific paper and pencil instruments administered to clients exhibiting this dysfunction would be: the Erection Difficulty Questionnaire (Price, 1981); The Sexual History Form (Schover et al., 1980); Index of Sexual Satisfaction (Hudson et al., 1981); and The Goals For Sex Therapy. Interviews, client self-monitoring, and archival records would also be used as indicated in Part II:B.

### 4. Treatment

Depending on their theoretical orientation, authorities in the field of sexual dysfunction have variously advocated hormonal (Johnson, 1968; Cooper et al., 1972; Kaplan, 1974), psychoanalytic (Reckless and Geiger, 1978; Cooper, 1978), behavioural or derivatives of (Jehu, 1979;

Kockott et al., 1978; LoPiccolo et al., 1978, Kaplan, 1974; Ellis, 1980; Zilbergeld, 1978) and marital therapy (Jehu, 1979) as the treatment of choice for impotence. Though all these modalities are effective in some cases; it has been found that brief, symptom-focused forms of treatment which actively intervene to modify the client's sexual behaviour are most successful (Cooper, 1978).

It has been found that post-treatment success rates vary from 59% for primary cases to 74% for secondary cases following the Masters and Johnson (1970) treatment program. Kaplan (1974) stated that she had excellent results with secondary impotence; while primary impotence had a less favorable prognosis. She did not state what her exact figures were; but, she did mention that she followed a modified Masters and Johnson approach combined with various types of psychotherapeutic interventions which were conducted with the couple. Other modified Masters and Johnson approaches such as Ansari's (1976) had a 67% reported cured/improved rate. A similar 66% cured/improved rate was reported by Kockott et al. (1975) in respect to those patients who crossed over to Masters and Johnson treatment after failing to improve during desensitization. While the success rates achieved by Masters and Johnson were generally maintained over a 5 year follow-up period; the Ansari figure dropped to 33% during an eight month follow-up and there was no obvious explanation for this discrepancy.

The treatment of choice derives from the various components presented in Part III. A combination of active-directive, cognitive, emotive, and behavioural treatment is often required for lasting results (Ellis, 1980). The different therapeutic tactics and strategies are employed to implement the treatment goal.

The basic premise on which sex therapy rests is that anxiety occurring at the moment of sexual intercourse disrupts the client's erectile response. "The overriding objective of treatment, therefore, is to diminish this anxiety, or to prevent its occurrence" (Kaplan, 1974, p. 267). The idea is not only to aid the client to restore his confidence in his ability to obtain an erection; but, also to help the client review his own belief system re: enjoying or performing in a sexual situation (Zilbergeld, 1978).

"Treatment generally begins with a period of ejaculatory abstinence, during which the client is exposed to teasing erotic stimulation on the assumption that freedom from pressure of sexual demands will facilitate the attainment of an erection" (Kaplan, 1974, p. 267). The various exercises to be performed by the client alone are outlined in Zilbergeld's book (1978) and include: losing and gaining an erection; masturbation with fantasy of sex with a partner, masturbating with fantasy of losing and regaining an erection; and masturbation with fantasy of no erection.

Once the client is confident of his erectile capacity; exercises can be expanded to include partner involvement (where applicable). The exercises that would be used would again be drawn from Zilbergeld (1978) and could include: the partner playing with the client's soft penis, partner stimulation of penis with focusing; oral stimulation of penis with focusing; losing and regaining erections; penis in vagina with minimum movement; penis in vagina with movement; and losing an erection.

These exercises, while dealing with the overt behaviour, might also draw out various psychogenic difficulties that had helped to cause and maintain the erectile dysfunction. These influencing factors might be dealt with at the point of their inception into treatment; or at some other point determined by the discretion of the therapist.

The psychologic components of the dysfunction, as already mentioned, would entail using treatment strategies from Part III. The writer would, in addition, suggest that the treatment program outlined by Ellis (1980) would give a wide range of therapeutic techniques that could be implemented. Such techniques as cognitive restructuring (Ellis, 1980; Jehu, 1979; Beck, 1970); provision of information (Jehu, 1979; Ellis, 1980); myth-attacking (Zilbergeld, 1978; Ellis, 1980; Masters and Johnson, 1970); cognitive distraction (Jehu, 1979; Masters and Johnson, 1970); imaging methods (Masters and Johnson, 1970); sensual focusing (Masters and Johnson, 1970; Jehu, 1979; Kaplan, 1974); relaxation training (Jacobson, 1938; Jehu, 1979); desensitization (Jehu, 1979; Kockott et al., 1975; LoPiccolo et al., 1978); bibliotherapy and audio-visual aids (Zilbergeld, 1978; film on The Treatment of Erectile Dysfunction), fantasy training (Jehu, 1979; LoPiccolo et al. 1978); and emotive methods (Ellis, 1980) would all be tools used by the therapist.

Finally, in cases where the client is totally impotent, a form of artificial penis or penile implant may be used as a form of treatment.

In the case of implants, two major types are currently available. "The Scott prothesis is an inflatable implant in the penis that employs a hydraulic system to enable a male, through compressing a bulb in his scrotum when he desires an erection, to give himself one. The Small-Carrion prothesis is a silicone device surgically implanted in each corpora cavernosa ... It gives a permanent erection while leaving the penis flexible enough to be inconspicuous under clothing" (Ellis, 1980, p. 250). As was indicated, the treatment of choice offered to the writer's client was a penile implant.

## 5. Case History

Frank - Secondary Erectile Dysfunction

### Demographic Data

Frank was a 67 year old widower who had 6 grown children. His wife had died four years previously and he greatly missed her. He was a successful grain and cattle farmer; but, presented as a man of little means.

### Assessment

Description of Problem. Frank presented with an inability to gain and/or sustain an erection. His difficulty began after the death of his wife, four years previously. Approximately six months after her funeral Frank had attempted to masturbate. He had been unable to get a full, firm erection at that time. He had attempted, almost daily, from that point onwards to masturbate to orgasm. Constant disappointment seemed to have compounded Frank's performance anxiety to the point where he was totally preoccupied with the thought of regaining erectile ability. His attempts at sexual intercourse were failures. He was humiliated by his lack of performance and gave up coital activity in July 1981.

Situational Antecedents. It seemed that Frank's grief over the loss of his wife left him emotionally unready for the resumption of sexual activity. He had attempted masturbation to prove his continued maleness; his ability to continue in the face of aging. His inability to attain a firm erection had left him anxious, which compounded with each additional failed attempt.

Also, because of Frank's advancing age (67) it was likely that he needed prolonged and intensified stimulation. This he had not allowed himself, feeling that he should be able to perform with the same amount

of tactile stimulation as when he was 40. (It should be noted that Frank considered his coital frequency during his 38 years of marriage to be 4-5 times a week, with no sexual difficulty).

Organismic Variables. Frank closely monitored his erections. He desired an erection to such an extent, that his performance anxiety - and subsequent performance inability - were likely correlated. He also had very little sexual knowledge - per se. He did not know that retrograde ejaculation (due to a prostate operation) did not mean an inability to have an orgasm. He had difficulty with many terms (i.e., didn't know what masturbation meant etc.). He also felt that his sexual abilities should have been immune to the aging process.

His masculinity was very much tied into his ability to perform sexually. An inability to gain and sustain an erection were profound blows to his self-image.

Due to the medications - naprosyn, metandren, hydrochlorothiazide - that Frank took, his advancing age, and his sporadic and soft a.m. erections, it was decided that he should have NPT monitoring and a full physical checkup to assess physiological implications for these erectile difficulties. An urological examination by a doctor verified that a good part of Frank's difficulties were organically based. It was suggested that psychological counselling for other than the acceptance of a penile implant would be of dubious benefit.

Frank was unwilling to opt for a penile implant, and agreed that counselling would seem to be futile in this instance. He also did not have a sexual partner, therefore, the operation seemed an unnecessary inconvenience for just himself.

Personal and Family Background. Frank was a 67 year old widower who farmed a large portion of land in a rural section of this province. He had little formal education and had been a successful beef and grain farmer for most of his life. He was married for 38 years and felt that he had had a happy marriage. He had lost his wife 4 years ago, and missed her dearly.

He was a practising Roman Catholic as was his family. He had 6 children, 4 boys - 2 girls, all of whom lived near his home town. The boys were all farmers like himself and ranged from ages 37 through to 26. His two daughters were 25 and 22 years of age. His youngest girl and two bachelor sons lived at home with him.

Frank's parents came from the Ukraine in 1899 and eventually settled in the homestead's area in 1911. His parents died in 1944 (father) and in 1950 (mother) in their late 50's. Frank has 4 brothers, of which he was the twin to one. All his children and brothers were in good health.

Childhood and Puberty. Frank's parents never talked about sex. If the subject were mentioned, the children were spanked for it. In his own family, neither Frank nor his wife (P.) mentioned the topic to the kids. However, Frank always said that he greatly enjoyed sex and took a liberal attitude towards his children's escapades.

Throughout his marriage Frank said that he had had coitus 4-5 times a week. The only times that this differed was during P.'s pregnancies and menstrual period. He said that he would have continued sexual activity during these times, but his wife had put up opposition.

He could not remember exactly when 1st emissions and secondary sexual characteristics came within his awareness, but he assumed that he

probably had been about 13 years old when he first noticed these physical changes.

Current Partnerships. P. was Frank's only sexual partner until her death 4 1/2 years ago. During marriage Frank did not masturbate though, prior and post he partook of the activity. He stated that he had desired sex daily for most of his life, and felt that he and his wife had had a good sex life - though they'd never talked about it.

He had attempted intercourse a couple of times after his wife's death, but was unable to gain an erection. He entertained the idea of getting a local woman to move in with him. Upon further investigation, it was found that Frank had dated this lady only a handful of times in two years. She had never given any indication that she wanted to date him steadily, never mind sleep with him or live with him.

Frank, on the other hand, had entertained this possibility quite seriously, to the point of investigating with his lawyer common-law arrangements. Frank had wanted to regain his sexual functioning for their potential sex life together. He did not believe that a woman could want him if he were no good in bed.

Frank's sexual outlet, since his wife's death in '78, had been largely self-stimulation with little subjective pleasure. He did look at erotic literature from time to time and felt that he still had sexual desire on a daily basis.

Self-Concept. Frank was a plump man of approximately 5'8" in height. He had a ruddy outdoor complexion and was not one overly concerned about dress. He felt quite emasculated because of his inability to obtain facile erections. He had based a lot of his personal appeal to women on his ability to perform sexually. He had a few close male friends, but

kept to himself quite a bit. After his wife's death he felt that his social circle had contracted quite a bit. He found that he no longer was invited out to the homes of P.'s friends. Frank was a lonely man who wanted to fill the void with female companionship. This he had wanted to do so badly that he had convinced himself that this female acquaintance had been equally interested in himself. Upon exploration of this possibility with the writer it was found to be largely a fabrication of Frank's imagination.

#### Progress and Outcome

Frank was seen for four in-office sessions. Frank was highly motivated to seek psychological treatment for his dysfunction. He was concerned about his condition to the point that he made frequent long distance calls to the writer to talk about his problem, and came to the clinic - without an appointment - whenever he was in the city.

The medical report verified that Frank's erectile difficulty seemed to be largely physical. A penile implant was suggested to Frank by the Doctor; however, he was not amenable to this suggestion. Frank realized that the operation might have been painful and that it meant that he would be dependent on a prosthetic aid for sexual performance. He had come to the realization, in discussion with the writer, that his relationship with his girlfriend was only a pipe dream. Since he was not sexually active with a partner, and since it looked unlikely that he would become involved in the future with anyone, he did not feel that he needed to pursue the medical option.

Frank left the clinic amicably. He had explored his options, come to terms with the reality of his relationship with his female acquaintance, and had chosen not to proceed with surgery.

## G. Retarded Ejaculation

### 1. Description

Retarded ejaculation (R.E.) is commonly defined as a "persistent delay or failure in the occurrence of orgasm and ejaculation despite the presence of an adequate erection" (Jehu, 1979, p. 93; Apfelbaum, 1980; Kaplan, 1974; Munjack and Kanno, 1979; McCarthy, 1981; Pryde and Woods, 1980; Razani, 1972; Morse and Morse, 1981). The female counterpart, coital anorgasmia, is quite common; but, the male phenomenon tends to be a rarity among men who seek treatment for sexual dysfunction.

Masters and Johnson (1970), for example, in an 11 year period, saw only 17 (3.8%) out of 448 males who could be diagnosed as having retarded ejaculation. Cooper (1968) reported 13 cases; Oversey and Meyers (1968) treated 10 males with this complaint; and Johnson (1968) had 3 (3.9%) clients exhibiting this difficulty. It is suggested (Kaplan, 1974; O'Conner, 1976; McCarthy, 1981) that this complaint may be more common than indicated by the statistics. It may be a complaint, once intermittent and/or situational dysfunction is included; that affects, at some point, as many as 15% of males (McCarthy, 1977).

Retarded ejaculation (also known as "ejaculatory incompetence", "ejaculatory inhibition", "ejaculation retardata", "absence of ejaculation", "impotentia ejaculandi", or "ejaculatory impotence") can be global, in that the man never reaches climax under any circumstances; or more usually, situational, as exemplified by an ability to ejaculate when he is with a particular woman; during masturbation or via nocturnal emissions. The difficulty can also be of a primary nature; whereby, the client can date his awareness of an inability to climax from his first attempt at masturbation and/or intercourse. In contrast, the male who

suffers from secondary retarded ejaculation enjoyed a period of good ejaculatory functioning prior to the onset of his problem.

The diagnosis of absent ejaculation seems straightforward enough until we recognize the range of cases that this includes. At one end of the spectrum are the most severe cases where the male is unable to reach orgasm by any means, masturbatory or otherwise. This condition is considered relatively rare as indicated by Kaplan (1974) who stated that, at that time, she had not treated any patient who had never ejaculated. The next most severe would be the male who could masturbate to orgasm; but, not ejaculate in the presence of a partner. The male who could ejaculate with a partner; but, not intravaginally, would be next on this continuum. At the opposite end of this spectrum would be the men who could ejaculate intermittently with a partner; and then those who could only do so within certain situations or via certain ritualistic behavior (Jehu, 1979; Munjack and Kanno, 1979; McCarthy, 1981; Apfelbaum, 1980; Kaplan, 1974).

The syndrome should be distinguished from retrograde ejaculation in which "ejaculation occurs and orgasm is experienced but the ejaculate moves in a retrograde manner in the bladder rather than directly through the urethra and penile meatus" (Munjack and Kanno, 1979, p. 140). The literature has not always been clear in identifying which of these problems - absent ejaculation or retrograde ejaculation - has accompanied organic etiology. This had lead to some confusion as to which difficulty, allegedly has coexisted with the physical concern (Jehu, 1979).

While masturbatory and coital ejaculatory incompetence are, most times, seen as gradations under the same heading; Apfelbaum (1980) would not agree with this classification. He clearly differentiates between a

"true retarded ejaculation" and someone who has "masturbatory anorgasmia". The former would be a male who could have orgasms, often easily and pleurably with masturbation; but, who had a coitus-specific difficulty. The latter would be considered a desire disorder: a person who neither had sufficient libido nor sufficient motivation to work at having orgasms.

Apfelbaum goes even further and states that he would remove masturbatory anorgasmia from the retarded ejaculation category and would place it amongst the desire disorders. One reason for this is that he considers the key diagnosis for retarded ejaculation to be that "only the patient's own touch is erotically arousing, and "that" his basic sexual orientation is 'autosexual' (masturbatory), rather than homo-sexual or heterosexual" (Apfelbaum, 1980, pp. 266-267). The patient is inhibited by the touch of a partner and, with her, his penis is relatively insensitive or numb. Therefore, Apfelbaum states, R.E. would be harder to identify - given the key diagnostic sign - if masturbatory anorgasmia were left as inclusive in this dysfunction.

Another interesting variant of retarded ejaculation is the condition that Kaplan (1974) referred to as "partial ejaculatory incompetence". In this syndrome the ejaculatory response is only partially inhibited. The emission phase is not impaired; while the ejaculatory phase seems to be absent. The point of ejaculatory inevitability is experienced; but the expulsion component consists of a seepage rather than a spurting of semen, and it is not accompanied by the usual muscular contractions and pleasurable sensations of orgasm. Kaplan suggests that transient occurrences of this phenomenon are not uncommon when men are fatigued, in conflict situations, or in the process of learning to exercise adequate voluntary control during treatment for premature ejaculation; but she cites a personal communication with William Masters saying that its more chronic occurrence is extremely rare" (Jehu, 1979, p. 93). What seems to be quite common among men who suffer from absent ejaculation is a presence of facile and sustained erections. It is not uncommon for the male to be able to maintain an

erection for an hour or more. "Another startling finding is that the retarded ejaculator's partners are multi-orgasmic despite his coital anorgasmia. Still more surprising, this is found even when the patient admits feeling sexually repelled by or angry at his partner" (Apfelbaum, 1980. p. 267). Though there doesn't seem to be an adequate explanation for this phenomenon at present; it does seem to be a consequence of a lack of erotic arousal rather than of a high level of arousal (Apfelbaum, 1980). It has also been found that erectile dysfunction can develop when R.E. is not resolved. This happens "perhaps because of the anxiety and other stress reactions evoked by the original difficulty" (Jehu, 1979, p. 94).

## 2. Etiology

"In contrast to impotence, which often has organic components, few physical illnesses play a specific role in the etiology of ejaculatory disturbance" (Kaplan, 1974, p. 320; Jehu, 1979). Spinal cord injured patients (Jehu, 1979; Munjack and Kanno, 1979); patients with demyelinating and degenerative diseases of the cord, after surgery involving the sympathetic ganglia (Kaplan, 1974; Jehu, 1979; Munjack and Kanno, 1979); those with diabetes (usually in combination with impotence) (Munjack and Kanno, 1979; Jehu, 1979; Kaplan, 1974); as part of any disease or trauma that destroys any part of the anatomical or neurophysical substrate subserving ejaculation (Munjack and Kanno, 1979; Jehu, 1979; Kaplan, 1974); any condition which depresses the androgen level (Kaplan, 1974); and persons with local genital disorders such as gonorrhoea (Jehu, 1979) have reported an inability to ejaculate.

"The one non-psychogenic potentially reversible cause of retarded ejaculation is drug ingestion. Medications affect ejaculation either by depressing the whole sexual response cycle, including the libido, or by a relatively specific effect on ejaculation while leaving other aspects of the sexual response cycle, as well as the libido, relatively intact. Some medications apparently have both effects" (Munjack and Kanno, 1979, p. 142).

Those drugs which may retard ejaculation while reducing libido and slowing the entire sexual response cycle include narcotics such as heroin (Mintz et al., 1974; Cushman, 1972), morphine (Mintz et al., 1974), Methadone (Cushman, 1972), Demerol (Kaplan, 1974); Dilaudid (Kaplan, 1974) and Codeine (Kaplan, 1974), sedative drugs such as alcohol and barbituates, and hormones such as estrogens.

Drugs with an apparently more specific antiadrenergic effect include phenoxybenzamine hydrochloride (Dibenzylamine) (Kaplan, 1974; Green and Berman, 1954), the ergot alkaloids (Kaplan, 1974), guanethidine (Kaplan, 1974; Huff, 1976), the Rauwolfia alkaloids (Kaplan, 1974; Blair and Simpson, 1966) and methyldopa (Aldomet) (Kaplan, 1974).

Also implicated in the etiology of retarded ejaculation are the antipsychotic medications (perhaps through both central and peripheral mechanisms). Such compounds include thioridazine (Mellaril) (Singh, 1961), fluphenazine (Permitil) (Huff, 1976), butaperazine (Repoise) (Huff, 1976), trifluoperazine (Stelazine) (Blair and Simpson, 1966), acetophenazine maleate (Tindal) (Huff, 1976), chlorporthizene (Taractan) (Ditman, 1964), and perphenazine (Trilafon) (Blair and Simpson, 1966).

Several authors have reported that antidepressants such as pargyline (Eutony) (Huff, 1976), isocarboxid (Marplan) (Bennett, 1961; Selikoff and Robitzek, 1952); and phenelzine sulfate (Mardil) (Bennett, 1961), as well as amphetamines (Gay and Sheppard, 1972), can have anti-ejaculatory effect. Also occasionally known to cause retarded ejaculation are antianxiety agents such as (Librium) chlordiazepoxide (Hughes, 1964) and diazepam (Valium) (Munjack, unpublished data). (The preceding drug information has been taken from Munjack and Kanno, 1974, pp. 142-143).

### Psychological Factors

Psychoanalytic theory propounds that retarded ejaculation is an expression of a man's unconscious fears of the dangers he associates with ejaculation (Kaplan, 1974). The man wishes to ejaculate in the vagina; but, is unable to do so because unconsciously he fears that he will be castrated, or that he will die (Fenichel, 1945). There is also the "fear of a loss of self and death resulting from loss of semen (Alexander, 1950; Oversey and Meyers, 1968), castration by the female genital (Ferenczi, 1950; Oversey and Meyers, 1968)" fear that ejaculation will "hurt the female (Bergler, 1935; Friedman, 1973; Levine, 1976), fear of being hurt by the female (Levine, 1976) and fear of retaliation by other males for ejaculating, yet simultaneously denying impotence by maintaining an erection (Friedman, 1973; Levine, 1976; Oversey and Meyers, 1968)" (Munjack and Kanno, 1979, p. 143).

Other fears and etiological issues such as performance anxiety (Masters and Johnson, 1970; Munjack and Kanno, 1979; Razani, 1972; McCarthy, 1981; Jehu, 1979); fears of impregnating the female partner (Kaplan, 1974; Masters and Johnson, 1970; Munjack and Kanno, 1970; Jehu, 1979; Apfelbaum, 1980 - which he takes as a consequence of the R.E.'s experience of total lack of choice in the matter); secondary guilt to a strict religious upbringing (Munjack and Kanno, 1979; Kaplan, 1974; Masters and Johnson, 1970; Jehu, 1979); fear of losing control (Jehu, 1979; McCarthy, 1981); a feeling that semen will "soil", "defile", or "contaminate" a partner (Jehu, 1979; Apfelbaum, 1980 - which he takes as a sign that the retarded ejaculator is not sexually aroused, since it is not uncommon for people in a sexual situation to show a disgust reaction until they become aroused at which point the disgust often disappears); and an unwillingness to give of oneself as an expression of love (Fenichel, 1945; Oversey and Meyers, 1968) have been thought to contribute to retarded or absent ejaculation.

An interesting phenomenon noted by Apfelbaum (1980), Pryde and Woods (1980) and the writer has been the difficulty that these clients have had in urinating in public men's rooms. It has been found that these men feel self-conscious about using public facilities. It is unknown, given that these observations are drawn from 3 individual cases, if the anxiety experienced in this situation can be generalized as symptomatic of most retarded ejaculators.

Problems with aggression and hostility have also been connected with this disorder. "More specifically, conflict about expressing anger, along with defenses of "holding back" expressions of such impulses, seem to play a role in the pathogenesis of some retarded ejaculators" (Kaplan, 1974, p. 325). Global subjective descriptions of personality patterns of individuals with retarded ejaculation have found no conclusive evidence to support psychological pathology (Munjack and Kanno, 1979).

The relationship within which the client finds himself can contribute to his problem. Partner discord (Jehu, 1979; Munjack and Kanno); feelings of anxiety and anger evoked by the partner (Jehu, 1979; Apfelbaum, 1980; Masters and Johnson, 1970); an on-going power struggle (Jehu, 1979; Kaplan, 1974); an ambivalence towards the wife and/or towards the relationship (Kaplan, 1974; Jehu, 1979); feelings of interpersonal hostility and resentment (Masters and Johnson, 1970; Jehu, 1979); and feelings of being used (Apfelbaum, 1980) have been seen as causative in some instances.

Besides the various psychological and relationship factors listed above; secondary retarded ejaculation has been reported to be caused by specific traumatic events either in early life or in adulthood (Munjack and Kanno; 1979; Masters and Johnson, 1970; Kaplan, 1974; Jehu, 1979).

Examples of events which could severely affect ejaculatory ability would be: a boy being caught for masturbating and severely punished for this; or in adulthood, being interrupted during intercourse - as in being spot-checked by police while in a compromising position in the car.

### 3. Assessment

Assessment of this dysfunction follows the outline presented in Part II: A (Appendix B). Specific paper and pencil instruments administered to clients exhibiting this dysfunction would be the Sexual History Form (Schover et al., 1980); Index of Sexual Satisfaction (Hudson et al., 1980); and the Semantic Differential Scale (Whitehead and Mathews, 1976). Interviews, client self-monitoring, and archival records would also be used as indicated in Part II:B.

### 4. Treatment

Due to the paucity of literature, and the prevalence in that literature for single case reports and uncontrolled studies, it is only tenuously that success rates can be presented for the treatment of retarded ejaculation. Masters and Johnson (1970) reported an improvement rate of 82% (14 out of 17 cases) in patients. The therapy program included the use of a co-therapy team, sensate focus exercises, sex education and specific graduated assignments geared to gradually enable the male to ejaculate intravaginally. Schellen (1968) treated 11 cases of retarded ejaculation by utilizing an electrovibrator cup placed on the glans penis. Success was achieved in nine instances. With the remaining two patients, one was reported as being able to ejaculate only 40% of the time; and the other eventually became able to ejaculate with masturbation. Tuthill (1955) achieved a 50% 'satisfied with improvement' rate in a sample of 12 retarded ejaculators treated with advice on

sex techniques (including the use of fantasy), the application of a vasodilator such as 'Trafuril' to the penis; and other medications which "increased sexual excitability" (Munjack and Kanno, 1979, p. 146). Oversey and Meyers (1968), utilizing psychoanalysis with 10 males suffering from retarded ejaculation, although not necessarily their first complaint, had a success rate of 50%. Other studies by Friedman (1973); O'Conner and Stern (1972), Cooper (1968) and Mann (1976) reported a 46%-71% success rate in treated retarded ejaculation. The treatment formats used respectively were: dynamically oriented therapy; unspecified; a program utilizing deep muscle relaxation; provision of an 'optimum sexual environment'; sex education; and superficial psychotherapy; and a men's group augmented by individual counselling; but, without partner involvement.

Treatment should initially involve an urological examination to rule out medical causes and the normal physiological occurrence found in the aging male of a lessened need to ejaculate at every sexual interaction (McCarthy, 1981). A subsequent thorough assessment (implementing the format supplied by Jehu, 1979) could follow. Based on whether the therapist views retarded ejaculation as a desire disorder, an arousal disorder or an orgasmic disorder; the treatment program could differ significantly.

If the problem is seen as the result of a reflex concept (a block of the orgasmic reflex due to trauma and not the process of erotic arousal) then R.E. could be viewed as a male version of vaginismus. When the muscles should be responsive, they are locked in a clonic spasm (Apfelbaum, 1980). " A major difference from the treatment of vaginismus is that the spasm is "forced" abruptly in the case of the R.E. rather

than gradually as in the case of vaginismus. The female partner is encouraged "to manipulate the penis demandingly", so as "to force ejaculation". Once this is achieved, she is to manipulate her partner nearly to orgasm and then to execute "rapid intromission" (This is what Kaplan called the "male bridge maneuver"). If orgasm does not quickly follow, she is to "demandingly" manipulate the penis, "quickly" reinserting (Masters and Johnson, 1970)" (Apfelbaum, 1980, pp. 278-279).

Apfelbaum (1980) on the other hand, goes on the premise that the patient is not sexually aroused; but, rather feels compelled to perform. The patient experiences performance anxiety at least as intense as that found in any other sexual disorder; but "it drives him into performance rather than nonperformance in the excitement (erection) phase, only resulting in dysfunction in the orgasm phase" (Apfelbaum, 1980, p. 281).

Since he views R.E. not only as a performance dysfunction; but, also as a desire dysfunction, he interprets R.E. as the male analogue of female coital inorgasmia (Morse and Morse, 1981; Jehu, 1979). "Treatment involves both the elimination of performance anxiety (the demand that the male must ejaculate intravaginally and enjoy it) and the prescription to become erotically aroused (that is, subjectively aroused) before intercourse. A considerable amount of relabelling and cognitive reappraisal accompanies treatment so that the male can change his view of himself as a 'withholding individual' and see himself instead as having learned to give compulsively albeit without desire, arousal or pleasure" (Apfelbaum, 1980, p. 264).

Apfelbaum (1980) also incorporates a technique called "counterby-passing"; whereby the "unconscious refusal to ejaculate" is made "conscious". This he believes breaks the retarded ejaculator's compulsive sexual set and/or would be less likely to reinforce this set when it failed. He also believes that this would lead the patient to the next idea - that sex is drudgery and that he does not feel entitled to complain about this experience to his partner. Once the patient could

accept this belief system within himself; Apfelbaum says that the person would no longer feel abnormal for not having coital orgasms and therefore would be free to explore these feelings. It is at this point that Apfelbaum would assign 'complaining exercises' to aid the client to ventilate these feelings.

Clearly, the patient needs an individualized program which could adapt to the possibility of a difficulty at the desire, arousal and/or orgasm phases; and meld the multitude of psychological issues that could accompany the dysfunction.

Discussion around the client's attitudes toward women and sexual expression could be explored via intervention strategies geared for maladaptive masculine role and sexual attitudes. These might include cognitive restructuring (Jehu, 1979, McCarthy, 1981, Apfelbaum, 1980); bibliotherapy (Zilbergeld, 1978; McCarthy, 1981); and the therapist using him/herself as a role model for different attitudes towards masculinity and sexuality (McCarthy, 1981; Jehu in personal communication, 1982).

Treatment for sexual anxiety, when experienced, could follow Kaplan's (1979) psychosexual therapy format for the mild, mid-level and profound remote causes of this symptom (i.e., problems with intimacy and commitment, fears of rejection, severe anger, mistrust and envy of the partner etc. are but a few of the causes cited by Kaplan). Her therapy format would be the treatment of choice should the retarded ejaculator's dysfunction stem from a disorder of desire.

Other tools such as guided imagery (Jehu, 1979; McCarthy, 1981; Beck, 1979; Pryde and Woods, 1980); behavior rehearsal focusing on verbal interaction between the man and his partner (McCarthy, 1981; Jacobson and Margolin, 1979); gradual shaping of the client's ejaculatory response

towards the goal of ejaculating in his partner's vagina during sexual intercourse (Jehu, 1979; Kaplan, 1974; Pryde and Woods, 1980; Razani, 1972; McCarthy, 1981); hetero-social skills - since males who suffer from R.E., typically, have maladaptive views of male-female roles and deficits in expressive and cooperative skills (McCarthy, 1981) have been used in the treatment of retarded or absent ejaculation.

## 5. Case History

Sam - Inhibited Ejaculation, Desired Frequency much higher than Current Activity Level

### Demographic Data

Sam was a 35 year old, single male who held a professional job outside of the city. He had never been married and currently lived alone.

### Assessment

Description of Problem. Sam presented with an inability to ejaculate inside the vagina of a woman. He was able to have and maintain an erection for long periods of time (1-2 hours), but had never had an orgasm with vaginal containment of the penis. He had no difficulty in becoming aroused physically, and had subjective sexual desire, at least, once a day. Sam was diagnosed as having inhibited ejaculation of a global and long-standing nature.

Sam began sexual activity at the age of 4 or 5. He said that he began masturbating at that age until he was caught and reprimanded by his mother. The reprimand was justifiable, he said because a mother can't have her child masturbating. He did think that his mother had been very angry at the time, and that it had been mean for her to have asked him to desist from this activity.

Sam did not masturbate again until he turned 18. At that time he began to fantasize S & M scenes to accompany his masturbating. Whenever he felt depressed he'd revert to this type of activity. Sam, at the time of therapy, masturbated at least 5 times a week.

He continued to use the S & M fantasies until the age of 29. At that time he saw a psychologist to help him with this ideation. He was able to successfully discontinue this type of thought pattern; and replaced it with fantasies of having intercourse with a woman and ejaculating inside her. To be specific, Sam fantasized that he was with 2 prostitutes - a young one, age 18 approximately, who excited and aroused him; and an older woman, age 40 approximately, who skillfully brought him to climax.

His masturbating routine was extremely specific. He rubbed his penis with the thumb and index finger of his left hand (Sam is right-handed). He used a very specific rhythm and pressure that only he could render. No woman has ever been able to duplicate his touch. He was able to bring himself to climax usually within 5 - 20 minutes. He then had an almost uncontrollable urge to have a bath; to feel the warmth and sensation of the water. After this bath, he usually wanted to sleep.

Sam became sexually active with a woman at the age of 29. This he had done deliberately - he said - at the urging of the psychologist that he had been seeing at the time. He had been seeing the woman he chose to attempt intercourse with for approximately 1 1/2 years. He was able to penetrate and thrust - bringing the woman to climax; but, was unable to do so himself. His primary inability to climax inside a woman persisted through time and with different partners. As aforementioned, Sam had no difficulty bringing himself to climax.

On one occasion, a woman had been able to manually stimulate Sam to climax. He had given her his specific requirements, had directed her step-by-step, had made her use her thumb and index finger on her left hand etc. and had reverted to using his fantasy of the two prostitutes. The stimulation had lasted for about 15 minutes and then Sam had ejaculated.

Sam was a university educated man of 35 years, who had never been married. He, at the commencement of treatment, had been seeing a woman from out of town about once a month. He was sexually active with this person. Sam refused to call this woman his girlfriend. He was unsure how to define the relationship; because he felt that this friendship was not leading to anything permanent.

#### Contemporary Influences of Problem

##### Situational Antecedents.

(a) sexual stresses: Sam had no difficulty in obtaining and retaining an erection. However, he had very mixed feelings about ejaculation. He felt that he was defenseless if a woman stimulated him. He was afraid that she would not be able to stimulate him appropriately. He said that ejaculating in a vagina and urinating in public gave him the same vaguely uncomfortable feeling.

He held the belief that he would allow his partner to gain control over him if he ejaculated within her - and this was something that he will never allow. He felt that his ejaculate would soil the woman - though that he didn't find his own fluids on himself distasteful - or that of his partner's. He held the emotional belief - though at the intellectual level, he knew that it was irrational - that he would hurt the woman with the power of his ejaculation.

He also felt that his partner would be bored and displeased with him if he took the time to get stimulated enough to climax inside of her ("they'd be going for hours").

(b) deficient or inappropriate stimulation: Sam was only able to achieve appropriate stimulation via his already cited self-masturbatory technique.

(c) relationship with partner: Sam's relationships with his partners have been less than satisfactory. He had had 6 girlfriends with whom he had attempted intercourse. As will be clearly delineated, the women Sam picked were all below his high standards. They were all "flawed" in some basic way. This coincided with Sam's belief that there was a basic flaw in the universe. He held this belief because life owed him something - and so far - had jipped him of his rights. This one thing that was his birth right was a long-term relationship with a woman.

The only explanation that he could formulate for his lack of female companionship was that (1) there was a flaw in the universe; (2) there was a flaw in himself that he hadn't been able to detect; or (3) all women were flawed. It was this last belief with which he identified. Sam also added another belief to this repertoire; this being that he had perhaps failed at romance. This belief came out of what he specifically picked up from therapy.

Sam's first girlfriend, of 1 1/2 years, had been the person with whom he first attempted intercourse. He had become engaged to her; but, then had called it off because he had felt (1) he didn't love the woman; (2) she was ugly; (3) he couldn't commit for an eternity; (4) it was as if "a snake had risen its head" - he had had an all encompassing fear

envelop him; and (5) the woman had had alot of hang-ups. This woman subsequently married someone else.

His second girlfriend turned out to be schizophrenic. He went out with her for 6 months. He lived with her for 2 months to establish if he loved her. He found out that he didn't; and that he felt very guilty about sleeping with her. He, therefore, broke off the relationship. She had been upset that Sam had been unable to reach climax in their sexual relationship.

His third girlfriend, whom he thought open-minded, turned out to be a lesbian. She had called off the relationship. At the time Sam hadn't known she was a lesbian. He only knew that he had been very upset at the break-up.

His fourth girlfriend was a divorced woman with 2 children. She was the only woman that he hadn't been able to bring to climax. She was a Mormon and Sam had felt that he was being maneuvered into a commitment. He had thought that she had low self-esteem and bad stretch marks. He voluntarily had ended the relationship when she seemed too dependant on him.

His fifth sleeping partner had been a one night stand at a transactional analysis convention. The woman only slept with him once. He had felt used and was extremely angry. He stated that if he ever saw her again he'd teach her a lesson. He said he felt that she'd been a very insecure woman.

His 6th and most current relationship had been with a woman from another city whom he had met at a transactional convention. She was 28 years old and a born-again Christian. She was technically a virgin though they did everything, minus coitus. They had known each other for

approximately 5 months. Sam detested religious people and felt that they were all neurotic. This woman terminated their relationship early on in treatment. Sam was quite upset about this turn of events. He wrote her a very angry letter using exactly what he's learnt in therapy. He pointed out all her contradictory statements, and questioned how she could hold opposing beliefs at the same time. He also, for the first time, expressed his anger. He, however, was not able to express it directly; but, rather tended to generalize it and used 'guilt' to hook the woman.

Sam had a basic ideology that negated the worth of women. At the same time, however, he said that he wanted a meaningful relationship with a woman.

(d) timing and setting of encounter: Sam had the time, the privacy and did set the atmosphere via lighting, temperature, music etc. for his encounters.

(e) con-comitant non-sexual stresses: Sam had just moved to a new town, had begun a new job and had a long-distance romance. It became evident that Sam tended to run away from long-term commitments whether it be job, friendships or locale. He also returned to a non-partnered status when his girlfriend terminated their relationship mid-way in treatment.

Organismic Variables. Thought processes. Same held conflictual belief systems that the writer attempted to delineate under the rubric of paradoxical statements.

Sam set up women to fail. He said that he used guilt to get his first girlfriend to sleep with him. He also said that he was upset that women felt inadequate when they could not bring him to climax. He, however, would push a woman to have sex until she gave in - then he would blame her for being weak-willed.

Sam stated that he'd never had a long enough relationship within which he could feel secure. He didn't feel that his 1 1/2 year relationship; nor his 2, 6 month relationships qualified as long-term. His definition of long-term was a 5 year commitment. On the other hand, Sam questioned his inability to get close to someone.

In looking at the pattern of Sam's relationships - he stated that the women he dated had all been flawed in some vital aspect. His ability to choose viable partners was of major suspect.

Sam said that he enjoyed it when oral sex was performed on him; but, disliked to do the same to a woman.

Sam said that he wanted to have a long-term relationship with a woman; but, he believed that "all women were assholes". He held very negative views about women, his sisters and his mother. He, for instance, would start off by saying something positive about a woman, but, than would negate it. Examples of this would be (1) he really liked his sister but she slept around - she'd had an abortion (how awful!); and (2) he loved his mother but she'd never supported him in anything - she'd been angry when she'd caught him masturbating and he'd thought that that was mean but he understood her feelings.

Sam wanted to be in total control. He knew, however, that in a relationship it was impossible to maintain this and still have a reciprocal relationship.

Sam wanted to have children. He fantasized about being in a situation where he knew he was the father; but, that the child didn't know this. He was in control as to when he made this knowledge known to the child. He was a single parent in his fantasy. In actuality, he stated that he would never be a single parent because he wanted a 2 parent

family. He didn't like women to make social advances to him; but, it was o.k. for him to make social contact. He wanted to be totally sexually involved; but, he was always cognitively monitoring. He believed that he was a good lover; but, also believed that he would bore a woman if he tried to gratify his own needs. He said that he had 2 close male friends; but, in fact, these people lived thousands of miles away and he seldom saw them.

Emotional Reactions. Same felt that ejaculating in a woman would soil and hurt her.

He was anxious and fearful that sex would cause a loss in his ability to control - women in this instance. He felt very guilty about the fact that he'd lived with someone that he hadn't loved. Sam was fearful of making someone pregnant - this could have stemmed from his father's threats to beat him if he ever got anyone pregnant.

His greatest reaction was his extreme anger at not having a close relationship. This existed to the extent that any exhibition of closeness in others infuriated him. He went into a rage when "he saw a nice girl and a greasy guy together on the street", when he read sexual passages in a book, or when a friend's girlfriend left him etc. At times, his rage became externalized in that he'd scream at the T.V., beat car seats, walls etc. At these times, he almost could not manage his outbursts of emotion.

He believed that he would never lower himself enough to have intercourse with a woman.

Sam's most prevalent fantasy, one in which he had engaged in almost daily for 18 years, and was used whenever he was angered went as follows: Sam would go back in time and he would be in total control. He had

developed a gun with which he could shoot people, stun them, and give them an orgasm. The people had to be virgins. This fantasy angered him - escalating this feeling especially in the last year. This fantasy paralleled his own actual experience of disliking women; but, still giving them orgasms. Like in his fantasy, he refrained from experiencing a climax himself; while retaining complete sexual control. The fact that this happened, also greatly angered Sam.

Sam's partners had shown concern over his inability to ejaculate which he felt had made them feel inadequate. He said that this upset him. This could not be verified in fact since he did not have a partner willing to come into therapy with him.

However, the writer would like to hazard the guess that this reaction reinforced Sam's retarded ejaculation. He disliked women, though he denied this, overtly. By making them feel inadequate in this subtle fashion - he was able to maintain control; thereby, exhibiting his superiority.

Personal and Family Background. Sam was a 35 year old never-married, professional. He held a science degree, a teaching degree and a meteorological diploma. He had gone to university, not because he had wanted to; but, because he'd been forced to by his parents. He left school twice in a fit of rebellion. He went against his parents wishes by going into classical education - greek, history etc.; but, later returned to physics.

He taught for awhile in this province; then left for a major city for another job. He then quit that job and went to Quebec to learn French. He then moved to another province for employment and finally moved to this locale for his current position.

His favorite past-time was transactional analysis. He analyzed everything he and others did via this field of reference. He had met most of recent girlfriends through conventions that he'd attended on the topic.

Sam had acquaintances and few friends. He was a non-practising Anglican; and felt that religious people were neurotic at the very best.

Sam had two sisters whom he seldom saw since they lived out of the province. His parents lived here in the city; and he, felt that they had been non-supportive of his endeavors for most of his life.

Childhood and Puberty. The family's attitudes about sex had been very strict. His father had threatened to beat him if he ever got a girl pregnant. If his sisters had been late getting home from a dance; then, his father would go to the dance and get them and call them whores and sluts.

His mother caught him masturbating at about 5; and, had angrily reprimanded him for this.

He felt that the family were prudes about sex and that at first he had adopted this same attitude.

Sam had picked up the ideas that (1) you shouldn't have sex outside of marriage; (2) shouldn't marry unless in love like in the movies; (3) sex was only to propagate children; (4) women only put up with sex + men (Sam vowed to give all women orgasms at this point); (5) that all women were assholes; (6) premature ejaculation was selfish on the part of the male; and (7) if a man was a man he would perform sexually.

Learning About Sex. Sam's mother wrote him a letter describing sex and gave him a book to read. His dad had given him a man to man talk. He couldn't understand why people would be interested in sex until at 19

when he'd read Fanny Hill. It all became clear to him then that it was pleasurable. As is evident - Sam spent a great deal of time fantasizing about sexual activity.

Sam began masturbating at age 4 or 5 until he was stopped by his mother. He started up this practise again at 18 years and has been active, daily, ever since.

Traumatic Episodes. Though Sam said that he'd never experienced any traumatic episodes, it would seem that his father and mother's severe reprimands; and the fact that in church the minister had not served communion to his sister because of her divorced status (humiliated in front of the whole congregation); did leave indelible marks on Sam's memory.

Puberty. Sam suppressed his sexual urges for a time during his early and mid-teens. He later began his active fantasy life (to relieve anger) and masturbatory activities (to release tension) in his late teens.

Sexual Experiences Before Current Partner and Current Partner. Sam had had 6 girlfriends (or more accurately) sexual partners to date. A detailed outline of these women has already been done.

Sam was mildly turned on by erotic literature and suggestive movies; but, mostly he was extremely angered by being aroused. He felt cheated, caught unawares by publications etc. because he couldn't have the relationship that these pictures etc. suggested.

During the assessment, Sam's girlfriend called off their relationship. She had told him that she felt drained by the contact. Sam was hurt and furious at this outcome. Over the phone, Sam acted in a very understanding and accepting manner. However, in actuality, Sam was seething with rage. He wrote a very angry letter to this woman stating

that women were untrustworthy; and that he felt that he wanted to get revenge. His suggested revenge tactic would be to send her a beautifully wrapped Xmas gift - contents 2 cows tongues - to mock her belief in the gift of tongues (religiously-based act).

Self-Concept. Sam said that he felt that he had an o.k. body; though he carried a little too much weight in the middle. He was active in public speaking (confident about his public appearance) and in his career choice.

He, however, had little confidence in his ability to attract and keep a mate. He floundered when it came to women. He covered up this insecurity by the use of arrogance, and he often put women down in order to feel superior.

Attitudes Towards Treatment. Sam liked therapy. He liked to talk about himself - and needed constant reassurance that he was not crazy. He was intelligent and extremely structured (i.e., made files on everything: homework, letters he'd written and that people had written him). He brought these files to the sessions to verify his activities. He also attempted to trip up the therapist via mental debate. He enjoyed mental banter and found that it pleased him to be 'caught' on a point.

Desire Outcome. Sam wanted to have a relationship with a woman; and to be able to have an orgasm/ejaculate with a female partner.

Treatment Formulation and Plan. As is self-evident from the information presented, Sam had a conscious wish to be close to women; but, he simultaneously possessed the equally strong belief that women were unapproachable, untrustworthy and controlling individuals.

He consciously strove for relationships; but, unconsciously chose inappropriate partners/withheld complete commitment via withholding

ejaculation. To him this represented his death/his loss of control at the hands of a woman (fantasies, belief systems support this).

He had a strict upbringing where sex/religion/humiliation/immorality were closely linked. Women/power/immorality were also closely associated. Women/death also had significant meaning for Sam (i.e., sickened by his sister's cold manner when <sup>she</sup> aborted her baby, other 1 gave baby up for adoption).

Sam's father also had made him feel powerless, small, and he'd swore to gain control over this situation (which he says he did in his 20's).

Maintaining control in all situations was important to Sam (i.e., he didn't want to break down and call his ex-girlfriend so he unhooked the phone/wrapped it up and put it in the closet). If he had to, he was willing to become a hermit or a mercenary, to remain in control, if relationships and/or the world didn't work out.

#### Progress and Outcome

The writer saw Sam for 16 sessions. During this period treatment focused on several facets. For his sexual dysfunction, therapy was directed at expanding Sam's masturbatory activities (using the Zilbergeld model, 1978). As was outlined in the assessment section, Sam initially was orgasmic via self-stimulation of his penis with his left thumb and index finger. The therapist directed the client to explore different pressures, speeds and manners of masturbation. As well, he was directed to use his right hand for self-stimulation (the client was right-handed and it was hypothesized that perhaps he masturbated only with his left-hand as a distancing measure).

Sam's fantasies, also previously described in the assessment section, were consciously altered to more closely assimilate an actual heterosexual experience. A sequential series of fantasies were worked out with the client. Sam progressively worked from his original fantasy with two prostitutes, to having sex with one person, to making love to a woman. At the termination of treatment, Sam was able to use this last fantasy for erotic stimuli. He was also able to masturbate bi-manually, using a variety of speeds and techniques. At this point, he has not been able to see if his widened range of self-pleasuring techniques can be generalized to a heterosexual relationship. He realizes that should a partner become available to him, that continued therapy may be needed.

Other issues that were dealt with in therapy involved challenging Sam about his belief system concerning women. The discrepancies in his beliefs, and life goals; his fluctuations between fate and personal control as the guiding factors in his life were continuously brought to his attention. His paradoxical thought processes, at one point, were listed and discussed item by item.

Anger management and relaxation exercises were combined to help Sam handle his irrational fluctuating of emotion (i.e., extreme anger at seeking a nice looking woman walking with a scruffy male). He had already used hath-yoga for relaxation purposes, and found reverting to this technique helped physically to relieve anger, tension, frustration etc.

Lastly, reflecting back to Sam his mannerisms towards women; as well as, hopefully, providing a positive female role-model were learning tools for the client. He began to see, using these techniques, how he might have had some small part in his lack of female companionship. As

for the therapist providing a positive role-model, Sam saw her as a neuter person who had provided help to him (i.e., called her 'doctor', 'my psychiatrist').

Sam's life philosophy, heterosocial skills, attitudes towards women and relationship with his family (to name a few areas) remained somewhat skewed once the presenting problem (retarded ejaculation) had been as successfully treated as it could be, without his access to a female partner. As these problems contributed to his sexual and heterosocial difficulties; additional therapy directed at these basic issues was thought necessary. For this reason, the writer referred Sam to a female psychologist who could help him explore further his detrimental and self-defeating beliefs. Sam complied with the referral since it came from someone that he had placed in the position of an "expert". At the time of writing, this client has been seen privately by the above mentioned therapist for 3 months.

Verbal reports by the client verified his positive gains in dealing with his sexual dysfunction. Paper and pencil instruments did not show major change. A possible reason for this could have been that at the time that the tests were first administered, Sam had had a sexual partner. When the tests were re-administered at the termination of treatment, he was again single, and bitter about this state of affairs. He also was unable to practise his expanded sexual abilities in a heterosocial context. This also proved a great disappointment to him.

#### Sexual History Form

Oct./82 Desired frequency much higher than current activity  
Inhibited ejaculation of a global and long-term standing

Mar./83 Results the same as above

#### Index of Sexual Satisfaction (cutting point 28-30)

Oct./83  
45

Mar./83  
49

## CONCLUSION

The writer came to realize, in working with the aforementioned clients, that their courage, ability to risk and change was as much a learning experience for her, as the treatment options she offered were for them. Having come from a work experience where the human spirit had lost its rejuvenative quality due to poverty, near illiteracy, and a sense of helplessness and hopelessness; the writer, likewise, had lost some of her perspective re: the potential for change and successful change. The positive results achieved by the majority of clients in this practicum renewed her belief in the viability of therapy, in general, and the ability of people to nurture themselves and their relationships.

The objectives that the writer initially set out to accomplish, those being: (1) to gain expertise in dealing with the current, major categories of sexual dysfunction (as cited in Jehu, 1979); and (2) to accrue secondary learning benefits from dealing with the factors that could be associated with sexual dysfunction (i.e., phobic reactions, depression, marital discord, health, rape, incest, aging, pregnancy, medications, and others) were acquired. These purposes, however, would not have been accomplished without the well-organized, and supportive guidance, coupled with a subtle, but ever present, expectation for excellence of work supplied by her advisor, Dr. D. Jehu. Humour, understanding and knowledge were melded in one easy package that made the writer's learning experience a joy.

The program for the treatment of sexual dysfunction had been a well organized approach before the writer began her practicum. The clear procedural and theoretical guidelines, already established, kept her from floundering in her tentative, initial attempts to treat these clients.

As the program became more familiar, flexibility and creativity were easily married with this approach. This occurred because, in a sense, the definite structure freed one to experiment. Also, the overt expectation that each and every client and, therefore, treatment plan were unique, fostered the use of one's imagination. It pushed one to the limits of possibility in lieu of handing out prescription therapy.

The writer acquired not only theoretical knowledge, interviewing skills, and a greater awareness of herself as a tool in therapy; but, also, she grew in her own attitudes and approach towards sexuality. As her clients explored their belief systems, expanded their awareness of the tactile world, sensuality and love-making, so did she.

The rewards, both professional and personal, were manifold. The unique experience of being appreciated (having come from the aforementioned milieu where the therapist was seen as a hinderance at best) for work being done, continually was a source of pleasure and motivation to likewise return this feeling to the client. It seems to have fostered a positive cyclical effect, since in the writer's case, her clients gave her the greatest compliment by overcoming their difficulties with the confidence that they could maintain their gains independantly.

APPENDIX A

TABLE I: *Effects of Drugs on the Sexual Response*<sup>1</sup>

Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
<p><b>DRUGS WHICH ACT ON THE BRAIN (i.e., CNS)</b></p> <p><i>Sedative-Hypnotics</i> Alcohol, and non-toxic doses of: barbiturates and other similar agents (e.g., ethchlorvynol, chloral hydrate, and methaqualone)</p>	<p>Insomnia and anxiety states</p>	<p>General CNS depression. Effects are dose-related. In general, the higher the dose the more interference with sexual performance. All of these drugs affect the central state. Set and setting are very important. Expectation can override or alter pharmacologic effect. Most of these drugs potentiate one another. Alcohol with CNS depressants leads to greater CNS depression. In low doses, desire may be increased by reducing inhibition (anecdotal reports of methaqualone acting as an aphrodisiac have been described). In higher doses all phases of sexual response are inhibited. Chronic alcoholism may result in permanent neurologic damage and consequent impaired genital functioning.</p>	<p>Increased(?) in low doses in presence of inhibition. Expectation may play a major role on this parameter. Decreased in high doses.</p>	<p>With low doses excitement may be prolonged due to decreased sensitivity or to intimacy and shared feelings. Impotence with high chronic intake of alcohol and barbiturates.</p>	<p>Delayed in high doses.</p>
<p><i>Anti-anxiety Drugs</i> Diazepines; Valium; Librium; Tranxene; Meprobamate</p>	<p>Anxiety states; muscle tension; convulsive states</p>	<p>Action on limbic system, and on interuncial neurons in the spinal cord.</p>	<p>May enhance desire slightly if inhibited or avoided due to anxiety. Diminished in high doses.</p>	<p>None reported</p>	<p>No effect in usual doses. In very high doses orgasm may be delayed.</p>

<sup>1</sup>The table on Effects of Drugs on the Sexual Response was prepared in collaboration with David Benjamin, Ph.D.

TABLE 1 (continued)

Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
C. <i>Narcotics</i> Morphine, codeine paragoric, d- propoxyphene and methadone	Analgnesia (pain relief); control of: diarrhea, coughing, and narcotic withdrawal (methadone)	General depression of CNS and possible direct depression of sex centers; alteration of normal balance of biogenic amines in CNS.	Absent in high doses.	Impotence in high doses.	Inhibited by high doses.
D. <i>Antipsychotic agents</i>	Psychosis	Probably have no direct effect on the brain's sex center (with the possible exception of haloperidol, which may affect the sexual response directly). These drugs may affect sexuality indirectly because of their favorable effects on the psychic state. In addition, some agents infrequently are reported to cause erectile and ejaculatory difficulties probably because of their mild anti-adrenergic and/or anticholinergic or antidopamine effects.			
Phenothiazines: Stelazine, Mellaril, Thorazine	Psychiatric disorders; anti-emetic	Sexual response may be improved as by-product of recovery from mental illness. "Dry" ejaculation may be caused by effects on internal vesical sphincter paralysis, causing semen to empty into bladder; often seen with Mellaril.	Decreased desire reported, only in very high doses.	Impotence reported with some agents (rare).	Inhibition of ejaculation reported with Mellaril.
Butyrophenones: Haldol	Gilles de la Tourette syndrome, schizophrenia	Reported to reduce libido and potency and cause retarded ejaculations in some patients; mechanism unknown—may involve central or peripheral antiadrenergic and/or antidopamine activity.	May be decreased.	Impotence reported with some agents (rare).	None reported.

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Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
E. <i>Antidepressants</i> (e.g., tricyclics, MAO inhibitors)	Depression	No direct effects on sexuality; sex drive and performance may improve as depression lifts. The antidepressants have some peripheral autonomic effects which rarely cause some potency and ejaculatory problems in men.	Probably none	None	Some females report delay of orgasm.
Tricyclics (Elavil, Tofranil)		Anticholinergic side-effects	Probably none	None	
MAO inhibitors (e.g., Nardil, Marplan, Norpramine)					
Lithium Carbonate	Manic states and possible prevention of depression in bipolar illness	No reported effects on the sexual response, except that sexual urgency may diminish manic activities.	Urgency or desire may be reduced.	None	None
F. <i>Stimulants</i> Cocaine	Local anesthetic	General CNS stimulant; augments sympathetic NS function.	Reported to be enhanced.	Reported to be enhanced; high doses may cause impotence.	May be enhanced; high doses may interfere with orgasm, more so in females.

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TABLE I (continued)

Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
Amphetamines	Stimulant, appetite suppressants, minimal brain damage in children; narcolepsy	General brain stimulation. In acute doses, reported to enhance libido; in chronic doses, diminishes libido and sexual functioning as well as causing general debility.	Reported to be enhanced at low doses; diminished at high doses.	Decreased in chronic doses.	May be enhanced; high doses may interfere with orgasm, more so in females.
<b>G. Hallucinogens</b>					
LSD (lysergic acid diethylamide)	methysergide (LSD analog) used in prophylaxis of migraine headaches; no medical use for LSD except for experimental purposes.	Vasoconstrictor; may be a central inhibitor of (5-HT) 5-hydroxytryptamine; serotonin.	Mixed effects reported.	None	Physiologically none. Altered experience reported.
DMT (dimethyl tryptamine) Mescaline (trimethoxyphenethylamine)		Disrupt neurotransmission in limbic system and RAS. Reported by some to enhance libido and orgasm, by others to have no effect, while some users report impaired sexuality	Mixed effects reported.	None	Mixed effects reported.
THC (tetrahydrocannabinol)		May have some effects on muscle contractions; some reports of enhanced erotic feelings (?)	Mixed effects reported.	Mixed effects reported.	Enhanced orgasm reported (?).

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Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
<b>H. Miscellaneous CVS Agents</b>					
L-DOPA (dihydroxyphenylalanine)	Parkinson's disease	Increased levels of dopamine centrally	Reports of increased desire in elderly male patients.	None	None
p-CPA (parachlorophenylalanine)	Carcinoid syndrome	Inhibitor of serotonin synthesis	Reports of increased desire.		
<b>II. HORMONES</b>		These drugs presumably stimulate the sex centers of the CNS and so increase the libido and the genital response. Also maintain the genital organs in a functional state.			
Androgens (e.g., testosterone)	Impotence, as replacement therapy; anabolic agent; low libido states	Stimulates sex centers of both genders. Fetal androgen causes gender differentiation of behavior. Androgens also act on periphery to enhance the growth, development, and functioning of the male genitals and of the clitoris.	Stimulates sexual desire in both sexes.	In males, may increase ability to have an erection in testosterone-deficient states.	In males, volume of ejaculate may be increased.

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TABLE I (continued)

Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
Estrogens (e.g., Estriol, Estradiol, Estrone)	Oral contraceptive; replacement therapy in postmenopausal women; prostatic cancer	Do not increase libido, in fact, may decrease sexual interest; act on the cells of the female genitalia to enhance their growth, development and functioning.	In men, may decrease desire; in women, variable response reported; increased desire may be due to decreased fear of pregnancy.	May cause impotence in males.	Ejaculatory delay; volume of ejaculate decreased.
Progesterones (Physiological precursor to testosterone)	Endometriosis; component of some oral contraceptives		Probably none	Probably none	Probably none
Thyroxine	Hypothyroid states; depression	Increased motor activity and augmented sympathetic nervous system activity. May decrease depression.	Enhanced desire reported.		
Cyproterone acetate	Experimental; employed in treatment of compulsive sexual disorders	Antagonizes testosterone	Loss of libido in both genders.	Impotence in males.	In males, volume of ejaculate may decrease; ejaculatory delay.

Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
Adrenal Steroids	Addison's disease; allergic and inflammatory disorders	Mechanism unknown	May decrease libido in high doses.		
Spirolactone	Edema, hypertension and hypokalemia	May block the binding of testosterone to the androgen receptor; gynecomastia due to action on breast tissue.	Occasional loss of libido.	May cause impotence in males.	None
<b>III. ANTIHYPERTENSIVES</b>					
A. Centrally Acting (e.g., Responsive alpha-methyl dopa)	Hypertension	Block adrenergic nerves and innervated structures in periphery causing disturbances in the hemodynamics of erection by various mechanisms; occasional inhibition of emission.	Decreased	Decreased; impotence is major problem.	May be inhibited.
B. Diuretics Thiazides	Hypertension	Dilate blood vessel walls; decreases circulating fluid volume. Disturbs penile blood pressure.	None	May cause impotence.	None
Spirolactone	Hypertension, edema, hypokalemia	May block binding of testosterone at receptor site; gynecomastia due to action on breast tissue.	Occasional loss of libido.	May cause impotence.	None
Ganglionic Blockers Quaternary ammonium compounds	Hypertension	Block post-ganglionic nerves and innervated structures; disturb penile blood pressure; may inhibit sympathetic mediation of emission.	None	Often causes impotence.	May be inhibited.

TABLE 1 (continued)

Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
<b>D. General Antiadrenergic Drugs</b>					
phentolamine; phenoxylbenzamine; ergot alkaloids	pheochromocytoma; migraine headaches				
alpha-blockers: clonidine	Hypertension; narcotic withdrawal	Blocks alpha-adrenergic receptors—central and peripheral action	None	None	Blocks emission in males—dose-related.
Sympathoplegic drugs: Guanethidine, Bretylium		Deplete adrenergic nerves of norepinephrine		Often cause impotence.	May be inhibited.
beta-blockers: propranolol	Hypertension; angina; mitral prolapse	Blockade of beta-adrenergic receptors of heart—central and peripheral action	Sometimes decreased.	Sometimes decreased.	None reported.
<b>IV. ANTICHOLINERGIC DRUGS</b>					
Banthine, probanthine, atropine, scopolamine; cogentin	Peptic acid disease; GI irritability; alleviation of extrapyramidal effects of phenothiazines	These drugs block the nerves controlling the smooth muscles and blood vessels of the genital organs which are involved in the sexual responses. They inhibit the action of acetylcholine on structures innervated by post-ganglionic parasympathetic nerves. Also has central anticholinergic action.	None	May rarely cause impotence.	None

Drug	Medical Indications	Possible Mechanism of Action	Phase of Sexual Response Affected		
			Desire	Excitement	Orgasm
<b>V. "APHRODISIACS"</b>					
Spanish Fly (Cantharides), amyl nitrite	Poisonous—no medical indications; vasodilator, angina pectoris	Irritates GU tract—causes priapism. Enhances vascular response of genitals (?) and reported to improve orgasm (?).	None	Priapism, organic impotence.	None
<b>VI. MISCELLANEOUS DRUGS</b>					
Disulfiram (Antabuse)	Alcohol Abuse		None	Occasional impotence reported	Delay of ejaculation.
Tryptophan		Increased CNS concentration of serotonin	Decreased	Decreased	
Ephedrine	Antiasthmatic agent	Alpha-adrenergic stimulator			Treatment of failure to ejaculate
Amantadine	Peptic ulcer	Inhibits H <sub>2</sub> receptors, may cause lowered sperm count			
<b>VII. NEURO-TOXIC AGENTS</b>					
Halogenated aromatic hydrocarbons	No medical indications; agricultural fungicides	Neuropathy	Decreased	Decreased	
Carbon disulfide	No medical indications; industrial exposure	Neuropathy and premature arteriosclerotic changes due to hyperlipidemia.	Decreased	Decreased	
Mangan intoxication	Industrial exposure	Degeneration of the ganglion cells.		Decreased	
Lathyrism	Ingestion of seeds of genus Lathyrus	Sclerotic changes of spinal cord		Decreased	

TABLE II: *Effects of Illness on the Sexual Response*<sup>1</sup>

<i>Disorder</i>	<i>Libido</i>	<i>Excitement</i>	<i>Orgasm</i>	<i>Pathogenic Mechanism</i>
<b>I. NEUROGENIC DISORDERS</b>				
<b>A. Disorders Affecting the Sex Centers of the Brain</b>	Usually decreased; very rarely increased in hypothalamic lesions	Not usually affected or decreased secondarily	Not usually affected	
1. Head trauma; cardiovascular accident	May be disturbed	Sensations may be disturbed—may be decreased	Sensations may be disturbed—may be decreased	Injury to the sex centers and/or limbic system and/or parietal lobe.
2. Arnold-Chiari malfunction	Sometimes increased as initial symptom			Pressure on cerebral structures
3. Hypothalamic lesions, Chranio-pharyngioma	Variable, usually decreased			
4. Chomophobe adenoma (pituitary tumor)	Decreased	Decreased	May be delayed	Pressure on sex circuits and/or limbic system and elevation of prolactin which may persist after surgical removal of tumor
5. Psychomotor epilepsy	May be decreased	May be decreased	May be decreased	Disturbance of limbic sexual circuits
6. Encephalitis	Variable	Variable	Variable	Disturbance of sexual circuits

<sup>1</sup> The table on Effects of Illness on the Sexual Response was prepared with the assistance of Dr. Damir Velceck of the Department of Urology, New York Hospital.

<i>Disorder</i>	<i>Libido</i>	<i>Excitement</i>	<i>Orgasm</i>	<i>Pathogenic Mechanism</i>
<b>B. Disorders Affecting the Lower Neural Structures that Serve the Genital Reflexes</b>				
1. <i>Neurologic conditions</i>	Not affected	May be decreased or absent	May be decreased or absent	These disorders cause irregular lesions in the spinal cord. If these affect the erection or orgasm centers, corresponding genital reflexes are disturbed.
a. <i>Conditions injuring the spinal cord</i>				
combined system disease; malnutrition and vitamin deficiencies; tabes dorsalis; amyotropic lateral sclerosis; *multiple sclerosis; *alcoholic neuropathy; syringomyelia; myelitis				
b. <i>Conditions injuring the peripheral nerves:</i>	Not affected	Decreased or absent	May be impaired	Injury to somatic and autonomic nerves subserving erection and orgasm (may be associated with pain and/or bladder and rectal problems).
Alcoholic neuropathy; herniated lumbar disc; lumbar canal stenosis				
Primary autonomic degeneration—Shay-Drager syndrome.		Decreased or absent	May be impaired	Disorder of autonomic nerves subserving erection and/or ejaculation.

Frequent cause of sexual difficulties.

TABLE II (continued)

Disorder	Libido	Excitement	Orgasm	Pathogenic Mechanism
*Diabetes Mellitus	Not affected	Impotence may be early sign (most common medical cause of impotence)	<i>Male:</i> retrograde ejaculation <i>Female:</i> absence or decrease in orgasm	<i>Male:</i> Peripheral neuropathy destroys the autonomic fibers that mediate the erectile reflexes. There may also be diabetic lesions in the penile blood vessels. Ejaculation can be impaired because of paresis of internal vesicle sphincter. <i>Female:</i> Neuropathy of the sensory nerves of the clitoris can impair orgasm.
2. <i>Surgical injuries to the spinal cord and peripheral nerves subserving erection and orgasm</i>				
Surgical thoraco-lumbar or lumbar sympathectomy;	Not affected		Impaired	Operations which interfere with or disrupt the sympathetic nerves will impair ejaculation.
Retroperitoneal lymphadenectomy	Not affected		Impaired	Operations which interfere or disrupt sacral somatic nerves will impair orgasm because of paralysis of the perineal muscles.
Aorto-iliac surgery	Not affected	Diminished if dissection is distal to iliac bifurcation	Impaired	

\* Frequent cause of sexual difficulties.

Disorder	Libido	Excitement	Orgasm	Pathogenic Mechanism
Radical pelvic surgery (sacral resections, operations for rectal, bladder and extensive prostate cancer ( <i>not</i> trans-urethral or suprapubic prostate surgery))	Not affected	Diminished or absent	Diminished or absent	These radical procedures may disrupt the parasympathetic, sympathetic and sensory fibers that are necessary for excitement and orgasm.
3. <i>Traumatic injuries to the peripheral nerves and spinal cord serving erection and orgasm</i>				
Paraplegia (transection of spinal cord)				
a. low lesion	Not affected	Only psychogenic erection; no sensation.	Some reflex ejaculation; no sensation.	Sensory pathways interrupted. Poor expulsion due to paralysis of perineal muscles.
b. high lesion	Not affected	Reflex erections; no sensation.	Rare reflex ejaculation; no sensation.	Sympathetic fibers may be disrupted.
Posterior urethral rupture	Not affected	Diminished		Injury to sympathetic fibers and vascular injury

TABLE II (continued)

Disorder	Libido	Excitement	Orgasm	Pathogenic Mechanism
<b>II. VASCULAR CAUSES OF SEXUAL DYSFUNCTION</b>	Vascular disorders do not affect desire.	Vascular disorders may disrupt the penile hemodynamic system.	Vascular disorders do not affect orgasm.	Vascular disorders disrupt erection in the male. The effect of local circulatory problems has not been studied in the female because they seem far less disabled by disorders of the genital blood vessels.
<b>A. Local—Disorders of the Penile Blood Vessels</b>				
Large vessel disease—Lariche syndrome		Diminished or absent		Arteriosclerotic changes in pelvic and penile blood vessels impede the blood flow needed for erection or alter the outflow mechanism.
*Small vessel disease—i.e., pelvic vascular insufficiency		Diminished or absent		
<b>B. Systemic Vascular Disorders</b>				
Leukemia; sickle cell disease	Not affected	May be diminished or absent	Not affected	Thrombotic injury and occlusion of penile and pelvic blood vessels.
Cardiac disease, coronary artery disease; post-coronary syndrome; hypertension	May be diminished due to depression, antihypertensive drugs	May be diminished due to anxiety about sudden death, antihypertensive drugs	May be diminished due to anxiety about sudden death	Pelvic blood vessels may also be affected.

\* Frequent cause of sexual difficulties.

Disorder	Libido	Excitement	Orgasm	Pathogenic Mechanism
<b>III. ENDOCRINE AND METABOLIC DISORDERS</b>				
<b>*A. Diabetes Mellitus (see above)</b>	Not affected	Diminished or absent	Retrograde ejaculation in the male; orgasm impaired in the female.	See above.
<b>*B. Testosterone Deficiency States</b>	Variable, but both genders lose libido when testosterone is totally absent	Erection and lubrication may be diminished.	Orgasm and ejaculation may be retarded. Reduced volume of ejaculate.	Sex centers require testosterone. Neural transmission and cellular response of genitals may be impaired
<i>In males:</i> old age, disease of the testicles, disease of the pituitary, surgical or traumatic injury to the testicles, pituitary stress, antiandrogen medication (cyproterone, Provera), Klinefelter's Syndrome, hyperprolactinemia states, bilaterally undescended testicles, hydrocoele, varicocele.				
<i>In females:</i> surgical removal of adrenals, ovaries, or pituitary for treatment of estrogen sensitive breast cancer.				

\* Frequent cause of sexual difficulties.

TABLE II (continued)

Disorder	Libido	Excitement	Orgasm	Pathogenic Mechanism
*C. Thyroid Deficiency States surgery, trauma, infection of thyroid gland, iodine deficiency.	Variable, may be diminished	May be diminished	May be retarded	Not understood
D. Other Endocrine Disorders Addison's disease; Cushing's disease; acromegali; hypopituitarism	Usually diminished			These diseases produce various endocrine deficiencies which affect the sexual circuits of the brain and/or cellular response of the genital organs.
E. Other Medical Diseases				
1. Carcinoid syndrome	Decreased	May be diminished		Elevated serotonin levels depress brain sex centers.
2. Hemochromatosis	May be decreased	May be diminished		Hemosiderin deposits in the anterior pituitary produce endocrine deficiency.
3. Liver Problems: Hepatitis; hepatic failure due to alcoholic cirrhosis; postmononucleosis hepatitis	May be decreased	May be diminished	May be retarded	Compromised liver does not conjugate estrogen sufficiently with the result that androgens are neutralized.
4. Kidney Problems: Nephritis; renal failure; dialysis	May be decreased	May be diminished	May be retarded	Depression may play a role. Premature arteriosclerotic changes in pelvis and penis

\* Frequent cause of sexual difficulties.

Disorder	Libido	Excitement	Orgasm	Pathogenic Mechanism
IV. DEBILITATING DISEASES Advanced malignancies Degenerative diseases Pulmonary Diseases Some infections	Decreased or absent			General ill health, depression (in some advanced kinds of illness, such as, for instance, tuberculosis, libido is preserved until the end).
V. GENITAL DISORDERS OF THE FEMALE				Diseases of the female genitals do not affect desire but may result in a secondary avoidance of sex
Clitoral adhesions	Not affected	No effect	Anorgasmia or difficult orgasm	Interfere with clitoral stimulation
Clitoral phymosis	Not affected	Not affected	Anorgasmia	Stimulation of the clitoris is painful
Atrophic vaginitis	Not affected	Lubrication is reduced or absent	Not affected	Estrogen withdrawal, as in age-related or surgical menopause; coitus may be painful
*Atrophy, fibrosis, degeneration and/or weakness of the pubococcygeal muscles	Not affected	Not affected	Orgasm is absent or feeble	Age, injury during birth, poor muscle tone

\* Frequent cause of sexual difficulties.

APPENDIX B

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

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

DESCRIPTION OF PROBLEM(S)

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

CONTEMPORARY INFLUENCES ON PROBLEM(S)

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

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\*Reproduced from Jehu, D. Sexual Dysfunction: Behavioural approaches to diagnosis, assessment and treatment. Wiley, London, (In press).

9. Organismic variables

(a) thought processes

e.g. (i) cognitive avoidance

(ii) cognitive monitoring

(iii) deficient or false information

(b) emotional reactions

e.g. (i) anxiety

(ii) guilt

(iii) depression

(iv) anger

(c) organic states

e.g. (i) aging

(ii) illness

(iii) surgery

(iv) drugs

10. Situational consequences

e.g. (a) partner's reactions

(b) absence of sexual relationships, due to avoidance reactions

PERSONAL AND FAMILY BACKGROUNDS

1. Both partners

(a) age

(b) sex

(c) marital status and history

(d) occupation

(e) education

(f) ethnic background

- (g) religion and moral beliefs
- (h) leisure activities
- (i) friendship pattern
- (j) health (including inter alia venereal disease, infertility, pregnancies, abortions, menstruation, menopause, use of alcohol or illicit drugs, and psychiatric disorders).

12. 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 of orgasm from all outlets

28. Traumatic sexual experiences

CURRENT PARTNERSHIP

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

SEXUAL EXPERIENCE OUTSIDE CURRENT PARTNERSHIP

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

SEXUAL EXPERIENCE SINCE LAST PARTNERSHIP ENDED

(e.g. by death, separation or divorce)

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

51. Traumatic sexual experiences

SEXUAL VARIATION

52. Homosexuality

53. Bestiality

54. Paedophilia

55. Voyeurism

56. Exhibitionism

57. Fetishism

58. Transvestism

59. Transsexualism

60. Sadomasochism

61. Sexual assault and rape

62. Incestuous behaviour

SELF CONCEPT

63. Body image

64. Gender identity

65. Popularity and attractiveness

66. Self-esteem

ATTITUDES TOWARDS TREATMENT

67. Motivation

68. Organizational capacity

69. Prognostic expectancy

70. Desired outcome

APPENDIX C

PROCESS OF ASSESSMENT AND PLANNING TREATMENT

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FOR SEXUAL DYSFUNCTION

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by

Derek Jehu

e.g. (i) cognitive monitoring

(ii) cognitive avoidance

(iii) deficient or false information

(b) emotional feelings

e.g. (i) anxiety

(ii) guilt

(iii) depression

(iv) anger

(c) organic states

e.g. (i) cold, fatigue, lack of comfort

(ii) menstruation, pregnancy, post-partum

(iii) aging

(iv) illness

(v) surgery

(vi) drugs

3. Situational consequences

e.g. (a) partner's reactions

(b) absence of sexual relationships

## FORMULATING PROBLEMS, SELECTING GOALS AND

### PLANNING TREATMENT

#### Problem formulation

1. Specification of dysfunctional behaviour
2. Hypotheses concerning the contemporary conditions that initiate and maintain this behaviour
3. Appraisal of resources for treatment

#### Selection of therapeutic goals

1. Nature of goals
2. Choice of goals
3. Specification of goals

#### Planning Treatment

1. Therapists
  - (a) dual sex teams
  - (b) qualifications and competence
2. Treatment setting
3. Timing of treatment
4. Treatment programme
  - (a) initiation of treatment
  - (b) selection of components
  - (c) sequencing of components
  - (d) maintenance of treatment effects
  - (e) group treatment

APPENDIX D

## An Inventory for the Measurement of Female Sexual Arousability: The SAI

Emily Franck Hoon, B.A.,<sup>1</sup> Peter W. Hoon, Ph.D.,<sup>2</sup>  
and John P. Wincze, Ph.D.<sup>3</sup>

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*This report describes the development of a self-report Sexual Arousability Inventory (SAI) for women. Sexual arousability was defined as the sum of respondent's ratings of 28 erotic experiences along a 7-point Likert arousal dimension. Multiple-regression and factor analyses were used to select valid items from a 131-item pool and build in factorial purity. The SAI has concurrent validity with respect to sexual experience, activity, and satisfaction, and discriminates between clinical and normal populations. In addition, the SAI is easy to administer and score, may be used with single, married, or lesbian women, is available with norms and in alternate forms, and possesses exceptional internal consistency. Although the SAI was designed primarily for clinical use, the construct it measures may have theoretical significance in future research.*

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**KEY WORDS:** sexual arousability; female; sex; scale.

### INTRODUCTION

Sexual dysfunction in women may be due to an inability to become sufficiently aroused sexually, perhaps along both cognitive and physiological dimensions.

Currently, there are no clinical instruments to measure the construct of sexual arousability in women. It is necessary to have an adequate measure of the construct for three purposes:

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<sup>1</sup>Psychology Department, Nova Scotia Hospital, Halifax, Nova Scotia, Canada.

<sup>2</sup>Psychological Services Centre, Dalhousie University, Halifax, Nova Scotia, Canada.

<sup>3</sup>Psychiatry Department, Brown University, Providence, Rhode Island.

1. Diagnostic: It is important to determine, first, whether a woman has an arousal dysfunction problem and, second, which erotic experiences may be problematic.
2. Assessment: A clinician needs to know if a program of therapy is beneficial, and a researcher may wish to determine which of several treatment programs are most effective in treating sexual arousal dysfunction.
3. Research: Several theoretical questions need to be examined: What is the relationship between anxiety and sexual arousal? How do they covary during the process of treatment for sexual arousal dysfunction? Under what conditions, if at all, is it possible to be both anxious and sexually aroused at the same time? Are there basic dimensions which underlie experiences that women find sexually arousing? Are there cultural/sub-cultural differences in these dimensions? Can new learning experiences during therapy increase both the range and kinds of sexual experiences which women find sexually arousing?

With few exceptions, existing sex inventories have been inappropriate from the standpoint of assessment and treatment of the sexual problems of women. They have been either difficult to use, psychometrically unsubstantiated, or based on constructs which have little relevance to positive treatment outcomes (Heiman, 1974). For example, an inventory developed by LoPiccolo and Steger (1974) shows promise for couples but is somewhat difficult to score and not useful for single or lesbian women. A sexual interest questionnaire (Harbison *et al.*, 1974) is 140 items long and requires computer scoring. Obler (1973) developed an unpublished scale to measure heterosexual anxiety, and Wincze and Caird (1976) developed a card-sort technique to assess self-reported anxiety associated with sexual activity, but neither approach has been psychometrically substantiated. Mosher (1968) developed a sex guilt scale, but the utility and appropriateness of a guilt construct for the assessment and treatment of female sexual dysfunction are in doubt. A massive 200-item inventory developed by Thome (1966) may be useful for diagnosing sexual psychopaths but is hardly appropriate for the typical sexual problems of women.

Since there are no inventories to date to measure sexual arousability in women, and existing inventories have drawbacks in the routine clinical assessment of sexual dysfunction, this investigation was undertaken to develop a sexual arousability inventory. The inventory was designed with the following criteria in mind:

1. Easy to administer, score, and interpret.
2. Useful for the assessment of sexual arousal dysfunction whether it occurs in the presence or absence of relationships with either men or women.
3. Valid in terms of sexual experience and activity, satisfaction with sexual responsivity, and awareness of physiological changes during sexual arousal.

#### An Inventory of Female Sexual Arousability: The SAI

4. Capable of discriminating between a normal population and women seeking therapy for sexual dysfunction.

## METHOD

### Subjects

Validation and cross-validation samples consisted of 151 and 134 women, respectively, from primarily two sources: undergraduate and graduate populations, and womens' groups in the United States and Canada. Briefly, subjects ranged in age from 17 to 48, and were involved in homemaker, clerical, student, and professional roles. The sample included women who were single, cohabiting, married, divorced, or widowed and remarried, and women who had no intercourse experience as well as women who had extensive experience with multiple partners.<sup>4</sup>

A third sample of 15 women, referred by Halifax physicians to the Dalhousie Psychological Clinic for sex dysfunction therapy, completed the SAI as part of assessment prior to treatment at the same time cross-validation data were obtained.

### Item Pool

The authors consulted a variety of books and articles dealing with aspects of female sexuality to develop the item pool. Portions of *Free and Feminine* (Seaman, 1972), articles and letters in *Sexology* and *Forum*, and descriptions of erotic slides by Schmidt and Sigusch (1970) were particularly useful in determining experiences which might be sexually arousing to respondents. Six clinical psychologists (three Ph.D.'s and three M.A.'s) read through the item pool and suggested changes and additions. Prior to item selection, the item pool consisted of 131 items. Instructions accompanying the item pool stated that the purpose of the inventory was to acquire knowledge about female sexuality and to develop methods of helping women who were experiencing sexual problems.

### Item Selection

One hundred and fifty-one women in the validation sample rated 131 descriptions of sexual activities and situations on the basis of how sexually arousing they thought they were. A 7-point Likert rating scale was used. The lo

<sup>4</sup>Item statistics, factor loadings, and additional demographic data are available from the second author.

Table 1. The 28-Item Sexual Arousal Inventory (SAI) with Administration Instructions<sup>a</sup>

*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	0	1	2	3	4	5
*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

## An Inventory of Female Sexual Arousability: The SAI

Table I. Continued

20. When you see a strip show	-1	0	1	2	3	4	5
21. When you stimulate you 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

<sup>a</sup>Maximum possible score 140, mean 80.9, SD = 22.7. Total score is obtained by (1) adding positive scores, (2) adding negative scores, and (3) subtracting the sum of any negative scores from the sum of positive scores. Asterisks indicate those items comprising form A. Form B consists of items without asterisks.

end, characterized by a -1, indicated that the item adversely affected arousal. The high end of the scale (+5) indicated that the item always caused arousal. was extremely arousing. Women were asked to rate how aroused they felt when they experienced the activity or situation described in the item, or how aroused they thought they would be during that experience (see Table I).

Cronbach's reliability coefficient was equally high for two 20-item sets chosen on the basis of (1) highest correlations with total score ( $r = 0.92$ ) and highest multiple correlations with four criteria variables ( $r = 0.91$ ). The latter set was chosen to maximize concurrent validity and therefore clinical utility (Nunnally, 1967; Guilford, 1970). The criteria included:

1. Reported awareness of physiological changes during sexual arousal. Total score was a total score based on a 7-point Likert rating of how frequently respondents noticed nine physiological changes during sexual arousal. The changes included vaginal lubrication, nipple erection, sex flush, heart rate increase, breast swelling, muscular tension, pelvic warmth, hyperventilation, and decreasing awareness of the environment.
2. A 7-point Likert rating of satisfaction with present state of sexual responsiveness.
3. Reported present frequency of intercourse.
4. Estimated total episodes of intercourse before marriage.

A factor analysis of the 20-item set specified five basic dimensions of erotic arousability. Two additional successive factor analyses designated items to add and delete until a 28-item set was produced which optimally represented the five dimensions, and which possessed high concurrent validity and reliability.

### Cross-validation

A second sample of women ( $n = 134$ ) completed the 28-item version of the SAI. One hundred women in this sample concurrently completed the Bentler Heterosexual Experience Scale (Bentler, 1968). Eight weeks later, 48 women were retested with the SAI. Women who participated in cross-validation were somewhat younger than those in the validation sample, but were about equally sexually experienced.

## RESULTS

Table I provides administration instructions, the 28-item SAI, the 7-point Likert rating scale, and scoring instructions.

Table II. Validity Data: Correlations Between Total Score and Selected Variables for Original and Cross-validation Samples

Variable <sup>a</sup>	Validation sample ( $n = 151$ )	Cross-validation sample ( $n = 134$ )
1. Age	0.46 <sup>b</sup>	0.11
2. Years of education	0.43 <sup>b</sup>	0.17 <sup>c</sup>
3. Number of children	0.28 <sup>b</sup>	0.07
4. Number of sexual partners <sup>d</sup>		0.33 <sup>b</sup>
5. Satisfaction rating of adequacy of sexual responsiveness	0.30 <sup>b</sup>	0.24 <sup>b</sup>
6. Awareness of physiological changes during sexual arousal <sup>e</sup>	0.50 <sup>b</sup>	0.57 <sup>b</sup>
7. Reported frequency of intercourse before marriage	0.38 <sup>b</sup>	0.34 <sup>b</sup>
8. Reported present frequency of intercourse	0.40 <sup>b</sup>	0.43 <sup>b</sup>
9. Reported frequency of orgasm by masturbation	0.43 <sup>b</sup>	0.23 <sup>b</sup>
10. Reported frequency of orgasm by intercourse	0.32 <sup>b</sup>	0.32 <sup>b</sup>
11. Bentler Heterosexual Experience Scale <sup>f</sup>		0.42 <sup>b</sup>

<sup>a</sup>Variables 5, 6, 7, and 8 were used as item selection criteria in the validation sample.

<sup>b</sup> $p < 0.01$ .

<sup>c</sup> $p < 0.05$ .

<sup>d</sup>Correlation not obtained in validation sample.

<sup>e</sup>This variable was a total score based on change awareness ratings of seven different physiological processes (see text).

<sup>f</sup> $n = 100$ . Available only for cross-validation sample.

## An Inventory of Female Sexual Arousability: The SAI

### Reliability

$\alpha$ -Coefficients for the validation and cross-validation samples were 0.92 and 0.92, respectively. Spearman-Brown split-half coefficients were 0.92 each sample. The inventory therefore has exceptionally high internal consistency. A test-retest reliability coefficient was 0.69, which compares favorably that of the MMPI scales.

### Validity

Table II shows that the correlations between the validation sample total scores and each of the four criteria variables were consistently high. There were significant correlations in the cross-validation sample between total score and both the Bentler Heterosexual Experience Scale and number of sexual partners. In general, inventory total scores bear satisfactory relationships with self-reported sexual activity.

A  $t$  test between clinical and cross-validation sample means showed that the SAI discriminates at a highly satisfactory level between these two populations:  $t(147) = -5.61, p < 0.001$ .

### Norms

The original and cross-validation samples were combined to produce norms shown in Table III. The mean score of the 15 women seeking therapy for sexual dysfunction fell at the 5th percentile.

### Caution

Generally, both the validation and cross-validation samples are made up of North American women from middle and upper-middle class backgrounds. Although the norms in Table III may be applicable to women from other socioeconomic and ethnic origins, additional data are necessary to establish this possibility.

### Alternate Forms

Items with asterisks in Table I comprise form A, and the remainder comprise form B. These two alternate forms were selected by choosing two sets

<sup>6</sup>See footnote 4.

Table III. Smoothed Cumulative Percentile SAI Norms Based on 285 North American Women

Raw total score	Cumulative percentile
4	1
17	2
25	3
32	4
37	5
48	8
52	10
56	12
60	15
66	20
70	25
73	30
77	35
80	40
83	45
86	50
88	55
91	60
94	65
97	70
99	75
102	80
105	85
107	88
108	90
110	92
113	95
115	96
118	97
121	98
126	99

items with an equal spread of loadings on the five factors previously mentioned in item selection. Correlations between form A and the full-length SAI and form B and the full-length SAI were 0.94 and 0.95, respectively. The two alternate forms may be used interchangeably to assess sexual arousability during either service or research-oriented therapy for sexual dysfunction in women.

#### Card Sort

Either the two 14-item alternate forms or the full-length 28-item SAI may be used in card-sort format. The arousal dimension in Table I should be used. The SAI items could be sorted along a 7-point anxiety dimension either before or after a client had completed the sort along the arousal dimension. When

#### An Inventory of Female Sexual Arousability: The SAI

appropriate, it would be possible to determine how measures of sexual arousability and sexual anxiety covary during therapy. It is assumed that the psychometric properties of the SAI in card-sort form are identical to the properties of the pencil-and-paper format. However, the psychometric properties of the SAI items when sorted along an anxiety dimension are unknown, and it would have to be assumed that the total score represents an overall measure of sexual anxiety.

#### DISCUSSION

Factor loadings indicated that there were five underlying dimensions which mediate self-reported erotic responsivity in women.<sup>6</sup> Factor 1 represented for play: dancing, caressing, and kissing. Factor 2 depicted vicarious arousal mediated by erotic visual and verbal stimuli in different media forms. Items on the third factor were exclusively related to breast stimulation, and the fourth factor pertained to preparation for and participation in intercourse. The fifth factor was comprised of either genital stimulation by or genital stimulation of a partner.

The SAI appears to be useful for the purposes of diagnosing sexual arousal dysfunction and assessing change during therapy. One woman who underwent therapy with the first and second authors showed SAI changes from the 5th percentile at the onset of therapy to nearly the 80th percentile near the conclusion of therapy. This SAI change corresponded to reports by the patient and her husband of improved sexual functioning. Additional data from clinical subjects are being obtained to substantiate this observation.

One might expect that volunteers for sex research would not be representative of the general population and that the norms from such a group would be misleading. However, Kaats and Davis (1971) observed that volunteers who completed questionnaires dealing with self-reported sexual behavior and attitudes did not differ from nonvolunteers. Although the norms presented in this investigation may not be useful for socioeconomic groups which differ from the validation and cross-validation samples, the norms are useful for educated middle and upper-middle class North American women.

An important finding in this investigation is that women who have had more sexual experience have higher scores on the SAI, indicating that they report being more readily aroused by erotic activity. Although the causal direction in this relationship is not yet known, the finding may have implications for sexual dysfunction therapy; i.e., successful therapy for female arousal dysfunction might include the gradual expansion of the variety and frequency of erotic experiences. Perhaps such seemingly different therapeutic strategies as video

<sup>6</sup> See footnote 4.

desensitization (Wincze and Caird, 1976) and orgasmic training (Lobitz and LoPiccolo, 1972) share this basic ingredient.

In summary, the SAI has high internal consistency and stability and possesses concurrent validity in terms of reported physiological changes during sexual arousal, and sexual activity, experience, and satisfaction. Construct validity has been shown through factor analysis: the basic dimensions of female erotic responsiveness make logical sense and are similar to the content of the independently developed Bentler Heterosexual Experience Scale. From the standpoint of discriminant validity, the SAI distinguishes between a sample of normal women and a clinical group seeking sexual dysfunction therapy.

The SAI may be used in future work to delineate the process of change along the cognitive dimension of sexual arousal during sex dysfunction therapy. Future research may also focus on the relationship of the SAI to other pencil-and-paper measured constructs (e.g., the Taylor Manifest Anxiety Scale) as well as behavioral and physiological measures of sexual arousal.

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## Effect of Modeling on Sexual Imagery

Donald H. Sachs, Ph.D.,<sup>1</sup> and Karen G. Duffy, Ph.D.<sup>2,3</sup>

*Social learning theory was used to examine the effects of a model's sex imagery on the observer's sexual imagery. In the guise of a creative writing experiment, male and female college students were asked to listen to a recording of a same- or opposite-sex model relating a story in response to a sample TAT card. The story described a man and a woman in a physical encounter (high sex), a romantic date (medium sex), or a casual study date (low sex). The sample TAT picture and model's story were omitted in the control groups. All subjects wrote stories in response to two other TAT cards. The stories were scored for sexual imagery by a male and a female judge who was blind to experimental conditions and who used a standard sexual imagery scoring manual. The following predictions were based on social learning theory: There would be greater sexual imagery in the stories of subjects who heard the high sex model than in the stories of those who heard the medium or low sex model or no model. Past research implied the prediction that the model effects would be greater for males than for females in the high sex model condition and greater for females than for males in the medium sex model condition. The results were analyzed using two factorial analyses of variance. There was greater sexual imagery by subjects who heard the high sex model than by those who heard the low sex model or no model. The sexual imagery of subjects who heard the medium sex model was intermediate between the*

<sup>1</sup>H.D. Ostberg Assoc., 300 Park Avenue South, New York, New York 10010.

<sup>2</sup>State University of New York, Department of Psychology, Geneseo, New York.

<sup>3</sup>Requests for reprints should be sent to Karen Duffy, Ph.D., Department of Psychology, State University of New York, Geneseo, New York 14454.

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.

When a loved one stimulates your genitals with mouth and tongue.	-1	0	1	2	3	4	5
When a loved one fondles your breasts with his/her hands.	-1	0	1	2	3	4	5
When you see a loved one nude.	-1	0	1	2	3	4	5
When a loved one caresses you with his/her eyes.	-1	0	1	2	3	4	5
When a loved one stimulates your genitals with his/her finger.	-1	0	1	2	3	4	5
When you are touched or kissed on the inner thighs by a loved one.	-1	0	1	2	3	4	5
When you caress a loved one's genitals with your fingers.	-1	0	1	2	3	4	5
When you read a pornographic or "dirty" story.	-1	0	1	2	3	4	5
When a loved one undresses you.	-1	0	1	2	3	4	5
When you dance with a loved one.	-1	0	1	2	3	4	5
When you have intercourse with a loved one.	-1	0	1	2	3	4	5
When a loved one touches or kisses your nipples.	-1	0	1	2	3	4	5
When you caress a loved one (other than genitals.)	-1	0	1	2	3	4	5
When you see pornographic pictures or slides.	-1	0	1	2	3	4	5
When you lie in bed with a loved one.	-1	0	1	2	3	4	5
When a loved one kisses you passionately.	-1	0	1	2	3	4	5
When you hear sounds of pleasure during sex.	-1	0	1	2	3	4	5

(CONTINUED ON SECOND PAGE).

SEXUAL AROUSAL INVENTORY - (CONTINUED)

- 1 adversely affects arousal; unthinkable, repulsive, distracting
- 0 doesn't affect sexual arousal
- 1 possibly causes sexual arousal
- 2 sometimes causes sexual arousal; slightly arousing
- 3 usually causes sexual arousal; moderately arousing
- 4 almost always sexually arousing; very arousing
- 5 always causes sexual arousal; extremely arousing

How you feel or think you  
would feel if you were actually  
involved in this experience.

When a loved one kisses you with an exploring tongue.	-1	0	1	2	3	4	5
When you read suggestive or pornographic poetry.	-1	0	1	2	3	4	5
When you see a strip show.	-1	0	1	2	3	4	5
When you stimulate your partner's genitals with your mouth and tongue.	-1	0	1	2	3	4	5
When a loved one caresses you (other than genitals).	-1	0	1	2	3	4	5
When you see a pornographic movie (stag film).	-1	0	1	2	3	4	5
When you undress a loved one.	-1	0	1	2	3	4	5
When a loved one fondles your breasts with mouth and tongue.	-1	0	1	2	3	4	5
When you make love in a new or unusual place.	-1	0	1	2	3	4	5
When you masturbate.	-1	0	1	2	3	4	5
When your partner has an orgasm.	-1	0	1	2	3	4	5

APPENDIX E

A MULTI-AXIAL DESCRIPTIVE SYSTEM FOR THE SEXUAL DYSFUNCTIONS:  
CATEGORIES AND MANUAL

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Leslie R. Schover

Jerry Friedman

Stephen Weiler

Julia Heiman

Joseph LoPiccolo

Sex Therapy Center  
Department of Psychiatry and Behavioral Science  
State University of New York at Stony Brook

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## DESCRIPTIVE SYSTEM MANUAL

Assessment should include the desire, arousal, and orgasm phases of the sexual response. Questions should also be asked to assess the presence of coital pain, dissatisfaction with the frequency of sexual activity, and other sexual problems that might affect the individual or couple's sexual functioning. At the end of each descriptive category, relevant questions from the Sex History Form (SHF) are listed. The questions are intended as a guide for eliciting more detailed information during the intake interview.

Each descriptive category in this manual (except for the Qualifying Information categories) should include a modifier L or N indicating whether the problem is lifelong or not lifelong. Lifelong problems have been present during the client's entire adult life. For example, a man who has always had difficulty achieving and maintaining his erections would be given the description of 23, Difficulty achieving and maintaining erections, lifelong. A woman who has only been able to reach orgasm with a vibrator would be diagnosed 44, Inorgasmic except for vibrator or other mechanical stimulation, lifelong. "Not lifelong" is used to modify a category if there has been at least one episode of normal functioning. This includes cases where the sexual problem has recently become worse. For example a woman who had coital orgasms up to a year ago, but now is orgasmic only by masturbation or partner manipulation would be given category 42, Not lifelong. There may also be intermittent periods of normal sexual functioning, as in the case of ejaculatory incompetence (17) that has recurred only during times of other life stress.

Each category in this manual (except for the Qualifying Information categories) should include an additional modifier S or G stating whether the problem is situational or global. This dimension refers only to current functioning. Historical differences in functioning are specified by the L vs. N dimension. Situational problems occur only with some partners (often the spouse) or only in some activities. Thus a man who can achieve and maintain erections during masturbation but who loses his erection when he attempts intercourse would be described as 22, Difficulty maintaining erections, situational. Global descriptions are given when the problem occurs in all situations. For example, a woman who experiences low sexual desire both with her mate and in other situations, including no attraction to other partners, a lack of sexual dreams or fantasies, and lack of response to sexual books or pictures would be given the description of 10, Low sexual desire, global. Even if the client engages in a very narrow range of activities, if the dysfunction is present in all current situations, the description should be global. The female orgasm phase categories are automatically either global or situational, according to the individual category. The appropriate modifiers for the orgasm phase categories are therefore indicated next to each on the category listing sheet.

A MULTI-AXIAL DESCRIPTIVE SYSTEM FOR THE SEXUAL DYSFUNCTIONS

<u>Desire Phase (1)</u>	<u>Arousal Phase (1)</u>	<u>Orgasm Phase (1)</u>
10 Low sexual desire	20 Decreased subjective arousal	30 Premature ejaculation, before entry (G vs. S)
11 Aversion to sex (L vs. N) (G vs. S) (P)	21 Difficulty achieving erections	31 Premature ejaculation, less than 1 min. (G vs. S)
	22 Difficulty maintaining erections	32 Premature ejaculation, 1-3 min. (G vs. S)
	23 Difficulty achieving & maintaining erections	33 Premature ejaculation, 4-7 min. (G vs. S)
	24 Decreased subjective arousal + difficulty achieving erections	34 Inhibited ejaculation (G vs. S)
	25 Decreased subjective arousal + difficulty maintaining erections	35 Anhedonic orgasm (G vs. S)
	26 Decreased subjective arousal + difficulty achieving & maintaining erections	36 Orgasm with flaccid penis (G vs. S)
	27 Decreased physiological arousal, female	37 Anhedonic orgasm with flaccid penis (G vs. S)
	28 Decreased physiological & subjective arousal, female (L vs. N) (G vs. S) (P)	38 Rapid ejaculation with flaccid penis (G vs. S)
		39 Anhedonic orgasm with rapid ejaculation (G vs. S)
		40 Inorgasmic (G vs. S)
		41 Inorgasmic except for masturbation (S)
		42 Inorgasmic except for partner manipulation (S)
		43 Inorgasmic except for masturbation or partner manipulation (S)
		44 Infrequent coital orgasms (S)
		45 Inorgasmic except for vibrator or mechanical stim. (S) (L vs. N) (P)

<u>Coital Pain (1)</u>	<u>Frequency Dissatisfaction (1)</u>	<u>Qualifying Information (up to 4)</u>
50 Vaginismus	60 Desired frequency much lower than current activity level	70 Prefers gender other than that of partner
51 Dyspareunia	61 Desired frequency much higher than current activity level (L vs. N) (G vs. S) (P)	71 Transvestism
52 Pain on ejaculation		72 Fetishism
53 Pain after ejaculation		73 Voyeurism
54 Other pain exacerbated by sexual activity (L vs. N) (G vs. S) (P)		74 Exhibitionism (Male)
		75 Sexual pleasure from inflicting pain
		76 Sexual pleasure from experiencing pain
		77 Sexual assaultiveness
		78 Rape victim
		79 Incest as parent
		80 Incest as child
		81 Unconsummated marriage
		82 Sexual pleasure from humiliating partner
		83 Sexual pleasure from being humiliated
		84 History of severe psychopathology
		85 Current severe psychopathology
		86 Severe marital distress
		87 History of substance abuse
		88 Current substance abuse
		89 History of physically abusing spouse
		90 Currently physically abuses spouse
		91 Active extramarital affair
		92 Medical condition possibly affecting sex
		98 No dysfunction
		99 No diagnosis (P)

L vs. N (Lifelong vs. Not Lifelong) = Never had normal functioning vs. some episode(s) of normality  
 G vs. S (Global vs. Situational) = In all situations vs. only in some activities or with some partners  
 P (Presenting Complaint) = Problem is mentioned by couple at intake as one reason for seeking therapy

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Authors: Leslie R. Schover, Jerry Friedman, Stephen M. Weiler, Julia R. Heiman, & Joseph LoPiccolo  
 Copies of Descriptive System Manual & Sex History Form are available by writing to: Dr. Joseph LoPiccolo, Health

92 Medical condition possibly affecting sex  
 98 No dysfunction  
 99 No diagnosis  
 (P)

Each category in this manual should also be given a modifier, P, if it is one of the problems that the couple brings in as their presenting complaint. For example, a couple may come in with the complaint of inorgasmia in the wife. In the intake, it develops that she also has difficulty getting aroused, does not lubricate during sexual activities, and feels little or no sexual desire. There would thus be a problem described in each of the three phases of the sexual response, but only the 39, Inorgasmic category would be labeled as a presenting complaint. Some couples may have more than one presenting complaint, in which case this label can be added to all the problems that they mention which fit into the descriptive system.

Thus every category number assigned to a client (except for Qualifying Information categories) should also include:

L vs. N = Lifelong vs. Not Lifelong  
G vs. S = Global vs. Situational

All category numbers, including Qualifying Information categories, that are presenting complaints should end with a P.

#### Desire Phase Axis

##### 10 Low sexual desire (male or female)

A description of low desire should be given when the patient reports either global or situational lack of subjective desire for sex. This includes an absence or clear decline or desire for sexual activity. Assessment should include desire for sex with mate, desire for sex with other partners, sexual dreams and fantasies, reactions to seeing attractive people of the opposite or same sex, and in men, spontaneous erections.

In addition, there should be a low frequency of sexual activity. Assessment should include sexual activity with mate, other partners, and masturbation. A low frequency is defined as less than once every two weeks. If the client complains of an absence of subjective desire, but engages in sex fairly often due to pressure from mate, low sexual desire can still be diagnosed.

Explanatory factors for low desire, such as depression, ill health, or marital conflict, should be assessed. Even if a plausible explanation is found, however, the description of low desire should still be given, since this category is intended to specify sexual behavior rather than to imply a certain etiology.

SHF: 1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 19

##### 11 Aversion to sex (male or female)

This category is used when the client experiences clearly negative emotional reactions to a variety of sexual activities. These emotions may include disgust, fear, severe anxiety, guilt, and shame. Aversion is usually associated with a lack of sexual desire, but the

active dislike of sex distinguishes this category from low sexual desire (10).

SHF: 1, 2, 3, 4, 5, 11, 12, 13, 15, 19

### Arousal Phase Axis

#### 20 Decreased subjective arousal (male or female)

This category should be distinguished from a decreased desire for sexual activity. This client may or may not have wanted sex, but feels a subjective decreased arousal and pleasure once the activity has started. For example, the client may look forward to sex with their mate, and even initiate it, but be disappointed to find that they do not experience sex as very exciting. The client may report feeling "numb" or "dead" during sex. If the subjective decreased arousal is also associated with physiological symptoms of arousal difficulty, the correct categories are 24, 25, or 26 for a male and 28 for a female. Making the distinction between decreased subjective arousal and impaired physiological arousal necessitates careful assessment during intake.

SHF: 8, 14

#### 21 Difficulty achieving erections

This category describes a man who often has trouble achieving full erections during sexual activities. This number is used when a male client reports feeling pleasure and arousal subjectively during most parts of a sexual experience, but still has trouble getting an erection.

SHF: 8, 20

#### 22 Difficulty maintaining erections

This category is used when a man can achieve full erection during sexual activities, but loses the erection before he reaches orgasm. This is often seen in men who have erectile problems only when attempting intercourse, in which case the category is situational. The dysfunction may also be more global, however. This number is used when a male client reports feeling pleasure and arousal subjectively during most parts of a sexual experience, but still has trouble maintaining his erection.

SHF: 8, 21

#### 23 Difficulty achieving & maintaining erections

This category describes a man who often has trouble achieving erections, and who has difficulty maintaining his erection on those occasions when he is successful in getting one. This number is used when a male client reports feeling pleasure and arousal

subjectively during most parts of a sexual experience, but still has trouble getting and keeping erections.

SHF: 8, 20, 21

24 Decreased subjective arousal + difficulty achieving erections

This number is used for a man who has difficulty achieving full erection and who also reports a lack of subjective arousal.

SHF: 8, 14, 20

25 Decreased subjective arousal + difficulty maintaining erections

This number is used to describe a male client who reports difficulty both in maintaining feelings of subjective arousal and in keeping his erections once he has achieved them.

SHF: 8, 14, 21

26 Decreased subjective arousal + difficulty achieving and maintaining erections

This number is used for a man who has difficulty both in feeling subjectively aroused and in achieving and maintaining his erections.

SHF: 8, 14, 20, 21

27 Decreased physiological arousal, female

This description is used when a female client reports feeling subjectively aroused during sexual activities, i.e., enjoys them, likes the sensations, feels turned on, but fails to lubricate vaginally and also does not show increased respiration, pulse, breast engorgement, and other physical signs of arousal.

HSF: 8, 27

28 Decreased physiological + subjective arousal, female

This number is used when a female client reports feeling sexual desire, but when activities begin, fails to feel subjectively aroused, and also does not show the physiological signs of sexual arousal. This pattern is also seen in women who do not experience much sexual desire, but who agree to engage in sex to comply with spouse pressure.

SHF: 8, 14, 27

### Orgasm Phase Axis

#### 30 Premature ejaculation, before entry

This description is used when a male client usually ejaculates at some point during sexual activities before intercourse starts or while attempting intromission.

SHF: 8, 9, 10

#### 31 Premature ejaculation, less than 1 min.

This number is used when ejaculation occurs after less than one minute of sexual intercourse on most occasions. While intercourse is the most salient situation in defining premature ejaculation as a problem, latency to ejaculation during masturbation or partner stimulation should also be assessed and may be used as well as performance with different current partners, to decide if the category is global vs. situational.

SHF: 8, 9

#### 32 Premature ejaculation, 1-3 min.

Ejaculation occurs routinely after one to three minutes of intercourse. While intercourse is the most important situation in defining premature ejaculation as a problem, latency to ejaculation during masturbation or partner stimulation should also be assessed, and may be used as well as performance with different partners during intercourse, to decide if the category is global vs. situational.

SHF: 8, 9

#### 33 Premature ejaculation, 4-7 min.

Ejaculation usually occurs after four to seven minutes of intercourse. Some couples may not identify this pattern as a problem, so diagnosis should depend to some extent on their distress and on the male client's feeling that he lacks adequate control over the rapidity of his ejaculation. Again, the global vs. situational dimension depends on sexual activities other than intercourse as well as on latency to ejaculation with different current partners.

SHF: 8, 9

#### 34 Inhibited ejaculation

This category is used when a male client either cannot ejaculate at all during sexual activities or takes an unusually long time to ejaculate, even with adequate stimulation. The severity of the problem can range from a man who has never ejaculated, even during masturbation, to, more commonly, a man who cannot ejaculate inside

a vagina. It is important to assess any neurophysiological conditions that could interfere with stimulation and also to get an accurate list of current medications to differentiate ejaculatory incompetence from retrograde ejaculation.

SHF: 8, 9, 16, 17, 18

### 35 Anhedonic orgasm (male)

This category is used when a male client reports one of two patterns:

1. Anesthetic orgasm, in which the client ejaculates with normal force but feels no sensation.
2. Inhibition of the ejaculatory phase of orgasm, in which the client only goes through the emission phase, resulting in seepage of semen from the urethra and a lack of pleasurable sensation.

SHF: 28

### 36 Orgasm with flaccid penis

This category describes a man who reports ejaculating without having a firm erection. While this phenomenon may be due to an impairment of the arousal phase, it is considered an orgasm phase category to avoid confusion with the erectile dysfunction categories. If the orgasm is anhedonic, see category 37, or if ejaculation is rapid, see category 38.

SHF: 9, 22

### 37 Anhedonic orgasm with flaccid penis

This category is used when a man reports both having orgasm with a flaccid penis a good deal of the time, and having little pleasure under those circumstances. If he reaches orgasm with a flaccid penis, but feels it is a normal orgasm in terms of pleasure, use 36.

SHF: 22, 28

### 38 Rapid ejaculation with flaccid penis

This description applies to a man who usually ejaculates with a flaccid penis, and also tends to ejaculate sooner than he would like. Sometimes this pattern is difficult to assess, since many men measure their period of latency to ejaculation by their erections. Probably the most common example of this phenomenon is the man who has an erection sufficient for intromission, but loses it and subsequently ejaculates almost immediately.

SHF: 9, 22

### 39 Anhedonic orgasm with rapid ejaculation

This describes a man who reports having rapid ejaculations with little or no sensation of pleasure during the orgasm itself.

SHF: 9, 28

40 Inorgasmic (female)

This category is used for a female client who is not currently orgasmic by any kind of direct sexual stimulation. Therefore, it is a global description unless a woman is orgasmic during intercourse with some current partner and not with others. This diagnosis may be used for a woman whose only orgasms have occurred during nocturnal dreams or while under the influence of alcohol or street drugs. If such orgasms have occurred in the past three months, the description would be situational. If they occurred more than three months previously, the category would be global, not lifelong.

SHF: 16, 17, 18, 25, 26

41 Inorgasmic except for masturbation

This number is used for a female client who is able to reach orgasm, but only through self-stimulation. Therefore, it is a situational disorder.

SHF: 16, 17, 18

42 Inorgasmic except for partner manipulation

A client is given this description if she reaches orgasm only through oral or manual stimulation from a partner, and not from masturbation or intercourse. Therefore, the disorder is situational.

SHF: 16, 17, 18

43 Inorgasmic except for masturbation or partner manipulation

This category is used for women who are orgasmic on masturbation or partner stimulation, but not during sexual intercourse. This category is always used for research purposes, but is only defined as a focus of work during therapy if it is seen as problematic by the client. It is a situational category.

SHF: 16, 17, 18, 26

44 Infrequent coital orgasms

This category is reserved for women who are orgasmic occasionally during intercourse, but not often enough for their own satisfaction. Again, this category is always used for research purposes, but is only defined as a focus of therapy if requested by the client. These women may or may not have orgasms through masturbation and/or partner manipulation. The criterion is that they are sometimes orgasmic during coitus in their current sexual life.

SHF: 16, 17, 18, 26

45 Inorgasmic except for vibrator or other mechanical stimulation

This description is used when a female client can reach orgasm with stimulation from an electric vibrator or other mechanical apparatus, such as running water, or a shower massage. This is a situational category.

SHF: 16, 17, 18, 25

Coital Pain Axis

50 Vaginismus

Vaginismus is described when an involuntary spasm of the muscles surrounding the vaginal entrance prevents the client from having intercourse, and usually causes a good deal of pain if intercourse is attempted. The description of vaginismus supersedes the category of dyspareunia (51) since pain is almost always a part of the problem.

SHF: 1, 23

51 Dyspareunia (male or female)

Dyspareunia is described when the client complains of pain in the genital area during sexual activity. The category is used whether or not there is a clear physical etiology for the pain. The global vs. situational distinction is made depending on whether pain is present during all sexual activities involving direct manipulation of the genitals and with all current partners.

SHF: 24

52 Pain on ejaculation

This category is used when a male client complains of pain that begins during, or is restricted to, his ejaculatory response. The category is used whether or not there is a clear physical etiology for the pain.

SHF: 24, 28

53 Pain after ejaculation

This category is used for clients who complain of pain that begins shortly after ejaculation.

SHF: 24, 28

54 Other pain exacerbated by sexual activity

This category is used when some health problem, such as arthritis or low back pain, results in chronic pain which is worsened by the phy-

sical activity involved in sex. It is important to assess this pattern in clients with histories of chronic pain, since counseling on sexual techniques and positions may be needed. This kind of pain could also contribute to low sexual desire or lack of arousal.

SHF: ----

#### Frequency Dissatisfaction Axis

##### 60 Desired frequency much lower than current activity level (male or female)

This category is used when the client complains of being pressured into having sex more often than it is desired. This category can be used in addition to a category of low sexual desire, or independently of a description of low desire. This category is based primarily on the client's own dissatisfaction with their current level of sexual activity. The description could also apply to a client who felt he or she was masturbating too frequently. In that case, the problem would be situational, rather than global. If there is any doubt about using this description, refer to SHF questions 1 and 6. There should be a discrepancy of at least two categories between actual frequency of sex and frequency of feeling desire. Example: occurs 3 or 4 times a week, and only feels sexual desire once a week.

SHF: 1, 2, 3, 4, 5, 6, 7, 11, 12, 13

##### 61 Desired frequency much higher than current activity level (male or female)

This category is used when the client is dissatisfied with the lack of sexual activity in their life. This will often be true for the partner of a low sexual desire or sexual aversion client. The complaint, "I want to desire sex more often," will not fall into this category, however. The category should reflect a dissatisfaction of frequency vs. desire. Global vs. situational modifiers depend on whether the desired increase in activity includes partner activities of various types as well as masturbation, and applies to all current partners. If there is any doubt about this description, refer to SHF questions 1 and 6. There should be a discrepancy of at least two categories between actual frequency of sex and frequency of feeling desire. Example: sex occurs once a week vs. feels sexual desire 3 or 4 times a week.

SHF: 1, 2, 3, 4, 5, 6, 7, 11, 12, 13

#### Qualifying Information Axis

These descriptive categories are included because they sometimes affect a couple's sexual satisfaction. Whether or not there is a clear influence on sexual functioning, these numbers should be used if the client mentions that one of the descriptors below applies to

their case. These categories should not be seen as diagnoses, but rather are behavioral tags useful for research and clinical reference. The list of descriptors used in our clinic thus far is below. Others may be added as needed.

- 70 Prefers gender other than that of partner
- 71 Transvestism
- 72 Fetishism
- 73 Voyeurism
- 74 Exhibitionism (male)
- 75 Sexual pleasure from inflicting pain
- 76 Sexual pleasure from experiencing pain
- 77 Sexual assaultiveness
- 78 Rape victim
- 79 Incest as parent
- 80 Incest as child
- 81 Unconsummated marriage
- 82 Sexual pleasure from humiliating partner - includes such activities as bondage, urinating or defecating on partner, playing master-slave, light spanking, etc., where humiliation is clearly the goal.
- 83 Sexual pleasure from being humiliated by partner - see 82
- 84 History of severe psychopathology - includes history of psychosis, affective disorder, severe anxiety symptoms, that have not recurred for at least 3 months.
- 85 Current severe psychopathology - see 84, occurring within the past 3 months.
- 86 Severe marital distress - used with client who reports feeling quite apprehensive about the future of the relationship, and whose Locke-Wallace is at or below 77 (2 SD's below the mean). Assess each spouse separately.
- 87 History of substance abuse - abused alcohol or street drugs, but not for the last three months.
- 88 Current substance abuse - abused alcohol or street drugs within last 3 months.
- 89 History of physically abusing spouse - use when spouse has stopped

subsequent to a therapeutic intervention, or abuse has not occurred at all for at least 3 months.

90 Currently physically abuses spouse - episodes of violence have occurred in the past 3 months. Note that there is not a category for victim of spouse abuse, since abusive relationships are flagged by noting the abusing spouse.

91 Active extramarital affair - use if the client is having an affair at the time of intake. It is used whether or not the spouse is aware of the affair.

92 Medical condition possibly affecting sex - use to note any organic problem that may be affecting sexual functioning.

93 Medication possibly affecting sex - use to note any current medication that may be affecting sexual functioning.

98 No dysfunction - use for the partner of a dysfunctional client who does not fit into any category except frequency dissatisfaction.

99 No diagnosis - use when there is not enough information to make a diagnosis, as in the case of a client who rejects treatment, or in the case of a client whose problem is not a sexual dysfunction.

APPENDIX F

5. How often do you masturbate?
- |                         |                           |
|-------------------------|---------------------------|
| 1) more than once a day | 6) once every two weeks   |
| 2) once a day           | 7) once a month           |
| 3) 3 or 4 times a week  | 8) less than once a month |
| 4) twice a week         | 9) not at all             |
| 5) once a week          |                           |
6. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to a lack of sex, etc....
- |                         |                           |
|-------------------------|---------------------------|
| 1) more than once a day | 6) once every two weeks   |
| 2) once a day           | 7) once a month           |
| 3) 3 or 4 times a week  | 8) less than once a month |
| 4) twice a week         | 9) not at all             |
| 5) once a week          |                           |
7. For how many years have you and your mate been having sexual intercourse?
- |                       |                       |
|-----------------------|-----------------------|
| 1) less than 6 months | 4) 4 to 6 years       |
| 2) less than 1 year   | 5) 7 to 10 years      |
| 3) 1 to 3 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 | 5) 11 to 15 minutes     |
| 2) 1 to 3 minutes       | 6) 16 to 30 minutes     |
| 3) 4 to 6 minutes       | 7) 30 minutes to 1 hour |
| 4) 7 to 10 minutes      |                         |

9. How long does intercourse usually last, from entry of the penis until the male reaches orgasm (climax)?
- |                       |                         |
|-----------------------|-------------------------|
| 1) less than 1 minute | 6) 11 to 15 minutes     |
| 2) 1 to 2 minutes     | 7) 15 to 20 minutes     |
| 3) 2 to 4 minutes     | 8) 20 to 30 minutes     |
| 4) 4 to 7 minutes     | 9) more than 30 minutes |
| 5) 7 to 10 minutes    |                         |
10. Does the male ever reach orgasm while he is trying to enter the woman's vagina with his penis?
- |                                      |  |
|--------------------------------------|--|
| 1) never                             | 4) sometimes, 50% of the time          |
| 2) rarely, less than 10% of the time | 5) usually, 75% of the time            |
| 3) seldom, less than 25% 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  | 4) slightly satisfactory   |
| 2) moderately unsatisfactory | 5) moderately satisfactory |
| 3) slightly unsatisfactory   | 6) extremely satisfactory  |
12. Overall, how satisfactory do you think your sexual relationship is to your mate?
- |                              |                            |
|------------------------------|----------------------------|
| 1) extremely unsatisfactory  | 4) slightly satisfactory   |
| 2) moderately unsatisfactory | 5) moderately satisfactory |
| 3) slightly unsatisfactory   | 6) extremely satisfactory  |

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 | 4) seldom, about 25% of the time |
| 2) usually, about 75% of the time      | 5) never                         |
| 3) sometimes, about 50% of the time    | 6) have never tried to           |

18. If you try, is it possible for you to reach orgasm through sexual intercourse?

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

19. What is your usual reaction to erotic or pornographic materials (pictures, movies, books)?

- |                     |  |
|---------------------|--|
| 1) greatly aroused  | 3) not aroused                         |
| 2) somewhat aroused | 4) negative--disgusted, repulsed, etc. |

20. Does the male have any trouble in getting an erection, before intercourse begins?

- |                                      |  |
|--------------------------------------|--|
| 1) never                             | 4) sometimes, 50% of the time          |
| 2) rarely, less than 10% of the time | 5) usually, 75% of the time            |
| 3) seldom, less than 25% 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%<br>of the time | 4) seldom, about 25% of the<br>time |
| 2) usually, about 75% of<br>the time      | 5) never                            |
| 3) sometimes, about 50%<br>of the time    | 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%<br>of the time | 4) seldom, about 25% of the<br>time |
| 2) usually, about 75% of<br>the time      | 5) never                            |
| 3) sometimes, about 50%<br>of the time    | 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%<br>of the time | 4) seldom, about 25% of the time |
| 2) usually, about 75% of<br>the time      | 5) never                         |
| 3) sometimes, about 50% of the time       |                                  |

## A Short-Form Scale to Measure Sexual Discord in Dyadic Relationships

WALTER W. HUDSON, DIANNE F. HARRISON, AND PAUL C. CROSSCUP

### Abstract

This paper presents a new short-form scale for use by clinical workers and researchers in measuring the degree or magnitude of a problem in the sexual component of a dyadic relationship, as seen by the respondent. The scale was designed for use in repeated administrations at periodic intervals in order that therapists might continually monitor and evaluate their clients' response to treatment. Internal consistency and test-retest reliability were found to be in excess of .90, and the scale has a discriminant validity coefficient of .76.

Clinical workers and researchers who are involved in the treatment and study of sexual dysfunction frequently require a global measure of an individual's sexual dissatisfaction for diagnostic, assessment, and outcome purposes. To be useful in both treatment and research efforts, such a measure should be short, easy to administer and score, relevant to treatment outcome, applicable for use in repeated administrations, and possess psychometric characteristics which indicate instrument reliability and validity. Currently, few inventories exist which measure overall satisfaction or dissatisfaction within a dyadic relationship, and none fulfill the utility and psychometric characteristics described above.

This article reports on the Index of Sexual Satisfaction (ISS), a 25-item self-report scale that measures the degree or magnitude of sexual discord or dissatisfaction of one's relationship with a partner. The ISS was specifically developed for therapists and researchers to use in repeated administrations in evaluating the quality of the sexual relationship between partners. The scale was designed to meet the criteria of ease of

Walter W. Hudson, PhD, is a Professor of Social Work, and Dianne F. Harrison, PhD, is an Assistant Professor of Social Work, at the Florida State University School of Social Work. Paul C. Crosscup, MSW, is currently working in private industry.

Requests for reprints should be sent to Walter W. Hudson, PhD, Professor of Social Work, School of Social Work, Florida State University, Tallahassee, Florida 32306.

administration and scoring, relevance for treatment and research, clinical validity, and high reliability.

The literature reflects a growing proliferation of inventories which purport to measure some aspect of sexual behavior. These range from Thorne's (1966) 200-item Sex Inventory, which assesses sexual psychopathology, to Hoon, Hoon, and Wincze's (1976) Sexual Arousability Inventory, which measures sexual arousability in women. Several scales are available to evaluate satisfaction with specific sexual activities, but they do not relate to overall satisfaction within a dyadic relationship (Foster, 1977; Lo Piccolo & Lobitz, 1973; Whitley & Paulsen, 1975).

Only three instruments have been found which include some measure of global sexual satisfaction: Stuart's (1973) Marital Precounseling Inventory, DeRogatis' (1975) Sexual Functioning Inventory, and Lo Piccolo and Steger's (1974) Sexual Interaction Inventory. Stuart's inventory is an extensive questionnaire which measures numerous aspects of a couple's marital relationship, including a nine-item measure of sexual satisfaction. These satisfaction items, however, focus on how decisions are made and to what extent sexual encounters are considered affectionate. To our knowledge, data concerning validity and reliability have not been made available.

The DeRogatis Sexual Functioning Inventory (DSFI) is a 247-item self-report questionnaire that has eight subscales relating to different dimensions of sexual functioning (e.g., information, experience, gender role definition, and fantasy). There is, in addition, a one-item global self-report rating of sexual satisfaction in which the respondent rates the sexual relationship on an 8-point scale ranging from "could not be better" to "could not be worse." In an updated version of the DSFI (DeRogatis, 1978), 10 items dealing with sexual satisfaction were added in which the respondent indicates "true" or "false" to general statements about the quality of the relationship. While normative data are available for this instrument, its length may be prohibitive for use in repeated administration during treatment.

Lo Piccolo and Steger's (1974) Sexual Interaction Inventory (SII) comes closest to meeting the psychometric and utility criteria described earlier. The SII consists of 17 items related to marital heterosexual behaviors; husbands and wives separately rate actual and preferred occurrences, actual self and perceived mate pleasure, and ideal pleasure with the behaviors. For treatment and research purposes, the scoring of the SII is time consuming and complicated. Because the SII focuses

exclusively on satisfactions with specific sex acts, it may not provide an assessment of more qualitative aspects of the dyadic sexual relationship that some clinicians and researchers may be seeking.

Because of the problems associated with existing inventories and the continued need for short, reliable, and valid measures of sexual dissatisfaction, the ISS was developed as an additional aid for use in treatment and research application. The remainder of this paper describes the development of the ISS and its clinical utility. Also presented are details concerning its scoring and interpretations, and findings concerning its psychometric characteristics.

### The Index of Sexual Satisfaction

The Index of Sexual Satisfaction<sup>1</sup> (ISS) was designed as a 25-item summated category partition scale to measure the magnitude of a problem in the sexual component of a dyadic relationship as seen by the respondent. Approximately half of the items on the ISS were structured as positive statements, and the remainder were negatively worded in as positive statements, and the remainder were negatively worded in order to partially control for any response set by the client. Scale items were ordered by the use of a table of random numbers. A copy of the ISS is shown as Table 1.

It was intended that each of the ISS items be as sexually specific as possible without unduly imposing upon the sensitivities or the right of privacy of the respondent. The hope was that the ISS could then be used with markedly heterogeneous groups of persons with differing moral standards, backgrounds, sexual experiences, and attitudes concerning human sexuality and its expression. Considerable experience in a wide variety of clinical settings and in conducting several research studies indicates the item content is not offensive to clients or research subjects.

A common approach to the development of a new scale is to select or develop a fairly large pool of items that is thought to measure the construct in question and to then select from that pool a subset of items that appears to be best suited for the task. Such an approach was not used in the development of the ISS. Instead, the 25 items were developed on the basis of clinical and personal experience, and they reflect a number of the common complaints that clients provide when they are discussing dissatisfaction with the sexual component of their relationship. In devel-

<sup>1</sup> The scale was conceived and developed by the first author.

Table 1  
Index of Sexual Satisfaction (ISS)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

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

Please begin:

1. I feel that my partner enjoys our sex life \_\_\_\_\_
2. My sex life is very exciting \_\_\_\_\_
3. Sex is fun for my partner and me \_\_\_\_\_
4. I feel that my partner sees little in me except for the sex I can give \_\_\_\_\_
5. I feel that sex is dirty and disgusting \_\_\_\_\_
6. My sex life is monotonous \_\_\_\_\_
7. When we have sex it is too rushed and hurriedly completed \_\_\_\_\_
8. I feel that my sex life is lacking in quality \_\_\_\_\_
9. My partner is sexually very exciting \_\_\_\_\_
10. I enjoy the sex techniques that my partner likes or uses \_\_\_\_\_
11. I feel that my partner wants too much sex from me \_\_\_\_\_
12. I think that sex is wonderful \_\_\_\_\_
13. My partner dwells on sex too much \_\_\_\_\_
14. I feel that sex is something that has to be endured in our relationship \_\_\_\_\_
15. My partner is too rough or brutal when we have sex \_\_\_\_\_
16. My partner observes good personal hygiene \_\_\_\_\_
17. I feel that sex is a normal function of our relationship \_\_\_\_\_
18. My partner does not want sex when I do \_\_\_\_\_
19. I feel that our sex life really adds a lot to our relationship \_\_\_\_\_
20. I would like to have sexual contact with someone other than my partner \_\_\_\_\_
21. It is easy for me to get sexually excited by my partner \_\_\_\_\_
22. I feel that my partner is sexually pleased with me \_\_\_\_\_
23. My partner is very sensitive to my sexual needs and desires \_\_\_\_\_
24. I feel that I should have sex more often \_\_\_\_\_
25. I feel that my sex life is boring \_\_\_\_\_

Note. Copyright © Walter W. Hudson, 1974. Items 1, 2, 3, 9, 10, 12, 16, 17, 19, 21, 22, 23 must be reverse-scored.

oping the ISS items, a major criterion was that a large majority refer directly to the quality of the sexual relationship with a partner, and the remainder should at least reflect upon that relationship. Inspection of Table 1 shows that 19 of the 25 items refer directly to some aspect of the quality of the sexual relationship, and the remaining six items (2, 5, 6, 8, 12, and 25) reflect positive or negative consequences of the quality of the sexual relationship or are measures that influence its quality.

In order to score the ISS, it is necessary to first reverse-score all the positively worded items; the numbers of all items that must be reverse-scored are listed in Table 1. After all the positively worded items have been reverse-scored, the total score is computed as

$$S = (\sum Y - N)(100)/[(N)(4)] \quad (1)$$

where Y is an item score and N is the total number of items completed by the respondent; an omitted item or one that is scored outside the range from 1 to 5 is given a score of 0. This method of scoring produces a minimum possible score of 0 and a maximum score of 100; a high score indicates the presence of a sexual problem. Another advantage of this scoring procedure is that scores will range from 0 to 100, even though a respondent may fail to complete one or more items.

Although the overwhelming majority of clients do complete all of the ISS items, on rare occasions clients will omit one or two items or fail to use the scale properly. Even though the scoring formula compensates for the loss of a few items, clinical experience indicates that when a client refuses to complete a large number of items, the validity of a resulting score should be challenged. Those instances are usually indicative of a client who is having some sensitivity or difficulty in discussing the sexual relationship problems. In such cases the therapist should ignore any obtained ISS score and explore the reasons for so many items omissions. This can lead to valuable clinical evidence concerning the nature of any difficulty the client may have in working on the sexual relationship problem. For clinical and research purposes, the writers have chosen to disregard any ISS score that is based on fewer than 20 items.

For those persons who properly respond to all 25 items on the ISS, a simpler scoring formula can be used: reverse-score the positively worded items and then compute:

$$S = \sum Y - 25 \quad (2)$$

### Methodology and Findings

To investigate the reliability and validity of the ISS, data were used from three separate samples. The first sample consisted of 378 individuals from a multi-ethnic population in Hawaii who were surveyed to study the relationships between affective and interpersonal relationship disorders among persons aged 40 to 80 (Murphy, Hudson, & Cheung, 1980). The respondents were non-institutionalized married persons (189 couples). Caucasians comprised 37.8% of the sample, as compared to 32.8% Japanese, 11.8% Hawaiian or part Hawaiian, 8.7% Chinese, and 8.1% Filipino, Samoan or Korean. The mean age of the sample was 55.2 years, and the annual family income was \$23,370. This study sample will be referred to as the Social Problem Survey (SPS) sample (Murphy, 1978).

The second sample used in this study consisted of 689 persons who voluntarily participated in a survey to investigate the relationships among six different types of sexual activities and preferences and a number of problems concerning personal and social functioning (Nurius, 1980; Hudson & Nurius, Note 1). The ethnic composition of this sample was 46.1% Caucasian, 3.1% Hawaiian or part Hawaiian, 30.2% Japanese, 9.2% Chinese, and 11.3% were described as a "mixed or other" ethnic group. The majority of the sample was single (69.9%); 20.3% were married, and 9.8% claimed some other marital status: 70.3% had never married, 24.7% had married once, and 4.9% said they had married two or more times. Two-thirds (67.5%) of the sample was female. The mean age of the sample was 25.0 years, and their average annual income was \$16,344. This sample will be referred to as the Sexual Activity and Preference (SAP) sample.

The third sample consisted of 100 persons who were seeking counseling services for one or more personal or interpersonal relationship problems; 49 were selected by experienced therapists who independently determined that the person was having a sexual relationship problem with a spouse or partner, and 51 were selected by therapists who determined that the person did not have a clinically significant sexual relationship problem. Males comprised 34.3% of the sample, which was 78.6% Caucasian, 15.3% Japanese, Chinese, or Korean ancestry, and 6.1% from some other or unknown ethnic background. There were 18.4% who were single, 61.2% were married, 10.2% were divorced, and the remaining 10.2% were separated, widowed, or of unknown marital status. The mean age of the respondents was 32.7 years, and their mean annual income was \$14,400. This sample will be referred to as the Clinical Survey (CS) sample.

### Reliability

The reliability of the ISS was examined separately for the three study samples using coefficient Alpha, which was selected for several reasons. It produces an internal consistency estimate of reliability that is based on all of the inter-item correlations. It represents an estimate of the correlation between the ISS and some other equally good alternate form measure of sexual discord. When the value of Alpha equals or exceeds .90, it constitutes direct evidence to support the claim that a scale measures only one construct. Finally, Alpha represents the average of all possible split-half reliabilities (Nunnally, 1978).

Coefficient Alpha for the three samples was found to be .925, .906, and .916, respectively. Averaging these three estimates, the best estimate of Alpha is .916. These findings indicate that the ISS has excellent reliability over three different and markedly heterogeneous samples.

Because reliability coefficients that are based on correlations can vary considerably from one sample or population to the next because of differences in the standard deviations, the standard error of measurement (SEM), which is not influenced by such differences (Helmstadter, 1964; Nunnally, 1978), was computed separately for the three samples.<sup>2</sup> The SEM for the SPS sample was 4.08, as compared to 4.13 and 3.27 for the SAP and CS samples, respectively. The average of these three estimates of the SEM is 3.83, which indicates that about 95% of the time a person will obtain an observed score which will be within a range of approximately  $\pm 7.5$  points of the "true" score. Since the ISS has a score range from 0 to 100, the reliabilities and SEMs reported above indicate that the ISS is an excellent scale in terms of its measurement error characteristics.

Since the ISS was developed for use in repeated administrations in order to monitor and evaluate the level or severity of sexual relationship problems, it is important to determine whether the scale provides a stable measure of such difficulties. The test-retest reliability of the ISS was evaluated by asking graduate students in social work to complete the scale on two occasions separated by a one-week interval. Students were asked to participate in this test only if they were married or were involved in a stable relationship with a partner. The test-retest reliability was found to be .93 with a sample size of 79.

<sup>2</sup> For the CS sample the SEM was computed by using the pooled within-group variance as an estimate of the population variance.

*Discriminant Validity*

Although the ISS appears to have excellent measurement error characteristics, it has not yet been shown to be a valid measure of sexual relationship problems. If the ISS is a valid measure of such problems, it should be capable of distinguishing clearly between two or more groups of persons who are known to have different degrees of sexual relationship problems. Moreover, it should do a better job of discriminating among such groups than one or more other scales that measure different constructs or problems within the domain of human sexuality. These issues were studied using only the CS sample.

In addition to completing a social background questionnaire and the ISS, each member of the CS sample also completed a measure of marital discord, the Index of Marital Satisfaction (IMS), (Cheung & Hudson, 1981; Hudson & Glisson, 1976), and a measure of the degree of liberal vs. conservative orientation toward human sexual expression, the Sexual Attitude Scale (SAS), (Hudson & Murphy, Note 2). All three of these scales clearly fall within the domain of human sexuality, but each purportedly measures a different aspect of that domain; both the IMS and SAS have good validities, and their reliabilities are in excess of .90.

In order to examine the discriminant validity of the ISS, the clinical status of the 100 clients from the CS sample (sex problem vs. no sex problem) was treated as the independent variable, and the ISS, IMS, and SAS scores were treated as the dependent variables in three separate one-way analyses of variance. In the psychometric literature this is referred to as a form of concurrent criterion validity, but the procedure is referred to here as a test of discriminant validity, because that more aptly describes the task being performed.

The results of these analyses are shown in Table 2. The difference between the mean scores for the sex problem and no sex problem groups was 26.3 for the ISS, 21.9 for the IMS, and 4.8 for the SAS scales. The difference for the ISS and IMS scales was highly significant, but the one for the SAS was not statistically significant at the .05 level.

Although the means and their differences help to evaluate the ISS in its ability to discriminate between the two criterion groups, a much more useful device is the point-biserial correlation between clinical status and each of the three scales. These point-biserial correlations (and their squared values) are also shown in Table 2, and are the primary discriminant validity coefficients for the three scales.

Table 2  
Discriminant Validities for the Index of Sexual Satisfaction, Index of Marital Satisfaction and Sexual Attitude Scale Scales

Dependent Variable	Mean Scores		SD	F-ratio	<i>r</i>	<i>r</i> <sup>2</sup>
	Problem Group	No-problem Group				
ISS <sup>a</sup>	41.5	15.2	11.28	139.18*	.7626	.5815
IMS <sup>b</sup>	45.0	23.1	18.13	36.66*	.5217	.2722
SAS <sup>c</sup>	27.4	22.6	15.32	2.51	.1590	.0250

<sup>a</sup> Index of Sexual Satisfaction.

<sup>b</sup> Index of Marital Satisfaction.

<sup>c</sup> Sexual Attitude Scale.

\*  $p < .001$ .

It should be remembered that correlations do not represent an equal interval metric, and direct comparisons of their magnitudes can be very misleading. For this reason it is much better to compare the squared values of the point-biserial correlations. In these comparisons, the ISS scale is about twice as powerful as the IMS in terms of its ability to discriminate between the two criterion groups; the difference<sup>3</sup> between these two discriminant validity coefficients was significant at  $p < .0001$ . Since the ISS correlates very highly with a criterion it is supposed to be related to (the existence of a sex problem), and the other two scales correlate lower with the same criterion, these data also provide some evidence in support of the claim that the ISS also has good construct validity (Campbell & Fiske, 1959).

*Clinical Cutting Point*

In developing a scale for use in clinical practice it is important to determine a useful clinical cutting point for the scale, that score at or above which a person would be classified as having a problem in the area being assessed and below which there is little or no evidence of a clinically significant problem. The clinical cutting score for the ISS was evaluated by preparing a separate frequency distribution for the two clinical groups and then determining which score, if used as a cutting point, would minimize the sum of the false positives and false negatives.

<sup>3</sup> The test of this difference was based on a test for non-independent samples (Glass & Stanley, 1970, pp. 313).

positives and false negatives. If a score of 28 is used as the clinical cutting score, the ISS has a misclassification error rate of 11.8% for the "no sex problem" group (false positives) and an error rate of 14.3% for the "sex problem" group (false negatives). This yields an overall error rate of 13.0%. Stated differently, by using a cutting score of 28, the ISS correctly classified 88.2% of those without sex relationship problems, 85.7% of those with such problems, and 87.0 percent of the total CS sample.

It should be recognized that the above cutting score was estimated with the use of a relatively small sample, and future validation studies of the ISS may show that a more precise estimate will be slightly higher or lower. In a number of other studies concerning the validation of seven other similarly structured scales, it was found that the optimal cutting score appeared to fluctuate around a score of 30 (Cheung & Hudson, 1981; Giuli & Hudson, 1977; Hudson, Acklin & Bartosh, 1980; Hudson & Glisson, 1976; Hudson & Proctor, 1977; Hudson, Wung & Borges, 1980). Since these seven scales along with the ISS constitute a convenient clinical assessment package, we were curious to know what would be the consequences of using the cutting score of 30 for the ISS, which seems to be very effective for the other seven scales.

If a cutting score of 30 is used for the ISS, the rate of false positives becomes 7.8%, the false negatives increase to 20.4%, and the classification error rate for the total CS sample increases to 14.0%. That is, by using a clinical cutting score of 30, the ISS correctly classified 92.2% of those in the "no sex problem" group, 79.6% of those in the "sex problem" group, and 86.0% of the total CS sample. On the basis of these findings it appears safe to conclude that the use of 30 as a clinical cutting score for the ISS does not result in important or clinically significant consequences in terms of misclassifying respondents into sex relationship problem and no problem groups. For those who wish to adhere to the precision of available data, it would be advisable to regard a score of 28 as the proper cutting score for the ISS. However, for those who wish to use the ISS as part of a larger battery of assessment devices (Hudson, Note 3),<sup>4</sup> it is not likely that the use of 30 as a common cutting score will entail serious risks. Actually, no single score for the ISS (or any other such scale) should be taken too seriously. In clinical applications it would be unwise to

<sup>4</sup> Copies of the other scales can be obtained by writing to the first author.

Table 3  
Discriminant Validity of the Index of Sexual Satisfaction in Terms of Classification Frequencies

ISS* Groups	Clinical Status	
	Sex Problem	No Sex Problem
30+	33	4
<30	10	47

Note.  $\chi^2(1) = 52.49, p < .0001$  Phi = .7245.  
\* Index of Sexual Satisfaction.

presume that someone who obtains an ISS score of 33, for example, definitely has a sexual relationship problem. On the other hand, it is probably equally unwise to regard a score of, say, 27 as representing clear evidence that the client is free of problems in the sexual component of the dyadic relationship. In such ambiguous cases it is probably wise to suspend judgment concerning the presence or absence of a clinically significant sexual relationship problem whenever an obtained ISS score falls within a range of about plus or minus 5.0 points<sup>5</sup> of the cutting score that is being used. In all cases it is important to evaluate the obtained ISS score in relation to all other clinical evidence that is available concerning the presence and severity of difficulties in the sexual component of a dyadic relationship.

While the major focus of the above discussion has been upon the development of a clinical cutting score, this also relates to the discriminant validity of the ISS. If the cutting score of 30 is used, the above rates of correct classification can be regarded as separate discriminant validity coefficients. Thus, the discriminant validity of the ISS could be seen as .92 for the no-problem group, .80 for the problem group, and .89 for the total CS sample. A better way to regard these data is to arrange the frequencies in a two-way table as shown in Table 3, and then compute the Phi coefficient as a discriminant validity coefficient. In this case the obtained value of Phi was .724, which is quite large and significant.

#### Factorial Validity

If the ISS has good factorial validity, its items should correlate very highly with a sexual discord factor, and they should have lower correla-

<sup>5</sup> This is a bit more than one SEM and a bit less than two. Again, this interval is recommended because it seems to serve well for the other seven scales mentioned earlier, and there is likely to be little practical risk of any serious or clinically significant misclassifications. Those who feel less secure with this recommendation might choose to use an interval of plus or minus two SEMs around the clinical cutting score.

tions with other factors. Since all the subjects in each of the three samples were asked to complete the ISS, IMS, and SAS scales, these can be used to investigate the factorial validity of the ISS items. If the ISS items do have good factorial validity, they should correlate more highly with the ISS total score, and they should not correlate well with the IMS and SAS total scores.

In addition to the ISS, IMS, and SAS scales, members of the SPS and SAP samples also completed a measure of depression, the Generalized Contentment Scale (GCS), (Byerly, 1979; Hudson & Proctor, 1977; Hudson, Hamada, Keech, & Harlan, Note 4), and a measure of self-esteem, the Index of Self-Esteem (ISE), (McIntosh, 1979; Hudson and Proctor, Note 5). The GCS and ISE scales also have good construct and discriminant validities, and they have reliabilities of .90 or greater. These scales, along with age, sex, years of education, and income, were also used to examine the factorial validity of the ISS.

The reader should recall that the simple item-total correlations between the ISS, the total scores for the five scales, and the measures of sex, age, education, and income are precisely equal to the factor loadings one obtains from a multiple group factor analysis (Overall & Klett, 1972) with units on the main diagonal of the inter-item correlation matrix. Although simple in its mathematics and execution, the multiple group method of factor analysis is a very powerful method for testing a large number of a priori hypotheses about the direction and magnitude of factor loadings.

One shortcoming of this factoring method is that the correlation between an ISS item and the ISS total score is a correlation between that item and the sum of 24 items plus itself. It is a part-whole correlation. The presence of this item-self correlation could, in some cases, present an inflated picture of the factorial validity of one or several items. In order to avoid this problem, the ISS item-total correlations were adjusted to remove the effect of all item-self correlations (Nunnally, 1978, p. 281).

Finally, in order to increase the power of this analysis, the three samples were combined into a single sample of 1,167 respondents,<sup>6</sup> and the resulting item-total correlations are shown in Table 4. Since attention

<sup>6</sup>Since members of the CS sample did not complete the GCS and ISE scales, all correlations involving these scales are based on a sample of 1,067 respondents. Because of item omissions or improper responses, the actual sample size for the correlations shown in Tables 4 and 5 will vary for each bivariate correlation. In no case, however, did the effective sample size drop below 850 for any of the bivariate correlations, and the overwhelming majority had an N close to 1,000 or greater.

is focused only upon the factorial validity of the ISS, and in order to conserve space, only the item-total correlations for the ISS scale are shown in Table 4.

Examination of the item-total correlations shown in Table 4 shows that all but four of the ISS items make large contributions to the ISS total score, and they have smaller correlations with the other measures. It is not surprising to find that the ISS items also correlate rather well with the IMS, GCS, and ISE total scores, and for reasons that are discussed below. In general, it appears that the ISS items have excellent factorial validity. Since they correlate highly with the total score they are supposed to correlate with, less highly with the total scores for the other scales, and very low with the measures they should not correlate with, these data clearly suggest that all but four of the ISS items have good convergent and discriminant validity (Campbell & Fiske, 1959).

Close examination of the correlations in Table 4 shows that item 14 appears to do a better job of measuring sexual attitude than discord, and item 16 loads equally well on the ISS, IMS, GCS, and ISE factors. Item 20 loads rather highly on the IMS and better on the SAS than on the ISS, and item 24 loads better on the IMS than on the ISS. What should be done with these items? There are three choices: (a) discard them and regard the ISS as having only 21 items, (b) replace them with new items, or (c) retain them. From a practical point of view it is very likely that selection of any of these three options will not have a dramatic impact on the performance of the ISS. By discarding the items the scale will be shortened, and there may be a very modest improvement in its reliability and validity. However, it will then be necessary to always use Equation 1 to score the ISS if the score range from 0 to 100 is to be retained. In spite of the problems noted above for these four items, they do make a significant contribution to the total ISS score, and that could be used as an argument for their retention.

The writers prefer the second option of replacing the weak items with new ones, despite the lack of currently available data to assess the performance of such new items. Nonetheless, the desire and intent is to seize upon an opportunity to further improve the ISS, and it is therefore suggested that the following items be used as replacements for those shown in Table 1.

14. I try to avoid sexual contact with my partner.
16. My partner is a wonderful sex mate.

Table 4  
Index of Sexual Satisfaction Item-Total Correlations for the Combined Sample

ISS <sup>a</sup> Items	ISS <sup>b</sup>	IMS <sup>c</sup>	GCS <sup>d</sup>	ISE <sup>e</sup>	SAS <sup>f</sup>	Sex	Age	SCH <sup>g</sup>	INC <sup>h</sup>
1	.65	.50	.33	.33	.05	-.02	-.01	-.03	-.02
2	.72	.55	.33	.33	.05	.09	-.04	.06	.01
3	.77	.57	.36	.32	.12	.05	.03	-.06	-.04
4	.39	.47	.34	.30	.14	.05	.01	-.14	-.03
5	.38	.23	.25	.32	.15	.05	-.10	-.07	.03
6	.62	.45	.27	.23	.07	.05	-.07	.01	.04
7	.50	.35	.26	.26	.14	.04	-.03	-.13	-.03
8	.71	.55	.29	.31	.06	-.01	-.03	-.02	-.01
9	.71	.52	.26	.25	.12	.01	.02	-.01	-.05
10	.72	.46	.33	.31	.17	-.01	.01	-.07	-.01
11	.42	.33	.26	.31	.14	.11	-.07	-.11	-.03
12	.55	.33	.31	.35	.29	.12	-.01	-.10	-.01
13	.38	.34	.22	.26	.12	.15	-.08	-.05	-.02
14	.19	.08	.14	.13	.32	-.11	.06	-.29	-.01
15	.35	.26	.22	.20	.09	.11	-.04	-.05	.03
16	.24	.21	.24	.20	.08	.01	-.06	-.10	.05
17	.54	.38	.34	.30	.14	.05	-.12	-.12	.06
18	.33	.26	.15	.18	.07	-.18	.03	-.07	.01
19	.61	.48	.31	.26	.08	.05	-.19	-.01	.01
20	.28	.44	.14	.06	-.31	-.22	-.22	.10	.13
21	.67	.44	.29	.26	.15	.14	.01	-.05	-.03
22	.68	.46	.32	.33	.08	-.03	.01	-.02	-.01
23	.65	.45	.31	.25	.10	-.05	.03	-.07	-.04
24	.23	.28	.16	.09	-.09	-.19	-.05	.01	.05
25	.68	.52	.26	.25	.03	.05	-.01	.02	.02

<sup>a</sup> Index of Sexual Satisfaction.

<sup>b</sup> The effect of item-self correlation has been removed.

<sup>c</sup> Index of Marital Satisfaction.

<sup>d</sup> Generalized Contentment Scale.

<sup>e</sup> Index of Self-Esteem.

<sup>f</sup> Sexual Attitude Scale.

<sup>g</sup> Schooling.

<sup>h</sup> Income.

20. My partner seems to avoid sexual contact with me.

24. My partner does not satisfy me sexually.

### Construct Validity

In order to examine the construct validity of the ISS it is useful to examine the correlations among the total scale scores and the measures of age, sex, education, and income. This was done by using the pooled sample of 1,167 respondents from the SPS, SAP, and CS samples.

If the ISS is a valid measure of sexual discord, it should obtain correlations with other measures that are consistent with theoretical and clinical predictions. The most important prediction is that the ISS will have a fairly large correlation with the IMS; persons who are having problems in their sexual relationship are very likely to also be having problems in their marital relationship. A second important prediction is that persons who are having marital and sexual relationship problems are very likely to have problems with depression and self-esteem; both the ISS and IMS scales should have at least moderate correlations with the GCS and ISE scales. A third prediction is that the GCS scale will have a fairly high correlation with the ISE scale; persons who are having serious problems with depression are very likely to also be having problems with self-esteem. Substantiation of these predictions will provide some evidence in support of the claim that the ISS has good convergent validity (Campbell & Fiske, 1959).

A final very important set of predictions is that the ISS will have a relatively low correlation with age, sex, education, income and the SAS scale; these latter variables are also predicted to have low or moderate correlations among themselves. That is, there appears to be no good theoretical or clinical reason to believe that the quality of a person's sexual (or marital) relationship is markedly affected by sex, age, or socio-economic status, and persons who adhere to either a liberal or conservative stance concerning human sexual expression can have an equally good

Table 5  
Construct Validity Correlations for the Combined Samples

	IMS <sup>a</sup>	GCS <sup>b</sup>	ISE <sup>c</sup>	SAS <sup>d</sup>	Sex	Age	SCH	INC <sup>e</sup>
ISS	.68	.47	.44	.14	.01	-.06	-.10	.01
IMS		.45	.39	-.05	.09	-.17	-.01	.07
GCS			.74	.05	.02	-.23	-.19	.12
ISE				.16	.02	-.16	-.15	.09
SAS					-.02	.41	-.38	-.21
SEX						-.18	.02	.04
AGE							-.12	-.45
SCH								.11

Note. All values of  $r > .07$  are significant at  $p < .05$ .

<sup>a</sup> Index of Marital Satisfaction.

<sup>b</sup> Generalized Contentment Scale.

<sup>c</sup> Index of Self-Esteem.

<sup>d</sup> Sexual Attitude Scale.

<sup>e</sup> Schooling.

<sup>f</sup> Income.

or poor sexual and marital relationship with their spouse or partner. Confirmation of these predictions will provide some evidence in support of the claim that the ISS has good discriminant validity (Campbell & Fiske, 1959), and the correlations among these measures are shown in Table 5.

Estimation of the data shown in Table 5 shows that all of the above predictions are very well supported, and, on the basis of these findings,<sup>7</sup> it was concluded that the ISS has good construct validity.

### Conclusions

This paper has presented the ISS as a new short-form, self-report measure of the degree or magnitude of problems in the sexual component of a dyadic relationship as seen by the respondent. It must be acknowledged that the task of establishing reliability and validity for a new scale is a long and arduous one that must depend on a series of different investigations that are conducted under different conditions and with different populations. Thus, while the findings reported in this paper seem to provide good evidence in support of the ISS as a reliable and valid measure of sexual discord in dyadic relationships as seen by the respondent, they must be regarded as providing only partial and tentative support for such claims. However, on the basis of the findings it appears safe to recommend the ISS for use in both clinical and research applications.

In using the ISS as an aid to diagnosis or to monitor progress in treatment through repeated administrations, it should be noted that the clinical cutting score was estimated by using a fairly small sample. While it is highly doubtful that future validation studies will produce any large revision in the cutting score, it may be found that a moderate adjustment is necessary. Thus, the optimal cutting score of 28, or the convenience cutting score of 30, should be regarded as useful, but tentative, estimates.

Since a major purpose for developing and testing the ISS was to produce a device for monitoring and assessing progress in treatment

<sup>7</sup> The reader may note that there is a moderate negative correlation between age and income and a moderate positive correlation between age and SAS. The former arises because the sample contains a significant number of older persons who have retired and have reduced incomes as a consequence of their retirement. The latter occurs because the same older persons were socialized in their youth at a time when a more conservative attitude toward human sexual expression was the predominant social norm, and the converse holds for the younger members of the sample.

through the use of regular or periodic administrations to the same client, a major issue is one of determining what constitutes evidence of real change in the level or magnitude of the sexual relationship problem. Because of the measurement error inherent in the ISS, a change of a few score points in one direction or the other cannot be interpreted as evidence of real change in the severity of the problem. Given the SEM of 3.83, it would seem judicious to regard any change of about  $\pm 4$  points or less as representing noise in the scale, and changes in either direction as producing increasingly stronger evidence of real change as their size exceeds 4 points; changes of 8 or more points are very likely indicators of real change.

A final caution in using the ISS in clinical or research applications concerns its self-report nature. Because the ISS is a self-report measure, it suffers all the weaknesses and threats to validity that are common to self-report instruments (Hersen & Barlow, 1976). The content and measurement intent of the ISS items is quite apparent, and respondents can therefore make themselves appear to be as problem-laden or as problem-free as they wish. In spite of this obvious feature of the ISS, it has been found to be a reliable and valid measure of sexual discord among those who actively seek help for sexual relationship problems; the fairly large validity coefficients reported in this paper suggest that social desirability and impression-management responding may not be a serious problem. Nonetheless, if the ISS is used in clinical or research applications one should make a special effort to reduce any potential for clients or subjects to respond in a socially desirable manner.

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INDEX OF SEXUAL SATISFACTION (ISS)

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

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

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

Please begin:

- 1. I feel that my partner enjoys our sex life . . . . . \_\_\_
- 2. My sex life is very exciting . . . . . \_\_\_
- 3. Sex is fun for my partner and me . . . . . \_\_\_
- 4. I feel that my partner sees little in me except for the sex I can give . . . . . \_\_\_
- 5. I feel that sex is dirty and disgusting. . . . . \_\_\_
- 6. My sex life is monotonous. . . . . \_\_\_
- 7. When we have sex it is too rushed and hurriedly completed. . . . . \_\_\_
- 8. I feel that my sex life is lacking in quality. . . . . \_\_\_
- 9. My partner is sexually very exciting . . . . . \_\_\_
- 10. I enjoy the sex techniques that my partner likes or uses. . . . . \_\_\_
- 11. I feel that my partner wants too much sex from me. . . . . \_\_\_
- 12. I think that sex is wonderful. . . . . \_\_\_
- 13. My partner dwells on sex too much. . . . . \_\_\_
- 14. I feel that sex is something that has to be endured. . . . . \_\_\_

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

APPENDIX G

ORIGINAL

# Measuring Dyadic Adjustment: New Scales for Assessing the Quality of Marriage and Similar Dyads\*

GRAHAM B. SPANIER\*\*  
The Pennsylvania State University

*This study reports on the development of the Dyadic Adjustment Scale, a new measure for assessing the quality of marriage and other similar dyads. The 32-item scale is designed for use with either married or unmarried cohabiting couples. Despite widespread criticisms of the concept of adjustment, the study proceeds from the pragmatic position that a new measure, which is theoretically grounded, relevant, valid, and highly reliable, is necessary since marital and dyadic adjustment continue to be researched. This factor analytic study tests a conceptual definition set forth in earlier work and suggests the existence of four empirically verified components of dyadic adjustment which can be used as subscales [dyadic satisfaction, dyadic cohesion, dyadic consensus and affectional expression]. Evidence is presented suggesting content, criterion-related, and construct validity. High scale reliability is reported. The possibility of item weighting is considered and endorsed as a potential measurement technique, but it not adopted for the present Dyadic Adjustment Scale. It is concluded that the Dyadic Adjustment Scale represents a significant improvement over other measures of marital adjustment, but a number of troublesome methodological issues remain for future research.*

The concept of marital adjustment has taken a prominent place in the study of marriage and family relationships. Despite widespread criticism of marital adjustment and related concepts (Spanier and Cole, 1974; Hicks and Platt, 1970), it is probably the most frequently studied dependent variable in the

field.<sup>1</sup> Although writers such as Lively (1969) have suggested that we abandon the use of such vague and ambiguous concepts, it is clear that this advice has not been heeded since a plethora of studies on marital adjustment have been published since these criticisms have appeared. My colleagues and I have argued, from a pragmatic standpoint (Spanier and Cole, 1974), that methodologists cannot ignore the clear continuing need that family researchers have for adequate measures, including those of the paper and pencil type, in order to assess the quality of adjustment in marital relationships.<sup>2</sup>

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<sup>1</sup>Spanier and Cole (1974) cited over 150 empirical studies using the marital adjustment concept. In a marital adjustment propositional inventory and theoretical integration project presently being conducted in collaboration with Robert Lewis, we have identified over 300 articles in which marital adjustment or a related concept is the dependent variable.

\*\*Division of Individual and Family Studies and Department of Sociology, The Pennsylvania State University, University Park, Pennsylvania 16802.

<sup>2</sup>Although previous work has been critical of marital adjustment scales and research (Spanier, 1972; Spanier, 1973; Spanier and Cole, 1974; Spanier, Lewis, and Cole, 1975), we have argued that it would be most fruitful to direct our efforts at clarification of the problems in definition, conceptualization, and measurement. The

During the past few years an increasing interest in the study of nonmarital cohabitation and other emerging household arrangements has suggested the importance of generalizing our methods for assessing relationship adjustment to include nonmarital dyads. It can be argued that a family sociology which has as its foundation the study of familial structures and functions must also provide for the study of household arrangements in which functions common to formal marriage arrangements exist within the context of variant family structures.<sup>3</sup>

This article presents a new scale for the measurement of dyadic adjustment, including subscales which measure four empirically verified components: dyadic satisfaction, dyadic consensus, dyadic cohesion, and affectional expression. The scale construction process is among the most comprehensive used to date in the development of a measure of adjustment for dyadic relationships, including marriage. This article presents a summary of the process followed in scale construction; the theoretical rationale and conceptual framework used as a basis for the study; an evaluation of validity and reliability; and a factor analytic assessment of the relationship between the items, subscales and the total Dyadic Adjustment Scale. The final 32-item scale is presented in the appendix.

#### CONCEPTUAL RATIONALE<sup>4</sup>

Spanier and Cole (1974), in addressing conceptual and measurement problems associated with marital adjustment scales, suggested that an adequate scale would need to follow from a definition of adjustment which met the following conditions: (1) It would be distinguishable from other con-

present study is an attempt to improve the measurement in this area by integrating nominal definitions, operational definitions, and measurements in a more consistent manner than has been done previously. It has been argued (Spanier and Cole, 1974) that adjustment is an appropriate concept for investigation and can be conceptually distinguished from concepts such as success, happiness, satisfaction, stability, integration, cohesiveness, or consensus.

<sup>3</sup>Winch (1974) has called such an arrangement a "domestic family." He delineates the specific variants of familial social systems when structural and/or functional requirements are not met.

<sup>4</sup>The discussion in this section is adapted from Spanier and Cole (1974).

cepts; (2) It would be operationalizable. In other words, a measure could be developed which follows from and is consistent with the definition proposed; (3) It would account for all criteria thought to be important in the conceptualization of adjustment; (4) It would not be so abstract that it could not be clearly conceptualized nor would it be so specific that it could not apply to a study of all marriages.

Previous scale development has focused on the marital dyad, since this relationship was of greatest interest to family researchers. However, the need to have more general measures which will allow us to simultaneously or independently study nonmarital dyads led us to consider a fifth point suggesting that: (5) Definitionally, we can allow for investigation of any nonmarital dyad which is a primary relationship between unrelated adults who are living together.

Marital or dyadic adjustment may be viewed in two distinct ways—as a process, or as a qualitative evaluation of a state. Defining dyadic adjustment as a process rather than a state has several implications for measuring the concept, the most important of which is that a process can best be studied over time. Although cross-sectional studies have some value in the investigation of adjustment, it is evident that "process" could be studied best with a longitudinal design.

The second view of adjustment, as a qualitative evaluation, may itself be defined in two distinct ways. First, the assessment of adjustment may assume that there exists a continuum of adjustment in which a "snapshot" of the continuum is taken at one point in time. This definition acknowledges a process, but studies dyadic adjustment by looking at the process only at specific points on the continuum. It is the evaluation of the characteristics and interactions of the relationship which are the focus of this approach. Alternately, one may define dyadic adjustment without reference to a time dimension. When adjustment is conceptualized as an unchanging state, the technique of studying it is simplified since the researcher need only be concerned with the quality of the relationship at the time of data collection.

Current measures of marital adjustment generally do not assess a changing process, but rather measure a position on a continuum

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from well-adjusted to maladjusted. A "process" definition, however, is predicated not only on the existence of a continuum, but also on the belief that *movement* along the continuum. Definitionally, then, we could say movement is measured. The process consists of those events, circumstances and interactions which move a couple back and forth along this continuum. Definitionally, then, we could say that dyadic adjustment is a process of movement along a continuum which can be evaluated in terms of proximity to good or poor adjustment.

Considering both the complexities of studying process and the oversimplification resulting from a static "snapshot" conception, a definition evolved which represents a synthesis of the marital adjustment literature as well as our own thinking about the phenomenon (Spanier and Cole, 1974). We have accepted the idea that dyadic adjustment is a *process* rather than an unchanging state, but that the most heuristic definition would allow for a measure which would meaningfully evaluate the relationship at a given point in time. This approach is most consistent, we believe, with previous research which has sought to evaluate the quality of the marital (dyadic) relationship within a given time frame. Thus, we subscribe to the notion that adjustment is an ever-changing process with a qualitative dimension which can be evaluated at any point in time on a dimension from well adjusted to maladjusted. Consistent with this point of view, dyadic adjustment can be defined as a process, the outcome of which is determined by the degree of: (1) troublesome dyadic differences; (2) interpersonal tensions and personal anxiety; (3) dyadic satisfaction; (4) dyadic cohesion; and (5) consensus on matters of importance to dyadic functioning. We have suggested that these hypothesized components of adjustment are applicable to both marital and other dyadic relationships. Consequently, my purpose in developing the Dyadic Adjustment Scale is to create a measure which can be used by researchers interested in the marital relationship but also by researchers interested in other dyadic relationships, such as unmarried cohabiting couples. The present study attempts to go beyond the standard procedure of presenting the scale and its reliability and validity by additionally attempting to test the adequacy

of the definition suggested above. A final working definition, designed to determine the presence of the suggested components, will be presented.

## PREVIOUS MEASURES OF MARITAL ADJUSTMENT

The study of marital adjustment has a history dating back to Hamilton's (1929) classic study. Since that time a number of measures have been developed which have purported to assess the quality of marital relationships. The measures which have been developed and published over the years and descriptive information about them are summarized in Table 1. A cursory examination of these previous measures indicates that few of them have an adequate demonstration and reporting of validity and reliability, nor do they have a clear conceptual plan behind the scale development. In addition, none of these previous scales is specifically designed for use with dyads other than marriage.

## OVERVIEW OF PROCEDURES

The procedures used in the development of the Dyadic Adjustment Scale are extensions of those used by Terman (1938) and Locke and his colleagues (Locke, 1947; Locke and Karlsson, 1952; Locke and Wallace, 1959; Locke and Williamson, 1958) many years ago. The present scale, however, is the product of a more comprehensive process, which attempts to go beyond the procedures used by Locke, his colleagues, and the developers of other marital adjustment scales (e.g., Nye and MacDougal, 1959; Orden and Bradburn, 1968; Burgess and Cottrell, 1939). The process is briefly outlined below, and is discussed in more detail in subsequent sections of this article:

1. All items ever used in any scale measuring marital adjustment or a related concept were identified. This search produced a pool of approximately 300 items.

2. All duplicate items were then eliminated from the original pool of items, thus leaving for further analysis all items previously used at least once.

3. Three judges other than the principal investigator examined all items for content validity. Items were judged unacceptable and eliminated if a consensus existed that an item did not meet content validity criteria. Items had to be relevant for relationships in the

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TABLE 1. OVERVIEW OF PUBLISHED MEASURES OF MARITAL ADJUSTMENT AND RELATED CONCEPTS\*

Developer	Name of Scale	Year Published	Reliability	Validity	Number of Questions	Number of Respondents
Adams	Marriage Adjustment Prediction Index	1960	NR†	Predictive, Concurrent, and Construct	24311	100
Bernard	Success in Marriage Instrument	1933	.96-.97 Split half	Content, Concurrent, Construct	100	115 males 137 females
Bowerman	Bowerman Marriage Adjustment Scales	1957	.80-.90 Reproducibility	Concurrent	67	102 couples
Buerkle & Rodgers	Yale Marital Interaction Battery	1959	.90 Reproducibility	Concurrent	40	186 adjusted couples 36 unadjusted couples
Burgess & Cottrell	Burgess-Cottrell Marital Adjustment Form	1939	NR	Content, Concurrent, Predictive	130	526 couples
Hamilton	Marital Adjustment Test	1929	NR	Concurrent, Construct	13	104 couples
Inselberg	Marital Satisfaction Sentence Completion	1961	NR	Concurrent	13	29 wives 80 couples
Katz	Semantic Differential as Applied to Marital Adjustment	1965	NR	Content, Construct	20	40 couples
Locke	Marital Adjustment Test	1951	NR	Concurrent	29	201 divorced couples 200 happy couples 127 others
Locke & Williamson	Marital Adjustment Test	1958	NR	Concurrent	20	171 males 178 females
Locke & Wallace	Short Marital Adjustment Test	1959	.90 Split half	Content, Concurrent	15	118 males 118 females
Manson & Ferner	Marriage Adjustment Inventory	1962	NR	Construct	157	120 males 117 females
Manson & Ferner	Marriage Adjustment Sentence Completion Survey	1962	NR	Content	100	120 males 117 females
Most	Rating of Marital Satisfaction and Friction	1960	NR	Concurrent, Construct	65	40 females
Nye & MacDougall	Nye-MacDougall Marital Adjustment Scale	1959	.86-.97 Reproducibility	None	9	1300 females
Orden & Bradburn	Dimensions of Marriage Happiness	1968	NR	Content, Construct	18	781 males 957 females
Terman	Marital Happiness Index	1938	.60 B-W Correlation	Concurrent	90	792 couples

\*Adapted from Straus (1969) and original sources. This summary does not include related measures of variables such as marital integration (Farber, 1957), marital strain (Kurvitz, 1965), or marital communication (Navran, 1967); some scales based on modification of earlier scales (Burgess and Wallin, 1953; Karlsson, 1951); indirect measures (Kirkpatrick, 1937); single-item measures (Rollins and Feldman, 1970); or multiple-item measures not intended for use as scales (Burt, 1970).

[NR = Not Reported]

[†]Not all questions in this scale were considered measures of marital adjustment

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1970's and judged to be indicators of marital adjustment or a closely related concept, as defined by Spanier and Cole (1974). This preliminary screening of items was necessary to avoid presenting the respondent with too lengthy a questionnaire.

4. Approximately 200 remaining items were included in a questionnaire with a standard complement of social background variables. Among the questionnaire's 200 items were several new items which were developed to tap areas of adjustment which I thought had been ignored in previous measures. In addition, sets of items and scales previously used were expanded in order to make them more complete. Finally, to test the hypothesis that alternative wording in a fixed-choice dyadic adjustment scale might produce different results and unpredictable response sets, approximately 25 items were included with alternative wording in the question and in the fixed choice response categories.

5. The questionnaire was administered to a purposive sample of 218 married persons in central Pennsylvania. The sample consisted primarily of working and middle class residents of the area who worked for one of four industrial or corporate firms which agreed to cooperate in the study.

6. Questionnaires were mailed to every person in Centre County, Pennsylvania, who had obtained a divorce decree during the 12 months previous to the mailing. These respondents were asked to respond to the relationship questions on the basis of the last month they spent with their spouses. Ninety-four usable questionnaires were obtained from approximately 400 persons whom we were able to locate.

7. A small sample of never-married cohabiting couples was given the questionnaire to determine potential problems in question-wording and applicability of the scale for nonmarital dyads. These data are not part of the scale construction analysis.

8. Frequency distributions were analyzed

<sup>1</sup>Although the Dyadic Adjustment Scale was designed for use with unmarried dyads and pretested for validity, appropriateness and relevance, only married couples were used to assess reliability. Future research has been planned (Lewis and Spanier, 1975) which will assess the reliability of the scale for unmarried dyads and which will allow us to compare married and unmarried couples.

and all items with low variance and high skewness were eliminated.

9. Questions with alternative wording, structure, and category choices were further examined. Where differences in response variation were significant, items with the lesser variation were excluded.

10. Remaining variables were analyzed using a *t*-test for significance of difference between means of the married and divorced samples. Items which were not significantly different at the .001 level were eliminated. Fifty-two variables remained following application of this stringent criterion.

11. Remaining questions with alternative wording were reexamined and items with the lowest *t*-value were excluded. Forty items remained at this point.

12. The remaining 40 variables were factor analyzed to assess the adequacy of our definition, determine the presence of hypothesized components, and make a final determination of items which were to be included in the scale. Thirty-two items remained after eight were eliminated due to low factor loadings (below .30).

13. The issue of variable weighting was considered. After empirical comparisons were considered, using alternative weighting procedures and consideration of the scaling literature, a decision was made against weighting.

### SAMPLING AND SOCIAL CHARACTERISTICS OF SAMPLE

A nonprobability purposive sampling technique was used to locate respondents for this study. It was not the study's objective to generalize findings to a larger population, but rather to obtain samples of married and divorced persons who would complete a lengthy self-administered questionnaire in order to allow us to do a comprehensive item analysis and scale assessment. Therefore, probability sampling techniques were not considered necessary.

Two hundred and eighteen white, married persons were located through the cooperation of four cooperations in Centre County, Pennsylvania. We wanted to avoid the university community and any special problems with response sets which might exist in a population of sophisticated test-takers. However, limited funds necessitated that we remain within 30 miles of the

university. Consequently, the strategy described was utilized for locating the married sample. Respondents were promised and subsequently given a summary of the findings, and employers were promised and given a similar, but more complete, summary of the study.

The divorced sample was obtained through questionnaires which were mailed to all persons in Centre County, Pennsylvania, whose final decree had been granted during the 12 months previous to the mailing of the questionnaire. These respondents, located through county divorce records, were asked to respond to each item in the context of the last month they spent with their former spouse. Four hundred of the five hundred and fifty persons were located using the addresses available in the courthouse records. Ninety-four completed questionnaires were obtained through this process.<sup>6</sup> Selected social characteristics of the sample are summarized in Table 2.

TABLE 2. SELECTED SOCIAL CHARACTERISTICS OF MARRIED AND DIVORCED RESPONDENTS

Characteristic	Married Sample	Divorced Sample
Number of males	109	41
Number of females	109	49
Number married only once	206	74
Number married more than once	12	20
Mean age	35.1	30.4
Median months engaged	7	4
Mean number of years married	13.2	8.5
Percent Catholic	12.4	14.4
Percent Methodist	38.7	26.7
Percent Lutheran	11.5	13.3
Percent Presbyterian	7.4	11.1
Percent Other Protestant	25.1	23.3
Percent Jewish	None	1.1
Percent Atheist, Agnostic, None	5.1	10.0
Percent interfaith marriages	10.7	4.7
Median frequency of church attendance	Once a month	Occasionally
Median yearly family income	\$12,000.00	\$10,000.00
Mean years education	13	14
Median family life-cycle stage (Duvall, 1967)	4	3
Mean number of children	2.0	1.6

### FACTOR ANALYSIS: TESTING THE ADEQUACY OF THE DEFINITION

Following the selection of the best 40 potential items for the scale, a factor analysis was performed with the following objectives: (1) To test the adequacy of the proposed definition of dyadic adjustment. Our interest was in confirming whether or not the hypothesized components of adjustment could be empirically verified; (2) To determine which items should be included in the final adjustment scale; whether each item loaded highly on the appropriate factor, and whether items could be eliminated without influencing the validity or reliability of the scale; (3) To facilitate understanding of how each of the items included in the scale relates to each other, the subscales, and the total scale.

The factor analysis program available in SPSS was used for this study.<sup>7</sup> Since the hypothesized factors were thought to be interrelated and not orthogonal, oblique rotation was specified.<sup>8</sup> Using the criteria specified in the previous section, all of the items included in the questionnaire which were designed to assess interpersonal tensions and personal anxiety had been discarded.<sup>9</sup> Thus, the 40 items included in the factor analysis tested the adequacy of four of the original five dimensions (dyadic satisfaction, dyadic cohesion, dyadic consensus, and troublesome dyadic differences).

<sup>6</sup>This low response rate appears to be normative for survey samples of recently divorced individuals. See, for example, Scanlon (1968:455) and Dean and Bresnahan (1969).

<sup>7</sup>The factor analysis program available in SPSS (Nie, Bent, and Hull, 1970) was used and the following program options were in effect: oblique rotation, principal factoring with iteration, maximum number of factors specified = 5, minimum eigenvalue = 1.0, maximum number of iterations = 25, delta value for oblique rotation = zero.

<sup>8</sup>Indeed, the average intercorrelation between the four empirically derived subscales was subsequently found to be .58.

<sup>9</sup>This finding should not be interpreted to mean that interpersonal tensions and personal anxiety are unimportant to dyadic functioning, but rather that it is not a clearly identified component of dyadic adjustment, as conceptualized and operationalized in this study. I should like to hypothesize for future research that this dimension is an important, but conceptually separate, dimension of dyadic functioning.

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TABLE 3. SCALE COMMUNALITY, SUBSCALE AFFILIATION, AND SUBSCALE FACTOR LOADINGS OF DYADIC ADJUSTMENT SCALE ITEMS

Variable Number	Communi- nality	Subscale	Factor Loadings			
			Dyadic Consensus Factor	Dyadic Satisfaction Factor	Dyadic Cohesion Factor	Affectional Expression Factor
1	.62	Dyadic Consensus	.54	-.15	.10	-.02
2	.63	Dyadic Consensus	.72	.12	.14	-.01
3	.31	Dyadic Consensus	.57	.09	.05	.02
4	.75	Affectional Expression	.35	-.10	.12	-.57
5	.56	Dyadic Consensus	.64	-.00	.03	-.17
6	.61	Affectional Expression	.21	-.07	.11	-.56
7	.60	Dyadic Consensus	.58	-.21	.04	-.06
8	.61	Dyadic Consensus	.73	-.15	-.06	-.05
9	.33	Dyadic Consensus	.46	-.16	-.11	-.09
10	.72	Dyadic Consensus	.59	-.20	.05	-.06
11	.68	Dyadic Consensus	.34	-.22	.21	-.24
12	.56	Dyadic Consensus	.59	-.22	.13	.04
13	.34	Dyadic Consensus	.51	-.02	.00	-.11
14	.47	Dyadic Consensus	.52	-.15	.16	-.06
15	.31	Dyadic Consensus	.40	-.16	-.08	-.13
16	.71	Dyadic Satisfaction	-.03	-.70	.01	-.20
17	.53	Dyadic Satisfaction	.01	-.54	.12	-.09
18	.85	Dyadic Satisfaction	.03	-.67	.23	-.17
19	.62	Dyadic Satisfaction	.10	-.48	.27	-.03
20	.69	Dyadic Satisfaction	.01	-.82	-.01	.02
21	.66	Dyadic Satisfaction	.07	-.65	.13	-.02
22	.67	Dyadic Satisfaction	.07	-.61	.19	-.01
23	.44	Dyadic Satisfaction	.14	-.32	.28	.09
24	.47	Dyadic Cohesion	.20	-.11	.50	.07
25	.48	Dyadic Cohesion	-.09	.01	.71	-.05
26	.68	Dyadic Cohesion	.16	-.09	.65	-.07
27	.66	Dyadic Cohesion	.17	-.04	.68	-.04
28	.51	Dyadic Cohesion	-.00	.05	.65	-.02
29	.24	Affectional Expression	-.04	.06	-.02	-.48
30	.54	Affectional Expression	.04	-.19	.12	-.55
31	.76	Dyadic Satisfaction	.07	-.53	.24	-.16
32	.57	Dyadic Satisfaction	.27	-.62	-.07	.06

The analysis indicated that one of the hypothesized factors, troublesome dyadic differences, could not be empirically verified and these items were accordingly eliminated.<sup>10</sup> However, four items which were thought to be indicators of dyadic satisfaction or dyadic consensus were combined and verified as a separate factor, which I have called affectional expression.

Table 3 lists the item communality with the total scale, the subscale affiliation of each item, and the loading for each item on each subscale factor. The items are numbered

<sup>10</sup>Conceptually, troublesome dyadic (marital) differences may be indistinguishable from consensus on matters of importance to dyadic functioning. The attempt to define two groups of items which separate these concepts may be premature from a conceptual standpoint. Nevertheless, items were retained in the scale only if they had a factor loading above .30. The troublesome dyadic differences questions did not emerge as a clearly identified factor, and had lower than acceptable factor loadings on any other factor.

according to their position in the scale, as presented in the appendix.

Table 3 indicates that 32 items remained in the total Dyadic Adjustment Scale following the elimination of the eight items suggested as inappropriate by the factor analysis. Three of the original five hypothesized components were found to exist (dyadic satisfaction, dyadic consensus, and dyadic cohesion). In all cases, except the four affectional-expression items, the items hypothesized as indicators of each factor were confirmed to have their highest loading (in all cases above .30) with that factor.<sup>11</sup>

<sup>11</sup>It can be noted that an earlier factor analytic study by Locke and Williamson (1958) identified four factors similar to those found in the present study (companionship, agreement, affectional intimacy, and euphoria). However, Locke and Williamson's interpretation of the factors and the items which loaded highly on each factor are at variance with the findings in the current study, even though many of the items are identical or similar. This differential finding may be due to differences in

The factor analysis allows us to conclude that 32 items give a more or less composite indication of dyadic adjustment. These 32 items can be grouped into four meaningful components (dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression) which are conceptually and empirically related to dyadic adjustment.

#### SCALE DESCRIPTION

The Dyadic Adjustment Scale is designed to serve a number of different needs. First, for those wishing to use an overall measure of dyadic adjustment, the 32-item scale can be completed in just a few minutes, is only two pages in length, can easily be incorporated into a self-administered questionnaire, and can be adapted for use in interview studies.

The scale is additionally useful since it allows researchers with more limited needs to use one of the subscales alone without losing confidence in the reliability or validity of the measure. For example, researchers interested specifically in dyadic satisfaction may use the 10-item subscale for this purpose. The format of the scale allows for easy coding or scoring. We have not been able to deal adequately with the problems of direction-of-wording and halo effects, but we have attempted to structure the scale in a way that encourages the respondent to think about each of the items being presented.

The scale has a theoretical range of 0-151. The source of the items included in the scale varies considerably. Some will be found in previous scales, others are modifications of items used previously, and others were developed specifically for the present study.<sup>12</sup>

procedures or may indicate a shift in the nature of marital adjustment during the 20 years since the data for the first study were collected. A fifth factor found in the earlier study, masculine interpretation-wife accommodation, did not emerge in the present study. It must be stated, however, that the factors found by Locke and Williamson are lacking in conceptual clarity, since a cursory examination suggests that some of the items associated with the factors appear to be conceptually unrelated.

<sup>12</sup>Some questions included in the final scale were not originally intended as measures of adjustment, but met the criteria for inclusion in our study. For example, items 25-28 are from a marital stress scale developed by Feldman (1965). The final item on the scale, part of the dyadic adjustment component, was developed originally as a measure of commitment (Spanier, 1971). A later study (Dean and Spanier, 1974) suggests that commitment was an overlooked variable in marital adjustment

We cannot claim to have adequately dealt with the problems of conventionality and social desirability as measurement issues (Edmonds, Withers and Dibatista, 1972; Spanier and Cole, 1974) but recent research and critiques (Dean and Lucas, 1974; Clayton, 1975) suggest that these limitations may have been overstated. We have attempted to minimize these and other traditional methodological problems throughout. However, researchers concerned about these issues who still wish to measure adjustment could use the approaches of Murstein and Beck (1972) or Dean and Lucas (1974), who measured potentially confounding influences and then controlled for them in their final analyses. It should be noted, however, that neither set of findings was significantly altered by controls for conventionality or social desirability.

Previous work has explored the problem of unit of analysis in marital adjustment scales (Spanier, 1972, 1973; Spanier and Cole, 1974). The problem of clarifying whether the present scale can be considered a measure of individual adjustment to the relationship versus adjustment of the dyad as a functioning group has not been solved. Some scale items (notably item 32) assess the individual's adjustment to the relationship. Most of the items, however, attempt to assess the respondent's perception of the adjustment of the relationship as a functioning group. Since this latter type of item predominates, the researcher could assume that partner differences in responding to the scale items largely reflect differing perceptions of the relationship's functioning.

#### VALIDITY

*Content Validity.*<sup>13</sup> Items included in the Dyadic Adjustment Scale were evaluated by three judges for content validity. Items were included only if the judges considered the items: (1) relevant measures of dyadic adjustment for contemporary relationships; (2) consistent with the nominal definitions

and an argument was made for its inclusion in future measures of the concept. The importance of this concept as a component of adjustment was confirmed in the present study.

<sup>13</sup>Content validity involves the systematic examination of the test content to determine whether it covers a representative sample of the behaviors, attitudes, or characteristics to be measured.

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TABLE 4. SUMMARY SCORES AND STANDARD DEVIATIONS FOR THE DYADIC ADJUSTMENT SCALE AND ITS SUBSCALES, BY MARITAL STATUS

	Married		Divorced		Total	
	Mean	SD	Mean	SD	Mean	SD
Dyadic Consensus Subscale	57.9	8.5	41.1	11.1	52.8	12.1
Dyadic Satisfaction Subscale	40.5	7.2	22.2	10.3	35.0	11.8
Dyadic Cohesion Subscale	13.4	4.2	8.0	4.9	11.8	5.1
Affectional Expression Subscale	9.0	2.3	5.1	2.8	7.8	3.0
DYADIC ADJUSTMENT SCALE	114.8	17.8	70.7	23.8	101.5	28.3
	N = 218		N = 94		N = 312	

suggested by Spanier and Cole (1974) for adjustment and its components (satisfaction, cohesion, and consensus); and (3) carefully worded with appropriate fixed choice responses.

*Criterion-related Validity.*<sup>14</sup> The scale was administered to a married sample of 218 persons and a divorced sample of 94 persons. Each of the 32 items in the scale correlated significantly with the external criterion of marital status. In other words, for each item, the divorced sample differed significantly from the married sample ( $p < .001$ ) using a *t*-test for assessing differences between sample means. In addition, the mean total scale scores for the married and divorced samples were 114.8 and 70.7 respectively. These total scores are significantly different at the .001 level. Table 4 presents the summary scores for the Dyadic Adjustment Scale and each of its subscale.

*Construct Validity.*<sup>15</sup> Since all items with content validity used in previous marital adjustment scales were included in the research instrument originally tested, it is possible to assess how the Dyadic Adjustment Scale correlated with other, previously-used marital adjustment scales. We selected the Locke-Wallace Marital Adjustment Scale (1959—the most frequently used scale) for assessing whether the Dyadic Adjustment Scale measures the same general construct as a well-accepted marital adjustment scale. The correlation between these scales was .86

<sup>14</sup>Criterion-related validity indicates the effectiveness of a test in predicting an individual's behavior, attitudes, or characteristics in specified situations (predictive validity) or diagnosing or assessing an existing status (concurrent validity). The present scale has been demonstrated to have concurrent validity.

<sup>15</sup>Construct validity refers to the extent to which a test measures a theoretical construct or trait.

among married respondents and .88 among divorced respondents ( $p < .001$ ).<sup>16</sup>

Construct validity was further established through the factor analysis of the final 32-item scale. As previously noted, four interrelated components (dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression), three of which were hypothesized as components of adjustment, were found to exist. Thus, the Dyadic Adjustment Scale partially appears to measure the theoretical construct defined earlier (Spanier and Cole, 1974).

#### RELIABILITY

Because of this study's interest in producing a comprehensive dyadic adjustment scale, with identifiable and empirically verified components, reliability was determined for each of the component scales as well as the total scale. The most appropriate measure of internal consistency reliability is Cronbach's Coefficient Alpha (1951), a conservative estimate of internal consistency which is a variant of the basic Kuder-Richardson (1937) formula (Anastasi, 1968). Table 5 summarizes the reliability coefficients

<sup>16</sup>The correlation for the total sample ( $N = 312$ ) was .93 ( $p < .001$ ). The high correlation between the Dyadic Adjustment Scale and the Locke-Wallace Marital Adjustment Scale suggests the possibility that the scales are redundant. It can be argued that an established scale with a large normative data base is preferable, all other things being equal, to a newer scale tested on a limited population. The high correlation was expected, however, since many of the items are similar, if not identical, and since the basic procedures for scale development were also similar. Nevertheless, I shall argue that the advantages of the present scale (namely, its appropriateness for use with unmarried dyads; the availability of subscales with separate reliability estimates; an evaluation of validity using a contemporary sample; and the consideration of a number of methodological and conceptual issues not previously included in reports of marital or dyadic adjustment scale development) speak favorably for its use in future research requiring a paper and pencil measurement assessing dyadic adjustment.

TABLE 5. RELIABILITY ESTIMATES FOR THE DYADIC ADJUSTMENT SCALE AND ITS COMPONENT SUBSCALES\*

Scale	Reliability	Number of Items
Dyadic Consensus Subscale	.90	13
Dyadic Satisfaction Subscale	.94	10
Dyadic Cohesion Subscale	.86	5
Affectional Expression Subscale	.73	4
DYADIC ADJUSTMENT SCALE	.96	32

\*Cronbach's coefficient alpha is used as the reliability estimate.

for the total scale and its components. The total scale reliability is .96.<sup>17</sup> The data indicate that the total scale and its components have sufficiently high reliability to justify their use.

#### THE WEIGHTING ISSUE

In an earlier discussion of the weighting issue (Spanier and Cole, 1974), it was suggested that paper and pencil adjustment scales have the disadvantage of having to define, *a priori*, which variables are important for assessing the quality of a relationship. We suggested that only in the event that empirical research should confirm that couples nearly universally define the same areas as important in their relationships, would it be acceptable to use fixed lists of items from one couple to the next. We also pointed out, however, that previous research in other areas has found attempts at weighting items troublesome. This study has examined the problems associated with weighting items by including a set of items in the questionnaire which asked the respondent to: (1) indicate the importance of each of the items on a traditional list of problem areas (on a dimension of very important, somewhat important or not at all important); and (2) indicate the approximate extent of agreement or disagreement between the respondent and his or her partner.

The purpose of this dual approach was to assess whether items should be weighted on the agreement-disagreement continuum according to their importance to the person. It can be argued, for example, that it is of lesser

<sup>17</sup>A separate assessment of scale reliability using the Spearman-Brown average inter-item formula for internal consistency (Guilford, 1954: 354, 359) was also found to be .96.

consequence to the relationship if the couple disagrees on a matter of no importance than if they disagree on an item of great importance.

Our data demonstrate quite clearly that individuals are able to answer two-part questions of this nature without difficulty, and they are able to make a clear judgment about the importance of the item. However, we found that on the areas surveyed by the 32 items in the scale, the importance variable is skewed in the direction of "very important." The only items on which a nontrivial proportion of the respondents indicated that the item was not at all important were religious matters (28.7 percent) and ways of dealing with in-laws or parents (20.6 percent).

The correlation between weighted and unweighted adjustment scores was .53 among married persons, .48 among divorced persons, and .63 for the total sample. The analysis indicated, therefore, that correlations between weighted and unweighted adjustment scores, although significant at the .001 level, are sufficiently different from 1.0 to merit consideration of weighting. However, primarily because of the skewness toward "very important" in rating areas of dyadic adjustment and the moderately high correlation between the weighted and unweighted scores in the present sample, a decision was made not to use weighted scores. Although theoretically and methodologically relevant, weighting does not appear to enhance our ability to assess adjustment to a degree which would indicate that weighting items according to importance is worth the additional effort. Consequently, the evidence for the use of weighted items was not compelling in the present study.

An extensive literature has developed concerning the desirability of another form of weighting, namely, weighting items according to factor loadings obtained through factor analysis or beta weights obtained through multiple regression analysis (e.g., Allen, 1973; Smith, 1974; Werts and Linn, 1970; Lawler and Porter, 1967, 1973; Nathanson and Becker, 1973). The Locke-Wallace Marital Adjustment Scale (1959), among others, contains differential weights for each of the 15 items. Locke and Wallace did not explain how they decided on the weights for their items, but researchers have continued to

use the scheme.

In a weighted scale scores, reported carefully against empirical samples the inter-rational basis. Scale continues the non-coding.

SUMM

The develop confide and set to the develop need to which marital. An attempt the develop. This study cannot method the fact that the scales the des

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use the scale without questioning the coding scheme.

In a further similar analysis, items were weighted by factor loadings and the total scale scores correlated with unweighted scale scores. The correlations were similar to those reported for weighting by importance. After carefully examining the arguments for and against weighting according to norms empirically derived from one or more samples, we have decided against weighting the items. Although there is a theoretical rationale, but not a convincing empirical basis, for weighting, the Dyadic Adjustment Scale is coded according to interval continuums ranging from zero to one less than the number of fixed choices. The suggested coding scheme is indicated in the appendix.

#### SUMMARY AND RECOMMENDATIONS FOR THE FUTURE

The primary objective of this study was to develop a scale which could be used with confidence to assess the quality of marriage and similar dyads. This paper has attempted to thoroughly present the results of a scale development process designed to meet the need for relevant, valid and reliable measures which can be used in survey research on marital and nonmarital dyadic relationships. An earlier paper (Spanier and Cole, 1974) attempted to present an exhaustive review of the problems with and prospects for developing a measure of dyadic adjustment. This study and the scales which have resulted cannot claim to have solved all of the methodological problems which have plagued the field for some time. I believe, however, that the process used in this study and the scales which have resulted represent a step in the desired direction.

Methodological problems inherent in the use of paper and pencil measures can only be minimized, never eliminated. Indeed, it would be desirable to supplement the present study with one which would develop measures for use in laboratory or observational research. The multitrait-multimethod approach (Campbell and Fiske, 1959) would, of course, give us greater confidence in our methods. Future studies should consider the problems of conventionality, social desirability, unit of analysis, and husband-wife or partner differences in perceptions. Finally, research similar to that presented in this

article might profitably start from a larger pool of items. These should reflect a broader conception of marital functioning, including the concept of marital adjustment but also dimensions of marital quality, such as adaptability, communication, interpersonal tensions, or conflict. Such a reconceptualization could be combined with the use of unidimensional and multidimensional scaling techniques to provide carefully validated, reliable and relevant marriage and family measurement instruments.

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APPENDIX

DYADIC ADJUSTMENT SCALE

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionality (correct or proper behavior)	5	4	3	2	1	0
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents or in laws	5	4	3	2	1	0
10. Aims, goals, and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0
14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0
	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married? (or lived together)	0	1	2	3	4	5
21. How often do 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	Occasionally	Rarely	Never
23. Do you kiss your mate?	4	3	2	1	0
	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	4	3	2	1	0

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

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

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

	Yes	No	
29.	0	1	Being too tired for sex.
30.	0	1	Not showing love.

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

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

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

- 5 I want 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.

DYADIC ADJUSTMENT SCALE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionality (correct or proper behaviour)	5	4	3	2	1	0
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents or in-laws	5	4	3	2	1	0
10. Aims, goals and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0
14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occa- sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married? (or lived together)	0	1	2	3	4	5
21. How often do you and your partner quarrel?	0	1	2	3	4	5
22. How often do you and your mate "get on each other's nerves?"	0	1	2	3	4	5
	Every Day	Almost Every Day	Occa- sionally	Rarely	Never	
23. Do you kiss your mate?	4	3	2	1	0	
	All of them	Most of them	Some of them	Very few of them	None of them	
24. Do you and your mate engage in outside interests together?	4	3	2	1	0	

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

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

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

- |     | Yes      | No       |                          |
|-----|----------|----------|--------------------------|
| 29. | <u>0</u> | <u>1</u> | Being too tired for sex. |
| 30. | <u>0</u> | <u>1</u> | Not showing love.        |

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point "happy" represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6
<u>Extremely Unhappy</u>	<u>Fairly Unhappy</u>	<u>A little Unhappy</u>	Happy	Very Happy	Extremely Happy	Perfect

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

- 5 I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
- 4 I want very much for my relationship to succeed, and will do all I can to see that it does.
- 3 I want very much for my relationship to succeed, and will do my fair share to see that it does.
- 2 It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
- 1 It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
- 0 My relationship can never succeed, and there is no more than I can do to keep the relationship going.



APPENDIX H

## Attitude change during behavioural treatment of sexual inadequacy

Antonia Whitehead and Andrew Mathews

Attitudes towards 'self' and 'partner' were studied in couples undergoing three different behavioural treatments for sexual inadequacy: systematic desensitization with counselling; guided practice with counselling; and practice with minimal counselling. Factor analysis of semantic differential scales identified five components - general evaluation, anxiety, and three factors relevant to sexual evaluation designated as 'loving', 'sexually attractive' and 'easy to arouse'. Differences in derived factor scores were found which related to sex of rater, identity of complainant, and treatment received; with the treatment combining guided practice with counselling being followed by significantly greater attitude changes.

Successful treatment of sexual difficulties is likely to involve changes in both behaviour and attitudes. Mathews *et al.* (1976) recently reported a comparative trial of three forms of behavioural therapy for sexual inadequacy. All the therapeutic programmes involved the full participation of both members of the dysfunctional couple over a three-month period. They differed in that one was based on the desensitization paradigm, with training and counselling focusing on the reduction of anxiety; the second used a modification of the approach developed by Masters & Johnson (1970), with treatment aimed at the growth of pleasurable sexual responding; while the third was similar to the second except that the counselling element was eliminated as far as was possible, by using mailed instruction sheets. In terms of assessments of changes in behaviour and satisfaction, the results of the trial were equivocal, but there were consistent trends for the fuller Masters & Johnson approach consisting of both guided practice and counselling to produce greater beneficial effects than either desensitization plus counselling or the Masters & Johnson based treatment not involving counselling.

In an attempt to assess the attitudes of the members of each couple both to themselves and to their partner, semantic differential scales (Osgood, Suci & Tannenbaum, 1957) were used as an additional outcome measure before and after treatment, and at follow-up. Marks (1965) has discussed the usefulness of the semantic differential technique in the evaluation of attitudes in psychiatric patients; and in a later paper (Marks & Sartorius, 1968) this was extended to the assessment of sexual attitudes. Following a factor analysis, the authors suggested the use of three scales described as general evaluation, sexual evaluation, and anxiety, corresponding to the three oblique factors extracted.

The first purpose of the present study was to further investigate the utility of the semantic differential in assessing sexual attitudes and to see whether the factor structure reported previously could be confirmed with a population of couples complaining of sexual difficulties. The second part of the study was concerned with the changes in sexual attitudes occurring during treatment for sexual inadequacy. Any treatment that was successful in changing sexual behaviour might also be expected to change sexual attitudes, by observation of behaviour change in oneself (Bem, 1967) or in one's partner. In addition to this, two of the present treatments included a specific counselling component, the main purpose of which was to modify attitudes thought to be obstructing behavioural progress. As a result, it was possible that these two treatments would be associated with a greater change in attitudes, whether or not accompanied by greater behavioural change. Finally, since the emphasis of these two treatments was to some extent different (i.e. pleasure enhancement vs. anxiety reduction), it was possible that there might be some qualitative differences between them in attitude changes.

## Method

### *The scales*

The semantic differential forms contained a total of 15 bipolar adjective pairs, nine derived from Marks & Sartorius (1968) to sample each of their three factors, and a further six pairs chosen to increase the description of affectionate and sexual attributes. Pairs were presented so as to avoid juxtaposition of items of similar meaning and the position of the positive end of the scale was varied. The pairs used in the order presented are shown in the first column of Table 1. On each occasion of testing, the subject completed four sets of scales - the items to be described were 'myself as I am', 'myself as I would like to be', 'my partner' and 'my ideal partner'.

### *The subjects*

These are described fully by Mathews *et al.* (1976). Briefly, they were 36 couples treated for sexual difficulties. In half, the problem was judged more severe in the male partner (usually impotence) and in the other half in the female partner (usually low sexual interest). That partner within each couple who was judged as having the more severe difficulty will be referred to as the 'main complainant'.

### *Procedure*

The semantic differentials were completed on three occasions - four weeks before treatment (PRE), four weeks after completion of active treatment (POST) and twelve weeks later (F.U.). Partners filled out their sheets in separate rooms.

## Analysis and results

### *1. The factorial composition of the scales*

It was first necessary to establish whether similar factors emerged from analyses of data obtained under different circumstances. Thus, for each sex and for each occasion of testing, the scales describing 'myself' and 'my partner' were subjected to separate factor analyses, giving a total of 12 such analyses (the data from the 'ideal self' and 'ideal partner' were not thought adequately distributed to allow for these to be included). Factors with an eigenvalue of at least one accounted, on average, for 76 per cent of the variance. These were then subjected to varimax rotations and the resulting solutions compared. This was done by cross-correlating factor loadings from different analyses; factors from the various analyses were then considered to be equivalent provided that (a) the loadings on each factor within a group of supposedly equivalent factors had significant correlations with those of at least half the other factors in the group and (b) the group contained factors from at least half the analyses. In this way, all but four of the rotated factors could be accounted for and five 'replicable factors' were established, of which the first two occurred on all 12 analyses. The mean factor loadings are shown in Table 1. It will be seen that there are factors corresponding to Marks & Sartorius' general evaluation (factor IV) and anxiety (factor II) but that sexual evaluation is represented by three factors; inspection of the loadings suggests that these might be designated 'loving' (factor I), 'sexually attractive' (factor III) and 'easy to arouse' (factor V).

Thus it seems meaningful to evaluate sexual attitudes in terms of these five stable factors and, for the following analyses, simple factor scores were derived by averaging the scores from those adjectives with factor loadings in excess of 0.6. The five factors were thus defined as follows:

LOVING - loving, warm, affectionate

ANXIOUS - anxious, jittery

SEXUALLY ATTRACTIVE - sexually attractive, seductive

GOOD - good, kind

EASY TO AROUSE - easy to arouse sexually, erotic

Equivalent factor scores were derived for the 'ideal' elements since, although it was possible that the factor structure would be different, the derived 'ideal' factor scores thus became directly comparable with the 'self' and 'partner' scores, while at the same time improving their distribution compared with that of the raw scores.

**Table 1.** Average loadings of adjectives on the five factors extracted (loadings  $< \pm 0.3$  and decimal points omitted)

Items	I	II	III	IV	V
Pleasant-unpleasant*	45	—	—	45	—
Anxious-calm (R)*	—	80	—	—	—
Sexy-sexless*	39	—	58	—	48
Loving-unloving	80	—	—	—	—
Sexually satisfied-sexually frustrated (R)	—	—	—	—	—
Good-bad (R)*	—	—	—	78	—
Jittery-placid*	—	81	—	—	—
Seductive-repulsive(R)*	—	—	71	—	—
Warm-cold*	68	—	—	—	—
Sexually attractive-unattractive	—	—	76	30	—
Kind-cruel (R)*	32	—	—	68	—
Erotic-frigid*	43	—	36	—	61
Affectionate-unaffectionate	79	—	—	—	—
Uninhibited-inhibited (R)	—	—	—	—	46
Easy to arouse sexually-hard to arouse	36	—	—	—	75
Number of analyses in which factor occurred	12	12	10	9	8
Mean % total variance when factor occurred	35	9	16	13	11

\* Derived from Marks & Sartorius.  
(R) these pairs reversed for presentation.

## 2. Analysis of factor scores

(a) *Effects due to sex and identity of main complainant.* Pre-treatment scores were subjected to analysis of variance with two factors - sex of the rater and sex of the main complainant within that couple; and the following significant differences were found:

(i) *Myself - anxious:* the women rated themselves as more anxious than the men (4.9 vs. 3.7;  $F = 14.2$ , d.f. = 1, 68,  $P < 0.001$ ).

(ii) *Myself - easy to arouse:* overall, the men rated themselves as more arousable ( $F = 31.7$ , d.f. = 1, 68,  $P < 0.001$ ), but there was an interaction with the sex of the main complainant (male non-complainants 5.9, female non-complainants 4.3, male complainants 4.2, female complainants 2.4;  $F = 38.1$ , d.f. = 1, 68,  $P < 0.001$ ).

(iii) *My partner - sexually attractive:* the men saw their partners as more attractive (5.4 vs. 4.8;  $F = 4.4$ , d.f. = 1, 68,  $P < 0.05$ ).

(iv) *My partner - easy to arouse:* this was the converse of the self-ratings, with the women rating their partners higher ( $F = 19.4$ , d.f. = 1, 68,  $P < 0.001$ ) and there was an equivalent interaction (female complainants 5.8, male complainants 4.4, female non-complainants 4.1, male non-complainants 2.5;  $F = 26.3$ , d.f. = 1, 68,  $P < 0.001$ ).

(v) *Ideal self - loving:* the women's ratings were higher than the men's (6.7 vs. 6.4;  $F = 4.4$ , d.f. = 1, 68,  $P < 0.05$ ).

## (b) Relationship with treatment

(i) *Main effects due to treatment.* The mean factor scores within each treatment are shown in Table 2. Post-treatment and follow-up scores were subjected to analysis of covariance with the pre-treatment score acting as covariate; there were three factors, sex, sex of main complainant and treatment. Where a significant main effect due to treatment was revealed, separate planned comparisons were made between the adjusted POST and F.U. means, comparing practice and

**Table 2.** Mean factor scores according to treatment

	Desensitization and counselling (D/C)			Practice and counselling (P/C)			Practice alone (P)		
	PRE	POST	F.U.	PRE	POST	F.U.	PRE	POST	F.U.
<b>Myself</b>									
Good	5.4	5.2	5.3	5.3	5.6	5.6	5.0	5.3	5.3
Anxious	4.3	4.0	4.1	4.2	3.6	3.7	4.4	4.5*	3.9
Loving	5.5	5.5	5.2	5.3	5.9	5.6	5.1	4.9**	4.8
Sexually attractive	4.1	4.3*	4.2*	4.6	5.1	5.1	4.6	4.5*	4.6
Easy to arouse	4.0	4.0*	4.0	4.3	5.0	4.6	4.3	3.9**	3.9
<b>My partner</b>									
Good	6.2	6.0	5.8	6.2	6.3	6.1	6.0	5.9	6.0
Anxious	3.7	3.7	3.7	3.7	3.4	3.5	4.5	4.3	3.6
Loving	5.8	5.6	5.5	5.8	6.2	6.0	5.4	5.5	5.4
Sexually attractive	5.1	5.0**	5.0	5.0	5.7	5.6	5.1	5.1*	5.3
Easy to arouse	4.3	4.1**	3.8**	4.3	5.2	4.7	4.0	4.6	4.8
<b>Ideal self</b>									
Good	6.3	6.0	5.9	6.1	6.4	6.1	5.9	6.4	6.1
Anxious	2.0	2.1	2.1	1.9	2.1	1.7	1.6	1.8	2.0
Loving	6.5	6.3	6.1	6.7	6.6	6.4	6.6	6.6	6.4
Sexually attractive	5.7	5.7	5.7	6.2	6.1	6.1	6.1	6.0	6.2
Easy to arouse	5.8	5.4	5.3	6.1	6.0	5.8	5.9	6.1*	6.1
<b>Ideal partner</b>									
Good	6.4	6.1	6.0	6.4	6.3	6.1	6.2	6.1	6.1
Anxious	2.2	2.4	2.6	1.8	1.8	1.7	1.8	2.1	2.1
Loving	6.8	6.5	6.3	6.7	6.7	6.6	6.7	6.4	6.6
Sexually attractive	6.3	5.9	5.9	6.4	6.3	6.2	6.3	6.2	6.5
Easy to arouse	6.0	5.8	5.6	6.1	6.1	6.1	6.2	6.1	6.2

\*, \*\* Adjusted mean differs significantly from that for P/C ( $P < 0.05$ , 0.01).

counselling (P/C) with practice alone (P) and with desensitization and counselling (D/C); significant differences between means are indicated in Table 2. It can be seen that the most notable treatment effects are on post-treatment scores for 'myself'; P/C has significantly greater effects than P for four of the five factor scores. For several comparisons, P/C appears to effect a greater change than D/C and for no score is there a trend in the reverse direction. Even for 'anxious', there is a non-significant tendency for P/C to induce greater changes than D/C, despite the fact that anxiety reduction is the main target in desensitization.

Changes in the other scores tend to parallel those for 'myself', but with one notable exception. Ratings of self for 'easy to arouse' in those couples receiving treatment P show a tendency to remain lower than in those receiving P/C (significant at POST) while the direction of this difference is reversed in the case of 'ideal self' (significant at POST). Thus, with treatment P, there appears to be an increasing disparity between the person's evaluation of how sexually responsive he is and how he would like to be.

(ii) *Interactions between treatment, sex and main complainant.* Sex and identity of main complainant did not appear to affect treatment changes; only 2 of 120 interaction effects inspected were significant (and those at only the 0.05 probability level) so that interactions between type of treatment and sex, or sex of main complainant appear unimportant in the present data.

(c) *Relationships with improvement.* Overall improvement was assessed by taking the change from PRE to F.U. in the impairment of the sexual relationship as rated by the blind assessor (see Mathews *et al.* 1976). Couples were dichotomized into those showing greater or lesser improvement. This split was not balanced according to sex of main complainant, so that this effect could not be extracted in the subsequent analyses.

(i) Pre-treatment analysis of variance revealed one significant pre-treatment predictor of improvement. This was 'my partner - sexually attractive' which was rated higher by those who subsequently improved most (see Table 3).

**Table 3.** Factor scores for which significant improvement effects were demonstrable

	More improved			Less improved		
	PRE	POST	F.U.	PRE	POST	F.U.
<b>Myself</b>						
Anxious	4.3	3.7**	3.6**	4.2	4.4	4.3
Loving	5.3	5.7	5.7***	5.3	5.2	4.7
Sexually attractive	4.6	5.0**	5.1***	4.3	4.2	4.1
Easy to arouse	4.3	4.8**	4.7***	4.1	3.8	3.7
<b>My partner</b>						
Anxious	4.1	3.5*	3.4	3.8	4.1	3.8
Loving	6.0	6.1	6.0*	5.5	5.4	5.3
Sexually attractive	5.5**	5.5	5.6	4.6	5.0	5.0
Easy to arouse	4.5	5.2*	5.1***	3.9	4.1	3.8

\*, \*\*, \*\*\* This mean differs significantly from that for the less improved group ( $P < 0.05, 0.01, 0.001$ ).

(ii) *Post and F.U. covariance analysis* revealed a number of significant effects, which are shown together with the appropriate means in Table 3. There were marked differences between those showing greater or lesser degrees of improvement, in the case of scores for 'myself' and to a lesser extent for 'my partner'; but no effect existed for the 'ideal' elements.

(iii) *Interactions with sex.* Once again, there were only two (of 40) interaction effects significant at the 0.05 level of confidence, and thus interactions may be considered unimportant.

(d) *Further analysis of factor 'easy to arouse'.* It has already been noted that at post-treatment, couples receiving treatment P, practice alone, rated themselves as less arousable than those receiving P/C, practice combined with counselling, but rated their ideal as more arousable. This suggests that treatment P might produce an increased discrepancy between how couples saw themselves and how they would like to be. To look at this further, it was decided to extend the analyses to include two elements at a time - firstly 'self' and 'ideal self' and then 'self' and 'partner'. In order to make the ratings of the different items comparable, data for each were converted to standard scores, using the pre-treatment means and standard deviations for that item. Analyses of covariance were again performed on POST and F.U. scores for all three treatments, using the pre-treatment score as covariate.

The focus of interest in this analysis was on the interaction between item rated and treatment. The analyses of 'self' and 'ideal self' revealed significant interactions with treatment ( $P < 0.01$ ) at post-treatment and follow-up, with the means showing a greater divergence between 'self' and 'ideal self' for treatment P than for the other two treatments. Comparisons of 'self' and 'partner' showed the same interaction significant ( $P < 0.01$ ) only at follow-up. Again this was related to an increased discrepancy following treatment P, but a significant ( $P < 0.05$ ) quadruple interaction suggested that this held most strongly for the main complainants.

(e) *Contribution of two therapists.* The analysis of the clinical data (Mathews *et al.* 1976) had revealed no notable overall difference in outcome of couples treated with one or two therapists; but there were trends suggesting that, for treatment P/C, two therapists might be more effective than one. To explore possible attitude changes dependent on therapist numbers, analyses were carried out including the additional factor, number of therapists, with the hope of demonstrating a significant interaction between number of therapists and treatment, and it was expected that this was most likely to occur for 'myself - easy to arouse'. However, no such effect was demonstrable on this factor score. The only comparable finding was of a significant ( $P < 0.05$ ) interaction between sex, treatment and number of therapists on the general evaluative factor for 'myself' at follow-up, that suggested that females receiving practice and counselling fared better with two therapists, while males did better with one. Other significant effects were found but, in the absence of specific predictions, these were difficult to interpret.

### Discussion

Factor analysis of 15 semantic differential scales, including but not limited to those used by Marks & Sartorius (1968), and based on the rating of 36 couples with sexual difficulties, resulted in our being able to both confirm and extend the previously found factor structure. Five factors were found to be relatively stable over different occasions and subject groups, two of which corresponded to those reported previously ('general evaluation', and 'anxiety'), while the third original factor of 'sexual evaluation' has now been subdivided into three - designated 'loving', 'sexually attractive' and 'easy to arouse'. These three factors appear to be psychologically meaningful and conceptually distinct; the first seems to refer to feelings of affection in general, the second refers specifically to sexual attractiveness, while the third presumably relates to perceived sexual responsiveness or arousability. The adjective 'sexy' which loaded highly on the sexual evaluation factor of Marks & Sartorius is ambiguous in this context, and apparently can be used to mean either attractive or arousable, or perhaps both. It remains to be shown whether or not this factor structure would prove stable in different populations (e.g. sexually adjusted couples) or in different cultures. Irrespective of this, with the present population the factor scores were found useful in demonstrating some pre-existing differences in self-concepts within the group. Women rated themselves as more anxious, and would have liked to be more loving, while men rated their partners as more sexually attractive. In rating both self and partner, there was agreement that women were less easy to arouse than men, but also that main complainants were less arousable than non-complainants. Thus, it was on this sexual responsivity dimension that the complainants differed from the non-complainants within couples.

The remaining aims of the present study concerned possible changes in attitude which might occur following different types of behavioural treatment for the sexual difficulty. It became clear in the analysis that attitudes about self and partner changed systematically as a function of behavioural improvement and of type of treatment. When couples were divided into improved and unimproved groups, using independently derived outcome measures, one of the pre-treatment factor scores (my partner - sexually attractive) was predictive of outcome, and following treatment the more improved group were found to have changed in their attitudes both towards themselves (more 'loving', more 'arousable', more 'attractive' and less 'anxious') and towards their partners (seen as more 'loving', more 'arousable' and less 'anxious'). It remains unclear, of course, as to whether any causal relationship exists between the behavioural and attitudinal changes and, if so, in which direction it operates. However, a more detailed consideration of these changes in the different treatments might well provide clues as to the nature of the relationship.

Turning first to the question of the role of counselling in bringing about this attitude change, the clear superiority of practice with counselling (P/C), in contrast to practice with minimal counselling (P), might suggest counselling to be the main agent of attitude change. However the

equivalent superiority of the former treatment (P/C) to imaginal desensitization with counselling (D/C) refutes this, and suggests instead that practice and counselling might interact in some way, and perhaps potentiate each other. The finding that the minimal counselling treatment (P) had the effect of widening the gap between perceived and ideal sexual responsiveness is of considerable significance, since it implies that the practice component can operate for better or worse. This increasing discrepancy may be attributable to the setting of behavioural goals without making provision for problems arising from an initial failure to achieve them. To overcome such failures is likely to require close supervision and guidance, and perhaps it is this guiding function that is provided by regular counselling.

Such an explanation would account for the relative lack of attitude change in treatment D/C, where counselling was prevented from acting in this way. It was particularly striking in this respect that (even though not statistically significant) the trend of the 'anxiety' scores also favoured treatment P/C over D/C, despite the emphasis on reducing anxiety in the desensitization procedure and the associated counselling. This may be taken as further evidence that guided practice is a potent component of the treatments compared, and that the reported attitude changes did not merely reflect expectancy or compliance with perceived therapeutic demand. Although we would suggest that attitude change tended to follow behavioural advance to a greater extent than vice versa, it seems that the two factors tend to be closely intertwined, so that attitude changes provide a convenient and useful measure of outcome. While the earlier comparison between treatments in terms of relationship ratings and sexual behaviour (Mathews *et al.* 1976) provided some tentative evidence of treatment related differences, the attitude measures derived in the present study provided unequivocal evidence favouring guided practice with counselling over the other two behavioural treatments.

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Requests for reprints should be addressed to Antonia Whitehead, Department of Psychology, University of Reading, Whiteknights, Reading, Berkshire. Andrew Mathews is at the University of London.



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.









APPENDIX I

## ERECTION DIFFICULTY QUESTIONNAIRE

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

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

1. During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.  
 Always     Usually     Sometimes     Rarely     Never
2. Even though I admit to myself that I have an erection problem, I tell my partner(s) that "I've had too much to drink," "I guess I'm just tired," or something else so they may not know about my problem.  
 Always     Usually     Sometimes     Rarely     Never
3. If I get a partial or full erection during foreplay, my penis gets soft again when I try to insert my penis into my partner.  
 Always     Usually     Sometimes     Rarely     Never
4. I get (would get) an erection when I see, hug, dance with, or otherwise interact with a dressed, attractive potential partner.  
 Always     Usually     Sometimes     Rarely     Never
5. If I (would) experience erection difficulty, I (would) feel guilty because my partner might be frustrated and sexually unsatisfied.  
 Always     Usually     Sometimes     Rarely     Never
6. I have trouble getting an erection during foreplay with a partner.  
 Always     Usually     Sometimes     Rarely     Never
7. Because of my erection problem I avoid having sex with the same person more than once.  
 Always     Usually     Sometimes     Rarely     Never

Erection Difficulty Questionnaire 2

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

Completely true     Mostly true     Equally true and false     Mostly false     Completely false

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

Always     Usually     Sometimes     Rarely     Never

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

Always     Usually     Sometimes     Rarely     Never

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

Completely true     Mostly true     Equally true and false     Mostly false     Completely false

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

Completely true     Mostly true     Equally true and false     Mostly false     Completely false

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

Completely true     Mostly true     Equally true and false     Mostly false     Completely false

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

Completely true     Mostly true     Equally true and false     Mostly false     Completely false

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

Always     Usually     Sometimes     Rarely     Never

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

Completely true     Mostly true     Equally true and false     Mostly false     Completely false

Erection Difficulty Questionnaire 3

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

Always  Usually  Sometimes  Rarely  Never

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

Always attempt  Usually attempt  Sometimes attempt  Rarely attempt  Never attempt

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

Always  Usually  Sometimes  Rarely  Never

20. I am dissatisfied with my sexual functioning.

Completely true  Mostly true  Equally true and false  Mostly false  Completely false

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

Completely true  Mostly true  Equally true and false  Mostly false  Completely false

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

Completely true  Mostly true  Equally true and false  Mostly false  Completely false

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

Completely true  Mostly true  Equally true and false  Mostly false  Completely false

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

Completely true  Mostly true  Equally true and false  Mostly false  Completely false

APPENDIX J

## GOALS FOR SEX THERAPY

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

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

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

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

- |   |   |   |   |   |   |   |     |  |
|---|---|---|---|---|---|---|-----|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 1.  | Being able to anticipate (think about) having intercourse without fear or anxiety.       |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 2.  | Being able to get an erection by stimulating myself when I am alone.                     |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 3.  | Being able to get an erection during foreplay with a woman while both of us are clothed. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 4.  | Being able to get an erection during foreplay while both of us are nude.                 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 5.  | Being able to regain a erection if I lose it during foreplay.                            |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 6.  | Being able to get an erection sufficient to begin intercourse.                           |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 7.  | Being able to keep an erection during intercourse until I ejaculate.                     |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8.  | Being able to regain an erection if I lose it during intercourse.                        |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 9.  | Being able to engage in intercourse for as long as I like without ejaculating.           |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 10. | Being able to stimulate my partner to orgasm.  |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 11. | Feeling like I am sexually desirable to my partner.                                      |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 12. | Feeling comfortable about my own sexuality.  |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 13. | Being able to enjoy a sexual encounter without having intercourse.                       |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 14. | Being able to anticipate a sexual encounter without feeling I should have intercourse.   |

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### Arousal and Erection Guidelines

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

2. The great majority of potency problems are caused by psychological or relationship factors, not medical or physiological malfunctions. To check out possible medical causes you could consult a urologist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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APPENDIX K

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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Beck Depression Inventory. Although originally conceived as a clinician administered scale, the Beck Depression Inventory (BDI) (Beck, 1972; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is now used almost exclusively as a self-report instrument. Its 21 items consist of a series of ordered statements relating to a particular symptom of depression. The subjects indicate which statements describe their current state. Each statement is scaled from 0 to 3. Items and weights were derived logically. A 13-item short form is also available (Beck & Beck, 1972). The intent of the BDI was to cover the symptomatology of depression comprehensively, but it tends to emphasize cognitive content. Two items are devoted to affect (one of these to irritability), eleven to cognition, two to overt behavior, five to somatic symptoms, and one to interpersonal symptoms. All of the major signs are covered.

While no manual exists, considerable psychometric data on the BDI has accumulated. Some standardization data are available in the original report (Beck et al., 1961), and cut-off scores of 13 for screening and 21 for clinical research have been recommended (Beck & Beamesderfer, 1974). While designed for use in clinical populations, it has frequently

been used in normal populations such as college students with cut-off scores in the 7 to 9 range. The instrument appears to be valid in this range (see Blumberg, Oliver, & McClure, 1978).

The accumulated reliability and validity data on the scale is quite large and beyond the scope of this chapter to fully review. Only representative data will be cited in an attempt to summarize the findings. Beck (1972) reports Kruskal-Wallis item-total correlations of .31 to .68 and a .93 Spearman-Brown corrected split-half reliability. Weckowicz et al. (1967) report a Kuder-Richardson -20 of .78. Test-retest reliabilities of .75 for 23 undergraduates after one month (author's unpublished data), .74 for 31 undergraduates after 3 months (Miller & Seligman, 1973), and .48 for 59 psychiatric patients after 3 weeks (May, Urquhart, & Tarran, 1969) have been obtained.

Correlations reported with other self-report depression scales are generally fairly good. While Beck (1972) asserts that the BDI has excellent discriminant validity, differentiating it from self-report of anxiety, this can be questioned. Moderate to high correlations with anxiety have been reported (see Papazian, unpublished), suggesting considerable method variance. Good correlations have been found with clinician rating scales and with a behavioral observation scale (Williams, Barlow, & Agras, 1972). The BDI is sensitive to clinical change as demonstrated in its frequent use as an outcome measure in drug trials (see McNair, 1974) and behavior therapy outcome studies (see Rehm & Kornblith, 1979).

In summary, the BDI is a relatively short and easily administered instrument with a fairly solid psychometric base. While stressing cognitive symptoms, its structure allows for the possibility of systematic item or "subscale" analyses. It has become a very popular instrument in research and clinical practice.

APPENDIX L

Table 22-1. Organic Con-  
ditions Causing Di-  
minished Libido

<i>Conditions That Typically Lower Libido</i>	<i>Conditions That Sometimes Lower Libido</i>
Addison's disease	Acromegaly
Alcoholism	Amyloidosis
Chronic active hepatitis	Anemia
Chronic renal failure	Brain tumors
Cirrhosis	Cerebrovascular disease
Congestive heart failure	Chronic obstructive pulmonary disease
Cushing's syndrome	Collagen diseases
Drug addiction	Drug ingestion:
Drug ingestion:	Alcohol
Antiandrogens (in men)	Alpha-methyl dopa
Estrogen (in men)	Antihistamines
Feminizing tumors (in men)	Barbiturates
Hemochromatosis	Clofibrate
Hyperprolactinemia (in men)	Clonidine
Hypopituitarism	Diphenylhydantoin
Hypothyroidism	Marihuana
Kallmann's syndrome	Monoamine oxidase inhibitors
Klinefelter's syndrome	Phenothiazines
Male climacteric	Propranolol
Myotonic dystrophy	Reserpine
Parkinson's disease	Spironolactone
Pituitary tumors	Hyperaldosteronism
Tuberculosis	Hyperthyroidism
	Hypoglycemia
	Hypokalemia
	Malabsorption
	Malignancy
	Multiple sclerosis
	Nutritional deficiencies
	Parasitic infestation
	Prostatitis
	Sarcoidosis
	Wegener's granulomatosis

APPENDIX M

# NEUROLOGIC DISEASES CAUSING HYPOSEXUALITY

Method of Joseph A. Kott, M.D.,  
Research Fellow and Resident in Neurosurgery,  
and David G. Kline, M.D., Professor and Head,  
Division of Neurosurgery, Louisiana State  
University Medical Center, New Orleans.

Hyposexuality due to injury or disease of the nervous system can be attributed to two fundamentally different but related concepts—decreased libido and decreased sex response, particularly male impotence. Although patients complain of hyposexuality for a variety of reasons, the physician should determine which are neurologic in nature and suggest the need for proper referral. In addition to patients who present with sexual problems, the physician may treat a number of individuals with previously documented neurologic conditions who have hyposexuality as a more subtle facet of their overall neurologic problem.

1. *Temporal lobe epilepsy.* Global hyposexuality with loss of libido as well as impotence can be a prominent feature in this disorder. The complaint is usually brought to the physician at the marital partner's insistence. The patient has a marked decrease in both libido and genital arousal. Sexual excitation terminating in intromission can occur; however, the frequency of intercourse is drastically reduced. If the onset of the disorder is before puberty, the individual may never experience arousal.

The diagnosis of temporal lobe epilepsy depends on the clinical picture of a typical temporal lobe epileptic attack, including an aura such as *déjà vu*, automatic behavior, and mild convulsive movements with confirmation by abnormal EEG activity. Patients carry out what appears to be integrated, purposeful activity, but when given a specific command it becomes evident that they are out of contact with their surroundings. Convulsive movement usually involving facial musculature and consisting of chewing or lip-smacking gestures are common.

Neurologic consultation is, of course, indi-

cated. The most dramatic results have been obtained with temporal lobectomy, although some patients are very successfully treated by anticonvulsant medication alone. There is usually a rebound hypersexuality occurring after successful treatment which gradually subsides in approximately one year.

2. *Panhypopituitarism (Simmonds' disease).* This pathologic entity is generally caused by a destructive process involving the hypothalamic-pituitary axis. The primary cause of the disease may be neoplastic such as chromophobe adenoma or a craniopharyngioma. Other causes are infarction, intrasellar internal carotid artery aneurysms, chronic inflammation, radiation change, and diabetes. This process may affect either sex, but because of occasional pituitary destruction during pregnancy and particularly during labor, the entity is more common in females than males. Onset is usually in the third or fourth decades of life.

The classical clinical picture includes thin, dry skin, loss of body hair, marked decrease in libido, and severe impotence. Both internal and external genitalia may become atrophic. All organ systems under pituitary control are affected including the ovaries, thyroid, and adrenal cortex and, as a result, signs and symptoms of hypothyroidism, hypoadrenalism, and amenorrhea may occur.

Endocrine as well as neurologic consultation is in order and should be obtained as soon as possible. Hormonal replacement therapy may restore a functional social and sexual existence in nonsurgical cases. Neurosurgical extirpation of mass lesions responsible for this syndrome should be performed early, not only to arrest the ongoing process but to protect other neural

structures such as the visual system. Hormonal replacement is necessary postoperatively.

3. Cushing's disease or syndrome. Cushing's disease is due to a basophilic adenoma involving the pituitary gland, while Cushing's syndrome is caused by hypersecretion of either a hyperplastic adrenal cortex or one affected by neoplastic invasion. Basophilic adenomas are relatively rare neoplasms but are seen far more commonly in females than males. The hyposexual complex seen in males is characterized by testicular atrophy, azoospermia, loss of libido, and severe impotence. Breast enlargement due to pectoral fat deposition and true mammary tissue hyperplasia may occur in the male. Truncal obesity, diminished body hair, or actual hirsutism may be apparent.

In the female, facial skin becomes glossy or may take on a ruddy appearance and acne may develop. Sexual intercourse for the female becomes increasingly uncomfortable because of thinning of the vaginal mucosa as well as diminished genital secretions. These changes plus those of malaise and the general disability associated with these disorders contribute to a progressive and severe decrease in libido. The hypogonadism seen in Cushing's disease is primary in nature and thought to be due to the direct effect of cortisone on the ovaries. Patients suspected of having Cushing's disease or syndrome require endocrine consultation which may lead to neurosurgical consultation.

4. Head injury. There are a number of reported cases of relative loss of potency as well as diminished libido following otherwise complete recovery from head injury. The exact anatomic site of the damage which is presumably responsible for the occasional hyposexuality seen in head injury is unclear. Testosterone and psychotherapy are two potential resources available to such patients.

5. Arteriosclerosis. Both diffuse and localized cerebral arteriosclerosis may result in decreased libido and impotence. Spinal arteriosclerosis can result in impotence by direct interruption of the erector and ejaculation reflex mechanisms. All types of therapy for this disorder seem to have poor results.

6. Myelitis, syringomyelia, spinal tumor, and multiple sclerosis. Patients with one or more of these disorders become impotent due to loss of spinal cord function and interference with the reflex arc. There is usually no decrease in libido although a few scattered reports attribute decreased libido to relatively mild spinal injury or disease. Occasional cases of spina bifida, even of the occult variety, may exhibit impotence. For those patients who have a reasonable life expectancy, urologic and psychological consultation are advised. Some of these

patients should be considered for prosthetic urologic surgery.

7. Tabes dorsalis. Impotence is a common sequela to this rare entity. It may be preceded by anesthetic priapism. Psychologic and urologic consultation should be sought, especially for consideration of a penile prosthesis.

8. Paraplegia and quadriplegia. Sexual function in these patients is purely segmental and reflex in nature in spite of the fact that libido itself is usually not affected. Such a patient has absolutely no cortical or psychic control over erection. By the same token, there is no sensual appreciation of genital stimulation. Erection becomes dependent on the function of spinal cord levels S2 to S4 and their respective nerve roots. Erection can be elicited by any type of tactile stimulation.

Ejaculation is sympathetic in nature originating in the lower thoracic and upper lumbar gray matter and involving the paraspinal sympathetic chain. For this reason, male patients having dorsolumbar sympathectomy for peripheral vascular disease or causalgia should be thoroughly informed by their surgeon about the possibility of impotence.

In the patient with severe cord injury, erection alone can be sustained without ejaculation if the lesion is below the L3 and above the S2 to S4 cord segments. Even if ejaculation occurs, it may be ineffective from a fertility standpoint due to retrograde propulsion. In addition to this problem, spermatogenic arrest may ensue due to loss of sympathetically mediated scrotal thermoregulation. A small percentage of these patients do successfully impregnate their mates. Female patients with cord injury may readily become pregnant, but obstetrical risks are great. Sexual intercourse and reproduction must be thoroughly discussed by all concerned.

9. Dystrophic myotonia. This hereditary disorder presents with gonadal atrophy and other endocrine disturbances. It occurs more commonly in males than females. Impotence is a frequent symptom. Neurologic and endocrinologic consultation are appropriate.

10. Diabetic neuropathy. If the lumbar or sacral roots are involved, the reflex pathway for erection is interrupted and impotence results. This process should be differentiated from the less specific decreased libido seen in some diabetic patients. Treatment of either problem usually yields poor results.

11. Postmyelography or lumbar puncture. There are a few scattered case reports of transient impotence secondary to arachnoiditis after myelography or lumbar puncture. In each alleged incident, the physician must consider fraudulence, preexisting sexual deficit, or hysteria in the differential diagnosis.

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APPENDIX N

## DESCRIPTIONS OF ORGASM

— A sudden feeling of lightheadedness followed by an intense feeling of relief and elation. A rush. Intense muscular spasms of the whole body. Sense of euphoria followed by deep peace and relaxation.

— Feels like tension building up until you think it can't build up any more, then release. The orgasm is both the highest point of tension and the release almost at the same time. Also feeling contractions in the genitals. Tingling all over.

— I often see spots in front of my eyes during orgasm. The feeling itself is so difficult to describe other than the most pleasurable of all sensory impressions. I suppose the words "fluttering sensation" describe the physical feeling I get. All nerve endings sort of burst and quiver.

— There is a great release of tensions that have built up in the prior stages of sexual activity. This release is extremely pleasurable and exciting. The feeling seems to be centered in the genital region. It is extremely intense and exhilarating. There is a loss of muscular control as the pleasure mounts and you almost can not go on. You almost don't want to go on. This is followed by the climax and refractory states!

— An orgasm feels extremely pleasurable, yet it can be so violent that the feeling of uncontrol is frightening. It also is hard to describe because it is as if I am in limbo — only conscious of release.

— To me an orgasmic experience is the most satisfying *pleasure* that I have experienced in relation to any other type of satisfaction or pleasure that I've had which were nonsexually oriented.

— The period when the orgasm takes place — a loss of a real feeling for the surroundings except for the other person. The movements are spontaneous and intense.

— They vary a great deal depending on circumstances. If it's just a physical need or release it's OK, but it takes more effort to "get there." If you're really very much in love (at least in my case) it's so close at hand that the least physical expression by your partner, or slightest touch on the genitals brings it on. And then if the lovemaking is continued it repeats again and again. It's about 90% cortical or emotional and the rest physical. But one has to have the emotion or (in my case) I don't even want to begin or try.

— Obviously, we can't explain what it feels "like" because it feels "like" nothing else in human experience. A poetic description may well describe the emotions that go with it, but the physical "feeling" can only be described with very weak mechanical terminology. It is a release that occurs after a period of manipulation has sufficiently enabled internal, highly involuntary spasms that are pleasurable due to your complete involuntary control (no control).

— It's like shooting junk on a sunny day in a big, green, open field.

— It is like turning a water faucet on. You notice the oncoming flow but it can be turned on or off when desired. You feel the valves open and close and the fluid flow. An orgasm makes your head and body tingle.

— An orgasm . . . located (originating) in the genital area, capable of spreading out further . . . legs, abdomen. A sort of pulsating feeling — very nice if it can extend itself beyond the immediate genital area.

— A buildup of tension which starts to pulsate very fast, and then there is a sudden release from the tension and desire to sleep.

— Begins with tensing and tingling in anticipation, rectal contractions starting series of chills up spine. Tingling and buzzing sensations grow suddenly to explosion in genital area, some sensation of dizzying and weakening — almost loss of conscious sensation, but not really. Explosion sort of flowers out to varying distance from genital area, depending on intensity.

— A heightened feeling of excitement with severe muscular tension especially through the back and legs, rigid straightening of the entire body for about 5 seconds, and a strong and general relaxation and very tired relieved feeling.

— A tremendous release of buildup tension all at once lasting around 5-10 seconds where a particular "pulsing" feeling is felt throughout my body along with a kind of tickling and tingling feeling.

— I really think it defies description by words. Combination of waves of very pleasurable sensations and mounting of tensions culminating in a fantastic sensation and release of tension.

— Physical tension and excitement climaxing and then a feeling of sighing, a release of tensionlike feeling.

— It is a pleasant, tension-relieving muscular contraction. It relieves physical tension and mental anticipation.

— It is a very pleasurable sensation. All my tensions have really built to a peak and are suddenly released. It feels like a great upheaval; like all of the organs in the stomach area have turned over. It is extremely pleasurable.

— Orgasm gives me a feeling of unobstructed intensity of satisfaction. Accompanied with the emotional feeling and love one has for another, the reality of the sex drive, and our culturally conditioned status on sex, an orgasm is the only experience that sends my whole body and mind into a state of beautiful oblivion.

— Tension builds to an extremely high level — muscle are tense, etc. There is a sudden expanding feeling in the pelvis and muscle spasms throughout the body followed by release of tension. Muscles relax and consciousness returns.

- A release of a very high level of tension, but ordinarily tension is unpleasant whereas the tension before orgasm is far from unpleasant.
- Basically it's an enormous buildup of tension, anxiety, strain followed by a period of total oblivion to sensation then a tremendous expulsion of the buildup with a feeling of wonderfulness and relief.
- Intense excitement of entire body. Vibrations in stomach-mind can consider only your own desires at the moment of climax. After, you feel like you're floating — a sense of joyful tiredness.
- It is a great release of tension followed by a sense of electriclike tingling which takes over all control of your senses.
- A building up of tensions — like getting ready for takeoff from a launching pad, then a sudden blossoming relief that extends all over the body.
- The feeling of orgasm in my opinion is a feeling of utmost relief of any type of tension. It is the most fulfilling experience I have ever had of enjoyment. The feeling is exuberant and the *most enjoyable* feeling I have ever experienced.
- I think that there are a variety of orgasms that I experience. I have noted a shallow "orgasm" which consists of a brief period which is characterized by an urge to thrust but which passes quickly. On the other hand, I have also experienced what I call a hard climax, characterized by a mounting, building tension and strong thrusting movements which increase in strength and frequency until the tension is relieved.
- An orgasm is a very quick release of sexual tension which results in a kind of flash of pleasure.
- An orgasm is a great release of tension with spasmodic reaction at the peak. This is exactly how it feels to me.
- A building of tension, sometimes, and frustration until the climax. A *tightening* inside, palpitating rhythm, explosion, and warmth and peace.
  
- An orgasm feels like heaven in the heat of hell; a tremendous buildup within of pleasure that makes the tremendous work of releasing that pleasure worthwhile.
- There is a building up of "tension" (poor description) to a very high stage. There is then a surging release which is exhilarating, leaving me in a totally relaxed, exhausted state.
- Spasm of the abdominal and groin area, tingling sensation in limbs, and throbbing at the temples on each side of my head.
- Experience of a buildup of tension, uncoordination of movement — to a few seconds of amazing feeling, to a release of tension and a period of satisfaction and relaxation.

— Often loss of contact with reality. All senses acute. Sight becomes patterns of color, but often very difficult to explain because words were made to fit in the real world.

— A feeling where nothing much else enters the mind other than that which relates to the present, oh sooo enjoyable and fulfilling sensation. It's like jumping into a cool swimming pool after hours of sweating turmoil. "Ahh Relief!" What a great feeling it was, so ecstatically wild and alright!

— A feeling of intense physical and mental satisfaction. The height of a sexual encounter. Words can hardly describe a feeling so great.

— Stomach muscles get "nervous" causing a thrusting movement with hips or pelvis. Muscular contraction all over the body.

— Building of tenseness to a peak where it seems as if everything is going to drain out of you. It's almost like a complete physical drain.

— Starts with hot-cold tingles up in the back of the thighs. What happens from there depends on the strength of the stimulation. Usually, shuddery contractions and the same sort of hot-cold feeling only in the genital area. Sometimes, with really strong stimulation, there's more of a blackout of complete mental awareness of what's happening, then a gradual letting down.

— An orgasm is a heightening relief of tension wherein the muscles are flexing and a great deal of tension is relieved in an extremely short period. It's a feeling of incurring climax and enjoyment due to the acute sensual nerve feelings and consciousness (kind of two opposing dialectics).

— Building up of a good type of tension. With the release of all this buildup in one great rush that makes your whole body tingle and feel very pleasurable. Feeling is weakening and is great. Just want to stay still for a long time.

— Has a buildup of pressure in genitals with involuntary thrusting of hips and twitching of thigh muscles. Also contracting and releasing of the genital muscles. The pressure becomes quite intense — like there is something underneath the skin of the genitals pushing out. Then there is a sudden release of the tension with contraction of genitals with a feeling of release and relaxation.

— I have had orgasm at times under certain conditions. I also have had it during intercourse. It is more relaxing with less mental duress during intercourse. It is a tensing of the whole body and a bright sensual feeling of release after.

— Orgasm amounts to a buildup of muscle tension accompanied by an increase in respiration rate. A sudden release of the buildup constitutes an orgasm. All in all, a highly pleasurable physical sensation.

— A complete relief of all tensions. Very powerful and filled with ecstasy. Contraction of stomach and back muscles.

APPENDIX 0

Sexual Activity Checklist

Please fill in this form when you have participated in any of the activities in which you have entered in the 41 items listed. Indicate to what degree you reached the degree of arousal and indicate whether you achieved orgasm. After checking these activities place the sheet in the envelope provided.

Activity	Check if engaged in	Degree of Arousal					Was orgasm Reached
		Very Low	Medium		Very High		
		1	2	3	4	5	
Genital pleasuring, excluding genitals (alone)--exploration of your body, excluding genital areas, for feelings of pleasure							
Genital pleasuring, excluding genital areas (together)--exploration of each other's bodies, excluding genital areas, for feelings of pleasure							
Genital and genital pleasuring (together)--exploration of each other's bodies for feelings of pleasure.							
Masturbation Alone							
Masturbation alone--with erotica.							
Masturbation alone--with vibrator.							
Masturbation alone--with role-playing or orgasm.							
Masturbation with partner observing.							
Genital masturbation by partner.							
Genital masturbation.							
Oral sex in mutual mouth-genital pleasuring with partner.							
Oral sex using partner's genitals with mouth.							
Oral sex partner caressing your genitals with his mouth.							
Oral sex with manual clitoral stimulation							
Oral sex without manual or vibrator stimulation.							
Use of vibrator during foreplay							
Use of vibrator during intercourse							

APPENDIX P

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Belief Inventory

Please check (✓) one column from 1 to 5 that best indicates how strongly you believe each statement to be true in your own case. Please answer according to what you really believe yourself, not what you think you should believe.

	Partly true				
	Absolutely Untrue	Mostly Untrue	Partly untrue	Mostly true	Absolutely True
	1	2	3	4	5
1. I must be an extremely rare woman to have experienced sex with an older person when I was a child					
2. I am worthless and bad					
3. You can't depend on women, they are all weak and useless creatures					
4. No man can be trusted					
5. I must have permitted sex to happen because I wasn't forced into it					
6. I don't have the right to deny my body to any man who demands it					
7. Any man can be seduced					
8. Anyone who knows what happened to me sexually will not want anything more to do with me					
9. I must have been seduced and provocative when I was young					
10. It doesn't matter what happens to me in my life					

Belief Inventory

Page 2

	Absolutely Untrue	Mostly Untrue	Partly true Partly untrue	Mostly True	Absolutely True
	1	2	3	4	5
11. No man could care for me without a sexual relationship					
12. It is dangerous to get close to anyone because they always betray, exploit, or hurt you					
13. I must have been responsible for the sex when I was young because it went on so long					
14. I will never be able to lead a normal life, the damage is permanent					
15. Only bad, worthless guys would be interested in me					
16. I must have been unnatural to have felt any pleasure during the molestation					
17. I am inferior to other people, because I did not have normal experiences					
18. I've already been used so it doesn't matter if other men use me					

APPENDIX Q

Formulating Problems, Negotiating  
Objectives, and Planning the  
Intervention and Evaluation

The assessment provides information for a clinical formulation which includes a) a specification of the client's problems, b) some hypotheses about their causes, and c) an appraisal of the available therapeutic resources. On the basis of this formulation the objectives of therapy will be negotiated with clients and the intervention and its evaluation will be planned (Jehu, 1979).

Intervention

Within the broad context of some general conditions of a therapeutic nature, the intervention package will comprise several more specific modules that will be deployed to suit particular victims and their partners. This means that modules will be included, sequenced, and implemented in individually tailored treatment packages according to each client's needs and circumstances. The modules are listed in Table 2 at the end of this section, together with their major, though not exclusive, objectives.

General therapeutic conditions

These conditions include a good relationship between client and therapist, together with an expectation of receiving effective help on the part of the client. It is generally held that good therapeutic relationships are characterized by mutual feelings of liking, respect, and trust, and that the better the relationship the more open the client is about his or her problems and the more likely he or she is to listen

to and act upon any advice offered by the therapist, with beneficial consequences for the progress and outcome of therapy. Similar consequences are widely recognized to stem from a client's expectations of receiving effective help (e.g. Jehu, 1979).

More particularly in the case of victims these general therapeutic conditions are likely to provide several benefits. Disclosure of the victimization secret to a therapist who believes the story and who remains calm, matter of fact, accepting, supportive, and therapeutically constructive, tends to reduce the client's feelings of isolation and rejection. The love and anger that often co-exist towards each parent can be expressed to an empathic therapist who validates these mixed feelings as understandable reactions. A victim's profound mistrust of people can be mitigated in a corrective relationship with a therapist who does not dominate or exploit her, as the offender may have done, or neglect or abandon her, as her parent(s) may have done. Finally, a therapist who is knowledgeable and competent in the area of victimization may be able to modify the commonly held belief that the effects of such traumatic experiences are permanent and irremediable, and thus to enhance the client's motivation for treatment. It is on the necessary basis of such general therapeutic conditions that the more specific intervention modules will be implemented.

#### Relaxation training

For most clients this will be the initial module in the programme. There are least three major reasons for its inclusion, especially at an early stage. Having to explore and confront the victimization experience and other distressing topics during the intervention

frequently evokes a great deal of anxiety in clients, and relaxation training is a well established method of alleviating anxiety. Furthermore, the ability to relax as a means of coping with anxiety evoking material is likely to enhance a client's sense of competence and mastery. Lastly, relaxation training is a necessary preliminary to some of the specific procedures use<sup>d</sup> later in the programme for the treatment of sexual dysfunction.

In this project relaxation training will be provided as described in appendix L (Goldfried and Davison, 1976).

#### Cognitive restructuring

This module is based on the premise that:

. . . a person's assumption, expectations or beliefs about a situation have a significant influence on his emotional or behavioural responses to that situation. If these things people say to themselves . . . are of an irrational or illogical nature then they are likely to be conducive to feelings and actions that are inappropriate responses to the situation itself, although they may be quite appropriate to the person's subjective interpretation or labelling of that situation . . . (Jehu 1979, p. 131).

Clients very commonly hold certain false beliefs about their victimization and related matters that contribute to later emotional, interpersonal, and sexual difficulties. Among the many possible examples of such beliefs are the following:

1. the victimization
  - a) I must be an extremely rare woman to have experienced

sex with an older person when I was a child

b) I must have permitted sex to happen because I wasn't forced into it

c) I must have been seductive and provocative

d) I must have been responsible because it went on so long

e) I used sex to get favors from my father that he did not give to my brothers and sisters

f) I must be unnatural to have felt any pleasure during the molestation

g) I must have been to blame because I was removed from home

h) I stole my father from my mother

i) no one will believe that I am telling the truth about what happened to me

j) if I tell anyone what happened, this will be disloyal to my father

k) I was the cause of my father going to jail

l) I was the cause of my family breaking up

2. self-concept

a) I am inferior to other people, because I did not have normal experiences

b) I am worthless and bad

c) I don't have the right to deny my body to any man who demands it

d) it doesn't matter what happens to me

e) I will never be able to lead a normal life, the damage

is permanent

3. interpersonal relationships

- a) anyone who knows what happened to me will not want anything more to do with me
- b) it is dangerous to get close to anyone because they always betray, exploit, or hurt you
- c) you can't depend on women, they are all weak and useless creatures
- d) no man can be trusted
- e) any man can be seduced
- f) no man could care for me without a sexual relationship
- g) only bad, worthless guys would be interested in me
- h) I've already been used so it doesn't matter if other men use me.

Cognitive restructuring procedures

Basically, cognitive restructuring consists of four aspects:

- 1. the client becomes aware of her beliefs concerning the victimization and related matters,
  - 2. she recognizes any of these beliefs that are false,
  - 3. she substitutes more accurate beliefs,
- and 4. she receives feedback on the correctness of the changes in her belief system from the therapist and others.

To bring about these changes certain procedures will be implemented that are derived from the work of Beck and his colleagues (Beck, 1976., Beck & Emery, 1979., Beck, Rush, Shaw, & Emery, 1979). These procedures include:

Rationale. The influence of her beliefs on her feelings and actions are explained to the client.

Provision of information. Factual data is provided to correct any inaccurate information that may be contributing to a client's false beliefs. For example, feelings of difference and alienation may be based upon the belief that sexual victimization is extremely rare in childhood, and accurate information about its prevalence may serve to modify the false belief and alleviate the associated negative feelings.

Logical analysis. The client's logic is reviewed to determine whether the evidence supports the conclusion she has drawn. For instance, "no man can be trusted" is an overgeneralization. "I am worthless and bad" is an example of dichotomous thinking in which people are categorized as either saints or sinners with the client placing herself in the totally negative category. An arbitrary inference is being drawn by a client who concludes that "I must have been to blame because I was removed from home."

Decastrophizing. When predicting the direst consequences for herself a client may not utilize all the information available. Thus, "I will never be able to lead a normal life, the damage is permanent" ignores the fact that some victims do succeed in making a satisfactory adjustment or recovery, and the therapist can widen the client's perspective in this respect.

Distancing. Vicarious exposure to the victimization of other women may enable a client to take a more objective view of her own experience. For example, if she does not blame another woman for being victimized, she may be less inclined to blame herself.

Decentering. This refers to the process of having the client challenge the basic belief that she was the focal point of the victimization. For instance, " I must have been seductive", might be challenged by the client looking at the experience from the offender's perspective and recognizing that his insistence on secrecy is a clear indication of his awareness that his behaviour is unacceptable and of his own responsibility for the transgression.

Reattribution. This procedure follows logically from distancing and decentering and it is designed to correct a client's tendency to assume total responsibility for the victimization and not to take into account factors that were beyond her control. These might include her immaturity and lack of power compared to the offender.

Feedback. In order to affirm and reinforce the client's more accurate appraisal of her victimization she is encouraged to relate the experience to at least one other person in addition to the therapist. This person may be the client's partner if she has not already told him, or alternatively another practitioner might be brought in for this purpose.

#### Bibliographical and audio-visual material

To facilitate the cognitive restructuring process certain readings and a film will be presented to clients in a graded manner from the least to the most disturbing. These materials range from factual information through to personal testimonies of adult victims, and they are attached as appendices M to R in the usual order of presentation.

### Interpersonal skill training

In appendix B it is noted that the interpersonal relationships of many victims are characterized by feelings of isolation, alienation, and difference from other people. Some victims avoid any lasting relationship with a man, and a series of causal encounters is common. Relationships with men tend to be oversexualized, ill-matched, and hurtful, and fears of intimacy are often exhibited.

Following the cognitive restructuring<sup>ur</sup> module some victims<sup>s</sup> will be less likely to involve themselves in dissonant relationships, their enhanced self-esteem and confidence will reduce their vulnerability in this respect. Similarly, some women who are already in a dissonant relationship will have acquired the capacity to bring about changes so that the relationship becomes more satisfactory. For instance, a woman may be able to prevent a tyrannical partner from dominating her as he did before she entered treatment.

Other victims will need additional help aimed specifically at improving their capacity to establish and/or maintain satisfying intimate relationships. This is particularly important in those cases where the earlier part of the programme has been accompanied by an exacerbation of conflict between a victim and her partner. Such deterioration is quite understandable in the light of the changes that have occurred in the victim during treatment. As noted above, because of the adverse effects of victimization a woman may be in an ill-matched or oppressive relationship, and the alleviation of these effects in the course of treatment may well mean that she is no longer prepared to tolerate this situation. In effect, she is no longer the same woman that her husband married. Consequently, the respective roles of the

partners and the implicit or explicit rules governing their relationship need to be renegotiated between them. When necessary this module will be implemented to provide the interpersonal skills required to undertake this task, including the abilities to communicate with each other and to collaborate in the resolution of conflicts. It must be recognized however, that the transmission of such skills may still be ineffective in maintaining an altered relationship that has become intolerable to either partner, and separation is likely to occur in a proportion of cases.

#### Basic communication skills

These are the skills required to be an effective speaker and listener. Training in effective speaking emphasizes three features: (a) being direct, speaking for oneself (b) being emotionally expressive about one's own feelings, and (c) being specific about the particular events that evoke these feelings. Effective listening requires the skills of summarizing, reflecting, and validating, in order to demonstrate to a speaker that one has heard and understood what has been said.

In addition to these verbal components of effective speaking and listening there are also certain non-verbal components in which some clients may need specific training. These latter components include (a) eye contact (b) voice volume (c) voice intonation (d) response latency (e) speech rate (f) speech dysfluencies (g) physical gestures (h) facial expressions, and (i) posture.

Both the verbal and non-verbal communication skills will be taught using three major procedures (Jacobson & Margolin, 1979., Liberman, Wheeler, de Visser, Kuehnel, & Kuehnel, 1980.):

- (a) feedback, where clients are provided with information about their current maladaptive communication patterns,
- (b) coaching and modelling, where the therapist provides alternative, more desirable, communication patterns for clients,
- and (c) behaviour rehearsal, where clients practice the communication patterns provided by the therapist.

#### Conflict resolution skills

Relationships are governed by rules which specify acceptable and unacceptable behaviour for each partner. In most cases these rules are not explicitly spelled out, but each partner has covert expectations about matters such as (a) the division of household tasks (b) the handling of children (c) the management of money (d) decision making in the family (e) the initiation of sex (f) the degree of autonomy permitted to each member, and (g) the ways in which one partner may seek to influence the behaviour of the other, such as requests, persuasion, demands, threats, intimidation, or physical abuse. Conflict arises when some change necessitates a modification of the rules governing a relationship and this revision is not forthcoming. Thus, a victim whose self-esteem and confidence have improved during treatment may no longer be prepared to remain a subordinate, exploited, or abused partner, and conflict will arise unless the necessary adjustments are made in the rules of the relationship.

Some couples lack the capacity to resolve such conflicts in a smooth and mutually satisfactory way, and they may benefit from specific training in the necessary skills. While the basic communication skills discussed above can lead to an understanding of conflicts, these skills

alone do not produce solutions. Training in conflict resolution teaches the couple (a) to define their conflicts (b) to generate possible solutions (c) to evaluate these solutions, and (d) to negotiate agreements embodying particular solutions. The details of such training are described in the manual (Jacobson & Margolin, 1979) attached as appendix S which will be given to couples as part of this module. It is emphasized that the aim is to train couples in the skills they require to resolve their conflicts themselves, and not for the therapist to impose a solution on them.

#### Specific treatment of sexual dysfunction

Clinical experience of treating victimized women over many years has led to the strong impression that the specific treatment of sexual dysfunction before dealing with the victimization experience is rarely, if ever, successful, clients do seem to need to work through the victimization trauma first. On the other hand dealing with trauma alone will rarely alleviate the sexual dysfunction, additional specific treatment for this is almost always necessary.

Similarly, for treatment focussed upon sexual dysfunction to succeed it is generally necessary for the partners to find each other attractive, to like each other, to put aside any hostility between them, and to have a genuine desire to work together towards the enhancement of their mutual sexual relationship (Jehu, 1979). If these conditions are seriously lacking then the interpersonal skills training module will usually be offered with the aim of improving the couple's general relationship before the specific <sup>t</sup>reatment of sexual dysfunction is attempted.

This specific treatment consists of certain office procedures and home assignments, many of which are listed in Table 3 at the end of this section and described fully elsewhere (Jehu, 1979). From among such procedures and assignments individually tailored treatment programmes will be planned and implemented to suit particular victims and their partners.

#### Office procedures

Some of these procedures are listed in Table 3 under sub-headings indicating the major, though not the exclusive, purpose of each procedure. Information will be provided in several ways in order to rectify any deficiencies or inaccuracies in sexual knowledge that may be impairing sexual functioning or impeding its therapeutic improvement. Similarly, when such impairment or impediment is due to adverse attitudes or beliefs, then an attempt will be made to modify these by procedures such as sanctioning, self-disclosure, role playing and cognitive restructuring. Other procedures have a relative emphasis on either stress reduction or sexual enhancement. For example, systematic desensitization might be used when a sexual phobia is blocking a client's progress in treatment, or self-hypnosis might be taught to facilitate sexual imagery and arousal.

#### Home assignments

These assignments are undertaken in the privacy of the clients' own homes and they are designed to reduce stress reactions evoked by sexual activities, as well as to promote more effective sexual stimulation and responses.

To illustrate the nature and purposes of these assignments a programme is described that is often useful in the treatment of a range

\*of dysfunctions including impaired motivation, sexual phobias, difficulties in arousal, and problems in reaching orgasm. In addition to the therapist describing the assignments, the victim and partner if any are assigned appropriate reading in a manual (Heiman, Lo Piccolo, & Lo Piccolo, 1976) and shown the associated segments of an accompanying film series (appendix T). When a partner is involved, he and the victim are also assigned readings in another self-help manual (Zilbergeld, 1978) which is written for men particularly, although it is useful for both partners to read it so that they can discuss the material.

It is noted in appendix B that victimized women often react adversely if they feel that they are being in any way pressured or coerced in sexual activities. Consequently, it is often desirable to negotiate with the couple for a ban on intercourse and any other threatening activities until a suitable stage in treatment is reached. Additionally, it is very important that the woman move through the stages of the programme at her own pace, and without any pressure from the therapist to undertake particular assignments before she feels ready to attempt them.

The general aim in using this programme with victimized women is to reduce the disturbing nature of those features of sexual activity that are stressful for them. This is done by gradually exposing the client to these stressful features while she remains in a non-anxious state:

Step 1. Many victimized women regard their genitals particularly as an unfamiliar, isolated, bad, or dirty part of their body. The first step in the programme may be especially useful in helping such clients to become more aware, comfortable, and positive towards their bodies as a whole and their genitals specifically. The client is asked to examine

her nude body and to appreciate its attractive features. Additionally, it is recommended that she use a handmirror to explore her genitals and to identify the various parts with the aid of a diagram.

Step 2. The slightest sign of sexual pleasure may evoke phobic reactions in some victimized women (appendix B), and the next step in the programme is useful in beginning the process of helping these clients to tolerate and enjoy such pleasurable feelings. The client is asked to explore her genitals tactually, with the aim of locating sensitive areas that are pleasurable to touch. She is not given any expectation of sexual arousal at this stage.

Stage 3.<sup>ep</sup> The process of accepting and enjoying sexual pleasure in continued in this and the following steps. In step 3 it is suggested that the client stimulate manually those sensitive areas that she located in the previous step. Some ways of doing this are discussed with her, including the use of a lubricant to heighten pleasure and reduce any discomfort.

Step 4. In step four the client is asked to increase the intensity and duration of the manual stimulation. She may also be encouraged to explore the use of erotic materials and fantasies to extend and enhance her capacity for arousal. In the cases of clients who fear loss of control during orgasm, it may be helpful if they roleplay their conception of the orgasmic response in an exaggerated manner. The simulation of anticipated reactions such as involuntary screaming or gross muscular movements may alleviate their stressfulness and sometimes results in the occurrence of a real orgasm during the roleplay.

Step 5. Again, particularly in the cases of those women who have difficulty in climaxing, the next step may be to repeat the previous

step using a vibrator instead of manual stimulation, or some combination of the two.

Step 6. From here on, the subsequent steps in the programme all involve both partners. Accordingly, it is important to emphasize some general points concerning partner related activities for victimized women.

First, because of their vulnerability to adverse reactions to any feelings of coercion or exploitation, they should be given control of partner related activities, including their initiation and duration.

Second, if the woman experiences flashbacks to the victimization that adversely affect her current responses with her partner, then she should let him know that she is flashing, so that he can understand what is happening and not blame her or himself. Third, the woman may experience strong feelings of anger during current activities with her partner that he has done nothing to evoke. Again, these feelings should be recognized as arising from the past rather than the present circumstances.

Often the first partner related activity to be prescribed in the programme is general pleasuring or sensate focus. This is fully described in other places (e.g. <sup>Jelwa</sup>~~D.-J.~~, 1979), but briefly it means that the partners take it in turns to explore the sensual pleasures of touching and carressing each other's bodies with tenderness and affection. At this stage the breast and genital areas are excluded, but otherwise the couple is left to discover for themselves where and how they like to be touched and to communicate these preferences to each other. One reason for this assignment is the reduction of avoidance reactions. Quite often victimized women and their partners have been avoiding any physical expression of affection as well as sexual

foreplay, in case these should involve or lead on to activities that are very stressful for the woman. This threat is removed by the therapeutically negotiated limits to general pleasuring, and the associated avoidance reactions are correspondingly alleviated.

Step 7. Once couples are able to respond positively to general pleasuring, then they can move on to the next step of including the breast and genital areas. It is very important to stress that this genital pleasuring is a gradual extension of general pleasuring, which is not superseded by the incorporation of the genitals. At this stage, the women will communicate to her husband what she has learned earlier about the most effective means of stimulation for her, and it is important that he follow her guidance concerning her preferences.

Step 8. When the woman is anxiety free and aroused during general and genital pleasuring the couple might move on to the next step of "non-demand coitus". She adopts the female superior position and inserts her partner's penis into her vagina. Initially, she simply contains the penis while experiencing the sensations and feelings this evokes. These may be enhanced by the woman contracting her vaginal muscles on the penis, and subsequently, as her arousal mounts, by moving slowly up and down and experimenting with other different movements. She is told to concentrate on her own sensations and pleasure without worrying about her partner's gratification at this stage. If he becomes too aroused, then movement can be stopped for a while, and he can either remain inside his partner or withdraw until the excitement subsides. Such withdrawal and reinsertion is often a teasing and arousing experience for the woman, and her arousal may also be maintained by clitoral stimulation while penile movement is suspended. This

assignment continues for so long as the woman wishes, at which point her partner might reach climax either intravaginally or by manual or oral stimulation as long as this is not stressful for the woman. An important feature of this assignment for victimized women is that it provides an opportunity for them to explore and appreciate the vaginal sensations and erotic feelings evoked by the man's penis, without having to subordinate her own preferences and pleasure to those of her partner.

Step 9. The final step is for the couple to proceed to full intercourse, while either the woman or her partner concurrently stimulates the woman's genitals either manually or with a vibrator. If the couple so desire, this concurrent stimulation can gradually be faded out by stopping it when the woman is near climax. Probably the majority of women however, do require some more direct stimulation than that provided by penile movement alone in order to reach climax on many occasions.

#### Duration of the intervention

The modules of relaxation training, cognitive restructuring, interpersonal skills training, and the specific treatment of sexual dysfunction will be included in treatment packages according to the needs of particular clients. Additionally, the implementation of each module will be tailored to individual clients. Because of these variations it is neither feasible nor desirable to standardize the number of sessions in the intervention. It is estimated that this number will vary between 25 and 35 sessions in most cases, and normally sessions will be held at weekly intervals and last about one and a half hours on each occasion.

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