# A Clinical Trial of Sensate Focus with Couples experiencing Secondary Erectile Dysfunction

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A thesis submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Arts



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## Abstract

Sensate focus (SF), a standard procedure in the treatment of sexual dysfunction, is claimed to have a number of therapeutic effects. Despite popular use of the method, evidence supporting these claims is limited. The present study attempted to validate the claimed effects.

Three heterosexual couples presenting with secondary erectile dysfunction at the Sexual Dysfunction Clinic, University of Manitoba served as subjects. After screening for inclusion in the study, the couples were assessed over three to five sessions before treatment. Assessment focussed on identification and specification of the couple's sexual problems. The couples were then instructed in the use of SF. The initial phase of therapy consisted of general pleasuring followed by genital pleasuring. After completing the SF phase, therapy continued following standard clinical practice.

The present study was a natural multiple baseline across subjects design with additional pretreatment and posttreatment measures. All data was collected using self-report measures. Outcome variables specific to the primary effects of SF were: (a) degree of avoidance of sexual activity, (b) level of performance anxiety, and (c) frequency of spectatoring. Outcome variables specific to secondary effects of SF were: (a) attitude towards spouse

as a sexual partner; (b) attitude towards non-coital sexual activity; (c) enjoyment of non-coital sexual activity: (d) communication between partners concerning preferred forms of sexual stimulation; (e) affectional expression towards spouse; (f) physiological arousal to sexual stimuli (males only, genital phase); and (g) satisfaction with sexual relationship and sexual functioning.

The results of the present study did not demonstrate that the SF phase is an active ingredient of sex therapy. Considerable inter-subject and intra-subject variability, and client improvement on several of the dependent variables during the assessment/baseline phase made it impossible to accurately evaluate most of the claims. Only the claims that the SF phase positively affects affectional expression and attitude towards non-coital sexual activity, and the claim that the SF phase promotes greater satisfaction with sexual functioning appear to have been substantiated. The primary claim that the SF phase reduces sexual anxiety was not clearly substantiated by the data. In view of SF's popularity, further research is required to assess the specific ways in which this procedure in itself is therapeutic.

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# Introduction

The relationship between anxiety and sexual functioning has been of interest to mental health professionals for many years. Freud was one of the first to highlight the relationship between these two phenomena, claiming initially that anxiety is the consequence of a repressed libido. He later reversed this formulation designating anxiety as the cause rather the consequence of a repressed libido (Freud, 1936). With the advent of behaviourism a different view of the relationship between anxiety and sexual functioning evolved. Influenced by the behavioural school's emphasis on directly observable behaviour and the premise that pathological behaviour develops according to the same laws governing the development of normal behavior, researchers and clinicians began to focus on the observable immediate causes of sexual dysfunction rather than upon unconscious causes. (e.g., Cooper,1969; Lazarus, 1963; Masters & Johnson, 1970; Wolpe, 1958). As a result, anxiety specifically related to sexual activity (sexual anxiety) and generated by the anticipation of sexual failure was proposed to be more important etiologically than generalized neurotic anxiety.

Both schools of thought have given rise to treatment strategies aimed at reducing anxiety. Psychoanalysis has been used, but with relatively little success. In a review

of early treatment studies, Cooper (1971) noted that the empirical data regarding the clinical efficacy of psychoanalytic treatment for sexual dysfunction were extremely limited. In a later review, Reynolds (1977) came to a similar conclusion. In contrast, behaviorally based treatments have been reported to be quite successful. In this regard there are two principal treatment strategies: systematic desensitization (SD) in various forms and the sensate focus phase (SF) of Master's and Johnson's (1970) treatment paradigm.

In the late 1950's, Wolpe (1958) first reported successful outcomes utilizing SD to treat males suffering from erectile dysfunction or premature ejaculation. Since then, SD has been used extensively and in a variety of ways for treatment of male and female sexual dysfunctions. Numerous authors have reported that it is an effective procedure in those cases where anxiety inhibits sexual functioning (e.g. Lazarus, 1963; Mackay,1976; Obler, 1973). In addition, reviews of outcome studies have for the most part concluded that SD is an effective means of reducing sexual anxiety (Glick, 1975; Kilman & Auerbach, 1979; Norton, Jehu, & de Luca, 1985; Sotile & Kilman, 1977).

In contrast, little substantial empirical evidence exists concerning the clinical effectiveness of SF. Introduced by Masters and Johnson (1970), it is a widely accepted procedure. Unfortunately, there are many unanswered

questions about the utility and applicability of SF. For example: Are the clinical claims concerning the effectiveness of SF valid? How does SF affect the different sexual dysfunctions? What are the key therapeutic ingredients of SF? These and other questions warrant atttention given the popularity of SF. Research focussing on these questions would provide more adequate information than that presently available. Such information would help the clinician determine when SF is appropriate and would contribute to etiological theory of sexual dysfunction.

A review of the literature concerning SF illustrates the lack of empirical data and the need for such evidence. First, however, a brief overview of the literature pertaining to the role of anxiety in sexual dysfunction is in order.

## The Role of Anxiety in Sexual Dysfunction

Since Freud, a great deal of attention has been focussed on the role of anxiety in sexual dysfunction. Nevertheless, many issues face today's clinicians and researchers. There are three basic issues concerning the role of anxiety. The first issue concerns the association between anxiety and sexual dysfunction: Is anxiety commonly associated with sexual dysfunction? The second issue concerns the type of anxiety associated with sexual dysfunction: What type of

anxiety is it? Is it generalized neurotic anxiety? Is it sexual anxiety? Or, is it both? This issue is presently a contentious one. Some researchers (e.g. Kleegman, 1971; Meyer, Schmidt, & Lucas, 1975; O'Connor & Stern, 1972) emphasize generalized neurotic anxiety whereas others dismiss it as irrelevant and consider anxiety specifically related to sex as the important factor (e.g. Cooper, 1969; Faulk, 1973; Lazarus, 1972; Masters & Johnson, 1970). To further complicate matters, others (e.g. Kaplan, 1974) view both types as important. The third issue concerns the functional relationship between anxiety and sexual functioning. If they coexist, does anxiety cause sexual failure? Or is it simply an effect of the failure? Or, is it both a cause and effect? The research literature provides the following information concerning these three issues.

## The Association between Anxiety and Sexual Dysfunction

The coexistence of anxiety and sexual dysfunction is accepted by most experts in the area. Bancroft (1983) noted wide agreement that anxiety is commonly present in the sexually dysfunctional population. Similarily, Norton, Jehu, and de Luca (1985) reviewed major studies which compared the anxiety reactions of sexually dysfunctional persons with normals and concluded that anxiety is common in the dysfunctional population. Nevertheless, it appears that

anxiety is neither a necessary nor a sufficient condition for sexual dysfunction. Several authors have reported sexual failure in the absence of observed anxiety. In fact, Bancroft (1983) noted that erection commonly occurs amongst pre-adolescent boys when they are frightened. Masters and Sarrel (1983) reported several cases where men who have been sexually assaulted by women were able, without exception, to perform sexually and even to attain additional erections when threatened with bodily harm. Apart from this anecdotal evidence, empirical data ( discussed later) indicates that anxiety may facilitate sexual arousal (Dutton & Aron, 1974; Hoon, Wincze, & Hoon, 1977; Wolchik et al., 1980). In addition, the suggestion has been made that anxiety when present is not always associated with sexual failure. Bancroft (1983) stated that anxiety may simply accompany sexual failure in some cases. He noted that a sexual experience that is perceived as threatening may directly inhibit sexual response via neuro-physiological inhibitory mechanisms which do not require the presence of manifest anxiety. He argues that anxiety experienced in such cases is subjective and is caused by the threat but does not itself cause the inhibition. Finally, anxiety need not be present for sexual dysfunction to occur. Several authors (e.g. Jehu, 1979) have noted that there are numerous other emotional and physiological factors that in and of themselves can cause sexual dysfunction (e.g., depression, guilt, anger, and diabetes).

## Type of Anxiety associated with Sexual Dysfunction

Although anxiety is neither a necessary nor a sufficient condition for sexual dysfunction, it appears to be present in a substantial number of persons experiencing sexual failure. The issue is: What type of anxiety is commonly present? Norton, Jehu, and de Luca (1985) concluded that the level and nature of anxiety varies in this population. They suggested that the evidence supports a view of sexual disorders in which both neurotic anxiety and sexual anxiety are etiological factors. However, regarding the relative importance of the two types, the evidence favors sexual anxiety over neurotic anxiety. Although Johnson (1965) found that 48 % of a sample of dysfunctional males had a "neurotic constitution", Cooper (1968, 1969a) found that only 10-12 % of dysfunctional males were clinically neurotic. Fifty-one % of the males, however, suffered from "marked coital anxiety" defined as:

> anxiety related temporarily to the act of coitus (either imagined or actual) or sexual overtures and stimulations (imagined or actual) short of intercourse, but which the male subject believed at the time would culminate in a coital attempt...(Cooper, 1969a, pp143-144).

Coital anxiety was perceived by subjects to be related to the following factors: failure (73 %), being perceived by the spouse as sexually incompetent (43.5 %), and fear of ridicule from the spouse (40 %). On the basis of these results, Cooper (1969a) suggested that most potency disorders are due to events associated with sexual activity rather than neurotic anxiety.

In support of this conclusion, Ansari (1975) found that 66 % of males with acute onset erectile dysfunction stated that their dysfunction developed in reaction to psychological or physical trauma (e.g. first coital attempt, following bereavement, or upon marriage). Of those males whose erectile problems had an insidious onset, severe marital conflict, and the low sexual responsiveness of their wives' were reported to be associated with the onset of the dysfunction.

Kockott,Feil,Revenstorf,Aldenhoff, and Besinger (1980) also reported findings which support the relative importance of sexual anxiety. Men whose erectile dysfunction was psychogenic in origin, men whose erectile dysfunction was due to diabetes, men complaining of premature ejaculation, and normally functioning men were assessed for the presence of anxiety. No significant differences were found between the groups concerning neuroticism. However, men with psychogenic erectile dysfunction were found to experience significantly more sexual anxiety than the diabetic men who, in turn, experienced more sexual anxiety than the normals.

In spite of the findings of Cooper (1969a), Ansari (1975), and Kockott et al. (1980), it may be that neurotic anxiety plays a hitherto underestimated role in sexual dysfunction. Munjack, Oziel, Kanno, Whipple, and Leonard (1981) found that premature ejaculators and retarded ejaculators were significantly more neurotic than control subjects. Derogatis, Meyer, and King (1981), found that sexually dysfunctional males and females experienced psychological symptoms at levels ranging from one to two standard deviations above normal. Thirty-seven % of the men with erectile dysfunction, 50 % of the anorgasmic women, and 33 % of the premature ejaculators were assigned psychiatric diagnoses. On the basis of these results, the authors concluded that sexual dysfunction and psychopathology tend to coexist. They rejected the contention of Masters and Johnson (1970) and others that dysfunctional individuals are essentially psychologically intact (i.e. not neurotic), as clinically untenable. They maintained that previously reported findings of a low incidence of psychopathology/neuroticism (e.g. Cooper, 1969a; Maurice & Guze, 1970) were the result of inadequate psychiatric and psychometric assessments or the use of non-representative samples.

Nevertheless, Derogatis et al. (1980) and Munjack et al. (1981) acknowledged that their results did not substantiate a causal relationship between psychopathology/neuroticism

and sexual dysfunction. What seems valid , however, is the assertion that neurotic anxiety is associated in someway with sexual dysfunction.

Turning to sexual anxiety, the empirical data indicates that it is reliably associated with sexual difficulties (Norton, Jehu, & de Luca, 1985). In addition to evidence of its presence in the sexually dysfunctional population, studies investigating the effectiveness of treatment procedures used to reduce this type of anxiety have found that reduction of this anxiety leads to improvement in sexual functioning (e.g. Anderson,1981; Everaerd & Dekker,1982; Wincze & Caird,1976). The observed improvement is further evidence of an association between the variables (Norton , Jehu, & de Luca, 1985).

Nature of Association between Sexual Anxiety and Sexual Dysfunction

Given that sexual anxiety appears to be commonly associated with sexual dysfunction what is the nature of the association?

Although theorists disagree about the importance of the type of anxiety associated with sexual failure, it is unaminously agreed that 'anxiety' causes sexual dysfunction by inhibiting natural arousal to sexual stimuli (Kaplan, 1974; Lief, 1979; Mackay,1976; Masters & Johnson, 1970; Wolpe,1958).

The inhibition of sexual functioning by sexual anxiety is thought to involve the following components: a) an affective component, often labelled "performance anxiety" and b) a cognitive component involving failure expectancies, perception of performance demands, and "spectatoring" where an individual excessively and critically monitors their sexual performance ( LoPiccolo & LoPiccolo, 1978; Masters & Johnson, 1970).

It is hypothesized that the affective component directly inhibits functioning by disrupting the autonomic functions controlling sexual response ( Masters & Johnson, 1970; Wolpe, 1973). For example, in the case of arousal dysfunctions (erectile failure and vasocongestive dysfunction) suppression of the parasympathetic nervous system (PNS), which is believed to mediate sexual arousal, is thought to occur due to excessive sympathetic nervous system (SNS) activity.

The cognitive components are thought to inhibit sexual functioning via negative cognitions concerning sexual stimuli and responses (Walen,1980). Perceptual errors such as "My erection is smaller...I know I am becoming impotent," and evaluative errors such as "I've got to do better!" are believed to generate negative emotions ( anxiety, guilt, or anger) which block natural arousal. Also, the cognitive factors are thought to distract the individual from responding to sexual stimuli (Bancroft,1970; Masters & Johnson, 1970).

Clinical Studies. The empirical data indicates that the association between anxiety and sexual dysfunction is not as straight forward as has been proposed. First, it appears that anxiety is rarely an original cause of sexual dysfunction. In only 14 % of a sample of 49 sexually dysfunctional men was sexual anxiety originally responsible for the sexual difficulties (Cooper, 1969a). Rather, the majority of the men reported experiencing anxiety after sexual failure and as a result of fear of failure, fear of being seen by their spouse as sexually incompetent, and fear of ridicule by their spouse (Cooper, 1969a). On the other hand, studies which have focussed on the reduction of sexual anxiety have reported improved sexual functioning (Norton, Jehu, & de Luca, 1985). This indicates that anxiety is contributing to sexual failure in some way. It may be that in these situations, sexual anxiety maintains the sexual dysfunction once it occurs. Presently, the most tenable position is that sexual anxiety is both a precipitant and maintainer of sexual dysfunction with the emphasis on the latter.

Physiological Studies. Evidence from physiological studies of the association between anxiety and sexual arousal indicates that anxiety does not necessarily inhibit sexual arousal. Although the first report implicating the sympathetic nervous system (SNS) and the parasympathetic

nervous system (PNS) dates back to 1895 when Lange and Anderson noted that SNS activity inhibits erection and facilitates ejaculation, recent research suggests that sympathetic activity may be necessary for adequate sexual functioning. Schiavi (1981) reported the results of several animal and human studies which indicate this. First, it appears that sympathetic constriction of the arteries supplying nonerectile penile tissues may help sustain tumescence. Second, there is evidence that increased SNS activity may result in the contraction of smooth muscle in the cavernous tissues of the penis, thereby decreasing blood flow resistance and facilitating erection. Third, enhancement of erections by beta-2 adrenergic stimulants as well as by alpha adrenergic blocking agents suggests the participation of the SNS.

In spite of evidence that the SNS plays a facilitatory role in sexual functioning, little is known about the relative importance of the two nervous systems. It may be that the PNS plays the major role and that an overly active SNS overrules the PNS and thus inhibits sexual arousal.

Although the role of the SNS in sexual arousal is yet to be understood, there is some data to suggest that heightened SNS activity does not inhibit sexual arousal. Lange, Wincze, Zwick, Feldman, and Hughes (1981) investigated the effects of artificially increased SNS activity on changes in penile tumescence in response to

sexual stimuli. Twenty-four normal males were given injections of epinephrine to induce a physiological state similar to clinical anxiety prior to viewing neutral or erotic videotapes. Their sexual arousal was monitored by measuring penile tumescence. The results indicated that the epinephrine affected penile tumescence but only following cessation of the sexual stimulus (i.e. during tumescence). Subjects under the influence of epinephrine did not differ from those in the placebo condition in erectile response during the sexual stimulation. However, the authors noted that the absence of an inhibitory effect may have been due to a low level of epinephrine and the fact that the subjects were normal. They concluded that the findings provide some support for an inhibitory effect of psychophysical anxiety, but that further research is required to demonstrate unequivocally that anxiety inhibits sexual arousal.

Analogue Studies. Several other investigators have reported findings wherein anxiety enhanced sexual arousal rather than inhibited it. Dutton and Aron (1974) found that subjects' sexual imagery to TAT cards and attraction to female confederates increased as a result of heightened anxiety produced by crossing a suspension bridge or by being told they would receive an electric shock. Hoon, Wincze,and Hoon (1977) demonstrated that normal women experienced greater sexual arousal viewing an erotic videotape if they

had previously seen an anxiety-evoking video rather than a neutral video. In a similar study (Wolchick et al.,1980), normal males were shown either a neutral videotape, an anxiety-and-anger videotape, or a depression-and-anger videotape before viewing an erotic videotape. Again, exposure to the anxiety videotape produced significantly greater sexual arousal compared with the neutral and depression videotapes.

Dutton et al. (1974) offered a further alternative interpretation of their results. They suggested that the subjects' misinterpretation of the anxiety as arousal may have been responsible for their finding that anxiety enhanced sexual arousal. Concerning Hoon et al. (1977) and Wolchik et al. (1980), Wolpe (1978) has suggested that anxiety relief provided by the erotic films may have been responsible for the enhanced sexual arousal.

Norton, Jehu, and de Luca (1985) state that the analogue findings must be viewed cautiously due to methodological weaknesses of the studies and the alternative competing interpretations of the results. All of the studies were analogue studies using normal subjects in laboratory situations. As such, they can be criticized for not being sufficiently analagous to real life situations. On the one hand, normally functioning individuals may not react the same way as sexually dysfunctional individuals to anxiety. On the other hand, none of the studies replicated the social

context in which anxiety is thought to inhibit sexual arousal (i.e., sexual interaction with a partner). This is important since the type of anxiety most commonly associated with sexual dysfunction appears to be sexual anxiety (i.e., situation specific anxiety evoked by sexual stimuli). By definition, the context is paramount in determining if this type of anxiety is evoked. Finally, the studies fail to replicate the conditions under which anxiety is thought to inhibit arousal by not having paired anxiety with sexual arousal. According to Wolpe's (1958) theory of reciprocal inhibition, this must occur for anxiety to have an inhibitory effect.

Given the findings so far, the claim that anxiety can enhance sexual arousal seems limited to circumstances that do not apply normally to sexual functioning. Future research involving clinical studies with sexually dysfunctional clients may be a more appropriate means of investigating the effects of anxiety on sexual arousal.

Cognitive Studies.

Several studies have investigated the role of the cognitive components of sexual anxiety in the inhibition of sexual arousal. Findings pertaining to the influence of arousal expectancies have been inconsistent (Norton, Jehu, & de Luca, 1985). In two studies, positive expectancy

instructions enhanced sexual arousal as measured physiologically and subjectively (Wilson & Lawson, 1976; 1978). However, other studies have failed to find an expectancy effect (Briddell & Wilson, 1976).

Concerning distraction, the evidence is that distraction is an effective inhibitor of sexual arousal (Norton, Jehu, & de Luca, 1985). In studies where subjects have been distracted from sexual stimuli, sexual arousal has been significantly reduced (Geer & Fuhr, 1976; Farkas, Sine, & Evans, 1979). However, the type of distraction used in these studies is not the type that is typically present in actual sexual interaction. Geer and Fuhr (1976) distracted subjects using a dichotic listening task while Farkas et al. (1979) used tones heard through headphones. Consequently, the findings may not be applicable to clinical cases of sexual dysfunction.

Three studies have investigated the effects of spectatoring on sexual arousal. Winze et al. (1980). assessed the effect of self monitoring on male and female subjects' sexual arousal. The subjects monitored their arousal by manipulating a lever apparatus to indicate their degree of arousal while watching erotic films. The data indicated that females who monitored their arousal did not differ significantly in arousal from females who did not self-monitor. Self-monitoring males, however, had significantly lower levels of tumescence than non-self-

monitoring males. This finding corresponds with Master and Johnson's (1970) claim that males are affected more than females by spectatoring.

Lange et al. (1981) also assessed the effects of self-monitoring on sexual arousal. Using a procedure similar to that of Wincze et al.(1980), normal males monitored their physiological and subjective arousal while watching erotic films. In contrast to Wincze et al.(1980), however, self-monitoring had no effect on tumescence. The authors proposed that this finding was due to an inadequate experimental analogue of self-monitoring. They concluded that the hypothesized inhibitory effect of self-monitoring has yet to be rejected.

Studies investigating the impact of performance demand have not been able to provide conclusive evidence that it adversely effects sexual functioning. Farkas et al. (1979) introduced performance demand by telling normal male subjects either that the erotic film they were about to watch was "highly erotic" (and would probably cause them to become "quite aroused") or that it was "not very erotic" (and that they wouldn't become "very aroused"). The results indicated that performance demand did not significantly effect arousal (penile tumescence), although it was found that high performance demand produced greater arousal than low performance demand while the subject was distracted. The authors interpreted this last finding as an indication

that performance demand interacts with other cognitive variables to affect sexual arousal. Similarily, Lange et al. (1981) found that performance demand had no inhibitory effect on penile tumescence of normal males. Contrary to expectations, performance demand actually increased arousal. In this study the experimental analogue of performance demand was introduced by telling subjects either that they should try to achieve an erection as quickly, as fully, and for as long as possible (demand) or that they should not concentrate on getting an erection but focus on the sexual pleasure the film brings them ( no demand). All of the subjects experienced both conditions and no expectancy regarding the effects of demand conditions on sexual arousal were given.

More recently, Barlow, Sakheim, and Beck (1983) investigated the effect of performance demand on sexual arousal within the context of an anxiety producing situation (threat of electric shock). Normal male volunteers were shown moderately arousing sex film sequences after being told that their level of arousal was being evaluated continuously and that there was a 60 % chance of receiving a mild electric shock if their level of arousal (penile tumescence) was below that of the average subject. The second condition of the experiment consisted of watching the film sequences after being signaled that there was no evaluation or threat of shock. The third condition involved

viewing the films after being signaled that there was a 60 % chance of receiving an electric shock. No shocks were actually delivered during the experimental phase, although shocks were given each subject beforehand to convince them of the authenticity of the threat of shock.

Similar to Lange et al. (1981), the data did not support an inhibitory effect of performance demand, but indicated that performance demand actually increased arousal relative to the other experimental conditions. Significantly greater increases in penile tumescence occurred in the performance demand/anxiety condition, followed by the anxiety condition, with the no anxiety/performance demand producing the least arousal.

Lange et al. (1981) posited that their failure to find an inhibitory effect was due to a number of weaknesses in the experimental analogue (e.g. the use of normal subjects) and concluded that rejecting performance demand as an etiological factor would be premature. A report by Heiman and Rowland (1980) is pertinent in this regard. These investigators compared sexually dysfunctional males (premature ejaculation and erectile failure) with normal males in their reaction to erotic films under conditions of performance demand instructions and sensate focus instructions. First, the dysfunctional men reported feeling less sexually aroused, more inhibited, and more incompetent while viewing the films than did the functional men.

Second, the sexually dysfunctional men showed greater genital arousal to an erotic film preceded by sensate focus instructions than by performance demand instructions. The sexually functional men, on the other hand, showed greater arousal when the film was preceded by the performance demand instructions. These findings suggest that evidence contradicting the inhibitory role of performance demand may be applicable only to sexually functional populations. Importantly, it also supports the claim that performance demand has an negative effect on sexual arousal for dysfunctional populations.

Summary. Anxiety appears to play a complex and varied role in sexual dysfunction. Although it is a common factor in sexual failure, primarily in the form of situation specific anxiety (sexual anxiety), it is neither a necessary nor a sufficient condition for dysfunction. In some cases it may inhibit sexual functioning: in others it may facilitate it. These and other relationships have been summarized by Bancroft (1983) and are presented in figure 1.

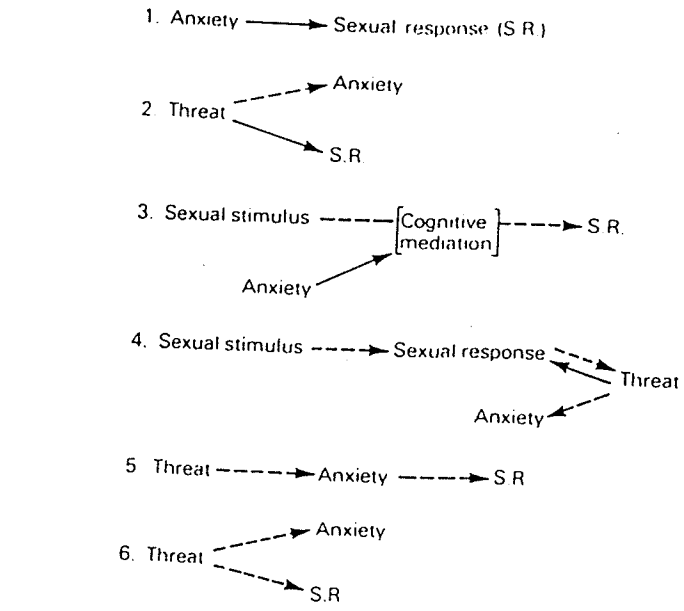


Figure 1. The role of anxiety in sexual dysfunction.

Note. From Human Sexuality and its Problems (p. 204) by J. Bancroft, 1983. New York: Churchill Livingstone.

Unfortunately, most research concerning the role of anxiety in sexual dysfunction has focussed on males. Consequently, the above relationships may not be generalizeable to females. Evidence concerning females is extremely limited and inconclusive. Norton, Jehu, and de Luca (1985) reviewed the available studies and concluded that present knowledge concerning the role of anxiety in female sexual dysfunction is even more inadequate than that for men. More research focussing specifically on the role of anxiety in female sexual dysfunction needs to be done.

## Sensate Focus

As previously discussed, sexual anxiety can be a major factor contributing to sexual dysfunction. Consequently, a principal focus of some treatment strategies has been on anxiety reduction. SF is such a technique. Introduced by Masters and Johnson (1970), it has become one of the staples in the armamentarium of the sex therapist. Depending upon the orientation of the therapist, it is used for treating all types of dysfunction (e.g., Masters and Johnson who have recommended using it at the start of treatment for every dysfunction) or it is used only for the treatment of specific sexual difficulties (e.g., by behavioral therapists for the treatment of erectile failure). Essentially, its use is deemed appropriate whenever sexual anxiety plays a major etiological role in the dysfunction being treated. In spite of its popularity, the use of SF is far ahead of any direct empirical validation of its therapeutic properties. In this section, then, SF will be described and the available evidence pertaining to its therapeutic effect will be presented.

### Description of SF

As a technique, SF has four distintinguishing features:

1) It involves the use of tactile stimulation , i.e., mutual touching, feeling, and caressing of the body.

2) The touching occurs in the context of non-verbal and/or verbal communication.

3) The touching is of a non-demand nature (Masters & Johnson, 1970). During the SF phase there is an interdiction against intercourse or stimulation to orgasm and the clients are instructed to focus on the sensuality versus the sexuality of the touching. Pressure to perform is thought to be reduced by the demand characteristics of the procedure.

4) The touching proceeds in a hierarchial fashion starting with the relatively non-erotic body parts (stage 1) then including the breasts and genitals (stage 2).

These four features are thought to produce the therapeutic effects of SF.

In a typical session of SF, the couple take turns touching and exploring each other's body. The partner doing the touching concentrates on discovering and implementing ways of touching that please their partner while enjoying the experience of doing the touching. The partner receiving the touching guides the giver, both verbally and non-verbally, as to where and how to be caressed, all the while "selfishly" focussing on the sensuality of receiving the touching. During each session neither the giver nor the receiver are to monitor themselves for arousal.

The SF exercises take place under certain conditions. First, the couple is to ensure their privacy so that they will be free from fears of interruption. Second, they are to be in the nude to avoid the distraction of clothes providing full nudity is not stressful for either partner. In the event this is the case, other anxiety reduction techniques (e.g., progressive relation training or SD) are used to reduce the client's anxiety regarding nudity before starting SF (Jehu, 1979). Third, they are to be in a good mood to avoid distraction for reasons such as being tired or angry. Finally, the timing of each session is mutually agreed to by the couple and lasts only as long as it is pleasurable for both partners; a session is never to go to the point of fatigue or boredom.

In the first stage of SF, the touching and caressing is restricted to the relatively non-erotic body parts. Stimulation of the breast and genital areas is explicitly excluded and there is a ban on intercourse. In the second stage, the touching is extended to include the breasts and genitals, but the ban on intercourse remains in effect. At this stage, the partners are to massage the genitals in a "tender and teasing manner with the aim of enhancing sensual and sexual feelings" (Jehu, 1979,p. 141). They are to avoid, however, stimulation aimed at causing an orgasm. Before commencing this stage the couple is provided with adequate information about the structure and function of the genitals to ensure effective stimulation.

There is no set timetable for the duration of the SF exercises. The transition between stages occurs gradually and only when the couple has been able to respond positively to the pleasuring of the non-erotic body parts. Typically, the pacing and sequence of the exercises are tailored to meet the needs of each couple. As a rule, a couple continues the pleasuring until such time that they report that the sexual anxiety has been substantially reduced or extinguished and non-coital sexual activity becomes comfortable and enjoyable. Once this point is reached the first phase of treatment is complete and the specifics of procedures which follow differ depending on the type of sexual dysfunction being treated.

Alleged Therapeutic Effects of SF

SF is claimed to have a number of therapeutic effects (Kaplan, 1974; Masters & Johnson, 1970). The principal alleged effect is the reduction of the adverse psychological and physiological reactions that constitute sexual anxiety. Masters and Johnson (1970) claim that the non-demand component obviates performance fears, which induces a reduction in performance anxiety, avoidance reactions, and spectatoring. Avoidance reactions are alleviated by the fact there is nothing threatening to avoid due to the ban on intercourse. Likewise, spectatoring is thought to be reduced because of the elimination of performance standards.

With the ban, there are no standards to be achieved and the individual need not monitor their behavior.

In counterconditioning terms, SF can be conceptualized as an in vivo desensitization procedure (Annon, 1975; Bass, 1974; Laughren & Kass, 1975; Sotile, 1977). Via the gradual exposure to sexual situations without the anxiety arousing stimuli (i.e., no performance demands) and the concurrent experienced pleasure (i.e., increased PNS activity and decreased SNS activity), counter-conditioning is assumed to occur and sexual anxiety is extinguished.

In cognitive terms, SF is believed to make it difficult for an individual to have perceptions and/or make evaluations which may inhibit arousal (Walen, 1981). Essentially, the absence of performance demand and the simultaneous focus on sensual pleasure versus sexual performance is thought to promote the positive preception and evaluation of sexual stimuli. Because it is difficult to fail in SF, the stimulation and arousal that occurs is assumed to become positively evaluated with a concomitant reduction in interfering negative cognitions and emotions.

In addition to the reduction of sexual anxiety, SF is thought to foster the learning of effective sexual skills (Jehu, 1979; Walen, 1980). Via tactile stimulation and the instructions to communicate their reactions to each other, it is claimed that the couple is able to develop effective

sexual skills, learning what kind of touching pleases self and other, and improving their ability to communicate such information to each other. Increased enjoyment of mutual touching is thought to result as well. A further claimed effect is an increase in postive attitudes towards each other and towards sexual activities (Jehu, 1979; Walen, 1980).

Alleged therapeutic effects that are specific to the genital pleasuring stage are increased physiological arousal (e.g., erections and vaginal lubrication) and psychological arousal (e.g., excitement) (Jehu, 1979). The combined effect of the lack of pressure to perform, the reduction in adverse stress reactions, and the more effective stimulation often results in the couple becoming sexually aroused.

Unfortunately, SF may evoke negative reactions. These include performance anxiety, anxiety stemming from the increased intimacy, guilt reactions from having enjoyed the pleasuring, anger at having to be intimate with a partner who is disliked, and avoidance reactions (e.g., failure to do the exercises). When such reactions occur, they can often be resolved by providing the couple with additional information, modifying negative attitudes, utilizing specific behavioral procedures, or prescribing other assignments (Jehu, 1979).

## Evidence for Therapeutic Effects of SF

Having presented what the therapeutic effects of SF are claimed to be, to what extent does empirical evidence support such claims?

Unlike research concerning SD, there is little substantial evidence to support commonly accepted assumptions regarding SF's multiple positive effects. There are no reports of SF having been prescribed in isolation and only one component analysis study of a treatment program that includes SF has been reported (Fitchen, Libman, & Brender, 1983). The bulk of evidence pertaining to SF comes from anecdotal clinical reports or studies supporting the effectiveness of treatment packages which include SF (e.g., Kaplan, 1974; Kockott et al., 1975; Masters & Johnson, 1970; McCarthy, 1973; Mathews et al., 1976).

Although collectively this data is considerable, at best it is merely suggestive of positive results using the SF procedure as the reported positive outcomes apply solely to the overall effects of the treatment packages. One can only assume that SF had the effects claimed. Given the considerable methodological weaknesses of the various reports (e.g., no control groups, non-representative samples, inadequate follow-up, inadequate criteria for treatment success) the reliabilty of any assumptions made using these studies is questionable.

Fitchen et al. (1983) reported the results of the one study which directly explores the effects of SF. Twenty-three married couples presenting with secondary orgasmic dysfunction participated in a therapy program lasting 14 weeks which covered the following aspects of intervention:

> "Weeks 1-3: Information Acquisition and Self-focus. This period included didactic information on sexual anatomy, the physiology of sexual response, and sexual myths and misconceptions related to orgasmic responding. Assigned exercises included relaxation, Kegel exercises, self-exploration, and directed masturbation.
>
> Weeks 4-9: Acquisition of Interpersonal Sexual Skills and Elimination of Performance anxiety. This period included learning to initiate and to refuse sexual relations and to express sexual tastes and preferences. During this time, intercourse was banned and the emphasis was first on nongenital, then on genital caressing. Sensate Focus I nongenital caressing exercises were assigned during weeks 4-6, while Sensate Focus II genital caressing exercises were assigned during weeks 7-9.

Weeks 10-11: Enhancement of Sexual Repetoire and Skills. This period included specific techniques in self and interpersonal pleasuring to facilitate sexual enjoyment and expression, and learning to receive prolonged sexual stimulation without feeling obliged to reciprocate immediately. Intercourse was resumed during this period.

Weeks 12-14: Maintenance of New Skills. This period included a written evaluation of the gains produced by the program, individual problems encountered and effective measures to overcome these. This evaluation formed the basis of an individualized maintenance program for each couple" (p. 195).

The couples were randomly placed in one of three conditions: standard couple therapy (n=7), group therapy (n=8), and minimal contact therapy (n=8). Assessment procedures consisted of completion of questionnaires at pre-therapy, post-therapy, and at a three month follow-up. The subjects also kept a detailed behavioral report of their daily sexual activities during the 14 weeks. In this report, the subjects indicated whether they engaged in a variety of sexual behaviors, rated their enjoyment of the behaviors, and reported whether they reached orgasm and if so, how.

The data obtained revealed only a few differences between treatment conditions, consequently, group effects were not reported. As for the general effects of SF, contrary to clinical claims, no changes in the frequency and enjoyment of affectional display occurred for either males or females during the SF stages. Consistent with clinical claims was a significant increase in the level of enjoyment of non-coital caressing and non-coital sex.

This study is important because it is the first attempt to assess what the therapeutic effects of SF may be. Nevertheless, it is a limited analysis of SF. Only frequency and enjoyment of affectional display, frequency and enjoyment of non-coital activities, and level of sexual arousal were measured. No assessment of SF's effect on the level of sexual anxiety was done. A further limitation concerns the population sampled. Only couples presenting with secondary orgasmic dysfunction were treated. For this dysfunction, insufficient or inappropriate stimulation and marital discord may be more important etiological factors than sexual anxiety (Jehu, 1979). Comprehensive analysis of the effects of SF is still necessary.

Aside from the clinical reports and the report of Fitchen et al.(1983), there are a few controlled studies from which some evidence can be gleaned concerning the effects of SF.

In this regard the investigations concerning the general effects of performance demand on sexual arousal are relevant, since an integral part of SF is the absence of performance demand. Barlow et al. (1983), Farkas et al. (1979), and Lange et al. (1981) found that experimentally induced performance demand did not inhibit the sexual arousal of normal males. Contrary to clinical reports they found that performance demand actually facilitated arousal. On the other hand, Heiman and Rowland (1981) found a difference between performance demand and SF instructions depending on whether or not the individual was sexually functional. Sexually dysfunctional men showed greater genital arousal to an erotic film preceded by SF instructions than by performance instructions. Concerning the therapeutic validity of SF, the former results suggested that the absence of performance demand is not necessarily therapeutic and that it may even be counter-therapeutic (i.e., some performance demand may be necessary for normal sexual arousal). In contrast, the latter results coincide with clinical reports of the inhibitory effect of performance demand and, importantly, support the claimed benefits of decreasing performance demand and increasing sensual pleasure.

Other pertinent studies are those which have examined the role of spectatoring. These studies are relevant since another integral aspect of SF is the redirection of the

individual's attention on sensual pleasure versus their sexual performance in the belief that it will eliminate spectatoring and increase arousal. Wincze et al. (1980) found that the sexual arousal of normal females who monitored their sexual arousal (i.e., were spectatoring) did not differ significantly from those who did not. However, males who self-monitored showed lower levels of arousal than those who did not. In contrast, Lange et al. (1981) found that self-monitoring had no effect on male sexual arousal, although they believe that this may have been due to an inadequate experimental analogue.

Assuming that Lange et al. (1981) are correct, Wincze et al.'s finding lends some support to the claim that SF reduces spectatoring and increases arousal. In view of the conflicting findings, however, further data concerning the validity of this claim is necessary.

Beck, Barlow, and Sakheim (1983) also examined the effects of attentional focus on sexual arousal. Unlike the previous two studies, however, self-focus is conceptualized as being equivalent to sensate focus. Beck at al. (1983) noted that self-focus, where the individual focusses on their physical sensations during non-sexual massaging, and partner-focus, where the individual focusses on their partner's responses during sex, have been reported to be clinically effective as treatment for spectatoring. Consequently, they examined the effects of self-focus and

partner-focus on sexual arousal. A second independent variable was level of partner arousal (low, high, and ambiguous). The authors hypothesized that the two variables would interact.

The procedure was as follows. Eight sexually functional males and eight dysfunctional males watched an erotic film depicting a heterosexual couple making love. The subjects in the self-focus condition were instructed to put themselves in the role of the male in the film and to monitor their arousal using a lever device similar to that used by Wincze et al. (1980) and Lange et al. (1981). Assessment of arousal was done physiologically (penile tumescence) and subjectively (subjects' self-report). In the partner-focus condition the subject was instructed to focus on the woman and to indicate her level of arousal during the film. All subjects experienced the two conditions.

The main finding was that type of focus and level of partner arousal interact to either facilitate or inhibit sexual arousal. Sexually dysfunctional and functional men showed greater arousal when self-focussing in the high partner arousal condition compared with the low and ambiquous partner arousal conditions. Partner focus produced significantly lower levels of arousal for both groups in the low partner arousal condition compared with high and ambiquous partner arousal which did not differ.

Concerning the effect of the type of focus, self-focus produced significantly higher tumesence compared with partner focus only for low partner arousal. In the ambiquous partner arousal condition both groups showed greater arousal during partner focus relative to self-focus. In the high partner arousal condition, the dysfunctionals demonstrated higher responding under self-focus compared with partner focus, whereas the functionals showed higher responding under partner focus relative to self-focus.

These results indicated that focussing an individual's attention on their sensual pleasure has a positive effect on sexual arousal under certain conditions and supports the claim that SF is therapeutic. The reaction of the dysfunctional subjects to the different types of focus was particularily supportive of SF, as self focus produced higher levels of arousal when the dysfunctional subjects perceived the sexual situation as threatening. On the other hand, in the ambiquous partner arousal condition, which the dysfunctionals perceived as posing little or no performance demand, partner focus produced the highest arousal. The dysfunctional's greater arousal in the threatening situations under self-focus matches the clinical claims of SF. Nonetheless, as the authors noted, the results did not demonstrate that self-focus is either clinically effective or important. Further empirical data is required to substantiate this.

The final group of studies concerning SF are studies which have compared the effectiveness of treatment programes that include SF with other treatments (e.g., systematic desensitization). Mathews et al., 1975) compared the following three treatment methods:

1) conventional SD plus counselling;

2) directed practice plus counselling-directed practice (a ban on intercourse, the implementation of SF, and sexual exercises tailored specifically to the problem); and

3) directed practice with minimal therapist contact (the therapist's contact with the client was mainly by mail).

Thirty-six couples were randomly assigned to one of the three treatments. In the case of half the couples, the patient was the woman and in half, the man. The male sexual complaints included erectile failure, premature ejaculation, and ejaculatory incompetence. The female complaints were inorgasmia, low interest in sex, and vaginismus. Assessment was done by an independent assessor and by the therapists at pre-treatment, post-treatment, and at a four month follow-up. The quality of the marital and sexual relationship, frequency of intercourse and love-making, and presence of sexual difficulties were assessed. All treatment conditions produced improvement in the noted areas although no significant differences between treatments were found.

Nevertheless, directed practice and counselling consistently produced superior results compared with SD plus counselling or directed practice by mail.

Everaerd and Dekker (1982) also compared the effectiveness of SD with a variant of Masters and Johnson's (1970) treatment procedure in treating couples experiencing secondary orgasmic dysfunction. Forty-eight couples were randomly assigned to one of four treatment conditions:

1) a no treatment waiting list control group;
2) SD with a focus on reducing sexual anxiety and inhibitions plus a ban on intercourse;
3) Masters and Johnson (1970) treatment consisting of six SF and sexual stimulation exercises with a focus on teaching sexual skills plus a ban on intercourse; and
4) a combination of treatment conditions 2 and 3.

Treatment was twice weekly for 12 sessions. Treatment effectiveness was assessed on three variables: sexual functioning; sexual anxiety; and satisfaction with the marital relationship. Assessment occurred at pre-treatment, post-treatment, and at a six month follow-up.

Comparison of the pre-treatment, post-treatment, and follow-up scores revealed no significant overall differences among the three treatments. They were all significantly better than the no treatment control group. However, there

were some specific differences between treatments. Both the Masters and Johnson and the SD treatment groups showed significant improvement in sexual functioning and satisfaction with the marital relationship. Only the SD group, however, showed a significant reduction in sexual anxiety. The authors interpreted this as indicating that the Masters and Johnson treatment affects the reduction of sexual anxiety minimally. They noted the need for further data to substantiate this interpretation, however.

Evidence gleaned from the findings of these studies suggests that SF enhances overall sexual functioning and satisfaction with the marital relationship. However, the finding that sexual anxiety was not reduced by SF contradicts the claim that SF reduces anxiety.

Summary

The literature concerning the effectiveness of SF is limited to anecdotal clinical reports, outcome studies of treatment packages which include SF, one empirical study that has assessed SF in a limited manner, and a few comparative studies from which indirect evidence concerning the impact of SF can be obtained. The issues examined in the literature included: (a) the effect of performance demand on sexual arousal; (b) the effect of spectatoring on sexual arousal; (c) the effect of attentional focus (self-

focus/ partner focus) on sexual arousal; (d) the impact of SF on the frequency and enjoyment of affectional display and on the frequency and enjoyment of non-coital sexual activities; and (e) the impact of SF on overall sexual functioning, sexual anxiety, and the marital relationship. Evidence obtained concerning the examined issues is both supportive and contradictory of the therapeutic claims. However, numerous methodological difficulties including no control groups, non-representative samples, and inadequate followup and treatment criteria reduce the reliability of the results reported in the literature. Rigorous investigation of the effects of SF and determination of the key components of SF is still required.

## Rationale for Study and Hypotheses

As indicated, no study exists in which the claimed therapeutic effects of SF have been rigorously investigated. Given the prevalence of SF, the lack of empirical validation of its therapeutic effects constitutes a serious gap in our knowledge. Thus, a study investigating whether or not SF achieves the effects it is purported to achieve was conducted. The study was a natural multiple baseline across subjects design. Subjects were three couples in which the male was experiencing secondary erectile dysfunction. The main hypothesis was that the SF phase of therapy results in the reduction of sexual anxiety as measured by reduction in the males' reported frequency of avoidance of sexual

activities, the males' reported level of performance anxiety, and the males' and females' reported frequency of spectatoring. The avoidance of sexual activity was assessed for only the males because they were the dysfunctional partner and were expected to be avoiding sexual activity because of their dysfunction. However, future research should assess the female's avoidance of sexual activity as the females' verbal reports in the assessment phase indicated that they often avoided initiating sex so as not to put pressure on the male. The level of performance anxiety was assessed only for the male, again, because they were the dysfunctional partner and because the literature suggested that the dysfunctional partner would be the one most likely to experience performance anxiety. A measure of the females' anxiety experienced during mutual sexual activity was taken during the study, but is not reported since it did not yield readily interpretable data. The frequency of spectatoring was assessed for both males and females because the literature indicated that spectatoring occurs for both partners in a couple experiencing sexual dysfuction (e.g., in the case of erectile dysfuction, the female may monitor the male's arousal).

Secondary hypotheses were that the SF phase:

(a) promotes positive attitudes towards sexual activities;

(b) promotes positive attitudes towards the sexual partner;

(c) increases enjoyment of non-coital sexual activities;

(d) improves communication concerning preferred forms of sexual stimulation;

(e) increases satisfaction with sexual relationship and sexual functioning;

(f) increases affectional expression towards spouse; and

(g) increases physiological arousal during genital pleasuring (the fullness and duration of erections as reported by the males).

Based on previous clinical reports, it was predicted that all of the above hypotheses would be supported.

## Method

### Subjects

Subjects were three couples presenting with secondary erectile dysfunction at the Sexual Dysfunction Clinic at the University of Manitoba. The demographic characteristics of the subjects are summarized in Table 1.

TABLE 1

Subject Characteristics

| Characteristic | Couple One | Couple Two | Couple Three |
|---|---|---|---|
| Age | | | |
| male | 43 yrs. | 39 yrs. | 24 yrs. |
| female | 43 yrs. | 35 yrs. | 22 yrs. |
| Education | | | |
| male | Gr. 12 | Univ. | Gr. 12 |
| female | Gr. 12 | Univ. | Gr. 12 |
| Occupation | | | |
| male | skilled labor | business | athelete |
| female | sales | teacher | skilled labor |
| Length of Marriage | 24 yrs. | 15 yrs | 1 yr. |
| Duration of Erectile Difficulties | 3 yrs. | 3 yrs. | 4 yrs. |

Secondary erectile dysfunction was operationally defined as follows:

a) "The persistent inability to achieve and maintain an erection that is sufficient to allow intromission, pelvic thrusting, and in the absence of ejaculatory difficulties, ejaculation during intercourse." (Reynolds, 1977, p. 1218).

b) This inability is present more than 75 % of coital attempts.

c) The onset of failure follows a previous history of adequate erectile functioning with a partner.

The decision to focus on secondary erectile dysfunction was made for a number of reasons. First, SF is believed to be an effective anxiety reduction technique. Therefore, a population in which anxiety is a key etiological factor was necessary. Second, SF is commonly used for the treatment of erectile dysfunction (Masters & Johnson, 1970; Kaplan, 1974). Third, this type of dysfunction is common among clients seeking treatment at the Sexual Dysfunction Clinic. Fourth, and finally, use of a homogenous sample facilitates the comparison of treatment outcome studies (Fitchen et al., 1983; Kilman & Auerbach, 1979; Levine, 1980; Reynolds, 1977).

Subjects were selected using the following criteria:

a) The male had to be suffering from secondary erectile dysfunction as defined and this had to be

the primary therapeutic target for the couple. Sexual anxiety had to be a relevant factor. The erectile failure must have been present at least three months.

b) The male had to be between the ages of twenty and fifty years.

c) The client's sexual partner had to be free of sexual dysfunction that could contribute to the client's erectile difficulties (e.g., dyspareunia and vaginismus). Sexual dysfunction on the part of the partner that could be construed as a result of the male's difficulties was not grounds for rejection. The partner had to be willing to participate actively in therapy.

d) The couple had to have a stable relationship which had lasted longer than three months. This was to preclude the possibility of the difficulty being due to a lack of experience with the partner. In addition, the relationship had to be satisfactory. This was assessed using the Dyadic Adjustment Scale (DAS) (Spanier, 1976). The criterion was a score above 102 which is one-half of a standard deviation below the mean score for the well adjusted sample used to validate the measure. This was chosen as a cut-off point to ensure that severe marital difficulties were not contributing to the erectile failure and that such difficulties would not

interfere with treatment. The couple had to also report the absence of marital stress in the intake interview.

In addition to assessing the stability of the marital relationship, the defensiveness (the tendency to respond in a socially desireable manner) of each couple about their marital relationship was measured. The Marital Defensiveness Scale (MDS), a subscale of the Marital Relationship Questionnaire (MRQ) (Jemail & Lopiccolo,1982) was used to accomplish this.

e) Given recent evidence that physiological causes of sexual dysfunction are more prevalent in cases of erectile failure than has been assumed (Fracher, Leiblum, & Rosen, 1981; Schiavi, 1981; Schumacher & Lloyd, 1981) the male could not be suffering from any physiological disorder that has been implicated as affecting erectile functioning. Furthermore, he could not be taking medication known to affect sexual motivation or functioning. Finally, he had to report experiencing at least one of the following conditions:

1. normal erections during masturbation through to orgasm and ejaculation;
2. normal erections upon awakening during the last three months and which the client judged to be suitable for intercourse; and

3. normal erections during foreplay.

f) The client could not be suffering from any psychopathology that is known to impair sexual functioning (e.g. depression, alcoholism). Furthermore, he could not be receiving concurrent therapy. Each client was asked during the intake session if he was suffering from any psychopathology and if he was receiving other psychotherapy.

g) The couple's goal had to be the improvement of their mutual sexual relationship. The Index of Sexual Satisfaction (ISS) (Hudson, Harrison, & Crosscup, 1981) was used to assess the couples' satisfaction with their sexual relationship. Also, the Sexual Defensiveness Scale (SDS), a subscale of the MRQ (Jemail & Lopiccolo, 1982) was used to measure each couple's defensiveness (the tendency to respond in a socially desireable manner) about their sexual relationship.

h) The male's goal had to be improvement of his erectile functioning.

i) Finally, the couple had to consent to participate in the study and demonstrate their willingness to complete all the requirements.

Couple One

At treatment Mr. R., a locomotive engineer by profession, was 43 years old. Mrs. R., also aged 43, was unemployed due to a recent back injury. Until the injury, she was a cashier clerk for fifteen years.

The R's. had been married for 24 years and have three children. They reported that they married because Mrs. R. was pregnant and that they had severe marital discord for the first four years of their marriage. During this period, apparently Mr. R. was drinking heavily and the child-rearing was left to Mrs. R. They stated that when Mr. R. stopped drinking heavily their relationship improved. Mr. R. claimed to have not been ready for marriage and thus explains the marital discord and his drinking.

At the start of treatment the R's. appeared to be well-adjusted maritally. Verbally, they reported that the relationship was satisfactory and that they both cared for each other. Also, their DAS scores were well within one-half standard deviation of the mean for well-adjusted couples (see Table 2). On the MDS, Mr. R. scored within the normal range of defensiveness (see Table 2). However, Mrs. R. scored in the extreme range of defensiveness (i.e., scores greater than 29, 2% of the normal sample) indicating that she may have had a tendency to respond in a socially desireable manner.

The R's. description of their satisfaction with their sexual relationship differed. Mr. R. described his sexual relationship with Mrs. R. as extremely unsatisfactory. Privately, he believed that Mrs. R. also found it to be extremely unsatisfactory. In contrast, Mrs. R. described her sexual relationship with Mr. R. as slightly to moderately satisfactory. Privately, she believed that Mr. R. found their relationship to be slightly satisfactory. Mr. R's. ISS score was above the cut-off point for satisfaction with the sexual relationship (see Table 2). Mrs. R's. score was below the cut-off point (see Table 2). On the SDS, Mr. R. was in the normal range for defensiveness, whereas Mrs. R. was in the moderate range (see Table 2).

Mrs. R. did not report having any sexual dysfunction that may have contributed to Mr. R's. difficulties. She reported enjoying sexual activity and stated that she is orgasmic. Her first sexual experiences were with Mr. R. and she reported no other sexual partners.

Mr. R. reported experiencing secondary erectile dysfunction. He couldn't maintain a full erection in over 90 % of sexual encounters. Typically, he would lose his erection during foreplay or insertion. He reported, however, the ability to attain and maintain an erection during masturbation. Additionally, he had morning erections and his erectile performance was adequate whenever he was slightly inebriated.

TABLE 2

Preassessment Questionnaire Scores

| Questionnaire | Couple | | |
|---|---|---|---|
| | One | Two | Three |
| DAS | | | |
| male | 114 | 107 | 123 |
| female | 112 | 114 | 111 |
| MDS | | | |
| male | 15 | 12 | 4 |
| female | 30 | 4 | 7 |
| ISS | | | |
| Male | 33 | 42 | 28 |
| Female | 19 | 45 | 23 |
| SDS | | | |
| Male | 6 | 2 | 8 |
| Female | 11 | 0 | 7 |

Note.
DAS= Dyadic Adjustment Scale. A score greater than 102 indicates a well adjusted relationship.

MDS = Marital Defensiveness Scale. The range for normal defensiveness is 5-15 (males) and 7-18 (females).

ISS = Index of Sexual Satisfaction. Scores greater than or equal to 28 indicate dissatisfaction with the sexual relationship.

SDS = Sexual Defensiveness Scale. The range for normal defensiveness is 3-8.

The erectile failure fluctuated in course prior to treatment. Mr. and Mrs. R. reported that, typically, he would experience few problems during the summer when they would spend a great deal of time at their cottage. However,

in the late Fall and Spring, erectile failure would increase to the present level of over 90 % of sexual encounters. Also, after drinking moderately (i.e., "feeling happy") his erectile performance would be satisfactory.

Mr. R. did not recall the surrounding circumstances in which he first had difficulty, nor did he recall his or his wife's reaction to the inital failure. Mrs. R. reported that Mr. R. was flustered when the failures started. She stated that she occasionally was frustrated with his failure but wouldn't show it as she was afraid it might affect him. Both reported that their marital relationship was satisfactory and that there were no significant events in their life when the problem started.

In addition to the erectile problem, Mr. R. reported diminished interest in sex. Prior to treatment, the R's. were having intercourse/ sexual relations less than once a month. Both stated that their sexual encounters were too hurried and less frequent than they liked. Mr. R. was masturbating once a week and was concerned that this was affecting his his sexual desire and/or ability to get erections during sex with Mrs. R.. Mrs. R. reported avoiding sex so as not to put pressure on Mr. R.

Mr. R. first sought help approximately three years ago. A talk with his physician relieved him and for a period he experienced no difficulty. In the Fall, 1983 he again

experienced erectile failure which gradually increased in frequency. In the Spring, 1984 he had a medical examination; no physiological factors were revealed and he was referred to the Sexual Dysfunction Clinic.

Couple Two

At the start of treatment Mr. L. was 39 years old and had recently become employed as a computer technician. Mrs. L. was 35 years old and a primary school teacher. They had been married for fifteen years and had one child, age 12 years.

They appeared to have a well adjusted marriage. Their scores on the DAS were well within one-half standard deviation of the mean for well adjusted couples. Additionally, the L's. scores on the MDS indicated below normal to normal levels of defensiveness. Mr.L. reported being "happy" with the relationship, while Mrs. L. reported being "very happy". Both were optimistic about the future of their relationship and were willing to "...do all I can" to see that it succeeds.

Mr. and Mrs. L. both described their sexual relationship as extremely unsatisfactory. Their ISS scores (see Table 2) were well above the clinical cut-off point for satisfaction, indicating extreme dissatisfaction with their sexual relationship. On the SDS (see Table 2), their scores indicated below normal defensiveness.

Mrs. L. did not report any sexual difficulties that might have been contributing to Mr. L's. erectile problems. Her sexual development was normal and she had not had any adverse sexual experiences. She reported enjoying sexual activity and did not have any negative attitudes towards sex.

Mr L. reported experiencing secondary erectile dysfunction. He stated that he was unable to maintain a full erection in over 90 % of sexual encounters. He reported being able to get an erection almost instantly but that he would lose it during foreplay or during insertion. The average duration of an erection was two minutes. He said that he was able to obtain and maintain an erection during masturbation and had morning erections.

Mr L. first experienced erectile difficulties approximately three years prior to treatment. His erectile ability had gradually declined from the occasional failure to the point where in the six months prior to treatment, failure occurred on every occasion.

The onset of the problem coincided with the L's. moving back to Canada after an extended residence in Europe. The move necessitated reorganization of the L's lifestyle. Mr. L. took over management of the household, while Mrs. L. became the breadwinner. At the start of treatment, Mr. L. became employed for the first time since their departure from Europe.

Mr. L's. reaction to the onset of the problem was that of anger, frustration, and a feeling of being cheated. Mrs. L's. reaction was also one of anger, although her anger was a result of feeling rushed to have sex while the erection lasts.

Mr. and Mrs. L. attempted to resolve the problem initially by practising more. They hypothesized that the problem was the result of a lack of sexual activity and/or inadequate sexual techniques. Their practicising only resulted in an increase in the frequency of erectile failure. They did not attempt any other means of dealing with the problem.

At the time of assessment, the L's. were having intercourse less than once a month. Mrs L. was initiating most sexual encounters. Mr. L. reported being reluctant to initiate anything because of a fear of failure to maintain an erection. When Mrs L. would initiate something, Mr L. reported doing his best to avoid it. He would often respond to Mrs. L. by refusing her advances.

Mr L. initially sought help by visiting his family physician who referred him to a urologist for a medical examination. A full physical examination revealed nothing significant. Mr. L. was then referred to the Sexual Dysfunction Clinic.

Couple Three

At the start of treatment, Mr V. was 24 years of age and employed as a professional athelete. He had never been married. He had a grade twelve education and was a non-practicising Roman Catholic. Ms. M. was 22 years of age and a hair stylist. She, also, had never been married and was a non-practising Roman Catholic. Mr. V. and Ms. M had been involved intimately for nearly a year at the time of assessment. Typically, they would see each other everyday and Mr. V. would stay overnight. Both stated that they love each other and that they were planning to live together. Their score on the DAS placed them in the well-adjusted range for married couples. Their score on the MDS fell in the normal range of defensiveness for married couples (see Table 2).

Sexually, both described their relationship to be slightly satisfactory. However, they both believed privately that each other found the relationship to be slightly unsatisfactory. Mr. V's. ISS score was just above the cut-off point for satifaction with the sexual relationship (see Table 2). Ms. M's. score was just below the cut-off point (see Table 2). On the SDS, Mr. V's and Ms. M's. scores fell in the normal range of defensiveness (see Table 2). Both agreed verbally that the sexual difficulties had a minimal effect on their general relationship although Ms. M. did say that she found it frustrating at times.

Ms. M's. sexual development and previous sexual experiences were normal. She reported being orgasmic and having no sexual dysfunction. Her attitude towards sex was satisfactory although she expressed a dislike for having oral sex performed on her. She stated that she dislikes oral sex because she is concerned the odour would turn off her partner.

Mr. V. was experiencing secondary erectile dysfunction. He reported having difficulty obtaining a full erection 50 % of the time. He, also, complained of having trouble over 90 % of the time maintaining an erection once intercourse had started. Mr. V. did not experience any erectile problems during masturbation or during oral sex.

Mr. V. was having erectile problems four years prior to treatment. Although he was able to achieve and maintain satisfactory erections during masturbation and oral sex, he had never had satisfactory intercourse.

The first erectile failure occurred when he was 18 years old. The failure occurred during an attempt at intercourse with a woman he had been dating. It was his first attempt at intercourse and he had been drinking heavily. Following that, during attempts at intercourse with several different women he again had erectile failure. On some of the occasions he had been out drinking until late.

Mr. V. reported being embarassed by his erectile problems. He would avoid future dates with these women because he was fearful that he would fail again. He stopped seeing the woman with whom the failure had originally occurred because she was acquainted with his female cousin and he was afraid she would tell her about his sexual inadequacy. Mr. V. did not recall what the different partners' reactions were.

Since the initial failure, Mr. V. had brief periods of satisfactory erectile performance during intercourse. As a rule, however, attempts at intercourse resulted in erectile failure.

Mr. V. was initially referred to the Sexual Dysfunction Clinic in the Fall, 1981 by his urologist. At that time he had been involved with a woman for nearly a year, but had never successfully completed intercourse with her due to his inability to obtain and /or maintain an erection. He came alone to therapy for five one hour weekly sessions but discontinued before successful resolution of his difficulties. Mr. V. discontinued therapy because his relationship with this woman ended and he was no longer motivated.

Mr. V. returned to therapy nearly a year later. This time his motivation was higher. He attended for seven one hour weekly sessions. The focus of therapy was on

correction of a deficiency in Mr. V's. knowledge of sexual matters (e.g., sexual anatomy and response). Also, Mr. V. worked through a series of masturbatory exercises (Zilbergeld, 1978). Mr. V. terminated at the end of the exercises and after having successful intercourse.

Mr. V. sought treatment in the Fall, 1984 after experiencing erectile failure in the present relationship. Mr. V. and Ms. M. had not been able to have intercourse due to his inability to obtain and/or maintain an erection. Mr. V. was able, however, to have adequate erections during oral sex and other non-coital activities. At the time of assessment, Mr. V. and Ms. M. were having non-coital sex three to four times a week. They would occasionally attempt intercourse and each attempt would end in failure. A medical examination revealed no physiological factors that may have been causing the difficulties.

## Procedure

### Assessment

Couples presenting at the Sexual Dysfunction Clinic with erectile dysfunction were screened for suitability for inclusion in the study in a 30 minute intake interview conducted by the director of the clinic. Those couples who met the study criteria were referred to the researcher who contacted them to make an appointment.

The first appointment was a general information session. The researcher introduced himself and the study using a prepared script (Appendix A) which explained the nature of the research and outlines its requirements. Any questions the couple had were answered. They were then invited to participate. Upon giving their consent, they were given the Client Consent Form (Appendix B) to sign. The remainder of the session was devoted to administration of questionnaires. The Dyadic Adjustment Scale (Appendix C), the Sexual History Form (Appendix D), the Sexual Preferences Form (Appendix E), the Index of Sexual Satisfaction (Appendix H), and the Marriage and Sexual Relationship Questionnaire (Appendix K) were given to both partners. The Erection Difficulty Questionnaire (Appendix I) and the Goals for Sex Therapy (Appendix J) were administered to the male only. The partners filled out the questionnaires separately. From this point on, sessions were scheduled weekly except for times when the couple was unable to attend.

The next 3-5 sessions were 60-90 minute assessment sessions in which detailed information about the couples' problem was gathered. These sessions were semi-structured following the format of the Treatment of Sexual Dysfunction: Protocol for Assessment Interviews (Appendix L). A focus of these sessions was on ensuring that sexual anxiety was a major complaint and to further ensure that the couple met the selection criteria. The sessions also provided data on

individual differences between couples which was useful for interpretation of possible differences in response to SF.

Baseline data was collected during the assessment period using the Male Card Sort (Appendix F) and Sexual Activity Form (Appendix M).

The Male Card Sort was introduced at the first assessment session using a prepared script (Appendix N). The Male Card Sort was used to measure the amount of performance anxiety experienced by the male in reaction to description of certain sexual situations (e.g., having difficulty obtaining an erection). At the start of each weekly session and after shuffling the cards, the male privately sorted the cards. Each male was instructed to imagine himself in the situation depicted by the card and to place the card in the envelope which best described the amount of anxiety evoked.

Originally, the Male Card Sort was to be administered only at the clinic. However, it became apparent that there would be times when the couples would be unable to attend. Consequently, a set of identical cards was given to each male. In the event of not being able to attend a session, the male was instructed to sort the shuffled cards in private and on the same day of the scheduled session.

The Sexual Activity Form was introduced at the first assessment session using a prepared script (Appendix G). The couples were instructed to complete it independently on

a daily basis and at a set time of day. They submitted them in provided sealed envelopes at the start of the preceding weekly session for the duration of therapy. The therapist telephoned them between each session for the first few weeks to help with any difficulties they encountered and to encourage compliance. The data obtained using the Sexual Activity Form allowed verification of treatment compliance and also provided partner validation of reported sexual activities. The couples did not report having any difficulties with the form and, for the most part, were diligent in completing them.

At the end of the assessment/baseline phase the Dyadic Adjustment Scale, the Sexual History Form, the Index of Sexual Satisfaction, the Sexual Preferences Form, and the Marriage and Sexual Relationship Questionnaire were administered to the couple. Again, the Erection Difficulty Questionnaire and the Goals for Sex Therapy were administered to the male only.

Treatment Program

Since the purpose of this study was to validate clinical claims about SF, it was implemented in the usual therapeutic manner (e.g., Jehu, 1979). Treatment started with general pleasuring (SF I) and moved to genital pleasuring (SF II). The couples attended weekly 30-60 minute sessions to be given information when appropriate and to discuss any

difficulties they were having with SF. Difficulties encountered were systematically monitored and are included in the report. In order to verify that the therapist followed the treatment plan, the therapist completed a topics and assignment checklist (Appendix U ) after each session. The whole treatment program, including the SF phase, was conducted by the researcher under the supervision of Dr. Derek Jehu.

SF I. In the first session of the SF I phase, general pleasuring was verbally introduced using a prepared text (Appendix O). The text outlined the rationale of SF and provided instructions for its implementation. The couple was given a typewritten copy of the text for future reference. They were then shown the film "Treating Erectile Problems" (LoPiccolo, Friedman, & Weiler, 1981) which gives a brief explanation of SF, describing its purpose and goals followed by a demonstration of a couple doing SF. The couple was only shown that part of the film which demonstrates SF I. After the film, the therapist discussed the procedure with them to ensure that they understood it and to answer any questions they might have. None of the couples had any questions. They were then assigned chapter eight of Male Sexuality (Zilbergeld, 1978) on touching, to be read prior to commencing pleasuring. Following this session the couple commenced SF I and a ban on intercourse lasting the duration of the pleasuring was put into effect.

The couple was instructed to pleasure at least twice between sessions. Their progress was monitored at each session and the transition to SF II occurred when the couple was able to respond positively to SF I as indicated by their response on the Sexual Comfort Checklist (Appendix P) i.e., scored 6 out of 7 items.

SF II. Once the couple was ready to shift to genital pleasuring they were provided with information concerning sexual anatomy and response as is normal clinical practice (e.g., Jehu, 1979). This information included:

1. a discussion of the Arousal and Erection Guidelines (Appendix Q);
2. a discussion of sexual anatomy as presented in Male Sexuality (Zilbergeld, 1978) on pages 113-119 (male anatomy) and on pages 239-244 (female anatomy). This discussion included presentation of that part of the film "Becoming Orgasmic", film 1: Self Discovery, (Lopiccolo & Friedman, 1976) which depicts female genitalia.
3. a discussion of sexual response as covered in Male Sexuality (Zilbergeld, 1978) on pages 120-130 (male) and pages 245-254 (female).

Following this each couple was given the Sex Knowledge Checklist (Appendix R) to verify their knowledge. If they were able to answer 80 percent of the checklist items their knowledge was considered adequate.

Once criteria for comfort and knowledge were reached, SF II was introduced using a prepared text (Appendix S) describing the procedure and providing step-by-step instructions. The couple was then shown that part of the film "Treating Erectile Problems" (Lopiccolo, Friedman, & Weiler, 1981) which depicts a couple doing genital pleasuring. After the film they were asked if they had any questions and given copies of the prepared script to take home.

Typically, there is no set timetable for the duration of the SF phase. The pacing and sequence of the exercises are tailored to meet the needs of each couple. As a rule, the couple continues the phase until such time that sexual anxiety has been substantially reduced and mutual pleasuring becomes comfortable and enjoyable. Thus, the length of the SF phase had no upper limit. In this study, SF II was terminated when the couple indicated on the Sexual Comfort Checklist-SF II (Appendix T) that they were comfortable with this activity. The length of each SF phase for each couple is presented in Table 3.

During SF I and SF II, data was gathered using the Male Card Sort and the Sexual Activity Form. At the end of SF II the Dyadic Adjustment Scale, the Sexual History Form, the Index of Sexual Satisfaction, the Sexual Preferences Form, and the Marriage and Sexual Relationship Questionnaire were readministered to the couple. As before, the Erectile

Difficulty Questionnaire and the Goals for Sex Therapy were administered to the male.

At the end of SF II the research per se ended, but treatment continued focussing on following standard clinical practice.

Research Design

Due to the limited number of subjects available at any one time at the Sexual Dysfunction Clinic, a natural multiple baseline across subjects design with additional pre-treatment and post-treatment measures was used. The natural multiple baseline across subjects, proposed by Hayes (1981), allows a researcher to incorporate in a multiple baseline design subjects who present at different times. The length of the baseline in this design, in contrast with the traditional multiple baseline design, is determined by naturally occurring events (e.g., the number of weekly assessment sessions needed for each subject). In this study, for example, couple one required four assessment sessions resulting in a baseline of four weeks. Couple two required three sessions and couple three needed five sessions.

In spite of the fact the multiple baselines in the natural multiple baseline design do not start at the same time for each subject, this design provides nearly the same control against threats to validity as that of the

traditional multiple baseline design. The effect of extraneous variables is controlled by the improbability of the occurrence of external events coinciding with the onset of treatment for each subject. If the change from baseline to treatment differs for each subject in real time, then it is highly unlikely that an extraneous variable will be present at the same time for each subject and, thus, confound the results. Control for the possibility that the factor(s) which signals that it is appropriate to change from one phase to another is correlated with the factor(s) which influence treatment outcome, is accomplished a) by replication across several subjects and b) by gathering detailed data why each phase change occurred for each subject (Barlow, 1981). Again, if the phase change for each subject occurred for different or arbitrary reasons, then it is unlikely that a third factor(s) could have a consistent effect across subjects in subsequent phases.

The repeated measures were:

a) The couples' self-reports on the Sexual Activity Form. The data was gathered daily starting with the first session of the assessment phase and continued until termination of treatment.

b) The male card sort. This was completed by the male at the start of each weekly session, commencing with the assessment phase and continuing until termination of treatment.

The additional questionnaires were administered at preassessment, pretreatment, posttreatment, and followup ( 6 weeks after posttreatment for couples one and two; 6 weeks after posttreatment and 10 weeks after posttreatment for couple three) (see figure 2).

| | Measures | Pre-Assessment | Post-Assessment | Pre-SF | Post-SF | Followup |
|---|---|---|---|---|---|---|
| MALE | 1. Dyadic Adjustment Scale | * | * | * | * | * |
| | 2. Sexual Activity Checklist | | daily | daily | daily | |
| | 3. Sexual History Form | * | * | * | * | * |
| | 4. Index of Sexual Satisfaction | * | * | * | * | * |
| | 5. Sexual Preferences Form | * | * | * | * | * |
| | 6. Male Card Sort | | each session | each session | each session | |
| | 7. Erection Difficulty Questionnaire | * | * | * | * | * |
| | 8. Goals For Sex Therapy | * | * | * | * | * |
| | 9. Marriage and Sexual Relationship | * | | | | * |
| FEMALE | 1. Dyadic Adjustment Scale | * | * | * | * | * |
| | 2. Sexual Activity Checklist | | daily | daily | daily | |
| | 3. Sexual History Form | * | * | * | * | * |
| | 4. Index of Sexual Satisfaction | * | * | * | * | * |
| | 5. Sexual Prefences Form | * | * | * | * | * |
| | 6. Marriage and Sexual Relationship | * | | | | * |

Figure 2. Flow chart of measurement administration ( * = when administrated ).

Several outcome variables were assessed. The main outcome variable was sexual anxiety, operationalized as the level of performance anxiety (males only), the degree of avoidance of sexual activity (males only), and the frequency of spectatoring (males and females). The level of performance anxiety was assessed using the Male Card Sort, the Erection Difficulty Questionnaire (items 1, 10, and 15), Goals for Sex Therapy (item 1), Sexual History Form (item 15), and the Sexual Activity Form (item 14). The Erection Difficulty Questionnaire (item 22), the Sexual History Form (item 13), and the Index of Sexual Satisfaction (item 14) were used to assess the degree of avoidance of sexual activity. Spectatoring was assessed using the Sexual Activity Form (item 13).

Secondary outcome variables were:

1. attitudes towards the spouse as a sexual partner as measured by the Index of Sexual Satisfaction (items 9, 16, 21, and 23);
2. attitudes towards sexual activities as assessed by the Index of Sexual Satisfaction (items 12 and 17), The Goals for Sex Therapy (items 13 and 14), and the Erectile Difficulty Questionnaire (item 11);
3. satisfaction with the sexual relationship with the partner as assessed by the total score on the

Index of Sexual Satisfaction , by the Sexual History Form (items 11 and 12), and the Erectile Difficulty Questionnaire (item 20);

4. enjoyment of mutual non-coital sexual activity as assessed by the Sexual Activity Form;

5. awareness of the spouse's sexual preferences as assessed by the Sexual Preferences Form;

6. communication of sexual preferences as assessed by the Sexual Preferences Form;

7. physiological arousal (fullness and duration of erection ) assessed by the Sexual Activity Form; and

8. affectional expression towards spouse as assessed by the affectional expression subscale of the Dyadic Adjustment Scale.

## Measures

### The Dyadic Adjustment Scale (Appendix C)

This scale was developed by Spanier (1976) to measure the quality of a marriage and similar partnerships. It consists of 32 items which can be subdivided into four component subscales assessing dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression. These four components have been substantiated by factor analysis (Spanier, 1976; Spanier & Thompson, 1982).

A sample of married, divorced, and recently separated persons was used to determine the scales's psychometric properties. Evidence is reported supporting the construct, criterion, and content validity (Spanier, 1976). The subscales reliability ranges from .73 (affectional expression scale) to .94. Overall reliability is .96 (married and divorced sample) and .91 (recently separated sample) (Spanier, 1976; Spanier & Thompson, 1982).

Erection Difficulty Questionnaire (Appendix I)

Developed by Price et al. (1981), this scale assesses the erectile capacity of dysfunctional males and their emotional and attitudinal reponses to their dysfunction. It consists of 24 items (e.g., "During sex I worry about what my patner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty). The man rates the items on a 5 point scale from "always" to "never" or as "completely true" to "completely false".

Pretreatment and posttreatment change on the questionnaire was found to correlate positively with clients' self-report on the frequency of erectile failure and improvement in erectile functioning. Additionally, Price et al. (1981) and Reynolds et al. (1981) report significant pre- and posttreatment changes for overall scores on the questionnaire.

Index of Sexual Satisfaction (Appendix H)

This 25 item scale, designed by Hudson, Harrison, and Crosscup (1981), provides a measure of an individual's satisfaction with their sexual relationship with a partner. It was specifically designed for use as a repeated measure. It is administered individually and the person rates statements such as "I feel my partner enjoys our sex life" and "I feel my sex life is boring" on a 5 point scale.

The psychometric properties of the scale appear to be good. It was validated on a sample of lower-middle to middle class multi-racial Americans. Internal consistency reliability is .91 and test-retest reliability is .93 (Hudson et al., 1981). In addition, the scale appears to have adequate discriminant, factorial, and construct validity (Hudson et al., 1981).

Goals for Sex Therapy (Appendix J)

Developed by Lobitz and Baker (1979) this is a 14 item scale which assesses a sexually dysfunctional male's satisfaction with various sexual behaviours, feelings, and attitudes. The male rates each item on a 7 point scale ranging from "much less than satisfied" to "much more than satisfied".

Reports of studies with men without partners experiencing erectile failure indicate that the scale is sensitive to treatment induced changes (Lobitz & Baker, 1979; Price et al., 1981; Reynolds et al., 1981). Specifically, Lobitz and

Baker (1979) found that self-reports of a significant decline in frequency of erectile failure were associated with significant increases in satisfaction.

Marriage and Sexual Relationship Questionnaire (Appendix U)

Recently developed by Jemail and LoPicollo (1982), this measure assesses a couple's tendency to respond in a socially desireable manner concerning their marital and sexual relationship. The questionnaire consists of two scales for which separate forms are provided for each sex. The first scale assesses social desireability tendencies concerning the marital relationship; the second scale assesses such tendencies concerning the sexual relationship. Each partner independently responds to the scale items answering either true or false.

Psychometric data gathered using a sample of 217 couples indicates that the questionnaire has good reliability (.90 and .93 for the marital and sexual relationship scales and .80 and .75 for the male and female forms) (Jemail & LoPicollo, 1982). The questionnaire is also reported to have adequate construct validity (Jemail & LoPicollo, 1982). Finally, comparison of the questionnaire with other measures of social desireability (e.g., the MarloweCrowne Social Desireability Scale) indicates that it provides a more accurate measure of social desireability response tendencies regarding marital and sexual relations.

The questionnaire is particularily recommended for use in sexual therapy outcome research.

Male Card Sort (Appendix E)

The card sort procedure is a technique that has been previously used for the assessment of sexual anxiety (Caird & Wincze, 1974; Nemetz, Craig, & Ruth, 1978; Wincze & Caird, 1976). It is also a procedure recommended by Nelson (1981) as a dependent variable in clinical research.

This method of assessment involves the use of index size cards which depict in written form situations and activities that are sources of anxiety for the subject. The subject sorts the cards according to the degree of anxiety aroused into envelopes marked 1=a little anxiety, 2=a fair amount of anxiety, 3=much anxiety, and 4=very much anxiety. After the subject has sorted the cards, the totals are calculated to give a score which represents the degree of anxiety felt at that particular moment. If, for example, all the cards were placed in the no anxiety envelope the card sort total would equal zero and indicate that the subject experiences no anxiety about the situations depicted.

The Male Card Sort was tailored especially for this study. The therapist constructed a total of sixteen cards focussing on the themes of erectile difficulty (e.g., failure or difficulty in maintaining an erection) and sexual interaction with a female (e.g., kissing an aroused and

eager female's neck and ears). The male was instructed to imagine himself in that situation and place the card in the envelope which best described the amount of anxiety evoked. Possible scores range from 0 to 64. The higher the score the greater the amount of anxiety experienced.

Sexual Activity Form (Appendix M)

This form is a variation of a form developed by Fitchen et al. (1983). It provides a continuous measure of:

(a) individual sexual activities--fantasies, reading erotica, seeing erotica, and masturbation;

(b) couple non-coital sexual activities--1. kissing and hugging, 2. non-genital manual caressing (giving and receiving), 3. genital manual caressing (giving and receiving), and 4. foreplay; and

(c) intercourse.

The couple individually completes the form. On a daily basis, they (1) indicate whether they engaged in any of the behaviours, (2) rate their enjoyment of each activity engaged in on an 8 point scale, and (3) specify how much anxiety was evoked and whether they were spectatoring.

For this study, an assessment of erectile capacity was included. This assessment is adapted from a sexual activity checklist developed by Jackson (1983). Fullness of erection and duration of erction during general and genital pleasuring was rated by the male and female on a scale of 1

("completely soft") to 7 ("completely hard") for fullness of erection and on a scale of 1 ("completely unsatisfactory") to 7 ("completely satisfactory") for duration of erection.

The Sexual History Form (Appendix D)

Developed by Schover, Friedman, Weiler, Heiman, and LoPicollo (1980), this form consists of 28 items which describe a number of sexual activities and possible reponses to them (e.g., How frequently do you and your mate have sexual intercourse or activity?). The person's responses are used to assign him or her to one or more of the categories in the Multi-axial Descriptive System for the Sexual Dysfunctions (Schover et al., 1980) (e.g., low sexual desire, difficulty achieving an erection, inorgasmic).

Sexual Preferences Form (Appendix E)

This measure was specifically developed for this study. It consists of four items and is filled out individually. It is designed to assess a couple's awareness of each other's sexual preferences (e.g., I am aware of my partner's sexual likes and dislikes. 1. completely aware 2. somewhat aware 3. not at all aware) and to assess their ability to communicate their sexual preferences to each other (e.g., I am able to tell my partner what types or amounts of sexual stimulation I want or need. 1. always 2. usually 3. sometimes 4. rarely 5. never). It also assesses the individual's perception of how aware they believe their

partner is of their sexual preferences and how able they believe their partner is in communication of their sexual preferences (e.g., My partner is aware of the sexual activities that I enjoy and dislike; My partner is able to tell me what types or amounts of sexual stimulation he/she wants or needs).

## Results

Analysis of the data obtained using the repeated measures was done visually using graphs that were maintained for each subject. The criteria for evaluation of the graphs were the magnitude of change, the frequency of replication of the effects, and the degree of agreement with the existing data and theory (Martin & Pear, 1978). Additionally, the graphs were inspected for changes in variability, trend, and level (Barlow, Hayes, & Nelson, 1984). Inter-observer reliability between the husband and wife on the Sexual Activity Form was calculated to provide a check on the validity of the responses. This was done by dividing the number of statements on which the couple agreed by the total number of statements and multiplying by 100. The inter-rater reliability for couple one is 86.9%, for couple two is 80%, and for couple three is 85%. Disagreement amongst the couples mainly concerned the occurrence of kissing. If this item is dropped from analysis, inter-rater reliability for couple one is 95.6%, for couple two is 100%, and for couple three is 85%.

As for the battery of pretreatment and posttreatment questionnaires, no statistical analysis of the data was performed due to the small sample and the questionable reliability of some of the measures. This data was cautiously examined, however, for trends.

### Outcome of Sensate Focus

At the completion of the Sensate Focus (SF) phase all of the couples verbally reported that they found it to be enjoyable and relaxing. None made any negative comments or reported having any difficulties doing the exercises. However, finding the time to do the exercises was a problem for couple one initially. This issue was discussed with the couple to determine reasons why they could not find the time and to help them overcome any obstacles. They reported not being able to find time due to their involvement in the preparation of their daughter's wedding and due to job related time constraints. After discussion of how finding time is a prerequisite for good sex, they set aside several time blocks during which they could be together in privacy. The frequency of doing the SF exercises is presented in Table 3.

## Primary Hypothesis

The main hypothesis was that the SF phase would result in reduction of sexual anxiety experienced during mutual sexual activity i.e., the level of performance anxiety (males only), the frequency of avoidance of sexual activity (males only), and the frequency of spectatoring (males and females).

### Performance Anxiety

Each male's level of performance anxiety as assessed by the relevant questionnaires at each phase of the study is

TABLE 3

Length of Sensate Focus Phases

| | Couple | | |
|---|---|---|---|
| Phase | One | Two | Three |
| SF I | 6 wks. (5 sessions) | 5 wks. (5 sessions) | 4 wks. (4 sessions) |
| SF II | 4 wks. (2 sessions) | 3 wks. (8 sessions) | 2 wks. (4 sessions) |

presented in Table 4. Figure 3 and Figure 4 depict each male's level of performance anxiety as assessed using the Male Card Sort (MCS) and Sexual Activity Form (SAF) respectively. As can be seen, each male was experiencing performance anxiety at the pre-assessment phase.

Subject one's questionnaire responses on item 1 of the EDQ and on the GST indicate a consistent decrease in the level of performance anxiety. However, this decrease starts in the assessment phase. With the exception of these items, there was no pretreatment-posttreatment change.

Subject one's MCS scores (see Figure 3), show a downward trend and a moderate change in level from baseline to the SF phase, with little change in variability and trend from

baseline to treatment. On the SAF (figure 4) there was no change in the level or trend from baseline to SF I. However, from SF I to SF II there was a change in level indicating an slight increase in performance anxiety. This increase occurred during each episode of genital pleasuring. On each occasion he reported experiencing "a little" anxiety. At followup, his level of anxiety had decreased to baseline levels.

Subject two's level of performance anxiety at preassessment was high on all of the questionnaire items (the highest of all the subjects) and was unchanged at pretreatment with the exception of one item (#15, EDQ) where his performance anxiety increased. Pretreatment-posttreatment change was in the predicted direction, although his level of performance anxiety remained high for most items except the GST. On the GST, his ability to anticipate intercourse without anxiety changed from "much less than satisfied" to "somewhat more than satisfied". At followup, his performance anxiety had declined to the point where he reported experiencing anxiety only "sometimes" for all the items except the GST, which remained the same.

TABLE 4

Male Performance Anxiety

| Instrument | Subject | Phase | | | |
|---|---|---|---|---|---|
| | | PA | Pre | Post | F |
| EDQ | | | | | |
| During sex I worry about what my partner is thinking especially if I am having (would have) erection difficulty | One | 2 | 3 | 4 | 4 |
| | Two | 1 | 1 | 2 | 3 |
| | Three | 2 | 3 | 3 | 2/3 |
| During sexual activity I worry about whether or not I will get or keep an erection. | One | 2 | 3 | 3 | 5 |
| | Two | 1 | 1 | 2 | 3 |
| | Three | 2 | 3 | 3 | 2/4 |
| If I lose (would lose) my erection during sexual activity, I worry (would worry) that I won't get an erection again. | One | 5 | 5 | 5 | 5 |
| | Two | 2 | 1 | 3 | 3 |
| | Three | 3 | 3 | 5 | 4/5 |
| SHF | | | | | |
| When you have sex with your mate do you have negative emotional reactions such as fear, disgust, shame, or guilt? | One | 1 | 1 | 1 | 1 |
| | Two | 6 | 6 | 5 | 4 |
| | Three | 4 | 4 | 3 | 1/1 |
| GST | | | | | |
| Ability to anticipate (think about) having intercourse without fear or anxiety. | One | 1 | 2 | 4 | 4 |
| | Two | 1 | 1 | 5 | 5 |
| | Three | 2 | 2 | 3 | 4/4 |

Note.
PA = preassessment. Pre = pretreatment. Post = posttreatment
F = followup. EDQ = Erectile Dysfunction Questionnaire.

SHF = Sexual History Form. GST = Goals for Sex Therapy.

EDQ: 1=always, 2=usually, 3=sometimes, 4=rarely, and 5=never.

SHF: 1=never, 2=rarely, 3=seldom, 4=sometimes, 5=usually, 6=always.

GST: 1=much less than satisfied, 2=less than satisfied, 3=somewhat less than satisfied, 4=satisfied, 5=somewhat more than satisfied, 6=more than satisfied, 7=much more than satisfied.

a : Subject three was assessed at 6 weeks after the SFphase and at termination of treatment.

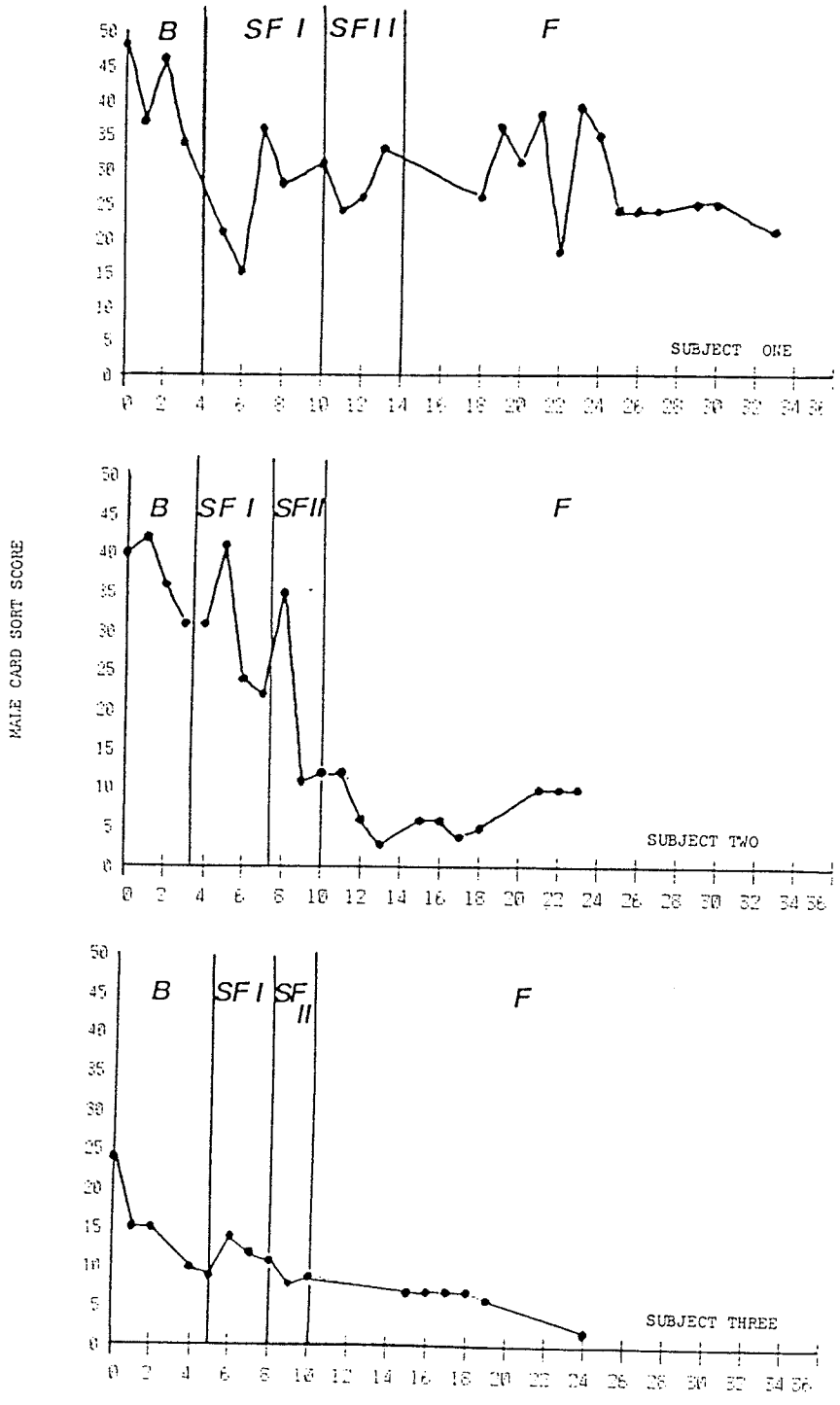


Figure 3. Males' level of performance anxiety assessed using the Male Card Sort ( B = baseline. SF I = general pleasuring phase. SF II = genital pleasuring phase. F = followup. Male Card Sort score range: 0-no anxiety to 50-high anxiety).

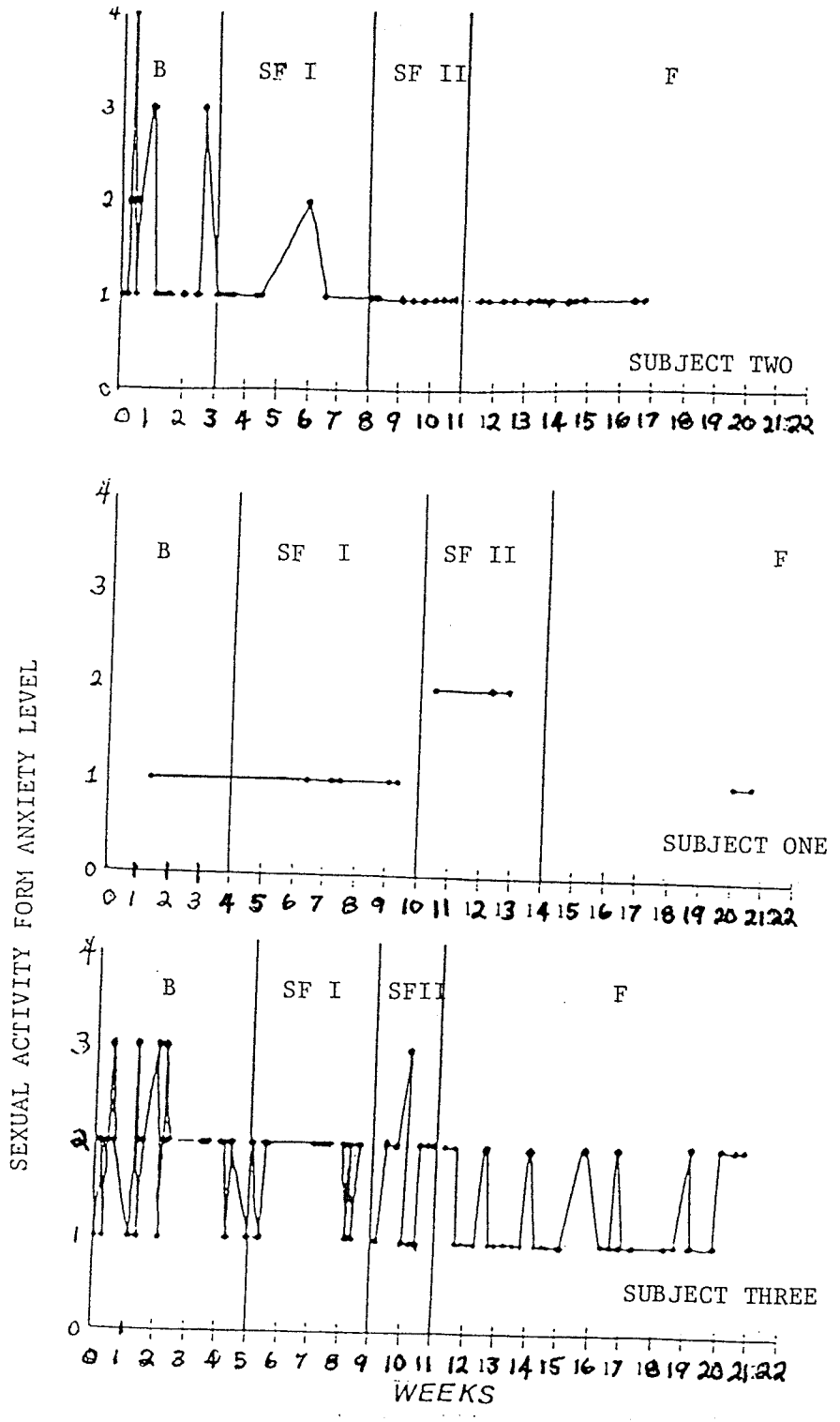


Figure 4: Males' level of anxiety during mutual sexual activity assessed by the Sexual Activity Form ( B=baseline, SF I=general pleasuring, SF II=genital pleasuring, F=followup). Sexual Activity Form range: 1=no anxiety, 2=a little, 3=some, 4=much, 5= a great deal of anxiety.

Subject two's MCS scores (Figure 3) gradually changed in level from baseline to treatment to followup, indicating a gradual reduction in performance anxiety. However, there was no change in trend or variability. A downward trend was present at baseline. The level and trend on the SAF (Figure 4) did not change from baseline to treatment to followup. Nevertheless, his SAF responses indicate that he experienced no anxiety while doing general and genital pleasuring.

At preassessment Subject three's questionnaire responses (Table 3) indicated a high level of performance anxiety. At pretreatment there was no change except for items 1 and 10 of the EDQ. On these items he showed a decrease in performance anxiety. At posttreatment there was a change in the level of performance anxiety on most items in the predicted direction. However, the level of performance anxiety was still high on the GST and on items 1 and 10 of the EDQ. A substantial change in performance anxiety occurred only on item 15 of the EDQ. At followup (1), the level of performance anxiety had declined further on the SHF and the GST, but had increased on item 1 of the EDQ. At followup (2), subject three's level of performance anxiety declined on those items which still had high levels of performance anxiety and remained the same on the items on which performance anxiety was already low.

Similar to subject one and subject two, subject three's MCS scores (Figure 3 )declined in level over the duration of

the study. However, there was no change in trend or variability and a downward trend was present at baseline. On the SAF (Figure 4), subject three showed a change in variability and level during the latter stage of baseline which continued unchanged from treatment to followup suggesting that the SF phase had little impact on his level of performance anxiety. Unfortunately, subject three's level of anxiety experienced while doing the pleasuring exercises cannot be determined from his SAF data.

Avoidance

It was predicted that avoidance of sexual activity would be reduced after the SF phase. Table 5 depicts each male's response to the questionnaire items assessing avoidance behavior.

At preassessment, subject one's response indicates that he was not avoiding sexual activity. At pretreatment, his response was similar and remained the same at posttreatment and followup.

Subject two was engaging in avoidance behavior at preassessment. The level of avoidance increased slightly at pretreatment. After the SF phase, he experienced a decline

TABLE 5

Male Avoidance of Sexual Activity

| Instrument | Subject | Phase | | | |
|---|---|---|---|---|---|
| | | PA | Pre | Post | F |
| EDQ | | | | | |
| I would rather avoid sex altogether than to experience erection problems again. | One | 5 | 5 | 5 | 5 |
| | Two | 2 | 1 | 3 | 4 |
| | Three | 5 | 5 | 5 | 5 |
| SHF | | | | | |
| When your mate makes sexual advances, how do you usually respond? | One | 1 | 1 | 1 | 1 |
| | Two | 3 | 3 | 3 | 2 |
| | Three | 1 | 1 | 1 | 1/1 |
| ISS | | | | | |
| I try to avoid sexual contact with my partner. | One | 1 | 1 | 1 | 1 |
| | Two | 3 | 4 | 2 | 3 |
| | Three | 1 | 1 | 1 | 1/1 |

Note.
PA =preassessment. Pre = pretreatment. Post = posttreatment.
F = followup. EDQ = Erectile Dysfunction Questionnarie.
SHF = Sexual History Form. ISS = Index of Sexual Satisfaction.

EDQ: 1=completly true, 2=mostly true, 3=equally true & false, 4=mostly false, 5=completely false.

SHF: 1=usually accept with pleasure, 2=accept reluctantly, 3=often refuse, 4=usually refuse.

ISS: 1=rarely or none of the time, 2=a little 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.

in avoidance behavior as indicated by his response to item 22 (EDQ) and item 14 (ISS). However, he was still engaging in avoidance behavior. At followup, avoidance behavior had declined further, except for item 14 (ISS).

Subject three did not report the avoidance of sexual activity at preassessment, pretreatment, posttreatment, or followup.

Spectatoring

It was predicted that spectatoring during mutual sexual activity would be reduced after the SF phase. The effect of SF on spectatoring varied for each subject.

Males. At baseline, subject one reported spectatoring "a little" during the sole episode of mutual sexual activity. During SF I, SF II, and followup he reported no spectatoring.

Subject two showed a lot of variability in spectatoring during baseline. His reports of spectatoring varied from "not at all" (11/15 episodes) to "a little" (2/15 episodes) to a "fair amount" (2/15 episodes). During SF I the variability decreased and the level dropped ("no spectatoring" 7/9 episodes, "a little" 2/9 episodes -intercourse occurred), while the trend remained the same. He reported no spectatoring during SF II or followup.

Subject three also showed variability in level of spectatoring ("not at all" 6 episodes, "a little" 10 episodes, "a fair amount" 5 episodes) during the first three weeks of baseline. However, during the last two weeks of baseline the variability and level declined to the point where he was spectatoring "a little". During SF I the level remained relatively constant until the latter part of the phase when he reported spectatoring "a fair amount" on one occasion (intercourse occurred). During SF II there were no noteable changes in variability, level, or trend with the exception of one instance of spectatoring "a fair amount" (intercourse occurred). At followup, variability in spectatoring continued and the trend was unchanged. However, there was a clear drop in level relative to previous phases (26/38 episodes "no spectatoring" and 12/38 episodes "a little" spectatoring.

Females. Subject one did not report spectatoring during baseline or during SF I. However, during the latter part of SF II, she reported spectatoring on two out of three episodes of genital pleasuring. At followup, she reported no spectatoring.

Subject two had some variability in spectatoring during baseline. During SF I the variability disappeared and she reported no spectatoring. During SF II and followup there was no spectatoring.

During baseline subject three reported no spectatoring 12 out of 16 episodes and "a little" spectatoring 4 out of 16 episodes. During SF I, she reported spectatoring only once out of seven episodes. During SF II, the frequency of spectatoring increased as she reported spectatoring "a little" three out of eight episodes. The frequency of spectatoring was similar during followup.

Summary

The data obtained concerning the prediction that the SF phase would result in the reduction of sexual anxiety does not allow a conclusive statement to be made regarding the effect of the SF phase. Inconsistent results within and across subjects and changes in the level of sexual anxiety in the predicted direction during the assessment phase mask the effect of the SF phase.

## Secondary Hypotheses

### Attitudes Towards Spouse

It was predicted that the SF phase would result in positive attitudes towards the spouse as a sexual partner. The results for each couple are presented in Table 6.

## Table 6

Sexual Attitudes towards Partner

| Instrument | Couple | Phase | | | |
|---|---|---|---|---|---|
| | | PA | Pre | Post | F |
| ISS | | | | | |
| My partner is sexually very exciting. | One | | | | |
| | Male | 4 | 4 | 5 | 5 |
| | Female | 5 | 5 | 5 | 5 |
| | Two | | | | |
| | Male | 3 | 4 | 3 | 4 |
| | Female | 3 | 2 | 2 | 3 |
| | Three | | | | |
| | Male | 5 | 5 | 4 | 4/5 |
| | Female | 4 | 5 | 5 | 4/4 |
| My partner is a wonderful sex mate. | One | | | | |
| | Male | 4 | 4 | 5 | 5 |
| | Female | 5 | 5 | 5 | 5 |
| | Two | | | | |
| | Male | 3 | 4 | 3 | 4 |
| | Female | 4 | 3 | 3 | 3 |
| | Three | | | | |
| | Male | 5 | 5 | 5 | 4/5 |
| | Female | 4 | 5 | 5 | 5/5 |
| It is easy for me to get sexually excited by my partner. | One | | | | |
| | Male | 4 | 4 | 5 | 4 |
| | Female | 5 | 5 | 5 | 5 |
| | Two | | | | |
| | Male | 3 | 3 | 3 | 3 |
| | Female | 3 | 3 | 3 | 3 |
| | Three | | | | |
| | Male | 4 | 4 | 4 | 4/4 |
| | Female | 4 | 4 | 4 | 4/5 |
| My partner is very sensitive to my sexual needs and desires. | One | | | | |
| | Male | 4 | 4 | 5 | 5 |
| | Female | 5 | 5 | 5 | 3 |
| | Two | | | | |
| | Male | 4 | 4 | 3 | 5 |
| | Female | 2 | 2 | 3 | 3 |
| | Three | | | | |
| | Male | 4 | 5 | 5 | 4/5 |
| | Female | 5 | 5 | 4 | 4/4 |

Note.
PA = preassessment. Pre = pretretment. Post = posttreatment.
F = followup. ISS = Index of Sexual Satisfaction.

ISS: 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 the time.

Couple one. Mr. R. showed a positive attitude change from preassessment and pretreatment to posttreatment. This was maintained at followup except for item 21 which dropped to preassessment and pretreatment levels.

Mrs. R's. attitude towards Mr. R. as a sexual partner did not change from preassessment to pretreatment to posttreatment to followup except for her response to item 23 at followup where she rated Mr. R. as being less sensitive to her sexual needs and desires.

Couple two. Mr. L's. attitude towards his spouse as a sexual partner fluctuated. At pretreatment his attitude had changed favorably from preassessment ratings. However, posttreatment ratings declined to preassessment ratings. At followup the ratings had returned to pretreatment ratings.

Mrs. L's. attitude towards Mr. L. as a sexual partner did not change significantly. At preassessment she rated him as "sexually very exciting" some of the time, as "sensitive to my sexual needs and desires" a little of the time, and as "sexually exciting" some of the time. At pretreatment her attitude had changed negatively on items 9 and 16. At posttreatment her attitude remained the same on all items except for item 23 where attitude change in the predicted direction occurred. At followup there was no change except for item 9 where Mrs. L's. attitude changed postively.

Couple three. Mr. V's. attitude towards Ms. M. as a sexual partner was at the top of the scale for most items at preassessment and pretreatment. At posttreatment there was no noteable change. At followup (one) his attitude changed slightly and in the negative direction on items 16 and 23, but returned to pretreatment levels at followup (two).

Ms. M's attitude towards Mr. V. did not change significantly. Change occurred from preassessment to pretreatment where she rated Mr. M. as "sexually very exciting" and "a wonderful sex mate" most or all of the time from a good part of the time. Pretreatment-postreatment change occurred only on two of the items. On item 21 it occurred in the predicted direction. On item 23 it occurred in the opposite direction. At followup (one ) her attitude changed negatively on items 9 and 21. At follow up (two) her attitude did not change except for item 21 which changed positively.

Summary. The results indicate that the SF phase had a definite positive effect on only one subject's attitude (male subject one). One other subject's attitude (male subject two) changed negatively from pretreatment to posttreatment. The remaining subjects either did not change or changed inconsistently from pretreatment to postreatment in their attitude towards their spouse as a sexual partner.

Affectional Expression

It was predicted that the SF phase would positively affect the couples' affectional expression. The results are presented in Table 7.

TABLE 7

Scores on the Affectional Expression Scale

| Couple | Phase | | | |
|---|---|---|---|---|
| | PA | Pre | Post | F |
| One | | | | |
| Male | 11 | 9 | 10 | 8 |
| Female | 9 | 10 | 12 | 11 |
| Two | | | | |
| Male | 6 | 8 | 9 | 7 |
| Female | 8 | 6 | 8 | 7 |
| Three | | | | |
| Male | 10 | 10 | 10 | 11/10 |
| Female | 10 | 10 | 12 | 11/10 |

Note.
PA = preassessment. Pre = pretreatment. Post = posttreatment.
F = followup.

Mean for well adjusted married couples: 9.0 +/- 2.3.
Mean for divorced couples: 5.1 +\- 2.8.

Couple one. Mr. R's affectional expression was nearly one standard deviation above the mean for well adjusted married men at preassessment. At pretreatment this had

dropped to the mean. At posttreatment his score increased to one-half standard deviation above the mean. At followup his score had dropped to one-half standard deviation below the mean, the lowest score he obtained. At all phases, however, his affectional expression score was within the range for well adjusted married men.

Mrs. R's. affectional expression score at preassessment was the mean for well adjusted married women. At pretreatment her score increased to one -half standard deviation above the mean. At posttreatment, her score had increased to one and one-half standard deviations above the mean. At followup her score decreased one-half standard deviation. Similar to Mr. R., her score at all phases was within the range for well adjusted married women.

Couple two. Mr. L's. affectional expression score at preassessment fell below the range for well adjusted married men (approximately one and one-half standard deviations below the mean). At pretreatment his score increased to place him within the range, but was still one-half standard deviation below the mean. At posttreatment his score increased one-half standard deviation and was exactly the mean. This was not maintained, however, as his score fell to near preassessment levels at followup, placing him one standard deviation below the mean.

Mrs. L's. affectional expression scores fluctuated. At preassessment she was within the range for well adjusted married females (approximately one-half standard deviation below the mean). At pretreatment, however, her score was below the range (approximately one and one-half standard deviations below the mean). At posttreatment, her score increased nearly one standard deviation, although her score was still one-half standard deviation below the mean. At followup this was not maintained. Her score had decreased one-half standard deviation placing her at the bottom of the range for well adjusted married women.

Couple three. Mr. V's affectional expression score did not change from preassessment to pretreatment to posttreatment. At each of these phases his score was one-half standard deviation above the mean for well adjusted married men. At followup (one) it increased one-half standard deviation, but decreased at followup (two) to posttreatment levels.

Ms. M's affectional expression score at preassessment and pretreatment was one-half standard deviation above the mean. At posttreatment her affectional expression score had increased to nearly one and one-half standard deviations above the mean. At followup (one) and followup (two) her affectional expression score declined to pretreatment levels. Nevertheless, both scores were above the mean for well adjusted married females.

Summary It was expected that the SF Phase would postitively affect the subjects' affectional expression. The impact of the SF phase was as predicted for all subjects except for Mr. V., whose affectional expression was high to start with and did not change.

## Attitudes towards Sexual Activity

It was predicted that the SF phase would induce positive attitudinal change in the males and females concerning general sexual activity. Another prediction was that a positive attitudinal change regarding non-coital sexual activity would result for the males. The results are presented in Table 8 (males) and Table 9 (females).

TABLE 8

Males' Attitude towards Sexual Activity

| Instrument | Subject | Phase PA | Pre | Post | F |
|---|---|---|---|---|---|
| ISS | | | | | |
| I think that sex is wonderful. | One | 5 | 4 | 5 | 5 |
| | Two | 5 | 5 | 4 | 5 |
| | Three | 5 | 4 | 4 | 4/4 |
| I feel that sex is a normal function of our relationship. | One | 1 | 5 | 5 | 5 |
| | Two | 5 | 5 | 5 | 5 |
| | Three | 4 | 4 | 4 | 4/4 |
| GST | | | | | |
| Being able to enjoy a sexual encounter without having intercourse. | One | 3 | 2 | 4 | 4 |
| | Two | 4 | 3 | 5 | 5 |
| | Three | 5 | 5 | 6 | 5/5 |
| Being able to anticipate a sexual encounter without feeling I should have intercourse. | One | 3 | 2 | 4 | 4 |
| | Two | 4 | 4 | 5 | 5 |
| | Three | 5 | 5 | 4 | 4/4 |
| EDQ | | | | | |
| I do not enjoy sexual activity when I do not have an erection. | One | 4 | 4 | 4 | 3 |
| | Two | 3 | 2 | 3 | 3 |
| | Three | 4 | 5 | 5 | 5/5 |

#

Note.
PA = preassessment. Pre = pretreatment. Post = posttreatment. F = followup. ISS = Index of Sexual Satisfaction. EDQ = Erectile Dysfunction Questionnaire. GST = Goals for Sex Therapy.

ISS: 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.

GST: 1=much less than satisfied, 2=less than satisfied, 3=somewhat less than satisfied, 4=satisfied, 5=somewhat more than satisfied, 6=more than satisfied, 7=much more than satisfied.

EDQ: 1=completely true, 2=mostly true, 3=equally true and false, 4=mostly false, 5=completely false.

TABLE 9

Females' Attitude towards Sexual Activity

| Instrument | Subject | Phase PA | Pre | Post | F |
|---|---|---|---|---|---|
| ISS | | | | | |
| I think that sex is wonderful. | One | 5 | 5 | 5 | 5 |
| | Two | 3 | 3 | 3 | 3 |
| | Three | 5 | 5 | 5 | 5 |
| I feel that sex is a normal function of our relationship. | One | 2 | 5 | 5 | 3 |
| | Two | 3 | 3 | 4 | 3 |
| | Three | 3 | 5 | 5 | 5/5 |

Note.
PA = preassessment. Pre = pretreatment. Post = posttreatment.
F = followup. ISS = Index of Sexual Satisfaction.

ISS: 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.

Regarding the latter prediction, male subject two had a negative attitudinal change from pretreatment to posttreatment regarding the notion that sex is wonderful, male subject one had a positive change, while male subject three remained unchanged. None of the females' attitude concerning this item changed. As for the item "sex is a normal function of our relationship", none of the males changed from pretreatment to posttreatment, although one male showed preassessment-pretreatment change in the predicted direction. Only one female's attitude changed positively on this item from pretreatment to posttreatment. The two other females had reached the top end of the scale at pretreatment and did not change at posttreatment.

Regarding the males' attitude towards non-coital sexual activity, all the males showed pretreatment-posttreatment change in the predicted direction on the item "being able to enjoy a sexual encounter without having intercourse". Two of the males had a positive attitude change concerning their ability to anticipate a sexual encounter without feeling they should have sexual intercourse. The other male's attitude changed in the opposite direction from pretreatment to posttreatment. Regarding the ability to enjoy sex without having an erection, two males did not change from pretreatment to posttreatment having indicated at pretreatment that they were able to enjoy sex without an erection. The other male changed from pretreatment to posttreatment in the predicted direction.

Summary. The results do not indicate a consistent effect of the SF phase on the males' and females' attitude towards general sexual activity. The males reported both negative and positive attitudinal changes. The females did not experience any pretreatment-posttreatment attitudinal change. Regarding the males' attitude toward non-coital sexual activity, the results indicate that the SF phase had a positive impact for the most part.

Awareness and Communication of Sexual Preferences

A prediction was that the subjects' awareness of his/her partner's sexual preferences and their ability to communicate their sexual needs and desires to their partner would be increased after the SF phase. The results for the males are presented in Table 10, those for the females in Table 11.

## Table 10

Males' Awareness and Communication of Sexual Preferences

| Instrument | Subject | Phase PA | Pre | Post | F |
|---|---|---|---|---|---|
| SPF - Awareness | | | | | |
| My partner is aware of the sexual activities that I enjoy and dislike. | One | 1 | 1 | 1 | 1 |
| | Two | 2 | 2 | 2 | 2 |
| | Three | 1 | 1 | 1 | 1/1 |
| I am aware of my partner's sexual likes and dislikes. | One | 2 | 1 | 1 | 1 |
| | Two | 2 | 2 | 2 | 2 |
| | Three | 1 | 1 | 1 | 1/1 |
| SPF - Communication | | | | | |
| I am able to tell my partner what types or amounts of sexual stimulation I want or need. | One | 1 | 2 | 1 | 2 |
| | Two | 3 | 3 | 3 | 3 |
| | Three | 3 | 2 | 2 | 2/2 |
| My partner is able to tell me what types or amounts of sexual stimulation she wants or needs. | One | 3 | 2 | 2 | 2 |
| | Two | 2 | 2 | 2 | 2 |
| | Three | 3 | 2 | 2 | 2/2 |
| EDQ | | | | | |
| If I (would) have difficulty getting or keeping an erection I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need. | One | 5 | 4 | 5 | 4 |
| | Two | 2 | 3 | 3 | 4 |
| | Three | 3 | 3 | 2 | 3/3 |

Note.
PA = preassessment. Pre = pretreatment. Post = postreatment.
F = followup. SPF = Sexual Preferences Form.
EDQ = Erectile Dysfunction Questionnaire.

SPF: - Awareness: 1=completely aware, 2=somewhat aware, 3=not at all aware.

SPF: - Communication: 1=always, 2=usually, 3=sometimes, 4=rarely, 5=never.

EDQ: 1=completely true, 2=mostly true, 3=equally true and false, 4=mostly true, 5=completely false.

TABLE 11

Females' Awareness and Communication of Sexual Preferences

| Instrument | Subject | Phase PA | Pre | Post | F |
|---|---|---|---|---|---|
| SPF - Awareness | | | | | |
| My partner is aware of the sexual activities that I enjoy and dislike. | One | 1 | 1 | 1 | 1 |
| | Two | 2 | 2 | 2 | 2 |
| | Three | 1 | 1 | 1 | 1/2 |
| I am aware of my partner's sexual likes and dislikes. | One | 2 | 2 | 1 | 1 |
| | Two | 2 | 2 | 2 | 2 |
| | Three | 1 | 1 | 1 | 1/2 |
| SPF - Communication | | | | | |
| I am able to tell my partner what types or amounts of sexual stimulation I want or need. | One | 3 | 2 | 1 | 3 |
| | Two | 4 | 3 | 3 | 2 |
| | Three | 2 | 2 | 2 | 2/2 |
| My partner is able to tell me what types of amounts of sexual stimulation he wants or needs. | One | 2 | 2 | 1 | 1 |
| | Two | 3 | 3 | 3 | 2 |
| | Three | 2 | 2 | 2 | 2/2 |

Note.
PA = preassessment. Pre = pretreatment. Post = posttreatment.
F = followup. SPF = Sexual Preference Form.

SPF - Awareness: 1=completely aware, 2=somewhat aware, 3=not at all aware.

SPF - Communication: 1=always, 2=usually, 3=sometimes, 4=rarely, 5=never.

Awareness. Two of the three males reported being completely aware of their partner's sexual preferences at pretreatment and did not change at posttreatment or at followup. Male subject one reported being "somewhat aware" at preassessment and pretreatment and did not change his awareness at posttreatment or at followup. Two of the females were "somewhat aware" of their partner's sexual preferences at preassessment and pretreatment. At posttreatment one reported "being completely" aware; the other did not change at posttreatment or at followup.

Communication. Concerning the abilty to tell a partner what types of sex stimulation they want or need, male subject two did not change from preassessment to pretreatment to posttreatment. Male subject one showed a decline in ability from preassessment to pretreatment and then changed in the predicted direction at posttreatment. This was not maintained at followup. Male subject three changed his ability to communicate his sexual needs in the predicted direction from preassessment to pretreatment and maintained this at posttreatment and at followup.

Two females (subjects one and two) reported at preassessment an inability to communicate sexual needs and desires to their partner. At pretreatment this had improved for both. At posttreatment, subject one showed further improvement whereas subject two had not changed. At followup, subject one's ability declined to preassessment

status while subject two's ability improved. Female subject three reported being able to tell her partner what she wants sexually at preassessment and did not change at pretreatment, posttreatment, or at followup.

Finally, the effect of the SF phase on the males' ability to tell their partner what types of stimulation they would want and/or need if they were having difficulties obtaining and/or maintaining an erection differed for each male. Subject one showed a decline from preassessment to pretreatment and, then, improvement at posttreatment which was maintained at followup. Subject two improved from preassessment to pretreatment which was maintained at posttreatment and then improved further at followup. Subject three did not change from preassessment to pretreatment. At posttreatment his ability declined, but returned to pretreatment levels at followup (one and two).

Summary. The SF phase appears to have had little effect on the subjects' awareness of their partner's sexual preferences. Of the three subjects who were "somewhat aware" of their mates' sexual preferences at pretreatment, only one's awareness had increased at posttreatment.

Regarding the subjects' ability to communicate their sexual needs to their partner, the SF phase appears to have had a weak effect. Only one subject's (male subject one) ability to communicate improved from pretreatment to

posttreatment. Two subjects did not change from pretreatment to posttreatment. The remaining three subjects' ability to communicate improved from preassessment to pretreatment. Of these, only one's communicative ability had improved further at posttreatment. The other two had not changed. Finally, the SF phase appears to have had a weak positive effect on the males' ability to tell their partner what stimulation they want or need if they were having erectile difficulties.

Sexual Satisfaction

A prediction was that SF would promote greater satisfaction with the subjects' sexual relationship. A further prediction was that the males would be more satisfied with their sexual functioning post-SF versus pre-SF. Table 12 presents the results for the males, Table 13 the results for the females.

TABLE 12

Males' Satisfaction with their Sexual Relationship

| Instrument | Subject | Phase PA | Pre | Post | F |
|---|---|---|---|---|---|
| ISS | | | | | |
| | One | 33 | 18 | 16 | 12 |
| | Two | 42 | 38 | 39 | 35 |
| | Three | 28 | 20 | 22 | 21/15 |
| SHF | | | | | |
| Overall, how satisfactory to you is your sexual relationship with your mate? | One | 6 | 2 | 5 | 2 |
| | Two | 6 | 2 | 5 | 2 |
| | Three | 4 | 5 | 5 | 5/5 |
| EDQ | | | | | |
| I am dissatisfied with my sexual functioning. | One | 2 | 3 | 5 | 3 |
| | Two | 1 | 2 | 3 | 3 |
| | Three | 2 | 3 | 3 | 3/4 |

Note.
PA = preassessment. Pre = pretreatment. Post = posttreatment. F = followup. ISS = Index of Sexual Satisfaction. SHF = Sexual History Form. EDQ = Erectile Dysfunction Questionnaire.

ISS: scores greater than 28 indicate dissatisfaction with the sexual relationship.

SHF: 1=extremely unsatisfactory, 2=moderately unsatisfactory, 3=slightly unsatisfactory, 4=slightly satisfactory, 5=moderately satisfactory, 6=extremely satisfactory.

EDQ: 1=completely true, 2=mostly true, 3=equally true and false, 4=mostly false, 5=completely false.

TABLE 13

Females' Satisfaction with their Sexual Relationship

| Instrument | Subject | Phase PA | Pre | Post | F |
|---|---|---|---|---|---|
| ISS | | | | | |
| | One | 19 | 19 | 9 | 20 |
| | Two | 45 | 54 | 51 | 52 |
| | Three | 23 | 15 | 13 | 15/14 |
| SHF | | | | | |
| Overall, how satisfactory is your sexual relationship with your mate? | One | 5 | 4 | 6 | 5 |
| | Two | 2 | 1 | 2 | 1 |
| | Three | 4 | 5 | 5 | 5/5 |

Note.
PA = preassessment. Pre = pretreatment. Post = posttreatment.
F = followup. ISS = Index of Sexual Satisfaction.
SHF = Sexual History Form.

ISS: a score greater than 28 indicates dissatisfaction with the sexual relationship.

SHF: 1=extremely unsatisfactory, 2=moderately unsatisfactory, 3=slightly unsatisfactory, 4=slightly satisfactory, 5=moderately satisfactory, 6=extremely satisfactory.

Males. All of the males showed an increase in satisfaction during the assessment period as reflected by their lower ISS scores at pretreatment. However, at the end of the SF phase only one male's (subject one) satisfaction had increased further. The two other males showed a relative decrease in satisfaction as indicated by their higher ISS scores. At followup, subject one's ISS score had decreased further and indicated satisfaction with his sexual relationship. Similarily, subject two's and subject three's scores had declined relative to their previous scores. Subject two's score, however, was still above the clinical cutting point reflecting dissatisfaction with his sexual relationship. Subject three's scores at followup were below the clinical cutting point and indicate that he was quite satisfied with his sexual relationship.

On the SHF, subject two's and subject three's responses coincide with their ISS scores. However, there is a discrepancy between subject one's ISS scores and his SHF responses at preassessment, pretreatment, and followup on item 11.

Concerning the male's satisfaction with their sexual functioning, at preassessment each male was dissatisfied with his level of functioning. At pretreatment each male's level of satisfaction had increased. At posttreatment subject one's and subject two's level of satisfaction had increased further, while subject three's level of

satisfaction had remained unchanged. At followup, subject one's level of satisfaction had decreased to pretreatment levels. Subject two's remained the same, while subject three's level stayed the same at followup (1) and increased at followup (2).

Females. Subject one's level of satisfaction at preassessment and pretreatment was below the clinical cutting point and remained unchanged. At posttreatment, her ISS score decreased considerably indicating satisfaction with the sexual relationship. At followup, her score increased to near pretreatment levels, but was still below the clinical cutting point. Her ratings of satisfaction on the SHF coincide with the ISS.

Subject two's ISS scores at preassessment and pretreatment were quite high indicating dissatisfaction with her sexual relationship. This coincides with the SHF. At posttreatment, her ISS score dropped slightly, as did her rating on the SHF. Thus, it appears that her level of satisfaction had increased relative to pretreatment. At followup, her ISS score and SHF rating returned to pretreatment levels.

Subject three's level of satisfaction with her sexual relationship increased from preassessment to pretreatment to posttreatment. At followup, her level of satisfaction lowered to pretreatment levels, but increased at followup

(two) to near posttreatment level. Her ratings on the SHF coincide roughly with her ISS scores.

Summary. The overall effect of the SF phase on satisfaction with the sexual relationship differed for males and females. Each male's satisfaction increased during the assessment phase, but only one's satisfaction had increased after the SF phase. In contrast, each female's level of satisfaction had increased at posttreatment.

Concerning the impact of the SF phase on the males' satisfaction with their sexual functioning, each male's level of satisfaction increased from pretreatment to posttreatment. However, the change in level of satisfaction commenced during the assessment phase. Thus, no conclusive statement can be made about the effect of SF on the males' satisfaction with their sexual functioning.

Enjoyment

It was predicted that enjoyment of mutual non-coital sexual activity (kissing and hugging, foreplay, general pleasuring, and genital pleasuring) would increase during the SF phase.

Males. Subject one did not report any mutual sexual activity during baseline and consequently no data is available on the level of enjoyment. During SF I and SF II he rated his enjoyment of mutual non-coital sexual activity

(general and genital pleasuring only) as complete enjoyment. This was maintained at followup.

Subject two's level of enjoyment during baseline steadily declined. During SF I the trend changed direction and the level of enjoyment increased indicating that SF I had a positive effect. This effect was maintained throughout SF II. During followup there was a gradual decline in level, a gradual change in trend opposite in direction to that predicted, and an increase in variability. Concerning enjoyment of the SF exercises, subject two's typical enjoyment of each episode of general pleasuring was 5 on a scale of 1 (no enjoyment) to 7 (complete enjoyment). His enjoyment of the genital pleasuring episodes was higher, the typical rating being 6.

Subject three's enjoyment of mutual non-coital sexual activity during baseline was high, with no changes in variability, level, or trend. During SF I and SF II, the level declined and variability increased indicating that his enjoyment declined. During followup, there was no further change. As for his enjoyment of the pleasuring exercises, subject three typically gave the general pleasuring episodes a rating of 5 and the genital pleasuring a rating of 6.

Females. Subject one's enjoyment of non-coital activity did not change from baseline to SF I to SF II to Followup. She reported "complete enjoyment" of general and genital pleasuring.

The effect of the SF phase on subject two's level of enjoyment is unclear. At baseline, SF I, and SF II there was a lot of variability in the level of enjoyment and no consistent effect is evident. During followup, the variability remained with a gradual decline in level of enjoyment. As for her enjoyment of the general pleasuring, subject two gave low ratings initially which improved as the SF phase progressed. Her initial rating was 3; at the final episode the rating was 7. During SF II the initial rating was 5: at the end of the phase it was 7.

Subject three's level of enjoyment during baseline was stable and quite high. During SF I there was a slight increase in variability. During SF II, there was less variability, but the level of enjoyment slightly declined relative to previous phases. Her enjoyment of the general pleasuring was consistently 6. During the genital pleasuring her ratings varied from 5-6. The ratings of 5 were given exclusively on occasions when she was doing the "giving".

Summary. The results do not indicate a consistent effect of the SF phase on the enjoyment of mutual non-coital sexual activity for either the males or females. Only one subject (male subject two) showed a clear increase in enjoyment at posttreatment. The other subjects' level of enjoyment either stayed the same ( four subjects) or declined (male subject three). Concerning the SF exercises, all subjects appear to have enjoyed them.

Males' Arousal

It was predicted that the males' physiological arousal (fullness and duration of an erection) would increase during the genital phase of SF.

Fullness of erection. Subject one did not record the data required during the genital phase of SF. However, he did so during SF I. In this phase his erection was "completely soft" at each occurence of general pleasuring.

Subject two and subject three completed the data collection as required. During SF I, subject one's erection was completely soft on every occasion of general pleasuring. During genital pleasuring, his level of arousal was, for the most part, higher than in SF I. There was a great deal of variability in his degree of fullness, however. His fullness of erection ranged from "completely soft" (3 out of 8 occasions) to "completely hard" (1 out of 8 occasions).

Subject three's fullness of erection during SF I was in the "completely soft" to "semi-hard" range. During SF II his degree of fullness increased slightly, but remained variable.

Duration. Subject one and Subject two did not record the required data. Consequently, no comment can be made concerning the effect of genital pleasuring on the duration of their erections. Subject three did record the data. It

appears that genital pleasuring had a weak positive effect on the duration of his erections. His satisfaction with the duration of his erections was higher on SF II compared to SF I overall. However, there was a great deal of variability in his degree of satisfaction.

Summary. No conclusive statement can be made concerning the effect of the genital phase of SF on the males' physiological arousal due to incomplete data. The one subject for whom data was complete, appears to have been only minimally affected by the genital phase.

## Progress and Outcome after the SF Phase

All of the couples successfully completed the sensate focus phase. However, only couple three completed the second half of treatment which focussed more directly on restoration of erectile capacity. They reported having consistently successful intercourse at termination and at a one month followup. At termination, couple one reported having had successful intercourse on several occasions and felt it was unnecessary to continue further treatment. Couple two discontinued therapy because of time constraints and stress from adjustment to new jobs. At that time they had had successful intercourse on three occasions, but they still felt it was necessary to continue therapy at a later date. When contacted four months later, their sexual relationship had deteriorated to pre-treatment status. Nevertheless, they declined further therapy.

## Discussion

The present study is the first rigorous investigation of the claimed therapeutic effects of SF. Prior to this study, evidence concerning the effects of SF was limited to anecdotal clinical reports, treatment outcome studies which include SF, a few controlled studies indirectly related to SF, and one empirical study assessing SF in a limited manner. The data obtained confirms some, but not all of the clinical claims. Overall, the present study does not unequivocally demonstrate that the SF phase is an effective ingredient of sex therapy.

### Primary Claim

The primary therapeutic claim concerning SF is that it reduces sexual anxiety (i.e., performance fears, avoidance of sexual activity, and spectatoring). Masters and Johnson (1970) state that "Sensate focus in the early stages of therapy tends to dissipate anxieties related to sexual performance on the part of either or both spouses" (p. 553). The major goal of this study was to validate this claim. Unfortunately, the data obtained does not clearly demonstrate the impact of SF on the components of sexual anxiety.

Starting with performance anxiety, although all the males experienced a decline in anxiety such that the levels of anxiety were considerably lower at posttreatment compared

with pretreatment, the decline started in the assessment phase . Thus, the effect of the SF phase is obfuscated and the clinical claim concerning performance anxiety cannot be accurately evaluated. At the very most, since the decline continued throughout the SF phase, a tentative conclusion is that, overall, the SF phase does not have detrimental effect on performance anxiety. This conclusion must be viewed cautiously, however, as there is some indication that the SF exercises may promote performance anxiety. Some subjects reported experiencing anxiety while doing the SF exercises. This occurred for both male and female subjects primarily during genital pleasuring and is consistent with previous reports of performance anxiety being evoked by genital pleasuring (Jehu, 1979). Unfortunately, this study did not allow for dissociate assessment of anxiety experienced while doing the SF exercises. The subjects gave a global rating of anxiety for all sexual activities engaged in during a 24 hour period. Data concerning the effect of the SF exercises on performance anxiety was obtained only when that was the sole activity the couple had engaged in. Consequently, a complete picture of the amount of performance anxiety evoked by the pleasuring exercises was not obtained. Future research should investigate the amount of anxiety evoked by the SF exercises themselves. A further focus should be on determining whether or not the roles of "giver" and "receiver" have different effects upon performance anxiety.

The data obtained concerning the claim that avoidance of sexual activity is reduced by the SF phase is not sufficient to confirm or disconfirm the claim. There is some indication that the SF phase did reduce avoidance behavior as the sole subject who was experiencing avoidance behavior at pretreatment, reported declining levels at posttreatment. It must be noted, however, that the avoidance behavior was reduced, but not diminished altogether, and that at posttreatment he was still engaging in avoidance behavior. A cautious interpretation is that the SF phase did not promote or maintain avoidance behavior as none of the subjects reported an increase in avoidance behavior.

The claim that the SF phase reduces spectatoring, again, cannot be decisively evaluated on the basis of the data obtained. The SF phase simply did not have a uniform effect. Two subjects (males) reported a decrease, two subjects reported an increase (females), and two reported no change (one male, one female).

It is interesting to note that the SF phase seemed to affect the males differently from the females. Whereas the males tended to show a decline in spectatoring, the women tended to show an increase. The females who reported an increase in spectatoring did so primarily during SF II. This suggests that the inclusion of the genitals in the pleasuring may have reintroduced monitoring of arousal. It

may be that at this stage the women were "spectatoring" their partner's arousal (i.e., erection). The observation of an increase in spectatoring during the genital phase coincides with previous reports that stress reactions are often evoked during this phase (Jehu, 1979). Again, future research should separately investigate the effect of the different SF exercises and the effect of the different roles of "giving" and "receiving" upon spectatoring. Also, a focus of future research should include examination of sex differences in response to SF and differences in response between the dysfunctional partner and the functional partner.

Although no conclusive statement can be made about the effect of the SF phase on sexual anxiety, the data does lend support to the etiological theory concerning the association between sexual anxiety and sexual dysfunction. All the couples reported having successful intercourse at termination of therapy. The return of erectile ability in conjunction with the overall diminution of performance anxiety and spectatoring is consistent with the etiological theory. In addition, each male did complain of performance anxiety and spectatoring thus supporting the validity of these constructs and their presence in men experiencing erectile dysfunction.

Factors Affecting Interpretation of the SF Phase

The inability to confirm the clinical claim concerning the anxiety relief properties of SF is due, in part, to the reduction of sexual anxiety which occurred during the assessment phase. This reduction can be attributed to a number of factors. These factors are:

(a) the reactivity of self-monitoring;

(b) the reactivity of assessment; and

(c) the client-therapist relationship.

The reactivity of self-monitoring. One measure used in the present study to assess sexual anxiety, the SAF, required self-monitoring. A well documented characteristic of self-monitoring measures has been labelled "the reactivity of self-monitoring". This term refers to therapeutic changes which occur as a result of self-monitoring. For example, it has been demonstrated that self-monitoring of smoking, eating, and studying procedures produces positive change despite the absence of therapeutic intervention (Johnson & White, 1971; Lipinski & Nelson, 1974; McFall, 1970; Nelson, Lipinski, & Black, 1975 cited in Hersen & Bellack, 1978). In addition, research on the self-monitoring of fear behavior indicates that it may reduce a client's anxiety (Emmelkamp, 1974; Hepner & Cauthen, 1975; Leitenberg, Agras, Allen, Butz, & Edwards, 1975; Rutner, 1973 cited inHersen & Bellack, 1978). Specifically concerning sexual dysfunction, Jehu (1979) noted that self-monitoring increases a client's awareness of the nature of

their dysfunction and of factors which influence it. The upshot of reactivity is that it can make it difficult to interpret treatment effects. Although it is beneficial for clinical outcome, it can act as a confounding variable by producing an inaccurate pretreatment baseline. Such a baseline makes it difficult to determine whether changes observed during treatment are due to treatment or self-monitoring.

It is possible that reactivity occurred in the present study. The observed reduction in sexual anxiety that occurred during the assessment, treatment, and followup phases might simply have been a result of self-monitoring. On the other hand, the SF phase may have had an anxiety reducing effect that is impossible to detect because of the reactivity of the self-monitoring. Ideally, in order to control for reactivity, future research concerning the effect of SF on sexual anxiety should employ means of measurement that do not require self-monitoring. Unfortunately, given the private nature of sexual dysfunction, self-monitoring is often the only practical method of assessment. A caveat must be that caution be exercised when interpreting data obtained using self-monitoring measures.

The reactivity of assessment. The purpose of assessment in sex therapy is to gather detailed information concerning the nature of the sexual problem including: definition of

the problem; information about its onset, course, and duration; how it was dealt with; and the effect upon the relationship. The phase concludes with formulation of a hypothesis regarding the cause of the dysfunction and determination of appropriate treatment. This information is typicallly discussed with the client.

Traditionally, the assessment is considered to be an important, but inert ingredient of sex therapy. It has been assumed that the client's dysfunction is unaffected by assessment. Indeed, research evaluating the effectiveness of different sex therapy techniques often includes the assessment as part of the treatment phase under the assumption that it is inert (e.g., Everaerd & Dekker, 1981; Mathews et. al., 1975; Obler, 1973). However, the reduction of sexual anxiety during the assessment phase of this study suggests that this assumption may not be true. Completion of the assessment tasks may have been therapeutic. It is conceivable that open and frank discussion of the nature of the problem within a safe environment (the client-therapist relationship) produced anxiety relief. Furthermore, the definition and causal explanation of the problem may also have been therapeutic. Jehu (1979) noted that provision of plausible explanations for problems can be reassuring to a client experiencing sexual dysfunction. The attribution of a client's complaints to normal and temporary causes versus pathological and permanent causes can increase the client's

optimism regarding cure and decrease negative emotions about self and disorder. Moreover, the end result of the assessment phase i.e., determination of appropriate therapeutic techniques and goals, and discussion of this with the client may, also, act to increase the client's expectations of receiving effective help and thus relieve anxiety.

All of the above factors may have contributed to the decline in anxiety observed during the assessment, treatment, and followup phases and thus masked any therapeutic effect SF may have had.

The client-therapist relationship. The nature of the client-therapist relationship is commonly considered to have an important influence upon the outcome of psychotherapy. Research indicates that a client's perception of the therapist as empathic, warm, and genuine is positively correlated with a favorable outcome (Truax & Carkuff, 1967). Applying this to sex therapy in general and the role of assessment specifically, the importance of a good relationship is widely acknowledged. LoPiccolo (1982) notes that the "...fate of the therapeutic undertaking...." (p. 130) is determined by the quality of the relationship between the client and therapist. Jehu (1979) comments that in order to "...facilitate the whole treatment programe, it is necessary to establish certain general conditions in the course of early interviews with clients." (p. 126).

Regarding the importance of a good client-therapist relationship during the assessment process Masters and Johnson (1970) state:

> "in taking a sexual history the interrogator should (1) convey an aura of comfort with the subject (and respond without embarassment to unfamilar material), (2) reflect factual knowledge when it is appropriate, and (3) create an atmosphere free of discernible prejudice toward the sexual values, ideas, or practices discussed by the patient" (p. 27).

In a similar vein, Hersen and Bellack (1978) remark that an interviewer's tasks include creation of "...the nonspecific conditions that maximise the chances of a client honestly discussing his problems..."(p.176 ). Another task is to "...increase rapport..." and "...reduce the client's anxiety about self-disclosure" (p.177 ).

Jehu (1979) observed that certain beneficial effects result in sex therapy when a good client-therpist relationship exists. These include:

(1) enhancement of the client's morale;

(2) improvement of the client's motivation and coping ability; and

(3) development of trust in the therapist, which in turn promotes good communication and an increase in the willingness of the client to disclose feelings and problems".

Assuming that a good client-relationship was achieved during the assessment phase and maintained throughout the study, it seems reasonable to assume that the clients' level of sexual anxiety was positively affected and that the decline in sexual anxiety in the assessment, treatment, and followup phase was due partially to the therapeutic relationship. Future research concerning the effect of SF must control for therapeutic effects due to the client-therapist relationship.

Two other factors may have contributed to the inability to determine whether or not the SF phase had a therapeutic effect on the clients' sexual anxiety. These are: (1) the gradual decline in sexual anxiety and (2) the integrity of treatment.

The sporadic shifts and gradual decline over time in sexual anxiety. SF is conceptualized as an in vivo desensitisation procedure. As such, it involves gradual exposure to a progression of sexual activities. Thus, one would expect any effect SF may have to be gradual; sexual anxiety should be gradually reduced versus immediately reduced. The data obtained does indicate a gradual reduction in sexual anxiety over the SF phase, thus supporting this contention. However, when change is gradual or delayed and small versus immediate and large it is difficult to attribute the change to treatment even if it is real. Assuming that reactivity of measurement, reactivity

of assessment, and the client-therapist relationship all had a reductive effect on the clients' sexual anxiety and assuming that SF has a small, gradual effect on sexual anxiety, the lack of a clear distinction between the assessment and treatment phases may have been due to the nature of the effect of SF. That is, the SF phase may have had an effect which was undetectable simply because it is a small and gradual effect.

Treatment integrity. The inability to clearly demonstrate an effect of SF on sexual anxiety may have been due, in part, to violation of treatment integrity. Although steps were taken to ensure that the couples were trained to do SF (a written script describing SF, discussion of SF with the couples, and observation of a film depicting a couple doing SF), there were no means, other than the clients' self-report on the SAF, of determining whether or not SF occurred as it should have. The data obtained using the SAF suggests that essentially SF occurred as it should have. However, this data also indicates that all the couples broke the ban on intercourse at one point or other during the SF phase. Additionally, one of the couples consistently engaged in foreplay to orgasm throughout the SF phase (couple three). This lack of compliance with the therapeutic instructions may have diluted or even contradicted the beneficial effect of SF via the reintroduction of performance demands and/or other negative factors.

A further possibility is that the clients did not do the SF exercises frequently enough for a strong, immediate effect to occur. All the clients spread the exercises over a long period of time (range of six to ten weeks). This is in contrast with Masters' and Johnson's program where the couples complete the exercises in two-three days. the length of the SF phase in this study may have produced a gradual, small effect.

Finally, a recent finding is that dysfunctional males resist the SF exercises (Everaerd & Dekker, 1985). Thus, it is possible that the males in this study were resisting the exercises unbeknownst to the therapist. If this did occur, then the effect of SF may have been minimised or even negated.

Two interpretations can be made about the present study's failure to unequivocally demonstrate what the effect of SF is concerning sexual anxiety. One interpretation is that the lack of a difference between the baseline and treatment phases indicates that the SF phase has no anxiety-reduction effect. The anxiety-reduction that has been observed by clinicians may simply have been a result of the client-therapist relationship and the reactivity of the assessment procedure. This interpretation coincides with previous reports that SF either did not reduce sexual anxiety or had only a slight non-significant reduction in anxiety (Everaerd & Dekker, 1982, 1985). These findings, however, must be

viewed cautiously. Each of these studies included the assessment phase as part of the treatment. Consequently, the findings of no effect or a minimal effect may be due to obfuscation of the effects of SF by the placebo factors discussed earlier.

Another interpretation is that the SF phase has a gradual reductive effect on sexual anxiety that was not detected in this study because of similar anxiety-reducing effects of the assessment process and the client-therapist relationship. The similarity of effect would make it difficult, if not impossible, to separate the effect of treatment from that of the assessment process and client-therapist relationship. This conclusion coincides with analoque studies of SF in which these factors did not exist and which found an anxiety-relief effect (e.g. Heiman & Rowland, 1981). Future research which controls for these factors is necessary to determine which interpretation is valid.

Secondary Claims

Support for the validity of the secondary effects attributed to SF varies. Some claims have not been supported by the present data, some have been, and for some, it is not possible either to confirm or to disconfirm the claims.

The SF phase appears to have had no impact on the clients' awareness of their partner's sexual preferences. Of three subjects who reported being unaware of their partner's sexual preferences, only one subject reported an increase in awareness at posttreatment.

This finding contradicts the expectation that a client would be fully aware of their partner's sexual preferences after having completed the "giving" role of SF. Takefman and Brender (1984) reported that couples in which the male was experiencing secondary erectile dysfunction did not improve their awareness of their partner's sexual preferences after treatment involving a ban on intercourse and the instruction to work on communication of their sexual preferences. Thus, the present finding may be reliable. This must be a tentative conclusion, however, as Takefman and Brender's treatment was not completely comparable with the treatment phase of the present study.

Those claims which appear to be supported by the data are:

(a) the SF phase positively affects affectional expression;

(b) the SF phase positively affects the male's attitude towards non-coital sexual activity; and

(c) the SF phase promotes greater satisfaction for the male with his level of sexual functioning.

Previous research on the effects of the SF phase found that the SF I and SF II exercises, contrary to expectation, did not increase the frequency and enjoyment of affectional display for couples in treatment for secondary orgasmic dysfunction (Fitchner et al., 1983). This contradicts the finding of the present study. Differences in the target dysfunction may be responsible for the discrepancy. For secondary orgasmic dysfunction, insufficient or inappropriate stimulation and marital discord may be more important etiological factors than sexual anxiety.

The clinical claims that were not either confirmed or disconfirmed are:

a) the SF phase induces positive attitudinal change concerning general sexual activity;

(b) the SF phase improves a client's ability to communicate their sexual needs and desires to their partner;

(c) the SF phase promotes greater satisfaction with the sexual relationship;

(d) the SF phase promotes positive attitudes towards the spouse as a sexual partner;

(e) the genital phase of SF promotes an increase in the male's physiological arousal (i.e., increased erectile ability); and

(f) the SF phase increases enjoyment of mutual non-coital sexual activity.

Previous findings have been reported concerning four of the above claims. First, Tullman, Gilner, Kolodny, Dornbush, and Tullman (1981) reported significant improvement in interpersonal communication skills for couples who underwent treatment for sexual dysfunction following Masters' and Johnson's procedures. Although Tulman et al.(1981) did not directly assess sexual communication skills, it follows that improvement in general communication skills would generalize to sexual communiction skills. However, Takefman and Brender (1984) found that couples experiencing erectile dysfunction and who received treatment similar to the SF phase, did not perceive themselves as improving their sexual communication skills. The discrepancy between these two studies and the present study's inability to confirm or disconfirm the effect of the SF phase on sexual communication is perplexing. Future research is needed to clarify this issue.

Second, Takefman and Brender (1984) reported significant improvement in the treated couples' overall satisfaction with their sexual relationship. Similar results were predicted in the present study and did occur. All the subjects' satisfaction with their sexual relationship increased from preassessment to posttreatment. However, this increase started for some of the subjects (all the males) during the assessment phase thus masking the effect of the SF phase. Examination of Takefman's and Brender's

(1984) data revealed that significant preassessment-pretreatment change occurred for their couples also, thus undermining the reliability of their finding. Again, further research is required to determine the effect of the SF phase on satisfaction with the sexual relationship.

Third, investigators have reported both positive and negative effects of SF on sexual arousal. Everaerd and Dekker (1982,1985) reported that women experiencing secondary orgasmic dysfunction and men experiencing premature ejaculation or secondary erectile dysfunction both improved their sexual functioning (defined as the level of appetitive sexual motivation) after treatment consisting of a series of six sensate focus and sexual stimulation exercises, including a ban on intercourse. Unfortunately, they did not assess physiological arousal and their findings are not directly comparable to the present study. Fitchner et al. (1983), did assess physiological arousal and found that the SF I and SF II exercises did not significantly affect orgasmic responsiveness for women experiencing secondary orgasmic dysfunction. Their partners' orgasmic responsiveness, on the other hand, did significantly improve. Again, the discrepancy between these results and the present study's may be due to a difference in target dysfunction. Takefman and Brender (1985), in contrast with Fitchner et al. (1983), found significant improvement on several measures of erectile functioning after treatment.

In the present study, one can tentatively interpret the data as indicating that arousal was positively affected by the SF phase. The inability to confirm or disconfirm the clinical claim is mainly due to a lack of data. Only one male completed the data and that male did not consistently achieve improved arousal during the genital phase. However, his arousal varied dependent upon whether or not he was giving or receiving pleasuring; it was consistently higher when receiving genital pleasuring. Thus, the trend is in the predicted direction. Once more, further data is required in order to evaluate this claim.

Fourth and finally, Fitchner et al. (1983) observed that the SF I and SF II exercises did not increase the frequency and enjoyment of couple non-coital activities. This finding is in contrast with the results of Takefman and Brender (1985) who reported a significant increase in the enjoyment of "sexual activities" after treatment. These two studies, however, may not be comparable due to differences in the definition of sexual activities. Takefman and Brender (1985) did not define what sexual activities meant. Inconsistent results were obtained in the present study.

The inability to confirm or disconfirm these claims is mainly due to inter-subject variability in response to the SF phase. Typically, for each variable, some subjects had a positive reaction, some a negative reaction, and some no reaction. Furthermore, there did not appear to be any

discernible pattern to the inter-subject variability (i.e., one subject consistently having a positive response, one a negative response, and one no response).

Another factor contributing to the inability to confirm or disconfirm these claims was the frequent occurrence of preassessment-pretreatment change in the predicted direction. Similar to the situation described earlier concerning sexual anxiety, the occurence of preassessment-pretreatment change hid the effect of the SF phase and suggests that placebo effects were occurring. Again, future research must control for placebo effects mentioned earlier in order to accurately evaluate the SF phase.

Methodological Factors influencing the SF Phase

A number of methodological factors may have contributed to the inability to confirm or disconfirm some of the secondary clinical claims. These factors may also have influenced the results obtained concerning the claim that the SF phase reduces sexual anxiety. The factors are:

(a) reliabilty and validity of the measures;

(b) sample characteristics; and

(c) therapist variables.

Measures. A problem endemic to sex therapy research is the lack of adequate measures. Many currently used instruments are either borrowed from other fields or specially developed for sex therapy and lack acceptable

psychometric properties. Consequently, a sex therapy researcher is often forced to either create measures or select items from established measures and use them independently. Neither of these situations is psychometrically desireable, but for lack of better instruments a researcher has the dilema of either doing no research or doing research with instruments whose adequacy is questionnable. In the present investigation most of the measures were either developed specifically for the study or consisted of individual items borrowed from other questionnaires. Thus, although the measures have face validity, a distinct possibility is that they lack reliability and/or construct validity. The observed intra-subject variability and inter-subject variability, then, may simply have been a reflection of the inadequacy of the measures. Better measures must be developed before many questions concerning sex therapy and sexual dysfunction can be adequately researched.

Sample characteristics. The characteristics of this sample may have contributed to the inability to confirm the clinical claims. The first characterisic is sample size. This sample was the minimum required for the study due to the unavailability of suitable subjects. It is possible that the sample was too small to adequately demonstrate the effects of the SF phase. A larger sample may have resulted in less variability. Future research should incorporate a larger sample.

The second characteristic of this sample that may have contributed to the variability is its heterogeneity. Although all the subjects had the same problem, they had distinctly different demographic characteristics, different personalities, different histories, and different lifestyles. This heterogeneity may have resulted in different responses to the same treatment.

The heterogeneity also expressed itself in terms of degree of fit to the desired etiology. Although all the males complained of sexual anxiety, the severity varied greatly. This difference may have contributed to the variability in response to treatment.

Therapist variables. In this investigation, the researcher and the therapist were the same. Consequently, a degree of experimental bias may have been introduced. The therapist may have unwittingly given away the hypotheses of the study and thus influenced the results. The expectancy of a reduction in level of sexual anxiety on the part of the therapist, for example, may have favorably influenced the client.

In addition, conflict between the role of scientist and the role of practitioner may have affected the integrity of treatment. Whereas a clinician must be flexible in response to changes in a client's behavior and sometimes, in the light of new data, reformulate the presenting problem, a

scientist, in the middle of a research project, must resist such changes in the interest of consistency. It is possible that there was a conflict of interest by virtue of one person playing two roles in this study and that this conflict influenced the treatment process.

Conclusion

The present study attempted to validate alleged therapeutic effects of the SF phase. The SF phase is purported to:

(a) reduce sexual anxiety:

(b) increase affectional expression;

(c) positively affect the client's attitude towards non-coital sexual activity;

(d) postively affect enjoyment of non-coital sexual activity and sexual activity in general;

(e) promote satisfaction with sexual functioning and the sexual relationship;

(f) improve sexual communication skills; and

(g) increase sexual arousal.

Unfortunately, considerable inter-subject and intra-subject variability, and client improvement on several of the dependent variables during the assessment/baseline phase made it impossible to accurately evaluate most of the claims. Only the claims that the SF phase positively affects affectional expression and attitude towards non-coital sexual activity, and the claim that the SF phase

promotes greater satisfaction with sexual functioning appear to have been substantiated. The primary claim that the SF phase reduces sexual anxiety was not clearly substantiated by the data.

A number of factors may have contributed to the inability to evaluate several of the claims. Reactivity to self-monitoring, reactivity to assessment, therapeutic effects of the client-therapist relationship, inadequate measures, heterogeneity and size of sample, and therapist variables all may have affected treatment outcome.

Overall, the present study did not demonstrate that SF is an active ingredient of sex therapy. In view of its popularity as a treatment technique, further research is necessary to determine its utility. Such research is necessary from (1) a cost-benefit perspective and (2) from a theoretical perspective. For example, discovery that the SF phase is inert would shorten the time required for treatment and perhaps result in a speedier recovery for the client. Determination of the actual effects of the SF phase would also contribute to present etiological knowledge. and perhaps, provide a partial solution to the question "What treatment, by whom, is most effective for whom, under what set of circumstances" (Paul, 1967 cited in LoPicollo, 1984). A common assumption is that the SF phase is beneficial for all types of sexual dysfunction.

The present study was highlighted by significant improvement on several of the dependent variables during the assessment/baseline phase. This finding is significant as it suggests that the the assessment phase of sex therapy is not an inert ingredient. Future clinical investigation of the SF phase and future treatment outcome research in sex therapy must control for the therapeutic effects of the assessment process.

Future research on the SF phase should also focus on (a) determining the effect of the SF exercises themselves, (b) determining the effect of the "giver" and "receiver" roles, and (c) investigation of possible differences in response to SF based on gender, type of dysfunction, and status within the couple (dysfunctional or functional). Future study of the SF phase should also take steps to ensure that the integrity of treatment is safeguarded. Finally, the SF phase should be condensed in terms of frequency of sessions such that any effect would tend to be large and immediate, versus small and gradual.

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Appendices

Appendix A

Introduction

"I would like to invite you to participate in a study I am doing. This study is investigating the effects of a technique called "Sensate Focus" or "Pleasuring" which is used in the treatment of sexual dysfunction. This technique is a common treatment method and is used to help couples overcome any sexual difficulties they may be experiencing. It is essentially a form of body massage. Unfortunately, although it is a very successful technique, little is known about how it works. This study is designed to discover exactly what happens when a couple uses this technique.

If you decide to participate in this study you will first undergo a standard assessment procedure where I will gather more detailed information about your difficulties, yourselves, and other pertinent topics. After this is complete we will commence treatment. Sensate focus will be the first part of treatment. After you have finished this part, you will receive the remaining part of treatment with myself continuing as therapist.

Although this is a research study, the treatment you will receive does not differ from what you would receive

normally. However, you will be required to fill out a certain number of questionnaires and other measures which enable me to record your progress. All of these measures are short and easy to fill out.

Any information gathered will be held in strictest confidence. No individual partner will be identified in the report of the study. Do you have any questions?

Appendix B

Study of Sensate Focus

Client Consent Form

Client:_____Time:_____Date:_____

1. The procedures to be carried out during this study have been explained to me and I understand this explanation.

2. I understand that I can ask for and obtain any further information concerning the procedures at any time.

3. I am also aware that I am free to withdraw my consent and discontinue participation in the study at any time.

4. I understand that all information gathered and the results of the study will remain confidential with regard to my identity.

5. I hereby agree to participate in the study of Sensate Focus at the Sexual Dysfunction Clinic, carried out by _____.

_____

_____ Therapist

Client Signature

Appendix c

Name: _____

Dyadic Adjustment Scale

Date: _____

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreements or disagreements between you and your partner for each item on the following list.

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

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

| | All the time | Most of the time | More often than not | Occa-sionally | Rarely | Never |
|---|---|---|---|---|---|---|
| 16. How often do you discuss or have you considered divorce, separation, or terminating your relationship? | 0 | 1 | 2 | 3 | 4 | 5 |
| 17. How often do you or your mate leave the house after a fight? | 0 | 1 | 2 | 3 | 4 | 5 |

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

| | | | | | |
|---|---|---|---|---|---|
| 23. Do you kiss your mate? | Every Day 4 | Almost Every Day 3 | Occa-sionally 2 | Rarely 1 | Never 0 |
| 24. Do you and your mate engage in outside interests together? | Every Day 4 | Almost Every Day 3 | Occa-sionally 2 | Rarely 1 | Never 0 |

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

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

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

| | Yes | No | |
|---|---|---|---|
| 29. | 0 | 1 | Being too tired for sex. |
| 30. | 0 | 1 | Not showing love. |

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point "happy" represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

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



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

5 I want despaerately for my relationship to succeed, and would go to almost any length to see that it does.

4 I want very much for my relationship to succeed, and will do all I can to see that it does.

3 I want very much for my relationship to succeed, and will do my fair share to see that it does.

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

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

0 My relationship can never succeed, and there is no more that I can do to keep the relationship going.

Appendix D

## Sexual History Form

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

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

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

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

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

3. Who usually initiates having sexual intercourse or activity?

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

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

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

5. How often do you masturbate?

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

6. How frequently do you feel sexual desire? This feeling may include wanting to have sex, planning to have sex, feeling frustrated due to a lack of sex, etc.

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

7. For how many years have you and your mate been having sexual intercourse?

1) less than 6 months
2) less than 1 year
3) 1 to 3 years
4) 4 to 6 years
5) 7 to 10 years
6) more than 10 years

8. For how long do you and your mate usually engage in sexual foreplay (kissing, petting, etc.) before having intercourse?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. If you try, is it possible for you to reach orgasm through sexual intercourse?

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

19. What is your usual reaction to erotic or pornographic materials (pictures, movies, books)?

1) greatly aroused
2) somewhat aroused
3) not aroused
4) negative--disgusted, repulsed, etc.

20. Does the male have any trouble in getting an erection, before intercourse begins?

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

21. Does the male have any trouble keeping an erection, once intercourse has begun?

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

22. Does the male ejaculate (climax) without having a full, hard erection?

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

23. Is the female's vagina so "dry" or tight that intercourse cannot occur?

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

24. Do you feel pain in your genital during sexual intercourse?

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

25. (WOMEN ONLY, MEN GO ON TO QUESTION 28) Can you reach orgasm through stimulation of your genitals by an electric vibrator or any other means such as running water, rubbing with some object, etc.?

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

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

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

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

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

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

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

Appendix E

Name:_____ Sexual Preferences Form (Females)

Date:_____

For each statement please indicate which number describes your situation the best. Fill it out seperately.

1. My partner is aware of the sexual activities that I enjoy and dislike.
   1.completely aware 2. somewhat aware 3.not at all aware

2. I am aware of my partner's sexual likes and dislikes.
   1.completely aware 2. somewhat aware 3. not at all aware

3. I am able to tell my partner what types or amounts of sexual stimulation I want or need.
   1. always 2. usually 3. sometimes 4. rarely 5. never

4. My partner is able to tell me what types or amounts of sexual stimulation he wants or needs.
   1. always 2. usually 3. sometimes. 4. rarely 5. never

Name:_____ Sexual Preferences Form (males)

Date:_____

For each statement please indicate which number describes your situation the best. Fill it out seperately.

1. My partner is aware of the sexual activities that I enjoy and dislike.
   1. completely aware 2. somewhat aware 3. not at all aware

2. I am aware of my partner's sexual likes and dislikes.
   1. completely aware 2. somewhat aware 3. not at all aware

3. I am able to tell my partner what types or amounts of sexual stimulation I want or need.
   1. always 2. usually 3. sometimes 4. rarely 5. never

4. My partner is able to tell me what types or amounts of sexual stimulation she wants or needs.
   1. always 2. usually 3. sometimes 4. rarely 5. never

Appendix F

Male Card Sort-Directions

This procedure is concerned with your present feelings towards sexually related activities and experiences that may cause you fear or other unpleasant feelings.

Read each card and put it into one of the four envelopes that best describes your present feeling about that card. When reading each card ask yourself the question " If I were confronted by such a situation today, how fearful or anxious would I be?"

This procedure provides useful information for the progress of your treatment. There are no right or wrong answers.

1. Kissing an aroused and eager female's neck and ears.
2. Failure or difficulty in maintaining an erection.
3. Sitting in a movie with a female during a hot love scene and taking her hand.
4. Sitting in a movie with a female during a hot love scene.
5. Caressing the buttocks and thighs of an aroused and eager female.
6. Engaging in sexual intercourse with an aroused and eager female.
7. Taking off an aroused and eager female's clothes.

8. Caressing the breasts of an aroused and eager female with your hand.

9. Caressing the genitals of an aroused and eager female with your hand.

10. An aroused and eager female caressing your penis with her hand.

11. In bed with a female who is aroused and eager and you can't get an erection.

12. Lying on a couch with an aroused and eager female.

13. Pressing your body against an aroused and eager female.

14. In bed with a female who is aroused and eager and you can't maintain your erection.

15. Failure or difficulty in achieving an erection.

16. In bed with a female who is aroused and eager and you are having trouble maintaining your erection.

Appendix G

Introduction of Sexual Activities Form

"This form describes certain sexual activities. Each evening, I would like you to check the activities you engaged in during the 24 hour period preceding 6:00 p.m. of the present day. I would also like you to indicate a) the degree of enjoyment you experienced as a result of each activity, and b) whether you were spectatoring, that is, critically monitoring your sexual performance. Finally, I would like you (the male) to indicate the fullness and duration of your erection when engaged in any of the activities. I would also like you (the female) to indicate the fullness and duration of your husband's erection during any mutual sexual activities.

You are to fill out the form seperately and without discussion. Place them in the provided envelopes and bring them to the weekly sessions. I will call you during the first few weeks to help you with any problems you may be having with it. The regular filling out of the form will provide useful information for your treatment. It is like a physician checking how effective his or her treatment is by taking your temperature or blood pressure at regular intervals."

Appendix H

Index of Sexual Satisfaction

---

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 br 5. most or all of the time

please begin:

1. I feel that my patner 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 sex is wonderful.....__

13. My partner dwells on sex too much.....__

14. I try to avoid sexual contact with my partner.....__

15.My partner is too rough or brutal when we have sex.....__

16. My partner is a wonderful sex mate.....__

17. I feel that sex is a normal part 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 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 that I have an erection problem, I tell my partner(s) that "I've had too much to drink", "I guess I'm just tired", or something else so they may not know about my problem.

___Always ___Usually ___Sometimes ___Rarely ___Never

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Completely true ____Mostly true ____Equally true and false ____Mostly false ____Completely false

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Completely true ____Mostly true ____Equally true and false ____Mostly false ____Completely false

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

____Completely true ____Mostly true ____Equally true and false ____Mostly false ____Completely false

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

____Completely true ____Mostly true ____Equally true and false ____Mostly false ____Completely false

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

____Completely true ____Mostly true ____Equally true and false ____Mostly false ____Completely false

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

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

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

___Always ___Usually ___Sometimes ___Rarely ___Never

18. Because of my erection problem, I do <u>not</u> 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 less than somewhat satisfied somewhat more much than satisfied less than with my more than more than satisfied satisfied current than satis- satisfied behavior satis- fied or feelings fied

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 an erection if I lose it during foreplay.

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

1 2 3 4 5 6 7 7. Being able to keep an erection during 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 desireable to my partner.

1 2 3 4 5 6 7 12. Feeling comfortable about my own sexuality.

1 2 3 4 5 6 7 13. Being able to enjoy a sexual encounter without having intercourse.

1 2 3 4 5 6 7 14. Being able to anticipate a sexual encounter without feeling I should have intercourse.

Appendix K

## Marriage and Sexual Relationship Questionnaire (M)

Initials _____ Date _____

Age _____

Sex _____

Client Couple *_____

How may years have you been married? _____

### INSTRUCTIONS

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

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

Example:

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

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

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

Please answer every question, either T or F.

## MARRIAGE ATTITUDES SCALE (M)

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

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

## SEXUAL ATTITUDES SCALE (M)

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

Marriage Relationship Questionnaire (F)

Name:_____Date:_____

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

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

Example: Sometimes when I am tired I am short temmpered with my mate. T F sk If you feel this statement is mostly true about you, cross out the T. sk If you feel this statement is mostly false about you, cross out the F.

Please answer every question, either T or F.

Marriage Attitudes Scale (F)

1. There are times when I wonder if I made the best of choice. T F

Once in a while I make fun of my spouse. T F

3. No matter what my spouse is saying, I'm always a good listener. T F

4. I sometimes exaggerate my troubles in order to gain sympathy from my spouse. T F

5. I have never been upset when my spouse expressed views very different from mine. T F

6. I am careful to say something nice to my spouse every day. T F

7. I can't imagine ever wanting to have an affair. T F

8. On occasions I have had doubts about my ability to succeed in my marriage. T F

9. When disagreements arise they are always settled in a peaceful fair and democratic manner. T F

10. There have been times when I felt like hitting my spouse. T F

11. My mate occassionally makes me feel miserable. T F

12. I have never felt my spouse was angry at me without a cause. T F

13. I am always happy with how affectionate my spouse is to me. T F

14. My mate completely understands and sympathizes with my every mood. T F

15. I don't think any couple could live together with greater harmony than my mate and I. T F

16. My mate and I understand each other completely. T F

17. There are moments when I dislike my mate. T F

18. I never say anthing bad about my spouse even to my close friends. T F

19. I have never deliberately said something to hurt my spouse's feelings. T F

20. I have never regretted my marriage, not even for a moment. T F

18. I never say anything bad about my spouse even to my close
friends. T F

19. I have never deliberately said something to hurt my spouse's feelings. T F

20. I have never regretted my marriage, not even for a moment. T F

21. There is never a moment that I do not feel "head over heels" in love with my mate. T F

22. I get impatient if my spouse interrupts me when I am working on something important. T F

23. Some of my dealings with my mate are prompted by selfish motives. T F

24. If I had my life to live over I wouldn't even think of marrying another person. T F

I sometimes try to get even with my spouse rather than forgive and forget. T F

26. I sometimes resent my spouse when I can't get my own way. T F

27. My mate has all the qualities I've always wanted in a mate. T F

28. Every new thing I have learned about my mate has pleased me. T F

29. My spouse and I are always happy with the amount of affection we show each other. T F

30. There have been occasions when I took advantage of my spouse. T F

31. Once in awhile I am not completely truthful with my spouse. T F

32. I have some thoughts I wouldn't want my spouse to know about. T F

33. There is nothing about my mate's appearance that I would want to see changed in any way. T F

34. My marriage is not a perfect success. T F

35. There are times when I do not feel a great deal of love and affection for my mate. T F

36. I am always courteous to my spouse. T F

37. Sometimes I am tempted to say things to my spouse which I would regret. T F

Sexual Attitudes Scale (F)

1. Sometimes I dislike my body. T F

2. Occasionally I feel sexual intercourse is tedious. T F

3. My spouse and I never feel unhappy about how often we have sex together. T F

4. I do not always initiate sex when I would like to. T F

5. My spouse always knows exactly what I would like him to do when we are making love. T F

6. My spouse always does the things I like during sex. T F

7. Our sex life seems a little routine and dull to me at times. T F

8. I have always been satisfied with how often my spouse and I have sex. T F

9. I never turn my spouse down for sex because I am angry with him. T F

10. Sometimes I just can't seem to get turned on sexually. T F

11. I must admit that sometimes I am not considerate of my mate when we make love. T F

12. Sex always lasts as long as I would like it to. T F

13. My spouse and I are never too busy to have sex. T F

14. I have never made an excuse to get out of having sex. T F

15. Every now and then my mate does not please me sexually. T F

Appendix L

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

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# INTRODUCTION

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

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

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

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

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

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

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

## DESCRIPTION OF PROBLEM(S)

Nature

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

Frequency

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

Timing

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

Surrounding circumstances

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

Duration

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

Onset

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

Course

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

## PERSONAL AND FAMILY BACKGROUND

Client and partner

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

Children of client and/or partner

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

Parents of client and partner

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

Siblings of client and partner

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

5. Occupation.

6. Marital status and history.

7. Educational level.

Quality of relationships in the families of origin of the client and partner

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

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

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

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

(d) how affectionate were parents towards informant?

(e) was affection usually verbal or physical?

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

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

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

(i) how punitive were parents toward informant?

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

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

(b) was this affection usually verbal or physical?

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

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

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

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

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

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

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

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

Other domiciles

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

SEXUAL HISTORY

Parental attitudes

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

Parental messages

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

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

(b) "sex is wrong",

(c) "sex is sinful",

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

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

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

(g) "nice girls don't",

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

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

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

Talking about sex in the home

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

Nudity/modesty

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

Vicarious exposure to intercourse

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

Sex games

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

Influence of siblings or friends

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

First pleasurable genital feelings

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

Masturbation

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

Sexual dreams

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

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

2. (Males only).

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

(b) what were his reactions to this experience?

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

Menstuation (females only)

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

Knowledge of reproduction

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

Dating

1. At what age did informant start to date?

(a) in groups.

(b) on single dates.

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

Petting before current partnership

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

Sexual intercourse before current partnership

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

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

(b) to care for each other,

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

(d) to be engaged,

(e) to be married,

(f) no emotional involvement required.

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

e.g., (a) satisfaction,

(b) pleasure,

(c) guilt,

(d) embarrassment,

(e) anxiety.

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

<u>Romantic relationships before current partnership</u>

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

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

Traumatic experiences

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

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

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

   (c) indecent exposure,

   (d) unwanted pregnancy,

   (e) abortion,

   (f) venereal disease.

2. How did informant react to such experiences?

Erotic materials

1. What experience has informant had with erotic materials?

   e.g., (a) written,

   (b) photographs,

   (c) films.

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

Homosexual experiences

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

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

Deviant experiences

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

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

Sexual experience with current partner

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

CURRENT CONDITIONS

Sexual practices

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

4. Which partner usually initiates sexual activity?

   What types of sexual advance are made?

   What are the informant's reactions to these advances?

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

5. How does the informant feel:

   (a) about seeing the partner nude?

   (b) about the partner seeing the informant nude?

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

   What types of sexual activity occur during foreplay?

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

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

7. How frequently does sexual intercourse take place?

   How long does intercourse usually last?

   What positions and techniques are used during intercourse?

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

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

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

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

   What would the informant like them to do differently?

9. What form of contraception is used?

   How satisfactory is this for the informant?

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

10. How frequently does the informant masturbate?

What techniques/aids does he or she use?

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

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

How does he or she feel after masturbating?

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

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

If so, what is the preferred content?

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

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

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

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

What changes would the informant like in these settings?

<u>Sexual stresses</u>

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

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

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

(ii) losing control during orgasm,

(b) anticipation of harm;

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

(ii) venereal disease,

(iii) unwanted pregnancy,

(iv) sexual frustration,

(v) threatening degree of intimacy or commitment,

(c) anticipation of failure;

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

(ii) in controlling ejaculation,

(iii) in reaching climax,

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

(d) moral or religious contraventions;

e.g., (i) masturbation,

(ii) premarital intercourse,

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

(iv) symbolic recapitulation of tabooed sexual relationship.

Negative emotional reactions

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

e.g., (a) anxiety,

(b) guilt,

(c) depression,

(d) anger.

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

Physical avoidance reactions

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

   e.g., (a) vaginismus?

   (b) inhibition of orgastic/ejaculatory reflexes?

   (c) reduction in frequency of sexual activity?

   (d) constriction of variety of sexual activity?

   (e) restriction of physical affection?

   (f) cessation of communication about sex?

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

Negative cognitive reactions

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

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

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

   (c) negative thoughts,

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

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

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

(d) negative imagery,

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

(e) impaired imagery,

(i) inability to fantasize.

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

Sexual attitudes

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

e.g., (a) good,

(b) pleasurable,

(c) dirty,

(d) sinful,

(e) degrading.

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

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

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

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

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

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

(a) his or her partner?

(b) his or her religion?

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

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

Sexual information

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

General relationship

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

(b) avoid certain topics or argue over them,

(c) discuss their sexual problems,

(d) speak openly and honestly,

(e) listen, empathize, and validate,

(f) get their points across,

(g) resolve their conflicts,

(h) express criticism, resentment, and anger,

(i) express affection, appreciation, and praise,

(j) express specific sexual preferences.

7. How committed to the relationship is the informant?

   Has he or she ever considered separation or divorce?

8. How much does the informant trust the partner?

   Does the informant fear that he or she may be hurt, rejected, or abandoned by the partner?

9. How often do the informant and partner have arguments/rows/fights?

   What are these conflicts usually about?

   What happens during a conflict?

   How are conflicts handled or resloved?

10. Does the informant feel angry, bitter, resentful, or hostile towards the partner?

    If so, what evokes these feelings?

11. Does physical violence ever occur between the informant and partner?

    If so, in what circumstances does such violence happen?

Organic conditions

1. Are there any organic conditions that might contribute to sexual dysfunction, either physically or psychologically?

   e.g., (a) disease,

(b) disabiltiy,

(c) surgery,.

(d) medication,

(e) aging,

(f) menopause,

(g) method of contraception,

(h) pregnancy,

(i) post-partum period,

(j) miscarriage,

(k) abortion,

(l) drug abuse,

(m) alcohol abuse.

Psychopathological conditions

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

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

Self concept

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

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

   (b) impaired gender identity,

   (c) low self esteeem,

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

Non-sexual stresses

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

   e.g., (a) unemployment,

   (b) problems at work,

   (c) financial difficulties,

   (d) family illness,

   (e) child behavior problems.

Lifestyle

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

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

   (b) couple spend litttle time together becuase of;

   (i) long working hours,

   (ii) markedly discrepant working hours,

   (iii) work requiring location away from home,

   (c) separate rather than shared leisure time,

   (d) discrepant career plans and objectives,

   (e) children adversely affecting marital/sexual relationships,

   (f) low priority accorded to sexual activity,

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

Extra-marital relationship

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

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

Homosexual encounters

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

ATTITUDES TO TREATMENT

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

Appendix M

Name:_____ Sexual Activities Checklist (Females) Date:_____

Please fill out this form daily and at the same time (e.g. 6:00 p.m.), whether or not you have had a sensual or sexual experience in the previous 24 hours. Record the date. Then circle the number(s) corresponding to the activity experienced (column 1): the overall enjoyment of the activity (column 2); the fullness of your partner's erection(s) during mutual activities (column 3); and your partner's satisfaction with the duration of the erection(s) during mutual activities (column 4).

| 1. Activity | 2. Overall Enjoyment (no enjoyment … complete enjoyment) | 3. Fullness of Erection (completely soft … semi-hard … completely hard) | 4. Duration of Erection (completely unsatisfactory … completely satisfactory) |
|---|---|---|---|
| 1. sexual fantasies | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 2. masturbation | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 3. reading sexy material | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 4. seeing sexy material | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 5. kissing and hugging | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 6. foreplay | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 7. intercourse | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 8. pleasuring excluding genitals-giving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 9. pleasuring excluding genitals-receiving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 10. pleasuring including genitals-giving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 11. pleasering including genitals-receiving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 12. NO SENSUAL/SEXUAL ACTIVITY | | | |

13. During any of the above activities did you find yourself monitoring your sexual performance? 1. not at all 2. a little 3. a fair amount 4. much 5. very much

14. Did you experience anxiety during any of the above activities? 1. not at all 2. a little 3. a fair amount 4. much 5. very much

Name: _____ Sexual Activities Checklist (Males) Date: _____

Please fill out this form daily and at the same time (e.g. 6:00p.m.), whether or not you have had a sensual or sexual experience in the previous 24 hours. Record the date. Then circle the number(s) corresponding to the activity experienced (column 1); the overall enjoyment of the activity (column 2); the fullness of your erection(s) (column 3); and your satisfaction with the duration of the erection(s) (column 4).

| 1. Activity | 2. Overall Enjoyment (no enjoyment … complete enjoyment) | 3. Fullness of Erection (completely soft … semi-hard … completely hard) | 4. Duration of Erection (completely unsatisfactory … completely satisfactory) |
|---|---|---|---|
| 1. sexual fantasies | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 2. masturbation | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 3. reading sexy material | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 4. seeing sexy material | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 5. kissing and hugging | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 6. foreplay | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 7. intercourse | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 8. pleasuring excluding genitals-giving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 9. pleasuring excluding genitals-receiving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 10. pleasuring including genitals-giving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 11. pleasuring including genitals-receiving | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 | 1 2 3 4 5 6 7 |
| 12. NO SENSUAL/SEXUAL ACTIVITY | | | |

13. During any of the above activities did you find yourself monitoring your sexual performance? 1. not at all 2. a little 3. a fair amount 4. much 5. very much

14. Did you experience anxiety during any of the above activities? 1. not at all 2. a little 3. a fair amount 4. much 5. very much

## Appendix N

Sensate focus: Stage one

Today, I would like to introduce to you the first pleasuring exercise. This exercise is very simple and involves each of you giving the other a body rub in a sensual, but not a sexual manner. The distinction is made between sensual and sexual because the object of this exercise is simply for you to experience the pleasure of caressing and being caressed. The object is not sexual arousal. This may or may not happen. Whether it does or not is not important. This exercise is helpful because it provides you with an opportunity to discover and learn about physical sensations that are pleasureable both to you and your partner. From today until you finish the pleasuring exercises, there will be a ban on intercourse. Couples experiencing sexual difficulties often find intercourse quite stressful. The ban alleviates this and will help you concentrate on the pleasurable aspects of the exercises.

There are two stages to this exercise, but for the time being we shall just be concerned with the first. In this stage, the body rub does not include the breasts or genitals. You are to give light, stroking caresses to all other parts of the body with guidance from person

receiving the caressing. You should avoid the heavy, kneading type of rubbing typical of a massage.

To do pleasuring there are certain things that are necessary. You will need a warm and private room, a comfortable place for the person receiving the body rub to lie, and some lotion or powder if you wish. You should not do the exercise when you are tired, angry, or tense.

You may wish to take a bath or shower together before starting or you may engage in some other mutual activity (e.g. watching television or going for a walk). When you start the exercise you should be in the nude.

When doing this exercise there are certain distinct roles you must take. One of you must be a "giver" and the other a "receiver". This time, I will decide who will be who, but in the future you will decide. During a body rub session you may change roles whenever and as often as you wish. You should not, however, become stuck in one role.

Each of these roles has special duties to be performed. The "giver" is to:

1. caress the receiver in a light, stroking manner;
2. focus on discovering and using different ways of touching that give pleasure to the receiver; and

3. focus on the sensations aroused in themselves while giving the body rub.

The "receiver" is to:

1. simply lie there and indulge themselves in the pleasureable sensations of being caressed;

2. be "selfish"; they are not to touch or do anything else to or for the "giver"; and

3. guide the "giver" verbally and non-verbally as to how and where they like or do not like to be caressed.

Continue the body rub only as long as both of you find it pleasureable. Do not do it to the point of boredom or fatigue. Finally, do the exercise at least twice per week and switch roles at least twice.

Appendix O

Sexual Comfort Checklist - Sensate Focus 1

Instructions:

The following items describe certain sexual experiences. Please read each item carefully and then circle the number which describes how comfortable you feel whenever you engage in such activity. Complete the checklist independently .

Items

1. When you see a loved one in the nude.
   1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

2. When a loved one caresses your hair and face.
   1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

3. When a loved one caresses your shoulders and neck.
   1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

4. When a loved one caresses your buttocks and thighs.
   1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

5. When you caress a loved one's hair and face.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

6. When you caress a loved one's shoulders and neck.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

7. When you caress a loved one's buttocks and thighs.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

Appendix P

## 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix Q

Sexual Knowledge Checklist (males)

For each statement please circle T if you believe the statement is correct and F if you believe it is incorrect.

Items

1. It is possible to "will" an erection. T F
2. The penis is a muscle and becomes erect by flexing. T F
3. It is normal for erections to come and go during foreplay. T F
4. Genital appearance varies amongst men. T F
5. With age sexual arousal takes somewhat longer. T F
6. Ninety percent of males by age 40 have experienced at least one erectile failure. T F
7. The clitoris is located inside the vagina. T F
8. If you have a small penis you will have problems with intercourse. T F
9. The clitoris is usually the most important source of sexual pleasure for women. T F
10. Sexual arousal may vary depending on how you are feeling toward your partner. T F

Appendix Q

Sexual Knowledge Checklist (females)

For each statement please circle T if you believe the statement is correct and F if you believe it is false.

Items

1. It is possible to "will" an erection. T F
2. The penis is a muscle and becomes erect by flexing. T F
3. It is normal for erections to come and go during foreplay. T F
4. Genital appearance varies amongst women. T F
5. With age sexual arousal takes somewhat longer. T F
6. Ninety percent of males by age 40 have experienced at least one erectile failure. T F
7. The clitoris is located inside the vagina. T F
8. If you have a small vagina you will have problems with intercourse. T F
9. The clitoris is usually the most important source of sexual pleasure for women. T F
10. Sexual arousal may vary depending on how you are feeling toward your partner. T F

Appendix R

Sensate Focus- Stage two.

Now that you are familiar and comfortable with pleasuring of the general body parts, it is time to move to the second stage of pleasuring. At this stage, the breasts and genitals are to be included in the pleasuring. This is the only change. Again, you may or may not become sexually aroused. If this happens that is fine. If it doesn't happen that, too, is fine.

Instructions

1. Start with caressing those general body parts that you know the receiver likes. Gradually, include caressing the genitals. Do not focus completely on the genitals, but pleasure both the genitals and other parts in turn.
2. The "giver" is to touch the "receiver's" genitals in a tender and teasing manner. Do not vigorously stroke or use other manipulations aimed at bringing the "receiver" to orgasm. Orgasm is not the goal.
3. Remember that the "receiver" is to tell the "giver" what feels good and what doesn't and to "selfishly" enjoy the sensations. Remember, also, that the "giver" is to focus on what feels good for them while caressing the "receiver".

Appendix S

Sexual Comfort Checklist - Sensate Focus 2 (Male form)

The following items describe certain sexual experiences. Please read each item carefully and then circle the number which describes how comfortable you feel whenever you engage in such activity. Complete the checklist independently .

Items 1. When a loved one caresses your penis with her fingers.

1. very comfortable 2. fairly comfortable. 3. fairly uncomfortable 4. very uncomfortable

2. When a loved one caresses or kisses your inner thigh.

1.very comfortable 2. fairly comfortable 3. farlry uncomfortable 4. very uncomfortable

3. When you caress a loved one's breasts and genitals with your fingers.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

4. When you caress a loved one's nipples.

1. very comfortable 2. fairly comfortable 3. fairly incomfortable 4. very uncomfortable

5. When you hear expressions of pleasure from your partner during pleasuring.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

6. When you caress or kiss a loved one's inner thighs.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

Sexual Comfort Checklist - Sensate Focus 2 (Female form)

Instructions:

The following items describe certain sexual experiences. Please read each item carefully and then circle the number which describes how comfortable you feel whenever you engage in such activity. Complete the checklist independently .

Items

1. When a loved one caresses your vagina with his fingers.

   1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

2. When a loved one caresses your clitoris with his fingers.

   1. very comfortable 2. fairly comfortable 3.fairly uncomfortable 4. very uncomfortable

3. When a loved one caresses or kisses your inner thighs.

   1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

4. When you caress your loved one's penis with your fingers.

   1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

5. When you caress your loved one's testicles with your fingers.

   1.very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

6. When you touch or caress your loved one's nipples with your fingers.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

7. When you hear expressions of pleasure from your partner during pleasuring.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

8. When you caress or kiss your loved one's inner thighs.

1. very comfortable 2. fairly comfortable 3. fairly uncomfortable 4. very uncomfortable

Appendix T

Topics and Assignment Checklist

Sensate Focus- Stage one

Session 1

1. ban on intercourse
2. introduction of general pleasuring
3. film: "Treating Erectile Problems" (first-half)
4. discussion of general pleasuring
5. assignment: chapter 8, Male Sexuality (Zilbergeld, 1978)

Subsequent sessions

1. difficulties encountered by couple with SF 1: list
2. if any difficulties, describe how were overcome
3. session prior to SF 2: assignment of readings on male and female sexuality

Sensate Focus -Stage Two

Session one:

1. discussion of Arousal and Erection guidelines
2. discussion of sexual anatomy
3. discussion of sexual response
4. Sexual knowledge checklist
5. introduction of genital pleasuring
6. film on sensate focus (second part)

7. discussion of genital pleasuring

8. film: "Becoming Orgasmic" (film one)

Subsequent sessions

1. discussion of any difficulties encountered in SF 2: list

2. describe how difficulties, if any, were overcome