A CONTROLLED COMPARATIVE EVALUATION OF CONJOINT COUNSELLING AND SELF-HELP BEHAVIOURAL TREATMENT FOR SEXUAL DYSFUNCTION

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Thesis submitted for
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C O N T E N T S

CHAPTER 12./.....

Acknowledgements

I am indebted to the following for their help with this project:

Professor M.R. Bond, Department of Psychological Medicine, University of Glasgow, who supervised and reviewed the manuscript;

Dr. J.G. Greene, Principal Psychologist, and Mr. D.J. Cooke, Senior Psychologist, both of Gartnavel Royal Hospital, for their advice on research methodology, statistics and computer use;

Dr. J. Bancroft, M.R.C. Reproductive Biology Unit, Edinburgh, for his valuable advice and inspiration;

Dr. R. Lyle, Principal Psychologist, Stobhill General Hospital, and Dr. D.N. Brooks, Senior Lecturer, Department of Psychological Medicine, University of Glasgow, for reviewing the final draft;

Dr. J. Greenwood, Community Psychiatrist, Edinburgh, and Dr. J. Bancroft for use of selected parts of their guide, "Counselling for Sexual Problems", in the preparation of the self-help booklets;

Professor William L. Mikulas and Dr. John C. Lowe, University of West Florida, for providing a copy of their therapy guide on which the self-help booklets in this study were modelled and

Miss Mina Parks for typing the thesis.

Finally, I am deeply grateful to all the patients who participated in the study, and to my wife, Lillian, and to my children, Claire and Ross, for their encouragement, patience, and for all they have sacrificed.

ABBREVIATIONS

MJ	a modified Masters and Johnson treatment approach, involving both directed practice and counselling as defined in full in the text.
SH	a self-help minimal contact "bibliotherapy" approach based on Masters and Johnson's behavioural or directed practice component
WT	Waiting-List Control Group
FSU	Female Sexual Unresponsiveness
VAG	Vaginismus
PE	Premature Ejaculation
EI	Erectile Impotence
ANOVA	Analysis of Variance
ANCOVA	Analysis of Covariance

INTRODUCTION

Based on a somewhat unrefined and restricted aetiological view of sexual inadequacy, early behavioural treatments for male and female sexual dysfunction tended to be based mainly on anxiety reduction principles in which systematic desensitisation figured prominently. With the publication in 1970 of Masters and Johnson's work on treatment, a new emphasis was placed on the couple and their relationship as a whole, their attitudes to sexuality and the effectiveness of their communication. These aspects of treatment, however, became submerged to some extent by the wave of enthusiasm which accompanied the introduction of a new "treatment package", viz. sensate focus and other specific behavioural directives. To some extent, therefore, the theoretical basis and other more practical aspects of Masters and Johnson's treatment have been poorly understood and variously interpreted.

In general, there has also been a paucity of sound empirical evidence for the efficacy of this approach, both as conducted by Masters and Johnson themselves and, in modified form, by others. There is some consistent evidence, however, that some aspects of their original treatment recommendations (e.g. the use of dual sex co-therapy teams, and frequent intensive counselling sessions) may not be wholly justified on cost-effectiveness grounds. The relative importance of the two main components of their prodedure, viz. directed practice and counselling, has also been investigated. They have been shown to interact to potentiate change through the identification and resolution of attitudes, marital conflicts and other "resistances" to behavioural progress.

Nevertheless, the response to behavioural directives alone (i.e. in the absence of regular intensive counselling) appears to be particularly variable, producing marked benefit for some couples, but little or none for others. It is still unclear, however, which factors relate to outcome, particularly with a minimal counselling approach. This issue, it is proposed, may be clouded by the practice of comparing, as a whole, treatment groups which are heterogeneous for type of dysfunction, since not all forms of dysfunction may be equally amenable or responsive to behavioural directives alone. That such a

preliminary examination of the relationship between individual differences and treatment response should focus first on form of dysfunction is suggested by the differing behavioural features and demands of treatment for the separate dysfunctions, their differing proposed aetiologies and other distinctive characteristics of the problems themselves.

A second factor prompting further examination of minimal contact approaches for sexual dysfunction is the current proliferation of "self-help" behavioural programmes, and their expected continued growth and availability, in the absence of any adequate empirical evaluation.

Other factors underscoring the need for further research in this field is the potential value of self-help programmes in increasing the cost-effectiveness of our treatment methods and their relationship to aspects of patient compliance with therapy.

The present study, therefore, is an attempt to conduct a controlled comparative evaluation of a modified Masters and Johnson approach (involving both directed practice and counselling) and a minimal contact "self-help" procedure based on similar behavioural lines (directed practice with minimal counselling) in the treatment of sexual dysfunction. A waiting-list control group is also included.

A separate comparison of treatment outcomes within and across each of four major dysfunctional categories is also conducted since a significant interaction between treatment and problems may have important implications for the design and analysis of future research in this field.

Based on the results of previous related research and the theoretical basis of counselling, two hypotheses of a superiority of directed practice plus counselling over directed practice alone in facilitating greater marital adjustment and sexual attitude change are also proposed.

Abstract

Forty-eight couples representing four of the most commonly referred forms of sexual dysfunction in this country (viz. female sexual unresponsiveness, vaginismus, premature ejaculation and erectile impotence) were treated by either a modified form of Masters and Johnson's approach (i.e. directed practice and once weekly counselling with a single therapist) or a minimal contact bibliotherapy programme, based on the same behavioural lines. Half of the couples were randomly allocated to a no treatment control condition before receiving either therapy.

Treatment effects with both approaches were evident but those of the self-help approach were more circumscribed with respect to not only the sexual but also the non-sexual relationship. Thus, some evidence was obtained in support of the hypotheses that practice plus counselling would be superior to self-help in facilitating change in the general relationship and in sexual attitudes.

However, a wide range of significant pre-treatment differences among the four problem subgroups comprising the sample was found. In particular, the sexually unresponsive female complainants reported less satisfaction with the general relationship, whereas the reported difficulties of those with vaginismus were less generalised, being restricted mainly to coital fears. In general higher baseline levels, i.e. less disturbance of the sexual and marital relationship, were reported by each of the two male subgroups.

There was also evidence that the differential response to the two treatments was not uniform across forms of sexual dysfunction. As hypothesised, guided practice plus counselling was significantly more effective than the self-help regime in enhancing marital and sexual adjustment for female unresponsiveness. On the other hand, in contrast to other problem subgroups, vaginismus was shown to respond favourably to both treatments. In general, few significant changes with either treatment and few notable differences between treatments, were observed within the male problem subgroups.

The implications of these results for the design and analysis of future treatment outcome research in this field are discussed.

CHAPTER 1

FORMS OF SEXUAL DYSFUNCTION - DEFINITIONS AND AETIOLOGY

In general behavioural terms, sexual dysfunctions may be construed as resonses to sexual stimulation that the complainants* and/or their partners* consider to be inadequate. The responses involved may include sexual interest, desire, excitement, responsiveness, intromission, orgasm or pleasure and may be affected in different ways to lead, in some individuals, to a disturbance of sexual functioning. This dysfunction may take one, or more, of the following forms - erectile impotence, premature ejaculation, retarded or absent ejaculation and retrograde ejaculation in the male; general unresponsiveness, vaginismus and orgasmic dysfunction in the female; and inhibited or hypoactive sexual desire, inadequate sexual pleasure and dyspareunia in both sexes.

The disorders of principal interest in the present study are erectile impotence, premature ejaculation, female sexual unresponsiveness and vaginismus. Results of surveys, conducted among both clinical and non-clinical samples, indicate that they represent four of the five most common forms of sexual dysfunction (Bancroft and Coles, 1976; Frank et al, 1978; Levine and Yost, 1976). Female anorgasmia, in which the principal difficulty is attaining orgasm, is not included in the present study, as this was found to be a relatively infrequent problem. Although this accords with Bancroft's (1975) findings in Oxford, it contrasts with Masters and Johnson's (1970) series where this was classed as the most common female dysfunction. They used the term, however, in a broader, if not misleading way, to encompass more generalised 'excitement phase' disorders.

The four problems above may be defined as follows:

Erectile Impotence

For the purposes of this study, this dysfunction refers to the inability to obtain or maintain erectionssufficient for vaginal

* For descriptive ease, the term 'complainant' is consistently used here to refer to that individual within the partnership who is considered to have the main form of sexual dysfunction. The non-complainant is consistently referred to as the 'partner'.

penetration and coitus on at least 75% of coital experiences. This disorder may be 'primary', i.e. an erection sufficient for satisfactory intercourse has never been achieved; or 'secondary', i.e. at some point in the past, satisfactory coitus has occurred.

Premature Ejaculation

Objective criteria for the definition of premature ejaculation are lacking. Some researchers (e.g. Cooper, 1969b, Lowe and Mikulas, 1975; Kilmann and Auerbach, 1979) have advocated the need to include some consideration of actual ejaculatory latency, before or after intromission, in defining this disorder. Kaplan (1974) and Jehu's (1979) definition, on the other hand, is based exclusively on the absence of voluntary control over the ejaculatory reflex.

Masters and Johnson (1970) arbitrarily define this dysfunction as the inability to control ejaculation 'for a sufficient length of time during vaginal containment to satisfy the partner on at least 50% of their coital connections'.

This definition seems reasonable in view of their recognition of mutual sexual satisfaction, but unfortunately, it does not lend itself to unequivocal interpretation. If the definition implies female orgasm, as some have believed (e.g. Kaplan, 1974; Kilmann and Auerbach,1979), then it is necessary to take account of the finding that about 10% of women will never, or rarely, experience coital orgasm, although the duration of intercourse may exceed sixteen minutes (Gebhard, 1966). However, 73% of a non-clinical sample of 195 women studied by Butler (1976) reported that it was not necessary for them to have an orgasm in order to enjoy sexual relations. Similarly, Wallin and Clark (1963) found that 17% of women in their sample experienced strong coital enjoyment although they were orgasmic only very rarely or not at all. Consequently, it seems reasonable to employ Masters' and Johnson's (1970) definition with the clear understanding that female satisfaction does not necessarily mean female orgasm.

Female General Sexual Unresponsiveness

This refers to a lack of interest in sex and/or a difficulty in responding to erotic stimuli, with or without associated anxiety or

revulsion (Bancroft 1975). Following Kaplan (1974), a distinction is drawn between the initial "excitement" and later "orgasmic" phases of normal human sexual response. This type of problem typically involves some impairment of the lubrication-swelling or vasocongestive phase of the female response cycle, so that vaginal lubrication, the expansion of the inner two-thirds of the vagina and the formation of an orgasmic platform may not occur normally. In physiological terms, this disorder may, therefore, be considered analogous to erectile dysfunction in the male (Jehu, 1979), but it is more often in terms of the cognitive response to sexual stimulation that the problem is defined, as above.

Vaginismus

This disorder is defined as the involuntary spasm of the pelvic muscles surrounding the outer third of the vagina, including the perineal muscles and the levator ani muscles (Masters and Johnson, 1970; Kaplan, 1974; Ellison, 1972). In severe cases of vaginismus, the adductors of the thighs, the rectus abdominis and the gluteus muscles may be involved (Lamont, 1977). This reflex contraction is triggered by anticipated or, in some cases, imagined attempts at vaginal penetration or during the act of intromission or coitus.

Aetiology

A considerable range of factors, either individually or in combination, has been proposed as being implicated in the aetiology of the above and other major forms of sexual dysfunction.

Following Bancroft (1975) these factors may be grouped into five main categories:

(a) pre-dyad factors : lack of knowledge or misinformation about sex; early environmental problems (e.g. disturbed parental relationship, rape, incest, religious orthodoxy) leading to guilt, anxiety or inhibitions about sex affecting one or both partners prior to and "brought" by them to the relationship.

(b) Sexual maladaptation in the dyad : where sexual problems develop as maladaptive responses to be pattern of sexual functioning in the partner (e.g. premature ejaculation and female orgasmic dysfunction or general unresponsiveness).

(c) Non sexual role conflicts in the dyad : relationship problems

including hostility, ineffective communciation and dominance and control conflicts.

(d) Reaction to salient life events:
  (i) Psychological (e.g. loss of job, bereavement, infidelity, marriage.
  (ii) Psychophysiological (e.g. hysterectomy, vasectomy, childbirth, menopause).

(e) Response to illness or drugs (e.g. hypotensive agents, depression, diabetes, prostatitis, etc).

To the above list may be added other more immediate factors such as unsuitable circumstances (fatigue; lack of privacy or time; fear of being overheard, etc), specific negative feelings about sexual relations (fears of pregnancy or of pain).

Hogan (1978) has indicated that particular aetiological factors have been proposed as being associated more often with some type of dysfunction than others. Thus, physical and physiological factors, reported as being involved in only 3 to 20% of sexual dysfunctions (Kaplan, 1974) are implicated more frequently in male and female dyspareunia, vaginismus and erectile failure (Masters and Johnson, 1970). He also reports that arousal and orgasm appear to be more resistant to organic problems in the female than in the male. Misinformation and lack of knowledge about sex and lack of a skilled partner are often implicated in primary orgasmic dysfunction (Annon, 1974; Kaplan, 1974) while secondary orgasmic dysfunction would appear to be more often associated with marital problems (McGovern et al, 1975; Blakeney et al, 1976) although the evidence on the latter point is not wholly consistent (Sotile and Kilmann, 1978).

However, the retrospective identification of specific aetiological factors among dysfunctional couples, particularly in the absence of suitable controls, may do little to enhance our understanding of the development and maintenance of sexual dysfunction without their being integrated within a coherent theoretical framework which:

(a) differentiates adequately between dysfunctional and non-dysfunctional couples, and

(b) helps account for the development of different types of sexual dysfunction

The former issue is particularly important, since any adequate theory must account for the fact that some or all of the proposed aetiological factors above may also feature in the histories of patients and non-patients who do not have any form of sexual dysfunction.

Psychoanalytic theory, apart from the fact that it suffers from being non-disconfirmable and is, therefore, not amenable to the generation of testable hypotheses, also fails to account for the issues noted above.

While it seems reasonable to suggest that many of the above proposed pathogenic influences interact with each other and with other "intrapersonal" vulnerability factors in the aetiology of sexual dysfunction (cf. Hogan, 1978), early traditional medical, psychoanalytic and behavioural models appeared to be based on a simple unifactorial conception of aetiology. Although never integrated within an adequate theoretical model, anxiety, for example, has been considered to play a primary aetiological role. Moreover 'anxiety' in this context has never been adequately defined. It has been construed as a worry about performance (Masters and Johnson, 1970); a pervasive psychological trait (Derogatis and Meyer, 1979; Kaplan, 1974) and a phenomenon confined to the individual's reaction to sexual relations or to the perceived reaction of the partner (Cooper, 1969b). Wolpe (1973), for example, believed that anxiety - a sympathetic response - inhibits sexual arousal (a parasympathetic response) because they are physiologically incompatible. Such a hypothesis would suggest that 'excitement' phase disorders, such as erectile impotence and female sexual unresponsiveness, would be largely a function of anxiety by virtue of the inhibition of the arousal/vasocongestive phase. Such an oversimplified view, however, fails to account for the evidence that erections may occur, in both animals and man, in situations which evoke anxiety (Ramsay, 1943; Gantt, 1944; Bancroft, 1970). There is also no sound evidence for the effectiveness of anxiolytics in the treatment of these disorders and, indeed, there is a suggestion that diazepam may have, for some females, a negative effect on libido (Mathews, 1981). Furthermore, there is much informal evidence, based albeit largely on clinical impression, that anxiety may not be a particularly clear primary feature of many cases of erectile impotence (Cooper, 1968; Ansari, 1975) and of female unresponsiveness (Wincze et al, 1978; Kaplan, 1979).

Wolpe (1973) also discusses the role of anxiety in the development of premature ejaculation. Since the visceral aspects of the ejaculatory reflex are governed by the sympathetic branch of the ANS, anxiety may facilitate ejaculation. To date, however, this purported relationship has not been examined in any detail, and Cooper's (1969b) impression is that, in terms of symptomatology and aetiology, anxiety may be highly variable among an unselected sample of men presenting with premature ejaculation. Accordingly, treatment procedures which have relied almost exclusively on anxiety reduction have met with variable results (e.g. Friedman, 1968).

Anxiety has also been implicated in the development of orgasmic dysfunction and retarded ejaculation. Most of the evidence, however, is based on clinical impression. Masters and Johnson (1970) and Lazarus (1963) describe cases of female orgasmic dysfunction in which anxiety appears to be involved, but the former's failure to differentiate between orgasmic dysfunction and general unresponsiveness is one major factor which confounds appraisal. Kaplan (1974) also construes the inhibition of ejaculation as a function of aversive conditioning 'exactly as though the patient anticipated punishment by an electric shock each time he ejaculated or even had the impulse to ejaculate' (page 327). While this may be true for some cases, Cooper (1969a) and Dow (1981), however, observed only a very weak relationship between anxiety and the onset of retarded ejaculation.

Masters and Johnson's (1970) identification of the role of 'performance anxiety' (involving a fear of failure and a tendency to 'spectate' on one's own sexual behaviour and functioning), both as a cause and effect of sexual dysfunction, thereby helping to maintain the disorder, is an important contribution. As Apfelbaum (1977) has indicated, however, even if performance anxiety were construed as a first-order cause and all other specific pathogenic influences, such as those noted in the introduction, as second-order causes, it does not help answer adequately either of the two central questions above.

A meaningful contribution, however, is provided by Kaplan (1974) who, in following the psychosomatic model, proposes, as does Bancroft (1975), that the tendency for a particular individual to respond to performance anxiety and all other proposed aetiological factors with sexual dysfunction, would depend, in part, on a physiological or "organ-system"

vulnerability of that individual's sexual responses to psychological factors. This hinges on the notion of 'response specificity' advanced by Lacey and his colleagues (Lacey, 1950; Lacey et al, 1953; Lacey and Lacey, 1958). The goal of therapy, therefore, becomes one of alleviating the stress evoked by these factors, since there may be limited scope for altering the basic constitutional vulnerability. An additional (not necessarily alternative) possibility is also suggested by Kaplan (1974) and extended by Apfelbaum (1977), and relates to other individual differences in the vulnerability to stress. Thus, it is proposed that relatively invulnerable sexual functioning may be the manifestation of a particular defense style, i.e. a particular way of coping or "bypassing" potential stress, and that this process may be either spontaneous or a function of effort. Indeed, Apfelbaum (1977) proposes that performance anxiety may even stimulate some individuals to bypass potential pathogenic influences, and it is this differential response to performance anxiety which, therefore, may be the first-order cause. Such a theory may be considered consistent with some laboratory findings of mild anxiety facilitating genital sexual arousal to erotic material in non-dysfunctional men and women (Wolchik et al, 1980; Hoon et al, 1977) and some evidence of a difference between non-dysfunctional and dysfunctional men in the differential effects of demanding and undemanding sexual sets on subsequent penile tumescence to erotic visual material (Heiman and Rowland, in preparation).

An additional factor which may determine the way in which potential stress may affect the vulnerable individual is that of "avoidance of success" (Bancroft, 1975). This concept may be regarded as overlapping, to some extent, with a more traditional psychodynamic view of sexual dysfunction, in which some attention is paid to the purpose the symptom(s) serves as a defense against threats to one's self-esteem or balance of control in the relationship (Bieber, 1974; Rosen, 1982).

As an adjunct to these models which appropriately incorporate some notion of individual differences (constitutional or/and psychological) in vulnerability to stress, other more detailed formulations, largely based on learning theory, have been proposed for the development of the more specific defining symptoms of some of the main forms of dys-

function. In general, however, these have been confined to vaginismus, premature ejaculation, ejaculatory failure and orgasmic dysfunction. Mann (1976) and Dow (1981) have already outlined such a hypothesis for the aetiology of ejaculatory failure and, since the last two disorders are not relevant to the present study, only the first two will be considered here.

Vaginismus

In learning-theory terms, the salient distinguishing clinical features of vaginismus (viz. the involuntary spasm of the pelvic musculature with attempted or imagined vaginal penetration) is interpreted as a conditioned response that results from the association of pain or fear with vaginal entry. The source of the initial anticipatory anxiety may range from ignorance and misinformation, to more general sexual guilt arising from deeper sexual conflicts, but such anxiety may lead to a withdrawal and tensing of the pelvic muscles (perhaps initially voluntary) and, in some cases, to an inhibition of sexual arousal and vaginal expansion and lubrication. The net result of attempted penetration (i.e. pain) then serves to reinforce both the anxiety and muscular spasm, which become conditioned to the stimulus (imagined or real) of vaginal penetration.

Although a wide range of other specific aetiological factors have been proposed, including unwillingness to assume an adult role (Poinsard, 1968), personality factors (Dawkins and Taylor, 1961), sexual unassertiveness in the partner (Friedman, 1962; Weiner, 1973), the above view is cited as being one of the few theories sufficiently clearly formulated to account for the defining symptoms, and which accords with the results of related behavioural treatment strategies.

Premature Ejaculation

Premature ejacultation has been interpreted by Masters and Johnson (1970) as essentially a result of early autonomic conditioning in which initial stress and/or encouragement by the female partner to ejaculate quickly, perhaps after a period of prolonged sexual play, leads to rapid ejaculation with intimate coital or non-coital sexual relations. Subsequent conditioned sexual anxieties combined with reinforcement of rapid ejaculation by orgasm itself is considered to be implicated in the conditioning process.

Kaplan (1974), however, postulates that adequate sensory feedback is necessary for the development and exercise of control over the ejaculatory reflex. There are a number of ways in which such recognition might fail to develop or operate, e.g. rushed early sexual experiences, distracting anxiety, or cognitive avoidance reactions to various stresses, so that sensations premonitory to orgasm are not perceived.

These proposed aetiologies are not mutually exclusive and, of course, like the others are speculative at the present time. Arguably, however, they offer somewhat more detailed proposed explanations for the development and maintenance of the defining features of vaginismus and premature ejaculation, than the more general psychosomatic models alone for erectile impotence and general unresponsiveness.

However, the main reason for their being outlined above is to illustrate the fact that, from a starting point which offered a somewhat undifferentiated view of "sexual dysfunction", all manifestations of which may have a common base, there has grown a body of more specific learning theory formulations, which have attempted to account for the discrete symptoms of the different dysfunctions.

In accordance with these theories, (and lending some indirect support for them) has been the development of separate behavioural programmes specifically designed to deal with each of the main forms of dysfunction.

As will be discussed later, some recognition of these differences may be important for sample composition and the general design and analysis of treatment outcome studies in this field.

Before examining this in more detail, it may be of value to examine first the efficacy of the main behavioural treatments for sexual dysfunction.

CHAPTER 2

BEHAVIOURAL TREATMENTS FOR SEXUAL DYSFUNCTION

A Critical Appraisal of the Effectiveness of Desensitisation Models

An examination of the evidence for the efficacy of conventional systematic desensitisation, and variants thereof, is prompted by two main factors: (1) the prominent position desensitisation has occupied historically in the development of behavioural treatment for sexual dysfunction; and (2) the apparent lack of agreement concerning the theoretical basis of Masters and Johnson's treatment programme.

Thus, with regard to the latter, Dengrove (1971), for example, has argued that Masters and Johnson's approach is basically a pure behavioural treatment which is 'typically Wolpeian', whereas Marmor (1971) suggests that their treatment is both behavioural and psychodynamic in orientation, whilst Masters and Johnson themselves, it has been argued (Murphy and Mikulas, 1974), conceptualise their approach as essentially a form of insight oriented psychotherapy. In view of this lack of agreement and, in particular, the presumed close relationship the Masters and Johnson approach has with desensitisation, both practically and theoretically, it may be of value to examine first the evidence for the effectiveness of this behavioural technique, before attempting to distinguish between the two approaches in the light of recent empirical findings.

It is outwith the scope of this review to give a detailed critique of the plethora of uncontrolled single case reports and single treatment studies in this area. Instead, only controlled comparative studies of desensitisation for sexual dysfunction will be considered.

In controlled studies of the efficacy of desensitisation for sexual dysfunction, treatment has taken one of three main forms:

(a) imaginal and in vivo desensitisation
(b) group desensitisation, and
(c) video desensitisation

Most of the studies purporting to demonstrate the effectiveness of these procedures may be criticised, however, on a number of grounds. In the interests of parsimony, therefore, it may be of value to review

these studies on the basis of their major methodological deficiencies. These include (1) sampling bias; (2) restricted focus of assessment; (3) confounding of salient treatment variables and (4) inadequate presentation and statistical treatment of the data.

Sample Representativeness

A primary consideration in reviewing these studies are the findings reported above that (a) anxiety may not always be present or occupy a central aetiological role among those presenting with a psychogenic sexual dysfunction (Wincze et al 1978; Kaplan 1977; 1979) and (b) that anxiety may be associated for some individuals with an enhancement rather than an impairment of sexual arousal (Hoon et al 1977; Wolchik et al, 1980). It is the former observation which, in particular, deserves attention in appraising this body of research, along with other evidence of sampling bias.

In two published accounts of the same study, in which a modified form of desensitisation was compared with group psychotherapy and an untreated control condition for a variety of forms of sexual dysfunction, Obler (1973; 1975) implies selecting only those subjects whose measured trait anxiety was well above average. Moreover, his sample was also selected from a larger group of 235 volunteers, partly on the basis of at least one year college education, average or above intelligence, and a high motivation for treatment.

A similar sampling bias is evident in a study of group desensitisation for erectile impotence by Auerbach and Kilmann (1977). Furthermore, although a statistically significant treatment effect was reported, almost two-thirds of their treatment group still experienced erection problems post-treatment on at least a third of their coital experiences. This raises doubts, therefore, about the clinical significance of their findings.

Wincze and Caird (1976) in their controlled evaluation of imaginal and video desensitisation with sexually unresponsive women described their subjects primary complaint as "excessive anxiety associated with most or all aspects of sexual behaviour ... " (page 336).

Although significant treatment effects with group desensitisation for

orgasmic dysfunction were reported by Sotile and Kilmann (1978), among the inclusion criteria for subject selection was that each patient show specific sexual anxiety as measured by an appropriate scale.

Thus, these studies may be considered to have limited external validity (Campbell and Stanley, 1963; Mahoney, 1978) in view of the evidence of sampling bias, particularly with regard to the presence of sexual anxiety - a feature which may favour those receiving desensitisation. Indeed, there is some evidence from studies involving anorgasmic subjects, that desensitisation may only be beneficial for those cases in which specific sexual anxiety is present (Husted, 1975).

Focus of Assessment

Lo Piccolo (1977) has stressed the importance of ensuring that in any comparative study, a balanced assessment is conducted to minimise the possibility of any bias favouring any one treatment, and that all relevant aspects of the desired behavioural change are represented. The former is particularly relevant where therapies of conflicting theoretical bases and conceptually distinct objectives are being compared (e.g. Obler, 1973; 1975).

In general, there would appear to be an overemphasis on measures of sexual anxiety in controlled desensitisation studies. Thus, five out of the six outcome measures used by Obler (1973) related to subjective anxiety, general neuroticism and autonomic arousal. Similary, Wincze and Caird (1976) relied almost exclusively on measures of anxiety (sexual and general) in their comparison of imaginal and video desensitisation.

This restricted range of outcome measures in the latter study is particularly regrettable given that exposure to explicity sexual material has been reported to facilitate attitude change (Lehman, 1974), assist in the acquisition of new behaviour and facilitate the expression of pre-existing responses in the behavioural repertoire. Some support for these views is provided by Nemetz et al (1978) who showed that both group and individual video desensitisation, in contrast to a waiting list control group, were associated with significantly greater change, not only in sexual anxiety, but also in attitudes and frequency of sexual behaviours.

Confounding of Treatment Variables

Occasionally some of the studies have involved a number of techniques in addition to desensitisation. For example, O'Gorman (1978) and Sotile and Kilmann (1978) combined desensitisation with group discussion and sexual educative counselling. In Obler's (1973) study, all subjects in the desensitisation group received, in addition, assertive training, including role playing and modelling and "confidence training" for related heterosocial/sexual fears. Also explicit sexual material was used in addition to imaginal desensitisation and, although not reported in the first published account, Obler (1975) states that "biofeedback was continuously given to each patient's anxiety responses" (page 57).

Inadequate Presentation and Statistical Methodology

Again, Obler's (1973) study may again be criticised for its inadequate presentation of follow-up data and method of analysis, and for the dubious validity of GSR and heart-rate records as measures of anxiety while subjects viewed sexually explicit films. The absence of an independent assessor, and an exclusive reliance on self-report measures have been other consistent shortcomings in most of the studies (Obler, 1973; Auerbach and Kilmann, 1977; Sotile and Kilmann, 1978; O'Gorman, 1978). Indeed, Munjack et al (1976) assert that 'reliance on self-report measures of improvement usually biases results in the direction of favourable outcomes' (page 500). Wincze and Caird (1976) also used measures of self-estimated change in the assessment of sexual satisfaction, a procedure associated with less reliability than ratings at each period of assessment of current sexual behaviour and affect (Adams, 1978).

Finally, inadequate presentation and inaccurate data analysis are also major flaws in a comparison of individual and group desensitisation for "frigidity" by O'Gorman (1978). It would appear that almost all major forms of female sexual dysfunction were subsumed under this general label, and several fundamental statistical errors in her analysis render her results and conclusions virtually meaningless.

More Adequate Controlled Studies

In contrast to the above findings, Kockott et al (1975), in a more adequately controlled study, compared imaginal desensitisation with a

"routine therapy" and a waiting list control condition in the treatment of erectile impotence. Based on the results of an inquiry among general practitioners and psychiatrists in the Munich area, "routine therapy" was defined in terms of that form of treatment usually provided by these physicians, i.e. 'medication and some general advice'. Despite a greater reduction in subjective coital anxiety among those receiving desensitisation, there was an absence, on any measure, of any differential improvement in sexual functioning favouring desensitisation. Those who failed to improve were then treated with a modified Masters and Johnson approach, and the authors report on the overall outcome of twelve of these patients, two-thirds of whom were described post-treatment as "cured" or "improved". The absence of clinically relevant change with desensitisation in this study is interesting and parallels similar findings by Husted (1975) and Wincze and Caird (1976), who both found among anorgasmic subjects, that desensitisation may reduce sexual anxiety among some women, but was not particularly effective in increasing orgasmic capacity.

Similar findings are also reported by Mathews et al (1976), in a study comparing imaginal desensitisation plus counselling, a modified Masters and Johnson approach (i.e. directed practice plus counselling) and directed practice alone with a mixed sample of dysfunctional couples. This study will be described in detail later, but, despite the absence of significant inter group differences, they found consistent trends favouring directed practice plus counselling. The 'mainly small changes' with desensitisation plus counselling led them to conclude that there seems little justification for its use 'except possibly in those cases where there is a strong phobic element' (page 9).

Conclusions

The weight of empirical evidence, therefore, suggests that imaginal or in vivo desensitisation, on an individual or group basis, and as originally conceived and developed by Wolpe (1958), is of limited efficacy in the treatment of an unselected sample of individuals or couples with sexual dysfunction.

There is some evidence, however, (1) that it may be of value for some patients, viz those with high levels of sexual anxiety, and (2) that certain variants of the procedure involving the use of visually

presented sexual hierarchies may be of benefit for some patients (Nemetz et al, 1978), but it remains unclear at present (a) what aspect(s) of this procedure is responsible for change (e.g. attitude change, sex education, modelling, vicarious extinction, response facilitation and disinhibition, or some combination of these), and (b) for which patients this variant may be of value.

A Critical Appraisal of Masters and Johnson's Treatment Outcome Research

As noted above, prior to 1970, and the publication of Masters and Johnson's treatment outcome research, the therapeutic emphasis was largely on the individual complainant and, in the behavioural field, treatment was based for the most part on a direct anxiety reduction model, based principally on desensitisation. There is general agreement that Masters and Johnson's research was heralded as a landmark in the treatment of sexual dysfunction. This was largely attributable to a new emphasis Masters and Johnson placed on central features of their programme. Firstly, they stressed the need to involve both partners in treatment, which was conducted by a female and male co-therapy team. Secondly, the new therapy was concentrated - daily sessions for two or three weeks, with most couples coming from outwith the St Louis area and living there for the duration of therapy. Thirdly, Masters and Johnson emphasised current obstacles to functioning rather than unconscious conflicts or childhood events. Fourthly, and perhaps the most appealing feature, was the prescribed sexual homework, based on a series of specific suggestions and assignments for each of the dysfunctions. A final factor, which may have contributed to the growth of professional interest in their technique, was their claims for the programme's efficacy. Table 1 below summarises their findings.

Table 1 : Outcome Data Among Couples Treated by Masters and Johnson

Complaint	N	F	IFR%	N	TR	RR%	OFR%
Primary Impotence	32	13	40.6	7	0	0	40.6
Secondary Impotence	213	56	26.3	90	10	11.1	30.9
Premature Ejaculation	186	4	2.2	74	1	1.5	2.7
Ejaculatory Imcompetence	17	3	17.6	5	0	0	17.6
Vaginismus	29	0	0				
Primary Orgasmic Dysfunction	193	32	16.6	77	2	2.6	17.6
Situational Orgasmic Dysfunction	149	34	22.8	60	3	5.0	24.8

F = Failures; IFR = Initial Failure Rate; TR = Treatment Reversal; RR = Reversal Rate; OFR = Overall Failure Rate.

Excluding the vaginismus subjects who would appear to have been subsumed within the orgasmic dysfunction subgroup in their tables, they report having treated 790 individuals during an eleven year period and having obtained five year follow-up data on 313 couples treated prior to 1965.

Many of the criticisms of Masters and Johnson's work are based largely on the view that they have failed to provide the information necessary for intelligent interpretation or replication (Zilbergeld and Evans, 1980). More specifically, the main criticisms focus on four main issues: (1) their criterion measures of therapeutic outcome; (2) degree of change; (3) sampling problem and (4) follow-up assessment.

(1) Therapeutic Outcome - Criteria for Success and Failure

Masters and Johnson appear to recognise the importance of experimenter or evaluation bias, although they did not employ the standard methods of minimising this factor by the use of independent assessors, or even separate ratings by clinicians and couples. In fact, not even the minimal condition of employing ordinal scale measures of sexual adjustment for independent completion by both partners was used. Instead, the only assessment of outcome is a rather crude dichotomous judgement of treatment failure using ill-defined criteria by therapists, with a considerable investment in their own techniques, namely Masters and Johnson themselves.

(2) Assessment of Degree of Change

This leads to the second main criticism: that measurement of outcome in terms of failure rates pre-empts assessment of degree of change. Change in sexual functioning is not an "all or nothing" phenomenon and some acknowledgement of this is implicit in a recent statement by Masters and Johnson, and reported by Zilbergeld and Evans (1980), that their failure rates should not be directly translated into success rates, despite the common practice of so doing (e.g. Kilmann and Auerbach, 1979; Reynolds, 1977). Thus, since Masters and Johnson do not adequately define failure, and since not all non-failures are successes, unequivocal interpretation of their results to allow some form of comparison of outcome data across studies, and empirical replication of their work, becomes impossible.

(3) Sampling Bias

They clearly specify that their results are based on a largely middle and upper middle class sample, the majority of which (i.e. 72%) had received some form of tertiary education. Indeed, 17.5% of their sample had prior medical training and of that group, almost half were psychiatrists. In addition, 90% of their case-load were referred from outside St Louis and clearly also were financially able and sufficiently motivated to make the trip.

(4) Five Year Follow-up Assessment

Results of a five year follow-up survey of these couples seen between 1959 and 1964 are, superficially at least, fairly clear from the tabular presentation of their data (see Table 2 below).

Table 2 : Reported Five-Year Follow Up Outcome Data of 313 Marital Units, 1959-1964 (Masters and Johnson, 1970)

Complaint	N	TR	RR%
Primary Impotence	7	0	0
Secondary Impotence	90	10	11.1
Premature Ejaculation	74	1	1.5
Ejaculatory Incompetence	5	0	0
Primary Orgasmic Dysfunction	77	2	2.6
Situational Orgasmic Dysfunction	60	3	5.0
Total	313	16	5.1

The figures suggest that follow-up data were obtained from each of the 313 cases treated during that period and the table headings (Masters and Johnson, 1970, pages 366 and 367) clearly reinforce that impression. However, examination of the text suggests that follow-up data were obtained from 226 cases.

Recalculation of their data suggests, therefore, that their true reversal rate was 7.08% (i.e. $\frac{16}{226}$) and not 5.1%. This rate of relapse is, of course, still remarkably low, given the stimulus contrast which presumably existed between the conditions during the treatment period and those which prevailed at home (Murphy and Mikulas, 1974), and given the consistently higher relapse rate reported by others (e.g. Levine

and Agle, 1978; Meyer et al, 1975; Clarke and Parry, 1973).

There are several possible reasons for Masters and Johnson's low reported relapse rate. Firstly, it may relate to the nature of their sample; secondly, it may be due to the telephone contact they maintained with couples following therapy - there is already evidence of the therapeutic value of such contact (Lindstrom et al, 1976; Rosenbaum, 1977); and thirdly, their criteria of relapse may have been more loosely adhered to than they imply, as suggested by the frequent reports of continuing ejaculatory difficulties and episodes of erectile failure among those treated for premature ejaculation.

In short, all these flaws and uncertainties confound clear interpretation and generalisation. It is necessary, therefore, to examine additional evidence of the effectiveness of this approach, as normally conducted in this country.

CHAPTER 3

THE EFFECTIVENESS OF A MODIFIED MASTERS AND JOHNSON APPROACH

There is little doubt that Masters and Johnson's (1970) treatment developments became a springboard for a renewed interest in the treatment of sexual dysfunction. Yet it would appear that, in general, cautious interpretation has not accompanied the wave of enthusiasm generated by their work. Numerous treatment modifications and innovations based on their model have been introduced, but there has been a scarcity of adequate controlled investigation of the effectiveness of a modified Masters and Johnson approach.

The term 'modified', for the purpose of this review, will refer mainly tothose adaptations involving one as opposed to two therapists, and less frequent (e.g. weekly rather than daily) counselling sessions. Therefore, only those controlled studies of the basic procedure as typically adapted for use within an NHS or comparable setting will be reveiwed in detail here.

It is outwith the scope of this review to describe in detail the range of uncontrolled single treatment studies in this field, the results of which are difficult to interpret in view of a number of methodological flaws, in addition to the interpretive constraints of such single treatment designs. Favourable results have been reported by Prochaska and Marzilli (1973); Meyer et al (1975); Levine and Agle (1978). As with most of the desensitisation studies, the major shortcomings, in almost all of these studies, have been inadequate specification of relevant subject characteristics, imprecise accounts of the content and duration of therapy and post-treatment contact, absence of adequate outcome measures, absence of attempts to minimise experimenter bias and evidence of grossly unrepresentative samples as a result of overstringent criteria for subject selection.

As will be seen, a review of the area almost necessarily brings into focus an examination of the relationship between the proposed two main components of the Masters and Johnson approach, viz. directed practice and counselling, (Mathews et al, 1976). As mentioned briefly above, this is partly because of some apparent uncertainty concerning the theoretical basis of Masters and Johnson's approach and what, in turn, the approach, in practical terms, entails.

The Relationship Between Directed Practice and Counselling

One of the difficulties in reviewing this field has been in determining how a Masters and Johnson approach has been construed theoretically and how it has been administered. Although there is evidence that Masters and Johnson themselves adopted an eclectic approach based on behavioural and psychodynamic principles (Lowry, 1975; Masters and Johnson, 1976), it is possible that their almost exclusive discussion of the behavioural aspects of their treatment (Masters and Johnson, 1970) may have, in itself contributed to a somewhat oversimplified view of their programme, based essentially on in vivo desensitisation (Dengrove, 1971). Others, such as Kaplan (1974), Bancroft (1975), Mathews et al (1976), have, on the other hand, emphasised the importance of both the behavioural part of the programme (i.e. sensate focus and other more specific behavioural directives, such as finger dilatation exercises for vaginismus, the "squeeze" or "stop-start" technique for premature ejaculation, etc), and the counselling component. The latter is less easily defined, but may include sex education, the identification and resolution of key attitudes and resistances which may impede progress with the behavioural aspect of the programme, as well as the facilitation of improved communication between partners. In short, the latter involves that part of treatment which overlaps more clearly with traditional psychotherapy. This distiniction has not always been clear and the confusion in this regard is perhaps reflected in the following uncontrolled study.

Lansky and Davenport (1975) reported on the outcome for seven couples who were unselected members of lower socio-economic classes. Although no formal measures were administered, outcome was considered satisfactory for only two of the couples. The reasons proposed for such generally poor results centred on the observation that 'the prescribed intimacy brought into focus issues that the marriage was organised around avoiding' (page 175) and that primary attention to symptom removal may highlight more general marital dissatisfactions. They presented this as a criticism of the Masters and Johnson procedure on the grounds that it appeared to aggravate those couples' sexual problems which appeared to be mediated and maintained by non-sexual role conflicts, inhibited attitudes, impaired communication, etc. Yet the dual component proponents would suggest that this is one of the strengths of the treatment and it seems possible that the relatively

poor results of Lansky and Davenport (1975) may have been due, in part at least, to a failure to use a more eclectic marriage of therapeutic approaches, involving both directed practice and counselling, to permit a more flexible shift of attention in treatment, when required, to less directly sexual aspects of the relationship.

Similar evidence that a Masters and Johnson approach may have been administered mainly in terms of its behavioural component is suggested by a brief report of three studies by Everaerd (1977), two of which involved a comparison between (a) imaginal systematic desensitisation with in vivo training at home and (b) a modified Masters and Johnson approach. In the first of these, (see also, Everaerd and Dekker, 1982) the sample comprised 48 couples whose main complaint was female orgasmic dysfunction, and who were assigned at random to either of the two treatment approaches above, or to a third treatment : a combination of (a) and (b) above. An independent waiting-list control group was also included. In general, significant improvement pre-post-treatment was observed only for the Masters and Johnson and desensitisation groups on sexual and marital satisfaction measures. While these changes on both measures were maintained at six months follow-up for the desensitisation group, the Masters and Johnson subjects maintained their improvement only on the marital satisfaction measures. No significant difference was observed between the groups, although there was a strong trend post-treatment favouring both the Masters and Johnson and desensitisation approaches on sexual adjustment measures, compared to the combination and waiting-list groups.

In a second study, only treatments (a) and (b) above were compared with a mixed sample of dysfunctional couples in which the main complaint was in the male. Again Everaerd (1977) reported a significant improvement with both treatments maintained at six months follow-up, on a measure of sexual satisfaction and an absence of any significant difference between them on any measure.

Insofar as the Masters and Johnson approach is shown to be as effective as desensitisation, this finding conflicts, to some extent, with that of Kockott et al (1975) and Mathews et al (1976). However, one possible reason for the failure to observe a differential response to these treatments, may be the manner in which treatment was conducted.

In each case, relatively inexperienced therapists were employed who 'implemented treatment programs according to stipulated procedures in a manual' (Everaerd, 1977, page 154). It is debatable whether the clinical skills required for conjoint counselling in particular, including the identification of attitudes and other "resistances" to treatment, can be effectively conveyed in a manual, and practised thereafter by post-graduate students, relatively inexperienced in treatment. The fact that they were required, in addition, to cope with the presumably additional complexities of a programme in which the two approaches were combined, as in the first study above, tends to reinforce the impression that a modified Masters and Johnson approach in this instance involved largely, if not only, its behavioural components. However, Everaerd's presentation of his findings pre-empts unequivocal interpretation and other factors, e.g. sample representativeness, which may also have influenced outcome and the clinical significance of the results, remain unclear. Nevertheless, in reviewing this field, it would appear to be important to recognise that a Masters and Johnson approach may be defined and practised differently across studies; more specifically, counselling and directed practice may not be uniformly regarded as integral parts of the treatment procedure.

The Relative Value of Directed Practice and Counselling Components

There are at least three comparative studies which relate to this issue, two of which have involved a direct comparison between a modified Masters and Johnson approach and marital, as opposed to specifically sexual counselling.

In the first of these, Everaerd (1977) tested a hypothesised relationship between marital and sexual satisfaction, by comparing his adaptation of a Masters and Johnson procedure with an approach specifically designed to enhance interpersonal communication, without any explicit focus on sexual interaction. His sample again comprised 48 couples for whom female orgasmic dysfunction was the presenting complaint. Although he concludes that sex therapy would appear to be the method of choice when the treatment goal is an increase in sexual satisfaction, there is no clear evidence from the results, as presented, to support this interpretation, particularly for the female complainants. He would also appear to violate the basic methodological requirement of

standardisation of procedure within each treatment approach, since he reports that those couples in the sex therapy group who were more highly sexually anxious, also received desensitisation. This also suggests a lack of pre-treatment uniformity among the subjects in this group.

Crowe et al (1981) attempted to clarify some of the above issues and, in particular, to test the assumption that the specific behavioural features involving the ban on intercourse, sensate focus, etc, were a necessary part of the Masters and Johnson programme. Their study, similar to that of Everaerd(1977) above, involved a comparison of three treatment groups: a modified Masters and Johnson approach (one v two therapists) and conjoint marital therapy (one therapist) with a mixed sample of dysfunctional couples. In the latter treatment, the emphasis was again on enhancing interpersonal communication, so that sexual issues were managed only within the context of general marital counselling. Common to all groups were relaxation instruction, marital counselling and marital contracts of the 'quid pro quo' type (Stuart, 1969; Crowe, 1978). On a wide range of measures they found no significant differences among the groups, and, therefore, concluded that 'a modified Masters and Johnson approach is no more effective in the treatment of sexual dysfunction than approaches which do not involve the specific Masters and Johnson techniques of a ban on intercourse, followed by sensate focus, etc' (page 53). In this respect their conclusions parallel to some extent those of Everaerd (1977) among female anorgasmic patients. However, there are, again, a number of important factors in this research.

(1) Firstly, even on the basis of their own results, the above conclusion would not appear to be fully justified. Couples in the Masters and Johnson groups reported significantly more interest in sex immediately after therapy - a finding which they dismiss as being probably due to chance, on the grounds of its being inconsistent with trends on other variables, and the fact that it was not observed at follow-up. However, the authors discount the fact that this finding involved <u>both</u> sex therapy groups.

(2) Secondly, partner scores were pooled in this study to form couple scores on which all data analyses were performed. It seems difficult to justify such a procedure given the wide

pre-treatment differences which may be reasonably considered to exist between the partners for reasons related to sex differences and status as main complainant. Apart from difficulties in the interpretation of the scores, it seems possible that actual differences among the complainants may be submerged among such pooled data.

(3) Crowe et al (1981) suggest that their results support a simple anxiety reduction hypothesis of treatment action, on the grounds that this was a feature common to both of their main treatment approaches, as well as to those in related studies (e.g. Ansari, 1976; Mathews et al, 1976; Everaerd, 1977) which failed to show significant differences between sex therapy and other procedures specifically designed to reduce anxiety. This interpretation is unwarranted, however, and based on an uncritical examination of their own findings, those of the above studies and other related research. The design of Everaerd's (1977) studies does not help in identifying the effective ingredients of therapy, and there is insufficient evidence to support an "anxiety reduction" hypothesis. The same applies to Ansari's (1976) study, which is replete with a number of weaknesses, including empirically unsubstantiated assumptions about the classification of impotent patients, inadequate outcome assessment, and an imprecise account of treatment; it, therefore, vitiates firm conclusions. Finally, as already noted, Mathews et al (1976) observed consistent trends favouring directed practice plus counselling and little evidence to support the use of imaginal desensitisation in an unselected group of patients. Kockott et al (1975) also reported similar findings, which Crowe et al (1981) again ignore as they do other clinical and laboratory findings noted above which fail to support a simple anxiety-reduction model.

These studies, therefore, do not offer any clear evidence that counselling alone may be as effective as a modified Masters and Johnson approach or, in the latter case, that the behavioural features of the treatment are 'less important to successful outcome' than previously believed.

One of the best and most informative comparative outcome studies in

recent years involving a modified Masters and Johnson approach is that of Mathews et al (1976). Their study was designed in part as a preliminary investigation of the relative importance of the directed practice and counselling components. With a sample of 36 couples, which was mixed in terms of major form of sexual dysfunction, they examined the relative efficacy of three treatments.

(a) a modified Masters and Johnson approach (i.e. both directed practice and counselling)
(b) a "correspondence" or minimal contact approach (i.e. directed practice with counselling minimised)
(c) systematic desensitisation plus counselling.

Mathews et al (1976) found no significant difference between treatments on any measure, although there was a striking consistency among the trends, in each case favouring directed practice plus counselling over the other two treatments. This would suggest that both components of the Masters and Johnson procedure are of greater importance than the behavioural aspect alone.

Two other aspects of their results are particularly important:

(1) One feature of their results which may have contributed in part to the failure to observe statistically significant differences among the treatment groups, was a high degree of within-group variability of response to both approaches involving directed practice. This was particularly marked in the "correspondence" approach. Thus, some couples clearly responded well to simple behavioural directives, but Mathews et al suggest that for others, perhaps those with greater marital and communcation difficulties, their problems may be aggravated by this approach when used alone.

(2) Their results with respect to attitude change were also particularly interesting (Whitehead and Mathews, 1977). Using the semantic differential to measure attitudes toward four concepts - "myself" and "ideal self", "my partner" and "ideal partner" - they found that attitudes changed systematically as a function of behavioural improvement and type of treatment. Thus, not only did those who improved change significantly more in their

attitudes towards themselves and their partners, compared to the unimproved subjects, but directed practice plus counselling was shown to be associated with significantly more positve attitude change compared to the other two treatment groups. This would suggest that practice and counselling were interacting in some way to facilitate such change, possibly as a result of the way in which counselling, in the context of a Masters and Johnson approach, provides a relatively greater opportunity, compared to desensitisation, for identifying and resolving obstructive attitudes impeding behavioural progress.

Summary and Conclusions

This review indicates that overall conclusions concerning the efficacy of a modified Masters and Johnson approach and the relative contributions of its two main components are confounded by a number of methodological problems in some of the studies and, to some extent, by the apparently non-standardised manner in which the approach has been conducted across studies. The weight of evidence also suggests that a simple direct anxiety reduction hypothesis does not satisfactorily explain the technique's primary mode of action.

The studies by Mathews et al (1976) and Whitehead and Mathews (1977) are among the few which are sufficiently sound methodologically and sufficiently clearly presented to permit meaningful conclusions about (a) the general efficacy of a modified Masters and Johnson approach, as normally conducted in this country, and, in particular, about (b) the relative importance of its two main components.

There is evidence that the directed practice and counselling components interact with each other and perhaps potentiate each other by the provision of the opportunity to resolve attitudes, communication difficulties, mismatched preceptions and other "resistances" highlighted by, and obstructing progress with, the behavioural part of the programme.

Mathews et al's (1976) results also indicate a variable response, particularly to that approach in which regular counselling is virtually absent. It would, therefore, be of value to examine this finding in more detail and, in the first instance, to determine whether this variability may be related to form of dysfunction. Moreover, in so doing,

one may test two hypotheses suggested by the previous findings above: that, in contrast to directed practice alone, a combined counselling and practice approach would effect: (a) greater positive attitude change; and (b) greater marital and interpersonal adjustment.

Implications for "Minimal Contact" Treatment Research

In Mathews et al's (1976) study, it is proposed that the failure to observe significant differences may have been due partly perhaps to the variability of response within the two directed practice approaches (but particularly the minimal contact format), as Mathews et al indicate. In this regard, the fact that their treatment groups, though balanced for sex of the main complainant, were mixed in terms of dysfunction, may be particularly relevant. As Lo Piccolo (1977) points out, in his review of methodological issues in sex therapy research,

> 'differences in patient and therapist characteristics, in the nature of the patients' dysfunction and in type of treatment given, more or less ensure that in any unselected group of patients and therapists, there will be wide variability in response to "treatments". Thus, the mean effectiveness of sex therapy in the broadest sense can be expected to be minimal, as "successes" will be balanced by "failures", (page 6).'

Although Mathews et al failed to demonstrate a significant association between type of problem and outcome (irrespective of treatment form), it remains a possibility that this within treatment group variability may be related to problem type and conceal an interaction between the nature of treatment and particular forms of dysfunction. Thus, in this context, any differential response to regular and minimal counselling approaches may not be uniform across different diagnostic categories.

Of course, it may be argued that prognostic judgements in relation to therapy generally or to specific treatments should probably be made, not on the basis of membership to major sexual diagnostic groups alone, but in terms of specific features common to different couples within and across diagnoses. This issue is discussed in detail by Fordney-Settlage (1975), who points out that classification of patients in terms of presenting sexual complaint is rarely adequate for diagnostic or prognostic evaluation. Nevertheless, preliminary investigation of a potential relationship between response to a minimal contact approach and problem type, as opposed to other patient characteristics is prompted by two interrelated factors: (1) differing problem characteristics and aetiological factors; and (2) contrasting behavioural features of the programmes.

Firstly, Mathews et al (1976) reported that females responded less well to treatment generally than the male complainants, a finding which may have been due to the evidence of a more generalised disturbance among the female subjects. Although no firm evidence is provided to support the view, they suggest that a minimal counselling approach may prove less helpful and possibly even aggravate those sexual problems which are compounded by interpersonal and communication difficulties. One implication of this view is that among such female problem groups (and perhaps in contrast to other groups), there may be a differential response to treatments which in themselves vary in terms of the provision of counselling for general interpersonal conflict, etc. Some support for this suggestion is provided by McGovern et al (1975) who showed that secondary orgasmic dysfunction responded less well than primary anorgasmia to a directed masturbatory training programme - a finding possibly attributable to greater marital problems associated with the former problem. McMullen and Rosen (1979) also report that minimal contact programmes are less likely to help those presenting with very low sexual desire, or those whose relationships are more generally disturbed.

Secondly, most of the studies which purport to demonstrate the efficacy of minimal contact programmes have been confined, for the most part, to the treatment of premature ejaculation (Lowe and Mikulas, 1975; Zeiss, 1977a; 1977b) and primary orgasmic dysfunction (McMullen and Rosen, 1979). This is also largely true of those behavioural group treatments for sexual dysfunction, which have involved less intensive counselling (Zeiss et al, 1978; Kaplan et al, 1974; Golden et al, 1978 Wallace and Barbach, 1974; Barbach, 1974; Leiblum and Ersner-Hershfield, 1977). One of the most frequently reported reasons for this apparent focus of interest in these two disorders in minimal contact outcome research relates to the specific behavioural features of the programmes themselves. Thus, it has been argued (Murphy and Mikulas, 1974; Zeiss, 1977a; 1977b; Heiman et al, 1976; Kass and Stauss, 1975) that these programmes, in particular, may lend themselves more readily than others to translation into written or video-taped form. It is, therefore, possible that the specific and discrete behavioural features of the treatments for different problems may contribute to a differential outcome when presented in written form by virtue of differential plausibility, length and complexity and the differing

technical demands of the directives themselves.

Proposed aetiological differences *per se* may not be sufficient at this stage to permit specific hypotheses about which problems are and are not likely to respond to different forms of the same treatment, but, combined with the other factors above, it may be of heuristic value to retain diagnostic distinctions to determine whether there is any evidence of a differential treatment response among different problem groups. That such distinctions should be made in outcome studies has been supported by others (Reynolds, 1977; Hogan, 1978; Lo Piccolo, 1977) and the important findings of Mathews et al (1976), particularly in relation to their "correspondence" approach, may be viewed as a springboard for such research.

CHAPTER 4

THE DEVELOPMENT OF SELF-HELP TREATMENT PROGRAMMES FOR SEXUAL DYSFUNCTION

From the above discussion it is clear that one of the principal reasons for examining minimal contact programmes for sexual dysfunction has been the theoretical one of clarifying the role of the therapist and of counselling in the context of a modified Masters and Johnson model. Also, it is proposed, in view of the response variability to such treatments (Matthews et al, 1976), that it would be of value to study the nature of the relationship between treatment response and problem type in the course of further comparative evaluation.

However, there are other important reasons for examining in more detail minimal contact programmes. These include:

(a) the need for controlled evaluation
(b) evidence relating to the effects of frequent v. infrequent counselling sessions
(c) potential relevance to patient compliance with treatment
(d) potential implications in terms of treatment cost-effectiveness

Before examining these issues in detail and the results of previous "self-help" outcome studies, it may be appropriate first to outline briefly the historical development of behavioural bibliotherapy.

Historical Development of Bibliotherapy

Although the term "bibliotherapy" probably smacks of contemporary "psychobabble", like the technique to which it refers, it has a lengthy history. It first appeared in Dorland's Illustrated Medical Dictionary in 1941 and was defined as 'the employment of books and the reading of them in the treatment of nervous diseases' - a definition which was expanded twenty years later to include physical disorders. The therapeutic use and value of books have been recognised since ancient times. Tews (1970) reports that the libraries of three millennia ago bore the inscription in Greek, 'Medicine (or remedy) for the soul', and she notes that records of early Roman encyclopaedists 'leave little doubt that books were made to serve curative objectives, particularly in the treatment of the emotionally disturbed patient' (page 173) and in the sixteenth century Rabelais (1494-1553) prescribed literature for his patients as part of their treatment (Schneck, 1944).

Of course, the theoretical rationale for their use in treatment has changed throughout history. Originally, the therapeutic emphasis was mainly on the act of reading itself, with the material considered more a source of moral and intellectual sustenance, rather than a medium for directive guidance.

At the inception of its more modern development, bibliotherapy was used mainly as an adjunct to psychoanalysis, either as a form of projective assessment (Hartman, 1951; Lazarsfeld, 1949) or as an aspect of psychotherapy in its own right. Shrodes (1949, 1960, 1961) and Slavson (1950), submitted the hypothesis, derived from psychoanalytic theory, that the use of imaginative literature may produce results similar to those of conventional analysis by virtue of the presumed comparability of experiences during reading with specific phases in psychoanalysis viz. universalisation, identification, introjection, catharsis and insight. Thus, it was used in the context of group psychotherapy (Floch, 1958; Powell et al, 1952; Roman, 1957), with children (Cohoe, 1960), for stammerers (Emerick, 1966) and with schizophrenics (Mascarino and Goode, 1940). However, the most obvious criticism is the total absence of empirical evidence to substantiate these claims for its effectiveness (Bry, 1942; Darling, 1957; Oathout, 1954; Peterson, 1935; Ryan, 1957).

The Need for Controlled Evaluation

Over the last fifteen years in particular, there has been a proliferation of self-help behavioural programmes designed to train the individual in the application of techniques such as systematic desensitisation (Baker et al, 1973; Kahn and Baker, 1968) or relaxation (Rosen, 1976b). The majority, however, are problem-oriented, the range being so wide that almost every main area of "outpatient" behaviour therapy is represented. Examples include self-help booklets for weight-reduction (Hagen, 1974; Hanson et al, 1976; Harris, 1969; Stuart and Davis, 1972); toilet training (Azrin and Foxx, 1974); phobic disorders (Marshall et al, 1976; Mathews et al, 1977); study behaviour (Beneke and Harris, 1972); social skills (Fensterheim and Baer, 1975) and sexual dysfunction, such as female orgasmic dysfunction (Barbach, 1975; Heiman, Lo Piccolo and Lo Piccolo, 1976; Kline-Graber and Graber, 1975), premature ejaculation (Lowe, cited in Lowe and Mikulas, 1975; McIlvenna and Vanderwoort, 1972; Zeiss and Zeiss, 1975) and general sexual

dysfunctions (Kass and Stauss, 1975; McCarthy et al 1975; Brown and Faulder, 1977; Raley, 1976). Despite this substantial number of self-help guides for sexual dysfunction, evidence for their general efficacy is conspicuously lacking. All of these programmes are packaged as written guides, but one may confidently predict that further advancement of video technology and marketing over the next decade will spotlight the clinical and commercial potential for a corresponding expansion of home-based self-help treatment programmes, thereby reinforcing the need for adequate scrutiny of their validity (Rosen, 1976a; 1978).

The development and examination of behavioural bibliotherapy have been prompted by a number of potential advantages with this form of treatment:

(a) enhanced cost-effectiveness (Rosen, 1976a; Phillips, et al, 1972; Kahn and Baker, 1968)

(b) may help counteract negative views of behaviour therapy by providing "power to the person" (Rosen, 1976a; Mahoney and Thoresen, 1974)

(c) increased accessibility of treatment (Bastien and Jacobs, 1974)

(d) may help maintain treatment gains (1) by extending the involvement of significant others (Mathews et al, 1977; Wells, et al, 1980), or (2) by increasing perception of self-efficacy by self-initiated change (Kopel and Arkowitz, 1975; O'Brien and Kelley, 1980; Bandura, 1977)

(e) providing vicarious support by reducing feelings of "standing alone" (McCary and Flake, 1971; Mudd, 1957).

(f) increased privacy and reduced embarrassment (Kass and Stauss, 1975)

(g) potential use in enhancing compliance with treatment (Ley, 1977; Dow, 1982).

The case for an emphasis on outcome research in applied psychology has been strongly argued in recent years (Azrin, 1977; Agras and Berkowitz, 1980). This has been fuelled largely by the enormous growth of behavioural treatment innovations, including self-help guides, which, despite their often intuitive, if not theoretical appeal, typically lack empirical evidence for their validity. Perhaps of particular concern, in addition, is the increasing availability and apparent professional endorsement of "self-help" material without even recognition of the

importance of such evaluation.

Following an examination of the book review section of "Behaviour Therapy" Journal, Rosen (1978) noted that 4.4% (i.e. $\frac{3}{68}$ of the full length reviews published in 1975-6 were concerned with self-help programmes, compared to a 17% rate for 1977. Although he conceded that there was controversy concerning the best way of ensuring consumer controls (Goldiamond, 1976; Rosen, 1977), he showed that professional reviews of these self-help guides, which encompassed statements of clinical efficacy, as distinct from literary style, content or presentation, tended to eschew the results of empirical analysis in favour of personal opinion.

The fact that self-help guides have not been more adequately or extensively evaluated, is also regrettable in view of the possibility that instructional advice in the absence of close professional guidance may, in some instances, increase behavioural complaints (Glasgow and Rosen, 1978). This possibility has already been suggested in the self-help treatment of sexual dysfunctions which are compounded by marital problems (Mathews et al, 1976; McMullen and Rosen; Kass and Stauss, 1975). It should also be considered with problems with a strong anxiety component. For example, Barbach (1975) in her self-help guide advises women with strong inhibitions about masturbation to prolong self-stimulating exercises and to exaggerate reactions. Such advice, based in part on a flooding and response prevention strategy, seems theoretically sound, but there is no clear evidence to demonstrate that patients can successfully self-administer procedures involving prolonged exposure to the most feared situation or activity. The possibility of incubation, rather than extinction of conditioned anxiety (Eysenck, 1976), with unsupervised repeated practice remains a realistic possibility.

In the field of sexual dysfunction, there has been a relatively small number of controlled studies of the effectiveness of self-help programmes, and, as noted above, these have been restricted largely to the treatment of premature ejaculation and primary orgasmic dysfunction.

One of the first controlled studies was that of Lowe and Mikulas (1975) who found that males receiving an intensive three week minimal contact

treatment programme for premature ejaculation (involving sensate focus, squeeze technique, etc) as presented in an eighty page instructional manual, reported a significantly greater increase in estimated ejaculatory latency compared to an untreated control group.

It is difficult to generalise from their finidngs, however, in view of the unrepresentative nature of their sample, which comprised volunteers. Moreover, all couples with 'interpersonal problems' were exluded, and the educational level of the subjects was well above average. The authors also relied on the patients' subjective estimates of ejaculatory latency as the sole outcome measure and those approximations may also have been influenced by the demand characteristics of the study. They also did not provide details of the amount of telephone contact involved, or of the content of the calls, and follow-up measures and independent ratings of sexual adjustment were also absent.

A second self-directed treatment manual for premature ejaculation, based on Masters and Johnson's (1970) approach, as well as the Semans' procedure (Semans, 1956; Kaplan, 1974), was developed by Zeiss and Zeiss (1975). After a preliminary report of a successful outcome for two couples (Zeiss, 1977a), Zeiss (1977b) conducted a comparative study of three forms of administration of the above procedure with a total sample of 20 couples, whose main complaint was premature ejaculation. Three treatment groups were compared:

(a) standard directed practice and once weekly counselling
(b) a self-help approach using the above manual on a totally self-administered basis, and
(c) the same approach as for (b), but on a minimal contact basis - therapist involvement being restricted to once weekly telephone contact.

All couples except one dropped out of treatment in the totally self-administered condition and the remaining couple was subsequently rated post-treatment as unimproved. On the other hand, all six couples in the standard counselling group and five out of six in the minimal contact group were condisered to have been successfully treated. No significant differences were found post-treatment between these two treatment groups on any measure. Although follow-up measures of ejaculatory control were still significantly higher than pre-treatment

levels, there was also evidence of a significant decrease in latency in the four months following therapy.

It is difficult to determine the representativeness of his sample, since an unkown number of subjects were recruited through local newspaper advertisements and the principal diagonostic criterion was a temporal one (viz. latency less than 5 minutes), there being no concession for female satisfaction. Nevertheless, the results suggest that a minimal contact approach can be an effective means of treating some cases of premature ejaculation, and that some degree of therapist involvement may be necessary in order for couples to comply with treatment demands. With respect to the latter finding, it is noteworthy that similar results have been reported by Bellack (1975; 1976); Bellack et al (1974); Hagen (1974) and Mahoney et al (1973) in relation to weight reduction self-help programmes. The general conclusion has been that external control at some level may be necessary for compliance and the maintenance of self-control, and that the degree of external control invoked may be less important than its presence or absence per se (Bellack, 1976; Bellack et al, 1976; Mahoney, 1974; Kanfer and Karoly, 1972).

In addition to method of administration, the instructional medium of self-help programmes has also been examined. McMullen and Rosen (1979) who have conducted the only other controlled study in this field, compared written and videotaped forms of a nine step directed masturbatory programme (Lo Piccolo and Lobitz, 1972) with 60 women with primary anorgasmia. No significant post-treatment differences on any dependent measure were found between the video and written treatments, both of which were significantly better than a waiting list control group in terms of frequency of coital and non-coital orgasms. McMullen Rosen (1979) interpreted these results as showing that the didactic or informational content was the effective variable. Yet, such a conclusion may not be justifiable since each medium of presentation may have been contributing to change non-didactically, or in a way specific to itself.

Finally, the only other programme for which data have been reported is that of Kass & Stauss (1975) who briefly described a minimal contact treatment self-help programme for thirty couples with a variety of

forms of sexual dysfunction. Details of the problems treated and the number of individuals within each problem category are not clearly specified. Moreover, the only results described are those relating to orgasmic capacity. Of the nineteen couples who remained in treatment after the first week, all but one were orgasmic by the end of the programme. Possible reasons offered for eleven couples dropping out of treatment in the first week were the 'unpolished and cryptic' style of the early version of the guide and the presence of other more general interpersonal problems.

In general, therefore, there is some evidence that some cases of premature ejaculation and primary orgasmic dysfunction may respond to self-help programmes, but any conclusions concerning their general efficacy for such disorders must still be tempered by some obvious qualifications relating to sample representativeness and initial severity of the disorder. Correlates of improvement with self-help procedures are still inadequately investigated and so there are no clear prognostic indicators even within these problem subgroups, as to which couples may or may not benefit from this approach.

Even more scarce are outcome studies of self-help treatments for other forms of sexual dysfunction, despite the large number of published texts and their "over the counter" availability. It would, therefore, be important to examine more fully and adequately the effectiveness of such programmes in the treatment of not just premature ejaculation,but other disorders such as erectile impotence, veginismus and female sexual unresponsiveness - these being among the most frequently referred types of dysfunction.

Frequent versus Infrequent Counselling Sessions

Another reason behind the decision to investigate the relative efficacy of minimal contact and regular counselling programmes is derived from the evidence from those studies comparing frequent with less frequent counselling.

Although a study by Arentewicz (1978) involved a comparison between long-term therapy (i.e. twice weekly sessions) and intensive treatment (i.e. daily sessions), interpretation of the effects of frequency of counselling (which was not a central aim of the study) is confounded by the fact that therapy was not time-limited. However, no significant

differences were found between the two therapy conditions.

At least three time-limited studies have consistently shown no significant advantage of frequent (i.e. weekly) over less frequent (i.e. monthly) counselling sessions. In the first, Carney et al (1978), using a balanced factorial design, compared the effects of testosterone and a minor tranquilliser (diazepam), each combined with conjoint counselling, conducted either weekly or monthly with a sample of 32 couples, whose main complaint was female sexual unresponsiveness. At the end of treatment, there was no significant differences between the weekly and monthly conditions on the direct measures of sexual response. However, the monthly regime was associated with the male partner being rated by his wife as more loving and less tense than those having weekly sessions. This was interpreted as suggesting that the non-presenting partner may feel under less pressure when less frequent attendance is required. Thus, although the evidence is not particularly strong and requires replication, there is some suggestion that less frequent sessions (viz. 5 sessions) in some respects at least, may even be more helpful than more frequent attendance (viz. 16 sessions).

A sequel to the above study by Mathews et al (cited in Mathews, 1981) with a comparable group of 48 couples with general unresponsiveness in the female as the main complaint, was conducted. In this study, one versus two therapists, testosterone versus placebo and weekly versus monthly sessions were compared in a factorial design. The treatment duration was about 3 months, at the end of which no significant differences were found between weekly (a total of 13 visits) and monthly (a total of 5 visits) counselling sessions.

Finally, the results of an unpublished study by Lo Piccolo (cited by Marks, 1981) also revealed no significant advantage with weekly over monthly sessions of behavioural treatment for sexual dysfunction.

While it is conceded that such findings may be considered to be only indirectly related to the study of minimal contact self-help programmes, insofar as the form and content of therapist contact also differs between the above treatments and self-help programmes, the general weight of evidence so far consistently suggests no clear advantage with

frequent as opposed to infrequent counselling.

Potential Relevance to Patient Compliance with Treatment

Another major reason for examining the efficacy of written guides in the management of sexual dysfunction, is that the use of such material may have an important role in the enhancement of patient compliance with treatment, particularly when used as an adjunct to normal clinical procedure. If so, one may predict an increasing use of written material in behaviour therapy for a wide range of disorders.

The potential value of written material in relation to treatment compliance demands consideration for a number of reasons:

(a) Behaviour therapy, by definition, involves behavioural change and typically demands the patient's active co-operation and implementation of procedures on a "homework" basis. There is already a considerable amount of evidence to show, however, that co-operation in therapy is less easily achieved when treatment demands active as opposed to passive involvement (Davis, 1967; Johanssen et al, 1966). Indeed, 'a steep gradient has been demonstrated in which the compliance exhibited by patients who must acquire new habits, such as taking medications, is much greater than that exhibited by those who must alter old behaviours, such as dietary or vocational habits, which exceeds in turn, that of those who must break personal habits such as smoking, or drinking or non-medical use of drugs' (Haynes, 1976, page 31).

(b) There are obvious constraints with most forms of homework or "instigation therapy" (Shelton, 1979) in terms of evaluating progress, correcting misunderstandings, obtaining and providing feedback, etc. This may be considered to be particularly true in sex therapy, in which there are even greater limitations on the therapist's control over the procedural aspects of treatment, for ethical and practical reasons.

(c) Compliance has also been shown to be lower among patients with a psychiatric diagnosis than among those whose problems have been diagnosed as organic (Alpert, 1964; Atkinson, 1971; Carr and Wittenbaugh, 1968; Wilson and Enoch, 1967).

(d) A decline in compliance in direct relation to the length and complexity of therapy has also been demonstrated (Bergman and Werner, 1963; Francis et al, 1969). Insofar as sex therapy typically

extends over weeks and months rather than days, consideration of compliance issues is again suggested.

(e) Finally, there is evidence, in support of a cognitive hypothesis of compliance, that there is a direct relationship between a patient's comprehension and retention of medical information presented to him by a doctor, and his satisfaction with the communication and his compliance with the advice therein (Ley et al, 1976). This was experimentally demonstrated by Ley and his colleagues in a series of studies which began in 1965, after having first shown that there are indeed problems of comprehension and recall of medical information in the general population.

Thus, there is a surprising lack of elementary medical knowledge, as well as active misconceptions, about basic bodily functions among the lay population (Boyle, 1970; Roth et al, 1962; Spelman and Ley, 1966). One may reasonably suspect that the same deficiencies of knowledge and mistaken beliefs would characterise the layman's understanding of sexual issues given that even medical undergraduates have been shown to have an alarlmingly poor knowledge of central aspects of human sexuality (Lief, 1968).

With regard to recall of medical information, there is also evidence that patients tend to forget substantial amounts of information given to them by their doctor. For example, medical outpatients have been shown to forget about 40% of information within 10-80 minutes of its being presented, a tendency unrelated to age or intelligence (Ley and Spelman, 1965; 1967). Similarly, Ley et al (1973) found among patients attending their general practitioner, that 50% of the statements given to them were forgotten within 5 minutes of the consultation.

These findings, in general, lend weight to the view that there is an urgent need for therapists (and perhaps particularly behaviour therapists) to consider ways of facilitating patient recall and understanding, particularly when direct therapist supervision is impractical. Suitably prepared and intelligible written guides, whether used as part of a self-help programme or not, may be one contribution toward resolving this potential problem, and may, therefore be considered to become an increasingly used adjunct to behavioural intervention (Dow, 1982).

Cost-Effectiveness

Finally, a comparison between self-help and regular counselling formats for sexual dysfunction also has implications for treatment cost-effectiveness. Examination of the relative cost-effectiveness of our treatment methods may be increasingly important for a variety of reasons principally related to the provision and demand for services in this field.

Although estimates of prevalence of sexual dysfunction in the general population are confounded by a number of factors, including the difficulty of defining norms, and the extent to which individuals or couples regard themselves as both having sexual problems and wanting help for them (Hawton, 1982).

Nevertheless, prevalence estimates have been made, and are highly variable depending on the sample. They range from a spuriously high rate of approximately 50% (Masters and Johnson, 1970; Frank et al, 1978) to about 25% of patients attending a clinic for sexually transmitted diseases (Catalan et al, 1981) and 10% of women attending a family planning clinic (Begg et al, 1976). A similar figure of 11% was reported among a sample of newly referred married psychiatric out-patients (Swan and Wilson, 1979).

As Hawton (1982) has stressed, however, despite uncertainty concerning the precise prevalence of sexual dysfunction in the general population, the demand for treatment at most sexual problem clinics, with, for the most part, considerable delays before being able to initiate treatment, is in itself an index of the need for expansion and streamlining of services in this area. This argument is further strengthened by the potential contribution of sexual dysfunction to general marital disharmony (Frank et al, 1976), the effect of the latter on the children of such marriages, and the rising rate of divorce.

Thus, given the need to develop our resources in this field, coupled with staffing and other economic constraints on so doing, the cost-effectiveness of our methods is becoming an increasingly important factor in determining choice of treatment. Yet, only rarely are cost-effectiveness indices accounted for in the design and assessment of "self-help" outcome research (Glasgow and Rosen, 1978), although, as

noted above, such factors have been prominent among the reasons for the development of bibliotherapy. Rosen (1976a) has argued, in addition, that if patients can be shown to treat themselves effectively, then these treatments can usefully serve as a standard against which more costly forms of treatment might be compared.

General Conclusions

The above review reveals that there has been a paucity of adequate controlled investigation of an adaptation of Masters and Johnson's procedure as conducted within an NHS or comparable setting. One of the few studies to fulfil the basic methodological requirements of such outcome evaluation and which is sufficiently clearly presented to allow reasonably clear interpretation is that of Mathews et al (1976), and the need for a sequel to this research is proposed.

One of the aims of Mathews et al's comparative study, with their inclusion of a minimal contact approach, was to help identify the effective component(s) of a "Masters and Johnson's" treatment. In so doing they observed a variability of response to the minimal counselling procedure which may be considered to warrant, in itself, further examination. In addition, it has been argued that there is an increasing need to examine more closely the relationship between differential response and salient patient and problem characteristics.

The need for further examination of a minimal contact approach for sexual dysfunction is also clearly apparent in view of the current ready availability of such programmes, whether in 'non-prescription' form or not, and the anticipated growth of such programmes - in written, audio or video format - in the absence of adequate empirical evidence of their efficacy. Controlled evaluation is also prompted by the methodological shortcomings of much of the previous limited research in this field, and the restricted focus of interest in terms of problems treated.

Previous outcome research in this area has been bedevilled by a significant problem of non-compliance and, in general, the evidence so far suggests that, in order to help minimise this potential problem (a) some degree of therapist involvement is necessary and (b) that general level of readability and intelligibility of the material should be primary considerations in its design.

Similarly, despite the widely recognised implications of self-help procedures for treatment cost-effectiveness, the design and methodology of comparative studies in this field have, for the most part, offered little opportunity for examination of this factor.

Thus, at least three major conclusions may be drawn from the foregoing review:

(a) that there is a need for controlled evaluation;

(b) that an examination of the relationship between treatment outcome differences and patient/problem variables may be of interest; and

(c) that a study of the cost-effectiveness of our treatment methods may also be of value.

Aims of Present Study

Thus, in accordance with the above conclusions, the first aim of the study is to examine the treatment effects of a modified Masters and Johnson approach (involving both directed practice and counselling) and a comparable self-help approach presented in written guides (directed practice with minimal counselling) with a mixed sample of couples with sexual dysfunction. These effects are examined by comparing each treatment group with a similar sample of untreated, waiting-list, control couples.

The second aim is to examine the pre-treatment relationship among the different problem subgroups comprising the sample on a range of dependent measures of sexual and marital adjustment.

The third aim is to examine the relative effects of the treatments within and across each of the problem subgroups.

Statement of Hypotheses

In the light of previous findings reported above, the following hypotheses may be proposed:

(1) that both treatment procedures would be superior to a waiting-list control group in increasing sexual adjustment

(2) that a modified Masters and Johnson approach, by virtue of the addition of regular counselling, would be superior to the self-help procedure in

(a) improving aspects of the general marital relationship

and (b) producing greater positive sexual attitude change.

CHAPTER 5

METHODOLOGICAL ISSUES RELEVANT TO RESEARCH DESIGN

Before describing the present study in detail, there are at least two important methodological issues relevant to research in this field which should be briefly discussed. These are (1) outcome assessment in the treatment of sexual dysfunction and (2) the use of control groups.

Assessment of Outcome in Research on Treatment of Sexual Dysfunction

The problem of measurement of therapeutic-effects is a long-standing issue in psychotherapy research in general. One problem in assessing outcome is that different measures, or types of measure, when applied to the same case, may indicate different outcomes (cf O'Gorman, 1978) i.e. there may be a low correlation among various outcome measures (Garfield et al, 1971a; 1971b; 1974;, Leve, 1974). While such a generally poor relationship between different measures of treatment outcome may be improved to some extent by fairly elaborate statistical manipulation of the raw data, the conceptual problem may still be a very real one (Fiske, 1971; Luborsky, 1971; Berzins et al, 1975). One way of resolving this problem has been proposed by Strupp and Hadley (1977) who note that a treatment's effects may be evaluated from three different perspectives: behaviour; affect; and personality factors - there being no logical reason why these types of outcome data should be highly correlated. Thus, low correlations among these measures may simply be a function of the contrasting but complementary perspectives from which outcome is measured.

In any case, it is important in this, and similar areas of research, to include multiple measures of outcome (Mahoney, 1978; Lo Piccolo, 1977), not only to enhance assessment reliability but to test for generalisation effects. From the introductory review, it would appear that much of the research on the treatment of sexual dysfunction may be criticised on the grounds of a lack of broad spectrum, multi-level measures of a number of apsects of sexuality and related features of the relationship as a whole. Some of the studies have relied exclusively on self-report scales, a practice which has been criticised mainly on the basis of reduced reliability (Mahoney, 1972) and for its purported effects, in itself, either positively (Rubin and Mitchell, 1976; Bean, 1952; Kanfer, 1975) or negatively (Rubin and Mitchell,

1976; Katz, 1973) on the specific behaviour under study. Findings with respect to sexual behaviour, however, have to some extent, been conflicting as Persky et al (1981) failed to provide supportive evidence for similar effects of the assessment process on the sexual behaviour of non dysfunctional couples.

Another assessment problem concerns the lack of comparability among measures in related research projects. While this problem may be considered to relate to the broader issue of whether outcome assessment should be more idiographic and particularised to individual cases and to the possible insensitivity of standardised measures to particular patients (Garfield et al, 1971a), it has also been argued (Fiske, 1971; Strupp and Hadley, 1977) that unless some standardised set of outcome measures are uniformly used across studies involving group designs, it may retard the development of a systematic body of knowledge about the therapy process. However, it should also be stressed that there is still a need for further evaluation of assessment strategies and measures with respect to sexual functioning.

Another major problem concerns the use of therapists' global judgements of "success" or "failure" as outcome data. The dubious value of such judgements stems principally from experimenter bias, and the fact that it has been shown that therapists tend to exaggerate the general benefits of treatment compared to more objective data (Garfield et al, 1971a). Lo Piccolo (1977) asserts that in studies of treatment outcome for sexual dysfunction, therapists' unsubstantiated global judgements remain the most common outcome data, despite the fact that it may be the least meaningful of the three classes of outcome data proposed by Strupp and Hadley (1977).

Furthermore, Lo Piccolo (1977) argues that 'researchers have a tendency to make up new sexual assessment questionnaires and inventories without consideration of the statistical issues involved in test construction (e.g. reliability, validity, factorial purity, internal consistency, etc), and, therefore, may be gathering meaningless data' (page 48).

In view of the above issues, the following recommendations may be proposed for improving outcome assessment in the treatment of sexual dysfunction.

(a) Breadth of Assessment

Following Lo Piccolo (1977), and consistent with Strupp and Hadley's (1977) views, evaluation of outcome should involve a multi-dimensional approach involving behavioural data, patient self-reports and evaluation by a qualified experienced independent clinician, blind to group membership and whose focus of assessment is theoretically unbiased and based on clear operationally predefined criteria.

(b) Reliability and Validity of Measures

These should be demonstrated rather than assumed, although it is conceded that there is to date little relevant data on a suitably wide range of acceptable scales for use across studies, across discrete forms of dysfunction and across cultures. There has been a strong tendency, therefore, for clinicians to compose their own specific scales, albeit with high face validity, but without recourse to the principles of test construction so that the extent to which such measures may reflect the effects of social desirability, defensiveness, etc, may be unknown. Although some attempts have been made to provide reliable and valid measures for treatment outcome research (e.g. Lo Piccolo and Steger, 1974; Hoon et al, 1976; Harbison et al, 1974) at least one of these - the Sexual Interaction Inventory (Lo Piccolo and Steger, 1974) has been subject to significant criticism (McCoy and D'Agostino, 1977) as will be described in more detail later. This entire area is an important field for further research by clinical psychologists, in particular, but in the meantime reasonable steps ought to be made, not only to select scales for which reliability and validity data are available and which may be culturally appropriate, but also to demonstrate at least an acceptable level of reliability (test-retest, split-half or inter-rater) among those with already high face validity.

(c) Standardised Assessment

Whenever possible, the assessment battery should include scales used in related research to permit, to some extent, a cross-study comparison of results, thereby facilitating the accumulation of a coherent body of scientific data in a particular area.

(d) Symptom Focussed Assessment

Lo Piccolo (1977) has stressed that there is as yet no valid assessment device which focusses on particular forms of sexual dysfunction, in contrast to the more broad focus of scales such

as the Sexual Interaction Inventory (Lo Piccolo and Steger, 1974) or the Sexual Arousability Inventory for females only (Hoon et al, 1976). One scale which was devised specifically for impotence, viz. the Male Impotence Test (Senoussi, 1964) has been shown to be invalid (Beutler et al, 1975). The Derogatis Sexual Functioning Inventory (Derogatis, 1975) is purported to have predictive value in discriminating between impotence of organic and psychogenic aetiology (Derogatis et al, 1976), but its value as a measure of treatment outcome has not been established and would seem to be of limited usefulness in this context. Similar criticisms may also be directed towards other published questionnaires, e.g. Sexual Interest Questionnaire (Harbison et al, 1974) and the Sexual Adjustment Inventory (Stuart et al, 1975). While validity and reliability data are available for the former scale, both are lengthy and, when given together with other related measures, raise the possibility of reduced compliance.

Psychophysiological Assessment

It is not the purpose of this review to discuss in detail the application and uses of physiological assessment of sexual arousal in both men and women, which has already been fully documented elsewhere (e.g. Geer, 1975; 1980; Hoon, 1979; Rosen and Keefe, 1978; Zuckerman, 1971; Heiman, 1978). However, it may be useful to summarise the main potential utility of incorporating psychophysiological measures of sexual arousal in the assessment and treatment of sexual dysfunction.

Heiman (1978) indicates four principal uses of genital plethysmography:

(a) in the laboratory assessment of arousability in which for example clinical and non-clinical samples may be compared in their response to erotic stimuli as a means of identifying physiological differences in sexual response (e.g. Wincze et al, 1976).

(b) in the assessment of the relationship between subjective and objective measures of sexual arousal in both men (e.g. Bancroft, 1971b) and women (e.g. Heiman, 1977).

(c) in the assessment of treatment effects (e.g. Barlow et al, 1973; Bancroft, 1971b).

(d) as an integral part of the treatment process itself, such as biofeedback (e.g. Reynolds, 1980; Varni, 1973; Csillag, 1976).

Another recent line of inquiry has been in assessing the diagnostic validity of genital plethysmography in differentiating between cases of organic impotence from those of psychogenic or mixed origin (Fisher et al, 1975; Karacan, 1978a b; Karacan et al, 1975, 1977) - an area of research still essentially in its early stages.

It is important to stress, however, that such physiological data do not replace, but complement, the subjective data provided by self-report questionnaires or independent rating scales as a measure of treatment outcome (Jehu, 1979).

Firstly, the issue of whether such vasocongestive responses to discrete erotic stimuli in a laboratory setting has external validity to the normal sexual situation outside requires further investigation. Heiman (1978) points out that some recent developments in the continuous recording of vaginal blood volume outside the laboratory may have potential in this respect (Sarrel et al, 1977).

In addition, aspects of sex therapy also clearly extend beyond an individual's genital vasocongestive responses. Increased marital adjustment and attitude change may be particularly important issues (e.g. Tullman et al, 1981; McGovern et al, 1975; Whitehead and Mathews, 1977; Renshaw, 1975).

Thirdly, direct measures of physiological sexual arousal, while providing an objective measure of a specific genital response, are not the only source of "truth" about human sexual functioning. Such measures of physiological arousal and the self-reports of subjective arousal are not always in agreement, and neither is necessarily an accurate index of the other.

Finally, the special equipment and expertise required for such physiological measurement contribute further to its limitations in clinical practice.

Use of Theoretically Relevant Measures

Lo Piccolo (1977) and Bentler and Abramson (1981) have criticised a recent tendency to include measures only tangentially related to the hypotheses or objectives of the research.

It is important that the range of assessment measures be sufficiently wide to allow valid and reliable assessment of the main areas of clinical interest, but also be limited to those which may be justified in terms of their theoretical relevance. The importance of being selective in the choice of measures may be justified on the following grounds:

(a) evidence of frequently low correlations among therapy outcome measures referred to above.

(b) the possibility of reduced patient compliance in direct relation to the range and volume of assessment measures, and

(c) statistical theoretical hazards of including a large number of measures in the absence of detailed hypotheses, given the possibility of "discovering" statistically significant findings which may be a function of chance (Cook and Campbell, 1979).

Methodological Issues in the Use of Control Groups

In the evaluation of new methods of treatment, particularly when these may be available for use in the absence of adequate therapist supervision, the need for comparison with suitable control group(s) seems obvious. Ideally, alternative conditions should control for "non specific" therapy effects, such as therapist contact and attention, suggestion, patient and therapist expectancy effects, and spontaneous remission. The two principal conditions used to control some of these factors are a waiting list no treatment control group and a placebo control group - both of which have received some criticism in recent years (Lo Piccolo, 1977; O'Leary and Borkovec, 1978).

Waiting-list control groups do not of course control for expectancy effects and are not an alternative to an attentional or placebo control group. However, they have been considered to provide 'crucial information regarding the natural history of a disorder' (O'Leary and Borkovec, 1978, page 829). Yet one of the major criticisms of waiting list controls is that they do not provide control for the effects of spontaneous remission. Thus, it is argued that so called "spontaneous remission" may not be spontaneous at all, but reflect the effects of (1) environmental events; (2) assessment reactivity; (3) normal cyclicity of functioning and regression effects (Lo Piccolo, 1977).

Environmental Events

Lo Piccolo (1977) asserts that the disappointment of being placed on a waiting list at a time when motivation for treatment is already high may prompt the couple to seek out informal therapy, e.g. buy sex-therapy manuals; seek advice from G.P.; marriage guidance counsellor or clergyman; watch sexually explicit films, etc.

Assessment Reactivity

Certain assessment materials and procedures may lead incidentally to an increased awareness of aspects of potential methods of treatment, e.g. use of vibrators, erotic material, masturbatory procedures, coital positions, etc, which may then be self-administered during the waiting period.

Normal Cyclicity of Functioning and Regression Effects

That many couples may seek out help at a time of crisis or acute upset should also be recognised, since it may have at least two implications for a waiting list control condition:

(a) scores obtained at initial assessment may be extreme. The instability of such extreme scores, however, is likely, with a second assessment, to lead to 'regression toward the mean', which in turn, therefore, may appear to indicate "spontaneous remission" (Campbell and Stanley, 1963; Davis, 1976).

(b) In addition to the above statistical effect, the more extreme acute upset which may prompt initial presentation is also likely to diminish over the waiting period.

For all of the above reasons, a waiting-list control group, it has been argued (Lo Piccolo, 1977), may obscure the true effectiveness of treatment, although some of these "spontaneous remission" effects may be minimised by using, for example, assessment procedures which are as unreactive as possible, and by asking about any informal therapy sought out by couples during the waiting period, etc.

The arguments against the use of placebo control groups in sex therapy research (which does not involve drug evaluation) are even more cogent, and impinge on issues of theoretical, methodological, practical and ethical relevance. The most frequent use of placebo treatments in this field has been in psychopharmacology and therapy-analogue

research. In these contexts, the use of such controls has been, in general, appropriate and instructive. Unfortunately, it would seem to be virtually impossible to control for placebo effects in psychotherapy, including sex therapy.

Firstly, if a placebo treatment is developed which is genuinely therapeutically inert, patients are quite likely to realise that they are not receiving an "active" treatment (Silbergeld et al, 1976). On the other hand, if the placebo treatment is sufficiently similar to a genuine treatment to be plausible, it is probably not a placebo at all, but has actual therapeutic ingredients. In either case, however, the therapists clearly cannot remain 'blind' throughout as to group membership, which is a potentially major shortcoming, since therapist expectation for change has been shown to be a good predictor of outcome (Martin and Stern, 1975; Lick and Bootzin, 1975).

Finally, in his review of the area, Lo Piccolo (1977) draws the following conclusions and recommendations for the controlled evaluation of sex therapy, which does not involve drugs:

> 'In studies evaulating the effects of treatment innovations, the investigator should probably use two different control groups. An untreated waiting list control group has utility in controlling some threats to validity but creates an additional set of problems, as discussed above. Addition of a "placebo" control group deals with many of these problems. What is proposed here as a "placebo" control group is simply the standard Masters and Johnson sort of sex therapy. This is not truly a placebo control group, of course, as it is an active treatment in itself. In evaluating the effects of a treatment innovation, however, the standard therapy can serve as a baseline against which new procedures can be compared.' (Pages 45 and 46)

The design of the present study, therefore, ought to comply with these recommendations.

CHAPTER 6

DESIGN OF THE STUDY

Successive couples presenting for therapy for sexual dysfunction, who met the criteria below for inclusion in the study, were allocated, according to a pre-arranged random list, to one of two treatment groups or a waiting list control group. Allocation was so arranged that half of the total sample were offered an immediate start in treatment and half were put on a waiting list, the duration of which ranged from 2.5-4 months (modal no. weeks = 13) i.e. did not exceed the maximum duration of therapy. The 'immediate start' and waiting list groups were also balanced for main type of dysfunction as indeed, as far as possible, were the two treatment groups throughout. At the end of the waiting-list period, control couples in each of the separate problem categories were then allocated at random to one of the two treatment groups. Details of the design are summarised in Fig. 1 overleaf.

In most cases, at the outset, members of each couple were interviewed by a psychiatrist of at least Registrar level, and who was independent of the study, to exclude the possibility of primary or concomitant psychopathology which would pre-empt direct treatment of the sexual problem. Thereafter, an additional detailed sexual history and assessment was conducted with each partner independently and then conjointly by the author, before a final decision was reached as to the predominant problem, if either more than one dysfuction was present in the same partner, or there was evidence of sexual dysfunction in both members of the couple. At the end of this assessment interview, each partner was given a series of questionnaires to complete at home, for baseline assessment, and was asked to return these on the next appointment, one to two weeks later. In the case of the control subjects independent ratings of sexual functioning in the complainant were completed, but it was explained that because of a waiting list, therapy would have to be postponed for about three to four months. Indeed, in view of the fact that only one therapist was involved throughout, it was necessary, in any case, to have a waiting list which all couples, so informed, appeared to accept. The importance of their completing the assessment forms as soon as possible after the initial interview was impressed upon both partners.

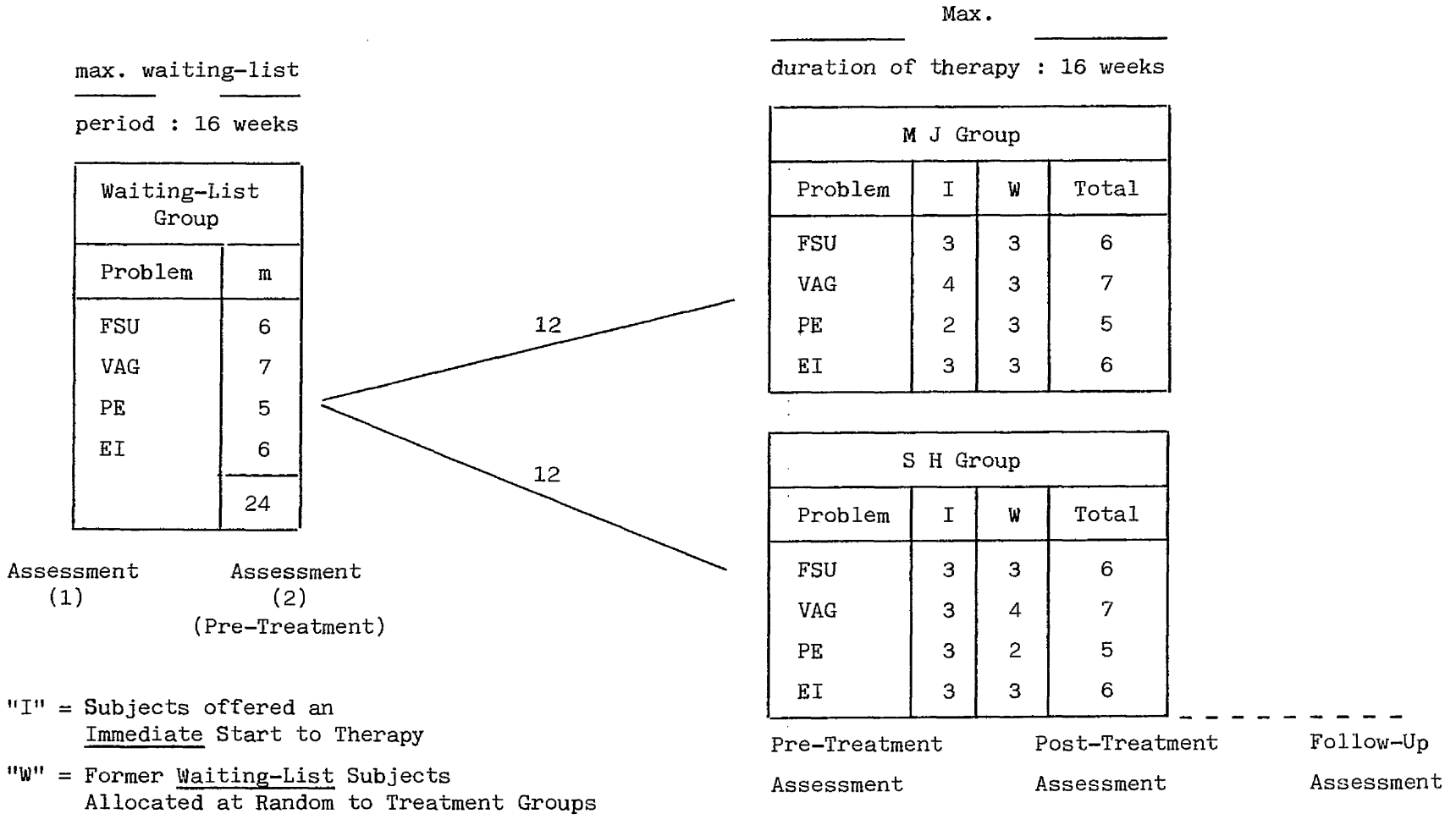


Fig 1 Summary of design showing assessment points and breakdown of treatment and control group patients by form of dysfunction.

The second session for all couples was arranged as a form of 'round-table' discussion, in which a simplified aetiological view of the problem was presented together with further details of the implications of treatment for both partners. Independent ratings of sexual functioning were then completed at the end of this session.

The different treatments then began either with once weekly visits to the clinic or with weekly telephone contact and continued for a maximum of sixteen weeks. At the end of this time, or when it was clear that the treatment goals were attained, post-treatment independent assessment was conducted and the same series of questionnaires was completed. A final follow-up interview with the assessor and distribution of questionnaires were arranged after a further four months.

CLINICAL AND DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE AND SELECTION CRITERIA

All salient demographic and clinical characteristics of the sample are summarised in Tables 3 to 12 (including Appendix 2). Forty-eight couples, representing four of the most frequently referred types of sexual dysfunction, were included in the study. Twenty-six couples were classified as primarily female problems and twenty-two as male. For twelve of the female complainants, the principal sexual dysfunction was general sexual unresponsiveness, and for fourteen, the main complaint was vaginismus.

Among the twelve females with general unresponsiveness, three also experienced forms of orgasmic dysfunction (viz. situational, primary and secondary anorgasmia) and an additional two showed varying degrees of inhibited sexual attitudes. In each case, however, the principal and presenting complaint was an 'excitement phase', rather than an 'orgasmic phase', disorder (Kaplan, 1974). There was evidence of sexual dysfunction in the partners of only three of these females: in two cases, mild premature ejaculation and, in one, intermittent ejaculatory failure.

Of the fourteen females with vaginismus, seven experienced additional sexual difficulties. Three experienced a more generalised impairment of sexual responsiveness (combined with primary orgasmic dysfunction for one), one reported orgasmic dysfunction, and three others reported primary anorgasmia. Among the partners of these females, only two showed evidence of a sexual difficulty, characterised in one case by inhibited sexual attitudes and low libido, and premature ejaculation in another.

The twenty-two male complainants formed two subgroups according to the principal dysfunction. For ten, this took the form of premature ejaculation, and for twelve, erectile impotence.

In no case was premature ejaculation associated with any other sexual difficulty or dysfunction among the male complainants. However, for six couples, the female partner showed evidence of some impairment of sexual responsiveness (combined with secondary orgasmic

dysfunction* for four) and one other female partner was fearful of reaching orgasm.

Couples whose presenting complaint was erectile failure comprised two males with primary impotence and ten with secondary impotence. Only the latter group showed evidence of additional sexual dysfunction in the form of intermittent premature ejaculation in two of the complainants and anaesthetic ejaculation for a third. Among the female partners of the impotent subgroup, mild vaginismus was also apparent in two couples (i.e. those with primary impotence), general unresponsiveness was evident in two others and secondary orgasmic difficulties were present in four. Thus, the distribution of conjoint sexual difficulties in the sample - with the larger proportion among the male as opposed to the female presenters - is consistent with that found in the samples of recent related studies in this country (e.g. Mathews et al, 1976; Crowe et al, 1981).

Criteria for Subject Selection

(1) Each relationship should be characterised by at least one of the following dysfunctions, as previously defined:

(a) General sexual unresponsiveness in the female

The results of independent blind pre-treatment ratings showed that of the twelve couples with the above as the principal dysfunction, three of the females were 'repulsed by the thought of "normal" sexual activity'; six experienced an interest or desire for sexual relations only rarely (less than once monthly); and two less than once weekly. One couple was not available for such pre-treatment assessment.

In accordance with these findings, six of the females never achieved adequate vaginal lubrication during coitus, and only occasionally exhibited a vaginal response during foreplay which was difficult to achieve or/and short-lived.

*Given the brevity of ejaculatory latency, it should perhaps be pointed out that this term is used here to refer to an orgasmic incapacity irrespective of the form or source of stimulation.

At the other extreme, only two couples achieved adequate vaginal lubrication throughout foreplay and coitus, but only on approximately 50% of occasions.

In the absence of any established objective diagnostic criteria, these measures lend weight to the view that this was a clinically significant dysfunction for these couples.

(b) Vaginismus

Of the 14 couples presenting with vaginismus, independent ratings revealed that twelve of the females would allow, at most, stimulation of the external genitalia by her partner, but not vaginal entry of any kind; one could accept only one of her partner's fingers, but not his penis; and one would not allow her partner to touch her genitals at all.

(c) Premature Ejaculation

Independent ratings again confirmed that all subjects met the diagnostic criteria outlined in the introduction. Thus, two of the ten males were judged to be able to delay ejaculation during coitus to "satisfy" their partners (does not necessarily mean orgasm) but on no more than 25% of occasions. Seven could delay ejaculation beyond 30 seconds on more than 50% occasions, and one on less than 50% of occasions, but none of them ever had "adequate" control, as defined in terms of that which contributes to mutual coital "satisfaction".

(d) Erectile Impotence

Of the twelve impotent patients, one could get an erection on waking only; six could obtain an adequate erection during sexual play with their partner on less than 25% of occasions but never sustained for intercourse; one could get an adequate erection during non coital play about 50% of the time, but never sustained for intercourse; finally, only three were able to obtain an erection for intercourse, but on no more than 25% of occasions.

The temporal frame of reference for the above ratings was, in each case, the six-twelve months prior to referral.

(2) Each complainant should have a regular sexual partner and both

should be prepared to participate in the treatment programme, and in the provision of assessment data.

(3) Absence of an organic basis to the problem should be established by recent physical examination (i.e. within the twelve months prior to referral). If this had not been conducted, this was arranged at a nearby gynaecology or urology clinic. This was considered particularly important for those in which vaginismus or erectile disturbance was involved. Detailed medical assessment to exclude the possible effect of drugs or/and physical and mental illness on sexual functioning was routinely conducted for all individuals. In the latter category, those who were severely depressed, or were suffering from a psychotic illness or who were alcoholics were excluded.

(4) Absence of gross primary marital disturbance, as determined by initial independent assessments by both psychiatrist and author, should be established. Formal psychometric assessment of marital adjustment was not conducted at this stage, although concordance of clinical judgement, independently reached, was imperative.

(5) There should be no regular significant practical constraints on the opportunity for engaging in 'homework assignments' at the prescribed frequency.

Use and Form of Contraception

It was considered important that all couples, where appropriate, take suitable contraceptive measures for at least the duration of therapy and follow-up period. Some couples, however, were reluctant to accept this recommendation for medical, religious or other personal reasons. It will be seen from Table 3 that a disproportionately high number of such cases fell within the vaginismus group, a finding which appeared to be a result of both religious proscription and a desire to plan a family among these subjects, ten of whom were Roman Catholic. One of the Catholic subjects in the vaginismus group was post-menopausal and so contraception was not a relevant consideration. She is consequently excluded from Table 4 which shows a breakdown of contraceptive use by religion for the vaginismus group. A Fisher Exact Probability Test showed that there was no significant relation-

Table 3 Use and General Form of Contraception Within Each Diagnostic Category and Treatment Group

	M J				'Self-Help'			
	Pill	Non* Pill	Post Meno-pausal	None	Pill	Non Pill	Post Meno-pausal	None
Female Sexual Unresponsiveness	3	2	-	1	3	3	-	-
Vaginismus	4	-	-	3	2	-	1	4
Premature Ejaculation	4	-	1	-	4	1	-	-
Erectile Impotence	2	1	2	1	2	2	1	1
	13	3	3	5	11	6	2	5

*Non Pill includes male and female sterilisation.

Table 4 Use of Contraception By Religion Among Vaginismus Group

	RC Comp. or Partner	Other	Total
Use of Contraception	3	3	6
Absence of Contra-ception	6	1	7
	9	4	13

Fisher Exact Prob. Test

P = .20 (n.s.d.)

ship ($p = 0.20$) between these two factors. (See Table 4)

The use of oral contraceptives has been implicated in female sexual responsiveness both positively (Westoff et al, 1969) and negatively (Grant and Pryse-Davies, 1968; Cullberg et al, 1969; Cullberg, 1973; Royal College of General Practitioners, 1974). Although a detailed examination of the studies of the effects of oral contraceptives on female sexual behaviour is outwith the scope of this review, Bancroft (1978), following his review of the area, concludes that the weight of evidence so far suggests that, for the majority of women, oral contraceptives do not directly reduce overall coital frequency, although individual susceptibility to oral contraceptives may exist in a small proportion of females either directly, by their effect on sexual responsiveness, or indirectly, by means of mood change.

Table 3 shows, however, that the two treatment groups as a whole, and within each diagnostic category, were broadly balanced with respect to use and type of contraceptive.

Sexual Dysfunction in the Partner

Sexual maladaptation in the relationship, in which both partners may exhibit significant sexual difficulties, has been widely documented (Bancroft, 1975; Levine, 1975; Kaplan, 1974), and Bancroft (1975) reports findings which show that sexual difficulties in both partners may be present in approximately one in four cases, although this proportion may be substantially higher, depending on the nature of the presenting complaint. This is clearly of importance both aetiologically, and in terms of management, reinforcing the argument in favour of conjoint therapy (Masters and Johnson, 1970; Kaplan, 1974; Brown and Cottman, 1974).

Table 5 shows the number of cases in which a sexual difficulty was considered to be present in the non-complainant partner. Again, these figures show no significant difference between treatment groups on this measure.

Duration of Problem

Information was obtained from each partner independently, during the initial assessment interview, as to the duration of the problem.

Table 5 Number of Couples in each Diagnostic Category and Treatment Group in which Sexual Difficulty Present in the Partner

	M & J	Self-Help
Female Sexual Unresponsiveness	2	1
Vaginismus	1	1
Premature Ejaculation	4	3
Erectile Impotence	4	3
	11	8

Table 6 Mean Estimated Duration of Problem (Years) within Each Diagnostic and Treatment Group

	M & J	'Self-Help'
Female Sexual Unresponsiveness	3.75	6.33
Vaginismum	4.21	8.21
Premature Ejaculation	4.8	6.2
Erectile Impotence	6.92	3.92
Overall Group Means (and Standard Deviations)	4.90 (3.81)	6.25 (5.32)

If there was any discrepancy in the estimates, this was discussed and an agreed figure obtained. These estimates are presented in Table 6 . There was no significant difference between the two treatment groups as a whole on this variable.
Moreover, no significant differences were found between treatment groups within each of the four problem categories, as determined by Mann-Whitney 'U' tests.

Social Class Distribution

The social status of each couple was determined according to the Registrar General's Classification (O.P.C.S., 1970), and Table 7 shows the distribution of subjects on this variable for each treatment group and within each problem category. The overall distribution in each treatment group is almost identical, and no significant differences between treatment groups were found within each problem category.

Age Distribution and Length of Cohabitation

Tables 8 and 9 give data on the above variables to the nearest year. Again, no significant difference was found between the two treatment groups, either as a whole or within each problem subgroup.

Source of Referral and Nature of Previous Therapy for Presenting Sexual Dysfunction

The number of couples referred from each major source, and the nature of any previous therapy for the presenting dysfunction are detailed in Tables 65 and 62. (See Appendix 2).

Together with the other data above, there would appear to be no evidence to suggest that the sample is unrepresentative of the sexually dysfunctional patient population normally presenting at NHS clinics, or biased toward a more favourable outcome with one or other treatment approach.

Table 66 summarises additional demographic and clinical characteristics of the sample (See Appendix 2).

Sample Attrition

As noted above, a feature consistently reported in studies employing self-help programmes is a failure of patients to comply with treatment,

Table 7 Social Class Distribution of Couples in each Treatment and Problem Group.

	Treatment											
	'M & J'						'Self-Help'					
Class	1	2	3 non man	3 man	4	5	1	2	3 non man	3 man	4	5
Female Sexual Unresponsiveness	-	1	-	4	-	1	-	-	-	4	2	-
Vaginismus	1	2	1	3	-	-	-	3	1	2	-	1
Premature Ejaculation	1	2	-	1	1	-	-	2	1	2	-	-
Erectile Impotence	-	2	1	1	1	1	-	2	1	2	1	-
TOTAL	2	7	2	9	2	2	0	7	3	10	3	1

Table 8 Mean Age of Sample by Problem and Treatment Group

Problem Type	Treatment MJ	Treatment SH	$\bar{x}$	S.D.
FSU	28.8	28.8	28.83	4.93
VAG	26.6	30.3	28.43	6.68
PE	29.2	35.0	32.1	8.52
EI	41.3	41.2	41.21	12.29
	$\bar{x}$ 31.35 S.D. 9.77	$\bar{x}$ 33.63 S.D. 9.80		

Table 9 Mean Length of Cohabitation (in Years) by Problem and Treatment Group

Problem Type	Treatment MJ	Treatment SH	$\bar{x}$	S.D.
FSU	5.8	8.1	6.96	4.84
VAG	4.3	8.2	6.25	5.26
PE	5.4	9.8	7.60	6.62
EI	6.7	14.9	10.79	10.49
	$\bar{x}$ 5.5 S.D. 4.43	$\bar{x}$ 10.19 S.D. 8.49		

and, more specifically, a tendency to drop out of therapy or/and a failure to attend for assessment purposes (Glasgow and Rosen, 1978). This problem may be expected to be compounded by the generally high drop-out rates reported among those attending psychiatric out-patient clinics. In a review of the area, Baekeland and Lundwall (1975), for example, report that 20%-50% of such patients fail to return after the first visit and 31%-56% attend no more than four times.

In the field of sex therapy, a sample attrition rate of up to 40% in a study involving hormone and counselling treatments for sexually unresponsive females has been reported (Mathews, 1981).

In the present study, ten couples (21% of the original sample) defaulted within the first five therapy sessions. A breakdown of these subjects by treatment and problem categories is provided in Table 10 below.

Table 10 Number of Couples in Each Treatment and Problem Group who Defaulted from Therapy Within the First Five Sessions

	Treatment		
	MJ	'Self-Help'	
Problem			
FSU	2	-	
VAG	-	1	
PE	1	2	
EI	3	1	
	6	4	= 20.8%

In view of the fact that this problem seemed to be due to random effects and, because of the aims of the study and the consequent need for adequate numbers in each separate problem category, it was decided to randomly replace those who dropped-out of therapy within the first five treatment sessions. Despite the fact that the number of 'drop-outs' was roughly evenly divided between treatments, it is possible that some couples may have defaulted for reasons associated with therapy - a possibility which in itself may have contributed to sampling bias. Clearly, defaulting from treatment may be difficult

to determine with a minimal contact regime, in which actual clinic attendance is not required. This may have accounted for the slightly larger number of known defaulters in the regular counselling group. However, in the case of those self-help couples who dropped-out of therapy, their decision to discontinue treatment was fairly clear, and took the form of not making themselves available for telephone contact, or openly affirming their reluctance to continue.

It would be wrong to infer that all drop-outs are invariably treatment failures, since favourable results from sex therapy have been reported after five to seven sessions (Cooper, 1979). Rosenthal and Frank (1958) also found that among psychiatric outpatients in psychotherapy who were discharged as improved, 32.5% attended no more than five sessions. Nevertheless, Baekeland and Lundwall (1975) report that 'on the average, the dropout seems to do worse than his counterpart who perseveres in treatment' (page 745-6). On this premise, his exclusion from the data pool in treatment studies can engender spuriously inflated success rates. For this reason, replacement of the early "drop-outs" was considered justifiable, and following Crowe et al (1981, page 48), it was viewed as 'the lesser of two evils'.

The numbers of couples in each problem and treatment group who defaulted after the fifth week of treatment are outlined in Table 11.

Table 11 Number of Couples in Each Treatment and Problem Group who Defaulted from Therapy After the First Five Sessions

	Treatment	
	MJ	'Self-Help'
Problem		
FSU	-	3
VAG	-	-
PE	2	1
EI	2	1
	4	5 = 18.8%

The procedure of replacement would not appear to have reduced appreciably the number of defaulters. However, the nine couples

involved included four who were members of the original sample. Thus a potential default rate of 14 out of 48 (i.e. 29.2%) was curtailed to 19%. The latter is certainly not an abnormally high figure but due to the small original size of the problem groups, it was sufficiently large to pre-empt a full statistical analysis of the data across problems and treatments. Therefore, for these nine couples, post-treatment data were secured only by written or/and telephone correspondence and ultimately, in most cases, by arranging a home visit. Thus, all the relevant data were obtained with the exception of the independent ratings.

The follow-up assessment presented, as expected, even more problems. Excluding those with vaginismus (all of whom remained in treatment after five weeks and attended for follow-up assessment), the proportion of couples in each problem group who failed to attend for follow-up were Female Sexual Uresponsiveness : 33%; Premature Ejaculation : 40% and Erectile Impotence : 42%. (See Table 12)

Table 12 Number of Couples in each Problem and Treatment Group who Failed to Attend for Follow-Up Assessment

	MJ	'Self-Help'	
Problem			
FSU	1	3	33.3%
VAG	0	0	
PE	2	2	40%
EI	3	2	41.7%
	6	7	

Exc. VAG group Follow-up default rate = 38.2%

Again, rather than lose all the data for these couples, it was decided that a much more restricted range of assessment measures (viz. the SMAR and PAD scales) be sent with a stamped addressed envelope, and in some cases a supporting telephone call, to encourage their completion and return. Again, most of the above couples (61.5%) responded to this procedure.

CHAPTER 7

TREATMENT PROCEDURES

The first interview, common to all couples, was, as noted briefly above, a history-taking and clinical assessment session, which concentrated on sexual and social development, history of the dysfunction, and a detailed account of past and present sexual attitudes and behaviour.

The second session was a "roundtable" discussion, in which the therapist (the author) summarised and attempted to integrate the account given by both partners, and to clarify any apparent disparity in the information previously obtained. Thereafter, a brief and simplified resumé of the basic physiology of sexual response was given and a subsequent discussion focussed on a simple theoretical and descriptive account of the possible aetiology of the disorder, based largely in learning terms. This included, for example, the role of 'performance anxiety' and 'spectatoring' (Masters and Johnson, 1970) generated by goal-directed sexual relations. Also discussed may have been the role of shared obstructive or conflicting attitudes or behaviour which may have been brought by both partners to the relationship, and the need perhaps to focus in the course of therapy on enhancing aspects of interpersonal communication.

At this stage, further details of the implications of treatment for both partners were discussed, in order to establish a treatment contract. Aspects of this contract differed for the two treatment groups in relation to the respective demands of each treatment which will be described in more detail below. The following salient features were common to both:

(1) The importance of accepting the role both partners play in maintaining and resolving the difficulty. Thus, both members of the couple should be prepared to be equally involved in therapy.

(2) The importance of making time at least three times each week for regular homework assignments.

(3) Couples should ensure that there are no significant regular practical constraints on the opportunity for engaging in homework assignments during therapy (e.g. changing job, moving house, prolonged visits from friends, work commitments away from home, or holidays more than a few days duration, etc.) The need to keep

the following four months relatively clear of potential distractions was, therefore, stressed. If couples foresaw any particular problem in this regard, they were informed that it would be reasonable to postpone therapy until this condition could be met.

(4) Therapy would not exceed sixteen weeks.

(5) The importance of obtaining assessment data both at the end of therapy and four months later was strongly stressed. It was explained that this was imperative for the purposes of the study, and that the information would not be included in case-notes, and that couples need only use their initials on the forms to preserve confidentiality.

Modified Masters and Johnson Approach - Once Weekly Conjoint Counselling

This procedure was that version of Masters and Johnson's approach which is normally conducted in this country in an NHS setting, and closely followed that described by Mathews et al (1976). The principal modifications were the use of one therapist and once weekly appointments.

At the end of the second "roundtable" session, a complete ban was placed on both intercourse and intimate (i.e. genital and breast) stimulation. Couples were thus advised to make time at least three times weekly for 'sensate focus' exercises. These have been described in detail by Masters and Johnson (1970) and Kaplan (1974) and will, therefore, not be expanded on here, although fuller details are provided in Appendix 8. In short, the first phase of sensate focus required each partner to alternate in caressing and being caressed within the limits set, and to focus his/her attention on pleasurable sensations from stroking and being stroked. Each partner was advised to concentrate on whatever he or she found pleasurable at any given time, either as the more active or passive partner, and to communicate any specific desires or preferences as necessary. The rationale for so doing was also fully explained, in general terms, by discussing the maintenance of sexual inhibition by anticipatory 'performance anxieties' and the tendency to 'spectate'.

The second main phase of sensate focus usually began from one to approximately three weeks later, contingent on adequate relaxation and mutal enjoyment of the first stage, and included permitting more intimate genital and breast contact with instructions to guide the more active partner's hand, or otherwise communicate preferred types of stimulation, in terms of both place and form.

This second main phase of sensate focus continued for about two weeks before the introduction of additional techniques for each specific problem, while the ban on intercourse was maintained. Therapy continued throughout at a rate largely determined by the couple's progress.

Additional Behavioural Instructions Specific to Each Problem

Premature Ejaculation:

In the treatment of premature ejaculation, couples were instructed in the 'squeeze' technique (Masters and Johnson, 1970), an extension of the procedure first adopted by the urologist, Semans (1956).

In the present study, the female was advised to stimulate the penis manually until he experienced the earliest sensations premonitory to orgasm. She was then advised to place her thumb on the frenulum and her index and middle finger on the dorsal surface of the penile glans, straddling the coronal ridge. She was then to apply a three to four second squeeze to the glans. Couples were advised to practise this 'squeeze' procedure about three times in each homework session.

Erectile Impotence:

In cases of erectile impotence, couples were encouraged to engage in "diversionary" non-demanding genital play (Bancroft, 1975), with verbal or/and non-verbal guidance concerning the most pleasurable form of stimulation. With the return of erections during this phase, they were then advised to follow a "teasing" technique (Masters and Johnson, 1970), which involved the cessation of sexual play to allow a period of distraction for the male with consequent loss of erection, before resuming intimate non-demanding genital stimulation. This procedure was to be followed for about thirty minutes in each session, the aim being to reduce fears of being unable to sustain an erection or, in particular, to regain an erection if one were lost.

General Female Sexual Unresponsiveness:

Other than guided undemanding genital stimulation with the use of a suitable lubricant, if desired, no other behavioural instruction, specific to the treatment of this disorder, was provided at this stage. More specifically, since the attainment of female orgasm was not a primary aim of treatment, couples were not directly encouraged to engage in deliberate masturbatory stimulation for the explicit purpose of inducing female orgasmic release (cf Lobitz and Lo Piccolo, 1972; Kohlenberg, 1974; Reisinger, 1974).

Vaginismus:

Relevant sex education was supported by the use of drawings of the female pelvic anatomy. Advice concerning relaxation and discrimination of tension and relaxation in pelvic muscle groups was also offered. Couples were instructed to follow a hierarchical sequence of dilation exercises using first the female's smallest finger, progressing gradually to two of her partner's fingers in order to decondition the inhibitory muscle spasm. A suitable artificial lubricant was recommended at all times during these exercises.

The next stage of therapy for all couples involved practising non-demanding sexual intercourse with the emphasis initally on relatively passive intravaginal containment of the penis, rather than on a pattern of immediate mutual thrusting. Typically, the female was advised to control vaginal entry of the penis and to adopt, in so doing, the female superior position, unless an alternative position facilitated greater mutual pleasure and comfort.

Thus, with the exception of some of the more specific behavioural techniques introduced prior to attempting intercourse, couples were encouraged, within the above general standardised framework, to experiment to some extent, to communicate preferences, and to learn to focus on the immediacy of the sexual experience, rather than be distracted by an overconcern about what they felt they ought to achieve.

Counselling Aspect of Therapy

This aspect of treatment is less easily described, but is principally concerned with the identification and resolution of key attitudes or resistances which may impede progress with the more clearly behavioural

or 'directed practice' aspects (Mathews et al, 1976) of the Masters and Johnson approach.

The modification of these attitudes and resistances is the area which overlaps with more traditional psychotherapeutic procedures and may include, for example:

(a) identifying and helping to provide insight into the role particular attitudes may have in maintaining sexual problems.

(b) encouraging couples to communicate more openly and frequently about their own feelings both in the sexual and more general marital relationship, and to identify and correct any difficulties couples may have in so doing.

(c) helping resolve guilt about aspects of sexual behaviour, e.g. by 'giving permission' (Annon, 1974).

(d) providing feedback about the possible contribution of non sexual role conflicts to the maintenance of the problem, e.g. unexpressed hositility, dominance-submission conflicts (Jehu, 1979), related "fears of success", etc.

(e) resolving unrealistic expectations about aspects of sexual functioning and treatment itself.

(f) educative counselling - providing information, correcting misunderstandings, debunking sexual myths, etc.

From a more clearly behavioural perspective, strategies for modifying obstructive attitudes, derived mainly from theoretical models of attitude change from social psychology, can also be applied. These are based mainly on cognitive dissonance and balance theories in which interpersonal attraction and insufficient incentive figure prominently as well as procedures designed to create inconsistency between attitudes or between attitudes and behaviour, thereby provoking in the patient a need to reduce this inconsistency. Such procedures are more fully discussed by Bancroft (1974a; 1974b) and Goldstein and Simonson (1971).

Behavioural 'Self-Help' Approach

A separate manual was prepared for each of the four forms of dysfunction in the present sample. Each manual was designed to instruct couples in the behavioural aspects of Masters and Johnson's treatment, as outlined above. (See also Appendix 8).

Towards the end of the second (i.e. "roundtable") session, those couples allocated to the 'Self-help' approach were given general instruction in the use of the booklet.

(1) They were advised that it was not necessary to read the entire booklet from start to finish prior to commencing treatment, but, instead, couples should read only those instructions relevant to the particular phase of treatment through which they were working, reminding themselves about any aspect of an earlier phase if they so wished. Thus, the aim was that couples be guided principally by the booklet or, more specifically, by the "feedback" obtained following the choice of "statements" at the end of each session. In this way, decisions concerning a couple's rate of progress throughout therapy ought to have been essentially self-determined on the basis of advice and directives provided primarily by the booklet rather than by the therapist.

(2) Each member of the couple received a copy of the same booklet, the choice of booklet being determined by the nature of the predominant problem.

(3) The need to make time available for both reading and discussing the material in the booklet and for practice sessions was emphasised. This served as an introduction to the inclusion of regular telephone contact in this self-help approach. The rationale for such contact was based on the importance of adequate motivation to co-operate with each other, and with the therapist, and to comply with treatment. Many studies of bibliotherapy programmes have observed significant drop-out problems, but Marshall et al (1976), Zeiss (1977 b) and Bellack et al (1974) reported that even minimal contact with a therapist may be sufficient to reduce significantly this characteristic problem.

Only two couples refused to accept these conditions and were excluded from the study, and in only one case was a couple offered regular counselling (but who would otherwise have received the self-help approach) because they did not have a telephone.

Form and Content of Telephone Contact

Telephone contact was always initiated by the therapist to the couple's home, and was conducted on a once weekly basis at a pre-arranged time.

The particular time may have been variable but was always determined in advance, i.e. at the end of the previous week's call. To minimise any potential embarrassment, each contact began with an enquiry as to the convenience of the call and, in the event of lack of privacy etc, an alternative time was arranged. The therapist spoke to both partners, and, on each occasion, the lines of enquiry followed, as far as possible, a standardised format. The average duration of each call was about ten to fifteen minutes.

The following issues were discussed each week:

(a) Frequency and Nature of the Sexual Sessions

How often had they engaged in the homework assignments and what general form did they take? Their efforts were then reinforced by praise and encouragement should the frequency have been at least three times weekly. If not, they were asked if they had experienced any difficulties which may have prevented them from carrying out the exercises. Reasons offered for non-compliance may have been practical and ostensibly unforeseen (e.g. required to work late, unexpected visitors, illness, etc) or interpretable perhaps in terms of avoidance or resistance. In the latter case, no formal attempt would be made to explore, in detailed "psychotherapeutic" terms, reasons for the couple's failure to engage in therapy at the prescribed frequency. Instead, it would be pointed out that many couples express similar difficulties, particularly in the early stages of treatment, that these may be construed as an understandable, but maladaptive tendency to avoid initial anxieties, etc, and the importance of making time available would be cogently restressed.

(b) Specific Difficulties During Sessions

Had the couple encountered any particular difficulties during any of their sessions? If either partner expressed any specific concern, this was responded to in fairly general terms by reiterating or paraphrasing briefly the appropriate advice in the booklet and directing them to the relevant section. The therapist was careful to avoid introducing content not contained in the manual.

(c) Comprehension of Manual

Had the couple failed to understand any aspect of the manual? Any uncertainties or areas of disagreement between partners about

sections of the booklet were again briefly clarified, again without any supplementary instruction or advice.

(d) Arrangement of Future Behavioural Sessions

The booklet was so designed as to be the primary guide to progress through the different phases of treatment. However, if there was any uncertainty regarding the next stage of therapy, the therapist attempted to clarify areas of doubt, or to endorse or correct the couple's own decisions concerning the rate of progress, or the form the next phase of therapy should take.

(e) Arranging Time for Next Call

A mutually convenient time for the therapist to call again was arranged.

There is little information on the nature of telephone contact in similar studies involving behavioural self-help programmes. Those details which are available, however, suggest that the telephone correspondence in the present study, in terms of general form, duration and content, was comparable to that described in similar related research reports (e.g. Zeiss, 1977b; Lindstrom et al, 1976).

CHAPTER 8

FAILURE TO COMPLY - EXTENT OF THE PROBLEM AND IMPLICATIONS FOR THE DESIGN OF SELF-HELP MANUALS

As noted earlier, it seems possible that one response to the evidence of a relationship between a patient's understanding and recall of medical advice and his compliance with that advice is that recorded material whether in auditory, visual or written form may play an increasingly central part in our methods of communicating with patients.

Yet, in self-help bibliotherapy programmes, there is already a substantial body of evidence which shows that at least one form of failure to comply, viz. failure to remain in therapy, is a particularly consistent problem (Glasgow and Rosen, 1978). For example, this finding has been reported with the use of fear reduction manuals (Clark, 1973; Marshall et al, 1976; Phillips et al, 1972; Rosen et al, 1976; 1977); weight reduction programmes (Hanson et al, 1976; Mahoney et al, 1973); study skills training (Beneke and Harris, 1972; Harris and Ream, 1972) as well as in sex therapy (Kass and Stauss, 1975; Zeiss, 1977b) and 'in this respect, self-adminstered programs may be similar to weight reduction programs, exercise regimes or other procedures that require sustained self-directed efforts' (Zeiss, 1977b, page 216). That this should be a major consideration in the design and presentation of self-help booklets is reinforced by the fact that adherence to treatment has been shown to be a strong correlate of improvement with such programmes (Repucci and Baker, 1969; Rosen et al, 1976; Bellack et al, 1974; Beneke and Harris, 1972; McMullen and Rosen, 1979).

This latter observation, in particular, has led to attempts to facilitate involvement in these programmes. Barrera and Rosen (1977) studied the effects of a self-reward contigency contracting procedure as an adjunct to self-adminstered desensitisation among snake phobic undergraduates. The procedure, however, did not increase the degree of compliance and indeed those subjects encouraged to use the self-reward procedure completed significantly fewer sessions than a comparable group not using this technique. Findings from a study by Hagen (1974) suggest, on the other hand, that telephone calls reminding patients of their appointments may help, and other untested

suggestions to enhance compliance include recruiting the support of significant others (Barrera and Rosen, 1977; Baekeland and Lundwall, 1975); the use of refundable contingency deposits and abbreviation and simplification of manuals (Zeiss,1977b; Barrera and Rosen, 1977)..

Indeed, of the many instructional features of a programme of potential relevance to treatment compliance, general intelligibility and readability may be among the most important (Ley, 1977). However, these factors have received virtually no formal recognition by those involved in the design of behavioural self-help guides.

It is outwith the scope of this review to discuss in detail Ley's main findings in this area, which in relation to bibliotherapy, have already been covered elsewhere (Dow, 1982). In summary, however, the design of such booklets could be improved by incorporating the following features based on his research conclusions (Ley, 1977):

(1) In view of a primacy effect on retention, patients should, as far as possible, be provided with instructions and advice at or near the start of the information to be presented.
(2) The importance of instructions and advice, in relation to other aspects of the communication (e.g. diagnosis), should also be given particular emphasis.
(3) The use of short words and sentences (which are closely related to reading ease) and the avoidance of jargon should be observed.
(4) Explicit categorisation of information should be used where possible.
(5) Advice or other important issues should be repeated.
(6) Information should be as specific and concrete as possible.

Content and Readability of Self-Help Manuals

The booklets were designed as self-directed manuals and contained instruction in the behavioural aspect of treatment described by Masters and Johnson (1970) - see Appendix 8 . A separate manual was prepared for each of the four forms of dysfunction in the present study to permit detailed instruction in the more specific techniques (e.g. squeeze technique, finger dilatation, etc) relevant to each disorder. Apart from the introduction, the sections describing sensate focus and sexual intercourse were virtually identical across all manuals.

Thus, each manual included the following sections:

(a) an introductory outline of a proposed aetiology of the disorder based largely on learning theory.

(b) instruction in sensate focus.

(c) techniques specific to the disorder in question and related body positions.

(d) preparation for sexual intercourse.

(e) advice specifically related to intercourse, e.g. use of female superior or/and lateral coital positions.

Following the design of the manual of Lowe and Mikulas (1975), a six to eight item true/false quiz was included at the end of each main section to aid recall and provide feedback on the couple's understanding of the text. This was considered to be an important refinement over other self-help guides in this field (e.g. Heiman et al, 1976; Raley, 1976; McCarthy et al, 1975; Barbach, 1975; Brown and Faulder, 1977) in view of the above evidence of Ley (1977) on the effects of enhanced recall and understanding on patient compliance with treatment.

For the same reason, an attempt was made to ensure that the material was intelligible to the average reader by enhancing reading ease, which according to Flesch (1948), Fry (1968) and Klare (1963) is for the most part negatively correlated with word and sentence length. Flesch's (1948) formula was therefore applied to assess the reading ease of the booklets. Details of the reading ease of the four booklets and, for comparison purposes, those of other published self-help guides for the treatment of sexual dysfunction are shown in Table 13 .

Separate t-test analyses were used to compare the reading ease (RE) scores based on ten 100 word samples selected at random from each of the ten manuals. The results, summarised in Table 14 , show that the booklets used in the present study were significantly more easily read than most of the published texts. More important, perhaps, was the finding that virtually all of the latter were unsuitable for the majority (i.e. about 60%) of the general population, unlike the four booklets used in this study, all of which are appropriate for those of at least low average IQ (see Table 15). No significant differences were found among the RE scores for these four manuals.

Table 13 Reading Ease (RE) Scores for Ten Self-Help Guides for the Treatment of Sexual Dysfunction: Means and S.D.s Based on Ten Random 100 word samples.
(High Score = More easily read)

Title and Author(s)	R E Mean	S.D.
Sexual Awareness (McCarthy et al, 1975)	46.97	13.6
For Yourself (Barbach, 1976)	49.79	17.8
Treat Yourself to Sex (Brown and Faulder, 1977)	52.90	16.7
Becoming Orgasmic (Heiman et al, 1976)	54.29	10.5
Making Love (Raley, 1976)	56.80	11.7
Sex Therapy at Home (Kass and Stauss, 1975)	60.73	14.4
Vaginismus (Dow, Unpublished)	62.51	8.2
Premature Ejaculation (Dow, Unpublished)	63.14	7.2
Erectile Impotence (Dow, Unpublished)	64.44	6.7
Female Sexual Unresponsiveness (Dow, Unpublished)	68.52	6.2

Table 14 Results of Comparative Analysis (t-Tests) of Reading Ease Scores for Six Published[1] "Self-Help" Sex Therapy Guides and for Four Manuals used in Present Study (figure in each cell is 't' value)

TITLE OF MANUAL	SA	FY	TYTS	BO	ML	STH	VAG	PE	EI
1 Sexual Awareness (SA)									
1 For Yourself (FY)	0.40								
1 Treat Yourself to Sex (TYTS)	0.87	0.40							
1 Becoming Orgasmic (BO)	1.35	0.69	0.22						
1 Making Love (ML)	1.74	1.04	0.60	0.51					
1 Sex Therapy at Home (STH)	2.20 *	1.51	1.12	1.14	0.67				
Vaginismus (VAG)	3.1 **	2.06 *	1.63	1.71	1.05	0.34			
Premature Ejaculation (PE)	3.32 **	2.20 *	1.78	2.19 *	1.46	0.47	0.47		
Erectile Impotence (EI)	3.65 **	2.44 *	2.03	2.56 *	1.80	0.74	0.88	0.42	
Female Sexual Unresponsiveness (FSU)	4.57 **	3.15 **	2.77 *	3.69 **	2.81 *	1.58	1.86	1.79	1.42

df in each case = 18 $*p < .05$; $**p < .01$

Table 15 Interpretation of Reading Ease Scores
(from Ley, 1977, p.20)

Score	% who would understand	IQ required* for comprehension
0- 30	4.5	126+
31- 50	24	111+
51- 60	40	104+
61- 70	75	90+
71- 80	80	87+
81- 90	86	84+
91-100	90	81+

*The figures above, as Ley (1977) points out, should be interpreted cautiously as the IQ levels are simple linear equivalents of the comprehensibility percentiles and do not take into account regression effects.

Finally, in addition to the use of short words and sentences, some attempt was made to incorporate concrete and specific illustrations, categorisation of information and repetition of important points in the presentation of the material, in accordance with Ley's (1977) recommendations noted above.

CHAPTER 9

MEASURES

The following measures of sexual and marital adjustment were obtained pre and post-treatment. In view of the fairly large number of couples who failed to reattend for follow-up assessment, the test battery was reduced in range to facilitate compliance (those scales re-administered at follow-up are marked thus *). All of the measures, as used in the present study, are detailed in Appendix 3.

(a) Short Marital Adjustment Test (Locke and Wallace, 1959).
(b) Selected Parts of the Sexual Interaction Inventory (Lo Piccolo and Steger, 1974).
(c) Semantic Differential Measure of Sexual Attitudes (Whitehead and Mathews, 1977).
*(d) Sexual and Marital Adjustment Self-Rating Scales (SMAR).
*(e) Self-Ratings of Sexual Pleasure/Anxiety/Disgust (PAD).
(f) Independent Rating Scales Relating to Sexual Pleasure, Interest and Frequency of Adequate Sexual Functioning.

The above scales were selected in order to provide a balanced assessment of treatment effects with respect to behavioural aspects of sexual functioning, satisfaction with sexual and non-sexual aspects of the relationship, and sexual attitudes. Some scales were also selected on the basis of established validity and reliability, albeit in two cases, with a North American population. Another consideration in the choice of some of the measures was their use in related research in this country (e.g. Mathews et al, 1976; Carney et al, 1978) to render the findings, to some extent at least, comparable. While it is conceded that these aims led to the selection of some measures without demonstrated validity, each had high face validity, and satisfactory test-retest reliability was demonstrated prior to the study (see below).

In accordance with the previous recommendations for treatment outcome assessment, a series of independent rating scales, which adhered closely to those used by Mathews et al (1976), was also included. In addition to their resolving some of the problems associated with an exclusive reliance on self-report scales, they also provided a more detailed "symptom focussed" assessment (Lo Piccolo, 1977) in which

aspects of sexual functioning, specifically related to each problem category could be assessed, in contrast to the more global self-ratings of sexual satisfaction and adjustment.

Reliability Data

On most of these measures reliability data were obtained from a sample of twenty-one individuals who were independent of the present study. This sample comprised seven couples and one female who presented for treatment of sexual dysfunction at the clinic where the present study was conducted, and six female occupational therapists who worked in the same hospital. While it is conceded that the inclusion of non-dysfunctional subjects in this sample may have the potential effect of inflating, to some extent, the reliability coefficients, such a procedure may be justified on the grounds that not all individuals in the outcome study suffered from a specific sexual dysfunction. However, approximately half, i.e. at least ten of the twenty-one subjects in this reliability sample were shown, on the basis of an initial interview, to have a clearly identifiable sexual problem of the type under investigation.

Anonymity was preserved throughout, and subjects were required to complete the tests on two occasions (prior to therapy in the case of the patients) with an interval of at least one week to a fortnight maximum between the recordings.

Further Details of Each Measure

(1) Short Marital Adjustment Test (Locke and Wallace, 1959)

This test has been fairly widely used in outcome research in the treatment of sexual dysfunction, particularly in the United States (e.g. McGovern et al, 1975; Golden et al, 1978; Sotile and Kilmann, 1978). This abbreviated version has been shown to correlate highly with the longer version (Locke and Wallace, 1959). It comprises only 15 items, thereby facilitating scoring and, presumably also, patient compliance. Most important, it was one of the few tests available at the inception of the project to have adequate reliability and validity data.

Discriminant validity of the fifteen item test was initially assessed somewhat crudely by means of a comparison of scores

between a group of 48 subjects, for whom there was independent evidence of marital maladjustment, and a group of 48 subjects, matched for age and sex, but who were 'judged to be exceptionally well adjusted in marriage by friends who knew them well' (Locke and Wallace, 1959). On the basis of total mean scores, the test was shown to discriminate significantly between the two groups. Item analysis and weights had been based on previous factor analysis (Locke and Williamson, 1958), although this was subsequently criticised by Kimmel and Van der Veen (1974). Nevertheless, the latter's findings supported the initial construction of the questionnaire as a measure of one variable relating to marital adjustment and no appreciable changes, in relation to item inclusion, were recommended.

The reliability coefficient of the test, computed by the split-half technique, (and corrected by the Spearman-Brown formula) was 0.90. However, this assessment was conducted more than twenty years ago, and with an American sample, and so additional reliability data were obtained from sixteen of the twenty-one individuals in the "reliability" sample; the remaining five failed to provide complete data on this test. Seven of the sixteen subjects had some form of sexual dysfunction. The Pearson product-moment correlation coefficient between the test-retest scores for this sample was 0.93, endorsing the high published reliability of the test.

(2) Sexual Interaction Inventory or SII (Lo Piccolo and Steger, 1974)

This inventory, in its complete form, was designed to provide a treatment outcome measure of the actual and desired frequency and enjoyment of a range of sexual behaviours as reported by each member of the dyad. In the absence of objective standards of "normal" or "adequate" sexual functioning, the emphasis in its design was on the assessment of each couple's satisfaction with themselves and with each other as sexual partners, rather than using an implicit reference to an arbitary sexual standard. Moreover, items in the scale were overtly related to actual and desired behaviour, rather than "disguised" or projective.

In its complete form, the inventory comprises a list of seventeen heterosexual behaviours, each of which is rated on a standard series of scales relating to current and desired frequency, degree of pleasure and perceived degree of pleasure experienced by rater and partner respectively, and ideal degree of pleasure, again for both members of the couple. Lo Piccolo and Steger (1974) report test-retest reliability coefficients for each of the 11 subscales in the inventory based on data provided by 30 subjects. While all the correlations were statistically significant, their absolute magnitude was in some cases less than satisfactory, a result which they attributed to the effects of self-examination, and recording of sexual feelings, etc, on sexual behaviour itself. As noted earlier, while this is consistent with some reports, it is by no means a uniform finding (Persky et al, 1981). Lo Piccolo and Steger (1974) also report adequate internal consistency for the SII scales and provide supportive evidence for its convergent and discriminant validity.

Although much published criticism of the scale to date (McCoy and D'Agostino, 1977) may not be entirely justified (Lo Piccolo, 1977b), the complete inventory in its present form was not used for the present study. Informal evidence obtained by the author from pilot use of the inventory provided some support for McCoy and D'Agostino's (1977) allegations concerning the questionnaire's logical inconsistency, particularly with regard to the rating of enjoyment of behaviour, previously described as 'never' occurring. Also evident was an extremely skewed distribution of scores on test items relating to desired enjoyment, for self and for partner, with respect to a wide range of sexual behaviours. Thus, there was a consistent and understandable tendency for individuals to rate their desired frequency and enjoyment of sexual activities at the extreme positive end of the scale.

In the present study, therefore, all subjects provided ratings on only four of the six scales and for only two sexual activities viz. male and female having intercourse and the male and female having intercourse with both experiencing orgasm (see Appendix 3).

The four scales concerned were those relating to current and desired frequency of these activities, and degree of pleasure and perceived degree of pleasure experienced by self and partner respectively. They were originally included in the assessment battery as it was felt that those scales relating to one of those items (viz. intercourse - not necessarily with both having orgasm) may permit an additional assessment of goal attainment, which would be independently provided by both partners.

Assessment of Goal Attainment

For reasons noted earlier, an assessment of the relative cost-effectivness of the procedures was felt to be appropriate in the present study. Two factors, among others, may be considered to be particularly relevant in this regard: duration of therapy and behavioural goal attainment, neither of which is usually accounted for in the evaluation of self-help programmes.

This may be in part due to, or at least perpetuated by, the use of time-limited therapy - a regime which, in general, has been shown to be more effective and efficient than treatment conducted on a time-unlimited basis (McNair et al, 1963; Bancroft, 1971 a). For this reason, treatments of pre-arranged duration are to be preferred, but not, in this context, to the exclusion of the identification and possible attainment of the ultimate goals of treatment, since these provide a clinically relevant framework for assessing a treatment's cost-effectiveness.

Thus, behavioural targets may constitute predetermined criteria for discontinuing therapy prior to a pre-set maximum duration of therapy. It is, therefore, suggested that care should be observed in comparisons of self-help with parallel therapist-directed approaches to ensure that data relating to goal attainment (e.g. numbers of patients achieving the goal, and number of weeks to criterion) are available. This also implies, of course, that the ceiling duration in time-limited therapy should not be unrealistically rigorous. Any limit should have an appropriate bearing on normal clinical practice (i.e. should have external validity) and hopefully permit a comparison of treatments that is both methodologically sound, and avoids

obscuring clinical with statistical significance (Lick, 1973).

The goal of therapy, which was also the criterion for discontinuing treatment prior to the maximum sixteen week treatment duration, was agreed and defined in terms of each partner's report of mutually satisfactory sexual intercourse on six occasions over a period not exceeding eighteen days, i.e. over about a fortnight during therapy. Eighteen days were chosen as the maximum limit, since, although sessions or contacts were arranged weekly, each contact may not always fall on the same day each week.

Semantic Differential Measure of Sexual Attitudes (Whitehead and Mathews, 1977)

This semantic differential comprises a total of fifteen bipolar adjectival scales. Nine were derived from Marks and Sartorius (1968) to sample each of their three factors of general evaluation, sexual evaluation and anxiety, and a further six pairs were selected to increase the description of affectionate and sexual attributes. The precise composition of the scale and order of items were identical to those of Whitehead and Mathews (1977), the design of the measure being such that the juxtaposition of items of similar meaning was avoided and the position of the positive end of the scales varied to help prevent response set.

In the Whitehead and Mathews (1977) study, data were obtained from 36 couples who were subjects in the Mathews et al (1976) comparative study. For each sex, and for each occasion of testing (pre and post-treatment, and at 4 month follow-up), the scales describing "myself" and "my partner" were subjected to separate factor analyses. Five factors were found to be relatively stable over different occasions and subject groups. Two of these corresponded to those described by Marks and Sartorius viz. "general evaluation" and

"anxiety", while the third original factor of "sexual evaluation" was divided into three distinct factors, labelled "loving","sexually attractive" and "easy to arouse".

Given the broadly similar nature of the present sample to that of Mathews et al (1976) and given the similar treatments involved, this semantic differential, and the five factors derived from it, were considered to be appropriate measures of sexual attitudes. An additional reason for its inclusion in the assessment battery is the theoretical significance of Whitehead and Mathew's (1977) finding of significant differences in factor scores related to sex of rater, identity of the complainant, and, of particular relevance to this study, to the nature of the treatment received.

The test-retest reliability for each of the five factors, when used to assess attitudes toward "myself" and "my partner" (i.e. a total of ten variables) was measured with the aforementioned independent sample of individuals. Nineteen subjects provided complete data on this test and correlation coefficients were all within acceptable limits, with the exception of "myself - sexually attractive" ($r = 0.48$) and "my partner - general evaluation" ($r = 0.40$).

Factor	"Myself"	"My Partner"
General Evaluation	.68	.40
Anxiety	.94	.83
Loving	.94	.91
Sexual Attractiveness	.48	.91
Erotic Arousal	.88	.90

Independent Rating Scales of Sexual Functioning

The ordinal scales used in this study were related to the frequency of different aspects of adequate sexual functioning and the degree of pleasure derived from intimate non-coital and coital sexual relations.

A preliminary check, to ensure that each scale was unequivocally worded and interpretable as ordinal, was conducted. Thus, the items within each scale were randomly arranged and three clinical psychologists, independent of the study, were asked to rerank them

independently in appropriate ascending order. The results showed 100% concordance and accuracy, confirming an absence of ambiguity in its interpretation.

Sexual and Marital Adjustment Self-Rating Scales (SMAR)

This questionnaire consists of five seven-point bipolar adjectival scales providing self-ratings of satisfaction with the sexual and general marital relationship, degree of sexual anxiety, degree of effective communication and degree of affection shown in the sexual relationship. Two additional five-point scales relate to the degree of general concern about the presenting symptoms, and the degree of concern about these symptoms during actual sexual play.

Pre-treatment scores for these seven items were subjected to principal components analysis based on the ratings of the complainants and partners and for the sample as a whole, giving a total of three separate analyses. The purpose of this analysis was to determine firstly whether clinically meaningful factors could be identified, so that, for each individual, factor scores could be generated based on all items individually weighted on each factor. Such a procedure would facilitate the construction of scales with high internal consistency. The principal potential advantage of such factor scores over individual item scores would be their increased reliability.

Table 69 shows the rotated factor loadings for the items in this scale. The results reveal three separate stable factors interpretable as (1) general marital satisfaction; (2) general sexual satisfaction; and (3) sexual anxiety, according to the major factor loadings.

The number of factors extracted, prior to varimax rotation, was determined by Kaiser's criterion. It may be seen from the results in Appendix 3, that the factor structure was the same for both complainants and partners - the only difference being the order of the first two factors. Since there was no difference between the factor structures for complainants and partners, the solution used for the computation of factor scores was that derived from the total sample of complainants and partners combined, i.e. 96 subjects.

The precise method of calculating the factor scores is described in Appendix 3.

The general marital satisfaction factor, the sexual satisfaction factor and the sexual anxiety factor account for 28.9%, 27.1% and 17.1% of the variance respectively - a total of 73.1% of the variance. The third factor, sexual anxiety, was not included in most of the analyses, however, as only one item showed a substantial loading on it and, as will be seen below, an alternative measure of sexual anxiety across a range of specific behaviours was obtained from another scale (the PAD scale).

Test-retest reliability of the factor scores for the first two of the three factors was, therefore, assessed using the same independent sample of twenty one subjects as described above.

For the marital satisfaction and the sexual satisfaction factors, the correlation coefficients were 0.82 and 0.90 respectively. Thus, a high level of reliability is demonstrated in the scores derived from these two factors.

Self-Ratings of Sexual Pleasure/Anxiety/Disgust (PAD Scale)

This scale, details of which are provided in Appendix , page provides a self-report measure of the extent to which each of five categories of shared sexual activity evokes pleasant and unpleasant feelings. It represents a modified form of a similar unpublished scale provided by Bancroft (personal communication). With respect to negative responses to sexual play, a distinction was drawn between those of fear, anxiety or tension, and those of disgust or distaste. Although it would be reasonable to expect some overlap between the two forms of negative affect, particularly among subjects endorsing feelings of disgust, this distinction was made to provide a rough measure of inhibited sexual attitudes toward aspects of normal sexual behaviour, as distinct from anxiety (e.g. "performance anxiety") per se. Thus, both partners were asked to describe the degree to which each of five different aspects of normal sexual relations evoked feelings of (a) pleasure or enjoyment, (b) anxiety and (c) disgust, on a five-point rating scale (0 = none, 4 = extreme). The total number of responses required, therefore, was fifteen.

Again, in order to facilitate scoring (and, in particular, to establish weights for each of the fifteen items) and to enhance the reliability of the scale, principal components analyses were conducted on the pre-treatment scores provided by both the complainants and the partners, combined, and for each of these two subject groups separately. The solution was, in each case, subjected to varimax rotation, and the results, summarised in Appendix 3 , revealed three stable factors readily identifiable as (1) sexual aversion, (2) sexual pleasure, and (3) sexual anxiety. The stability of the factor structure was demonstrated by the fact that the same three factors emerged among the scores of both complainants and partners. Thus, again, for the purpose of deriving appropriately weighted factor scores, the solution used was that based on the total sample of complainants and partners combined. The method of calculating factor scores was the same as that used for the SMAR scale.

Test-retest reliability for each of the above three factor scores was assessed using the same independent sample of twenty-one subjects described above, and was determined by Pearson product-moment correlation coefficient

The reliability coefficients for each of the three factors were shown to be well within acceptable limits, viz. Sexual Aversion Factor, $r = 0.92$; Sexual Pleasure Factor, $r = 0.89$ and Sexual Anxiety Factor, $r = 0.94$.

CHAPTER 10

RESULTS AND DISCUSSION

In accordance with the aims of the study outlined earlier, it is appropriate to divide the presentation of the results and the discussion thereof, into four main sections:

(1) an examination of treatment effects, i.e. results of the comparison between the control group and each of the two treatment groups

(2) justification for re-allocating waiting-list control subjects to the treatment groups

(3) an examination of pre-treatment differences among the four problem subgroups

(4) analysis of treatment outcome differences within and across problem subgroups

Examination of Treatment Effects

Hypothesis One

At the outset, it would be important to determine whether there is a treatment effect associated with the SH and MJ approaches for each of the main dependent measures of marital and sexual adjustment and sexual attitudes. This involves examining the hypothesis that both treatments are significantly better than the waiting list control condition on these measures.

Statistical Methodology

The scores obtained at the end of the waiting period (for the control group) and post-treatment scores for the "immediate start" subjects in each of the two treatment groups were compared using one-way analysis of covariance, using initial scores as the covariate. This method of analysis is to be preferred to either the use of change or gain scores which may compound error variance (Cronbach and Furby, 1970), or to a repeated measures analysis of variance, which, in the context of a pre-test - post-test design, may yield, among other weaknesses, an F value which is too small, thereby increasing the probability of Type II error (Huck and McLean, 1975).

Following a significant F value from analysis of covariance, the specific significant intergroup differences were then identified using Newman-Keuls test which was subsequently conducted on the adjusted post-treatment/post-waiting period means. The principal advantages of the Newman-Keuls test are that it preserves the overall significance level and it is possible, therefore, to determine which pairs of means differ significantly with more assurance, and more parsimoniously, than by the use of multiple paired comparisons (Zivin and Bartko, 1976).

However, the Newman-Keuls test does not permit a precise examination of trends toward significance and consequently the results tables also display the findings from separate analysis of covariance between the controls and each of the treatment groups.

*****

Although not the primary purpose of this analysis, this intergroup comparison clearly also permits a preliminary examination of the two remaining hypotheses, viz. that the MJ approach would effect greater improvement than the SH approach with respect to

(a) marital satisfaction and adjustment

and (b) positive attitude change.

A summary of the results is presented in Tables 16 to 19 .

From Tables 16 to 19 , it may be seen that of the twenty-five variables examined, significant differences between either treatment group and the controls were found for eleven. The MJ and SH approaches were shown to be significantly better than the waiting-list control group on all eleven, and on seven of these variables respectively.

In terms of marital adjustment and satisfaction (see Table 16), it is clear that only the MJ group shows significantly more favourable change compared to the control group. Indeed, consistent with the hypothesis that the MJ treatment would produce greater change in the general relationship than the SH group, the MJ complainants perceive themselves as significantly more loving, as determined by ratings of "myself" on the semantic differential, compared to both the controls and the SH subjects (p 0.5, in each case). Again, although there was no significant difference between the MJ and SH treatment groups, only the MJ group was shown to score significantly higher than the controls on self-ratings of marital adjustment (p 0.5) as measured by the Locke-Wallace M.A.T. Thus, while only one clearly significant difference was found between the treatments, on these measures - **favouring** the MJ group - (viz. ratings of 'self' on the "loving" factor) this preliminary comparison provides some support for the hypothesis relating to greater positive marital change with directed practice plus counselling. On only one "marital" measure - the marital satisfaction factor from the SMAR scale - were both treatments shown to be better than the control group, but the results of each comparison just failed to reach significance (p = 0.6). In short, in contrast to the MJ approach, there is no clear evidence that the SH format is significantly better than no treatment in effecting change with respect to the general marital relationship.

Table 16 Pre and Post Treatment/Waiting Period Means and Standard Deviations on Marital Adjustment Self-Rating Scales and Related Attitude Factors - Results of Analysis of Covariance[1]

Variable		MJ		SH		WT		F(df)[d]	Prob	Newman-Keuls	Paired Comparisons ANCOVA			
											MJ v WT		SH v WT	
		PRE	POST	PRE	POST	PRE	POST				F	Prob	F	Prob
Locke-Wallace Marital Adjustment[a]	m	100.5	105.9	107.7	107.5	101.6	94.9	3.36 (2,40)	*	MJ>WT*	5.7 (1,29)	*	2.1 (1,30)	NS
	σ	20.1	16.7	25.7	26.5	21.6	26.7							
Marital Satisfaction Factor (SMAR scale)[b]	m	1021.5	973.4	996.5	959.8	1039.1	1046.2	3.04 (2,40)	.059	WT almost > MJ WT almost > SH	3.8 (1,30)	.06	3.9 (1,31)	.06
	σ	59.6	90.1	81.1	89.7	73.1	92.1							
Myself-Loving (Sem. Diff)[c]	m	12.9	15.6	15.6	15.7	14.5	14.1	4.13 (2,38)	*	MJ> WT* MJ>SH*	6.9 (1,29)	*	0.7 (1,29)	NS
	σ	3.5	3.3	4.3	4.2	4.6	4.3							
Partner-Loving (Sem. Diff)[c]	m	19.0	19.3	19.4	18.7	18.5	18.2	0.76 (2,38)	NS		1.2 (1,28)	NS	0.02 (1,29)	NS
	σ	1.7	2.4	2.3	2.5	3.3	2.8							

1 Post-Treatment and Post Waiting Period scores above are the unadjusted group means.

* $p < .05$
** $p < .01$

a low value, low marital adjustment; high value, high marital adjustment
b low value, high marital satisfaction; high value, low marital satisfaction
c low value, low affection; high value, high affection
(3 = extremely unloving, 21 = extremely loving)
d Full details of results in Appendix 4 Tables 74 to 76

In terms of attitude change (see Table 17), only two significant differences were observed among the groups. Thus, both treatment groups were shown to score significantly higher than the control group on ratings of "myself" on the "sexually attractive" and "erotic arousal" factors ($p < .05$ in each case). However, on a third, 'general evaluative' factor only the MJ approach showed a near significant treatment effect ($p = .06$) on ratings of "myself". There was no significant difference between the treatment groups on this measure, however.

On ratings of "my partner", no significant intergroup differences were found on any of the five semantic differential factors. This negative finding, however, may be consistent with the evidence, to be presented later, that the partners perceive themselves and are perceived by their spouses as less handicapped generally in the relationship.

Although only the MJ treatment effected an improvement in self-ratings on the "loving" factor, there was no additional consistent support from these preliminary results for the hypothesis of a differential treatment response, favouring the MJ approach, in terms of attitude change. On the two semantic differential factors on which significant differences were found, both treatment groups were significantly better than the controls and no significant difference was found between the two treatment groups.

Examination of the findings with respect to adequacy of sexual functioning and adjustment (see Tables 18 and 19) reveals that both treatments are significantly better than the control group on independent measures of the frequency of pleasurable intercourse and frequency of sexual interest and on self-ratings of the frequency of sexual intercourse, degree of anxiety about the presenting symptoms during sexual play, and general sexual satisfaction. Moreover, strong trends favouring both treatment groups over the control group were apparent on independent ratings of the degree of enjoyment of intimate foreplay (MJ v WT, $p = .08$; SH v WT, $p = .07$) and on self-ratings of the degree of coital enjoyment, as measured by the SII ($p = .08$). However, on the latter measure, separate comparisons between the control group and each of the treatment groups did show significant treatment effects (in each case, $p < .05$).

Table 17 Pre and Post Treatment/Waiting Period Means and Standard Deviations on Sexual Attitude Factors - Results of Analysis of Covariance[1]

Variable		MJ		SH		WT		F(df)[c]	Prob	Newman-Keuls	Paired Comparisons ANCOVA			
											MJ v WT		SH v WT	
		PRE	POST	PRE	POST	PRE	POST				F	Prob	F	Prob
Myself-General Evaluation [a]	m	6.6	9.8	9.5	10.7	8.9	9.3	3.03 (2,38)	.06	MJ almost > WT	5.6 (1,28)	*	1.8 (1.29)	NS
	σ	1.8	3.2	1.8	2.0	2.6	2.7							
Myself-Anxiety [a]	M	10.3	8.3	8.5	7.8	10.2	9.7	2.25 (2,38)	NS		3.9 (1,28)	.06	0.9 (1,29)	NS
	σ	2.6	3.1	3.3	2.1	2.2	2.7							
Myself-Sexual Attractiveness [a]	m	7.0	8.3	8.3	8.9	7.3	6.9	3.79 (2,38)	*	MJ > WT* SH > WT*	5.2 (1,28)	*	4.4 (1,29)	*
	σ	2.4	2.1	1.6	1.9	2.3	2.4							
Myself-Erotic Arousal [a]	m	5.8	7.8	6.8	8.6	6.0	6.2	4.5 (2,38)	*	MJ > WT* SH > WT*	6.7 (1,28)	*	8.3 (1,29)	*
	σ	3.0	2.8	4.0	3.9	4.0	3.4							
Partner-General Evaluation [a]	m	12.2	12.9	12.4	12.3	11.9	11.8	2.2 (2,38)	NS		3.9 (1,28)	.06	0.04 (1,29)	NS
	σ	1.5	1.1	1.6	1.6	1.8	1.8							
Partner-Anxiety [a]	m	6.0	5.7	8.2	6.8	7.6	6.8	0.16 (2,38)	NS		0.11 (1,28)	NS	0.5 (1,29)	NS
	σ	3.1	3.4	3.1	2.7	2.9	3.8							
Partner-Sexual Attractiveness [a]	m	11.6	12.8	11.3	11.4	10.7	10.8	1.8 (2,38)	NS		2.8 (1,28)	NS	0.1 (1,29)	NS
	σ	1.3	3.2	2.6	2.5	1.5	1.6							
Partner-Erotic Arousal [a]	m	11.7	11.1	11.1	10.7	10.0	11.0	0.89 (2,38)	NS		1.1 (1,28)	NS	1.2 (1,29	NS
	σ	1.8	3.1	1.3	2.6	2.9	2.4							
Sexual Aversion Factor (PAD Scale) [b]	m	1007.6	980.3	973.9	993.4	984.8	970.6	1.22 (2,37)	NS		0.21 (1,28)	NS	1.6 (1,28)	NS
	σ	154.6	143.9	140.4	67.2	118.0	121.5							

1 Post-Treatment and Post Waiting Period scores above are the unadjusted group means.

* $p < .05$

** $p < .01$

a to 2 = very low general evaluation/anxiety/sexual attractiveness/erotic arousal
14 = " high " " " " " " "

b low value, high sexual aversion; high value, low sexual aversion

c Full details of results in Appendix 4 Tables 77 to 79

Table 18 Pre and Post Treatment/Waiting Period Means and Standard Deviations on Independent (IR) and Self-Rating (SR) Scales of Sexual Satisfaction and Pleasure - Results of Analysis of Covariance[1]

Variable		MJ		SH		WT		F(df)[b]	Prob	Newman-Keuls	Paired Comparisons ANCOVA MJ v WT		Paired Comparisons ANCOVA SH v WT	
		PRE	POST	PRE	POST	PRE	POST				F	Prob	F	Prob
IR Scales														
Frequency of Pleasurable Intimate Foreplay	m	2.6	2.9	3.3	3.8	2.4	2.4	2.51 (2,34)	NS		1.24 (1,27)	NS	4.7 (1,26)	*
0=never; 4=nearly always	σ	1.6	1.4	0.9	0.7	1.2	1.3							
Degree of Pleasure from Intimate Foreplay	m	3.0	3.2	3.1	3.3	2.7	2.5	2.61 (2,34)	.088	MJ almost > WT	3.4 (1,27)	.076	3.7 (1,26)	.067
0=little; 4=very high	σ	1.4	1.4	0.8	0.7	1.1	0.9			SH almost > WT				
Frequency of Pleasurable Sexual Intercourse	m	0.9	2.8	1.3	2.6	1.8	1.3	12.7 (2,33)	**	MJ > WT**	23.9 (1,26)	**	17.1 (1,26)	**
0=never; 4=nearly always	σ	1.4	1.2	1.5	1.2	1.4	1.3			SH > WT**				
Frequency of Sexual Interest	m	3.1	4.0	3.6	4.4	2.8	2.8	5.85 (2,34)	**	MJ > WT*	8.6 (1,27)	**	8.8 (1,26)	**
0=repulsed; 7=every day	σ	1.7	1.8	1.1	0.9	1.4	1.3			SH > WT**				
SR Scales														
Frequency of Sexual Intercourse	m	2.3	3.6	2.5	3.9	2.9	2.8	3.9 (2,40)	*	MJ > WT*	7.9 (1,30)	**	6.7 (1,30)	*
1=never; 6=always	σ	1.6	1.7	1.5	1.6	1.7	1.6			SH > WT*				
Degree of Enjoyment from Sexual Intercourse	m	2.9	4.3	3.7	4.7	4.1	3.9	2.82 (2,29)	.076	MJ almost > WT	4.8 (1,21)	*	5.1 (1,23)	*
1=very low; 6=very high	σ	2.3	1.6	2.1	1.3	1.7	1.7			SH almost > WT				
Sexual Satisfaction Factor (SMAR) Scale[a]	m	1053.3	836.6	1035.1	897.9	1034.8	1018.1	7.5 (2,40)	**	WT > MJ** WT > SH*	19.0 (1,30)	**	6.5 (1,31)	*
	σ	65.8	170.4	99.3	199.6	74.5	108.0							
Sexual Pleasure Factor (PAD Scale)[a]	m	1039.9	988.3	991.0	974.9	1030.6	1037.3	3.3 (2,37)	*	WT > MJ*	7.0 (1,28)	*	2.0 (1,28)	NS
	σ	94.4	103.7	148.0	155.2	98.5	83.6							

1 Post Treatment and Post Waiting Period Scores above are the unadjusted group means.

* P < .05 ** P < .01 a = low value, high satisfaction/pleasure; high value, low satisfaction/pleasure

b Full details of results in Appendix 4 Tables 80 to 86

Table 19 Pre and Post-Treatment/Waiting Period Means and Standard Deviations on Independent (IR) and Self-Rating (SR) Scales of Sexual Anxiety and Negative Sexual Experience - Results of Analysis of Covariance[1]

Variable		MJ		SH		WT		F(df) [b]	Prob	Newman-Keuls	Paired Comparisons ANCOVA MJ v WT		SH v WT	
		PRE	POST	PRE	POST	PRE	POST				F	Prob	F	Prob
IR Scales														
Frequency of Unpleasurable Intimate Foreplay	m	2.3	3.2	3.3	3.5	2.5	2.5	2.5 (2,34)	NS		3.95 (1,27)	.06	1.1 (1,26)	NS
0=nearly always;4 rarely unpleasant	σ	1.8	1.4	0.9	0.8	1.1	1.3							
Frequency of Unpleasurable Sexual Intercourse	m	1.2	2.8	1.6	2.6	1.4	1.8	3.2 (2,34)	0.052	MJ Almost > WT	7.7 (1,27)	**	2.2 (1,26)	NS
0=nearly always;4=rarely unpleasant	σ	1.5	1.1	1.6	1.1	1.4	1.7							
SR Scales														
Degree of Anxiety about Symptoms during Sexual Play ("Spectating")	m	1.5	3.1	1.6	2.4	1.6	1.6	9.1 (2,42)	**	MJ > WT** MJ > SH* SH > WT*	23.1 (1,31)	**	5.9 (1,32)	*
1=high; 7=low	σ	0.5	1.2	0.9	1.4	0.7	0.7							
Sexual Anxiety Factor (PAD Scale) [a]	m	923.4	1069.5	911.8	988.1	970.3	975.4	8.1 (2,38)	**	MJ > WT** MJ > SH*	14.55 (1,28)	**	8.92 (1,29)	**
	σ	102.8	102.1	109.6	117.0	87.7	100.1							

1 Post-Treatment and Post-Waiting Period Scores above are the unadjusted group means.

* P< .05

** P< .01

a = low value, high anxiety; high value, low anxiety

b = Full details of results in Appendix 4 Tables 87 to 89

In general, as with the results on the marital satisfaction and adjustment measures, there is some consistent evidence for the general superiority of the MJ approach in contrast to the other two groups.

Thus, in terms of anxiety about the presenting sexual symptoms during actual sexual play (a variable which may be considered to relate to the "tendency to spectate"), although a significant treatment effect was found with both approaches, the MJ treatment is also shown to be significantly superior to the SH approach ($p < .05$). Moreover, even on the basis of this initial comparison between treatment groups, the MJ treatment is also significantly more effective than the SH format in the reduction of general sexual anxiety ($p < .05$) as measured by the PAD scale which measures the degree of anxiety evoked across a range of sexual behaviours. (See Table 19)

There was, in fact, no evidence of a signficant treatment effect with the minimal contact approach on this measure of general sexual anxiety. Perhaps consistent with this general pattern among the results was the near significant treatment effect only apparent with the MJ approach in the reduction of the frequency of unpleasurable intercourse ($p = .05$) and the enhancement of general sexual pleasure ($p = .05$).

Discussion

As noted, earlier, there is a paucity of adequate controlled studies of the efficacy of a Masters and Johnson approach, as typically modified for use in an NHS or comparable setting or of a further variant of this approach based on self-help bibliotherapy programmes. One of the aims of the present study, therefore, was to compare, on an appropriate range of measures, each of these two treatment methods with a waiting-list control group. Only the results of this comparison between the controls and each treatment group will be discussed here and no attempt will be made at this point to present a preliminary detailed discussion of treatment group differences. This will be confined to a later section following the presentation of the results of a comparison between the treatment groups involving all subjects.

Treatment Effects on Sexual Functioning and Adjustment

In terms of sexual functioning and adjustment both treatment groups

were shown to be significantly better than the controls in terms of a reduction in the tendency to "spectate" during sexual play, frequency of sexual interest and frequency of coital enjoyment.

Consistent with the emphasis in both treatments on undemanding sexual relations and on the communication and enhancement of mutual sexual pleasure, trends favouring both treatments over the controls were apparent in terms of the degree of coital ($p = .08$) and non-coital ($p = .09$) enjoyment. However, neither treatment was superior to the controls in altering the frequency (or, more accurately, the proportion) of pleasurable and unpleasurable non coital experiences, despite some evidence of an increase in enjoyment when it occurred. Perhaps, however, this negative finding may be an artefact of the measure itself and may be a function of a high reported baseline percentage of pleasurable non-coital experiences among all couples.

Thus, perhaps one powerful determinant of whether foreplay will be initiated and reciprocated at all, in treated and untreated couples, is the initial perception or mutual anticipation of pleasure. In this way, while the absolute frequency of pleasurable sexual sessions may be relatively low among an untreated dysfunctional sample, the proportion of occasions when foreplay may be positively experienced may be high - thus reducing the scope for change. Such a proposed effect may not necessarily extend to measures of the proportion of pleasurable coital experiences, and indeed, both treatments were shown to be significantly better than the controls on this variable. This again seems reasonable, given the effectiveness of the treatments in reducing specific sexual anxieties about the presenting syptoms and, in addition, given the criterion for discontinuing treatment which was based on the frequency of mutual satisfaction with coitus.

On two measures relating to sexual pleasure, the MJ approach alone only just showed a significant treatment effect ($p = .05$ in each case). Thus, only the conjoint counselling approach was shown to have an effect in reducing the frequency of unpleasurable intercourse and increasing the overall level of sexual enjoyment.

Such findings may be considered consistent to some extent with the relative effects of the treatments on anxiety reduction. Again

regular practice and counselling was significantly better than both the controls and the self-help approach in terms of reducing general sexual anxiety and, although there was evidence of a treatment effect with both approaches in the reduction of the tendency to spectate, the MJ approach was again significantly superior on this measure to directed practice alone. It may be resonable to suppose that a graded hierarchical approach combined with the regular opportunity in counselling sessions for emphasising the importance of communicating sexual preferences, for "giving permission" to engage in particular activities (Annon, 1976) for describing sexual initiation skills (Maddock, 1975) and, to a limited extent, for self-disclosure (Lobitz and Lo Piccolo, 1972) may contribute to both anxiety reduction and sexual pleasure enhancement which may have mutually reinforcing benefits for those receiving the MJ approach. It is noteworthy that Whitehead and Matthews (1977) also found directed practice plus counselling to be superior to both directed practice alone and de-sensitisation plus counselling in reducing anxiety self-ratings, despite the fact that anxiety reduction is the primary aim of the latter approach.

Finally, the present treatment outcome differences with respect to anxiety reduction and sexual pleasure also suggest that, although the SH treatment had a significant effect (albeit less strong than the MJ treatment) in reducing the tendency to "spectate", the reduction of this source of anxiety in itself may not necessarily be associated with a significant increase in sexual pleasure. It will be recalled that Mathews et al (1976) proposed that a central distinction between desensitisation and sensate focus was that in the latter, behavioural steps are guided more by the occurrence of mutual pleasure rather than anxiety reduction per se. However, since both approaches in the present study involved sensate focus, it is unclear whether the additional counselling component in the MJ treatment facilitated this enhancement of sexual enjoyment and anxiety reduction, or whether the therapeutic process in this self-help approach, by virtue of the absence of regular contact, rendered it more akin to that of in vivo desensitisation.

Treatment Effects on Attitude Change

In relation to attitude change, significant differences between either

treatment group and the controls were observed on only three variables. While complainants in both treatment groups rated themselves as significantly more sexually attractive and more sexually responsive compared to the controls, there was a significant treatment effect only for the MJ complainants on ratings of "myself" on the "loving" factor of the semantic differential. There was also a strong trend ($F\ [2,38]\ 3.03$, $p = .06$) in favour of the MJ subjects only, compared to the controls, on ratings of "myself" on the general "evaluative" factor.

Therefore, these results from this initial comparison among the three groups lend only some very limited support to the hypothesis of greater positive attitude change with directed practice plus counselling. Despite the above trends, there was no evidence that the MJ approach was superior to the minimal contact format in increasing self-perceived sexual attractiveness and responsiveness as found by Whitehead and Mathews (1977).

However, contrary to the treatment effects observed in the present study on other measures of sexual anxiety, and in contrast to the results reported by Whitehead and Mathews (1977), no significant differences among the three groups were observed on ratings of "myself" on the "anxiety" factor from the semantic differential. In view of the similarities between the present study and that of Mathews et al (1976), from which Whitehead and Mathews' (1977) data were derived, it is difficult to explain this apparent discrepancy. Despite a trend favouring the MJ approach over the other two groups, two possible reasons for the failure to observe more clearly signficant differences on this measure may be (a) the fairly marked pre-treatment variability among the problem groups' ratings of "myself" on this anxiety factor*; (b) that the measure may have been perceived as relating more to general level of anxiety rather than to more specific aspects of sexual stress.

*Vaginismus Complainants were shown to be significantly more anxious than the other three groups.

(See Page 136).

Among the complainants' ratings of their partner, however, no significant treatment effect was observed on any of the five semantic differential factors. Although Whitehead and Mathews (1977) also observed a much more limited range of treatment differences in attitude ratings of "my partner", the significant superiority of directed practice plus counselling over directed practice alone which they found on the "sexual attractiveness" factor was not replicated from this preliminary comparison between the group. It is possible that the failure to observe a significant treatment effect on attitudes towards the partners may have been due to their generally higher baseline scores limiting the scope for further measurable change.

Finally, no significant treatment effect was found with either form of therapy with regard to the modification of attitudes of distaste or revulsion toward aspects of normal sexual behaviour. However, while it is possible that intrusive longstanding and generalised attitudes of revulsion may not indeed be amenable to attitude change procedures (based on the reduction of cognitive dissonance, etc) when applied within the temporal and procedural constraints of this study, it is also important to note that such obstructive attitudes were not a common feature among the problems treated in the present study. This in itself would again have the effect of lowering the probability of finding a significant difference between the groups, since any improvement among those with inhibited attitudes would be "submerged" by the non-improvement of those already well adjusted in this respect.

Treatment Effects on Marital Adjustment

Although there was a strong trend favouring both treatments in contrast to the controls, on the general marital satisfaction factor ($p = .06$) only the MJ approach showed a significant treatment effect on the Locke-Wallace M.A.T. and, as noted above, on ratings of "myself" on the "loving" factor of the semantic differential. These latter results are clearly consistent with the hypothesised superiority of practice plus counselling in promoting general marital adjustment compared to the self-help approach, which in this respect conferred little advantage over the no treatment control conditon.

As indicated earlier, it is not the principal aim of this Section to draw preliminary comparisons between treatments and to discuss in

detail their relative effects on specific aspects of sexual and marital change. However, it is clear that the significant effect only apparent with the MJ treatment in enhancing marital adjustment and attitudes of affection toward the spouse are in keeping with the view expressed by others (Lobitz and Lo Piccolo, 1972; McCarthy, 1973; Prochaska and Marzilli, 1973; Kaplan, 1974; Sadock et al, 1975; Snyder et al, 1975) that the establishment of effective interpersonal communication is an important aspect of the successful treatment of sexual dysfunction and that much more than a narrow focus on exclusively sexual issues is involved in a Masters and Johnson directed practice plus counselling approach (Renshaw, 1975). More detailed recent empirical support for this view is, furthermore, provided by Tullman et al (1981) who showed that, following the intensive two-week sex therapy programme as conducted by Masters and Johnson (1970), both males and females reported increased assertiveness and a greater ability to share their feelings with their partners. Both findings are considered consistent with Masters and Johnson's theoretical model of communication which occupies a central part of counselling and in which the concepts of self-representation, vulnerability and problem-solving are strongly emphasised. Unfortunately, no adequate controls were employed in their study in which the analysis of treatment effects was based principally on within group pre-post treatment change. Nevertheless, their results may be regarded as broadly consistent with the less directly sexual benefits observed in the present study.

* * * *

There are at least two other studies which have found a modified Masters and Johnson approach to be significantly better than a waiting list control group (Everaerd, 1977; Munjack et al, 1976). It is difficult, however, to compare the results from these two studies with the present findings due to differences in the outcome measures used, as well as in sample characteristics; the two earlier studies above being concerned mainly with female orgasmic dysfunction. Munjack et al (1976), moreover, employed a mixed behavioural treatment package and although, in contrast to the treated group, no significant improvement in orgasmic frequency or in ratings of satisfactory sexual relations was found among their control subjects, no statistical comparison between treated and control groups was conducted.

* * * *

As noted in the introduction, one of the main criticisms of waiting-list control groups is that they may be particularly prone to artefactual "spontaneous remission" effects which may, therefore, disguise genuine therapeutic effects. However, there was no evidence of any consistent significant change in the waiting-list group. Indeed, routine comparison between pre- and post-waiting period scores on all relevant variables revealed only two significant changes, one positive and one negative (i.e. at the end of the waiting period complainants rated their partners as less anxious and the complainants were rated as experiencing less coital enjoyment compared to the pre-waiting period level). These findings may be interpreted as being consistent with the two in forty significant results one may expect from chance alone. There appears to be no reason, therefore, for doubting the validity of the treatment effects reported above or for supposing that additional true treatment effects were submerged by "pseudo spontaneous remission" effects among the control subjects. Therefore, together with the limited information available from the two other controlled studies, the present evidence in general indicates that a modified Masters and Johnson approach does have a significant treatment effect on a range of aspects of sexual and marital adjustment and attitude change.

With respect to self-help approaches, only two other outcome studies in this field have used waiting-list control data (viz. Lowe and Mikulas, 1975; McMullen and Rosen, 1979). Each used homogeneous samples in which the main complaint was premature ejaculation and primary orgasmic dysfunction respectively, and each provided evidence of significant treatment effects in terms of ejaculatory control and orgasmic attainment. Unfortunately, comparison between the self-help and the control groups on a wider range of dependent measures was not conducted in either study.

The present results based on a mixed dysfunctional sample confirms the finding of a significant treatment effect with a self-help procedure, although this was particularly evident in relation to aspects of sexual functioning, rather than marital change on which this minimal contact approach had, in general, a negligible effect.

Finally, as will be seen from the subsequent discussion of interaction

and problem main effects obtained from treatments x problems analysis, and from Chapter 11 which describes the pre-treatment differences among the four problem groups, it is possible that the increase of within-group variance which would accompany the inclusion of different problem subgroups within each treatment and control group may serve to reduce the chances of obtaining significant findings from overall comparison between such mixed dysfunctional treatment and control groups. Clearly further research in this area may be improved by allowing for the examination of treatment effects within more homogeneous samples.

CHAPTER 11

Examination of Change Within the Waiting-List Control Group

It will be recalled that the above results, from the examination of treatment effects, were based on analysis of covariance, using the pre-treatment score as the covariate. As noted earlier, this serves to reduce the error variance in the dependent measure that could be attributed to initial pre-test score differences among the groups (Campbell and Stanley, 1963; Kerlinger, 1973; Wincze and Caird, 1976; Cook and Campbell, 1979). However, prior to more detailed examination of the change within the waiting-list group, it would be important at the outset to confirm that random allocation of subjects to either the waiting-list or an immediate start to therapy had not, by chance, led to significant pre-test group differences.

Thus, a comparison between the pre-treatment scores for the 'immediate start' subjects in each treatment group and the pre-waiting period scores for the waiting list subjects was conducted by means of t-test analyses for independent samples. No significant difference on any of the 46 variables was observed between the 'immediate start' SH subjects and the waiting-list subjects. A similar comparison between the 'immediate start' MJ group and the waiting list controls revealed only one significant difference. This was on ratings of "myself" on the general evaluative factor of the semantic differential in which the waiting list subjects scored more positively ($t = 2.66$, $df = 30$, $p < .05$).

This highlights an important issue with such analyses viz. with such a large number of variables under routine examination in this way, the probability of discovering a significant difference by chance will be at least one in twenty. Thus, the above difference between the groups is within the limits of chance and there is, in general, no strong evidence to disconfirm the pre-test equivalence between the waiting-list and each of the treatment groups.

Subsequent re-allocation of the waiting-list subjects to each of the treatment groups pre-supposes that there has been:

(a) no significant change over the waiting period

and (b) that there is no significant difference between the waiting-list group at the end of the waiting period and the 'immediate start' subjects, pre-treatment.

Thus, to determine the absence of any significant pre/post waiting period change in the control group, comparison of the pre/post scores on all variables was conducted by means of paired t-tests. Significant changes were found on two variables only (see Table 20): the complainants rated their partners on the semantic differential as less anxious at the end of the waiting period ($p < .05$, two-tailed) and the complainants were rated by the independent assessor as experiencing pleasure from sexual intercourse less frequently post-waiting period ($p < .01$, two tailed).

Again, given the relatively large number of variables examined in the absence of any specific hypotheses about the direction or nature of change, these findings may well represent the two in forty significant changes one may reasonably expect from chance alone.

Analysis of change over the waiting period was also conducted for each of the four dysfunction categories using Wilcoxon matched pairs signed ranks test. Only one significant change was observed. This was found among the complainants with premature ejaculation who rated themselves on the semantic differential as significantly less loving towards their partner ($z = 2.02$, $n = 5$, $p < .05$ two-tailed).

Thus, there is clearly no evidence of any widespread change among the waiting list group either as a whole, or indeed, for each of the dysfunction subgroups over the waiting period.

However, as noted above, prior to including the waiting list subjects in the two treatment groups, it would be important to demonstrate their equivalence at the end of the waiting period with the non waiting list subjects, pre-treatment. These two groups as a whole (comprising 24 couples each) were thus compared on the same range of 46 pre-treatment variables using t-tests for independent samples. No significant differences were found on any variable. A similar comparison between waiting list and non waiting-list subjects was conducted for each of the four problem subgroups, using Mann-Whitney 'U' tests for all 46 pre-treatment/post waiting period measures. **(The main findings are summarised in Table 21.)**

For the FSU subgroups, no significant differences were found on any variable.

Table 20 Significant Results from Paired t-Test Analyses[1] Within Waiting-List Control Group : Pre - Post Waiting Period Means and Standard Deviations (Complainants only)

Variable		PRE	POST	t	df	Prob
Partner - Anxiety (Sem. Diff.) (2 = v. low anxiety; 14 = v. high anxiety)	m	7.6	6.8	2.21	20	*
	σ	2.9	3.8			
Frequency of Pleasurable Sexual Intercourse (0 = never; 4 = nearly always)	m	1.8	1.3	2.95	20	**
	σ	1.4	1.3			

1 two-tailed probability

* $p < .05$

** $p < .01$

For the VAG subgroups, only one significant difference was observed. This was on a measure of sexual aversion, in which the control subjects were shown to be more impaired than their immediate start counterparts ($U = 6.5$, $n_1 = 6$, $n_2 = 7$, $p < .05$). As noted above, however, there was no evidence of a significant deterioration on this same measure over the waiting period for this particular problem subgroup.

For the premature ejaculation subgroups (PE), only one significant difference was observed between the waiting and non-waiting subjects. This was on the semantic differential measure of 'loving' toward one's partner in which the control subjects were again shown to be more impaired ($U = 0$, $p < .01$). It will be recalled that the waiting list PE subjects also showed a significant reduction in scores over the waiting period on this variable.

For those with erectile impotence (EI), a similar comparison between waiting list subjects at the end of the waiting period and non-waiting subjects pre-treatment revealed two significant differences which were not apparent from within group analysis of this waiting-list subgroup.

These differences were on the Locke-Wallace Marital Adjustment Test and the marital satisfaction factor (SMAR) and show the waiting list EI subgroup to report greater impairment with respect to the more general relationship than their non-waiting counterparts. The fact that these changes were in the same direction, and both involved measures of marital adjustment suggests that they may not in this case be a function of Type I error, the probability of which, as noted above, increases with such multiple comparisons (Cook and Campbell, 1979).

Discussion

There was evidence that the requirement of initial equivalence between the waiting-list and each of the two treatment groups had been fulfilled - as one would expect from random allocation of subjects. Only one significant difference was found, i.e. between the 'immediate start' MJ subjects and the control group, but given the number of variables routinely examined, this may be considered to fall within the limits of chance.

Table 21 Significant Results from Comparison between the Waiting-List Control Subjects (Post-Waiting Period) and "Immediate Start" Subjects (Pre-Treatment) Within Each Problem Subgroup : Mann Whitney 'U' Tests.

Problem	Variable	IS		WT		U	Prob
		n	m	n	m		
Vaginismus	Sexual Aversion Factor [a]	6	1079.0	7	929.9	6.5	*
Premature Ejaculation	'Myself' as Loving (Sem. Diff.) [b]	5	17.8	5	15.2	0	**
Erectile Impotence	Locke-Wallace Marital Adjustment [c]	6	113.5	6	82.3	5.0	*
Erectile Impotence	Marital Satisfaction Factor SMAR) [d]	5	954.0	6	1099.7	1.0	*

IS = Immediate Start Subjects

WT = Waiting-List Control Subjects

n = Number of Subjects

* $p < .05$

** $p < .01$

a low value, high sexual aversion

b high value, more loving

c high value, good adjustment

d low value, high marital satisfaction

More important in justifying the subsequent re-allocation of waiting-list subjects to each of the treatment groups is the demonstration of the absence of any significant change over the waiting-list period, and of no widespread significant differences between the control group and the other subjects at the start of therapy.

In brief, overall within control group analysis revealed only two changes which again one might expect from chance alone. Significant differences between the waiting and non waiting subjects in the VAG, PE, EI subgroups were observed. These were restricted to no more than two variables in each case and all differences were in the direction of greater impairment among the control subjects. In the PE and EI subgroups, there was evidence to suggest more impairment in the general relationship after the waiting period. However, it should be noted that it was intended that within each problem sub-group, control subjects be randomly allocated to one or other of the two treatment groups to ensure adequate stratification by form of dysfunction.

In general, therefore, there would appear to be no contra-indication to re-allocation of the control subjects in each problem subgroup to the two treatment groups.

Examination of Pre-Treatment Differences among the Four Problem Subgroups

Before comparing the effectiveness of the SH and MJ treatments, it would be of value to examine the pre-treatment relationship among the four problem subgroups as a whole, with respect to aspects of sexual functioning, attitudes and marital adjustment. In the first instance, this is because any significant differences which are found among the problem groups may have implications for the choice of analysis of treatment outcome differences between the SH and MJ approaches, since the relative efficacy of the two treatments within and across the four problem categories may then be of more central interest than an over-all comparison between treatment groups as a whole.

It is important to emphasise that the principal aim of this analysis

is to examine and determine the nature of any initial differences among the problem subgroups, rather than to interpret any differences shown to exist. The latter in any case would be extremely difficult in view of an unavoidable confounding of status as complainant (or partner) among the four problem subgroups, and sex of the rater. Thus, it becomes distinctly possible that any differences among the problem groups may be principally a function of sex differences rather than of characteristics intrinsic to the problems per se. Nevertheless, if interproblem differences were shown to exist pre-treatment, (and the distinctive clinical features and, to some extent, the differing proposed aetiological factors associated with each disorder raise the possibility that there may be) such findings may also have implications for the design and analysis of future comparative studies (particularly when different problem subgroups are included in the sample) and ultimately perhaps choice of treatment.

Statistical Methodology

The pre-treatment data for each of the four diagnostic groups on all variables were compared using one-way analysis of variance. The significant differences between the group means were then identified by Newman-Keuls tests. As noted earlier, the latter is one of the more sensitive tests for determining which specific differences contribute to a significant F value (Zivin and Bartko, 1976) with the result that, in this case, it is possible to identify which pairs of problem group means differ significantly, with more assurance than by the use of multiple t-tests. Where significant F values were observed, the results of the one-way analyses of variance are included in Appendix 5. .

It seems meaningful to describe more fully only the salient differences between each problem group and the other three groups so as to minimise repetition. Unless otherwise specified, the following account will focus mainly on the results for the complainants. Tables 22 to 25 summarise these findings. (The results of similar analyses among the partners' data are included in Appendix 1).

Female Sexual Unresponsiveness

(a) Sexual Functioning

The FSU group was shown to be significantly more impaired than the other three groups on four measures of sexual functioning

and enjoyment:

(1) Independent ratings of the degree of enjoyment of intimate foreplay. (FSU v VAG $p < .01$; FSU v PE $p < .01$; FSU v EI $p < .05$)

(2) Independent ratings of the frequency of pleasurable intimate foreplay. (FSU v VAG $p < .01$; FSU v PE $p < .01$); FSU v EI $p = .05$)

(3) Independent ratings of the frequency of sexual interest (FSU v VAG $p < .01$; FSU v PE $p < .01$; FSU v EI $p < .05$)

and (4) Sexual Pleasure Factor (PAD self-rating scale) (FSU v VAG $p < .05$; FSU v PE $p < .01$; FSU v EI $p < .01$)

The FSU group was also rated as experiencing a significantly higher frequency of unpleasurable intimate foreplay compared to the VAG ($p < .01$) and PE groups ($p < .01$).

These differences are consistent with the major clinical features of this disorder. The general findings of relatively low enjoyment of intimate non-coital activity in particular would seem to reflect the impairment of sexual pleasure and arousal during the initial 'excitement' phase, characteristic of this disorder.

(b) Attitudes Toward 'Self' and 'Partner' (Semantic Differential)

Consistent with the above findings are the differences between the FSU and the two male problem subgroups on the 'erotic arousal' factor of the semantic differential. Thus, on this factor, the FSU complainants' ratings of themselves were significantly lower than the corresponding ratings of the PE ($p < .01$) and EI complainants ($p < .01$). The opposite relationship with the PE and EI complainants, however, was apparent on ratings of "my partner" on the same factor. Thus, the FSU complainants rated their partner as significantly more easily aroused sexually than those of the PE ($p < .01$) and the EI subjects ($p < .05$).

(c) Marital Satisfaction and Adjustment

Of particular importance are the findings with respect to general marital adjustment, as measured by the Locke-Wallace MAT, the general marital satisfaction factor (SMAR), related attitude

Table 22 Pre-Treatment Means and Standard Deviations on Marital Adjustment Self-Rating Scales and Related Attitude Factors for each Problem Subgroup (Complainants only) - Results of One-Way Analysis of Variance and Newman-Keuls Test

Variable		FSU	VAG	PE	EI	F(df) [a]	Prob	Results of Newman-Keuls Tests
Locke-Wallace Marital Adjustment (High = Good)	m	82.8	111.1	98.7	97.9	3.1 (3,44)	*	FSU < VAG*
	σ	27.0	20.2	19.4	27.5			
Marital Satisfaction Factor (SMAR Scale) (Low = Good)	m	1094.0	1021.6	951.9	1033.5	6.36 (3,41)	**	PE < FSU**, PE < VAG*
	σ	71.2	32.4	74.3	102.3			
Myself-Loving (Sem. Diff.) 3=very unloving; 21=very loving	m	10.33	14.50	16.50	16.17	7.5 (3,42)	**	FSU < VAG*, FSU < PE**, FSU < EI**
	σ	3.06	4.70	1.84	3.64			
My Partner-Loving (Sem. Diff.) 3=very unloving; 21=very loving	m	18.08	19.25	18.40	18.83	0.53 (3,42)	NS	
	σ	3.32	1.60	2.37	1.99			
Self-Rating Communication 1=v.poor; 7=v.good	m	1.83	3.07	4.2	3.83	6.4 (3,44)	**	FSU < VAG*, FSU < PE**, FSU < EI**
	σ	1.03	1.14	1.87	1.53			
Self-Rating Affection 1=v.low, 7=v.high	m	2.58	3.86	5.6	4.42	9.08 (3.44)	**	FSU < VAG*, FSU < PE**, FSU < EI**, VAG < PE*
	σ	1.08	1.35	1.07	1.83			

* p < .05
** p < .01
NS Non-significant
a Full details of results in Appendix 5 Tables 90 To 94

Table 23 Pre-Treatment Means and Standard Deviations on Sexual Attitude Factor for Each Problem Subgroup (Complainants only) - Results of One-Way Analyses of Variance and Newman-Keuls Tests

Variable			FSU	VAG	PE	EI	F(df) [c]	Prob	Results of Newman-Keuls Tests
Myself - General Evaluation	a	m	8.75	6.92	10.10	9.08	3.24	*	VAG < PE*
		σ	2.67	2.61	2.13	2.39	(3,42)		
Myself - Anxiety	a	m	9.83	12.00	7.70	8.08	7.5	**	VAG > FSU*, VAG > PE**, VAG > EI**
		σ	2.76	1.35	2.67	2.71	(3,42)		
Myself - Sexual Attractiveness	a	m	5.83	7.33	8.50	7.75	3.2	*	FSU < PE*
		σ	2.79	1.87	1.43	2.01	(3,42)		
Myself - Erotic Arousal	a	m	3.25	5.00	11.60	6.67	51.1	**	FSU < PE**, FSU < EI**, VAG < PE** VAG < EI*, EI < PE**, FSU < VAG*
		σ	1.71	1.60	1.65	1.61	(3,42)		
Partner - General Evaluation	a	m	11.75	12.67	12.00	11.58	1.04	NS	
		σ	1.91	1.30	1.41	1.73	(3,42)		
Partner - Anxiety	a	m	5.42	6.25	8.70	8.25	2.76	NS	
		σ	3.92	3.22	2.91	2.49	(3,42)		
Partner - Sexual Attractiveness	a	m	10.33	10.67	11.90	11.83	2.53	NS	
		σ	2.27	1.56	1.37	1.40	(3,42)		
Partner - Erotic Arousal	a	m	12.25	12.00	9.60	10.17	7.0	**	PE < FSU**, EI < FSU*, PE < VAG** EI < VAG*
		σ	0.87	1.35	2.55	1.64	(3,42)		
Sexual Aversion Factor (PAD) Scale	b	m	902.5	998.7	1005.1	1027.5	2.33	NS	
		σ	176.4	133.5	51.8	57.8	(3,40)		

NS Non-significant
* $p < .05$
** $p < .01$
a 2 = very low, 14 = very high
b low value, high sexual aversion; high value, low sexual aversion
c Full details of results in Appendix 5 Tables 95 to 99

Table 24 Pre-Treatment and Standard Deviations on Independent (IR) and Self-Rating (SR) Scales of Sexual Satisfaction and Pleasure for Each Problem Subgroup (Complainants only) - Results of One-Way Analyses of Variance and Newman-Keuls Tests

Variable			FSU	VAG	PE	EI	F(df)[c]	Prob	Results of Newman-Keuls Tests
IR Scales									
Frequency of Pleasurable Intimate Foreplay (0-4)	a	m	1.18	3.36	3.20	2.08	12.6	**	FSU< VAG**, FSU< PE**, FSU< EI (p=.05)
		σ	0.98	1.01	0.79	1.08	(3,43)		EI< VAG**, EI< PE*
Degree of Pleasure from Intimate Foreplay (0-4)	a	m	1.36	3.57	2.80	2.25	19.1	**	FSU< VAG**, FSU< PE**, FSU< EI*,
		σ	1.03	0.51	0.92	0.45	(3,43)		PE < VAG*, EI< VAG**
Frequency of Pleasurable Sexual Intercourse (0-4)	a	m	1.09	0.07	2.60	1.67	15.6	**	VAG< FSU*, VAG< PE**,
		σ	0.94	0.27	1.17	1.15	(3,43)		VAG< EI**, FSU< PE**
Frequency of Sexual Interest (0-7)	a	m	1.64	3.00	4.70	3.00	15.8	**	FSU< VAG**, FSU< PE**, FSU< EI*,
		σ	1.12	0.88	0.82	1.21	(3,43)		VAG< PE**, EI< PE*
SR Scales									
Frequency of Sexual Intercourse (1-6)	a	m	3.25	1.21	4.56	2.00	24.8	**	VAG< FSU**, VAG< PE**,
		σ	1.42	0.43	1.13	0.74	(3,43)		FSU< PE*, EI< PE**
Degree of Enjoyment from Sexual Intercourse (1-6)	a	m	2.92	1.40	4.56	5.30	11.2	**	VAG< FSU*, FSU< PE*, FSU< EI**,
		σ	1.44	0.89	1.59	1.34	(3,32)		VAG< PE**, VAG< EI**
Sexual Satisfaction Factor (SMAR Scale)	b	m	1018.5	1037.4	1025.1	1036.6	0.1	NS	
		σ	98.9	92.15	91.46	110.38	(3,41)		
Sexual Pleasure Factor (PAD Scale)	b	m	1122.4	1039.9	910.4	1004.4	13.4	**	VAG< FSU*, PE< FSU**, EI< FSU**,
		σ	52.8	56.9	95.4	95.1	(3,40)		PE< VAG**, PE< EI*

NS Non-significant
* $p < .05$
** $p < .01$
a low value, low frequency/pleasure; high value, high frequency/pleasure
b low value, high satisfaction/pleasure; high value, low satisfaction/pleasure
c Full details of results in Appendix 5 Tables 100 to 106

Table 25 Pre-Treatment Means and Standard Deviations on Independent (IR) and Self-Rating (SR) Scales of Sexual Anxiety and Negative Sexual Experience for each Problem Subgroup (Complainants only) - Results of One-Way Analysis of Variance and Newman-Keuls Tests

Variable		FSU	VAG	PE	EI	F(df)[d]	Prob	Results of Newman-Keuls Tests
IR Scales								
Frequency of Unpleasurable Intimate Foreplay (0 - 4) [a]	m	1.18	3.43	3.70	2.00	15.3 (3,43)	**	FSU < VAG**, FSU < PE**, EI < VAG**, EI < PE**
	σ	0.98	0.94	0.48	1.41			
Frequency of Unpleasurable Sexual Intercourse (0 - 4) [a]	m	1.82	0.07	3.30	2.50	19.5 (3,43)	**	VAG < FSU**, FSU < PE*, VAG < PE**, VAG < EI**
	σ	1.47	0.27	0.95	1.38			
SR Scales								
Desgree of Anxiety About Symptoms during Sexual Play ("Spectating") (1 - 7) [b]	m	1.58	1.71	1.60	1.50	0.18 (3,44)	NS	
	σ	0.79	0.83	0.52	0.80			
Sexual Anxiety Factor (PAD Scale) [c]	m	980.8	879.5	1003.1	970.0	3.8 (3,41)	*	VAG < FSU*, VAG < PE*, VAG < EI (p = .05)
	σ	65.1	62.9	133.6	129.3			

NS Non-significant
* $p < .05$
** $p < .01$
a low value, high frequency of unpleasurable non coital and coital experiences; high value, low frequency
b low value, strong tendency to "spectate"; high value, low tendency to spectate
c low value, high anxiety; high value, low anxiety
d Full details of results in Appendix 5 Tables 107 to 109

measures and self-rating scales of the degree of affection and communication between partners.

Firstly, significantly poorer pre-treatment scores on the general marital satisfaction factor were obtained in the FSU group compared to the PE group. In addition, a strong trend in the direction of lower marital satisfaction on the same measure was apparent on comparing the FSU and VAG, and FSU and EI groups and indeed when t-test analyses were conducted, the former difference (i.e. FSU v VAG) did reach significance ($t = 3.3$, $df = 24$, $p < .05$).

On the Lock-Wallace MAT, the FSU group showed consistent signs of more impaired marital adjustment in relation to the other three groups, but only one difference reached significance, viz. between the FSU and VAG groups ($p < .05$).

On the other hand, the FSU group perceived themselves as significantly less loving on the semantic differential compared to all of the other three problem groups (FSU v VAG $p < .05$; FSU v PE $p < .01$; FSU v EI $p < .01$). Similar findings were also obtained on measures of interpersonal communication and affection. On the former scale, the FSU group rated themselves as significantly less communicative compared to the VAG group ($p < .05$); the PE group ($p < .01$) and the EI group ($p < .01$). Measures of affection revealed similar results with the FSU group rating themselves as significantly less affectionate than the VAG subjects ($p < .05$); the PE group ($p < .01$) and the EI group ($p < .01$).

Vaginismus (VAG)

(a) Marital Adjustment

As noted above, there is consistent evidence that the VAG group report significantly less impairment of their general marital relationship than the FSU group.

(b) Frequency and Enjoyment of Sexual Intercourse and Coital Anxiety

Again, as expected, several pre-treatment inter-problem differences with regard to specific aspects of sexual functioning were

found. Most of the significant differences among the VAG and and other problem groups involved measures of coital frequency and enjoyment and were observed among the partners as well as the complainants. Thus, the pre-treatment frequency of sexual intercourse, was significantly lower in the VAG group compared to the FSU ($p < .01$) and PE ($p < .01$) groups. Sexual intercourse was rated not only as being significantly more often a negative experience for the VAG group compared to the FSU, the PE and EI groups ($p < .01$ for all), but was also considered to be a pleasurable experience significantly less often compared to the PE and EI groups ($p < .01$) and the FSU group ($p < .05$). These findings from the independent rating scales were endorsed by the complainants' self-ratings of the degree of enjoyment of sexual intercourse as determined by the Sexual Interaction Inventory (SII). On this measure the VAG group again reported significantly less coital enjoyment than the FSU group (p .05); the PE group ($p < .01$) and the EI group ($p < .01$).

Sexual anxiety in relation to a range of sexual behaviours, was also measured by means of an anxiety factor derived from the PAD Scale. Again the VAG complainants rated themselves on this measure as significantly more anxious than the FSU group ($p < .05$) and the PE group ($p < .05$) and more anxious, though not quite significantly so, than the EI group ($p = .05$). No such inter-problem differences were found, however, from the partners' data on these anxiety measures.

(c) Non-Coital Sexual Relations

The VAG group showed a significantly greater degree of enjoyment of intimate foreplay compared to the FSU group ($p < .01$); the PE group ($p < .05$) and the EI group ($p < .01$) - the findings being largely endorsed by the partners in each problem subgroup. Consistent with these results were the findings among the complainants with respect to the frequency of pleasurable and unpleasurable non-coital activity in each case favouring the VAG group in relation to two of the other three groups (VAG v FSU, $p < .01$; and VAG v EI, $p < .01$).

Attitudes Toward 'Self' and 'Partner'

An additional finding was that the VAG group were shown to have lower scores on the general evaluative factor of the semantic differential compared to each of the two male problem groups. However, only the difference between the VAG and PE groups was shown to be significant from Newman-Keuls test ($p. < .05$), whereas the trend apparent from the comparison between the VAG and EI means did reach significance from t-test analysis ($t = 2.1$, $df = 22$, $p < .05$) only.

Moreover, in keeping with the VAG group's higher sexual anxiety reported above, the VAG complainants also perceived themselves as being significantly more anxious compared to the FSU ($p < .05$), and each of the two male problem groups ($p < .01$).

Premature Ejaculation

(a) Attitudes Toward 'Self' and 'Partner'

As noted above, the PE group, consistent with the nature of this dysfunction, perceived themselves as more sexually responsive than each of the other three groups ($p < .01$ in each case), as measured by the 'erotic arousal' factor. Similar intergroup differences on this measure were obtained by the non-complainants' ratings of their partners.

On this 'erotic arousal' factor, in particular, it is evident that the respective positions of the PE partners and the FSU complainants (and vice versa) in relation to the other three problem groups are strikingly similar.

However, the salient differences involving the PE group are with respect to sexual functioning.

(b) Frequency and Enjoyment of Sexual Relations

The PE subjects were shown pre-treatment to engage in sexual intercourse significantly more frequently than the other three groups (PE v FSU $p < .05$; PE v VAG $p < .01$; PE v EI $p < .01$). Moreover, the frequency of pleasurable sexual intercourse and the frequency of sexual interest were rated by the independent assessor as being significantly higher in the PE group compared

to each of the two female groups ($p < .01$, in each case). The frequency of pleasurable intimate foreplay was also shown to be significantly higher for the PE complainants compared to the FSU ($p < .01$) and EI subjects ($p < .05$).

Comparable significant differences were obtained on independent ratings of the frequency of unpleasurable intimate foreplay, again favouring the PE complainants. Consistent with this finding are the results for the Sexual Pleasure Factor (PAD Scale) in which PE subjects again reported experiencing a significantly greater degree of general sexual enjoyment compared to each of the other groups (PE v FSU $p < .01$; PE v VAG $p < .01$; PE v EI $p < .05$).

All these findings above are based on the complainants data, however. Again, the general pattern of the intergroup differences for the partners in each group are strikingly different from those of the complainants.

In relation to non-complainants in the other groups, the PE partners' enjoyment of sexual relations as measured by the above variables, again appears more like that of the FSU complainants. Thus, in contrast to the above findings for the complainants, the PE partners are rated as enjoying intimate foreplay significantly less than the other three groups and the frequency of pleasurable coital and non-coital relations is signficantly lower in each case than that for the FSU partners and VAG partners.

Erectile Impotence (EI)

Most of the salient findings from interproblem comparisons involving the EI group has already been referred to above. There was no evidence from this study of a more impaired general marital relationship among the EI group compared to the others and this finding was endorsed by the partners. It is noteworthy that the pattern of results on the erotic arousal factor of the semantic differential was such that the EI complainants rated themselves as significantly more responsive than the FSU complainants ($p < .01$) and the VAG complainants ($p < .05$),while results in the opposite direction were reported by the partners in each of these groups.

Discussion

Among the problem categories there is clearly a wide range of pre-treatment differences, the vast majority of which may of course simply reflect the discrete clinical features on which the original diagnostic classification was based. Thus, it may be scarcely surprising to note, for example, that the degree of sexual pleasure, frequency of sexual interest and the frequency with which non-coital activities are experienced as pleasurable are lower for the FSU subjects compared to those with other disorders; that those with vaginismus experience significantly less sexual enjoyment from intercourse than other complainants; or that males with premature ejaculation report significantly higher levels of erotic arousal compared to each of the female groups. It is important, of course, to stress that it is not the purpose of this comparison among the problem groups (and nor is it possible here in any case) to interpret unequivocally the differences among them. The aim was only to determine their existence, given their implications for the design and analysis of this and future related therapy outcome studies. The possibility of differential denial, perception of, concern with, or/and willingness to report sexual and marital difficulties between the sexes as additional variables, confounding interpretation is, therefore, amply conceded.

Indeed, in their discussion of the higher frequency of reported sexual dysfunction in women compared to men, Frank et al (1978) refer to the possibility that such a result may be a function of "the wives' greater willingness to admit to having problems". Sex of the rater may be a potentially very important confounding variable for a number of other reasons. Although Schmidt (1975) has suggested that differences in sexual behaviour patterns of males and females has diminished, there is already a substantial body of evidence to suggest gender specific differences in terms of sexual responsiveness to material of varying erotic content and form (Kinsey et al, 1948; 1953; Steele and Walker, 1974; Sigusch et al, 1970; Heiman, 1977; Steinman et al, 1981). Most of these studies, however, employed non-dysfunctional subjects and, of course, the results were based on their responses to specific external sexual stimuli (e.g. films, written material), rather than to forms of actual sexual activity. The weight of evidence suggests, however, that males and females show

discriminably different subjective and genital arousal patterns in reaction to erotic material in a laboratory setting. The possibility that they may also show comparable differences in the direction and magnitude of their reported responsiveness to aspects of their sexual play may also lead to increased variability among the scores on self-report scales from a mixed dysfunctional sample - a variability which may be related to both the nature of the presenting problem as well as to gender differences.

Perhaps one of the most important pre-treatment differences was with respect to marital adjustment. Thus, in general, there was a consistent trend, from the complainants' data only, toward a greater disturbance of the more general aspects of the marital relationship as reported by the FSU group, compared to the other three groups. However, on only three scales did the differences between the FSU and the other groups reach significance, i.e. ratings of the degree of effectiveness of interpersonal communication, degree of affection, and attitudes toward self as 'loving'. Similarly, on the marital satisfaction factor (SMAR Scale), the FSU complainants reported significantly less marital satisfaction compared to the PE group and almost significantly less than the VAG complainants. (However, this latter difference did reach significance from t-test analysis : $t = 3.3$, $df = 24$, $p < .05$.).

However, greater marital dissatisfaction in the FSU group compared to other problem groups was not found from analysis of the partners' data, again suggesting that some of these findings, with respect to marital adjustment, may reflect in part at least a different emphasis the sexes place on sexual as opposed to more general marital aspects of the relationship (Kaplan, 1974) or a differential tendency to report such problems, as suggested above (cf. Frank et al, 1978). Nevertheless, the present findings lend some weight to the trends reported by Mathews et al (1976) of 'a more generalised disturbance' among females with loss of sexual interest.

Another important finding involved the VAG group who showed consistent evidence of a less generalised impairment of sexual satisfaction. Thus, independent ratings of the frequency of pleasurable and unpleasurable intimate foreplay in each case favoured the VAG

complainants compared to those in the FSU and EI groups. The VAG group was also rated as experiencing a greater degree of enjoyment of non-coital sexual relations compared to each of the other three groups. These findings, together with those above, with regard to marital adjustment, and the evidence of a greater degree of coital anxiety among those with vaginismus, suggest a more clearly circumscribed difficulty for these complainants, compared to those in the other three groups. That most women with vaginismus may not also experience a more generalised impairment of sexual responsiveness has been well documented. For example, Stourzh (1961) reported that in only 20% of females with vaginismus did he find a concurrent loss of libido, and Lamont (1977) found that about 70% of a sample of vaginismic women had experienced or were experiencing orgasm when first seen. Lamont concludes that 'many paitents with the complaint of vaginismus have no difficulty with sexual responsiveness or sexual appetite and their problem is confined solely to involuntary perineal muscle spasms and the resulting coital difficulties' (Page 195). Malleson (1942; 1951); Friedman (1962) and Ellison (1968) have reported similar observations with which the present findings appear to be broadly consistent.

Thus most of the results for the VAG group, in relation to the others, are interpretable in terms of the defining symptoms of vaginismus, and would seem to be consistent with earlier reported features of this patient group. Again, of course, it is possible that some of the differences may have been inflated by a possible tendency for the males to minimise the extent of their sexual anxieties or/and to report greater coital satisfaction on the occasions intercourse occurred. Nevertheless, the similar, wide range of differences between the FSU and VAG groups, in terms of marital adjustment and satisfaction, sexual (particularly coital) anxiety, and non-coital enjoyment suggest that they are not wholly attributable to simple sex differences among the raters.

It is also perhaps of interest that a lower "self" rating on the 'general evaluative' factor was found among the VAG complainants compared to each of the two male groups. Given the nature of the scales comprising this factor (viz. 'good-bad'; 'cruel-kind'), one possible interpretation of this finding may be in terms of lower perceived self-

worth in the VAG group and hence possibly even increased self-blame. It may be hypothesised that vaginismic females may be pre-disposed to such a self-perception which may be mediated or reinforced in part perhaps by the more obvious or cicumscribed nature and source of their sexual difficulties and a consequent identification of themselves as 'the patient'. Clearly, the above general caveat in terms of additional sex differences still, of course, applies.

In contrast, the PE complainants, in general, reported less impairment of sexual functioning and responsiveness. Thus, the PE subjects scored higher in sexual responsiveness compared to the other three groups, as measured by the 'erotic arousal' factor of the semantic differential. This again may be construed as consistent with the defining symptoms of the disorder. The PE complainants also rated themselves, and were rated, as enjoying sexual relations to a greater degree, and engaging in sexual intercourse more frequently, than the other three groups. In striking contrast, however, were the findings on the same measures for the female partners of the PE group, who were shown to enjoy non-coital sexual relations significantly less than the partners in the other three groups and who were rated as experiencing sexual interest, and pleasurable intimate foreplay significantly less often than the VAG and FSU partners. Thus, the partners' scores on these variables, relative to the other partners, were akin to the FSU subjects in relation to the other three groups of complainants (with the exception that the former showed no evidence of relatively greater marital dissatisfaction). Nevertheless, these results may be regarded as consistent with an interactional view of sexual dysfunction and, more specifically, with the way in which female sexual unresponsiveness and premature ejaculation have been considered to reinforce each other (Bancroft, 1975; Levine, 1975).

In relation to the other groups, couples whose main problem was erectile impotence tended to respond in a manner largely similar to the PE couples, with the exception of these pre-treatment measures relating to erotic arousal, pleasurable non-coital sexual relations and frequency of intercourse, on all of which the PE complainants scored more favourably. From the partners' data, however, there was evidence of a trend in the opposite direction, with the female partners of the EI subjects showing less impairment of non-coital

enjoyment than the partners of the PE complainants, as noted above. In general, the males, whether partners or complainants, consistently reported less impairment of sexual functioning, interest and enjoyment compared to their female counterparts.

To reiterate, it is not possible from this part of the analysis to provide a reasonably clear interpretation of the above differences among the problem groups which seem likely to be due to an interaction among a number of factors. These may include the discrete clinical features of each disorder and their effects on other aspects of sexual/marital relationship, (and vice versa), and biologically and culturally determined differences between the sexes which may account for a differential tendency to experience, perceive or/and report specific areas of sexual difficulty and specific forms of sexual arousal.

Yet, the primary purpose of this series of analyses was to examine the nature and extent of these initial interproblem differences rather than provide an empirical basis for their interpretation. The fact that such widespread differences have been shown to exist on a range of measures, commonly applied in "mixed dysfunctional" group comparative outcome research, has important implications for the design and analysis of such studies. In view of the present findings, it seems reasonable to suggest that the use of samples, heterogeneous with respect to type of dysfunction, may have the effect of increasing the overall pre-treatment variance within each treatment group to the extent that it may reduce the chances of finding significant differences from overall group comparison. This is because any improvement among the more impaired on any particular variable may be submerged by the non-improvement in those already well-adjusted on the same variable.

Furthermore, the pre-treatment interproblem differences also reinforce the possibility, raised in the introduction, that the relative effects of some treatments for sexual dysfunction may vary across problem categories. Some recognition of this possibility would seem to be important in the comparative analysis of the effect of regular conjoint counselling and minimal contact treatment programmes for these disorders.

For example, previous evidence suggests that those with greater marital

difficulties may respond poorly to minimal contact approaches in general (Leiblum et al, 1976; Zeiss et al, 1978; McMullen and Rosen, 1979). Together with the present results, it seems reasonable therefore to hypothesise that couples whose main complaint is female sexual unresponsiveness would respond less well to the 'self-help' compared to the regular counselling approach. It would also be of interest to determine whether this proposed difference in outcome would in itself be greater than that apparent among those other problem groups for whom marital difficulties were less marked.

CHAPTER 12

Comparison of Outcome Between the 'SH' and 'MJ' Treatments

As noted in the introduction, several researchers in this area have argued in recent years for a shift in research focus from a concern with which therapy is best to the more complex question of what kinds of treatment are best suited for specific types of people with particular clinical problems. Reynolds (1977), for example, in his review of outcome of psychological treatments for erectile dysfunction, has recommended that erectile dysfunction and other male sexual disorders be studied separately. Such a view implies some recognition of the confounding effects of initial subject differences, as does Hogan's (1978) similar plea for an examination of the way in which specific patient groups, characterised by particular clinical and demographic features, may respond more favourably to one treatment compared to another. Similarly, Glasgow and Rosen (1978) in their review of bibliotherapy outcome research, have asserted that 'related to the efficiency and effectiveness of self-help manuals is the need for program developers to provide guidelines that assist potential consumers in determining the appropriateness of any given program' (page 14). Such questions, of course, relate to perhaps the most fundamental question in psychotherapy research in general, for which there are still too few scientifically acceptable answers:

> "What treatment, by whom, is more effective for this individual with that specific problem, under which set of circumstances?" (Paul, 1967, page 144).

There is no reason to presume of course that such issues with respect to such a specialised area such as bibliotherapy research will be any more readily resolved.

Clearly the number of significant pre-treatment differences observed from the above comparison among the problem groups is likely to have

been inflated by a number of factors distinct from the problems themselves. Sex of the rater has already been mentioned, while another may well be a certain amount of redundancy among the measures themselves, i.e. the extent to which they intercorrelate, so that they may be merely measuring differing facets of the same factor.

Nevertheless, in view of:

(a) previous evidence of a variability of response to directed practice treatments, and a minimal contact approach in particular (Mathews et al, 1976),

(b) the present evidence of widespread pre-treatment differences among the four problem groups; and

(c) to some extent, in response to the above recommendations for future research,

it would be of value to compare the two treatment groups in such a way as to permit:-

(1) an examination of the relative efficacy of the treatments by comparison between the treatment groups as a whole, i.e. across problem subgroups;

(2) a comparison of treatment response among the problem groups, regardless of treatment form, i.e. to examine the possibility of problem main effects;

(3) a comparison between treatments within each problem group separately, and

(4) as a prelude to further research, a comparison of the differential effects of the treatments between problem groups, i.e. to examine the possibility of an interaction between type of treatment and nature of the dysfunction.

In the context of this analysis, the precise details of which are outlined below, it will be recalled that two specific hypotheses are proposed:-

that the MJ approach would effect greater change than the SH format with respect to more general marital aspects of the relationship, in view of the greater opportunity with the former treatment for more intensive counselling. In view of the evidence of greater more generalised interpersonal difficulties among the FSU group, compared to the other problem groups, one may further hypothesise that this predicted difference between treatments would be particularly evident in this

group of patients;
that the MJ approach would be superior to the SH approach in changing sexual attitudes.

The first part of this comparison between treatments, however, will involve an analysis of the 'goal attainment' data.

Analysis of 'Goal Attainment' Data

Since a predetermined criterion for discontinuing therapy had been operationally defined in terms of mutually satisfactory intercourse on at least six occasions over a period not exceeding eighteen days (as determined by independent reports from each partner), it clearly becomes possible to obtain general or global measures of improvement based on goal attainment for each of the couples in the study.

Table 26 overleaf shows such general findings using this criterion measure.

General comparison of the two treatment groups as a whole in terms of goal attainment was conducted using Chi-Square analysis. No significant difference between the treatment groups was found ($X^2 = 0.76$, $df = 1$).

Even superficial inspection of these raw nominal data in terms of goal attainment suggests no significant differences between treatments within each of the four problem categories - this being confirmed by the results of Fisher Exact Probability Tests.

Outcome data for the four problem groups, irrespective of treatment group membership, were then compared, so that a total of six Chi-Square analyses were conducted. The only significant difference between the problem groups was that found between the VAG and PE subgroups ($X^2 = 5.53$, $df = 1$, $p < .05$). Thus, irrespective of treatment form, the vaginismic couples reported a significantly more favourable outcome on the above measures, compared to those with premature ejaculation. A similar strong trend was apparent favouring the VAG group compared to the FSU group, but the difference just failed to reach significance ($X^2 = 3.76$, $df = 1$, $p = .06$).

Finally, the goal attainment scores among the problem subgroups and within each treatment group were compared, as a preliminary analysis of differential outcome within each treatment group. The Fisher exact probability test was used and two significant differences were found in each case within the SH treatment group. Thus, significant differences on the above measure of goal attainment were found between

Table 26 Number of Couples Within Each Category of Dysfunction and Treatment Group Who Attained Predetermined Goal of Therapy

	MJ		SH	
	Total No.	Goal Attained	Total No.	Goal Attained
FSU	6	4	6	1
VAG	7	6	7	6
PE	5	2	5	1
EI	6	3	6	3
	24	15	24	11

the VAG and FSU groups who had received the self-help approach ($p = .03$) and between the VAG and PE groups again within the SH group ($p = .045$). No other significant differences were found, but these preliminary results in general confirmed the impression that not all dysfunctional groups were responding uniformly to treatment, at least in terms of goal attainment, and this seemed to be attributable to a differential response among these subgroups to the SH approach in particular. More specifically, the vaginismus subgroup responded significantly better to this minimal contact regime compared to both the premature ejaculation and female unresponsiveness subgroups.

Also significantly more of the former group were considered improved, irrespective of treatment form, compared to the PE group and almost significantly more than the FSU group.

To provide some cross-validational evidence of the above informal reports of goal attainment, part of the Sexual Interaction Inventory was originally selected as being a potentially appropriate scale, as it was designed to provide a measure of satisfactory coital frequency and pleasure appropriate to each couple, which obviates independent value judegements. Unfortunately, as noted earlier, it was found in the course of treatment that the scale seemed to have little discriminant validity, with the distribution of scores in the 'desired frequency' and 'desired pleasure' categories being particularly skewed (cf, McCoy and D'Agostino, 1977).

Instead, independent rating scales of the frequency of "adequate" sexual functioning, relevant to each condition were used to help verify the claims of goal attainment informally, though independently, provided by each spouse.

Based to some extent on the definitions of the four forms of dysfunction outlined in the introduction, the following additional criteria of sexual improvement were selected. It should be noted that these were not additional criteria for discontinuing therapy, but are supplementary arbitrary post-hoc measures of global sexual improvement, which it was hoped might provide some independent cross-validational support for the goal-attainment data.

Female Sexual Unresponsiveness

Spontaneous interest or desire for sexual relations (including sexual intercourse) at least once a week.

Vaginismus

Attempts at vaginal entry of penis successful on more than 50% of occasions.

Premature Ejaculation

Has "adequate" ejaculatory control on about 50% of coital occasions. ("Adequate" again being defined as that which contributes to mutual satisfaction - not necessarily female orgasm.)

Erectile Impotence

Obtains an erection sustained throughout sexual intercourse on more than 75% of occasions.

The results are summarised in Table 164, Appendix 7, where it may be seen that complete concordance is observed between the two sets of data for the VAG and PE subgroups. However, three of the six EI subjects who reported having attained the treatment goal just failed to reach the criterion as defined above.

Cost-Effectiveness (Duration of Therapy)

The results of a comparison between the two treatment groups in terms of the number of weeks to the reported attainment of the treatment goal indicate no significant difference between treatments. The average number of weeks to criterion among the 15 "successful" couples given the MJ approach was 12.47 (S.D. = 2.39) and among the "successful" SH couples was 12.45 (S.D. = 3.30). Data for each of the four problem groups were then analysed using separate Mann-Whitney 'U' Tests. In general, there was little difference among the groups with the exception of the FSU and EI subgroups ($U = 6.0$, $p = .063$), due to the fact that therapy extended most often to, or close to, the sixteen week maximum among the FSU couples compared to the EI couples.

There was a striking tendency among those who defaulted in therapy after the fifth week to do so very soon afterwards, there being a very limited range in the data (6 - 8 weeks, modal = 8) among the nine couples involved.

Statistical Methodology

In order to provide the most efficient and parsimonious means of examining (a) differences between treatment groups as a whole, (b) differences among the four problem groups as a whole, and (c) the interaction between treatments and problems, an initial series of two way (Treatments x Problems) analyses of covariance was conducted - both at post-treatment and at follow-up - using the pre-treatment score as the covariate. As noted earlier, in the description of the analysis of treatment effects, analysis of covariance in pretest - posttest designs, in which the pre-treatment score is used in this way, has the effect of reducing the error variance in the dependent measure that could be attributed to initial pretest score differences (Campbell and Stanley, 1963). Moreover, it is now a more sensitive and versatile method of analysis than one which, for example, involves gain or "change" scores which are 'systematically related to any random error of measurement' (Cronbach and Furby, 1970; page 68). It has also been recommended in preference to a repeated measure analysis of variance, when applied to pretest-posttest designs (Huck and McLean, 1975).

In the present study, any complete Treatments x Problems (i.e. 2 x 4) two-way analysis of covariance will yield eight adjusted post-treatment (or follow-up) means based on fairly small numbers in each cell. It is readily conceded that care must be observed in the interpretation of any such parametric analysis with such small numbers in each cell for reasons relating to the nature of the distribution of scores, to heterogeneity of variance, and the possibility of more serious Type I error.

It is proposed, however, that such preliminary two-way analysis may be justified on two main grounds:

(1) Firstly, as a screening procedure which may help identify problem or treatment main effects, the significance of which may be subsequently confirmed by one-way analysis of covariance, in which cell sizes (and consequently the distribution of scores) may be statistically more acceptable, as indeed may the reliability of the adjusted post-treatment means. Moreover, the results of such one-way analysis of covariance, in the case of problem

group differences, would also permit the use of a Newman-Keuls test to help determine which specific pairs of problem group means differ significantly.

(2) Secondly, such two-way analysis of covariance affords a preliminary examination of interaction effects between treatments and problems. The term "preliminary" here is intended to imply some recognition of the need for caution in interpreting such effects derived from parametric analysis with such small numbers involved.

The subsequent identification of those problem subgroups involved in a significant interaction effect was then conducted by means of separate two-way (i.e. 2 x 2) treatments x problems analysis of covariance involving each dual comparison between problem subgroups (i.e. this would lead to a maximum of six possible multiple comparisons).

It is important to reiterate that this analysis should be regarded only as a preliminary examination of interaction effects, the results of which may be seen as a springboard for further more detailed replicative research involving a larger sample.

A more detailed examination of differential treatment response within each problem group separately was conducted by means of non-parametric analyses. Within-treatment group change was analysed using Wilcoxon matched pairs signed ranks test and between treatments analysis by Mann-Whitney 'U' tests at each period of testing. Thus, in the latter case, the analysis of change or gain scores was avoided except in those few cases where significant pre-treatment differences on particular variables were found. Such a comparison of post-treatment and follow-up scores only, given initial random assignment of subjects to the treatment groups, is considered preferable to a comparison between gain scores for reasons again relating to assessment reliability and the reduction of error variance (Adams, 1978).

Of course, the presence, within any one problem group, of a signficant difference between treatments which may be absent in another subgroup, does not necessarily mean that there is a significant interaction effect between treatments and problems. Yet, the results of such

separate non-parametric analyses may allow informal inspection of the pattern of differential treatment responses among the four diagnostic categories, and thereby lend some additional weight to, and clarification of, any interaction effects demonstrated by two-way analysis of covariance.

In summary, therefore, to compare the effectiveness of the treatments, both within and across the four dysfunctional categories comprising each treatment group, the following methods of analyses were conducted:

(a) Two-way (Treatments x Problems) ANCOVA was used in the first instance.

(b) Subsequent confirmation of the significance of any treatment or problem main effect was conducted using one-way ANCOVA. In the case of problem main effects, the procedure enabled application of the Newman - Keuls test to help identify those pairs of means which differed significantly.

(c) Interaction effects found with analysis (a) above were also further examined by means of a series of two-way ANCOVA involving each dual combination of problem subgroups.

(d) Non-parametric within and between treatment groups analyses for each problem group separately were conducted using Wilcoxon matched pairs signed ranks test and Mann-Whitney 'U' test respectively. Given random allocation of couples to the treatment groups and, in the absence of any significant pre-treatment differences, the latter test involved a comparison between post-treatment or follow-up scores only, rather than change scores.

In accordance with the other main areas of assessment and the hypotheses under investigation, the results of the rest of the comparative analysis between the two treatment groups may be divided into four main sections:

(1) sexual pleasure

(2) general sexual adjustment and functioning

(3) marital adjustment and satisfaction, and

(4) sexual attitudes.

Sexual Pleasure

Several measures relating to the degree of pleasure derived from a variety of sexual activities were included in the assessment battery.

These may be divided into three categories (a) self-ratings of general sexual pleasure (PAD scale); (b) independent ratings of pleasure from non-coital sexual play; and (c) self-ratings of enjoyment of sexual intercourse (SII).

(a) Self-Ratings of General Sexual Pleasure (PAD Scale)

Table 27 shows that no significant differences were found between the MJ and SH treatment groups as a whole at any period of testing.

Separate within-group analyses of the complainants' and partners' date on this measure were conducted using paired

Table 27 General Sexual Pleasure Factor (PAQ Scale)[a]: Means and Standard Deviations for Treatment and Problem Groups (Complainants only) - Results of Two-Way (Treatments x Problems) Analysis of Covariance

		MJ			SH		
Problem		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	1136.0	1028.0	1007.0	1108.8	1127.8	1112.6
	σ	41.18	69.97	78.77	63.20	82.90	77.45
VAG	m	1036.4	979.4	963.0	1043.8	990.7	984.0
	σ	42.95	117.89	65.05	74.29	90.68	97.58
PE	m	934.3	949.3	936.0	886.5	879.8	905.3
	σ	55.88	75.76	60.57	128.84	115.66	70.76
EI	m	1018.0	996.8	1036.4	993.0	985.7	998.0
	σ	52.06	82.45	78.47	124.78	105.19	88.20
TOTAL	m	1040.8	991.1	986.7	1019.1	1006.5	1003.9
	σ	32.31	89.59	75.94	119.85	124.91	107.19

a high value, low sexual pleasure; low value, high sexual pleasure
b post-treatment and follow-up means above are unadjusted cell means

POST-TREATMENT

F Treatments (df 1,35) 1.5 NS
F Problems (df 3,35) 0.64 NS
FT x P (df 3,35) 2.44 p = .08

FOLLOW-UP

F Treatments (df 1,33) 1.61 NS
F Problems (df 3,33) 1.95 NS
FT x P (df 3,33) 2.12 NS

Full details of the results are provided in Appendix 6 , Table 118

t-tests. Significant improvement post-treatment was observed only for the complainants within the MJ group ($t = 2.5$, $df = 21$, $p < .05$) and this change was maintained at follow-up ($t = 2.8$, $df = 21$, $p = .01$). (See Table 28)

However, among the complainants only, there was evidence of a near significant interaction effect from 2 x 4 (Treatments x Problems) analysis of covariance ($F\ [3,35]\ 2.44$, $p = .08$). In order to clarify the nature of this interaction effect, a series of pairwise or 2 x 2 (Treatments x Problems) analysis of covariance involving only dual comparisons among the four problems was conducted. The results of these 2 x 2 analyses of covariance revealed two significant interaction effects (See Appendix 6, **Tables 119 and 120.** Thus, there were significant differences between the differential treatment responses for the FSU and EI groups ($F\ [1,18]\ 5.02$, $p < .05$) and the FSU and PE groups ($F\ [1,15]\ 7.32$, $p < .05$). The nature of these interactions is illustrated in Figure 2 overleaf, the scores being the adjusted post-treatment means derived from two-way analysis of covariance involving all four problems.

While there was no significant difference between the two treatment groups as a whole, the above results reveal that the effects of the treatments with respect to sexual pleasure are not additive across different forms of sexual dysfunction. Thus, the SH approach would appear to be of less benefit than the MJ approach for those females with loss of sexual responsiveness, and this differential response, in terms of sexual pleasure, is greater than that found among those with premature ejaculation and erectile impotence. At follow-up, however, no significant interaction or problem main effect was observed from the complainants' data.

In order to clarify further the nature of these interactions between treatments and problems, it would be relevant to compare the effects of treatments for each problem group separately, as these interaction effects refer only to differences in the differential treatment response among the diagnostic groups and not to the statistical significance of the treatment differences within each problem group independently.

Table 28 General Sexual Pleasure Factor (PAD Scale)[a]: Means and S.D.s for each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests[1])

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	1040.8	991.1	986.7	1019.1	1006.5	1003.9
σ	82.31	89.59	75.94	119.85	124.91	107.19
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	959.1	972.6	966.6	963.8	961.2	975.1
σ	130.36	101.03	112.73	100.53	86.93	68.85

MJ Complainants		SH Complainants	
PRE v POST	t = 2.52, df = 21,p*	PRE v POST	NS
PRE v F.U.	t = 2.79, df = 21,p*	PRE v F.U.	NS
POST v F.U.	NS	POST v F.U.	NS

MJ Partners		SH Partners	
PRE v POST	NS	PRE v POST	NS
PRE v F.U.	NS	PRE v F.U.	NS
POST v F.U.	NS	POST v F.U.	NS

a high value, low sexual pleasure; low value, high sexual pleasure
* $p \leq .05$
** $p \leq .01$
1 All probabilities are two-tailed

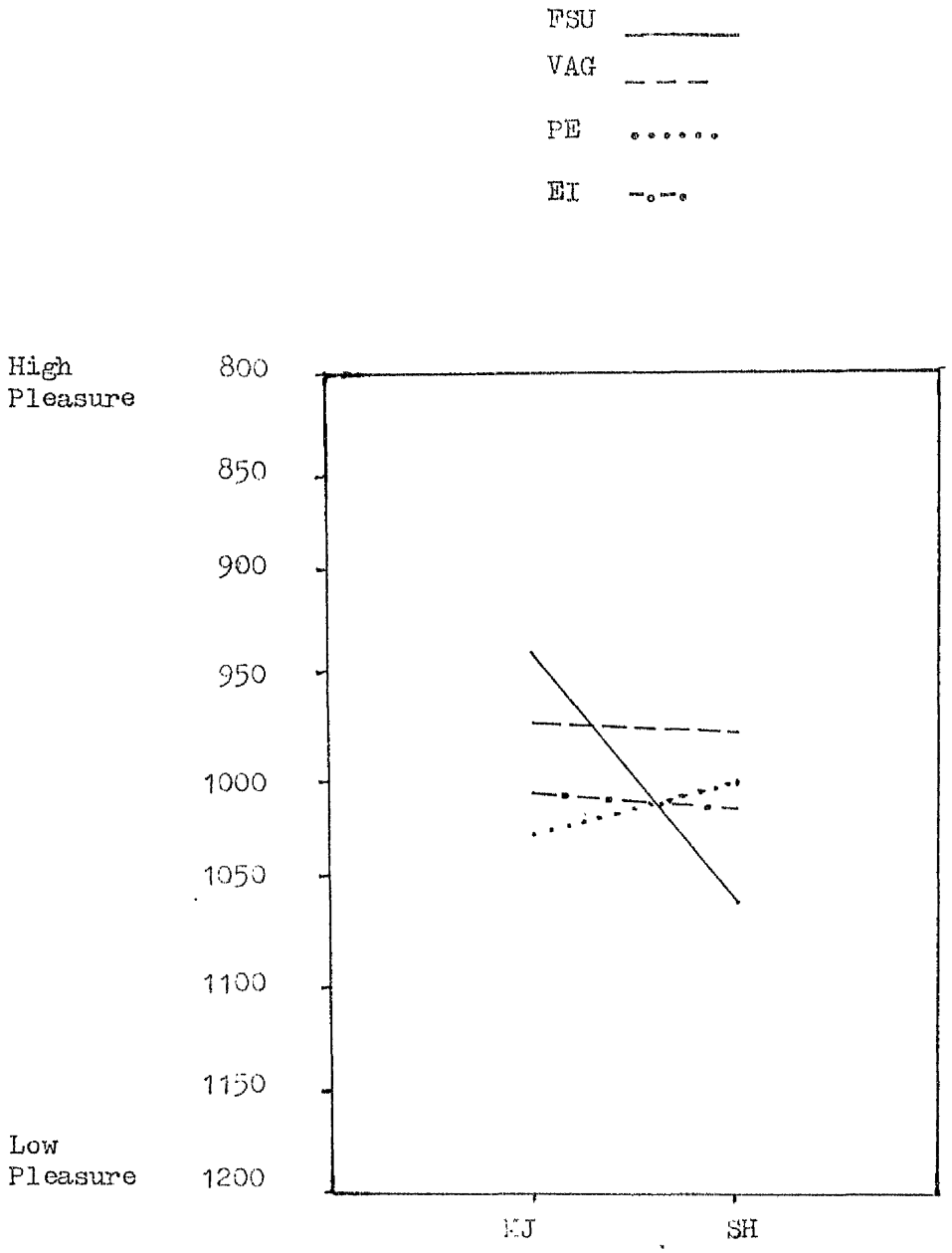
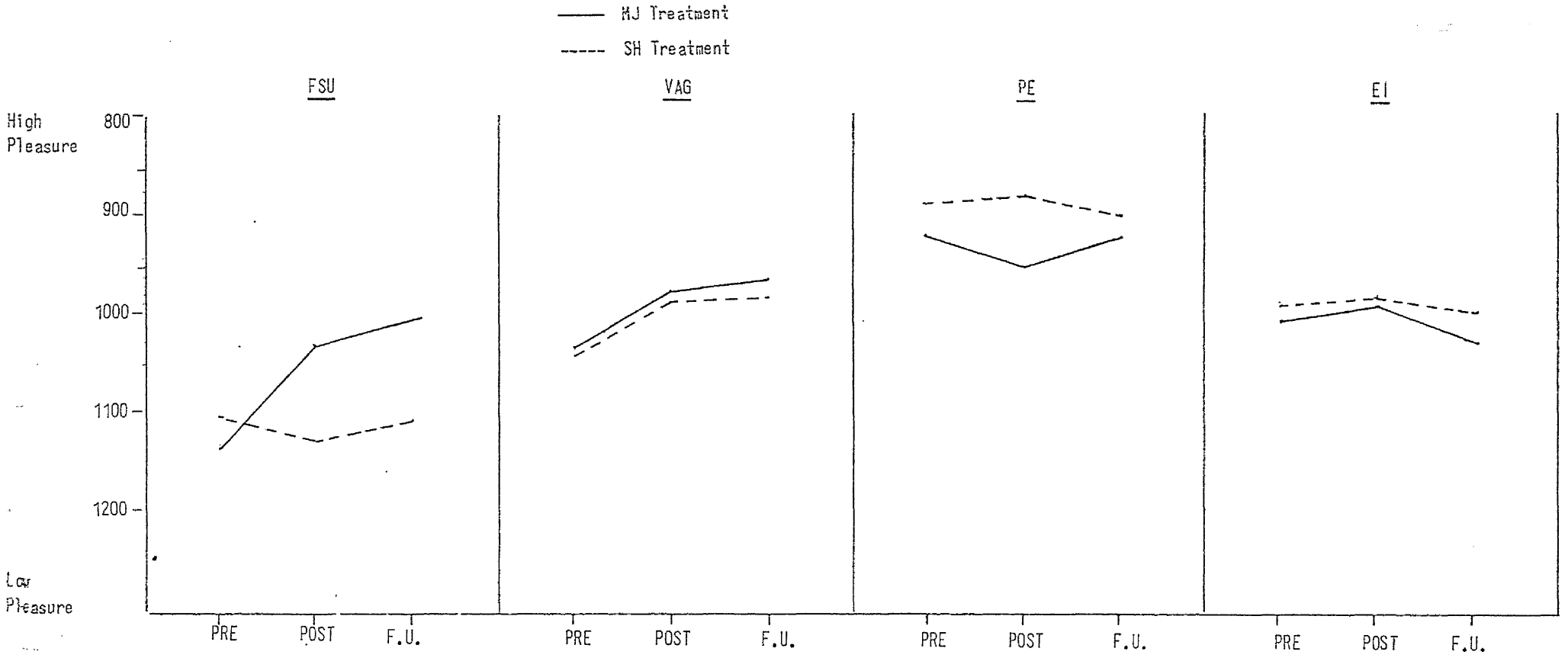


Fig. 2 General Sexual Pleasure (PAD Scale) : Adjusted Post-Treatment Means of Each Problem Subgroup (Complainants only) According to Treatment Form.



	FSU	VAG	PE	EI
Within MJ	PRE v POST Z = 1.99, p = .046 PRE v F.U. Z = 1.99, p = .046	PRE v POST NS PRE v F.U. Z = 2.2, p = .03	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
Within SH	PRE v POST NS PRE v F.U. NS	PRE v POST Z = 1.78, p = .08 PRE v POST NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
MJ v SH	POST U=7.0, n_1=6, n_2=6, p=.08 F.U. U=5.0, n_1=5, n_2=6, p=.07	POST NS F.U. NS	POST NS F.U. NS	POST NS F.U. NS

Fig. 3 General Sexual Pleasure (PAD Scale) : Mean pre, post-treatment and follow-up MJ and SH Scores with each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

Figure 3 summarises the results of non-parametric analyses within each problem group (complainants only).

On this measure of sexual pleasure, there were no significant pre-treatment differences between the treatment groups in any problem category. The results of within and between treatments analyses for each problem group separately indicate only one near significant difference between treatments, both at post-treatment (U [6,6] * 7.0, p = .08) and at follow-up (U [5,6] 5.0, p = .07) which was with the FSU group and favoured the MJ approach, largely as a result of a signficant pre-post treatment improvement sustained at follow-up among those FSU subjects receiving the combined directed practice and counselling regime. While there was no significant change for either of the two male groups, nor any significant treatment difference, there was evidence that both treatment approaches were associated with increased sexual pleasure for the VAG subjects (though only at the one tailed level within the SH treatment group, and only at follow-up within the MJ group).

These results, therefore, endorse the above finding that the relative effects of the treatments, in terms of sexual pleasure, varied across problem categories, and, in particular, that the interaction effect noted above was largely due to a strong differential trend between the treatments in the FSU group, which was absent in the other problem groups.

(b) Independent ratings of Pleasure from Coital and Non-Coital Sexual Relations

Lack of complete data on the above scales rendered invalid a Treatments x Problems analysis of covariance. The summarised results (See Table 29) are, therefore, based on separate one-way analyses of covariance and paired t-tests between and within the treatment groups as a whole. No follow-up data were available on these measures.

Thus, both treatments were associated with significant

* Figures in square brackets, in the presentation of Mann-Whitney results, refer to n_1 and n_2 respectively.

Table 29 Independent Ratings of Pleasure from Coital and Non-Coital Sexual Relations: Pre and Post-Treatment Means[1] and Standard Deviations for Each Treatment Group as a Whole (Complainants only) - Results of Within[2] and Between Groups Analyses

Variable		MJ		SH		Results of One-Way ANCOVA
		PRE	POST	PRE	POST	
Independent Rating Scales						
Frequency of Pleasurable Intimate Foreplay (0 - 4)	a					
	m	2.53	3.21	2.63	3.26	F (1,29) = 0.39
	σ	1.35	1.23	1.26	1.10	NS
		t = 2.39, df = 18, p < .05		t = 2.88, df = 18, p < .05		
Frequency of Pleasurable Sexual Intercourse (0 - 4)	a					
	m	1.39	3.11	1.05	2.37	F (1,34) = 3.18*
	σ	1.46	1.02	1.31	1.26	p = .084
		t = 4.79, df = 17, p < .01		t = 4.05, df = 18, p < .01		
Degree of Enjoyment of Intimate Foreplay (0 - 4)	a					
	m	2.79	3.32	2.74	2.68	F (1,35) = 6.63*
	σ	1.08	1.11	0.99	1.00	p < .05
		t = 3.29, df = 18, p < .01		t = 0.29, df = 18, NS		
Degree of Enjoyment of Sexual Intercourse (0 - 4)	a					
	m	2.91	3.00	2.50	2.33	F (1,20) = 1.88
	σ	1.04	0.89	1.51	1.07	NS
		t = 0.27, df = 10, NS		t = 0.43, df = 11, NS		
Self-Rating Scale						
Personal Enjoyment of Sexual Intercourse (1 - 6)	a					
	m	3.63	5.06	3.65	4.35	F (1,30) = 2.71
	σ	2.09	1.29	1.80	1.50	NS
		t = 3.03, df = 15, p < .01		t = 1.76, df = 16, p = .097		
Partner's Perceived Enjoyment of Intercourse (1 - 6)	a					
	m	5.29	5.29	5.00	5.25	F (1,27) = 0.10
	σ	0.99	1.07	1.03	1.06	NS
		t = 0, df = 10, NS		t = 1.00, df = 15, NS		

1 Post-Treatment Means above are unadjusted group means

2 All probabilities are two-tailed

a low value, low frequency or enjoyment; high value, high frequency or enjoyment

* FURTHER DETAILS OF THESE ANALYSES OF COVARIANCE IN APPENDIX 6 TABLES 121 and 122

Table 30 Frequency of Pleasurable Intercourse: Pre and Post-Treatment Means and Standard Deviations for Each Problem Group as a Whole (Partners Only) - Results of One-Way Analysis of Covariance

	FSU		VAG		PE		EI		F(df)	Prob	Results of Newman Keuls Test
	PRE	POST	PRE	POST	PRE	POST	PRE	POST			
m	3.71	3.86	0.21	3.14	2.43	2.57	2.56	2.78	3.33 (3,32)	*	VAG > PE* VAG > EI* VAG > FSU*
σ	0.49	0.38	0.58	1.41	1.13	1.40	1.59	1.30			

* $p < .05$

(Full details of results in Appendix 6 Table 123

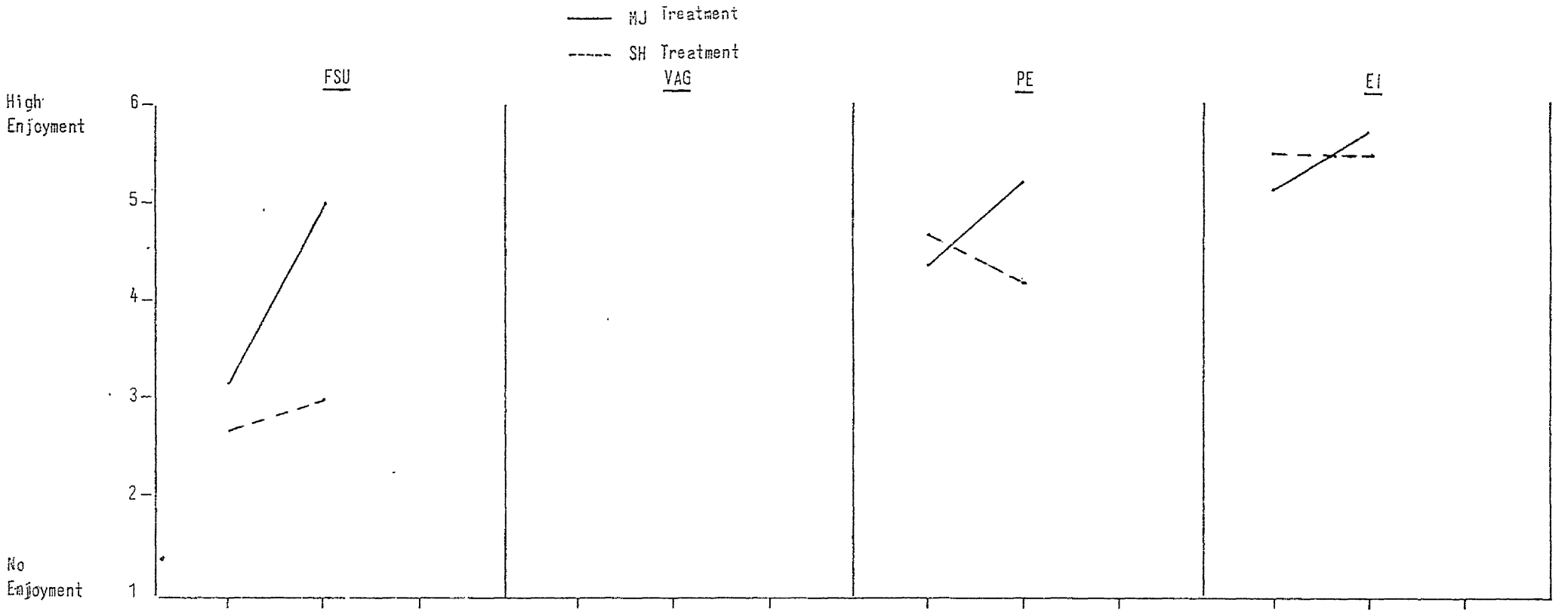
improvement in the frequency of pleasurable sexual relations (coital and non-coital) and in self-ratings of the degree of coital enjoyment.

Only one clearly significant difference was found between the treatment groups. Thus, among the complainants only, there was evidence that the MJ approach was associated with significantly greater enjoyment of intimate foreplay ($F\ [1,35]\ 6.6$, $p < .05$). There was also a non-significant trend ($F\ [1,34]\ 3.2$, $p = .08$) again favouring the MJ group on ratings of the frequency of intercourse as a positive experience.

On this latter variable, a further one-way analysis of covariance among the problem group means revealed a significant post-treatment problem main effect among the partners of each of the problem groups ($F\ [3,32]\ 3.33$, $p < .05$). Subsequent Newman-Keuls analysis showed that the VAG partners were rated at the end of therapy (regardless of form) as experiencing intercourse as a pleasurable experience significantly more often than the partners of each of the other three groups ($p < .05$ in each case) - see Table 30 overleaf.

In the absence of any significant pre-treatment differences between treatment groups within each problem category, Mann-Whitney 'U' tests were conducted on the post-treatment scores to determine whether there were any significant differences between the treatments in each problem group.

As noted above, no significant difference between treatments was observed from comparison between the treatment groups as a whole on measures of the degree of coital enjoyment. However, among the FSU subjects only, the MJ approach was shown to be significantly better than the SH treatment in enhancing coital pleasure. This difference among the FSU subjects, was observed on both independent assessment ($U\ [3,6]\ 0.5$, p .05) and self-ratings of the degree of pleasure derived from intercourse ($U\ [6,6]\ 4.5$, $p < .05$) - See Table 31 and Fig. 4.



	FSU	VAG	PE	EI
Within MJ	PRE v POST Z = 1.78, p = .08	N/A	PRE v POST NS	PRE v POST NS
Within SH	PRE v POST NS	N/A	PRE v POST NS	PRE v POST NS
MJ v SH	POST U = 4.5, n_1 = 6, n_2 = 6, p = .03			

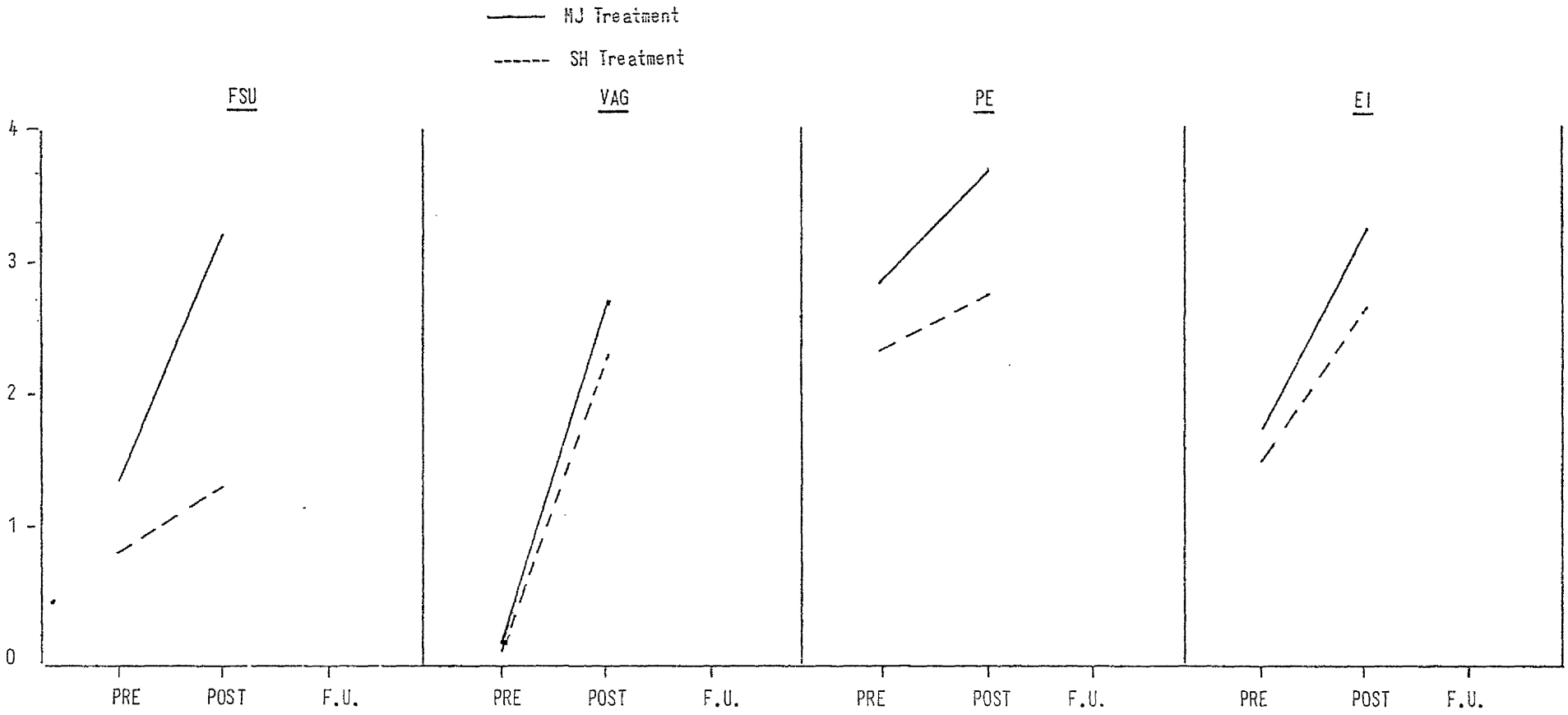
Fig. 4 Self-Ratings of Coital Enjoyment (SII): Mean pre and post-treatment MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

Table 31 Independent Ratings of Degree of Enjoyment of Sexual Intercourse: Pre and Post Treatment Means and S.D.s for each Problem and Treatment Group and Results of Within (Wilcoxon) and Between Treatment Group (Mann-Whitney 'U') Non-Parametric Analyses for Each Problem Subgroup (Complainants only)

Problem		FSU		VAG		PE		EI	
Treatment		MJ	SH	MJ	SH	MJ	SH	MJ	SH
PRE	m	2.75	1.00	*	*	2.80	3.20	2.83	3.40
	σ	1.50	0.89	-	-	0.84	1.10	1.47	0.55
POST	m	3.17	1.00	3.17	2.67	3.10	2.25	3.00	3.20
	σ	0.75	1.00	0.75	0.82	0.98	0.50	1.00	0.45
Within 'MJ'		NS		*		NS		NS	
Within 'SH'		NS		*		NS		NS	
Between Treatments		U 3,6 0.5 $p < .05$		NS		NS		NS	

* Analysis not appropriate pre-treatment n too small

NS non-significant



	FSU	VAG	PE	EI
Within MJ	PRE v POST NS	PRE v POST $Z = 2.20$, $p = .03$	PRE v POST NS	PRE v POST NS
Within SH	PRE v POST NS	PRE v POST $Z = 2.20$, $p = .03$	PRE v POST NS	PRE v POST NS
	POST $U=0.5$, $n_1=3$, $n_2=6$, $p=.024$	POST NS	POST NS	POST NS

Fig. 5 Independent Ratings of Frequency of Pleasurable Intercourse: Mean pre and post-treatment MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

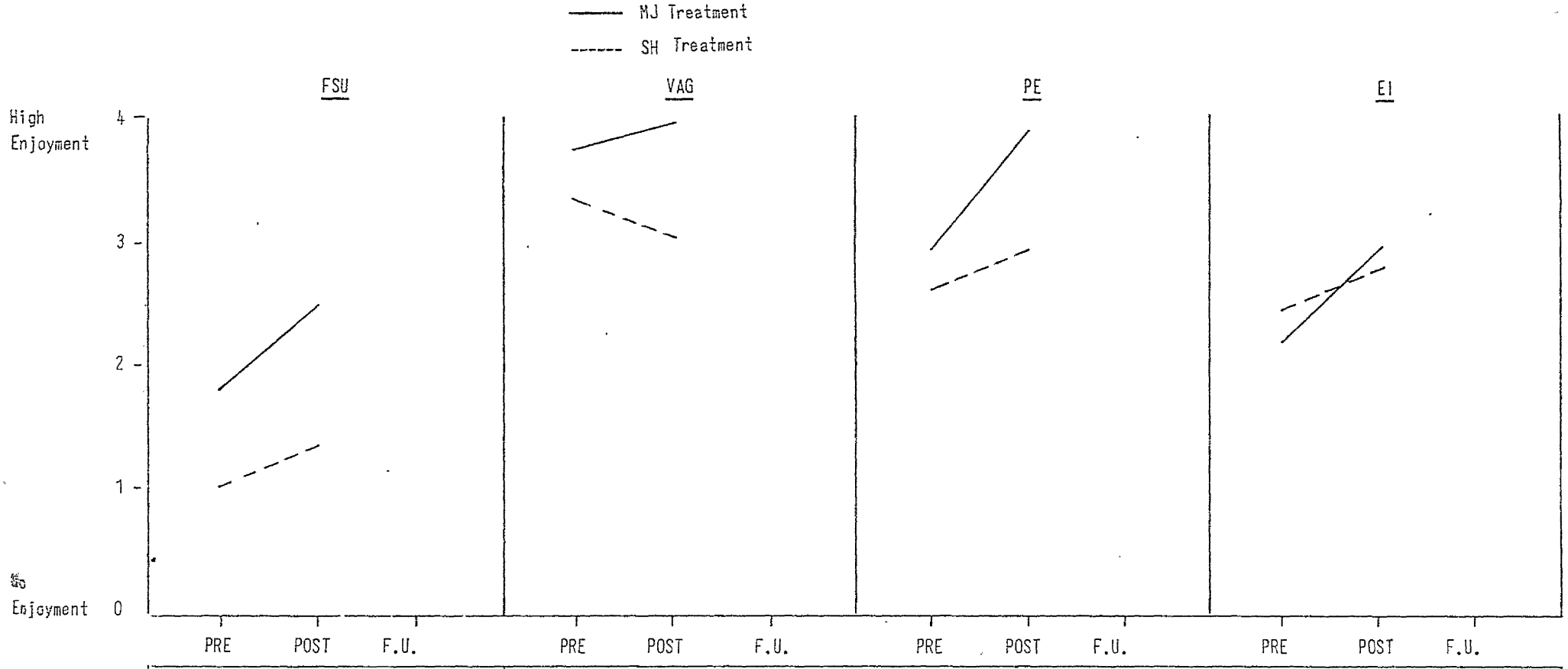
Consistent with the overall trend favouring the MJ group as a whole on independent ratings of the frequency of pleasurable coitus, were the findings on the same measure within each problem subgroup. In each case, those receiving the MJ approach scored consistently higher but a clearly significant difference between treatments was found again only within the FSU group ($U = 0.5$, $n_1 = 3$, $n_2 = 6$, $p < .05$). For the VAG group, on the other hand, both treatments were associated with a significant increase in the frequency of pleasurable intercourse, there being again no significant difference between them. (See Fig. 5)

On the other hand, the MJ approach was shown to be significantly superior to the SH format for the VAG group only on ratings of the degree of enjoyment of intimate foreplay ($U\ [7,7]\ 7.0$, $p < .01$). However, for each problem subgroup, a trend in favour of the MJ approach was consistently found, in keeping with the overall treatment group difference on this measure, as noted above. (See Fig. 6 overleaf)

In general, therefore, the MJ approach was shown to be associated with significantly more sexual pleasure, in terms of both frequency and degree, than the SH treatment. Although this was a uniform trend among all problem subgroups, significant changes and treatment differences were observed only among the female complainants whose pre-treatment or baseline levels were generally lower, particularly on measures relating to coital pleasure. Such lower baseline levels would allow greater scope for change in these groups.

(c) Self-Ratings of Enjoyment of Sexual Intercourse (SII)

An additional self-report measure of the degree of coital enjoyment was provided by part of the Sexual Interaction Inventory. This measure differed from the independent rating scale on the same factor insofar as it was bipolar, encompassing unpleasant feelings as well as the pleasant end of the continuum. Complainants in both treatment groups reported an increase post-treatment in their own coital enjoyment. However, when the complainants rated the extent to which they felt their spouses enjoyed intercourse, the results of the Newman-Keuls test showed that the PE partners were perceived as enjoying coitus significantly less than



	FSU	VAG	PE	EI
Within MJ	PRE v POST NS	PRE v POST NS	PRE v POST NS	PRE v POST NS
Within SH	PRE v POST NS	PRE v POST NS	PRE v POST NS	PRE v POST NS
MJ & SH	POST NS	POST U=7.0, n_1=7, n_2=7, p=.009	POST NS	POST NS

Fig. 6 Independent Ratings of Degree of Non-Coital Enjoyment : Mean pre and post-treatment MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

the partners of each of the other groups. ($F\ [2,22]\ 10.9$, $p < .001$) - see Table 32 overleaf.

In summary, comparison between the two treatment groups as a whole on measures of sexual pleasure revealed only one clearly significant difference and one strong trend in each case in favour of the MJ approach. Thus, directed practice plus counselling was significantly more effective in increasing the degree of pleasure couples experienced from intimate foreplay. In addition, an almost significantly greater frequency of pleasurable intercourse was associated with the MJ approach.

When a similar comparison between treatment was conducted within each dysfunctional group separately, it was clear that the MJ approach was shown to be associated with significantly more sexual pleasure, in terms of both frequency and degree, than the SH treatment, but that such significant changes and treatment differences were apparent only among the female complainants. This may be partly due to the fact that pre-treatment or baseline levels were generally lower, particularly on measures of coital pleasure. This would allow greater scope for change in these groups. It was also apparent that the effects of the treatments on general sexual pleasure were not additive across problems, since the difference between treatments for the FSU group on this measure was in itself significantly different from that found in the EI and PE groups. There was also evidence that the female spouses of those with premature ejaculation were perceived by their husbands as experiencing less coital pleasure post-treatment than the partners in other problem groups.

General Sexual Adjustment and Functioning

The results with respect to other aspects of sexual functioning may be further subdivided into two main sections : general sexual satisfaction, and sexual anxieties.

(a) Self-Ratings of General Sexual Satisfaction (SMAR Scale)

The full details of the results of these analyses at post-treatment and at follow-up are provided in Appendix 6.

The results of within groups analysis are summarised overleaf in

Table 32 Complainant's Perception of Degree of Partner's Coital Enjoyment (SII Scale): Pre and Post-Treatment Means and Standard Deviations for Each of Three Problem Groups as a Whole[1] (Complainants Ratings of Spouse) - Results of One-Way Analysis of Covariance

	FSU		PE		EI		F(df)	Prob	Results of Newman-Keuls Test
	PRE	POST	PRE	POST	PRE	POST			
m	5.36	5.82	4.63	4.00	5.43	5.43	10.94 (2,22)	***	PE < FSU**, PE < EI*
σ	0.92	0.60	1.19	0.93	0.98	0.79			

1 The scores for the Vaginismus subjects were excluded as pre-treatment data for ten of the fourteen complainants (i.e. 71.4%) were "missing", as sexual intercourse was rarely attempted by these couples pre-treatment.

*** $p < .001$

** $p < .01$

(Full details of results in Appendix 6 Table 124)

Table 33, which shows that both treatment groups showed a significant pre-post treatment improvement, for both complainants and partners, which was sustained at follow-up. A further significant improvement between post-treatment and follow-up was apparent among the partners only within the SH group.

In general, the results of between groups analysis (See Tables 34 and 35) show no significant difference post-treatment between the treatment groups as a whole, for either the complainants or partners, although there was a trend among the latter favouring the MJ approach, post-treatment ($F\ [1,38]\ 3.31$, $p = .077$). At follow-up, however, there was a strong trend from the complainants' data, in particular ($F\ [1,34]\ 4.01$, $p = .053$) again in favour of the MJ approach.

There was also evidence of a significant problem main effect from the complainants' data both at post-treatment ($F\ 3,36\ 2.98$, $p < .05$ and at follow-up ($F\ [3,34]\ 4.11$, $p < .05$).

These results were confirmed by one-way analysis of covariance among the four problem groups at post-treatment and at follow-up. This was conducted so that further analysis (i.e. Newman-Keul test) may then be performed to help identify the significant interproblem differences. Table 36 below provides details of the post-treatment and follow-up means (adjusted) and standard deviations derived from this analysis, further details of which are presented in Tables 127 **and 128, Appendix 6.**

Table 36 Adjusted Post-Treatment and Follow-Up Means and S.D.s for Each Problem Group on the General Sexual Satisfaction Factor

		FSU			VAG			PE			EI		
		M	S.D.	n	M	S.D.	n	M	S.D.	n	M	S.D.	n
Complainants	POST	925.6	156.5	12	771.7	146.6	14	950.4	191.5	8	871.5	161.7	11
	F.U.	876.2	128.3	11	754.1	171.9	14	910.4	101.4	8	923.1	127.9	10
Partners	POST	861.5	142.7	12	762.5	162.5	14	878.9	152.7	9	905.8	129.6	12
	F.U.	776.3	141.2	11	700.9	167.1	14	916.0	134.4	8	867.2	103.6	10

Table 33 General Sexual Satisfaction Factor (SMAR Scale): Means and S.D.s for each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests)

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	1017.5	828.4	802.8	1041.9	907.7	907.1
σ	93.2	170.2	149.0	98.2	164.3	143.0
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	953.1	804.3	760.5	982.6	887.3	839.0
σ	98.3	153.3	145.8	93.3	140.8	156.6

MJ Complainants

PRE v POST t = 4.95, df = 21, p**

PRE v F.U. t = 6.08, df = 21, p**

POST v F.U. NS

SH Complainants

PRE v POST t = 3.77, df = 22, p**

PRE v F.U. t = 4.46, df = 20, p**

POST v F.U. NS

MJ Partners

PRE v POST t = 4.72, df = 22, p**

PRE v F.U. t = 6.18, df = 21, p**

POST v F.U. NS

SH Partners

PRE v POST t = 2.69, df = 23, p*

PRE v F.U. t = 3.58, df = 20, p**

POST v F.U. t = 2.30, df = 20, p*

* $p < .05$

** $p < .01$

1 All probabilities are two-tailed

Table 34 General Sexual Satisfaction Factor (SMAR Scale)[a]: Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	1008.7	843.3	819.7	1028.3	997.5	926.8
	σ	98.0	175.5	136.4	108.0	93.9	100.4
VAG	m	1038.4	784.0	682.9	1036.3	766.0	827.6
	σ	89.7	150.0	126.9	101.7	154.5	189.0
PE	m	971.0	886.5	874.8	1079.3	1010.0	939.3
	σ	99.9	256.2	100.6	41.63	98.9	105.4
EI	m	1036.0	826.0	892.8	1037.2	915.0	973.2
	σ	102.8	153.0	143.5	126.2	171.1	110.4
TOTAL	m	1017.5	828.4	802.8	1041.9	907.7	907.1
	σ	93.2	170.2	149.0	98.2	164.3	143.0

a low value, high satisfaction; high value, low satisfaction
b post-treatment and follow-up means above are unadjusted cell means

Results of Two-Way (Treatment x Problems) Analysis of Covariance		Results of Confirmatory One-Way Analysis of Covariance of Main Effects
POST TREATMENT		
F Treatments (df 1,36) 2.39, NS		
F Problems (df 3,36) 2.98, $p < .05$		F (3,40) 3.02, $p < .05$
F T x P (df 3,36) 0.61, NS		
FOLLOW-UP		
F Treatments (df 1,34) 4.01, $p = .053$		F (1,40) 4.37, $p < .05$
F Problems (df 3,34) 4.11, $p < .05$		F (3,38) 3.81, $p < .05$
F T x P (df 3,34) 0.35, NS		

Further details of these results in Appendix 6 Tables 125 and 126

Table 35 General Sexual Satisfaction Factor (SMAR Scale)[a]: Means and S.D.s for Treatment and Problem Groups (Partners only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	977.2	775.7	707.2	988.0	957.8	873.8
	σ	118.0	139.3	132.4	107.1	74.1	94.7
VAG	m	979.9	776.0	716.6	1024.7	775.4	708.6
	σ	118.0	170.2	170.4	75.0	168.1	177.3
PE	m	890.0	797.5	831.5	920.6	898.6	952.5
	σ	32.6	199.5	121.6	114.7	105.2	132.7
EI	m	950.5	870.3	829.4	979.8	937.7	896.2
	σ	85.3	134.0	128.0	70.3	127.6	70.6
TOTAL	m	953.1	804.3	760.5	982.6	887.3	839.0
	σ	98.3	153.3	145.8	93.3	140.8	156.6

a high value, low satisfaction
b post-treatment and follow-up means above are unadjusted cell means

Results of Two-Way (Treatments x Problems)

POST TREATMENT

F Treatments (df 1,38) 3.31 p = .077
F Problems (df 3,38) 2.34 NS
F T x P (df 3,38) 1.05 NS

FOLLOW-UP

F Treatments (df 1,34) 3.00 NS
F Problems (df 3,34) 4.62 $p < .01$
F T x P (df 3,34) 0.96 NS

Results of Confirmatory One-Way Analysis of Covariance of Main Effect

F (1,44) 3.17 p = .08

F (3,38) 4.72 $p < .01$

Further details of these results in Appendix 6 Tables 129 and 130

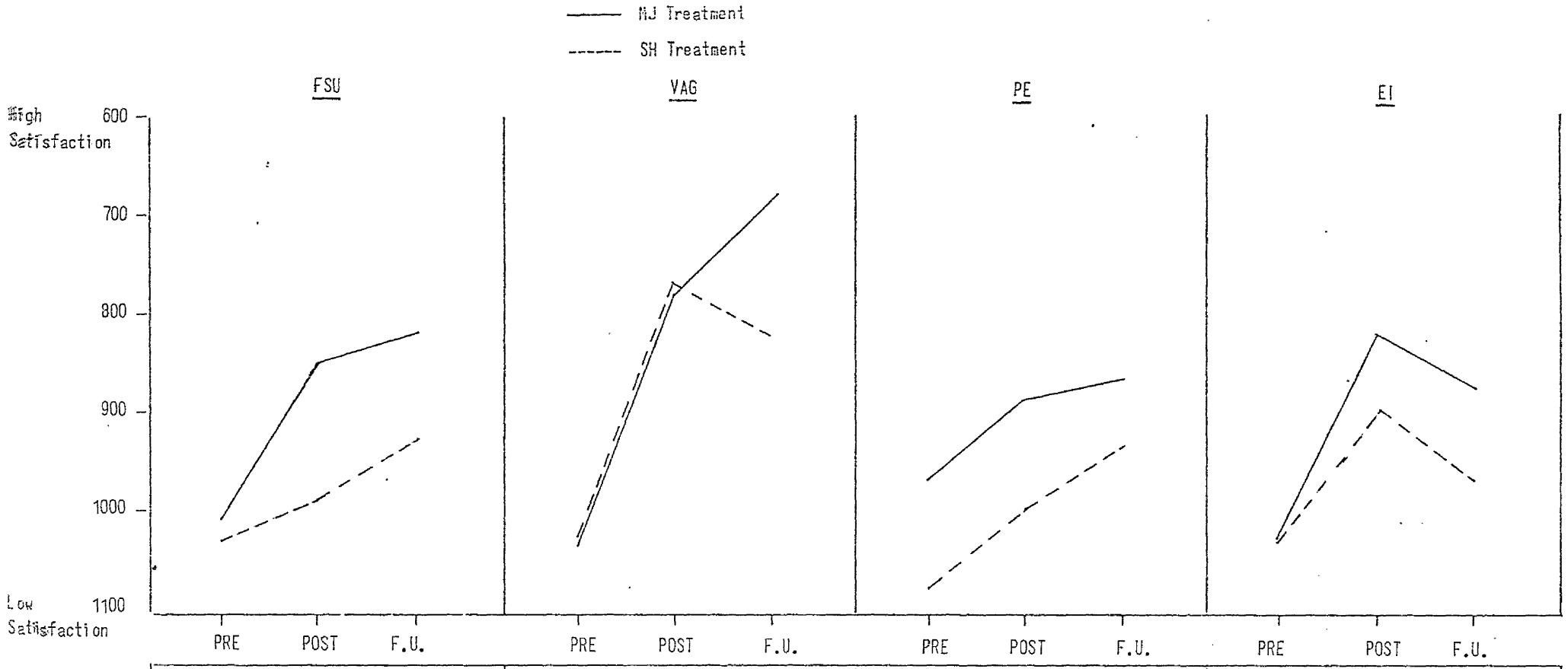
Newman-Keuls tests on the post-treatment and follow-up problem group mean differences showed that the vaginismus complainants as a whole reported significantly greater sexual satisfaction, both at post-treatment and at follow-up, compared to the FSU subjects ($p < .05$ in each case) and compared to the PE subjects ($p < .05$ in each case). Only at follow-up, did the difference between the VAG and EI complainants reach significance ($p < .05$), and again this was in the direction of better sexual adjustment for the VAG subjects.

These results, therefore, consistently indicate a more favourable response to treatment among the VAG subjects compared to the other three groups on the above measure of general sexual satisfaction.

Similar analysis, on this measure, were conducted for the partners and, although the post-treatment differences among the problem group means failed to reach significance, there was a non-significant trend favouring the VAG group ($F [3,42] 2.32$, $p = .089$).

However, at follow-up, the differences among the partners' scores reached significance ($F [3,38] 4.72$, $p < .01$) and further Newman-Keuls analysis showed that the VAG partners reported significantly greater sexual satisfaction compared to the female PE partners ($p < .01$) and the EI partners ($p < .05$). Thus these findings lend further support to the evidence of less sexual dissatisfaction after therapy among couples presenting with vaginismus compared to those in the other dysfuctional groups. Since pre-treatment scores were used as covariates in this analysis, these results cannot be explained solely in terms of pre-treatment differences among the groups.

The results of non-parametric within and between treatment groups analyses for each problem category separately on this measure of general sexual satisfaction are summarised below under Figure 7 which also illustrates the general nature of the treatment changes within each problem subgroup, based on the data provided in Table 34 .



	FSU	VAG	PE	EI
Within MJ	PRE v POST Z = 1.99, p = .05 PRE v F.U. Z = 2.20, p = .03	PRE v POST Z = 2.37, p = .02 PRE v F.U. Z = 2.37, p = .02	PRE v POST NS PRE v POST NS	PRE v POST Z = 2.02, p = .04 PRE v F.U. NS
Within SH	PRE v POST NS PRE v F.U. Z = 1.75, p = .08 POST v F.U. Z = 2.02, p = .04	PRE v POST Z = 2.20, p = .03 PRE v F.U. Z = 2.03, p = .04	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
MJ v SH	POST NS F.U. NS	POST NS F.U. NS	POST NS F.U. NS	POST NS F.U. NS

Fig. 7 General Sexual Satisfaction : Mean pre, post-treatment and follow-up MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

No significant differences between treatment groups were found at any period of testing. However, with the exception of those with vaginismus, who showed a significant improvement sustained at follow-up with both treatment approaches, a significant positive change was obtained only with the MJ approach for the FSU and EI complainants. It is noteworthy that, for the FSU group, the SH approach was associated with significant improvement only after therapy was terminated. As with most of the other measures, no significant changes nor any differential treatment effect was observed among the PE subjects.

(b) Degree of Anxiety About Sexual Symptoms During Sexual Relations

This measure may be considered to refer loosely to the tendency to spectate during sexual relations and was measured by a self-report five-point Likert-type scale. This scale was one of three comprising the general sexual satisfaction factor (SMAR) but, in view of its clinical and theoretical relevance and acceptably high test-retest reliability, separate statistical analysis of the scores on this particular measure was considered to be of value.

The means and standard deviations at each period of testing for complainants and partners in each treatment group as a whole are presented overleaf in Table 37 , together with the results of paired t-test analyses within each treatment group.

Thus, a significant reduction in the tendency to 'spectate' was observed in both treatment groups and was apparent among both complainants and partners. This change was, moreover, sustained at follow-up for each of the two groups with evidence of a continuing significant improvement after termination of therapy among the MJ partners.

Details of the results of analysis of covariance are provided in Table 38 , where it is apparent that there was a significant treatment main effect from the complainants' data both at post-treatment ($F\ [1,38]\ 5.92$, $p < .05$) and at follow-up ($F\ [1,34]\ 7.44$, $p = .01$) in each case favouring the MJ approach. The results of similar analyses among the partners revealed a significant treatment main effect in the same direction, but only at follow-up

Table 37 Self-Ratings of Degree of Anxiety About Sexual Symptoms During Sexual Play[a]: Means and S.D.s for each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests[1])

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	1.67	3.17	3.41	1.54	2.29	2.43
σ	0.64	1.37	1.14	0.83	1.20	1.12
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	2.54	3.43	4.00	2.25	3.17	3.19
σ	0.98	1.24	1.02	0.94	1.13	1.12

MJ Complainants

PRE v POST t = 5.30, df = 22, p**
PRE v F.U. t = 6.53, df = 21, p**
POST v F.U. NS

SH Complainants

PRE v POST t = 2.70, df = 23, p*
PRE v F.U. t = 3.19, df = 20, p**
POST v F.U. NS

MJ Partners

PRE v POST t = 3.15, df = 22, p**
PRE v F.U. t = 5.11, df = 21, p**
POST v F.U. t = 2.57, df = 21, p*

SH Partners

PRE v POST t = 3.25, df = 23, p**
PRE v F.U. t = 3.98, df = 20, p**
POST v F.U. NS

* $p < .05$
** $p < .01$
1 All probabilities are two-tailed
a range 1 - 7; low value, high anxiety

Table 38 Degree of Anxiety About Sexual Relations during Sexual Play[a]: Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	1.83	3.17	3.00	1.33	1.67	2.20
	σ	0.75	1.47	1.10	0.82	0.82	0.84
VAG	m	1.57	3.71	4.43	1.86	3.43	3.00
	σ	0.53	0.95	0.79	1.07	0.98	1.41
PE	m	1.80	2.50	2.75	1.40	1.40	2.25
	σ	0.45	1.91	1.26	0.55	0.55	0.96
EI	m	1.50	3.00	3.00	1.50	2.33	2.00
	σ	0.84	1.41	0.71	0.84	1.21	1.00
TOTAL	m	1.67	3.17	3.41	1.54	2.29	2.43
	σ	0.64	1.37	1.14	0.83	1.20	1.12

a range 1 - 7: low value, high anxiety

b post-treatment and follow-up means above are unadjusted cell means

Results of Two-Way (Treatment x Problems) Analysis of Covariance

POST TREATMENT

F Treatments (df 1,38) 5.92, $p < .05$
F Problems (df 3,38) 3.71, $p < .05$
F T x P (df 3,38) 0.46, NS

FOLLOW-UP

F Treatments (df 1,34) 7.44, $p = .01$
F Problems (df 3,34) 3.73, $p < .05$
F T x P (df 3,34) 0.45, NS

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

F (1,45) 6.03, $p < .05$
F (3,42) 3.59, $p < .05$

F (1,40) 7.43, $p < .01$
F (3,38) 3.11, $p < .05$

Full details of these Analyses are provided in Appendix 6 Tables 132 and 133

($F\ [1,40]\ 4.58,\ p < .05$). Thus, although there was a significant improvement within each treatment group on this variable, there was strong evidence that the MJ approach was significantly more effective than the SH treatment in reducing anxiety about the presenting sexual symptoms during actual sexual relations.

In addition, a significant problem main effect was apparent both at post-treatment and at follow-up among the complainants. Again, one-way Analysis of Covariance among the four problem groups confirmed the above significant problem main effect and the results are presented in Table 39 overleaf.

Further analysis to identify the significant problem group differences using the Newman-Keuls Test showed that, for the complainants, the VAG group post-treatment showed less "spectating" than the PE complainants ($p < .05$) and almost significantly less than the FSU complainants. However, with separate analyses of covariance between each dual comparison between problem groups, the difference between the VAG and FSU group did reach significance ($F\ [1,21]\ 6.94,\ p < .05$) and a strong trend also favouring the VAG complainants in relation to the EI complainants was also apparent ($F\ [1,21]\ 3.88,\ p = .062$).

Similar significant findings were obtained at follow-up and the Newman-Keuls test results revealed that the problem main effect then was due to a significant difference between the VAG and FSU complainants ($p < .05$). The differences between the VAG and PE complainants just failed to reach significance in each case. However, once more the results of dual comparisons using 2 x 2 (Treatments x Problems) Analysis of Covariance showed that the difference between the VAG and PE complainants at follow-up was significant ($F\ [1,17]\ 5.44,\ p < .05$) as was the difference between the VAG and EI complainants ($F\ [1,19]\ 7.11,\ p < .05$).

No significant main or interaction effect was observed post-treatment among the partners on this measure but, at follow-up, a number of significant interproblem differences accounted for the overall significant results shown in Table 39. Thus, Newman-Keuls test results indicated that the partners of the FSU subjects

Table 39 Adjusted Post-Treatment and Follow-Up Means and S.D.s For Each Problem Group on Self-Ratings of Anxiety About Sexual Symptoms During Sexual Play - Results of One-Way Analyses of Covariance

		FSU			VAG			PE			EI			
		M	S.D.	n	M	S.D.	n	M	S.D.	n	M	S.D.	n	
Complainants	POST	2.42	1.38	12	3.54	0.94	14	1.90	1.36	9	2.69	1.30	12	$F(3,42)$ 3.59 $p < .05$
	F.U.	2.63	1.03	11	3.69	1.33	14	2.50	1.07	8	2.54	0.97	10	$F(3,38)$ 3.11 $p < .05$
Partners	F.U.	4.08	0.94	11	4.08	1.21	14	2.77	1.04	8	3.08	0.74	10	$F(3,38)$ 4.81 $p < .01$

See Appendix 6 Tables 136 to 138 for further details of the above analyses

reported less tendency to "spectate" compared to both the PE and EI partners (both $p < .05$), as did the VAG partners in relation to the PE partners ($p < .05$).

These results, in general, therefore, are broadly consistent with those for general sexual satisfaction, showing the VAG group to be less severely impaired in terms of sexual anxiety, both at post-treatment and at follow-up, compared to the other groups.

However, the above findings also show a tendency for the male partners of both the VAG and FSU groups to report less anxiety about the presenting symptoms during sexual play at follow-up compared to the PE and EI partners.

The results of non-parametric analyses within each problem group separately are presented in Figure 8 overleaf, which also shows the general nature of treatment changes within each problem sub-group, based on the data detailed in Table 38 .

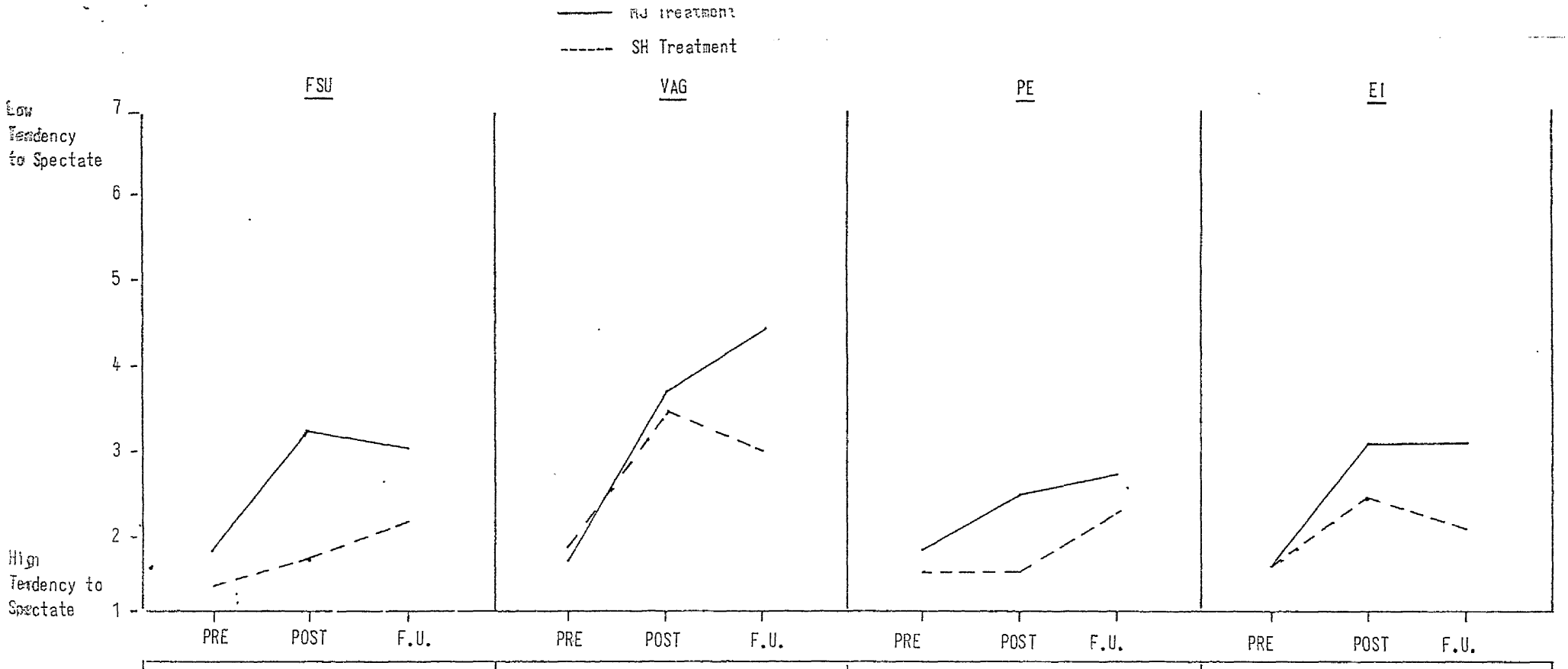
No significant pre-treatment differences between treatment groups were found within any of the problem subgroups.

Consistent with the finding that the VAG group as a whole reported less "spectating" than the other problem groups, both at post-treatment and at follow-up, was the significant reduction in scores on this measure within both treatment groups for these subjects.

As expected, in view of the overall treatment difference favouring the MJ treatment group as a whole on this measure, the pattern of results within each diagnostic group favoured the MJ approach. The difference between treatments, however, reached significance only within the VAG subgroup and at follow-up only ($p < .05$).

(c) General Sexual Anxiety

General anxiety factor scores were derived from the PAD Scale, which provided a self-report measure of anxiety across five forms of sexual activity. Means and standard deviations for complainants and partners in each treatment group as a whole, at each period of assessment, are shown overleaf in Table 40 .



	FSU	VAG	PE	EI
Within MJ	PRE v POST NS PRE v F.U. NS	PRE v POST $Z = 2.37$, $p = .02$ PRE v F.U. $Z = 2.37$, $p = .02$	PRE v POST NS PRE v F.U. NS	PRE v POST $Z = 1.83$, $p = .07$ PRE v F.U. $Z = 1.83$, $p = .07$
Within SH	PRE v POST NS PRE v F.U. NS	PRE v POST $Z = 1.89$, $p = .06$ PRE v F.U. NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
MJ v SH	POST $U=7.0$, $n_1=6$, $n_2=6$, $p = .07$ F.U. NS	POST NS F.U. $U=9.5$, $n_1=7$, $n_2=7$, $p=.047$	POST NS F.U. NS	POST NS F.U. NS

Fig. 8 Tendency to "Spectate" : Mean pre, post-treatment and follow-up MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

Table 40 General Sexual Anxiety Factor (PAD Scale)[a]: Means and S.D.s for each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests[1])

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	964.6	1058.2	1052.7	937.2	1003.6	993.3
σ	107.1	81.5	64.4	106.3	91.9	101.2
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	1048.9	1054.6	1060.9	1045.2	1064.0	1074.2
σ	86.9	84.6	84.7	68.9	49.1	61.7

MJ Complainants

PRE v POST t = 3.59, df = 21, p**
PRE v F.U. t = 3.76, df = 21, p**
POST v F.U. NS

SH Complainants

PRE v POST t = 3.36, df = 22, p**
PRE v F.U. t = 3.44, df = 20, p**
POST v F.U. NS

MJ Partners

PRE v POST NS
PRE v F.U. NS
POST v F.U. NS

SH Partners

PRE v POST NS
PRE v F.U. NS
POST v F.U. NS

* $p < .05$
** $p < .01$
1 All probabilities are two-tailed
a low value, high anxiety

It may be seen that among the complainants both treatments were associated with a significant reduction in general sexual anxiety - this being sustained at follow-up.

From two-way (Treatments x Problems) Analysis of Covariance no significant problem or interaction effect was observed, nor any significant difference between the treatment groups at any period of testing. However, there was a strong trend favouring the MJ approach, at post-treatment only, among the complainants ($F\ [1,36]\ 3.74$, $p = .061$) - See Table 41.

Among the partners, no significant differences were observed at post-treatment or at follow-up. There were, moreover, no significant changes within either treatment group due in part perhaps to a 'ceiling effect' as the partners' baseline level of anxiety was lower compared to that of the complainants.

Separate non-parametric analyses within each problem group separately revealed a pattern of results essentially similar to that found on the Sexual Pleasure Factor. Thus, again no significant changes or treatment differences were observed within either of the two male subgroups, whereas both treatments were equally effective for the VAG subgroup. The MJ approach, however, was shown post-treatment to have led to a greater reduction in sexual anxiety than the SH format only for the FSU subgroup (see Figure 9).

Thus, although no significant treatments x problems interaction effect was found, it is again clear that the problem subgroups were not responding uniformly to the respective treatments.

Summary

Although no significant treatment differences were found from comparison between the treatment groups as a whole on ratings of general sexual satisfaction and general sexual anxiety, there were strong trends favouring the MJ approach on both measures, at follow-up and at post-treatment respectively. In terms of reported anxiety about the presenting sexual symptoms during sexual play ("tendency to spectate"), there was evidence that the MJ approach was significantly more effective than the SH treatment in reducing this specific tendency, from both

Table 41 General Sexual Anxiety Factor (PAD Scale)[a]: Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	989.2	1071.3	1052.0	972.3	978.7	1011.6
	σ	66.7	63.6	65.7	68.6	46.9	73.7
VAG	m	861.6	1018.7	1054.9	897.4	1039.7	968.9
	σ	76.1	86.0	86.3	44.9	73.5	130.6
PE	m	1053.5	1046.8	1019.8	952.8	960.5	985.3
	σ	22.4	78.3	50.2	185.4	173.4	110.1
EI	m	1008.2	1106.8	1076.8	938.2	1015.0	1015.6
	σ	126.0	89.7	38.9	134.4	78.8	94.5
TOTAL	m	964.6	1058.2	1052.7	937.2	1003.6	993.3
	σ	107.1	81.5	64.4	106.3	91.9	101.2

a low value, high anxiety
b post-treatment and follow-up means above are unadjusted cell means

Results of Two-Way Analysis of Covariance

POST TREATMENT

F Treatments (df 1,36) 3.74, p = .061
F Problems (df 3,36) 1.60, NS
F T x P (df 3,36) 0.81, NS

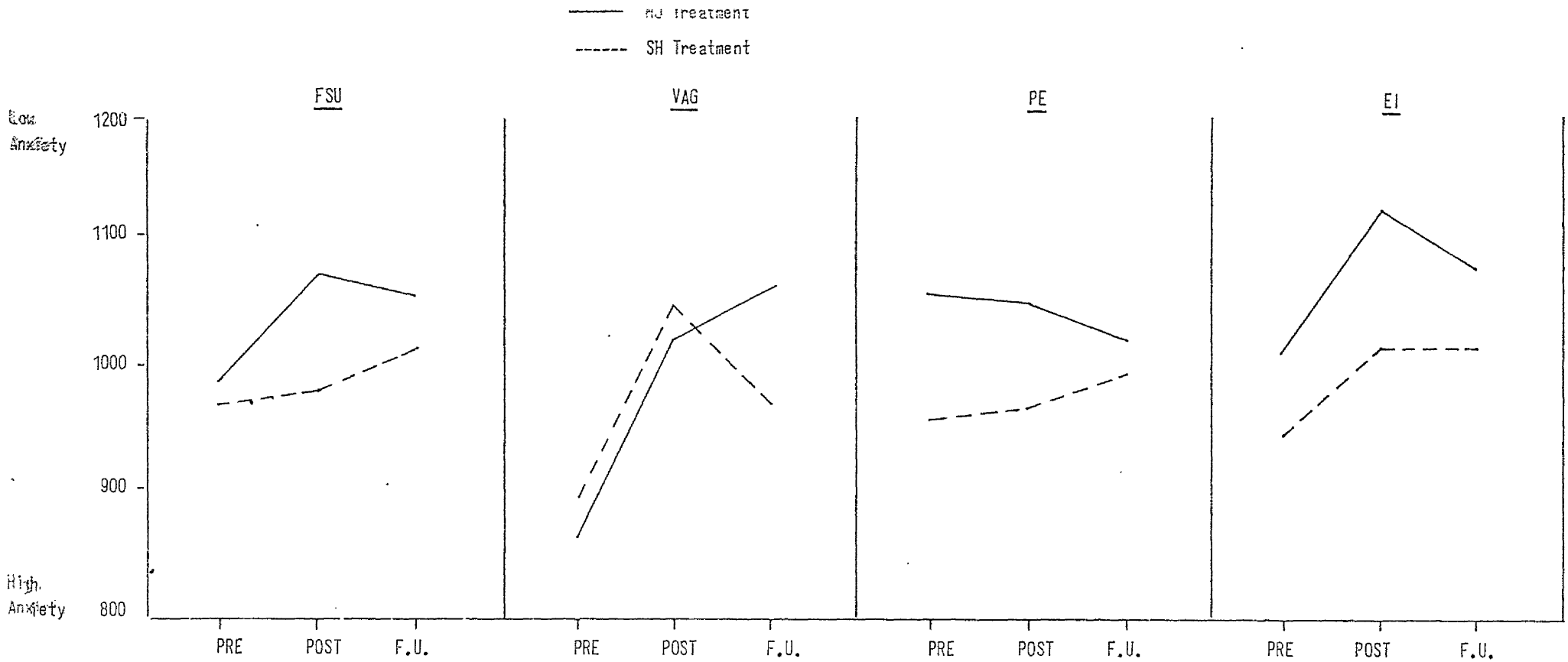
FOLLOW-UP

F Treatments (df 1,34) 1.41, NS
F Problems (df 3,34) 1.38, NS
F T x P (df 3,34) 1.20, NS

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

F (1,42) 3.55, p = .066

Full details of these results are provided in Appendix 6 Tables 139 and 140.



	FSU	VAG	PE	EI
Within MJ	PRE v POST Z = 1.99, p = .05 PRE v F.U. Z = 1.99, p = .05	PRE v POST Z = 2.20, p = .03 PRE v F.U. Z = 2.37, p = .02	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
Within SH	PRE v POST NS PRE v F.U. Z = 2.02, p = .04	PRE v POST Z = 2.37, p = .02 PRE v F.U. NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
MJ v SH	POST U=5.0, n_1=6, n_2=6, p=.04 F.U. NS	POST NS F.U. NS	POST NS F.U. NS	POST NS F.U. NS

Fig. 9 General Sexual Anxiety (PAD Scale) : Mean pre, post-treatment and follow-up MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

post-treatment and follow-up assessments.

There was additional evidence that the vaginismus complainants post-treatment and at follow-up showed less tendency to "spectate" compared to each of the other three groups of complainants.

Marital Adjustment and Satisfaction

Three measures in the present study may be considered to be relevant to the assessment of marital adjustment: (a) General Marital Satisfaction factor (SMAR Scale); (b) Locke-Wallace Marital Adjustment Test and (c) "Loving" factor from the semantic differential.

(a) General Marital Satisfaction Factor (SMAR)

The means and standard deviations for each treatment group at each period of assessment are shown overleaf in Table 42 .

A significant pre-post treatment improvement in self-ratings of marital satisfaction was observed only for the MJ complainants ($p < .05$, two tailed). This improvement was maintained at follow-up ($p < .05$, two tailed).

The detailed results of separate two-way (Treatments X Problems) Analyses of Covariance for complainants and partners are presented in Tables 43 and 44 overleaf.

It is clear that no significant differences were found between treatment groups as a whole, on this measure of marital satisfaction, and that this was so irrespective of the identity of the main complainant.

Of some importance, however, was the finding of a significant Treatment x Problems interaction effect on this measure. Thus, there was a significant difference in the differential response to treatments among the problem categories and this was apparent post-treatment among both the partners and the complainants. Among the latter, however, only a trend toward such an interaction was evident at follow-up from the full (2 x 4) Treatments by Problems Analysis of Covariance ($F [3,34] 2.41$, $p = .08$).

In order to clarify the nature of this interaction effect, a

Table 42 General Marital Satisfaction Factor (SMAR Scale)[a]: Means and S.D.s for Each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests[1])

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	1035.6	972.4	983.3	1027.4	996.9	1009.7
σ	75.0	84.2	68.1	93.6	91.0	80.1
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	1011.3	994.8	986.4	984.3	992.5	986.7
σ	91.0	103.3	81.4	99.9	70.6	85.5

MJ Complainants

PRE v POST t = 2.73, df = 21, p*
PRE v F.U. t = 2.69, df = 21, p*
POST v F.U. NS

SH Complainants

PRE v POST NS
PRE v F.U. NS
POST v F.U. NS

MJ Partners

PRE v POST NS
PRE v F.U. NS
POST v F.U. NS

SH Partners

PRE v POST NS
PRE v F.U. NS
POST v F.U. NS

* $p < .05$
** $p < .01$
1 All probabilities are two-tailed
a high value, low satisfaction

Table 43 General Marital Satisfaction Factor (SMAR Scale)[a]: Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	1079.5	939.7	972.3	1108.5	1090.0	1094.4
	σ	50.5	46.9	55.2	90.0	66.8	40.5
VAG	m	1025.9	943.9	969.7	1017.3	966.1	957.9
	σ	36.5	80.0	84.3	30.0	106.2	91.5
PE	m	979.5	947.3	966.8	924.3	962.5	982.5
	σ	92.5	99.3	73.4	47.8	31.5	47.3
EI	m	1041.4	1071.6	1028.8	1026.8	962.7	1019.4
	σ	108.1	38.5	49.7	107.1	61.6	40.8
TOTAL	m	1035.6	972.4	983.3	1027.4	996.9	1009.7
	σ	75.0	84.2	68.1	93.6	91.0	80.1

a high value, low satisfaction
b post-treatment and follow-up means above are unadjusted cell means

Results of Two-Way Analysis of Covariance

POST TREATMENT

F Treatments (df 1,36) 1.10, NS
F Problems (df 3,36) 1.49, NS
F T x P (df 3,36) 5.68, $p < .01$

FOLLOW-UP

F Treatments (df 1,34) 2.17, NS
F Problems (df 3,34) 2.16, NS
F T x P (df 3,34) 2.41, $p = .084$

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

Full details of Results are provided in Appendix 6 Tables 141 and 142

Table 44 General Marital Satisfaction Factor (SMAR Scale)[a]: Means and S.D.s for Treatment Problem Groups (Partners only) - Results of Analyses of Covariance

		MJ			SH		
		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	975.8	926.5	942.8	1057.2	1059.0	1049.8
	σ	57.1	52.9	46.9	114.7	57.1	56.4
VAG	m	1004.1	972.7	987.9	932.0	949.6	916.1
	σ	87.3	111.6	82.7	79.8	76.5	91.4
PE	m	1006.8	1013.5	968.0	926.0	989.6	978.8
	σ	112.1	134.7	85.6	93.6	49.3	62.9
EI	m	0158.8	1076.3	1051.2	1021.2	978.3	1028.6
	σ	106.5	61.5	88.8	53.4	50.9	44.4
TOTAL	m	1011.3	994.8	986.4	984.3	992.5	986.7
	σ	91.00	103.3	81.4	99.9	70.6	85.5

a high value, low satisfaction
b post-treatment and follow-up means above are unadjusted cell means

Results of Two-Way Analyses of Covariance

POST-TREATMENT

F Treatments (df 1,38) 0.04 NS
F Problems (df 3,38) 1.04 NS
F T x P (df 3,38) 3.21 $p < .05$

FOLLOW-UP

F Treatments (df 1,34) 0.99 NS
F Problems (df 3,34) 1.49 NS
F T x P (df 3,34) 2.18 NS

Full details of the results are provided in Appendix 6 Table 143

series of pairwise or 2 x 2 (Treatments x Problems) Analyses of Covariance involving only dual combinations of the four problems was conducted.

The results from these 2 x 2 Analyses of Covariance from the complainants' data revealed two significant interaction effects, both at post-treatment and at follow-up, which are more clearly apparent from Figures 10 and 11 overleaf.

Thus, at post-treatment, there was a significant difference between the differential treatment responses for the FSU and EI groups ($F\ [1,18]\ 29.5$, $p < .001$) and for the PE and EI groups ($F\ [1,14]\ 8.8$, $p = .01$). There was, moreover, a strong interactive trend between treatments and the FSU and VAG groups post-treatment ($F\ [1,21]\ 3.95$, $p = .060$) and the VAG and EI groups ($F\ [1,20]\ 4.10$, $p = .056$).

The former of the two significant post-treatment interaction effects, it will be noted, is crossed, due largely to the relatively poor response among the EI and FSU complainants to the MJ and SH approaches respectively, on this measure.

The results for the complainants at follow-up are similar. Pairwise analysis of covariance involving the FSU and EI groups again revealed a significant interaction effect ($F\ [1,16]\ 9.58$, $p < .01$). Similarly, the trend noted above involving the FSU and VAG groups was significant at follow-up ($F\ [1,20]\ 5.41$, $p < .05$). Thus, the difference between treatments for the FSU group, in terms of marital satisfaction, was significantly greater than that for the EI and VAG groups.

Among the partners, no significant effects were observed at follow-up, but post-treatment, again a significant interaction effect was found from the full two-way Analysis of Covariance ($F\ [3,38]\ 3.21$, $p < .05$). A further similar breakdown of this analysis into a series of 2 x 2 Treatments x Problems Analysis of Covariance revealed one significant interaction effect, again involving the FSU and EI groups ($F\ [1,19]\ 20.5$, $p < .001$). The post-treatment adjusted cell means are shown in

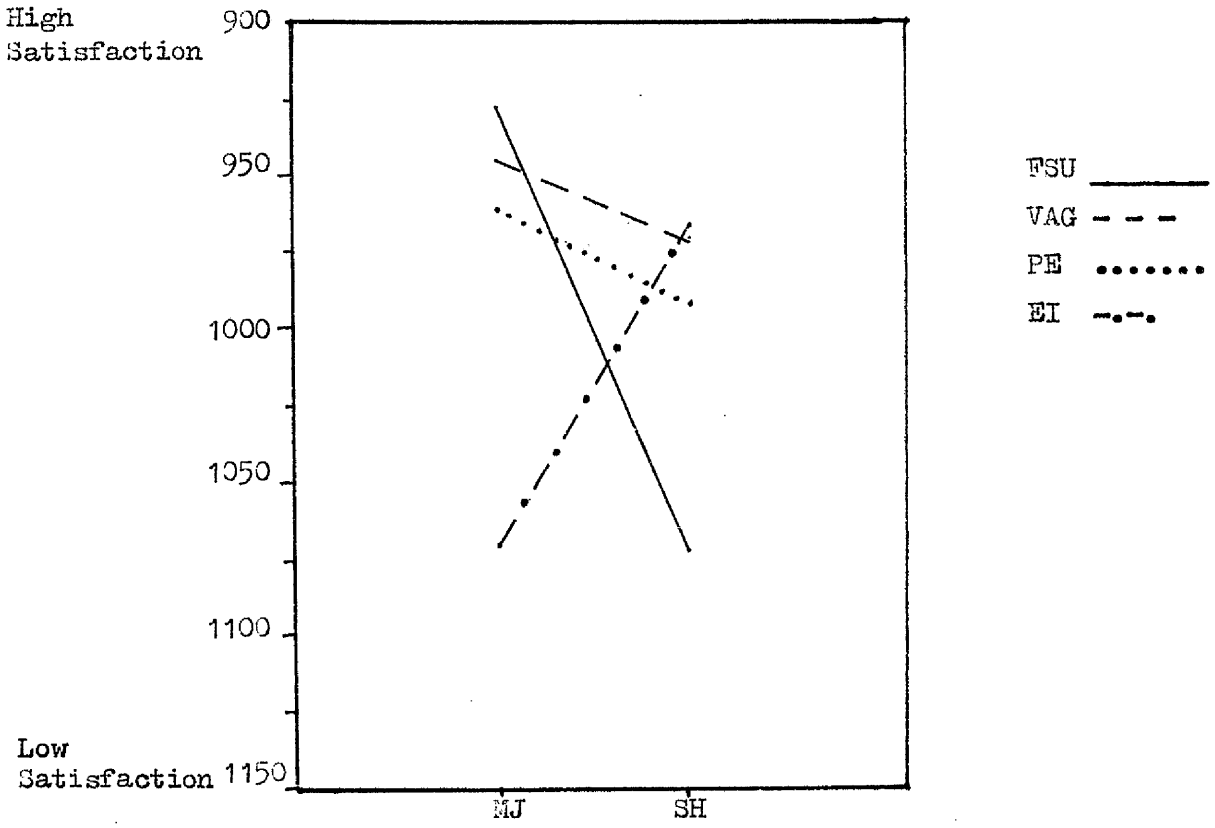


Fig. 10 General Marital Satisfaction (SMAR Scale) : Adjusted Post-Treatment Means of Problem Subgroups (Complainants only) within each Treatment Group.

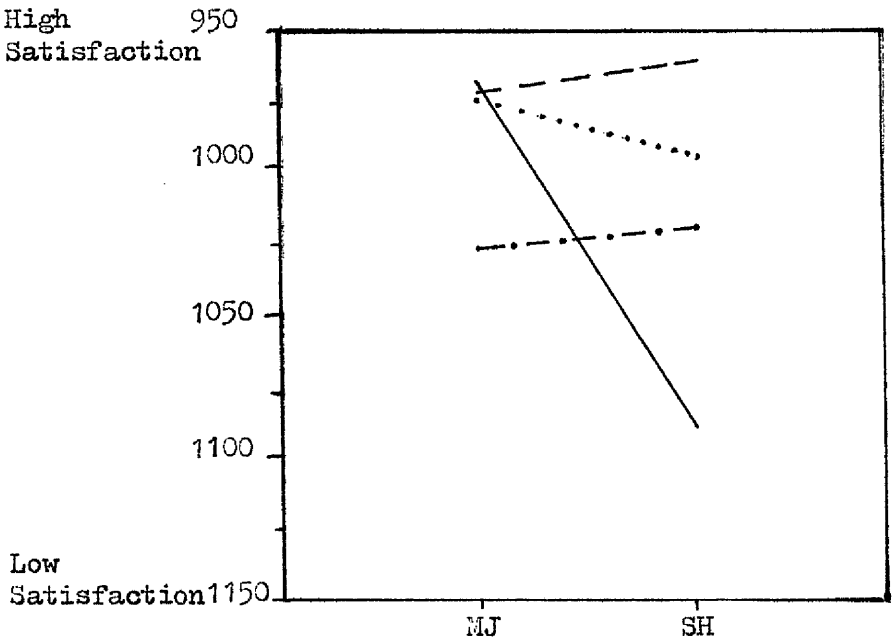


Fig. 11 General Marital Satisfaction (SMAR Scale) : Adjusted Follow-up Means of Problem Subgroups (Complainants only) within each Treatment Group.

Figure 12 overleaf, which again illustrates the pattern of means contributing to this crossed interaction effect.

Figure 13 provides a summary of the results of non-parametric analysis of treatment differences within each problem subgroup on this general marital satisfaction factor.

These results highlight more clearly the nature of the differences between the treatments for the FSU and EI groups. Thus, the MJ approach was shown among the FSU subjects to be associated with significantly greater marital satisfaction than the SH approach, both at post-treatment ($U\ [6,6]\ 0.0$, $p < .01$) and at follow-up ($U\ [5,6]\ 2.0$, $p < .05$), as a result of a significant improvement, largely sustained at follow-up among those FSU subjects receiving practice plus counselling.

On the other hand, among the EI subgroup, the post-treatment differences between treatment groups on this variable was not only shown to be significant ($U\ [5,6]\ 1.5$, $p < .05$) but was in the opposite direction to that hypothesised, i.e. EI complainants receiving the SH format reported greater marital satisfaction than their MJ counterparts, due to significant improvement only with the SH approach.

Figure 14 overleaf summarises the findings on the same measure for the partners where it may be seen that the above difference between treatments within the FSU and EI subgroups are replicated reinforcing the view that these differences, particularly in the EI subgroup, are not due to chance.

In summary, there was no significant difference between treatment groups as a whole on this measure, and hence no apparent support, from such overall group comparison, for the hypothesis that the MJ approach would effect greater marital satisfaction than the SH format. However, there was clear and consistent evidence of a differential response to treatments on this variable which varied across diagnostic groups. A treatment x problem interaction was particularly evident among those comparisons involving the FSU subgroups due largely to the significantly poor response of these

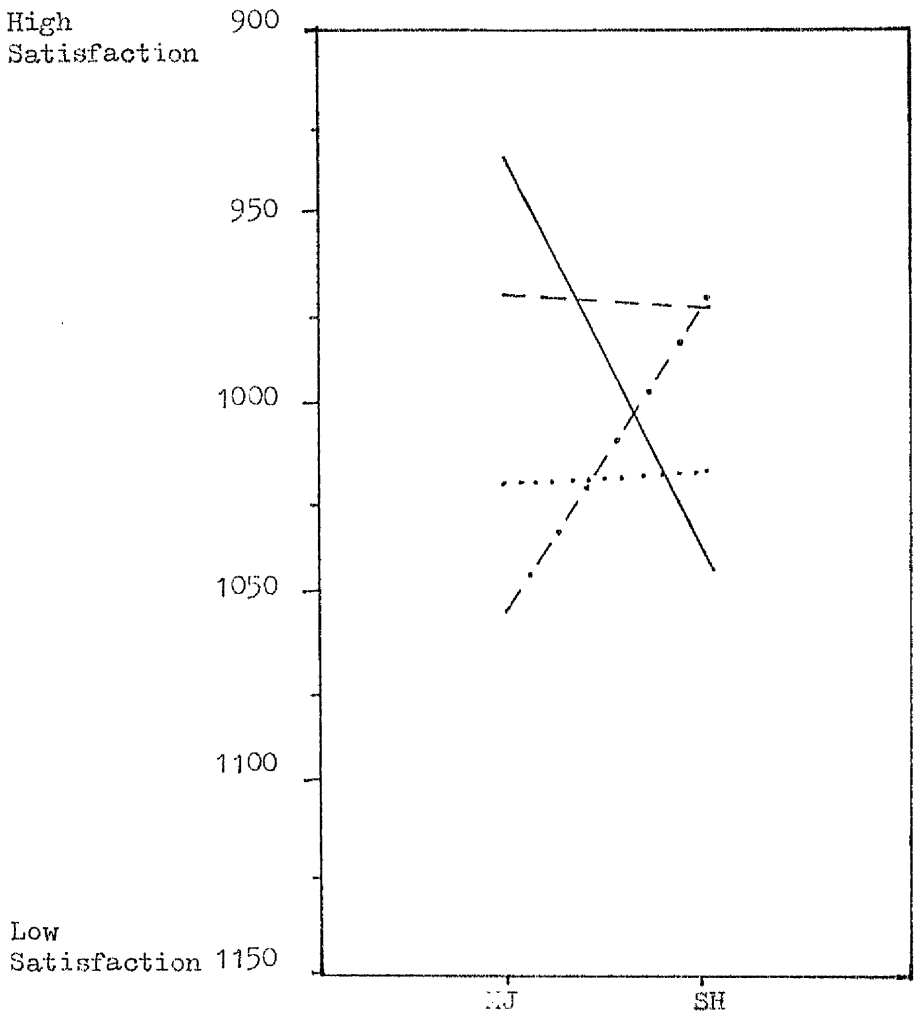


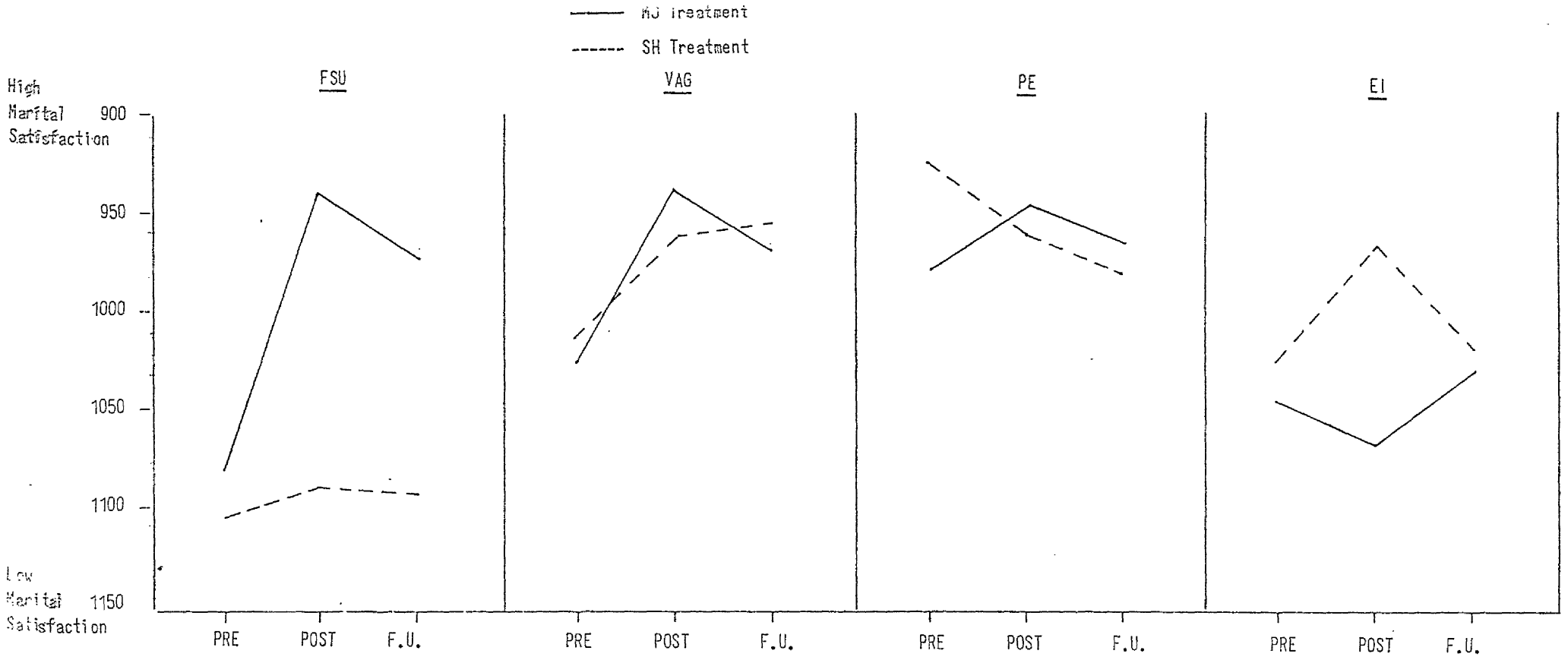
Fig. 12 General Marital Satisfaction (SMAR Scale) : Adjusted Post-Treatment Means of Problem Subgroups (Partners only) within each Treatment Group.

FSU ————————

VAG — — —

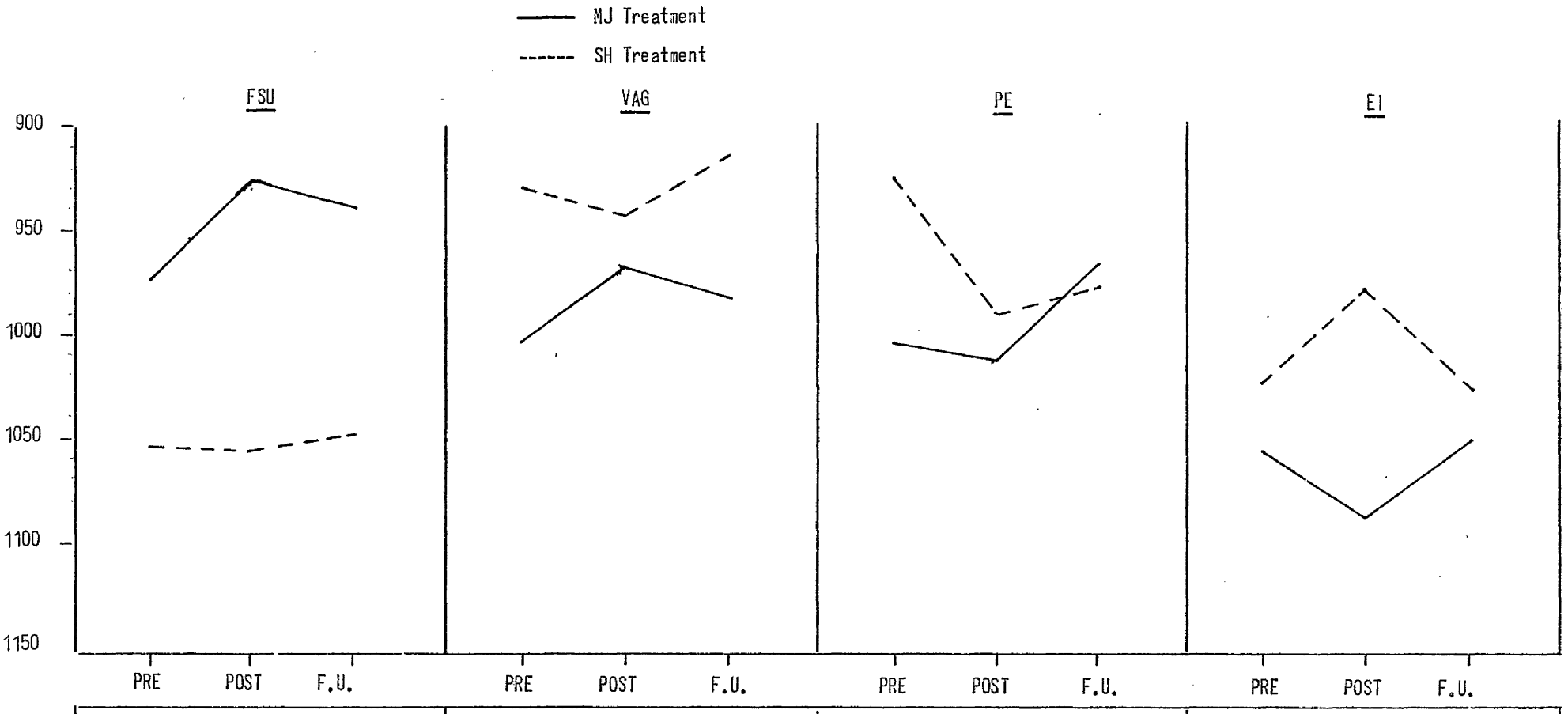
PE .....

EI —.—.



	FSU	VAG	PE	EI
Within MJ	PRE v POST Z = 1.99, p = .05 PRE v F.U. Z = 1.78, p = .08	PRE v POST Z = 1.69, p = .09 PRE v F.U. NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
Within SH	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v POST NS	PRE v POST Z = 1.83, p = .07 PRE v F.U. NS	PRE v POST Z = 2.20, p = .03 PRE v POST NS POST v F.U. Z = 1.75, p = .08
MJ v SH	POST U=0.0, n_1=6, n_2=6, p=.004 F.U. U=2.0, n_1=5, n_2=6, p=.02	POST NS F.U. NS	POST NS F.U. NS	POST U=1.5, n_1=5, n_2=6, p=.01 F.U. NS

Fig. 13 General Marital Satisfaction (SMAR Scale): Mean pre, post-treatment and follow-up MJ and SH Scores within each problem subgroup (Complainants only), and summary of results of non-parametric analyses within and between treatment groups.



	FSU	VAG	PE	EI
Within MJ	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
Within SH	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS	PRE v POST NS PRE v F.U. NS
MJ v SH	POST U=1.0, n_1=6, n_2=6, p=.01 F.U. U=2.0, n_1=5, n_2=6, p=.02	POST NS F.U. NS	POST NS F.U. NS	POST U=4.0, n_1=6, n_2=6, p=.03 F.U. NS

Fig. 14 General Marital Satisfaction (SMAR Scale) : Mean pre, post-treatment and follow-up MJ and SH Scores within each problem subgroup (partners only) and summary of results of non-parametric analyses within and between treatment groups.

subjects to the SH compared to the MJ approach in terms of marital satisfaction. This pattern of results was not so clearly apparent in the other groups and, indeed, there was evidence among the EI complainants that the relative effects of the treatments in terms of marital satisfaction were in the opposite direction to that hypothesised.

(b) Marital Adjustment (Locke-Wallace)

Means and standard deviations on the above measure at each period of testing are shown in Table 45 , as are the results of within-group analyses. No follow-up data were available for analysis on this measure.

The results are broadly consistent with those reported above for the general marital satisfaction factor and show no significant pre-post treatment change for the partners in either treatment group, with again only the MJ complainants showing a significant improvement which almost reached significance at the two-tailed level ($t = 2.05$, $df = 22$, $p = .052$).

The results of two-way Analysis of Covariance (Treatments x Problems) showed again no significant difference between treatments, although there was a consistent trend favouring the MJ approach among both the complainants ($F\ [1,38]\ 3.13$, $p = .085$) and among the partners ($F\ [1,37]\ 3.48$, $p = .070$) - See Tables 46 and 47. Only one other significant finding was observed : a problem main effect from the partners' data. This last finding prompted further analysis by means of a one-way Analysis of Covariance among the four problem groups. The adjusted post-treatment means and standard deviations are shown in Table 48, overleaf.

The above reanalysis permitted identification of the significant interproblem difference by means of the Newman-Keuls test. This showed that the partners of the VAG subjects rated their marriages as better adjusted than the EI partners ($p < .05$) and the PE partners ($p < .05$).

Unlike the findings on the general marital satisfaction factor, the results of separate non-parametric analyses within each problem group on this measure revealed no significant differences

Table 45 Locke-Wallace Marital Adjustment[a]: Means and S.D.s for each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests[1])

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	100.70	107.09	-	96.58	98.21	-
σ	21.21	18.33	-	29.28	26.74	-
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	101.77	106.41	-	100.33	98.58	-
σ	24.29	22.08	-	24.51	24.67	-

MJ Complainants

PRE v POST $t = 2.05$, $df = 22$, $p = .052$

SH Complainants

PRE v POST NS

MJ Partners

PRE v POST NS

SH Partners

PRE v POST NS

1 All probabilities are two-tailed

a high value, good adjustment

Table 46 Locke-Wallace Marital Adjustment [a]: Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	100.67	110.17	-	64.83	65.83	-
	σ	19.25	11.32	-	21.63	11.69	-
VAG	m	104.14	111.71	-	118.14	118.43	-
	σ	19.51	17.13	-	19.61	23.57	-
PE	m	97.80	104.25	-	99.60	99.00	-
	σ	24.54	34.64	-	15.65	13.64	-
EI	m	95.17	100.50	-	100.67	106.33	-
	σ	26.84	13.34	-	30.49	20.68	-
TOTAL	m	100.70	107.09	-	96.58	98.21	-
	σ	21.21	18.33	-	29.28	26.74	-

a high value, good adjustment
b post-treatment means above are unadjusted cell means

Results of Two-Way Analysis of Covariance

F Treatments (df 1,38) 3.13, p = .085
F Problems (df 3,38) 1.13, NS
F T x P (df 3,38) 1.93, NS

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

F (1,44) 2.82, NS (p = 0.10)

Full details of the results are provided in Appendix 6 Table 149

Table 47 Locke-Wallce Marital Adjustment: Means and S.D.s for Treatment and Problem Groups (Partners only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	102.17	112.17	-	79.00	74.83	-
	σ	13.32	11.82	-	11.45	5.49	-
VAG	m	108.14	116.86	-	119.57	123.57	-
	σ	20.97	25.74	-	18.60	21.53	-
PE	m	92.80	95.50	-	101.80	96.00	-
	σ	31.40	31.22	-	23.17	22.23	-
EI	m	97.60	93.60	-	98.00	95.33	-
	σ	33.54	9.76	-	26.72	15.74	-
TOTAL	m	101.77	106.41	-	100.33	98.58	-
	σ	24.29	22.08	-	24.51	24.67	-

Results of Two-Way Analysis of Covariance

F Treatments (df 1,37) 3.48, p = .070
F Problems (df 3,37) 4.14, p < .05
F T x P (df 3,37) 2.35, p = .09

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

F (1,43) 3.17, p = .082
F (3,41) 3,15, p < .05

Full details of Results are provided in Appendix 6 , Table 150

[b] unadjusted cell means

Table 48 Adjusted Post-Treatment Means and S.D.'s For Each Problem Group (Partners only) on Locke-Wallace Marital Adjustment Test - Results of One-Way Analysis of Covariance

FSU			VAG			PE			EI			
M	S.D.	n	M	S.D.	n	M	S.D.	n	M	S.D.	n	
101.28	21.39	12	110.65	23.06	14	97.37	24.75	9	96.93	12.76	11	$F(3,41)$ 3.15, $p < .05$

Full details of this analysis in Appendix 6 , Table 152

between treatments*. Within the FSU groups, however, both the complainants and partners given the MJ approach reported a near significant improvement in marital adjustment, ($p = .08$ and .05 respectively) while the female partners of the PE subjects given the minimal contact (SH) approach reported a significant drop in scores on this scale. ($z = 2.02$, $p < .05$).

In general, therefore, there was again no clear evidence to support the hypothesis of a differential treatment response in terms of marital adjustment, favouring the MJ approach, although trends from the complainants' and partners' data were in the predicted direction. There was additional evidence that both groups of female partners perceived their marriage as less well adjusted post-treatment than the male partners of the VAG subjects. This latter finding parallels that obtained on measures of general sexual satisfaction (see page 177).

The results from two additional measures may be reasonably included in this section insofar as they relate to less directly sexual aspects of the relationship : attitudes toward 'self' and 'partner' as 'loving'.

(c) Attitudes Toward 'Self' as 'Loving' (Semantic Differential)

Again, only incomplete follow-up data were obtained on this measure, and only pre and post-treatment mean scores for subjects in each group are shown below in Table 49 , along with the results of within groups analyses.

As may be seen from Table 49 , only one significant pre-post treatment improvement was observed and this was again found only among the complainants in the MJ group.

From between group analysis, only the results for the complainants were significant and details of two-way (Treatments x Problems) Analysis of Covariance are provided in Table 50 , where it may be seen that a significant effect was found at each

*In view of a significant pre-treatment difference between treatment groups within the FSU subgroup, the Mann-Whitney 'U' test for this subgroup was conducted using change scores.

Table 49 Attitudes Toward "Myself" on "Loving" Factor (Sem.Diff.)[a]: Means and S.D.s for each Treatment Group as a Whole and Results of Withing Group Analyses (Paired t-Tests[1])

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	14.50	16.27	-	13.96	14.39	-
σ	2.94	3.01	-	5.26	4.35	-
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	16.67	15.52	-	17.39	17.30	-
σ	1.71	3.80	-	2.04	1.87	-

MJ Complainants

PRE v POST $t = 2.47$, $df = 21$, p^*

SH Complainants

PRE v POST NS

MJ Partners

PRE v POST NS

SH Partners

PRE v POST NS

1 All probabilities are two-tailed
* $p < .05$
** $p < .01$
a range 3 - 21: low value, unloving

level. The apparently significant problem main effect, however, was not confirmed by one-way Analysis of Covariance and will, therefore, be discounted.

Firstly, a significant treatment effect was observed ($F\ [1,36]$ 5.00, $p < .05$), again in favour of the MJ group, who perceived themselves as more affectionate than the SH subjects post-treatment. Subequent one-way analysis of covariance between the treatment group scores post-therapy, however, again failed to endorse this effect but, instead, showed only a trend in favour of the MJ treatment ($F\ [1,42]$ 3.06, $p = .09$).

Of additional interest was a significant interaction effect which was confirmed by a further series of 2 x 2 (Treatment x Problems) analysis of covariance. Figure 15 overleaf provides details of this interaction (the scores being the adjusted post-treatment means derived from 2 x 4 analysis of covariance).

A significant crossed interaction between the FSU and EI groups and the two treatments was again observed ($F\ [1,19]$ 19.14, $p < .01$) and Figure 15 clearly illustrates the general form of this effect which clearly resembles that found for the marital satisfaction factor (SMAR).

Although non-parametric analysis failed to show a significant difference between treatments among the EI subjects, (see Figure 16) there was a clearly significant difference within the FSU group favouring the MJ approach, ($U\ [6,6]$ 0.5, $p < .01$). Moreover, this difference is shown from the above interaction effect to be in itself significantly greater than that found among the EI subjects.

Thus, there is again evidence that the effects of treatments are not additive and that their relative effects, at least with regard to aspects of marital adjustment vary according to type of problem.

This is an important finding in itself, even though sex of the rater is a confounding variable which vitiates clear interpretation of these interaction and problem main effects.

Table 50 Attitudes Toward "Myself" on "Loving" Factor (Sem. Diff.): Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	12.00	15.67	-	8.67	8.67	-
	σ	3.22	2.58	-	1.86	2.34	-
VAG	m	14.83	16.50	-	14.17	15.17	-
	σ	3.54	4.23	-	5.98	4.02	-
PE	m	15.50	18.50	-	17.20	17.40	-
	σ	1.00	2.52	-	2.28	1.67	-
EI	m	16.00	15.17	-	16.33	16.83	-
	σ	1.26	1.94	-	5.24	1.72	-
TOTAL	m	14.50	16.27	-	13.96	14.39	-
	σ	2.94	3.01	-	5.26	4.35	-

Results of Two-Way Analysis of Covariance

F Treatments (df 1,36) 5.00, $p < .05$
F Problems (df 3,36) 3.00, $p < .05$
F T x P (df 3,36) 4.02, $p < .05$

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

F (1.42) 3.06 $p = .088$
F (3,40) 1.58 NS

Full details of analyses are provided in Appendix 6, Table 153

b unadjusted cell means.

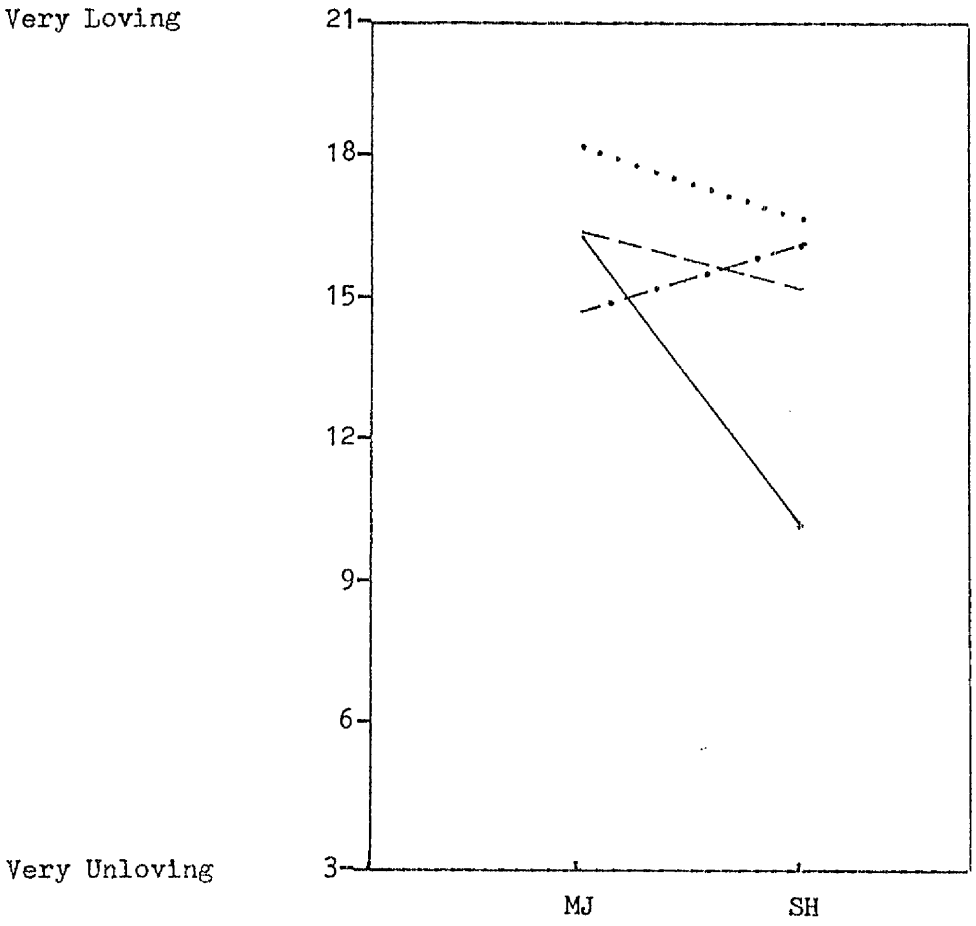


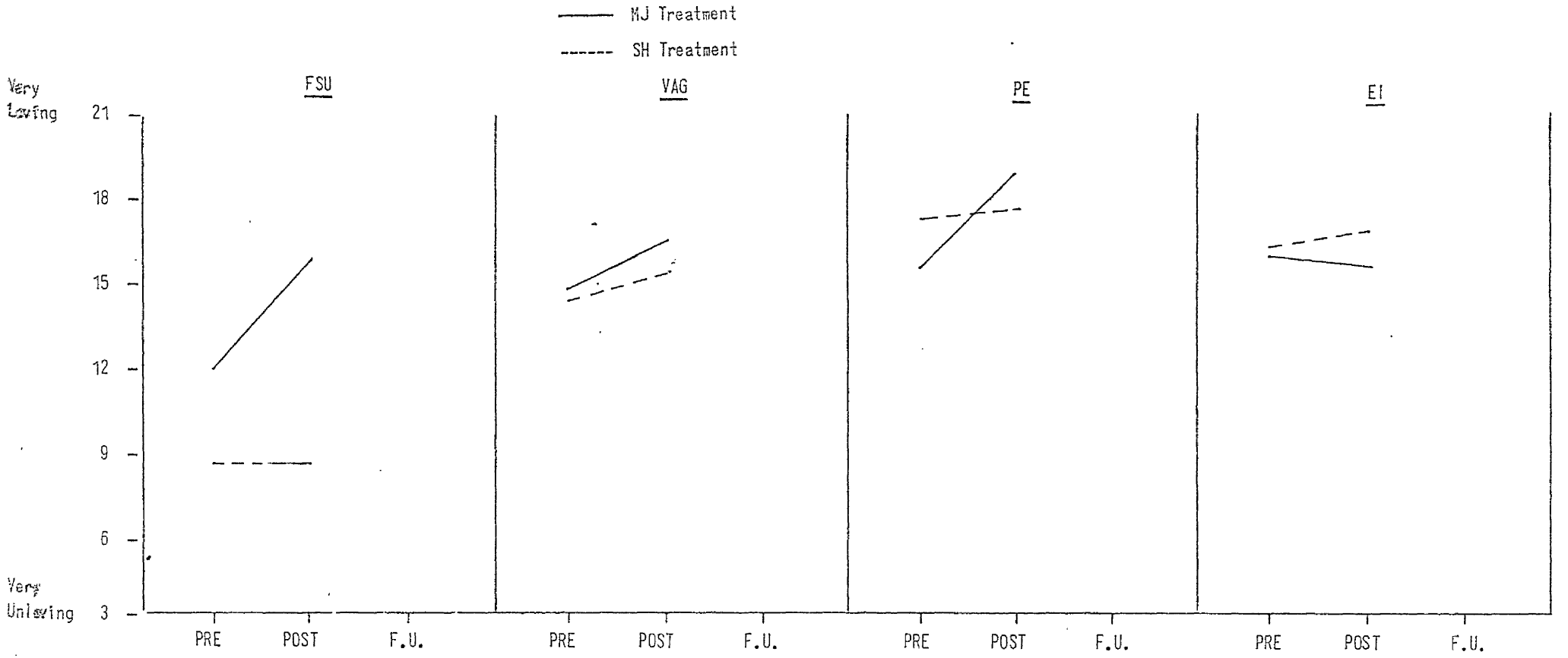
Fig. 15 Attitude Toward "Myself" on "Loving" Factor (Sem. Diff.) : Adjusted Post-Treatment Means for Problem Subgroups (Complainants only) Within each Treatment Group.

FSU ———

VAG - - -

PE .....

EI -.-.



	FSU	VAG	PE	EI
Within MJ	PRE v POST $Z = 1.75$, $p = .08$	PRE v POST NS	PRE v POST NS	PRE v POST NS
Within SH	PRE v POST NS	PRE v POST NS	PRE v POST NS	PRE v POST NS
MJ v SH	POST $U=0.5$, $n_1=6$, $n_2=6$, $p=.01$	POST NS	POST NS	POST NS

Fig. 16 "Myself" on "Loving" Factor (Semantic Diff) : Mean pre and post-treatment MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

(d) Attitudes Toward 'Partner' as 'Loving'

The results from within treatment groups analysis are presented overleaf in Table 51 along with the means and standard deviations pre and post-treatment. It may be seen that no significant pre/post treatment change was found within either treatment group, among complainants or partners.

The results from two-way (Treatments x Problems) Analysis of Covariance are presented in Table 52 . A significant treatment difference was found only among the complainants. Thus, those who received the MJ approach rated their partners as significantly more affectionate than those in the SH treatment group ($F\ [1,36]\ 6.57$, $p < .05$). The results also revealed a significant problem main effect ($F\ [3,36]\ 5.32$, $p < .01$) which was further examined by one-way analysis of covariance among the problem groups. The results of this analysis are presented in Table 53 , overleaf.

From the above results, a Newman-Keuls test was conducted to clarify the above effect. The results of this test indicated that the partners of the PE complainants were rated as significantly less loving at the end of treatment than those of each of the other three groups (PE v VAG and PE v FSU, $p < .01$; PE v EI $p < .05$).

That this finding may have been largely due to the effects of the SH treatment on the PE group is suggested by the results of separate non-parametric analysis within each problem group. Thus, a significant pre-post treatment decline in the PE complainants' ratings of their spouses as 'loving' was observed ($\bar{z} = 2.02$, $n = 5$, $p < .05$), but only among those receiving the SH treatment. This change did not contribute to a significant difference between treatments, but it is noteworthy that a similar pre-post treatment deterioration in marital adjustment was observed among those PE partners receiving the self-help approach, as determined by the Locke-Wallace M.A.T.

Summary

A significant difference between the treatment groups as a whole, in

Table 51 Attitudes Toward "My Partner" on "Loving" Factor (Sem. Diff.)[a]: Means and S.D.s for each Treatment Groups as a Whole and Results of Within Group Analyses (Paired t-Tests[1])

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	18.41	19.05	-	18.96	18.35	-
σ	2.11	2.73	-	2.64	2.90	-
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	17.33	16.19	-	16.83	16.52	-
σ	2.24	2.84	-	3.96	3.91	-

MJ Complainants

PRE v POST NS

SH Complainants

PRE v POST NS

MJ Partners

PRE v POST NS

SH Partners

PRE v POST NS

1 All probabilities are two-tailed
* $p < .05$
** $p < .01$
a range 3 - 21: low value, unloving

Table 52 Attitudes Toward "My Partner" as "Loving" Factor (Sem. Diff.): Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunction		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	19.50	20.17	-	16.67	16.33	-
	σ	1.52	1.72	-	4.13	3.83	-
VAG	m	18.67	20.33	-	19.83	20.00	-
	σ	1.51	1.21	-	1.60	2.45	-
PE	m	17.25	17.00	-	19.60	16.60	-
	σ	2.99	4.83	-	1.52	0.55	-
EI	m	17.83	18.00	-	19.83	20.17	-
	σ	2.40	2.19	-	0.75	0.98	-
TOTAL	m	18.41	19.05	-	18.96	18.35	-
	σ	2.11	2.73	-	2.64	2.90	-

Results of Two-Way Analysis of Covariance

POST-TREATMENT

F Treatments (df 1,36) 6.57, $p < .05$
F Problems (df 3,36) 5.32, $p < .01$
F T x P (df, 3,36) 1.65, NS

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

F (1,42) 5.06, $p < .05$
F (3,40) 5.17, $p < .01$

b unadjusted cell means.

Table 53 Adjusted Post-Treatment Means and S.D.'s for Each Problem Group (Complainants only) on ratings of "My Partner" on the "Loving" Factor (Sem. Diff.) - Results of One-Way Analysis of Covariance

FSU			VAG			PE			EI			
M	S.D.	n	M	S.D.	n	M	S.D.	n	M	S.D.	n	
18.77	3.47	12	19.69	1.85	12	16.89	2.99	9	18.96	1.98	12	$F(3,40)$ 5.17 $p < .01$

Full details of this Analysis are provided in Appendix 6 , Table 157

terms of marital adjustment, was observed only on the 'loving' factor from the semantic differential. Nevertheless, the consistency of the trends, in each case favouring the MJ treatment, provide some additional support for the hypothesis that this approach effects greater improvement than the SH regime with the more general and less directly sexual aspects of the relationship.

Significant interaction effects between the treatments and problems were apparent both post-treatment and at follow-up on the general marital satisfaction factor and, post treatment, on ratings of 'self' on the 'loving' factor. For the most part, these involved the FSU group, whose response to the minimal counselling approach was relatively poor compared to the MJ approach, and this differential response was greater than that observed among other problem groups, in particular, the EI group. In general, the results of non-parametric analyses of the data for each problem group separately lend further support for the hypothesis of a superiority of MJ over the SH approach among the FSU complainants, who showed signs of a more generalised marital disturbance pre-treatment.

Sexual Attitudes

In this study, sexual attitudes toward 'myself', 'my partner' and toward aspects of normal sexual relations were measured. Attitudes to the first two concepts were assessed by means of the semantic differential, while attitudes of "general aversion" toward sexual behaviour were measured by a factor derived from Principal Components analysis of the PAD Scale (see Chapter 9).

(a) Attitudes Toward 'Self' (Semantic Differential)

Again, unfortunately, no complete follow-up data were available to permit full statistical comparison between the groups. Also, since results have already been presented for the 'loving' factor, this presentation will be restricted to the remaining four factors on this scale: i.e. 'general evaluation', 'anxiety', 'sexual attractiveness' and 'erotic arousal'.

The results of within-groups analysis using separate paired t-tests, are summarised overleaf in Table 54 .

Table 54 shows that there was a significant improvement in

Table 54 Attitudes Toward "Myself" on Four Semantic Differential Factors[a]: Means and S.D.s for Each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests[1])

		MJ (Complainants)			SH (Complainants)		
		PRE	POST	PROB	PRE	POST	PROB
General Evaluation	M	8.23	10.32	**	9.17	10.22	NS
	σ	2.62	2.53		2.66	2.19	
Anxiety	M	9.82	8.41	**	9.13	8.91	NS
	σ	2.38	2.92		3.42	2.52	
Sexual Attractiveness	M	7.59	8.86	**	6.96	7.52	NS
	σ	1.87	2.03		2.60	2.41	
Erotic Arousal	M	6.27	8.32	**	6.26	7.43	*
	σ	3.15	2.59		3.53	3.76	

		MJ (Partners)			SH (Partners)		
		PRE	POST	PROB	PRE	POST	PROB
General Evaluation	M	10.19	10.24	NS	10.61	11.00	NS
	σ	1.47	2.00		1.47	1.51	
Anxiety	M	7.95	7.10	.07	7.87	7.61	NS
	σ	2.60	2.49		3.53	3.43	
Sexual Attractiveness	M	8.76	8.76	NS	8.91	9.22	NS
	σ	1.38	1.41		1.73	1.83	
Erotic Arousal	M	9.76	9.62	NS	9.78	10.35	NS
	σ	2.72	2.89		2.75	2.15	

MJ Complainants

General Evaluation $t = 3.53$, $df = 21$, p**
Anxiety $t = 3.24$, $df = 21$, p**
Sexual Attractiveness $t = 3.13$, $df = 21$, p**
Erotic Arousal $t = 3.58$, $df = 21$, p**

MJ Partners

Anxiety $t = 1.89$, $df = 20$, $p = .074$

SH Complainants

Erotic Arousal $t = 2.46$, $df = 22$, p*

* $p < .05$
** $p < .01$

a range 2 - 14 : low value, low on each factor
1 All probabilities are two-tailed

attitudes toward self on all four factors, among the MJ complainants ($p < .01$, in each case). Among the MJ partners, on the other hand, a significant improvement was observed only for ratings of 'myself' on the anxiety factor, but only at the one-tailed level ($t = 1.89$, $df = 20$, $p = .07$).

Only one significant pre-post change was observed among those receiving the SH approach and involved the complainants who perceived themselves as more sexually responsive post-treatment ($t = 2.46$, $df = 22$, $p < .05$)

As before, between groups analysis was conducted using two-way analysis of covariance (Treatments x Problems), unless missing data rendered this unsuitable when separate one-way analyses of covariance between the treatment groups as a whole and among the problem groups were conducted.

With regard to the partners' data, no significant differences between treatments were found on any of the four semantic differential factors.

The results for the complainants revealed no significant differences on the "general evaluative" or "anxiety" factors. However, there was a trend among those receiving the MJ approach to rate themselves as more sexually attractive post-treatment compared to those in the SH group, but this difference failed to reach significance from either two-way ($F [1,36] 3.66$, $p = .064$) or one-way ($F [1,42] 3.12$, $p = .085$) analysis of covariance (see Appendix 6, Tables 158 and 159).

Two-way analysis of covariance of the complainants' data on the erotic arousal factor, involving all four problem groups, showed that there was again no significant difference between the treatment groups as a whole, but there was evidence of a near significant interaction between treatments and problems ($F [3,36] 2.44$, $p = .081$). Full details of the results are provided in Appendix 6, Table 160.

Subsequent pairwise analysis of covariance to identify the

problem subgroups involved in this interaction effects leads, however, to a readjustment of post-treatment cell means for the problem groups under investigation, with the result that the crossed interaction between the FSU and PE groups is then shown to reach significance. (See Figure 17 overleaf.)

This was the only significant interaction effect obtained from such analysis and details of the results are provided in Table 161 of Appendix 6 , where it may be seen that the difference in the differential response to treatments for the FSU and PE groups, in terms of self-perceived erotic arousal, is significant ($F\,[1,16]\ 6.64$, $p < .05$).

Separate non-parametric analyses reveal that this is due largely to the near significantly greater effect of the MJ approach on erotic arousal among the FSU subjects, compared to the SH approach ($U\,[6,6]\ 6.5$, $p = .06$) this difference being absent within the PE subgroup, for whom neither treatment was shown to be associated with significant change (See Figure 18).

Caution is required as before in interpreting such effects across problem categories, not least because of the small numbers in each cell, or because of the danger of Type I error from a breakdown into pairwise analysis or because of a confounding of sex of the rater with problem group. In this case, an additional factor is worth noting: in accordance with the differing symptomatology of the FSU and PE complainants, improvement (or deterioration) for each of these two problem groups has alternate implications on this measure of 'erotic arousal', i.e. involves a change of scores in opposite directions for these two groups of subjects on this dimension. Thus, the effect of combining such subjects in overall treatment group comparison may be to "cancel out" equal improvement in both problem groups on this variable, rather than to enhance identification of a treatment effect.

(b) Attitudes Toward 'Partner' (Semantic Differential)

The results of within treatment group analysis (paired t-tests) are summarised overleaf, along with the means and SD's for

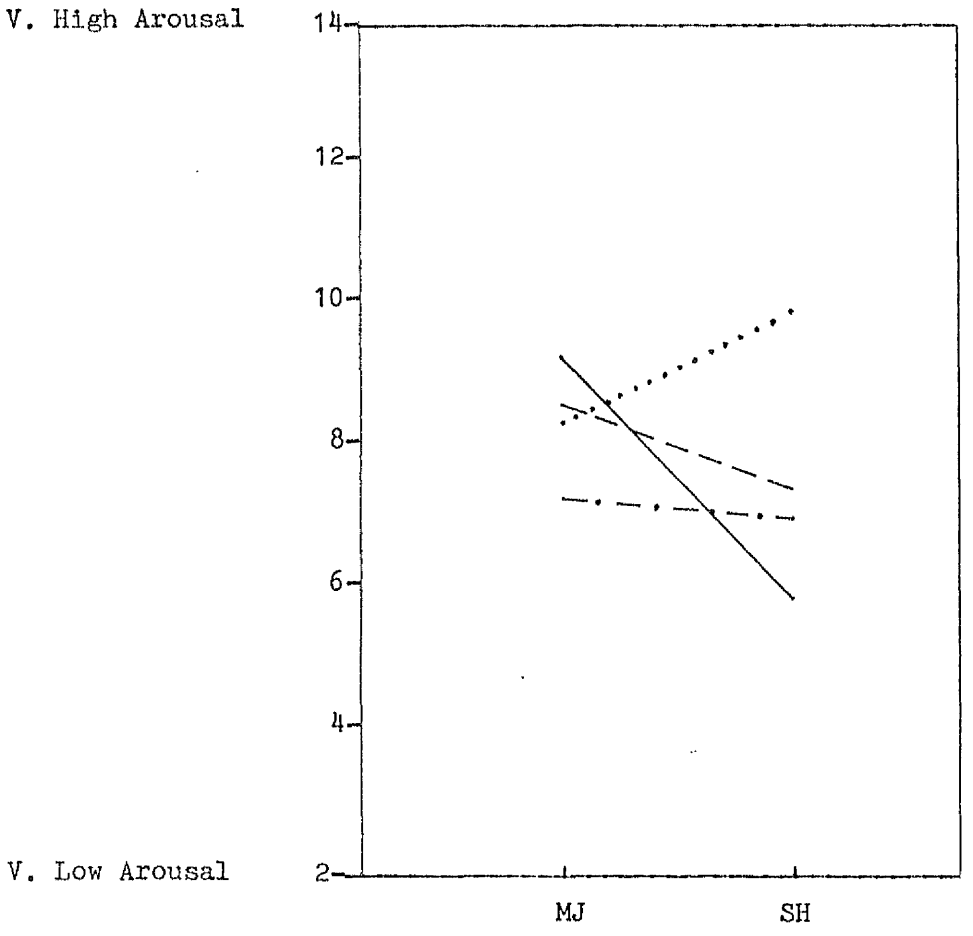


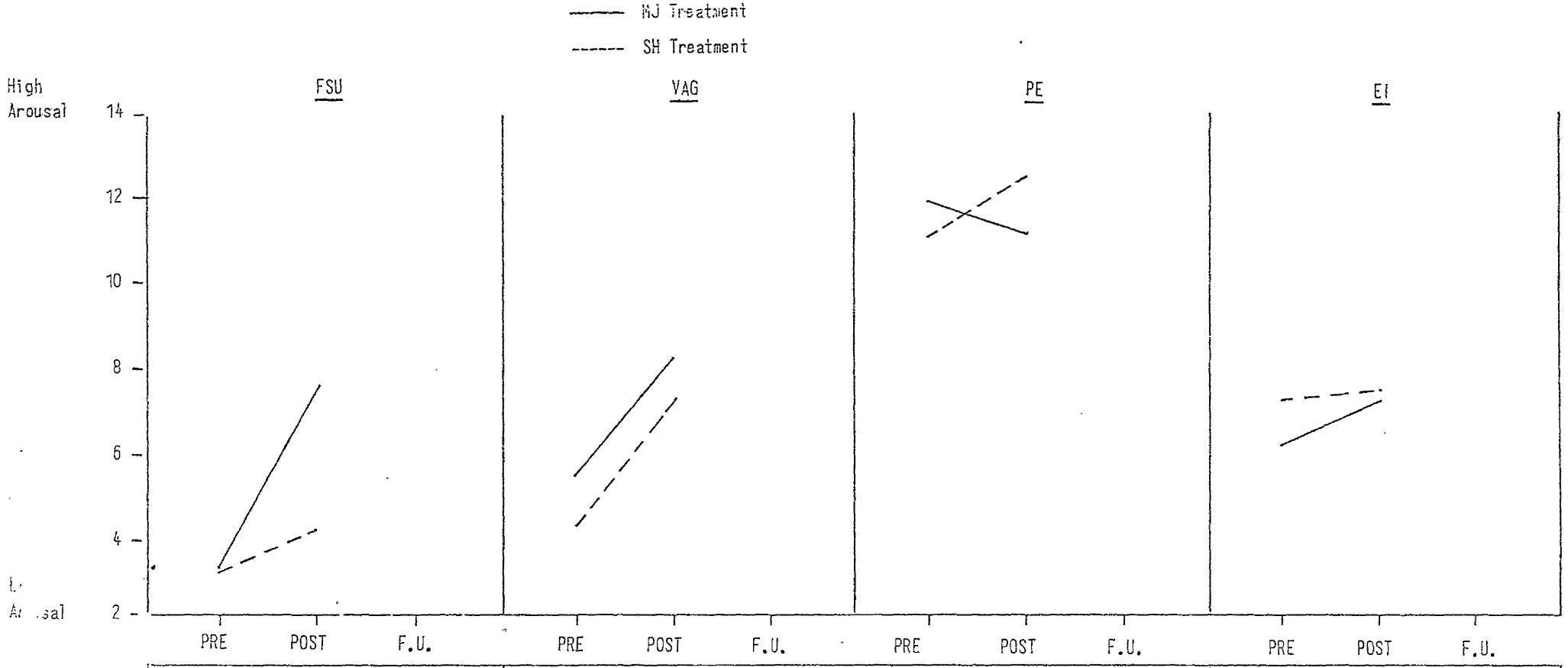
Fig.17 Attitude toward "myself" on "Erotic Arousal" Factor (Sem. Diff.) : Adjusted Post-treatment Means for Problem Subgroups (Complainants only) within Each Treatment Group.

FSU ————

VAG – – –

PE ••••••

EI –•–•



	FSU	VAG	PE	EI
Within MJ	PRE v POST Z = 2.02, p = .04	PRE v POST Z = 1.89, p = .06	PRE v POST NS	PRE v POST Z = 1.83, p = .07
Within SH	PRE v POST NS	PRE v POST Z = 1.89, p = .06	PRE v POST NS	PRE v POST NS
MJ v SH	POST U=6.5, n_1=6, n_2=6, p=.06	POST NS	POST NS	POST NS

Fig. 18 "Myself" on "Erotic Arousal" Factor (Sem Diff) : Mean pre and post-treatment MJ and SH Scores within each problem subgroup, and summary of results of non-parametric analyses within and between treatment groups.

complainants and partners, on each of the four remaining factors. (See Table 55)

Within the MJ group (complainants only), only one significant pre-post treatment change was found. These subjects rated their partners as significantly more sexually attractive ($t = 2.43$, $df = 21$, $p < .05$) post-treatment, compared to the pre-treatment level.

The widespread changes in the MJ complainant attitudes toward themselves reported above were largely endorsed by the MJ partners' perception of their spouses. Thus, significant pre-post therapy improvement was found on the MJ partners ratings of the complainants on the anxiety factor ($t = 2.30$, $df = 20$, $p < .05$); on the sexual attractiveness factor ($t = 1.83$, $df = 20$, $p = .08$) and the erotic arousal factor ($t = 1.91$, $df = 20$, $p = .07$). However, it will be noted that on these last two variables these pre-post treatment changes reached significance at only the one-tailed level.

Within the SH group, however, no significant pre-post treatment changes were found on any of the factors.

Comparison between the treatment groups as a whole revealed only one significant difference. This involved the complainants ratings of 'my partner' on the "sexual attractiveness" factor. Thus, those complainants exposed to directed practice plus counselling rated their partners as significantly more sexually attractive at the end of treatment compared to the SH group ($F\ [1,36]\ 4.65$, $p < .05$) - see Table 56 overleaf. A similar significant difference on the same variable was also found within the FSU group and this represented the only significant difference between treatments from separate non-parametric analysis within each problem group ($U\ [6,6]\ 3.5$, $p < .05$).

(c) Attitudes of Sexual Aversion Toward Normal Sexual Relations

A measure of distaste for normal sexual relations was provided by the sexual aversion factor from the PAD Scale and the means and standard deviations at each period of testing are shown

Table 55 Attitudes Toward "My Partner" on Four Semantic Differential Factors: Means and S.D.s for Each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests[1])

		MJ (Complainants)			SH (Complainants)		
		PRE	POST	PROB	PRE	POST	PROB
General Evaluation	M	11.86	12.32	NS	12.13	12.35	NS
	σ	1.52	1.49		1.77	1.70	
Anxiety	M	6.77	5.73	NS	7.35	6.70	NS
	σ	2.99	3.01		3.81	3.27	
Sexual Attractiveness	M	11.14	12.32	*	11.13	11.00	NS
	σ	1.28	2.48		2.22	2.13	
Erotic Arousal	M	11.00	10.73	NS	11.17	10.91	NS
	σ	2.27	2.88		1.72	2.17	

		MJ (Partners)			SH (Partners)		
		PRE	POST	PROB	PRE	POST	PROB
General Evaluation	M	11.67	11.95	NS	12.00	12.00	NS
	σ	1.32	1.40		1.31	1.54	
Anxiety	M	10.00	8.95	*	9.00	8.96	NS
	σ	2.28	2.73		3.62	3.66	
Sexual Attractiveness	M	10.43	10.86	.08	10.48	10.61	NS
	σ	1.60	1.71		1.70	1.85	
Erotic Arousal	M	7.33	8.57	.07	7.09	7.70	NS
	σ	3.37	2.69		3.81	3.94	

MJ Complainants

Sexual Attractiveness $t = 2.43$, $df = 21$, p^*

MJ Partners

Anxiety $t = 2.30$, $df = 20$, p^*
Sexual Attractiveness $t = 1.83$, $df = 20$, $p = .083$
Erotic Arousal $t = 1.91$, $df = 20$, $p = .070$

1 All probabilities at two-tailed level
* $p < .05$
** $p < .01$

Table 56 Attitudes Toward "My Partner" on "Sexual Attractiveness" Factor (Sem. Diff.): Means and S.D.s for Treatment and Problem Groups (Complainants only) - Results of Analyses of Covariance

		MJ			SH		
Dysfunctional		PRE	POST[b]	FU[b]	PRE	POST[b]	FU[b]
FSU	m	11.17	13.50	-	9.50	9.33	-
	σ	0.75	3.73	-	3.02	2.34	-
VAG	m	10.67	12.00	-	10.67	10.83	-
	σ	1.86	2.10	-	1.37	2.48	-
PE	m	11.50	11.75	-	12.20	11.80	-
	σ	1.00	2.63	-	1.79	1.64	-
EI	m	11.33	11.83	-	12.33	12.17	-
	σ	1.37	0.98	-	1.37	0.75	-
TOTAL	m	11.14	12.32	-	11.13	11.00	-
	σ	1.28	2.48	-	2.22	2.13	-

Results of Two-Way Analysis of Covariance

F Treatments (df 1,36) 4.65, $p < .05$
F Problems (df 3,36) 0.25, NS
F T x P (df 3,36) 1.02, NS

Results of Confirmatory One-Way Analysis of Covariance of Main Effects

F (1,42) 5.54, $p < .05$

Full details of this analysis in Appendix 6 , Tables 162 and 163

b unadjusted cell means.

overleaf in Table 57 . No significant change was found from within groups analysis with either treatment.

Similarly, between groups analysis revealed no significant treatment difference, nor indeed any trend in favour of the MJ approach. There was, moreover, no significant problem main or interaction effect. A further examination of treatment effects within each problem group separately using non-parametric analyses confirmed the absence of any differences between treatments on this measure of sexual attitudes.

In summary, the results provided limited support for the hypothesis that the MJ treatment would effect greater positive attitude change than the SH approach. Thus, only in terms of the complainants' perception of their partner and, to a lesser extent, of themselves as sexually attractive was the MJ approach shown to be superior from overall treatment group comparison.

However, on the 'erotic arousal' factor, an interaction between treatments and problems was observed due to a significant difference between treatments within the FSU group (again in favour of the MJ approach), which was in turn greater than that observed in the PE group. Thus, again the relative effects of the treatments, in terms of aspects of attitude change, differed across problem groups.

Despite this limited number of significant treatment differences, a significant pre/post-treatment improvement in sexual attitudes was found on a wider range of variables among those receiving directed practice plus counselling. This improvement was also confined to sexual aspects of interpersonal perception, as measured by the semantic differential - and did not encompass a change in inhibited attitudes toward sexual behaviours. In the latter case, however, it should be noted that there was limited scope for change, since attitudes of distaste were not particularly marked or prevalent in the sample.

Table 57 Attitudes of Sexual Distaste Toward Sexual Relations: Means and S.D.'s for each Treatment Group as a Whole and Results of Within Groups Analyses (Paired t-Tests)

	MJ (Complainants)			SH (Complainants)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	1015.6	1003.0	1006.3	946.00	972.7	984.4
σ	109.8	100.5	86.2	139.4	99.5	96.9
	MJ (Partners)			SH (Partners)		
	PRE	POST	F.U.	PRE	POST	F.U.
M	975.0	1004.2	995.4	1028.5	1027.5	1026.1
σ	118.1	63.3	63.7	36.3	36.4	26.0

MJ Complainants

PRE v POST	NS
PRE v F.U.	NS
POST v F.U.	NS

SH Complainants

PRE v POST	NS
PRE v F.U.	NS
POST v F.U.	NS

MJ Partners

PRE v POST	NS
PRE v F.U.	NS
POST v F.U.	NS

SH Partners

PRE v POST	NS
PRE v F.U.	NS
POST v F.U.	NS

CHAPTER 13

Discussion

In discussing these results, it may be appropriate to subdivide the findings into three main areas:

(a) the differences between the treatment groups as a whole;

(b) the treatment differences within each problem subgroup; and

(c) the interaction effects.

Comparison Between the MJ & SH Treatment Groups as a Whole

Prior to re-allocation of the control group, significant differences between the two treatment groups were restricted to three variables only: (a) ratings of "myself" on the "loving" factor of the semantic differential; (b) degree of anxiety about the presenting symptoms during sexual relations; and (c) self-ratings on the general sexual anxiety factor (PAD) - in each case favouring the MJ approach. Following inclusion of the waiting-list subjects, the MJ approach was again shown to be significantly superior to the SH regime on variables (a) and (b) above, but just failed to reach significance on variable (c), i.e. general sexual anxiety ($p = .061$). However, significant differences between the two treatment approaches, in each case in favour of guided practice with counselling, were observed on three other variables following inclusion of the control subjects. Thus, the MJ complainants described their partners as more loving, and more sexually attractive, and were rated as enjoying intimate foreplay more than those complainants given the minimal contact approach. Moreover, again from the complainants' data, a strong trend ($p = .053$) was apparent at follow-up on the general sexual adjustment factor (SMAR) again in favour of the regular counselling approach.

Firstly, therefore, a consistent finding, both before and after inclusion of the control subjects, was a superiority of MJ counselling over the minimal contact group with respect to the reduction of sexual anxiety, both generally and specifically, as measured in the latter case, by the tendency to focus on, and be concerned about, the presenting symptoms during sexual play. Thus, although both treatment groups as a whole showed signs of significant improvement, maintained at follow-up, on each of these two measures of sexual anxiety, there was evidence that the MJ approach effected greater improvement than

the SH regime, particularly among the complainants. It is interesting, however, that the differential effect with regard to the tendency to spectate was also apparent among the non-complainant partners, although only at follow-up, as a result of a continued improvement post-treatment for those receiving the MJ approach. This is consistent with the emphasis Masters and Johnson (1970) and Kaplan (1974) place on such anxieties being shared by both partners and again with the greater opportunity during regular conjoint counselling to focus on the couple rather than the individual Complainants.

In interpreting the differences between the treatment groups in terms of sexual anxiety reduction, and, in particular, the tendency to "spectate", one may propose that the self-help programmes may have involved, to a greater extent, a degree of self-examination, which may be less easily unlearned. However, the significant treatment effect and the sustained improvement observed on this measure among those receiving the minimal contact treatment, suggest that this interpretation may not wholly account for this difference.

An additional possibility is that practice plus conjoint counselling may be perceived as less intrusive in its effects on a couple's sexual relations, by affording an opportunity to identify and resolve "spectatoring", thereby allowing couples to relax more readily in their sexual play at home, and to focus their attention more readily on pleasurable sexual stimulation. This view is strengthened by the fact that the dual component (MJ) approach was also shown to be significantly more effective, particularly in enhancing the degree of enjoyment of intimate foreplay among the Complainants. There was also a trend favouring the MJ group in terms of the post-treatment frequency of pleasurable sexual intercourse ($F\ [1,34]\ 3.18$, $p = .084$). Together with the earlier findings (prior to the inclusion of the control subjects) of a near significant treatment effect only apparent with the MJ approach in terms of general sexual enjoyment ($F\ [2,37]\ 3.26$ $p = .05$) and a decrease in the proportion of negative coital experiences ($F\ [2,34]\ 3.2$, $p = .05$), the consistency of the evidence points to directed practice plus counselling being more effective than the self-help treatment not only in reducing sexual anxieties, but also in increasing sexual pleasure.

The way in which directed practice and counselling may interact to facilitate both sexual pleasure and anxiety reduction has already been discussed, as indeed has the consistency of the present findings with the proposed distinction by Mathews et al (1976) between an MJ approach and desensitisation to which it has been wrongly equated viz. that in the former, behavioural steps are guided more by the occurrence of mutual pleasure rather than anxiety reduction per se. The same distinction would appear to apply to conventional and minimal contact versions of the Masters and Johnson approach and subsequent evidence from comparison between the two treatment groups as a whole reinforces these earlier interpretations.

The fact that the only significant difference between the treatment groups as a whole, on measures of sexual pleasure, should be restricted to the degree of enjoyment of intimate foreplay may be regarded as consistent with part of the aims of sensate focus as a means of minimising goal-directed sexual relations. It is conceivable, given the greater and sustained reduction in the tendency to spectate in the MJ group, that these subjects found it easier to renounce a hierarchical approach to sexual relations, and to treatment itself, permitting a clearer focus on the "here and now" of undemanding non-coital sexual play. The opportunity in counselling to emphasise communication between partners about mutually pleasurable sexual play may also be relevant. On the other hand, potential awareness at any given time of all aspects of treatment and the perhaps unavoidable hierarchical or graded sequence of steps as presented in a self-help manual may serve to inhibit or distract the SH subjects to a greater degree, particularly during pre-coital sexual play.

The fact that there was only a trend favouring the MJ approach in terms of the proportion of pleasurable intercourse experiences ($p = .084$) and that there was no corresponding improvement or treatment difference in the <u>degree</u> of coital enjoyment, may also of course be simply due to: (a) the substantially greater proportion of overall treatment time afforded to the enhancement of non-coital sexual relations; (b) to the study's design, in which treatment was terminated and post-treatment assessment conducted after only six sessions of satisfactory intercourse over a relatively brief period; and

(c) to the significantly greater pre-treatment level of coital enjoyment reported by each male subgroup compared to each female subgroup which would contribute to a differential scope for change among the problem subgroups comprising each treatment group as a whole.

The next main finding from comparison between the treatment groups as a whole was a consistent trend toward greater general sexual satisfaction with conjoint counselling compared to the minimal contact group. Although the post-treatment difference between the groups on the general sexual satisfaction factor (SMAR) failed to reach significance among the complainants, there was a strong trend post-treatment favouring the MJ approach among the partners ($F_{1,38}$ 3.31, $p = .077$). At follow-up, however, the difference between the treatment groups (Complainants only) just reached significance ($F_{1,34}$ 4.01, $p = .05$) as a result of a continued trend toward further improvement at follow-up among those receiving the MJ approach. This superiority of directed practice plus counselling over the minimal contact approach is clearly consistent with other evidence in favour of the former treatment, viz. greater feelings of affection toward the partner, a trend toward greater marital adjustment and a greater reduction of sexual anxiety. The fact that this difference for the complainants reached significance only at follow-up, however, is of interest, being consistent with the view that a central part of the therapist's involvement with couples, particularly during the latter stages of counselling, is in transferring responsibility over to them, by encouraging them: (a) to accept more initiative in defining treatment goals, (b) to learn and apply problem solving strategies and (c) to identify, understand and communicate the probable reasons for treatment change in order to facilitate the maintenance or enhancement of treatment gains (Lobitz and Lo Piccolo, 1972).

On the other hand, it is important to stress that the absence of significant relapse and the consistency in the maintenance of treatment gains with both approaches are striking. Thus, on those variables from which follow-up data were available and on which significant treatment changes were apparent, these gains in every case were maintained at follow-up, irrespective of treatment format. Caution is obviously necessary in drawing conclusions based on such a limited

number of follow-up measures and on only a four month follow-up period. Possible factors which may have been responsible for the maintenance of improvement with the MJ approach have been described above. In the case of the SH regime, it has been proposed that the use of self-help manuals may facilitate a sustained improvement in a number of non-mutually exclusive ways:

(i) by a reduced dependence on external reinforcements and stimulus control (Kanfer, 1971; Mahoney and Thoresen, 1974).

(ii) given a characteristically strong directive and didactic element, they may also provide an opportunity for learning general coping strategies (Lazarus, 1976).

(iii) by their contributing to an altered self-perception, based on self-efficacy and personal causal attribution of behavioural change (Bandura, 1977; Kopel and Arkowitz, 1975; Festinger, 1957).

The present study was not designed to test the above hypotheses, but the sustained behavioural change observed with the present SH approach may be seen as "consistent" rather than "supportive" evidence. Similar evidence of maintained treatment effects has also been found with self-directed procedures for agoraphobia (Mathews et al, 1977); for snake phobia (Rosen et al, 1976); for acrophobia (Baker et al, 1973) and for obesity (Hanson et al, 1976). Such findings and their potential relationship to the above theoretical model warrant further research, particularly in view of the fact that generalisation over time, rather than place, may be for bibliotherapy (and for many other behavioural treatments) the more critical issue, given an increasing emphasis on therapy in the natural environment as opposed to the clinic alone.

Attitude Change Hypothesis

Consistent with the results of Whitehead and Mathews (1977), the present findings from overall treatment comparison provide some support for the hypothesis that the MJ approach would be associated with more positive attitude change compared to the minimal contact regime. Such differential change was found, however, on only a limited range of variables. Thus, there were no significant differences between the treatment groups as a whole from analysis of the partners' data,

and, among the complainants, only on the "loving" and "sexual attractiveness" factors were significant differences observed between the treatments, albeit, in each case, in the predicted direction. In short, the MJ complainants rated themselves and their partners on the semantic differential as significantly more loving, and their partners as significantly more sexually attractive compared to the minimal contact group.

However, despite such limited support for the hypothesis of a differential effect on sexual attitudes, the results from within group analysis of each treatment group as a whole showed the MJ approach to be associated with a wide range of significant pre-post treatment improvement which was largely absent in the SH group. Thus, the MJ complainants perceived themselves at the end of treatment as more kind, more loving, less anxious, more sexually attractive and more responsive sexually, while the SH complainants showed a significant positive change only on the last of these factors. It is noteworthy also that these changes in self-perception among the MJ complainants were also largely endorsed by their partners' ratings of their spouses.

As with the Whitehead and Mathews (1977) study, it is not possible to draw any firm conclusions about the precise factors responsible for mediating such change. Nevertheless, the weight of evidence from previous research so far suggests that it is the interactive therapeutic effect of the directed practice and counselling components which facilitates the identification and resolution of obstructive attitudes to improved sexual functioning. The present evidence may be regarded as consistent at least with this view. However, with respect to attitude change, significant differences from overall group comparisons were found on only three variables. as noted above - unlike the more widespread change observed by Whitehead and Mathews. It is perhaps worth noting that on two of these three factors, no significant pre-treatment differences were observed among the problem groups. These variables were "my partner - loving" and "my partner - sexually attractive". The existence of interproblem differences and, therefore, increased pre-treatment variance may have reduced the chances of observing a significant difference from overall group comparison, on other attitude variables. It is also possible that such pre-treatment differences may have

contributed to the lack of uniformity among the problem groups in the differential response to treatments, as was apparent, for example, on ratings of "myself" on the "loving" and "erotic arousal" factors. These interaction effects and their implications will be discussed in a later section, however.

It is also perhaps of interest that the factors on which significant differences in attitude change between the two treatment groups were apparent were largely those involving the relationship and interpersonal perception. Thus, no differential effect was found on the general evaluative and anxiety factors of the semantic differential and arguably ratings on these scales involve less consideration of interpersonal aspects of the sexual or marital relationship. The significant changes, therefore, on the "loving" and "sexual attractiveness" factors with the MJ approach may reflect, in part, the emphasis in counselling on effective communication between partners, on resolving mismatched perceptions, and aspects of more general interpersonal conflict, and perhaps also to the provision of consensual validation (Sullivan, 1947) of those attitudes more central to spouse interaction.

A similar interpretation may also be offered, for the trend toward greater marital adjustment ($F_{1,38} = 3.13$, $p = .09$), as measured by the Locke-Wallace M.A.T., with directed practice plus counselling. This trend, though not significant, is also consistent with the hypothesised effects of the MJ approach in relation to the SH treatment and will, therefore, be discussed below.

Marital Adjustment Hypothesis

The same interaction between directed practice and counselling has been considered to be important, not just in identifying and resolving obstructive attitudes, but also impaired communication and more general marital conflicts which may impede progress with the more clearly behavioural aspect of the Masters and Johnson treatment. This, combined with additional previous evidence of limited benefit with minimal contact therapy for those dysfunctional couples exhibiting more general relationship difficulties, led to the hypothesis that the MJ approach would facilitate greater marital satisfaction and adjustment compared to the minimal contact SH regime.

The evidence was shown to be broadly in support of this prediction. However, this effect was not particularly clear from overall group comparison. Thus, as noted above, only on ratings of "myself" on the "loving" factor from the semantic differential were clearly significant post-treatment differences favouring the MJ approach observed both prior to and after inclusion of the waiting-list subjects. A similar difference between treatments, in favour of the MJ group as a whole, was also found on the complainants' ratings of the partner as loving, although only after re-allocation of the control subjects. These were the only measures relating to the general relationship which provided clearly significant differences from overall treatment group comparison - both in the predicted direction.

However, trends toward greater marital adjustment were observed post-treatment on the Locke-Wallace M.A.T. by both complainants ($F\left[1,38\right]$ 3.13, $p = .09$) and partners ($F\left[1,37\right]$ 3.48, $p = .07$) receiving the MJ approach. Furthermore, it will be recalled that only the MJ treatment was significantly better than the controls in effecting change in marital adjustment, again as measured by the Locke-Wallace M.A.T.

However, it is important to recognise that the failure to observe a stronger differential treatment effect on measures of marital satisfaction and ajustment, from comparison of the two treatment groups as a whole (either before or after re-allocation of the control subjects) may have been due at least in part, to the variable nature of the treatment response among the diagnostic subgroups comprising each treatment group. This variability in terms of general relationship factors was particularly evident post-treatment and at follow-up from comparison between treatments within each problem subgroup independently, and from evidence of an interaction effect between treatments and problems.

It was proposed earlier that one of the possible reasons for the failure to observe significant differences in some of the previous related treatment outcome studies in this field (e.g. Mathews et al, 1976; Crowe et al, 1981) may have been in part the within group variability in response to the treatments. This in turn may have been

partly due to the composition of the groups which, while balanced, were heterogeneous for type of problem. As noted already, this view is consitent with the present evidence of widespread pretreatment differences among the problem groups.

In general, therefore, the identification of significant treatment differences and effects from overall group comparison may be confounded by a high level of pre-treatment variability among problem categories comprising such "mixed" samples.

Thus, discussion of the major findings from analyses of the interaction between treatments and problems and of treatment differences within each problem subgroup is indicated.

Differential Treatment Outcome Within and Across Problem Subgroups

Despite the small number in each cell, a number of signifcant differences between the treatments in each problem group were found from non-parametric analyses. More important, perhaps, for the design of future outcome studies in this specific field, was that some of these treatment differences were not additive across problem subgroups, i.e. there was evidence that the differential response to the treatments was itself significantly different among some of the problem groups.

It would appear that this stemmed largely, though not exclusively, from the relatively poor response in general among the FSU couples to the minimal contact treatment, compared to guided practice plus counselling - a difference which was less marked among other problem subgroups.

The discussion below will focus principally on the differences in treatment outcome within each of these problem categories, before interpeting the differences in the relative effects of the treatments shown to exist among them.

Female Sexual Unresponsiveness

Within this subgroup, directed practice plus counselling was shown to be significantly superior to directed practice alone in effecting change on a range of sexual and marital adjustment variables. Thus, there was consistent evidence that the MJ approach was more effective in enhancing sexual, and particularly coital, pleasure. For example, significant differences each in favour of the MJ treatment were observed on ratings of the frequency of pleasurable sexual intercourse, and on independent and self-ratings of degree of coital enjoyment. On the general sexual pleasure factor (PAD Scale), the MJ treatment again was almost significantly better than the SH approach, both at post-treatment ($p = .08$) and at follow-up ($p = .07$) as a result of a significant improvement, sustained at follow-up, only among those receiving practice plus counselling.

Broadly similar findings were obtained on measures of sexual anxiety and general sexual satisfaction. Thus, although there was no significant reduction with either treatment with respect to the tendency to spectate, the pattern of the results showed a distinct trend in favour of the MJ treatment which almost reached significance ($p = .07$). However, the MJ approach was shown to be significantly more effective than SH, at post-treatment only, in reducing general sexual anxiety, as measured by the PAD Scale.

It is interesting that the SH group showed a significant improvement on this PAD anxiety factor only at follow-up, a finding which parallels to some extent the results obtained on the general sexual satisfaction

factor (SMAR Scale). Thus, only after therapy was terminated was a significant positive change in sexual satisfaction observed among the minimal contact treatment group. A similar trend for this SH group was also apparent with regard to the tendency to "spectate". Such trends toward improvement after the formal end of the SH treatment for this FSU group, together with the evidence of its negligible effects in facilitating change in sexual satisfaction, anxiety or enjoyment during the course of treatment may be due to a number of factors. It is possible that the particular intrinsic demands of a self-help programme for such couples (e.g. regular telephone contact following written behavioural prescriptions, etc.) together with the perhaps more general interpersonal problems highlighted by the behavioural programme itself - in the absence of any means for dealing with them - may serve to offset any potential benefits from sensate focus in reducing goal-directed sexual anxieties, enhancing pleasure, etc. It seem possible that these proposed iatrogenic effects may be partially relieved only with the formal termination of treatment. This possibility, of course, requires further detailed examination and replication with a much larger sample before firmer conclusions may be drawn.

Of particular interest were the findings in support of the hypothesis that the MJ approach would effect greater improvement than the SH procedure in the general relationship and that this difference would be particularly evident among the FSU couples - in the light of their greater reported pre-treatment marital difficulties. Thus, although there was no evidence, as noted above, of an overall treatment main effect favouring the MJ treatment group as a whole on the marital satisfaction factor (SMAR Scale), significant differences favouring practice plus counselling were found post-treatment and at follow-up, among both the FSU complainants and their partners, on this variable. Similarly, those who received the MJ approach also rated themselves as significantly more "loving" on the semantic differential compared to the SH subjects, as a result of a significant improvement only with the former approach. Finally, although no significant post-treatment differences were found on the Locke-Wallace M.A.T., significant improvement on this measure was observed again only among those FSU

complainants and partners given the MJ treatment. Perhaps the failure to observe a significant difference between treatments on this measure among the FSU couples may have been due again to the small numbers involved, combined with the fact that this M.A.T. Scale includes specific items relating to marital adjustment which, compared to the other measures above, may be less central to satisfactory sexual interaction, - the principal focus of treatment.

In interpreting these findings, it is important to take into account the pre-treatment differences among the four problem groups in terms of marital satisfaction and other similar measures of the general relationship. It will be recalled that those females presenting with general sexual unresponsiveness perceived themselves, in relation to the VAG and PE complainants, as having a more impaired general relationship, as determined by scores on the marital satisfaction factor, and as less loving, less affectionate and less communicative compared to each of the other three problem groups. With the exclusion of those with vaginismus, this finding is consistent with the results of Mathews et al (1976), who also noted several trends pointing to 'a more generalised disturbance' among their female complainants.

The hypothesis of a differential treatment response in terms of marital satisfaction was based on the view that practice plus counselling would permit a greater opportunity to identify and correct communication difficulties, mismatched perceptions, resentment and other types of interpersonal conflict.

A similar hypothesis, for which there is some support, was also postulated by Everaerd and Dekker (1982); and Tullman et al (1981) also provide evidence of an enhancement of general interpersonal communication skills following the original intensive two-week sex counselling programme of Masters and Johnson. Foster (1978) also reports evidence of improved perceptual accuracy scores among couples who had undergone a modified Masters and Johnson approach - a finding which he attributed to 'better communication skills'.

Indeed, in the present study, when significant differences were found, on general relationship variables,

they were all in the predicted direction and were due largely to a significant improvement in marital adjustment among those receiving the MJ approach, rather than an exacerbation of pre-existing marital disturbance with the SH regime. The latter possible effect of minimal counselling procedures was raised by Mathews et al (1976), but evidence consistent with this view was found only among couples presenting with premature ejaculation, as will be discussed later.

Although there is some evidence that communication therapy may facilitate sexual and marital improvement, particularly among female partners presenting with orgasmic dysfunction (Everaerd, 1977), the present study does not, of course, permit the conclusion that it was the counselling component alone which, in this case, led to the more general enhancement of the sexual and marital relationship among the FSU subjects in the MJ group. On the other hand, the present results do strongly suggest that behavioural practice which affords minimal opportunity to deal with potentially obstructive attitudes or interpersonal difficulties, has in general little to offer couples presenting with female loss of libido, for whom these factors, relative to other dysfunctional groups, would appear to be more marked at the outset, and may perhaps have some bearing on the maintenance, if not the development, of the disorder. So the negligible effect of the minimal contact treatment for the FSU couples in this regard is consistent with other previous findings in this area. For example, Blakeney et al (1976) in discussing the effects of an intensive 2½ day workshop format for the treatment of a number of different sexual dysfunctions, reported that secondary orgasmic dysfunction (albeit a somewhat confusing term, as indicated earlier, and frequently embracing more general "excitement phase" disorders) was more resistant to change with this procedure and more often occurred 'in conjunction with other types of marital disturbance' (page 128). This finding has received consistent support from other clinicians employing groups (and therefore less intensive couple counselling) e.g. Leiblum et al (1976) and Wallace and Barbach (1974). Similarly, McMullen and Rosen (1979) reported that the presence of concurrent marital difficulties was associated with a poor response to self-help approaches in either written or video form.

Indeed, the present evidence of an improvement in both sexual and marital satisfaction only with the MJ approach among the FSU group is consistent with the findings of others (Everaerd, 1977; McGovern et al, 1975) which together suggest a relationship between sexual and marital adjustment among some female dysfunctional patients in particular. It is interesting that Morokoff (1978), in her discussion of the determinants of female orgasm, reports results by Terman (1938, 1951), Chesser (1956) and Gebhard (1966), all of whom found 'orgasm adequacy and marital happiness (as rated by women) to be highly correlated' (page 155). Despite the absence of any empirical evidence to support her impression, Kaplan (1974) also states that 'in contrast to the male, the female's sexual response is influenced to a much greater extent by the quality of her relationship with her lover' (page 357). While the present findings may be considered consistent with this view, it is recognised of course that increased female sexual satisfaction may be either a cause or a result of improved marital adjustment and that the design of the present study does not permit the identification of the effective ingredients of change, as noted above.

Nevertheless, in summary, the increased opportunity with the MJ approach for dealing with both aspects of the relationship was shown among this patient subgroup, to be associated with greater marital satisfaction, as hypothesised, and greater sexual adjustment compared to the SH approach. Indeed, the evidence so far suggests that there would appear to be little justification for the use of minimal contact programmes, with a virtually exclusive focus on sexual aspects of the relationship, with this patient group.

Vaginismus

A consistent finding of some importance in this study was the particularly favourable response to treatment, irrespective of its form, among those couples with vaginismus. Two series of analyses serve to highlight this particular finding, viz. separate non-parametric analysis of treatment outcome, within each diagnostic group, and two-way (Treatments x Problems) Analysis of Covariance.

Firstly, problem main effects from the latter set of analyses showed

that those females presenting with vaginismus, reported significantly greater general satisfaction with their sexual relationship (on the SMAR Scale), both at post-treatment and at follow-up, compared to the FSU and PE subject. There was a similar post-treatment trend on the same variable between the VAG and EI complainants (again favouring the former subjects) but this only reached significance at follow-up. This more favourable response to treatment generally among the VAG couples, on the same sexual satisfaction factor, was also endorsed by the partners. Although there was only a trend post-treatment ($p = .089$) in favour of the VAG group in relation to the EI partners, again a significantly greater level of sexual satisfaction was reported at follow-up by the partners of the VAG subjects compared to those of each of the two male groups.

Further evidence of a greater positive response to treatment generally among the VAG couples is provided by the measure of specific anxiety about the presenting symptoms during sexual play. Thus, both at post-treatment and at follow-up, the VAG complainants reported significantly less tendency to "spectate" compared to the complainants in the PE and FSU groups. Although the post-treatment difference between the VAG and EI complainants just failed to reach significance ($p = .062$) the consistency of the trends was clear, in each case in favour of the VAG group.

Moreover, the partners of the VAG subjects were rated post-treatment as experiencing sexual intercourse as a postive event significantly more often than the partners of each of the other three groups - a finding in striking contrast to the pre-treatment relationship among the problem groups on this measure.

It should be noted, however, that the VAG group as a whole had lower pre-treatment scores on this variable, compared to other problem groups and, therefore, greater scope for change. Yet another important consideration is raised by such interproblem group comparisons on dependent measures of coital satisfaction.

Because patients with different problems vary pre-treatment, as one might expect, on a number of salient aspects of sexual functioning and

marital adjustment, their needs and expectations from treatment may be correspondingly different in certain respects. Thus, the patients' own criteria by which coitus is judged as being pleasurable or satisfactory may vary across problem groups. For those with vaginismus or erectile impotence, the simple physical ability to engage in intercourse may be the primary determinant of how satisfactory the experience is considered to be. On the other hand, the quality of the coital experience may be a more central consideration among those with premature ejaculation and female unresponsiveness. This point could of course also apply to other aspects of sexual activity, but is particularly worth noting here, given that coital satisfaction was one of the primary goals of therapy.

In short, therefore, the VAG group following therapy may have been more "easily pleased" with the reinstatement of coitus per se, or, in most cases, with the new opportunity to consummate their relations. This would be in contrast to others, particularly the PE and FSU groups who could already engage in intercourse and whose aims may have been more closely concerned with coital pleasure. So this factor could have influenced the above findings, and is an issue which, as noted below, has implications for the way goal attainment should be measured when mixed dysfunctional samples are compared in treatment outcome studies.

The particularly favourable response of the vaginismus subjects, irrespective of treatment form, is similarly indicated by the results of separate non-parametric analyses of the data within each problem group. Thus, the VAG subjects were the only problem subgroup to show significant pre-post treatment improvement, with <u>both</u> treatments on any variable. More specifically, the MJ and SH treatments each effected significant pre-post treatment improvement for these subjects in terms of degree of sexual pleasure (PAD Scale); frequency of both negative and positive coital experiences; ratings of "myself" on the erotic arousal factor of the semantic differential; general sexual anxiety (PAD Scale); the tendency to "spectate" during sexual play; and general sexual satisfaction (SMAR Scale). So widespread was the improvement effected by both treatments for the VAG group that a differential treatment response was observed on only two measures, in

each case in favour of the MJ approach: the post-treatment measure of the degree of enjoyment of intimate foreplay (as a result of non-significant changes with each treatment) and the tendency to 'spectate' which was less marked at follow-up with the MJ treatment.

It seems reasonable to infer that couples presenting with vaginismus may have responded equally well in general to the two treatments, partly at least because of the evidence indicating a less generalised impairment of the sexual relationship before therapy, compared to the other three problem groups. Pre-treatment comparison among the dysfunctional subgroups showed that, while the VAG complainants reported, in relation to each of the other three subgroups, significantly lower coital enjoyment and coital frequency and higher sexual anxiety, they also were rated as experiencing a greater enjoyment of intimate foreplay. As noted earlier, such a less generalised impairment of sexual functioning among those with vaginismus has also been reported by Malleson (1942; 1951), Stourzh (1961), Friedman (1962), Ellison (1968) and Lamont (1977).

In addition, there was evidence that couples with vaginismus rated their marriage as more satisfactory than those females presenting with general sexual unresponsiveness (a finding which would not appear to be an artefact of the duration of cohabitation as there was no significant difference between these two subgroups on this measure). Together these results suggest that vaginismus may be more amenable than the other disorders to both minimal contact and conventional regular counselling approaches, in view of the apparently more clearly circumscribed nature of the problem, being characterised principally by coital anxieties with relatively little disturbance of the marital and non-coital sexual relationship.

This interpretation is congruent with the suggestion by Mathews et al (1976) that those with few interpersonal and communication difficulties may respond rather better, than those with many, to simple behavioural directives. It is also consistent with their view that desensitisation may only be indicated where there is a more clearly defined phobic quality to the disorder. Insofar as the current evidence suggests a more "coitally phobic" quality to those vaginismic

subjects in the present study, and that much of the specific behavioural package may be construed as sharing some of the features of an in vivo desensitisation model, this may help explain the equally favourable response among the VAG group to both the SH and MJ approaches.

Of course, any conclusions drawn from such a small sample must be tempered by several important qualifications at this stage and, as mentioned at the outset, it is important to construe the present research as preliminary to further detailed replication. At this point, however, and particularly in view of the favourable results, it would be important to examine the representativeness of the sample and to determine whether it may have been biased toward a favourable outcome with either treatment.

There has hitherto been little sound evidence on the incidence of concurrent marital disturbance among couples presenting with vaginismus. Lamont (1977) reported that about half of his sample of 80 vaginismus patients had 'moderate to severe interpersonal problems'. Eicher (1980) also states that, in his sample of 52 couples with vaginismus as the main complaint, 'in about all cases' ... there were 'problems of interaction' (page 587). There is no account, however, of any formal measures of marital adjustment being employed or of how this estimate was reached. It is also uncertain how these groups of patients relate to other dysfunctional samples in terms of marital adjustment.

O'Sullivan and Barnes (1978), on the other hand, in a study of 46 couples with vaginismus, found serious marital conflict to be a prominent feature only among the 22 couples in their sample who dropped out of therapy. Evidence of greater general disturbance among those who failed to complete therapy is also reported by Ellison (1968). However, since the tendency to drop out of therapy, in the former study, was found to occur within the first four visits (O'Sullivan and Barnes, 1978) it may be argued that the policy in the present study of replacing those who defaulted within this period may have contributed to a highly skewed sample comprising mainly those with a particularly favourable prognosis. In fact, only one out of fourteen couples "dropped out" within the first 5 weeks and was therefore replaced

- perhaps this again suggests that the original sample was unrepresentative. This seems unlikely, however, as ten of the fourteen couples had received prior unsuccessful treatment, a factor which has been reported as being associated with greater subsequent management problems (Friedman, 1962; Ellison, 1968). Although age, presence of a dysfunction in the partner and duration of the relationship have been reported as being unrelated to prognosis (O'Sullivan and Barnes, 1978), Ellison (1968) suggests that the duration of the relationship may be directly related to duration of treatment. The mean duration of marriage in the latter sample was reported as being 'about 2 - 5 years'; in O'Sullivan and Barnes' sample, the modal figure was 4 years. In the present study, the mean relationship duration was 6 - 25 years (median = 5 years; modal = 7 years), a figure which closely parallels the problem duration, as primary apareunia was the most common presenting feature (occurring in 12 of the 14 patients). In general, therefore, there is little to suggest that the vaginismus sample was unrepresentative or obviously biased toward a favourable outcome, at least according to the above criteria.

It should be stressed again, however, that sound empirical data relating to the sexual, marital and general psychological adjustment of vaginismic patients and their partners are as yet largely lacking due presumably in part to their relatively infrequent referral to sexual problems clinics (Bancroft and Coles, 1976). In addition, it is widely agreed that the prognosis for such couples is generally favourable (Masters and Johnson, 1970; Kaplan, 1974; Fertel, 1977; Eicher, 1980) an observation which has perhaps contributed to a paucity of sound descriptive data on those who fail to benefit from established treatment methods. There are reports of some cases of vaginismus in which the problem is felt to be part of a more global personality or/and psychosomatic disorder in which hypochondriasis, recurrent insomnia, general anxiety, tension headaches, palpitations, hyperventilation, psychogenic vomiting, etc. may also be implicated (cf. Mikhail, 1976; Dawkins and Taylor, 1961). In such cases a simple phobic element has been construed as less relevant than more profound personality and neurotic difficulties including, for example, conversion hysterical factors. In these the presumed aetiological significance of early sexual trauma (e.g. incest or rape experiences) with

a subsequent neurotic defense against intense guilt and a "fear of success" has been emphasised (Kaplan, 1974; Mikhail, 1976). For such cases, it therefore seems probable that a minimal contact approach would be of little value.

Secondly, the author knows of no other study of the effectiveness of a self-help approach for vaginismus. Mathews et al's (1976) sample included only one case of vaginismus and other studies of conjoint counselling and desensitisation (e.g. Crowe et al, 1981) have specifically excluded such cases.

Thus, that this present study should be regarded only as preliminary and that there is a need for further replicative research using a larger sample is again indicated.

Premature Ejaculation

In striking contrast to the general improvement observed among the VAG subgroup as a whole was the particularly poor outcome found among each of the male problem groups, particularly those with premature ejaculation.

Indeed, the results for the PE subgroups showed that there was no significant improvement with either therapy on any variable. Only two significant pre-post treatment changes were observed and both indicated a deterioration in the quality of the general relationship among those couples receiving the SH approach.

Thus, compared to the pre-treatment level, the female partners of the PE subjects given the self-help approach not only rated their marriage as significantly less well-adjusted after therapy (as measured by the Locke-Wallace M.A.T.), but were also rated by their complainant spouses as significantly less loving. Consistent with such significant negative marital changes were similar trends, from pre-post treatment comparison, toward greater reported marital dissatisfaction by the end of treatment among PE couples given the SH approach: a trend which almost reached significance among the complainants ($p = .07$, two-tailed).

Although these changes did not contribute to a significant difference

between treatments, the consistency of the trends is such that it raises the possibility that the specific demands of a behavioural treatment for premature ejaculation on the female partner in particular, without the opportunity for identifying and dealing with them, may impose further strain on the relationship generally. Such potential demands involve the clear emphasis placed on the female's active involvement in a procedure which may be construed as implying an unavoidable degree of self-sacrifice, particularly on her part, at a time when her needs in the relationship may be unmet, or perceived as ignored.

The relationship (in some cases a mutually reinforcing one) between premature ejaculation and loss of sexual interest in the partner has been well documented (Bancroft, 1975; Levine, 1975). This relationship is to some extent reflected in the results on a number of measures.

Consistent with the poor results observed with both treatments, the PE partners were rated post-treatment by their husbands as being significantly less "loving" and experiencing less pleasure from intercourse compared to the corresponding ratings of the partners of each of the other three problem groups. The PE partners themselves endorsed the latter result by reporting significantly less general sexual pleasure post-treatment and a significantly greater tendency to "spectate" on their sexual behaviour at follow-up, compared to the partners of each of the female problem groups. To some extent then,

the nature of the above changes and interproblem differences may be considered consistent with the evidence, both informal and empirical, that the relationship between marital and sexual satisfaction may be much closer, and possibly interdependent, among females with some general impairment of sexual interest, than among sexually dysfunctional males. As noted above, similar observations have been reported by Kaplan (1974) and are in keeping with some of the findings of Everaerd (1977) and McGovern et al (1975).

Thus, almost all of the significant negative changes and interproblem differences involved the partners of the premature ejaculators. These results may be regarded as lending further weight to an interactional view of sexual dysfunction but, of course, they still demand careful interpretation. While they may appear to reflect primarily the continuing effects of premature ejaculation on female sexual functioning, and vice versa, they may also be, in part, a function of the differing behavioural demands on each spouse in the treatment of premature ejaculation. Thus, interpretation of such results must account for a number of factors including each partner's behavioural role in therapy, the conjoint sexual difficultues of the couple, each partner's perception of the aims of the programme and of treatment progress itself, all of which may interact to influence outcome. The potential relevance of such factors to the particularly poor response of the premature ejaculators to treatment in the present study requires further investigation.

The generally poor, and in some respects negative response to treatment in the present study is in striking contrast to the remarkably successful results in the management of premature ejaculation reported by others using similar treatment methods. For example, Masters and Johnson (1970) reported an initial failure in only four out of 186 couples with premature ejaculation (2.2% initial failure rate) and only one relapse during their five year follow-up - an overall failure rate of 2.7%.

Similarly, Hastings (1971); Prochaska and Marzilli (1973); Clarke and Parry (1973); Adelson (1974); Lobitz and Lo Piccolo (1972) and Yulis (1976) all report highly favourable results using procedures largely based on that of Masters and Johnson.

As noted earlier, there has also been a large number of studies of the effectiveness of less intensive individual and couple counselling for this dysfunction. Thus, Kaplan et al (1974), Zilbergeld (1975), Zeiss et al (1978) and Golden et al (1978) all report a satisfactory outcome in the majority of patients with premature ejaculation treated either in male only, or couple only group formats. More important the present results are in stark contrast to the more favourable outcomes reported by Lowe and Mikulas (1975) and Zeiss (1977b) in their studies of the efficacy of minimal contact bibliotherapy for premature ejaculation.

There are, of course, numerous weaknesses in many of the above studies which confound clear interpretation and generalisation. These range from variable definitions of treatment outcome and of the disorder itself, to other fundamental methodological weaknesses relating to sample representativeness and methods of assessment. In general, however, despite these deficiencies, the consistency of the previous results suggests that both frequent and minimal counselling may be a reasonably effective and efficient means of treating some cases of premature ejaculation. It is unfortunate, however, that there is still a paucity of sound evidence relating th those variables which may influence outcome. As a prelude to further more detailed investigation, it may be of value to examine the possible reasons for the notably poor results obtained with both treatments for this disorder in the present study. These may be grouped under three main headings: patient characteristics; treatment characteristics; and scope for measurable change.

Patient characteristics:

As noted already, there is some largely anecdotal evidence that the presence of more general marital difficulties may in many cases contraindicate the use of minimal contact programmes (Blakeney et al, 1976; Leiblum et al, 1976; Zeiss et al, 1978; McMullen and Rosen, 1979) in keeping with the present findings for those with female sexual unresponsiveness. The results of pre-treatment comparison among the problem groups in the present study, however, do not indicate that couples with premature ejaculation report significantly greater marital maladjustment or dissatisfaction compared to other problem

groups. Indeed, the mean marital adjustment scores reported by complainants and partners in the PE group were within normal range, according to the data provided by Locke and Wallace (1959).

Similarly, in terms of educational level, only two complainants in each treatment group left school prior to 'certificate level'. There is no reason to suppose, therefore, that the sample was less likely on intellectual grounds to benefit from treatment.

Although Zeiss (1977b) failed to observe a relationship between individual differences and outcome - a finding which he concedes requires replication in view of the small numbers involved - Cooper (1969b) identified, from purely clinical impression, three separate types of premature ejaculator, two of which in particular, he maintains, have markedly different prognoses.

Thus, premature ejaculation of acute onset associated with a discrete psychological event and often occurring against a backdrop of sexual inexperience and coital anxiety (Type 2) was considered to be associated with a more favourable prognosis than that category in which the dysfunction had been present since adolescence (Type 1). Cooper's third type of premature ejaculation, occupying an intermediary position in terms of outcome with his treatment approach, was of insidious onset, with poorly formed or absent erections, a gradual decline in erotic interest, and less clear associated anxiety.

This classification is similar to that proposed for erectile impotence (Cooper, 1968; Ansari, 1975) but in the absence of adequate statistical validation of his classification of patient types, more methodologically sound confirmation of their purported relationship to treatment outcome, and, given a number of important differences between Cooper's treatment and a modified Masters and Johnson approach, it is inappropriate to extrapolate directly from this report to the present study. On the other hand, there does appear to be a consensus based largely on clinical observation that the following factors may be of generally positive prognostic significance for male disorders (Bancroft, 1971a):

(a) problem of recent onset.

(b) satisfactory sexual performance has occurred in the past (i.e.

that the problem is secondary).

(c) The problem developed acutely rather than insidiously.

(d) Absence of severe personality disorder, marital discord, undue religious orthodoxy or homosexual propensity in either partner.

(e) That both members are prepared to co-operate and be actively involved in treatment together (Prochaska and Marzilli, 1973; Blakeney et al, 1976; Bancroft, 1971a; Cooper, 1969a, b; Masters and Johnson, 1970; Kaplan, 1974).

Examination of the data shows that for the ten PE complainants (average age = 32.1 years, range 23 - 47) the average duration of the problem was 5.5 years (range 1 - 10 years). Thus, the sample's mean age was lower and the average duration of the problem was almost half as long as that reported in a comparable group referred to a psychosexual clinic in Oxford (Bancroft, 1975). Problem duration in itself, however, may have little significance for outcome outwith some recognition of the length of the relationship. Thus, calculation of the proportion of the entire duration of the sexual relationship in which premature ejaculation was present revealed that, in four of the ten cases, the problem was present from the start (i.e. 100% in each case); in one case it was present for 91% and in another four cases was present between 71% and 77% of the sexual relationship's duration. In the one remaining case, premature ejaculation was present for only 40%. In the absence of any normative data to give meaning to the term "recency of onset", it is clear that in a substantial proportion of cases premature ejaculation characterised the sexual relationship virtually from its onset, despite the relatively short duration of the problem. Although the problem was 'secondary' in six cases, the premorbid period of the relationship was judged to be fairly brief for five. Unfortunately, it is not possible to compare these data across studies, but it may be tentatively proposed that this factor may have contributed to the poor outcome in the PE sample as a whole. The data are also consistent in this respect at least with Cooper's (1969b) Type 1 patient for whom poor ejaculatory control was an early and constant feature and for whom the prognosis was considered to be relatively poor.

However, extreme caution should be exercised in using these factors as

the basis for any post-hoc assessment of potential sampling bias. Firstly, there is no adequate validation of their prognostic significance, and secondly, it is important to bear in mind that an early pattern of rapid ejaculation forms the basis of an autonomic conditioning theory of the aetiology of premature ejaculation (cf. Masters and Johnson, 1970). From this theory it would be reasonable to hypothesise that premature ejaculation would indeed be of early onset and therefore typically present throughout most of the relationship. Thus there is no strong evidence on these grounds that this small sample is unrepresentative.

There was no evidence that religious orthodoxy, homosexuality or personality disorder characterised the sample. The degree of co-operation and motivation shown by both partners are difficult to assess formally, but the fact that females derived little or no benefit from treatment and, if anything, showed negative marital changes, particularly with the SH approach, may reflect in part, and may also have contributed toward, a less than satisfactory degree of co-operation between partners.

Treatment Characteristics

The above speculation clearly requires further examination, but it may be reinforced by informal evidence, during the course of counselling sessions, of a failure among many of the couples to comply with therapy at home. The principal source of concern was the 'squeeze technique' and many reported a difficulty or unwillingness to adhere regularly to the advice to practise this procedure at the prescribed frequency. There was no previous evidence, or indeed any other factor, to suggest that this might be a problem, but the most common reasons offered for this compliance problem were that it was both awkward to administer, particularly at the time required, and that is was perceived as too intrusive and disruptive of the more spontaneous sexual "pleasuring" which preceded it.

It is recognised that these expressed reasons may have served to disguise other resistances, particularly on the female's part, but the failure to ensure an initial compliance with treatment seemed to be a factor contributing to an early decision among some of the couples to

discontinue treatment. This pre-empted resolution of these possible "resistances". It is the author's subsequent impression that the Seman's stop-start procedure is more readily taught and conducted - an observation also reported by Zilbergeld (1975). Other clinicians, however, have not reported any differential compliance or effectiveness with the 'squeeze' and Seman's procedures, and so the additional possibility that the author, as therapist,may have been transmitting, albeit unwittingly, a personal lack of confidence in the former technique or/and expertise as instructor cannot be discounted.

On the other hand, the role of sensate focus in relation to the 'squeeze' technique has been proposed as a possible factor contributing to poor outcome in the treatment of premature ejaculation. In contrast to most of the studies of group approaches for this disorder, Blakeney et al (1976) reported total symptom reversal in only eight of their seventeen premature ejaculators (i.e. 47%). They attributed this relatively poor outcome to the brevity of their programme (a 2½ day workshop format), lack of continued practice post-treatment, and to the possibility that the de-emphasis on coital performance and the simultaneous emphasis on mutual non-coital "pleasuring" with sensate focus may detract from the perceived importance of the 'squeeze' technique, the latter considered by them to be the sine qua non of effective control. This is an interesting proposal as the possibility that sensate focus may be an unnecessary component of the Masters and Johnson procedure and even 'a hindrance' for premature ejaculators has also been raised by Mikulas (personal communication) following comments expressed by many of the couples in their bibliotherapy study (Lowe and Mikulas, 1975). This is an issue which clearly demands further study, since findings by Zeiss (1977b) would imply otherwise. He found that improvement of the sexual relationship as a whole was the only significant post-treatment correlate of sustained improvement at follow-up. This may suggest, therefore, that sensate focus, and a consequent general enhancement of sexual pleasure, may indeed by relevant to outcome, although this may not necessarily be evident immediately after treatment.

In short, therefore, the logistics of the 'squeeze technique' and apparent compliance difficulties, possible therapist bias or/and

inadequately presented advice (whether written or oral) or counselling, may have contributed to the generally poor results with this problem group. The additional possibility that the relationship between sensate focus and the 'squeeze technique' may in some cases be counterproductive also warrents further examination.

Scope for Change

Finally, the limited number of significant changes observed with either treatment within each of the two male subgroups may have been due in part to the small numbers involved and to the generally higher baseline scores recorded pre-treatment among the male complainants compared to the females. Thus, there would seem to be relatively less scope for identifying measurable change among this PE group - and particularly among the male complainants.

An additional factor worth noting is that Zeiss et al (1978), in their study of a male only group treatment for premature ejaculation, observed that, despite increased recorded ejaculatory latencies (post-treatment range from 3.5 to 13 minutes), post-therapy self-reports of frequency of premature ejaculation were still fairly high, being in the range of 50% to 75% of coital experiences. Although premature ejaculation is defined in terms of more than ejaculatory latency alone, Zeiss et al (1978) suggest that this apparent inconsistency between these measures may reflect unrealistic expectations of adequate ejaculatory control among such patients. It is possible, therefore, that similar expectations may also have coloured to some extent the patients' self-assessment of post-treatment sexual functioning and adjustment in the present study. However, given the consistency of the trends, endorsed by both spouses, it seems unlikely that this potential effect was a major influence on the outcome measures.

To sum up, the outcome for those couples with premature ejaculation was uniformly poor, irrespective of therapy form. A number of possible reasons for this are proposed, including the lack of opportunity for resolving general relationship difficulties with the self-help format (which may help explain in part the pre-post therapy deterioration in general marital adjustment among minimal contact couples), apparent failure to comply adequately with the specific behavioural

techniques prescribed, patients' aims and expectations from treatment, small sample size and limited scope for the measurement of significant positive change.

Erectile Impotence

As with the PE subgroup, only limited changes were apparent from non-parametric analyses of within treatment group scores among the impotent subjects. Thus, the MJ approach only was associated with a significant pre-post treatment improvement on three measures: general sexual satisfaction; the tendency to spectate; and ratings of "myself" on the "erotic arousal" factor. Similarly, only two significant positive changes were found with the SH approach: the proportion of positive non-coital experiences; and general marital satisfaction. However, only one significant difference between the treatments was found and this was on the marital satisfaction factor (SMAR). Unexpectedly, in view of the hypothesised superiority of directed practice and counselling with respect to marital adjustment, the EI subjects who received the minimal contact programme reported greater marital satisfaction immediately following treatment compared to those receiving the MJ approach, due to a significant pre-post treatment improvement only with the SH approach. Although this treatment difference was not maintained at four month follow-up, (and indeed there was a near significant relapse $p = .08$, two tailed on this measure as determined by post-treatment/follow-up comparison from the complainants' data), the fact that the female partners also endorsed this treatment difference strengthens the case against its being a chance finding. Since this difference is in the direction opposite to that predicted, it is not at all clear why, in this respect, the SH programme should be more effective than the MJ approach for these couples. Of course, post hoc speculation about the possible reasons for this finding, without replication of the effect from further research involving a larger number of subjects, may be considered unreasonable at this stage. However, as a prelude to further research, the following factors may be tentatively proposed as contributing to the above treatment difference.

Firstly, it is possible that some findings reported by Carney et al (1978) may have some bearing on the above effect. In a comparative

treatment study involving couples whose main complaint was female sexual unresponsiveness, they observed that less frequent, i.e. monthly as opposed to weekly, counselling sessions were associated with the male partner being rated by his wife as more loving and less tense than those having weekly sessions. One possible interpretation of these results is that less frequent counselling may be perceived as less demanding and involve less pressure on "performing" for these males, which, in turn, may have an effect on their general attitude toward their spouses in the relationship. Perhaps minimal counselling in the present study had a similar effect on the impotent subgroup, so that the potential demands of treatment, and in particular those conceivably imposed by regular "in person" contact (with its focus on both sexual and general relationship issues) may have been perceived as less intense with the self-help programme. Clearly, however, this particular difference between treatments was apparent only among the EI couples and was in the direction opposite to that found in the FSU subgroup. The specificity of this effect with regard to problem category still, therefore, requires to be explained.

One possibility is that such treatment demands, and particularly the pressure on performing sexually, may be greater among those with erectile impotence compared to other forms of dysfunction - in view of the purported close association between erectile functioning and male self-esteem (Kaplan, 1974). Although such a view may seem intuitively reasonable, the only measure which comes close to measuring such performance pressures is the "tendency to spectate", but no significant pre-treatment differences were found among the problem groups on this variable.

It may also be of value to examine in the future the possibility that the specificity of the above effect concerning marital satisfaction may relate to the degree of spouse agreement with respect to their concern about the nature of their general relationship (a factor perhaps partly related to reciprocity) and consequently to the perceived need for counselling. Although there is some evidence that EI males reported less impairment of communication patterns and affection toward the partner, compared to the FSU complainants, perhaps a more relevant focus of examination in this regard may be the degree of concordance

between dyad members on the perceived importance of attitudinal, communication and other general relationship issues in maintaining their sexual problems. Thus, it remains uncertain whether in the present study counselling may have been construed as not only unnecessary by both partners in the EI group, but also as promoting undue attention to relationship issues of less primary concern for these couples.

However, it is important to reiterate that any such proposal can only be very tentatively made at this juncture not least because this apparent specific SH superiority in terms of marital satisfaction among the EI group clearly warrants further examination and replication before firmer conclusions may be drawn. This may be considered to be particularly necessary in view of the absence of any other significant differences between treatments and in view of the trends from within treatment group analyses, which, for the most part, favoured the MJ approach.

This apparently minimal response to either treatment is again noteworthy given the fact that half the couples in each treatment group were considered post-treatment to have achieved therapy goals. There is evidence, however, that the specific criterion of goal attainment used, based in terms of reported frequency of satisfactory sexual intercourse over, at most, an eighteen day period during treatment, may not have been the most sensitive or appropriate global measure of improvement for this patient group. If, for example, the criterion were redefined in accordance with Masters and Johnson's (1970) own apparently more rigorous standards of treatment "success", to include only those impotent patients who could sustain an adequate erection throughout intercourse on more than 75% of occasions, the data reveal that only three (rather than six) of the twelve patients would be considered to have been successfully treated (2 in the MJ group and 1 in the SH group). Thus, despite confirmation by the non-complainant partner of goal attainment during the course of therapy, 50% of this "improved" group were subsequently shown, from independent ratings, to be able to engage in satisfactory intercourse between 25% and 75% of occasions only - a mean change on the blind rating scale of 5.3 points

as opposed to 6.6 points among the "unequivocally improved" group using Masters and Johnson's criterion. Clearly, therefore, continuing difficulties among a substantial proportion of the impotent sample, including those deemed to have attained the treatment goal, may help account in part for the limited changes following treatment, irrespective of format, in this problem group.* Such findings concur with those of Levine and Agle (1978) who observed that, despite an initial improvement rate of 68.8% among 16 couples, presenting with secondary impotence, 'most of these men, despite improvement' (in erectile functioning) 'continued to have profound disturbances in their sexual lives' (page 246).

From the methodological standpoint, it seems clear that global informal reports of goal attainment, particularly when obtained by means of telephone contact in the case of self-help subjects, may not, in themselves, be the most reliable means of obtaining clinically relevant measures of improvement - at least with this problem group. Moreover, the fact that a fairly large proportion of these patients still complained of erectile difficulties at the end of treatment has important clinical implications, as there is evidence that incomplete treatment may predispose patients to relapse (Eysenck, 1963; Munjack et al, 1976; Zeiss et al, 1978). Unfortunately, the failure to secure sufficient follow-up data to permit full statistical analysis pre-empts adequate appraisal of this potential effect.

As noted above for the PE subgroup, another important factor which may also help explain the limited treatment effects among the impotent patients may be the higher reported baseline levels of sexual satisfaction on a fairly wide range of sexual measures. The evidence that the male complainants tend to report, pre-treatment, less generalised impairment of their sexual relationships, compared to the female complainants, has already been discussed. It may be relevant here to note that Levine and Agle (1978), in proposing possible reasons for the poorly sustained sexual improvement in their sample of impotent patients, suggest that couples, at initial assessment, and 'dominated by their hopes for improvement' ... 'often unconsciously minimise the significance of their anger and emotional isolation during the evaluation' (page 248). This is consistent with a similar proposal by

* See Appendix 7, Table 164.

Frank et al (1978). The possibility that this may account, in part at least, for the higher pre-treatment scores in the present sample of male dysfunctional patients cannot be discounted.

There is, to date, no adequate study of the efficacy of behavioural bibliotherapy for erectile impotence. Most cost-effectiveness studies have been restricted to group treatments. Thus, Lobitz and Baker (1979) reported a successful outcome in six out of nine single men with erectile impotence and, following a 2½ day workshop format, Blakeney et al (1976) reported total symptom reversal in seven out of eight couples with secondary impotence as the main complaint. Zilbergeld (1975) obtained similar results, but it is clearly difficult to extrapolate from these studies in view of the obvious differences in format and procedure between group and self-help approaches and that a fair amount of counselling was included, in addition to specific behavioural techniques, to supplement sensate focus and other behavioural aspects of the MJ approach in the above "group" studies.

Similar factors, but particularly differences in sample characteristics, and various improvement criteria confound comparison of the present findings with those reported by others using regular counselling (e.g. Masters and Johnson, 1970; Lobitz and Lo Piccolo, 1972; Meyer et al, 1975). In general, most of the studies report an immediate post-treatment "improvement" in about two-thirds of couples seen.

Although one may in any case expect less favourable results from an unselected sample of cases presenting at an NHS clinic and despite the small number of couples within each treatment group, it may be again of value to determine whether those who may be considered to have a poorer prognosis were over-represented in the present sample.

Johnson (1965), Rees (1935), Kaplan (1974), Masters and Johnson (1970), Levine and Agle (1978), Reynolds (1977) and Ansari (1976) have all reported on the factors believed to be of prognostic significance in the treatment of erectile dysfunction. These factors closely parallel those reported for premature ejaculation and will, therefore, not be reiterated here. To a large extent, these factors still require to be adequately validated, but, at present, they serve as a good yard-

stick by which the prognostic characteristics of the sample may be roughly assessed.

Firstly, it is of note that the sample included only two patients with primary impotence (one in each treatment group) and both were noted as successfully treated by the independent assessor post-treatment. These patients were also the youngest in the sample and the onset of the problem in each case was clearly acute, in response to a discrete and stressful event and was maintained in part by mild vaginismus in their partners. They were also the only patients in this subgroup who could be fairly clearly classed as Type I impotence according to the criteria of Cooper (1968) and Ansari (1975; 1976). The outcome for these cases, therefore, highlights perhaps a need to account for additional factors of more specific aetiological significance than the distinction between primary and secondary impotence per se, in assessing prognosis for erectile impotence.

On virtually all salient subject variables (i.e. duration of problem, age of complainant, presence of concurrent sexual dysfunction in the complainant) there was no evidence that the present sample differed appreciably from those described by Bancroft (1975) and Mathews et al (1976) in a comparable setting. Similarly, there was no evidence in this subgroup of significant marital difficulties, a factor associated with poor outcome in Levine and Agle's (1978) and Mathews et al (1976) studies. However, the proportion of couples in whom a sexual difficulty was also present in the female partner (seven out of twelve, i.e. 58.3%) was more than twice as high as that reported by Bancroft (1975) and about 20% higher than that in Levine and Agle's sample. It is difficult to determine, however, whether this represents a genuine difference between the present sample and those of other studies, given the failure in general to specify clearly the nature of these "partner dysfuctions" in those studies and the potentially variable definitions across studies as to what may constitute a "problem" as opposed to a "difficulty" in the partner, etc. In any case, there is also evidence that a distinction between symptomatic and asymptomatic partners may not be a particularly meaningful one clinically and, moreover, may not have prognostic significance (Cole et al, 1979). There is, therefore, again no clear evidence to suggest that the present sample,

compared to that of other related studies, was biased toward a less favourable outcome generally.

In summary, the global results in terms of goal attainment would indicate that each treatment was successful in only 50% of cases. Such apparent improvement, however, was not reflected in the other continuous measures of sexual and marital adjustment and indeed, when improvement was redefined in terms of Masters and Johnson's criteria of "non failure" the results are even less favourable. As with the PE group, both treatments were associated with minimal change, but the conclusion that neither therapy is particularly effective in dealing with this problem should be tempered by certain obvious qualifications, e.g. sample size, a possible tendency among complainants to minimise the extent or severity of the problem, the nature of the criteria for assessing goal attainment - and, therefore, for discontinuing therapy.

Interaction Effects Between Treatments and Problems

The above discussion has been concerned with an interpretation of the relative treatment effects for each diagnostic group separately - such a breakdown being prompted largely by the widespread significant pre-treatment differences shown to exist among these four problem groups. However, it is also apparent, even from such discrete problem group analyses, that these different subgroups do not appear to respond uniformly to each of the two treatments, i.e. that the relative effects of the treatments would seem to differ in some important respects among the problem categories. In particular, there are a number of significant differences between treatments, both at post-treatment and at follow-up, among the FSU couples, which are absent or are in a direction opposite to that found among other patient groups. The study was so designed as to permit a preliminary examination of these differences since:

(a) their identification may enhance our understanding of which treatments may be more or less appropriate for particular disorders - a research aim which has received strong support in recent years (Reynolds, 1977; Lo Piccolo, 1977; Sotile and Kilmann, 1977; Hogan, 1978);

(b) the results of such an analysis may also have implications for the future design of similar outcome research in this field.

The analysis in question involves a study of the interaction between treatments and problems and indeed significant interaction effects were found on four variables.

The first of these involved self-ratings of general marital satisfaction. While there was no evidence of an overall treatment main effect, the FSU problem subgroup, as predicted, was shown to have responded significantly better, both at post-treatment and at follow-up to the MJ approach compared to the SH treatment. There was also evidence that this difference between treatments within the FSU group was itself significantly greater both at post-treatment and at follow-up than that found among the EI subjects, who, it will be recalled, showed a significantly more favourable response post-treatment to the SH approach. This significant interaction effect was also confirmed, post-treatment only, by the partners of the FSU and EI groups.

That this effect may not be wholly explained in terms of sex differences is suggested by the fact that a similar interaction effect on the same measure was also found between treatments and the PE and EI groups - those with premature ejaculation reporting an impairment of marital satisfaction with the SH approach, while the opposite was found among those with erectile impotence. The FSU and VAG groups also responded differently to the two treatments in terms of marital satisfaction, with a strong interactive trend post-treatment ($F\ [1,21]\ 3.95$, $p = .06$) which reached significance at follow-up.

As for all interaction effects, it is conceded that the relatively small numbers in each cell may increase the chances of Type 1 error and that the above findings should of course be replicated in a further larger study before firmer conclusions may be drawn. Nevertheless, the consistency of the results is noteworthy.

Thus, with regard to non-sexual adjustment, there was additional evidence that the relative treatment effects varied according to type of disorder. This was found on ratings of "myself" on the "loving" factor of the semantic differential and the results on this measure closely paralleled those from the marital satisfaction factor reported above. Again, the significant difference between treatments for the

FSU complainants (favouring the MJ approach) was itself significantly greater than that for the EI group.

Consistent perhaps with the reported relationship between marital and sexual adjustment among some sexually dysfunctional females in particular (Kaplan, 1974; Everaerd, 1977; McGovern et al, 1975) was the third significant treatments x problems interaction effect. This was evident on self-ratings of general sexual pleasure. It will be recalled that, for the FSU group only, the MJ approach was associated with almost significantly greater self-ratings of sexual pleasure both at post-treatment ($p = .08$) and at follow-up ($p = .07$) compared to the SH approach. This treatment difference was, moreover, shown to be greater than that observed within the PE and EI groups. Perhaps, therefore, the failure of a minimal contact therapy to deal adequately with general relationship issues among the FSU couples, combined with the emphasis in counselling on communication about sexual preferences, may account to a large extent for the relative ineffectiveness of the SH approach in producing sexual improvement for this group.

Interpretation and discussion of the precise nature of the differences which contribute to these interaction effects have already been covered above in the examination of treatment effects for each problem group independently. In any case, it is particularly important to stress that it is not possible (and in any case it was not an aim of the study) to provide clear and unequivocal interpretation of these pre or post-treatment differences among the problem groups. In the first instance, the aims in this respect were exploratory, i.e. to determine whether such interaction effects would be found rather than provide a framework for their interpretation. It is, therefore, argued that it is the demonstration of their existence per se which has particularly important implications for future research. The results with regard to aspects of the general relationship and sexual pleasure indicate that some effects of the treatments are not additive across problem subgroups, and that failure to account for this possibility in the choice of design and analysis in future similar research may obscure to some extent the identification of which treatments may be more or less effective for particular disorders. Moreover, the present findings also suggest that this possible effect may not be wholly resolved by

focussing only on female or male dysfunctional groups: as noted above, significant interaction and problem main effects were found when the analysis was confined to female only or to male only problem groups. One cannot assume of course that the present results provide an explanation for previous reports of a response variability within other comparative treatment studies employing a mixed dysfunctional sample (e.g. Mathews et al, 1976; Crowe et al, 1981). The samples in each case differed from the present patient group - vaginismus, in particular being largely absent - and the treatments differed too. Nevertheless, the results suggest that future treatment outcome studies should be so designed as to allow an examination of the effects of sex therapy on discrete problem groups, particularly when therapy involves minimal counselling. As noted in the introduction, that such distinctions among the main forms of dysfunction should be made in outcome studies has been supported by others (e.g. Reynolds, 1977; Sotile and Kilmann, 1977). Similarly, Lo Piccolo (1977) asserts that questions relating to the global effectiveness of some general form of therapy may now be regarded as too simplistic and based on the false premise that patients and therapists are uniform entities.

This, of course, is not to suggest that classification of patients for treatment outcome research is best conducted according to broad diagnostic categories. The need for re-examination of our nosology in this field has been recognised for some time (Fordney-Settlage, 1975; Wincze et al, 1978, Kaplan, 1979; Lo Piccolo, personal communication). It may be argued, for example, that a potentially more productive approach than that offered by the group comparative design, even with control for type of problem, would be a factorial design in which the relative effects of treatments for subgroups within broad diagnostic categories could be examined. Such designs would allow for the view that patients with erectile impotence, female sexual unresponsiveness or premature ejaculation or indeed vaginismus may not constitute a homogeneous group in terms of aetiology or other major clinical characteristics.

Finally, and perhaps the most cogent argument against overall comparison between groups of mixed problem composition is derived from the fourth significant treatments x problems interaction effect. It demonstrates

that the same differential response to the treatments within each of two separate problem groups could potentially lead to a highly significant crossed interaction effect. Such a finding on a particular variable could emerge when improvement for each of the problem groups on that variable implies change in opposite directions. While this may not wholly account for the interaction effect observed on ratings of "myself" on the "erotic arousal" factor of the semantic differential, it may be theoretically possible, since the problem groups involved were the FSU and PE groups. Thus, the MJ approach was shown post-treatment to be associated with significantly greater self-ratings of sexual responsiveness than the SH treatment for the FSU group, while there was a slight but non-significant trend toward higher scores on the same measure for those PE subjects given the SH approach. Although this difference between the differential responses to treatment was significant ($p = .02$), the direction of treatment change was similar in each case, i.e. more improvement for both groups with the MJ approach, relative to the SH treatment. Had practice plus counselling been significantly better for both the FSU and the PE groups, the crossed interaction effect would have been even more marked. This is simply because improvement on this measure for those with premature ejaculation means a reduction in scores, while the same effect for sexually unresponsive females involves an increase in scores. Paradoxically, therefore, the **greater** the same treatment difference in each of the two problem groups, the lower the chance of its being identified from comparative analysis which combines the two categories of patient in each treatment sample.

A final cautionary note, however, is warranted. As indicated, in the discussion of the results for premature ejaculation, such treatment x problem interactions may also involve interactions between therapist and problem (or additional patient characteristics), in which differential expertise or intelligibility, etc, of the distinctive behavioural features of each programme may be important factors. In any case, it is conceded, as Bentler and Abramson (1981) point out, that 'statistical interactions as might be observed in analysis of variance tend to be very fragile: when observed, they may be due to chance rather than a true effect; they may depend on the arbitrary scale of measurement

too' ... 'the demonstration that complicated interactions are real phenomena requires an extra measure of care by the investigator' (page 242). It must be stressed, however, that this study respresents only an exploratory or preliminary examination of an interaction between treatments and problems. The principal statistical analyses include the non-parametric tests of treatment effects within each separate problem group and the analyses of main effects for which corroborative evidence was obtained by one-way analysis of covariance. Until replication of these interaction effects is obtained with much larger numbers in each cell, so that the main conditions of normality of distribution and homogeneity of variance can be more clearly fulfilled, only tentative conclusions may be drawn. This is so despite **evidence of the general robustness of similar** parametric techniques (Boneau, 1960).

Cost-Effectiveness

Two related factors in the present study may be considered relevant to the assessment of cost-effectiveness (a) behavioural goal attainment and (b) duration of therapy.

In terms of global measures of goal attainment, no significant differences were found between the treatment groups as a whole or between treatments within each of the four problem categories. However, consistent with many of the problem main effects, the goal attainment rate was significantly higher in the VAG group as a whole, compared to the PE group, and almost significantly higher than those in the FSU group. Again, the variability in response to the minimal contact approach, in particular, was highlighted by the fact that those with vaginismus showed a significantly better outcome, in terms of goal attainment, with the SH format, compared to those with premature ejaculation and female unresponsiveness. No comparable differences among the problem groups were found among those receiving practice plus counselling.

There was also no evidence that the two treatment approaches as a whole differed significantly with respect to the number of weeks to criterion. Only for the VAG group could a statistical comparison between treatments on this measure be conducted. Again no significant difference was found - the mean duration of therapy among those who completed it

being 12.7 weeks (range 9 - 16) and 12.5 weeks (range 8 - 16) in the MJ and SH groups respectively. Together with the goal attainment data, therefore, the SH procedure would indeed appear to be not only as effective but as efficient as directed practice plus counselling in dealing with vaginismus.

CHAPTER 14

SUGGESTIONS FOR FUTURE RELATED RESEARCH

The major implications of the present results for the design and analysis of future research in this field have already been discussed. Some appreciation of sample composition and method of analysis would seem to be nesessary in the design of comparative studies involving procedures in which a major treatment component of the MJ procedure is minimised or absent. Clearly further research with larger numbers in each problem category is required but it is possible, for example, on the basis of the present evidence, that vaginismus may respond equally favourably to both sex therapy and to desensitisation in contrast to other major dysfunctional groups in view of the more clearly defined phobic quality to the former problem (cf. Mathews et al, 1976). Similarly, it is possible that many sexually unresponsive women may respond more readily to both sex therapy and marital counselling alone (cf. Everaerd, 1977) compared to vaginismus or premature ejaculation. Thus, when the comparative study involves the manipulation of major aspects of treatment (e.g. presence or absence of counselling), rather than perhaps more specific aspects of administration of the same treatment (e.g. weekly v monthly sessions), then some consideration of initial subject or problem group differences seems particularly warranted.

One may be justifiably hesitant in studying treatment effects in a group comparison design using a heteoregeneous sample of sexual deviants comprising exhibitionists, transsexuals, fetishists, etc, without examining the actual impact of the treatment on each of the specific categories of deviant behaviour. The present results would suggest similar caution in relation to sexual dysfunction, although clearly much would depend on the treatments being compared and the nature of the sample.

Correlates of Outcome

Glasgow and Rosen (1978) assert that 'related to the efficiency and effectiveness of self-help manuals is the need for program developers to provide guidelines that assist potential consumers in determining the appropriateness of any given program' (Page 4). The present study would appear to fulfil in part this recommendation by helping to

determine which problems may be more or less amenable to a minimal contact approach.

Further research into the efficacy of self-help programmes in this and related fields may be enhanced by an examination of other subjects and personality variables which may influence outcome. As yet, there is only limited information in this area apart from the incidental comment that subjects frequently vary in their motivation to regulate their own behaviour (Kanfer and Karoly, 1972; Marston and Feldman, 1972). Schallow (1975), on the other hand, using the social learning theory construct of locus of control (Rotter, 1966), demonstrated that "internal" subjects (i.e. those perceiving their behaviour as principally under their own control, as opposed to fate, chance, astrological sign, etc) showed greater motivation and, consequently, greater success at modifying their own behaviour, than those whose scores indicated an external locus of control. His sample comprised 45 undergraduates who undertook to modify a variety of selected "problem" behaviours, including smoking and overeating, to more idiosyncratic behaviour, such as effeminate mannerisms and jealousy. Clearly he used a non-clinical sample and self-modification in this study, moreover, referred more to the subjects' application of the principles of contingency management, rather than adherence to a didactic and directive programme, as presented in an instructional written guide. Nevertheless, Schallow (1975) claims that the more extreme scores on this scale may have potential predictive utility, and it may be worthwhile examining this possibility in future research with clinical samples, particularly since additional evidence broadly consistent with Schallow's (1975) findings is provided by Repucci and Baker (1969). They found that subjects who showed the greatest improvement with self-directed desensitisation resembled Leary's autocratic personality (Leary, 1957). Thus, they were described as outgoing, energetic and well-organised, perceiving themselves as powerful, competent and "in-charge". The similarity of the latter half of this description with that of Schallow's (1975) "internal" subjects seems fairly clear. It is also noteworthy perhaps that those of autocratic personality were reported as typically dropping out of conventional or traditional psychotherapy.

Baker et al (1973), in a controlled comparison of self-directed and

therapist-directed desensitisation of acrophobia, also provided evidence that of all Leary's traits (eight in all), the managerial-autocratic scale was the only predictor of outcome, irrespective of treatment. They also showed that subjects who describe themselves as more phobic, introvert and obsessive tended to report less improvement with the therapist-directed treatment in which the therapist's presence allowed such subjects to provoke digressions into verbal interaction not required for desensitisation. Moreover, those who could differentiate aspects of their anxieties improved more in the self-help condition 'which relies more heavily on the subject's ability to be attuned to his anxiety to diagnose rough spots in the treatment' and to make appropriate modifications to his treatment himself (Baker et al, 1973 p.88). It is interesting to note that some of these views at least seem to concur with the interpretation offered in the present study for the favourable response to both treatments of the vaginismus subjects, i.e. their more circumscribed coital anxieties. Whether, in addition, their more specific and clearly defined anxiety coupled with the more obviously graded nature of the behavioural programme for this disorder allowed a more flexible attitude to therapy, as implied above, is difficult to determine.

Although the study of personality variables in relation to treatment outcome has become of late a less fashionable focus of research interest, the above findings and the implication that certain personality dimensions may be associated with a differential response to self and therapist-administered procedures would be an interesting area for further research. Clearly this view should not be seen as consistent with the trend for adding specific measures to the assessment battery which may be only tangentially related to the aims of the study - argued by some (e.g. Lo Piccolo, 1977; Bentler and Abramson, 1981) as being a weakness of many studies in this field. The incorporation of scales relating to locus of control, however, may be adequately justified on the grounds noted above. In any case, Bentler and Abramson (1981) assert that it may be appropriate to include some variables in a study, even though it may be essentially "confirmatory" as opposed to "exploratory", for purposes of hypothesis generation. This may be particularly appropriate in early research into a relatively new area but the potential hazards of

"discovering" significant results by chance with the routine examination of a large number of variables, in the absence of clear hypotheses, should also be clearly recognised.

Examination of Treatment Goal Attainment

As noted earlier, goal attainment data were obtained in this study principally to allow an examination of both the clinical significance of the findings and the relative cost-effectiveness of the treatments. In discussing recommendations for further research, however, it may be of value to comment on some of the practical and clinical difficulties involved in an assessment of goal attainment among a mixed dysfunctional sample.

Firstly, it became apparent not only that an informal assessment of goal attainment was more difficult in the course of a programme involving minimal therapist contact, but also that the criterion used in its assessment may not be uniformly applicable or measurable across dysfunctional categories. For example, when the presenting complaint was female sexual unresponsiveness or premature ejaculation, it became clear that for some of these couples, the occurrence of mutually satisfactory intercourse was less readily "measurable" compared to the relatively unequivocal application of this criterion for those with vaginismus or erectile impotence. In other words, although the general aim of therapy was superficially the same for all problem groups, it seems possible, if not probable, that one part of the criterion, viz. 'mutually satisfactory intercourse' may have different connotations for different patient groups. Thus, the occurrence of intercourse per se may have been a more central defining feature of goal attainment for couples with vaginismus and erectile impotence, compared to the other two groups for whom the main emphasis would be on the perceived "quality" of the experience. Clearly the latter is less easily assessed, whether formal psychometric measures are employed or not. This may help account for the fact that among those who were considered to have reached the goals of therapy, a greater proportion of couples in the FSU and PE groups continued in therapy up to or close to the maximum limit of sixteen weeks. Indeed, the difference between the FSU and EI groups in terms of the number of weeks to criterion (irrespective of treatment) almost reached significance ($U = 6.0$, $n_1 = 5$,

n_2 = 6, p = .063). Therefore, any conclusions concerning the cost-effectiveness of the treatments, measured in terms of number of weeks to criterion, must be tempered by the potentially different ways in which the same criterion measure may be interpreted across problem groups. Such differences may in turn influence the duration of therapy, and so confound data interpretation.

Nevertheless, for three FSU couples and two PE couples it was particularly clear prior to this maximum limit that further treatment was both unnecessary and inappropriate in view of the substantial gains which had already been made and the limited possibilities for further change.

Yet, as noted above, in hindsight, the initial agreed goal of treatment in terms of mutual coital enjoyment may not have been wholly appropriate, particularly for some of the FSU and PE couples. Perhaps additional changes in terms of orgasmic frequency, general sexual interest or non-coital enjoyment may have been more relevant goals for some of these patients. The specification of discrete goals tailored to the needs of particular problem samples would also be in keeping with the pre-treatment interproblem differences observed in the present study and the fact that the sample as a whole does not constitute a homogeneous group in terms of salient aspects of sexual functioning and reported marital adjustment. Thus, the use of a single criterion of goal attainment, particularly when allied with duration of therapy, may be in practice not only difficult to apply and interpret in a reasonably standardised way across dysfunctional groups, but also possibly inappropriate.

Finally, notwithstanding the above criticisms, in most cases separate independent assessments of sexual functioning, appropriate to each of the four problems (and whenever possible based on Masters and Johnson's (1970) criteria of "non-failure"), endorsed the informal reports of goal attainment. This was not so, however, for the erectile impotence group in which 50% of those considered to have attained the treatment goal were subsequently shown to be only partially improved according to Masters and Johnson's criteria. Again, with the benefit of hindsight, it could be argued that a much more rigorous criterion ought to have been applied for such couples.

This is not to suggest, in view of these criticisms, that any attempt to measure behavioural goal attainment should be abandoned. Instead it is recommended that future studies in this field may be improved by the use of time-limited therapy, but possibly over a less protracted period. In this way, any assessment of goal attainment may still be conducted post-treatment - and there are sound advantages for so doing in terms of providing evidence of the clinical significance of the findings - but decisions concerning the premature termination of treatment, and their associated problems, may be largely avoided.

It is obviously important that the dependent variables encompass the relevant domain of the expected or hypothesised effects. However, there is a paucity of published scales of established validity and reliability suitable for use in treatment outcome studies in this country to measure change among a range of dysfunctional patient groups. Some attempt has been made in this study to select only those scales, the reliability and validity of which has been demonstrated among a comparable patient population, albeit, in some cases, in the United States. Some scales were devised for the present study (viz. the SMAR and PAD Scales) from which factors were derived from principal components analysis. It would be meaningful, however, for further research to determine the relation of these factors to other relevant constructs of established validity, i.e. to determine, from cross-validational procedures (Campbell and Fiske, 1959), the construct validity of these two scales above.

Again, as indicated earlier, another contributory factor determining choice of measure in this study was use of the scale in previous related well conducted research of comparable aims (e.g. Mathews et al, 1976). For a variety of reasons, of course, there are limits on the extent to which one can directly compare data across studies, in psychotherapy (including sex therapy) research. Gurin (1981) has proposed,however, that a standard pool of measures related to sexual behaviour and sex research be compiled so that researchers may have adequate guidance in selecting the most technically and theoretically sophisticated instruments for a given purpose. This can only be achieved if further efforts are directed toward validating and refining our assessment techniques.

In so doing, however, the brevity, intelligibility and ease of completing the questionnaires, the breadth of the battery as a whole, as well as other aspects of the presentation (including timing and preserving anonymity) of material of a delicate and potentially embarrassing nature may be important considerations. This may be particularly true given the consistently high default rate reported in this field of outpatient research - and especially with minimal contact procedures. In the present study, post-treatment and follow-up data, in particular, were obtained, in some cases, only following repeated exhortation (which in itself may influence outcome) and a considerable abbreviation of the test battery. Prospective researchers in this field should be aware of such problems and tailor their assessment measures and procedures accordingly.

Conclusions

For a variety of reasons, including commercial, clinical and theoretical, there has been an increasing interest over the past decade, among both the "consumer" and the "supplier", in the use of self-administered behavioural programmes. That a behavioural psychology should share in this growth industry of manuals, kits and tapes is perhaps readily understandable in terms of a D.I.Y. Zeitgeist, a ready market, a theoretical framework based on behavioural self-control in its broadest sense, and a health service which may be primed to consider issues of cost-effectiveness. Whatever the reasons, the need for careful evaluation and preparation of any such package, whether available 'over the counter' or 'on prescription', is readily apparent. This project, therefore, represents an attempt to fulfil this need in relation to sexual dysfunction, by comparing in a controlled manner a Masters and Johnson approach, as typically adapted for use in an NHS setting, with a minimal contact bibliotherapy programme, based on the behavioural aspects of the former. The study, however, was designed to permit a preliminary examination of the relative effects of the treatments within and across four dysfunctional subgroups.

The following general conclusions from this research are as follows:

Treatment effects with this self-help approach were limited - being confined principally to fairly specific aspects of sexual adjustment,

such as a reduction in the tendency to spectate and an increased frequency of intercourse, of coital enjoyment and of general sexual interest. On the other hand, while significant improvement with practice plus counselling was also apparent on these variables, treatment effects were also more generalised in terms of both the sexual and the marital relationship, as hypothesised. The particular sexual benefits from the conventional Masters and Johnson procedure include sexual pleasure enhancement and the reduction of both specific and general sexual anxieties, even though its main mode of action may not be one of direct anxiety reduction. Moreover, some support for the hypothesised superiority of this approach in improving the less directly sexual aspects of the relationship was also obtained. Thus, only practice plus counselling was effective in increasing marital adjustment, and there is also evidence of the self-help procedure having a more limited effect on sexual attitude change, again as predicted.

Secondly, the wide range of pre-treatment differences shown to exist among the different subgroups of dysfunctional patients comprising the present sample suggest that extreme caution should be exercised in the design and analysis of future treatment outcome studies. In addition to these differences which may simply reflect the diagnostic features of each problem subgroup, the salient findings were that females presenting with general sexual unresponsiveness described greater marital dissatisfaction compared to the other three problem groups and that the reported difficulties of vaginismic patients were more cicumscribed and were restricted to mainly coital fears. Although the male complainants in general reported fewer problems, there were also trends suggesting greater sexual difficulties among the partners of premature ejaculators compared to those of impotent patients.

Although these findings have general implications for the design of treatment outcome research in this field, the nature of these differences also has more specific implications, particularly when the comparison involves the manipulation of a major treatment component, viz. counselling.

Thirdly, therefore, as hypothesised, there was evidence that the Masters and Johnson approach was significantly superior to the self-help

format on a range of measures of sexual and marital adjustment for those couples whose main problem was female unresponsiveness. Indeed, there seems little justification for using a minimal contact procedure for this paitent group. While it is not possible to partial out the effective ingredients of change, these results are consistent with the proposed interactive effect of directed practice and counselling in facilitating communication and the identification and resolution of intra and interpersonal resistances to improved sexual functioning. Relative neglect of such factors, as with the use of bibliotherapy, while not necessarily exacerbating the problem, does apparently little to resolve it.

In contrast, however, there was substantial evidence to indicate that both procedures were effective in the treatment of vaginismus. This is probably due to the more clearly defined coitally phobic quality of the disorder in the relative absence of more generalised sexual or marital problems among the present sample of such patients. Although there were some trends in favour of the Masters and Johnson approach, the evidence in favour of its use, on cost-effectiveness grounds, is not strong. While further research using a large sample of patients is required, particularly to help identify more clearly those who may not benefit from a minimal contact approach, it is conceivable, following Rosen (1976a) that, for vaginismus at least, this type of self-help programme could become the standard against which more costly forms of treatment may be compared.

The findings for the male dysfunctional groups were in many respects less satisfactory. For those with premature ejaculation, neither treatment was shown to be particularly effective, in contrast to other previous results. The reasons for the present negative findings are unclear but would appear, from informal reports, to be due in part to compliance difficulties. Many couples reported an early reluctance to continue with the 'squeeze' technique, ostensibly because its effects on the spontaneity of previous sexual play was perceived as too disruptive. Such an attitude in the context of shared sexual difficulties may have led to a resistance to treatment, including, where appropriate, counselling. On the other hand, without replication of the findings, the possibility of differential therapist expertise or of patients

having unrealistically high expectations from treatment, as reported by others (cf. Zeiss et al, 1978), cannot be discounted. Finally, the relatively high baseline levels of self-reported sexual and marital adjustment clearly limit the scope for measurable change with this group and may disguise a true treatment effect.

For similar reasons, it is difficult to draw firm conclusions about the relative effectiveness of the treatments for erectile impotence. Again only limited changes were apparent with both treatments which differed significantly only with respect to self-reported marital satisfaction. Contrary to the hypothesis, the self-help approach was associated with greater positive marital changes for this group. Such a finding is particularly difficult to interpret, but it may relate to the frequency or "intensity" of counselling (cf. Carney et al, 1978). The effect, however, was short-lived and, in the absence of confirmation with a larger sample, any conclusions in this respect can only be very tentative at this stage.

The results of these separate treatment comparisons within each problem group suggested, therefore, that the differential effects of treatment were not uniform across these dysfunctional subgroups. Although again only tentative conclusions may be drawn, in view of the exploratory and preliminary nature of the analysis, there was some evidence that the relative treatment effects were indeed not additive, particularly with regard to aspects of marital adjustment, sexual enjoyment and self-ratings of erotic arousal.

Whether similar interaction effects will be observed in future research in this area may of course depend on the nature of the sample, the treatment components under investigation, mode of therapy and type of therapist(s) involved. What the present results provide is some corroborative evidence of a greater variability of response to minimal contact procedures in particular and that those with greater marital or/and more generalised sexual difficulties do indeed respond poorly to the lack of adequate counselling. The maxim "Horses for courses" seems to apply here.

One particular crossed interaction effect between treatments and

problems, however, also illustrates the importance of care in the choice of measures and their interpretation. Failure to do so may disguise a true treatment difference when two or more problem groups show consistently greater improvement on a particular variable with one and the same treatment - but such improvement for each patient group implies change in opposite directions on that variable (e.g. self-ratings of sexual responsiveness for those with female unresponsiveness and premature ejaculation). Future research should account for these issues and similarly guard against a possibly over-ambitious attempt to examine goal attainment data using the same criterion measure, based on satisfactory coitus, across diagnostic groups.

Widely documented in the self-help literature, though rarely studied, are problems of compliance and dropping out of therapy. This was a potentially serious problem in the present study and only with some difficulty were data from defaulters obtained. It is suggested that simple fundamental questions relating to a programme's design, and particularly its comprehensibility, should be raised first before necessarily renouncing the whole concept of self-management in the light of a poor response. Some behavioural directives may be differentially amenable to presentation in a written form (i.e. lend themselves more readily to concrete and specific illustration, categorisation of information, etc, cf. Ley, 1977) and that this factor may account for some of the differences in this study. This is an area which clearly warrants further study.

At a time when the application of behavioural self-management techniques is likely to be expanded by a corresponding growth in home-based video technology and marketing, research in this area is long overdue. Hopefully, this project has offered for consideration several areas which may facilitate further research inquiry into what is certainly one of the most promising and demanding developments in clinical research.

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APPENDIX 1

Table 58 Pre-Treatment Means and Standard Deviations on Marital Adjustment Self-Rating Scales and Related Attitude Factors for each Problem Subgroup (Partners only) - Results of One-Way Analyses of Variance and Newman-Keuls Tests

Variable		FSU	VAG	PE	EI	F(df)[a]	Prob	Results of Newman-Keuls Tests
Locke-Wallace Marital Adjustment (High = Good)	m	90.58	113.86	97.30	97.82	2.4 (3,43)	.08	
	σ	16.93	19.95	26.44	28.41			
Marital Satisfaction Factor (SMAR Scale) (Low = Good)	m	1016.5	968.1	966.4	1040.0	1.84 (3,44)	NS	
	σ	96.3	88.6	106.2	82.7			
Myself-Loving[1] (Sem. Diff)	m	17.1	17.0	16.4	17.3	0.3 (3,41)	NS	
	σ	1.6	1.5	3.1	1.7			
My Partner - Loving[1] (Sem. Diff)	m	15.0	18.3	17.7	17.1	2.40 (3,41)	NS	
	σ	3.5	2.1	3.4	3.4			

* $p < .05$
** $p < .01$
NS non-significant
1 3 = very unloving, 21 = very loving

Table 59 Pre-Treatment Means and Standard Deviations on Sexual Attitude Factors for each Problem Subgroup (Partners only) - Results of One-Way Analysis of Variance and Newman-Keuls Tests

Variable			FSU	VAG	PE	EI	F(df) [c]	Prob	Results of Newman-Keuls Tests
Myself - General Evaluation	a	m	10.7	10.1	10.6	10.3	0.4	NS	
		σ	1.6	1.5	1.7	1.2	(3,41)		
Myself - Anxiety	a	m	6.6	7.3	8.6	9.2	1.8	NS	
		σ	3.1	3.1	3.2	2.6	(3,41)		
Myself - Sexual Attractiveness	a	m	8.92	8.50	9.33	8.83	0.49	NS	
		σ	1.31	1.88	1.58	1.47	(3,41)		
Myself - Erotic Arousal	a	m	12.00	10.67	8.00	7.92	10.8	**	PE < FSU**, EI < FSU**, PE < VAG*, EI < VAG**
		σ	1.13	1.50	2.74	2.64	(3,41)		
Partner - General Evaluation	a	m	12.17	12.08	11.89	11.00	1.97	NS	
		σ	0.72	1.00	1.54	1.81	(3,41)		
Partner - Anxiety	a	m	9.1	11.2	8.4	9.0	1.9	NS	
		σ	2.5	1.6	3.7	3.6	(3,41)		
Partner - Sexual Attractiveness	a	m	10.75	11.17	10.00	9.67	2.23	NS	
		σ	1.71	0.94	1.73	1.78	(3,41)		
Partner - Erotic Arousal	a	m	4.42	7.33	12.44	6.33	21.6	**	FSU < VAG*, FSU < PE**, VAG < PE** EI < PE**
		σ	2.81	2.02	1.42	2.57	(3,41)		
Sexual Aversion Factor (PAD Scale)	b	m	1014.3	1004.3	1000.8	997.2	0.08	NS	
		σ	21.1	70.5	169.1	67.9	(3,44)		

* $p < .05$
** $p < .01$
NS non-significant
a 2 = very low; 14 = very high
b low value, high sexual aversion; high value, low sexual aversion
c Full details of results in Appendix 5 Tables 110 to 111

Table 60 Pre-Treatment Means and Standard Deviations on Independent (IR) and Self-Rating (SR) Scales of Sexual Satisfaction and Pleasure for Each Problem Subgroup (Partners only) - Results of One-Way Analyses of Variance and Newman-Keuls Tests

Variable		FSU	VAG	PE	EI	F(df)[c]	Prob	Results of Newman-Keuls Tests
IR Scales								
Frequency of Pleasurable Intimate Foreplay	m	4.00	3.64	2.80	3.36	5.5 (3,41)	**	PE < FSU**, PE < VAG*, EI < FSU*
	σ	0.00	0.74	1.03	0.50			
Degree of Pleasure from Intimate Foreplay	m	3.70	3.79	2.30	3.09	12.0 (3,41)	**	PE < FSU**, EI < FSU**, PE < VAG**, EI < VAG*, PE < EI*
	σ	0.48	0.58	0.95	0.54			
Frequency of Pleasurable Sexual Intercourse	m	3.80	0.21	2.30	2.55	28.6 (3,41)	**	VAG < FSU**, PE < FSU**, EI < FSU*, VAG < PE**, VAG < EI**
	σ	0.42	0.58	0.95	1.57			
Frequency of Sexual Interest	m	5.20	4.36	3.30	3.64	7.5 (3,41)	**	PE < FSU**, EI < FSU**, PE < VAG*
	σ	0.92	1.22	0.82	0.81			
SR Scales								
Frequency of Sexual Intercourse	m	4.00	1.36	5.11	1.91	30.6 (3,42)	**	VAG < FSU**, EI < FSU**, VAG < PE**, EI < PE**
	σ	1.76	0.50	0.78	0.70			
Degree of Enjoyment of Sexual Intercourse	m	5.33	4.80	4.78	4.00	1.78 (3,31)	NS	
	σ	1.07	0.84	1.09	1.87			
Sexual Satisfaction Factor (SMAR Scale)	m	982.6	1002.3	905.3	965.2	2.3 (3,44)	NS	
	σ	107.6	97.8	81.1	76.1			
Sexual Pleasure Factor (PAD Scale)	m	940.3	927.8	1004.0	986.4	1.19 (3,44)	NS	
	σ	55.2	91.6	201.4	79.3			

* $p < .05$
** $p < .01$
NS non-significant
a low value, low frequency/pleasure; high value, high frequency/pleasure
b low value, high satisfaction/pleasure; high value, low satisfaction/pleasure
c Full details of results in Appendix 5 Tables 112 to 116

Table 61 Pre-Treatment Means and Standard Deviations on Independent (IR) and Self-Rating (SR) Scales of Sexual Anxiety and Negative Sexual Experience for Each Problem Subgroup (Partners only) - Results of One-Way Analyses of Variance and Newman-Keuls Tests

Variable		FSU	VAG	PE	EI	F(df) [d]	Prob	Results of Newman-Keuls Tests
IR Scales								
Frequency of Unpleasurable Intimate Foreplay [a]	m	4.00	3.57	3.10	3.45	2.7	NS	
	σ	0.00	0.76	0.99	0.69	(3,41)		
Frequency of Unpleasurable Sexual Intercourse [a]	m	3.80	0.71	2.90	3.45	33.2	**	VAG < FSU**, PE < FSU*, VAG < PE**, VAG < EI**
	σ	0.42	1.27	0.57	0.69	(3,41)		
SR Scales								
Degree of Anxiety About Symptoms during Sexual Play ("Spectating") [b]	m	2.50	2.29	2.30	2.50	0.18	NS	
	σ	1.24	0.99	0.82	0.80	(3,44)		
Sexual Anxiety Factor (PAD Scale) [c]	m	1075.5	1030.3	1005.7	1072.6	2.31	NS	
	σ	90.4	78.0	59.5	63.0	(3,44)		

* $p < .05$
** $p < .01$
NS non-significant
a low value, high frequency of unpleasurable non-coital and coital experiences high value, low frequency
b low value, strong tendency to spectate; high value, low tendency to spectate
c low value, high anxiety; high value, low anxiety
d Full details of results in Appendix 5 Table 117.

APPENDIX 2

Table 62 Nature of Previous Treatment for Presenting Dysfunction --Frequency with which Each Treatment Form Reported

	FSU		VAG		PE		EI		
	MJ	SH	MJ	SH	MJ	SH	MJ	SH	
Minor Tranquillisers		2		2	2		1		7
Hormonal Treatment	1						4	2	7
Anti-Depressants							1	3	4
Vaginal Dilators			4						4
Individual Psychotherapy	1		1				1		3
General Advice and Reassurance Only		1		2					3
Ban on Intercourse Plus Brief Instruction in Sensate Focus			1					1	2
Minor Gynaecological Surgery			2						2
Change or Termination of Contraception		1							1
Marriage Guidance Counselling		1							1
Hypnosis			1						1
	2	5	9	4	2	-	7	6	35

Table 63 Number of Couples who had Received Previous Treatment for Presenting Dysfunction

FSU		VAG		PE		EI		
MJ	SH	MJ	SH	MJ	SH	MJ	SH	
2	4	6	4	2	0	4	4	26

Table 64 Number of Couples in Which One Partner Treated Recently* for Other Psychiatric Problem

	MJ	SH
Female Sexual Unresponsiveness	1	2
Vaginismus	1	0
Premature Ejaculation	1	1
Erectile Impotence	2	1
	5	4

* 'Recently' = Within previous twelve months

Table 65 Source of Referral : Number of Couples Referred From Each Source

Referral Source	FSU		VAG		PE		EI		
	MJ	SH	MJ	SH	MJ	SH	MJ	SH	
Psychiatrist	5	6	2	1	2	1	3	3	23
General Practitioner	1	-	1	2	-	2	-	1	7
Gynaecologist	-	-	2	3	-	1	-	1	7
Family Planning Clinic	-	-	-	1	2	1	1	1	6
Urologist	-	-	-	-	-	-	2	-	2
Other (e.g. Social Agency, Psychologist, etc)	-	-	2	-	1	-	-	-	3
TOTAL	6	6	7	7	5	5	6	6	48

Table 66 Summary of General Demographic and Clinical Characteristics of Sample

Couple No.	Age of Comp.	Age of Part.	Duration of Sexual Rel'p	Religion of Comp.	Religion of Part.	Social Class	Employed	Contra-ception	Duration of Problem	Marital Status	No. of Children	Main Sexual Dysfunction	Problem in Part.	Treatment Group
1	27	28	4	Episc	Episc	3m	Yes	IUD	2	1st Marr	0	FSU	-	MJ
2	26	27	6	R.C.	C of S	5	Yes	Pill	3	1st Marr	2	FSU	-	MJ
3	33	33	10	C of S	C of S	3m	Yes	Pill	10	2 Marr for Comp	2	FSU	-	MJ
4	33	32	11	C of S	C of S	3m	Yes	Vasec.	5	1st Marr	2	FSU	-	MJ
5	22	31	2	None	R.C.	3m	Yes	Pill	1	1st Marr	0	FSU	PE	MJ
6	32	31	2	C of S	C of S	2	Yes	None	1.5	1st Marr	0	FSU	Intermit-tent RE	MJ
7	25	26	2	C of S	C of S	3m	Yes	Pill	1	1st Marr	0	FSU	PE	SH
8	26	27	6	C of S	C of S	3m	Yes	Pill	6	1st Marr	1	FSU	-	SH
9	22	22	3.5	RC	RC	4	Yes	IUD	1.5	1st Marr	0	FSU	-	SH
10	30	31	9	None	NK	3m	Yes	Pill	9	1st Marr	1	FSU	-	SH
11	38	39	18	C of S	C of S	4	Yes	Tubal Lig.	18	1st Marr	2	FSU	-	SH
12	32	33	10	NK	NK	3m	Yes	Tubal Lig.	2.5	1st Marr	3	FSU	-	SH

NK = Not Known
RE = Retarded Ejaculation

Table 66 Summary of General Demographic and Clinical Characteristics of Sample

Couple No.	Age of Comp.	Age of Part.	Duration of Sexual Rel'p	Religion of Comp.	Religion of Part.	Social Class	Employed	Contra-ception	Duration of Problem	Marital Status	No. of Children	Main Sexual Dysfunction	Problem in Part.	Treatment Group
13	23	22	3	R.C.	None	1	Yes	Pill	3	1st Marr	0	VAG	-	MJ
14	27	27	6	C of S	C of S	3nm	Yes	None	6	1st Marr	0	VAG	-	MJ
15	30	34	9	R.C.	R.C.	2	Yes	None	10	1st Marr	0	VAG	Abn Attit Low Libido	MJ
16	34	31	3	R.C.	R.C.	2	Yes	None	3	1st Marr	0	VAG	-	MJ
17	22	22	1	R.C.	C of S	3m	Yes	Pill	1	1st Marr	0	VAG	-	MJ
18	24	27	4	C of S	C of S	3m	Yes	Pill	4	1st Marr	0	VAG	-	MJ
19	26	29	4	C of S	C of S	3m	Yes	Pill	2.5	1st Marr	1	VAG	-	MJ
20	32	31	7	R.C.	C of S	3nm	Yes	None	7	1st Marr	0	VAG	-	SH
21	23	24	2	R.C.	R.C.	2	Yes	Pill	2	1st Marr	0	VAG	-	SH
22	26	28	7	R.C.	R.C.	5	Yes	None	7	1st Marr	0	VAG	PE	SH
23	31	35	12	R.C.	C of S	3m	Yes	None	12	1st Marr	0	VAG	-	SH
24	22	25	1.5	C of S	C of S	2	Yes	Pill	1.5	1st Marr	0	VAG	-	SH

NK = Not Known
RE = Retarded Ejaculation

Table 66 Summary of General Demographic and Clinical Characteristics of Sample

Couple No.	Age of Comp.	Age of Part.	Duration of Sexual Rel'p	Religion of Comp.	Religion of Part.	Social Class	Employed	Contra-ception	Duration of Problem	Marital Status	No. of Children	Main Sexual Dysfunction	Problem in Part.	Treatment Group
25	31	35	7	C of S	R.C.	3m	Yes	None	7	1st Marr	0	VAG	-	SH
26	47	44	21	R.C.	R.C.	2	Yes	None Necessary	21	1st Marr	2 Adopted	VAG	-	SH
27	25	24	2	NK	NK	1	Yes	Pill	2	Cohabit	0	PE	Loss of Interest	MJ
28	24	23	1	NK	NK	2	Yes	Pill	1	1st Marr	0	PE	-	MJ
29	27	26	8	R.C.	C of S	4	No	Pill	8	1st Marr	3	PE	Loss of Interest	MJ
30	23	22	3	R.C.	C of S	3m	Yes	Pill	3	1st Marr	0	PE	Fear of Orgasm	MJ
31	47	42	13	C of S	C of S	2	Yes	None Necessary	10	1st Marr	1	PE	Low Libido	MJ
32	27	23.5	2	NK	NK	2	Yes	Pill	1.5	1st Marr	0	PE	-	SH
33	34	24	2	C of S	C of S	2	Yes	Pill	1.5	2nd Marr for each	2	PE	Low Libido	SH
34	32	32	14	NK	NK	3m	Yes	Pill	10	1st Marr	2	PE	-	SH
35	38	36	11	C of S	C of S	3m	Yes	Pill	10	1st Marr	1	PE	Loss of Interest	SH
36	44	40	20	C of S	C of S	3nm	No	Tubal Ligat	8	1st Marr	3	PE	Loss of Interest	SH

NK = Not Known
RE = Retarded Ejaculation

Table 66 Summary of General Demographic and Clinical Characteristics of Sample

Couple No.	Age of Comp.	Age of Part.	Duration of Sexual Rel'p	Religion of Comp.	Religion of Part.	Social Class	Employed	Contra-ception	Duration of Problem	Marital Status	No. of Children	Main Sexual Dysfunction	Problem in Part.	Treatment Group
37	22	23	0.8	R.C.	R.C.	2	Yes	None	3	1st Marr	0	EI	Mild VAG	MJ
38	44	28	0.7	R.C.	R.C.	3m	Yes	Pill	1	2nd Marr for both	3	EI	-	MJ
39	39	41	0.3	NK	NK	5	Yes	Tubal Ligat	11	Cohabit	4 of former marr.	EI	-	MJ
40	57	64	12	R.C.	C of S	4	Yes	None Necessary	10	2nd Marr	0	EI	Loss of Libido Org Dys	MJ
41	34.5	32	10.5	C of S	C of S	2	Yes	Pill	3.5	1st Marr	2	EI	Loss of Libido	MJ
42	51	48	15	C of S	C of S	3nm	Yes	None Necessary	13	2nd Marr for both	1 of prev marr	EI	Org Dys	MJ
43	26	22	2	C of S	C of S	3m	Yes	Pill	3	1st Marr	0	EI	Mild VAG	SH
44	38	29	6.5	C of S	C of S	2	Yes	Pill	2	1st Marr	0	EI	-	SH
45	30	31	5	C of S	C of S	3m	Yes	None	5	1st Marr	0	EI	-	SH
46	42	39	18	C of S	Prot	3nm	Yes	IUD	3	1st Marr	2	EI	Org Dys	SH
47	48	47	24	NK	NK	4	Yes	None Necessary	9	1st Marr	4	EI	Org Dys	SH
48	63	62	34	Episc	Episc	2	Yes	None Necessary	1.5	1st Marr	0	EI	-	SH

NK = Not Known
RE = Retarded Ejaculation

APPENDIX 3

Name _____ Age _____ Year of Marriage _____

LOCKE/WALLACE M.A.T.

The questions below give you a chance to describe various aspects of your marriage. There are, of course, no "right" or "wrong" answers, but only what is true for you.

1. Check the dot on the scale line below which best describes the degree of happiness, everything considered, of your present marriage. The middle point, "happy", represents the degree of happiness which most people get from marriage, and the scale gradually ranges on one side to those few who are very unhappy in marriage and, on the other, to those few who experience extreme joy or felicity in marriage.

a	b	c	d	e	f	g
•	•	•	•	•	•	•
Very Unhappy			Happy			Perfectly Happy

State the approximate extent of agreement or disagreement between you and your spouse on the following items. Please look at each column and circle the letter which most accurately describes your position in your marriage.

		Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
2.	Handling family finances	a	b	c	d	e	f
3.	Matters of recreation	a	b	c	d	e	f
4.	Demonstrations of affection	a	b	c	d	e	f
5.	Friends	a	b	c	d	e	f
6.	Sex Relations	a	b	c	d	e	f
7.	Conventionality (right, good, or proper conduct)	a	b	c	d	e	f
8.	Philosophy of Life	a	b	c	d	e	f
9.	Ways of dealing with in-laws	a	b	c	d	e	f

10. When disagreements arise, they usually result in; husband giving in ___, wife giving in ___, agreement by mutual give and take ___.
11. Do you and your spouse engage in outside interests together? All of them ___, some of them ___, very few of them ___, none of them ___.
12. In leisure time do you generally prefer to be "on the go" ___, to stay at home ___? Does your spouse generally prefer: to be "on the go" ___, to stay at home ___?
13. Do you ever wish you had not married? Frequently ___, occasionally ___, rarely ___, never ___?
14. If you had your life to live over, do you think you would: marry the same person ___, marry a different person ___, not marry at all ___?
15. Do you confide in your spouse: almost never ___, rarely ___, in most things ___, in everything ___?

Sexual Interaction Inventory *

(a) The male and female having sexual intercourse

When you and your partner engage in sexual behaviour, does this particular activity usually occur? How often would you like this activity to occur?

1) Currently occurs:

1. _____ Never
2. _____ Rarely (10% of the time)
3. _____ Occasionally (25% of the time)
4. _____ Fairly Often (50% of the time)
5. _____ Usually (75% of the time)
6. _____ Always

2) I would like it to occur:

1. _____ Never
2. _____ Rarely (10% of the time)
3. _____ Occasionally (25% of the time)
4. _____ Fairly Often (50% of the time)
5. _____ Usually (75% of the time)
6. _____ Always

How pleasant do you currently find this activity to be? How pleasant do you think your partner finds this activity to be?

3) I find this activity:

1. _____ Extremely Unpleasant
2. _____ Moderately Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Extremely Pleasant

4) I think my partner finds this activity:

1. _____ Extremely Unpleasant
2. _____ Moderatley Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Extremely Pleasant

How would you like to respond to this activity? How would you like your partner to respond? (In other words, how pleasant do you think this activity ideally should be, for you and for your partner.

5) I would like to find this activity:

1. _____ Extremely Unpleasant
2. _____ Moderately Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Extremely Pleasant

6) I would like my partner to find this activity:

1. _____ Extremely Unpleasant
2. _____ Moderately Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Exiremely Pleasant

* Only two aspects of sexual relations were to be rated on this scale - as opposed to seventeen as published (Lo Piccolo and Steger, 1974)

(b) The male and female having sexual intercourse with both of them having an orgasm (climax)

When you and your partner engage in sexual behaviour, does this particular activity usually occur? How often would you like this activity to occur?

1) Currently occurs:

1. _____ Never
2. _____ Rarely (10% of the time)
3. _____ Occasionally (25% of the time)
4. _____ Fairly Often (50% of the time)
5. _____ Usually (75% of the time)
6. _____ Always

2) I would like it to occur:

1. _____ Never
2. _____ Rarely (10% of the time)
3. _____ Occasionally (25% of the time)
4. _____ Fairly Often (50% of the time)
5. _____ Usually (75% of the time)
6. _____ Always

How pleasant do you currently find this activity to be? How pleasant do you think your partner finds this activity to be?

3) I find this activity:

1. _____ Extremely Unpleasant
2. _____ Moderately Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Extremely Pleasant

4) I think my partner finds this activity:

1. _____ Extremely Unpleasant
2. _____ Moderatley Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Extremely Pleasant

How would you like to respond to this activity? How would you like your partner to respond? (In other words, how pleasant do you think this activity ideally should be, for you and for your partner.

5) I would like to find this activity:

1. _____ Extremely Unpleasant
2. _____ Moderately Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Extremely Pleasant

6) I would like my partner to find this activity:

1. _____ Extremely Unpleasant
2. _____ Moderately Unpleasant
3. _____ Slightly Unpleasant
4. _____ Slightly Pleasant
5. _____ Moderately Pleasant
6. _____ Extremely Pleasant

* Only two aspects of sexual relations were to be rated on this scale - as opposed to seventeen as published (Lo Piccolo and Steger, 1974)

Semantic Differential (Whitehead and Mathews, 1977)

Please put a cross, 'X', at the point on each scale below, which you feel best describes at present, the item at the top of each page.

(a) Myself As I Am

pleasant	___ ___ ___ ___ ___ ___ ___	unpleasant
anxious	___ ___ ___ ___ ___ ___ ___	calm
sexy	___ ___ ___ ___ ___ ___ ___	sexless
loving	___ ___ ___ ___ ___ ___ ___	unloving
sexually frustrated	___ ___ ___ ___ ___ ___ ___	sexually satisfied
bad	___ ___ ___ ___ ___ ___ ___	good
placid	___ ___ ___ ___ ___ ___ ___	jittery
repulsive	___ ___ ___ ___ ___ ___ ___	seductive
warm	___ ___ ___ ___ ___ ___ ___	cold
sexually attractive	___ ___ ___ ___ ___ ___ ___	sexually unattractive
cruel	___ ___ ___ ___ ___ ___ ___	kind
erotic	___ ___ ___ ___ ___ ___ ___	frigid
affectionate	___ ___ ___ ___ ___ ___ ___	unaffectionate
inhibited	___ ___ ___ ___ ___ ___ ___	uninhibited
easy to arouse sexually	___ ___ ___ ___ ___ ___ ___	hard to arouse sexually

(b) My Partner

pleasant	_ _ _ _ _ _ _	unpleasant
anxious	_ _ _ _ _ _ _	calm
sexy	_ _ _ _ _ _ _	sexless
loving	_ _ _ _ _ _ _	unloving
sexually frustrated	_ _ _ _ _ _ _	sexually satisfied
bad	_ _ _ _ _ _ _	good
placid	_ _ _ _ _ _ _	jittery
repulsive	_ _ _ _ _ _ _	seductive
warm	_ _ _ _ _ _ _	cold
sexually attractive	_ _ _ _ _ _ _	sexually unattractive
cruel	_ _ _ _ _ _ _	kind
erotic	_ _ _ _ _ _ _	frigid
affectionate	_ _ _ _ _ _ _	unaffectionate
inhibited	_ _ _ _ _ _ _	uninhibited
easy to arouse sexually	_ _ _ _ _ _ _	hard to arouse sexually

INDEPENDENT ASSESSORS' RATING SCALES

For Each Partner

Sexual Contact as a Negative Experience

(When Negative Aspects Outweigh Positive)

(a) Intimate Foreplay

Male	Female	
0	0	Rarely finds this other than unpleasant or anxiety provoking
1	1	Finds this unpleasant or anxiety provoking on more than 75% of occasions
2	2	Finds this unpleasant or anxiety-provoking between 25% and 75% of occasions
3	3	Finds this unpleasant or anxiety provoking on less than 25% of occasions
4	4	Rarely finds this unpleasant or anxiety provoking

INDEPENDENT ASSESSORS' RATING SCALES

For Each Partner

Sexual Contact as a Negative Experience

(When Negative Aspects Outweigh Positive)

(b) Sexual Intercourse

Male	Female	
0	0	Rarely finds this other than unpleasant or anxiety-provoking
1	1	Finds this unpleasnt or anxiety-provoking on more than 75% of occasions
2	2	Finds this unpleasant or anxiety-provoking between 25% and 75% of occasions
3	3	Finds this unpleasant or anxiety-provoking on less than 25% of occasions
4	4	Rarely finds this unpleasant or anxiety provoking

FOR EACH PARTNER

ENJOYMENT OF SEXUAL CONTACT
(When Positive Aspects Outweigh Negative)

(a) Intimate Foreplay

Male	Female	
0	0	Gets no pleasure from this at any time
1	1	Enjoys this on no more than 25% of occasions
2	2	Enjoys this on no more than 50% of occasions
3	3	Enjoys this on no more than 75% of occasions
4	4	Rarely fails to enjoy this

WHEN IT IS ENJOYABLE, HOW MUCH SO?

Male	Female	
0	0	Only very slightly or negligibly so
1	1	A little enjoyable
2	2	Moderately enjoyable
3	3	Fairly enjoyable
4	4	Extremely enjoyable

FOR EACH PARTNER

ENJOYMENT OF SEXUAL CONTACT
(When Positive Aspects Outweigh Negative)

(b) Sexual Intercourse

Male	Female	
0	0	Gets no pleasure from this at any time
1	1	Enjoys this on no more than 25% of occasions
2	2	Enjoys this on no more than 50. of occasions
3	3	Enjoys this on no more than 75% of occasions
4	4	Rarely fails to enjoy this

WHEN IT IS ENJOYABLE, HOW MUCH SO?

Male	Female	
0	0	Only very slightly or negligibly so
1	1	A little enjoyable
2	2	Moderately enjoyable
3	3	Fairly enjoyable
4	4	Extremely enjoyable

FOR EACH PARTNER

SEXUAL INTEREST

Male	Female	
0	0	Repulsed by (thought of) "normal" sexual activity
1	1	No spontaneous interest or desire at any time
2	2	Rare spontaneous interest or desire (less than once a month)
3	3	Occasional spontaneous interest or desire (less than once a **week**)
4	4	Spontaneous interest or desire at least once a week
5	5	Spontaneous interest or desire 2 to 4 times a week
6	6	Spontaneous interest or desire more than 4 times a week
7	7	Spontaneous interest or desire at least every day

FOR THE MALE

ERECTILE IMPOTENCE

0	Never gets adequate erection in waking state
1	Gets adequate erection on waking only
2	Gets adequate erection during love play with partner less than 25% of occasions (never sustained for S/I)
3	Gets adequate erection during love play with partner between 25% and 75% of occasions (never sustained for S/I)
4	Gets adequate erection during love play with partners on more than 75% of occasions (never sustained for S/I)
5	Virtually always able to get an adequate erection during love play with partner (never sustained for S/I)
6	Gets an erection sustained for S/I less than 25% of occasions
7	Gets an erection sustained for S/I between 25% and 75% of occasions
8	Gets an erection sustained for S/I on more than 75% of occasions
9	Virtually always able to have S/I

PREMATURE EJACULATION

0	Always ejaculate before or at the time of vaginal entry
1	Nearly always ejaculate within 30 seconds of vaginal entry
2	Can delay ejaculation beyond 30 seconds less than 50% of occasions but never has adequate control
3	Can delay ejaculation beyond 30 seconds on more than 50% of occasions but never has adequate control
4	Has adequate control on less than 25% of occasions
5	Has adequate control between 25% and 75% of occasions
6	Has adequate control on more than 75% of occasions
7	Rarely fails to have adequate control

N.B. 'Adequate control' is defined here in terms of the degree to which it contributes to female coital satisfaction.

Again note - female satisfaction does not necessarily mean female orgasm.

RETARDED EJACULATION

0	Ejaculation never occurs in the waking state
1	Occasionally (less than 50% of occasions) ejaculation can occur with self-masturbation. Cannot occur under any circumstances in partners presence
2	Fairly often (more than 50% of occasions) ejaculation can occur with self-masturbation. Cannot occur under any circumstances in partner's presence
3	Ejaculation always occurs with self-masturbation. Cannot occur under any circumstances in partner's presence
4	Occasionally (less than 50% of occaions) ejaculation occurs with "adequate" non-coital stimulation during love play, but never during S/I
5	Fairly often (more than 50% of occasions) ejaculation occurs with "adequate" non-coital stimulation during love play but never during S/I
6	Ejaculation always occurs wtih "adequate" non-coital stimulation during love play but never during S/I
7	Ejaculation occurs during S/I on less than 25% of occasions
8	Ejaculation occurs during S/I between 25% and 75% of occasions
9	Ejaculation occurs during S/I on more than 75% of occasions
10	Ejaculation virtually always occurs during S/I

FOR THE WOMAN

SEXUAL AROUSAL (VAGINAL LUBRICATION)

0	Never responds to sexual stimulation of any kind with vaginal response
1	Occasionally (less than 50% of occasions) has adequate vaginal response during foreplay only, but difficult to achieve or/and short-lived
2	Usually (more than 50% of occasions) has adequate vaginal response during foreply only, but difficult to achieve or/and short-lived
3	Always achieves adequate vaginal response during foreplay only, but never sustained for coitus
4	Rarely (less than 25% of occasions) has adequate vaginal response without difficulty and maintained throughout foreplay and coitus
5	On approximately 50% of occasions has adequate vaginal response without difficulty and maintained throughout foreplay and coitus
6	Usually (more than 75% of occasions) has adequate vaginal response without difficulty and maintained throughout foreplay and coitus
7	Rarely fails to have adequate vaginal response and to maintain it throughout foreplay and coitus

'Difficult to achieve' means "requires prolonged stimulation".

'Short-lived' means "preventing comfortable penetration or painless consummation of coitus".

'Adequacy of vaginal response' here may be defined in terms of degree to which vaginal lubrication and expansion would or does contribute to comfortable intromission.

VAGINISMUS

(Failure of entry due primarily to muscle spasms or/and fear of pain rather than inadequate lubrication and consequent dyspareunia per se)

0	Will not allow partner to touch her genitalia
1	Will allow stimulation of external genitalia but not vaginal entry of any kind
2	Can accept vaginal entry of only one of partner's fingers, but not penis
3	Can accept vaginal entry of two of partner's fingers but not penis
4	Attempts at vaginal entry of penis successful on less than 50% of occasions
5	Attempts at vaginal entry of penis successful on less than 75% of occasions
6	Vaginal entry of penis always successful

FOR THE WOMAN

DYSPAREUNIA

(Painful Vaginal Entry and Containment)

0	Pain or discomfort too great to allow vaginal entry (of any kind) on any occasion
1	Pain or discomfort too great to allow vaginal entry (of any kind) on more than 50% of occasions
2	Pain or discomfort too great to allow vaginal entry (of any kind) on less than 50% of occasions
3	Vaginal intercourse free from discomfort or pain on less than 25% of occasions
4	Vaginal intercourse free from discomfort or pain between 25% and 75% of occasions
5	Vaginal intercourse free from discomfort or pain on more than 75% of occasions
6	Virtually never experience discomfort or pain during vaginal intercourse

ORGASMIC FREQUENCY

0	Orgasm never occurs - irrespective of source or type of stimulation
1	Occasionally (less than 50% of occasions) orgasm occurs with "adequate" non-coital stimulation during love play *with (not necessarily by) partner, but never during S/I
2	Fairly often (more than 50% of occasions) orgasm occurs *with "adequate" non-coital stimulation during love play with (not necessarily by) partner, but never during S/I
3	Orgasm always occurs with "adequate" non-coital stimulation during S/I *with (not necessarily by) partner but never during S/I.
4	Orgasm occurs during S/I on less than 25% of occasions
5	Orgasm occurs during S/I between 25% - 75% of occasions
6	Orgasm occurs during S/I on more than 75% of occasions
7	Orgasm virtually always occurs during S/I

*with = in presence of

Sexual and Marital Adjustment Rating Scale (SMAR)

Initials _____ Sex _____ Date Commenced Treatment _____

The information you will be offering concerning your relationship is an essential part of treatment. Without it, therapy cannot be properly evaluated. Although treatment is a joint concern between you and your partner, each of you should complete this record independently. What each of you thinks on his or her own is more valid in this case, than what you, as a couple, feel to be so. All the information is entirely confidential and will be available only to your therapist.

Thank you for your co-operation.

Please put an "X" on the point in the scale which best describes, for you, your relationship at present. (Just put one "X".)

1. How satisfactory is your sexual relationship with your partner at present?

extremely unsatisfactory			moderately satisfactory			completely satisfactory

2. How satisfactory is your relationship (other than sexual) with your partner at present?

extremely unsatisfactory			moderately satisfactory			completely satisfactory

Please describe how you feel, and how you think your partner generally feels, during your sexual experiences at present. Put an "X" at the point which best describes yourself. Put a circle at the point which you think best describes your partner.

3.

very tense			moderately tense			very relaxed

4.

very free to express feelings very communicative			moderately communicative			fails totally to express feelings; very uncommunicative

5.

very unaffectionate very cold			moderately affectionate			very affectionate very warm

In general terms, to what extent are you bothered by the symptoms which led you, as a couple, to seek advice?

6.

extremely bothered by them			moderately so			not at all bothered by them

7. During your sexual play, to what extent do you find yourself thinking about or being concerned with the sexual problem(s) which led to your seeking advice?

extremely concerned, totally unable to stop thinking about it			moderately concerned			not at all concerned; do not think about it at all

Self-Rating Scale of Sexual Pleasure, Anxiety and Distaste (PAD Scale)

Please describe how you think you would feel during each of the five siutations listed below. After each situation you will see three scales: one labelled pleasant feelings, (enjoyment, pleasurable excitement, etc) and two scales relating to unpleasant feelings, namely fear and disgust. Since it is possible to experience more than one kind of feeling in these situations, you should circle one number from 0 - 4 on all three scales after each situation. To reassure you that your response will be kept strictly confidential do not put your name, only your initials, at the top of the page.

	PLEASANT FEELINGS (Enjoyment, pleasurable excitement)					UNPLEASANT FEELINGS: Fear or Tension					UNPLEASANT FEELINGS: Disgust or Distaste				
1. Being seen without clothes by your partner	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme
2. Being embraced in bed by your partner	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme
3. Having your body & sexual parts (genitals) caressed by your partner	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme
4. Caressing your partner's body including sexual parts	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme
5. During sexual intercourse with your partner	0	1	1	3	4	0	1	2	3	4	0	1	2	3	4
	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme	None	Slight	Moderate	Quite a lot	Extreme

Table 67 Rotated Factor Loadings of Each Item on SMAR Scale : based on Complainants Only

	Item	Factors		
		I	II	III
1.	Satisfaction with sexual relationship	78	38	- 11
2.	Satisfaction with marital relationship	29	73	- 16
3.	Sexual Anxiety	14	15	89
4.	Communication between partners	- 19	81	15
5.	Affection between partners	07	73	40
6.	General concern about presenting symptoms	76	- 05	45
7.	Concern about presenting symptoms during sexual play	90	- 10	12
	Eigen value	2.1	1.9	1.2
	Percentage Variance	30.6	27.2	17.6

Decimal points omitted

Table 68 Rotated Factor Loadings of Each Item on SMAR Scale : based on Partners only

	Item	Factors		
		I	II	III
1.	Satisfaction with sexual relationship	68	39	03
2.	Satisfaction with marital relationship	83	01	01
3.	Sexual Anxiety	01	00	87
4.	Communication between partners	45	06	62
5.	Affection between partners	78	- 10	42
6.	General concern about presenting symptoms	09	85	- 24
7.	Concern about presenting symptoms during sexual play	03	82	31
	Eigen value	2.0	1.7	1.5
	Percentage Variance	28.2	23.6	21.0

Decimal points omitted

Table 69 Rotated Factor Loadings of Each Item on SMAR Scale : based on Combined Sample of Complainants and Partners

	Item	Factors		
		I	II	III
1.	Satisfaction with sexual relationship	46	67	- 03
2.	Satisfaction with marital relationship	84	16	- 16
3.	Sexual Anxiety	11	20	89
4.	Communication between partners	66	- 04	45
5.	Affection between partners	81	02	31
6.	General concern about presenting symptoms	- 05	85	03
7.	Concern about presenting symptoms during sexual play	02	81	28
	Eigen value	2.0	1.9	1.2
	Percentage Variance	28.9	27.1	17.1

Decimal points omitted

Table 70 Rotated Factor Loadings of Each Item on PAD Scale : based on Complainants only

	Item	Factors		
		I	II	III
	Pleasant Feelings from:			
1.	Being seen naked by partner	- 29	81	- 10
2.	Being embraced in bed by partner	- 19	82	- 13
3.	Being caressed intimately by partner	- 10	76	- 22
4.	Caressing partner intimately	- 34	79	- 09
5.	Sexual intercourse	06	50	- 78
	Anxiety from:			
6.	Being seen naked by partner	87	- 15	23
7.	Being embraced in bed by partner	70	- 11	43
8.	Being caressed intimately by partner	50	- 23	58
9.	Caressing partner intimately	76	- 19	38
10.	Sexual intercourse	25	02	88
	Disgust or Distaste from:			
11.	Being seen naked by partner	76	- 43	03
12.	Being embraced in bed by partner	77	- 47	- 05
13.	Being caressed intimately by partner	63	- 63	04
14.	Caressing partner intimately	63	- 62	09
15.	Sexual intercourse	43	- 59	35
	Eigen value	4.5	4.4	2.3
	Percentage Variance	30.3	29.6	15.5

Decimal points omitted

Table 71 Rotated Factor Loadings of Each Item on PAD Scale : based on Partners only

	Item	Factors		
		I	II	III
	Pleasant Feelings from:			
1.	Being seen naked by partner	06	85	- 08
2.	Being embraced in bed by partner	- 19	76	12
3.	Being caressed intimately by partner	- 08	89	- 17
4.	Caressing partner intimately	- 07	85	- 10
5.	Sexual intercourse	- 04	20	- 68
	Anxiety from:			
6.	Being seen naked by partner	24	- 09	57
7.	Being embraced in bed by partner	61	05	44
8.	Being caressed intimately by partner	32	- 16	75
9.	Caressing partner intimately	66	00	16
10.	Sexual intercourse	23	14	63
	Disgust or Distaste from:			
11.	Being seen naked by partner	08	- 63	52
12.	Being embraced in bed by partner	92	- 12	03
13.	Being caressed intimately by partner	77	- 44	29
14.	Caressing partner intimately	90	- 16	26
15.	Sexual intercourse	87	03	23
	Eigen value	4.1	3.5	2.5
	Percentage Variance	27.2	23.6	16.7

Decimal points omitted

Table 72 Rotated Factor Loadings of Each Item on PAD Scale : based on Combined Sample of Complainants and Partners

	Item	Factors		
		I	II	III
	Pleasant Feelings from:			
1.	Being seen naked by partner	- 25	84	- 06
2.	Being embraced in bed by partner	- 25	80	- 19
3.	Being caressed intimately by partner	- 20	81	- 25
4.	Caressing partner intimately	- 31	80	- 19
5.	Sexual intercourse	- 04	41	- 69
	Anxiety from:			
6.	Being seen naked by partner	78	- 06	27
7.	Being embraced in bed by partner	60	- 11	55
8.	Being caressed intimately by partner	39	- 29	71
9.	Caressing partner intimately	64	- 11	50
10.	Sexual intercourse	20	- 03	88
	Disgust or Distaste from:			
11.	Being seen naked by partner	72	- 41	07
12.	Being embraced in bed by partner	84	- 26	07
13.	Being caressed intimately by partner	78	- 44	14
14.	Caressing partner intimately	79	- 37	21
15.	Sexual intercourse	66	- 29	37
	Eigen value	4.7	3.6	2.7
	Percentage Variance	31.5	23.8	18.2

Decimal points omitted

METHOD OF COMPUTING FACTOR SCORES

Factor Scores for each individual were computed by first calculating z or standard scores for each item. These were then multiplied by the item's respective factor score coefficient for each factor.

Factor Scores were calculated for each case by the formula

$$fi = fsc_{1i}z_1 + fsc_{2i}z_2 + fsc_{3i}z_3 + \ldots\ldots + fsc_{ni}z_n$$

where fsc_{ji} is the factor-score coefficient for item j and factor i, and zj is the case's standardised value on item j.

Table 73 Raw Data from Test-Retest Reliability Assessment

VARIABLE NAME

	SUBJECT	L/W M.A.T.		Self/ Gen. Eval.		Self/ Anxious		Self/ Loving		Self/ Sex. Attract.		Self/ Erotic Arousal		Part./ Gen. Eval.		Part./ Anxious	
		A	B[1]	A	B	A	B	A	B	A	B	A	B	A	B	A	B
*	R1	80	59	7	4	10	11	4	5	8	8	2	3	12	13	6	4
	R2	80	81	12	12	3	3	17	18	11	12	12	13	12	8	11	14
	R3	123	127	8	10	4	4	19	21	12	12	13	12	11	11	3	2
	R4	107	117	13	12	8	9	21	21	9	8	10	8	13	14	2	2
	R5	137	137	12	12	7	6	17	18	12	12	8	8	14	14	5	4
	R6	103	93	8	10	10	10	15	11	8	8	9	9	12	11	4	4
	R7	148	148	14	14	2	3	21	21	14	13	11	12	14	14	2	2
	R8	134	136	12	13	10	12	19	17	9	10	8	9	12	14	8	3
*	R9	110	124	9	14	7	6	5	10	5	13	2	9	14	14	8	14
	R10	97	107	14	13	9	11	21	21	11	11	12	13	12	6	7	8
*	R11	-	-	10	9	6	6	15	13	8	8	9	8	12	12	8	8
*	R12	-	-	13	8	10	10	19	21	8	8	10	9	8	14	2	3
*	R13	-	-	8	10	8	6	13	14	9	10	3	3	13	11	13	11
*	R14	95	99	8	5	10	11	3	5	8	6	2	2	13	11	3	4
*	R15	92	80	8	9	3	3	14	15	7	9	13	12	7	9	7	9
*	R16	127	-	13	14	6	6	19	21	8	12	13	13	14	14	6	5
	R17	115	113	14	14	5	5	21	21	13	12	13	12	14	14	5	5
*	R18	128	120	14	12	2	4	20	18	9	8	11	11	14	14	9	10
	R19	142	142	12	12	9	9	20	21	9	9	10	10	14	14	3	2
*	R20	130	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	R21	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

[1] A = Score from 1st Assessment; B = Score from 2nd Assessment

* denotes those subjects with known sexual dysfunction

Table 73 (Cont'd)

VARIABLE NAME

	SUBJECT	Part./ Loving		Part./Sex. Attract.		Part./Erotic Arousal		Marital Satis. Factor		Sexual Satis. Factor		Sexual Aversion		Sexual Pleasure		Sexual Anxiety	
		A	B[1]	A	B	A	B	A	B	A	B	A	B	A	B	A	B
*	R1	18	18	8	8	11	11	1185.0	1193.0	1076	1077	786	618	1155	1156	893	962
	R2	5	10	12	12	3	6	1034	1004	1006	1005	874	866	936	906	979	1012
	R3	20	19	12	13	14	13	903.7	882.4	637.9	691.7	990	1017	846	862	1124	1122
	R4	21	20	11	12	11	12	1084.5	932.5	891	687	1052	1058	999	1000	1140	1137
	R5	20	21	12	14	12	13	886.3	879.2	609	645	1034	1007	874	889	1074	1072
	R6	14	11	8	10	12	11	942.4	1043	590	605	1054	1039	994	1024	1137	1154
	R7	21	21	14	13	13	13	862.2	848.7	610	671	-	-	-	-	-	-
	R8	12	18	14	14	11	11	928.8	892.3	789	595	1061	1070	1024	1054	1155	1157
*	R9	21	21	14	14	12	14	1069	1110	1038	1037	1035	1040	922	860	1126	1059
	R10	5	3	9	8	4	4	871.1	962.2	1071	974	1063	1057	977	947	1135	1126
*	R11	18	18	11	10	10	9	942.8	981.0	894	827	1084	1049	1001	993	927	910
*	R12	20	21	11	11	10	9	931.5	896.4	967	908	1031	1019	884	934	826	895
*	R13	19	18	10	10	9	6	1031	1047	794	825	1109	1109	1086	1086	1090	1090
*	R14	14	11	8	8	9	12	900	956.8	1135	1108	596	553	1115	1107	839	864
*	R15	9	9	12	13	2	3	1041.4	977.5	1002	1067	1048	1039	982	952	1144	1142
*	R16	21	21	14	14	11	12	840.2	875.3	1083	1031	854	833	835	885	1006	1125
	R17	21	21	12	12	14	13	812.4	873.5	1052	1113	1104	1126	916	1079	923	960
*	R18	19	21	11	10	10	11	966.9	913.9	1048	998	1069	1056	936	929	999	1022
	R19	21	20	10	10	8	9	824.5	823.1	965	928	1026	1045	942	968	1019	1056
*	R20	-	-	-	-	-	-	963.8	934.4	1075	1008	1102	1097	1180	1157	1108	1105
	R21	-	-	-	-	-	-	882.4	856.0	870	975	1026	1026	892	892	1124	1124

[1] A = Score from 1st Assessment; B = Score from 2nd Assessment

* denotes those subjects with known sexual dysfunction

Table 73 (Cont'd)

	SUBJECT	VARIABLE NAME: Spectating		Freq. of Intercourse		Deg. Coital Enj. (Self)		Deg. Coital Enj. (Part.)									
		A	B[1]	A	B	A	B	A	B	A	B	A	B	A	B	A	B
*	R1	2	2	2	2	2	2	5	5								
	R2	3	2	2	2	5	5	2	2								
	R3	5	4	5	5	6	6	6	6								
	R4	4	4	5	5	6	6	6	6								
	R5	5	5	3	3	5	6	6	6								
	R6	5	5	6	6	6	6	6	6								
	R7	4	4	4	5	6	6	6	6								
	R8	3	5	3	3	6	6	6	6								
*	R9	1	2	-	-												
	R10	1	4	-	-												
*	R11	3	3	-	-												
*	R12	2	2	-	-												
*	R13	3	3	3	-	5	-	5	--								
*	R14	1	1	1	1	1	1	6	6								
*	R15	2	2	2	2	5	6	2	2								
*	R16	1	2	4	4	6	6	4	5								
	R17	2	2	3	4	4	4	6	6								
*	R18	2	2	5	1	2	-	4	-								
	R19	2	2	5	1	4	-	4	-								
*	R20	1	2	5	5	4	4	6	6								
	R21	4	3	5	5	6	6	5	5								

[1] A = Score from 1st Assessment; B = Score from 2nd Assessment

* denotes those subjects with known sexual dysfunction

APPENDIX 4

of Covariance Among Treatment and Waiting-List Control Group Scores on following variables:

Table 74 Ratings of "Myself" on "Loving" Factor of Semantic Differential

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	55.24	1	55.24	9.68	0.004	
Treatment	47.07	2	23.54	4.13	0.024	
1st Covariate	418.42	1	418.42	73.36	0.000	0.77
Error	216.73	38	5.70			

Adjusted Group Means

	MJ	SH	WT
m	16.75	14.78	14.09
n	10	11	21

Table 75 Locke-Wallace Marital Adjustment

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	64.99	1	64.99	0.39	0.54	
Treatment	1113.64	2	556.82	3.36	0.045	
1st Covariate	18125.69	1	18125.69	109.22	0.000	0.94
Error	6638.02	40	165.95			

Adjusted Group Means

	MJ	SH	WT
m	108.25	103.08	96.20
n	11	12	21

Table 76 Marital Satisfaction Factor (SMAR)

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	44686.3	1	44686.3	6.3	0.016	
Treatment	42999.9	2	21500.0	3.0	0.059	
1st Covariate	57707.7	1	57707.7	8.2	0.007	0.52
Error	282570.2	40	7064.3			

Adjusted Group Means

	MJ	SH	WT
m	974.9	974.3	1038.6
n	10	11	23

Table 77 Ratings of "Myself" on Sexual Attractiveness" Factor of Sem- Semantic Differential

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	38.23	1	38.23	12.00	0.001	
Treatment	24.19	2	12.09	3.79	0.031	
1st Covariate	63.72	1	63.72	19.99	0.0001	0.59
Error	121.10	38	3.19			

Adjusted Group Means

	MJ	SH	WT
m	8.60	8.45	7.00
n	10	11	21

Table 78 Ratings of "Myself" on "Erotic-Arousal" Factor of Semantic Differential

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	94.76	1	94.76	23.85	0.00	
Treatment	35.50	2	17.75	4.47	0.18	
1st Covariate	300.40	1	300.40	75.61	0.000	0.73
Error	150.98	38	3.97			

Adjusted Group Means

	MJ	SH	WT
m	8.08	8.18	6.29
n	10	11	21

Table 79 Ratings of "Myself" on "General Evaluation" Factor of Semantic Differential

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	39.37	1	39.37	8.90	0.005	
Treatment	26.84	2	13.42	3.03	0.060	
1st Covariate	102.40	1	102.40	23.16	0.000	0.73
Error	168.05	38	4.42			

Adjusted Group Means

	MJ	SH	WT
m	11.18	9.97	9.07
n	10	11	21

Table 80 Independent Ratings of Degree of Enjoyment of Intimate Foreplay

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	5.95	1	5.95	11.43	0.002	
Treatment	2.72	2	1.36	2.61	0.00	
1st Covariate	18.59	1	18.59	35.69	0.000	0.63
Error	17.71	34	0.52			

Adjusted Group Means

	MJ	SH	WT
m	3.14	3.09	2.57
n	9	8	21

Table 81 Independent Ratings of Frequency of Pleasurable Sexual Intercourse

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	4.151	1	41.51	38.69	0.000	
Treatment	27.21	2	13.60	12.68	0.0001	
1st Covariate	18.25	1	18.25	17.01	0.0002	0.51
Error	35.41	33	1.07			

Adjusted Group Means

	MJ	SH	WT
m	3.06	2.75	1.12
n	8	8	21

Table 82 Independent Ratings of Frequency of Sexual Interest

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	10.21	1	10.21	12.95	0.001	
Treatment	9.22	2	4.61	5.85	0.007	
1st Covariate	38.88	1	38.88	49.33	0.000	0.75
Error	26.80	34	0.79			

Adjusted Group Means

	MJ	SH	WT
m	3.96	3.95	2.94
n	9	8	21

Table 83 Self-Ratings of Frequency of Sexual Interest (SII)

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	52.45	1	52.45	24.77	0.000	
Treatment	16.52	2	8.26	3.90	0.028	
1st Covariate	28.03	1	28.03	13.24	0.0008	0.52
Error	84.70	40	2.12			

Adjusted Group Means

	MJ	SH	WT
m	3.82	4.00	2.68
n	11	11	22

Table 84 Self-Ratings of Degree of Enjoyment of Sexual Intercourse (SII)

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	38.43	1	38.43	28.86	0.000	
Treatment	7.52	2	3.76	2.82	0.076	
1st Covariate	35.75	1	35.75	26.85	0.000	0.56
Error	28.62	29	1.33			

Adjusted Group Means

	MJ	SH	WT
m	4.75	4.68	3.74
n	7	9	17

Table 85 Sexual Satisfaction Factor (SMAR Scale)

	ss	df	Mean Square	F	Prob	Beta Est.
Mean	6974.1	1	6974.1	0.36	0.55	
Treatment	293536.4	2	146768.2	7.50	0.002	
1st Covariate	133395.8	1	133395.8	6.82	0.013	0.72
Error	782657.3	40	19566.4			

Adjusted Group Means

	MJ	SH	WT
m	826.40	900.76	1021.16
n	10	11	23

Table 86 Sexual Pleasure Factor (PAD Scale)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	10575.2	1	10575.2	3.03	0.09	
Treatment	22762.9	2	11381.5	3.26	0.050	
Covariate	324077.6	1	324077.6	92.88	0.00	0.83
Error	129104.1	37	3489.3			

Adjusted Group Means

	MJ	SH	WT
m	974.47	1001.62	1031.20
n	10	10	21

Table 87 Independent Ratings of Frequency of Unpleasurable Sexual Intercourse

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	40.59	1	40.59	28.5	0.00	
Treatment	9.18	2	4.59	3.2	0.052	
1st Covariate	24.84	1	24.84	17.5	0.0002	0.59
Error	48.40	34	1.42			

Adjusted Group Means

	MJ	SH	WT
m	2.89	2.51	1.76
n	9	8	21

Table 88 Self-Ratings of Degree of Anxiety About Presenting Sexual Symptoms During Sexual Play (Tendency to "Spectate")

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	22.17	1	22.17	21.97	0.000	
Treatment	18.25	2	9.13	9.05	0.0005	
1st Covariate	4.93	1	4.93	4.89	0.0326	0.50
Error	42.37	42	1.01			

Adjusted Group Means

	MJ	SH	WT
m	3.13	2.40	1.60
n	11	12	23

Table 89 Sexual Anxiety Factor (PAD Scale)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	52279.5	1	52279.5	7.99	0.008	
Treatment	105663.8	2	52831.9	8.08	0.001	
Covariate	182300.4	1	182300.4	27.86	0.000	0.70
Error	248613.9	38	6542.5			

Adjusted Group Means

	MJ	SH	WT
m	1083.8	1010.6	956.8
n	10	11	21

APPENDIX 5

(Complainants only): Results of One-Way Analysis of Variance on following variables

Table 90 Marital Satisfaction Factor (SMAR Scale)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	45370123.4	1	45370123.4	8744.4	0.000	
Problem	99017.8	3	33005.9	6.36	0.001	
Error	212727.0	41	5188.5			

	FSU	VAG	PE	EI
n	12	14	8	11

Table 91 Ratings of "Myself" on "Loving" Factor of the Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	9446.4	1	9446.4	760.3	0.000	
Problem	279.5	3	93.2	7.5	0.0004	
Error	521.8	42	12.4			

	FSU	VAG	PE	EI
n	12	12	10	12

Table 92 Locke-Wallace Marital Adjustment

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	451049.5	1	451049.5	792.0	0.000	
Problem	5213.0	3	1737.7	3.05	0.038	
Error	25059.0	44	569.5			

	FSU	VAG	PE	EI
n	12	14	10	12

Table 93 Self-Ratings of Communication

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	495.11	1	495.11	253.7	0.000	
Problem	37.45	3	12.48	6.4	0.001	
Error	85.86	44	1.95			

	FSU	VAG	PE	EI
n	12	14	10	12

Table 94 Self-Ratings of Affections Toward Partner

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	801.07	1	801.07	419.9	0.0000	
Problem	51.97	3	17.32	9.08	0.0001	
Error	83.95	44	1.91			

	FSU	VAG	PE	EI
n	12	14	10	12

Table 95 Ratings of "Myself" on "General Evaluation" Factor of Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	3470.06	1	3470.06	567.13	0.0000	
Problem	59.45	3	19.82	3.24	0.032	
Error	256.98	42	6.12			

	FSU	VAG	PE	EI
n	12	12	10	12

Table 96 Ratings of "Myself" on "Anxiety" Factor of Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	4042.90	1	4042.90	682.80	0.0000	
Problem	132.79	3	44.26	7.48	0.0004	
Error	248.68	42	5.92			

	FSU	VAG	PE	EI
n	12	12	10	12

Table 97 Ratings of "Myself" on "Sexual Attractiveness" Factor of Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	2472.40	1	2472.40	555.05	0.0000	
Problem	42.66	3	14.22	3.19	0.033	
Error	187.08	42	4.45			

	FSU	VAG	PE	EI
n	12	12	10	12

Table 98 Ratings of "Myself" on "Erotic Arousal" Factor of Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	2008.95	1	2008.95	744.60	0.0000	
Problem	413.84	3	137.95	51.13	0.0000	
Error	113.32	42	2.70			

	FSU	VAG	PE	EI
n	12	12	10	12

Table 99 Ratings of "My Partner" on "Erotic Arousal" Factor of Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	5535.62	1	5535.62	1998.82	0.0000	
Problem	58.49	3	19.50	7.04	0.0006	
Error	116.32	42	2.77			

	FSU	VAG	PE	EI
n	12	12	10	12

Table 100 Independent Ratings of Frequency of Pleasurable Intimate Foreplay

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	279.10	1	279.10	290.12	0.0000	
Problem	36.38	3	12.13	12.60	0.0000	
Error	41.37	43	0.96			

	FSU	VAG	PE	EI
n	11	14	10	12

Table 101 Independent Ratings of Degree of Enjoyment of Intimate Foreplay

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	288.43	1	288.43	520.59	0.0000	
Problem	31.79	3	10.60	19.13	0.0000	
Error	23.82	43	0.55			

	FSU	VAG	PE	EI
n	11	14	10	12

Table 102 Indpendent Ratings of Frequency of Pleasurable Intercourse

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	85.27	1	85.27	99.35	0.0000	
Problem	40.03	3	13.34	15.55	0.0000	
Error	36.90	43	0.86			

	FSU	VAG	PE	EI
n	11	14	10	12

Table 103 Independent Ratings of Frequency of Sexual Interest

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	440.26	1	440.26	424.04	0.0000	
Problem	49.27	3	16.42	15.82	0.0000	
Error	44.65	43	1.04			

	FSU	VAG	PE	EI
n	11	14	10	12

Table 104 Self-Ratings of Degree of Enjoyment of Sexual Intercourse (SII)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	406.22	1	406.22	208.09	0.0000	
Problem	65.78	3	21.93	11.24	0.0000	
Error	62.44	32	1.95			

	FSU	VAG	PE	EI
n	12	5	9	10

Table 105 Sexual Pleasure Factor (PAD Scale)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	44187839.7	1	44187839.7	7903.63	0.0000	
Problem	225460.9	3	75153.6	13.44	0.0000	
Error	223633.0	40	5590.8			

	FSU	VAG	PE	EI
n	12	13	8	11

Table 106 Self-Ratings of Frequency of Sexual Intercourse (SII)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	347.75	1	347.75	366.24	0.0000	
Problem	70.66	3	23.55	24.81	0.0000	
Error	40.83	43	0.95			

	FSU	VAG	PE	EI
n	12	14	9	12

Table 107 Independent Ratings of Frequency of Unpleasurable Intimate Foreplay

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	307.53	1	307.53	292.79	0.0000	
Problem	48.15	3	16.05	15.28	0.0000	
Error	45.16	43	1.05			

	FSU	VAG	PE	EI
n	11	14	10	12

Table 108 Independent Ratings of Frequency of Unpleasurable Intercourse

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	171.06	1	171.06	142.37	0.0000	
Problem	70.21	3	23.40	19.48	0.0000	
Error	51.66	43	1.20			

	FSU	VAG	PE	EI
n	11	14	10	12

Table 109 Sexual Anxiety Factor (PAD Scale)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	39643684.2	1	39643684.2	4166.1	0.0000	
Problem	107892.2	3	35964.1	3.8	0.018	
Error	390144.6	41	9515.7			

	FSU	VAG	PE	EI
n	12	14	8	11

Pretreatment Differences Among Problem Groups (Partners Only): Results of One-Way Analysis of Variance on following variables

Table 110 Ratings of "Myself" in "Erotic Arousal" Factor of Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	4122.48	1	4122.48	962.63	0.0000	
Problem	138.73	3	46.24	10.80	0.0000	
Error	175.58	41	4.28			

	FSU	VAG	PE	EI
n	12	12	9	12

Table 111 Ratings of "My Partner" on "Erotic Arousal" Factor of Semantic Differential

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	2580.77	1	2580.77	479.93	0.0000	
Problem	349.17	3	116.39	21.64	0.0000	
Error	220.47	41	5.38			

	FSU	VAG	PE	EI
n	12	12	9	12

Table 112 Independent Ratings of Frequency of Pleasurable Intimate Foreplay

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	526.08	1	526.08	1114.14	0.0000	
Problem	7.84	3	2.61	5.53	0.003	
Error	19.36	41	0.47			

	FSU	VAG	PE	EI
n	10	14	10	11

Table 113 Independent Ratings of Frequency of Pleasurable Sexual Intercourse

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	216.63	1	216.63	229.01	0.0000	
Problem	81.13	3	27.04	28.59	0.0000	
Error	38.78	41	0.95			

	FSU	VAG	PE	EI
n	10	14	10	11

Table 114 Independent Ratings of Degree of Enjoyment of Intimate Foreplay

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	457.60	1	457.60	1074.18	0.0000	
Problem	15.33	3	5.11	12.00	0.0000	
Error	17.47	41	0.43			

	FSU	VAG	PE	EI
n	10	14	10	11

Table 115 Independent Ratings of Frequency of Sexual Interest

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	750.78	1	750.78	780.09	0.0000	
Problem	21.74	3	7.25	7.53	0.0004	
Error	39.46	41	0.96			

	FSU	VAG	PE	EI
n	10	14	10	11

Table 116 Self-Ratings of Frequency of Sexual Intercourse (SII)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	429.39	1	429.39	383.61	0.0000	
Problem	102.64	3	34.21	30.57	0.0000	
Error	47.01	42	1.12			

	FSU	VAG	PE	EI
n	12	14	9	11

Table 117 Independent Ratings of Frequency of Unpleasurable Sexual Intercourse

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	326.03	1	326.03	444.32	0.0000	
Problem	73.03	3	24.34	33.17	0.0000	
Error	30.08	41	0.73			

	FSU	VAG	PE	EI
n	10	14	10	11

APPENDIX 6

Appendix 6 Results of Two-Way (Treatments x Problems) and One-Way (Treatments or Problems) Analysis of Covariance - Complainants only, unless otherwise specified.

Table 118 Sexual Pleasure Factor (PAD Scale) - Post-Treatment - Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	3843.80	1	3843.80	0.78	0.382	
Problem	9424.92	3	3141.64	0.64	0.595	
Treatment	7536.84	1	7536.84	1.53	0.224	
Treat.x Problem	35876.46	3	11958.82	2.44	0.081	
Covariate	151346.47	1	151346.47	30.82	0.000	0.839
Error	171855.05	35	4910.14			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	939.02	1061.65	974.00	979.02	1029.55	1000.12	1006.83	1016.67
σ	69.96	82.90	117.89	90.68	75.76	115.66	82.45	105.19
n	6	6	7	6	4	4	5	6

Table 119 Sexual Pleasure Factor (PAD Scale) - Post Treatment. Results of Two-Way (Treatments x Problems) ANCOVA involving only FSU and EI problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	3196.07	1	3196.07	0.88	0.360	
Problem	200.56	1	200.56	0.06	0.817	
Treatment	23652.09	1	23652.09	6.54	0.020	
Treat.x Problem	18148.43	1	18148.43	5.02	0.038	
Covariate	76255.87	1	76255.87	21.09	0.807	
Error	65091.10	18	3616.17			

Adjusted Cell Means

	FSU MJ	FSU SH	PE MJ	PE SH
m	971.49	1093.24	1035.49	1044.53
σ	69.96	82.90	82.45	105.19
n	6	6	5	6

Table 120 Sexual Pleasure Factor (PAD Scale) - Post-Treatment. Results of Two-Way (Treatments x Problems) ANCOVA involving only FSU and PE problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	2145.19	1	2145.19	0.57	0.463	
Problem	172.70	1	172.70	0.05	0.834	
Treatment	9434.69	1	9434.69	2.49	0.135	
Treat.x Problem	27705.25	1	17705.25	7.32	0.016	
Covariate	59394.62	1	59394.62	15.69	0.001	0.823
Error	56789.71	15	3785.98			

Adjusted Cell Means

	FSU MJ	FSU SH	PE MJ	PE SH
m	946.98	1069.19	1034.34	1004.15
σ	69.96	82.90	75.76	115.66
n	6	6	4	4

Table 121 Post-Treatment Independent Ratings of Frequency of Pleasurable Sexual Intercourse: Results of One-Way Analysis of Covariance Between SH and MJ Treatment Groups.

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	116.78	1	116.78	97.06	0.000	
Treatment	3.83	1	3.83	3.18	0.084	
Covariate	5.29	1	5.29	4.39	0.044	0.28
Error	40.91	34	1.20			

Adjusted Group Means

	MJ	SH
m	3.06	2.41
σ	1.02	1.26
n	18	19

Table 122 Post-T Indep Ratings of Deg of Enjoyment of Intimate Foreplay: Results of One-Way Anal of Cov Between SH & MJ Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	3.54	1	3.54	7.07	0.012	
Treatment	3.32	1	3.32	6.63	0.014	
Covariate	22.69	1	22.69	45.31	0.000	0.76
Error	17.53	35	0.50			

Adjusted Group Means

	MJ	SH
m	3.30	2.70
σ	1.11	1.00
n	19	19

Table 123 Post-T Indep Ratings Frequency of Pleasurable Sexual Intercourse (Partners Only): Results of One-Way ANCOVA among problem groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	18.09	1	18.09	14.34	0.0006	
Problem	12.58	3	4.19	3.33	0.032	
Covariate	12.49	1	11.49	9.11	0.005	0.58
Error	40.35	32	1.26			

Adjusted Group Means

	FSU	VAG	PE	EI
m	2.78	4.11	2.24	2.37
σ	0.38	1.41	1.40	1.30
n	7	14	7	9

Table 124 Complainants' Post-Treatment Ratings of Spouse Coital Enjoyment (SII) - Results of One-Way ANCOVA among problem groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	9.51	1	9.51	20.13	0.0002	
Problem	10.34	2	5.17	10.94	0.0005	
Covariate	2.95	1	2.95	6.25	0.0204	0.35
Error	10.40	22	0.47			

Adjusted Problem Group Means

	FSU	PE	EI
m	5.74	4.18	5.33
σ	0.60	0.93	0.79
n	11	8	7

Table 125 General Sexual Satisfaction Factor (SMAR Scale) - Post-Treatment. Two-Way ANCOVA results.

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	81091.3	1	81091.3	3.29	0.078	
Problem	220175.7	3	73391.9	2.98	0.044	
Treatment	58751.9	1	58751.9	2.39	0.131	
Treat.x Problem	45249.8	3	15083.3	0.61	0.611	
Covariate	55598.1	1	55598.1	2.26	0.142	0.386
Error	886769.7	36	24632.5			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	851.56	998.13	780.74	763.57	909.25	990.99	823.68	912.23
σ	175.49	93.94	149.96	154.50	256.19	98.88	152.95	171.06
n	6	6	7	7	4	4	5	6

Table 126 General Sexual Satisfaction (SMAR Scale) - Follow-Up. Two-Way ANCOVA results (Complainants only)

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	80254.1	1	80254.1	4.48	0.042	
Problem	221081.9	3	73694.0	4.11	0.014	
Treatment	71932.6	1	71932.6	4.01	0.053	
Treat.x Problem	18836.2	3	6278.7	0.35	0.789	
Covariate	29723.1	1	29723.1	1.66	0.207	0.317
Error	609572.7	34	17928.6			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	827.82	931.94	681.60	826.99	894.83	925.07	892.31	956.63
σ	136.44	100.43	126.94	189.01	100.63	105.41	143.49	110.43
n	6	5	7	7	4	4	5	5

Table 127 General Sexual Satisfaction (SMAR) - Post Treatment: Results of One-Way ANCOVA among problem groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	63663.8	1	63663.8	2.58	0.116	
Problem	223178.5	3	74392.8	3.02	0.041	
Covariate	81699.2	1	81699.2	3.32	0.076	
Error	985211.9	40	24630.3			

Adjusted Cell Means

	FSU	VAG	PE	EI
m	925.6	771.7	950.4	871.5
σ	156.5	146.6	191.5	161.7
n	12	14	8	11

Table 128 General Sexual Satisfaction (SMAR) - Follow-Up: Results of One-Way ANCOVA among problem groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	71907.9	1	71907.9	3.77	0.060	
Problem	218181.0	3	72727.0	3.81	0.018	
Covariate	43898.0	1	43898.0	2.30	0.137	0.37
Error	724478.9	38	19065.2			

Adjusted Cell Means

	FSU	VAG	PE	EI
m	876.2	754.1	910.4	923.1
σ	128.3	171.9	101.4	127.9
n	11	14	8	10

Results of Newman-Keuls

VAG < EI VAG < FSU
VAG < PE all $p < .05$

Table 129 Sexual Satisfaction Factor (SMAR Scale) - Post-Treatment (Partners only): Two-Way ANCOVA Results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	95536.4	1	95536.4	4.81	0.035	
Problem	139410.7	3	46470.24	2.34	0.089	
Treatment	65801.3	1	65801.3	3.31	0.077	
Treat.x Problem	62630.8	3	20876.9	1.05	0.381	
Covariate	48198.8	1	48198.8	2.43	0.128	0.37
Error	754473.9	38	19854.6			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	772.9	951.1	772.2	755.3	826.6	916.4	877.3	933.9
σ	139.3	74.1	170.2	168.1	199.5	105.2	134.0	127.7
n	6	6	7	7	4	5	6	6

Table 130 General Sexual Satisfaction (SMAR Scale) - Follow-Up (Partners only): Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	72308.7	1	72308.7	3.93	0.056	
Problem	255213.8	3	85071.3	4.62	0.008	
Treatment	55246.2	1	55246.2	3.00	0.092	
Treat.x Problem	52905.7	3	17635.2	0.96	0.423	
Covariate	43614.3	1	43614.3	2.37	0.133	0.37
Error	625466.8	34	18396.1			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	706.4	862.2	714.8	690.3	862.7	962.6	833.3	899.9
σ	132.4	94.7	170.4	177.3	121.7	132.7	128.1	70.6
n	6	5	7	7	4	4	5	5

Table 131 General Sexual Satisfaction (SMAR Scale) - Follow-Up (Partners only): Results of One-Way ANCOVA among Problem Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	57545.1	1	57545.1	3.02	0.090	
Problem	269428.2	3	89809.4	4.72	0.007	
Covariate	61834.6	1	61834.6	3.25	0.080	0.43
Error	723635.4	38	19043.0			

Adjusted Group Means

	FSU	VAG	PE	EI
m	776.3	700.9	915.0	867.2
σ	141.2	167.1	134.4	103.6
n	11	14	8	10

Results of Newman-Keuls Test

PE > VAG $p < .01$
EI > VAG $p < .05$

Table 132 "Tendency to Spectate" - Post-Treatment: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	43.71	1	43.71	30.68	0.000	
Problem	15.87	3	5.29	3.71	0.019	
Treatment	8.43	1	8.43	5.92	0.020	
Treat.x Problem	1.96	3	0.65	0.46	0.713	
Covariate	0.71	1	0.71	0.50	0.484	0.17
Error	54.13	38	1.42			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	3.13	1.71	3.72	3.38	2.47	1.43	3.02	2.35
σ	1.47	0.82	0.95	0.98	1.91	0.55	1.41	1.21
n	6	6	7	7	4	5	6	6

Table 133 "Tendency to Spectate" - Follow-Up: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	45.02	1	45.02	40.78	0.000	
Problem	12.36	3	4.12	3.73	0.020	
Treatment	8.21	1	8.21	7.44	0.010	
Treat.x Problem	1.50	3	0.50	0.45	0.716	
Covariate	0.48	1	0.48	0.44	0.513	0.15
Error	37.53	34	1.10			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	2.96	2.23	4.43	2.96	2.73	2.27	3.00	2.06
σ	1.10	0.84	0.79	1.41	1.26	0.96	0.71	1.00
n	6	5	7	7	4	4	5	5

Table 134 "Tendency to Spectate" - Post Treatment: Results of One-Way ANCOVA between Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	41.26	1	41.26	17.99	0.000	
Treatment	13.84	1	13.84	6.03	0.018	
Covariate	3.60	1	3.60	1.57	0.217	0.38
Error	103.19	45	2.29			

Adjusted Group Means

	MJ	SH
m	3.39	2.32
σ	1.79	1.20
n	24	24

Table 135 "Tendency to Spectate" - Follow-Up: Results of One-Way ANCOVA between Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	48.91	1	48.91	37.86	0.000	
Treatment	9.59	1	9.59	7.43	0.010	
Covariate	0.78	1	0.78	0.61	0.441	0.19
Error	51.68	40	1.29			

Adjusted Group Means

	MJ	SH
m	3.39	2.44
σ	1.14	1.12
n	22	21

Table 136 "Tendency to Spectate" - Post-Treatment: Results of One-Way ANCOVA among Problem Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	39.28	1	39.28	25.79	0.000	
Problem	16.40	3	5.47	3.59	0.021	
Covariate	1.92	1	1.92	1.26	0.268	0.28
Error	63.98	42	1.52			

Adjusted Problem Group Means

	FSU	VAG	PE	EI
m	2.42	3.54	1.90	2.69
σ	1.38	0.94	1.36	1.30
n	12	14	9	12

Results of Newman-Keuls

VAG > PE $p \leq .05$

VAG almost > FSU

Table 137 "Tendency to Spectate" - Follow-Up: Results of One-Way ANCOVA among Problem Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	46.01	1	46.01	35.54	0.000	
Problem	12.07	3	4.02	3.11	0.038	
Covariate	0.70	1	0.70	0.54	0.466	
Error	49.20	38	1.29			

Adjusted Problem Group Means

	FSU	VAG	PE	EI
m	2.63	3.69	2.50	2.54
σ	1.03	1.33	1.07	0.97
n	11	14	8	10

Results of Newman-Keuls

VAG > FSU

Table 138 "Tendency to Spectate" - Follow-Up (Partners Only): Results of One-Way ANCOVA among Problem Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	49.37	1	49.37	50.84	0.000	
Problem	14.00	3	4.67	4.81	0.006	
Covariate	3.34	1	3.34	3.44	0.072	0.29
Error	36.90	38	0.97			

Adjusted Problem Group Means

	FSU	VAG	PE	EI
m	4.08	4.08	2.77	3.08
σ	0.94	1.21	10.4	0.74
n	11	14	8	10

Results of Newman-Keuls

VAG > PE $p < .05$
FSU > PE $p < .05$
FSU > EI $p < .05$

Table 139 General Sexual Anxiety (PAD Scale) - Post-Treatment: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	169118.8	1	169118.8	26.48	0.000	
Problem	30595.6	3	10198.5	1.60	0.207	
Treatment	23908.1	1	23908.1	3.74	0.061	
Treat.x Problem	15476.6	3	5158.9	0.81	0.498	
Covariate	49762.6	1	49762.6	7.79	0.008	0.38
Error	229961.5	36	6387.8			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	1056.81	970.48	1052.23	1059.73	1008.01	959.69	1085.12	1019.68
σ	63.60	46.86	85.95	73.52	78.30	173.39	89.68	78.75
n	6	6	7	7	4	4	5	6

Table 140 General Sexual Anxiety (PAD Scale) - Post Treatment: Results of One-Way ANCOVA between Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	290793.9	1	290793.9	43.87	0.000	
Treatment	23557.3	1	23557.3	3.55	0.066	
Covariate	46689.8	1	46689.8	7.04	0.011	0.31
Error	278387.1	42	6628.3			

Adjusted Group Means

	MJ	SH
m	1053.9	1007.7
σ	81.5	91.9
n	22	23

Table 141 General Marital Satisfaction (SMAR Scale) - Post Treatment: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	100598.2	1	100598.2	19.73	0.000	
Problem	22862.3	3	7620.8	1.49	0.232	
Treatment	5599.6	1	5599.6	1.10	0.302	
Treat.x Problem	86918.5	3	28972.8	5.68	0.003	
Covariate	13318.8	1	13318.8	2.61	0.115	0.26
Error	283512.5	36	5097.6			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	927.4	1070.3	945.3	969.8	960.5	989.9	1069.0	963.8
σ	46.9	66.8	80.0	106.2	99.3	31.5	38.5	61.6
n	6	6	7	7	4	4	5	6

Table 142 General Marital Satisfaction (SMAR Scale) - Follow-Up: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	140065.2	1	140065.2	31.42	0.000	
Problem	28909.0	3	9636.3	2.16	0.111	
Treatment	9681.6	1	9681.6	2.17	0.150	
Treat.x Problem	32188.8	3	10729.6	2.41	0.084	
Covariate	2438.1	1	2438.1	0.55	0.465	0.11
Error	151578.4	34	4458.2			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	966.5	1087.5	970.0	959.1	972.3	994.3	1027.3	1018.6
σ	55.2	40.5	84.3	91.5	73.4	47.3	49.7	40.8
n	6	5	7	7	4	4	5	5

Table 143 General Marital Satisfaction (SMAR Scale) - Post Treatment (Partners Only): Two-Way ANCOVA resutls

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	132511.3	1	132511.3	25.37	0.000	
Problem	16217.1	3	5405.7	1.04	0.388	
Treatment	220.8	1	220.8	0.04	0.838	
Treat.x Problem	50328.7	3	16776.2	3.21	0.034	
Covariate	37683.2	1	37683.2	7.22	0.011	0.35
Error	198456.3	38	5222.5			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	933.4	1037.7	969.8	971.7	1017.3	1013.8	1054.4	969.5
σ	52.9	57.1	111.6	76.5	134.7	49.3	61.5	50.9
n	6	6	7	7	4	5	6	6

Table 144 General Marital Satisfaction (SMAR Scale) - Post-Treatment: Results of Two-Way ANCOVA involving only FSU & EI problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	101260.4	1	101260.4	33.35	0.000	
Problem	644.3	1	644.3	0.21	0.651	
Treatment	2194.8	1	2194.8	0.72	0.406	
Treat.x Problem	89698.3	1	89698.3	29.54	0.000	
Covariate	3544.6	1	3544.6	1.17	0.294	0.15
Error	54653.8	18	3036.3			

Adjusted Cell Means

	FSU MJ	FSU SH	EI MJ	EI SH
m	937.5	1083.5	1075.2	968.4
σ	46.9	66.8	38.5	61.6
n	6	6	5	6

Table 145 General Marital Satisfaction (SMAR Scale) - Post-Treatment: Results of Two-Way ANCOVA involving only PE & EI problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	47795.8	1	47795.8	18.74	0.001	
Problem	3252.1	1	3252.1	1.28	0.278	
Treatment	4799.3	1	4799.3	1.88	0.192	
Treat.x Problem	22439.9	1	22439.9	8.80	0.010	
Covariate	21780.6	1	21780.6	8.54	0.011	0.40
Error	35699.6	14	2550.0			

Adjusted Cell Means

	FSU MJ	FSU SH	EI MJ	EI SH
m	955.1	992.4	1054.7	951.6
σ	99.3	31.5	38.5	61.6
n	4	4	5	6

Table 146 General Marital Satisfaction (SMAR Scale) - Follow-Up Results of Two-Way ANCOVA involving only FSU & EI problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	105942.0	1	105942.0	46.22	0.000	
Problem	93.63	1	93.63	0.04	0.842	
Treatment	16425.9	1	16425.9	7.17	0.017	
Treat.x Problem	21955.9	1	21955.9	9.58	0.007	
Covariate	1641.4	1	1641.4	0.72	0.410	0.11
Error	36671.2	16	2292.0			

Adjusted Cell Means

	FSU MJ	FSU SH	EI MJ	EI SH
m	970.5	1091.6	1031.0	1022.2
σ	55.2	40.5	49.7	40.8
n	6	5	5	5

Table 147 General Marital Satisfaction (SMAR Scale) - Follow-Up: Results of Two-Way ANCOVA involving only FSU & VAG problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	87368.8	1	87368.8	15.99	0.001	
Problem	33855.2	1	33855.2	6.20	0.022	
Treatment	18715.3	1	18715.3	3.42	0.079	
Treat.x Problem	29577.3	1	29577.3	5.41	0.031	
Covariate	5328.4	1	5328.4	0.98	0.335	0.31
Error	109294.5	20	5464.7			

Adjusted Cell Means

	FSU MJ	FSU SH	EI MJ	EI SH
m	981.8	1106.8	962.5	948.0
σ	55.2	40.5	84.3	91.5
n	6	5	7	7

Table 148 General Marital Satisfaction (SMAR Scale) - Post-Treatment (Partners Only): Results of Two-Way ANCOVA involving only FSU & EI problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	133914.6	1	133914.6	41.12	0.000	
Problem	6609.3	1	6609.3	2.03	0.171	
Treatment	1562.4	1	1562.4	0.48	0.497	
Treat.x Problem	66832.5	1	66832.5	20.52	0.001	
Covariate	297.7	1	297.7	0.09	0.766	0.04
Error	61878.4	19	3256.8			

Adjusted Cell Means

	FSU MJ	FSU SH	EI MJ	EI SH
m	928.81	1057.7	1075.0	978.6
σ	52.9	57.1	61.5	50.9
n	6	6	6	6

Table 149 Locke-Wallace M.A.T. - Post-Treatment: Two Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	2563.02	1	2563.02	20.13	0.000	
Problem	430.53	3	143.51	1.13	0.350	
Treatment	398.11	1	398.11	3.13	0.085	
Treat.x Problem	735.52	3	245.17	1.93	0.142	
Covariate	8953.88	1	8953.88	70.32	0.000	0.67
Error	4838.54	38	127.33			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	108.78	88.49	107.99	105.31	101.29	98.33	102.80	104.94
σ	11.32	11.69	17.13	23.57	34.64	13.64	13.34	20.68
n	6	6	7	7	4	5	6	6

Table 150 Locke-Wallace M.A.T. - Post-Treatment (Partners Only): Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	2053.14	1	2053.14	16.27	0.000	
Problem	1567.03	3	522.34	4.14	0.013	
Treatment	439.06	1	439.06	3.48	0.070	
Treat.x Problem	889.82	3	296.61	2.35	0.088	
Covariate	9459.90	1	9459.90	74.98	0.000	0.68
Error	4667.87	37	126.16			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	111.39	89.87	112.00	110.91	99.44	95.47	95.94	97.40
o	11.82	5.49	25.74	21.53	31.22	22.23	9.76	15.74
n	6	6	7	7	4	5	5	6

Table 151 Locke-Wallace M.A.T. - Post-Treatment (Partners Only): Results of One-Way ANCOVA between Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	999.25	1	999.25	6.23	0.016	
Treatment	507.85	1	507.85	3.17	0.082	
Covariate	17345.82	1	17345.82	108.20	0.000	0.81
Error	6893.33	43	160.31			

Adjusted Group Means

	MJ	SH
m	105.80	99.14
o	22.08	24.67
n	22	24

Table 152 Locke-Wallace M.A.T. - Post-Treatment (Partners only): Results of One-Way ANCOVA among Problem Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	1472.49	1	1472.49	10.04	0.003	
Treatment	1386.05	3	462.02	3.15	0.035	
Covariate	12460.52	1	12460.52	84.93	0.000	0.74
Error	6015.12	41	146.71			

Adjusted Cell Means

	FSU	VAG	PE	EI
m	101.65	110.65	97.37	96.93
o	21.39	23.06	24.75	12.76
n	12	14	9	11

Results of Newman-Keuls

VAG > EI $p < .05$
VAG > PE $p < .05$

Table 153 Post-Treatment Ratings of "Myself" on "Loving" Factor of Semantic Differential: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	291.74	1	291.74	40.85	0.000	
Problem	64.37	3	21.46	3.00	0.043	
Treatment	35.71	1	35.71	5.00	0.032	
Treat.x Problem	86.12	3	28.71	4.02	0.015	
Covariate	37.73	1	37.73	5.28	0.027	0.28
Error	257.13	36	7.14			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	16.29	10.22	16.33	15.19	18.14	16.57	14.67	16.24
σ	2.58	2.34	4.23	4.02	2.52	1.67	1.94	1.72
n	6	6	6	6	4	5	6	6

Table 154 Post-Treatment Ratings of "Myself" on "Loving" Factor of Semantic Differential: Results of Two-Way ANCOVA involving only FSU and EI problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	165.97	1	165.97	35.54	0.000	
Problem	25.71	1	25.71	5.50	0.030	
Treatment	33.18	1	33.18	7.10	0.015	
Treat.x Problem	89.40	1	89.40	19.14	0.000	
Covariate	5.60	1	5.60	1.20	0.287	0.16
Error	88.73	19	4.67			

Adjusted Cell Means

	FSU MJ	FSU SH	EI MJ	EI SH
m	15.87	9.41	14.72	16.33
σ	2.58	2.34	1.94	1.72
n	6	6	6	6

Table 155 Post-Treatment Ratings of "My Partner" on "Loving" Factor of Semantic Differential: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	2.94	1	2.94	1.28	0.265	
Problem	36.58	3	12.19	5.32	0.004	
Treatment	15.07	1	15.07	6.57	0.015	
Treat.x Problem	11.35	3	3.78	1.65	0.195	
Covariate	142.94	1	142.94	62.31	0.000	0.87
Error	82.59	36	2.29			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	19.46	18.09	20.35	19.00	18.25	15.81	18.74	19.17
σ	1.72	3.83	1.21	2.45	4.83	0.55	2.19	0.98
n	6	6	6	6	4	5	6	6

Table 156 Post-Treatment Ratings of "My Partner" on "Loving" Factor of Semantic Differential: Results of One-Way ANCOVA between Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	1.52	1	1.52	0.48	0.492	
Treatment	16.03	1	16.03	5.06	0.030	
Covariate	209.12	1	209.12	66.01	0.000	0.92
Error	133.05	42	3.17			

Adjusted Group Means

	MJ	SH
m	19.30	18.10
σ	2.73	2.90
n	22	23

Table 157 Post-Treatment Ratings of "My Partner" on "Loving" Factor of Semantic Differential: Results of One-Way ANCOVA among Problem Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	4.47	1	4.47	1.67	0.204	
Problem	41.64	3	13.88	5.17	0.004	
Covariate	176.95	1	176.95	65.87	0.000	0.86
Error	107.44	40	2.69			

Adjusted Group Means

	FSU	VAG	PE	EI
m	18.77	19.69	16.89	18.96
σ	3.47	1.85	2.99	1.98
n	12	12	9	12

Results of Newman-Keul Test

VAG > PE	p < .01
FSU > PE	p < .01
EI > PE	p < .05

Table 158 Post-Treatment Ratings of "Myself" on "Sexual Attractiveness Factor of Sem. Diff.: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	55.00	1	55.00	17.19	0.000	
Problem	10.21	3	3.40	1.07	0.374	
Treatment	11.65	1	11.65	3.66	0.064	
Treat.x Problem	19.02	3	6.34	1,99	0.133	
Covariate	54.17	1	54.17	17.03	0.000	0.55
Error	114.53	36	3.18			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	9.92	7.16	8.30	7.46	9.55	8.20	7.26	8.04
σ	2.59	2.61	1.86	3.27	1.91	1.34	0.52	1.47
n	6	6	6	6	4	5	6	6

Table 159 Post-Treatment Ratings of "Myself" on "Sexual Attractiveness" Factor of Semantic Differential: Results of One-Way ANCOVA between Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	64.36	1	64.36	18.81	0.000	
Treatment	10.68	1	10.68	3.12	0.085	
Covariate	70.63	1	70.63	20.64	0.000	0.56
Error	143.70	42	3.42			

Adjusted Group Means

	MJ	SH
m	8.68	7.70
σ	2.03	2.41
n	22	23

Table 160 Post-Treatment Ratings of "Myself" on "Erotic Arousal" Factor of Semantic Differential: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	44.60	1	44.60	9.35	0.004	
Problem	12.70	3	4.23	0.89	0.457	
Treatment	6.46	1	6.46	1.35	0.252	
Treat.x Problem	34.85	3	11.62	2.44	0.081	
Covariate	30.89	1	30.89	6.48	0.015	0.55
Error	171.72	36	4.77			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	9.28	5.87	8.50	7.40	8.23	9.89	7.22	7.00
σ	2.94	2.32	2.64	3.39	0.96	1.14	1.72	1.87
n	6	6	6	6	4	5	6	6

Table 161 Post-Treatment Ratings of "Myself" on "Erotic Aoursal" Factor of Semantic Differential: Results of Two-Way ANCOVA involving only FSU and PE problem subgroups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	47.89	1	47.89	10.23	0.006	
Problem	10.97	1	10.97	2.34	0.145	
Treatment	4.92	1	4.92	1.05	0.321	
Treat. x Problem	31.09	1	31.09	6.64	0.020	
Covariate	3.22	1	3.22	0.69	0.419	0.25
Error	74.90	16	4.68			

Adjusted Group Means

	FSU MJ	FSU SH	PE MJ	PE SH
m	8.51	5.05	10.03	11.51
σ	2.94	2.32	0.96	1.14
n	6	6	4	5

Table 162 Post-Treatment Ratings of "My Partner" on "Sexual Attractiveness" Factor of Sem. Diff.: Two-Way ANCOVA results

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	11.17	1	11.17	3.05	0.089	
Problem	2.74	3	0.91	0.25	0.862	
Treatment	17.06	1	17.06	4.65	0.038	
Treat.x Problem	11.21	3	3.74	1.02	0.396	
Covariate	56.82	1	56.82	15.49	0.000	0.72
Error	132.06	36	3.67			

Adjusted Cell Means

	FSU MJ	FSU SH	VAG MJ	VAG SH	PE MJ	PE SH	EI MJ	EI SH
m	13.48	10.51	12.34	11.17	11.49	11.03	11.69	11.30
σ	3.73	2.34	2.10	2.48	2.63	1.64	0.98	0.75
n	6	6	6	6	4	5	6	6

Table 163 Post-Treatment Ratings of "My Partner" on "Sexual Attractiveness" Factor of Semantic Differential: Results of One-Way ANCOVA between Treatment Groups

Source	ss	df	Mean Square	F	Prob	Beta Est.
Mean	11.96	1	11.96	3.41	0.072	
Treatment	19.41	1	19.41	5.54	0.023	
Covariate	81.52	1	81.52	23.25	0.000	0.75
Error	147.25	42	3.51			

Adjusted Post-Treatment Means

	MJ	SH
m	12.32	11.00
σ	2.48	2.13
n	22	23

APPENDIX 7

Table 164 Improvement* and Goal Attainment** Data and Number of Weeks in Therapy for Each Couple

		No. Weeks	Goal Attained	Improved			No. Weeks	Goal Attained	Improved	
Female Sexual Unresponsiveness	(1)	11	Yes	Yes		(7)	16	No	No	
	(2)	12	No	No		(8)	6	-	-	D.O.
	(3)	16	No	No		(9)	8	-	-	D.O.
	(4)	16	Yes	No		(10)	16	Yes	Yes	
	(5)	10	Yes	Yes		(11)	8	No	No	
	(6)	14	Yes	Yes		(12)	7	-	-	D.O.
Vaginismus	(13)	14	Yes	Yes		(20)	14	Yes	Yes	
	(14)	14	Yes	Yes		(21)	16	Yes	Yes	
	(15)	10	Yes	Yes		(22)	8	No	No	
	(16)	9	Yes	Yes		(23)	12	Yes	Yes	
	(17)	16	No	No		(24)	11	Yes	Yes	
	(18)	13	Yes	Yes		(25)	14	Yes	Yes	
	(19)	16	Yes	Yes		(26)	8	Yes	Yes	
Premature Ejaculation	(27)	6	No	No		(32)	16	Yes	Yes	
	(28)	15	Yes	Yes		(33)	6	No	No	
	(29)	7	-	-	D.O.	(34)	8	-	-	D.O.
	(30)	13	Yes	Yes		(35)	8	No	No	
	(31)	8	-	-	D.O.	(36)	10	No	No	
Erectile Impotence	(37)	11	Yes	Yes		(43)	9	Yes	Yes	
	(38)	6	-	-	D.O.	(44)	9	No	No	
	(39)	8	-	-	D.O.	(45)	14	Yes	No	
	(40)	9	Yes	No		(46)	6	No	No	
	(41)	12	Yes	Yes		(47)	8	-	-	D.O.
	(42)	16	No	No		(48)	7	Yes	No	

Average number of weeks before defaulting = 7.33 (range 6 - 8, modal = 8)
Average number of weeks to criterion for goal attainment (improved couples only)
MJ = 12.47 weeks S.D. = 2.39 Total = 187
SH = 12.45 weeks S.D. = 3.30 Total = 137

D.O. = Dropped-Out
* as determined by independent ratings of satisfactory sexual functioning
** as determined by informal reports of mutually satisfactory intercourse on at least six occasions over eighteen day maximum period

Table 165

MJ Raw Data: Pre, post-treatment and follow-up scores* of FSU complainants (C) in MJ treatment group on salient dependent measures.

	Variable	C1			C2			C3			C4			C5			C6		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
	Tendency to Spectate	2	5	4	2	2	3	1	1	1	1	4	3	2	4	4	3	3	3
SMAR	Marital Satisfaction	1120	979	952	1077	893	963	982	1015	1064	1088	916	1007	1115	912	909	1095	923	939
SMAR	Sexual Satisfaction	1006	664	732	1022	1016	763	1095	1098	1085	1112	695	820	978	784	712	839	803	806
	Sexual Aversion	1105	1026	966	1007	1042	1010	576	589	656	1009	1000	1046	1051	1056	1056	1068	1062	1040
PAD	Sexual Pleasure	1124	987	891	1196	1062	963	1109	1120	1129	1169	916	1032	1136	1030	1018	1082	1053	1005
PAD	Sexual Anxiety	900	967	936	962	1146	1045	1044	1057	1034	1038	1126	1114	932	1082	1072	1059	1050	1111
	Self-Gen. Eval.	9	12		5	10		6	8		8	12		7	13		11	10	
	Self-Anxiety	7	5		13	10		14	12		10	10		8	5		9	8	
	Self-Loving	14	18		7	14		13	12		14	16		9	19		15	15	
	Self-Sex. Attract.	8	11		2	8		4	6		9	11		8	13		8	8	
Sem -Diff	Self-Erot. Arous.	3	10		2	8		2	2		4	8		3	10		6	8	
Sem -Diff	Partner-Gen. Eval.	12	14		12	12		14	12		12	12		10	14		13	11	
Sem -Diff	Partner-Anxiety	4	2		3	4		4	3		3	2		3	4		4	5	
Sem -Diff	Partner-Loving	21	21		19	18		21	23		20	20		17	19		19	20	
Sem -Diff	Partner-Sex. Attract.	11	12		11	11		12	21		12	12		11	13		10	12	
Sem -Diff	Partner-Erot. Arous.	11	12		13	13		13	14		13	13		12	13		12	11	
	Freq. Neg. Foreplay	3	4		1	4		0	0		1	4		-	4		2	3	
	Freq. Neg. Inter	3	4		1	4		4	3		4	4		-	4		3	2	
	Freq. Pos. Foreplay	3	4		1	2		0	0		1	4		-	4		2	2	
	Degree Non Coital Pleasure	2	3		2	2		0	0		3	4		-	4		2	2	
	Freq. Pos. Inter.	1	4		0	3		3	3		1	4		-	3		2	2	
Indep. Ratings	Degree Coital Pleasure	1	3		-	3		4	4		4	4		-	3		2	2	
Indep. Ratings	Freq. Sex. Interest	3	5		2	3		0	0		2	5		-	5		3	4	
Indep. Ratings	Erec. Imp.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Prem. Ejac.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Ejac. Fail.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Vag. Lub.	2	7		1	7		2	1		1	7		-	6		5	5	
Indep. Ratings	Vaginismus	6	6		4	6		6	6		6	6		-	6		6	6	
Indep. Ratings	Dysparcunia	3	6		5	6		6	6		6	6		-	6		5	5	
Indep. Ratings	Orgasmic Freq.	2	2		2	3		2	2		2	5		-	2		4	4	
	L/W M.A.T.	115	129		97	105		115	116		96	103		66	97		115	111	
	Freq. Intercourse	4	5		2	6		5	5		6	6		2	5		5	6	
SII	Coital Enj. (Self)	3	6		2	5		3	2		5	6		1	5		5	6	
SII	Coital Enj. (Part)	5	6		6	6		6	6		6	6		4	6		6	6	

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

Table 166

SH Raw Data: pre, post-treatment and follow-up scores* of FSU complainants (C) in SH treatment group on salient dependent measures.

	Variable	C7			C8			C9			C10			C11			C12		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	2	3	1	1	-	1	2	2	3	3	3	1	1	1	1	1	2
SMAR	Marital Satisfaction	1106	1033	1057	1206	1077	-	1138	1152	1142	1132	1024	1048	1131	1190	1119	938	1064	1106
SMAR	Sexual Satisfaction	1060	965	814	1079	988	-	1074	1048	993	811	831	824	1100	1087	1029	1046	1066	974
PAD	Sexual Aversion	857	900	984	821	935	-	795	896	922	677	907	881	774	822	795	1090	1088	1084
PAD	Sexual Pleasure	1118	1132	1076	1073	1018	-	1178	1215	1201	1003	1036	1012	1158	1192	1179	1123	1174	1097
PAD	Sexual Anxiety	965	1009	1110	1105	940	-	907	969	915	962	1054	1037	959	974	1027	936	926	969
Som-Diff	Self-Gen. Eval.	8	8		10	9		6	10		12	12		14	10		9	9	
Som-Diff	Self-Anxiety	12	12		9	9		12	11		4	5		10	13		10	9	
Som-Diff	Self-Loving	5	8		9	9		9	8		10	12		9	5		10	10	
Som-Diff	Self-Sex. Attract.	2	4		2	3		7	8		8	9		4	4		8	8	
Som-Diff	Self-Erot. Arous.	7	5		2	2		2	3		2	8		2	2		4	5	
Som-Diff	Partner-Gen. Eval.	10	11		8	9		10	9		14	13		14	14		12	13	
Som-Diff	Partner-Anxiety	4	5		14	12		6	9		13	5		2	2		5	5	
Som-Diff	Partner-Loving	14	13		12	12		13	14		21	20		21	21		19	18	
Som-Diff	Partner-Sex. Attract.	7	8		12	11		9	8		5	6		12	12		12	11	
Som-Diff	Partner-Erot. Arous.	11	11		13	12		11	11		13	13		12	13		13	13	
Indep. Ratings	Freq. Neg. Foreplay	1	2		1	-		0	-		2	4		0	0		2	-	
Indep. Ratings	Freq. Neg. Inter	1	1		1	-		0	-		1	3		0	1		2	-	
Indep. Ratings	Freq. Pos. Foreplay	1	2		1	-		0	-		2	4		0	0		2	-	
Indep. Ratings	Degree Non Coital Pleasure	2	1		1	-		0	-		2	3		0	0		1	-	
Indep. Ratings	Freq. Pos. Inter.	1	1		1	-		0	-		1	2		0	1		2	-	
Indep. Ratings	Degree Coital Pleasure	2	1		2	-		0	-		1	2		0	0		1	-	
Indep. Ratings	Freq. Sex. Interest	2	3		2	-		0	-		2	4		0	0		2	-	
Indep. Ratings	Erec. Imp.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Prem. Ejac.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Ejac. Fail.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Vag. Lub.	2	4		4	-		5	-		-	5		4	1		1	-	
Indep. Ratings	Vaginismus	6	6		6	-		6	-		-	5		6	6		6	-	
Indep. Ratings	Dysparcunia	3	3		5	-		5	-		-	6		4	4		3	-	
Indep. Ratings	Orgasmic Freq.	3	3		4	-		0	-		-	4		0	0		4	-	
	L/H M.A.T.	52	59		39	49		77	74		54	62		67	69		100	82	
SII	Freq. Intercourse	2	2		3	2		2	2		3	5		2	2		3	3	
SII	Coital Enj. (Self)	4	4		3	3		1	2		3	4		1	1		4	4	
SII	Coital Enj. (Part)	6	6		-	6		4	6		4	4		6	6		6	6	

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

Table 167

MJ Raw Data; Pre, post-treatment and follow-up scores * of VAG complainants (C) in MJ treatment group on salient dependent measures.

	Variable	C13			C14			C15			C16			C17			C18		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	4	5	2	3	5	2	4	5	2	4	5	1	2	3	1	4	4
	Marital Satisfaction	1033	965	959	1035	827	848	1008	924	909	1020	890	977	992	1087	1103	1099	947	1045
	Sexual Satisfaction	1090	672	582	1064	857	687	971	715	587	874	817	574	1132	1069	908	1106	616	798
PAD	Sexual Aversion	1064	1052	1019	1086	988	1008	909	946	955	1064	1013	1012	1075	1076	1082	1095	1012	1015
	Sexual Pleasure	1022	946	930	966	864	941	1093	867	919	1012	965	969	1039	1162	1009	1041	930	890
	Sexual Anxiety	831	1013	1083	946	1115	1131	956	1090	1108	765	983	1137	866	852	956	775	1044	918
Sem -Diff	Self-Gen. Eval.	4	11		-	-		10	13		6	8		5	4		6	13	
	Self-Anxiety	13	8		-	-		12	11		14	14		12	13		10	5	
	Self-Loving	11	16		-	-		18	20		18	20		10	9		15	19	
	Self-Sex. Attract.	7	8		-	-		8	11		9	8		6	6		9	10	
	Self-Erot. Arous.	6	10		-	-		7	11		3	6		6	4		7	9	
	Partner-Gen. Eval.	12	14		-	-		13	14		12	10		14	14		11	14	
	Partner-Anxiety	4	3		-	-		11	4		6	5		4	5		10	2	
	Partner-Loving	20	20		-	-		17	21		20	21		20	21		17	21	
	Partner-Sex. Attract.	9	9		-	-		9	14		11	13		14	14		11	12	
	Partner-Erot. Arous.	12	12		-	-		10	12		12	10		14	13		13	13	
Indep. Ratings	Freq. Neg. Foreplay	4	4		3	4		4	4		4	3		4	2		4	4	
	Freq. Neg. Inter	0	3		0	3		0	4		0	2		0	0		0	3	
	Freq. Pos. Foreplay	4	3		3	4		4	4		4	4		4	2		4	4	
	Degree Non Coital Pleasure	4	4		4	4		3	4		4	4		4	4		4	4	
	Freq. Pos. Inter.	0	3		0	3		0	4		0	2		0	0		0	4	
	Degree Coital Pleasure	-	3		-	3		-	4		-	3		-	-		-	4	
	Freq. Sex. Interest	3	5		3	5		4	5		3	2		4	3		4	5	
	Erec. Imp.	-	-		-	-		-	-		-	-		-	-		-	-	
	Prem. Ejac.	-	-		-	-		-	-		-	-		-	-		-	-	
	Ejac. Fail.	-	-		-	-		-	-		-	-		-	-		-	-	
	Vag. Lub.	3	6		2	6		3	7		6	5		3	2		3	6	
	Vaginismus	1	6		1	6		1	6		1	6		1	1		1	6	
	Dysparcunia	0	5		0	5		0	6		1	3		0	0		0	5	
	Orgasmic Freq.	1	2		2	5		2	4		2	2		2	1		2	6	
	L/W M.A.T.	108	130		117	112		115	117		132	130		84	80		77	105	
SII	Freq. Intercourse	1	5		1	4		1	6		1	5		1	1		1	3	
	Coital Enj. (Self)	-	5		-	6		-	6		-	4		0	2		-	5	
	Coital Enj. (Part)	-	6		-	6		-	6		-	5		-	-		-	6	

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

Table 167 (Cont'd)

MJ Raw Data: Pre, post-treatment and follow-up scores * of VAG complainants (C) in MJ treatment group on salient dependent measures.

	Variable	C19			C			C			C			C			C		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	2	5	4															
SMAR	Marital Satisfaction	994	967	947															
SMAR	Sexual Satisfaction	1032	742	644															
PAD	Sexual Aversion	950	1048	973															
PAD	Sexual Pleasure	1082	1122	1083															
PAD	Sexual Anxiety	892	1034	1051															
Som.-Diff	Self-Gen. Eval.	5	9																
Som.-Diff	Self-Anxiety	11	10																
Som.-Diff	Self-Loving	17	15																
Som.-Diff	Self-Sex. Attract.	5	7																
Som.-Diff	Self-Erot. Arous.	5	9																
Som.-Diff	Partner-Gen. Eval.	13	12																
Som.-Diff	Partner-Anxiety	7	7																
Som.-Diff	Partner-Loving	18	18																
Som.-Diff	Partner-Sex. Attract.	10	10																
Som.-Diff	Partner-Erot. Arous.	13	12																
Indep. Ratings	Freq. Neg. Foreplay	2	3																
Indep. Ratings	Freq. Neg. Inter	1	3																
Indep. Ratings	Freq. Pos. Foreplay	2	4																
Indep. Ratings	Degree Non Coital Pleasure	3	4																
Indep. Ratings	Freq. Pos. Inter.	1	3																
Indep. Ratings	Degree Coital Pleasure	3	2																
Indep. Ratings	Freq. Sex. Interest	3	5																
Indep. Ratings	Erec. Imp.	-	-																
Indep. Ratings	Prem. Ejac.	-	-																
Indep. Ratings	Ejac. Fail.	-	-																
Indep. Ratings	Vag. Lub.	4	5																
Indep. Ratings	Vaginismus	2	6																
Indep. Ratings	Dysparcunia	1	4																
Indep. Ratings	Orgasmic Freq.	4	5																
	L/M M.A.T.	96	108																
SII	Freq. Intercourse	2	5																
SII	Coital Enj. (Self)	2	5																
SII	Coital Enj. (Part)	6	6																

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

SH Raw Data: Pre, post-treatment and follow-up Scores * for VAG complainants (C) in SH treatment group on salient dependent measures.

	Variable	C20			C21			C22			C23			C 24			C25		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	3	2	1	3	2	3	2	1	3	3	3	1	5	4	1	4	4
SMAR	Marital Satisfaction	1009	1016	940	985	1014	1059	1038	1158	1098	972	836	966	1024	910	862	1041	932	918
SMAR	Sexual Satisfaction	1099	970	939	1155	776	1030	928	986	1070	978	716	808	1155	624	610	1024	669	710
PAD	Sexual Aversion	1019	1003	996	1108	1074	1086	694	651	712	1068	1031	1018	1086	1007	979	765	969	1051
PAD	Sexual Pleasure	1096	1056	1073	976	1007	1054	1113	1109	1026	1124	979	892	969	848	833	985	945	1026
PAD	Sexual Anxiety	838	1055	1018	911	1025	862	887	888	856	925	1109	1061	890	1065	1113	974	1099	1085
Gen -Diff	Self-Gen. Eval.	3	12		8	10		8	4		-	14		9	14		12	12	
Gen -Diff	Self-Anxiety	13	12		11	8		12	14		-	2		10	7		14	11	
Gen -Diff	Self-Loving	3	15		18	17		13	9		-	21		18	21		19	13	
Gen -Diff	Self-Sex. Attract.	3	6		8	8		9	3		-	14		9	13		7	8	
Gen -Diff	Self-Erot. Arous.	3	4		5	7		3	2		-	14		7	12		4	7	
Gen -Diff	Partner-Gen. Eval.	14	14		12	14		10	13		-	14		13	14		14	14	
Gen -Diff	Partner-Anxiety	4	2		3	4		10	11		-	2		4	3		2	2	
Gen -Diff	Partner-Loving	20	21		21	21		17	15		-	21		19	21		21	21	
Gen -Diff	Partner-Sex. Attract.	9	10		13	13		10	7		-	14		11	14		10	10	
Gen -Diff	Partner-Erot. Arous.	13	13		12	13		13	12		-	14		12	14		10	9	
Indep. Ratings	Freq. Neg. Foreplay	3	4		4	3		1	2		4	4		4	4		3	4	
Indep. Ratings	Freq. Neg. Inter	0	4		0	3		0	0		0	3		0	3		0	2	
Indep. Ratings	Freq. Pos. Foreplay	3	4		4	3		1	2		4	4		4	4		2	3	
Indep. Ratings	Degree Non Coital Pleasure	3	3		4	2		3	2		3	3		4	4		3	3	
Indep. Ratings	Freq. Pos. Inter.	0	1		0	3		0	0		0	3		0	3		0	3	
Indep. Ratings	Degree Coital Pleasure	-	2		-	2		-	-		-	2		-	4		0	3	
Indep. Ratings	Freq. Sex. Interest	2	5		3	2		1	2		3	6		4	4		2	5	
Indep. Ratings	Erec. Imp.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Prem. Ejac.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Ejac. Fail.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Vag. Lub.	2	4		3	5		-	-		3	4		3	5		3	6	
Indep. Ratings	Vaginismus	1	6		1	6		0	1		1	6		1	6		1	5	
Indep. Ratings	Dysparcunia	0	6		1	5		0	0		0	5		0	5		0	5	
Indep. Ratings	Orgasmic Freq.	-	-		3	3		1	1		5	5		3	3		1	4	
	L/W M.A.T.	106	108		118	121		89	80		119	147		151	147		132	118	
SII	Freq. Intercourse	1	5		1	5		1	1		1	5		2	6		2	5	
SII	Coital Enj. (Self)	-	4		-	2		-	-		2	6		1	5		2	6	
SII	Coital Enj. (Part)	-	6		-	6		-	-		5	6		5	6		4	6	

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

SH Raw Data: pre, post-treatment and follow-up scores * for VAG complainants (C) in SH treatment group on salient dependent measures.

	Variable	C26			C			C			C			C			C		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	3	4	5															
SMAR	Marital Satisfaction	1052	897	862															
SMAR	Sexual Satisfaction	915	621	626															
PAD	Sexual Aversion	-	-	-															
PAD	Sexual Pleasure	-	-	-															
PAD	Sexual Anxiety	857	1037	787															
Sem.-Diff	Self-Gen. Eval.	7	8																
Sem.-Diff	Self-Anxiety	12	8																
Sem.-Diff	Self-Loving	14	16																
Sem.-Diff	Self-Sex. Attract.	8	7																
Sem.-Diff	Self-Erot. Arous.	4	6																
Sem.-Diff	Partner-Gen. Eval.	14	13																
Sem.-Diff	Partner-Anxiety	10	11																
Sem.-Diff	Partner-Loving	21	21																
Sem.-Diff	Partner-Sex. Attract.	11	11																
Sem.-Diff	Partner-Erot. Arous.	10	11																
Indep. Ratings	Freq. Neg. Foreplay	4	4																
Indep. Ratings	Freq. Neg. Inter	0	3																
Indep. Ratings	Freq. Pos. Foreplay	4	4																
Indep. Ratings	Degree Non Coital Pleasure	4	4																
Indep. Ratings	Freq. Pos. Inter.	0	4																
Indep. Ratings	Degree Coital Pleasure	-	3																
Indep. Ratings	Freq. Sex. Interest	3	4																
Indep. Ratings	Erec. Imp.	-	-																
Indep. Ratings	Prem. Ejac.	-	-																
Indep. Ratings	Ejac. Fail.	-	-																
Indep. Ratings	Vag. Lub.	3	7																
Indep. Ratings	Vaginismus	1	6																
Indep. Ratings	Dysparcunia	1	5																
Indep. Ratings	Orgasmic Freq.	2	5																
	L/W M.A.T.	112	108																
SII	Freq. Intercourse	1	6																
SII	Coital Enj. (Self)	-	5																
SII	Coital Enj. (Part)	-	6																

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

Table 169

MJ Raw Data: pre, post-treatment and follow-up scores * of PE complainants (C) in MJ treatment group on salient dependent measures.

	Variable	C27			C28			C29			C30			C 31			C		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	2	1	1	2	5	3	2	-	-	2	3	4	1	1	3			
	Marital Satisfaction	890	891	970	946	875	900		-	-	974	931	929	1108	1092	1068			
	Sexual Satisfaction	915	1059	1015	894	566	847		-	-	960	797	776	1115	1124	861			
PAD	Sexual Aversion	1039	1016	1040	946	957	958		-	-	984	1004	1009	1055	1062	1056			
	Sexual Pleasure	935	889	932	906	985	942		-	-	869	884	861	1012	1039	1009			
	Sexual Anxiety	1034	955	955	1053	1133	1060		-	-	1073	1085	1059	1042	1014	1005			
Som. -Diff	Self-Gen. Eval.	10	12		14	14		6	-		10	11		12	11				
	Self-Anxiety	7	5		10	4		10	-		6	4		8	9				
	Self-Loving	15	19		15	21		17	-		17	19		15	15				
	Self-Sex. Attract.	9	11		10	13		9	-		9	9		8	9				
	Self-Erot. Arous.	10	12		14	12		13	-		12	10		11	11				
	Partner-Gen. Eval.	9	11		13	14		12	-		13	12		11	9				
	Partner-Anxiety	8	8		10	5		8	-		12	9		7	11				
	Partner-Loving	18	18		18	21		17	-		20	19		13	10				
	Partner-Sex. Attract.	12	12		12	14		12	-		12	13		10	8				
	Partner-Erot. Arous.	8	6		13	13		10	-		8	10		6	4				
Indep. Ratings	Freq. Neg. Foreplay	4	3		4	4		3	-		4	4		4	-				
	Freq. Neg. Inter	3	3		4	4		4	-		2	3		4	-				
	Freq. Pos. Foreplay	4	4		2	4		3	-		4	4		4	-				
	Degree Non Coital Pleasure	3	4		2	4		3	-		4	4		3	-				
	Freq. Pos. Inter.	4	4		2	4		2	-		3	3		3	-				
	Degree Coital Pleasure	2	2		2	4		3	-		4	3		3	-				
	Freq. Sex. Interest	5	5		4	5		5	-		6	6		5	-				
	Erec. Imp.	9	9		9	9		9	-		9	9		9	-				
	Prem. Ejac.	3	3		3	6		2	-		3	5		3	-				
	Ejac. Fail.	10	10		10	10		10	-		10	10		10	-				
	Vag. Lub.	-	-		-	-		-	-		-	-		-	-				
	Vaginismus	-	-		-	-		-	-		-	-		-	-				
	Dyspareunia	-	-		-	-		-	-		-	-		-	-				
	Orgasmic Freq.	-	-		-	-		-	-		-	-		-	-				
	L/W M.A.T.	110	109		118	130		77	-		118	124		66	54				
SII	Freq. Intercourse	5	5		5	5		4	-		5	5		5	5				
	Coital Enj. (Self)	6	5		1	6		4	-		6	5		5	5				
	Coital Enj. (Part)	6	4		5	6		4	-		5	4		3	3				

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

SH Raw Data: pre, post-treatment and follow-up scores * of PE complainants (C) in SH treatment group on salient dependent measures.

	Variable	C 32			C 33			C34			C35			C36			C		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	2	2	2	1	1	1	1	–	1	2	3	2	1	3			
	Marital Satisfaction	922	939	987	922	951	939	–	–	–	868	951	1047	985	1009	957			
	Sexual Satisfaction	1046	913	900	1069	1148	1075	–	–	–	1140	994	957	1062	985	825			
PAD	Sexual Aversion	1076	1038	1052	913	936	966	–	–	–	1000	995	1014	1028	1037	1038			
	Sexual Pleasure	1024	987	965	711	728	804	–	–	–	877	854	913	949	950	939			
	Sexual Anxiety	1017	1042	1011	679	704	824	–	–	–	1085	1083	1069	1042	1013	1037			
Sem -Diff	Self-Gen. Eval.	11	13		10	12		10	9		8	8		10	11				
	Self-Anxiety	5	6		11	9		11	10		5	6		4	8				
	Self-Loving	17	18		21	20		17	16		15	16		16	17				
	Self-Sex. Attract.	11	10		6	10		8	8		8	8		7	7				
	Self-Erot. Arous.	13	13		9	14		13	13		11	12		10	11				
	Partner-Gen. Eval.	12	11		11	11		12	12		14	9		13	13				
	Partner-Anxiety	8	4		10	8		10	9		2	8		12	10				
	Partner-Loving	20	17		21	17		18	16		21	16		18	17				
	Partner-Sex. Attract.	12	13		14	14		10	11		14	10		11	11				
	Partner-Erot. Arous.	9	13		11	7		10	7		14	8		7	8				
Indep. Ratings	Freq. Neg. Foreplay	4	4		3	2		4	–		4	4		3	3				
	Freq. Neg. Inter	4	4		2	1		2	–		4	4		4	4				
	Freq. Pos. Foreplay	4	4		3	2		2	–		3	3		3	4				
	Degree Non Coital Pleasure	4	4		3	2		1	–		3	3		2	3				
	Freq. Pos. Inter.	4	4		1	1		2	–		4	4		1	2				
	Degree Coital Pleasure	4	3		4	2		2	–		4	2		2	2				
	Freq. Sex. Interest	5	5		5	5		5	–		4	4		3	4				
	Erec. Imp.	9	9		9	9		9	–		9	9		9	9				
	Prem. Ejac.	3	5		4	4		4	–		3	3		3	4				
	Ejac. Fail.	10	10		10	10		10	–		10	10		10	10				
	Vag. Lub.	–	–		–	–		–	–		–	–		–	–				
	Vaginismus	–	–		–	–		–	–		–	–		–	–				
	Dysparcunia	–	–		–	–		–	–		–	–		–	–				
	Orgasmic Freq.	–	–		–	–		–	–		–	–		–	–				
	L/W M.A.T.	93	95		105	107		123	117		81	81		96	95				
SII	Freq. Intercourse	–	–		6	4		4	3		5	5		2	5				
	Coital Enj. (Self)	–	–		4	4		6	5		5	5		4	3				
	Coital Enj. (Part)	–	–		5	4		6	4		4	4		3	3				

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

Table 171

MJ Raw Data: Pre, post-treatment and follow-up scores * of EI complainants (C) in MJ treatment group on salient dependent measures.

	Variable	C37			C38			C39			C40			C41			C42		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	5	4	1	2	–	3	3	3	1	3	2	2	4	3	1	1	3
SMAR	Marital Satisfaction	951	1046	949	–	–	–	1059	1116	1022	1217	1037	1079	957	1111	1059	1023	1048	1035
SMAR	Sexual Safisfaction	1118	691	943	–	–	–	888	866	944	1106	733	1077	968	766	870	1100	1074	893
PAD	Sexual Aversion	1053	931	1061	–	–	–	1038	1042	1022	1044	1030	1021	1065	1053	1062	1041	1061	1072
PAD	Sexual Pleasure	936	886	1024	–	–	–	1022	1029	973	1008	961	970	1070	999	1053	1054	1109	1162
PAD	Sexual Anxiety	804	1253	1053	–	–	–	1130	1130	1129	1086	1070	1108	989	1048	1050	1032	1033	1044
Som -Diff	Self-Gen. Eval.	9	12		7	5		10	10		10	8		7	11		10	10	
Som -Diff	Self-Anxiety	9	7		10	10		7	7		8	8		8	9		10	11	
Som -Diff	Self-Loving	15	16		15	17		18	17		16	12		17	15		15	14	
Som -Diff	Self-Sex. Attract.	9	8		8	7		8	7		7	8		8	8		8	8	
Som -Diff	Self-Erot. Arous.	7	10		6	7		5	5		6	7		7	8		6	6	
Som -Diff	Partner-Gen. Eval.	14	13		12	13		12	11		9	13		10	11		10	11	
Som -Diff	Partner-Anxiety	6	13		7	6		7	5		12	5		7	8		10	10	
Som -Diff	Partner-Loving	20	19		20	19		18	20		14	17		16	14		19	19	
Som -Diff	Partner-Sex. Attract.	12	11		13	13		12	13		9	12		11	11		11	11	
Som -Diff	Partner-Erot. Arous.	11	8		11	11		10	11		6	9		10	4		11	12	
Indep. Ratings	Freq. Neg. Foreplay	1	4		2	–		4	–		3	3		0	3		1	1	
Indep. Ratings	Freq. Neg. Inter	1	3		3	–		4	–		1	4		3	3		3	2	
Indep. Ratings	Freq. Pos. Foreplay	2	4		2	–		4	–		2	4		1	3		1	1	
Indep. Ratings	Degree Non Coital Pleasure	2	4		2	–		2	–		2	3		3	3		2	2	
Indep. Ratings	Freq. Pos. Inter.	0	–		2	–		1	–		4	4		1	3		3	3	
Indep. Ratings	Degree Coital Pleasure	0	–		3	–		4	–		3	4		4	3		3	2	
Indep. Ratings	Freq. Sex. Interest	4	5		3	–		4	–		2	4		2	4		2	2	
Indep. Ratings	Erec. Imp.	2	9		6	–		6	–		1	7		2	9		6	6	
Indep. Ratings	Prem. Ejac.	7	7		1	–		5	–		4	4		4	6		7	7	
Indep. Ratings	Ejac. Fail.	10	10		10	–		10	–		10	10		10	10		10	10	
Indep. Ratings	Vag. Lub.	–	–		–	–		–	–		–	–		–	–		–	–	
Indep. Ratings	Vaginismus	–	–		–	–		–	–		–	–		–	–		–	–	
Indep. Ratings	Dysparcunia	–	–		–	–		–	–		–	–		–	–		–	–	
Indep. Ratings	Orgasmic Freq.	–	–		–	–		–	–		–	–		–	–		–	–	
	L/W M.A.T.	104	85		87	89		95	104		50	97		132	122		103	106	
SII	Freq. Intercourse	1	1		3	2		2	2		3	5		3	3		2	–	
SII	Coital Enj. (Self)	2	5		6	–		6	6		5	6		6	6		6	–	
SII	Coital Enj. (Part)	1	–		6	–		6	6		4	5		6	4		6	–	

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

Table 172

SH Raw Data: Pre, post-treatment and follow-up scores * of E1 complainants in SH treatment group on salient dependent measures.

	Variable	C43			C44			C 45			C 46			C 47			C 48		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	4	2	3	3	9	1	3	3	1	1	1	1	2	3	2	1	1
SMAR	Marital Satisfaction	925	894	993	981	923	-	1133	1046	1041	998	974	1045	939	917	961	1185	1022	1057
SMAR	Sexual Satisfaction	1098	747	986	789	802	-	1110	742	822	1127	1133	1069	1067	1030	906	1032	1036	1083
PAD	Sexual Aversion	954	942	961	1061	1049	-	880	967	969	1049	1047	1069	1051	1042	1033	1066	1064	1078
PAD	Sexual Pleasure	777	782	844	1056	1024	-	1149	1090	1065	982	996	1018	1034	1004	1020	960	1018	1043
PAD	Sexual Anxiety	812	922	1029	1087	1082	-	868	1057	1070	947	933	898	1110	1108	1134	805	988	947
Sem.-Diff	Self-Gen. Eval.	11	12		10	12		3	9		10	10		10	9		12	12	
Sem.-Diff	Self-Anxiety	3	4		8	7		14	9		8	9		7	8		5	10	
Sem.-Diff	Self-Loving	21	19		18	18		6	15		17	18		18	15		18	16	
Sem.-Diff	Self-Sex. Attract.	11	10		6	7		3	8		8	9		7	6		10	9	
Sem.-Diff	Self-Erot. Arous.	10	9		8	8		5	9		6	4		5	8		9	7	
Sem.-Diff	Partner-Gen. Eval.	14	14		11	13		12	12		14	14		10	11		11	13	
Sem.-Diff	Partner-Anxiety	12	9		8	8		7	4		4	4		8	8		11	11	
Sem.-Diff	Partner-Loving	21	21		20	21		19	19		20	20		20	21		19	19	
Sem.-Diff	Partner-Sex. Attract.	14	13		12	12		11	12		12	11		14	13		11	12	
Sem.-Diff	Partner-Erot. Arous.	11	9		11	11		11	11		12	12		10	8		8	12	
Indep. Ratings	Freq. Neg. Foreplay	2	3		3	3		0	3		3	3		4	-		1	4	
Indep. Ratings	Freq. Neg. Inter	3	3		4	4		0	2		3	1		4	-		1	4	
Indep. Ratings	Freq. Pos. Foreplay	2	4		4	4		1	3		3	4		1	-		2	4	
Indep. Ratings	Degree Non Coital Pleasure	3	3		2	2		2	3		2	3		2	-		3	3	
Indep. Ratings	Freq. Pos. Inter.	3	3		2	2		1	3		1	1		1	-		1	4	
Indep. Ratings	Degree Coital Pleasure	3	3		3	3		-	3		3	3		4	-		4	4	
Indep. Ratings	Freq. Sex. Interest	4	4		2	2		1	4		3	3		4	-		5	5	
Indep. Ratings	Erec. Imp.	3	-		6	6		2	7		2	2		2	-		2	7	
Indep. Ratings	Prem. Ejac.	7	-		7	7		7	7		7	7		4	-		1	5	
Indep. Ratings	Ejac. Fail.	10	-		8	9		10	9		9	9		10	-		10	10	
Indep. Ratings	Vag. Lub.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Vaginismus	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Dysparcunia	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Orgasmic Freq.	-	-		-	-		-	-		-	-		-	-		-	-	
	L/W M.A.T.	135	128		104	109		45	67		104	107		119	116		97	111	
SII	Freq. Intercourse	1	5		2	2		1	5		2	2		2	2		2	5	
SII	Coital Enj. (Self)	-	6		4	4		-	5		6	6		6	6		6	6	
SII	Coital Enj. (Part)	-	5		6	6		-	6		6	6		6	6		4	5	

* A = Pre-Treatment Score; B = Post. Treatment Score; C = Follow-Up Score

Table 173

WT Raw Data: pre and post-waiting period scores * of control complainants (WT) on salient dependent measures – FSU subjects only.

	Variable	WT1		C*	WT2		C	WT3		C	WT4		C	WT5		C	WT6		C
		A	B		A	B		A	B		A	B		A	B		A	B	
SMAR	Tendency to Spectate	2	2		2	1		4	3		1	1		2	1		1	1	
	Marital Satisfaction	994	1120		1111	1088		1085	1095		1087	1106		1165	1206		1182	1131	
	Sexual Satisfaction	1060	1006		1073	1112		921	839		1023	1060		949	1079		1115	1100	
PAD	Sexual Aversion	1046	1105		1082	1009		1097	1068		854	857		821	821		684	774	
	Sexual Pleasure	1137	1124		1147	1169		1150	1082		1148	1118		1059	1073		1119	1158	
	Sexual Anxiety	911	900		979	1038		1027	1059		1071	965		1096	1105		990	959	
Sem -Diff	Self-Gen. Eval.	7	9		6	8		8	11		9	8		11	10		11	14	
	Self-Anxiety	10	7		8	10		12	9		11	12		9	9		11	10	
	Self-Loving	12	14		11	14		10	15		9	5		7	9		8	9	
	Self-Sex. Attract.	5	8		12	9		8	8		5	2		4	2		4	4	
	Self-Erot. Arous.	1	3		3	4		3	6		9	7		2	2		2	2	
	Partner-Gen. Eval.	14	12		14	12		12	13		10	10		9	8		14	14	
	Partner-Anxiety	6	4		5	3		6	4		7	4		13	14		3	2	
	Partner-Loving	21	21		18	20		18	19		9	14		10	12		21	21	
	Partner-Sex. Attract.	13	11		10	12		9	10		10	7		9	12		12	12	
	Partner-Erot. Arous.	12	11		12	13		11	12		12	11		11	13		13	12	
Indep. Ratings	Freq. Neg. Foreplay	2	3		1	1		1	2		2	1		2	1		0	0	
	Freq. Neg. Inter	4	3		3	4		3	3		1	1		1	1		0	0	
	Freq. Pos. Foreplay	1	3		1	1		1	2		2	1		1	1		0	0	
	Degree Non Coital Pleasure	0	2		2	3		2	2		3	2		2	1		0	0	
	Freq. Pos. Inter.	3	1		2	1		3	2		2	1		2	1		1	0	
	Degree Coital Pleasure	3	1		2	4		2	2		1	2		2	2		1	0	
	Freq. Sex. Interest	1	3		2	2		2	3		1	2		1	2		1	0	
	Erec. Imp.	–	–		–	–		–	–		–	–		–	–		–	–	
	Prem. Ejac.	–	–		–	–		–	–		–	–		–	–		–	–	
	Ejac. Fail.	–	–		–	–		–	–		–	–		–	–		–	–	
	Vag. Lub.	2	2		1	1		4	5		1	2		2	4		3	4	
	Vaginismus	5	6		6	6		6	6		6	6		6	6		6	6	
	Dysparcunia	5	3		6	6		5	5		4	3		5	5		4	4	
	Orgasmic Freq.	1	2		2	2		5	4		2	3		3	4		0	0	
	L/H M.A.T.	121	115		76	96		106	115		62	52		55	39		82	67	
SII	Freq. Intercourse	5	4		6	6		3	5		2	2		4	3		2	2	
	Coital Enj. (Self)	3	3		4	5		4	5		5	4		2	3		1	1	
	Coital Enj. (Part)	6	5		6	6		6	6		6	6		6	–		6	6	

* A = Pre-Waiting Period Score; B = Post-Waiting Period Score.

Table 174

WT Raw Data: pre and post-waiting period scores * of control complainants (WT) on salient dependent measures - VAG subjects only.

	Variable	WT7			WT8			WT9			WT10			WT11			WT12		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	3		2	2		2	2		1	2		1	1		1	1	
	Marital Satisfaction	1040	1038		1052	1008		1112	1020		1055	994		1065	1009		908	985	
	Sexual Satisfaction	1073	928		1047	971		891	874		1095	1032		1104	1099		1126	1155	
PAD	Sexual Aversion	757	694		874	909		1094	1064		967	950		1077	1019		1110	1108	
	Sexual Pleasure	1055	1113		1055	1093		1026	1012		1108	1082		1130	1096		1055	976	
	Sexual Anxiety	869	887		876	956		786	765		937	892		862	838		918	911	
Sem.-Diff	Self-Gen. Eval.	8	8		13	10		4	6		5	5		5	3		9	8	
	Self-Anxiety	10	12		12	12		14	14		12	11		13	13		11	11	
	Self-Loving	14	13		19	18		19	18		18	17		4	3		19	18	
	Self-Sex. Attract.	8	9		9	8		8	9		8	5		3	3		5	8	
	Self-Erot. Arous.	2	3		8	7		4	3		5	5		2	3		3	5	
	Partner-Gen. Eval.	10	10		13	13		11	12		13	13		14	14		12	12	
	Partner-Anxiety	11	10		11	11		7	6		5	7		6	4		5	3	
	Partner-Loving	18	17		18	17		19	20		21	18		21	20		21	21	
	Partner-Sex. Attract.	11	10		9	9		10	11		9	10		9	9		11	13	
	Partner-Erot. Arous.	13	13		7	10		11	12		13	13		11	13		12	12	
Indep. Ratings	Freq. Neg. Foreplay	2	1		3	4		4	4		2	2		2	3		3	4	
	Freq. Neg. Inter	0	0		0	0		0	0		2	1		0	0		0	0	
	Freq. Pos. Foreplay	1	1		4	4		4	4		2	2		3	3		3	4	
	Degree Non Coital Pleasure	3	3		3	3		3	4		3	3		3	3		4	4	
	Freq. Pos. Inter.	0	0		0	0		0	0		1	1		0	0		0	0	
	Degree Coital Pleasure	-	-		-	-		-	-		2	3		-	-		-	-	
	Freq. Sex. Interest	2	1		4	4		3	3		3	3		2	2		3	3	
	Erec. Imp.	-	-		-	-		-	-		-	-		-	-		-	-	
	Prem. Ejac.	-	-		-	-		-	-		-	-		-	-		-	-	
	Ejac. Fail.	-	-		-	-		-	-		-	-		-	-		-	-	
	Vag. Lub.	5	-		4	3		6	6		4	4		2	2		2	3	
	Vaginismus	0	0		1	1		1	1		2	2		1	1		1	1	
	Dysparcunia	0	0		0	0		1	1		1	1		0	0		1	1	
	Orgasmic Freq.	1	1		1	2		1	2		3	4		-	-		-	3	
	L/W M.A.T.	95	89		119	115		141	132		105	96		110	106		110	118	
SII	Freq. Intercourse	1	1		1	1		1	1		2	2		1	1		1	1	
	Coital Enj. (Self)	-	-		-	-		-	-		2	2		-	-		-	-	
	Coital Enj. (Part)	-	-		-	-		-	-		6	6		-	-		-	-	

*A = Pre-waiting Period Score; B = Post-waiting Period Score.

Table 174 (Cont'd)

WT Raw Data: pre and post-waiting period scores * of control complainants (WT) on salient dependent measures - VAG subjects only.

	Variable	WT13																	
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	1	1																
	Marital Satisfaction	990	1041																
	Sexual Satisfaction	1096	1024																
PAD	Sexual Aversion	980	765																
	Sexual Pleasure	1078	985																
	Sexual Anxiety	938	974																
Sem.-Diff	Self-Gen. Eval.	12	12																
	Self-Anxiety	13	14																
	Self-Loving	18	19																
	Self-Sex. Attract.	6	7																
	Self-Erot. Arous.	4	4																
	Partner-Gen. Eval.	14	14																
	Partner-Anxiety	3	2																
	Partner-Loving	21	21																
	Partner-Sex. Attract.	11	10																
	Partner-Erot. Arous.	12	10																
Indep. Ratings	Freq. Neg. Foreplay	3	3																
	Freq. Neg. Inter	0	0																
	Freq. Pos. Foreplay	3	2																
	Degree Non Coital Pleasure	3	3																
	Freq. Pos. Inter.	0	0																
	Degree Coital Pleasure	-	0																
	Freq. Sex. Interest	3	2																
	Erec. Imp.	-	-																
	Prem. Ejac.	-	-																
	Ejac. Fail.	-	-																
	Vag. Lub.	4	3																
	Vaginismus	1	1																
	Dyspareunia	0	0																
	Orgasmic Freq.	1	1																
	L/W M.A.T.	128	132																
SII	Freq. Intercourse	2	2																
	Coital Enj. (Self)	2	2																
	Coital Enj. (Part)	5	4																

* A = Pre-Waiting Period Score; B = Post Waiting Period Score.

Table 175

WT Raw Data: pre and post-waiting period scores * of control complainants (WT) on salient dependent measures - PE subjects only.

	Variable	WT14			WT15			WT16			WT17			WT18					
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	2	2		2	2		2	1		1	1		2	2				
SMAR	Marital Satisfaction	991	890		943	946		1030	1108		937	868		934	985				
SMAR	Sexual Satisfaction	942	915		992	894		1090	1115		1012	1140		982	1062				
PAD	Sexual Aversion	1006	1039		1026	946		1030	1055		1027	1000		1013	1028				
PAD	Sexual Pleasure	894	935		895	906		959	1012		883	877		861	949				
PAD	Sexual Anxiety	1043	1034		990	1053		1051	1042		1023	1085		1034	1042				
Sem.-Diff	Self-Gen. Eval.	9	10		13	14		10	12		7	8		10	10				
Sem.-Diff	Self-Anxiety	6	7		10	10		12	8		9	5		7	4				
Sem.-Diff	Self-Loving	16	15		17	15		16	15		18	15		18	16				
Sem.-Diff	Self-Sex. Attract.	10	9		9	10		9	8		9	8		8	7				
Sem.-Diff	Self-Erot. Arous.	11	10		13	14		12	11		11	11		12	10				
Sem.-Diff	Partner-Gen. Eval.	9	9		14	13		10	11		13	14		12	13				
Sem.-Diff	Partner-Anxiety	9	8		10	10		10	7		4	2		9	12				
Sem.-Diff	Partner-Loving	18	18		19	18		17	13		21	21		19	18				
Sem.-Diff	Partner-Sex. Attract.	12	12		12	12		11	10		13	14		11	11				
Sem.-Diff	Partner-Erot. Arous.	9	8		12	13		7	6		5	14		7	7				
Indep. Ratings	Freq. Neg. Foreplay	4	4		4	4		4	4		-	4		3	3				
Indep. Ratings	Freq. Neg. Inter	3	3		3	4		2	4		-	4		3	4				
Indep. Ratings	Freq. Pos. Foreplay	4	4		4	2		3	4		-	3		4	3				
Indep. Ratings	Degree Non Coital Pleasure	4	3		4	2		4	3		-	3		4	2				
Indep. Ratings	Freq. Pos. Inter.	3	4		4	2		3	3		-	4		1	1				
Indep. Ratings	Degree Coital Pleasure	2	2		2	2		3	3		-	4		3	2				
Indep. Ratings	Freq. Sex. Interest	5	5		5	4		5	5		-	4		4	3				
Indep. Ratings	Erec. Imp.	9	9		9	9		9	9		-	9		9	9				
Indep. Ratings	Prem. Ejac.	2	3		3	3		2	3		-	3		3	3				
Indep. Ratings	Ejac. Fail.	10	10		10	10		10	10		-	10		10	10				
Indep. Ratings	Vag. Lub.	-	-		-	-		-	-		-	-		-	-				
Indep. Ratings	Vaginismus	-	-		-	-		-	-		-	-		-	-				
Indep. Ratings	Dysparcunia	-	-		-	-		-	-		-	-		-	-				
Indep. Ratings	Orgasmic Freq.	-	-		-	-		-	-		-	-		-	-				
	L/W M.A.T.	120	110		105	118		86	66		104	81		107	96				
SII	Freq. Intercourse	5	5		5	5		4	5		5	5		5	2				
SII	Coital Enj. (Self)	6	6		2	1		5	5		5	5		4	4				
SII	Coital Enj. (Part)	6	6		6	5		6	3		4	4		3	3				

* A = Pre-Waiting Period Score; B = Post Waiting Period Score.

Table 176

WT Raw Data: pre and post-waiting period scores * of control complainants (WT) on salient dependent measures - E1 subjects only.

	Variable	WT19			WT20			WT21			WT22			WT23			WT24		
		A	B	C*	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C
SMAR	Tendency to Spectate	-	3		1	1		1	1		2	3		1	1		1	2	
SMAR	Marital Satisfaction	-	1059		1081	1217		1036	1023		962	981		1092	1133		1047	1185	
SMAR	Sexual Satisfaction	-	888		1081	1109		1031	1100		888	789		1105	1110		1104	1032	
PAD	Sexual Aversion	-	1038		1037	1044		-	1041		1044	1061		-	880		1054	1066	
PAD	Sexual Pleasure	-	1022		991	1008		-	1054		991	1056		-	1149		902	960	
PAD	Sexual Anxiety	-	1130		1079	1086		-	1032		1046	1087		-	868		850	805	
Sem.-Diff	Self-Gen. Eval.	-	10		8	10		10	10		11	10		-	3		-	12	
Sem.-Diff	Self-Anxiety	-	7		8	8		8	10		8	8		-	14		-	5	
Sem.-Diff	Self-Loving	-	18		18	16		16	15		17	18		-	6		-	18	
Sem.-Diff	Self-Sex. Attract.	-	8		6	7		9	8		9	6		-	3		-	10	
Sem.-Diff	Self-Erot. Arous.	-	5		5	6		5	6		10	8		-	5		-	9	
Sem.-Diff	Partner-Gen. Eval.	-	12		10	9		11	10		10	11		-	12		-	11	
Sem.-Diff	Partner-Anxiety	-	7		12	12		9	10		8	8		-	7		-	11	
Sem.-Diff	Partner-Loving	-	18		17	14		20	19		21	20		-	19		-	19	
Sem.-Diff	Partner-Sex. Attract.	-	12		8	9		13	11		12	12		-	11		-	11	
Sem.-Diff	Partner-Erot. Arous.	-	10		2	6		9	11		9	11		-	11		-	8	
Indep. Ratings	Freq. Neg. Foreplay	-	4		3	3		3	1		3	3		-	0		1	1	
Indep. Ratings	Freq. Neg. Inter	-	4		0	1		2	3		2	4		-	0		1	1	
Indep. Ratings	Freq. Pos. Foreplay	-	4		3	2		1	1		3	4		-	1		3	2	
Indep. Ratings	Degree Non Coital Pleasure	-	2		2	2		2	2		3	2		-	2		3	3	
Indep. Ratings	Freq. Pos. Inter.	-	1		4	4		3	3		3	2		-	1		3	1	
Indep. Ratings	Degree Coital Pleasure	-	4		4	3		3	3		3	3		-	-		4	4	
Indep. Ratings	Freq. Sex. Interest	-	4		3	2		2	2		2	2		-	1		5	5	
Indep. Ratings	Erec. Imp.	-	6		1	1		5	6		7	6		-	2		2	2	
Indep. Ratings	Prem. Ejac.	-	5		4	4		7	7		7	7		-	7		2	1	
Indep. Ratings	Ejac. Fail.	-	10		10	10		10	10		8	8		-	10		10	10	
Indep. Ratings	Vag. Lub.	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Vaginismus	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Dysparcunia	-	-		-	-		-	-		-	-		-	-		-	-	
Indep. Ratings	Orgasmic Freq.	-	-		-	-		-	-		-	-		-	-		-	-	
	L/W M.A.T.	-	95		79	50		116	103		-	104		-	45		106	97	
SII	Freq. Intercourse	-	2		3	3		2	2		2	2		-	1	1	2	2	
SII	Coital Enj. (Self)	-	6		6	5		6	6		6	4		-	-	-	6	6	
SII	Coital Enj. (Part)	-	6		3	4		6	6		6	6		-	-	-	5	4	

* A = Pre-waiting Period Score; B = Post-waiting period Score.

TREATMENT GUIDE FOR VAGINISMUS

ACKNOWLEDGMENT

Before we begin the programme, mention must be made of Dr. William Masters and Mrs. Virginia Johnson, the eminent sex researchers. It is from their work that the material for this booklet was derived. Dr. Masters began in 1954 researching the responses of the human body to sexual stimulation. Mrs. Johnson joined him in his work one year later. In 1966 they published their research findings in Human Sexual Response. This book is a landmark in the history of the scientific study of sex; it is popular with both the scientific and lay public.

After their work on human sexual response, Masters and Johnson developed a highly effective programme for treating human sexual inadequacies (such as impotence, inability to orgasm, premature ejaculation). Their treatment programme is presented in their book, Human Sexual Inadequacy. Virtually all the material for the programme is based on their research, so credit for the material is justly directed to them.

Finally, the major contribution to our understanding of sexual problems and their treatment in this country by Dr. John Bancroft should also be acknowledged. Many of the points contained in this booklet are taken directly from his own observations and writings.

INTRODUCTION

Almost all females have at some time experienced difficulties with intercourse. Some may find intromissionby their partner (i.e. entry of the penis) painful sometimes, but not always. Others may lose interest or become tense only toward the end of intercourse but not at the start. Still others may find intromissionby their partners difficult only when the male inserts his fingers but not his penis. Does this mean that most women suffer or have suffered from vaginismus? The answer is "no". The problem has certain featureswhich may be best illustrated by means of an example.

> Frances and Alex have been married for about a year. They went out with each other as teenagers, however, for more than three years. Neither had much experience sexually before marriage and their lovemaking extended only to kissing and caressing each other. Frances always said that she did not want to have intercourse until she got married. Once during petting, Alex tried to insert his finger in her vagina. It was very difficult though, as Frances became very tense. When they were married, sex was unsuccessful as she continued to be very anxious particularly when Alex was about to start intercourse. Her vagina was tight and penetration was at best only very slight - usually it was very sore for Frances. It has always been sore and difficult too for her to insert a Tampax when she has her periods. For this reason she prefers ordinary towels. Frances and Alex have not achieved regular full and relaxed sexual intercourse over any period. Frances and her husband have a sex problem which may be helped by this programme.

As Frances' vaginal muscles regularly tighten up at the start of intercourse (or any kind of ontry e.g. fingers, Tampax, gynaecologist's instruments) she may be considered to suffer from vaginismus. Although,as in this example, the problem really only became obvious after marriage, there are often signs of vaginismus during the teenage years. For example, the girl may always have found the insertion of Tampax to be very difficult or uncomfortable. She may also have feared her partner putting his finger into her vagina. As will be discussed in more detail later, it seems that there are two main aspects to the problem:

1. the woman's muscles in and around her genitals and thighs tend to tighten up when an approach is made toward her vagina, and
2. she also tends to have a fear of pain or discomfort with almost any kind of vaginal penetration.

She may not necessarily suffer from any loss of sexual desire. Indeed many women with vaginismus have a very strong desire to make love which unfortunately is blocked just as intercourse is attempted..

Why Should This Muscular Tightness Develop? - Learned Behaviour

Studies of the sexual histories of many women show that vaginismus is largely a learned disorder. This means that through experience the female has learned to fear vaginal entry and the muscles of the vagina and thighs too "learn" or become conditioned to contract and tighten. This response becomes so strongly ingrained that she cannot readily change it at will. Because she is tense during sexual play, her vagina may not lubricate, (or if it does, it may "dry up" with attempts to enter her) nor will it expand a little in size. The result then is that any attempt to have intercourse is painful. So this is the beginning of a vicious circle: anxiety about pain on entry leads to inadequate lubrication and tightness of the vagina which leads to penetration being difficult, indeed sore and uncomfortable. This leads to more anxiety, etc. Treatment is aimed at breaking this vicious circle and helping her to unlearn this learned anxiety.

Problems of the Couple

In spite of the fact that the woman may initially have the symptoms of a sexual difficulty, the problems that develop are shared by both partners. There is no such thing as an uninvolved partner sexually.

As time passes, the couple repeatedly tries to have mutually satisfying intercourse. Parents may begin to wonder why there are no children of the marriage and may drop embarrassing remarks occasionally. Friends may start a family and this may put extra pressure on the woman, in particular, to succeed somehow in her sexual relations. She tries to relax but the more she tries, the more difficult it seems.

She may feel that the problem is a purely physical one or that she is the only woman who has ever had this sort of difficulty. However, an exclusively physical cause for the difficulty is rare and she would be certainly wrong on the second point too. Many young women have this difficulty. The more the couple tries and fails, the more severe the problem seems to become. Eventually she may feel that it simply is not worth all the effort and, rather than face up to another night of anxiety and embarrassment, the couple avoid any attempt at intercourse. Sex may become less frequent and moods more irritable.

As time passes, the male is likely to feel a growing need for sexual satisfaction. She seems thoughtless, and selfish. His attitude towards his wife slowly changes from warm and encouraging to harsh, resentful and hostile. The female may feel that she has done her best. Seeing no improvement in sight, she worries more over her competence as a wife. When nothing the couple does seems to help, they cease to discuss their problem and communication breaks down.

If you have experienced any of those complications, you will know the emotional pains they can produce. Completing this programme and helping the female to overcome her sexual fears should help you prevent or alleviate those problems. But to improve your sexual relations both of you must work together. If you do not, the programme is unlikely to help. Perhaps your co-operation and motivation will be increased by considering the following points.

Points to Remember

The fact that you are reading this programme shows that you both want to eliminate this problem. It would therefore be helpful to you if you were to keep in mind a few points as you go through the programme. Your consideration and discussion with your partner of these points may help reduce ill feelings, improve communication and ensure the success of your efforts.

Note for the Male

The male partner usually feels he has been deprived of much sexual satisfaction. For this he may tend to blame his wife. It should be remembered that you and your partner are both victims of her early learning or conditioning over which she probably had no control.

The female shows marked tension during sexual relations particularly just as intercourse is attempted. So treatment is focussed mainly on her sexual response. By being involved in this programme you are again giving. This may seem unfair to you. You probably have already given a great deal and may feel that you should now be the one receiving something.

Yet, effective treatment requires a co-operative male - one who is willing to give fully of himself. If you do not fill this requirement, treatment will not succeed.

With your help, vaginismus will cease to be a problem. She cannot treat herself completely and in any case she probably feels guilty at not being able to give you more sexual satisfaction. With your full co-operation you will share with your partner a more satisfying and fulfilling sexual relationship.

Note for the Female

You may be doubtful that you will ever be able to have satisfactory sexual intercourse. Maybe you have tried many methods to help you to relax those muscles, but your efforts have been futile. The techniques presented in this booklet have been widely used in clinical settings. They have been shown to be effective. Among the cases where the use of the techniques have failed, either the female or the male partner or both have lacked motivation to practise them. Most couples who have used them have done so successfully. Those who improve least are usually those who fail to follow the programme as instructed. Now it is inevitable that at each stage in the programme (and perhaps particularly at the beginning) you will experience a certain amount of tension. But, as you will discover, the programme is so arranged that any tension you do feel ought to be within manageable limits. In this way you will gradually learn to overcome it.

Given that you and your partner want to overcome your problem and are willing to follow the programme, there should be every chance of improvement.

Instructions are given throughout this programme to guide you through your self-treatment. It is important that you try to follow these instructions. Do not rush or skip ahead. Relax, take it easy.

At the end of each major section is a true and false quiz. Your answers to this quiz will show you whether you understand the main points of the section. The correct answers are on the page indicated at the top of the quiz page. When doing a quiz, read a question answer it true or false, and immediately (before moving to another question) turn to the answer page and check your answer. Should your answer be correct, feel confident that you understand the portion of the programme represented by the question.

Turn back to the quiz and tackle the next question. Should your answer be incorrect, carefully read the explanation provided with the correct answer. After completing the quiz, follow the instructions at the end of the quiz page.

Throughout the programme are statements directing you to specific pages, such as "Turn to page 36." These statements direct you to parts of the programme you are to begin next.

You do not have to turn to the page immediately, although you may wish to. The statement may be regarded as a rest sign. You may put the programme aside and return to the specified page when you wish.

Therapy Sessions

The ultimate aim of therapy is obviously to enable the couple to engage in satisfactory intercourse. This is achieved by helping to eliminate the spasm in the woman's pelvic and vaginal muscles and lessening her fears of pain with entry (or intromission).

Within each part of treatment, there is a sequence of steps. These steps are easy to understand and should be followed when carrying out the exercises. These steps are important if one wants to increase the chance of success with therapy. So follow the recommended steps and improvement will occur more rapidly.

Now, for some of the treatment exercises you will need an artificial lubricant. You will use this to lubricate the opening of the vagina, your fingers, and your partner's fingers and penis. One of the best to use is K.Y. Lubricating Jelly (by Johnson and Johnson). It is recommended by most physicians and can be bought quite cheaply at most chemists.

Some parts of the treatment may be carried out by the woman on her own. Other parts will involve the woman and her partner together. Of course, I do not intend that you try all the parts in one session! The woman may choose to carry out her exercises on her own at one time of the day or evening and perhaps later in the day she and her partner can be involved together in their part of the programme. The blue pages cover the "woman only" exercises and the white pages instruct you in what you should do together.

How often should the woman carry out her exercises on her own?

The parts of treatment which involve the woman on her own are more like definite "exercises" and as such they should be carried out fairly regularly. At least one session of these exercises each day on no fewer than five days each week is what the woman should aim for.

These exercises are designed largely to overcome the muscular spasm and to help her relax with gradually greater degrees of penetration.

Let me now describe the details of the treatment.

QUIZ 1

The answers to this quiz are on page 62

Check your answer to each question before going on to the next

1. Vaginismus is basically a physical problem that the women affected are born with.

   True_____ False_____

2. When a woman becomes sexually aroused two changes occur in her vagina. - it becomes moist with its own lubricant and the vaginal barrel swells in size.

   True_____ False_____

3. A fear that entry into the vagina will be sore often underlies the tightening of the pelvic and vaginal muscles

   True_____ False_____

4. The problem is the woman's and its treatment has nothing to do with the male partner.

   True_____ False_____

5. The female should do all her exercises (on the blue pages) before going on to those that you do together (on the white pages).

   True_____ False_____

If you feel that you understand the material so far, turn to page 8

How Should You Start?

1. It is not uncommon among women with this problem to find that the vagina has become a sort of "taboo" area. It may be, in other words, a part of their body they have never felt particularly comfortable touching or having touched. There may be many reasons for this but among the most important are likely to be:-

(a) the fact that the vagina has become associated with difficulties or discomfort. As a rule we prefer to "steer clear" of activities, situations or anything that make us feel uneasy. Not only does that make us feel better but we may even feel that the problem will one day disappear by itself anyway.

(b) general sexual attitudes may be another reason. Touching our sexual parts ourselves we may feel to be "dirty" or just not the sort of thing decent folk should do.

(c) often related to anxiety is a lack of adequate sexual information and discussion. Most of us would probably deny that we had inadequate sexual knowledge. Yet most of us have sometimes large gaps in our understanding and familiarity with sexual issues. These gaps may increase our tensions sexually.

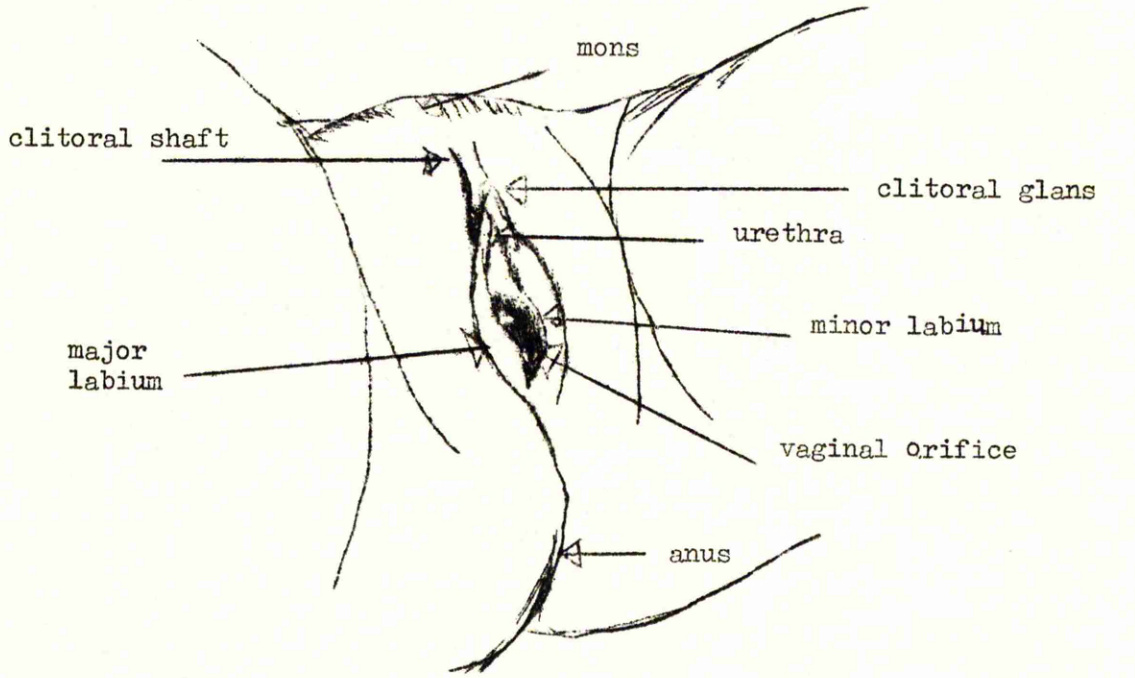
So first of all, on her own, and in the privacy of the bedroom, or in the bathroom, the woman should take a hand mirror, with a good light shining on it, and examine her own vagina. It may be helpful to put some K.Y. Jelly on her fingers and on the lips of the vagina. She should touch it, find and learn the names of the various parts with the help of the diagram below. At this stage she should not attempt to put her fingers well into her vagina but she should try to touch and separate the outer lips.

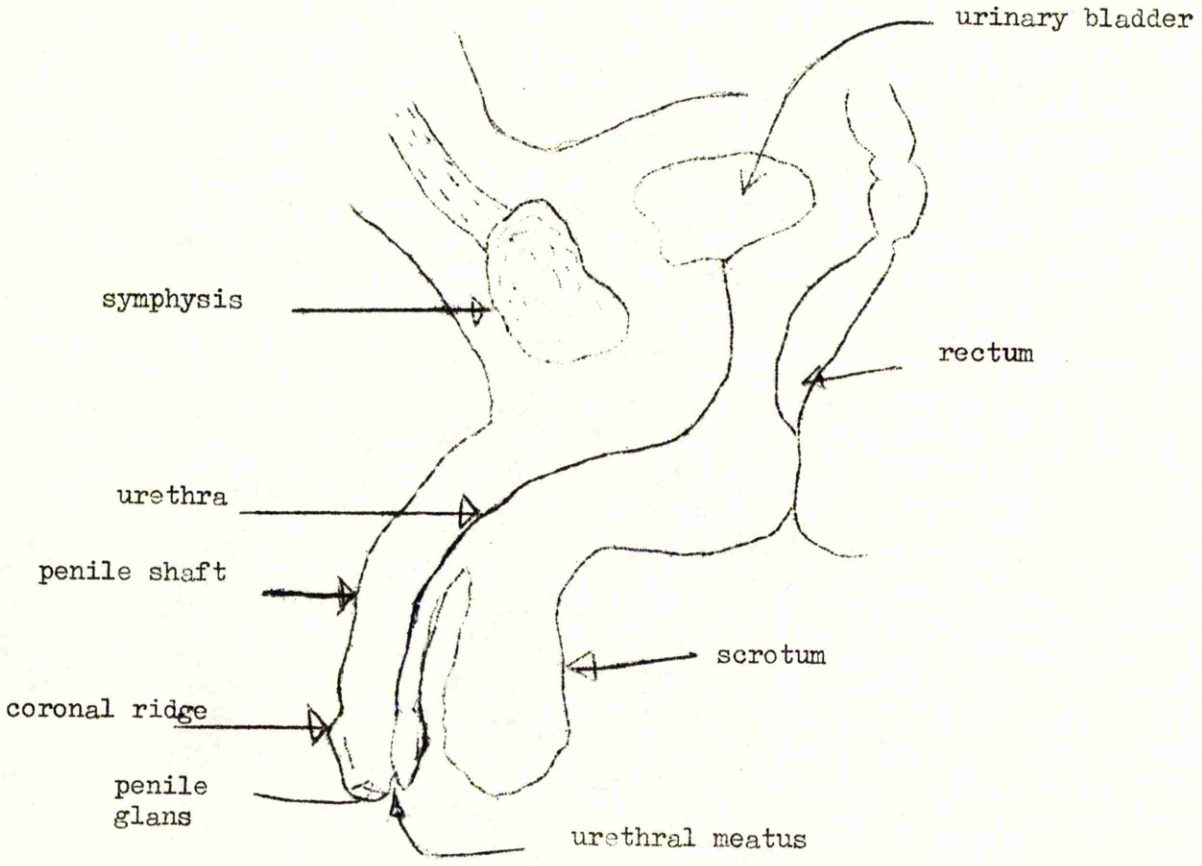
The aim of this exercise is that she becomes less inhibited about touching her vagina and also a bit more aware of its structure and the names of the parts.

She should continue to do this <u>for as long as it takes her to feel much more relaxed</u> about this kind of non sexual vaginal contact.

This may not take very long but nevertheless the woman should not just miss this part of the programme out because "she knows it all already." Every woman at some point benefits from any such activity in which she learns a little more about this part of her body but also to learn to relax while so doing.

If she wishes, when she feels more relaxed, she may ask her partner to join her. Both of you locating and identifying the various parts of his genitals too can be equally instructive ...





Phase Two

Now that you are more confident with touching your vagina and more familiar with its parts, it would be appropriate now to describe in detail additional relaxation exercises that the woman may try on her own followed by graded finger insertion to help overcome the muscular spasm.

At first, at least, the woman may carry out these exercises on her own.

For the Woman to Practise

Because accepting your partner's penis is difficult for you partly because the muscles of the vagina tend to tighten up, you should try to relax these muscles. This may sound "easier said than done" because you have probably been trying desperately to relax every time he tries to enter you. However, as will be described later, when you come to enjoy love play in bed together, there will be a ban on either of you attempting intercourse. So, in the meantime, until you feel more confident about having intercourse, the woman should try the following exercises.

Relaxation and Finger Exercises

Firstly, the woman should go to her bedroom on her own at a time of the day when she is sure of complete privacy - perhaps in the evening when the children are in bed or after lunch may be a suitable time.

Close the curtains and loosen all tight clothing and strip off from the waist down. You may actually prefer now to go under some of the sheets on the bed to keep yourself comfortably warm or you can have a small electric fire in the room so that you don't feel cold.

Lie down now on your back either on or in the bed (or on the floor if you prefer) and with the lighting dimmed, close your eyes.

Now, in this position, take a deep breath, fill your lungs, then breath out. Do this six or seven times then relax all over and just breathe normally.

Then you should concentrate only on that part of your body between your knees and your bottom. Now, slowly begin to tense and tighten those muscles. Take it slowly, do not rush. Just concentrate on the feelings of tightness slowly building up in the muscles of your thighs, of your vagina and around your buttocks.

Think only about the tension building up in those muscles. Muscles elsewhere may well be getting tense too but focus all your attention on the feelings of tension and discomfort building up as you slowly tighten those muscles. When, and only when you feel you cannot tighten anymore those muscles of your vaginal area, your thighs and buttocks, hold it for a few seconds and while still concentrating all the time, very slowly let those muscles relax. You relax them slowly. The temptation is to relax the muscles suddenly and quickly. Don't however. Just relax them gradually - as gradually and as slowly as you can, until they are totally relaxed. After a few moments, do this once again - slowly tensing those same muscle groups, then relaxing them equally slowly.

Do not do this any more than twice in any one session. By doing this exercise just a couple of times before going on to finger entry you will learn not only to relax the muscles more easily but to identify levels of tension that you were possibly unaware of before. You can learn then to relax and gain some degree of control over those muscles.

Finger Insertion

Finger insertion carried out immediately after relaxing the muscles in the way just described can be a useful way of unlearning vaginal muscular spasm. This should be carried out in a graded way starting with the least stressful, and presumably least difficult activity, to the most.

You may not like the idea of doing this

Now, many women with this problem do not, as a rule, like touching their own vagina. They may feel embarrassed doing this, perhaps consider it to be unnatural or even dirty - just the idea, never mind actually doing it may make them feel uncomfortable. To some extent this feeling is another symptom of the problem as a whole.

Treatment therefore ought to be aimed toward helping you learn to relax while experiencing vaginal entry. It is important therefore that you learn to cope with this part before attempting anything potentially more demanding - like accepting your partner's penis. First then get used to your own fingers. When you learn to cope with them on your own, acceptance of your partner's fingers and later still his penis will be easier for you.

You should use KY Lubricating Jelly

To help you during these finger insertion exercises you should use the above lubricating jelly available from most chemists. You should put some on your fingers and around the lips of your vagina. Do not be alarmed by this and feel that you should always need to use it. There are very good reasons for recommending it. During sexual arousal, the vaginal barrel widens and becomes moist with its own lubricant. As any woman would probably not be sexually aroused when doing these exercises, she would need to apply some artificial lubricant.

So remember, in its normal "resting" state the vaginal barrel is not so wide as it would be when you are sexually aroused. This means that whatever you manage to insert in your vagina when not aroused sexually (be it half of one finger or all of two fingers) from a purely physical standpoint, it would be even easier to do the same when sexually "turned on" because the vagina then would be wider and wet with its own natural oils.

If you Have Long Finger Nails...

It may help your self confidence to cut your finger nails. It is unlikely that a woman with long nails would hurt herself, but, since fear of pain from any kind of penetration is often central to what maintains the problem, it would seem appropriate to get rid of that possible additional source of tension.

Begin Finger Insertion Just After Relaxing The Muscles

Firstly you should put plenty of KY Jelly on your middle finger and around the lips of your vagina.

Now slowly tense the muscles of the vagina and slowly relax them again. Then you should gently insert a small part of the middle finger - about a half of the middle finger is fine. Just try to relax and keep your middle finger still inside the vagina. Do not yet try to move it inside. Remain still and keep taking deep slow breaths.

Usually, women with this problem feel uncomfortable when something is inside the vagina - even if it is only half of one finger. If you do, DO NOT IMMEDIATELY TAKE YOUR FINGER OUT. KEEP IT INSIDE. STAY WITH ANY UNCOMFORTABLE FEELINGS UNTIL YOU FEEL MORE RELAXED. It may take one minute, maybe even ten minutes or twenty minutes before you feel more at ease. But only when you feel reasonably relaxed and comfortable with that inch and a half of your middle finger inside, should you take it out.

You should repeat the procedure with that same amount of the same finger a number of times. You should repeat it a number of times in fact, so that you feel very little trace of tension or anxiety. There is no fixed number of times you should repeat this as every woman is different.

However, it is often helpful to "overlearn." In other words, when you no longer feel any tension or anxiety with this particular exercise do it another three or four times anyway.

When you feel that you have learned to relax the muscles to enable the reasonably comfortable entry of about an inch to an inch and a half of your middle finger, use exactly the same technique to get used to the acceptance of just a little bit more. Again relax yourself, lubricate your finger with K.Y. Jelly and gradually insert your finger two and a half inches. (Do not feel you should aim to insert all of your finger - about 2½ inches is fine, i.e. about the level of the knuckle of the finger). Always remember to keep it inside until you feel more at ease. Once again, repeat this a number of times in your session.

Is there any specific position to take up for these exercises?

There is no one position which all women find the most comfortable. For example many women prefer to lie on their backs while inserting their finger. Others find being on their knees to be the most comfortable. Still others like to be in a position in which they are half sitting and half lying back. In short then the best advice is to encourage you to find the position you personally find the most comfortable.

One final point - some women find it especially helpful to "bear down" on the finger. That means - moving your hips down on to your finger instead of just pushing your finger in alone. In other words, you may find that moving your body down on to your finger may be more helpful than just keeping it still while you slowly insert your finger. Try it and see how you get on. But remember when your finger is in - just relax the muscles - and keep it inside until any bad, uncomfortable feelings go away. Then repeat a number of times. That last point is one of the most important of all whichever way you finally choose to put your finger inside. Turn to page 14

QUIZ 2

The answers to this quiz are on page 63

Check your answer to each question before moving on to the next.

1. You should try to insert as much of your middle finger as you possibly can to begin with.
   True_____ False_____

2. If you can insert a particular amount of your finger reasonably confidently during the exercises, in purely physical terms, it should be even more comfortably accepted when you are sexually aroused. True_____ False_____

3. It is probably better to try finger insertion exercises some time before, rather than after, your love play together
   True_____ False_____

4. After inserting your finger, if you feel any tension, you should immediately withdraw it.
   True_____ False_____

5. Most women find these exercises very enjoyable
   True_____ False_____

If you feel that you understand the material covered by these questions, follow the advice when you come to carry out the exercises. When you have done this, turn to page 15 of the programme and follow the appropriate instructions.

Read the statments below. Choose the one that applies and turn to the page indicated.

Statement 1

I carried out the relaxation exercises and inserted most of the middle finger a number of times. I feel reasonably relaxed and confident now with this activity. Turn to page 16

Statement 2

I tried to insert most of the middle finger a number of times but was unable to relax sufficiently to accept it with reasonable confidence. Turn to page 17

You Chose Statement 1

Well done. You have already gone a considerable way toward overcoming that muscular spasm. The key of course is not withdrawing your finger at the first sign of any discomfort. Staying with any "bad" feelings and keeping the finger inside until any tension largely disappears is the most important aspect of effective training. Now that you have made this first step, do not just miss it out now. Start each future finger exercise session with the middle finger on its own before going on to other fingers. More will be said about this later when you turn now to page 18 to follow further instructions.

You chose statement 2

Don't worry unduly if you found you had difficulty with this particular exercise. Check the following points, read over them again carefully in the booklet and try to carry them out when you next have another session.

Firstly, slowly tense and then equally slowly relax the muscles of the thighs and buttocks. Do this a few times. When you feel you have relaxed these muscles adequately, put plenty of K.Y. Lubricating Jelly on your middle finger and around the opening of the vagina. Take up a position you feel comfortable with e.g. this may be on your back, legs bent at the knees and spread wide apart, or it may be on your knees. Try "bearing down" on your finger rather than the only movement coming from just your finger. You may find that more helpful. For the first time just be satisfied with learning to cope with only about a half of your finger. Finally, the most important point of all - you must always keep your finger inside until any uncomfortable tense feelings gradually begin to disappear. When you feel less tense, slowly remove your finger and do the exercise again. Try this several times until you feel comfortable with at least a half of your middle finger.

If you still find you have difficulties in accepting your middle finger, then a better starting point might be the insertion of your smallest finger before going on to the middle one. The same principles and method of insertion would of course remain the same.

So an alternative procedure should you continue to have difficulties with the middle finger would be:

(a) start with the smallest finger - repeat several times in your session

(c) Then with success at (a) go on to about an inch of your middle finger - repeat a number of times

(c) Then gradually increase the amount of entry.

TAKE YOUR TIME - ONLY WITHDRAW YOUR FINGER WHEN YOU FEEL MORE AT EASE WITH IT INSIDE.
REPEAT SEVERAL TIMES IN EACH SESSION.

During your next session you should try to follow this advice. Afterwards turn to page 15 and choose the statement which now applies and follow directions from there.

To have reached this stage, you have shown patience and an all important motivation to get rid of the muscular spasm. There is little new from now on - only a variation on the same theme. This is the last main part of the section which the woman can carry out on her own. Of course, there are no hard and fast "rules" about not having your partner present. If you choose, you can ask him to be with you.

This time the exercise will involve the insertion of two of your fingers - your index and middle finger - but the procedure is identical to that described already for the middle finger alone. It would be pointless going over again all the instructions and so I shall redescribe the advice as a sort of summary.

(a) Spend some time relaxing your body and in particular those muscles around your vagina, thighs and buttocks.

(b) Put lots of K.Y. Jelly on your index and middle finger and around the lips of your vagina.

(c) To begin with, do something you feel confident with - namely introduce your middle finger a few times first.

(d) Then, insert only about an inch or so of two of your fingers. Relax and insert that small amount.

(e) Don't forget to keep them inside until you feel any tension (which may be present) go away.

(f) Repeat this a few times.

(g) When you feel confident with this part of the exercise, relax and slowly insert a little more of those same two fingers.

(h) Allowing your confidence to increase in this way by repeating your successes, bit by bit you will find that insertion of your fingers will become an exercise you are more and more confident about.

(i) Insertion up to about or just below the level of the knuckles of your fingers is fine

A few additional reminders:

1. Always take up a position you feel comfortable with
2. Don't be mean with the K.Y. Jelly
3. Relax the muscles first
4. Keep whatever length of your fingers inside until any tension or anxious feelings go away.
5. It's just like learning to swim. You get used to small exercises at the shallow end first before plunging in at the deep end. Always remember to repeat your successes. If you manage something for the first time do it again a few times to let your confidence grow. Then go on and try a bit more.
6. It would probably be unrealistic to try to insert the entire length of your finger(s). Comfortable insertion of about half to three quarters of their length would be all that is necessary.

Read the statements below. Choose the one which applies and then turn to the page indicated.

Statement 1

I carried out the relaxation exercises and inserted most of two of my own fingers a number of times. I feel reasonably relaxed and confident now with this activity. Turn to page 21

Statement 2

I tried to insert mostof two of my own fingers a number of times but was unable to relax sufficiently to accept all of these fingers with reasonable ease. Turn to page 22

You Chose Statement 1

That's great. Now that you have reached this stage you have taken a considerable step toward overcoming the spasm. This should enable you to get more from sexual play with your husband in the sense that you will probably be less fearful of continued difficulties. It will also mean that you will both be in a better position to relax and enjoy your sexual relations together and benefit from the procedure described on the white pages.

In your next session on your own, repeat this exercise - relaxing, starting with the middle finger on its own, then going on to two finger insertion. Afterwards, assuming all goes well and it should, you will be in a position to benefit from the advice given on page 40. However, as you have been following the advice (on the white pages) together, you may not have reached the stage where you are encouraged to insert the male's finger. If so, the female should continue to spend about twenty minutes to half an hour every day on her own, practising to relax and continuing to get used to inserting her fingers in the manner outlined above.

Anyway, ONLY when you feel confident with this, should you go on to inserting the male's finger.

You Chose Statement 2

Don't be upset or too concerned if you had some difficulty in accepting two of your fingers. Again, just spend a little time now thinking about some possible reasons for this.

Perhaps you were simply trying too hard. In other words, maybe you were trying to force yourself to relax those muscles of the vaginal area. Spend some time before these exercises slowly tensing and relaxing them a few times.

Always use lots of K.Y. Jelly around your vaginal lips and on your fingers.

Always start by slowly building on some activity you feel more confident with. For example, it may be a good idea to start with inserting a small amount of your smallest finger. When you feel reasonably relaxed with that small amount inside withdraw your finger and insert a little more of your smallest finger. As your confidence increases, then do the same with your middle finger. Just insert a small amount of your middle finger to begin with. Then withdraw it again only when you feel reasonably at ease. Repeat this with a little more of your middle finger - and so on. The principles of finger insertion always remain the same. First, relax yourself and relax the muscles of your vaginal area in particular. Use lots of K.Y. Jelly. Always start slowly, no matter how eager you may be to finish the session. More hurry less speed. Proceed at your <u>own</u> pace (but <u>do</u> have regular sessions).

Never do these exercises when you are too tired, too rushed or too irritable. Never do them if you cannot be assured of complete privacy. Never do them in a cold or uncomfortable room. Never expect to feel sexually excited by these exercises or even completely and totally at ease (These exercises are designed only to help you overcome the muscular spasm). Never do the exercises so often in any one session that you feel marked physical discomfort. Above all - take your time and relax. Take each step gradually. Do <u>not</u> feel that you <u>must</u> in one session be able to accept most of two fingers. Following the advice given here, you may want to spread this over more than one or two sessions before feeling more confident with two of your own fingers.

When you have had your next session, turn back to page 20 and choose the statment which applies and follow directions from there.

First read this phase thoroughly and carefully. This part of the programme is for both of you.

Privacy and Comfort

You should have a private place such as a bedroom where both of you can relax and feel at ease. If you have children or other potential distractions, it may be necessary to arrange the training sessions so that you will not be rushed or otherwise disturbed. Distractions should be minimised so that your full attention can be devoted to the sessions.

You should not carry out sessions when either of you feels tired, anxious, irritated, or rushed. Both of you should feel comfortable with the place and the time. These, in fact are good rules for most sexual encounters.

Sensate Focus

Phase One

Our main source of sexual stimulation is physical contact-touching and feeling. Without this source, most of use, male and female alike, would never reach high levels of sexual arousal. The more we feel sexually, the more aroused we will become and, consequently, the more we will enjoy sex.

Physical contact with your partner is also the best means of sexual communication. There is no better way to find what physically excites your partner than to observe and feel his or her bodily responses to your touches. There is no better way to find what your physical preferences are than for your partner to stroke, fondle, and caress your body.

Many couples do little touching before intercourse. Thus they deprive themselves of much stimulation and valuable communication with their partners. It is important, then, that intimate bodily contact be a part of your sex life. For this reason, a part of this programme is devoted to getting you to think and feel physically.

To sharpen your touch sense, the first part of each training session will be devoted to what is called "sensate focus." This is an activity in which both of you, one at a time, explore your physical reactions to touch.

Keep in mind that sensate focus exercises are to get you to thinking and feeling physically. Many of us in our culture have been affected to some degree by a touch taboo. In line with this taboo we express our feelings for one another in largely non-physical ways (for example, saying things that have special meaning). Certainly There is nothing wrong with non-physical expressions of feelings, but physical expressions are just as desirable, if not more so. And in sex the most important form of expression is physical.

In a warm room where you can enjoy complete privacy in a relaxing atmosphere, both of you remove all your clothes. Some clothes worn in a sexy way can be arousing, but to avoid awkwardness and distractions it is better to start without clothes. Keep in mind that talking should be minimized--sensate focus is a physical experience.

The male is to lie down on something comfortable. His position does not matter: face up, back up, or side up--whichever he prefers. He is to relax and be comfortable. He has but two jobs. One, he is to give the female verbal and/or physical directions. He may tell her what is physically pleasurable to him, or show her by guiding her hands with his. Two, he is to keep her from doing anything that is too irritating or uncomfortable. This is important. One of you may be the kind of person who has never liked being touched by others. Or perhaps you are bothered if you are stroked and caressed anywhere other than a few parts of your body, such as your legs, your arms, or maybe your scalp. If so, don't hesitate to tell or show the other where these parts are and where they are not. During sensate focus exercises let her stroke, rub, caress, kiss, massage, or fondle those parts of your body that you like to have touched. Other than these jobs the male is to feel and think of the pleasures of being caressed. He is to focus and keep his attention fully on what he feels. He is not to return the touching at this point, nor does he need to express--with his body or his voice--the pleasure he feels unless it is spontaneous. It is not unusual to feel a little guilty about just lying quietly and receiving pleasure. Somehow it is difficult to not give in return. Both of you will have your turn to give, but while you are receiving just become totally involved in what you feel.

The female is to get in any position close to the male so that she is able to touch most of his body. She is to begin lightly touching his body anywhere (and everywhere) except his genitals (the area of his penis). Do not touch that part of his body. At a later point in the programme you will arouse each other more directly, but there is much to gain now by avoiding direct stimulation.

The female has two jobs: One, she is to provide the male with pleasure by touching him while observing his reactions to her touches.

Her other job is to explore her own pleasures in touching. She is to notice the sensations of rough and smooth, hard and soft, and warm and cool as she touches his body.

Sensate Focus exercises are not intended to be structured. Both of you should be calm and comfortable and respond to your impulses to caress the other. When feeling and when touching, you may move about freely on the bed. There is nothing specific that you must do, other than take turns in touching and observing and in feeling what it is to be loved physically.

After about fifteen minutes of the female touching and the male feeling, you are to change places. The female is to lie in any position she prefers, and the male is to position himself so that he can easily stroke most of her body. Now it is the job of the female to feel and think of the pleasures of being touched. Also she is to keep the male from doing anything to her that causes discomfort. It is the job of the male to touch, to fondle and massage the female and to observe her for signs of pleasure. He is also to attend to her pleasures of touching. At this point the male is not to touch the female's genitals (her vagina) or her breasts.

Do not have intercourse during or after sensate focus exercises.

There is good reason for putting a ban on more intimate sexual play and on intercourse at this stage:-

(a) because intercourse attempts have probably been associated in the past with anxiety and discomfort, it makes sense at this point to eliminate that source of tension. In this way, then, you will be free to enjoy physical pleasures in a more relaxed and non demanding way. After all, there are no goals for you to be concerned about during your loveplay now. You both must understand and accept why these bans exist Neither of you will obviously know that the other does understand and accept them unless you discuss them. So do please talk about your views and this phase, so as to reassure each other.

Communication in this way is absolutely crucial, not just at this stage but throughout this programme and afterwards.

(b) It is best that an atmosphere be created which helps promote communication between each other. This more relaxed atmosphere develops when there is no longer any fear of intercourse or any struggle to achieve it. In general then, your sexual play will be much less like "a performance" when you are free to just give each other pleasure without there being any demands to meet any target such as intercourse.

(c) Finally, you may be wondering now why there is also a ban on touching the breasts and genitals at this point. The reasons are similar to those given above. Also it is important that you both realise that there can be more to making love than just caressing the most intimate parts. To start with touching these parts may be seen as encouraging or actively seducing the other into intercourse. If the woman feels apprehensive

about intercourse (as she may well do) then she may feel guilty for not meeting his perceived needs and so on.

So please do not just mechanically follow the programme like a recipe book or a prescription - talk about it and reassure each other that you understand and accept the principles of treatment.

Other important principles of communication are these:

1. Aim to communicate with each other as two adults. In some marriages the husband communicates like a father and the wife like a child, and in others the wife behaves like a mother to her husband who reacts like a son. Such "parent and child" relationships do not encourage mature adult sexual responsiveness.

2. During the course of the programme (and later if you wish), teach yourself to 'self-assert' and 'self-protect' by using the expressions 'I would like' or 'I feel that...' instead of the more common 'should we' or 'would you like....?' The usual method of communication (often thought to be unselfish) is to think or guess what your partner would like rather than putting your own wishes first. This pattern can lead to all sorts of problems e.g. you may always guess wrong and he or she has never liked to tell you for fear of hurting you (being unselfish again). In that way long-standing assumptions about what each other likes or dislikes may be totally incorrect. A much safer and easier way to communicate is to express your own thoughts, feelings, ideas and desires and let your partner do the same thing. All the guess work then will have gone out of your communication.

3. Encourage your partner to use the term 'I' and allow him or her to express feelings of hurt or discomfort without you reacting too violently and so discouraging self-expression. You are both entitled to your own feelings and should be allowed to express them freely. Having respect for your own and each other's feelings is crucial. Feelings are real things whether you think they are justified or not. If they are not dealt with, and that usually means by expressing them in a suitable way, they will become bottled up and can cause havoc in a relationship.

4. You will need to negotiate fairly on those occasions where each of you wants something different. For example, if you want black and he wants white, you have both declared yourself and rather than have grey each day, far better to have black one day and white the next.

Praise and Encouragement

This works better than criticism. Noticing and commenting on the good things your partner does will have a much more positive effect than nagging about the bad things. Turn to page 27

QUIZ 3

The answers to this quiz are on page 64

Check your answer to each question before moving on to the next.

1. Sessions should be carried out when you are both tired so that you can relax more easily
   True_____ False_____

2. The purpose of having a ban on specific types of intimate sexual relations during sensate focus is so that neither of you gets too aroused sexually.
   True_____ False_____

3. Women with vaginismus often tense up during the early stages of sexual play, long before any kind of vaginal entry is attempted
   True_____ False_____

4. During sensate focus, you should talk as much as possible to convey to your partner what is most pleasurable to you.
   True_____ False_____

5. The partner being touched during sensate focus should let the touching partner know if he or she does anything irritating or bothersome.
   True_____ False_____

6. If sensate focus is pleasurable to both of you during a session, you may have in ercourse to increase your enjoyment
   True_____ False_____

7. One should aim to have at least three sessions of sensate focus a week, no more than one a day
   True_____ False_____

If you feel that you understand the material for this section, follow the advice given during your time together. When you have completed your session, turn to page28 of the programme and follow the appropriate instructions.

Phase One

Read the following statements and select the one that most clearly applies to you: turn to the page indicated after the statement you choose.

Statement 1 Our sensate focus exercise was pleasurable. Turn to page 29

Statement 2 Our sensate focus exercise was not especially pleasurable. Turn to page 30

Phase One

You chose Statement. Our sensate focus exercise was pleasurable.

Good! Bodily contact certainly can be enjoyable, and sensate focus exercises give you a chance to enjoy your physical reactions to touch.

When you return to your bedroom for your next session, do sensate focussing again. If you will relax and be thoroughly involved in your physical sensations, this second session should be enjoyable. After your session return to page 28., select the most appropriate statement, and follow the directions. If your next experience is pleasurable, skip this page when you are directed to it and turn to page 32.

Phase One

You chose Statement 2. Our sensate focus exercise was not especially pleasurable.

Sensate focussing can be highly pleasurable, but you didn't find your first experience to be so. Well, that's okay; it is not at all uncommon for people to feel awkward, uncomfortable, or simply neutral when first trying sensate focus exercises. To be sure that you understand the process of sensate focussing, carefully read and think about the points below. Discuss with each other whether you conducted your sensate focus exercise according to these points.

1) Your training sessions should be at a time and place in which you feel comfortable

2) When being touched, let your partner know if he or she does anything that is unpleasant to you. Also let him or her know what is particularly pleasurable to you. However, you should not be too concerned about signalling to your partner; just relax, don't talk too much and fully concentrate on the pleasures of being touched.

3) When caressing your partner, observe closely what is pleasurable to him or her. Also note your sensations from touching.

4) Sensate focussing is not intended to be structured. Do what the two of you like, whatever is pleasurable and enjoyable for you—except, at this point, touching each other's genitals.

5) It is extremely important that you both appreciate why there is a ban on attempting intercourse at the moment no matter how sexually aroused or "ready" either the male or female becomes. For example, if the woman feels guilty because she is "not satisfying him with intercourse" or if she is unable to relax during sensate focus because she thinks he may well try to have intercourse or that he will feel disappointed if he does not, then neither of you is communicating adequately and expressing a necessary understanding of the reasons for the ban. Both of you then MUST be confident that your sexual relations will not proceed to trying intercourse at the moment. The woman also MUST believe that her partner sincerely accepts and understands without any grudge the reasons for the ban. If she does not, then you must discuss this together. It is a myth that a man cannot be satisfied with sexual relations that do not go on to intercourse.

If she continues to feel (or be made to feel) guilty about not having intercourse, treatment will not succeed. You must communicate and discuss your feelings about this together.

When it is convenient, return to your bedroom or wherever for your next session if you feel you understand each of the above points. Keep the points in mind during the session.

Also remember there is no reason to rush through this programme. Take it easy, go slowly, and above all--enjoy yourselves.

After your session, return to page 28 and follow the instructions.

SENSATE FOCUS

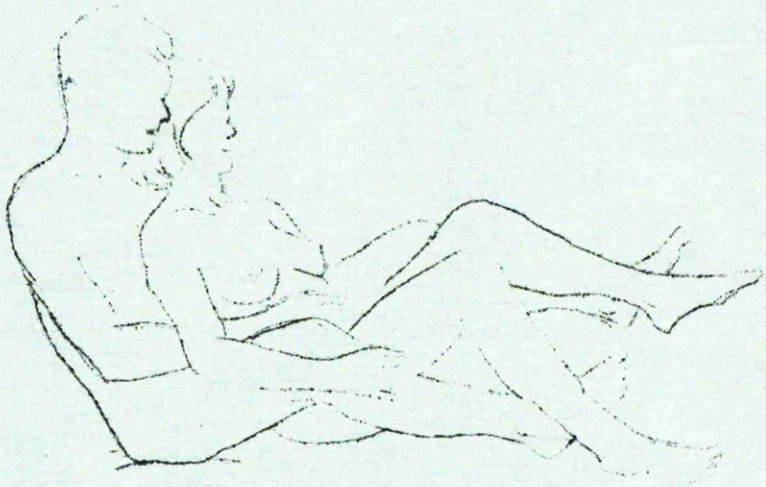
Phase Two

Through sensate focus you can become totally involved in the sensations of bodily contact. This total involvement is sure to help you both unlearn any performance anxieties if you both agree not to go on to have intercourse until instructed. You both MUST understand why the ban on intercourse exists. The ban is there to allow you both, but particularly the woman, to relearn to enjoy sexual stimulation to the full in a relaxed non demanding way. If there is any pressure, real or imaginary, to have intercourse this full relaxed sexual enjoyment will not be experienced. The woman therefore must not be afraid to show her sexual pleasure in case this be seen by her partner as the "come on" for intercourse. So the man should reassure his partner that he will not attempt intercourse at this stage.

Begin your next session together then with sensate focus exercises as described. When you feel you have done sensate focussing enough (when each of you has been able to relax and respond pleasurably to the other's touches), position yourselves comfortably for more intimate, but relaxing sexual play - but again without any goals. This stage then allows your sexual play to become more intimate. As before, one of you should be the "giver" first, then the "receiver."

When the Male is the "Receiver"

The woman should lie comfortably beside her partner in such a way that she can easily caress her partner's genitals as well as other body parts and be able to observe his pleasure. When he finds something pleasurable then he should show it - much of our sexual enjoyment comes from seeing and feeling the other respond in a positive way. This then also allows the male to show her how he likes to be touched, stroked or fondled. Perhaps, after all, she may pull his foreskin back too far, grip his penis too tightly, rub rather than caress, etc. As before then, he should indicate in a positive way what he likes and where and how he likes to be touched. This can not only be very instructive for a woman but also extremely rewarding.



When the Female is the "Receiver"

Many women have described how they like to have baby oil on their fingers while caressing their partner's body. This can cut down any possible irritation as well as enhance his pleasure.

At all times during this phase then the woman should think only of the nice feelings she gets as she sees her caresses bringing pleasure to her partner. So, he should remember to show his feelings, but not necessarily with words: movements, gestures, sighs, etc., can be just as, if not more, effective.

During this phase, as before, the couple should not set any clear goals. You are not doing this for any reason other than giving yourselves enjoyment. Of course, he may be brought to a climax, if you both wish and if at the time it seems appropriate to do so. If it does not, then you need not.

When the Woman is the "Receiver"

Now you can extend your pleasuring to include the genital areas and breasts. As for the other parts of the body, the man should not assume anything about what is likely to please his partner. Discover together the best places and the best ways. For the man pleasuring the woman it will be as well to arrange yourselves in an easy position for him to caress her genital areas and breasts while at the same time she can easily guide his hand by laying hers above it. One possible position is shown above. Try this but you may find another position of your own that is preferable. The one shown however, does have the advantages of allowing the woman the opportunity to relax and direct her partner's hands to the most pleasurable parts.

Neither should assume that the aim of this stage is for the male to stimulate only his partner's breasts and genitals. In fact the main point is that now he can caress all parts of her body. So do not feel that the aim is to direct all stimulation deliberately and exclusively towards the breasts and vagina.

Once again, as before, the only responsibility of the woman is to relax and enjoy the sensations she experiences. She should indicate in a positive way what she likes and where and how she likes to be touched. This can be not only very rewarding to the man but also very instructive. He can learn how she likes her breasts and vagina to be caressed.

At all times during this phase, the man should think only of the nice feelings he gets from seeing his caresses bringing pleasure to his partner. So, she should remember to show her feelings, not necessarily with words; movements, gestures, sighs, etc., can be just as, if not more effective and rewarding. She is free to relax and be open in this way, as she knows she can control and guide her husband's hands with hers and knows also that intercourse will not follow yet.

IIt can be really helpful very often for the male to use K.Y. Lubricating Jelly on his fingers when his partner directs his hand to her vaginal area. The woman should not feel she must, attempt to insert his fingers unless otherwise instructed but should just guide his fingers to the most pleasurable parts. She should show him <u>by laying her hand on his</u>, just <u>how</u> she likes to be touched. To cut down any possible irritation she may put some K.Y. Jelly around the lips of her own vagina. The main point is that the woman encourages her husband to do what <u>she</u> likes in order to give herself pleasure. The aim is to "be selfish" and to concentrate and enjoy her own nice feelings and NOT to think about what she might believe her partner is thinking about. She will inevitably be giving <u>him</u> pleasure as she <u>shows</u> her own pleasure.

<u>So to recap</u>. These sessions are best started slowly in a teasing fashion with phase one. Only gradually move on to the more intimate parts.

It is most important that - <u>the woman should take her partner's hand in hers and show him what she likes, where and how</u>. She should think about and enjoy only her own feelings and not be distracted by any concern about what she thinks he is thinking about. Particularly when she gets pleasure from vaginal stimulation she <u>must</u> guide his hand with her own not only to lessen any fears that he may do something unexpected, but to show him what she actually does enjoy.

The man should not spend a long time stimulating his partner's clitoris (a very sensitive part at the "top" of her vagina). Although indirect stimulation of this part may indeed be highly pleasurable for a woman, most females find prolonged direct rubbing of the clitoris to be irritating and bothersome. However, in any case, it is the woman's job to communicate to the male just how and where she does like to be touched. Communicating one's pleasures and indicating just what one does like is absolutely crucial to the success of this programme. So do not just "put up with" something for fear that it would hurt the other. Show each other what you do enjoy by guiding your partner's hand with your own or by telling your partner.

The male should not feel he should necessarily direct all his attention to her breasts and her vagina. He may move away and return to these areas as you both wish. Turn to page 36

QUIZ 4

The answers to this quiz are on page 65

Check your answer to each question before going on to the next.

1. One should not focus attention just on the breasts and genitals in this phase but see this as one allowing stimulation of all areas of the body.
   True_____ False_____

2. If the male wishes, he may insert a finger in his partner's vagina
   True_____ False_____

3. The female may deliberately masturbate her husband with the intention of bringing him to a climax if she so wishes
   True_____ False_____

4. The purpose of this phase is for the woman to relax sufficiently to enable both of you to have intercourse
   True_____ False_____

5. It is not too important if you do not wish to communicate your feelings to each other
   True_____ False_____

6. In a sense, we must learn to be more "selfish"
   True_____ False_____

If you feel that you understand the material covered by these questions, you should follow the advice in your next session. When you have done this, turn to page 37 and follow the appropriate instructions.

Read the statements below. Choose the one which you feel most clearly applies to you and turn to the page indicated.

Statement 1

1. We carried out this non demanding, intimate caressing and we both got much pleasure from doing it.

Turn to page 38

Statement 2

2. We carried out this non demanding, intimate caressing but the woman became tense, particularly with vaginal contact, and so neither partner got much enjoyment.

Turn to page 39

Statement 1

That's really good. It certainly can be most enjoyable to engage in this kind of intimate "give and take" without feeling that it must lead to intercourse. You will probably have found that it can be very stimulating just to see how much pleasure we get from giving when our partner responds to our touch.

With the woman convinced that intercourse would not follow as yet, she is free to relax and become aroused by the male's caresses. Of course, intercourse is to be encouraged later but there is much to be gained from strengthening her confidence and sexual enjoyment.

When you have your next session together, you should repeat this stage, making no deliberate effort at this point to insert his fingers. Just relax, set no specific targets and allow yourselves the chance to unlearn again your anxieties. If you both bear these points in mind beforehand, all should be fine during your next session and so you may skip this page when directed to it and turn then to page 40

Statement 2

The reasons for a woman's tension at this stage are normally reasonably clear to identify on examining the couple's feelings and attitudes after the session. You should both therefore discuss rather than ignore (which is often tempting) the following possibilities.

(a) the woman feared that her husband would just "get too excited" and would be disappointed at not going on to have intercourse.

If this is the case, then the male should give every reassurance that he is not preoccupied with having intercourse. Both should recognise that he can get enormous pleasure at the moment just from seeing her relax and enjoy herself. If the woman continues to feel guilty because she believes her partner is not being satisfied fully she may if she wishes bring him to a climax by masturbation when it is her turn to caress him.

(b) the woman feared he might insert his fingers into her vagina

This would suggest that she did not lay her hand on his to guide and show him what she liked. She should direct his hand at this point. It probably also indicates that the man could give more reassurance to his partner about his understanding and acceptance of the principles of treatment. He should also tell her that he gets his pleasure from seeing her relax and enjoy herself and that he feels in no way "let down" by not inserting his fingers or trying intercourse.

Remember too that despite persuading the couple not to try finger insertion by the husband at this point, it is clearly possible that insertion could occur if attempted. The vagina not only becomes moist when the woman is aroused but increases in size as well. However, it is probably best at this stage that you do not attempt introduction of his fingers at this point.

(c) In the past, the husband may have spent much time with lengthy stimulation by hand of his partner's clitoris in the hope that this would help. In fact, prolonged manipulation of the clitoris can be irritating for most women. If this has been the case then it is all the more important that the female by guiding his hand show him how she likes her vaginal area to be caressed.

Each of you should re-read the main points of this stage, discuss whether you feel any of the comments above apply to you before your next session of love play.

Afterwards, turn to page 37 and choose the statement which applies.

That you have reached this stage shows that you have both been co-operating and communicating with each other and adhering to the advice given. You will probably find as you continue in the same way that you can build steadily and surely on the progress you have made.

This next step now links the improvement the woman has made with the exercises on her own to your sexual play together.

When the woman is able to cope with two fingers on her own

This next step essentially combines the non demanding intimate sexual play you have both been involved in with the exercises the woman has been trying on her own. When the female feels reasonably comfortable with insertion of two fingers on her own (that would suggest that the muscular spasm is much less of a problem), she and her husband should try to associate that success with graded insertion of his fingers during intimate sex play together.

At this point, the woman would do well to remember a very important point. Whatever she can insert on her own ought to be even easier to insert during sexual arousal. After all, two things happen when she is aroused (a) her vagina produces its own lubricant and (b) the vaginal barrel expands. Both of these responses are the body's way of preparing itself for further pleasure from entry of the penis.

For the time being, the ban on intercourse remains.

Finger Insertion Involving Husband

The couple should continue to carry out phase two of sensate focus - that is the intimate, non-demanding sexual play in the manner already outlined on pages 32 to 35 . As you have already engaged in this and found it to be rewarding and pleasurable, there should be little difficulty in building on this. Remember to take turns giving and receiving pleasure and start off each session slowly with touching and stroking the non intimate parts (back, neck, scalp, etc) before going on to the intimate parts (genitals, breasts).

When the couple reach the point when it is the woman's turn to enjoy her partner's touches, they should take up the position they both favour (this may be the one shown on page 33). At some point then when the woman is enjoying his caressing she should, again under her direction and control guide his hand with her own to her vagina. She is to lay her hand on his.

As with any activity in which you are both involved, she should use his hand and fingers on her vagina primarily to give her pleasure in whatever way she wants. She should allow herself, as before, to abandon herself totally to the nice feelings she experiences. K.Y. Jelly around her vaginal lips and K.Y. Jelly on his fingers may not be strictly necessary (as her vagina will probably be producing its own lubricant) but it is recommended if only to increase your confidence further.

After she has been receiving pleasure in this way for a little while, she should direct one of his fingers into her vagina. "Bearing down" on it may be helpful. Be satisfied first with accepting just one finger. Remember, she should control the insertion with her hand on his, using his finger to give her pleasure. The man's role is to do at the same time only that which he knows she likes. (This may involve caressing her breasts, stroking her neck with his free hand, saying a few reassuring affectionate words, etc).

The important points are (1) that she is in control to a large extent - using his finger in the way she likes; (2) that if she feels at all tense soon after inserting it, she should relax the muscles in the way she knows she can. She should enjoy pleasant sexual thoughts and feelings and keep his finger inside for as long as it takes for any bad feelings to go. n no account should she take it out at the first sign of tension. She should learn to relax with it inside. (3) Obviously, continuing to enjoy other forms of sexual stimulation going on at the same time helps considerably to reduce any tension. So, finger insertion by the partner should probably not be the only activity going on at the time. While his finger is inside he should caress, kiss or fondle her neck, breasts, thighs, etc., or do whatever he knows she likes. She should concentrate on these pleasant sensations.

(4) Women with this difficulty very often find themselves playing a fairly passive role sexually. This is perhaps understandable in terms of their anxiety, fears and concern about what they believe their partners think about them, etc. Being "selfish" sexually is important - do what you want to do to give yourself pleasure and you will be giving pleasure to your partner anyway. This is helped if you aim to be assertive - don't just lie back and wait for things to happen to you. Guide his hand to the pleasurable parts, move your body against your partner or move on his finger if you wish and be active in giving yourself pleasure. Being more expressive and active in this way not only helps you be less anxious, but is very satisfying to your partner.

(5) Try insertion of his finger in the way described at least four or five times in the session. (6) Just relax. Don't think about anything other than enjoying the nice feelings you are experiencing at the time. (7) The woman should not necessarily feel that she must accept all of his finger. Getting used to a very small amount first, before inserting a little more is probably the best way to approach this. Take it gradually, relax and this can soon be an activity that will give you both much sexual pleasure.

Turn to page 43.

QUIZ 5

The answers to this quiz are on page 66

Check your answer to each question before going on to the next.

1. The best way to cope with this stage is for the female to do nothing other than leave her partner to insert his finger when and how he pleases
   True_____ False_____

2. The woman should not use K.Y. Jelly when she is sexually aroused as her vagina will be wet with its own lubricant then anyway.
   True_____ False_____

3. The female should only try accepting her partner's finger when she is confident with inserting two of her own, on her own.
   True_____ False_____

4. If either of you feels anxious, worried, guilty or whatever, it is best not to mention it for fear of hurting the other.

5. If the female feels in any way anxious with her husband's finger inside, she should immediately take it out
   True_____ False_____

6. If any difficulty should be experienced with his finger then both of you should just give up completely during the session
   True_____ False_____

If you feel that you understand the material covered by this quiz, follow the advice during your love play together. When you have completed your session, turn to page 44 of the programme and follow the appropriate instructions.

Read the statements below - choose the one that applies and turn to the page indicated.

Statement 1

Insertion of one of the male's fingers occurred as part of intimate, non demanding caressing. She accepted his finger a few times and feels reasonably relaxed and confident now with this activity. Turn to page 45

Statement 2

Insertion of one of his fingers was attempted as part of intimate, non-demanding caressing. Throughout the session the woman had difficulty relaxing sufficiently to accept his finger. Turn to page 46

You Chose Statement 1

Being able to accept one of your partner's fingers comfortably in the context of love play is a very considerable step forward. To begin with it is not unreasonable to expect the woman to feel apprehensive. However, this can be overcome and, as she has found, it can get easier and easier as she continues to relax and concentrate only on the pleasurable sensations that come with being caressed in the way she wants Relaxing the muscles, being actively involved while she guides his hand with hers can be even more helpful. When you next choose to have your next session, include this again in your love play which you will probably enjoy even more now that you feel rather more confident with this activity. Afterwards, return to page 44 to select the statement which applies. All being well (and if you both follow advice again there is no reason why it should not be) skip this page when directed to it and turn to page 47 instead.

You Chose Statement 2

If you found it difficult to accept his finger at this point don't worry. It does not mean that you have taken a step back. Consider the following points and re-read the advice given already.

1. You cannot force yourself to enjoy your love play, any more than you can force the muscles not to contract. The female will be able to accept his finger and still enjoy her loveplay if she just relaxes and guides his fingers with her own hand to lessen any fears that he will do something unexpected. Reassurance from him will help too of course.

2. Perhaps you both proceeded a bit too quickly. Try lengthening foreplay a little - let your loveplay proceed in a teasing relaxing fashion. There is nothing wrong either with her inserting her own fingers first a few times if she wishes, during loveplay, to give her added confidence.

3. Concentrate, both of you, on the pleasures you are receiving at the time (at "the here and now") rather than thinking too far ahead.

4. Although the female will produce her own vaginal lubricant when she becomes excited, there is no harm at all in her using K.Y. Jelly on his fingers and around her vaginal lips too. Many couples do this anyway.

5. She should guide his hands, not just to her vagina, but to any part of her body that brings her pleasure.

6. "Bearing down" on his finger may help too. Any initial tension will go if she does not take it out but relaxes and focusses on his caresses, elsewhere (e.g. her breasts, etc) and his expressions of pleasure. She should only remove his finger when she feels more relaxed, so that there is no "sigh of relief" when it is out.

7. It may seem that finger insertion is an exercise to be conducted in a rather cold, clinical way. It need not be if, at the same time as the entry of his finger, the couple continue to do that which you know you both enjoy. She may guide his free hand to her breasts, or to the outside of her vagina, to her thighs, neck or whatever.

8. If you wish, you may find it helpful to insert his smallest finger first before going on to his middle one. When you wish, spend some time together engaging in love play having first considered and discussed some of these points.

9. Remember to agree to express your feelings rather than bottle them up. Thereafter return to page 44 choose the statement which applies and follow instructions.

Now that the woman feels more confident with entry of one of her husband's fingers during loveplay it is worth emphasising again one or two points.

1. The spasm she was so troubled with in the past now no longer presents the same problem. She has learned to relax these muscles around and in her vagina and thighs. This, in turn, permits her to get more enjoyment from her sexual play than before.

2. The increased understanding you will both have of each other and of the principles of effective change, and the very gains you have already madd should help promote further progress.

This next step then involves the woman learning to accept two of the male's fingers. This is not in fact the huge hurdle which perhaps the couple feels it may be. If anything, in the light of the main points 1. and 2. mentioned above, this step can be achieved with relative ease and mutual enjoyment.

The procedure for this step remains basically identical to that for the previous one in which she learned to accept one finger of her partner. So there is nothing really new for this step. Just briefly remind yourselves of certain key points:-

(a) For the time being both should agree not to attempt intercourse - no matter how "ready" the female or the male may be. First learn to give pleasure in less intimate ways.

(b) Follow the procedure for the previous step. Relax, slowly carry out the sensate focus exercises, taking turns in giving each other pleasure.

(c) When it is the woman's turn to be caressed all over in a relaxing fashion, when she wants, she should guide his hand to her vagina. She may guide one of his fingers into her vagina. She should do and think about only that which gives her pleasure. You can stop and repeat this as often as you like as long as she does not remove his finger at the first sign of any possible tension. K.Y. Jelly again may be used to enhance your pleasure.

(d) Then while you are both enjoying this relaxing loveplay, she should insert two of his fingers. Remember the main thing is to get pleasure from your loveplay and to insert them when you do feel sexually excited. Relaxing the muscles will help as well as using K.Y. Jelly in addition to her own lubricant. As before, let the female be in control as this will lessen any possible fears she may have of discomfort or pain. "Bearing down" may help too as well as her being active in doing and thinking about only that which gives her pleasure. If at any point she does feel uneasy she should "stay with her feelings" until she feels better.

However, concentrating on relaxing and enjoying her partner's caresses at the same time will do much not just to lessen any slight tension she may feel but to make it a more enjoyable sexual episode.

So the procedure is really the same as before and the main points and principles remain the same. Discuss them. Reassure each other that you do both accept them. This time when the female comes to use his fingers she should insert one first before going on to two.

Always remember - never rush things. Take each step gradually and you will be able to cope with this stage. In other words after getting used to one of the male's fingers (under the female's control) relax, and just be content to accept only an inch or so of two fingers. Then when you feel confident with that amount, bit by bit, the woman can learn to relax with a little more inside. The woman should guide his hand and fingers with her own (this will help her to relax by lessening any fears she may have that he might do something unexpected).

It is best not to go on to intercourse until the female can regularly accept reasonably comfortably and confidently two of her partner's fingers in the way described.

There is no rush. If you do not succeed on any occasion do not worry, there is always another time. You are not trying to break any records. But remember - only go on to intercourse when both of you feel reasonably confident with the female's ability to accept two of his fingers.

Should you have any difficulties with this stage - do not worry. Re-read the advice given already on pages 40 to 46 , (the same principles apply) discuss it together and eventually, you will progress.

The final step in this programme is that of sexual intercourse. As it probably used to be one of the most feared activities for you both and the one most frequently associated with disappointment and frustration, one might still expect you both to feel a bit apprehensive about it now. You probably feel you have too many unhappy memories to make it something you can look forward to with complete ease.

But let's forget about the past. Too many changes have taken place now. The progress that you have made together means that neither of you is the same as you used to be. After all, when the problem first became obvious, the female had extreme difficulty inserting anything inside the vagina. That has changed.

Most sexual play in the past caused frustration and tension. That has changed.

You possibly argued or at least talked little in a constructive way about the problem. I expect that too will have changed.

The female in particular probably felt very guilty about not satisfying her partner. She will feel less so now. The list could go on.

So, as a couple and as individuals, you are really not the same as before. Think positively. Think about what you have achieved and together you will see that any fears you may have of intercourse are based only on the "old you" and not on the "new you." You have come a long way since starting the programme.

Sensate Focus

Some of this final phase will be similar to earlier ones. For instance, you should begin your sessions with sensate focus exercises - gradually building on less intimate, gentle, caressing and stroking of each other's body to more intimate stroking of the breasts and genital areas. Both of you, of course, should remove all your clothes. This time the male should lie down comfortably and be caressed first. When you are ready to change places, the female is to lie down and the male is to touch and caress her. Change roles from touching to being touched as often as you like. Keep in mind that these exercises are not meant to be stiff and mechanical. When either the male or female comes to caress the partner's genitals he or she need not spend all the time then stimulating those parts. Moving away and returning to them just as one might any other body area is often much better. In any case, if you are the one being touched, let your partner know if he or she does anything that irritates you, and also express the pleasures you feel - but only if this expression is spontaneous. Be totally involved in your reactions to being touched. When you are touching, be sensitive to the other's reactions and note your own pleasures.

So, take turns in caressing and include all body parts that give nice feelings. At some point when the female is enjoying this stimulation she should direct his hand to her vagina and guide finger insertion - first one of his fingers and then two if you wish. This, of course, should be encouraged when she feels sufficiently excited sexually. Her moist and wider vaginal barrel will ease entry as will some K.Y Jelly, or Vaseline or Baby Oil, as well. Lots of couples use some artificial lubricant even though they produce their own vaginal oils during lovemaking. Lubricants cut down possible irritation and do make entry even easier and more enjoyable. The couple should not spend too long with finger entry and it probably should not go on until the woman reaches a climax (orgasm).

It is important that while both of you are feeling sexually aroused, you go on to entry of the penis. While aroused, the woman will find this much easier than she probably thinks because of vaginal widening and lubrication. Use some K.Y. Jelly or Baby Oil on his penis during your loveplay and the male can put some around his partner's vaginal lips - not only does it enhance your pleasure during loveplay but it can assist entry even more.

A Position You May Find Helpful

is one in which the female is above the male. Inserting his penis is a phase women often like to be in control of. From the man's point of view, he often welcomes her help with insertion as, after all, she knows exactly where it goes. Males, in general, often prefer a woman's help anyway. No matter how experienced he may be, it is often distracting for him trying to find the entrance, as well as irritating for the female to have him do so. One other point: it is, after all, surely a myth that it is the man's "responsibility" to take all the initiative sexually. The position shown below allows her then to be rather more in control at this point.

It is of course possible, just after moving into this position (or indeed any other) that there may be some slight drop in sexual feelings - purely because of the time taken to move into it. It is therefore a good idea not to insert his penis immediately but to spend a few moments first caressing and stimulating each other while in this new position.

Some couples do not like this position. They feel it makes the "woman less womanly" or "the man somehow less manly." If, for any reason you do not wish to use the "female-above position, you may find some other you find more comfortable. The female, may, for example prefer a position in which she is on her back, legs apart with her partner on top (see page 54). As long as the woman can control and guide his penis inside comfortably, then that position is entirely suitable. However, the possible advantages of the female-above position are that:

1. it affords the woman easy access to the penis and control of entry.
2. it also allows the male the opportunity to caress comfortably her breasts, genitals, etc.

As you can see from the illustration, the male should rest on his back with the female straddling his body. Her knees are to be placed roughly in line with his nipples. She should move back on his penis rather than sit down on it.

When and How to Insert the Penis

As mentioned earlier, this should be done when both of you feel reasonably relaxed and when the woman feels reasonably at ease. When you first move into the position for entry it is often helpful to caress and fondle each other for a little while before inserting the penis. The use of K.Y. Jelly or Baby Oil can be used on the genitals while fondling each other.

The female may well feel a bit apprehensive but she should relax the muscles by first tensing and then relaxing them in the manner described earlier in this booklet. With her vagina and the penis moist with lubricant she should then guide his penis inside. "Bearing down" on the penis may help too.

Any uncomfortable feelings she may have at first will go away if she just "stays with her feelings." Neither of you should move at this stage. Just relax. Entry of about half of the penis is fine. While the penis is inside, neither of you should thrust. The male should

reassure his partner that he will remain motionless and he may wish to caress and stroke her at the same time to help her, and him, feel more sexual enjoyment..

It is very important that neither of you withdraws the penis until any slight tension or anxiety gradually disappears. And it will. The length of time it takes for any such feelings to go varies from woman to woman. However, the importance of "staying with" these fears until they subside cannot be overstated. If you follow this advice, you will become more confident of this activity and there will be increased enjoyment of it too.

It is clearly possible, of course, that there may only be very slight fear or none at all. Perhaps, the woman may very quickly realise that penis entry really is "not so bad after all" and that this reaction is virtually instantaneous. Whatever the reaction, "stay with it" to allow your confidence to grow.

When you feel it would be appropriate to withdraw, do so and continue to caress and stroke each other in a relaxing fashion for a little while. Then, insert the penis again first making sure that you have plenty of K.Y. Jelly on his penis and around the vaginal lips.

So the aim at this stage is just to get used to penis entry not full intercourse. On no account feel that you should aim toward completing intercourse with the male ejaculating inside or/and the female reaching a climax. Entering the vagina a few times first is fine.

What if neither of you wants to adopt the female above position? What if you find it uncomfortable or totally unsuitable for either of you?

Then you should use any other that you both feel comfortable with. This may well be the one in which the woman is on her back while the man lies between his partner's legs. (see Page 54).

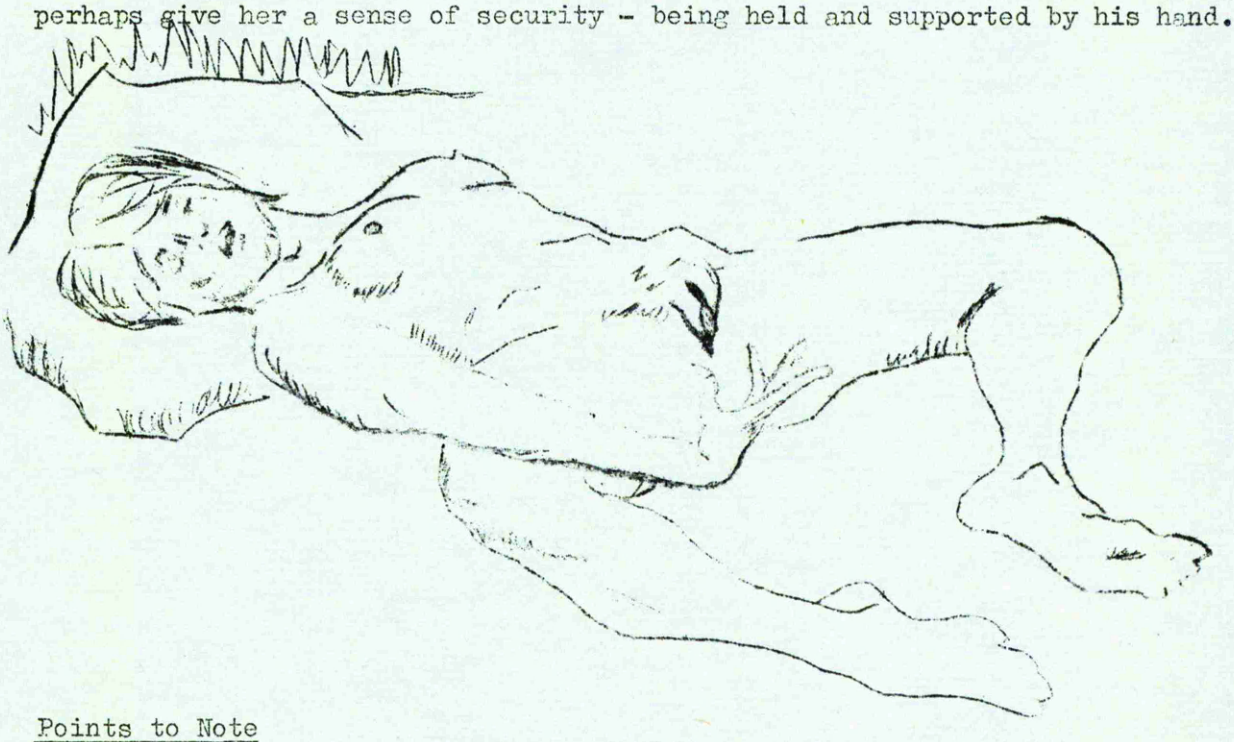
The same principles apply of course. The couple should continue with caressing and fondling for a little while after moving into this position before she inserts the penis. Just prior to entry she can tighten and then relax her vaginal and thigh muscles and stretch her hand over or under her right leg to stimulate and guide his penis inside. Again use K.Y. Jelly if you wish on each others genitals. The female, rather than the male, should guide his penis inside.

Incidentally, it is probably better that the male support his own body weight by pushing himself up with his arms and legs. This would clearly allow the woman more freedom to move her arms underneath him and to move on to his penis too.

Again at this stage neither of you should thrust but should just be content with a number of entries first. Always remember to withdraw the penis only after any uncomfortable feelings begin to go away.

A Tip You May Find Helpful If You Choose The Position Below

Some womem, who may be tense or apprehensive at the start of intercourse, find it helpful if her lover puts a hand under her buttocks. At the moment she begins to feel a bit uneasy or tense, she should press hard with her buttocks on to his hand. This will ensure relaxation at the vaginal entrance, and at the same time perhaps give her a sense of security - being held and supported by his hand.



Points to Note

(a) Allow yourselves the chance to relax and enjoy sensate focus. Both of you should just concentrate on pleasurable feelings you are experiencing at the time. Never think beyond that.

(b) Use finger insertion as a part of your love play in the way you have done before.

(c) As part of your love play, tease each others genitals with lots of K.Y. Jelly or Baby Oil.

(d) When you both wish, go on to insert the penis, remembering to keep it inside until any slight fears you may have had begin to fade away.

(e) While the penis is inside, do not thrust meantime unless the woman wants to. Continue caressing each other while it is inside.

(f) Let the penis come out while the female is fairly relaxed (not when anxious), continue loveplay and then reinsert the penis. Do this a few times - just getting used to insertion rather than completing intercourse.

Turn to page 55

Quiz 6

The answers to this quiz are on page 67

Check your answer to each question before going on to the next.

1. Even if the female is quite unable to accept two of her partner's fingers during loveplay, the couple may proceed with sexual intercourse

   True_____ False_____

2. The couple may choose the position for intercourse that they find most comfortable.

   True_____ False_____

3. When you both go on to have intercourse, neither of you should necessarily aim to complete it with the male ejaculating or/and the female reaching a climax

   True_____ False_____

4. Both partners should thrust immediately the penis enters the vagina

   True_____ False_____

5. At the start of intercourse the female should guide the penis inside her vagina

   True_____ False_____

If you feel that you understand the material for this stage follow rhe advice during your time together.

Afterwards, you should turn to page 56 of the programme and follow the appropriate instructions.

Read the statements below. Choose the one that applied and turn to the page indicated.

Statement 1

The penis entered the vagina satisfactorily and reasonably easily, without undue discomfort. Turn to page 57

Statement 2

The penis entered the vagina but entry or/and containment of the penis was uncomfortable. Turn to page 58

Statement 3

We tried entry of the penis into the vagina but found that it was not possible. Turn to page 59

You Chose Statement 1

That's excellent. Now possibly for the first time despite probably a few initial fears, you have experienced satisfactory entry of the penis. The fact that you have managed this will give your confidence now a tremendous lift. You will know now that by relaxing, not thinking too far ahead, and to some extent by being assertive (i.e. not avoiding the very thing which caused you stress before) you can proceed to enjoy a normal sex life. In your next session of lovemaking, start intercourse by again having a series of successful entries and then follow the advice given on page 60

You Chose Statement 2

Don't worry if the female, in particular, found this to be a bit uncomfortable at first. The chances are that this discomfort was due to the woman's own natural lubricant drying up a little. Perhaps the female was not sufficiently aroused during foreplay - maybe she would have liked intimate caressing to have gone on for a bit longer before inserting the penis. Indeed one of the most common causes of this kind of discomfort is insufficient vaginal lubrication.

The most likely reason for this is the woman's slight apprehension or wariness of intercourse. She is aware that she has made progress but at the back of her mind she knows that she would dearly love to accept his penis (something she may not have done before without pain or a fear of pain). So, it may not be surprising to find that there are still traces of slight anxiety - it may not be the dread of intercourse she had before - but just a mild wariness. If that were so, it would serve to dampen her enjoyment of foreplay a little and therefore cut down the production of her own natural lubricant. The fact that the penis entered suggests that the muscular spasm is less of a problem now.

Always ensure that together you consider the following points:

(a) Use K.Y. Jelly - use lots of it. Even though she may be very excited and her vagina very wet, the knowledge that this will ease entry even more will lessen any anxieties

(b) Let her be in control of entry - perhaps the female above position will help.

(c) She should realise that it is not essential, for the male's or the female's enjoyment, that all of the penis be inserted. A couple of inches is fine.

(d) Neither of you should aim to complete intercourse but should be happy just getting used to a series of entries first.

(e) The woman should never be made to feel guilty about the problem or having to abide by the advice or instructions.

So both of you should communicate clearly, give and accept reassurance.

(f) Don't rush and don't worry. When you wish, return to your bedroom having first considered these points. Never rush your lovemaking. Try to be "selfish" and think of your own pleasurable feelings. Afterwards, turn again to page 56 choose the statement that applies and follow instructions.

You Chose Statement 3

You will probably feel a bit downhearted because of this difficulty. But it does not mean you've taken a backward step. Remember to bear in mind the following points.

(a) Before penis entry, encourage the insertion of one and then later two of the male's fingers during lovemaking.

(b) The more the female relaxes, the more she can enjoy this activity. She should concentrate only on the pleasant feelings she gets from this.

(b) During your love play, put lots of K.Y. Jelly on the genitals - both male and female.

(c) When the female feels relaxed and is enjoying intimate foreplay, she should take up a position she feels comfortable with and one which enables her to control entry.

(d) The depth of entry is not all that important. About two inches of the penis is fine. Learn to feel confident with a small amount first. In any case, it would be wrong to believe that the deeper the entry the more the satisfaction.

(e) Neither of you should thrust or aim to go beyond just entering the vagina in this way and then withdrawing when still relaxed. Do this a few times. Be content with that and no more. You can enjoy full intercourse at some other time.

(f) Try to be assertive. In other words, do not avoid entry because you feel a bit apprehensive about it. Learn to relax with it and then you can be sure that it will become more and more enjoyable.

(g) Never think ahead. Concentrate on enjoying pleasurable sensations at any given moment.

(h) What does it matter if any difficulty is experienced? You will probably know the reasons. There is always another night.

(i) Be open about each other's feelings - not just the bad but the good ones too. Communicating with each other is important.

(j) After the penis is out of the vagina just continue relaxing with pleasurable caressing and fondling before penis entry again. The only aim is to enjoy what you do together.

When you wish enjoy loveplay again, having first considered and discussed the above points. Then afterwards, turn back to page 56 choose the appropriate statement and follow instructions.

The approach recommended in this booklet has been a graded one. You have taken one step at a time to minimise fear and maximise pleasure. Sex, after all, is about giving and receiving pleasure. Moreover, we get pleasure from giving it. So we need not be concerned about what our partner is thinking about or feeling. If one concentrates on getting as much out of lovemaking for his or her own sake it will be inevitable that the partner will be picking up those signs of pleasure anyway. So again "be selfish." Do what you want to please yourself. Your partner will "protect" him or herself anyway.

The last phase obviously involves allowing the passive containment of the penis to go on to more pleasurable intercourse. This simply involves extending what you have done already.

(a) You should commence with whatever kind of sexual play you like. Perhaps Sensate Focus going on to more intimate play you may find appropriate.

(b) At some point in intimate sexual play, it might be a good idea for the woman to guide her partner's fingers to her vaginal area. Finger play is not only highly pleasurable but will serve to increase her confidence further for intercourse. She should move on to one finger and later two fingers ("bearing down") and totally immerse herself in the nice feelings she gets. K.Y. Jelly again may be used to boost confidence. If anything does become a little uncomfortable she should feel free to say so and indicate just what she does prefer.

(c) Try the female-above position for intercourse or some other that is preferable. So far then there's nothing new.

(d) Only she should move gently at first. He should lie still. It is most important that the man does not begin a very demanding pattern of vigorous thrusting as this may be quite threatening or anxiety arousing to a woman with past sexual difficulties. When the woman is more in control she is then free to do what she wants to give pleasure to herself.

(e) In this position, of course, the male can offer his partner additional forms of sexual stimulation by caressing her breasts or clitoral area (at the "top" of the vagina).

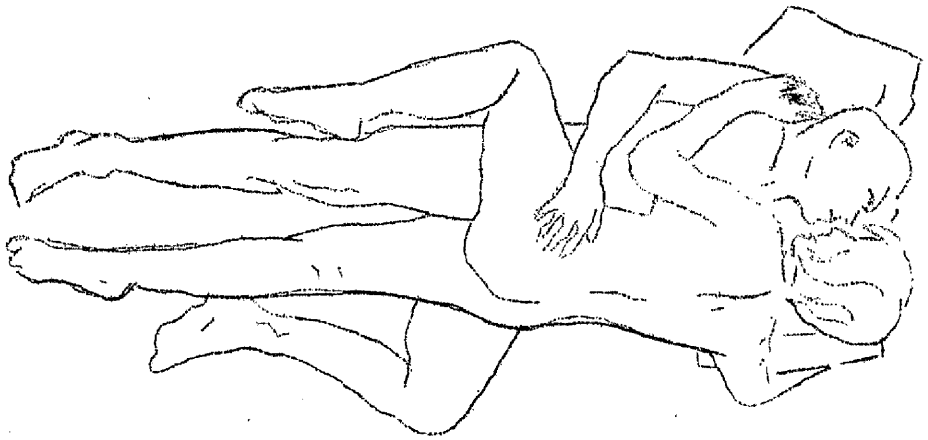
(f) The female, in particular, should not be too concerned with reaching a climax herself. Many women report that having a climax is not crucial to their enjoyment of intercourse. It will only happen anyway, when you are not "forcing" one.

(g) Because the male may find this experience particularly exciting he may tend to reach a climax and ejaculate quite quickly. Neither of you should be worried about this. This will probably resolve itself with more experience and patience.

(h) When you both feel more confident and when the female requests, the male can commence some gentle movement as well. But, to begin with, the female should move on her own, and as she wishes, to give herself pleasure.

(i) You may not choose to stay with this same position every time you make love. Two positions have been described so far. Another some find comfortable is the 'lateral' position in which each of you lies on your side. Couples can move into this position fairly easily from the female-above position (see below)

(j) There is little more advice that may be given. By the time a couple reach this stage, normally they have a sufficient understanding of each other and of the best way for them of making love.



ANSWERS TO QUIZ 1

1. Although the actual contraction or tightening of the muscles is a physical response, the problem in most cases is a learned one. In other words, the woman has developed a learned anxiety with respect to vaginal entry and the muscles have similarly "learned" to tighten up. She is not "born with the problem" and unlearning can occur (False).

2. These changes do indeed occur and in most women they persist throughout lovemaking. Anxiety and tension may make it impossible for some women to become or remain sexually "turned on" and so these responses of the body may then **not** occur or may be short-lived. (True).

3. This indeed very often is a factor involved. Of course, if the muscle tightness continues and her vagina stops lubricating because of her fears then entry (with a finger or penis) will be sore. This then just confirms and strengthens the woman's fears. (True)

4. This is definitely not the case. Successful treatment demands that the man understand and accept that sexual relations involve him as well as the woman. Similarly if the male is unwilling or even seen to be unwilling to co-operate fully, treatment will almost certainly not succeed. Both of you must be motivated and determined in a really positive way to overcome the problem (False).

5. No, The reason for the two different sets of coloured pages is purely to make it easier for you to locate the instructions. The woman carries out most of the "blue" activities on her own but later in the day you both can make a start on sensate focus, etc., as described on the white pages. (False)

ANSWERS TO QUIZ 2

1. Use lots of K.Y. Jelly, relax yourself and just be happy at first to contain a fairly small amount of your middle finger. Do this a number of times, always keeping it inside until any initial tension begins to drop. Then gradually increase the amount you insert. (False)

2. This is true because, during sexual arousal, a woman produces her own lubricant and the vaginal barrel widens (True)

3. The woman may find it better to do the finger exercises first so that you are free to relax and completely abandon yourselves later to sensate focus (as described on the white pages) (True)

4. The female should try to learn to relax with her finger inside so that she does not experience any sudden wave of relief when she removes it (False)

5. It would be wrong for you to believe that all women (including those who have never experienced this problem) would be really happy and completely at ease with these exercises. After all, finger insertion in this way is not a normal everyday activity for most women. However, from the point of view of overcoming this difficulty and enabling the woman to see improvement from day to day, this activity has lots of advantages. You may not like the idea of finger entry too much, but these feelings will become much less marked if you follow the advice. (False)

ANSWERS TO QUIZ 3

1. Mix unpleasant feelings with sexual activities and you will tend to associate these in the future. Mix pleasant feelings with sex and you will tend to associate these. Avoid, then, having your sessions when either of you is tired, irritable or rushed (False)

2. The purpose of the ban (firstly on touching the breasts and genitals and also on intercourse) is to reduce the discomfort, stress and tension associated with sexual foreplay i.e. everything that happens before intercourse attempts. The ban then is designed to help remove the main source of tension so that you may enjoy giving and receiving pleasure for its own sake. Sex then will become less of a performance as neither of you need worry (as you probably did before) about what might happen later. So, the bans often help couples to feel more at ease sexually (False).

3. Although stress may have been triggered to begin with by attempts at intercourse or any other kind of vaginal contact, the woman may come to learn that a cuddle, kiss or caress by her partner is a sign which shows he wants intercourse. In this way, tension may indeed start early on in love play. This illustrates why it is so important that the male reassure her that he will not break the bans (True).

4. You should communicate to each other about what is pleasurable and not so pleasurable to you. Though some talking cannot be avoided, most of this communication can occur without words, such as by movements, sighs, gestures, etc (False)

5. Sensate focus should be pleasurable; irritation and discomfort are to be avoided. It is not an endurance test. Only by notifying your partner when he or she causes you to feel discomfort can he or she learn to avoid doing so. You can inform in a positive, encouraging way, however. (True)

6. This early in the programme it is best to avoid attempting intercourse. (False)

7. At least three times weekly is fine. As the programme is about unlearning anxieties, any such learning is best carried out on a regular rather than on an infrequent haphazard basis. So you <u>must</u> make time available for those sessions. (True)

ANSWERS TO QUIZ 4

1. This phase is basically the same as the first except that the more intimate parts may be included as part of the whole body. It is designed for giving and getting pleasure in a non demanding way and not as a prelude to intercourse (True)

2. It is better if he does not at this point. At present, when the woman is the one being caressed she may direct and guide his hands if she experiences anything she does not care for (False)

3. If you both wish, then there is no reason why she should not bring him to a climax (True)

4. There is no such goal in this phase. Indeed sensate focus is without goals like these. Only when there are no goals and when you both are agreed on that, that you will enjoy each other's caresses for their own sake (not what they could lead to). ~~(False)~~

5. Communication is essential. You both should learn to express your feelings openly so that no misjudgements may develop. Expressing them means that you don't bottle them up for "fear of hurting the other." If you feel a certain way, that feeling is real whether it is justified or not. Each of you then should learn to respect the other's feelings (False).

6. With sex, we can often spoil our enjoyment by thinking or worrying too much about what the other may be thinking. "What does he or she think about me etc.,?" We should try to concentrate and enjoy our own nice feelings. That is not distracting and when we express our pleasure we give pleasure anyway to our partner - without even trying (True)

ANSWERS TO QUIZ 5

1. You will recall that "self-assertion" can be important in treating these problems. That means neither of you should "just put up with" something you don't like. It means that in sexual relations it is best to think only of your own pleasurable feelings - when you show these you'll be giving pleasure to your partner anyway. In this context then the female should guide and direct his hand and fingers with her own to her vaginal area. This will allay any initial anxieties she may have (False)

2. Even though she may well be producing her own lubricant, the use of K.Y. Jelly in addition should be used to increase confidence and ease any slight fears either of you may have (False).

3. It is better to allow her confidence to increase with her own fingers on her own first. Also, after having got used to two of her own fingers, the muscles will have "learned" to relax more easily by then (True).

4. No. In an adult relationship, each of you should be open about particular feelings you have (whether good ones or bad). If we don't, our partner will have to guess how you feel, may guess wrong and arguments develop. Similarly don't bottle up feelings for fear of hurting the other - be "selfish" and be open about how you feel (False)

5. No. She may not feel anxious, but if she does, she must try to relax herself and keep it inside until any bad feelings begin to go (False)

6. Why not just relax, take it easy and continue caressing each other in other ways. When you both feel easier, you may wish to try to relax with his smallest finger, bit by bit slowly increasing the amount you can accept reasonably comfortably. Take your time and don't rush. Get as much enjoyment as possible out of your time together. (False)

When you feel you understand the material covered by these questions, follow the advice given in your next time together. Afterwards, turn to page choose the statement which applies and follow instructions from there.

ANSWERS TO QUIZ 6

1. The width of two of the male's fingers is much the same as the thickness of the erect penis. By getting used to two finger insertion during sexual play first, the female is prepared mentally and physically for sexual intercourse (False)

2. The suggested positions for intercourse are considered by many to afford certain advantages. But the couple's feeling of ease with the position they choose is also very important. But do try the recommended position first (True)

3. Neither of you should have any such aims. Be content to withdraw the penis at any time after entry as long as both of you feel reasonably relaxed (True)

4. Do not thrust immediately. The female remember may still have some slight fears or apprehension. Immediate thrusting by the male in particular may only serve to strengthen any such fears (False)

5. The female guiding the penis inside should help her confidence. It is also distracting for the male if this is left to him (True)

TREATMENT GUIDE FOR FEMALE SEXUAL UNRESPONSIVENESS

Following a vast amount of research into learned problems, among which sexual difficulties may be classed, effective treatment techniques have been devised. They are fairly easy to follow and if taught to use the techniques properly, many couples can successfully treat themselves. The couple carries out the procedures in the privacy of their own home and at set times, they report their progress.

Because the couple can quickly learn the techniques and, so effectively use them on themselves, all that is needed - besides motivation on their part - is a means by which to teach and guide them in the use of the techniques. This booklet has therefore been designed for this purpose.

However, like any other form of therapy, success really demands (1) that a couple be prepared to follow the advice reasonably regularly, (2) to discuss together their views, attitudes etc about what they may be asked to do, and (3) to be motivated toward improvement

Guide to the Treatment of Sexual Disinterest.

Of all the female sexual problems, general disinterest in sex or loss of libido (as it is sometimes called) is the most common. The woman, in question, gets little if any, sexual pleasure from intimate contact with her partner - she feels devoid of sexual feelings. In terms of physical response, such a woman may show no sign of being ready for intercourse - her vagina may remain dry and tight - or she may respond only partially with light lubrication and then again perhaps only after lengthy stimulation.

Many women who might consider themselves "frigid" (a term which I think ought to be done away with) feel that sex is an ordeal. Some may tolerate sexual contact only in order to maintain their marriage; others may be disgusted or frightened by sexual contact and so go to great lengths to avoid it. Still others may really enjoy intercourse when it does occur but find that it is only very rarely that they ever feel like having sex.

So the precise nature of the symptoms may vary from one patient to the next. But whatever the cause of them in the first place, it is clearly not surprising to find that the problem itself in turn produces considerable emotional upset for both partners. Anxiety, guilt, frustration and anger are among the most common of these emotions with which the couple is presented. These feelings, in most cases, serve to maintain or "feed" the problem and they are often most intense during sexual play.

How do sexual problems arise ?

Sex is a natural function like digestion - and like digestion, can be upset by a whole variety of problems, usually not involving physical disease.

We all accept that faulty eating, being rushed or under stress, anxious or uptight or in a bad mood can lead to a variety of complaints like loss of appetite, indigestion, diarrhoea or constipation even though your body is basically healthy. We also know that if we eat normally and in a relaxed way, our digestive system works with no problems and no conscious effort on our part - and we enjoy our food.

In a similar way (though less understood by most people) if sex is allowed to happen naturally and in a relaxed way your body will respond normally without any conscious effort on your part.

Common examples of problems or situations that can upset this normal sexual responsiveness are as follows:-

1. Misunderstandings or lack of information about sex - not knowing what to expect or how to act.

2. Bad feelings about sex or its consequences

- fear of pregnancy, or pain
- fear of being 'caught', overheard or interrupted
- fear of failing to perform 'normally' or well
- fear of losing control (becoming animal-like, undignified, incontinent or unattractive)
- fear of partner losing control
- guilt (sex is wrong)
- disgust (sex is dirty or messy)

3. Problems in the relationship

- feeling angry, bitter or resentful towards your partner
- feeling insecure and frightened of being hurt

4. Bad feelings about yourself

- feeling depressed, worthless, not deserving pleasure
- feeling unattractive, unhappy with one's body

5. Unsuitable circumstances

- too tired, or hurried, or preoccupied with other things
- lack of comfort, warmth or privacy

6. Alcohol, some drugs or medicaments

- these can interfere with your normal responsiveness, though only temporarily

7. Being in generally poor condition

- appetite for sex, like appetite for food, often (though not always) goes when you have been ill or had an accident. It gradually returns as you regain health.

There are many other types of problem that might be relevant, but these are the most common and some of them may apply to you.

Whatever it is that starts off the difficulty, once you become aware that sex is not 'working' properly, two things happen:

1. You develop 'performance anxiety' and become a 'spectator' to your own performance instead of a full participant. We call this 'spectatoring' and once it happens it can easily stop the normal body responses to physical contact. So a vicious circle develops - the more you watch, the worse it gets.

2. Your partner becomes aware that something is wrong and gets caught up in the spectator role too, with doubts of his or her own sexual ability. There is no such thing as an uninvolved partner. That is one important reason why we work with the couple.

Why should the problem persist ?

It could be argued that more important than why the problem began is why the problem persists. Why does it not just go away with the passage of time alone ?

To some extent, the answer to this question has been given already. The difficulty in responding sexually almost always makes the woman and her partner anxious and upset. We know also that it is impossible for someone who feels anxious in bed to respond sexually. Even if intercourse were attempted, it would be sore for the woman, as her vagina would be rather dry and a little tight. That might also make her feel a bit tense the next time her partner makes some sexual advance.

The tension in the situation may be evident in other ways. For example, having intercourse regularly with a partner who gets pleasure from sex every time while she simply lends her body for the experience may be deeply frustrating and disappointing for her. This may be made worse by the feeling that she should have sex 'out of duty'. "It's a woman's job", she may think. Unfortunately many men also share that view, which scarcely helps.

The male partner can react in different ways to the difficulty - some can be warm, reassuring and decisive while others may see his wife's problem as personal rejection or a result of his own inadequacies. In order to counteract these feelings, such men may put pressure on their partner to "perform" which, of course, further inhibits her response.

To say that all women with this difficulty feel anxious in bed then might be overstating the case. Yet, the very things which do very often tend to keep the problem going are (1) a feeling that sex must go on to intercourse (2) a feeling that she is being "used" (3) a feeling that she may be letting her partner down if she doesn't have intercourse (4) a feeling of guilt if she turns him down.

All these and more are feelings which clash with the normal development of sexual arousal. We cannot experience sexual enjoyment and these sorts of bad feelings, described above, at the same time. Besides, whatever it is that the woman specifically does not like (e.g. breast or vaginal contact or intercourse) she may tend to switch

off sexually with the very first approach her partner makes.

This can happen for a number of reasons - firstly, if the woman has learned that a particular response he makes (e.g. arm round her shoulder, kiss on the cheek) is the first link in a chain of responses leading up to intercourse or whatever, she will tend to reject him immediately. It's a bit like this - if you know that after your favourite T.V. programme you must go to the dentist (and who likes doing that ? !) you will enjoy the programme less because of it. Our tension and anxiety then becomes anticipatory - they happen earlier and affect our enjoyment of things we do earlier.

Now another related factor is this - what if the woman actually enjoys kissing or being caressed but doesn't want it to go any further ? If she does respond warmly to being kissed, she may fear that he may view this as the "come on" for more.

So what happens - she rejects him immediately he starts any sexual advance. She may feel bad doing that and so he learns to avoid touching her at all. Because sex has been linked so often in the past with difficulties of one sort or another, it is easier to avoid all contact altogether. So sex stops. You don't talk about it. Instability in the relationship generally builds up and you both get caught up in a web of tension from which there seems no escape.

PROBLEMS OF THE COUPLE.

You may well recognise some, if not all, of the above features in your relationship. Let's examine some of the points in a little more detail.

Firstly, as the couple become more aware of the fact that there are difficulties, there is a tendency perhaps to start setting goals in your lovemaking. Sex, in fact, becomes either a "success" or a "failure" and the fear of failure may be so great that it is better to avoid having any sex at all. Sex then is a "performance", rather than something that is enjoyed purely for the pleasure it brings and that's all.

The next main point to understand is that because both of you (but particularly perhaps the woman) feel uneasy, but still would like to feel in the mood for sex, she may find herself watching herself or "spectatoring". This means that she becomes a spectator to her own sexual play. It may seem as though she were involved but, in a sense, she feels apart from what is happening because most of the time is spent in watching her own body for a response. The same sort of "spectatoring"

usually affects the male partner as well. He too, begins to feel detached as he tries to force his partner to become aroused. Such feelings, for each of you, are part of what we call "performance anxiety".

So, in a number of ways, each of you begins to "block off" necessary sexual stimulation and pleasure. You are not concentrating or just enjoying pleasant feelings but you become distracted by your concern that it must work out. This distraction effectively puts a barrier down on any purely sexually pleasurable feelings.

Moreover, we know that during sexual play we respond to more than just touch or physical stimulation. All the senses are involved and contribute to our feeling sexy. The scent we wear, the way we move, sigh, the words we may speak and our tone of voice, the glances we give, the feelings of warm, soft, moist - a whole range of cues of which we may not consciously be aware - all these, and more, are extremely important to our feeling and functioning sexually. If then, the male or female, should be preoccupied with other uncomfortable feelings, not only do we not pick up these cues above, but we do not give out any either. The net effect then is that neither partner is likely to receive much sexual pleasure.

Another factor which often comes into play here is a tendency for either or both of you to be thinking about the other rather than concentrating and abandoning yourself to the pleasant feeling you could experience. There is a tendency to have thoughts like " what does he or she think about me"? etc. As you will see later, an important part of enjoying sexual play is to be"selfish" - in other words, to focus our attention on our own pleasurable feelings.

So, as time passes, sex becomes more and more frustrating and the problems just described seem to increase. The female and her partner slowly find themselves tumbling into a general breakdown of communication. She may tend to blame herself. He may feel she no longer finds him attractive, or that she has found another lover. Perhaps he feels that she is being thoughtless and inconsiderate. His attitude may change from warm and encouraging to harsh, resentful and hostile. When nothing the couple does seems to help, they stop discussing their problem and communication breaks down.

If you have experienced any of the above, you will know the emotional pains they can produce. Reading, discussing and following this programme should help you overcome these difficulties. But to do so, you both must work together. From the above account, it should be clear by now that there is no such thing as an uninvolved partner. Perhaps

your co-operation will be enhanced by considering the following points.

Points to remember.

That you are reading this programme indicates that you both wish to overcome this difficulty. It is important then to emphasise now a few points that should be kept in mind as you go through the programme. Your consideration and discussion of these points may halp reduce ill-feelings and improve communication and ensure the success of your efforts.

Note to the Male.

The partner of the woman with this problem may feel that he has been deprived of much sexual satisfaction. For this he may tend to blame her. But she was not born with the problem, and it may be viewed, therefore, as a learned pattern of sexual behaviour. This means that as a result of various experiences the female acquires a habit of responding in a particular way (e.g. anxiety, guilt etc.,) which is incompatible with sexual arousal. She may not be aware of having learned this. Yet to restore normal sexual functioning she will have to unlearn certain maladaptive tendencies. So it should be remembered then that you and your partner are both victims of the learning or conditioning over which she probably had no control. The female may be the one with the symptoms, but there is no such thing as an uninvolved partner sexually. Sexual intercourse cannot occur without a relationship and it is this relationship which is the focus of change not any one individual.

Indeed, in most cases, the man shares some of his partner's anxieties and gets caught up in the spectator role too, with doubts of his own sexual ability. That is another important reason why we work with the couple.

By participating in the programme you may feel you are again giving. This may seem unfair to you. You may feel you have given a great deal already and that you should now be the one receiving.

If treatment is going to help, however, it demands a co-operative male - one who is willing to give fully of himself. If you do not fill this requirement, treatment will not succeed.

Note to you both.

You may be doubtful that the problem will ever be overcome. Perhaps you have tried many methods in the past, but to no avail. The techniques presented in this booklet have been widely used in clinical settings. Most couples who have been involved in this kind of therapy have improved. Those who improve least, however, generally fail to follow the advice. Therefore, your co-operation as a couple and your motivation to overcome the problem are absolutely essential.

General principles of treatment.

It is usaully possible to overcome the sexual difficulties if they are tackled in an appropriate way. The approach is aimed at the following:

1. Getting you out of the "spectator" role.
2. Correcting any misunderstandings about sex in general and your sexual relationship in particular.
3. Helping to tackle the background problems that were keeping the sexual difficulties going and in particular improving communication between you.
4. Allowing you to enjoy naturally your sexual relationship with each other.

Before explaining the stages of treatment in more detail it is important to spell out some general and basic principles first.

1. Treatment is aimed at the relationship or the couple, not at the individual. Both of you should understand and accept that there is 'no such thing as an uninvolved partner". What you are asked to do affects both of you equally.

2. This approach is primarily a learning one. You are not being asked to "cure an illness". You will be helped however to learn new and more satisfactory ways of relating to each other. Like any other learning process, responsibility for change lies with you both. The booklet will advise and guide - you have to do the work. It may seem at first as though you are simply adhering to a prescription - making love to "doctor's orders". This is a temporary phase and normally such feelings tend to become much less marked after a short while. By reading the booklet carefully, and discussing together the advice, you'll see that the responsibility for change in fact really lies with you.

3. For these reasons you are taking on a big commitment if you are to make proper use of our help. It's important therefore that you are clear in your mind that you want to continue and improve your relationship with each other.

How often should we have sexual play ?

You will be asked to set aside adequate time during the week to be together for physical and sexual contact with each other. Although the more spontaneous and natural these occassions are the better, you are asked to ensure that you keep three periods of at least half an hour for this purpose. During these times you need privacy (a lock on the door is not anti-social), comfort and warmth so that you can be undressed, and not unduly over-heard

so that you can talk or make noises as you feel like (if sound proofing is a problem, use some background music). It is quite important that during treatment that you try to maintain some continuity and therefore it is probably best that during this time you do not go on holiday (a week-end away can be valuable providing you are alone and not with friends), you do not have people to stay (the odd night doesn't matter), that neither of you has business trips or any other "major distraction" like moving house or changing jobs, etc. If it looks as though such things are bound to happen then it is better to delay treatment until you can ensure a period free from such distractions. You must think clearly about these major commitments before you decide to accept or begin treatment. If you do not, you are much less likely to be helped.

4. As mentioned earlier, sexual problems often stem from other problems in the relationship and even when they don't, they can lead to other problems which not only spoil the relationship, but serve to keep the sexual difficulties going . It is therefore necessary to look carefully at your general relationship, particularly as it may affect your sexual relationship.

There are two aspects of relating which are important to sex, but if improved, have more far reaching benefits. These are good communication and the use of positive rather than negative reinforcement.

Communication

It is never too late to learn new ways of communicating, however long you have been together. In our experience improved communication is essential if the sexual problem is to be resolved.

Here are some basic principles of communication which you must think about and discuss together :

(a) Aim to communicate together as two adults. In many marriages the husband may communicate like a father and the wife like a child; and in others the wife behaves like a mother to her husband who reacts like a son. Such "parent, wife and child" relationships do not promote or encourage healthy, adult, sexual responses.

(b) During the course of the programme, (and later, if you both find this helpful), teach yourself to "self-assert" and "self-protect" by using the expression "I would like" or "I feel that ...." - instead of the more traditional "should we" or "would you like...?". The usual method of communication (often thought to be unselfish) is to think or guess what your partner would like, rather than putting your own wishes first. This pattern of communication can lead to all sorts of problems - you may always guess wrong and he or she has never liked to tell you for

fear of hurting you (being unselfish again). In this way, long-standing assumptions about what each other likes or dislikes may be quite incorrect. A much safer and less complicated way to communicate is to express your <u>own</u> thoughts and feelings and ideas, and let your partner do the same. This keeps your own house in order by asserting and protecting yourself and lets your partner do the same, so that you are both equally represented and equally protected , yet all the guess work has gone out of your communication.

(c) Encourage your partner to use the term "I" and allow him or her to express feelings of hurt without your reacting too violently, and so discouraging self-expression. You are both entitled to your own feelings and should be allowed to express them freely. Having respect for your own and each other's feelings is crucial. Feelings are real things whether you think they are justified or not. If they are not dealt with, and that usually means by expressing them in a suitable way, they may become "bottled up" and can cause all sorts of havoc in a relationship.

(d) You will need to negotiate fairly on those occasions where each of you wants something different. For example, if you want black and the other wants white, you have both declared yourself, and rather than have grey each day, far better to have black one day and white the next.

<u>Praise and encouragement</u> (Positive reinforcement)

This works better than criticism. Work hard, noticing and commenting on the <u>good</u> things your partner does, as this will have a much more positive effect than nagging about the bad things.

All these points above then are extremely important to the success of your efforts. Please read and think about and discuss these points together. Now we can describe in more detail the different stages in lovemaking which you will be asked to go through during the course of your treatment.

INSTRUCTIONS.

Instructions are given throughout this programme to guide you through your self-treatment. It is critical to your success that you follow these instructions. Do not rush or skip ahead. Relax, go slowly, and enjoy yourselves.

At the end of each major section is a true and false quiz. Your answers to this quiz will show you whether you understand the main points of the section. The correct answers are on the page indicated at the top of the quiz page. When taking a quiz, read a question, answer it true or false, and immediately (before moving to another question) turn to the answer page and check your answer. Should your answer be correct, feel confident that you understand the portion of the programme represented by the question. Turn back to the quiz and tackle the next question. Should your answer be incorrect, carefully read the explanation provided with the correct answer. After completing the quiz, follow the instructions at the end of the quiz page.

Throughout the programme are statements directing you to specific pages, such as "Turn to page 36". These statements direct you to parts of the programme you are to begin next.

You do not have to turn to the page immediately, although you may wish to. The statement may be regarded as a rest sign. You may put the programme aside and return to the specified page whenever you wish.

The Training Sessions.

The training sessions of the programme are divided into three main phases. The written material for each phase explains and describes what you are to do in the training sessions for that phase. 1. In phase one you will do an exercise that will help you to relax and enjoy the sensations of touch. 2. In phase two, you will learn ways of giving each other further pleasure in a non-demanding way. 3. In pahes three, you will learn to feel more confident during sexual intercourse.

In each of the phases there is a sequence of steps. You must clarly understand these before you begin your sessions. Research has shown that each of these steps is essential to successful treatment. You must follow the outlined stops if you are to learn to relax and enjoy your sexual play more.

There is a natural tendency to go quickly through the programme. Of course you want to finish the whole thing as soon as possible, but there are dangers in rushing. Each and every step is recommended for a specific purpose; each step must be taken in its turn. Rush and you may fail to take a step. So, within any one session take it easy. There is no rush. But do please have regular sessions, at least three a week, (no more than one a day).

In their sessions, some couples like to use a lubricant to increase the pleasure they get from caressing their partner. This serves to cut down any possible irritation and can feel and smell pleasant on the skin. If you wish to try this, you should have the bottle beside you before you start. Baby oil is a suitable one for the body as a whole or KY lubricating jelly for the genitals (penis or vagina). Both are readily available quite cheaply from any chemist. If you do not like using them, then that's o.k. It is a suggestion only, as many couples at some point find a lubricant very pleasant, others may not.

QUIZ 1.

The answers to this quiz are on page 51
Check your answers to each question before going on to the next.

1) The problem really has nothing to do with the male who has no part to play in treatment.

TRUE_____ FALSE_____

2) Playing the "spectator's role" is one of the most common reactions to a sexual problem and explains to some extent why the difficulty continues.

TRUE_____ FALSE_____

3) A co-operative male is desirable but not essential in the treatment of this sort of problem.

TRUE_____ FALSE_____

4) The only thing most couples need do is to carry out the exercises and the problem will clear up.

TRUE_____ FALSE_____

5) A conscious effort to feel sexy is desirable during sexual play.

TRUE_____ FALSE_____

6) Before starting a session of sexual play, it is essential that each partner feel very much in a sexy mood.

TRUE_____ FALSE_____

Turn to page 14

PHASE ONE

Privacy and Comfort

You should have a room where you can be completely private (not necessarily the bedroom as it can often be helpful being away from the place associated in the past with problems). If you only feel comfortable and assured of privacy in the bedroom, then you should use it. If you have children or other potential distractions (e.g. dogs, cats) it may be necessary to arrange the sessions so that you will not be rushed or otherwise disturbed. Distractions should be minimised so that your full attention can be devoted to what you do.

Your should never carry out any session when either of you feels tired, anxious, irritable or rushed. Both of you should feel comfortable with the place and time. These, clearly, are good rules for most sexual encounters.

Sensate Focus, without genital or breast contact - touching each other for your own pleasure.

Our main source of sexual stimulation is physical contact - touching and feeling. Without this source, most of us, male and female alike, would never reach high levels of sexual arousal. The more we feel sexually, the more aroused we will become and, consequently the more we will enjoy sex.

Physical contact with your partner is also the best means of sexual communication. There is no better way to find what physically excites your partner than to observe and feel his or her bodily responses to your touches. There is no better way to find what your physical preferences are than for your partner to stroke, fondle and caress your body.

Many couples do little touching before intercourse. Thus they deprive themselves of much stimulation and valuable communication with their partners. It is important then, that intimate bodily contact be a part of your sex life. For this reason, a part of this programme is devoted to getting you to think and feel physically.

To sharpen your touch sense, the first part of each session will be devoted to what is called "sensate focus". This is an activity in which both of you, one at a time, explore your physical reactions to touch.

Keep in mind that sensate focus exercises are to get you to thinking and feeling physically. Many of us in our culture have been affected to some degree by a touch taboo. In line with this taboo we express our feelings for one another in largely non-physical ways (for example, saying things that have special meaning). Certainly there is nothing wrong with non-physical expressions of feelings, but physical expressions are just as desirable, if not more so. And in sex, the most important form of expression is physical.

So this stage of the programme emphasises the importance of keeping safe

within limits. You must agree between you to ban all attempts at intercourse or genital contact, no matter what. This means that trust is very important. Each of you must trust that the other will abide by this agreement and no attempt should be made by either of you to sabotage this trust. In this way, then, there are no demands on your sexual play (probably for the first time in months or years) - there are no goals or targets to reach. The ban on intimate play and on intercourse in the meantime should eliminate any such pressures on "performance". Neither of you then should be concerned with trying to feel sexually aroused - not just because you will have proved to yourselves already that that doesn't work, but also because it wouldn't work for anyone. So, remember, the bans mean that you do not have to prove anything at all. The main thing is that you relearn to enjoy receiving and giving pleasure - and that's all. When you enjoy what you are doing, your body responds naturally and without any effort anyway.

How to start.

Partner A (the male or the female) starts a session when he or she wants by saying to partner B "I would like to touch and caress you". Partner B can accept the offer or decline as he or she wishes. If B accepts the invitation, then the assumption is made that B will later in the same session want to caress A.

Let's imagine that Jim and Anne are a couple just like you. Jim has approached Anne and told her that he would like to caress her. She accepts.

In a warm room where they can enjoy complete privacy in a relaxing atmosphere, they remove all their clothes. Some clothes worn in a sexy way may be pleasing, but to avoid awkwardness and distractions it is better to start without clothes. Keep in mind that talking should be minimised - sensate focus is a physical experience.

Ann lies down on something comfortable. Her position does not matter : face up, back up, or side up - whichever she prefers. She is just to relax and be comfortable. She has two jobs. One, she is to give Jim verbal and/or physical directions. She may tell him what is pleasurable to her or show him by guiding his hands with hers. Two, she is to keep him from doing anything that is too irritating or uncomfortable. This is important. So PROTECT YOURSELF when being caressed, if you don't like what is being done to you (the easiest way to do this is to move your partner's hand elsewhere). You will need to recognise if and when you are 'spectatoring' which means watching your body being touched rather than abandoning yourself fully to the sensations that you are experiencing. Don't worry if this happens at first, you must learn to realise when you are doing it and learn ways to get out of it. There are two things to do - concentrate on relaxing your whole body and concentrate as well on the pleasurable feelings produced by your partner's touch. It may be necessary to ask your

partner to stop caressing for a short time until you feel sufficiently relaxed and ready to start again.

So during this sensate focus phase, Anne let him stroke, rub, caress, massage those parts of her body that she liked to have touched. She just felt and thought of the pleasures of being caressed. She did not return the touching at this point and when it was spontaneous, she expressed - with her body or her voice - the pleasure she felt. She only did so, however when it seemed natural to do so.

It is not unusual to feel a little guilty about lying quietly receiving pleasure. Somehow it is difficult not to give in return. Both of you will have your turn to give, but while you are receiving just become totally involved in what you feel.

While Jim was touching Anne, he got into a comfortable position close to her body. He began lightly touching her body anywhere (and everywhere) exoept her genitals (the area of the vagina) and her breasts. Do not touch these part of her body. At a later point in the programme you will stimulate each other there but there is much to gain now by avoiding that kind of more intimate play.

If you are doing the caressing- ASSERT YOURSELF. This is what Jim did - he touched Anne where he wanted to touch (anywhere on the body except her breasts and genitals) in a way that was nice for him and for as long as he wished. He experimented a little and touched parts of the body he had not touched before and if he did anything or touched any part Anne did not care for she protected herself by showing him (not necessarily with words) what she preferred.

So, while the male is caressing, he touches where he wants (within the limits set) and observes her reactions to his touches. His other job is to explore his own pleasures in touching : he is to notice the sensations of rough and smooth, hard and soft, and warm and cool as he touches her body. He should focus his attention too on how he sees and hears her express pleasure (the way she moves, sighs etc.) and on other sensations from other senses (her scent, etc.)

Sensate Focus exercises are not intended to be structured. Both of you should be calm and comfortable and respond to your impulses to caress the other. When feeling and when touching, you may move freely on the bed. There is nothing specific that you must do, other than take turns in touching and observing and in feeling what it is to be loved physically.

After about fifteen minutes of the male touching and the female feeling, you are to change places. The male is to lie in any position he prefers and the female is to position herself so that she can easily stroke most of his body. Now it is the job of the male to feel and think of the pleasures of being touched. Also he is to keep the female from doing anything to him that causes discomfort. It is the job of the female to touch, to fondle and massage the male and to observe him for signs of pleasure. She is also to attend to her pleasures in touching.

At this point the female is not to touch the male's genitals (his penis and testicles.) After the female has caressed and massaged the male for about 15 minutes, you can hold each other together for a few moments if you wish. Do not attempt intercourse during or after sensate focus exercises.

It does not matter too much how long you continue sensate focus. The important thing is that you take turns (approximately equal lengths of time) giving and receiving physical expressions of love. If you do sensate focus in a comfortable, non-demanding manner, physical pleasures beyond those you have experienced before may emerge.

Important points for you both.

1. It is nice to touch and feel close to your partner.
2. It is nice to see your partner enjoy being touched by you (when the one being touched somehow shows his or her pleasure, we get pleasure from giving it).
3. It's nice to be touched.
4. It's best to maintain continuity throughout this programme. So aim for at least three sessions a week (no more than one a day) taking it in turns to start the sessions with the initiator caressing first.
5. You may have to push yourself into starting a session, feeling little motivation or drive to begin with. This is a common experience partly because of the artificiality of the situation, partly because people feel a little embarressed and awkward at first and also perhaps because of long-standing resistance to body contact from previous experiences that have gone wrong. It is important then to see this as a stepping stone to a more spontaneous sexual relationship.
6. Some people find this stage pleasantly relaxing, others find it arousing. It really does not matter which. But it is important for you to recognise what you are feeling.
7. Some couples like to do sensate focus after they have had a bath together. Some couples like to lie down on a couple of towels in front of a fire. Some like to have baby oil on the fingers when caressing their partner. Some like to dim the lights etc. It really is up to you. There are no absolute "musts" but are mentioned only so that if you think they may help you to enjoy your sessions more, and only if you feel comfortable doing them, then you should feel free to do so.

Turn to page 18

QUIZ 2

The answers to this quiz are on page 52
Check your answer to each question before going on to the next.

1. Sessions should be carried out when you are tired so that you can relax more easily.

   True_____ False_____

2. There must be something wrong with a woman whose vagina does not get moist with its own lubricant during this phase of sensate focus.

   True_____ False_____

3. The main aim of sensate focus is for the woman to become "turned on" sexually.

   True_____ False_____

4. During sensate focus exercises you should ta k as mu h as possible to convey to your partner what is most pleasurable to you.

   True_____ False_____

5. The partner being touched in sensate focus should let the touching partner know if he or she does anything irritating or bothersome.

   True_____ False_____

6. While involved in sensate focus, you are to resist any impulse to move about on the bed, floor or whatever you are lying on.

   True_____ False_____

7. If sensate focus is enjoyable to both of you during a session, there is no reason why you should not have intercourse to strengthen your enjoyment.

   True_____ False_____

If you feel that you understand the material for phase one, follow the advice in your session together. When you have finished, turn to page 19 of the programme and follow instructions.

Read the following statements and select the one which most clearly applies to you; turn to the page indicated after the statement you choose.

Statement 1 Our sensate focus session was pleasurable.
Turn to page 20

Statement 2 Our sensate focus was not especially pleasurable.
Turn to page 21

You Chose Statement 1

Good ! Sexual contact without goals or targets certainly can be very enjoyable. Sensate focus gives you a chance to enjoy pleasurable stimulation purely for its own sake.

The woman should on no account feel guilty about "depriving" her partner of sexual intercourse . Intercourse after all is not the "be all and end all". It would be a myth anyway to believe that a man cannot get enjoyment from anything other than intercourse. The other important thing to remember is that both of you are victims of the learned difficulties and are both equally involved in getting pleasure from your physical relations.

So once again the main points are for each of you (a) to enjoy your session together (b) to give up watching your own body's responses ("spectatoring") and thereby (c) focus your attention only on the pleasurable sensations you receive.

When you wish to have another session of love play, do the first phase of sensate focus again. If you will relax and be thoroughly involved in your own pleasurable feelings, this next session will be just as, if not even more enjoyable. After your session, turn back to page 19 , select the most appropriate statement and follow the directions. In all, you ought to have at least three enjoyable sessions at this phase in a row, before skipping this page when directed to it and going on to page 23 instead.

You chose statement 2

Sensate focussing can be highly pleasurable, but you didn't find your first experience to be so. Well, that's okay; it is not at all uncommon for people to feel awkward, uncomfortable or simply neutral when first trying sensate focus. A fairly typical reaction may be "It was a bit like making love to doctor's orders" or "It was a bit like doing homework". Such feelings are understandable. After all, there may have been little sexual contact just before seeking help. Now, suddenly, you're being asked to have some love play "to order", in a way and at a frequency you have not been used to.

Perhaps either or both of you think - "We didn't have much love play before, but now we are. We are only doing this because someone told us to". Yet, you should both appreciate why you rarely had sexual play before you requested help. The most likely reason is that sex before now meant pressure on performing; it meant anger, frustration, guilt or shame when it didn't work out. The simplest thing to do, therefore, was to avoid sex; that way there would be no upset. This avoidance of sex, therefore, had probably nothing to do with the man's feelings for his wife whom he no doubt loved very much and still does.

You should realise too, that any feeling you have that this is 'artificial' or 'contrived' is common and that most people who do this, report that this feeling goes away after one or two sessions.

In the past, you have been in the habit of "spectatoring" - watching your body for a response. Any man or woman would have difficulty sexually if he did this. Both of you then should try to remember this important point : you are not doing sensate focus in order to get "turned on." You are having sexual play in this way only to relearn to relax, and to concentrate on and enjoy pleasurable sensations. Whether the woman becomes sexually "turned on" or not is absolutely irrelevant, immaterial and unimportant. Any woman would probably not. The only thing to do here is to "be selfish", relax, concentrate on and enjoy your own nice feelings while being caressed stroked or massaged.

Also carefully consider and discuss whether you conducted your sensate focus session according to these points.

(a) Your sessions should be at a time and place in which you feel comfortable.

(b) When being touched, let your partner know if he or she does anything that is unpleasant yo you. Also, let him or her know what you particularly like. However, you should not be too concerned about directing your partner; just relax, don't talk too much and fully concentrate on the pleasures of being touched. In other words, learn to be "selfish". Don't then think about what you believe is going through your partner's mind. As you show your pleasure, you'll be giving pleasure to your partner without even trying.

(c) When caressing your partner, observe closely what is pleasurable to him or her. Also note your own pleasurable feelings from touching.

(d) Sensate focussing is not intended to be structured. Do what the two of you like, whatever is pleasurable and enjoyable for you - except at this point, touching each others genitals. Try to think of the advice here in terms of what not to do, rather than what you should specifically do.

(e) Be open with your feelings. Praise and encourage each other too, of course.

(f) Re-read the earlier pages dealing with this phase. When it is convenient, return to your room or wherever for your next session if you feel you understand each of the above points.
Also remember there is no reason to rush through the programme. Just make time for regular sessions - no fewer than three a week.
Take it easy and enjoy yourselves.

After your session, return to page 19 and follow the instructions.

PHASE TWO

Sensate foucs involving any part of each other's body.

The ban on intercourse remains.

Through sensate focus you can become totally involved in the pleasant sensations of bodily contact for their own sake. Now that you feel easier and more comfortable with the first phase of sensate focua you may feel that it's appropriate now to allow any part of each other's body to be caressed, touched or fondled.

The first phase of sensate focus you will recall was non goal-orientated. In other words, you touched only for the pleasure you got - no more, no less. There were no goals. Well, the same applies now.

You may feel that it's all very well saying "Don't think about trying to get sexually worked up". After all, watching yourself or your body for a response - "spectatoring - may be a strongly ingrained habit. You may think that the main reason you as a couple are engaging in these session is so that the male can make the female sexually aroused.

But to think that would be to miss the point of the programme. The main purpose of the booklet and the advice within it is not to make or force anyone to produce a sexual response. No man can force or 'will' an erection and no woman can force her vagina to become wet with its own lubricant. Body responses such as these are beyond direct control. They occur, an the other hand, as naturally as breathing when you both learn (or relearn) to relax and focus yourattention only on pleasurable feelings when you are caressing each other. When you enjoy what is happening in a relaxed, comfortable way without any pressure or demands (either from the male or the female herself) and when the degree of stimulation is sufficient, then such body responses will occur. And it will occur only without effort and only when not waited for.

So how can we help each other take the pressure off ?

(a) Firstly by telling each other about the way you feel. If the man or the woman feels tense or ill at ease then do not bottle that feeling up inside: tell the other. Be open at all times.

(b) This kind of communication takes the guess work out of the way you relate. (see pages 9&10). After all, what is really inhibiting with these kinds of problems is a tendency to think more about what you believe your partner to be thinking about than about your own nice feelings. For example, the woman may have thoughts like "He must think I'm odd or inadequate". Such thoughts

are more often than not totally wrong. By being open with each other you correct these misconceptions. By being open, you can then be more "selfish" and simply allow yourselves to enjoy your own pleasant feelings.

(c) Reassurance from the male that he is not interested in anything other than giving himself and his woman pleasure. Again this involves "being open".

(d) Before and during your sexual play, both of you might tell each other that you could both be happy just to let your lovemaking involve giving each other pleasure, without intercourse: NO MATTER WHAT. Obviously neither of you will know that you understand or accept this ban unless you tell each other.

So the advice given in this programme is to help you enjoy your lovemaking more. But they are not exercises to be followed mechanically like a recipe book or a car workshop manual. You both must feel comfortable with them, to enjoy them. And this comfort will be increased if you share your feelings together. That way pressures can be lifted.

In your next few sessions, exactly the same principles apply. A ban on intercourse continues but now contact with the female's breasts and genitals and the male's genitals is permitted.

Each session is divided into two parts - A caressing B, then B caressing A.

Sensate Focus with genital contact

With sensate focus you can become totally involved in the sensations of bodily contact in a non-demanding way (in other words when there are no goals). This total involvement is sure to increase the pleasures the two of you share. Now that you have used sensate focus and found it pleasurable you are ready to lift one of the bans. In this second phase, you may allow your sexual play to extend to caressing, fondling, and teasing the more intimate parts of each other's body. The male may now touch his partners's breasts and vagina and similarly the female can touch her partner's penis and testicles as a part of your non-demanding sex play.

The ban on intercourse remains, however.

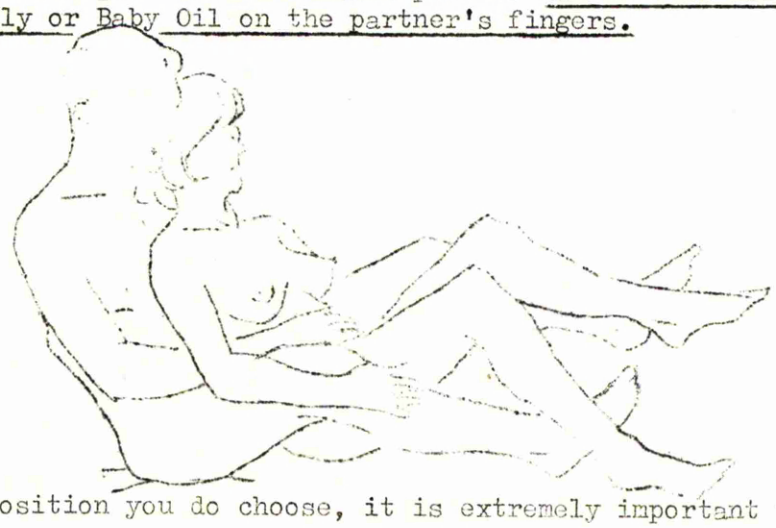
Each session should not, of course, begin with sexual stimulation of these more intimate parts but should always begin with caressing other parts (neck, back, etc) as you did with the first stage of sensate focus. Instead, to start with, just consider the sessions, unless otherwise instructed, as just an extension of the first stage of sensate focus in which all parts of the body may now receive your partner's non-demanding stimulation. You should "take turns" as before and again what you do sexually should be done primarily to

give sexual pleasure to yourself. This of course applies to both the female and the male.

To enhance your pleasure and to minimise the possibility of irritation for either partner, you should have some Baby oil or K.Y. Jelly near at hand to use when, or if, desired.

Positions to Adopt

Now you are going to extend your sexual play to include the genital areas and the breasts. As for the other parts of the body, you should not assume before hand what is likely to please your partner. Discover together the best places and the best ways. For the woman giving pleasure to the man, include the genital area as part of the whole body. For the man pleasing the woman, it will be as well to arrange yourselves in an easy position for him to caress her genital area and breasts. At the same time she can easily direct his hand by laying hers above it. One possible position is shown below. Try this, but you may, of course, find another position of your own that you prefer. Stimulation of the genitals for either partner can be even more pleasurable with K.Y. Jelly or Baby Oil on the partner's fingers.



Whichever position you do choose, it is extremely important that the woman guides and controls her partner's hand by laying her hand on his (a) to increase her self confidence and (b) to show him where and how she likes to be touched.

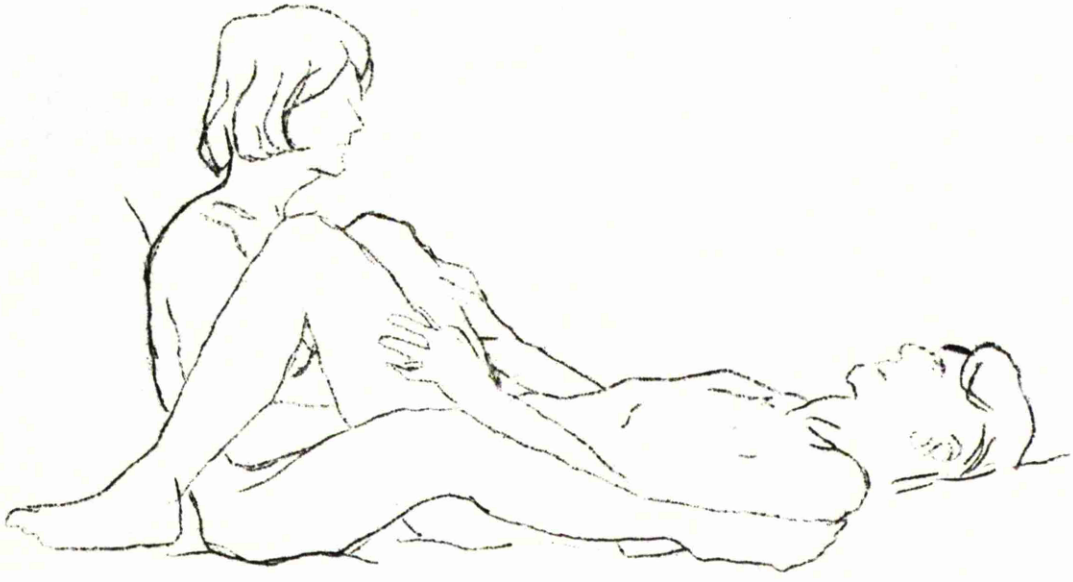
The woman's only responsibility is to enjoy the sensations she receives and to communicate somehow her desires and feelings to her partner. The aim is only to do that which gives you both pleasure and not to work specifically towards reaching a climax or towards attempting sexual intercourse. There is still a ban on sexual intercourse - no matter how "ready" either of you may feel. Remember, the idea at this phase is, as before, to give pleasure to each other but not to aim specifically toward deliberate masturbation or intercourse. This may seem rather unusual but as soon as targets, and goals are set too soon in your sexual play, so the whole episode becomes a "performance" rather than something each of you does just for the pleasure it brings. In the past, sex has

been a "performance" which has led to stress. The stress may stem from worrying about your sexual feelings, or lack of them, and from watching yourself in bed ("spectatoring") or from being too concerned with your partner's feelings (not "being selfish"). In all these ways you "block off" the kinds of stimuli which we find pleasurable. But let's forget about goals. It has been shown that we are more likely to enjoy ourselves sexually, and allow natural physical reactions to occur when we do not think too far ahead and when we engage in sensate focus in a comfortable sexual atmosphere without any goals.

The man while pleasuring his partner should not make any assumptions about what is likely to please her. In particular, he should not approach her clitoris unless she directs him to it; when he does he will need some lubrication - either baby oil, K.Y. Jelly or some natural lubrication from the entrance to the vagina. The man should caress and stroke his wife for as long as both enjoy it and for as long as you feel it is appropriate. Do not obviously continue until the point of displeasure or fatigue. The man should not feel he must continue until his partner reaches orgasm (i.e. has a climax).

When it is the woman's turn to give pleasure to her partner, it then becomes his responsibility to communicate his likes and dislikes, both about the places caressed and the way they are touched. He should lay his hand loosely over hers and guide it. The use of baby oil can be particularly useful to increase pleasure.

One possible position for this phase in which the woman caresses her partner is shown below, but you can change it if you find others you prefer. The female may sit with her back resting against something such as the headboard of the bed or a cushion againsta wall or chair.



In this position the man can relax, and guide his partner's hands to the most pleasurable parts. He should not tolerate any discomfort but should show his wife the best way to touch and caress. For example, she may without realising it, pull his foreskin back too far, she may hold too tightly, etc. With communication, not necessarily with words, she can be shown the most pleasing methods. In this session she can tease, touch, caress, stroke the penis, the testicles and around the genital area. She need not spend all the time touching these parts but may move her fingers to other body parts and return to the genital area as she wishes. She should use Oil to increase the pleasure received. She may gently rub her husband's penis but not as though she is deliberately masturbating him. Again, the man should show his pleasure somehow when he finds something enjoyable. It can be arousing and satisfying for the "giver" to see the "receiver" enjoy this non-demaning stimulation.

Apart from communicating like this, the partner receiving pleasure should be as "selfish" as possible, concentrating only on the pleasant sensations he or she experiences at the time.

If the man is the one receiving the stimulation he should not think about what he thinks his partner feels like, whether she is enjoying it or not etc. As he shows his pleasure he will inevitably be pleasing her. The only goal of this phase, like the first, is just to enjoy relaxing sexual play for its own sake. When you enjoy what is happening, physical responses will occur naturally and without effort.

An important point to remember is that in this phase the female should <u>not</u> feel she <u>must</u> spend all the time stimulating the man's penis. In the same way the man need <u>not</u> devote <u>all</u> the time to caressing her vagina. This phase simply allows contact with these parts which may be regarded as just other areas of our bodies that bring us pleasure. So you can touch them, move away and return to them as you wish, and as you might with other parts.

So, if caressing a particular part (e.g. neck, scalp, vagina, penis etc.,) is enjoyable to your partner and yourself you will probably want to spend longer doing that - but don't feel you must spend all the time touching that one part.

Remember anyway, the one being caressed should "be selfish" and indicate what he likes, what he prefers etc. Only by this kind of communication and "self-protection", can we feel confident that we are doing what our partner really enjoys.

Sometimes women feel a bit guilty by arousing their partner who then is not allowed intercourse. If she does feel this, then she may masturbate him to a climax (if both of you wish, of course).

Turn to page 28

QUIZ 3.

The answers to this quiz are on page 53
Check your answer to each question before going on th the next.

1. The goals of this phase are different from the first as now the main aim is that the woman be really 'turned on' sexually.

TRUE_____ FALSE_____

2. In this phase, the woman should bring her partner to a climax.

TRUE_____ FALSE_____

3. In every respect, this phase is the same as the first, except that breasts and genitals may now be included in your sexual play.

TRUE_____ FALSE_____

4. In this phase, it is not recommended that the male caress his partner's vagina all the time to the exclusion of other body parts.

TRUE_____ FALSE_____

5. If both of you feel sexually 'in the mood', there is nothing wrong with your going on to have intercourse.

TRUE_____ FALSE_____

If you feel you understand the material covered by these questions, follow the advice for this second phase during your next session. When you have completed your session, turn to page 29 and follow the instructions.

Read the statemnts below. Choose the one which applies and turn to the page indicated.

Statement 1.

We did not find ourselves 'spectatoring'; we were both reasonably relaxed, and this phase of sexual play was highly pleasurable.

Turn to page 30

Statement 2.

One or both of us found it difficult to give up 'spectatoring' during this phase and were rather tense. We therefore did not find it particularly pleasurable.

Turn to page 31

You chose statement 1.

When things don't work out during this phase, it is usually because of "spectatoring" (watching yourself for some response), waiting for some reaction or thinking about what you believe may be going through you partner's mind. All these mean that one's thoughts are non sexual. It also means that the individual is rather tense and uncomfortable.

But you didn't find yourselves reacting in this sort of way. That really is a massive leap forward. For that, as a couple, you deserve much praise and encouragement. It shows you are communicating well. It shows you are "being open" with each other. It shows you are more relaxed -- and you are more relaxed because you (in particular the female) need do longer go to bed 'to try to prove something' -- she doesn't have to worry about the possibility of intercourse not working out, or of meeting some other such goal. With trust, and the security that stems from it, you can both relax to enjoy physical ontact. The deve-- lopment of that trust depends also on communicating openly .th each other. This you have done. Again well done.

Why not remain with the activities of this phase for a little longer ? After all, it may be the first time in a while that you have enjoyed love play so much. But remember, because you enjoyed it this time, don't feel that it must be as good or even better the next. Don't set targets like these.

So stay with this phase for a little while and, after each session, turn back to page 29 and choose the statement which applies. After at least four enjoy-- able, relaxed sessions at this phase, in a row, you should skip this page when directed to it and turn instead to page 33

You Chose Statement 2

It often is difficult at first to give up 'spectatoring.' It is often difficult not to feel that something is expected of you (particularly the woman). Some couples find that the first phase goes alright because they don't feel any pressure on performing; in other words, there's no pressure on becoming sexually aroused. Now, suddenly you may feel that because you may touch the more intimate parts of your bodies that sexual arousal should quickly follow. Well, let's remind ourselves of some important points.

1. Sexual feelings will occur only if you are relaxed and are concentrating only on the pleasant feelings you get from all the senses - from touch, from sounds and words, from the sight of your partner enjoying giving you pleasure, etc. If you are watching yourself and your body, you are not concentrating on these pleasurable feelings. The aim of this phase, like any other, is just to enjoy yourselves - THAT'S ALL.

2. You can help yourselves to relax and concentrate only on pleasant feelings. How? By both of you realising that it may be normal for a woman not to feel sexually aroused during all of your sexual play. In the same way, it may be normal for a man not to have an erection all the time. In addition, what makes us feel good one night may not the next. So our sexual feelings may fluctuate within any one session and from one session to the next. That's alright. She doesn't have to prove anything to her partner. He will know she is a normal woman, with an ability to respond warmly and sexually as well as any other woman. But this ability is simply masked or hampered. If we help lift that barrier, the ability will show itself.

What is the Barrier?

The barrier is a number of things. The fear that she may not become sexually aroused. The fear of appearing inadequate. The guilt she may feel for depriving her partner of intercourse. (Yet, she has every right to enjoy sex too. She also is being deprived of sexual feelings). Such feelings bring a barrier down on sexual enjoyment. In any case, the ban on intercourse has not been set by either of you - it is part of the programme.

What the Female Should Know

She should remember that her husband does not think less of her. She should remember that he is not impatient and that he gets his pleasure from giving it. Contrary to popular belief, a man can get a considerable amount of pleasure from sensate focus alone -

it is a myth to believe that a man must have intercourse and that he is left totally frustrated and disappointed if he does not experience it, on any one occasion.

If you both talk about these things together, you will realise that he really does feel that way about it. Remember it is not you who is not allowing intercourse. The ban is an essential part of the programme and has therefore been set for you.

What the Man Should Know

The chances are quite high that she is reluctant to express her feelings of pleasure in case they be seen by you as a sign that she wants to have intercourse. In other words, she may not totally trust you and may feel that you will be greatly disappointed if you do not go on to have intercourse. Be open and tell her that this is not the case. Don't wait for her to bring it up. Tell her anyway.

She may also feel guilty that she is not letting you have intercourse. Yet, it is not she who is not allowing intercourse - it is this programme that is not allowing it. It may be a good idea to reassure her on this point also. Convince her that you are not impatient, that you won't break the ban or be disappointed because you can't go on to intercourse. Convince her too that you get your kicks from seeing her enjoy your caresses and touches - no more, no less. Encourage her to 'be selfish' too, so that you give her no reason to be concerned about your feelings.

She also gets enormous pleasure from seeing and having you respond warmly to her touches. So always try to show your pleasure.

Always bear this in mind:

the aim of this phase is only to enjoy what you do together in a relaxed way. It is to give and receive pleasure purely for its own sake. The ban on intercourse remains at this point - no matter what.

Read again and discuss the other points in this booklet (pages 23 to 28). Make sure you know the other understands and accepts them by talking about them before you start your next session.

When you have finished, turn to page 29 choose the statement that applies and follow instructions. Should you be directed to this page again, do not be disappointed. There is no hurry at all. Be patient, discuss your feelings together and you will discover that this phase can be really enjoyable.

Now you are relearning to relax and really enjoy what you are doing together as a couple. This may well be the first time in a long while that you have both felt so good together. It certainly can be really nice just being able to relax together. The woman by now will be learning to feel more secure. Hopefully too you will have found ways of overcoming the 'spectator role' and will have learned too to be rather more 'selfish' sexually (i.e. concentrating only on your <u>own</u> nice feelings and thoughts). Sex is a natural response, then, if you let it happen.

<u>Sensate Focus with Genital Contact and Caressing Each Other at the Same Time</u>

As caressing and genital contact become easier for both of you, you should now go on to simultaneous caressing so that both of you are giving and receiving pleasure at the same time. Remember all the principles you have already learned. In particular remember:-

1. Sex is a natural response if you let it happen.
2. Be on your guard for 'spectatoring.' If you feel yourself watching your body for a response - divert such thoughts.
3. Communicate to your partner when she or he is doing some thing particularly nice for you. You need not use words, unless it feels natural to do so. Often our signs, our movements and gestures can be just as clear.
4. Protect yourself if your partner does something you don't like. Show him or her what you do prefer.
5. Neither of you should go on to try intercourse yet. The ban therefore remains regardless of how aroused either of you are. Please try to understand and accept that there is much to be gained at present from sex play without goals, without pressure, without demands.
6. Do try to have regular sessions - at least three each week. Never try to hurry progress.
7. The male should reassure his partner that he really is not impatient for intercourse. Be positive to each other - show that you are enjoying what you are doing together.

If you feel that you understand these points then try to carry them out during your next session. Afterwards turn to page 34 choose the statement that applies and follow directions from there.

Read the statments below. Choose the one which you think applies and turn to the page indicated.

Statement 1

We carried out this phase of caressing each other at the same time and both found it highly pleasurable.

Turn to Page 35

Statement 2

We carried out this phase of caressing each other at the same time but one or both of us found it difficult to give up "spectatoring." It was therefore not particularly pleasurable or satisfactory.

Turn to page 36

You Chose Statement 1

That really is very good and you should both feel very much more relaxed together now. You will know now then, that, whilst secure with each other, when there are no pressures on 'performing', that you can enjoy love play. When you enjoy sexual play without any demands, natural physical responses like for example, a slight increase in heart rate, skin flush and the vagina becoming moist with its own lubricant, will happen without any effort on the woman's part. Indeed, when you do make an effort these changes will not occur.

Probably, by now, you will begin to feel a little impatient. The female may think that she is letting her partner down by not going on to have intercourse. Yet, that implies that she is again thinking more about her partner than concentrating purely on her <u>own</u> pleasant feelings. Once again, remind yourself of the fact that it really is a myth that sex is something to be enjoyed only by men! So, don't feel compelled to go on to have intercourse just because the woman feels she is letting her husband down. Of course, intercourse can be very exciting, but so too is carressing, stroking and fondling each other. There is always another time to have intercourse - besides, the man is probably not impatient for intercourse. It's just that the woman <u>thinks</u> he is and so puts pressure on herself.

During your next session you should try to follow this advice once again. Thereafter turn back to page 34 choose the statement which applies and follow instructions from there. However, should you find yourself directed to this page again, miss this out and turn instead to page 37

You Chose Statement 2

You found that your session was not as enjoyable as previous ones. Well, don't worry. That is the same for us all. Some sessions are really good, and others are not so enjoyable.

Were you too tired? Were you comfortable with the place and time? Did either of you feel that because your last session was enjoyable that it had to be just as pleasant on this occasion? Always bear in mind that the aim of the booklet is to help you enjoy love play. No-one, including yourselves, can force a sexual response. Sexual pleasure and natural physical responses like vaginal lubrication and erections, occur when you are relaxed, secure and comfortable sexually.

So give some thought to why you found it less enjoyable. Were you impatient for intercourse? Did the woman feel she would be letting her partner down if she didn't go on to have intercourse? Were you playing the spectator's role? Did you both agree not to have intercourse, regardless of how each of you felt? Were you simply tired? Did you find yourself worrying about what you felt your partner was thinking, rather than being more "selfish?" If so, each of you should be open with each other. Reward each other too for the nice feelings he or she gives you.

Do please read again pages 23 to 33. Talk about how you felt and how you might make your time together better, less threatening, less anxiety arousing. After your next session, turn to page 34 and choose whichever statement applies and follow directions from there.

Phase 3

By now you both will be learning to get more out of your sexual play. You will have learned that it can be really enjoyable just relaxing and enjoying this kind of sexual "give and take" for its own sake. With this increase in enjoyment natural physical changes in the vagina will be occurring, namely lubrication and expansion of the vaginal barrel. She will have learned to let such changes occur only when she doesn't try to produce them.

So, when you have reached this stage you are both ready to go on to entry of the penis into the vagina.

The aim of this stage is not to proceed with intercourse but just for both of you to get used to the penis inside the vagina for a short while. On no account should either of you go on to try and complete intercourse. So, as before, this phase is designed to allow you freedom to experience sensations of physical contact with each other without performance anxiety i.e. fear of failure to achieve a particular goal. You should begin your session in this phase just as you did in the last. In other words, you continue with a spell of mutual carressing - including any parts of each others bodies that you know gives pleasure, first of all to yourself. In other words, the male does whatever he wants to his partner to give pleasure principally to himself, and the female does whatever she wants to him, first and foremost for the pleasure it gives her.

Again, as before, each of you can protect him or herself if one's partner does anything irritating or bothersome. Or, if there is some form of carressing or some part of the body you prefer to have carressed, stroked or fondled, you can indicate this to your partner. So there is absolutely nothing new so far. The male and female should just concentrate on the nice feelings you experienced at the time.

If you both feel sexually inclined - then that's fine. If not, don't worry - there's always another night. Don't think about your own bodies' responses ("spectatoring") and never feel that you must become sexually turned on. As mentioned earlier if you don't feel sexually in the mood then, that's O.K. - you will know that there is another time. In any case, it is perfectly normal for sexual feelings to fluctuate.

Just as suggested earlier you can use baby oil or K.Y. Jelly to enhance your pleasure by genital stimulation if you want.

Vaginal Containment of the Penis

When you have carried out Sensate Focus with genital stimulation for a while and when both of you are ready, the female should invite the penis into her vagina. Clearly, this should be done only when the woman feels ready (when her vagina is wet with its own lubricant) and when the male has a reasonably firm erection. There is no need to rush this. Wait until you both feel it is appropriate to do this.

What Position May Be Best For This

The position most couples find easiest for penis entry is that shown below. The female positions herself above the male who lies on his back. Immediately after she moves into this position, it might be best if she spends a little time caressing and stroking his penis first before guiding the penis inside. This is simply because the time taken to move into this position may be distracting for both of you and may lead to a slight drop in sexual arousal. It may not, of course, but in any case there really is no hurry. Wait until you are both ready.

As you can see from the illustration, the woman's knees should be roughly in line with his nipples. In this position, she can be in control of entry. After all, she knows exactly where the penis goes and it would not be uncommon for even the most experienced man to have difficulty in finding exactly the vaginal entrance. Besides, most women enjoy helping in this way. After all, it is surely a myth that it is only the man's responsibility.

So when you both want, she can guide his penis into her vagina, by moving back on the penis rather than sitting straight down on it. Neither of you should make any thrusting movements yet.

What Is The Aim Of This Stage

The only aim of this phase is to re-acquaint yourselves with the comfortable feeling of a penis inside a vagina. Do not complete intercourse. Try to accept this. There's plenty of time to enjoy full intercourse later.

With the penis inside, the woman may tighten and relax her vaginal muscles on the penis which she may or may not be able to feel once it is inside the vagina. This may be because of the lack of movement.

For the man's part, he should try to relax and to concentrate only on the pleasurable feelings he gets from his genital region - warmth, moistness, and his partner's vaginal muscles tighten around his penis. Remember, the female will be concentrating only on the nice feelings she gets. The man therefore should not be distracted by any concern for what he believes may be going through her mind. Each of you then should be "selfish." Do not start any thrusting movements yet.

How Long Should Entry Last

To begin with, you should allow the penis to remain in the vagina for a brief period (around 15 seconds). The length of time you keep it inside can be gradually lengthened in each session. But to start with, it's best not to set goals that may make either of you too anxious.

What If The Male Ejaculates Inside

Then that's O.K. Don't worry about it. It may have been that the man's ejaculating quite quickly was one of the things which bothered the woman before the programme started. However, in due course, this may well be something which you can overcome with patience and more frequent sexual relations. So, in the meantime, neither of you should be too concerned about this.

Don't Set Goals

Throughout this booklet, certain really important points have been stressed. The bans that you have both agreed to follow have been there to help abolish any goals or aims that probably made you feel anxious. Goals of any sort usually do make us feel anxious in case we don't achieve them. Do please remember that at this stage there are still no goals.

(a) You are not to thrust - either of you

(b) You are not to try and keep the penis inside for as long as possible

(c) You are not to try to produce a climax (in either the male or the female).

Be content with getting used to the penis entering and remaining in the vagina for a short time - that's all.

What If Either Of You Does Not Like The Female-Above Position?

Some couples find the female above position offensive. They refuse to use it for reasons such as "it somehow makes the man less manly, or the woman less womanly." If, for one reason or another, you do not wish to use the female above position, you should try another. But the position you do choose ideally should be one which offers similar advantages.

What Are The Advantages Of The Female Above Position?

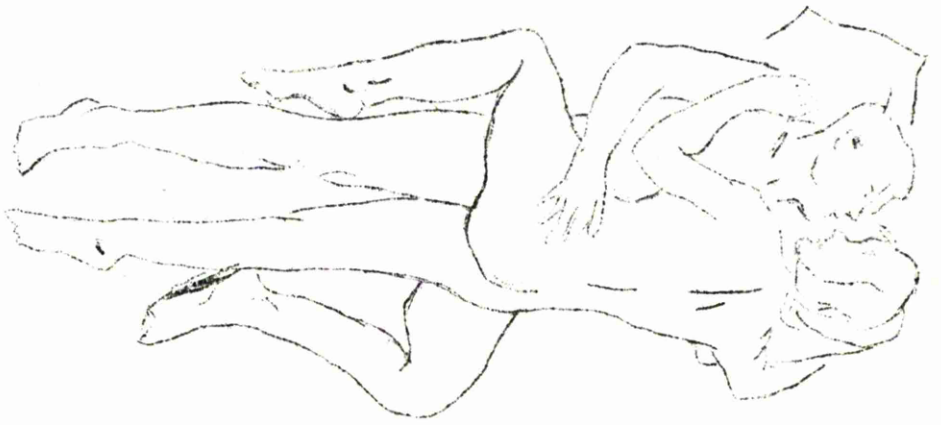
(a) It allows the female partner to be more in control of entry. There is absolutely nothing wrong or abnormal in allowing a woman to help in this way. Besides, they usually prefer it.

(b) It allows the male to caress and stroke his partner comfortably at the same time. For example, there is easy access to her breasts, her vagina and clitoris, etc.

(c) It has been shown that in this position, the male partner is much less likely to reach a climax as quickly as he might in certain other popular positions.

What Other Position Is There?

One other position which you may prefer - but only if you don't like the female-above position - is the so-called "lateral" position. That is one in which each of you lies on your sides. (see below). As you can see the female straddles the male's right leg. Sometimes there is a problem of what to do with the male's left arm and the female's right arm. To help in balancing your bodies you might both circle your arms (male's left and female's right) around a pillow placed just above the male's left shoulder. This is only a suggestion as it is really up to the couple to find what really suits them.



This position, though it may seem a bit awkward, still allows for both of you to have reasonable control over entry. However, the female above position is the one that most couples prefer and perhaps ought to be tried first.

Turn to page. 42

Quiz 4

The answers to this quiz are on page 54
Check your answer to each question before going on to the next.

1. This phase is about encouraging you to complete intercourse True/False

2. As soon as the woman feels sexually aroused she should proceed with directing the penis into her vagina. True/False

3. K.Y. Jelly or Baby Oil is useful for both partners during your genital play True/False

4. It may be quite common for a man to ejaculate soon after entry True/False

5. To begin with, the longer the female contains the penis the better True/False

6. After directing the penis inside, the woman should experiment with tightening her vaginal muscles around the erect penis. True/False

7. Because the woman's vagina will be producing its own natural lubricant, there is no need to use K.Y. Jelly either on the man's penis or on the woman's vaginal lips as well. True/False

If you both feel that you understand the material for this phase, follow the advice in your next session. Then turn to page 43 choose the statement which applies and follow instructions.

Read the statements below. Choose the one that applies and turn to the page indicated.

Statement 1

We enjoyed carressing each other and the female directed the penis into her vagina satisfactorily and comfortably.

Turn to page 44

Statement 2

We enjoyed carressing each other and the female directed the penis into her vagina satisfactorily and comfortably. The male ejaculated almost immediately after entry.

Turn to page 45

Statement 3

The female directed the penis into her vagina but entry was rather sore and uncomfortable.

Turn to page 46

You Chose Statement 1

That's great. Again this progress just underlines how well you have been co-operating together. All that remains now is for you both to remain patient. This is probably the first time for a while you have experienced comfortable entry of the penis into the vagina. And, if you both felt that you wanted to go on, then that in itself is probably not a bad sign. After all, when was the last time that both of you really wanted to have intercourse. In your next session, follow the same advice again. You could also try a series of entries perhaps two or three, then turn back to page 43 choose the statement that applies and follow instructions from there. All being well, and it probably will be, skip this page when directed to it and turn instead to page 48.

You Chose Statement 2

Don't worry if the male reached a climax very soon after entry. Almost all men tend to ejaculate quicker than they would like after a spell without sexual release. A certain amount of tension in the situation may also sometimes make ejaculation occur more quickly. But often the most likely explanation is the fact that the man has not experienced intercourse for a while and so becomes excited much more easily. One would therefore expect that that would resolve itself with time, patience, and more frequent sexual relations. In fact, that is often all that is necessary. So just be relaxed. Don't be concerned, either of you, if to begin with, ejaculation occurs quite soon after entry. After a few weeks, that will probably be less of a problem.

Have another session at this stage. Be content, for the time being, just to get used to a series of entries into the vagina (perhaps about two or three in a session) gradually increasing the length of time inside if you wish. The woman can tighten her vaginal muscles a little around the penis and move very gently on it. Don't feel there should be an immediate start to more vigorous thrusting by either of you, however.

Afterwards, go back to page 43 and choose the statement that applies. Should it be this one again, don't be concerned, remember rapid ejaculation may well sort itself out with time and more frequent practice. When you feel more comfortable with this phase turn instead to page 48 .

You Chose Statement 3

Don't think that something really terrible has happened. On the contrary, there are a number of perfectly logical reasons why the female felt as she did. The most likely reasons are any one or a combination of the following.

1. The female directed the penis inside before she was ready. In other words she was not sufficiently excited and therefore her vagina was not wet enough with its own lubricant. (Even though it is wet, it is always a good idea for the female to have some K.Y. Jelly on her vaginal lips and on the penis as well. This will make entry even easier and even more comfortable).

2. Perhaps just a bit of "spectatoring" because what you were doing was fairly new to you. You hadn't experienced entry for some-time and it possibly made you all the more determined to be successful.

3. Perhaps on this particular occasion, either the male or female, or both of you, was simply too tired, too rushed, too irritable to enjoy sexual relations.

4. There may also have been a residual fear on the woman's part that entry would be sore. Now it is quite easy to see how this kind of fear can become a self-fulfilling prophecy. In other words, the very fact that she has this fear makes the likelihood of that fear being confirmed much greater. She has the fear and so it probably will happen. To help the female overcome this fear, she may find it very helpful to concentrate only on the pleasant sensations she is experiencing at the time. In other words, never think ahead. Secondly, she should always remember to use some Baby Oil or other lubricant to make entry even easier. This is bound to increase her confidence.

5. Neither of you should feel that there are any specific aims in this phase. You should not feel that you must begin a pattern of thrusting with the intention of completing intercourse with either of you having an orgasm. When goals like these are set initially, sex usually doesn't work out too well. So just relax. Your only aims are to give each other pleasure for its own sake. When, and only when, the woman feels sufficiently excited should she direct the penis inside having <u>first</u> used some additional lubricant on each others genitals as part of your love play. Be content to begin with, with containing the penis inside for a short while rather than feeling that you <u>must</u> complete intercourse.

Some additional reassurance from the male partner that he will not rush ahead and that he will remain motionless for a time being may also help make the female feel more secure.

Try to follow this advice in your next session. Afterwards turn back to page 43 , choose the statement which now applies and follow instructions from there.

Sexual Intercourse

It is important to stress again at this point that you use the same principles concerning your physical contact with each other as you used right at the start. You should be touching and being touched in a way that is pleasant for both of you and with no particular goal or performance in mind other than that of giving and receiving pleasure.

As before, start with caressing each other involving both non-genitals (e.g. back, neck, arms, etc) and genital areas (e.g. penis, vagina), in a way that feels good for both of you. Remember, during sensate focus and genital contact, the female should direct her partner's hand to her vaginal area, guiding it and thereby showing him exactly how she likes to be touched and where the most pleasurable parts are. Although the man may have an erection fairly quickly, it is important that both of you should feel aroused and ready for intercourse before vaginal entry takes place.

You will remember that the female-above position (see page 38) does offer several advantages over others at this stage and so you may wish to use this meantime. The female in this position can easily direct the male's penis inside the vagina. So, after the woman has reached a fairly high level of arousal as a result of the sensate focus exercises and genital stimulation, she may begin intercourse. After a few moments she can begin some gentle, rhythmic movements of her hips in a non-demanding way. She definitely should not start some vigorous thrusting as this may be seen as being too demanding to begin with. So, in other words, her movements should be slow and exploratory at first rather than rapid, driving and demanding. Moreover, she should try to focus her attention on the physical sensations emanating from her vagina as she slowly thrusts against the erect penis. She may also experiment if she wishes by slowly tightening her vaginal muscles around the penis as she moves. For the time being it is best if the male partner does not move or thrust along with the female. Again, if you wish, you can stop and separate without the male ejaculating and carry on caressing each other. If you are both really enjoying the feelings this movement produces, you may of course allow it to continue. DO NOT feel that intercourse must go on to the male ejaculating or the female reaching a climax. Of course if the female or the male should reach a climax, that's fine - but do not set out with this aim firmly fixed in your mind. The most important thing is your enjoyment of what is happening at the time - don't be concerned with what may be ahead.

In this female-above position, the male is in a position to caress and fondle his partner's breasts or vaginal area at the same time if he or she (or both) wishes.

So We Don't Necessarily Have to Complete Intercourse?

By this stage, it is essential that either of you can say "stop" at any point. In this way, you avoid the feeling that once intercourse has started you have to go on regardless. You are setting the limits for yourselves now. You can do this by "stop." Remember, that even if you are enjoying love making, your partner may want to stop and may need to be able to do so without fearing that you will get angry. This is what a secure, safe sexual relationship is about - and when you feel really safe, you'll probably want to carry on anyway!

So, to begin with, only the female should begin some gentle thrusting in a way which she herself finds gives her the most pleasure. If the male feels he would really like to move as well, then of course he should. You can stop at any point you like, as mentioned above. So don't feel you must go on to a climax - either for the male or the female. With increasing confidence, the male can play a more and more active part if he wishes. When you feel more secure and happy with intercourse you can of course experiment with other positions if you wish. The movements of intercourse feel different in the different positions you can try. You should try to find the positions that suit you both. You may find one position nicer for one of you and another position better for the other. The lateral position (which may seem a little awkward and difficult to sort out is well worth the effort - particularly perhaps for the woman) may be a good one to try.

Your responsiveness will vary from session to session and month to month. This is normal for both sexes. For example, many women have slightly less lubrication and are less likely to reach a climax just before a period but this is not always the case. Many women enjoy stimulation of the clitoris by hand at the same time as the thrusting of the penis. This is normal and not a sign that they are not fully aroused.

Many women can also have a highly satisfactory and highly arousing sexual experience without a climax. It is an important rule to remember that, provided physical contact is enjoyable, an orgasm (or climax) is not necessary. It is also a myth that a climax together is the ideal.

Most people find it very pleasurable to enjoy the experience of their partner's climax separate from their own - on other occasions they may enjoy coming together. These are all variations on the theme of making love and what you enjoy will depend on your feelings and state of mind at the time.

The goal really is to enjoy yourselves - together.

One last point - if the man's urge to ejaculate (reach a climax) becomes too strong quite early on during his partner's thrusting, you may find it useful to separate or at least stop all movement. The man's feelings of reaching a climax will then disappear quickly, and he may if he wishes stimulate his wife by hand while he rests. So, to begin with, the male should make little or no thrusting movements. Just allow the woman to please herself and find out what she really enjoys in her own time by moving on her own on the penis. Only gradually the male can begin to start moving as well.

This booklet then has been about learning, or re-learning, to feel relaxed, safe and secure within limits. Much of these feelings stem from understanding how each other feels and knowing that the other understands the principles underlying this programme and knowing also that the other accepts these principles and advice. It is important therefore that you do communicate your feelings to each other as only by so doing can you learn to establish the kind of secure relationship on which enjoyable sexual relations are based.

Answers to Quiz 1

1. There is no uninvolved partner sexually. Although the woman may be the one who is seen to have the difficulty (loss of sexual feelings), the man in most cases also gets caught up with "performance anxiety" and the "spectators role" etc. The problem is learned and the man too is a victim of this learning and he too will be inhibited by the difficulty in all probability. The most important point to accept is that the relationship between the man and the woman is "the patient" not either partner on his or her own. In other words, what is important is how you as a couple generally relate to each other in bed. (False)

2. Yes. The "spectator's role" refers to a tendency of a person to watch his or her own body for a response. In this case, the woman may start to think about her own apparent lack of reaction to being caressed, etc., she may check whether her vagina is lubricating or not, and so on. It is as though she were mentally standing in a corner watching herself. This reaction is a common one for a couple with sexual difficulty. Such thoughts are non-sexual; such thoughts are distracting and also make us feel tense. Such thoughts then prevent us from feeling sexy. (True)

3. The female must learn to relax and so enjoy again sexual relations with her partner. He must therefore be present; both must communicate their feelings and give reassurance. He must therefore co-operate or treatment will not succeed. (False)

4. This booklet is not like a recipe book or a car workshop manual. Do not assume that if you rather mechanically carry out the exercises that all will be well. Sexual enjoyment involves more than a series of physical manoeuvres. You both must understand and accept the reasoning underlying therapy and each of you must know that the other understands and accepts this reasoning too. (False)

5. Definitely not. This is probably what you have been trying to do in the past. No woman or man can will or force themselves to feel sexually aroused any more than one could will or force one's digestive processes to change. The only thing both of you should try to do is to focus all your attention on the nice feelings you get from each other. (False)

6. To begin with, it is not uncommon for couples to feel that each session of love play is a little bit artificial or contrived. Also, because of past difficulties they may be rather wary of starting a session - particularly, in this case the woman. So, there will be a temptation to avoid starting your sessions. If you do, of course there will be little chance of improvement. Moreover, if you wait to be sexually aroused before starting either of you may well wait a long time. So, make time - there are no short cuts. As long as neither of you feels too tired or irritable then it may be an appropriate time to start. (False).

Answers to Quiz 2

1. Mix unpleasant feelings with sexual feelings and you will tend to associate these in the future. Mix pleasant feelings and sex and you will tend to associate these. Avoid having your sessions when either of you is tired, irritable or rushed. (False).

2. It may be quite normal for a woman not to show any such physiological response during this phase of sensate focus. The degree of stimulation is mild. In any case the main point of sensate focus is that you learn to relax and enjoy yourselves again.

It will be in the context of this enjoyment that later, when sex can be more intimate, that such changes will return - and only without any such deliberate effort on your part. (False)

3. The main aim is to learn to enjoy being close sexually. This means learning to feel secure with each other and therefore, comfortable and relaxed sexually. When that happens you will enjoy your sexual play and natural physical responses e.g. an erection for the male, or vaginal lubrication for the female, will happen anyway in their own good time. We cannot, and certainly should not, try to force such responses. (False)

4. You should communicate about what is pleasurable and non pleasurable to you. Although some talking cannot be avoided, most of this communication need not be with words; facial expressions, gestures, actions, sighs, moans, etc., are just as clear and indicate pleasure just as well. Too much talking could be distracting and irritating. On the other hand, the occasional word or comment, when spontaneous, can be entirely appropriate. (False)

5. Sensate focus exercises should be pleasurable. Irritation and discomfort are to be avoided. Only by notifying your partner when he or she causes you discomfort, can he or she learn to avoid doing so. (True)

6. You should be as comfortable as possible and enjoy yourselves. This may involve moving about freely in your bed, or whatever - so do so if you wish. (False)

7. This early in the programme, it is best that you do not have intercourse during your sessions. Just allow yourselves to be totally involved in touching and being touched - no matter how "ready" either of you feels. (False)

Answers to Quiz 3

1. Never aim to become turned on. To have such an attitude would imply that you are forcing yourself. In fact, we most enjoy our sexual play precisely when we don't have such aims. Try only to enjoy what you do together, and that means taking the "pressure on performing" sexually, out of your lovemaking. (False)

2. The woman should not feel she must do anything. Whatever each of you does is done because he or she wants to do it. So, only if she wishes she may bring him to a climax. (False)

3. This is absolutely correct. Regard the breasts and genitals as just other parts of the whole body which you can now touch to get and give pleasure. (True)

4. In the same way as the woman should not feel she must direct all her attention to her partner's penis - so the man should not focus all his stimulation on her genitals - he can approach and move away from them as he pleases - just as he might any other part. (True).

5. For the time being, do not go on to have intercourse. No matter how "ready" either of you may feel, do not break the ban. You must learn not to break that trust between you. (False)

Answers to Quiz 4

1. It is best to get used to the penis entering and remaining inside the vagina for a short while first. Do not feel you should go on to complete intercourse then. (False)

2. Take your time. Because of the time taken to move into the female-above position there might be a slight loss of sexual feeling for both the woman and the man. So spend sometime caressing each other while in this position, before the woman guides the penis inside. (False)

3. Many couples find the use of K.Y. Lubricating Jelly or Baby Oil to be very satisfying especially when used on the genitals. It can help cut down any possible irritation. If, for some reason either of you does not really like it then that's O.K. (True)

4. All men from time to time ejaculate quicker than they would like,, usually this will happen when a man has not had a sexual climax for a time. It may be quite normal for the man in this case to ejaculate soon after entry. That will probably sort itself out in time so don't worry. (True)

5. No. About fifteen seconds to begin with is fine. You can increase the length of time, with movement too, a little later. (False)

6. Rather than feel you must complete intercourse as soon as the penis is inside, this stage is designed to try and help particularly women to get used to all the feelings associated with containing the penis. Learning to give herself and her partner pleasure with little or no thrusting e.g. with some tightening and relaxing of the vaginal muscles can be a useful exercise. (True)

7. Although the woman may well feel quite aroused sexually and while her vagina may be quite wet with its own lubricant, the additional use of K.Y. Jelly can ease entry even further. Sometimes natural lubricant does not reach the outer lips of the vagina without a little bit of encouragement. K.Y. Jelly therefore can eliminate that possible irritation and so increase the female and her partner's confidence. (False)

TREATMENT GUIDE FOR PREMATURE EJACULATION

ACKNOWLEDGEMENT

Before we begin the programme, mention must be made of Dr. William Masters and Mrs. Virginia Johnson, the eminent sex researchers. It is from their work that the material for this booklet was derived. Dr. Masters began in 1954 researching the responses of the human body to sexual stimulation. Mrs. Johnson joined him in his work one year later. In 1966 they published their research findings in Human Sexual Response. This book is a landmark in the history of the scientific study of sex; it is popular with both the scientific and lay public.

After their work on human sexual response, Masters and Johnson developed a highly effective programme for treating human sexual inadequacies (such as impotence, inability to orgasm, premature ejaculation). Their treatment programme is presented in their book, Human Sexual Inadequacy. Virtually all the material for the programme is based on their research, so credit for the material is justly directed to them.

INTRODUCTION

Effective techniques are available for the treatment of premature ejaculation, yet this sexual inadequacy remains a widespread problem. Masters and Johnson estimate that there are hundreds of thousands of males who ejaculate too quickly to satisfy their partners. But a shortage of personnel trained to treat premature ejaculation severely limits the number of males who can be treated.

The Masters and Johnson techniques for treatment of premature ejaculation are not only effective, but are also rather easy to employ. If taught to use the techniques properly, many couples can successfully treat themselves. In treating premature ejaculation, the therapist instructs his clients in the use of the treatment procedures. The couple uses these in the privacy of their own home. At set times, the couple reports the results of their efforts to the therapist. He then instructs them in other steps to take until treatment is completed. In short, they are instructed and guided in the use of the techniques, and they use the techniques on themselves.

Because the couple can so quickly learn the techniques and so effectively employ them on themselves, all that is needed--besides motivation on their part--is a means by which to teach and guide them in the use of the techniques. Although the assistance of a trained therapist is valuable, it is hardly required for this job since a booklet can do the job adequately. When a booklet is used, the clients treat themselves and are saved considerable expense and time--all this without any loss in the effectiveness of the programme.

Premature Ejaculation

Almost all males sometimes ejaculate too quickly to satisfy their partners. Others ejaculate rapidly often, but not always. And still other males ejaculate too fast each time they attempt intercourse. Because most males ejaculate too soon at times, should we call most males premature ejaculators? Probably not, at least not as far as we are concerned in this programme. Let us explain by illustrations.

1) Donald's job requires that he travel to other cities. Sometimes he is out of town and away from his wife for as long as seven days. After these business trips Donald and his wife are excited to be together again. Donald is so excited in fact that when they have intercourse, he ejaculates within a few seconds. Donald ejaculates before his wife is satisfied, thus prematurely. But since he ejaculates prematurely only after an absence from his wife, she regards it as a sign that he is eager to have her sexually, and not as a sex problem. Donald and his wife do not need this programme.

2) The children spent last night with their grandmother, so Ralph and Mary had the evening to themselves. Mary served a candle-light dinner and wore a sexy negligee. After dinner they retired to their bedroom where they spent considerable time in sex play. When they finally began intercourse, Ralph ejaculated within a few moments. Normally he has no trouble delaying ejaculation until Mary is satisfied, but tonight he was aroused too intently for too long. Ralph was amused at his rapid response. Mary was pleased that after ten years of marriage she could still excite Ralph so much. They have no sex problem and do not need this programme.

Occasionally then, premature ejaculation can result from sexual abstinence and from prolonged and intense arousal prior to intercourse. Occasional prematurity deprives the female of negligible sexual satisfaction and hardly constitutes a problem.

3) Martin rolls to Susan's side from his position above her. As he settles himself he turns to her and says "I'm sorry". Susan kisses Martin as if to tell him it's okay. But they both know it is not okay. Their intercourse almost invariably ends only seconds after it has begun. Martin usually ejaculates within seconds, and Susan is left with her needs unfulfilled. Aware of Susan's frustration, Martin feels that he is not fulfilling his responsibility as a male. Martin and Susan have a sex problem and do need this programme.

If Susan, in the last illustration, cannot be satisfied, even when intercourse is prolonged, she should seek professional help. For, even if Martin delays ejaculation for quite some time, she will still be left unfulfilled. If she can be satisfied, albeit only when intercourse is prolonged, then it is reasonable to expect Martin to delay ejaculation long enough for her to do so. If he cannot, in at least 50 per cent of their attempts at intercourse, then for the purposes of this programme, they are troubled with premature ejaculation.

When the male frequently ejaculates too soon, leaving his partner frustrated, the sexual relationship can become intolerable for both him and her. The key here, of course, is the female's dissatisfaction, and subsequently the male's self-dissatisfaction with his quick ejaculatory response.

Learned Behaviour

Many people believe premature ejaculation to be the outcropping of some underlying mental illness. Before much was known scientifically about sexual inadequacies, the mental illness concept was advanced by some authorities to explain premature ejaculation. But recent investigations of the sexual histories of many people show that premature ejaculation is a learned pattern of sexual behaviour. This means that through experience the male acquires the habit of reaching ejaculation rapidly, although he may not be aware of learning this.

He learns this sexual pattern in the early part of his sex life. The habit is so strongly ingrained that all his efforts to control ejaculation are hopeless.

What kind of early experiences teach a man to ejaculate prematurely? Researchers have found a consistent answer to this question: In his early sexual experiences, ejaculation was reached as soon as possible with the full co-operation of the female. This theme is present in most cases, but the circumstances of each male's first sexual contacts may differ.

The male past forty might report that his first sexual experience was with a prostitute. Eager for a rapid customer turnover, the prostitute encouraged him to finish as quickly as possible. The total focus of the experience was on his sexual expression.

The younger premature ejaculator often had his first sexual encounter with a girl about his own age. The scene frequently was in the back seat of a car or maybe at his or her parents' home. In these situations discovery by others was likely, so the male mounted and climaxed as quickly as possible. All this was done with little regard for the female's sexual expression. After he ejaculated, they hurried back into their clothes, relieved that they had not been caught. After a few such episodes the male could not keep from ejaculating quickly, even when his sexual contacts were in the utmost privacy.

Sometimes the initial sex experience of the premature ejaculator was simulated intercourse. In this activity the couple, fully clothed petted until sex tensions were high. The male then mounted the female and together they pantomimed intercourse until the male climaxed. The intention of the couple was to bring the male to orgasm as rapidly as possible. This form of sex play preserved virginity and prevented pregnancy, but it often taught the young male to ejaculate prematurely.

The withdrawal technique of contraception has also conditioned males to ejaculate prematurely. Couples using this technique might prolong foreplay until the male's sexual tensions are high. He then mounts the female, makes several rapid thrusts, withdraws his penis, and ejaculates outside her vagina. The possible results of this practice are avoidance of pregnancy, lack of sexual release for the female, and a pattern of premature ejaculation for the male.

Masturbation, also, is often believed to cause premature ejaculation. However, sex researchers have not found evidence for this, regardless of how much or in what way a man masturbates.

It can be seen from the above examples that males learn premature ejaculation. Fortunately for them and their partners, what we humans learn, we can unlearn; and we can learn new patterns of behaviour that are more to our liking. This programme is intended to show you how to learn one new pattern of behaviour - that of control over ejaculation.

Problems of the Couple

The couple troubled with premature ejaculation generally has a typical pattern of difficulty. Upon their initial attempts at intercourse they become aware that the male cannot refrain from ejaculating long enough to satisfy the female. They then reassure themselves that with love, concern, and continued sexual contacts, they will overcome their problem.

As time passes they repeatedly attempt mutually satisfying intercourse. The male uses an array of tactics to delay ejaculation. Some of these are simple distractions by which he tries to keep his mind off the sexual situation. He may work math problems, count backward from 100, think of business affairs, or do anything else that will distract him during intercourse. He might even inflict pain upon himself by pinching himself, biting his cheek or tongue, or flexing his toes to the point of painful spasm. However, these techniques seldom block sexual stimulation enough to retard ejaculation.

He also tries another technique: applying to the head of his penis a local anesthetic such as nupercainal ointment. This reduces the sensitivity of his penis and in fact may provide some measure of control. However, applying too much anesthetic, or waiting too long before having intercourse after its application, may leave his penis too insensitive for erection. This, of course, can be as frustrating as ejaculating too quickly.

In using distractions and anesthetics to retard ejaculation, he reduces the amount of pleasure he otherwise would receive from sexual activities. This, and the frustration he feels when the techniques do not work, result in a tendency to avoid sexual encounters with his mate. If he avoids sexual contacts and does not ejaculate for some time, he becomes more easily aroused. When he and his partner finally attempt intercourse, he quickly becomes intensely excited, his control tactics help even less--and he ejaculates even faster than before. Now he feels incompetent for not holding back, and disappointed over the failure of his control methods. He knows his partner is frustrated. All this causes him to avoid sex even more.

Finally, on an occasion when he is not interested in sex, his partner insists on having intercourse. Fearing rapid ejaculation and his partner's subsequent disappointment and frustration, he fails to have an erection. Fearing that his sexual incompetence is greater than he imagined, he watches himself in his next sexual encounter hoping that his penis will harden. The distraction of watching for an erection and his fear that it will not occur prevent adequate stimulation; thus his penis does not erect. From such an experience he may become impotent although the majority of premature ejaculators do not. As in most cases, however, he and his partner eventually tumble into a breakdown of sexual and verbal communication.

As time passes, the female feels a growing need for sexual satisfaction. Her partner seems thoughtless and inconsiderate of her as a human with sexual needs. Her disposition slowly changes from warm and encouraging to harsh, resentful, and hostile. The male has done his best. Seeing no improvement in sight, he worries more over his competence as a man. When nothing the couple does seems to help, they cease to discuss their problem, and communication breaks down.

If you have experienced any of the above complications, you know the emotional pains they can produce. Completing this programme and increasing the male's control should help you prevent or alleviate such problems and live a more satisfying and harmonious life together. But to improve the male's control, you must work together. Perhaps your co-operation will be enhanced by considering the following points.

Points to Remember

That you are reading this programme indicates that you want to eliminate your premature ejaculation. Perhaps it is appropriate here to emphasise a few points that should be kept in mind as you go through the programme. Your consideration of these points may help reduce ill feelings, improve communication, and ensure the success of your efforts.

Note to the female. The partner of the premature ejaculator usually has been deprived of much sexual satisfaction. For this she may tend to blame. It should be remembered that you and your partner are both victims of his early conditioning over which he probably had no control. Until now he has ejaculated prematurely because he has not had the advantage of effective therapy.

The male climaxes too quickly, so treatment procedures focus mainly on his sexual response. By participating in this programme you are again giving. This may seem unfair to you. You probablyhave given a great deal and may feel that you should now be receiving.

Effective treatment of premature ejaculation requires a co-operative female, one who is willing to give fully of herself. If you do not fill this requirement, treatment will not succeed.

With your help, premature ejaculation will cease to be a problem. You will then share with your partner a more satisfying and fulfilling sexual relationship.

Note to the male. You may be doubtful that you will ever be able to control ejaculation. Maybe you have tried many methods to retard ejaculation, but your efforts have been futile. The techniques presented in this booklet have been used widely in clinical settings. They are nearly 100 per cent effective in teaching ejaculatory control. In the few cases where the use of these techniques failed, the males lacked motivation to learn ejaculatory control. Most couples who have used the programme have done so successfully. Those who improved least failed to follow the programme as instructed. Given that you and your partner want to overcome your problem, and are willing to follow this programme, there should be little chance of failure.

Turn to page 7

INSTRUCTIONS

Instructions are given throughout this programme to guide you through your self-treatment. It is critical to your success that you follow these instructions. Do not rush or skip ahead. Relax, go slowly, and enjoy yourselves.

At the end of each major section is a true and false quiz. Your answers to this quiz will show you whether you understand the main points of the section. The correct answers are on the page indicated at the top of the quiz page. When taking a quiz, read a question, answer it true or false, and immediately (before moving to another question) turn to the answer page and check your answer. Should your answer be correct, feel confident that you understand the portion of the programme represented by the question. Turn back to the quiz and tackle the next question. Should your answer be incorrect, carefully read the explanation provided with the correct answer. After completing the quiz, follow the instructions at the end of the quiz page.

Throughout the programme are statements directing you to specific pages, such as "Turn to page 36." These statements direct you to parts of the programme you are to begin next.

You do not have to turn to the page immediately, although you may wish to. The statement may be regarded as a rest sign. You may put the programme aside and return to the specified page whenever you wish.

The Training Sessions

The training sessions of the programme are divided into four phases. The written material for each phase explains and describes what you are to do in the training sessions for that phase. 1. In phase one you will do an exercise that will help you to relax and enjoy the sensations of touch. 2. In phase two a technique used to teach ejaculatory control will be described. 3. In phase three you will learn to insert and keep the penis in the vagina without ejaculating. 4. In phase four you will learn to keep the penis in the vagina while you are in a position that permits intercourse in a free and unrestrained manner.

In each of these phases there is a sequence of scientifically determined steps. You must clearly understand each of these before you begin the training sessions. Research has shown that each of these steps is essential to successful treatment. You must follow the outlined steps if you are to learn ejaculatory control.

There is a natural tendency to go quickly through the programme. Of course you want to finish the whole thing as soon as possible; but there are dangers in rushing. Each and every step is recommended for a specific purpose; each step must be taken in its turn. Rush and you may fail to take a step. Thus for the fastest progress, GO SLOWLY!

Read the step-by-step instructions carefully. Pay particular attention to the sequence of the steps---know which step comes first, second, third, and so on. Keep in mind that although the steps are listed and explained separately for clarity, they are parts of an on-going process; each step is an important part of a sequence; each must be taken in its turn if results are to be highly successful.

In the sessions in phase three you will need some kind of lubricant. You will use this to lubricate the penis and the opening of the vagina so that the penis can be inserted easily. You should have a lubricant on hand when you begin the phase. Vaseline, mineral oil, Baby oil, (by Johnson & Johnson or Mothercare) all these will serve well, but probably the best to use is K.Y. Lubricating Jelly (by Johnson and Johnson). K.Y. Jelly is preferred by most physicians for medical purposes. It can be bought quite cheaply at most chemists.

A Word of Precaution

As you progress toward the end of the programme, or after you have completed it, you will find that you can engage in intercourse for a much longer period than you previously could. Delighted with this new ability, you might have intercourse much more often than you did before. This is all very well, but there is one possible result you should know about.

Just as sex too seldom will increase the speed and intensity of your sex response, sex too often will decrease its speed and intensity. This is true for both of you. But when a male has sex too often, his penis will tend not to erect fully, or it may not erect at all. Chances are that you will not experience this reaction, but if the male does become unable to erect, do not be alarmed. He is not developing a new kind of sex problem; you are just having intercourse too often. The remedy for this inability to erect is to have intercourse a little less often. Give yourselves a break.

Turn to page 9

The answers to this quiz are on page 51

Check your answer to each question before moving on to the next one.

1. Most males sometimes ejaculate too quickly to satisfy their partners. _____

2. For the purposes of this programme, a couple has premature ejaculation if the male ejaculates too quickly in about 10 percent of their attempts at intercourse. _____

3. Mental illness may be the cause of premature ejaculation in some males. _____

4. Masturbation does not cause premature ejaculation. _____

5. When a male does not have intercourse for a long time, he becomes sexually aroused more easily and may ejaculate more quickly. _____

6. A co-operative female partner is desirable but not essential in the treatment of premature ejaculation. _____

7. The techniques used in the programme have proved effective except with couples who lacked motivation to learn ejaculatory control, or who failed to follow directions. _____

Turn to page 10

PHASE ONE

The first phase consists of four steps. First read this phase thoroughly and carefully.

Privacy and Comfort

You should have a private place such as a bedroom where both of you can relax and feel at ease. If you have children or other potential distractions, it may be necessary to arrange the training sessions so that you will not be rushed or otherwise disturbed. Distractions should be minimised so that your full attention can be devoted to the sessions.

You should not carry out sessions when either of you feels tired, anxious, irritated, or rushed. Both of you should feel comfortable with the place and the time. These, in fact are good rules for most sexual encounters.

Sensate Focus

Our main source of sexual stimulation is physical contact--touching and feeling. Without this source, most of us, male and female alike, would never reach high levels of sexual arousal. The more we feel sexually, the more aroused we will become and, consequently, the more we will enjoy sex.

Physical contact with your partner is also the best means of sexual communication. There is no better way to find what physically excites your partner than to observe and feel his or her bodily responses to your touches. There is no better way to find what your physical preferences are than for your partner to stroke, fondle, and caress your body.

Many couples do little touching before intercourse. Thus they deprive themselves of much stimulation and valuable communication with their partners. It is important, then, that intimate bodily contact be a part of your sex life. For this reason, a part of this programme is devoted to getting you to think and feel physically.

To sharpen yourtouch sense, the first part of each training session will be devoted to what is called "sensate focus." This is an activity in which both of you, one at a time, explore your physical reactions to touch.

Keep in mind that sensate focus exercises are to get you to thinking and feeling physically. Many of us in our culture have been affected to some degree by a touch taboo. In line with this taboo we express our feelings for one another in largely non-physical ways (for example, saying things that have special meaning). Certainly there is nothing wrong with non-physical expressions of feelings, but physical expressions are just as desirable, if not more so. And in sex, the most important form of expression is physical.

In a warm room where you can enjoy complete privacy in a relaxing atmosphere, both of you remove all your clothes. Some clothes worn in a sexy way can be arousing, but to avoid awkwardness and distractions it is better to start without clothes. Keep in mind that talking should be minimized--sensate focus is a physical experience.

The female is to lie down on something comfortable. Her position does not matter: face up, back up, or side up--whichever she prefers. She is to relax and be comfortable. She has but two jobs: One, she is to give the male verbal and/or physical directions. She may tell him what is physically pleasurable to her, or show him by guiding his hands with hers. Two, she is to keep him from doing anything that is too irritating or uncomfortable. This is important. One of you may be the kind of person who has never liked being touched by others. Or perhaps you are bothered if you are stroked and caressed anywhere other than a few parts of your body, such as your legs, your arms, or maybe your scalp. If so, don't hesitate to tell or show the other where these parts are and where they are not. During sensate focus exercises let him stroke, rub, caress, kiss, massage, or fondle those parts of your body that you like to have touched. Other than these jobs the female is to feel and think of the pleasures of being caressed. She is to focus and keep her attention fully on what she feels. She is not to return the touching at this point, nor does she need to express--with her body or her voice--the pleasure she feels unless it is spontaneous. It is not unusual to feel a little guilty about just lying quietly and receiving pleasure. Somehow it is difficult to not give in return. Both of you will have your turn to give, but while you are receiving just become totally involved in what you feel.

The male is to get in any position close to the female so that he is able to touch most of her body. He is to begin lightly touching her body anywhere (and everywhere) except her genitals (the area of her vagina and breasts. Do not touch these portions of her body. At a later point in the programme you will arouse each other more directly, but there is much to gain now by avoiding direct stimulation.

The male has two jobs: One, he is to provide the female with pleasure by touching her while observing her reactions to his touches. If she does not give any signs of what is particularly pleasurable to her, questions such as "Do you like this?" or "Should I rub harder?" or "What has felt best so far?" will elicit some directions from her. His other job is to explore his own pleasures in touching: he is to notice the sensations of rough and smooth, hard and soft, and warm and cool as he touches her body.

Sensate Focus exercises are not intended to be structured. Both of you should be calm and comfortable and respond to your impulses to caress the other. When feeling and when touching, you may move about freely on the bed. There is nothing specific that you must do, other than take turns in touching and observing and in feeling what it is to be loved physically.

After about fifteen minutes of the male touching and the female feeling, you are to change places. The male is to lie in any position he prefers, and the female is to position herself so that she can easily stroke most of his body. Now it is the job of the male to feel and think of the pleasures of being touched. Also he is to keep the female from doing anything to him that causes discomfort. It is the job of the female to touch, to fondle and massage the male and to observe him for signs of pleasure. She is also to attend to her pleasures in touching. <u>At this point the female is not to touch the male's genitals (his penis and testicles)</u>.

After the female has caressed and massaged the male for about fifteen minutes, change places again. The female is to lie on the bed and receive the male's physical affections. <u>Do not have intercourse during or after sensate focus exercises</u>.

It does not matter how long you continue sensate focus exercises. The important thing is that you take turns (approximately equal lengths of time) giving and receiving physical expressions of love. If you do sensate focus exercises in a comfortable, nondemanding manner, physical pleasures beyond those you have experienced before may emerge.

Turn to Page 13

The answers to this quiz are on page 52
Check your answer to each question before moving on to the next.

Quiz 2

1. Sex too often (for him) will cause the male to ejaculate too quickly when he has intercourse. _____

2. Sessions should be carried out when the male is tired so that he can control ejaculation more easily. _____

3. Sensate focus exercises are to get you involved in your physical reactions to touch. _____

4. During sensate focus exercises you should talk as much as possible to convey to your partner what is most pleasurable to you. _____

5. The partner being touched in sensate focus exercises should let the touching partner know if he or she does anything irritating or bothersome. _____

6. While doing sensate focus exercises you are to resist your impulses to move about on the bed. _____

7. If sensate focus exercises are pleasurable to both of you during a session, you may have intercourse to reinforce your enjoyment of the exercises. _____

If you feel that you understand the material for phase one, follow the phase instructions in your private quarters. When you have completed your training session, turn to page 14 of the programme and follow the appropriate instructions.

Phase One

Read the following statements and select the one that most clearly applies to you; turn to the page indicated after the statement you choose.

Statement 1 Our sensate focus exercise was pleasurable. Turn to page 15

Statement 2 Our sensate focus exercise was not especially pleasurable. Turn to page 16

Statement 3 Ejaculation occurred during our sensate focus exercise. Turn to page 17

Phase One

You chose Statement 1. Our sensate focus exercise was pleasurable

Good! Bodily contact certainly can be enjoyable, and sensate focus exercises give you a chance to enjoy your physical reactions to touch.

When you return to your bedroom for your next session, do sensate focussing again. If you will relax and be thoroughly involved in your physical sensations, this second session should be enjoyable. After your session return to page 14, select the most appropriate statement, and follow the directions. If your next experience is pleasurable, skip this page when you are directed to it and turn to page 18.

Phase One

You chose Statement 2. Our sensate focus exercise was not especially pleasurable.

Sensate focussing can be highly pleasurable, but you didn't find your first experience to be so. Well, that's okay; it is not at all uncommon for people to feel awkward, uncomfortable, or simply neutral when first trying sensate focus exercises. To be sure that you understand the process of sensate focussing, carefully read and think about the points below. Discuss with each other whether you conducted your sensate focus exercise according to these points.

1) Your training sessions should be at a time and place in which you feel comfortable.
2) When being touched, let your partner know if he or she does anything that is unpleasant to you. Also let him or her know what is particularly pleasurable to you. However, you should not be too concerned about signalling to your partner; just relax, don't talk too much, and fully concentrate on the pleasures of being touched.
3) When caressing your partner, observe closely what is pleasurable to him or her. Also note your sensations from touching.
4) Sensate focussing is not intended to be structured. Do what the two of you like, whatever is pleasurable and enjoyable for you--except, at this point, touching each other's genitals.

When it is convenient, return to your bedroom or wherever for our next session if you feel you understand each of the above points. Keep the points in mind during the session.

Also remember there is no reason to rush through this programme. Make it easy, go slowly, and above all--enjoy yourselves.

After your session, return to page 14 and follow the instructions.

Phase One

You chose Statement 3. Ejaculation occurred during our sensate focus exercise.

It certainly is difficult sometimes to keep from ejaculating, particularly when you are so physically close to your partner. So to help you avoid ejaculating when doing sensate focussing, keep the following points in mind.

Neither of you is to touch the other's genitals during sensate focus exercises. The female is especially not to touch the male's penis; this is to avoid causing him to ejaculate.

It is possible that some part of the male's body is extremely sensitive and if touched while in a sexual situation may cause ejaculation. If this is true of the male, you should determine where these sensitive zones are The female should avoid caressing these zones until the male has learned better ejaculatory control.

It is possible, too, that the male, simply by being close to his nude partner, becomes highly excited and ejaculates. This may appear to be quite a problem, but it can be corrected. In your next session both of you remove your clothes. First, the female is to lie and receive the male's touches. Next, the male is to lie and be touched. Whenever the male feels he may ejaculate, he is to signal to the female and she is to stop what she is doing. For example, if she is massaging the male, she is to stop and immediately take her hands from his body. The urge to ejaculate should then subside. If not, the female, on signal from the male, may have to leave the bed, or move out of the male's sight---whatever is necessary for the male to lose his urge. When the urge subsides, you are to return to what you were doing before the urge appeared. If by chance the male ejaculates, don't be dispirited; end the session and begin again at a convenient time. As you progress through the programme, ejaculatory control will come.

Whenever it is convenient, return to your bedroom for another sensate focus exercise. Remember to relax and be totally involved in your physical reactions to touch. After your next session, return to page 14 and follow the directions.

PHASE TWO

Through sensate focus you can become totally involved in the sensations of bodily contact. This total involvement is sure to increase the pleasures the two of you share. Now that you have used sensate focus and found it pleasurable, you are ready to use the squeeze technique in your next training session. The squeeze technique is the first of the techniques you will use for the male to learn ejaculatory control. In this phase you will learn the training position for ejaculatory control--the position in which you can best use the squeeze technique. Remember, you are not to rush ahead or skip any of the material in the programme.

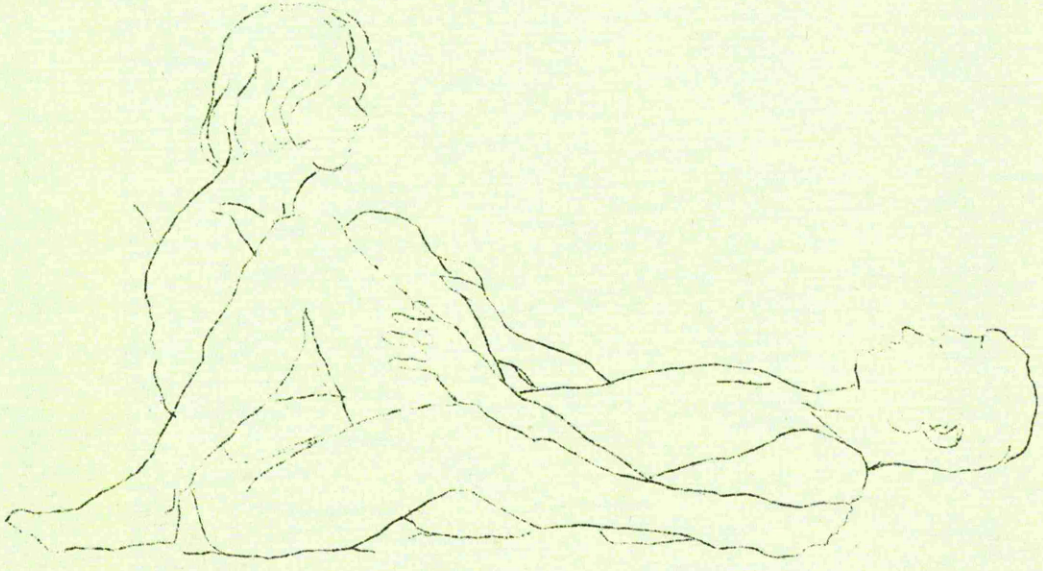
Begin your next session with sensate focus exercises. When you feel that you have done sensate focussing enough (when each of you has been able to relax and respond pleasurably to the other's touches), position yourselves as described below.

The Training Position for Ejaculatory Control

This position is encouraged because it enables the female to easily reach the male's penis. Thus she can easily apply the squeeze technique.

As in Figure 1 the female is to sit with her back resting against something such as the headboard of the bed. She can use pillows behind her back for comfort. Her legs are to be spread apart.

The male is to lie in between the female's legs (Figure 1) His legs go over and on the outside of her legs. His head goes away from her so his pelvis is between her legs close to her body. This position is neither as difficult nor odd as it may seem.



The Squeeze Technique

Sexual arousal may result from psychological stimulation such as seeing your partner's nude body, or from physical stimulation such as when your partner fondles your genitals. The male's first reaction to sexual stimulation is penile erection. Blood flows into the tissue of the penis, causing it to become rigid and hard. If stimulation is continued, congestion of tissues with blood, and muscle tensions increase until the male reaches a climax, which is when he ejaculates. After ejaculation he loses his erection.

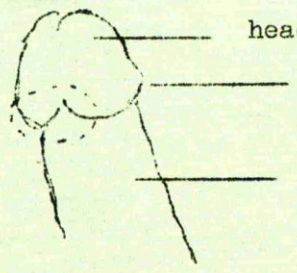
For the female partner to reach orgasm (or climax) during intercourse, the male must maintain an erection long enough for her sexual tensions to increase to the point of orgasm. The premature ejaculator has the habit of progressing rapidly from the start of stimulation (when his penis becomes erect) to ejaculation (after which he loses his erection); so the female does not have time to reach a climax.

Just before the male ejaculates, he experiences sensations deep in his pelvis and genitals. These are the first signs that climax is soon to follow. Shortly after these sensations of "coming" begin, he can no longer control the process. If stimulation is continued, he will ejaculate. The squeeze technique is for teaching the male to control these sensations, and thus delay ejaculation long enough for the female to become sexually satisfied.

In teaching ejaculatory control it is essential that the female master the squeeze technique. This requires 1) learning proper finger placement on the penis and 2) learning to apply enough pressure to the penis at the correct time.

During each training session the female will bring the male to erection by some means of stimulation (to be explained later). When the penis is fully erect, she should immediately apply the squeeze technique.

In applying the squeeze technique, the female places her thumb on the underside of the penis just where the head of the penis connects with the shaft (Figure 2)



The first and second fingers of the same hand are placed on the upper side of the penis. These fingers should be beside each other, one on either side of the coronal ridge. In other words, they straddle the coronal ridge.

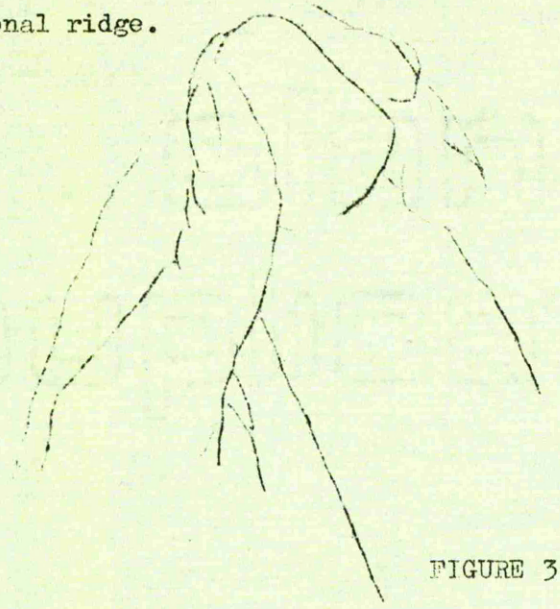


FIGURE 3

Strong pressure should be applied to the erect penis. If the penis were soft (not erect) strong pressure might be uncomfortable to the male, but when the penis is erect, the pressure is not painful. If the female fears that she will cause pain by squeezing too hard, the male should place his fingers over hers and apply strong pressure through her fingers. Showing her how much pressure can be applied without resulting in pain should relieve her fear. Pressure is applied by squeezing the thumb and the two fingers together for three to four seconds. After squeezing the penis for this period of time, the female should gently release the pressure.

There should be no trouble in correctly placing the fingers on either a circumcised or uncircumcised penis. Figure 4 is a diagram of an uncircumcised and a circumcised penis. When soft, the head of the uncircumcised penis is covered by a fold of skin called the foreskin. This foreskin has been surgically removed from the circumcised penis and the head is always exposed. With the uncircumcised penis the female may have to feel with her fingers to locate the coronal ridge. Once her first two fingers are in place, she should estimate the correct position for her thumb.

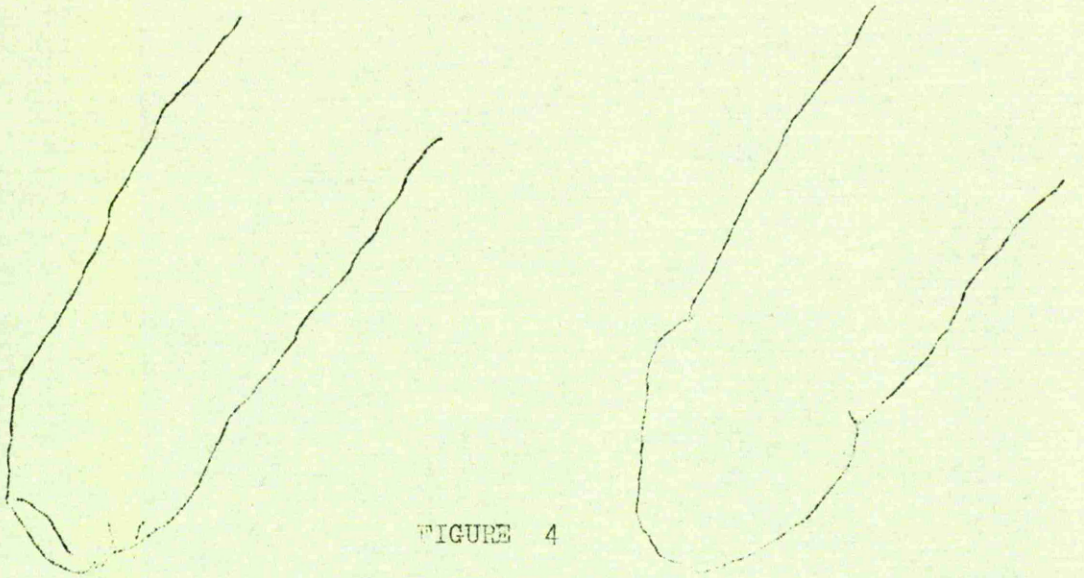


FIGURE 4

If the fingers are correctly placed and enough pressure applied to the erect penis, the male will lose his urge to ejaculate. He may also lose 10 to 30 percent of his erection. But for the squeeze technique to work, the female must remember to apply strong pressure.

Once you are in the training position, the female is to begin stimulation of the penis. She might do this in any number of ways. For example, she may fondle the penis and testicles with her hands and fingers, or with her lips, tongue, or mouth. She may use any one or any combination of these that are arousing to the male and acceptable to both of you.

It's likely that the female may not know what to do to bring the male to erection. This would not be unusual in the least. If she does not know, the male can communicate to her what is most arousing to him. He can do this in several ways. He might, for instance, tell her what to do. Often, however, it is hard to describe in words what is sexually stimulating to us; so it may be easier to show her what excites him to erection. He can do this by stimulating himself to erection as she watches closely, or by placing his hands over and guiding her hands. In this way he can teach her exactly how much pressure to apply and what rhythm to use in stroking and fondling his genitals.

Some forms of stimulation may be distasteful or even repulsive to you. This is perfectly allright; everyone has his individual likes and dislikes. There are methods of stimulation acceptable to both of you that will bring the male to erection. You can find these by discussion, experimentation, and wholehearted co-operation with each other.

By whatever means, the female is to stimulate the penis until it erects fully. If she cannot distinguish the fully erect penis, the male should signal to her when he has got one. If she watches his reactions closely she will learn to recognize how strongly aroused he is.

The male may not ejaculate until some moments after reaching full erection. If this is so, the female can continue stimulation until the male feels the first vague sensations of approaching ejaculation. He is then to signal to her and she is to immediately apply the squeeze technique. You should note that it is possible that ejaculation will accidentally occur if the squeeze technique is not applied soon enough. If the male feels that ejaculation may accidentally occur, then the female should apply the squeeze technique as soon as the male is fully erect. This will prevent accidental ejaculation.

The female must be careful to place her fingers correctly on the penis. The first two fingers go on the top of the penis, one on each side of the coronal ridge, and the thumb goes on the bottom of the penis, directly on the line that divides the head from the shaft. If she is not sure in her understanding of the squeeze technique, she can refer back to the diagrams on page 19 22and practice positioning her fingers on the penis. This is to be done before the next training session.

With the penis fully erect and the fingers correctly positioned, apply strong pressure for three to four seconds. Remember that strong pressure does not hurt the male when his penis is erect. As pressure is applied to the penis, the male will lose his urge to ejaculate. When three or four seconds have passed, gently release the pressure. Some of the erection will probably be lost so that the penis is no longer fully erect.

When the female releases finger pressure, she is to move her hands away from the penis. She is to wait from 15 to 30 seconds before beginning to stimulate the penis again. This period of "no touching" allows the urge to ejaculate to subside. After the male loses his ejaculatory urge, or when about 30 seconds have passed, the female is to return to stimulating the penis. Remember that any form of stimulation can be used as long as it is arousing to the male and acceptable to you both.

When the penis is fully erect or when the male feels that ejaculation is coming, the female should immediately apply the squeeze technique again. After three or four seconds she should gently release her fingers take her hands away completely and let him lose his urge to ejaculate.

While in the training position, repeat the process as many times as the two of you like. But remember that the more times you do it in your sessions, the more quickly ejaculatory control will be developed. The number of repetitions you do should be determined by how many you enjoy and feel comfortable doing.

The female is not to bring the male to ejaculation during this session. He would ejaculate quickly after the start of stimulation and would strengthen his habit of rapid ejaculation.

Coming close, but not ejaculating during the training session can be frustrating; the male may feel an urgent need to ejaculate. Masturbation can relieve his frustration, but he must not masturbate in the presence of the female. The purpose of the programme is to teach the male to delay ejaculation when with the female. Masturbating and ejaculating quickly while in private is perfectly all right, but ejaculating quickly in the female's presence will, again, strengthen his habit of premature ejaculation. If the male does not wish to masturbate, he is not to ejaculate until the programme instructs him otherwise.

Before you end the session the female may want to be brought to orgasm. This is fine as long as the male does not use his penis, such as in intercourse; some other method should be used to stimulate the female to orgasm. For instance, the male may use his fingers, hands, mouth, tongue, or any part of his body other than his penis to satisfy her desires. Devices such as a hand vibrator might be used if you wish. The male should be concerned with what arouses the female. To reach orgasm the female may have to guide his hands with her own to show him exactly what parts of her body she prefers to be stimulated, and in what way.

Turn to page 24

The answers to this quiz are on page 53.
Check your answer to each question before going on to the next.

Quiz 3

1. In the training position for ejaculatory control, the female must reach around the male's trunk to reach his penis with her hands.

_____

2. When using the squeeze technique, applying strong enough pressure is as important as placing the fingers properly on the penis _____

3. The thumb and fingers are correctly placed on the penis when the thumb is on the underside of the penis and the first two fingers are on the upper side, both positioned just behind the coronal ridge.

_____

4. Strong pressure applied to the penis will cause pain unless the fingers are correctly placed. _____

5. The male should signal to the female to apply the squeeze technique when he feels the first sensations of approaching ejaculation_____.

6. After applying the squeeze technique, the female is to take her hands away from the penis. _____

7. After you have used the squeeze technique as many times as you like, you may end the session with the female stimulating the male to ejaculation _____

If you feel that you understand the material for phase two, follow the phase instructions in your private quarters. When you have completed your training session, turn to page 25 of the programme and follow the appropriate instructions.

Phase Two

Read the two statements below. Choose the one that is most appropriate and turn to the page indicated.

Statement 1 We used the squeeze technique and successfully delayed ejaculation. Turn to page 26

Statement 2 Ejaculation occurred before or while we were using the squeeze technique. Turn to page 27

Phase Two

You chose Statement 1. We used the squeeze technique and successfully delayed ejaculation.

That's great! Successful use of the squeeze technique is a big step toward control of ejaculation. When it is convenient, go to your bedroom once more. Do sensate focussing, get into training position for ejaculatory control, stimulate the penis and use the squeeze technique as many times as you like. If for some reason you aren't successful with the squeeze technique this time, return to page 25, and choose the appropriate statement. However, you will probably use the squeeze technique as well as you did in your last session, and you will have taken another big step toward complete ejaculatory control. Continue your sessions with the squeeze technique until the male can maintain an erection without ejaculating for as long as he wishes to do so with the female stimulating his penis. This will probably require several sessions. When the male has developed this much control--and not before!--move on to phase three on page 28.

Phase Two

You chose Statement 2. Ejaculation occurred before or while we were using the squeeze technique.

Don't be troubled if ejaculation occurred before you could effectively use the squeeze technique, it takes practice to succeed at anything. If ejaculation happened while the female was applying the squeeze technique, both of you should turn to page 19 and re-read the section on the squeeze technique. The female should then practice placing her fingers correctly on the penis. The male should place his fingers over hers on his penis and demonstrate to her that very strong pressure can be applied without causing pain. Remember, to be successful you must co-operate with one another. When it is convenient, return to your private quarters for your next session, and remember to relax and enjoy yourselves. After your session, return to page 25 and follow directions.

Let's now review two important points. You will do well to keep these in mind during your next session.

1. For the male to delay ejaculation at this point in the programme, the female must effectively employ the squeeze technique by placing her fingers correctly on the penis and applying strong pressure.

2. For the female to use the squeeze technique effectively, the male must signal to her as soon as his ejaculatory urge appears.

PHASE THREE

You have come a long way since you started this programme. The male should now be able to delay ejaculation much longer than he could before. To have got this far along in the programme implies that the two of you have been communicating very well, both physically and verbally. As a couple you deserve praise.

Now that you have finished phase two, the male should be able to keep an erection for some time without ejaculating. It is time now to go on to phase three. In phase three you will learn to insert and keep the penis in the vagina in such a way that the male does not ejaculate. This is an important step in the programme, so read carefully and take your time.

Some of phase three will be similar to phases one and two. For instance, you will begin the sessions of phase three with sensate focus exercises. Also, you will use the squeeze technique at least a few times during each session.

After the male has got an erection and the female has used the squeeze technique a few times, you will position yourselves so that the penis can be gradually introduced into the vagina. Getting into the special position and inserting the penis into the vagina are the unique parts of this phase. First read phase three thoroughly, then follow the first set of instructions at the end of this phase.

Sensate Focus

The training sessions in phase three, like all the training sessions in the programme, start out with sensate focus exercises. Both of you remove all your clothes. This time the male should lie down comfortably and be caressed first. When you are ready to change places, the female is to lie down and the male is to touch and caress her. Change roles from touching to being touched as many times as you like. Keep in mind that these exercises are not meant to be stiff and mechanical. Through your touches, show the warmth and affection you feel for your partner. Remember that touching is our best form of emotional and sexual communication.

Kissing, hugging, and other types of touching can easily fail to show the affection they are meant to express, and sometimes they can cause discomfort. By watching and feeling the other's reactions to your touches, you are both learning what comforts or excites the other. This knowledge will allow you to convey physically your feelings to your partner in a way that is pleasing to him or her.

If you are the one being touched, let your partner know if he or she does anything that irritates you, and also express the pleasures you feel--but only if this expression is spontaneous. Otherwise just relax and receive your partner's intimacies. Be totally involved in your reactions to being touched. When you are touching, be sensitive to the other's reactions, and note your own pleasures in touching.

Training Position

When both of you are satisfied with the sensate focussing you have done and are ready to move on, place yourselves in the training position for ejaculatory control. Your instructions for the training position are the same as in phase two. (Refer to page 18) Position yourselves so that the female will have free access to the penis.

Squeeze Technique

The female is to use some form of stimulation to bring the penis to full erection. She is to stimulate the penis to erection at least two or three times, each time using the squeeze technique so that the male loses his urge to ejaculate. The male is to relax and focus his attention on the pleasure he feels. If he senses that ejaculation is going to occur he should signal to the female so that she can apply the squeeze technique.

Female-Above Position for Intercourse

At this point you are beginning an important step in the programme Read the instructions very carefully; and in the bedroom be just as careful to follow the instructions.

Inserting the penis into the vagina is a touchy business for most males who experience premature ejaculation. But because you have effectively used the squeeze technique in phase two, the male will be able to control ejaculation and gradually insert his penis in the vagina--but remember, it must be inserted gradually. With your partner's body close to yours, and with warm emotions and climbing sexual excitement, it is hard to resist rushing ahead into intercourse. This is only human. But by rushing ahead the male may lose all the control he has gained, and you may end up repeating phase two. So, as inviting as it may be, do not rush into intercourse. Take it slow and easy. In fact, the slower you go, both in reading this programme and in carrying out the training sessions, the better your progress will be.

By using the female-above position for intercourse (Figure 5) the male can learn to delay ejaculation for long periods of time with his penis inside the vagina. It is extremely important that you use this position for intercourse at this time. Most couples use the male-above position. If the male tends to ejaculate rapidly, this position is the worst they could use. Research has shown that of all the positions used in intercourse, the male-above position provides the male with the least ejaculatory control. The female-above position is one of the two that provide the best control. The other will be discussed later in phase four of the programme.

Some couples find the female-above position offensive. They refuse to use it for reasons such as, "It somehow makes the man less manly, or the woman less womanly." If for one or another reason you do not wish to use the female-above position, you may try any you like. But, of course, research and clinical data show that other positions--especially the male-above position-will reduce the effectiveness of the programme. If you use another position and the male regains his rapid ejaculation habit, you should go back to phase two to reestablish his control.

You will make rapid progress with the female-above position. Figure 5 illustrates this position. The male rests on his back and the female straddles his body. Her knees are to be placed about at his nipple line and her legs alongside his body. The nearer you are to the same height, the nearer the female's knees should be to the male's nipple line. If the female's body is shorter than the male's her knees should be somewhat below his nipple line. If her body is longer than his, her knees should be slightly above his nipple line. In this position, leaning slightly forward, the female is able to lower her body to insert the penis into her vagina. In lowering her body she should move back on the penis rather that sit straight down on it. It is important that the female be able to move up and down is a slightly backward and forward manner over the penis (Figure 5). She must be able to raise her body quickly from the penis and apply the squeeze technique when necessary. The female above position beautifully allows for this action.

FIGURE 5

Introducing the Penis into the Vagina

After your sensate focus exercises the female should stimulate the penis to erection and apply the squeeze technique two or three times. This is to exercise the male's control of his ejaculatory process and to give the female practice in the use of the squeeze technique. After using the squeeze technique the female is to place herself over the male in the female-above position. The male should lie flat and both of you should be comfortable. The female is to check to see that when she sits back the penis is in position to enter her vagina smoothly--but she is not to touch the penis with her vagina. Also to assure smooth entry one of you is to lubricate the vagina and the head of the penis with some kind of lubricant. If the female is sexually excited her vagina may be naturally lubricated, but when in the female-above position natural lubrication may not be enough for the penis to enter smoothly. You should have the lubricant within reach of the bed.

When comfortably positioned over the male, the female should stimulate the penis to full erection. This is not to be done by bringing the penis and vagina together. She should probably use her hands.

When the penis is fully erect the female is to lower her body so that her vagina comes into contact with the penis. It is extremely important that this be done slowly and gradually. Insert the penis into the vagina gradually. While inserting the penis and after it is inserted, the female is not to thrust her pelvis and hips; she is to remain as motionless as possible. Pelvic movement at this point will cause too much stimulation and might set off ejaculation. With the penis inserted, both of you should remain motionless so the male can become accustomed to the inside of the vagina; gradually he will develop the habit of having his penis in the vagina without ejaculating.

While inserting the penis, ejaculation may be set off at any time. If the male feels the slightest sign that ejaculation is coming, he is to signal to the female. She should immediately rise from the penis and apply the squeeze technique. As before, she squeezes for three or four seconds or until the urge to ejaculate is lost Then she pauses for about thirty seconds. When the urge is lost, she is to stimulate the penis back to full erection and, again, slowly and gradually insert it into the vagina. When entry is completed, both of you should remain motionless, allowing the male to get used to his penis being contained in the vagina.

You can avoid ejaculation by remaining motionless and by using the squeeze technique when the urge first appears. You may have to go through the process of partially inserting the penis, taking it out of the vagina and applying the squeeze technique quite a few times until control is learned, but the period of time the penis can remain in the vagina without ejaculation occurring will gradually increase.

The reason for remaining motionless when the penis is inserted is to reduce the physical stimulation so that ejaculation does not occur. However, remaining motionless for too long will cause the penis to lose its erect state and the vagina to become a little dry. This can be prevented by increasing the stimulation by moving. So when the male can control ejaculation with the penis inserted, he should begin thrusting--but only very slightly at first! He should thrust just enough to provide stimulation to keep the penis erect and the vagina lubricated. The female should remain motionless as the male thrusts.

If the urge to ejaculate appears, the male should stop thrusting. With both of you motionless, the urge should subside. If it does not, the male should quickly signal to the female and she should rise from the penis and apply the squeeze technique. After the urge has subsided, repeat the process: Slowly insert the penis, but remain motionless. If having the penis in the vagina does not trigger ejaculation, then the male should begin thrusting--but only very slightly. If the ejaculatory urge appears he should stop thrusting, and if necessary the female should withdraw the penis and use the squeeze technique. If ejaculation does not threaten, the male should continue thrusting, gradually increasing the depth of his thrusts until he can thrust freely without ejaculating. If he continues in this way, alternately thrusting and stopping to control the ejaculatory urge, the male will develop enough control to thrust without threat of ejaculation. When he reaches this stage of control, the female should begin thrusting--very slightly though! If her thrusting evokes the ejaculatory urge, the male should signal to her and both of you should cease thrusting and remain motionless (or, if necessary, withdraw the penis and use the squeeze technique) until the urge disappears. Once it disappears, repeat the process until both of you can thrust freely without causing ejaculation. The process involves five main steps:

1) You are to assume the female-above position for intercourse
2) The female is to stimulate the penis to erection and apply the squeeze technique about two or three times.
3) The female is to insert the penis into the vagina gradually. If the ejaculatory urge appears, you are to withdraw the penis and use the squeeze technique again.
4) The male is to begin thrusting, if the urge appears, he is to stop thrusting and both of you remain motionless. If necessary, the squeeze technique is to be used.
5) Only when the male can thrust freely, the female is to begin thrusting. If the urge appears, you are to stop thrusting and remain motionless. If necessary, the squeeze technique is to be applied.

When you can insert the penis and thrust freely without causing ejaculation, the female can thrust and mo e about so that she is stimulated to orgasm. If she has never achieved an orgasm during penile-vaginal intercourse, she should move about on the penis to explore and experiment with her physical sensations and find what stimulates her to orgasm. If at any time the male feels ejaculation coming, he should signal to the female and both of you should stop thrusting, and if necessary withdraw the penis and use the squeeze technique. After the female reaches orgasm, the male may ejaculate in thevagina. If you find that the female cannot reach orgasm, even after a considerable time in intercourse, the male should ejaculate if he wishes and if the female approves. The female can perhaps reach orgasm in another session when she is more relaxed.

Turn to page 35

The answers to this quiz are on page 54

Check your answer to each question before going on to the next.

Quiz 4

1. Equal control over ejaculation is provided by both the male-above and the female-above positions for intercourse _____

2. Rather than setting straight down on the penis when using the female-above position, the female should move back on the penis _____ .

3. The female-above position provides the male with ejaculatory control, but it makes the squeeze technique difficult to use _____

4. When the female is positioned over the male, she is to stimulate his penis to erection by bringing her vagina into contact with the penis _____.

5. As the penis is gradually inserted, both of you are to remain as motionless as possible and let the male become accustomed to the inside of the vagina. _____

6. When the penis can be kept inside the vagina without ejaculation occurring, the male should begin slight thrusting. _____

7. When he can keep his penis inserted without ejaculating while remaining motionless, the male can ejaculate in the vagina to reward your progress. _____

If you feel that you understand the material for phase three, follow the phase instructions in your private quarters. When you have completed your training session, turn to page 36 of the programme and follow the appropriate instructions.

Phase Three

Read the statements below and select the one that is most correct. Follow the instructions at the end of the statement.

Statement 1 We successfully used the female-above position and inserted the penis into the vagina without ejaculating prematurely. Turn to page 37.

Statement 2 Premature ejaculation occurred before, during, or after inserting the penis into the vagina. Turn to page 38

Phase Three

You chose Statement 1 We successfully used the female-above position and inserted the penis into the vagina.

Very good! You are doing well. When you are ready, return to your bedroom and again use the female-above position to insert the penis. But remember, take it easy, and GO SLOWLY. In this way you can avoid setting off ejaculation too soon. It is unlikely that you will have any trouble, but if ejaculation accidental y occurs, return to page 36 select the appropriate statement, and follow the instructions. Otherwise continue your sessions using the female-above position. Continue until the male can delay ejaculation long enough to satisfy the female. This may require several sessions. Then turn to phase four, page 39.

Phase Three

You chose Statement 2. Premature ejaculation occurred before, during, or after inserting the penis into the vagina.

Don't be unduly concerned that ejaculation occurred. You might keep in mind that your mistakes and failures during this programme are valuable learning experiences. When the male ejaculates accidentally, this means you are moving too quickly and providing too much stimulation. Think back and try to recall what caused him to ejaculate. Was the sight of the female's body too exciting? Did the sensations of the female holding the penis cause excitement to increase too fast? When the penis and vagina touched, were the sensations too stimulating? Or was it a combination of these that caused ejaculation?

Regardless of what evoked ejaculation you should take careful note of a few points;

1) as the female positions herself above the male, she is to avoid touching the penis or any other part of the male that might cause unintended ejaculation

2) The male is to notify the female any time that he feels ejaculation might occur. This might be as the female positions herself over him, as she stimulates the penis to erection, or as she inserts the penis. If signalled, she is to use the squeeze technique quickly to stop ejaculation.

3) Inserting the penis is to be done GRADUALLY. If you insert it too quickly, ejaculation may occur. So, GO SLOWLY. If the female has to apply the squeeze technique, wait until the ejaculatory urge has subsided completely, then begin again to GRADUALLY insert the penis.

4) If ejaculation occurs accidentally, don't be dismayed. Recall at what point in the process you moved too quickly, then start over again, knowing where you made your mistake, you will probably avoid making it again.

Whenever you both feel up to it, return to your private quarters for your next session. After your next session, return to page 36 and follow directions.

PHASE FOUR

Much of phase four is like the other phases. That is, in each training session you will begin with sensate focus exercises, you will stimulate the penis to erection several times and use the squeeze technique, and you will have intercourse in the female-above position.

When you began using the female-above position the male was not able to keep his penis in the vagina long without ejaculating. It was necessary for you to be in the female-above position; this allowed the female to take the penis out of her vagina quickly and apply the squeeze technique. But now the male should be able to delay ejaculation during intercourse in the female-above position. If not, go back to phase three and continue your sessions, using the female-above position until he can.

Ejaculation is less likely to occur than before, so you no longer need to use only the female-above position. You can now begin using the lateral position. By following a sequence of steps you will manoeuvre into this position from the female-above position. The sequence of steps is described below in the section on the Lateral Position for Intercourse. Take particular care in reading this section. The lateral position will allow you to satisfy yourselves sexually in a more free and easy manner. Many couples who have been clinically treated for sexual inadequacies, come to use the lateral position regularly - although eventually you will not have to if you do not wish.

In phase three we mentioned that the female-above position was one of the two best positions for providing ejaculatory control. The lateral position is the other of those two, and it provides maximum ejaculatory control.

As in the female-above position, the male can delay ejaculation when having intercourse in the lateral position. But in the lateral position when he feels ejaculation coming he can stop thrusting and control ejaculation more easily. yet keep his penis in the vagina and maintain a full erection.

This new skill can give the male great satisfaction, for he knows that he can provide the female with sexualgratification. And the female, aware of the male's new skill and his new self-confidence, can immerse herself in the pleasures of fulfilling her sexual desires. In the lateral position neither partner becomes tired from supporting his body weight. The position does not cramp or pin the pelvis, chest, or legs and arms This allows the female complete freedom in moving her pelvis thus she can relax and move spontaneously to stimulation from the male's penis and body.

In general then, the lateral position allows the male maximum control of ejaculation, and both of you maximum freedom to reach sexual satisfaction.

Carefully note the five steps below. Remember not to rush in reading the material; each point was written into this programme because it is essential to successful treatment. Also remember that these steps are not separate and distinct, but are parts of an on-going process. For example, you do not have to end sensate focussing formally before you get into the training position for ejaculatory control and use the squeeze technique. The transition from step to step can be done smoothly.

Sensate Focus

Do sensate focus exercises basically as you have in previous training sessions. In the sessions of this phase the female is to be touched first. But change places from being caressed to caressing as many times as you like.

During sensate focus the female is not to touch the male's genitals; but you may do anything else to sexually stimulate each other. For example, instead of touching primarily with your hands to arouse the other, you may want to use your trunk, arms, legs, lips, or tongue.

Training Position for Ejaculatory Control

When you end sensate focus, you are to place yourselves in the training position. If you need to, refer back to the description of this position on page 18 and to the diagram on page 20.

Squeeze Technique

The female is to stimulate the penis to full erection several times. At the first sign of ejaculation she is to apply the squeeze technique. This is to strengthen the male's confidence in his control over ejaculations. If the male does not feel the urge to ejaculate when the female has stimulated the penis for a while, then move on to step four.

Female-Above Position

When the female has used the squeeze technique a few times, causing the male to lose his urge to ejaculate, you are to get into the female-above position. When positioned over the male, the female is to move back on the penis and insert it into the vagina. If the male feels ejaculation coming, he should signal to the female and she is to rise from the penis and use the squeeze technique. If ejaculation does not threaten to occur both of you can move your bodies against each other if you like, enjoying the sensations of intercourse. The male is not to ejaculate in the vagina; when he feels the urge to ejaculate he is to signal to the female, and both of you are to cease thrusting. If this

does not stop ejaculation, the female may have to rise and apply the squeeze technique. Do not worry if control is sometimes a little shaky. It takes time to overcome a strong habit such as rapid ejaculation. Just be slow and careful in reading the programme and in your training sessions and you should succeed.

Lateral Position for Intercourse

When you have kept the penis in the vagina to your mutual satisfaction, you are to change from the female-above position to the lateral position. In changing positions carefully follow the steps below.

As in Figure 6, the male, with the female straddling him, lifts the female's right leg with his left hand. He moves his left leg to the outside from under her right leg. When he moves his leg to the left he is to bend it at the knee.

As the male lifts the female's right leg, she is to extend it back as in Figure 6. At the same time she leans forward against the male's chest. She then slides her trunk to the side of the male's bent knee (his left side).

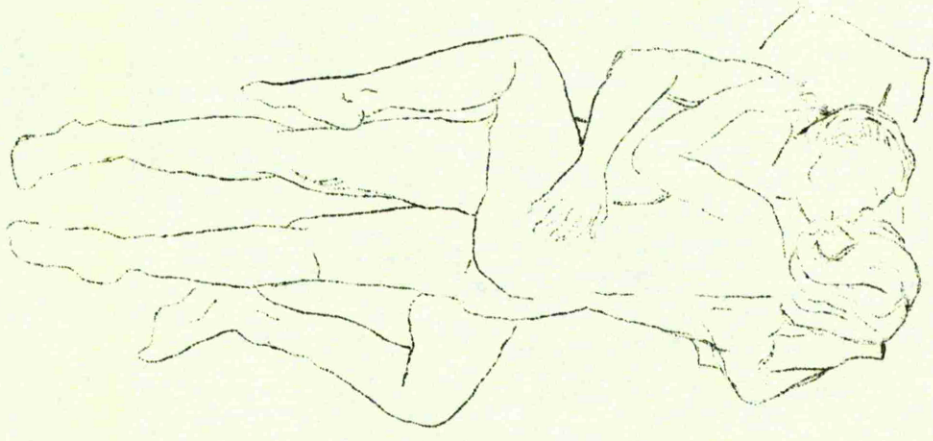


FIGURE 6

Sometimes there is a problem of what to do with the male's left arm and the female's right arm. To help in balancing your bodies you might both circle your arms (male's left, female's right) around a pillow placed just above the male's left shoulder at the female's head. The male can circle his arm under and around the pillow; the female can circle hers above and around.

An alternative is for the female to place her left hand under the male's neck. With her right hand she can clasp his left shoulder. The male can place his hands around the female's back, his left hand just below her shoulders, his right on her buttocks.

Wherever you place the male's left arm and the female's right arm, you will tend to use them for support. The female's left arm and the male's right arm will be free to caress and play with the other's body. This is one more advantage of the lateral position.

Getting into the lateral position may require a few practice runs. After sensate focussing in your next session, try it a few times without the penis inserted. Do not get into the female-above position; just place yourselves in the lateral position. Notice how it feels to lie with the female straddling the male's right leg.

Next, without the penis inserted, start from the female-above position and practise moving a few times into the lateral position. It is really very easy, but, to do it smoothly, practice is essential.

When you first try moving from the female-above position to the lateral position with the penis inserted, give yourselves a few practice trials. Get the feel of the sequence of steps and find what variation of the position is most comfortable for you. Remember that sex is an individual matter; even though basic instructions can be given, as with the lateral position, you must find <u>through experimenting</u> what modifications fit you best as a couple. So, try out the lateral position.

Your instructions for the training sessions are as follows: 1) do sensate focussing exercises; 2) get into the training position for ejaculatory control; 3) use the squeeze technique several times 4) insert the penis but do not ejaculate while in the female-above position; and 5) convert from the female-above position to the lateral position; have intercourse, and enjoy it.

When you have mastered the lateral position the male may ejaculate with his penis in the vagina. But he should delay ejaculation long enough for the female to be satisfied. If the first signs of ejaculation are felt before the female has been satisfied, the male can stop thrusting, yet leave his penis inserted, and delay his urge. The female can continue to move and thrust until she is fulfilled. Should her movements interfere with the male's control, she is to minimize these until he regains control. She can then move on to fulfill her needs.

With the control and freedom the lateral position provides, you can wholeheartedly express your love for each other. Free from the fear of rapid ejaculation you can both become more involved in the pleasures of giving and receiving sexually.

The answers to this quiz are on page 55

Check the answer to each question before going on to the next

Quiz 5

1. The lateral position for intercourse provides more control over ejaculation than any other position. _____
2. The steps in this phase should be carried out exactly as outlined, each step being fully executed and completed before moving onto the next step _____
3. When moving into the lateral position, the male lifts the female's right leg with his hand and moves his left leg to the outside of her right leg _____.
4. When in the lateral position, the female's left arm and the male's right arm will be free to caress and play with the other's body _____.
5. Before using the lateral position in your sessions, you should practise it without the penis inserted _____
6. Experimentation has shown that the lateral position should be practised exactly as described in this programme, variations of the position usually make control over ejaculation more difficult _____.
7. If ejaculation threatens while you are in the lateral position, you are to remove the penis immediately from the vagina and apply the squeeze technique _____.

If you feel that you understand the material for phase four, follow the phase instructions in your private quarters. When you have completed your training session, turn to page 45 of the programme and follow the appropriate instructions.

Phase Four

Choose the statement below that is most appropriate, and then turn to the page indicated at the end of the statement.

Statement 1 We successfully moved into the lateral position with the penis inserted. Turn to page 46

Stagement 2 We had difficulty assuming the lateral position, and/or ejaculation accidentally occurred. Turn to page 47

Phase Four

You chose Statement 1. We successfully moved into the lateral position with the penis inserted.

Good for you! You're now in the final phase of developing ejaculatory control. Practise using the lateral position for intercourse. The more you use it the more natural it will become, and the easier it will be to control ejaculation. During your next sessions use the lateral position. If you have any difficulties return to page to review your instructions. If things go well and they certainly should, continue using the lateral position uhtil you both feel confident while having intercourse.

Turn to page 48

Phase Four

You chose Statement 2. We had difficulty assuming the lateral position, and/or ejaculation accidentally occurred.

This is nothing to be seriously bothered about. The lateral position is sometimes a little difficult to learn, but it's not as hard as it may seem. As soon as you get into the swing of moving into the lateral position, it will be as easy as any other position.

When you return to your bedroom for your next session, practise moving into the lateral position. Move into it several times without the penis in the vagina; then practise with the penis inserted. Soon the position will become second nature to you, but you must familiarise yourself with it through practice.

If the male ejaculated while you were moving into the lateral position or after you got into the position, keep the following in mind. When the male ejaculates unintentionally, he has simply received too much stimulation too rapidly. This can easily happen during the process of changing from the female-above position to the lateral position. So, as you change positions, be conscious that the female, on signal from the male, may have to remove the penis and apply the squeeze technique. Also keep in mind that it may not be necessary to use the squeeze technique every time the male feels an ejaculatory urge. Sometimes you might stop thrusting or shift positions slightly to stop the urge. At other times you may have to separate from each other. In any case, when the urge appears, you should make some adjustment to reduce the stimulation that is causing the urge. DISCUSSION EXPERIMENTATION, and COOPERATION will help you learn what adjustments you must make. To make sure you have a clear understanding of what you are to do in the training sessions for this phase, turn to page 41 and reread the section on the lateral position for intercourse.

When you feel that you understand the instructions for use of the lateral position, return to your bedroom for your next session. After your session, return to page 45 and follow instructions.

Preventative Techniques

You have nearly completed the programme now, and the male has learned to control ejaculation. As we said earlier, premature ejaculation is a tough habit to break; it takes much practice to overcome it completely. Although the male now has good control, with more experience he will gain even more control.

For about a year after you have finished this programme the male at times may ejaculate too quickly. This is no cause for alarm, for he will not be losing the control he has so far gained It will only be the weakened traces of his rapid ejaculatory habit. Keep in mind that each time ejaculation is successfully delayed, strength is built up with which to control it. Over the period of a year or possibly much sooner, ejaculatory control will become a strong habit.

When ejaculatory control has become a strong habit, you will seldom have problems with premature ejaculation---except, of course, for occasional prematurity which almost all males experience (pages 1 and 2). Before the male has this strong control, he may sometimes ejaculate rapidly in a number of successive sexual sessions. If this happens his habit of quick ejaculation may build up strength. In this case you may have to repeat parts of this programme. This as you well know would involve a lot of work.

To make sure you continue to develop ejaculatory control (and simultaneously weaken the rapid ejaculatory habit) you are to use the techniques listed below. Study them, make sure you understand them, and refer back to them if necessary. If you do not use these techniques you may once more be troubled with premature ejaculation. Use them and you will certainly build stronger ejaculatory control.

There are four techniques:

Regular Sexual Activity

If the male does not have intercourse often enough (for him) he will tend to ejaculate rapidly when he does have intercourse. The male may avoid this rapid ejaculation merely by having intercourse more often.

To have sex regularly does not mean to set a special time of the day for intercourse and to not depart from that schedule. Sexual activity sho ld best occur spontaneously---when the urge strikes you. If your daily routine is such that you can not be spontaneous, then set a special time, but set a time when you can relax with the fewest possible distractions and immerse yourselves in the pleasure of sex.

Squeeze Technique Once a Week

For the first six months after completing this programme you are to use the squeeze technique (page 19) before intercourse at least once a week. After bringing the penis to erection the female is to apply the squeeze technique if the urge to ejaculate appears. Repeat the process several times. This will strengthen the male's ability to control ejaculation and increase his confidence. Over a period of months his control will grow until premature ejaculation is no longer a threat.

Squeeze Technique Sessions Once a Month

Once a month you are to have a session during which you spend from 15 to 30 minutes using the squeeze technique. Repeatedly the female is to stimulate the penis to erection and apply the squeeze technique so that the ejaculatory urge is lost.

If, therefore, you are unable to have intercourse regularly, use the squeeze technique several times before you do have intercourse. This will reinstate the strength of the male's control of ejaculation.

For best results you should do sensate focus exercises (page 10) for a while, both of you taking turns at caressing and being caressed. After getting into the training position for ejaculatory control (page 18), the female should several times bring the penis to erection and apply the squeeze technique. Next, you should get into the female-above position (page 31). The female should gradually insert the penis so as not to cause ejaculation. If, when the male begins thrusting, rapid ejaculation does not threaten, the female can also begin thrusting. When the male feels confident in his control, you can change to the lateral position (page 41 and allow yourselves free sexual and emotional expression.

If, for some reason, the male consistently ejaculates too rapidly, go back to the section on the squeeze technique (page 19). From this section, progress through the programme again according to instructions. If you employ the four techniques above you should have no trouble with premature ejaculation recurring.

The penis can be brought to erection and the squeeze technique applied numerous times during a 15 to 30 minute session. This will powerfully strengthen the male's control of ejaculation.

A good time for this session is during the female's menstrual period (the period during the month when blood is discharged from the female's vagina). If during the female's period you prefer not to have intercourse, the whole session can be devoted to use of the squeeze technique.

After Periods of No Intercourse

When you have intercourse for the first time for a week or so, you may find that the male ejaculates prematurely. Pelvic congestion will have built up and he will be highly sensitive to stimulation by the female. To keep down the congestion during the time you do not have intercourse, the male can masturbate, but unfortunately this will not eliminate the problems of rapid ejaculation. Merely by not having sex with the female often enough, the male will come to respond to her more quickly when you do have intercourse. This will occur even if he has masturbated during the period of no intercourse.

You may get the impression from the material above that you will be using the squeeze technique for the rest of your life. You will not if you do use it now while your ejaculatory control is shaky. Remember that earlier we said that premature ejaculation is a habit, a learned pattern of behaviour. As such, it can be unlearned, and a new pattern of behaviour namely greater ejaculatory control, can be acquired. But new behaviour is learned gradually and so you must persist for a while in your efforts. If you do persist in using the preventative techniques, you should soon feel the deep satisfaction that comes from sharing a mutually fulfilling sexual relationship. This satisfaction should then persist.

Answers for Quiz 1

1. For a number of reasons, most males ejaculate prematurely sometimes in their sex lives (True page 1)
2. In this programme, the couple has premature ejaculation if the male ejaculates too quickly in about 50 per cent of their attempts at intercourse (False page 2)
3. There is no scientific evidence that premature ejaculation is caused by an underlying mental illness. It is simply a learned habit (false page 2)
4. No matter how much or in what way a man masturbates, it seems to have no permanent bearing on his ability to control ejaculation (true page 3)
5. The male, just like the female may become highly sensitive to sexual stimulation if long periods ensue between his sexual experiences (true page 4).
6. The male must develop the habit of delaying ejaculation while engaged in sexual activities with the female. She must be present and she must co-operate or treatment will not succeed. (False, page 6)
7. The techniques in this programme have proven nearly 100 per cent successful. The only failures were with couples who lacked enough motivation, or/and who did not follow the instructions. (true, page 6)

Answers for Quiz 2

1. Sex too often will cause a reduction in the speed and intensity of your sex response. Not only may ejaculation occur less readily, but the penis may tend to erect less fully (False, page 8).
2. Mix unpleasant feelings with sexual activities and you will tend to associate these in the future. Mix pleasant feelings and sex and you will tend to associate these. Avoid having your sessions when either of you is tired, irritable, or rushed. (False, page 10)
3. Sensate focus exercises teach you to focus your attention on your physical reactions to touch. These are the most important ingredients in the enjoyment of sex. (True, page 10)
4. You should communicate to each other about what is pleasurable and not pleasurable to you. Though some talking cannot be avoided, most of this communication should be nonverbal, such as by facial expressions indicating pleasure (False, page 11).
5. Sensate focus exercises should be pleasurable; irritation and discomfort are to be avoided. Only by notifying your partner when he or she causes you discomfort can he or she learn to avoid doing so. (True, page 11).
6. You should be as comfortable as possible and enjoy yourselves. This may involve moving about freely on your bed, so do so if you wish. (False, page 12)
7. This early in the programme it is best that you do not have intercourse during your sessions. Just allow yourselves to be totally involved in touching and being touched. (False, page 12)

Answers for Quiz 3

1. When in the training position for ejaculatory control, the male's penis is directly in front of the female where she can easily reach it. She does not have to reach around his trunk. Refer to figure one on page 18. (false, page18)
2. Strong pressure applied to the wrong place on the penis will not stop ejaculation; neither will weak pressure when the fingers are placed correctly on the penis. It is necessary that strong pressure be applied with the fingers properly placed. (true, page 22)
3. The thumb is placed on the underside of the penis where the head and shaft intersect and the first two fingers are placed on the upperside of the penis; but these fingers should straddle the coronal ridge. See figures two and three on pages 19 and 20 . (False, page 20)
4. Strong pressure applied to the erect penis does not cause discomfort even if the fingers are not in the correct position. Experimentation with different amounts of pressure applied with her fingers in different positions should verify this for the female. (False, page 20)
5. If the squeeze technique is correctly applied upon the appearance of the first ejaculatory sensations, ejaculation usually will be stopped, but the technique must be applied immediately. (true, page 22)
6. By removing her hands from the penis the female avoids causing ejaculation by accidentally stimulating the penis
(true, page 22)
7. At this point in the programme it is best that the female does not bring the male to ejaculation. He probably would ejaculate quickly after the onset of stimulation and would strengthen his response of ejaculating quickly in the presence of the female (false, page 23)

Answers for Quiz 4

1. These two positions usually do not provide equal control. The male-above position provides the least ejaculatory control, especially for males who tend to ejaculate prematurely. The female-above position is one of the two that provides the best control. (False, page 30)
2. The male and female bodies are constructed in such a way that sitting straight down on the penis might make insertion difficult. Insertion is smooth when the female moves back and down on the penis. (true, page 30)
3. The female-above position provides the male with ejaculatory control and allows easy use of the squeeze technique. In this position the female can quickly rise from the penis and apply the squeeze technique (false, page 30)
4. Bringing the penis into contact with the vagina may set off ejaculation. The penis probably should be stimulated to erection with the hands and then gradually brought into contact with the vagina. (false, page 31)
5. By both of you remaining as motionless as possible, the male is allowed to experience having his penis in the vagina without much of the stimulations that normally triggers ejaculation. When he can keep his penis inserted without ejaculating, the husband may gradually start gentle thrusting (true, page 32)
6. If the penis is left in the vagina without movement, the lack of stimulation will eventually cause the penis to soften and the vagina to cease lubricating. To avoid these, the male should begin thrusting--but cautiously, to prevent ejaculation. (true, page 32)
7. The male should develop the habit of controlling ejaculation while both of you are thrusting. So he should ejaculate in the vagina only after both of you can thrust with the penis inserted. (false, page 34)

Answers for Quiz 5

1. In the lateral position the male can stop thrusting and easily control ejaculation, yet he can keep his penis in the vagina and maintain a full erection. No other position offers this advantage. (True, page 39)
2. The steps are not separate and distinct but are parts of an ongoing process. The transition from one step to another can be smooth. Each step should be taken, but a mechanical execution is not necessary. (false, page 40)
3. The purpose of this manoevre is to end up with the female's right leg between the male's two legs. As the male lifts her right leg, she should extend it back and lean her body forward against his chest. (True, page 41)
4. The male's left arm and the female's right arm will tend to be used for support. The male's right arm and the female's left arm will be uncramped and free to be moved as you wish (true, page 42).
5. The lateral position may seem awkward at first. But by lying in the position and by practising moving into it, you should become as comfortable with it as with any other position (true, page 42)
6. In most aspects of sexual activity you must find through experimentation what suits you best as a couple. This is true in the use of the lateral position. You may enjoy using the lateral position as we have described it, but you may find it desirable to use a variation of the position. Experimentation will tell (false, page 42)
7. In the lateral position the male can usually delay ejaculation by ceasing to thrust; he can leave his penis inserted and the female can continue to thrust and satisfy herself. Of course, if her movements interfere with the male's control over ejaculation, she should cease thrusting also, until the male's urge to ejaculate subsides. Sometimes it may be necessary to remove the penis and use the squeeze technique, but this should be the exception and not the rule. (false, page 43).

TREATMENT GUIDE FOR ERECTILE IMPOTENCE

INTRODUCTION

Among the most common of all sexual difficulties is that of erectile dysfunction. The precise nature of this problem may vary from one patient to the next. For example in some cases, the man may be unable to get an erection when he would like to or/and he may get one but be unable to keep an adequate erection for intercourse. Whatever the cause of the problem in the first place, it is clearly not surprising to find the problem itself in turn produces considerable emotional upset for both partners. Anxiety, guilt, frustration and anger are among the most common of these emotions with which the couple (but perhaps particularly the man) is presented. These feelings in most cases, serve to maintain or "feed" the problem and they are often most intense during sexual play.

Why sexual problems arise

Sex is a natural function like digestion - and like digestion, can be upset by a whole variety of problems, usually not involving physical disease.

We all accept that faulty eating, being rushed or under stress, anxious or uptight or in a bad mood can lead to a variety of complaints like loss of appetite, indigestion, diarrhoea or constipation even though your body is basically healthy. We also know that if we eat normally and in a relaxed way, our digestive systems work with no problems and no conscious effort on our part - and we enjoy our food.

In a similar way (though less understood by most people) if sex is allowed to happen naturally and in a relaxed way your body will respond normally without any conscious effort on your part.

Common examples of problems or situations that can upset this normal sexual responsiveness are as follows:

1. Misunderstandings or lack of information about sex - not knowing what to expect or how to act.
2. Bad feelings about sex or its consequences
   - fear of pregnancy, or pain - fear of being "caught", overheard or interrupted
   - fear of failing to perform "normally" or adequately
   - fear of losing control (becoming animal like, undignified, incontinent, unattractive)
   - fear of partner losing control
   - guilt (sex is wrong)
   - disgust (sex is dirty or messy)

3. Problems in the relationship
   feeling angry, bitter or resentful towards your partner
   feeling insecure and frightened of being hurt
4. Bad feelings about yourself
   feeling depressed, worthless, not deserving pleasure
   feeling unattractive, unhappy with one's body
5. Unsuitable circumstances
   too tired or hurried, or preoccupied with other things
   lack of comfort, warmth or privacy
6. Alcohol, some drugs or medicaments
   these can interfere with your normal responsiveness though only temporarily
7. Being in generally poor condition
   appetite for sex, like appetite for food, often (though not always) goes when you have been ill or had an accident. These senses gradually return as you gain health.

There are many other types of problems that might be relevant, but these are the most common and some of them may apply to you.

Why should the problem persist?

It could be argued however that more important than why the problem began is why the problem persists. The difficulty in getting an erection almost always makes a man and his partner anxious and upset. This is likely then to lead to a feeling that the problem will occur again and, with each failure, the anxiety increases. We know also that it is virtually impossible for a man who feels anxious in bed to get and keep an erection. He will probably try to force or "will" himself to get an erection. In so doing, his mind is focussed on his penis rather than on enjoying pleasurable sexual feelings in a relaxed and comfortable way. The longer his penis stays soft, the more tense he may become and the more he tries to fix his mind on forcing some sort of reponse. The situation in which he finds himself may be embarrassing to say the least. After all, many men may feel somehow they should be the more active partner or more dominant sexually; they may feel "less of a man" because of the difficulty since being able to function satisfactorily in bed they may feel is an essential part of "being a man". So a situation may develop rather rapidly in which his lowered self-esteem and self-confidence make him all the more eager for a prompt return to normal sexual functioning. His eagerness leads to tension,

anxiety, and a tendency perhaps to force or will an erection. It would be virtually impossible for any man under these circumstances to respond as he would like, but he does not think about that. He might struggle on, becoming more ill at ease, probably very angry, if not guilty. So develops what may seem an impossible vicious circle. Sex has become a nightmare and the simplest way out it seems is to (a) avoid sexual play and (b) not to talk about the problem. To do either might be too painful or uncomfortable for either partner.

Problems of the couple

You may well recognise some, if not all, of the above features in your relationship. Let's examine some of these in more detail.

Firstly, there is the tendency for the male in particular to come to set goals in his love-making. As soon as he and his partner begin to kiss and caress each other, he begins to feel tense; that he must get an erection, and, if he does not, sex will have been a failure. "Success" or "failure" is measured in terms of whether he has an erection that can be sustained for intercourse. Sex then becomes a performance, rather than something that is enjoyed purely for the pleasure it brings.

Secondly, as time passes, the male will begin to use an array of tactics to either produce or keep an erection. This is where the forcing or "willing" an erection comes into play. He may not believe at the time that any man would have similar difficulties in forcing such a response. However, he continues to try and continues to have difficulties. He becomes a sort of spectator to his own sexual play. It may seem as though he were involved but in a sense he feels apart from what is happening because most of the time is spent in watching and examining his own body's responses. We call this "spectatoring" and once it happens it can easily stop the normal body responses to physical contact. So a vicious circle develops - the more you watch, the worse it gets. You develop what may be called "performance anxiety".

This fact that the male is more detached and less involved in sexual play because of this spectator role will mean that he is "blocking off" necessary sexual stimulation and sexual pleasure. He is not concentrating on just enjoying pleasant feelings but is distracted by his conern for getting an erection. This distraction effectively puts a barrier down on any purely sexually pleasurable feelings.

Moreover, we know that during sexual play we respond to more than just touch or physical stimulation. All the senses are involved and contribute to our feeling sexy. The scent we wear, the way we move, sigh, the words we may speak, the glances we give, the feelings of warm, soft, moist - a whole range of cues of which we may not be consciously aware - all these, and more , are extremely important to our feeling and functioning sexually. If, then, the male (or the female) should be preoccupied with other matters, such as watching for or forcing an erection , not only do we not pick up these cues above but we do not give out any either. The net effect then is that neither partner is likely to receive much sexual pleasure.

Another factor which often comes into play here is a tendency for either or both of you to be thinking about the other rather than concentrating and abandoning yourself to the pleasant feelings you could experience. There is a tendency to have thoughts like "what does he or she think about me", etc. As you will see later, an important part of enjoying sexual play is to be "selfish" - in other words to focus our attention on getting pleasure for ourselves.

So, as time passes, sex becomes more and more frustrating and the problems just described seem to increase. The man and his partner slowly find themselves tumbling into a general breakdown of communication. She may tend to blame herself. She may feel he no longer finds her attractive, or that he has found another lover. Perhaps she feels that he is thoughtless and inconsiderate. Her attitude may change from warm and encouraging to harsh, resentful and hostile. The male may feel he has done his best. Seeing no improvement in sight, he worries more over his competence as a man. When nothing the couple does seems to help, they cease to discuss their problem, and communication breaks down.

If you have experienced any of the above, you will know the emotional pains they can produce. Reading, discussing, and following this programme should help you overcome these difficulties. But to do so, you both must work together. There is no such thing as an uninvolved partner. Perhaps your co-operation will be enhanced by considering the following points.

Points to remember

That you are reading this programme indicates that you both wish to overcome this difficulty. It is appropriate then to emphasise now a few points that should be kept in mind as you go through the programme. Your consideration and discussion of these

points may help reduce ill feelings and improve communication and ensure the success of your efforts.

Note to the female

The partner of the man with this problem may feel that she has been deprived of much sexual satisfaction. For this she may tend to blame him. He was not born with the problem however, and it may be viewed as a learned pattern of sexual behaviour. This means that through experience the male acquires a habit of responding in a particular way which is incompatible with getting and keeping an erection. He may not be aware of learning this, but to restore normal sexual functioning he will have to unlearn certain maladaptive tendencies. So it should be remembered then that you and your partner are both victims of this learning or conditioning over which he may have had no control. The male is the one with the symptom, but there is no such thing as an uninvolved partner sexually. Sexual intercourse cannot occur without a relationship and it is this relationship which is the focus of change not any one individual. Indeed, in most cases the woman shares some of her partner's anxieties and gets caught up in the spectator role too, with doubts of her own sexual ability. That is another important reason why we work with the couple.

By participating in the programme you may feel you are again giving. This may seem unfair to you. You may feel that you have given a great deal already and that you should now be receiving. Effective treatment however demands a co-operative female - one who is willing to give fully of herself. If you do not fill this requirement, treatment will not suceed.

Note to you both

You may be doubtful that the problem will ever be overcome. Perhaps you have tried many methods in the past, but to no avail. The techniques presented in this booklet have been widely used in clinical settings. Most couples who have been involved in this kind of therapy have improved. Those who improve least however generally fail to follow the advice. Therefore, your co-operation as a couple and your motivation to overcome your problem are absolutely essential.

General principles of treatment

It is usually possible to overcome the sexual difficulties if they are tackled in an approriate way. The approach is aimed at the following:

1. Getting you out of the "spectator" role.
2. Correcting any misunderstandings about sex in general and your sexual relationship in particular.
3. Helping to tackle the backround problems that were keeping the sexual difficulties going and in particular improving communication between you.
4. Allowing you to enjoy naturally your sexual relationship with each other.

Before explaining the stages of treatment in more detail it is important to spell out some general and basic pronciples first.

1. Treatment is aimed at the relationship or the couple, not at the individual. Both of you should understand and accept that there is "no such thing as an uninvolved partner". What you are asked to do affects both of you equally.

2. This approach is primarily a learning one. You are not being asked to "cure an illness". You will be helped however to learn new and more satisfactory ways of relating to each other. Like any other learning process, responsibility for change lies with you both. The booklet will advise and guide - you have to do the work. It may seem at first as though you are simply adhering to a prescription - making love to "doctor's orders". This is a temporary phase and normally such feelings tend to become much less marked after a short while. By reading the booklet carefully, and discussing together the advice, you'll see that the responsibility for change in fact really lies with you.

3. For these reasons you are taking on a big commitment if you are to make proper use of our help. It is important therefore that you are clear in your mind that you want to continue and improve your relationship with each other.

How often should we have sexual play?

You will be asked to set aside adequate time during the week to be together for physical and sexual contact with each other. Although the more spontaneous and natural these occassions are the better, you are asked to ensure that you keep three periods of at least half an hour for this purpose. During these times you need privacy (a lock on the door is not anti-social), comfort and warmth so that you can be undressed, and not unduly overheard so that you can talk or make noises as you feel like (if sound proofing is a problem, use some background music). It is quite important that during treatment that you try to maintain some continuity and therefore it is probably best that during this time you do not go on holiday (a week-end away can be valuable providing you are alone and not with friends), you do not have people to stay (the odd night doesn't matter), that neither of you has business trips or any other "major distraction" like moving house or changing jobs, etc. If it looks as though such things are bound to happen then it is better to delay treatment until you can ensure a period free from such distractions. You must think clearly about these major commitments before you decide to accept or begin treatment. If you do not you are much less likely to be helped.

4. As mentioned earlier, sexual problems often stem from other problems in the relationship and even when they don't, they may lead to other problems which not only spoil the relationship, but serve to keep the sexual difficulties going. It is therefore necessary to look carefully at your general relationship, particularly as it may affect your sexual relationship.

There are two aspects of relating which are important to sex, but if improved have more far reaching benefits. These are good communication and the use of positive rather than negative reinforcement.

Communication

It is never too late to learn new ways of communicating, however long you have been together. In our experience improved communication is essential if the sexual problem is to be resolved.

Here are some basic principles of communication which you must think about and discuss together:

(a) Aim to communicate together as two adults. In many marriages the husband may communicate like a father and the wife like a child; and in others the wife behaves like a mother to her husband who reacts like a son. Such "parent, wife and child" relationships do not promote or encourage healthy, adult, sexual responses.

(b) During the course of the programme, (and later, if you both find this helpful), teach yourself to "self-assert" and "self-protect" by using the expression "I would like" or "I feel that...." - instead of the more traditional "should we" or "would you like....?". The usual method of communication (often thought to be unselfish) is to think or guess what your partner would like, rather than putting your own wishes first. This pattern of communication can lead to all sorts of problems - you may always guess wrong and he or she has never liked to tell you for fear of hurting you (being unselfish again). In this way, long-standing assumptions about what each other likes or dislikes may be quite incorrect. A much safer and less complicated way to communicate is to express your <u>own</u> thoughts and feelings and ideas, and let your partner do the same. This keeps your own house in order by asserting and protecting yourself and lets your partner do the same, so that you are both equally represented and equally protected, yet all the guess work has gone out of your communication.

(c) Encourage your partner to use the term "I" and allow him or her to express feelings of hurt without your reacting too violently, and so discouraging self-expression. You are both entitled to your own feelings and should be allowed to express them freely. Having respect for your own and each other's feelings is crucial. Feelings are real things whether you think they are justified or not. If they are not dealt with, and that usually means by expressing them in a suitable way, they may become "bottled up" and can cause all sorts of havoc in a relationship.

(d) You will need to negotiate fairly on those occasions where each of you wants something different. For example, if you want black and the other wants white, you have both declared yourself, and rather than have grey each day, far better to have black one day and white the next.

Praise and encouragement (Positive reinforcement)
This works better than criticism. Work hard, noticing and commenting on the good things your partner does, as this will have a much more positive effect than nagging about the bad things.

All these points above then are extremely important to the success of your efforts. Please read and think about and discuss these points together. Now we can describe in more detail the different stages in lovemaking which you will be asked to go through during the course of your treatment.

Turn to page 10.

INSTRUCTIONS

Instructions are given throughout this programme to guide you through your self-treatment. It is critical to your success that you follow these instructions. Do not rush or skip ahead. Relax, go slowly, and enjoy yourselves.

At the end of each major section is a true and false quiz. your answers to this quiz will show you whether you understand the main points of the section. The correct answers are on the page indicated at the top of the quiz page. When taking a quiz, read a question, answer it true or false, and immediately (before moving to another question) turn to the answer page and check your answer. Should your answer be correct, feel confident that you understand the portion of the programme represented by the question. Turn back to the quiz and tackle the next question. Should your answer be incorrect, carefully read the explanation provided with the correct answer. After completing the quiz, follow the instructions at the end of the quiz page.

Throughout the programme are statements directing you to specific pages, such as "Turn to page 36." These statements direct you to parts of the programme you are to begin next.

You do not have to turn to the page immediately, although you may wish to. The statement may be regarded as a rest sign. You may put the programme aside and return to the specified page whenever you wish.

The Training Sessions

The training sessions of the programme are divided into five main phases. The written material for each phase explains and describes what you are to do in the training sessions for that phase. 1. In phase one you will do an exercise that will help you to relax and enjoy the sensations of touch. 2. In phase two, this relaxing non-demanding caressing may be extended to include more intimate contact. 3. In phase three, you will engage in a procedure aimed at lessening any fears that a lost erection cannot be regained. 4. In phase four, advice concerning vaginal entry is outlined. 5. Phase five includes advice about intercourse.

There is a natural tendency to go quickly through the programme. Of course, you want to finish the whole thing as soon as possible; but there may be dangers in rushing. Each and every step is recommended for a specific reason; each step must be taken in its turn. Rush and you may fail to take a step. Rush and you will put unnecessary pressure on yourselves. Thus, for the fastest progress, GO STEADILY AND SLOWLY!

By all means, have regular sessions : you should aim for at least three sessions a week. Do not rush things during your sessions, however.

In their sessions, some couples like to use a lubricant to increase the pleasure they get from caressing their partner. This serves to cut down any possible irritation and can feel and smell pleasant on the skin. If you wish to try this, you should have the bottle beside you before you start. Baby oil is a suitable one for the body as a whole or KY Lubricating Jelly for the genitals (penis or vagina). If you do not like using them, then that's O.K. It is a suggestion only as many couples find a lubricant very pleasant, others may not. Turn to page 12

Quiz 1

The answers to this quiz are on page 59

Check your answer to each question before going on to the next.

1. Erectile difficulties are a man's problem and so the woman should have no part to play in the treatment.

   True _____ False _____

2. Playing the 'spectator's role' is one of the most common reactions to a sexual problem and explains to a large extent why the difficulty continues.

   True _____ False _____

3. Masturbation is a common cause of sexual difficulty.

   True _____ False _____

4. A co-operative female is desirable but not essential in the treatment of erectile disorders.

   True _____ False _____

5. All most couples need do is to carry out the exercises and the problem will clear up.

   True _____ False _____

6. A conscious effort to get an erection is desirable during sexual play.

   True _____ False _____

PHASE ONE

Privacy and Comfort

You should have a room where you can be completely private (not necessarily the bedroom as it can often be helpful being away from the place associated in the past with problems). If you only feel comfortable and assured of privacy in the bedroom, then you should use it. If you have children or other potential distractions (e.g. dogs, cats) it may be necessary to arrange the sessions so that you will not be rushed or otherwise disturbed. Distractions should be minimised so that your full attention can be devoted to what you do.

You should never carry out any session when either of you feels tired, anxious, irritable or rushed. Both of you should feel comfortable with the place and time. These, clearly, are good rules for most sexual encounters.

Sensate Focus, without genital or breast contact - touching each other for your own pleasure.

Our main source of sexual stimulation is physical contact - touching and feeling. Without this source, most of us, male and female alike, would never reach high levels of sexual arousal. The more we feel sexually, the more aroused we will become and, consequently the more we will enjoy sex.

Physical contact with your partner is also the best means of sexual communication. There is no better way to find what physically excites your partner than to observe and feel his or her bodily responses to your touches. There is no better way to find what your physical preferences are than for your partner to stroke, fondle and caress your body.

Many couples do little touching before intercourse. Thus they deprive themselves of much stimulation and valuable communication with their partners. It is important then, that intimate bodily contact be a part of your sex life. For this reason, a part of this programme is devoted to getting you to think and feel physically.

To sharpen your touch sense, the first part of each session will be devoted to what is called "sensate focus". This is an activity in which both of you, one at a time, explore your physical reactions to touch.

Keep in mind that sensate focus exercises are to get you to thinking and feeling physically. Many of us in our culture have been affected to some degree by a touch taboo. In line with this taboo we express our feelings for one another in largely non-physical ways (for example, saying things that have special meaning). Certainly there is nothing wrong with non-physical expressions of feelings, but physical expressions are just as desirable, if not more so. And in sex, the most important form of expression is physical.

So this stage of the programme emphasises the importance of keeping safe within limits. You must agree between you to ban all attempts at intercourse or genital contact no matter what until you feel comfortable with this stage of the programme. This puts implicit trust on each partner to abide by this agreement and no attempt should be made by either of you to sabotage this trust. In this way then, there are no demands on your sexual play (probably for the first time in months or years), there are no goals or targets to reach. The ban on intimate play and on intercourse in the meantime eliminates any such pressures on "performance". No one should be concerned with trying to achieve or force an erection not just because you have already proved to yourself that that doesn't work, but also because it wouldn't work for any man. The bans mean that you do not have to try to prove anything. The male no longer need feel anxious in case he should disappoint his partner. Whether an erection is achieved or not is absolutely immaterial. It simply does not matter. Indeed, any man may not get an erection anyway with this first phase. So the bans then are essential if the 'spectator role' and 'performance anxiety' are to be reduced and eliminated. They remove any particular aim and allow you to experience new feelings and let physical contact become an end in itself.

How to start

Partner A (the male or the female) starts a session when he or she wants by saying to partner B "I would like to touch and caress you". Partner B can accept the offer or decline as he or she wishes. If B accepts the invitation, then the assumption is made that B will later in the same session want to caress A.

Let's imagine that Jim and Anne are a couple just like you. Jim has approached Anne and told her that he would like to caress her. She accepts.

In a warm room where they can enjoy complete privacy in a relaxing atmosphere, they remove all their clothes. Some clothes worn in a sexy way may be pleasing, but to avoid awkwardness and distractions it is better to start without clothes. Keep in mind that talking should be minimised - sensate focus is a physical experience.

Anne lies down on something comfortable. Her position does not matter: face up, back up, or side up - whichever she prefers. She is just to relax and be comfortable. She has two jobs. One, she is to give Jim verbal and/or physical directions. She may tell him what is pleasurable to her or show him by guiding his hands with hers. Two, she is to keep him from doing anything that is too irritating or uncomfortable. This is important. So PROTECT YOURSELF when being caressed, if you don't like what is being done to you (the easiest way to do this is to move your partner's hand elsewhere). You will need to recognise if and when you are 'spectatoring' which means watching your body being touched rather than abandoning yourself fully to the sensations that you are experiencing. Don't worry if this happens at first, you must learn to realise when you are doing it and learn ways to get out of it. There are two things to do - concentrate on relaxing your whole body and concentrate as well on the pleasurable feelings produced by your partner's touch. It may be necessary to ask your partner to stop caressing for a short time until you feel sufficiently relaxed and ready to start again.

So during this sensate focus phase, Anne let him stroke, rub, caress, massage those parts of her body that she liked to have touched. She just felt and thought of the pleasures of being caressed. She did not return the touching at this point and when it was spontaneous, she expressed - with her body or her voice - the pleasure she felt. She only did so, however when it seemed natural to do so.

It is not unusual to feel a little guilty about just lying quietly receiving pleasure. Somehow it is difficult not to give in return. Both of you will have your turn to give, but while you are receiving just become totally involved in what you feel.

While Jim was touching Anne, he got into a comfortable position close to her so that he was able to touch most of her body. He began lightly touching her body anywhere (and everywhere) except her genitals (the area of the vagina) and her breasts. Do not touch these parts of her body. At a later point in the programme you will stimulate each other there but there is muchto gain now by avoiding that kind of more intimate play.

If you are doing the caressing - ASSERT YOURSELF. This is what Jim did - he touched Anne where he wanted to touch (anywhere on the body except her breasts and genitals) in a way that was nice for him and for as long as he wished. He experimented a little and touched parts of the body he had not touched before and if he did anything or touched any part Anne did not care for she protected herself by showing him (not necessarily with words) what she preferred.

So, as the male's caressing, he touches where he wants (within the limits set) and observes her reactions to his touches. His other job is to explore his own pleasures in touching: he is to notice the sensations of rough and smooth, hard and soft, and warm and cool as he touches her body. He should focus his attention too on how he sees and hears her express pleasure (the way she moves, sighs etc.) and on other sensations from other senses (her scent, etc.)

Sensate Focus exercises are not intended to be structured. Both of you should be calm and comfortable and respond to your impulses to caress the other. When feeling and when touching, you may move freely on the bed. There is nothing specific that you must do, other than take turns in touching and observing and in feeling what it is to be loved physically.

After about fifteen minutes of the male touching and the female feeling, you are to change places. The male is to lie in any position he prefers and the female is to position herself so that she can easily stroke most of his body. Now it is the job of the male to feel and think of the pleasures of being touched. Also he is to keep the female from doing anything to him that causes discomfort. It is the job of the female to touch, to fondle and massage the male and to observe him for signs of pleasure. She is also to attend to her pleasures in touching. At this point the female is not to touch the male's genitals (his penis and testicles). After the female has caressed and massaged the male for about 15 minutes, you can hold each other together for a few moments if you wish. Do not attempt intercourse during or after sensate focus exercises.

It does not matter too much how long you continue sensate focus. The important thing is that you take turns (approximately equal lengths of time) giving and receiving physical expressions of love. If you do sensate focus in a comfortable, non-demanding manner, physical pleasure beyond those you have experienced before may emerge.

Important points for you both

1. It is nice to touch and feel close to your partner.
2. It is nice to see your partner enjoy being touched by you (when the one being touched somehow shows his or her pleasure, we get pleasure from giving it).
3. It's nice to be touched.
4. It's best to maintain continuity throughout this programme. So aim for at least three sessions a week (no more than one a day) taking it in turns to start the sessions with the initiator caressing first.
5. You may have to push yourself into starting a session, feeling little motivation or drive to begin with. This is a common experience partly because of the artificiality of the situation, partly because people feel a little embarressed and awkward at first and also perhaps because of long-standing resistance to body contact from previous experiences that have gone wrong. It is important then to see this as a stepping stone to a more spontaneous sexual relationship.
6. Some people find this stage pleasantly relaxing, others find it arousing. It really does not matter which. But it is important for you to recognise what you are feeling.
7. Some couples like to do sensate focus after they have had a bath together. Some couples like to lie down on a couple of towels in front of a fire. Some like to have baby oil on the fingers when caressing their partner. Some like to dim the lights etc. It really is up to you. These are not absolute "musts" but are mentioned only so that if you think they may help you to enjoy your sessions more and only if you feel comfortable doing them, then you should feel free to do so.

Turn to page 18

QUIZ 2

The answers to this quiz are on page 60

Check your answer to each question before going on to the next.

1. Sessions should be carried out when you are tired so that you can relax more easily.

   True _____ False _____

2. There must be something wrong with a man who cannot get an erection during sensate focus.

   True _____ False _____

3. The main aim of sensate focus is to get an erection.

   True _____ False _____

4. During sensate focus exercises you should talk as much as possible to convey to your partner what is most pleasurable to you.

   True _____ False _____

5. The partner being touched in sensate focus should let the touching partner know if he or she does anything irritating or bothersome.

   True _____ False _____

6. While involved in sensate focus you are to resist any impulse to move about on the bed, floor or whatever you are lying on.

   True _____ False _____

7. If sensate focus is pleasurable to both of you during a session, there is no reason why you should not have intercourse to strengthen your enjoyment.

   True _____ False _____

If you feel that you understand the material for phase one, follow the advice in your session together. When you have finished, turn to page 19 of the programme and follow the appropriate instructions.

Read the following statements and select the one which most clearly applies to you; turn to the page indicated after the statement you choose.

Statement 1 Our sensate focus session was pleasurable.
Turn to page 20

Statement 2 Our sensate focus was not especially pleasurable.
Turn to page 21

You chose Statement 1

Good! Sexual contact without goals or targets certainly can be very enjoyable. Sensate focus gives you a chance to enjoy pleasurable stimulation purely for its own sake.

An important point to remember is that it should not be considered abnormal or surprising for any man (including those who have never experienced any erection difficulties before) not to have or keep an erection during this phase. The degree of sexual stimulation is relatively mild. In any case, it is absolutely unimportant and irrelevant whether there was one or not. The main points here are (a) your enjoyment of this session (b) your giving up watching your own body's responses ("spectatoring") and thereby (c) being able to focus your attention purely on the pleasurable sensations you receive. Remember that the man has nothing to prove to his woman who knows anyway that his sexual potential is normal.

When you wish to have another session of love play, do the first phase of sensate focus again. If you will relax and be thoroughly involved in your own pleasurable feelings, this next session will be just as, if not even more enjoyable. After your session turn back to page 19, select the most appropriate statement and follow the directions. In all, you ought to have at least three pleasurable sessions at this phase in a row before skipping this page when directed to it and going on to page 23 instead.

You chose Statement 2

Sensate focussing can be highly pleasurable, but you didn't find your first experience to be so. Well, that's okay; it is not at all uncommon for people to feel awkward, uncomfortable or simply neutral when first trying sensate focus. A fairly typical reaction may be "It was a bit like making love to doctor's orders" or "It was a bit like doing homework". Such feelings are understandable. After all, there may have been little sexual contact just before seeking help. Now, suddenly, you're being asked to have some love play "to order", in a way and at a frequency you have not been used to.

Perhaps the woman thinks -"He didn't want to be close to me before, but now he does. He is just doing this now only because someone has told him to". Yet, you should both appreciate why you rarely had sexual play before you requested help. The most likely reason is that sex before now meant pressure on performing; it meant anger, frustration, guilt or shame when it didn't work out. The simplest thing to do, therefore, was to avoid sex; that way there would be no upset. This avoidance of sex, therefore, had probably nothing to do with the man's feelings for his wife whom he no doubt loved very much and still does.

You should realise too, that any feeling you have that this is 'artificial' or 'contrived' is common and that most people who do this, report that this feeling goes away after one or two sessions.

In the past, you have been in the habit of "spectatoring" - watching your body for a response. Any man or woman would have difficulty sexually if he did this. Both of you then should try to remember this important point: you are not doing sensate focus in order to get an erection. You are having sexual play in this way only to relearn to relax, and to concentrate on and enjoy pleasurable sensations. Whether an erection occurs or not is absolutely irrelevant, immaterial and unimportant. Besides, do not believe that there is something wrong if an erection does not occur.

A man who has never experienced any sexual problem, may not have an erection during these exercises.

Also carefully consider and discuss whether you conducted your sensate focus session according to these points.

(a) Your sessions should be at a time and place in which you feel comfortable.

(b) When being touched, let your partner know if he or she does anything that is unpleasant to you. Also, let him or her know what you particularly like. However, you should not be too concerned about directing your partner; just relax don't talk too much and fully concentrate on the pleasures of being touched. In other words, learn to be "selfish". Don't then think about what you believe is going through your partner's mind. As you show your pleasure, you'll be giving pleasure to your partner without even trying.

(c) When caressing your partner, observe closely what is pleasurable to him or her. Also note your own pleasurable feelings from touching.

(d) Sensate focussing is not intended to be structured. Do what the two of you like, whatever is pleasurable and enjoyable for you - except at this point, touching each other's genitals. Try to think of the advice here in terms of what not to do, rather than what you should specifically do.

(e) Be open with your feelings. Praise and encourage each other too, of course.

(f) Reread the earlier pages dealing with this phase.
When it is convenient, return to your room or wherever for your next session if you feel you understand each of the above points.
Also remember there is no reason to rush through the programme. Just make time for regular sessions - no fewer than three a week.
Take it easy and enjoy yourselves.

After your session, return to page 19 and follow the instructions.

PHASE TWO

Sensate focus involving any part of each other's body.
The ban on intercourse remains.

Through sensate focus you can become totally involved in the pleasant sensations of bodily contact for their own sake. Now that you feel easier and more comfortable with the first phase of sensate focus, you may feel that it's appropriate now to allow any part of each other's body to be caressed, touched or fondled.

The first phase of sensate focus you will recall was non-goal orientated. In other words, you touched only for the pleasure you got - no more, no less. Well the same applies now.

You may feel that it is all very well saying "Don't think about getting an erection". After all watching your body for a response ("spectatoring") may be a strongly ingrained habit. You may think that the main reason you as a couple are engaging in these sessions is so that the male may have an erection.

But to think those things would be to miss the point of the programme. The main purpose of the booklet and the advice within it is not to make the man produce erections. Nobody or no thing can do that. You both always must remember that. A penile erection will occur as naturally as breathing when you both learn (or relearn) to relax and focus your attention only on pleasurable feelings when you are together. When you enjoy what is happening in a relaxed, comfortable way without any pressure or demands (either from the female or the male himself) and when the degree of stimulation is sufficient, then an erection will occur. And it will occur without effort and when not waited for or expected.

So how can we help each other take the pressure off?

(a) Firstly by telling each other about the way you feel. If the man or the woman feels tense or ill at ease then do not bottle that feeling up inside: tell the other. Be open at all times.

(b) This kind of open communication takes the guess work out of the way you relate (see page 8). Afterall, what is really inhibiting with these kinds of problems is a tendency to think more about what you believe your partner to be thinking about. For example, the male may have thoughts like "She must think I'm odd or inadequate". Such thoughts are more often than not totally wrong. By being open with each other you correct these misconceptions. By being open, you can then be more "selfish" and simply allow yourselves to enjoy only your own pleasant feelings.

(c) Reassurance from the female that she is not going to be "disappointed" if an erection does not occur will help too. Again this involves "being open".

(d) Before your sexual play, both of you might tell each other that you would both be happy just to let your lovemaking extend only to giving each other pleasure, without intercourse: NO MATTER WHAT, obviously neither of you will know that you understand or accept this ban unless you tell each other.

So the advice given in this programme is to help you enjoy your lovemaking more. But they are not exercises to be followed mechanically like a car manual or a recipe book. You both must feel comfortable with them to enjoy them, and this comfort will be increased if you share your views together. That way pressures can be lifted.

In your next few sessions, exactly the same principles apply. A ban on intercourse continues but now contact with the female's breasts and genitals and the male's genitals is permitted.

Each session is divided into two parts - A caressing B, then B caressing A.

Sensate Focus with genital contact

With sensate focus you can become totally involved in the sensations of bodily contact in a non-demanding way (in other words when there are no goals). This total involvement is sure to increase the pleasures the two of you share. Now that you have used sensate focus and found it pleasurable you are ready to lift one of the bans. In this second phase, you may allow your sexual play to extend to caressing, fondling, and teasing the more intimate parts of each other's body. The male may now touch his partners's breasts and vagina and similarly the female can touch her partner's penis and testicles as a part of your non-demanding sex play.

The ban on intercourse remains, however.

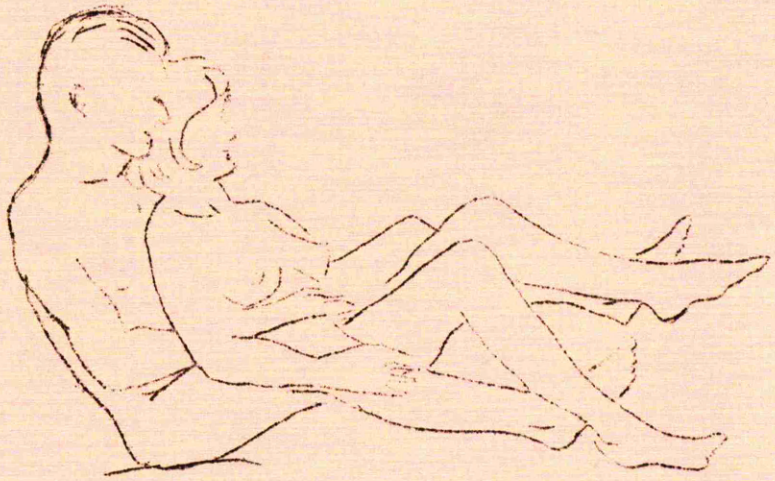
Each session should not, of course, begin with sexual stimulation of these more intimate parts but should always begin with caressing other parts (neck, back, etc.) as you did with the first stage of sensate focus. Instead, to start with, just consider the sessions, unless otherwise instructed, as just an extension of the first stage of sensate focus in which all parts of the body may now receive your partner's

non-demanding stimulation. You should "take turns" as before and again what you do sexually should be done primarily to give sexual pleasure to yourself. This of course applies to both the female and the male.

To enhance your pleasure and to minimise the possibility of irritation for either partner, you should have some Baby Oil or K.Y. Jelly near at hand to use when or if desired.

Positions to Adopt.

Now you are going to extend your sexual play to include the genital areas and the breasts. As for the other parts of the body, you should not assume before hand what is likely to please your partner. Discover together the best places and the best ways. For the woman giving pleasure to the man, include the genital area as part of the whole body. For the man pleasing the woman, it will be as well to arrange yourselves in an easy position for him to caress her genital area and breasts. At the same time she can easily direct his hand by laying hers above it. One possible position is shown below. Try this, but you may, of course, find another position of your own that you prefer.



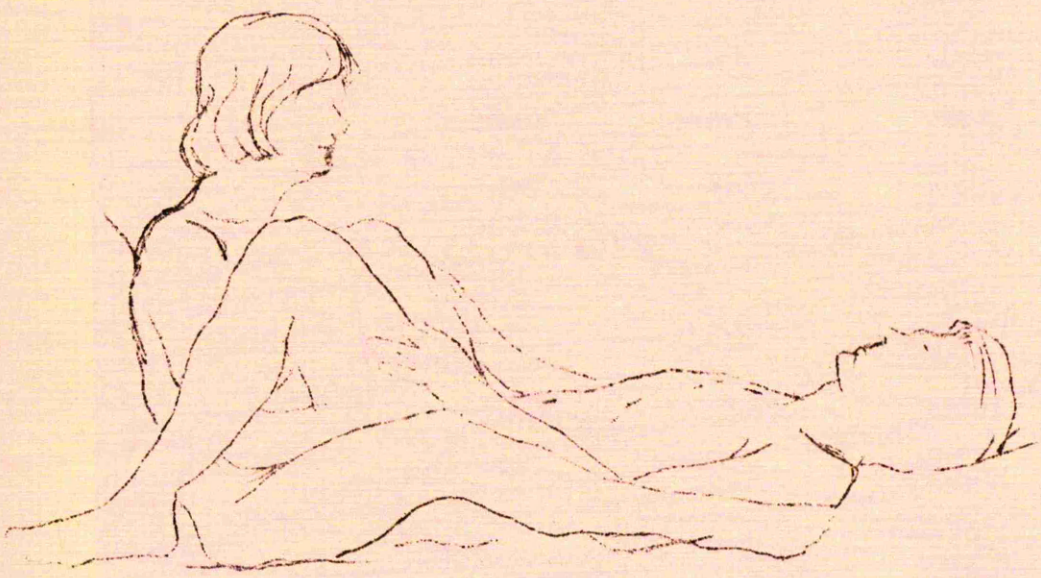
The woman's only responsibility is to enjoy the sensations she receives and to communicate somehow her desires and feelings to her partner. The aim is only to do that which gives you both pleasure and not to work specifically towards reaching a climax or towards attempting sexual intercourse. There is still a ban on sexual intercourse - no matter how "ready" either of you may feel. Remember, the idea at this phase is, as before, to give pleasure to each other but not to aim specifically toward deliberate masturbation or intercourse. This may seem rather unusual but as soon as targets, and goals are set too soon

in your sexual play, so the whole episode becomes a "performance" rather than something each of you does just for the pleasure it brings. In the past, sex has been a "performance" which has led to stress because of the goal of trying to achieve an erection. Let's at this point forget about that goal. It has been shown that we are more likely to enjoy ourselves sexually, and allow natural physical reactions to occur when we do not think too far ahead and when we engage in these exercises in a comfortable sexual atmosphere without any goals.

The man while pleasuring his partner should not make any assumptions about what is likely to please her. In particular, he should not approach her clitoris unless his partner directs him to it; when he does he will need some lubrication - either baby oil or possibly some natural lubrication from the entrance to the vagina. The man should caress and stroke his wife for as long as both enjoy it and as long as you feel is appropriate. Do not obviously continue until the point of displeasure or fatigue. If it seems appropriate and if both really want to the man may bring his wife to orgasm.

When it is the woman's turn to give pleasure to her partner, it then becomes his responsibility to communicate his likes and dislikes, both about the places caressed and the way they are touched. He should lay his hand loosely over hers and guide it. The use of Baby Oil can be particularly useful to enhance pleasure.

One possible position for this phase in which the woman caressess her partner is shown below, but you can change it if you find others you prefer. The female should sit with her back resting against something such as the headboard of the bed or a cushion against a wall or chair.



In this position the man can relax, and guide his partner's hands to the most pleasurable parts. He should not tolerate any discomfort but should show his wife the best way to touch and caress. For example, she may without realising it, pull his foreskin back too far, she may hold too tightly, etc. With communication, not necessarily with words, she can be shown the most pleasing methods. In this session she can tease, touch, caress, stroke the penis, the testicles and around the genital area. She need not spend all the time touching these parts but may move her fingers to other body parts and return to the genital area as she wishes. She should use Oil to increase the pleasure received. She may gently rub her husband's penis but not as though she is deliberately masturbating him. Again, the man should show his pleasure somehow when he finds something enjoyable. It can be arousing and satisfying for the "giver" to see the "receiver" enjoy this non-demanding stimulation.

Apart from communicating like this, the partner receiving pleasure should be as "selfish" as possible, concentrating only on the pleasant sensations he or she experiences at the time.

If the man is the one receiving stimulation he should not think about what he thinks his partner feels like, whether she is enjoying it or not etc. As he shows his pleasure he will inevitably be pleasing her. At this stage the woman should <u>not</u> give the impression that she is deliberately encouraging an erection. Nor should he think that she will be greatly disappointed if he doesn't. The only goal of this phase, like the first, is just to enjoy relaxing sexual play for its own sake. When you enjoy what is happening, physical responses will occur naturally and without effort.

An important point to remember is that in this phase the female should <u>not</u> feel she <u>must</u> spend all the time stimulating the man's penis. In the same way the man need not devote all the time to caressing her vagina. This phase simply allows contact with these parts which may be regarded as just other areas of our bodies that bring us pleasure. So you can touch them, move away and return to them as you wish and as you might with other parts.

So, if caressing a particular part (e.g. neck, scalp, vagina, penis etc.,) is enjoyable to your partner and yourself you will probably want to spend longer doing that - but don't feel you must spend all the time touching that one part.

Remember anyway, the one being caressed should "be selfish" and indicate what he likes, what he prefers etc. Only by this kind of communication and "self-protection", can we feel confident that we are doing what our partner really enjoys. Turn to page 28.

QUIZ 3

The answers to this quiz are on page 61

Check your answer to each question before going on to the next.

1. The goals of this phase are different from the first as the main aim now is for the man to have an erection.

   True _____ False _____

2. In this phase, the man should bring his partner to a climax.

   True _____ False _____

3. The woman may deliberately masturbate her partner with the intention of bringing him to a climax if she so wishes.

   True _____ False _____

4. In every respect this phase is the same as the first except that breasts and genitals may be included in your sexual play.

   True _____ False _____

5. In this phase it is not recommended that the woman caress and manipulate her partner's penis all the time to the exclusion of other body parts.

   True _____ False _____

6. If the male should have an erection, there is nothing wrong with it being used for intercourse.

   True _____ False _____

If you feel that you understand the material covered by these questions, follow the advice for this second phase during your next session. When you have completed your session, turn to page 29 and follow the instructions.

Read the statements below. Choose the one which applies and turn to the page indicated.

Statement 1

We did not find ourselves 'spectatoring'; we were both reasonably relaxed, and this phase of sexual play was highly pleasurable.

Turn to page 30

Statement 2

One or both of us found it difficult to give up 'spectatoring' during this phase and were rather tense. We therefore did not find it particularly pleasurable.

Turn to page 31

You chose statement 1

'Spectatoring' as you will know by now, refers to watching your own (or your partner's) body for a response (e.g. an erection). It is extremely unlikely that anyone - male or female - would respond sexually under such circumstances. 'Spectatoring' means not only having thoughts that are non-sexual but it means also that the individual is rather tense and uncomfortable - otherwise why do it.

So you did not find yourselves in the 'spectator role'? That really is a massive leap forward. For that, you as a couple deserve much praise and encouragement. It shows that you are communicating well. It shows you are 'being open' with each other. It shows you are more relaxed - and you are more relaxed because you (in particular the male) need no longer go to bed 'to try to prove something' - he doesn't have to worry about the possibility of intercourse not working out or of not getting an erection. Perhaps surprisingly, it will only be when he feels that the absence or presence of an erection really is not important, that it will return. So such feelings depend on open communication as a couple. This you have done. Again, well done.

Why not remain with the activities of this phase for a little longer? After all, it may be the first time in a while that you have enjoyed love play so much. But remember - erections only occur when you don't think about them. Never feel that because an erection occurred last time that it must occur again the next. Don't set targets like these.
Only after at least four enjoyable, relaxed sessions at this phase, in a row, should you skip this page when directed to it and turn to page 33 instead.

So stay with this phase for a little while and after each session, turn back to page 29 and choose the statement which applies.

You chose statement 2

It often is difficult at first to give up 'spectatoring'. So don't worry. Some couples find that the first phase goes alright because they don't feel any pressure on performing, in other words there's no pressure on having an erection. Now, suddenly you may feel that because you may touch the more intimate parts of your bodies that an erection should occur. Well let's remind ourselves of some important points.

1. An erection will occur only if you are relaxed and are concentrating only on the pleasant feelings you get from all the senses -from touch, from sounds and words, from the sight of your partner enjoying giving you pleasure, etc. If you are watching yourself and your body, you are not concentrating on these pleasurable feelings. The aim of this phase, like any other, is just to enjoy yourself - THAT'S ALL.
2. You can help yourselves to relax and concentrate only on pleasant feelings. How? By both of you realising that it may be quite normal for a man not to have an erection all the time. So the male did not have an erection. That does not matter at all. He can have one some other time. After all, he really does not have to prove anything to his partner. She will know he is a normal man, with an ability to respond with an erect penis as well as any man, that his ability has simply been masked or hampered. If we help lift that barrier, the ability will show itself. So just be patient. If the man is in any doubt, he can ask her. She will tell him that she knows he is no less of a man and that his sexual ability, which is normal, simply has a barrier down preventing its being expressed.
3. What is the barrier?
   The barrier is a number of things. The fear of not getting an erection. The fear of showing himself up as being inadequate. These fears lead to 'spectatoring' and trying to force a response. All these will never help. The female will tell her partner that she knows he is a normal man with a normal sexual ability that is simply not being allowed to express itself naturally.
4. What the man should know
   He should remember that his wife does not think less of him. He should remember that she knows that he can have an erection just like any other man and that there is no hurry. She will not be disappointed if it doesn't happen on any night.

She is not in any hurry.

If you as a couple talk about these things, you will realise that she really does feel that way about it.

5. What the female should know.

The man in this situation feels that if he doesn't have an erection you will think less of him. You will feel he is grossly inadequate and be really disappointed if he does not have an erection. You know that is nonsense - but he doesn't. Convince him that you will not be disappointed if he doesn't have an erection. Convince him that you don't think any less of him. Concince him that you are not in any hurry. You get your kicks from seeing him simply enjoying your caresses and touch - no more, no less. He also gets enormous pleasure from seeing and having you respond warmly to his touches. So always try to show your pleasure.

Always bear this in mind:

the aim of this phase is only to enjoy what you do together in a relaxed way. It is to give and receive pleasure purely for its own sake not to get an erection. If an erection does not occur then it doesn't matter. There is always another time to relax more and enjoy yourselves more. The ban on intercourse remains at this point - no matter what.

(Read again and discuss the other points in this booklet, pages 23 to 28. Make sure you know each other understands and accepts them before you start your next session.)

When you have finished, turn to page 29 choose the statement which applies and follow the instructions. Should you be directed to this page again, do not be disappointed. There is no hurry at all. Be patient and you will discover that this phase can be really enjoyable.

PHASE THREE

Now you are relearning to relax and really enjoy what you are doing together as a couple. This may well be the first time in a long while that you both have felt so good together. It certainly can be really nice just being able to relax together. The man will, or should, know by now that he has 'nothing to prove' to his partner. He never did have, except in his own mind. But he can be involved sexually now with more confidence. He will have found ways of overcoming the 'spectator role' and will by now feel that erections really do occur without trying - just as naturally as breathing - when he is relaxed and focussing only on pleasant feelings. Sex is a natural response if you let it happen.

Now this phase will involve caressing each other at the same time.

Sensate Focus with genital contact and caressing each other at the same time.

As caressing and genital contact become easier for both of you, you should now go on to simultaneous caressing so that both of you are giving and receiving pleasure at the same time. Remember all the principles you have already learned. In particular remember

1. Sex is a natural response if you let it happen.
2. Be on your guard for 'spectatoring'. If you feel yourself watching your body for a response - stop.
3. Communicate to your partner when she or he is doing some thing particularly nice for you. You need not use words, unless it feels natural to do so. Often our sighs, our movements and gestures can be just as clear.
4. Protect yourself if your partner does something you don't like. Show him or her what you do prefer.
5. Neither of you should go on to try intercourse yet. The ban therefore remains, regardless of whether an erection is present or not and regardless of how ready the female is. Please try to understand and accept that there is much to be gained at present from sex play without goals, without pressure, without demands.
6. Do try to have regular sessions - at least three each week. Never try to hurry progress.
7. The female should reassure her partner that she really is not impatient for intercourse. Be positive to each other -

show that you are enjoying what you are doing together.

If you feel that you understand these points then try to carry them out during your next session. Afterwards, turn to page 35 choose the statement that applies and follow directions from there.

Read the statements below. Choose the one which you think applies and turn to the page indicated.

Statement 1

We carried out this phase of caressing each other at the same time and both found it highly pleasurable.

Turn to Page 36

Statement 2

We carried out this phase of caressing each other at the same time but one or both of us found it difficult to give up "spectatoring". It was therefore not particularly pleasurable or satisfactory.

Turn to Page 37

You chose Statement 1

That really is very good and you should both feel very much more relaxed together now. You will know now then that, while secure with each other, when there are no pressures on "performing", that you can enjoy love play. When you enjoy sexual play without such demands, natural physical responses like a slight increase in heart rate, skin flush and the penis becoming hard will happen without any effort on the male's part. When we do make an effort, these changes do not occur.

Probably, by now, you will begin to feel a little impatient. The male may think he is letting his partner down by not going on to have intercourse. He may think it is a "waste" of an erection. Why not use it ? That question could be answered with another question. "Do you feel you must use it"? Of course, intercourse can be very exciting, but so too is caressing, stroking and fondling each other. There is always another time to have intercourse - besides, the woman is not impatient for intercourse. It's just that the man thinks she is and so puts pressure on himself.

Now you should turn to page 38 and read about the "stop-start" procedure. During your next session you should carry this out together.

You chose Statement 2

You found that your session was not as enjoyable as previous ones. Well, don't worry. That's the same for us all. Some sessions are really good, and others are not so good.

Were you too tired ? Were you comfortable with the place and time ? Did either of you feel that because an erection occurred last time, that another just had to be achieved in this session ? Always bear in mind that the aim of the booklet is to help you enjoy love play. No one, including yourselves, can make you get erections in a direct way. They happen when you are relaxed and enjoying sex play.

So give some thought to why you found it less enjoyable.

Were you impatient for intercourse ? Did the male feel he would be letting his partner down if he didn't get an erection ?

Were you "spectatoring"?

Did you both agree not to have intercourse, regardless of how each of you felt ?

Were you simply tired ?

Did you find yourself worrying about what your partner was thinking rather than being more "selfish" ? If so, each of you should be open with ech other. Reward each other too for the nice feelings he or she gives you.

Do please read again pages 33 to 34. Talk about how you felt and how you might make your time together less threatening or anxiety arousing.

After your next session turn to page 35 choose whichever statement applies and follow directions from there.

'STOP START' PROCEDURE

Before going on to the fourth phase - namely, entry into the vagina, many couples find this procedure to be very helpful. The aim of the procedure is to help the couple (but particularly the man) who thinks along the following lines - "I feel fine when I have an erection. But I'm concerned I might lose my erection. If I do lose it, then I will be worried in case it doesn't come back again."

You will probably appreciate now, if these fears exist, why it is best to overcome them before going on to entry into the vagina Like before, the very fact that you have these fears may make it more likely - not less likely - that you may indeed lose an erection and that you may have difficulty in regaining it.

The 'stop-start' game can be fun. What you should do is this:-

1. Carry out sensate focus exercises as before.

2. Allow sensate focus to include genital and breast contact just as you have done before. Of course, the ban on intercourse continues - no matter what.

3. You can spend as long as you wish at this stage - taking turns as before or doing this together at the same time if you prefer.

4. After the male partner has had a reasonably firm erection for a little while (about 2 or 3 minutes or so) then you should stop all sexual contact. For example, you could lie back to back, avoid all physical contact, even think of tomorrow's lunch or yesterday's football match! But don't stimulate each other with caresses, words, etc. In other words, you should deliberately stop all sexual contact to allow your sexual arousal to drop.

5. When each of you no longer feels sexy and this will mean when an erection has gone and when the woman's vagina has become a bit dry - then you can start sensate focus again.

6. Now the man may really feel at first that his sexual performance is under scrutiny. Of course it will not be. He may be concerned in case his erection does not quickly return. But no man's erection would quickly return. He may find himself spectating again - watching his body for a response - and trying to will or force an erection.

So let's examine these points once again.

Remember any man would have problems in getting an erection when he tries to force or will one. You have learned already that you do enjoy sexual play more and that erections occur when you don't think about them, and when you relax and when you communicate your pleasures to each other.

Remember, there is no reason why an erection deliberately lost cannot return when each of you relaxes and concentrates only on giving each other pleasure for its own sake.

Remember, any man's penis varies in firmness during sexual play. It may be quite normal for the man's penis to be perhaps completely soft at some point during sexual play. In almost every case it returns in its own time - never when rushed. So never time yourself. Your sexual enjoyment will increase (and with it the man's erection) under the same relaxing conditions that brought it in the first place. But the chances are that you won't become excited immediately you restart - that is normal. It takes time - so relax. The female should reassure her man that she simply enjoys his touches. She should show her enjoyment openly.

In any one session don't carry out this stop-start procedure any more than once - otherwise you may find you just get tired of it. Have at least a couple of sessions with this technique, however, so that you both can feel more confident that an erection lost, can return.

Study these points and discuss them. If you feel you understand them try to carry out this advice in your next session. Then turn to page 41

Choose the statement that applies and turn to the page indicated.

Statement 1

We carried out the 'stop-start' procedure and an erection returned when sexual play began again.

Turn to page 42

Statement 2

We carried out the 'stop-start' procedure but we did not become aroused when sexual play began again.

Turn to page 43

You Chose Statement 1

That's really good. Knowing that an erection deliberately lost can return is an enormous boost to confidence. After all, you possibly were tempted to try to "force" it back again, to "spectate" - in fact, to do all the things which you used to do and which really don't work at all. Learning to relax with the female partner and learning to observe her expressions of pleasure are important. Both of you should always show your pleasure. Seeing someone enjoy our touches, etc., can be very exciting.

Have another session of this stop start procedure and should you be directed to this page again then turn instead to page 44 and follow directions from there.

You Chose Statement 2

The reasons it did not work out particularly well when you began sexual play again may be quite straightforward. The most likely one is that the male was so desperate to get his erection back again that he became impatient and started to spectate on his own sexual play. He began to watch his own body for a response, etc. 'Performance anxiety' flooded back again.

When he worries like that, his anxiety in itself makes it impossible for him to become excited sexually. It also means that he "blocks off" all the sexy things that are happening around him and his own sexy thoughts.

So let's again discuss a few important reminders.

1. A man and a woman respond to each other - to our words, movements, sighs, gestures, caresses, kisses, attractive perfumes, clothing, etc., So if we enjoy something, SHOW IT. Just as a woman who is caressing her man, seeing, feeling, listening to her partner's expressions of enjoys pleasure, so too does a man. Each of you then should always express your pleasure. In that way, you really can make your partner feel ten feet tall.

2. Check yourself out of 'spectating.'

3. Any man will find that his erection will probably not return immediately - so don't be impatient.

4. Relax and try to restart with the same attitude as you started the session with.

5. Never start these sessions when either of you is tired.

6. Erections vary in strength for any man throughout any one session and from session to session. At certain moments the penis may be soft - at others firm.

Think about and discuss these points before your next session and try the 'stop-start' procedure again. Then turn to page 41, choose the statement which applies and follow directions from there.

PHASE FOUR

By now you both will be learning to get more out of your sexual play. You willhave learned that it can be really enjoyable just relaxing and enjoying this kind of sexual "give and take" for its own sake. With this increased enjoyment, the male will now be getting reasonably firm erections. He will have learned too that they occur only when he doesn't try to get them.

So when you have reached this stage you are ready to go on to entering the vagina.

The aim of this stage is not to proceed with intercourse but just for both of you to get used to the penis inside the vagina for a short while. On no account should either of you go on to try to complete intercourse.

So, as before, this phase is designed to allow you freedom to experience sensations of physical contact with each other without performance anxiety i.e. fear of failure to achieve a particular goal. You should begin your sessions in this phase just as you did in the last. In other words, you continue with a spell of mutual caressing - including any parts of each other's body that you know gives pleasure first of all to yourself. In other words, the male does whatever he wants to his partner to give pleasure principally to himself and the female does what she wants to him first and foremost for the pleasure it gives her.

Again, as before, each of you can protect him or herself if one's partner does anything irritating or bothersome. Or if there is some form of caressing or some part of the body you would prefer to have caressed, stroked or fondled you can indicate this to your partner So, there is absolutely nothing new, so far. The male and female should just concentrate only on the nice feelings you experience at the time.

If an erection does occur - fine. If not, don't worry - there's always another night. Don't think about your own body's responses ("spectatoring") and never feel you must get an erection and then try to force one. As mentioned earlier, if one does not occur then that's alright -- you will know that there's another time.

Just as suggested earlier, you can use baby oil or KY jelly to enhance your pleasure with genital stimulation if you want.

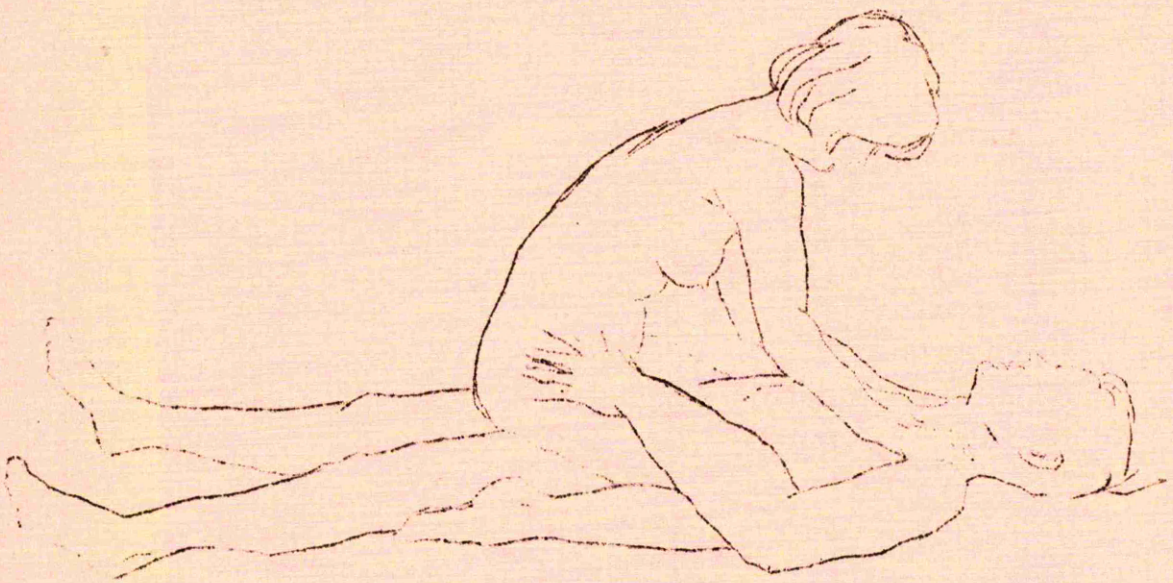
Entering the Vagina.

When you have carried out sensate focus with genital stimulation for a spell and when both of you are ready, the female should invite

The woman feels ready (when her vagina is wet with its own lubricant) and when the male has a reasonably firm erection. There is no need to do this immediately he gets an adequte erection, unless you both really want to.

What postion may be best for this ?

The position most couples find easiest for penis entry is that shown below. The female positions herself above the male who lies on his back. Immediately after she moves into this position, it might be best if she spends a little time caressing and stroking his penis first before guiding the penis inside. This is simply because the time taken to move into this position may be distracting for both of you and may lead to a slight drop in sexual arousal. It may not, of course, but in any case there really is no hurry. Wait until you're both ready.



As you can see from the illustration, the woman's knees should be roughly in line with his nipples. In this position, she can be in control of entry. After all, she knows exactly where the penis goes and it would not be uncommon for even the most experienced man to have difficulty in finding exactly the vaginal entrance. Besides, most women enjoy helping in this way. After all, it is surely a myth that sex is only the man's responsibility.

So when you both want she can guide his penis into her vagina, by moving back on the penis rather than sitting straight down on it. Neither of you should make any thrusting movements yet.

What is the aim of this stage ?

The only aim of this phase is to re-acquaint yourselves with the feelings of a penis inside the vagina. Do not complete intercourse. You must both accept this. There's plenty of time to enjoy full intercourse later.

With the penis inside, the woman should tighten and relax her vaginal muscles on the penis, which she may or may not be able to feel once it is inside the vagina. This will be because of the lack of movement.

For the man's part, he should try to relax and to concentrate only on the pleasurable feelings he gets from his genital region - the warmth, the moistness and his partner's vaginal muscles tighten round his penis. Remember, the female will be concentrating only on the nice feelings she gets. The man therefore should not be distracted by any concern for what he believes might be going through her mind. Each of you then should be "selfish". Do not start any thrusting movements.

Because the penis may be receiving little direct stimulation from this activity, it would not be abnormal for the erection to get less.

If you wish, you can start some genital caressing again and perhaps repeat entry into the vagina.

How long should entry last ?

To begin with, you should allow the penis to remain in the vagina for a brief period (around 15 seconds). The length of time you keep it inside can be gradually lengthened in each session But to start with, it's best not to set goals that may make either of you too anxious.

What if the male ejaculates inside ?

Then that's O.K. Don't worry about it. You may find that as you have more sessions like this that you'll feel more sure of yourself and be better prepared for intercourse.

Don't set goals

Throughout this booklet, certain really important points have been stressed. The bans that you have both agreed to follow have been there to help abolish any goals or aims that probably made you feel anxious. Goals of any sort usually do make us feel anxious in case we don't achieve them.

Do please remember - at this stage there are still no goals.

(a) You are not to thrust - either of you.

(b) You are not to try and keep the penis inside for as long as possible.

(c) You are not to try to produce a climax (in either the male or the female.)

Be content with getting used to the penis entering and remaining in the vagina for a short time.

What if either of you does not like the female-above position ?

Some couples find the female-above position offensive. They refuse to use it for reasons such as "It somehow makes the man less manly or the woman less womanly". If, for one reason or another you do not wish to use the female-above position , you should try another. But the position you do choose ideally should be one which offers similar advantages.

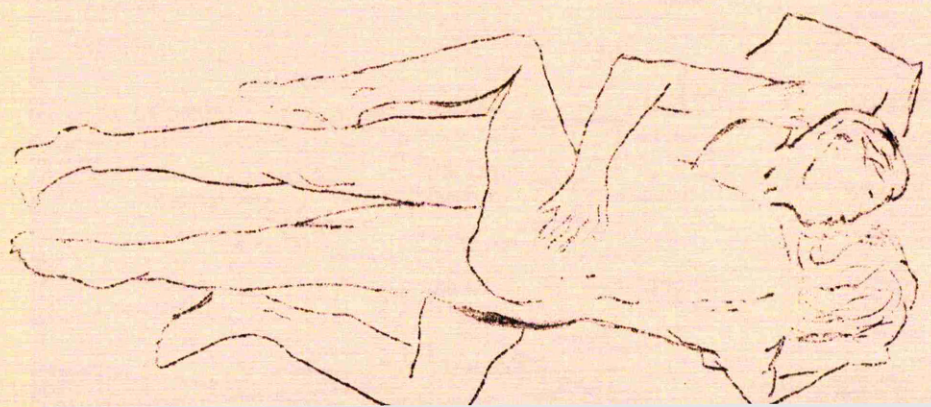
What are the advantages of the female-above position ?

(a) It allows the female partner to be more in control of entry. There is absolutely nothing wrong with allowing a woman to help in this way and, besides, they usually prefer it.

(b) It allows the male to caress and stroke his partner comfortably at the same time. For example, there is easy access to her breasts, her vagina etc.

What other position is there ?

One other position which you may prefer - but only if you don't like the female above - is the so-called "lateral" position. That is one in which each of you lies on your sides. (see below). As you can see, the female straddles the male's right leg. Sometimes there is a problem of what to do with the male's left arm and the female's right arm. To help in balancing your bodies you might both circle your arms (male's left and female's right) around a pillow placed just above the male's left shoulder. That is only a suggestion as it is really up to the couple to find what really suits them.



This position, though it may seem a bit awkward, still allows for both to have reasonable control over entry. However, the female-above position is the one that most couples prefer and perhaps ought to be tried first.

Turn to page 49

QUIZ 4

The answers to this quiz are on page 62
Check your answer to each question before going on to the next.

1. This phase is about encouraging you to complete intercourse.
   True_____ False_____

2. As soon as the male gets a reasonably firm erection you should proceed with entry into the vagina.
   True_____ False_____

3. KY jelly or baby oil is useful for both partners during your genital play.
   True_____ False_____

4. When the female moves in to the female above position she should insert his penis quickly incase he loses it.
   True_____ False_____

5. It may be quite common for a man to ejaculate soon after entry.
   True_____ False_____

6. To begin with, the longer the female contains the penis the better.
   True_____ False_____

7. If the man should lose his erection after entry you may if you wish go back to genital caressing and repeat the process.
   True_____ False_____

If you both feel that you understand the material for this phase, follow the advice in your next session. Then turn to page 50 choose the statement which applies and follow instructions.

Read the statements below. Choose the one that applies and turn to the page indicated.

Statement 1

We enjoyed caressing each other, and the erect penis entered the vagina satisfactorily. The penis remained reasonably firm while inside.

Turn to page 51

Statement 2

We enjoyed caressing each other and the erect penis entered the vagina satisfactorily. The erection was lost while inside.

Turn to page 52

Statement 3

We enjoyed caressing each other and the erect penis entered the vagina satisfactorily. The male ejaculated almost immediately after entry.

Turn to page 54

Statement 4

The male either did not get an adequate erection during love play or it did not remain sufficiently firm to allow entry into the vagina.

Turn to page 55

You chose statement 1.

That's great. Again this progress just underlines how well you have been co-operating together. All that remains now is for you both to remain patient. Erection difficulties are no longer a problem in so far as you know now how to help yourselves overcome them. However, in your next session, follow the same advice again. You could also try a series of entries perhaps two or three, then turn back to page 50 choose the statement that applies and follow instructions from there. All being well, and it probably will be, skip this page when directed to it and turn instead to page 57

You chose Statement 2

Don't think that something really terrible has happened. On the contrary, there are a number of perfectly logical reasons why the erection was lost. Indeed, many men, even those who have never experienced any difficulties before might lose an erection under similar circumstances. The most likely reasons are any one or a combination of the following.

1. Perhaps just a bit of "spectatoring" because what you were doing was new to you. You hadn't experienced entry for some time and it possibly made you all the more determined that it be successful.

2. The penis was kept inside just a bit too long without additional stimulation.

3. The absence of thrusting movements meant that the male or female lost a bit of interest or didn't feel much.

4. A factor still very much involved for the man may be this - I feel really good when an erection is present but I still have this fear that if it goes away, I won't get it back again.

Now it is quite easy to see how this kind of fear can become a self-fulfilling prohecy. In other words, the fact that he has this fear makes the likelihood of that fear being confirmed much greater. He has the fear and so it probably will happen. So in a situation in which the man thinks that the present erection may be his last - How can you get round this ?

The "Stop-Start" technique.

First of all, for a night or two forget about entering the vagina. Just be content with mutual caressing without any particular goal in mind - in dher words, caress, stoke and fondle each other purely for the pleasure it gives you both. As you have done this before and found it relaxing and enjoyable the male may at some point get an erection. When the male has had an erection for a little while she should stop caressing his penis. Infact both of you can stop all sexual play for a while to allow your sexual feelings to drop. The erection will go away and the vagina too will probably stop becoming wet. Then when both of you have stopped all sexual contact for a little while, you can then start your caressing again. Now, neither of you should believe that there will be a sudden and rapid return of sexual arousal. There probably won't be, but as you continue to "be selfish" and concentrate on relaxing and enjoying nice feelings while being caressed your body's sexual responses will

return. But don't go on to vaginal entry until the male becomes more confident that any erection lost can come back again.

It will return, but never if forced; never if the male watches himself or his penis; never if he puts pressure on himself e.g. if he thinks his partner will be so disappointed if it doesn't etc.

It will return, if both of you engage in sensate focus, caressing each other in the same frame of mind as before. So don't put pressure on each other. Relax and enjoy your love play.

So try the "Stop-Start" technique for as often as it takes for the male to feel more confident that erections can return.

Try to follow this advice in your next session. Afterwards, turn back to page 50, choose the statement which now applies and follow directions from there.

You Chose Statement 3

Don't worry if the male reached a climax very soon after entry. Almost all men tend to ejaculate quicker than they would like after a spell without sexual release. A certain amount of tension in the situation may also sometimes make ejaculation occur more quickly. But often the most likely explanation is the fact that the man has not experienced intercourse for a while and so becomes excited much more easily. One would therefore expect that that would resolve itself with time, patience and more frequent sexual relations. In fact, often that is all that is necessary. So just relax. Don't be concerned, either of you, if to begin with ejaculation occurs quite soon after entry. After a few weeks, that will probably be less of a problem.

Have another session at this stage. Be content, for the time being just to get used to a series of entries into the vagina (perhaps about two or three in a session) gradually increasing the length of time inside if you wish. The woman can tighten her vaginal muscles a little around the penis and move very gently on it. Don't feel there should be an immediate start to more vigorous thrusting by either of you, however.

Go back to page 50 afterwards and choose the statement that applies. Should it be this one again. Don't be concerned. Remember, rapid ejaculation may well sort itself out with time and more frequent practice. When you feel more comfortable with this phase turn instead to page 57

You Chose Statement 4

You will probably be aware of the most likely reasons for the difficulty in enjoying your love play on this occasion. For the first time in the programme, entry into the vagina has been suggested. Suddenly, the man (and the woman too) may feel that this is the big moment. This is what the programme has been all about. Yet it is not really. There is still a ban on intercourse. Vaginal entry is as far as you should go. So the emphasis again really is on what you should not do. Take your time, The man has nothing to prove to his partner. She knows he can get and keep an erection. He should continue to focus on what he finds pleasurable. This will be the nice feelings he gets from touching her; the nice feelings he gets from being touched; how good it feels to see her enjoying herself (so again she should show her pleasure and he should show his -- that way you feed each other 's enjoyment).

It may help if she strokes K.Y. Jelly or Baby Oil on his penis. With the oil on her hand, it will feel more like the inside of the vagina and so prepare him for entry.

Don't rush into directing the penis inside. Once the woman is in the female-above position she should spend a little while caressing and stroking her partner first, wherever she and he likes. If there is no erection, never mind. There's always another day.

Never think ahead. Just try to "live for the moment" as it were. If you aim only to enjoy your sessions (and not aim to get or keep an erection) you are much more likely to become sexually aroused.

The man should not be concerned about hurting his partner during entry. After all, she will 'protect herself' if there is anything she doesn't like. So again 'be selfish.'

Let the woman guide and control entry. It can be distracting for a man to have to search for the vaginal opening. There is nothing unusual with the woman doing this even in the most experienced partnership. With the woman controlling entry, this leaves the man free to relax and enjoy pleasurable feelings.

If the man should lose his erection just before entry, then he knows anyway that lost erections can return (from the 'stop-start' procedure). Both could start sensate focus again and try entry again when his erection returns a few minutes later.

At the end of your session, turn to page 50, choose the statement which applies and follow the appropriate directions. Should you be directed to this page again, then spend another session or two with the stop-start procedure. If you both do this again, then you can become more confident again that lost erections can return. This will prepare you both for vaginal entry on another day.

PHASE FIVE

It is important to stress again at this point that you use the same principles concerning your physical contact with each other as you used right at the start. You should be touching and being touched in a way that is pleasant for both of you and with no particular goal or performance in mind other than that of giving and receiving pleasure.

As before, start with caressing each other involving both non-genital (e.g. back, neck, arms etc) and genital areas (penis, vagina) in a way that feels good for both of you. Although the man may have an erection fairly quickly it is important that both of you should feel aroused and ready for intercourse before vaginal entry takes place.

You will remember that the female-above position (see page 45) does offer several advantages over others at this stage and so you may wish to use this meantime. The female in this position can easily direct the male's penis inside the vagina. After a few moments inside she can begin some gentle, rhythmic movements of her hips in a non-demanding way. She should not start some vigorous thrusting as this may be seen as being too demanding to begin with. If you wish, you can stop and separate without the male ejaculating and carry on with caressing each other. If you are both really enjoying the feelings that this movement produces, allow it to continue.

DO NOT feel that intercourse must go on to the male ejaculating or the female reaching a climax. The most important thing is your enjoyment of what is happening at the time - don't be concerned with what may be ahead.

So we don't necessarily have to complete intercourse ?

By this stage, it is essential that either of you can say "stop" at any point. In this way you avoid the feeling that once intercourse has started . you have to go on regardless. You are setting the limit for yourselves now. You can do this by saying "stop". Remember that even if you are enjoying lovemaking your partner may want to stop and needs to be able to without fearing that you will get angry. This is what a secure, safe sexual relationship is about - and when you feel really safe you'll probably want to carry on anyway !

So to begin with only the female should begin some gentle thrusting. If the male feels he would really like to move as well then of course he should. You can stop at any point you like as mentioned above. So don't feel you must go on to a climax - either for the male or the female. With increasing confidence, the male can play a more active

part if he wishes. When you feel more secure and happy with intercourse you can experiment with other positions if you wish. The movements of intercourse feel different in the different positions you can try. You should try to find the positions that suit you both. You may find one position nicer for one of you and another position better for the other. The lateral position (which may seem a little awkward and diffucult to sort out, is well worth the effort - particularly perhaps for the woman) may be a good one to try.

Your responsiveness will vary from session to session and month to month. This is normal for both sexes. Many women have slightly less lubrication and are less likely to reach a climax just before a period but this is not always the case. Many women enjoy stimulation of the clitoris by hand at the same time as the thrusting of the penis. This is normal and not a sign that they are not fully aroused.

Many women can also have a highly satisfactory and highly aroused sexual experience without a climax. It is an important rule to remember that provided physical contact is enjoyable, an orgasm (or climax) is not necessary. It is also a myth that a climax together is the ideal. Most people find it very pleasurable to enjoy the experience of their partner's climax, separate from their own - on other occasions they may enjoy coming together. These are all variations on the theme of making love and what you enjoy will depend on your feelings and state of mind at the time. The goal is to enjoy yourselves - together.

Answers to Quiz 1.

1. There is no uninvolved partner sexually. Although the man has the symptoms (the lack of adequate erections), the woman in most cases also gets caught up with "performance anxiety" and the "spectator's role" etc. The problem is learned and the woman too is a victim of this learning and she too will be inhibited by the difficulty. The most important point to accept is that the relationship between the man and the woman is "the patient" not either partner on his or her own. In other words, what is important is how you as a couple relate to each other in bed. (False).

2. Yes. The "spectator's role" refers to a tendency of the person to watch his own body for a response. In the case of the man, he may start to think about his penis and getting an erection, he checks whether his penis is getting erect or not and so on. It's as though he were mentally standing in a corner watching himself. This reaction is a common one for a couple with a sexual difficulty. Such thoughts are non-sexual; such thoughts are distracting and also make us feel anxious. Such thoughts then prevent us from feeling sexy and prevent erections too. (True).

3. Masturbation is not a recognised cause of sexual difficulties. If it were, then the vast majority of men and women would experience sexual problems. (False).

4. The male must learn to relax and so enjoy again sexual relations with his partner. She must therefore be present; both must communicate their feelings and give reassurance. She must therefore co-operate or treatment will not succeed. (False).

5. This booklet is not like a recipe book or a car workshop manual. Do not assume that if you rather mechanically carry out the exercises that all will be well. Sexual enjoyment involves more than a series of physical manoevres. You both must understand and accept the reasoning underlying therapy and each of you must know that the other understands and accepts this reasoning too. (False).

6. Definitely not. This is probably what you have been trying to do in the past. No man can will or force an erection any more than he could will or force his digestive processes to change. The only thing both of you should try to do is to focus all your attention on the nice feelings you get from each other. (False).

Answers to Quiz 2.

1. Mix unpleasant feelings with sexual activities and you will tend to associate these in the future. Mix pleasant feelings and sex and you will tend to associate these. Avoid having your sessions when either of you is tired, irritable or rushed. (False).

2. It may be quite normal for a man not to have an erection during this phase of sensate focus. The degree of stimulation is mild. The main point of sensate focus anyway is that you learn to relax and enjoy yourselves again.
   It will be in the context of this enjoyment that later, when sex can be more intimate, that orections will return. (False).

3. The main aim is to learn to enjoy being close sexually. This means learning to feel secure with each other and therefore, comfortable and relaxed sexually. When that happens, you will enjoy your sexual play and natural physical responses like an erection or the female's vagina lubricating will happen anyway in their own good time. We cannot and certainly should not try to force such responses. (False).

4. You should communicate about what is pleasurable and not pleasurable to you. Though some talking cannot be avoided, most of this communication need not be with words. Facial expressions, gestures, actions, sighs, moans etc are just as clear and indicate pleasure just as well. (False).

5. Sensate focus exercises should be pleasurable, irritation and discomfort are to be avoided. Only by notifying your partner when he or she causes you discomfort can he or she learn to avoid doing so. (True)

6. You should be as comfortable as possible and enjoy yourselves. This may involve moving about freely on your bed, - so do so if you wish. (False).

7. This early in the programme, it is best that you do not have intercourse during your sessions. Just allow yourselves to be totally involved in touching and being touched - no matter how ready either of you feel. (False).

Answers to Quiz 3.

1) Never aim to have an erection. In fact, we most enjoy our sexual play precisely when we don't have such aims. Try only to enjoy what you do together and that means taking the "pressure on performing" sexually out of your love making. (False)

2) The man should not feel he must do anything. Whatever each of you does is done because he or she wants to do it. So, only if he wishes, he may bring her to a climax. (False)

3) It is probably best not to have any specific goal or aim in mind at this point. The man may feel after all that he must have an erection if he believes that masturbation is to follow. Take it easy - don't put any "performance pressure" on yourselves. (False)

4) This is absolutely correct. Regard the breasts and genitals as just other parts of the whole body which you can now touch to get and give pleasure. (True)

5) In the same way as the man should not feel he must direct all his attention to his partner's vagina or breasts - so the women should not focus all her stimulation on his genitals - she can approach and move away from them as she pleases - just as she might any other part. (True)

6) For the time being, do not go on to have intercourse. No matter how "ready" either of you may feel, do not break the ban. You must learn not to break the trust between you. (False)

Answers to Quiz 4.

1) It is best to get used to the penis entering and remaining inside the vagina for a short while first. Do not feel you should go on to complete intercourse then. (False)

2) Take your time. Because of the time taken to move into the female-above, there may be a slight loss of sexual feeling for both the man and the woman. So spend some time caressing each other while in this position before the woman guides the penis inside. (False)

3) Many couples find the use of KY lubricating jelly or baby oil to be very satisfying especially when used on the genitals. It can help cut down any possible irritation. If, for some reason, either of you really does not like it, then that's o.k. (True)

4) Arousal, anyway, comes in waves. Both the man and the woman may find that their arousal comes and goes - with increasing and decreasing erections and vaginal responses. This is quite normal. A decline does not mean something is wrong - so don't get filled with "Perfomance Anxiety". Take your time and you will see that a lost erection can and will come back - but only if you relax and don't try to force anything. (False)

5) All men from time to time ejaculate quicker than they would like. Usually this will happen when the man has not had a sexual climax for a time. It may be quite normal for the man in this case to ejaculate soon after entry. That will probably sort itself out in time. So don't worry. (True)

6) No. About 15 seconds to begin with is fine. You can increase the length of time, with movement too, a little later. (False)

7) The loss of an erection when inside is probably just due to the fact that you may feel this is a "big step"; it could also be due to lack of much movement. Try to remember that any man may well lose his erection inside when there is little movement. Getting used to actual entry is a good start. Of course, if you wish, you can continue caressing after withdrawing the penis, but don't be tempted to keep the penis inside too long. (True)