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TIME-LIMITED SEX THERAPY FOR COUPLES: A CONTROLLED EVALUATION OF GROUPS AND INDIVIDUAL COUPLE INTERVENTION

by

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ABSTRACT

The effectiveness of a behaviourally based, broad band therapy for sexually dysfunctional couples was examined. Twenty-four couples were randomly assigned to either individual or group couple treatment. Treatment, identical for both conditions, consisted of: information and education; emphasis on mutual responsibility; attitude change; skills training; communication facilitation; reduction of all forms of sexual anxiety and graduated behavioral homework assignments. Measures of treatment effectiveness were repeatedly taken during a two-week baseline, five weeks of treatment and at the ends of the three week and three month follow-up periods. These measures included the Sexual Behavior Index, the Sexual Arousal Inventory and the Sexual Satisfaction Index. The six couples randomly assigned to the control condition were subjected to identical measurement without the benefit of treatment. Increases in arousal, satisfaction and behavior were evidenced for both treatment groups; however a trend towards increased generalization and maintenance of improvement was evidenced for those receiving group treatment.

Improvement was maintained through the three month follow-ups. Control clients showed no improvement and evidenced trends towards deterioration. The results of the present study document the efficacy of the short term behaviorally based program and indicate the viability of the group format as a cost-effective alternative to individual intervention.

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This work is dedicated to the memory of my beloved father and the successful completion of his dream.

OVERVIEW

The last thirty years has seen a growing scientific and public concern with the nature of human sexuality. This trend has been manifested in the proliferation of publications both investigatory and instructive and in the establishment of numerous clinics devoted to the study of all facets of human sexuality. In addition, there have been numerous large scale surveys and evidence of increased individual self-appraisal (LoPiccolo, 1978). Surveys have included works by Kinsey, Pomeroy, Martin and Gebhard (1953), Kinsey, Pomeroy and Martin (1948), Gebhard (1968), Shearer (1972), Fisher (1973), Hunt (1974) and Hite (1976). These studies, while primarily focussing on frequency of specific sexual activities such as pre and extra marital coitus, anal intercourse, etc., provide little information regarding the incidence of sexual dissatisfaction sufficient to cause couples to seek treatment.

Perhaps more relevant to the estimation of the prevalence of sexual dysfunction and dissatisfaction, Shearer (1972) found that approximately 50% of all married couples experience at least some form of sexual dysfunction. Based on a sample of one hundred couples not actively seeking sex therapy, Frank, Anderson and Rubinstein (1978) report that 50% of the males and 77% of the females indicated a lack of sexual interest which precluded satisfactory sexual activity. The authors suggested, moreover, that the number of marital difficulties reported was "more strongly and consistently related to overall sexual dissatisfaction than to the number of actual dysfunctions." These data

are clinically relevant as they are based on self-reported dissatisfaction, not merely on symptomatic accommodation to diagnostic criteria or on reported normative frequencies of sexual behavior.

Publication of reports of both sexual practice and dissatisfaction has led many couples to scrutinize their own sexuality. Indeed, engaging in robust sexual activity has become a "required ability" (LoPiccolo and Heiman, 1977) almost necessary for social acceptance. This increased public awareness has contributed to the unprecedented number of couples seeking sex therapy.

The nature of sex therapy has changed and must continue to change dramatically in order to respond effectively to the growing demand for service. The basic changes in format originated with Masters and Johnson (1970) who provided a brief, time-limited intervention which dealt directly with areas of dissatisfaction by way of educative, directive therapy. Since 1970, new short term broad band, problem specific therapies based on Masters and Johnson's work have proliferated. These therapies address themselves to the growing demand for sex therapy in that they are time-limited and contain sufficient information for, and techniques oriented towards, treatment generalization. Although masquerading under various nomenclatures, the treatment components and goals are generally similar. The broad band approach includes: information and education; emphasis on mutual responsibility; attitude change; skills training; communication facilitation; reduction of all

forms of sexual anxiety and graduated behavior homework assignments. While the available research and clinical case studies based on various combination of these techniques is most encouraging (Kaplan, 1974; Lobitz and LoPiccolo, 1972 and Barbach, 1974) there is little experimental research to document their efficacy (Sotile and Kilmann, 1977). The first objective of the present research is to document the efficacy of one such short term, broad band therapy while addressing many of the methodological flaws that have characterized previous research (Sotile and Kilmann, 1977).

Given the increasing demand for service in the face of a limited number of therapists, application of group format to these broad band therapies would reduce client costs and increase the availability of treatment. Utilization of the group format and direct comparison between individual and group treatment of sexual dysfunction is virtually nonexistent (Golden, Price, Heinrich and Lobitz, 1978) in the available literature. It is, therefore, the second objective of the present study to compare directly individual and group short term, broad based therapy to ascertain the feasibility of utilizing the more economical group approach for the treatment of heterogeneous sexual dysfunctions.

REVIEW OF THE LITERATURE

Although there are numerous perspectives from which to view the available literature on sex therapy, the distinction between individual and group therapy which is consistent with one of the objectives of this study and which also accurately reflects the course of development in this area, will be used as the organizational framework for this review. Discussion of each of these types of intervention will be divided further in terms of its application to males, females or couples.

Individual Intervention: Male and Female

Despite its therapeutic failings (Sherfey, 1972; Moore, 1961; Cooper, 1978 and Obler, 1973), Freudian psychoanalysis was the first attempt to examine systematically the nature of sexual difficulties and as such warrants discussion. The key concepts of this theory as it applies to sexual dysfunction are: unconscious conflicts which are presumed to mediate sexual difficulties; repression and resistance in acknowledging sexual attitudes and experiences; and infantile sexuality which is presumed to develop in predetermined stages and to determine future sexual potency (Freud, 1938). Dysfunction is seen as a symptom of underlying unconscious motives or conflicts and amelioration is said to take place only if basic changes in personality structure are effected (Freud, 1938).

In addition to theorizing about the etiology and treatment of sexual dysfunction, Freud (1938) also held

strong beliefs about the appropriate expression of female sexuality. Women who achieved clitoral rather than vaginal orgasms were assumed to be immature and emotionally disturbed. This assumption has not withstood experimental verification as Masters and Johnson (1970) and Sherfey (1972) cite anatomical and physiological data which indicate that vaginal orgasm is a myth and that orgasm has to be mediated by a combination of sexual fantasy and clitoral stimulation.

Psychoanalytic treatment of sexual dysfunction can be criticized on theoretical, practical and methodological grounds. It is assumed for example that "early incestuous experiences are the only causes of sexual conflict and that sexual dysfunctions are always caused by unconscious conflict which is the only etiologic factor and that care must be predicated on resolution of these specific underlying conflicts" (Kaplan, 1974, p.144). The demonstrated efficacy of treatment utilizing direct behavioral interventions (Nemetz, Craig and Reith, 1978 and Golden et al., 1978) provides evidence suggesting that intervention on a purely behavioral level can provide positive therapeutic results. Practical limitations of psychoanalytic therapy include: failure to deal with both partners; excessively long term involvement (Cooper, 1978); financial burden and refusal to deal with the immediate sexual behavior while insight into previously unexplored conflict occurs. Moreover, the majority of reports dealing with the use of

psychoanalysis for sexual dysfunctions are single subject case histories using the subject's verbal report as the outcome criterion (Stafford-Clark, 1954). While no controlled, outcome study has been done to evaluate the effectiveness of psychoanalysis for these disorders, the approach is considered to be ineffective (Obler, 1973; Cooper, 1978).

The first alternative to the psychoanalytic approach to sexual dysfunction was the behavioral approach introduced by Wolpe (1958). Wolpe (1958) viewed sexual dysfunction as a maladaptive behavior which could be influenced by the application of experimentally validated principles of learning. His theory of systematic desensitization is based on the principle of reciprocal inhibition which states that "if a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between the stimuli and the anxiety responses will be weakened" (Wolpe, 1958, p.71). The major assumption supporting the application of systematic desensitization to sexual dysfunction is that anxiety initiates and maintains maladaptive behavior. This technique involves progressive relaxation training (Jacobson, 1938) and the construction of a hierarchy of sexually-related, anxiety-inducing stimuli which are presented one at a time, in imagination while the client is in a state of deep relaxation.

Wolpe (1958) reported two cases of female dysfunction, one described as "partial frigidity" and the other as "sexual anxiety." Although both cases were reported to be successfully treated, the therapist's subjective report served as the only outcome criterion. Despite this methodological failing and severe criticism of the theoretical basis for the clinical techniques (Paul, 1969), Wolpe's work represents the first attempt to deal directly with problematic sexual behavior in a relatively short-term therapeutic program.

Subsequently, numerous other clinicians have reported successful use of systematic desensitization (in vivo or imaginal) to alleviate male and female sexual dysfunction (Cooper, 1968, 1969; Lazarus, 1961, 1963, 1965, 1968; LoPiccolo, Stewart and Watkins, 1972); Kraft and Al-Issa, 1964; Annon, 1974; Wincze, 1971 and Wolpe, 1953, 1958). Although the majority of these studies used small samples and omitted control conditions, the direction of the findings is consistently positive. Modifications of this therapeutic technique which have been used effectively with sexual dysfunction have included the use of: chemical relaxation (Brady, 1966); hypnotic relaxation (Lazarus, 1973) and sexual arousal (Wolpin, 1969; Clopton and Risbrough, 1973; LoPiccolo and Lobitz, 1973 and Frankel, 1979) to serve as anxiety inhibitors.

Video-taped desensitization has also been employed successfully, specifically in studies of female sexual dysfunction (Caird and Wincze, 1974; Woody and Schauble, 1969;

Nemetz et al., 1978). This modification, in which clients view models engaging in the desired behavior without experiencing adversive consequences, is based on Bandura and Walter's conclusion that "virtually all learning phenomena resulting from direct experiences can occur on a vicarious basis through observation of other persons's behavior and its consequences for them" (Bandura, 1969, p.118). Potential effects of modeling therapies previously identified (Bandura, 1969), include the acquisition of previously non-existent patterns of behaviors, weakening response inhibitions and facilitating the occurrence of preexisting responses in the behavior repertoire. In terms of sex therapy, viewing a previously anxiety-inducing situation as it produces positive consequences, not only serves to extinguish the anxiety and facilitate the response, but also shows the client the appropriate skills to utilize in his new behavior.

Several studies have investigated the relative efficiency of systematic desensitization and its variations in the treatment of sexual dysfunctions. Wincze (1971) compared the effects of conventional systematic desensitization to vicarious extinction (Bandura, Grusec and Menlove, 1967) in which the client observes models performing anxiety-producing behaviors without experiencing adverse consequences. The single subject for the comparison was a female who reported numerous problem areas including sexual apathy and anxiety. Wincze concluded that systematic desensitization was more effective than vicarious extinction for that particular

case on the basis of the single subject reversal design. Unfortunately, he failed to control for possible sequence effects of the therapeutic interventions utilized.

Wincze and Caird (1976) compared the relative efficiency of video-taped desensitization/vicarious extinction and standard imaginal desensitization using a sample of twenty-one women diagnosed in Kaplan's nomenclature as having a "general sexual dysfunction." The standard desensitization condition consisted of thirty hierarchical scenes presented in imagination. The video-taped condition contained the above thirty scenes presented visually. There were two or three weekly sessions for each subject which were continued until the subject completed the thirty hierarchy items. A cross-over control was included in which subjects were randomly assigned after a four week delay to the two experimental conditions. The results indicated that both treatment conditions significantly reduced sexual anxiety by comparison to the control condition although only the video-desensitization produced significant reduction of heterosexual anxiety. Since the instrument utilized to measure heterosexual anxiety (The Bentler Heterosexual Anxiety Hierarchy, Bentler, 1971) contained a number of novel sexual items not referred to during the course of therapy, this result suggests that the video-desensitization showed greater generalization of treatment effects.

It is imperative that systematic desensitization and its variations be evaluated with the appropriate subject

sample. For example, vicarious extinction/video-tape desensitization provides sex information, response facilitation and teaches the clients new sexual skills, whereas in vivo desensitization includes actual shaping of skills through practice with and feedback from the partner. If the client has no partner or is expressing extremely high levels of anxiety, imaginal exposure coupled with vicarious extinction is recommended (Kaplan, 1974; Lazarus, 1968). If clients are sexually naive and unskilled vicarious extinction would appear to be the most efficient method of transmitting information. Most sex therapies now use a combination of the three methods which provides both necessary information and the opportunity for actual practice with partner feedback.

One of the more recent developments in the treatment of sexual dysfunction is that of masturbation training (Lobitz and LoPiccolo, 1972). The assumption underlying the masturbation training is that masturbation is the most probable method of producing an orgasm (Kinsey, 1953). There is also some evidence to suggest that an intense orgasm which is more frequently produced by masturbation (Masters and Johnson, 1970) leads to increased vascularity in the vagina, labia and clitoris and that this in turn will enhance orgasmic potential (Bardwick, 1971). From a practical standpoint training in masturbation techniques is appropriate for both male and female clients who do not have partners (Annon, 1974); it enables a client to discover what types of stimulation are arousing which can then be communicated to a

partner (Annon, 1973; LoPiccolo and Lobitz, 1972); it produces less anxiety than heterosexual behaviors and thereby allowing the client to begin with a more relaxing assignment (Kaplan, 1974); and it provides an opportunity for males with the problem of premature ejaculation to practice the "squeeze" or "pause technique" without incurring performance demands from his partner (LoPiccolo and Lobitz, 1973).

LoPiccolo and Lobitz (1972) have developed a nine step masturbation training program for women in which the client systematically explores her body visually and tactually, locates areas of positive sensation, stimulates these areas manually and then with an electric vibrator, communicates these techniques to her partner and then engages in intercourse with concurrent manual or vibrator stimulation. Utilizing this technique with eleven cases of primary orgasmic dysfunction, Lobitz and LoPiccolo (1973) report that all eleven women became orgasmic through masturbation and that nine of the eleven were orgasmic with their partner (although apparently requiring concurrent manual stimulation). Given the lack of a control condition this study represents more of an initial clinical investigation than a rigorous attempt to evaluate the efficacy of masturbation training.

Within the individual treatment format, masturbation training has also been reported to be effective with erectile failure (Annon, 1974), premature ejaculation (LoPiccolo and Lobitz, 1973), primary orgasmic dysfunction (Kaplan, 1974) and secondary orgasmic dysfunction (Annon, 1973). Unfortunately,

these studies have numerous methodological failings. They do, however, suggest further areas for more rigorous experimental investigation as to the efficacy of masturbation training.

Individual Intervention: Couples

Masters and Johnson (1970) were the first to emphasize the importance of treating both partners in the sexual relationship. They maintain that there is no uninvolved partners either in the etiology or in the treatment of sexual dysfunction: "sexual dysfunction is indeed a marital unit problem, certainly never only a wife's or only a husband's personal concern" (Masters and Johnson, 1970, p.3).

These authors describe an extensive retraining program, essentially behavioral in nature, whereby couples reporting any type or combination of sexual dysfunction participate in an intensive two week therapeutic program. In addition to discussion, education and communication training, two new techniques were included in their program. The first, sensate focus, was designed to maximize partner feedback regarding the effects of sexual stimulation and to give both partners an opportunity to "give and receive" stimulation in a non-threatening situation. In conjunction with this exercise, intercourse is prohibited initially to remove performance anxiety and to allow couples to explore safely and to experience their intensified arousal. Secondly, Semans (1956) original "pause" technique for premature ejaculation, which consisted of penile withdrawal immediately prior to the

point of ejaculatory inevitability was modified to include the female's application of manual pressure to the frenulum to diminish the erection and the urge to ejaculate.

Evaluation of their treatment program is unfortunately complicated by uncertain external validity and imprecise outcome measures. The intensive two week residential program was presumably available only to a highly self-selected segment of the population because of the disruptive and financially burdensome nature of participation. In addition, selection criteria for treatment were extremely rigid. These included a history of at least six months of prior symptomatic treatment, a well-adjusted marriage and a high level of motivation for treatment. These criteria, in addition to the requirement of the two week commitment seriously call into question the representativeness of their sample. Secondly, the outcome criterion, "symptom reversal," is ambiguous especially in terms of female sexual dysfunction as it is not clear whether this criterion included only the ability to achieve orgasm through coitus or whether it was extended to include the ability to reach orgasm through other methods of stimulation (Sotile and Kilmann, 1977). In view of these limitations it is difficult to evaluate the reported 80% initial success rate in both the male and female samples. Despite these methodological considerations, Masters and Johnson are credited with conducting a large scale evaluation of their treatment, popularizing the concept of short term therapy, introducing the dual sex therapy

team and providing the major impetus for subsequent investigation of couple intervention.

Hartmann and Fithian (1972) and Kaplan (1974) have used sexual retraining programs similar to those of Masters and Johnson (1970). Hartmann and Fithian's intensive two week retraining program focused on audiovisual aids for sexual skills training and the use of Gestalt techniques to examine both the client's body image and the couple's method of interacting. Kaplan (1974) incorporated both dynamic psychotherapy and behaviorally oriented retraining methods in an intensive program of variable length. In addition, all clients were seen in individual psychotherapy sessions which explored intrapsychic obstacles assumed to impede sexual responsiveness. Neither author, however, presented any evaluative data on their programs, instead case histories were offered as a measure of program effectiveness.

The new short term, broad band therapies have also been applied to individual couples. Lobitz and LoPiccolo (1972), the original proponents of this form of intervention, describe a fifteen session treatment program which utilized in vivo graded exposure tasks to reduce performance anxiety, daily self-monitoring of sexual behaviors, the "squeeze" technique (Masters and Johnson, 1970) to ameliorate premature ejaculation, a classical conditioning procedure to condition sexual arousal, masturbatory skills training combined with fantasy and pornography to enhance sexual responsiveness, modeling and role-playing to facilitate

the acquisition of both interpersonal sexual and communication skills and client participation in maintenance planning to facilitate treatment gains. Following Masters and Johnson's (1970) criterion that the female partner be satisfied, that is reach orgasm "in at least 50% of coital connections," (Masters and Johnson, 1970, p.92) they reported success with all thirteen cases of female primary orgasmic dysfunction and three of nine cases of secondary orgasmic dysfunction. In addition, six of six cases of premature ejaculation and four of six cases of erectile failure were effectively treated. Although these results remain to be replicated in a controlled evaluation study, as an initial investigation of a new short term, broad band therapy, they are promising.

Although clinically promising, the literature on individual (male, female and couple) intervention in sex therapy is rife with methodological deficiencies (Sotile and Kilmann, 1977). Studies consistently utilize small subject samples with little or no attempt to examine prognostic subject characteristics. Control groups and adequate follow-up are often non-existent. In cases of single partner involvement, very often no corroborative data are solicited from the uninvolved partners. Data, when presented at all, too frequently rely on subject testimony about the efficacy of the intervention. An unqualified evaluation of the effectiveness of the sex therapies therefore will not be possible until more controlled and

methodologically sound research has been conducted.

Group Intervention

Although extremely sparse, the existing literature on group intervention in sex therapy may be divided on the basis of gender and also on the basis of heterogeneity or homogeneity of diagnosis. While not overcoming the numerous methodological deficiencies characteristic of earlier research (Sotile and Kilmann, 1977) this body of research addresses the current difficulties of increased cost and limited variability of treatment for sexual dysfunction.

Group Intervention: Female

Initial work with female groups was done by Stone and Levine (1950) and Boas (1950). Stone and Levine (1950) ran eight diagnostically heterogeneous groups consisting of nine women each. Treatment, focussing on sexual re-education and group discussion, consisted of three two-hour sessions. Spouses were seen once in a separate group to discuss their roles in their partners' therapy. Although no objective data were collected, solicited subjective reports suggested that increased communication and, in some cases increased female responsiveness had resulted.

Boas (1950) saw twenty secondary inorgasmic females for fourteen forty-five minute sessions. The purpose of the group sessions was to provide insight into the patients' conflicts and to examine sexual attitudes. Again, although no objective or systematized data were obtained, the

author reported anecdotal findings of increased understanding of sexuality and decreased sexual anxiety.

Systematic desensitization has been used in group treatment of female sexual dysfunction by Lazarus (1968), Obler, (1973), Husted (1975), Sotile and Kilmann (1978) and Nemetz, Craig and Reith (1978). Lazarus (1968) utilized a group procedure with four non-orgasmic women. Fourteen sessions were devoted to a combination of relaxation and systematic desensitization, re-education and group discussion. At the termination of treatment all women were experiencing orgasm (not further defined) in at least 50% of their sexual encounters.

Obler (1973) in a relatively well-controlled study compared a group receiving desensitization and one receiving dynamically-oriented therapy, to a non-participating control group. Sixty-four women were randomly assigned to the three conditions. Although the groups were matched for type and duration of dysfunction, no description of group composition was provided. Data indicated that subjects receiving desensitization reported significantly more reduction in the physiological correlates of anxiety than those in either of the other conditions. Obler, however, used graphic aids and assertive training in conjunction with the desensitization and consequently it is difficult to identify the effective treatment components.

Husted (1975) compared the effects of group imaginal systematic desensitization to group imaginal systematic

desensitization plus in vivo homework assignments in a diagnostically heterogeneous sample of females. After fifteen sessions, all showed significant increases in communication and orgasm. Significant decreases in sexual anxiety were also evidenced. While both treatments were equally effective in reducing sexual anxiety, imaginal desensitization alone was significantly more efficient in terms of time needed to produce therapeutic benefits. Husted suggests that this was due to the number of obstacles that interfered with the completion of homework assignments of the in vivo group. This observation draws attention to the limitations of homework assignments in sex therapy. If daily events are not conducive to sexual activity any therapy dependent on the completion of sexual behavioral homework assignments in jeopardized.

Sotile and Kilmann (1978) using a diagnostically heterogeneous sample, ran two groups of ten and twelve women respectively for fifteen biweekly sessions. Each woman served as her own control. Group systematic desensitization was conducted using four common hierarchies of sexual scenes. Measures of sexual behavior and satisfaction showed significant increases over baseline which were found to be maintained six weeks later when follow-up assessments were done. This study contributes to the knowledge on group systematic desensitization as it is one of the few to utilize a control measure and a follow-up period.

Nemetz, Craig and Reith (1978) used attitudinal, behavioral and sexual anxiety measures to assess the effects of individual and group graduated symbolic modeling through videotapes with concurrent behavioral tasks. All twenty-two women had reported severe sexual anxiety which precluded sexual enjoyment or activity. Sixteen subjects were randomly assigned to one of the two experimental conditions and received either group or individual treatment. Treatment consisted of relaxation training followed by viewing a hierarchy of forty-five video-taped vignettes depicting graduated sexual behaviors. Five sessions were held within two and one-half weeks. The other six women constituted an assessment only control group. Decreased anxiety, increased sexual behavior, and improvement on attitudinal measures were evidenced in both treatment conditions in contrast to the control; however, a trend toward greater improvement was observed for those who received group treatment. Improvements in both treated groups remained stable through a one year follow-up period. This study, together with those reported by Obler (1973), Husted (1972) and Sotile and Kilmann (1978) clearly indicate that group desensitization is an effective procedure for reducing sexual anxiety and increasing sexually effective behaviors.

The demonstrated efficacy of masturbation training (LoPiccolo and Lobitz, 1973) for non-orgasmic women treated individually has suggested its adaptation to group format.

Barbach (1974) saw eighty-three primary inorgasmic women (in groups of five to seven) twice a week for five weeks. Treatment procedures included masturbation training, sexual re-education through readings and discussion, and an individual component designed to facilitate sexual communication with the woman's partner. At the end of treatment Barbach found that seventy-six of the eighty-three women attained orgasm consistently through masturbation. After eight months only seventeen women were available for follow-up assessment, all of whom continued to be orgasmic (Wallace and Barbach, 1974). Of these seventeen all but two women failed to report orgasmic experiences with their partners. Given the greatly reduced sample available for follow-up, no firm conclusions regarding maintenance of treatment effects can be drawn.

Schneidman and McGuire (1976) examined the effects of masturbation training in conjunction with a multi-faceted approach, on two groups each consisting of ten primary inorgasmic women. One group included women over thirty-five and the other included women under thirty-five. The major components of the ten week program were re-education, group discussion, couple oriented therapy and masturbation training (LoPiccolo and Lobitz, 1972). The results indicated that the younger women became orgasmic earlier in treatment and that a greater percentage of this group was orgasmic at the termination of treatment. Only one woman became orgasmic during coitus. Although orgasm during coitus alone

should not be seen as the ultimate criterion for successful intervention, it appears that this extremely low percentage is due to the fact that the partners were not consistently involved in the therapy. Although Barbach (1974) can be credited with the introduction of masturbation training in group format to preorgasmic women, the research does not include adequate control or direct comparison to individual therapy.

Leiblum and Ersner-Hershfield (1977) dealt with three basic issues concerning the implementation of women's groups: (1) transfer of masturbatory skills to heterosexual behavior; (2) possible benefits of partner inclusion in therapy; and (3) value of diagnostic heterogeneity versus homogeneity of group composition. Three groups of women were seen for one and one-half hours for eight consecutive weeks. Composition of the groups varied: Group 1 contained six women with heterogeneous diagnoses with no male participation; Group 2 contained five women who reported primary orgasmic dysfunction, also with no male participation and Group 3 contained five heterogenously diagnosed females with male participation in two sessions. Treatment included sexual re-education and information, behavioral homework assignments and masturbation training. Although ten of the eleven primary inorgasmic women became orgasmic with the masturbation training, transfer of orgasm to coitus <u>without</u> additional genital stimulation, was not demonstrated. This finding which is consistent with other reports

(Schneidman and McGuire, 1976; Ersner-Hershfield and Kopel, 1979) seriously questions the likelihood of orgasm through coitus alone. Although the authors strongly recommend the participation of male partners on the basis of increased couple satisfaction in Group 3, as measured by the Locke Wallace Marital Adjustment Scale (Locke and Wallace, 1959) and the Sexual Interaction Inventory (LoPiccolo and Steger, 1974), it must be noted that none of the uninvolved partners in the other groups were given these measures. Consequently, conclusions about couple satisfaction are unwarranted.

Hershfield and Kopel (1979) compared the effect of couples and women's group treatment for primary orgasmic dysfunction. The authors were primarily concerned about the relationship of partner-included versus partner-excluded programs to the outcome criteria or orgasm via couple activities, as opposed to orgasm through self-stimulation. In addition, the authors addressed the question of massed versus distributed therapy sessions. Twenty-four primary inorgasmic females were randomly assigned to one of four treatment groups: (1) women; or (2) couple massed sessions (twice weekly for five weeks); or (3) women; or (4) couple distributed sessions (weekly for ten weeks). Treatment consisted of sexual education, communication and masturbation training (Barbach, 1975; LoPiccolo and LoPiccolo, 1976). Subjects served as their own waiting list control for an

unspecified baseline period. Measures repeated at the initial interview, end of baseline, immediately post-treatment and five and ten weeks post-treatment, included the Locke Wallace Marital Adjustment Scale (Locke and Wallace, 1959) and a Survey of Sexual Activities (Ersner-Hershfield and Kopel, 1979) which assessed changes in the frequency and pleasure ratings for self and couple sexual activities. All formats of the treatment were equally effective for both male and female participants in terms of self and couple sexuality. At the two week follow-up period 91% of the women achieved orgasm through self-stimulation and 82% experienced orgasm via couple activities, the greatest frequency occurring via vibrator stimulation utilized in a couple format. Consistent with previous research (Schneidman and McGuire, 1976; Leiblum and Ersner-Hershfield, 1977) orgasm through coitus alone was infrequent. No significant difference was observed between the groups receiving massed or distributed sessions. Despite the lack of adequate controls and direct comparison to individual procedures, the findings of the research on group intervention for female sexual dysfunction suggest that it is a potentially effective form of intervention.

Group Intervention: Male

Little research has been done on male dysfunction in general and there is a particular dearth of literature reporting group procedures with males.

Kaplan, Kohl, Pomeroy, Offit and Hogan (1974) reported on four couples whose major complaint was premature ejaculation. The couples were seen for six weekly forty-five minute sessions. The objective of the group session was to train the partners in ejaculatory control techniques and to deal with obstacles to sexual functioning and resistance to treatment. Success, maintained by all four males at the end of the four month follow-up period, was defined as the males' attainment of voluntary ejaculatory control with consequently prolonged coitus.

Zeiss, Christensan and Levine (1978) treated six males without their partners for premature ejaculation during six weekly sessions. Treatment included instruction in the "squeeze" technique (Masters and Johnson, 1970), the "pause" technique (Semans, 1956) and in communication skills. At the eight month follow-up 50% of the subjects had reported increased ejaculatory latency. As in the study by Kaplan et al., (1974), there was no control group with which these results could be compared.

Lobitz and Baker (1979) used group sessions for males without regular sexual partners in the treatment of primary and secondary erectile failure and premature ejaculation. Treatment focussed on sexual education, positive sexual attitudes, reduction of sexual anxiety, development of communication skills and increased sensitivity to physical sensations and erotic imagery. Two groups of six males each met for twelve weekly ninety minute sessions. Although

self-reported data indicated that 66% of the men showed significant improvements in their ability to obtain and maintain erections, interpretation of this finding is severely hampered by lack of a control group and reliance on undefined self-report measures.

None of the aforementioned studies describes the female partner, or attempts to measure her co-operation or indeed her execution of the training procedures. This is a significant omission in view of the research on unisexual groups, both male and female, which suggests the importance of treating both partners in the relationship (Masters and Johnson, 1970; Leiblum et al., 1977). Advantages of dyadic involvement include: ease of communication of homework assignments; assessment of partners' contribution to presenting problems and subsequent participation in therapy; assessment of partner reaction to therapeutic progress; and clarification of therapeutic difficulties. However, where there is no partner available, the unisexual group provides a setting for therapeutic intervention.

Group Intervention: Couples

Given the above mentioned difficulties of the unisexual group, the recent development of couples' groups in the treatment of sexual dysfunction merits special attention. Although the specific details vary, treatment components generally include information about sexuality, relaxation techniques, communication skills, specific sexual technique training and instructions for maintenance. This information

is communicated through books, films, lectures and group discussion. Although the majority of these studies have at least a two month follow-up, generalization of their results is limited by small samples and lack of any sort of control condition.

Hartmann and Fithian (1972) in discussing their bio-psycho-social approach, mention the use of group workshops lasting one to six days. Data or elaboration of the program was not included. Miller (1973) used a modified Masters and Johnson (1970) approach to treat two groups of four couples each. The presenting problems included primary and secondary orgasmic dysfunction and premature ejaculation. Thirteen four hour sessions were held within three and one-half weeks. Assessment was through a questionnaire about the presence or absence of various sexual dysfunction, current sex practices and deterrents to sexual activity. Of the sixteen individuals only two remained dysfunctional at the sixty day follow-up. Although this treatment outcome is comparable to the results described by Masters and Johnson (1970), only a small sample was used and no control condition was included.

McGovern, McMullen and LoPiccolo (1978) used a group format with four couples whose major complaints included both premature ejaculation and primary inorgasmia. Fifteen three hour sessions including warm-up exercises, relaxation training, round table discussion and behavioral rehearsal

were given. The authors report that at the end of treatment, all four females were completely orgasmic by means of masturbation and that three of the four males had succeeded in increasing their ejaculatory latency. At the six month follow-up assessment the Locke Wallace Marital Inventory (Locke and Wallace, 1959) showed an increase in marital satisfaction, but some behavioral regression was noted. The authors suggest that this regression may be due to the withdrawal of support and encouragement experienced in the group setting. They further suggest that the couples' changes in attitudes and behavior may have been affected more by the group involvement than by an improved dyadic relationship. While this may be the case, their finding appears to argue more for programmed maintenance strategies than for detrimental effects of group therapy.

Leiblum and Rosen (1979) utilized a group format to conduct two weekend workshops for fifteen diversely dysfunctional couples. Eight couples participated in the first workshop and seven participated in the second. Each workshop included sex re-education, couple communication, attitude change and the introduction of specific skills aimed towards amelioration of specific dysfunctions. As treatment was only available for two days, a strong self-help component was integrated into the workshop. Pretreatment instruments included the Lock Wallace Scale of Marital Adjustment (Locke and Wallace, 1959), the Sexual Interaction Inventory (LoPiccolo and Steger, 1974) and the Sexual

Assessment Inventory (Leiblum, 1973). The Sexual Interaction Inventory and the Locke Wallace were both readministered at the two month follow-up and the latter only at three months post-treatment. The results suggested that the workshop format was successful in increasing marital communication, satisfaction with the relationship and sexual interaction. Couples experiencing long-standing sexual dysfunction, however, reported no improvement as a result of group participation and information on self-help methods. Given this result the authors suggest that group treatment on a continuous basis would be the treatment of choice for those couples reporting long standing, specific sexual complaints. Clearly, identification of those couples who would benefit from this type of brief intervention would maximize therapeutic access.

Leiblum, Rosen and Peirce (1976) were concerned both with the outcome and the subject composition of group therapy. Six heterogeneous couples were seen for twelve weekly two hour sessions. The sessions focussed on education, attitude change, communication and skills training. Assessment techniques included the Locke Wallace Marital Adjustment Scale (Locke and Wallace, 1959) and the Sexual Interaction Inventory (LoPiccolo and Steger, 1974) both of which were administered at the beginning and end of treatment. Although a six week follow-up was conducted, these questionnaires were not readministered. In addition to significant improvements in both the aforementioned

measures, five of the six couples also reported significant attitude change, increased familiarity with sexual techniques and increased sexual knowledge. Although no control group was included, the authors felt that the significant results warranted further investigation into heterogeneous group composition.

The only study found which attempts to compare individual and group sex therapy with couples, was done by Golden, Price, Heinrich and Lobitz (1978). Of seventeen couples complaining of both premature ejaculation and secondary orgasmic dysfunction, eleven were assigned to group sessions and six to individual therapy. Couples were seen once a week for twelve weeks. As in other studies discussed previously, skills, training, communication, information and homework assignments were the major treatment components. The Sexual Interaction Inventory (LoPiccolo and Steger, 1974), a background information questionnaire and the Goals for Sexual Therapy (Price and Heinrich, 1975) were administered at intake. The Sexual Interaction Inventory and the Locke Wallace Marital Adjustment Scale were re-administered at treatment termination and at the two month follow-up. Results indicate significant improvement in clients receiving both forms of treatment, with group treatment showing a nonsignificant tendency to be more effective. Unfortunately, the findings of this study are limited by the small sample and lack of control condition.

In reviewing the existing literature on the application of group techniques to sexual dysfunctions, several issues become apparent. Given the educational, skill training, communication building nature of the promising, new, short-term sex therapies, their use in group form would appear to maximize treatment availability without jeopardizing treatment effectiveness. Even though, as has been mentioned repeatedly, studies in the area suffer severe methodological deficiencies such as lack of control, small samples and reliance upon verbal reports (Sotile and Kilmann, 1977) the majority suggest the value of the group approach. Only two studies have compared group and individual therapy and in both cases there was a non-significant tendency for the group treatment to be more effective (Nemetz et al., 1978; Golden et al., 1978). The elements in group therapy which are thought to contribute to its effectiveness include: support and encouragement from peers (Leiblum et al., 1976); atmosphere conducive to communication (Golden et al., 1978); modeling effects (McGovern et al., 1978); and ability to share other couples' coping strategies (Nemetz and Caird, 1978). Although the issue of group composition has not been examined systematically, it is generally recommended that both partners should be actively involved in therapy wherever possible (Masters and Johnson, 1970; Leiblum and Ersner-Hershfield, 1977). The desirability of diagnostic heterogeneity or homogeneity has received some attention.

Results suggest that mixed group format can be used effectively especially for the purpose of broadening sexual information and reducing the tendency for couple competition that may occur in homogeneous groups (Leiblum, Rosen and Peirce, 1976).

Purpose of the Present Study

Examination of the available literature on sex therapy reveals three important trends. First, it is generally recommended that both members of the dyad be involved in therapy (Masters and Johnson, 1970; Leiblum and Ersner-Hershfield, 1977). Second, the new broad band therapies which incorporate a wide range of coping skills applicable to a majority of current and potential sexual dysfunctions increase the likelihood of effective treatment despite the continued use of the imprecise diagnostic classification of sexual dysfunctions. Third, the use of group format reduces cost and increases the availability of treatment.

The purpose of the present study is to evaluate a broad band, short term therapy in its application to both individual couples and groups of couples, while avoiding the methodological flaws which have characterized previous research in the area (Sotile and Kilmann, 1977). It was not the intent, nor would it seem appropriate at this point in the development of the area (LoPiccolo, 1978) to evaluate the contribution of individual treatment components. Rather the principal objective is to examine the efficacy of the

program as a whole. The second objective is to compare individual couple and group couple format. Although it is hypothesized that the experimental conditions will result in significantly greater improvement on all measures than the control condition, no prediction is made regarding the relative efficacy of group as opposed to individual intervention.

METHOD

Subjects

The subjects were thirty sexually dysfunctional couples referred to the Human Sexuality Clinic in the Health Sciences Center Hospital at the University of British Columbia. Twenty of these had been referred to the clinic by psychiatrists, general practitioners or gynecologists. Eight couples had heard about the program through friends, and two other couples responded to a brochure about the program distributed by the Continuing Education Department of the University of British Columbia.

Each couple's suitability for admission to the program was assessed at a standardized initial interview (see Appendix I). Admission to the program was contingent on the presence of dysfunction defined as "cognitive, affective and/or behavioral problems that prevent an individual or couple from engaging in and/or enjoying satisfactory intercourse and orgasm" (Hogan, 1978, p.58). Disqualifying factors included: lack of a steady and co-operative sexual

partner; recent diagnosis of a medical condition which would impair sexual functioning; presence of psychotic symptomatology; presence of a severe marital problem which would preclude conjoint therapy; presence of an addictive behavior which would jeopardize effective intervention; and lack of commitment to either the partner or the therapeutic process. Nine couples were disqualified from treatment on the basis of the above criteria. These couples were subsequently referred to the Behavior Therapy Unit of St. Paul's Hospital, Vancouver, B.C. Of the qualifying subjects, twenty-two couples had one identified dysfunctional partner and in eight couples both partners reported dysfunctions. The sample consisted of ten primary inorgasmic and fifteen secondary inorgasmic females and nine premature ejaculators. In addition, two females and two males were sexually inactive. The subjects ranged in age from eighteen to fifty-seven ($\bar{X}$ = 33.6, SD = 5.6). Twenty-five of the couples were married and five cohabiting. The duration of the relationship ranged from .3 to thirty-five years ($\bar{X}$ = 8.6, SD = 4.3).

Design

A combined between/within subjects design was employed in which couples, who were assigned to three different groups were repeatedly assessed before, during and after treatment. Twelve couples were originally assigned to the individual group treatment condition; two groups of six couples each comprised the group couple condition and six

couples were assigned to the control condition. Random assignment to the three experimental conditions was carried out with the exception of two couples. As Golden et al., (1978) points out, ethical considerations demand a departure from random assignment when couples enter therapy over an extended period of time. The exception was made in the present study when four couples had been waiting for over nine weeks for the formation of a group. Because of this long delay, the next two couples were specifically assigned to group treatment.

Dependent Variables

The Sexual Behavior Inventory was designed by the author and colleagues (Nemetz, Craig and Reith, 1978) to measure specific sexual behaviors (see Appendix II). This instrument requires both partners to record the daily frequency of fourteen separate sexual behaviors. All items were operationally defined for the couple at the initial interview. All subjects were asked to complete this measure for two weeks prior to treatment, during the five weeks of treatment and for three weeks after treatment. During each week of treatment and follow-up records were collected and examined to ensure that subjects were completing them correctly.

The Sexual Satisfaction Index (Nemetz and Caird, 1978) consists of twenty-two statements about various aspects of both sexuality and communication (see Appendix III). Subjects were asked to rate these statements on a zero to six

scale with zero being entirely dissatisfied with the subject of the statement and six being extremely satisfied. This scale was designed to assess the potential effects of sexual dysfunction not only on couples' sexual behavior and relationship, but also on the individual partners perception of his or her own sexuality. This questionnaire was completed independently by both partners at the initial interview, at the first and last treatment session and at the three week and three month follow-ups, again with responses being monitored to ensure that the subjects were complying with instructions. Responses from eighty-one people, including both the subjects in the present study and previous clients at the Human Sexuality Clinic were analyzed to evaluate the internal consistency of this measure. When the Sexual Satisfaction Inventory was divided into conceptually inter-related subtests, no subtest received an alpha or Hoyt coefficient of less than .73 (see Table 1).

The Sexual Arousal Inventory (Hoon, Hoon and Wincze, 1976) (see Appendix IV) consists of twenty-eight statements describing potentially arousing situations. The subjects were asked to rate each situation on a scale from -1 indicating adversely effects arousal through to +5 indicating always causes arousal. The scale has been utilized in previous research (Hoon et al., 1976) with good test-retest reliability and high concurrent validity.

Procedure

Telephone contact was made with all prospective subjects to arrange a time for the initial interview. The only information gathered at this point was the availability of a partner and willingness to arrange an initial appointment. No questions concerning the program were answered over the telephone. It was explained to the clients that both the details of their problems and the therapeutic strategy would best be discussed in the presence of both partners at the initial interview. The subject was assured however, that the couple's presence at the interview in no way committed them to accept therapy.

The initial interview, conducted by both therapists, was standardized (see Appendix I) and lasted approximately one hour. At this time detailed sexual histories were taken; suitability for treatment was assessed; and the details of the program were explained. If the couple failed to meet the selection criteria, alternate sources of therapeutic intervention were suggested. If the clients were suitable for the program they were advised that therapy was offered in both group and individual couple settings and that they would be informed as soon as a position in either format became available.

Couples were clearly informed that they were free to decline assignment to the group treatment condition without jeopardizing their opportunity to receive individual

treatment. No couples refused the group treatment assignment. In the case of control clients, couples were advised that therapy would not be available for ten weeks due to a shortage of therapists. All of these subjects volunteered to participate in pre-treatment investigations which included completing the Sexual Satisfaction Index, the Sexual Behavior Inventory and the Sexual Arousal Inventory at the same intervals as those currently receiving therapy.

Subjects who were selected for the study were registered as outpatients of the Health Sciences Center Hospital Psychology Unit and, therefore, paid one dollar per session. In order to ensure informed consent, couples were clearly and repeatedly advised of the uses of their data and their right to withdraw from therapy (see Informed Consent Form, Appendix V). After signing the consent form, they were asked to complete the Sexual Arousal Inventory and the Sexual Satisfaction Index. They were also instructed to monitor their sexual activities using the Sexual Behavior Inventory for the following two weeks. Due to the sporadic referral rate, the interval from the end of the self-monitoring period to the beginning of treatment was not fixed, but averaged approximately three weeks.

There were six weekly treatment sessions lasting approximately two hours each. The structure of all sessions was the same. For the first hour of each session the female(s) were with the female therapist and the male(s) were

with the male therapist. For the second hour partners were together with the two therapists.* The procedure outlined below (and described in detail in Appendix I) was the same for both group and individual conditions.

Session 1:

The first session was devoted to making the subjects feel as comfortable as possible in the new situation and included discussion of their presenting problems in detail and an outline of the program. Subjects were also given a written outline of the program (Appendix VI), a tension management pamphlet (Appendix VII) and a reading list (Appendix VIII). During the second half of the session the couple(s) saw a film entitled Human Sexual Response (Szasz, 1974) and were given the rationale for refraining from intercourse for four weeks. They were instructed about the use of the relaxation exercises (modified from Bernstein and Borkovec, 1973) and were given the Sexual Satisfaction Index and the Sexual Arousal Inventory to complete for the second time. Homework for this session included: practice of the relaxation exercises at least once a day; reading and discussing the first three chapters of Our Bodies Ourselves (Boston Women's Health Collective, 1971) and increasing non-sexual physical contact such as hugging, kissing and massage.

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*Both therapists are members of the British Columbia Psychological Association

Session 2:

During the second session, the topic of masturbation for both males and females was reviewed. In the first half of the session, attitudes towards and experiences with masturbation were discussed by both the male and female subgroups. The film shown during the second half of the session, The Sexological Examination (Sutton, 1973), portrayed a systematized method of giving feedback to the partner regarding the subjective effects of sexual stimulation. Discussion included masturbation for both sexes, progress made in response to the relaxation exercises and compliance with the request for increased non-sexual physical contacts. Homework included: attempting the Sexological Examination at least twice (instructions for couples who anticipated difficulty with this exercise are contained in Appendix I); continuing the relaxation exercises; and jointly reading chapters one through three of For Yourself (Barbach, 1975). Females were instructed to explore their genitals visually and to list the positive/negative aspects of their bodies. Males were instructed to monitor the frequency of masturbation and to record their positive and negative attitudes to this activity.

Session 3:

During the third session, women were encouraged, when at home, to look for sensitive areas of their bodies that produced feelings of pleasure. They were also instructed

to attempt masturbation. The male session focussed primarily on the value of foreplay as an essential pre-requisite to communication and sexual satisfaction. The films shown were Women on Orgasm (Breitrose, 1973) and Handvoice (Sutton, 1970). Discussion during this portion of the session focussed on the importance of foreplay, feedback from the Sexological Examination and the introduction of various precoital behavior. The importance of the female communicating her findings regarding pleasurable areas discovered during the masturbation exercises and the Sexological Examination was also stressed. Homework included continuation of the Sexological Examination, discussion of preferred modes of foreplay and discussion of the remaining chapters of For Yourself (Barbach, 1975).

Session 4:

During the fourth session women were again encouraged to set time aside for themselves to carry out the homework assignments as this problem was frequently offered as an "explanation" for failure to comply with the treatment suggestions given in Sessions 2 and 3. When necessary, instructions were given for self-monitoring the exact number of hours a week they devoted to themselves. The types and uses of a vibrator were discussed both for those women reporting difficulty with masturbation and for those indicating that they wished to enhance their sexual response. The value of erotic fantasy in both masturbation and

intercourse was also discussed. The focus of the male session was definition and explanation of probable etiologies of premature ejaculation. During the second half of the session, the basic principles of the Semans' (1956) and Masters and Johnson's (1970) squeeze techniques were discussed and the film Sexuality and Communication (Chernik and Chernick, 1975) was shown. Communication strategies were also discussed and specific examples of problematic communication were elicited and clear strategies for accepting or rejecting sexual overtures were role-played. The reintroduction of intercourse was discussed and couples were advised to utilize all the coping and communication skills they had previously been practicing. Homework included the preparation of a list citing at least three instances where communication, sexual or general, broke down or became difficult and a reading assignment (My Secret Garden, Friday, 1973) which was to be read and discussed by both partners.

Session 5:

During the fifth session, the females discussed both contraception methods and vaginal disorders and their effects on arousal. In addition, communication skills were practiced in areas where women expressed common difficulties. The major focus of the male session was also on effective communication with special emphasis placed on areas where the men reported the greatest difficulty. In both

situations role-playing was utilized when necessary. In the second half of the session, the film Squeeze Technique (Sutton, 1970) was shown. This procedure was explained at length during the discussion period and couples were instructed to try this at least four times during the coming week. Positive and negative results of re-instituting intercourse were also discussed. Couples also role-played their most problematic communications and a demonstration of more effective strategies was given. Couples were also instructed to practice their communication skills during the coming week.

Session 6:

The objective of the sixth session for both males and females was to prepare subjects for termination of therapy. Specifically, subjects were asked to design their own maintenance program which was to include a description of problems the couple anticipated in the next three weeks and strategies for coping with these problems. In addition, areas of perceived progress were to be noted and discussed over the three week period. Feedback was elicited from the subjects about their impressions of the program and its utility for their particular situation. In the second half of the session the questionnaires were readministered (Sexual Arousal Inventory and Sexual Satisfaction Index), feedback from the couple as a unit about their experience in the program was solicited and the importance of continual

practice of all skills learned in the program was stressed. For homework, the couples were instructed to review systematically each other's maintenance list and discuss any points of contention, to continue monitoring their sexual behaviors by means of the Sexual Behavior Inventory for the next three weeks and to call the therapist if any problems arose. No couple phoned the therapists during the follow-up period.

At the three week follow-up all couples were seen individually. Current progress, expectations, problems and plans for the next three months were discussed. The Sexual Arousal Inventory and the Sexual Satisfaction Index were readministered. Specific content of this and the three month follow-up was dictated by the need of the individual couple. The Sexual Arousal Inventory and the Sexual Satisfaction Index were again readministered at the three month follow-up.

RESULTS

The Sexual Arousal Inventory

The Sexual Arousal Inventory was administered to all subjects at the initial interview, the final treatment session and at the three week and three month follow-ups. A total score for each assessment was obtained by subtracting the sum of the negative scores from the sum of the positive scores, with the highest scores being associated with higher levels of sexual arousal. The maximum possible score was one hundred and forty. Means of each group for all assessment

periods are presented in Figure 1 (see Appendix IX for a table of means and standard deviations). Scores from both partners were averaged to yield a combined couple score.

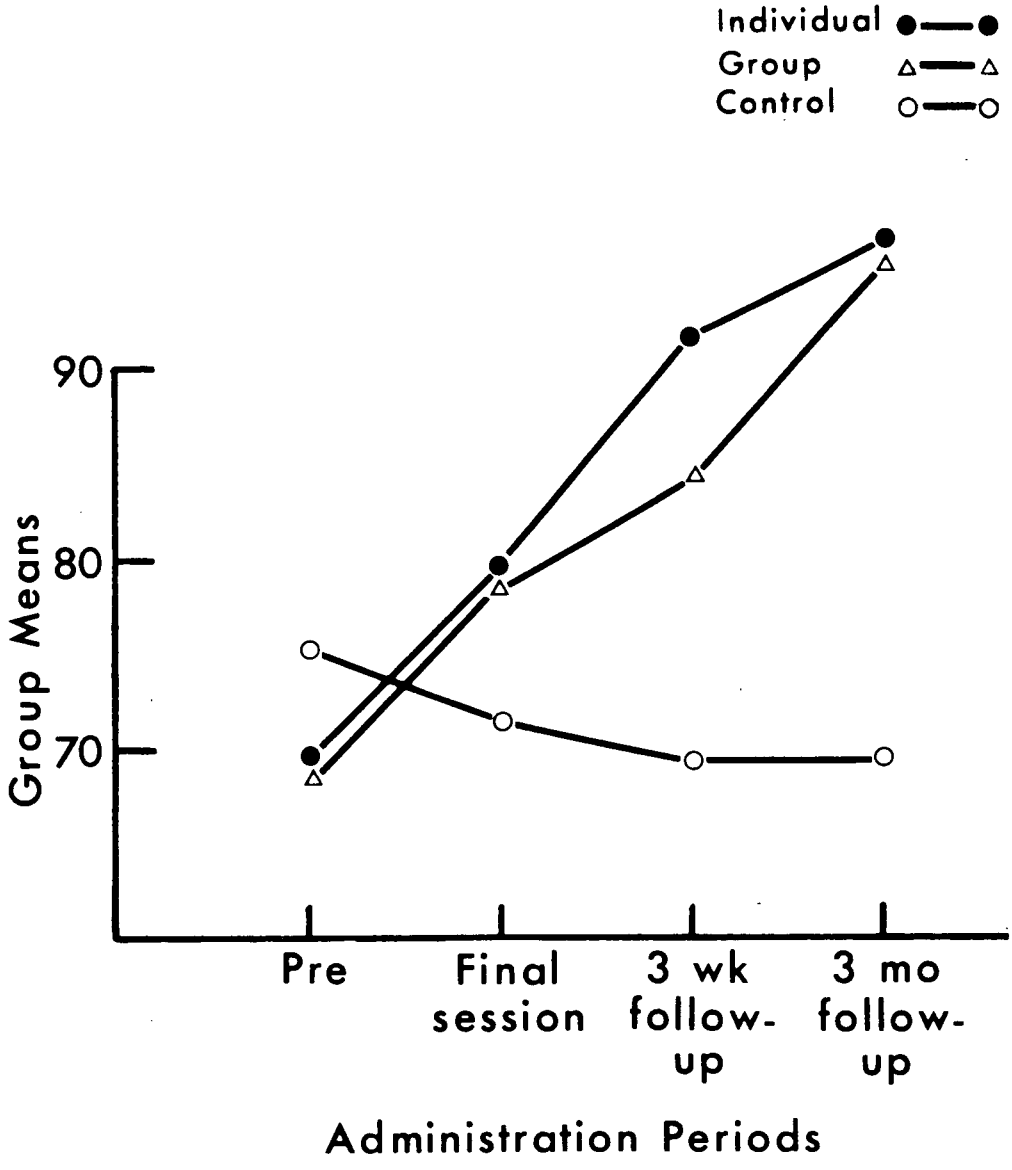
The pretreatment scores of the groups on the Sexual Arousal Inventory were analyzed using a one-way ANOVA to ascertain whether the groups were comparable initially as random assignment to the treatment conditions would indicate. The assumption of equal treatment group means prior to treatment on this variable was supported ($F(2,24) = .196$, $p > .05$) (see Appendix IX).

Data from the final treatment session and both follow-ups were analyzed separately using a one-way, fixed effects ANCOVA with pretreatment scores serving as the covariate. The rationale for utilizing the covariate procedure was to increase the precision of the experimental design. Although both treatment groups increased and the control group decreased in terms of self-rated arousal by the time of the final session, the treatment effect was non-significant ($F(2,23) = 1.078$, $p > .05$) (see Appendix IX).

Analysis of the data from the three week follow-up, however, indicated a significant treatment effect ($F(2,23) = 3.456$, $p < .05$) (see Appendix IX). Post hoc analysis using the Tukey's Studentized Range Test (TSRT) indicated that the individual couple treatment condition exhibited significantly higher scores than the control condition.

FIGURE 1

Mean Scores Over Administrations
For All Subjects On the Sexual
Arousal Inventory



Analysis of the data from the three month follow-up also indicated a significant treatment effect ($F(2,23) = 5.593$, $p < .05$) (see Appendix IX). Post hoc analysis indicated that both treated groups reported significantly higher levels of sexual arousal than their control counterparts, but did not differ from each other.

The Sexual Satisfaction Index

The Sexual Satisfaction Index (SSI) was administered to all subjects at the initial interview, the final treatment session, the three week and three month follow-ups. The twenty-two statements were grouped into five subtests according to the degree of conceptual similarity of the items. The subtests and their Alpha or Hoyt coefficients are shown in Table 1. Examination of the coefficients indicates a high degree of internal consistency for each subtest. Group means for each subtest at each assessment are in Figures two through six (see Appendix X for a table of means and standard deviations). Again, scores from both partners were averaged to yield a combined couple score.

Pretreatment scores of the three groups on the subtests of the SSI were analyzed using a one-way MANOVA to assess whether the groups were comparable initially on these variables consistent with random subject assignment to treatment conditions. The analysis indicated no significant differences ($F(5,2,24) = .948$, $p > .05$) (see Appendix X).

TABLE I

Subtest Items and Reliability Coefficients
Of the Sexual Satisfaction Index

General Satisfaction (alpha=0.763)

my role in our sexual relationship

my partner's role in our sexual relationship

my level of satisfaction with our sexual relationship

my partner's level of satisfaction with our sexual relationship

number of male sexual initiatives

number of female sexual initiatives

frequency of intercourse

duration of foreplay

Communication Satisfaction (alpha=0.890)

my ability to communicate with my partner

my partner's ability to communicate with me

my ability to discuss sex with my partner

my partner's ability to discuss sex with me

Orgasm Satisfaction (alpha=0.816)

my attitude towards masturbation

my ability to masturbate

my ability to achieve climax through intercourse

my ability to achieve climax through self-masturbation

my ability to achieve climax through genital manipulation by my parnter

Sexuality Satisfaction (hoyt=0.830)

my feelings about my own sexuality

my feelings about my body

Relationship Satisfaction (hoyt=0.801)

my level of satisfaction with the relationship in general

my partner's level of satisfaction with the relationship in general

Data from the final treatment session were analyzed using a one-way fixed effects MANCOVA with the pretreatment scores serving as the covariate. An omnibus multivariate F was not calculated as the high degree of dependence between the dependent variables and the covariates failed to render the matrix positive definite. Instead a more conservative procedure was utilized whereby the actual number of significant TSRTs for all subtests over all administration periods was examined in relation to the number that would be expected on the basis of chance alone. The results were highly significant (X^2 = 37.213, $p < .001$) thus ensuring protection against a Type 1 error in the subsequent analyses.

Univariate ANCOVAS were performed on each of the subtests of the SSI in turn, using the single corresponding pretreatment measure as the covariate (see Appendix X). This strategy can be justified as overall significance with simultaneous Type 1 error protection had been attained for the treatment factor with the chi square (Winer, 1971) and further probing was needed to ascertain the locus of the treatment group differences. The univariate analyses for all subtest scores obtained at the final session were significant: general sexual satisfaction ($F(2,23) = 8.791$, $p < .005$);communication satisfaction ($F(2,23) = 8.224$, $p < .005$); orgasm satisfaction ($F(2,23) = 11.091$, $p < .001$); sexuality satisfaction ($F(2,23) = 12.166$, $p < .001$) and relationship satisfaction ($F(2,23) = 5.406$, $p < .01$). Moreover, in each case TSRT analyses indicated that the

control subjects were significantly less satisfied than their treatment counterparts. There were no significant differences between the two treatment conditions.

Similarly, univariate ANCOVAS were performed on each of the subtests of the SSI at the three week and three month follow-ups. Analyses of the three week follow-up data on all subtests also revealed significant treatment effects: general sexual satisfaction ($\underline{F}(2,23) = 8.841$, $\underline{p} < .005$); communication satisfaction ($\underline{F}(2,23) = 14.557$, $\underline{p} < .0001$); orgasm satisfaction ($\underline{F}(2,23) = 15.91$, $\underline{p} < .0005$); sexuality satisfaction ($\underline{F}(2,23) = 10.57$, $\underline{p} < .0005$) and relationship satisfaction ($\underline{F}(2,23) = 4.366$, $\underline{p} < .05$). Subsequent post hoc TSRT analyses revealed that in each case, subjects in the control condition were significantly less satisfied on each variable than subjects in both treatment groups. There were no differences between the two treatment conditions. This pattern of results, however, was not repeated in the analyses of the three month follow-up data. Univariate ANCOVAS for four of the five subtests revealed significant treatment effects; general sexual satisfaction ($\underline{F}(2,23) = 5.243$, $\underline{p} < .02$); communication satisfaction ($\underline{F}(2,23) = 6.605$, $\underline{p} < .03$); orgasm satisfaction ($\underline{F}(2,23) = 4.573$, $\underline{p} < .03$); and sexuality satisfaction ($\underline{F}(2,23) = 4.954$, $\underline{p} < .03$). Post hoc TSRT analyses for two of the subscales, general sexual satisfaction and communication satisfaction indicated significantly greater

FIGURE 2

Mean Scores Over Administrations For All Subjects on the "General Satisfaction" Subscale of the Sexual Satisfaction Index

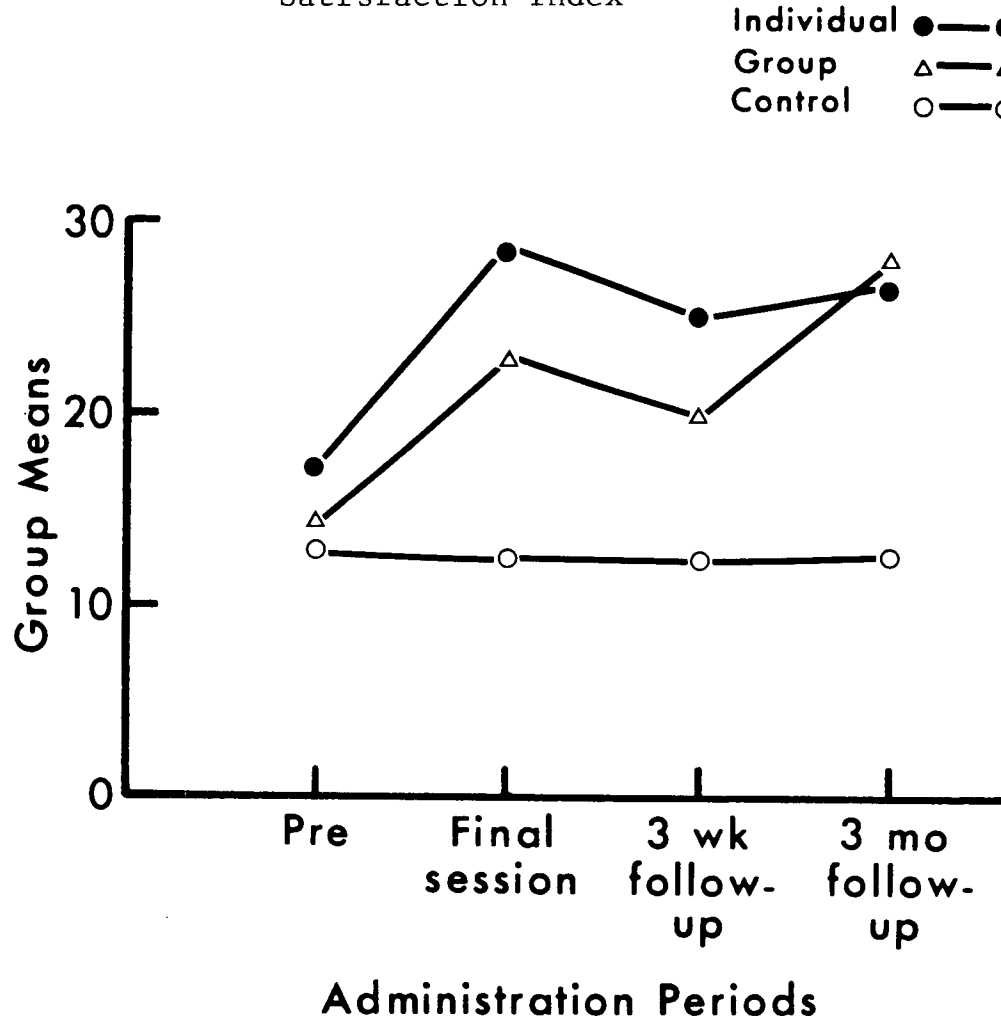


FIGURE 3

Mean Scores Over Administrations For All Subjects on the "Communication Satisfaction" Subscale of the Sexual Satisfaction Index

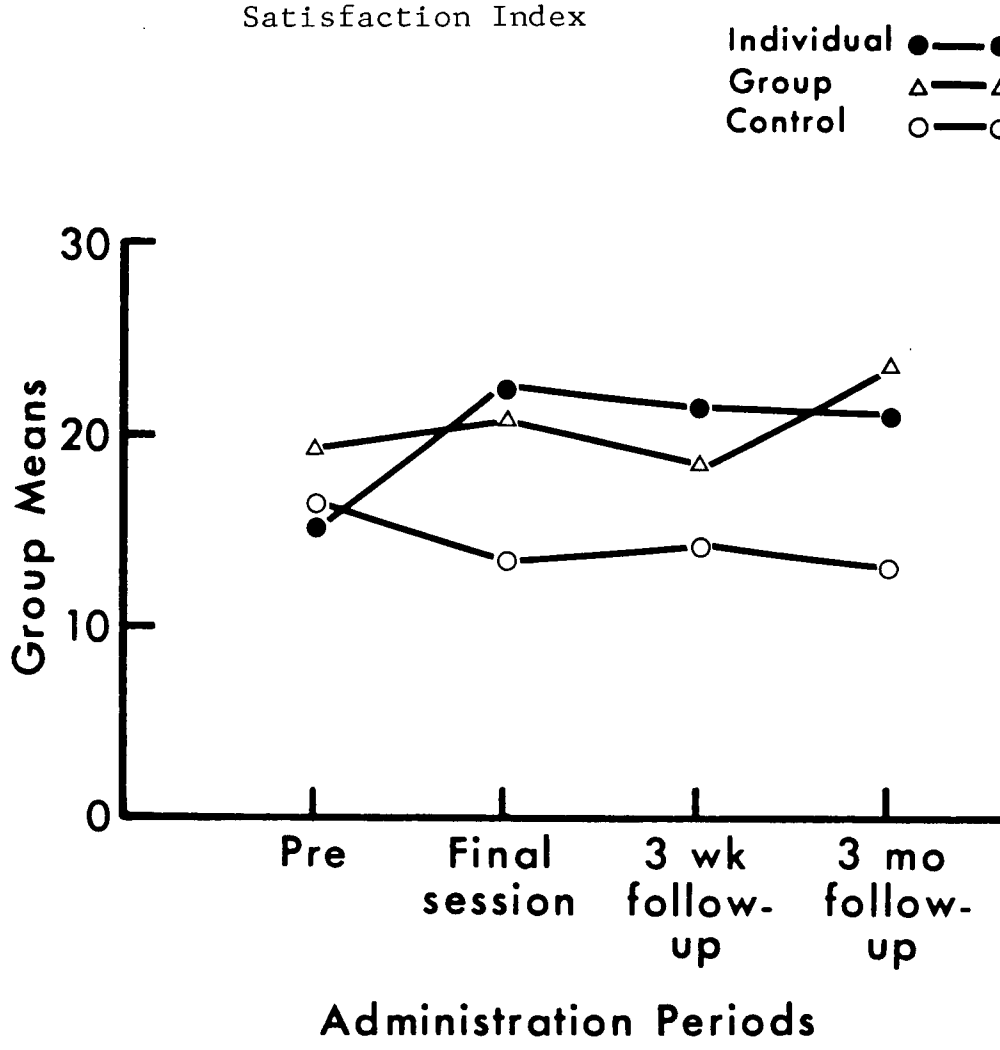


FIGURE 4

Mean Scores Over Administrations For All Subjects on the "Orgasm Satisfaction" Subscale of the Sexual Satisfaction Index

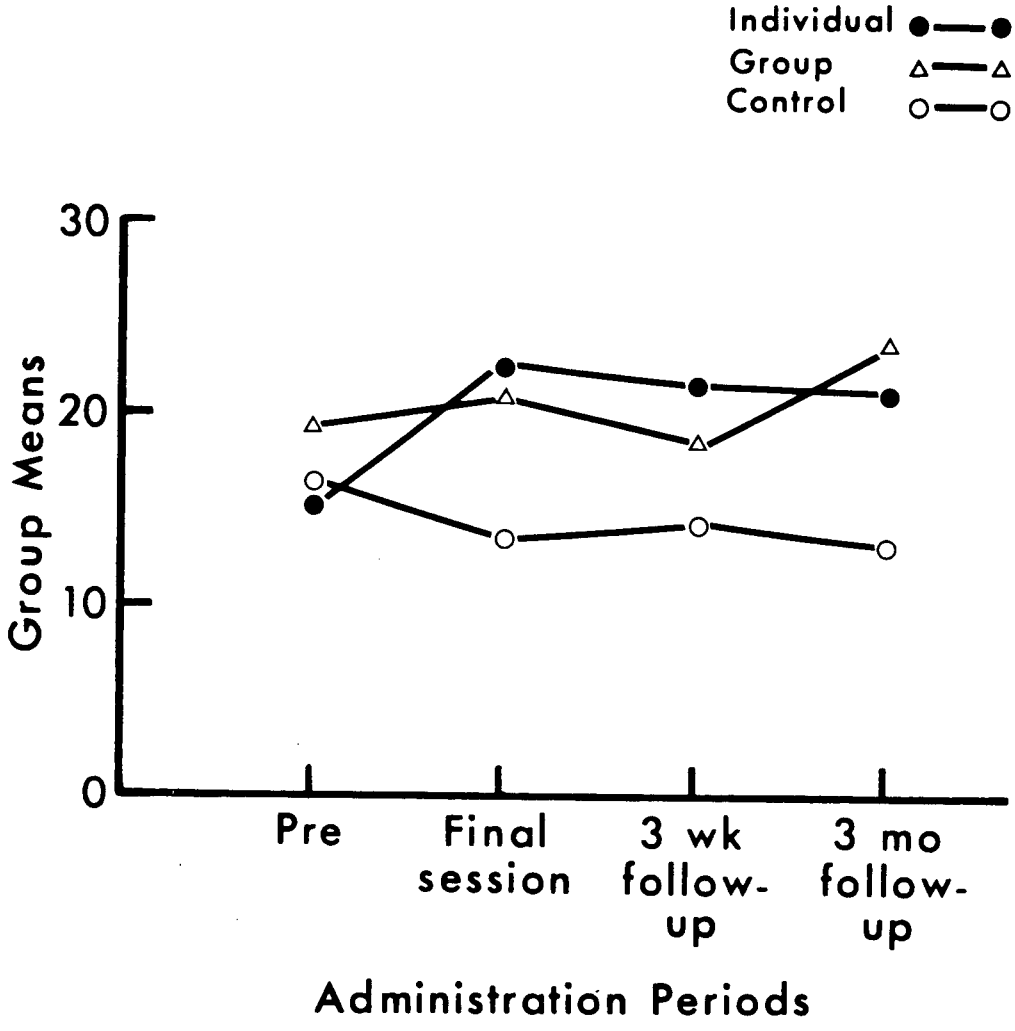


FIGURE 5

Mean Scores Over Administrations For All Subjects on the "Sexuality Satisfaction" Subscale of the Sexual Satisfaction Index

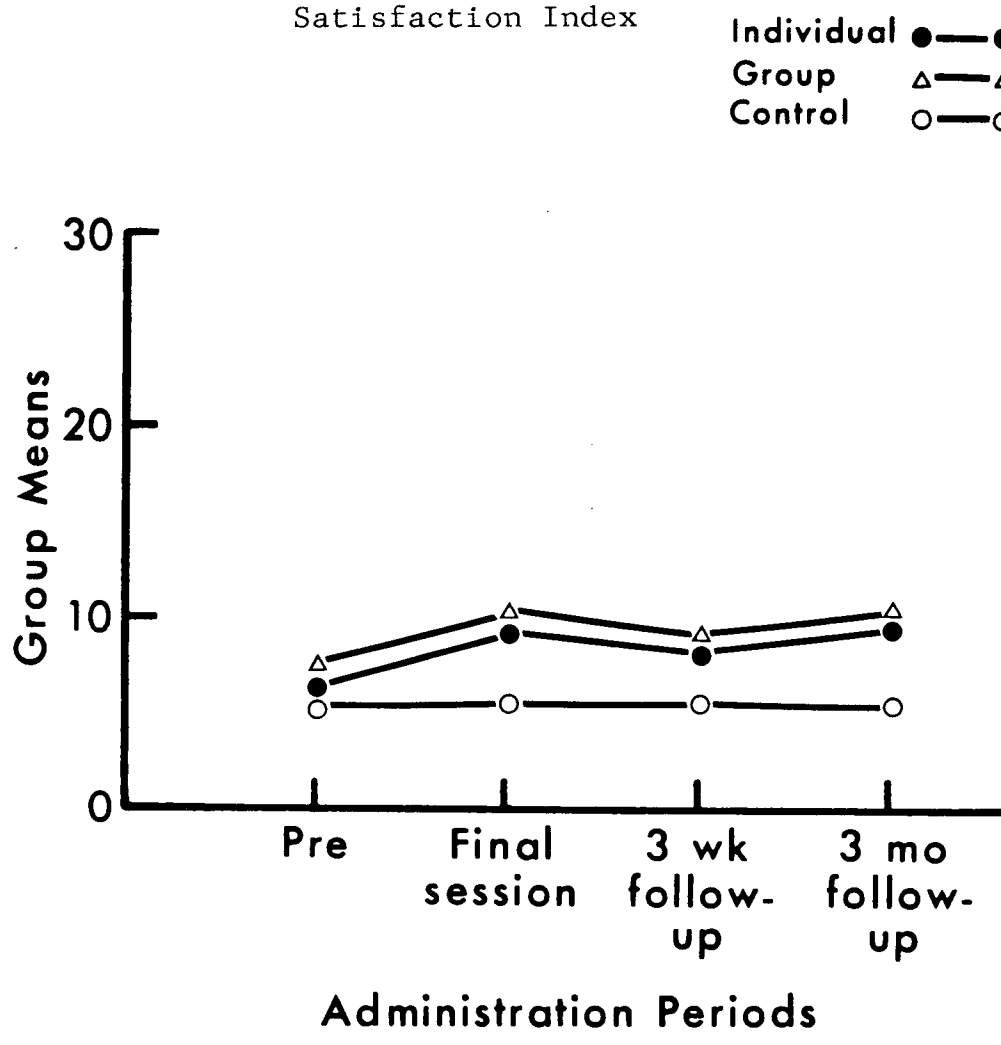
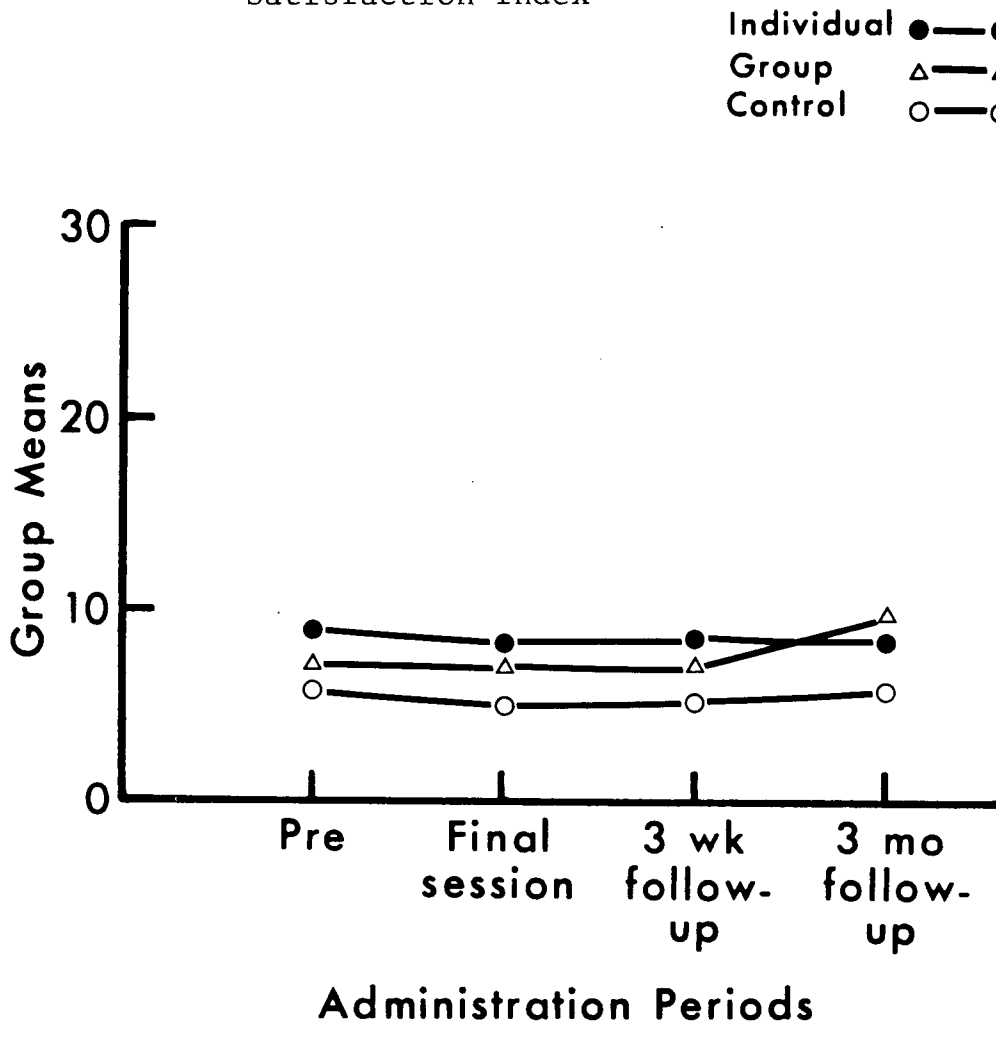


FIGURE 6

Mean Scores Over Administrations For All Subjects on the "Relationship Satisfaction" Subscale of the Sexual Satisfaction Index



satisfaction among subjects in the treatment conditions than among subjects in the control condition. The only significant differences revealed by post hoc analyses of sexuality satisfaction and relationship satisfaction subscales, however, was between the group treatment condition and the control condition. Again, as reported in the previous analyses, there were no significant differences between the two treatment conditions.

The Sexual Behavior Inventory

Both partners were instructed to complete the Sexual Behavior Inventory (SBI) daily for the two week period prior to treatment, the five weeks during treatment and for the three weeks following treatment. Of the initial fourteen items, four were discarded because the subjects complained that they were too ambiguous despite attempts to make the behavioural definitions explicit. Examination of responses on these items confirmed the subjects' concern as there were gross discrepancies in report frequencies of behavior. See Appendix XII for a detailed correlation matrix. The discarded items were, male seeing female nude, female seeing male nude, female initiated sexual behavior and male initiated sexual behavior. The remaining items were grouped in terms of the sex of the active participant (see Table 2). Group means for each item at each assessment period are presented in Figures seven through sixteen (see Appendix XI for a table of group means and standard

TABLE 2

Breakdown of the Sexual Behavior Inventory
According to the Sex of the Active Participant

Male Items

non-sexual massage

sensate focus female breasts (oral and manual touch)

sensate focus genitals

intercourse

Female Items

non-sexual massage

sensate focus male genitals

orgasm through masturbation

orgasm through foreplay

intercourse

orgasm through intercourse

deviations). As the behavioral data were averaged over week periods, it seemed inappropriate to combine the five weeks of treatment into one score as one would expect marked progress over the five week treatment period. As such a division was made between the initial three weeks of treatment and the latter two weeks of treatment in order to take into consideration treatment progress.

Analyses of Male Items by Males

Weekly scores obtained prior to treatment were averaged over the two week period. The scores were then compared among the three groups by a one-way MANOVA to assess whether any significant initial between group inequalities existed on these items despite random subject assignment to experimental conditions. The multivariate omnibus F indicated no significant differences ($F(4,2,24) = 1.420$, $p > .05$) (see Appendix XI).

Mean scores obtained during the first three weeks of treatment were averaged and then analyzed using a one-way fixed effects MANCOVA with the pretreatment scores serving as the covariate. The frequency of intercourse was omitted from this analysis as the behavior was prohibited for the first four treatment sessions. An omnibus multivariate F was not calculated as the high degree of dependence between the dependent variables and the covariates failed to render the matrix positive definite. Instead a more conservative procedure was utilized whereby the actual number of

significant TSRTs for all behavioural data over all administration periods was examined in relation to the number that would be expected on the basis of chance alone. The results were highly significant ($\underline{X}^2 = 24.076$, $\underline{p} < .001$) thus ensuring protection against a Type 1 error in the subsequent analyses.

Univariate ANCOVAS were then performed on each of the male items of the SBI for each assessment period, using the single corresponding pretreatment measure as the covariate (see Appendix XI). Of all the univariate analyses performed on the averaged data from the first three weeks of treatment only non-sexual massage by males was significant ($\underline{F}(2,23) = 11.202$, $\underline{p} < .001$). Results of the TSRT analysis indicated that self-reported non-sexual massage was significantly greater among males in the individual treatment condition than in either the group or control conditions. Of all the univariate analyses performed on the averaged data from the last two weeks of treatment (including frequency of intercourse) only sensate focus-breast area was significant ($\underline{F}(2,23) = 4.450$, $\underline{p} < .05$). Results of the TSRT revealed that male subjects in the two treatment conditions reported giving significantly more oral and manual breast stimulation to their partners than did their control counterparts. No differences were evidenced between the two treatment conditions. Of the four univariate ANCOVAS performed on the averaged data from

FIGURE 7

Mean Scores Over Administrations For Male Subjects on "Non-Sexual Massage" Item of the Sexual Behavior Inventory

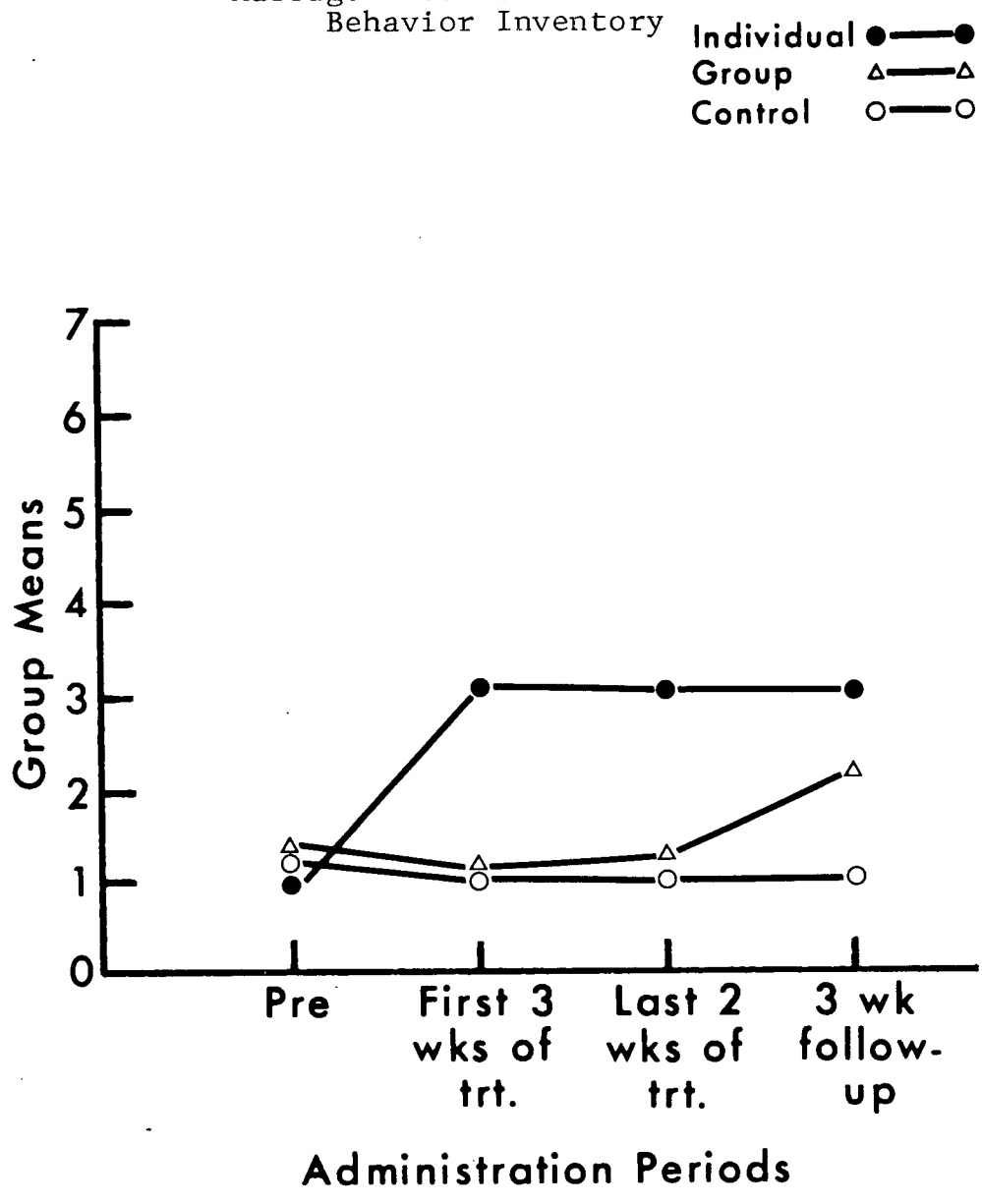


FIGURE 8

Mean Scores Over Administrations For Male Subjects on "Sensate Focus Female Breast" Item of the Sexual Behavior Inventory.

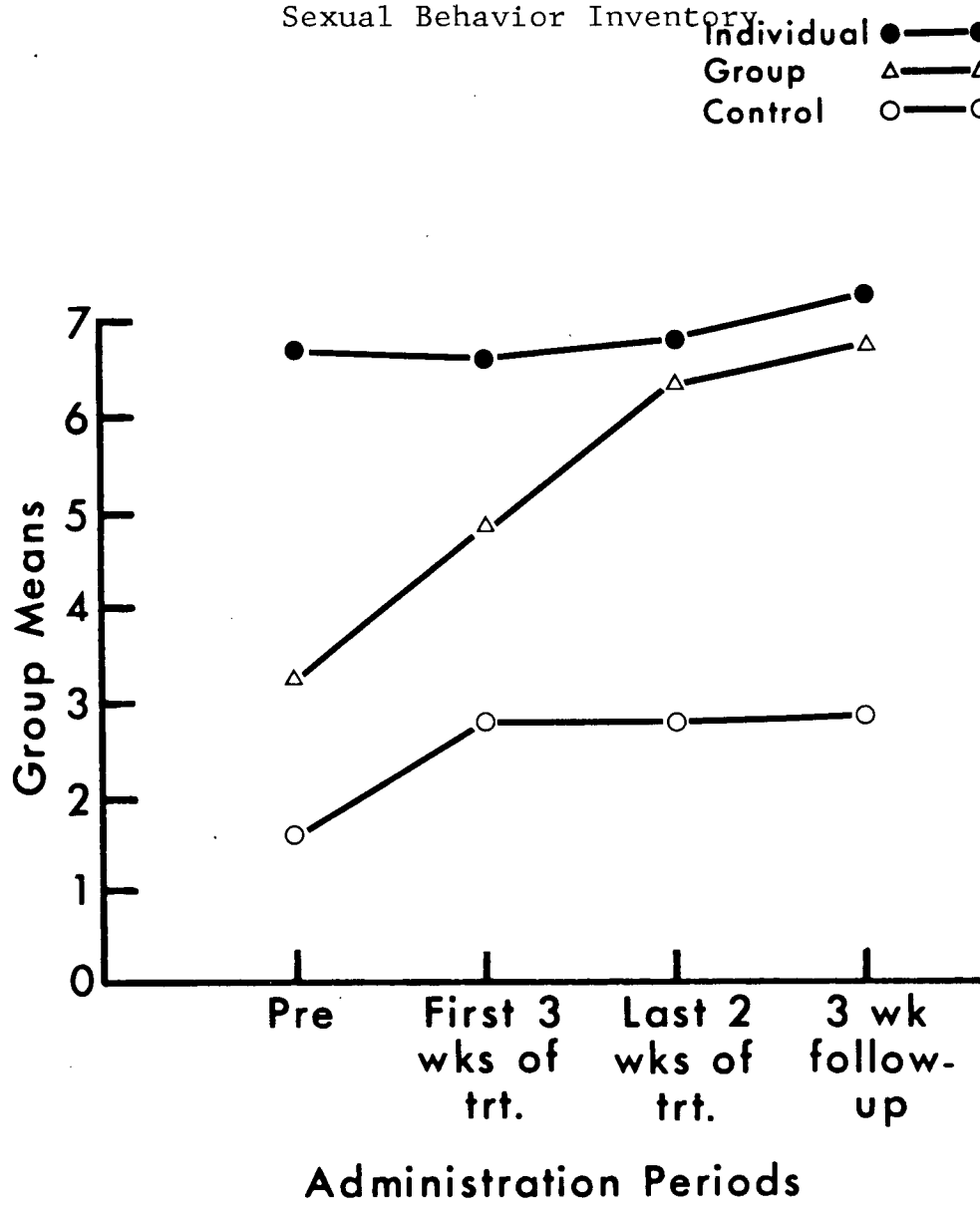


FIGURE 9

Mean Scores Over Administrations For Male Subjects on "Sensate Focus Female Genital" Item of The Sexual Behavior Inventory

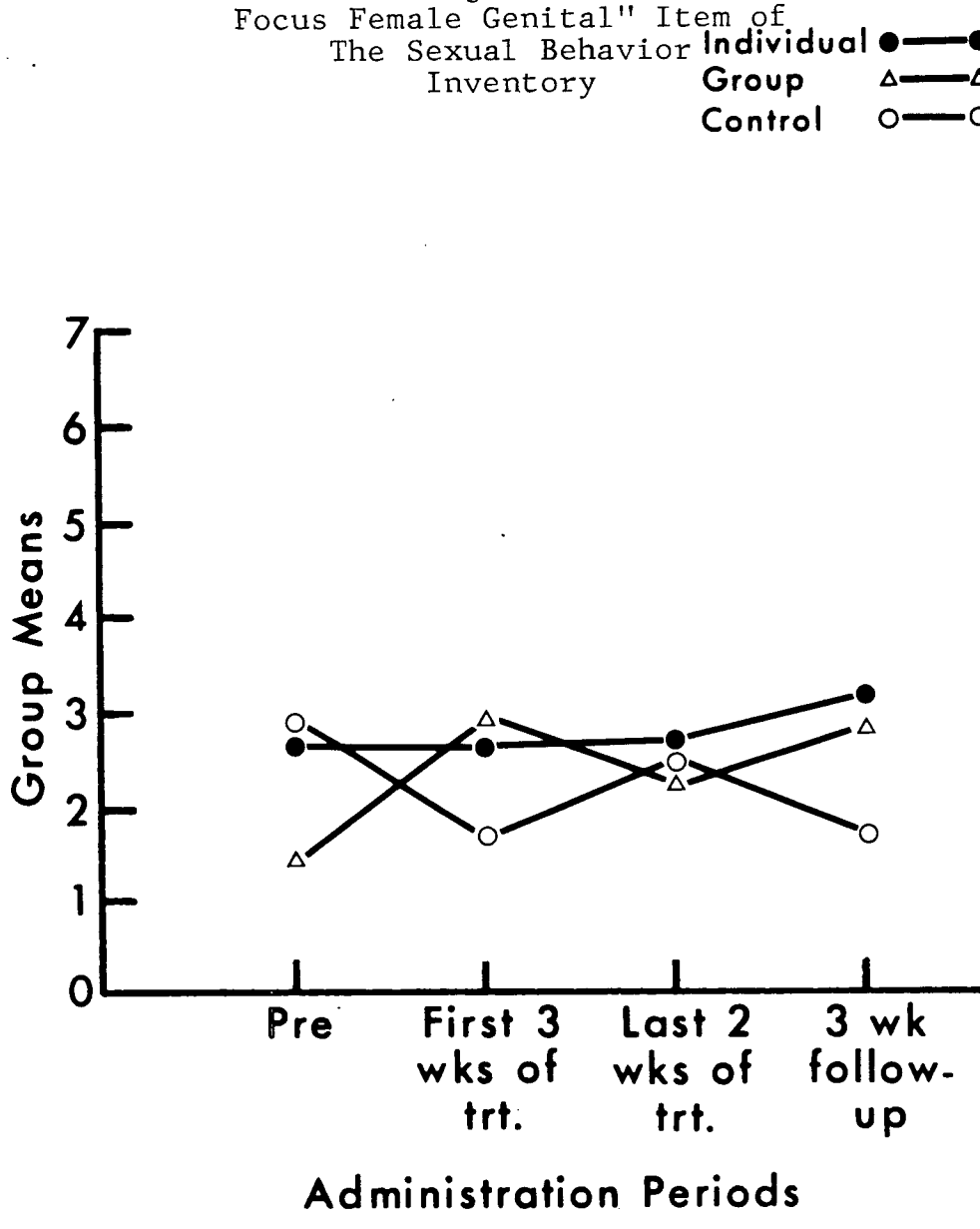
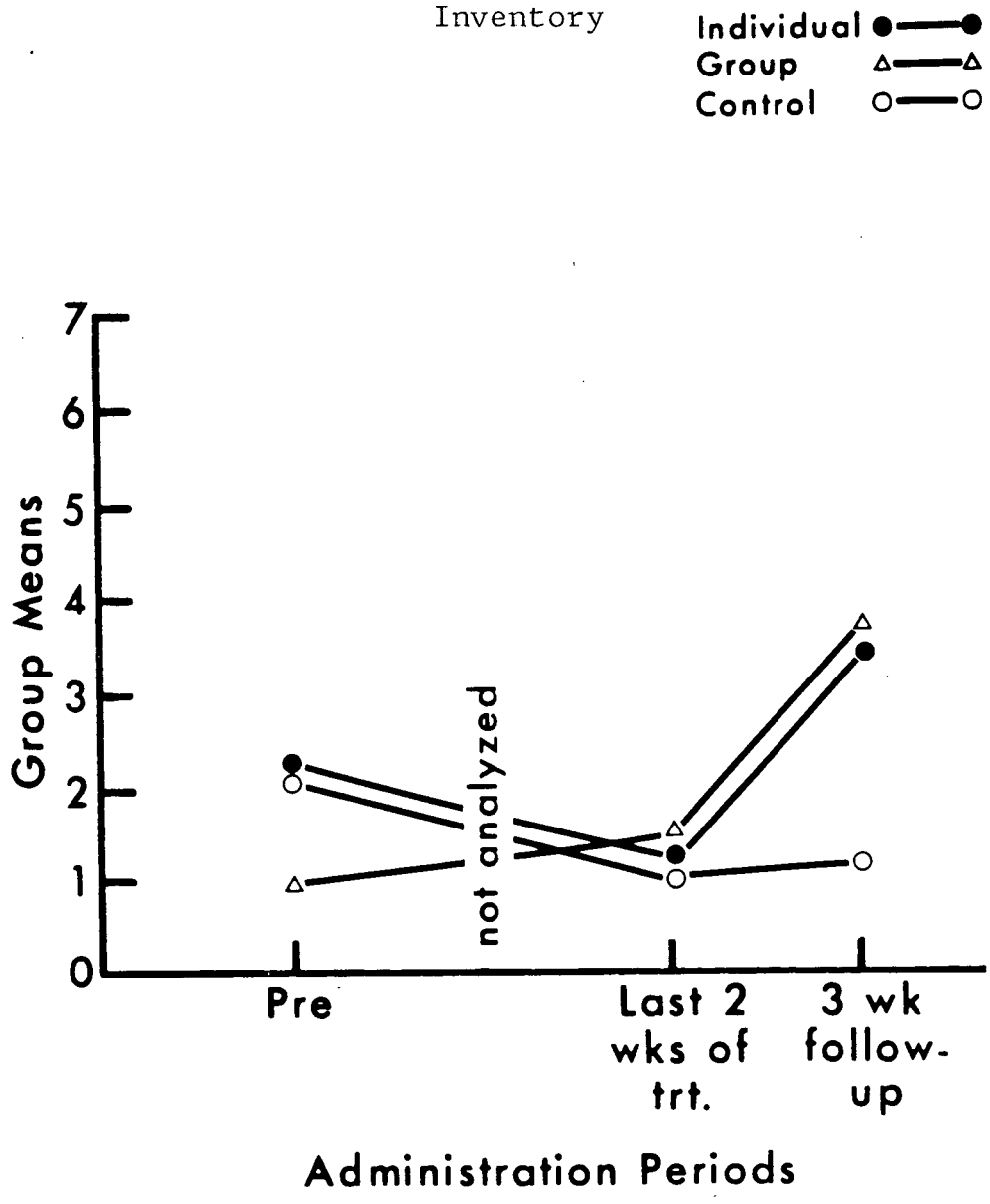


FIGURE 10

Mean Scores Over Administrations For Male Subjects on "Intercourse" Item of the Sexual Behavior Inventory



the three week follow-up only the item intercourse was significant ($F(2,23) = 5.548$, $p < .01$). Results of the TSRT indicate that subjects in both treatment conditions reported a significantly higher frequency of intercourse than did the control subjects. No difference was evidenced between the individual and group subjects.

Analyses of Female Items by Female

Scores obtained during the two week pretreatment period were averaged and then compared among the three groups by a one-way MANOVA to assess whether there were differences on these variables despite random subject assignment to the experimental conditions. The multivariate omnibus F revealed no significant differences ($F(2,23) = 1.563$, $p > .05$) (see Appendix XI) indicating that the groups were initially comparable in terms of the behaviors included in the SBI.

Scores reported for the subsequent assessment periods were averaged and univariate ANCOVAS were performed on each item with the single corresponding pretreatment measure being utilized as the covariate (see Appendix XI). As in the analysis of the men's data, the items dealing with intercourse were omitted from the first analysis. The four analyses performed on the averaged data for the first three weeks of treatment, only sensate focus-male genitals as significant ($F(2,23) = 3.831$, $p < .05$). Results of the TSRT indicated that women in the individual treatment

condition reported significantly more touching of male genitals than women in the group condition. The control subjects did not differ significantly from either of the treatment conditions. Of the univariate ANCOVAS performed on the averaged data for the last two weeks of treatment, two items, sensate focus-male genitals ($F(2,23) = 6.914$, $p < .01$) and orgasm through masturbation ($F(2,23) = 5.342$, $p < .05$) were significant. Results of the TSRT analyses revealed that women in both treatment conditions engaged in significantly more male genital sensate focus activities than did the control subjects. With respect to the second item, there was also a significant difference between the group and individual treatment subjects with the group subjects reporting significantly more orgasmic activity through masturbation. Of the univariate analyses performed on the averaged data for the three week follow-up, two items, orgasm through foreplay ($F(2,23) = 5.347$, $p < .05$) and intercourse ($F(2,23) = 8.77$, $p < .01$) were significant. Results of the TSRT analyses indicate that at the three week follow-up women in both treatment conditions were experiencing a significantly higher frequency of intercourse and orgasm obtained through foreplay than their control counterparts. The two treatment groups, moreover, did not differ significantly with respect to either of these behaviors.

With regard to the initial diagnosis for the female partners in the treatment conditions, the behavioral data indicate that five of the seven primarily non-orgasmic females experience orgasm and

FIGURE 11

Mean Scores Over Administrations For Female Subjects on "Non-Sexual Massage" Item of the Sexual Behavior Inventory

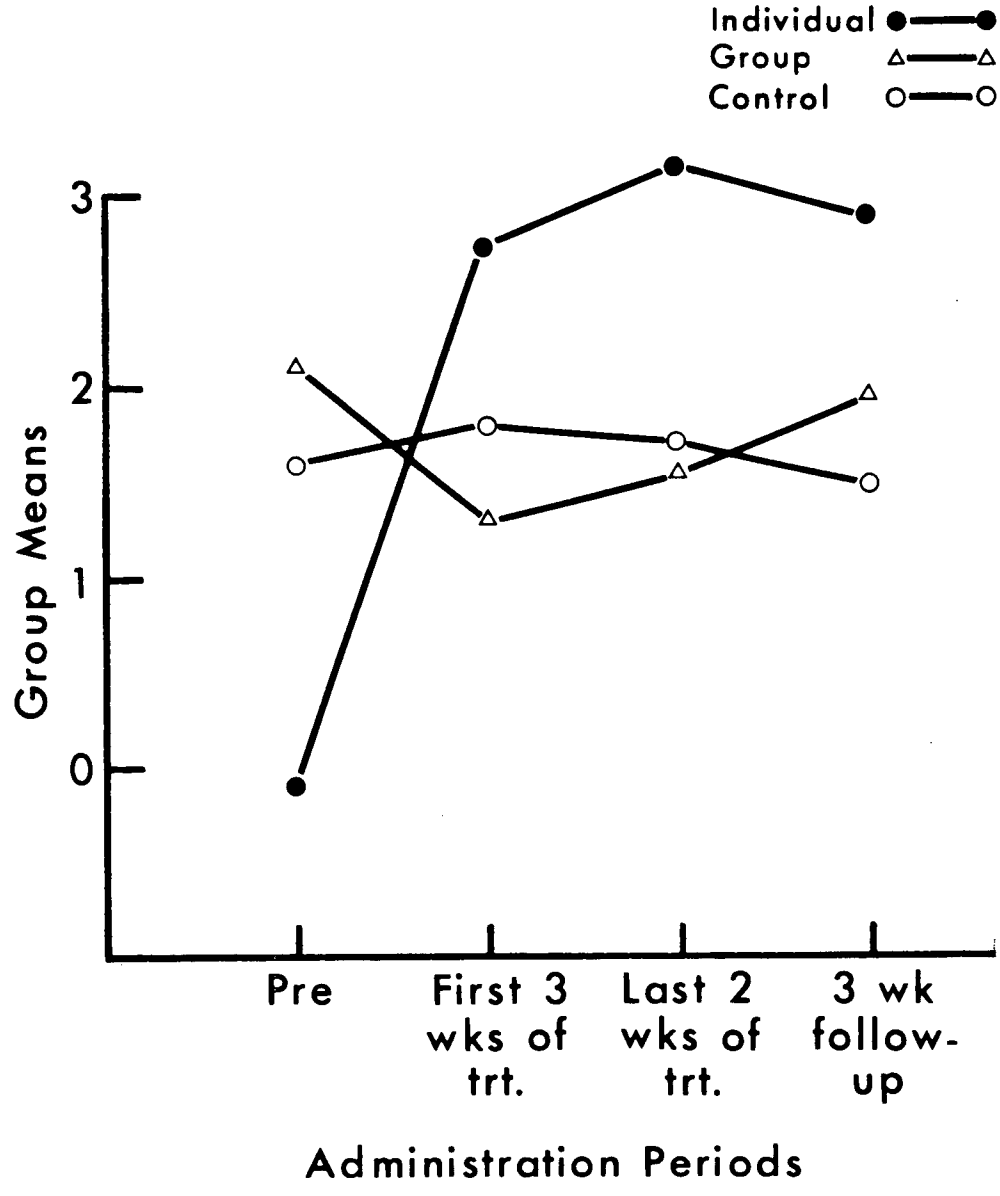


FIGURE 12

Mean Scores Over Administrations For Female Subjects on "Sensate Focus Male Genital" Item of the Sexual Behavior Inventory

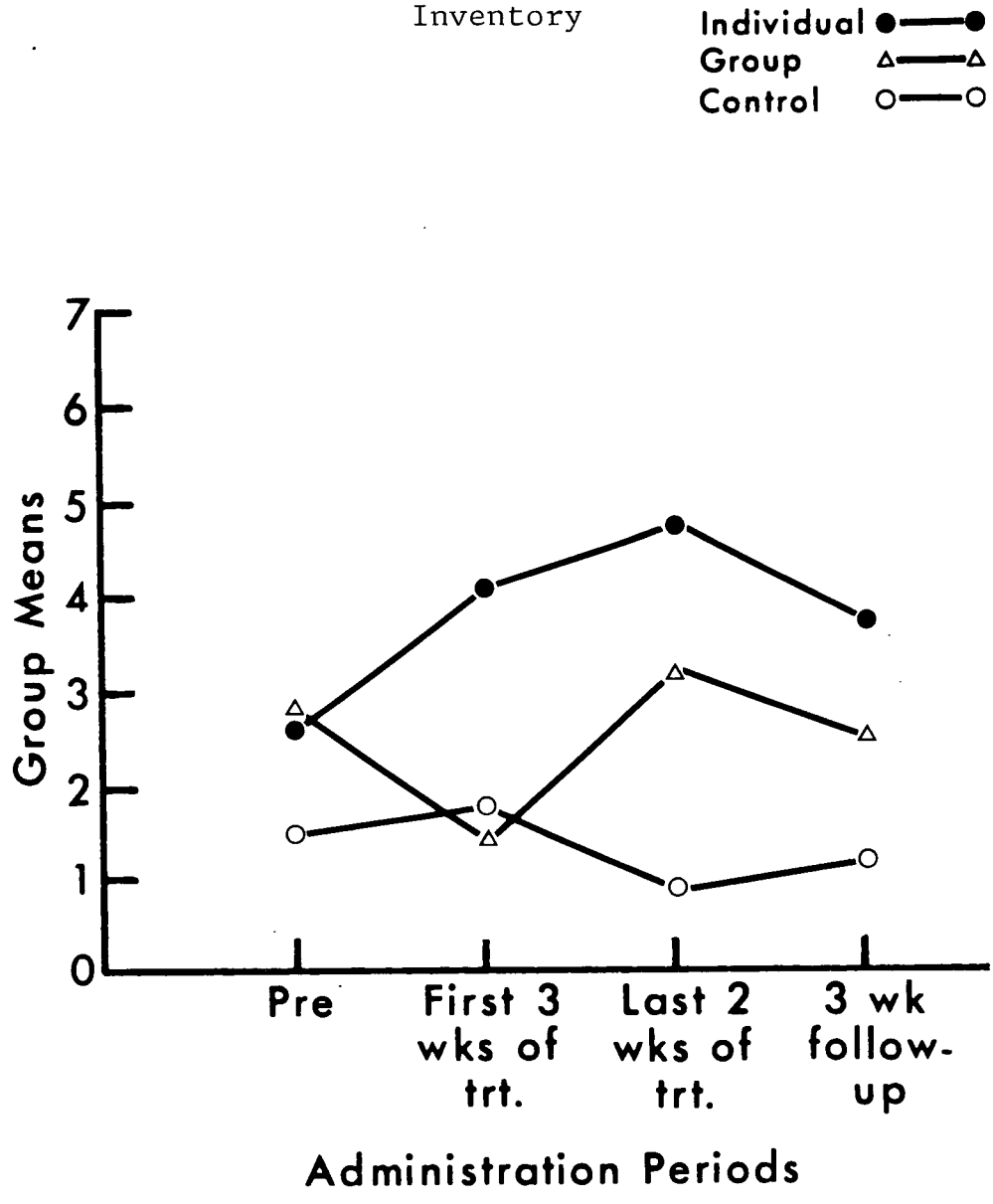


FIGURE 13

Mean Scores Over Administrations For Female Subjects on "Orgasm Through Masturbation" Item of the Sexual Behavior Inventory

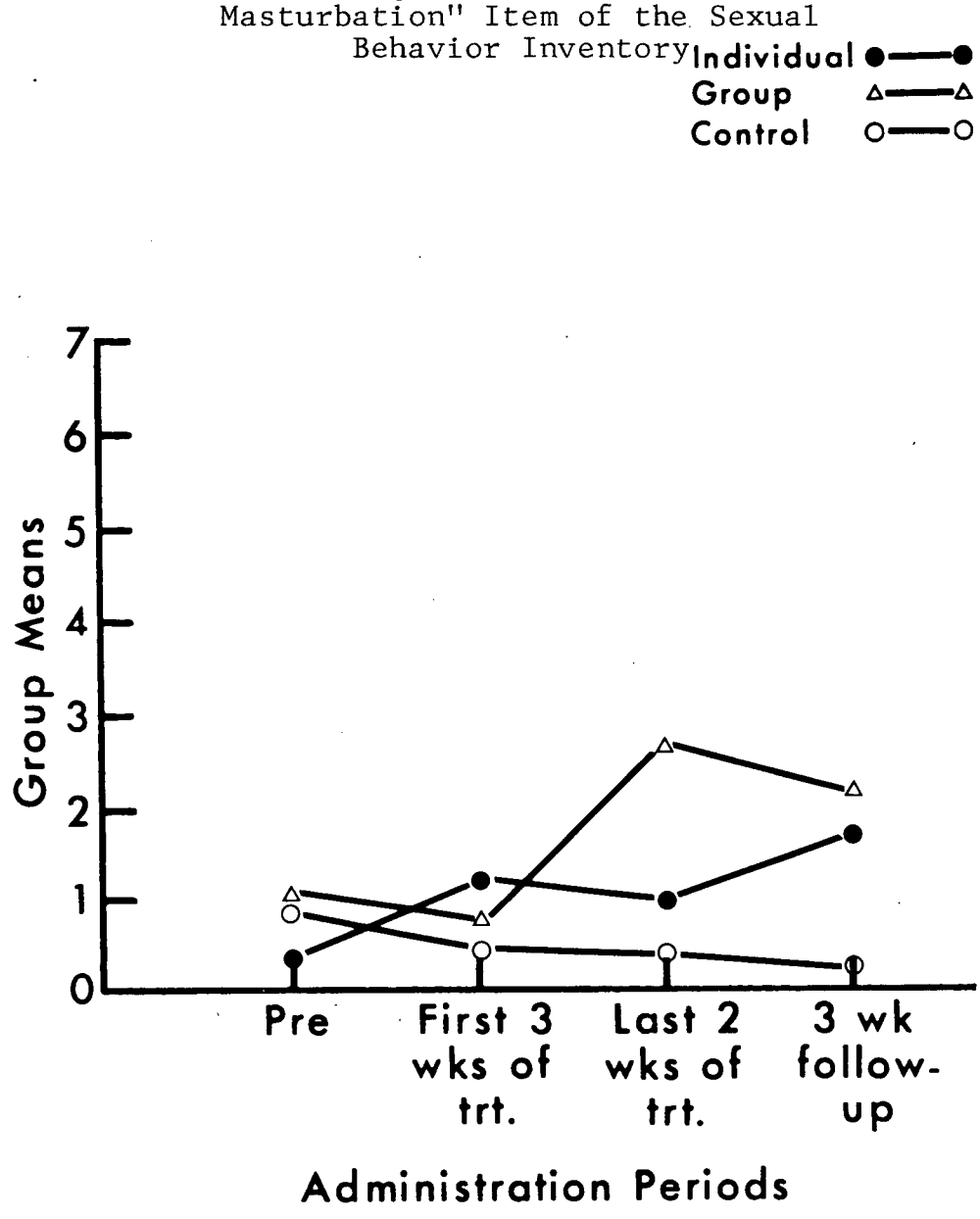


FIGURE 14

Mean Scores Over Administrations For Female Subjects On "Orgasm Through Foreplay" Item of the Sexual Behavior Inventory

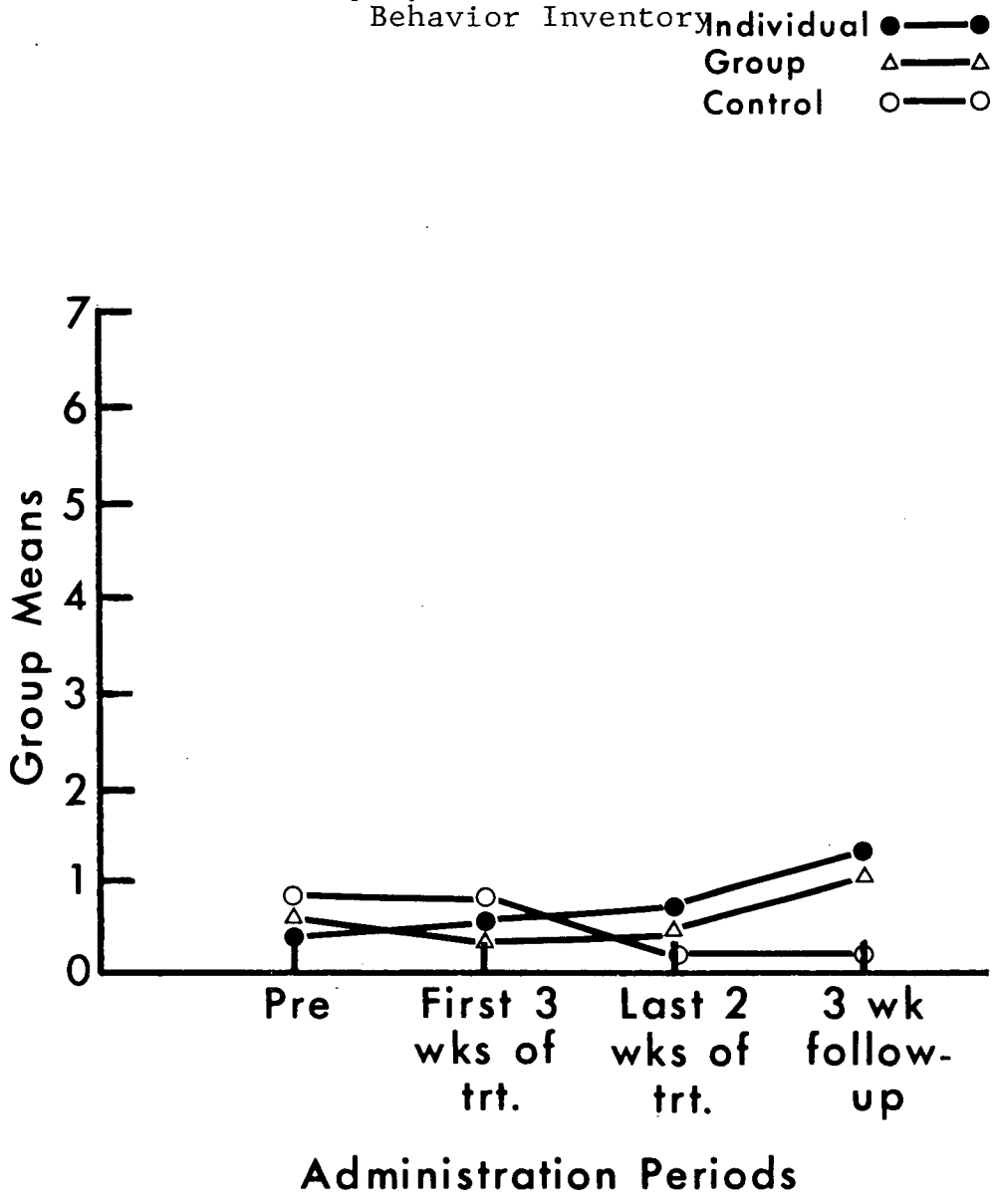


FIGURE 15

Mean Scores Over Administrations For Female Subjects on "Intercourse" Item Of The Sexual Behavior Inventory

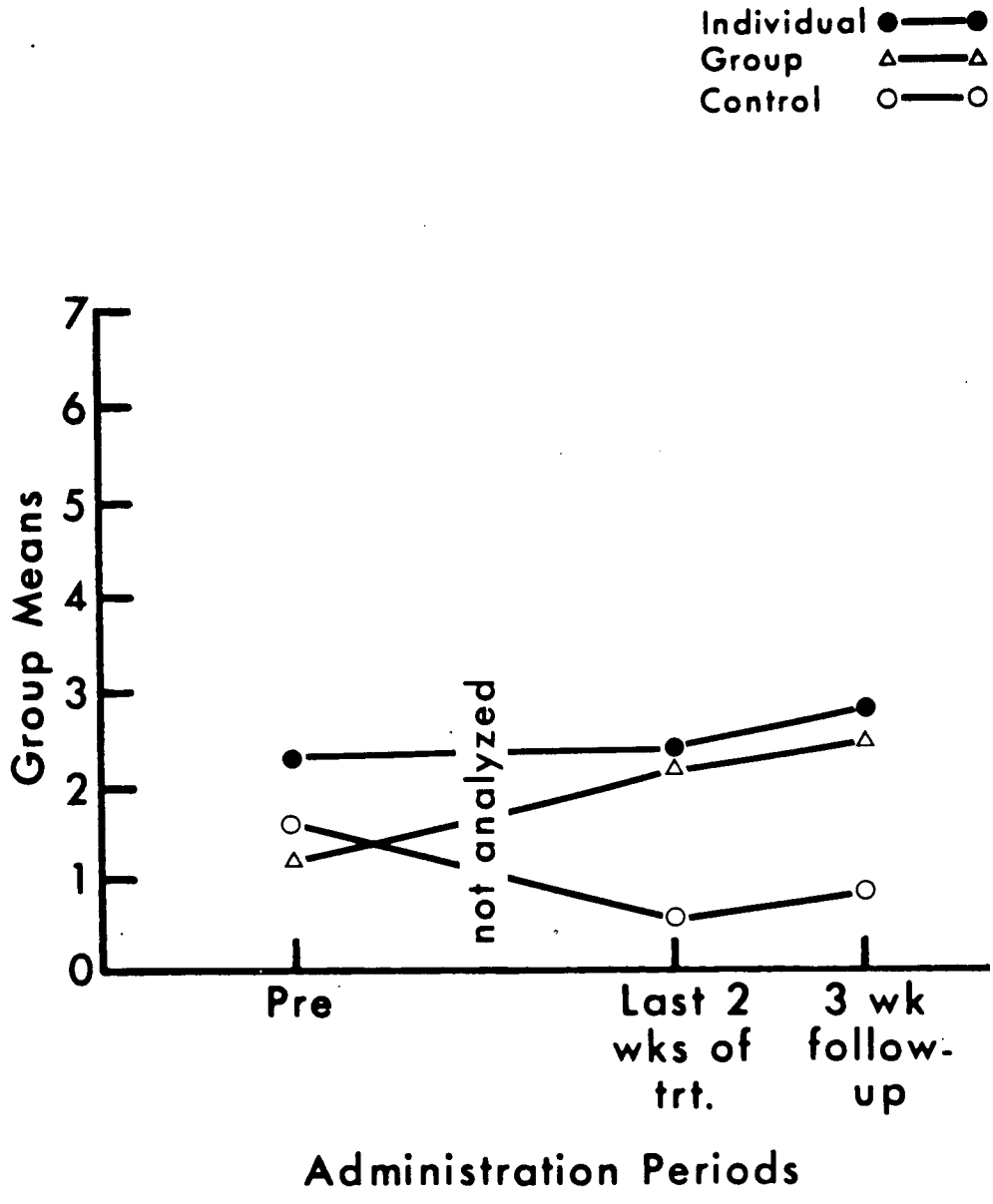
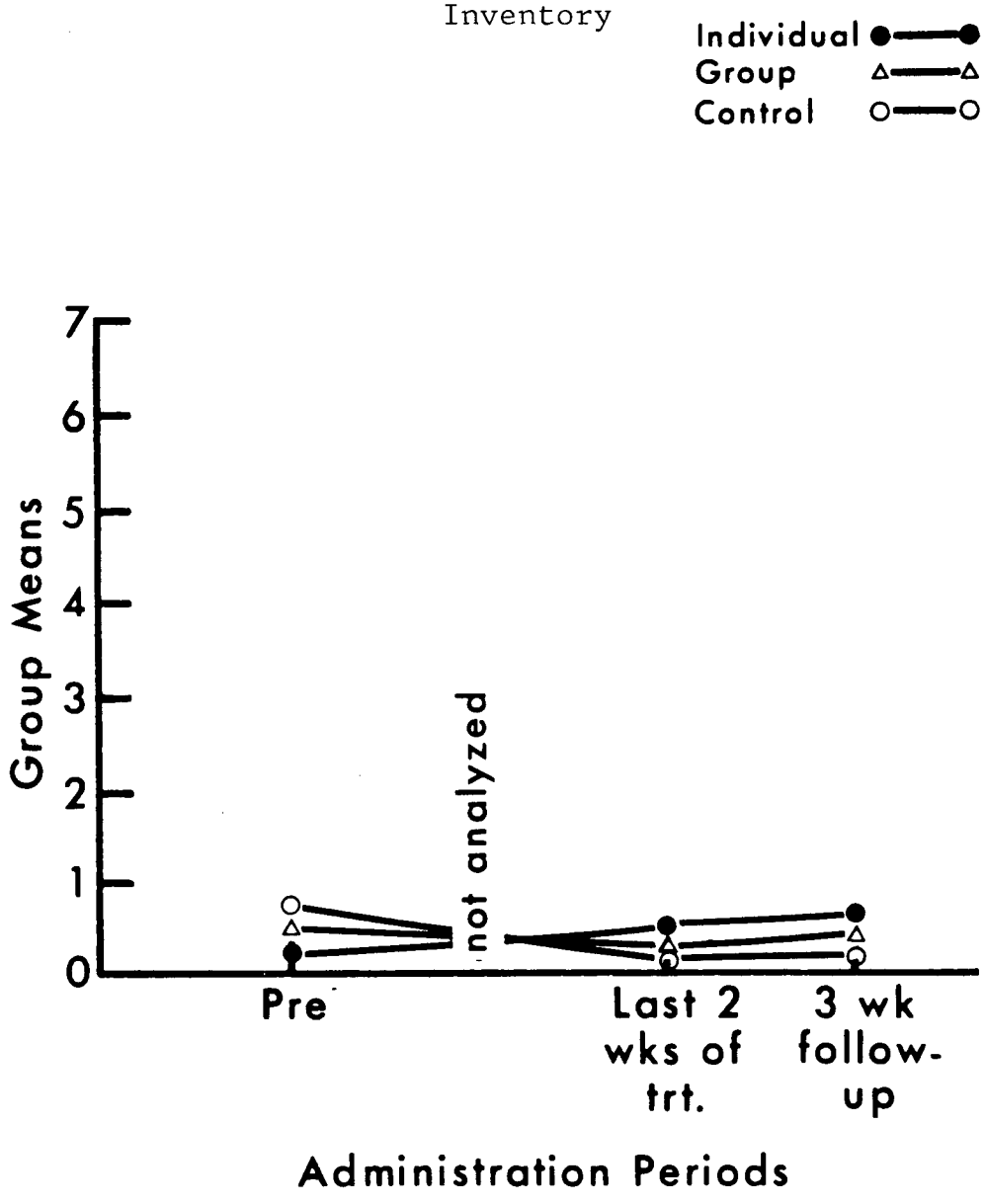


FIGURE 16

Mean Scores Over Administrations For Female Subjects on "Orgasm Through Intercourse" Item of the Sexual Behavior Inventory



that eight of the twelve secondarily inorgasmic females experienced orgasm through more than one form of stimulation.

DISCUSSION

Results from each of the dependent measures will be examined. These results will then be discussed in terms of their contribution to the current literature. Finally, implications for future research and conclusions drawn from the present study will be addressed.

The Sexual Arousal Inventory (SAI)

Results from the SAI were consistent with expectations, with both treatment groups showing a significantly higher level of reported arousal than the control condition at the three week and three month follow-ups. As one would expect increases in sexual arousal to follow positive behavioral experiences, the non-significant findings immediately post-treatment were not unexpected. Indeed it was assumed that the consolidation of the multi-faceted coping skills learned during the treatment would occur during the follow-up periods. Inspection of the group means at the three week and three month follow-up periods supports the above hypothesis in that a trend toward increased differentiation between the treatment and the control conditions is evidenced. Increased exposure to positively reinforced sexual behavior in conjunction with reduction of sexual anxiety may well be responsible for the reported changes

in the subjects' sexual arousal. In contrast a trend toward successive decreases in sexual arousal was evidenced in the control group over the same period of time. As the control subjects were asked to monitor their sexual arousal at four points during the ten week period, it may be possible to attribute the decrement in reported arousal to either a sensitization of the subjects to their own sexual habits or to an actual increase in sexual dissatisfaction. This finding is extremely relevant to the ethical issue of utilizing waiting list controls for treatment investigations (Franks and Wilson, 1980) in that it suggests potentially detrimental effects associated with the purposeful delay of treatment.

The Sexual Satisfaction Index

The results of the analyses for this variable will be discussed in terms of the subtests.

General Sexual Satisfaction. Results from this subtest were consistent with expectations with couples in both the group and individual couple treatment conditions reporting a significantly higher degree of general satisfaction than their control counterparts at the final session, three week and three month follow-up periods. The difference between the treatment and control condition means steadily increased through the three month follow-up. When mean scores of the two treatment groups are compared over the course of the study, two distinctly different patterns of response emerge.

Subjects assigned to the individual treatment condition reported large increases in general satisfaction at the final treatment session followed by maintenance of this level through to the three month follow-up. In contrast, subjects in the group condition showed smaller increments through to the three week follow-up, with large increases reported at the three month assessment. This differential pattern of response may be attributed in part to the possibility that clients in the individual condition are more at ease with therapy at an earlier point in time,given the one to one therapeutic interaction and the format's inherent ability to be more responsive to the couple's immediate needs. The large increase reported by group members at the three month follow-up may be directly attributed to the facility for treatment generalization and maintenance inherent in the group format (Leiblum, Rosen and Price, 1976). Perhaps participation in the group situation exposes the subjects to group pressure to communicate about their current difficulties (Golden et al., 1978) and to develop skills at communicating with more than one set of outside observers. In addition, the group situation allows the subjects to experience vicariously the treatment benefits of others (Bandura, 1969; Nemetz and Caird, 1978). The control subjects reported virtually no change in their level of general satisfaction.

Communication Satisfaction Subtest. Results from the communication satisfaction subtest were consistent with

expectations with subjects in both treatment conditions reporting a significantly higher degree of satisfaction with communication than their control counterparts at the final session, three week and three month follow-up periods. Inspection of individual and group treatment means reveals that subjects in these conditions reported gradual increments in satisfaction with their communication up to the three week follow-up. At the three month follow-up couples in the individual condition maintained their improvement whereas couples in the group condition reported a slight additional increase in communication satisfaction. The group result is consistent with previous research (Nemetz et al., 1978; Hogan, 1978) and supports the notion that group procedures foster communication skills (Golden et al., 1978) and enhance the generalization of problem-solving techniques (McGovern et al., 1978). The control subjects reported a decrease in satisfaction as measured by this subtest. Increased sensitivity to poor communication habits and continuation of maladaptive behavior in the absence of attempts at positive change is seen to account for this result.

Orgasm Satisfaction Subtest. Results from this subtest were consistent with expectations with both treatment conditions reporting a significantly higher degree of satisfaction with orgasm than their control counterparts at the final session and three week follow-up. At the three month follow-up only, subjects in the group condition

reported significantly more satisfaction with their orgasmic experience than did their control counterparts. Inspection of individual and group treatment means over administration periods reveals a familiar pattern. Subjects in the individual treatment condition reported a considerable increase in satisfaction immediately after treatment followed by slight decreases at the three week and three month follow-ups. Subjects in the group treatment condition reported little change in satisfaction until the three month follow-up. Again it appears that improvements reported by subjects in the group condition are more gradual and are facilitative of further changes following termination of therapy. Control subjects reported a gradual decline in satisfaction with their orgastic potential. Given the controversy over the utilization of orgasm per se as an outcome measure, the significance of these results in tandem with their behavioral counterparts will be discussed at a later point.

Sexuality Satisfaction Subtest. Results from this subtest indicated that subjects in both treatment conditions, reported significantly higher levels of satisfaction than did their control counterparts at the final and three week follow-up period. At the three month follow-up only subjects in the group condition reported significantly more satisfaction than those subjects in the control condition. This result again attests to the treatment maintenance and generalization inherent in the group situation and argues for increased

emphasis on generalization techniques for those clients receiving individual therapy. The control subjects reported no change in their original levels of satisfaction. The finding of increased satisfaction with both their own and their partner's sexuality evidenced in both treatment conditions is consistent with previous research (Frank, Anderson and Rubinstein, 1979) which suggests that in order to be able to relate intimately to another individual one must first have positive feelings about one's own sexuality

Satisfaction Relationship Subtest. Results of the subtest were partially consistent with expectations with couples in both treatment conditions reporting a significantly higher degree of satisfaction with their relationship than their control counterparts at the final session and three week follow-up. The difference between the two treatments and the control condition, however, was not maintained at the three month follow-up. Although couples in the group condition reported an increase in satisfaction at the three month follow-up, couples in the individual treatment condition reported a slight decrease. This result, coupled with a slight increase in satisfaction on the part of the control condition, led to the lack of differentiation between the treatment subjects and their control counterparts. Although evidencing only a slight increase in satisfaction, it is possible that the control group may have been responding to the imminent initiation of

treatment. The increase in satisfaction evidenced by treatment couples at the three week follow-up is consistent with the observed relationship between increased sexual satisfaction and marital satisfaction (Frank, Anderson and Rubinstein, 1979). The maintenance of this increased satisfaction reported by group members at the three month follow-up again attests to the generalization effects inherent in the group format.

As reported above, all of the five subtests were highly responsive to therapeutic intervention. More specifically, inspection of treatment means appeared to manifest a common pattern. Subjects in the individual couple condition reported maximal satisfaction in four of the five subscales immediately post treatment. This level of improvement deteriorated slightly through to the three month follow-up. Subjects in the group couple condition actually continued to improve on all measures post treatment and reported their highest levels of satisfaction at the three month follow-up. It is suggested that increased visual and verbal contact with individuals experiencing similar difficulties (Lazarus, 1968), mutual problem-solving discussions (Nemetz et al., 1978); Golden et al., 1978) and multiple sharing of coping strategies (Nemetz and Caird, 1979) all inherent in the group procedure combine to enhance communication and thus aid in treatment generalization and maintenance of learned coping skills.

The Sexual Behavior Inventory

The results of the analyses for this variable will be discussed in terms of the following items:

Male Items

Non-Sexual Massage. Results from the analyses for non-sexual massage indicate that subjects in the individual condition evidenced a significantly higher frequency of this behavior than did their group or control counterparts during the first three weeks of treatment. This result is partially consistent with expectations in that the importance of non-sexual contact was emphasized during sessions in the first three weeks of treatment. No significant differences were noted on this variable at any other point in the program. If one views dysfunction as a deficit in simple skills acquisition (McMullen and Rosen, 1979) it would be consistent for such basic and essentially non-sexual behavior to be either neglected or marginally maintained in the face of increasing sexual activities.

Sensate Focus Breast Area. Results from the analyses for this item were consistent with expectations with both treatment groups showing significantly higher frequencies of behavior than their control counterparts during the last two weeks of treatment. As the importance of foreplay and sensate focus activities was being emphasized during this phase of treatment, this result is consistent with therapeutic instructions. Failure of this item to achieve

significance at the three week follow-up was not expected and will be discussed later.

Sensate Focus Female Genitals. No significant effects were obtained for this variable at any of the reporting periods, although it would have been expected during the last two weeks of treatment and the three week follow-up period.

Intercourse. As intercourse was prohibited for the first four weeks of treatment the result of significance of the treatment effect at the three week follow-up is consistent with therapeutic expectations and represents evidence of consolidation of the skills training given during the treatment sessions.

Results from the male behavioral analyses were generally consistent with a simple skills acquisition model of sexual dysfunction (LoPiccolo, 1978; McMullen and Rosen, 1979). The difficulties inherent in the behavioral instrument will be discussed at a later point.

Female Items

Non-Sexual Massage. No significance was obtained for this variable at any of the reporting periods. This finding conflicts with both therapeutic instruction given during the first two weeks of treatment and is inconsistent with the male report of male initiated non-sexual massage during this same time period. It may well be that whereas males were comfortable initiating non-sexual massage, females were not. The unstructured nature of the activity may

have contributed to their reluctance. In addition, the amount of male initiated massage may have represented the maximal amount of time couples wanted to spend in that particular activity.

Sensate Focus Male Genitals. Results from this item indicated that subjects in the individual treatment condition evidenced a significantly higher frequency of this behavior than the control subjects during the five weeks of treatment. Group subjects reported significantly higher frequencies of this behavior during the last two weeks of treatment only. The Sexological Examination, a highly structured, limited exercise was assigned during the second week of treatment and consequently significant results from the sensate focus male genitals items would have been expected for both treatment groups during the first three weeks of treatment. The group couples' failure to report this increased frequency until the last two weeks is consistent with the evolving pattern of gradual compliance and learning evidenced for couples in the group condition.

Orgasm Through Masturbation. Women from the individual and group treatment conditions reported significantly higher frequencies on this item during the last two weeks of treatment than the control counterparts. This finding is consistent with therapeutic instruction in that masturbation training (Lobitz and LoPiccolo, 1972) was emphasized during this period of time. In addition, this is the only variable in which the group members

reported a significantly higher frequency of behavior than their individual counterparts. As masturbation is conceptualized as an important precursor to coital orgasmic activity (Bardwick, 1971; Masters and Johnson, 1970) this finding of significance for both treatment conditions is extremely important in terms of future development of orgasmic behavior. Given the prevalence of negative attitudes towards masturbatory behavior (Barbach, 1974; Bailey, 1978) the finding of group superiority with respect to this behavior argues for the disinhibiting effect of group membership on attitude change (Nemetz et al., 1978), transmission of coping skills (McGovern et al., 1978) and communication facilitation (Golden et al., 1978). The contribution of this finding to the previous research on transference of orgasmic potential will be discussed at a later point.

Orgasm Through Foreplay. Reported frequencies in this behavior differentiated women in both treatment conditions from control subjects at the three week follow-up. Given the previously discussed increased frequency in masturbation coupled with the therapeutic expectation of communication of masturbatory skills to male partners, this result was totally expected. Given the lack of specificity of this item (McMullen and Rosen, 1979) the nature of the stimulation utilized is not available. Again the bearing of this result on previous research will be discussed at a later point.

Intercourse. As intercourse was prohibited for the first four weeks of treatment, the result of significant findings obtained during the three week follow-up is not inconsistent with therapeutic expectations. Consistent with a gradual skills retraining model of sexual dysfunction (Nemetz and Caird, 1978), couples in both treatment groups reported a significantly higher frequency of intercourse than their control counterparts. These results are also consistent with those obtained from the male behavioral analysis for this item.

Orgasm Through Intercourse. No significance was obtained for this variable at any of the reporting periods. Given the previous research findings, this result is not incongruent. Again the contribution of this result to the more general issue of transference of orgasmic ability will be discussed at a later point.

General Issues

Conceptualization about the nature of sexual dysfunction is changing (McMullen and Rosen, 1979; LoPiccolo, 1978; Hogan, 1978). The new broad band therapies address themselves to this change in that they do not adhere to a simplistic conceptualization of etiology where one or two causative factors are given prominence. Rather, they utilize a broad, multifaceted treatment approach where a wider range of problematic behaviors are dealt with. Components of this approach include: information and

education; skills training; communication facilitation; reduction of all forms of sexual anxiety and graduated behavioral homework assignments. The present study utilizing all of the above components and addressing itself to a number of methodological flaws which have characterized previous research (LoPiccolo, 1978; Sotile and Kilmann, 1977), has demonstrated the efficacy of this approach. The utilization of multiple dependent measures (Sotile and Kilmann, 1977) in response to the broadened conceptualization of the nature of sexual dysfunction adds to the robust quality of the results.

Given the demonstrated efficacy of these broad band therapies and their direct treatment of behavioral symptomatology (Golden et al., 1978; Leiblum et al., 1976; Leiblum et al., 1977), the adequacy of the current diagnostic system must be questioned. The unitary diagnosis of "premature ejaculation" or "secondary orgasmic dysfunction" does not give the therapist sufficient information as to the current behaviors of the client. In one instance of "secondary orgasmic dysfunction" communication difficulties may be a major therapeutic focus, in another, lack of sexual skills may be the target for therapeutic intervention. While the broad based therapies do deal with this inadequacy by offering a spectrum of therapeutic techniques, the process would be facilitated by the introduction of a behaviorally based diagnostic system. For example, a woman might still be termed "secondary inorgasmic" however,

a behavioral analysis indicating mode of communication, level of sexual anxiety; partner sexual competency and couple's general level of sexual knowledge would be included. This information would aid the therapist in focussing on specific problem areas and also indicate the therapy of choice.

The results of the present study are also relevant to a number of existing issues in the literature. Firstly, the present research is relevant to the issue of group composition in terms of heterogeneity versus homogeneity of diagnosis. Homogeneity of group composition was originally conceptualized to deal with the potential difficulties inherent in a group situation; specifically, insufficient attention to individual problems and differential pacing of homework assignments (Kaplan et al., 1974; Barbach, 1974). Proponents of the heterogeneous group composition (Leiblum, Rosen and Peirce, 1976; Leiblum and Ersner-Hershfield, 1977) suggest that group members are exposed to a broadened range of attitudes, sexual problems and potential coping skills and accept new information and skills training more readily. Although not directly comparing heterogeneity versus homogeneity of group composition, the heterogeneous group utilized in the present study evidenced an ability to generalize and maintain therapeutic gains.

Secondly, results from the present study bear on the issue of transference of orgastic ability from masturbation to coitus. Previous research has consistently found a low

frequency of orgasm achieved through coitus alone among women undergoing sex therapy either individually or with a partner (Leiblum and Ersner-Hershfield, 1977; Barbach, 1974; Schneidman and McGuire, 1976). These results have been obtained despite the reported success of orgasm through masturbation for the same subjects. When orgastic ability does transfer to couple activity, additional stimulation particularly a vibrator is often necessary (Leiblum and Ersner-Hershield, 1977; Schniedman and McGuire). These experimental data are corroborated by inspection of large samples of normative data collected on the frequency of orgasm through intercourse alone (Hite, 1976). Given these results coupled with Kaplan's (1974) observation that type and duration of stimulation in addition to variations in anatomical structure makes orgasm with intercourse unreliable, the utilization of orgasm through intercourse alone, as a valid therapeutic criterion must be questioned (McMullen and Rosen, 1979). Results from the present study are consistent with the noted efficacy of masturbation training (Ersner-Hershfield and Kopel, 1979; Barbach, 1974). The findings of significance for the variable measuring orgasm through foreplay at the three week follow-up suggests the utility of specific, multiple measures in identifying areas of therapeutic gain. The transference of orgastic ability to a couple-related activity other than intercourse in conjunction with the high degree of satisfaction with orgastic behavior reported on the Sexual Satisfaction Index

again seriously questions the traditional treatment criterion of intercourse with orgasm. Because the definition of this category does not specify the nature of the foreplay stimulation, additional conclusions from its significance are limited.

Thirdly, as previously mentioned, the finding of the waiting list control's deterioration over time has implications for its utilization in future research (Franks and Wilson, 1980; Nemetz et al., 1978). If this finding is replicated by future research the ethical basis of the waiting list control must be thoroughly examined. Suggestions for future research are contained in the Implications for Future Research Section.

The major focus of the present study was to directly compare group to individual treatment formats. The present research is apparently the only investigation reported which attempts to directly compare individual couple to group couple application of a broad based therapy in contrast to a control condition. Given the generally positive results obtained for the group format in conjunction with ability to decrease patient cost and increase therapeutic availability, application of this format for a majority of clients is seen as highly desirable. This finding is entirely consistent with previous research in the area in terms of the positive benefits attributed to group participation (Nemetz et al., 1978; Golden et al., 1978;

McGovern et al., 1978; Ersner-Hershfield and Kopel, 1979). A characteristic response pattern emerged for couples participating in the group treatment. Inspection of the Sexual Satisfaction Index reveals a tendency towards a more gradual and maintained improvement in all facets of satisfaction for group couples. Group components potentially contributing to this maintenance and generalization of therapeutic techniques include the ability to share other couples' coping strategies (Nemetz and Caird, 1978, 1979); peer support and encouragement (Leiblum, Rosen and Peirce, 1976; Leiblum and Ersner-Hershfield, 1977); provision of an atmosphere conducive to communication (Golden et al., 1978) and the exposure to modeling effects (McGovern, 1978).

To the writer's knowledge, weekly monitoring of sexual behavior has not been reported previously in the literature. The present study indicates a number of problems associated both with the construction and actual utilization of the Sexual Behavior Index. Firstly, despite repeated explanations of the behavioral categories, subjects were confused as to the specific nature of the behaviors to be monitored. This confusion primarily occurred when behaviors were of a cumulative nature. For example, it would be difficult to engage in intercourse without some degree of breast and genital manipulation, however, it is felt that subjects often only indicated an occurrence of intercourse rather than entering a frequency count in all three categories.

The results from the Sexual Behavior Index would tend to uphold this notion.

Secondly, the difficulty of eliminating the noise in the monitored data is apparent. Menstrual cycles, partner holidays and visiting relatives all severely interfere with recording of data especially when data weeksare averaged together.

Lastly, there is difficulty in investigating pre-post behavioral data. Often individuals engage in optimal levels of sexual behavior with minimal satisfaction. This appears to be especially true for females (Barbach, 1980; Nemetz and Caird, 1979). If pre and post levels are examined for subjects in this situation, the behavioral data will not accurately reflect treatment gain, whereas a measure of sexual satisfaction will. Some suggestions for improvement of sexual behavioral monitoring are contained in Implications for Future Research.

Implications for Future Research

Given the demonstrated efficacy of the application of group format to a short term, broad band, therapy, a number of basic issues warrant further investigation. Firstly, group composition should be examined. Does heterogeneity or homogeneity of presenting diagnosis more effectively facilitate group interaction? Is there a combination of client demographic characteristics that would optimize group participation? Which clients should be directed towards

participation in the group format?

Secondly, the finding that the group couples' ability to maintain treatment gains and indeed increase benefits three months post discharge should be replicated. If these results are upheld, investigation as to factors which promote treatment maintenance and generalization would be warranted. If generalization is facilitated by multiple problem sharing and maximal exposure to varying models, the format of the treatment sessions might be rearranged. For example, the first part of each session might contain both males and females (not necessarily both partners), with the male and female therapists switching groups weekly.

Thirdly, the effective treatment components of the group format should be isolated. Factors which should be examined include: multiple problem sharing; exposure to individuals experiencing similar difficulties; peer pressure and support in terms of homework assignments and communication and exposure to numerous models employing suggested coping strategies with positive consequences.

In terms of the basic program itself, the results of this study suggest further areas of concern. Again, as mentioned above, effective treatment components should be isolated. To this end a number of treatment groups could be run, each utilizing a different therapeutic component. For example, the benefits of a sexual education group-reading only as compared to a sexual education group-video only could be investigated.

The difficulty evidenced by individual treatment couples in maintenance of therapeutic gains suggests a possible elongation of the treatment phase of the program in conjunction with shorter intervals between follow-up assessments. For example, treatment may be comprised of eight weekly sessions with an addition of eight follow-up assessments each occurring at three week intervals. As the group clients evidenced no difficulty in maintenance of treatment gains, a group format for individual couple follow-up might be beneficial.

As the present study was primarily concerned with demonstration of treatment efficacy, prognostic indicators were not examined. This issue, however, remains of paramount concern (Sotile and Kilmann, 1977; LoPiccolo, 1978). To this end a series of studies should examine clients with a wide range of presenting problems at varying levels of severity in their response to radically different forms of therapeutic intervention. Given the vastly differing types of sexual dysfunction, it is imperative to ascertain which type of presenting problem responds best to a specific therapy.

There were two areas of the present study that posed serious concern. Although the "assessment only" control had evidenced deterioration in previous studies (Nemetz et al., 1978) replication of this phenomena was nonethless disturbing. In order to further investigate this finding the "assessment only" control condition should be compared

to both a "waiting list" and a "placebo" control condition. If deterioration is evidenced in all forms of control conditions, further research into the effect of waiting for treatment on couples experiencing sexual difficulties is needed. If however, only the assessment control condition evidences increased dissatisfaction, the reactive effects of self-monitoring in couples with sexual dysfunction would warrant interest.

As discussed previously, there were a number of obstacles to accurate usage of the behavioral index. Future research should investigate the various methods of obtaining behavioral data and make recommendations as to the most efficient format. Given the confusion caused by finer measures of sexual behavior, examination of more gross measures might prove beneficial. Some suggestions include: usage of a basic occurrence-nonoccurrence measure; collapse of finer measures into broader categories, i.e. foreplay, intercourse, orgasm; and the institution of daily monitoring sheets to replace the weekly report.

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APPENDIX I

Therapist Manual

This outline was written to ensure standard treatment conent and procedure across all experimental conditions. The use of this outline serves as one check against the possible effects of experimenter bias (Barber 1976).

Initial Interview

Both male and female therapists are present, and the couple remains together throughout the hour long session. As stated to the clients, the main purpose of the session is "to find out from both of you, what problems you are experiencing, detail what our program has to offer and decide if this is the best place for you."

Initially, demographic data such as age, occupation, education, marital status, duration of problem, and duration of the relationship is obtained. A problem statement from either partner is then elicited and a comprehensive series of questions ensues. The areas covered by both question and discussion are identical for both partners and include the following:

1. Satisfaction with and commitment to the relationship
2. Current sexual habits
   - frequency of intercourse
   - ideal frequency of intercourse
   - perceived quality of intercourse in terms of satisfaction received

- foreplay activities
- masturbation practices
- use of fantasy or stimulation aids
- preferred times for intercourse

3. Attitudes towards sexuality
   - perception of own sexuality
   - perception of partner's sexuality
   - role of sexual behavior in a marriage
   - feelings towards - intercourse
     - masturbation
     - *manual genital stimulation
     - *oral genital stimulation
4. Psychosexual history
   - parental attitude towards sexuality
   - quality and quantity of information from patents
   - quality and quantity of information from educational sources, siblings and peers
   - attempts at and attitudes towards masturbation
   - attitudes towards premarital intercourse
   - initial attempts at intercourse
   - incidences of rape, molestation or incest
   - other traumatic sexual experiences
5. Details of contact with physician
6. Details of any previous treatment experiences

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*these are elicited with a view to the client both giving and receiving the stimulation

7. Assessment of motivation for treatment

   - this topic area includes questions as to "why treatment now," expectations of outcome and willingness to take responsibility for the majority of the "therapy work" in the form of behavioral homework assignments

8. Current self-assessment of level of sexual knowledge and areas that client feels need to be worked on

At this point, the clients are asked if there is any more information that might be relevant to their specific problem. An attempt is then made by either therapist to give a synpsis of the presenting problem and the possible etiological and maintaining factors. A detailed explanation of the Human Sexuality Program is then given. Points covered include the theoretical framework of the program, importance of continual attendance, responsibility in terms of the "behavioral homework" assignments, cost per session and appropriate session times. Questions and feelings about the program are solicited.

If the decision to participate is yes:

- the details of questionnaires and use of data are explained
- an informed consent form is given
- the purpose and use of the Behavioral Index in the two week baseline period is explained
- the Sexual Satisfaction Index and Sexual Arousal Inventory are completed
- couples are told that both group and individual sessions are run and that they will be placed in the first available form of treatment

- an appointment time for next session is decided upon

If the couple feels that this is not the appropriate treatment modality or conversely, if the therapists feel that the couple are not suitable for the program, an alternate referral source is always given.

Factors contraindicating therapeutic intervention

- lack of commitment to the relationship or to the therapy program
- recent diagnosis of a medical condition which would impair sexual functioning
- severe marital discord which would preclude conjoint therapy
- presence of psychotic symptomatology
- presence of an addictive behavior which would jeopardize effective intervention
- lack of a steady and co-operative sexual partner

Couples are always given one of the therapist's home telephone numbers and are encouraged to call if any questions or problems arise in the inter-treatment periods.

Sessional content outlined below is identical for both group and individual therapy conditions.

Session 1

A. First half of session female(s) with female therapist: The purpose of this session is to make the client(s) comfortable in the new situation and then outline

the procedures for the next five weeks.

Specific questions and comments include:

- how do you feel about being here
- what could be done to make you feel more comfortable
- assurances by the therapist that feelings of anxiety and hesitation are realistic reactions to a novel situation
- expectation for treatment progress are discussed
- the importance of looking for small progress steps instead of dramatic changes is underscored

Questionnaires including the Sexual Arousal Inventory and Satisfaction Index are re-administered. An outline of the program, tension management phamphlet and reading list are distributed and explained.

B. First half of session male(s) with male therapist:

Identical to female session

C. Male(s) and Female(s) Together:

Film: Anatomy and Human Sexual Response

Discussion Period:

1. report on session from male and female representative
2. discussion of the learning theory of sexual dysfunctions
3. rationale for restraining from intercourse for the first four weeks
4. emphasis on responsibility for homework assignments
5. rationale for and actual demonstration of tension management techniques

Homework - Couples are Instructed to:

1. increase non-sexual physical contact in terms of hugging, kissing, back rub, etc.

It is important to emphasize to clients, that very often when couples are having sexual difficulties, forms of previously pleasurable non-sexual activities cease due to their arousal potential. The object of this homework assignment is to reintroduce some of these behaviors in a situation where both partners realize that intercourse is prohibited.

2. it is suggested that both partners use the relaxation exercises at least twice daily for the coming week

3. the three introductory chapters from Our Bodies, Ourselves: A Book By and For Women (Boston Womens Health Collective, 1971) are assigned

It is suggested that each client read a chapter and then discuss it with his or her partner. This not only facilitates communication, but also helps partners explore and discuss new areas of sexual knowledge.

Session 2

A. First half of session female(s) with female therapist: The first portion of this and all succeeding sessions is given to a review of the past week's homework with emphasis on both new learning and progress. If any difficulties have arisen they are dealt with and alternate strategies are suggested.

The focus of this session revolves around attitudes towards and experience with masturbation. The role of parental attitudes and teaching towards masturbation and its effects are discussed

1. the first two steps of LoPiccolo and Lobitz's (1972) nine step masturbation program

Step 1 - to increase body self awareness the woman is encouraged to use a hand mirror to explore her genital area. Women are also encouraged to begin to practice the Kegel exercises (1952).

Step 2 - if the woman feels perfectly comfortable with Step 1 she is now encouraged to explore her genitals both tactually and visually.

If the woman has any anxiety in performing these exercises she is encouraged to break the exercises down into manageable parts and to utilize her relaxation exercises.

B. First half of session male(s) with male therapist: The first portion of this and all succeeding sessions is given to a review of the past week's homework with emphasis on both new learning and progress. If any difficulties have arisen they are dealt with and alternate strategies are suggested. The focus of this session revolves around attitudes towards and experience with masturbation. The role of parental attitudes and teaching towards masturbation and its

effects ared discussed.

Homework:

1. attempt masturbation and note any difficulties

C. Male(s) and Female(s) Together

Film: Sexological Examination - a short documentary on how to give feedback to partner's stimulation. Systematic methods of stimulation and feedback are modeled.

Discussion Period:

1. report on session from male and female representative
2. progress to date
3. feedback and questions about relaxation exercises
4. exact use and benefits of Sexological Examination

Here, the importance of being able to communicate likes and dislikes to partner is emphasized. For those who feel anxious or apprehensive about trying the exercise, it is suggested that they break it down into two parts - the genital and non-genital stages. Utilization of the relaxation exercises are also suggested as an additional aid.

Homework:

1. both partners are to begin reading <u>For Yourself</u>, by L.G. Barbach.

In order to facilitate discussion it is suggested that each partner underline the points he or she would like to discuss with their partner and proceed to do so at the end

of each chapter.

2. couples are instructed to continue with the relaxation exercises

3. couples are instructed to try graduated and full form of sexological examination at least three times during the week

Session 3

A. First half of session female(s) with female therapist:

1. review of homework and discussion of readings

2. special emphasis is placed on each client's (clients) experience with the first two steps in the masturbation program

3. attitudes and feelings towards masturbation are again discussed

Homework:

1. women are now encouraged to tactually look for sensitive areas that produce feelings of pleasure

2. once these areas have been ascertained women are encouraged to use manual stimulation to produce orgasm (if possible)

B. First half of session male(s) with male therapist:

1. discussion of readings and statement as to how week went

2. questions about specific problems with male masturbation

3. discussion of the value of foreplay with an emphasis on the length of time needed to arouse their partners

C. Male(s) and Female(s) Together:

Film: Documentary on Women and Orgasm-both instructional information and discussion of the nature of orgasm

Discussion

1. report on session from both male and female representative

2. feelings on and or problems with male or female masturbation

3. foreplay

   - why it is important

   - different strategies, e.g. incorporating massages and the sexological examination into foreplay

4. the importance of the female communicating her findings re pleasurable areas from the masturbation exercises - this may be done either verbally or non-verbally whichever method is more comfortable

Homework:

1. continue sexological examinations

2. discuss preferred modes of foreplay

3. finish and discuss For Yourself

Session 4

A. First half female(s) with female therapist:

   1. discussion of readings and report on masturbation attempts

A major focus of this session is the importance of setting time aside for personal activities. Very often women will complain that they have no time for masturbation in short for themselves. If necessary instructions are given for self-monitoring of exactly how many hours a week are devoted to self.

For those women having difficulty with masturbation or for those women who want to enhance their sexual response, the utilization of vibrators is suggested. Here, attitudes and questions of types are dealt with. Women are assured that they will not become "hooked" on the vibrator and are given strategies for gradually introducing it into their foreplay session.

2. the use of fantasy in both masturbation and intercourse is also discussed

Homework:

1. if masturbation is not successful continue attempts with or without vibrators
2. if masturbation produces pleasurable results, women are responsible for communicating these areas to the male
3. read My Secret Garden by Nancy Friday

B. First half male(s) with male therapist:

1. report on homework, readings and progress in general

The major focus of this session is definition of and explanation of probable etiological causes of premature ejaculation. The nature of learning and anxiety in causing and maintaining the problem is underscored. The basic principles of the Seamans (1956) and Masters and Johnson (1970) squeeze technique are introduced.

C. Male(s) and Female(s) Together:

Film: Sexuality and Communication Drs. A. and B. Chernick

Discussion Period:

1. report on session from both male and female representatives

2. discussion of communication strategies in the film as they apply to the couple(s)

If possible specific examples are elicited. The discussion also encompasses the importance of sexual communication in terms of likes and dislikes and also in terms of saying "yes and no" to sexual advances. Clear strategies for accepting or rejecting sexual overtures are role-played and discussed.

3. re-introduction of intercourse is discussed

Here couples are admonished to utilize all the coping and communication skills they have been practicing in the past three weeks

Homework:

1. both partners are to make a list of at least three instances where communication, sexual or general, breaks down or becomes difficult

2. list is to be discussed during the week and brought to the next session

3. reading My Secret Garden (Friday, 1973)

Session 5

A. First half female(s) with female therapist:

1. discussion of readings and statement as to how week went

2. questions and progress with masturbation

3. discussion of contraception and vaginal disorders and their effects on arousal and intercourse

The major focus of this session is on effective communication. Special emphasis is placed on the couple's (couples') specific communication difficulties. Areas where the woman has difficulty communicating are highlighted. Role-playing is utilized if necessary.

B. First half male(s) with male therapist:

1. statements as to how week went and progress in general
2. discussion of methods of contraception
3. causes and treatments of impotence are discussed

The major focus of this session is on effective communication. Special emphasis is placed on the couple's (couples') specific communication difficulties. Areas where the man has difficulty communicating are highlighted. Role-playing is utilized if necessary.

C. Male(s) and Female(s) Together:

Film: The Squeeze Technique

Discussion Period:

1. report on session from both male and female representatives
2. couple(s) roleplay their communication difficulties illustrating the "right" strategies to utilize
3. the repercussions, both positive and negative of reinstituting intercourse are discussed
4. further explanation of the squeeze technique and specific instructions for use
5. reminder of final session next week

Homework:

1. practice communication skills
2. try the squeeze technique at least four times during the week

Session 6

A. First half female(s) with female therapist:

1. statements as to how week went and progress in general
2. questions specifically about communication problems and the squeeze technique are solicited

The focal point of this session is to prepare clients for termination of therapy. Specifically, clients are asked to write a maintenance program including:

1. problems they foresee coming up in the next three weeks
2. strategies for coping with these problems
3. document all aspects of perceived progress, no matter how small

Feedback is elicited from the clients as to their impression of the program, specifically:

1. what benefits they experienced
2. parts of the program they felt were most useful
3. areas in the program they would like to see improved
4. suggestions for future inclusions or deletions

B. First half male(s) with male therapist:

This session is identical to the female session described above

C. Male(s) and Female(s) Together:

1. Sexual Arousal Inventory and Satisfaction Index are re-administered

2. feedback from couple(s) as a unit about their experience in the program is solicited

3. the importance of continuing all skills learned in the program is stressed

Homework:

1. couple(s) are instructed to systematically go through each other's maintenance list and discuss any points of contention or areas that need clarification

2. couple(s) are instructed to continue recording their sexual behaviors via the Sexual Behavior Checklist for the next three weeks

3. if problems arise couple(s) are told to immediately contact the therapists whether at home or at the office

4. an appointment is made for the three week follow up

Three Week Follow-Up

At this session all couples are seen individually. This session is seen as a check session where progress, problems and plans for the next three months are discussed. The Sexual Arousal Inventory, the Post Program Questionnaire and the Satisfaction Index are re-administered. Content of both this and the three month follow-up is tailored to the individual couple's specific needs.

Three Month Follow-Up

Format and focus is identical to the three week session.

APPENDIX II

Sexual Behavior Inventory

Name: .....

Date: .....

Please indicate your weekly frequency of the following

Male seeing female nude	1...5....10....15....20
Female seeing male nude	1...5....10....15....20
Male giving female body massage excluding breasts and genitals	1...5....10....15....20
Female giving male body massage excluding genitals	1...5....10....15....20
Male caressing female breasts with hands	1...5....10....15....20
Male caressing female breasts with mouth	1...5....10....15....20
Female caressing male genitals with hands	1...5....10....15....20
Male caressing female genitals with hands	1...5....10....15....20
Intercourse	1...5....10....15....20
Female orgasm through masturbation	1...5....10....15....20
Female orgasm through genital manipulation by male	1...5....10....15....20
Female orgasm through intercourse	1...5....10....15....20
Number of female initiated sexual behaviors	1...5....10....15....20
Number of male initiated sexual behaviors	1...5....10....15....20

APPENDIX III

Sexual Satisfaction Index

The following scale is to be used when responding to the questionnaire:

0 = entirely dissatisfied
1 = moderately dissatisfied
2 = slightly dissatisfied
3 = neutral
4 = slightly satisfied
5 = moderately satisfied
6 = extremely satisfied

Please indicate your level of satisfaction with respect to the following: circle the number that most applies to your present feelings.

1. my feelings about my own sexuality	0	1	2	3	4	5	6
2. my feelings about my body	0	1	2	3	4	5	6
3. my role in our sexual relationship	0	1	2	3	4	5	6
4. my partner's role in our sexual relationship	0	1	2	3	4	5	6
5. my ability to communicate with my partner	0	1	2	3	4	5	6
6. my partner's ability to communicate with me	0	1	2	3	4	5	6
7. my ability to discuss sex with my partner	0	1	2	3	4	5	6
8. my partner's ability to discuss sex with me	0	1	2	3	4	5	6
9. my level of satisfaction with the relationship in general	0	1	2	3	4	5	6
10. my partner's level of satisfaction with the relationship in general	0	1	2	3	4	5	6
11. my level of satisfaction with our sexual relationship	0	1	2	3	4	5	6
12. my partner's level of satisfaction with our sexual relationship	0	1	2	3	4	5	6
13. my knowledge about sex as learned from my parents	0	1	2	3	4	5	6
14. my attitude towards masturbation	0	1	2	3	4	5	6
15. my ability to masturbate	0	1	2	3	4	5	6

16. number of male sexual initiatives	0	1	2	3	4	5	6
17. number of female sexual initiatives	0	1	2	3	4	5	6
18. frequency of intercourse	0	1	2	3	4	5	6
19. duration of foreplay	0	1	2	3	4	5	6
20. my ability to achieve climax through intercourse	0	1	2	3	4	5	6
21. my ability to achieve climax through self-masturbation	0	1	2	3	4	5	6
22. my ability to achieve climax through genital manipulation by my partner	0	1	2	3	4	5	6

APPENDIX IV

Sexual Arousal Index

Instructions

The experiences in this inventory may or may not be sexually arousing to you. There are no right or wrong answers. Read each item carefully, and then circle the number which indicates how sexually aroused you feel when you have the described experience, or how sexually aroused you think you would feel if you actually experienced it. Be sure to answer every item. If you aren't certain about an item, circle the number that seems about right. The meaning of the numbers is given below:

-1 adversely effects arousal; unthinkable, repulsive, distracting

0 doesn't affect sexual arousal

1 possibly causes sexual arousal

2 sometimes causes sexual arousal; slightly arousing

3 usually causes sexual arousal; moderately arousing

4 almost always sexually arousing; very arousing

5 always causes sexual arousal; extremely arousing

ANSWER EVERY ITEM	How you feel or think you would feel if you were actually involved in this experience						
*1. When a loved one stimulates your genitals with mouth & tongue	-1	0	1	2	3	4	5
*2. When a loved one fondles your breasts with his/her hands	-1	0	1	2	3	4	5
3. When you see a loved one nude	-1	0	1	2	3	4	5
4. When a loved one caresses you with his/her eyes	-1	0	1	2	3	4	5
*5. When a loved one stimulates your genitals with his/her finger	-1	0	1	2	3	4	5
*6. When you are touched or kissed on the inner thighs by a loved one	-1	0	1	2	3	4	5
7. When you caress a loved one's genitals with your fingers	-1	0	1	2	3	4	5
8. When you read a pornographic or "dirty" story	-1	0	1	2	3	4	5
*9. When a loved one undresses you	-1	0	1	2	3	4	5
*10. When you dance with a loved one	-1	0	1	2	3	4	5
*11. When you have intercourse with a loved one	-1	0	1	2	3	4	5
*12. When a loved one touches or kisses your nipples	-1	0	1	2	3	4	5
13. When you caress a loved one (other than genitals)	-1	0	1	2	3	4	5
*14. When you see pornographic pictures or slides	-1	0	1	2	3	4	5

*15. When you lie in bed with a loved one	-1	0	1	2	3	4	5
*16. When a loved one kisses you passionately	-1	0	1	2	3	4	5
17. When you hear sounds of pleasure during sex	-1	0	1	2	3	4	5
*18. When a loved one kisses you with an exploring tongue	-1	0	1	2	3	4	5
*19. When you read suggestive or pornographic poetry	-1	0	1	2	3	4	5
20. When you see a strip show	-1	0	1	2	3	4	5
21. When you stimulate your partners genitals with your mouth & tongue	-1	0	1	2	3	4	5
22. When a loved one caresses you (other than genitals)	-1	0	1	2	3	4	5
23. When you see a pornographic movie (stag film)	-1	0	1	2	3	4	5
24. When you undress a loved one	-1	0	1	2	3	4	5
25. When a loved one fondles your breasts with mouth and tongue	-1	0	1	2	3	4	5
*26. When you make love in a new or unusual place	-1	0	1	2	3	4	5
27. When you masturbate	-1	0	1	2	3	4	5
28. When your partner has an orgasm	-1	0	1	2	3	4	5

Note - Maximum possible score = 140. Total score is obtained by (a) adding positive scores, (b) adding negative scores, and (c) subtracting the sum of any negative scores from the sum of positive scores.

Asterisks indicate those items comprising Form A. Form B consists of items without asterisks.

APPENDIX V

Advised Consent Form

To assure us that you are fully informed, will you please answer the following questions:

1. Do you willingly consent to participate in this treatment?

   YES* NO

2. I am not free to withdraw from this treatment whenever I choose.

   TRUE FALSE*

3. Details about the treatment have been explained to me.

   TRUE* FALSE

4. I understand that some of the techniques and information may be used for research purposes, but only if steps are taken to protect my confidentiality.

   YES* NO

SIGNED:_____ DATE:_____

WITNESSED:_____ DATE:_____

*Indicates correct response

Informed Consent Form

I_____have been informed of the procedures that will be utilized at the Human Sexuality Clinic, Outpatient Department, St. Paul's and Health Sciences Centre Hospital. While the staff will make every reasonable effort to help me, I understand that the ultimate success of such a program of treatment is largely my own responsibility. I understand that treatment success requires home practice and evaluate recording, and that benefits from treatment will diminish without such regular practice. Not everybody benefits from treatment and certainly no one is even problem free at the end of treatment. Paradoxically, the termination of treatment is often the start of real progress. On the other hand, the return of problems may serve as an important reminder to continue therapeutic practices.

Further, I understand that some of the procedures and data will be used for research purposes. All information about my treatment is strictly confidential and will not be released without my permission and/or steps being taken to protect my identity. It is my right to withdraw from this program whenever I choose.

APPENDIX VI

Program Outline: Human Sexuality Clinic

Initial Interview

1. Detailed sexual history
2. Program explanation
3. Decision as to participation in program
4. Informed consent
5. Discussion of and administration of the Sexual Satisfaction Index and the Sexual Arousal Inventory
6. Discussion of and instruction for the Sexual Behavior Inventory
7. Treatment assignment

Session 1

Female:
1. Treatment expectations
2. Problem statement

Male:
1. Treatment expectations
2. Problem statement

Couple:
1. Discussion of learning theory of sexual dysfunction
2. Rationale re: cessation of intercourse
3. Relaxation training
4. Film: Human Sexuality (Szasz, 1974)

Homework:
1. Relaxation exercises, twice daily
2. Increase non-sexual physical contact

3. Reading: Our Bodies, Ourselves, (Boston Women's Health Collective, 1971)

Session 2

Female:
1. Weekly summary
2. Attitudes towards and experience with masturation

Male:
1. Weekly summary
2. Attitudes towards and experience with masturbation

Couple:
1. Discussion of first half of session
2. Feedback on relaxation exercises
3. Film: The Sexological Examination (Sutton, 1973)
4. Discussion of the Sexological Examination

Homework:
1. Female: do first two steps of LoPiccolo and Lobitz (1972) Masturbation training. Also do Kegel exercises (1952)
2. Male: attempt masturbation and note physical sensations and cognitions
3. Couple: continue relaxation exercises
4. Attempt sexological examination at least 3 times
5. Reading: For Yourself (Barbach, 1975) Chapters 1-3

Session 3

Female:
1. Weekly summary

2. Discussion of masturbation attempts
3. Discussion of reading

Male:
1. Weekly summary
2. Discussion of masturbation attempts
3. Discussion of reading
4. Emphasis on value of foreplay

Couple:
1. Discussion of first half of session
2. Film: Handvoice (Sutton, 1970), Women on Orgasm (Breitrose, 1973)
3. Feelings on and or problems with male or female masturbation
4. Discussion of importance of foreplay
5. Importance of partners communicating masturbatory strategies

Homework:
1. Female: attempt masturbation
2. Couple: continue sexological examinations
3. Discuss preferred modes of foreplay
4. Finish and discuss For Yourself (Barbach, 1975)

Session 4

Female:
1. Weekly summary
2. Discussion of readings
3. Discussion of masturbation attempts
4. Self-monitoring of personal time
5. Use of fantasy and utilization of vibrators

Male:
1. Weekly summary
2. Discussion of readings

3. Discussion of premature ejaculation
4. Explanation of Semans (1956) and Masters and Johnson (1970) Squeeze Technique

Couple:
1. Discussion of first half of session
2. Film: Sexuality and Communication (Chernik and Chernik, 1975)
3. Discussion of film
4. Discussion of communication strategies including role-playing
5. Re-introduction of intercourse and summation of skills learned to date

Homework:

Female:
1. Continue masturbation if not successful try vibrator
2. Communication of pleasurable areas to partner

Couple:
3. List three instances where communication, sexual or general breaks down or becomes difficult
4. Reading: My Secret Garden (Friday, 1973)
5. Discussion of and perhaps re-introduction of intercourse

Session 5

Female:
1. Weekly summary
2. Discussion of readings
3. Discussion of masturbation

4. Discussion of attempts or thoughts about intercourse
5. Discussion of contraception and vaginal disorders
6. Practise of communication skills

Male:
1. Weekly summary
2. Discussion of readings
3. Discussion of attempts or thoughts about intercourse
4. Causes and treatment of impotence
5. Practice of communication skills

Couple:
1. Discussion of first half of session
2. Film: Squeeze Technique (Sutton, 1970)
3. Discussion of film and techniques for premature ejaculation and impotence
4. Role-play of communication strategies
5. Discussion of intercourse

Homework:
1. Practice communication skills
2. Try squeeze technique at least 4 times

Session 6

Female:
1. Weekly summary
2. Discussion of communication skills
3. Discussion of squeeze technique
4. Design maintenance list

Male:
1. Weekly summary
2. Discussion of communication skills

3. Discussion of squeeze technique
4. Design maintenance list

Couple:
1. Discussion of first half of session
2. Discussion of maintenance lists
3. Feedback about the program
4. Re-administration of the Sexual Arousal Inventory and the Sexual Satisfaction Index
5. Summation of skills learned

Homework:
1. Discussion of maintenance lists
2. Continue with the Sexual Behavior Index

3 Week Follow Up

1. Individual session
2. Sexual Satisfaction Index
3. Sexual Arousal Inventory

3 Month Follow Up

1. Individual session
2. Sexual Satisfaction Index
3. Sexual Arousal Inventory

APPENDIX VII

Tension Management

When people discuss the anxiety that they feel they typically report quite a bit of tenseness and anxiety in a variety of situations. This can take the form of stomach and neck becoming tense, pounding heart, sweaty palms, heavy breathing and so on. At the same time they frequently describe how difficult it is to focus attention on only the task at hand. Somehow their attention wanders away from what they are doing or what they are involved in, and they become preoccupied with irrelevant thoughts. Their thinking or self-statements, seem to get in the way of what they are attempting to do. They think about catastrophes and how terrible the consequences would be and these interfere with the way that one performs.

One goal of treatment is for you to become aware of the factors which are maintaining your anxiety. Once you know what these factors are you can change or combat them. One of the surprising things is that the factors contributing to anxiety are not something secretive but seem to be the thinking processes you go through in evaluation situations. Simply put, there seems to be a relationship between how anxious and tense people feel and the kinds of thoughts they are experiencing. For example, the anxiety you experience in a particular situation may be tied to the kinds of thoughts you had, what you chose to think about or how

you chose to focus your attention. Somehow your thinking gets all tied up with how you are feeling.

One purpose of these sessions will be to explore and share these feelings and thoughts. We will develop the ability to notice these thinking processes, to become aware of self-statements, and to see how we focus our attention. This may sound new to you, but you will probably come to see the role that thinking plays in influencing your behavior.

What is is that makes up anxiety? First of all, there is a heightened emotionality and tenseness. Secondly, there is worry or thinking processes which cause you to shift your attention to yourself and away from what it is you want to accomplish. Over the next little while we are going to work on ways to control how you feel; on ways of controlling your anxiety and tenseness. We will do this by learning how to relax. You will be trained to systematically relax all portions of your body. One of the advantages of learning how to relax is that the muscle systems in your body cannot be both tense and relaxed at the same time. Therefore, once you have learned the relaxation technique, you can use it to counter anxiety, tenseness and feelings like those you experienced in a variety of situations in the past.

In addition to learning and practicing the relaxation skills, you will learn how to control your thinking processes and

attention. The control of thinking or what we say to ourselves, comes about by first becoming aware of when we are producing negative self-statements, catastrophizing, being task irrelevant, etc. The recognition that we are in fact doing this will be a step forward in changing. This recognition will also act as a reminder; a cue for you to produce different thoughts and self-instructions, to challenge your thinking styles and to produce imcompatible task-relevant, self-instructions and incompatible behaviors. You will learn how to control your thinking processes by some specific techniques which will be described later on.

Some examples of negative self-statements are the following:

"people will laugh at me."

"I am afraid of looking ridiculous."

"I must achieve." "If I fail, then what?"

"I can't do anything. I'M inferior. I never could do anything."

"I don't know what to say. I'm coming across very badly," and so on.

The thinking processes of people who are tense and highly anxious might be categorized as follows:

1. Worrying about one's performance, including how well others are doing or might do as compared with himself.
2. Ruminating too long and fruitlessly over alternative answers or responses.

3. Being preoccupied with bodily reactions associated with anxiety.
4. Ruminating about possible consequences for doing poorly.
5. Concern about disapproval, punishment, loss of status or esteem, damage to one's work record.
6. Thoughts or feelings of inadequacy. These may include active self-criticism or self-condemnation - calling yourself stupid or considering yourself worthless.

Very often, people who are excessively tense and anxious, hold irrational belief and furthermore they act as if these irrational beliefs were in fact truth. For example:

1. I must be loved or approved by practically every significant person in my life and if I'm not, it's awful.
2. I must not make errors or do poorly and if I do, it's terrible.
3. People and events should always be the way I want them to be.

One way to counteract these irrational ideas in order that you may function more effectively, you might consider an alternative to these. For example:

1. It's definitely nice to have people's love and approval but even without it, I can still accept and enjoy myself.
2. Doing things well is satisfying but it's human to make mistakes.
3. People are going to act the way they want, not the way I want.

Basically, relaxation training consists of learning to tense and then relax various groups of muscles all through the body, while at the same time paying very close and careful attention to the feelings associated with both tension and relaxation. That is, in addition to learning how to relax, you will also learn how to recognize and pinpoint tension and relaxation as they appear in everyday situations as well as in the sessions here.

You should understand quite clearly that learning relaxation skills is very much like learning any other kinds of skill such as swimming, golfing, or riding a bicycle. In order for you to get better at relaxing you will have to practice it just as you would have to practice other skills. It's very important that you realize that progressive relaxation training involves learning on your part. There is nothing magical about the procedures. I will not be doing anything to you, I will merely be introducing you to the technique, directing your attention to various aspects of it, such as the presence of certain feelings in the muscles. Without

your active co-operation and regular practicing of the things you learn, the procedures are of little use.

As I mentioned, I'll be asking you to tense and then relax various groups of muscles in your body. You may wonder why, if we want to produce relaxation we start off by producing tension. The reason is that first of all everyone is always at some level of tension. If a person were not tense to some extent, he'd simply fall down. The amount of tension actually present in everyday life differs from individual to individual and we say that each person has reached some adaptation level in the amount of tension under which he operates day to day. The goal of progressive relaxation training is to help you learn to reduce muscles tension in your body far below your adaptation level at any time you wish to do so. In order to accomplish this I could ask you to focus your attention for example, on the muscles in your right hand and lower arm and to then just let them relax. Now you might think that you can let these muscles drop down below their adaptation level just by letting them go and to a certain extent you probably can. However, in progressive relaxation we want you to learn to produce larger and very much more noticeable reductions in tension and the best say to do this is first to produce a good deal of tension in the muscle group. That is, to raise the tension well above the adaptation level and then all at once release the

tension. The release creates a momentum which allows the muscles to drop well below the adaptation level.

Another important advantage to creating and releasing tension is that it will give you a good chance to focus your attention upon and become clearly aware of what tension really feels like in each of the various groups of muscles we will be dealing with. In addition, the tensing procedures will make a vivid contrast between tension and relaxation and will give you an excellent opportunity to directly compare the two and appreciate the difference in feelings associated with each of these states.

The purpose of the first session is to help you to learn to become deeply relaxed. Perhaps more relaxed than you've ever been before. We can begin by going over the muscle groups that we're going to be dealing with in relaxation training. At this point, there are 16 muscle groups to be dealt with. Sixteen groups which are tensed and relaxed. As your skill develops this number will be reduced significantly.

The significant muscle groups which will be dealt with are as follows:

1. Right hand and forearm.
2. Right bicep
3. Left hand and forearm

4. Left bicep.
5. Forehead.
6. Upper cheeks and nose.
7. Lower cheeks and jaws.
8. Neck and throat.
9. Chest, shoulders and upper back.
10. Abdominal or stomach region.
11. Right thigh.
12. Right calf.
13. Right foot.
14. Left thigh.
15. Left calf.
16. Left foot.

In learning to relax, the following sequence is observed:

1. Your attention is focussed on the muscle group on which you are working.
2. At a signal from me, the muscle group is tensed.
3. Tension is maintained for a period of 5 to 7 seconds.
4. At a predetermined cue the muscle group is released.
5. Your attention is maintained upon the muscle group as it relaxes.

To make this a little clearer, what we might do is go over all of the muscle groups that you'll be working on.

First of all, tense the muscles in the right hand and the right lower arm by making a tight fist. You should be able

to feel the tension in the hand, over the knucles and up into the lower arm. Hold that tension for a few seconds and now relax. Let all of the tension go. Now, concentrate on the feeling in your hand and in your lower arm when all of the tension is gone.

Now the right bicep. Tense these muscles by pushing your elbow down against the arm of the chair. You should be able to get a feeling of tension in the biceps without involving the muscles in the lower arm and hand. Just hold that tension for 5, 6, 7 seconds and then relax and concentrate on the feeling in your bicep when all of the tension is gone. Okay, now you will do the same with the left hand and forearm in the same way. Hold the tension, then relax. Just as you did with your other hand. Concentrate on the feeling when all the tension is gone. Now do the same thing with the muscles in the left bicep, just as you did with your right arm. Tense, hold the tension for a few seconds, concentrate on the feeling while it's tense. Now relax and concentrate on the feeling when all the tension is gone.

To make things a little easier, we'll divide the facial muscles into three groups. First the muscles in the forehead area, the upper part of the face; then the muscles in the central part of the face - the upper part of the cheeks and nose - and finally, the lower part of the face -

the jaws and the lower part of the cheeks. We can begin with the muscles in the upper part of the face and you can tense these muscles by lifting the eyebrows just as high as you can and getting tension in the forehead and up into the scalp region. Hold this tension, concentrate on the feeling while the muscles are tense and concentrate on the feeling when the tension is gone.

Now the muscles in the central part of the face. In order to tense these, squint your eyes very tightly and at the same time wrinkle up your nose and get tension through the central part of your face. You should be able to feel the tension in the upper part of the cheeks and through the eyes. Just concentrate on this - relax - and concentrate on the feeling when all the tension is gone. Next, tense the muscles in the lower part of your face by biting your teeth together and pushing your tongue against the roof of your mouth. Concentrate on the feeling in these muscles, relax and now concentrate on the feeling when the tension is gone.

Now we'll move on to relax the muscles in the neck. To do this, pull your chin down towards your chest and at the same time, try to prevent it from actually touching your neck. That is, counterpose the muscles in the front part of your neck against those of the back part of the neck. You should feel a little bit of shaking or trembling in these muscles as you tense them. Okay, now relax and concentrate

on the feeling when the tension is gone.

Now the muscles of the chest, shoulders and the upper back. Take a deep breath and hold it, while at the same time, pulling the shoulder blades together. That is, pull your shoulders back so that you are trying to make your shoulder blades touch. You should fee the tension in your chest, shoulders and upper back. Concentrate on the feeling here and relax and concentrate on the feeling when the tension is gone.

Now the muscles in the abdomen. Here, make your stomach hard. Just tense it up as though you were going to hit yourself in the stomach. You should feel a good deal of tension and tightness in the stomach area. Concentrate on the feeling, relax, and concentrate on the feeling when the tension is gone.

Now the muscles in the legs and the feet. We can begin with the right upper leg, the right thigh. Tense the muscles of your right upper leg by counterposing the one large muscle on top of the leg with the two smaller ones underneath. You should be able to feel that large muscle on top get quite hard. Hold the tension, concentrate on the feeling and relax and concentrate on the feeling when the tension has been removed.

Now the muscles of the right calf, the right lower leg. Tense the muscles here by pulling your toes up toward

your head. You should be able to feel tension all through the calf area. Concentrate on this feeling and relax. Concentrate on the feeling now.

Now the muscles of the right foot. In order to do this, point your toe away from your body while at the same time turning your foot inward and at the same time, curl your toes. Don't tense these muscles too hard. Just feel the tightness under the arch and the ball of the foot. Now relax and concentrate on the feeling with all the tensions gone.

Now the muscles in the left upper leg. Just tense and relax these as you did on the other side. Now do the muscles on the lower part of your left leg, and again using the same procedure, and finally the left foot - tensing and relaxing it as you did with your other foot.

This is the general procedure that you should follow when you're doing these exercises at home. Since learning to relax requires practice, what you should do is spend about 20 minutes in the morning going through these exercises and another 20 minutes in the early evening.

Once you have learned to tense and relax these 16 muscle groups it's possible then to combine some of the groups so as to reduce the amount of time required to go through the exercise. The first step is to reduce the original 16 groups to 7. These 7 groups are as follows:

1. All of the muscles in the left arm.
2. All of the muscles in the right arm.
3. All of the facial muscles.
4. The neck and the throat and this is the same as in the 16 group procedure.
5. The chest, shoulders, upper back and abdomen.
6. The muscles in the right leg.
7. The muscles in the left leg.

Once you have acquainted yourself with, and practised these 7 muscle groups they are reduced further to 4 muscle groups by combining various groups. These 4 are:

1. The muscles in both the right and left arms.
2. The muscles in the face and neck.
3. The muscles of the chest, neck, shoulders and abdomen.
4. The muscles in both left and right legs.

Having gone through all of these procedures, you should be able to relax very well. Once relaxation has been achieved there are a variety of strategies that can be used to achieve relaxation without the necessity of going through all of the exercises. These will be discussed in detail as we progress in the program.

Once you have learned to achieve deep muscle relaxation using the four muscle group procedure, you're ready to go on

to the next step. This is relaxation through recall.

Relaxation Through Recall

The recall procedure is quite different from what you have learned so far, in that no muscular tension and relaxation is required. However, it does require the full use of your ability to focus on tension and relaxation.

Relaxation with recall employs the same four muscle groups which you have been using to date. The procedure is to first of all seat yourself in a comfortable chair and now focus all your attention on the muscles of the arms and hands and very carefully identify any feeling of tightness or tension that might be present there now. Notice where this tension is and what it feels like. Concentrate on this for about 30 seconds and then relax and recall what it was like when you released these muscles after going through the exercises. Repeat this two or three or four times until you feel that the muscles in your hands and arms are completely relaxed.

Now you do the same thing with all the muscles in the face and the neck. Focus your attention on these muscles, recall what it felt like when you released the tension in these muscles and try to achieve the same sensation. Concentrate on this for about 30 seconds and then repeat it three or four times until the feeling and sensation you get is

similar to those after having done the exercises.

Now you just do the same thing with the third muscles group which includes the chest, shoulders, back and abdomen. When you are able to relax these muscles by recall, go on to the fourth muscle group, those in both legs and feet.

If you experience any difficulty in achieving relaxation while doing these exercises, go back and tense the muscles in question and then let them relax.

Relaxation by Recall with Counting

This is simply an extension of the Relaxation by Recall and the procedure is: Once having gone through a recall session where you have achieved a reasonable degree of relaxation, you can deepen this relaxation by counting. The procedure for this is to become relaxed and then to count to yourself from 1 to 10. As you count allow all the muscles throughout your body to become even more deeply and more completely relaxed at each count. What you might do to facilitate this is to have your counting coincide with exhaling. Every time you exhale add one more number. As you count you should be able to feel yourself becoming more and more relaxed. You just focus your attention on all the muscles in the body and notice them as they become more and more deeply relaxed.

Another strategy for achieving this is to ralate the counting to particular muscle groups so that you might say to yourself: "1, 2, my hands and arms are becoming more and more relaxed. 3, 4, the muscles in my face and my neck are becoming more and more relaxed. 5, 6, the muscles in my chest, shoulders, back and abdomen, are relaxing even more deeply. 7, 8, the muscles in my legs and feet are becoming more and more relaxed, 9, 10."

The relaxation by recall and relaxation by recall with counting should be practiced every day for a week or two or until you are able to achieve a fairly deep feeling of relaxation by the end of each session.

Differential Relaxation

Differential relaxation is one of the most common applications of the basic progressive relaxation skill. When you are involved in some activity, a variety of muscles become tensed during this. Muscles necessary for the accomplishment of an activity are frequently more tense than they need be and the muscles unnecessary for efficient performance become tense during the activity. In both cases there is residual tension which contributes nothing to the behavior and which needlessly increases psychological stress. Ideally, in terms of conservation of energy, and maintenance of a low tension level, only those muscles directly relevant to an activity should be tense only to the degree required for

the efficient performance of the activity. Differential relaxation can help you to approach this ideal situation. Deep relaxation is induced and maintained in the muscles not required for the ongoing activity. For muscles involved in the activity, excess tension is eliminated. Only the amount of tension necessary for behavioral performance remains. The result is that you can perform most daily activities with a minimum of tension and a maximum of relaxed comfort. Proper and consistent use of differential relaxation has three advantages. First, for any individual involved in progressive relaxation training it provides many opportunities to practice and thus improve the skill of relaxation. Second for chronically tense individuals it helps maintain lowered arousal throughout the day. Third, for individuals who become tense only in particular situations it allows for situation specific relaxation.

The procedure involves the periodic identification of tension during daily activities and the subsequent relaxation of muscles that are unnecessarily tense. Identification of tension is one of the skills that are learned during progressive relaxation training. Relaxation of those muscles identified as tense may then be accomplished by using either tension release cycles or recall.

The program for differential relaxation involves a series of practice steps beginning with relatively quiet

activities, non-essential muscles predominate and practise is similar to basic relaxation. As you continue with more complex behaviors, tension identification and elimination become quite easy.

There are three continuae over which the practice may develop. Lower levels of each continuum involve less distraction and you may more easily concentrate on the relaxation process. The three continuae are situation, position and activity level. Situation varies from being alone in a quiet room to being with others in a noisy place. Position varies from sitting to standing. Activity level ranges from inactivity to routine, complex levels.

You should first practice defining essential and non-essential muscles groups for various activities. It's important that you not only become aware of the necessary muscle groups involved but can also identify and be sensitive to the non-essential ones. The way to achieve this is to think about the various daily activities in terms of the muscles groups required for their performance.

There is a fair amount of homework in learning differential relaxation. What this means is practicing in a variety of situations. The scheduling of practice can follow 8 steps. These steps along with some examples of each are as follows:

1. Sitting, non-active, in a quiet place, e.g., sitting upright in a chair in the bedroom.
2. Sitting, non-active, in a non-quiet place, e.g., sitting in a cafeteria.
3. Sitting in an active, quiet place, e.g., typing in a study.
4. Sitting in an active, non-quiet place, e.g., eating in a cafeteria.
5. Standing, non-active, in a quiet place, e.g., standing in a living room.
6. Standing in a non-active,non-quiet place, e.g., waiting in line for a bus.
7. Standing active in a quiet place, e.g. working alone at a counter, perhaps at home.
8. Standing in an active, non-quiet place, e.g., walking on a street downtown.

The first step involves a transition from the usual relaxation practice position (all muscles supported, eyes closed) to a common sitting posture (head supportec by neck muscles, eyes open). You should periodically relax all muscle groups by using either the tension release cycles or by recall. There will be residual tension remaining in the eyes and neck muscles, but this tension should be minimal. All other muscles are to be relaxed.

Steps 2 through 8 involve increasing distraction as well as activity in more muscle groups. The procedure is the same. First identify and then eliminate the tension in each non-essential muscle. There is no need to be concerned about residual tension in muscles required for performance of ongoing behavior.

Your progress through these 8 steps should be determined by your ability to relax non-essential muscles deeply and to relax essential muscles to the point where tension in them is not uncomfortable. Once this goal is consistently achieved at one step you may continue to the next step, proceeding at your own rate. The speed of progress depends upon the frequency and the quality of practice. A reasonable time table would be, the first week step 1, the second week steps 2, 3, and 4; the third week steps 5, 6, 7, and 8. This time table assumes that you are adept at the four muscle group relaxation stage and that your practice each differential relaxation step for about 5 minutes, four times a day. Once you are able to relax fairly well in step 8, you should periodically throughout the day practice relaxation. The ultimate goal might be characterized by the following example. A man is driving to work. He needs to use the muscles of his eyes, neck, arms, hands, right foot and leg. After starting the motor he identifies tension and relaxes in each of the four muscle groups, all in about 60 seconds. As he is driving he may periodically

notice tension in unused muscles or discomfort in used muscles. This may be quickly eliminated by recall. He parks his car and walks a few blocks to his place of work. As he is walking he relaxes some tension in his facial and trunk muscles. At his desk he gets comfortably seated and spends a few seconds eliminating tension in all muscles. He repeats this each time he sits down. Further, while doing paper work, if he notices uncomfortable tension in his writing arm he spends a moment relaxing it by recall.

There are two things that you should know about this procedure. First, it is not intended that non-essential muscles be completely inactive. The idea is to limit activity to a minimum but not to such an extent that ongoing behavior is disrupted. Second, although it initially takes some deliberate effort to remember to use differential relaxation procedures, as the skill increases it becomes habitual and very little time and effort are required.

Conditioned Relaxation

The goal of conditioned relaxation training is to enable to achieve relaxation in response to a self-produced cue. That is, after you've mastered the progressive relaxation, you learn an association between the resulting deeply relaxed state and a self produced cue word such as 'calm, relax, control', or something similar. The way in which this is achieved is by first of all being seated in a comfortable chair and becoming completely relaxed. When you reach this

stage then sub-vocally, to yourself, you say the cue word 'calm, relax, control' or whatever. The cue coincides with your exhaling, i.e., every time you breathe out you say to yourself, 'relax'. You should spend about 5 minutes doing this at each session and this should be repeated at least once daily for at least two weeks. Following this you then practice using the cue word in a variety of situations; perhaps as described in the differential relaxation. For example, if you are standing in an elevator or if you're driving your car and you notice some excess tension in some muscles, you practice releasing this tension simply by providing yourself with the sub-vocal cue.

This is the kind of exercise that you can do almost anywhere, any time. As with other aspects of relaxation training, the more practice you have doing this, the more effective it is going to be. If this is done conscientiously, within a couple of months you should have this mastered to the point where you can turn off tension simply by cuing yourself.

APPENDIX VIII

Reading List

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APPENDIX IX

Means and Standard Deviations (in Parentheses) of the Sexual Arousal Inventory at Pretreatment, Final Session, Three Week and Three Month Follow-Ups (Final Three Measures are Adjusted for Covariates).

Assessment Period	Individual	Group	Control
	$\bar{X}$ SD	$\bar{X}$ SD	$\bar{X}$ SD
Pretreatment	69.00(22.23)	68.81(18.97)	75.25(25.51)
Final Session	79.88(12.83)	79.14(15.61)	71.08(23.15)
Three Week Follow-Up	91.24(13.81)	84.00(20.13)	69.69(22.86)
Three Month Follow-Up	96.25(15.74)	95.39(17.72)	69.68(23.14)

Analysis of Variance for Sexual Arousal Inventory - Pretreatment Data

Source	df	SS	MS	F	Prob.
Treat	2	188.06	94.03	0.196	0.8211
Error	24	11362.01	473.42		
Total	26	11550.07			

Analysis of Covariance for Sexual Arousal Inventory-Final Session Data

Source	df	SS	MS	F	Prob.
Treat	2	327.25	163.62	1.078	0.3601
Error	23	3509.92	152.61		
Total	26	6726.79			

APPENDIX IX (continued)

Analysis of Covariance for Sexual Arousal Inventory - Three Week Follow-Up

Source	df	SS	MS	F	Prob.
Treat	2	1726.10	863.05	3.456	0.0462
Error	23	5671.88	246.60		
Total	26	9670.50			

Analysis of Covariance for Sexual Arousal Inventory - Three Month Follow-Up

Source	df	SS	MS	F	Prob.
Treat	2	3136.26	1568.13	5.593	0.0083
Error	23	6059.45	263.45		
Total	26	10625.50			

APPENDIX X

Means and Standard Deviations (in Parentheses) on Subtests of the Sexual Satisfaction Index at Pretreatment, Final Session, Three Week and Three Month Follow-Up (Final Three Measures are Adjusted for Covariates)

Assessment Period	Individual	Group	Control
	$\bar{X}$ SD	$\bar{X}$ SD	$\bar{X}$ SD
Pretreatment			
general satisfaction	17.45 (7.86)	14.13 (5.05)	13.00 (9.38)
communication satisfaction	14.90 (6.40)	12.18 (4.87)	10.25 (7.03)
orgasm satisfaction	15.25 (5.24)	19.45 (3.36)	15.58 (6.24)
sexuality satisfaction	6.25 (2.62)	7.59 (1.26)	6.26 (2.44)
relationship satisfaction	9.00 (2.83)	7.00 (3.00)	6.50 (3.31)
Final Session			
general satisfaction	28.73 (5.21)	22.78 (11.88)	12.50 (4.33)
communication satisfaction	17.76 (3.96)	17.80 (4.98)	9.32 (4.46)
orgasm satisfaction	22.55 (5.31)	20.26 (4.61)	13.68 (4.86)
sexuality satisfaction	9.57 (2.17)	9.07 (1.54)	6.23 (2.01)
relationship satisfaction	8.68 (1.34)	7.58 (2.91)	5.37 (2.97)

APPENDIX X (Continued)

Means and Standard Deviations for Sexual Satisfaction Index Continued

Assessment Period	Individual		Group		Control	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Three Week Follow-Up						
general satisfaction	25.52	(6.04)	19.72	(8.69)	12.30	(8.16)
communication satisfaction	16.72	(5.10)	16.22	(4.92)	10.05	(4.59)
orgasm satisfaction	21.22	(5.85)	18.68	(3.31)	14.28	(5.47)
sexuality satisfaction	8.55	(1.84)	8.83	(0.95)	6.22	(2.01)
relationship satisfaction	8.80	(1.34)	7.43	(2.91)	5.44	(2.97)
Three Month Follow-Up						
general satisfaction	26.55	(11.98)	27.57	(12.16)	12.67	(7.40)
communication satisfaction	17.16	(7.28)	19.31	(5.27)	8.98	(4.46)
orgasm satisfaction	20.93	(9.15)	23.68	(4.99)	13.01	(4.86)
sexuality satisfaction	9.13	(3.47)	9.90	(1.52)	6.20	(2.01)
relationship satisfaction	8.46	(3.55)	8.67	(3.44)	5.90	(3.27)

APPENDIX X (Continued)

Multivariate Analysis of Variance for Sexual Satisfaction Index Pretreatment Data

Wilks Summary Table

Source	Wilks Lambda	df	Approx. F.	df	Prob.
A	6.5342E-01	5,2,24	0.9484	10.00, 40.00	0.5014

Analyses of Covariance for Sexual Satisfaction Index-Final Session Data

Source	df	SS	MS	F	Prob.
		Satisfaction General			
Treat	2	620.61	310.30	8.7913	0.0015*
Error	23	811.83	35.30		
Total	26	2442.67			
		Satisfaction Communication			
Treat	2	181.16	90.58	8.2249	0.0021*
Error	23	253.30	11.01		
Total	26	937.46			
		Satisfaction Orgasm			
Treat	2	180.67	90.33	11.00	0.0005*
Error	23	118.87	8.21		
Total	26	811.41			

*When significant ANCOVA retested against its own covariate only

APPENDIX X (Continued)

Source	df	SS	MS	F	Prob.
		Satisfaction Sexuality			
Treat	2	28.22	14.11	12.16	0.0003*
Error	23	26.67	1.16		
Total	26	103.91			
		Satisfaction Relationship			
Treat	2	38.164	19.08	5.41	0.0118*
Error	23	81.17	3.53		
Total	26	232.00			

Analyses of Covariance for Sexual Satisfaction Index - Three Week Follow-Up

Source	df	SS	MS	F	Prob.
		Satisfaction General			
Treat	2	933.91	466.95	8.8412	0.0015*
Error	23	1214.77	52.82		
Total	26	3371.63			
		Satisfaction Communication			
Treat	2	316.95	158.47	14.5570	0.0001*
Error	23	250.39	10.89		
Total	26	982.02			

*When significant ANCOVA retested against its own covariate only

APPENDIX X (Continued)

Source	df	SS	MS	F	Prob.
		Satisfaction Orgasm			
Treat	2	301.67	150.84	15.913	0.0006*
Error	23	218.059	9.48		
Total	26	986.407			
		Satisfaction Sexuality			
Treat	2	45.01	22.50	10.57	0.0006*
Error	23	48.95	2.13		
Total	26	143.79			
		Satisfaction Relationship			
Treat	2	32.031	16.1555	4.366	0.0131
Error	19	84.370	3.668		
Total	26	245.78			

Analyses of Covariance for Sexual Satisfaction Index - Three Month Follow-Up

Source	df	SS	MS	F	Prob.
		Satisfaction General			
Treat	2	955.147	477.573	5.2493	0.0131*
Error	23	2092.492	90.977		
Total	26	4379.166			

*When significant ANCOVA retested against its own covariate only

APPENDIX X (Continued)

Source	df	SS	MS	F	Prob.
		Satisfaction Communication			
Treat	2	416.110	208.055	6.6051	0.0055*
Error	23	724.486	31.499		
Total	26	1382.666			
		Satisfaction Orgasm			
Treat	2	417.975	108.987	4.5730	0.0210*
Error	23	1051.100	45.700		
Total	26	1684.629			
		Satisfaction Sexuality			
Treat	2	52.829	26.414	4.9546	0.0161*
Error	23	122.619	5.331		
Total	26	227.129			
		Satisfaction Relationship			
Treat	2	39.845	19.922	1.9740	0.1643
Error	19	191.754	10.092		
Total	26	339.240			

*When ANCOVA significant retested against its own covariate only

APPENDIX XI

Means and Standard Deviations (in Parentheses) on Male Items of the Sexual Behavior Index at Pretreatment, First Three Weeks of Treatment, Last Two Weeks of Treatment and Three Week Follow-Up (Final Three Measures are Adjusted for Covariates)

Assessment Period	Individual		Group		Control	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Pretreatment						
Non-sexual massage	1.100	(1.370)	1.455	(1.695)	1.333	(1.366)
Sensate focus female breasts	6.6000	(5.641)	3.273	(2.76)	1.667	(4.320)
Sensate focus gemale genitals	2.500	(2.173)	1.455	(1.440)	2.665	(2.582)
Intercourse	2.100	(1.853)	0.909	(1.136)	2.000	(1.673)
First Three Weeks of Treatment						
Non-sexual massage	3.861	(2.415)	1.390	(1.489)	1.350)	(1.366)
Sensate focus female breasts	6.583	(5.978)	4.883	(2.982)	2.742	(3.120)
Sensate focus female genitals	2.351	(1.418)	2.448	(1.300)	1.762	(.931)

APPENDIX XI (Continued)

Assessment Period	Individual		Group		Control	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Last Two Weeks of Treatment						
Non-sexual massage	3.138	(2.846)	1.668	(1.662)	1.378	(1.225)
Sensate focus female breasts	6.776	(4.142)	6.297	(2.979)	2.662	(3.656)
Sensate focus female genitals	2.576	(1.059)	2.144	(1.136)	2.275	(2.510)
Intercourse	1.348	(1.265)	1.665	(1.272)	1.367	(1.211)
Three Week Follow-Up						
Non-sexual massage	3.034	(2.470)	2.574	(2.461)	1.392	(1.225)
Sensate focus female breasts	7.247	(3.498)	6.620	(5.729)	2.785	(3.327)
Sensate focus female genitals	3.142	(1.494)	2.660	(1.753)	1.720	(1.835)
Intercourse	3.652	(1.287)	3.826	(1.214)	1.425	(1.119)

APPENDIX XI(Continued)

Multivariate Analysis for Sexual Behavior Inventory Male - Pretreatment Data

Source	Wilks Lambda	df	Approx. F.	df	Prob.
A	6.1312E-01	4,2,24	1.4202	8.00, 41.00	0.1273

Analyses of Covariance for Sexual Behavior Inventory Male First Three Weeks of Treatment

Source	df	SS	MS	F	Prob.
		Non-Sexual Massage			
A	2	30.703566	15.351783	12.029476	0.0006*
Error	23	29.352152	1.2761805		
Total	26	107.629630			
		Sensate Focus Female Breasts			
A	2	15.190268	7.595134	0.6494	0.05370
Error	21	245.613577	11.695884		
Total	26	782.74071			
		Sensate Focus Female Genitals			
A	2	1.615414	8.077067E-01	0.6609	0.5312
Error	21	25.664004	1.222095		
Total	26	73.185185			

*When significant ANCOVA retested against its own covariate only

APPENDIX XI (Continued)

Analyses of Covariance for Sexual Behavior Inventory - Male
Last Two Weeks of Treatment

Source	df	SS	MS	F	Prob.
		Non-Sexual Massage			
A	2	12.256578	6.128288	1.5460	0.2366
Error	20	79.280126	3.964005		
Total	26	117.407407			
		Sensate Focus Female Breasts			
A	2	51.520297	25.760147	4.4500428	0.0373*
Error	23	133.141052	5.7887413		
Total	26	396.000000			
		Sensate Focus Female Genitals			
A	2	8.235406E-01	4.117703E-01	0.3355	0.7228
Error	20	24.549448	1.227472		
Total	26	58.000000			
		Intercourse			
A	2	5.341686E-01	2.670842E-01	0.3056	0.7433
Error	20	17.478426	8.739213E-01		
Total	26	38.740741			

*When significant ANCOVA retested against its own covariate only

APPENDIX XI (Continued)

Analyses of Covariance for Sexual Behavior Inventory Male - Three Week Follow-Up

Source	df	SS	MS	F	Prob.
		Non-Sexual Massage			
A	2	7.413822	3.706861	0.7344	0.4962
Error	20	100.950734	5.047536		
Total	26	130.740741			
		Sensate Focus Female Breasts			
A	2	59.348206	29.674103	1.9560	0.1659
Error	20	303.423003	15.171149		
Total	26	590.000000			
		Sensate Focus Female Genitals			
A	2	5.487315	2.743657	1.4867	0.2493
Error	20	36.908916	1.845446		
Total	26	76.296296			
		Intercourse			
A	2	8.554402	4.277201	5.548397	0.0193*
Error	23	17.730460	.7708895		
Total	26	51.851852			

*When significant ANCOVA retested against its own covariate only

APPENDIX XI (Continued)

Means and Standard Deviations (in Parentheses) of Pretreatment, First Three Weeks of Treatment, Last Two Weeks of Treatment and Three Week Follow-Up on Female Items of the Sexual Behavior Inventory (All Data Except Pretreatment Are Adjusted for Covariate

Assessment Period	Individual	Group	Control
	$\bar{X}$ SD	$\bar{X}$ SD	$\bar{X}$ SD
Pretreatment			
massage	0.900 (1.853)	2.182 (1.940)	1.667 (1.862)
sensate focus male genitals	2.600 (3.565)	2.727 (3.409)	1.685 (2.251)
orgasm through masturbation	0.100 (0.001)	1.000 (1.612)	1.000 (1.265)
orgasm through foreplay	0.100 (0.316)	0.273 (0.647)	0.667 (1.211)
intercourse	2.200 (2.044)	1.182 (1.471)	1.667 (1.506)
orgasm through intercourse	0.010 (0.213)	0.000 (0.000)	0.500 (0.837)
First Three Weeks of Treatment			
massage	2.749 (2.273)	1.322 (1.128)	1.828 (1.602)
sensate focus male genitals	4.010 (3.028)	1.328 (1.348)	1.883 (2.000)
orgasm through masturbation	1.389 (1.059)	0.962 (2.014)	0.588 (1.095)
orgasm through foreplay	0.349 (.316)	0.258 (0.647)	0.613 (1.549)

APPENDIX XI (Continued)

Assessment Period	Individual		Group		Control	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Last Two Weeks of Treatment						
massage	3.180	(2.658)	1.535	(1.578)	1.719	(1.211)
sensate focus male genitals	4.501	(2.263)	3.132	(1.328)	0.756	(1.211)
orgasm through masturbation	1.157	(1.889)	2.533	(1.695)	0.429	(0.518)
orgasm through foreplay	0.652	(0.972)	0.463	(0.820)	-0.102	(0.010)
intercourse	2.292	(1.317)	1.230	(1.272)	0.593	(0.516)
orgasm through intercourse	0.381	(0.675)	-0.005	(0.302)	0.041	(0.015)
Three Week Follow-Up						
massage	2.892	(2.369)	1.991	(1.902)	1.531	(1.211)
sensate focus male genitals	3.755	(2.669)	2.488	(1.662)	1.013	(1.602)
orgram through masturbation	1.837	(1.567)	2.047	(2.272)	-0.6449	(0.000)
orgasm through foreplay	1.248	(1.101)	1.206	(1.079)	-0.292	(0.000)
intercourse	2.614	(1.287)	2.479	(1.293)	0.941	(0.516)
orgasm through intercourse	0.546	(1.075)	0.336	(0.505)	0.309	(0.408)

APPENDIX XI (Continued)

Multivariate Analysis for Sexual Behavior Inventory Female - Pretreatment Data

Source	Wilks Lambda	df	Approx. F.	df	Prob.
A	4.4031E-01	6,2,24	1.5633	12.00, 37.00	0.1459

Analyses of Covariance for Sexual Behavior Inventory Female - First Three Weeks of Treatment

Source	df	SS	MS	F	Prob.
		Non-Sexual Massage			
A	2	8.185611	4.092805	1.4704	0.2530
Error	20	55.669037	2.783451		
Total	26	76.962963			
		Sensate Focus Male Genitals			
A	2	29.388778	14.694388	4.4058678	0.0383*
Error	23	76.709274	3.3351858		
Total	26	138.66667			
		Orgasm Through Masturbation			
A	2	1.811297	9.056485E-01	0.7407	0.4933
Error	20	24.452446	1.222622		
Total	26	58.962963			

*When significant ANCOVA retested against its own covariate only

APPENDIX XI (Continued)

Source	df	SS	MS	F	Prob.
		Orgasm Through Foreplay			
A	2	7.827352	3.913675	4.4502	0.0229*
Error	23	20.226995	8.794345E-01		
Total	26	28.666667			
		Intercourse			
A	2	22.115030	11.057514	8.7780	0.0015*
Error	23	28.972690	1.259682		
Total	26	58.666667			
		Orgasm Through Intercourse			
A	2	1.950267E-01	9.751332E-02	0.1383	0.8682
Error	18	12.688484	7.049156E-01		
Total	26	14.518519			

Analyses of Covariance for Sexual Behavior Inventory Female - Last Two Weeks of Treatment

Source	df	SS	MS	F	Prob.
		Non-Sexual Massage			
A	2	10.534655	5.267327	1.3068	0.2952
Error	18	72.550550	4.030585		
Total	26	102.074074			

*When significant ANCOVA retested against its own covariate only

APPENDIX XI (Continued)

Source	df	SS	MS	F	Prob.
		Sensate Focus Male Genitals			
A	2	34.433775	17.216873	6.9145	0.0045
Error	23	57.269550	2.489980		
Total	26	116.666667			
		Orgasm Through Masturbation			
A	2	15.952634	7.976316	3.5339	0.0450
Error	23	51.912672	2.257072		
Total	26	80.66667			
		Orgasm Through Foreplay			
A	2	1.307926	6.539630E-01	1.0095	0.3859
Error	18	11.660167	6.477870E-1		
Total	26	16.518519			
		Intercourse			
A	2	7.285159	3.642579	3.0608	0.0705
Error	18	21.421323	1.190073		
Total	26	42.740741			
		Orgasm Through Intercourse			
A	2	5.778053E-01	2.889026E-01	1.8724	0.1881
Error	18	2.777319	1.542955E-01		
Total	26	5.407407			

*When significant ANCOVA retested against its own covariate only

APPENDIX XI (Continued)

Analyses of Covariance for Sexual Behavior Inventory Female - Three Week Follow-Up

Source	df	SS	MS	F	Prob.
		Non-Sexual Massage			
A	2	4.849964	2.424981	0.5586	0.5864
Error	18	78.136504	4.340917		
Total	26	96.666667			
		Sensate Focus Male Genitals			
A	2	17.003969	8.601984	2.1559	0.1431
Error	18	70.984848	3.943603		
Total	26	122.296296			
		Orgasm Through Masturbation			
A	2	20.100191	10.050096	3.4451	0.0531
Error	18	52.509859	2.917214		
Total	26	92.296296			
		Orgasm Through Foreplay			
A	2	7.827352	3.913675	4.4502	0.0229*
Error	23	20.226995	8.7943		
Total	26	28.666667			

*When significant ANCOVA retested against its own covariate only

APPENDIX XI (Continued)

Source	df	SS	MS	F	Prob.
		Intercourse			
A	2	22.115030	11.057514	8.7780	0.0015*
Error	23	28.972690	1.259682		
Total	26	58.666667			
		Orgasm Through Intercourse			
A	2	1.950267E-01	9.751332E-02	0.1383	0.8682
Error	18	12.688484	7.049158E-01		
Total	26	14.518519			

*When significant ANCOVA retested against its own covariate only

APPENDIX XII

Correlations For Male and Female Responses to the Sexual Behavior Inventory at Baseline and Three-Week Follow-Up

Item	Baseline	Three Week Follow-Up
*1	.366	.049
*2	.239	.051
3	.874	.893
4	.783	.934
5	.822	.971
6	.753	.897
7	.768	.911
8	.789	.930
9	.726	.899
10	.814	.950
11	.795	.920
12	.819	.835
*13	.275	.561
*14	.385	.508

*Discarded Items